AGENDA

FINANCE COMMITTEE

MEETING DATE: JULY 12, 2017
TIME: 11 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — **BERNARD ROSEN**

ADOPTION OF THE MAY 9, 2017 MINUTES

I. SENIOR VICE PRESIDENT'S REPORT — **P.V. ANANTHARAM**

II. FINANCIAL REPORTS STATUS

- **KEY INDICATORS** — **KRISTA OLSON**
- **CASH RECEIPTS AND DISBURSEMENTS** — **MICHLINE FARAG**

III. ACTION ITEM

- AUTHORIZING THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (THE "SYSTEM") TO ENTER INTO AN AGREEMENT WITH ST. GEORGES UNIVERSITY ("SGU") EFFECTIVE JULY 1, 2017 FOR THE SYSTEM TO ACCEPT AND FOR SGU TO SEND APPROXIMATELY 380 OF ITS THIRD AND FOURTH YEAR MEDICAL STUDENTS TO ROTATE AND RECEIVE TRAINING AT THE SYSTEM'S FACILITIES WHICH TRAINING IS STRUCTURED, PROVIDED AND ADMINISTERED BY STAFF OF SGU FOR WHICH SGU WILL PAY THE SYSTEM BOTH AN ANNUAL FEE PER SYSTEM FACILITY WHERE SGU STUDENTS ARE PLACED, AND A FEE PER STUDENT FOR EACH WEEK HE/SHE ROTATES THROUGH A SYSTEM FACILITY AS DETAILED IN THE EXECUTIVE SUMMARY ATTACHED WHICH WILL GENERATE INCOME TO THE SYSTEM OF APPROXIMATELY $12,105,600 PER YEAR WITH INCREASES OF3% PER YEAR STARTING IN 2019 FOR A TERM OF THREE YEARS WITH TWO, TWO-YEAR OPTIONS EXCLUSIVE TO THE SYSTEM.

DR. MACHELLE ALLEN

IV. ACTION ITEM

- AUTHORIZING NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (THE "SYSTEM") TO EXECUTE AN AGREEMENT WITH HURON CONSULTING GROUP INC. ("HURON") TO PROVIDE A REVENUE CYCLE OPTIMIZATION PROGRAM FOR THE ENTIRE SYSTEM OVER A 2-YEAR PERIOD, YIELDING ESTIMATED ONGOING ENHANCED ANNUAL REVENUE RANGE OF $130 AND $290 MILLION, , AND A ONE-TIME ANNUAL REVENUE

RECOVERY RANGE OF $30 AND 50 MILLION , FOR AN ESTIMATED TOTAL COMPENSATION TO HURON, NOT TO EXCEED $37 MILLION BASED ON THE ACHIEVEMENT OF PROGRAM MILESTONES.

PV ANANTHARAM, WILLIAM FOLEY

V. ACTION ITEM

- ADOPTING A SECOND REVISED STATEMENT OF BOARD POLICY FOR THE REVIEW AND AUTHORIZATION OF PROCUREMENT MATTERS ("SECOND REVISED STATEMENT") BY THE BOARD OF DIRECTORS (THE "BOARD") OF NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (THE "SYSTEM") IN THE FORM ATTACHED THAT SHALL BE EFFECTIVE AS OF AUGUST 1, 2017 SHALL BE BINDING UPON ALL EMPLOYEES AND OFFICERS OF THE SYSTEM AND DIRECTING THE PRESIDENT OF THE SYSTEM TO PREPARE AND ADOPT A REVISION OF OPERATING PROCEDURE 100-05 TO IMPLEMENT SUCH SECOND REVISED STATEMENT.

PAUL ALBERTSON

OLD BUSINESS
NEW BUSINESS
ADJOURNMENT **BERNARD ROSEN**

MINUTES

MEETING DATE: MAY 9, 2017

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on May 9, 2017 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Bernard Rosen
Stan Brezenoff
Mark Page
Emily Youssouf

OTHER BOARD MEMBER

Barbara Lowe

OTHER ATTENDEES

M. Elias, Analyst, IBO
J. DeGeorge, Analyst, Office of the State Comptroller
T. DeRubio, Analyst, OMB
M. Dolan, Senior Assistant Director, DC37
L. Garvey, Cerner Corporation
K. Kretz, PAGNY

HHC STAFF

P. Albertson, Vice President, Supply Chain Services
P.V. Anantharam, Senior Vice President/CFO, Corporate Finance
D. Ashkenase, AVP, Office of Medical & Professional Affairs (M&PA)
E. Barlis, AED, Jacobi
M. Beverley, Assistant Vice President, Corporate Finance
M. Brito, CFO, Coler/Carter Specialty Hospital & Nursing Facility
R. Colon-Kolacko, Senior Vice President & Chief People Officer
F. Covino, Senior Assistant Vice President, Corporate Budget
L. Dehart, Assistant Vice President, Corporate Reimbursement Services
M. Farag, Corporate Budget Director, Corporate Budget
S. Fass, Corporate Planning Services
R. Fischer, CFO, Bellevue

T. Green, CFO, Metropolitan Hospital Center
C. Hercules, Chief of Staff, Chairperson's Office
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
B. Keller, Legal
C. Keeley, Transformation
D. Koster, Director, Corporate Budget
P. Lockhart, Secretary to the Corporation, Office of the Chairman
A. Marengo, Senior Vice President, Corporate Communications/Marketing
K. Olson, Assistant Vice President, Corporate Budget
A. Pai, Chief of Staff to the SVP Finance/CFO, Corporate Finance
K. Park, CFO, Coney Island Hospital
C. Philippou, Planning
D. Rahman, Central Office, OIA
A. Saul, CFO, Kings County Hospital Center
J. Weinman, Corporate Comptroller, Corporate Finance
R. Wilson, Transformation

CALL TO ORDER **BERNARD ROSEN**

The meeting of the Finance Committee was called to order at 9:04 a.m. The minutes of the March 21, 2017 meeting were approved as submitted.

SENIOR VICE PRESIDENT'S REPORT **P.V. ANANTHARAM**

Mr. Anantharam noted that for the past month and a half, Health + Hospitals has been working diligently with OMB to update the plan, with the last update to the Committee being approximately a year ago. The Health + Hospitals plan is remarkably along the same lines as it was before. Mr. Anantharam ran through the major changes of the plan which was included in the meeting package.

The gaps were approximately where they were before in terms of the last time they were presented. The major changes are, as reported at the last Committee meeting, there is a decline in in-patient utilization and those declines in discharges are reflected in the revenue figures. Due to the diligent efforts of the finance offices in the facilities, Health + Hospitals has improved revenue collections. So, the net decline is where Health + Hospitals expected to be -- $70 million in discharge losses and an $80 million gain in revenue cycle improvements, including a reduction in Accounts Receivable (A/R) Days. There has been a target of $780 million in below the line initiatives that needed to be achieved, and this was exceeded by approximately $90 million, which gives Health + Hospitals the ability next year to have a better balance at the end of the year.

Mr. Anantharam reported that FY18 will still be a challenge, and Health + Hospitals rightsized the budget to reflect the new administration in Washington. Some of the items that were expected to be achieved are less likely to happen in the immediate future, but there are still intentions to pursue those ventures in FY19. Health + Hospitals made up those drops that had been expected through the waiver by increasing targets and efforts in revenue cycle and supply chain. The reduction of headcount also gives Health + Hospitals a better run rate for next year. Last year, the target had been 1,000. Through March, approximately 1,500 positions have been reduced with three more months remaining in the fiscal year. The City also agreed to postpone some City payments that had been expected to be made this fiscal year. The combination of all these efforts have put Health + Hospitals in a better position than expected. One last piece in the Financial Plan is that there are increased revenues from development opportunities in 2020 by $100 million and another $100 million in 2021, which brings Health + Hospitals back in line to where it was a year ago. The gaps are where Health + Hospitals expected them to be last year with minor charges to the discharges.

Mr. Rosen commented that there was a tremendous amount of work behind the nicely presented plan in the meeting package, and complimented the Finance group at Health + Hospitals that put it together. Mr. Rosen asked if the plan reflects potential cuts reflective of House bill legislation passed in Washington. Mr. Anantharam noted that the plan does not. Mr. Rosen reflected that the attrition plan is taking hold while acknowledging it was likely tough on hospitals and the staff running the hospitals.

Mr. Brezenoff asked if the disproportionate share was taken out of FY18. Mr. Anantharam noted that it was taken out and that the reason there is a gap in FY18 is that there is an assumption that the Feds will follow through in reducing the State allocation by approximately $225 million.

Ms. Youssouf asked why other supplemental payments had decreased dramatically and what those were. Mr. Anantharam answered the two main types of supplemental payments that are received are Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL). The numbers in FY17 are an accumulation of prior years payments so the FY17 payment was larger than normal. The decrease in FY18 is due to two things – the DSH reduction from Washington and the continuing transition from Fee For Service to managed care contributes to the decreasing capacity to claim UPL on discharges. The positive side is that if patient care is better managed in a managed care setting and in a risk arrangement, which Health + Hospitals is in for a bulk of its patients, then Health + Hospitals can retain revenue.

Ms. Lowe inquired about value-based payments which are enormous, and that Health + Hospitals has done well for a safety net hospital system. She noted that for FY18, Health + Hospitals should hold gains, did well on critical indicators, and asked if Health + Hospitals would continue to do so. Mr. Anantharam confirmed that Health + Hospitals did extremely well with the gaps that were being faced and significant skepticism to close that gap, and kudos to the Corporation and the City of New York for stepping up and helping Health + Hospitals to achieve a number of the revenue items that required negotiations with the State. He also noted that a number of the initiatives that were started this year will carry over to the next year which will give Health + Hospitals a run rate, while also pursuing additional items.

Ms. Youssouf asked for more discussion on why Federal and State Charity care was zeroed out in FY17 and then a slow and then big increase in the outyears. Mr. Anantharam noted that, a year ago, there had been plans to pursue an uninsured care program with the Federal government in which new dollars would be pursued to care for the uninsured to save Medicaid program dollars. This idea has been re-set because of the election outcome in November. This initiative is not being pursued in FY18, so $96 million was dropped. However, the initiative is important so it is being pursued in FY19 to help manage care and utilization in the system.

Ms. Youssouf asked about the assumption of $85 million in FY18 for Federal and State Charity Care. Mr. Anantharam answered that there are two items that are expected. Given the approval already received from the Feds for the $600M in State DSRIP allocation, there is an expectation to convert into a DSRIP type waiver of $33 million in FY18 and $100 million in FY19. Also, an equitable distribution of the $52 million in DSH cuts is being sought. Health + Hospitals receives DSH dollars after DSH has been distributed to others in the State. Therefore, if DSH is reduced, Health + Hospitals absorbs those cuts as the last recipient. The proposal is that the State budget has language included that allows it to reset the distribution in that the legislature can have the discussion. Consequently, Health + Hospitals would like to request the State relook at the cuts and ask for an equitable distribution of the $223 million cuts to try to save around $52 million.

After no further questions, Mr. Anantharam moved on to other reporting and noted that Health + Hospitals was doing well on cash due to Mr. Weiman's cash management oversight and making headway getting VBP/QIP and CREP dollars, receiving most of it with some more to come. Mr. Weiman reported that, as of April 14, the cash balance was $808 million, or 42 days, with the projected fiscal

year-end balance being $185 million. Health + Hospitals received $163 million in net Care Restructuring Enhancement Pilot (CREP) funds at the end of March as well as $96 million of Value Based Purchasing/Quality Improvement Programs (VBP/QIP) funds in the first week of May. Health + Hospitals is expecting to receive $153 million in UPL funds by the end of the year, $68 million in Indigent Care Adjustment (formerly known as Supp/SLIPA) by the end of May, and $32 million in Managed Care Enhancement by the end of May. With no further questions, the reporting was concluded.

KEY INDICATORS REPORT **KRISTA OLSON**

Ms. Olson began with utilization through March 2017, starting with acute care hospitals. Ambulatory care visits are down by 5.5%, which represents a further decline from the last report, when those visits were down by 3.2%. Drilling down, last year in February and March, the numbers were very high relative to the rest of that year. Typically, Health + Hospitals always sees an increase in March due to seasonality. March 2017 is high but down from last year. This will continue to be monitored, noting that in April last year, there had been a decline in visits. The declines for the most recent quarter are across the facilities and across nearly all services – including the emergency department, primary care, behavior health, and most specialties.

Inpatient discharges are down by 2.6%, compared to the last report when the discharges were down by 2.2%. The largest declines are at Kings County and Metropolitan, primarily in medicine and surgery, and across all payors. Increases continue at NCB - with increases in medicine as well as continued ramping of women's health services - and Queens (med/surg), and for both sites the improvement is across all payors. Voluntary hospitals are not experiencing the same declines, but rather their volume trends are flattening.

Ms. Youssouf asked if the voluntary hospitals are not experiencing any declines, and Ms. Olson noted this was a look at the overall average. Ms. Lowe asked if this should lead to more examination about whether the move to ambulatory care was being too aggressive, and Ms. Olson noted that ambulatory care was down as well. Mr. Anantharam stated that this does suggest more evaluation is required. Mr. Brezenoff stated that Health + Hospitals is looking into distinguishing between patients visits vs unique patients - if individuals were more stable in number, then care management efforts may be working. Ms. Lowe asked if the examination would find characteristics we were looking at. Ms. Youssouf asked if ER visits were included, and Ms. Olson answered yes in ambulatory care. Ms. Youssouf asked if everything was included in acute care hospitals, and Ms. Olson confirmed yes.

Average length of stay is comparing facilities against the system-wide average. Elmhurst and Kings County show the largest variance greater than the average. As mentioned previously, this is driven primarily by the discharge and transfer of a number of very long-staying patients out of the acute care setting into post-acute services as a coordinated effort to move them into a more appropriate and less expensive level of care. Lincoln, Metropolitan and NCB all show significant positive variances against the average. Finally, case mix index is up by 3.6% against last year at this time.

Gotham Diagnostic and Treatment Center visits continue to decline. Renaissance remains particularly steep, but declines are also quite large at Belvis and Cumberland, and notable at East New York and

Gouverneur as well. And continuing their positive trend, Post Acute Care services are up by 2.8%. Although primarily driven by the opening of new beds at Gouverneur, both Coler and Henry J Carter are showing positive increases in patient days as well.

Ms. Youssouf asked how Health + Hospitals' average length of stay compares with other hospitals. Ms. Olson noted that this was being looked into, and that Health + Hospitals is examining how to evolve this metric. The average length of stay is on par, but there may have to be an adjustment of the case mix index (CMI). For example, Bellevue has a high overall length of stay because the severity is higher.

Ms. Rosen noted that for the average length of stay, Health + Hospitals is holding its own. Ms. Olson stated in the past, Health + Hospitals had been higher but work had been done in terms of holding severity constant to allow for comparative analysis. Ms. Youssouf asked if the metric could be adjusted for CMI for the voluntaries, and Ms. Olson confirmed yes with SPARCS data.

Ms. Lowe asked if look at individuals could be in terms of continuum to determine of patients were being retained versus lost.

CASH RECEIPTS & DISBURSEMENTS REPORT **MICHLINE FARAG**

Ms. Farag reported that Global Full Time Equivalents (GFTE) through March 2017 have been reduced by 1,498, exceeding our fiscal year target and totaling a 2,470 GFTE decline since March 2016. For FY17, this translates into an annualized value of approximately $59 million. Mr. Anantharam noted that the expected reduction through June had already been met by March. Ms. Youssouf asked what the headcount figure included, and Ms. Farag noted it included staff, overtime, temps, and hourlies. For this fiscal year through March, receipts were $59.9 million less than budgeted, and disbursements were $14.9 million higher than budgeted.

Looking at current FY 17 actuals through March compared to the same period in FY 16 for both receipts and disbursements, receipts this fiscal year-to-date are on track with a $3.8 million difference. Patient revenue is higher this fiscal year to date than last year, by $60.3 million due to a larger Managed Care risk pool distribution received in FY 17, that amount is partially offset by this year having 1 less week through March in Fee For Service payments. Ms. Youssouf requested clarification on the $60.3 million in terms of the calculation. Ms. Farag noted that it was the total of in-patient and out-patient receipts in the last column of page 3. Mr. Rosen noted Health + Hospitals was down in in-patient and better in out-patient.

Disbursements are $412.6 million lower this fiscal year of which $309 million of that is a payment made to the City in FY16 for FY14. The remaining balance still leaves a spend in FY17 that is $103 million lower than FY16 thru March. The PS savings are reflected here.

Ms. Youssouf noted that outpatient was better than in-patient, with there being a big swing in grants. Ms. Farag noted this was due to a city subsidy received in FY16 for FY17 which was a prepayment last year.

The variance in receipts against budgeted is down to $59 million, which is almost half of the $117 million variance since the last report. This reflects the improvement in revenue collection as implementation of revenue cycle initiatives continue. Mr. Anantharam noted that all of Ms. Katz's work and the facility finance leads work on revenue has yielded very good results with A/R days down to around 68 days. Although pushing for further increases in revenue, there will be an impact on receipts from the decline in utilization.

For disbursements, Health + Hospitals continues to track closely to budgeted levels and are expected to get better as Global FTE reductions annualize on the PS dollars side. Mr. Rosen noted that as Health + Hospitals is dealing on a cash basis, distortions will occur.

INFORMATION ITEM **KRISTA OLSON**

PAYOR MIX REPORTS (INPATIENT, ADULT AND PEDIATRICS – 3rd QUARTER)

Ms. Olson reported that this is a third quarter report for January through March. Starting with Inpatient, Medicaid remains down slightly compared with FY16 at this time – driven entirely be a decline in Fee for Service that has not been entirely offset by the increase in Managed Care. Medicare plans are up slightly, driven by increases in Medicare Managed Care. Uninsured is up by 8/10ths of a percentage point – this is improved compared to reports earlier in the year showing, but still of concern. There was a survey was conducted over the last few months to understand some of the underlying causes. The survey confirmed that staffing is an issue, and Health + Hospitals is looking at ways to address this.

Mr. Page asked about the staffing issues. Ms. Olson answered that, for in-patient, the staff do applications while clients are in-house. Due to attrition, some facilities are experiencing shortages. With the headcount target met, Health + Hospitals is looking into staffing, training and engagement for staff, education about insurance, as well as patient documentation issues. Mr. Anantharam noted that all of these issues are being examined, and, as Ms. Olson stated, includes maximizing the in-patient time spent in the facilities. There is anecdotal examples of patients not wanting to give documentation due to immigration status. Ms. Youssouf asked if this was in-patient or out-patient, and Ms. Olson confirmed in-patient with variation at facilities. There are continued efforts around the uninsured, including trying to bring facilities down closer to the average.

Ms. Youssouf asked if Emergency Medicaid covered the uninsured. Mr. Anantharam noted that the uninsured without resources can be converted onto Emergency Medicaid or other qualified health plans. Ms. Youssouf asked if the undocumented can receive Emergency Medicaid. Mr. Anantharam noted that Health + Hospitals have had a number of undocumented covered by Emergency Medicaid.

Ms. Youssouf asked if Health + Hospitals knew the dollar amount connected to the uninsured. Mr. Anantharam noted that a back of the envelope calculation assuming an average of $6,000-12,000/case would yield about $60 million. Ms. Olson noted that there had been a historical look at this, and about a 1% increase in coverage for the uninsured would yield approximately $25 million over the course of a year.

Mr. Page asked if there was anything in particular in their circumstances with Lincoln or Coney Island with low percentages of uninsured, how they are collecting information and pushing it through versus the hospitals with high percentages in terms of enrollment activity. Ms. Olson stated that this has been looked at before, and a survey had been conducted. There may be difference in processes that might be able to be standardized across the system. For example, Bellevue gets patients from across the city, so documentation may be more difficult to obtain when patients are not in the facility locale. Mr. Anantharam noted that Health + Hospitals could dig deeper on differences and opportunities, including on work processes.

Ms. Youssouf asked if there was any data about the percentage of tourists, which New York City hosts a lot of, that were uninsured in facilities, with Bellevue likely treating some of them. Mr. Anantharam noted that it was unclear if there was data that noted that kind of indicator. Ms. Youssouf stated that perhaps knowing that percentage, Health + Hospitals may be able to calculate a number that will never be able to get insured or funds for.

Mr. Brezenoff stated that, broadly speaking, this is part of the revenue cycle work with ambitious targets. Some of the work can have particularized routes and some that have to be ascertained as to what is possible to achieve it, the tourist data is the latter. There must be all hands on deck to meet revenue targets.

Ms. Olson reported that outpatient adults are also down in Medicaid, again entirely in Fee for Service. Medicare plans are up one percentage point, and Commercial is up by .5%. Uninsured is down slightly, but not significantly compared to FY 16.

Ms. Youssouf asked, for outpatient adults and the uninsured total, what is the number at voluntary hospitals. Mr. Anantharam noted that Health + Hospitals could try to look for data at safety net hospitals. Mr. Anantharam recalled data that Health + Hospitals served about 50% of uninsured outpatients and about 75% of emergency care. Ms. Youssouf asked if data is available on emergency room visits. Ms. Olson stated that the data could be run, and has been on an ad hoc basis.

Outpatient pediatrics similarly shows a slight decline in Medicaid, with an increase in Commercial. Uninsured is down by 6/10ths of a percentage point. Please note for the record, the March report misreported an increase in the Child Health Plus payor mix in the second quarter. The numbers for CHP and non-CHP had been transposed. The overall increase in Commercial remains the same, and this quarter's report has been updated correctly.

Mr. Brezenoff noted that serving the uninsured is reflective of Health + Hospitals mission. If uninsured ambulatory care visits increase, it may be reflective of continuity of care in the ambulatory setting. Voluntaries likely do episodic care or urgent care. But the voluntaries likely do not have continuity of care – organized and continuous in an ambulatory setting like Health + Hospitals which sets us apart.

Ms. Youssouf noted that if there could be a comparison of emergency room visits, with more data and specifics, that it could be utilized to advocate in Washington for funds.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 9:51 a.m.

KEY INDICATORS
FISCAL YEAR 2017 UTILIZATION

Year to Date
May 2017

	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES						
	FY 17	FY 16	VAR %	FY 17	FY 16	VAR %	ACTUAL	EXPECTED	FY 17	FY 16
Acute										
Bellevue	522,855	553,333	-5.5%	20,309	21,110	-3.8%	6.4	6.5	1.2478	1.1770
Coney Island	288,791	310,984	-7.1%	12,541	13,128	-4.5%	6.5	6.1	1.0069	1.0299
Elmhurst	541,655	564,540	-4.1%	16,434	17,047	-3.6%	6.6	5.8	1.0076	0.9610
Harlem	272,951	287,172	-5.0%	10,788	11,104	-2.8%	5.6	5.6	0.9360	0.9503
Jacobi	375,049	385,716	-2.8%	16,573	16,399	1.1%	6.3	6.5	1.1007	1.0722
Kings County	602,518	619,061	-2.7%	17,878	19,057	-6.2%	6.7	6.0	1.0361	1.0276
Lincoln	479,999	504,729	-4.9%	19,697	20,203	-2.5%	5.1	5.8	0.9616	0.8716
Metropolitan	337,189	365,209	-7.7%	8,527	9,079	-6.1%	4.8	5.5	0.9665	0.8707
North Central Bronx	187,826	197,488	-4.9%	6,116	5,967	2.5%	4.2	4.7	0.6987	0.7028
Queens	361,194	367,188	-1.6%	11,655	11,209	4.0%	5.0	5.1	0.8038	0.8323
Woodhull	398,737	438,610	-9.1%	9,645	9,784	-1.4%	5.2	5.5	0.9325	0.8952
Acute Total	**4,368,764**	**4,594,030**	**-4.9%**	**150,163**	**154,087**	**-2.5%**	**5.9**	**5.9**	**1.0072**	**0.9755**
Gotham	VISITS									
Belvis DTC	45,761	51,182	-10.6%							
Cumberland DTC	57,533	63,872	-9.9%							
East New York	70,309	75,279	-6.6%							
Gouverneur DTC	212,410	226,772	-6.3%							
Morrisania DTC	73,286	74,501	-1.6%							
Renaissance	31,539	38,732	-18.6%							
Gotham Total	**490,838**	**530,338**	**-7.4%**							
Post Acute Care				DAYS						
Coler				247,043	238,324	3.7%				
Gouverneur SNF				74,652	68,747	8.6%				
H.J. Carter				105,702	102,713	2.9%				
McKinney				103,244	103,939	-0.7%				
Seaview				100,413	99,962	0.5%				
Post Acute Care Total				**631,054**	**613,685**	**2.8%**				
Discharges/CMI-- All Acutes				**150,163**	**154,087**	**-2.5%**			**1.0072**	**0.9755**
Visits -- All DTCs & Acutes	**4,859,602**	**5,124,368**	**-5.2%**							
Days-- All SNFs				**631,054**	**613,685**	**2.8%**				

Utilization

Discharges: exclude psych and rehab

Visits: Beginning with the November 2015 Board Report, FY16 and FY17 utilization is now based on date of service, and includes open visits. HIV counseling visits that are no longer billable have been excluded. Visits continue to include Clinics, Emergency Department and Ambulatory Surgery. LTC: SNF and Acute days

Average Length of Stay

Actual: days divided by discharges; excludes one day stays

Expected: weighted average of DRG specific corporate average length of stay using APR-DRGs

All Payor CMI

Acute discharges are grouped using New York State APR-DRGs version 32

KEY INDICATORS

FISCAL YEAR 2017 BUDGET PERFORMANCE ($s in 000s)

Year to Date May 2017

	GLOBAL FTEs			RECEIPTS		DISBURSEMENTS		BUDGET VARIANCE	
	Jun 16	May 17*	Target	actual	better / (worse)	actual	better / (worse)	better / (worse)	
Acute									
Bellevue	5,817	5,557	5,609	$ 665,922	$ (10,521)	$ 737,393	$ (15,416)	$ (25,937)	-1.9%
Coney Island	3,180	3,054	3,050	$ 281,822	16,555	374,463	299	16,854	2.6%
Elmhurst	4,493	4,247	4,333	$ 473,712	26,260	517,411	(4,843)	21,416	2.2%
Harlem	3,086	2,924	2,976	$ 305,871	(8,792)	345,602	2,045	(6,747)	-1.0%
Jacobi	4,141	4,022	4,064	$ 493,803	(348)	531,058	(12,541)	(12,888)	-1.3%
Kings County	5,381	5,143	5,249	$ 620,166	(27,123)	622,801	11,406	(15,717)	-1.2%
Lincoln	4,278	4,024	4,084	$ 469,429	(477)	471,309	(1,952)	(2,430)	-0.3%
Metropolitan	2,606	2,501	2,515	$ 242,727	(22,344)	297,642	(187)	(22,531)	-4.0%
North Central Bronx	1,423	1,374	1,389	$ 148,866	(4,605)	170,568	(6,151)	(10,755)	-3.4%
Queens	2,949	2,848	2,854	$ 331,184	13,029	343,609	(3,271)	9,758	1.5%
Woodhull	3,051	2,896	2,915	$ 333,854	(8,879)	366,161	9,731	852	0.1%
Acute Total	40,405	38,590	39,037	$ 4,367,353	$ (27,245)	$ 4,778,017	$ (20,880)	$ (48,125)	-0.5%
Gotham									
Belvis DTC	136	130	132	$ 15,764	$ (111)	$ 14,356	$ 626	$ 515	1.7%
Cumberland DTC	218	205	201	$ 16,937	3,405	27,292	(1,076)	2,329	5.9%
East New York	237	212	221	$ 21,675	(410)	22,325	1,868	1,458	3.2%
Gouverneur DTC	475	451	454	$ 41,285	(3,065)	51,105	3,007	(58)	-0.1%
Morrisania DTC	257	234	240	$ 22,843	401	25,087	642	1,043	2.2%
Renaissance	170	167	162	$ 11,650	2,348	18,808	(13)	2,335	8.3%
Gotham Total	1,493	1,399	1,411	$ 130,153	$ 2,568	$ 158,973	$ 5,054	$ 7,622	2.6%
Post Acute Care									
Coler	1,161	1,086	1,089	$ 58,763	$ 3,563	$ 118,581	$ 8,235	$ 11,798	6.5%
Gouverneur SNF	389	364	372	$ 25,117	(9,483)	41,813	3,359	(6,124)	-7.7%
H.J. Carter	979	909	933	$ 119,610	8,550	113,421	1,280	9,830	4.4%
McKinney	455	441	457	$ 26,401	(6,334)	43,006	3,236	(3,099)	-3.9%
Seaview	529	535	539	$ 32,763	362	49,531	7,930	8,293	9.2%
Post Acute Care Total	3,513	3,335	3,390	$ 262,655	$ (3,341)	$ 366,352	$ 24,040	$ 20,699	3.2%
Central Office	852	1,029	1,045	$ 1,171,226	10,050	329,274	(5,933)	4,117	0.3%
Care Management	440	381	373	$ 27,110	(10,586)	41,677	(1,091)	(11,677)	-14.9%
Enterprise IT/Epic	1,178	1,147	1,175	$ 8	0	213,887	3,420	3,420	1.6%
GRAND TOTAL	**47,881**	**45,881**	**46,431**	**$ 5,958,506**	**$ (28,554)**	**$ 5,888,181**	**$ 4,610**	**$ (23,944)**	**-0.2%**

*Actual Global FTEs have dropped by 2,277 since May 2016.

Global Full-Time Equivalents (FTEs) include HHC staff and overtime, hourly, temporary and affiliate FTEs. Enterprise IT includes consultants.

Care Management includes HHC Health & Home Care and the Health Home program.

NYC Health + Hospitals
Cash Receipts and Disbursements (CRD)
Fiscal Year 2017 vs Fiscal Year 2016 (in 000's)
TOTAL CORPORATION

	Month of May 2017			Fiscal Year To Date May 2017		
	actual 2017	actual 2016	better / (worse)	actual 2017	actual 2016	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 59,563	$ 55,995	$ 3,567	$ 646,312	$ 756,271	$ (109,959)
Medicaid Managed Care	65,538	66,524	(986)	700,478	674,659	25,819
Medicare	31,931	42,548	(10,617)	443,222	478,222	(35,000)
Medicare Managed Care	33,922	25,493	8,429	307,997	293,165	14,833
Other	26,817	17,667	9,150	227,672	197,096	30,575
Total Inpatient	$ 217,770	$ 208,227	$ 9,543	$ 2,325,681	$ 2,399,413	$ (73,732)
Outpatient						
Medicaid Fee for Service	$ 10,789	$ 16,047	$ (5,258)	$ 113,980	$ 144,923	$ (30,944)
Medicaid Managed Care	26,216	33,176	(6,960)	504,844	487,330	17,514
Medicare	6,406	5,569	837	60,594	50,958	9,636
Medicare Managed Care	6,714	10,460	(3,746)	139,976	118,932	21,044
Other	14,414	13,026	1,388	187,010	149,126	37,883
Total Outpatient	$ 64,540	$ 78,279	$ (13,739)	$ 1,006,402	$ 951,269	$ 55,133
All Other						
Pools	$ (2,406)	$ 81,629	$ (84,036)	$ 286,085	$ 304,348	$ (18,263)
DSH / UPL	-	-	0	1,625,729	1,467,007	158,722
Grants, Intracity, Tax Levy	402,742	19,359	383,384	584,780	641,822	(57,041)
Appeals & Settlements	33,142	4,492	28,649	62,680	52,174	10,505
Misc / Capital Reimb	6,121	5,761	359	67,148	77,895	(10,748)
Total All Other	$ 439,598	$ 111,241	$ 328,357	$ 2,626,422	$ 2,543,247	$ 83,175
Total Cash Receipts	**$ 721,908**	**$ 397,748**	**$ 324,161**	**$ 5,958,506**	**$ 5,893,928**	**$ 64,577**
Cash Disbursements						
PS	$ 200,281	$ 201,395	$ 1,115	$ 2,495,030	$ 2,499,432	$ 4,402
Fringe Benefits	71,626	81,178	9,552	944,355	1,013,675	69,320
OTPS	117,501	116,597	(904)	1,353,227	1,314,030	(39,197)
City Payments	-	-	0	-	309,405	309,405
Affiliation	104,531	82,182	(22,348)	1,014,604	958,247	(56,357)
HHC Bonds Debt	6,861	6,865	4	80,965	81,701	736
Total Cash Disbursements	**$ 500,799**	**$ 488,217**	**$ (12,582)**	**$ 5,888,181**	**$ 6,176,491**	**$ 288,310**
Receipts over/(under) Disbursements	**$ 221,109**	**$ (90,469)**	**$ 311,578**	**$ 70,325**	**$ (282,562)**	**$ 352,887**

NYC Health + Hospitals
Actual vs Budget Report
Fiscal Year 2017 (in 000's)
TOTAL CORPORATION

	Month of May 2017			Fiscal Year To Date May 2017		
	actual 2017	budget 2017	better / (worse)	actual 2017	budget 2017	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 59,563	$ 60,613	$ (1,051)	$ 646,312	$ 706,939	$ (60,627)
Medicaid Managed Care	65,538	65,207	331	700,478	726,375	(25,897)
Medicare	31,931	36,832	(4,901)	443,222	436,847	6,375
Medicare Managed Care	33,922	29,285	4,637	307,997	303,308	4,690
Other	26,817	18,824	7,993	227,672	198,459	29,213
Total Inpatient	$ 217,770	$ 210,760	$ 7,010	$ 2,325,681	$ 2,371,928	$ (46,247)
Outpatient						
Medicaid Fee for Service	$ 10,789	$ 9,178	$ 1,612	$ 113,980	$ 108,772	$ 5,207
Medicaid Managed Care	26,216	35,110	(8,894)	504,844	553,618	(48,774)
Medicare	6,406	7,478	(1,071)	60,594	65,630	(5,036)
Medicare Managed Care	6,714	7,960	(1,246)	139,976	121,395	18,580
Other	14,414	11,377	3,038	187,010	164,051	22,959
Total Outpatient	$ 64,540	$ 71,102	$ (6,562)	$ 1,006,402	$ 1,013,466	$ (7,063)
All Other						
Pools	$ (2,406)	$ (2,064)	$ (342)	$ 286,085	$ 284,108	$ 1,977
DSH / UPL	-	-	0	1,625,729	1,625,729	0
Grants, Intracity, Tax Levy	402,742	401,797	945	584,780	578,544	6,237
Appeals & Settlements	33,142	37,518	(4,377)	62,680	41,676	21,004
Misc / Capital Reimb	6,121	6,260	(139)	67,148	71,609	(4,462)
Total All Other	$ 439,598	$ 443,511	$ (3,913)	$ 2,626,422	$ 2,601,666	$ 24,756
Total Cash Receipts	**$ 721,908**	**$ 725,374**	**$ (3,465)**	**$ 5,958,506**	**$ 5,987,060**	**$ (28,554)**
Cash Disbursements						
PS	$ 200,281	$ 205,411	$ 5,130	$ 2,495,030	$ 2,493,840	$ (1,190)
Fringe Benefits	71,626	71,359	(267)	944,355	940,727	(3,628)
OTPS	117,501	121,425	3,924	1,353,227	1,358,352	5,125
City Payments	-	-	0	-	-	0
Affiliation	104,531	105,280	750	1,014,604	1,010,996	(3,608)
HHC Bonds Debt	6,861	8,307	1,446	80,965	88,876	7,911
Total Cash Disbursements	**$ 500,799**	**$ 511,782**	**$ 10,983**	**$ 5,888,181**	**$ 5,892,791**	**$ 4,610**
Receipts over/(under) Disbursements	**$ 221,109**	**$ 213,591**	**$ 7,518**	**$ 70,325**	**$ 94,269**	**$ (23,944)**

RESOLUTION authorizing the New York City Health and Hospitals Health and Hospitals Corporation (the "System" to enter into an agreement with St. Georges University ("SGU") effective July 1, 2017 for the System to accept and for SGU to send agreed upon numbers of its third and fourth year medical students to rotate and receive training at the System's facilities which training is structured, provided and administered by staff of SGU for which SGU will pay the System both an annual fee per System facility where SGU students are placed, and a fee per student for each week he/she rotates through a System facility as detailed in the Executive Summary attached which will generate income to the System of approximately $12,105,600 per year with increases of 3% per year starting in 2019 for a term of three years with two, two-year options exclusive to the System.

WHEREAS, SGU, based in Grenada and with more than 7,700 students, is the largest and best known of the Caribbean medical schools that train medical doctors in the United States; and

WHEREAS, the System contracted with SGU in 2007 for a five-year term with a five-year option that will expire July 30, 2017 based on a one-month extension; and

WHEREAS, under the prior contract, SGU sent its third and fourth year medical students to observe and rotate through the System's facilities as part of their medical training; and

WHEREAS, the relationship between the System and SGU has been mutually beneficial in that many SGU medical students have gone on to work within the System after graduation (including some who receive scholarships conditioned on such service), they have assisted in the operation of the System during their training and the SGU students have gained valuable medical training and experience enabling them to become valuable contributors to the medical profession; and

WHEREAS, the System has conducted a detailed analysis of the cost to the System in staff time of assisting with the education of the SGU students and of the number of students that the System can accommodate consistent with its primary mission of providing health care to New Yorkers; and

WHEREAS, the System management has determined that SGU must increase its fees to the System from those payable under the expiring contract and have the capacity to reduce the number of its students to properly reflect the costs to the System and the System's ability to accommodate students; and

WHEREAS, the System will continue to participate in the medical education of students of the System's academic medical affiliates such as New York University School of Medicine and Icahn School of Medicine at Mt. Sinai; and

WHEREAS, the responsibility for the administration of the proposed contract with SGU shall reside with the Senior Vice President and Chief Medical Officer.

IT IS THEREFORE RESOLVED, that the New York City Health and Hospitals Health and Hospitals Corporation (the "System") shall be and hereby is authorized to enter into an agreement with St. Georges University ("SGU") effective July 1, 2017 for the System to accept and for SGU to send agreed upon numbers of its third and fourth year medical students to rotate and receive training at the System's facilities which training is structured, provided and administered by staff of SGU for which SGU will pay the System both an annual fee per System facility where SGU students are placed, and a fee per student for each week he/she rotates through a System facility as detailed in the Executive Summary attached which will generate income to the System of approximately $12 Million per year with increases of 3% per year starting in 2019 for a term of three years with two, two-year options exclusive to the System.

EXECUTIVE SUMMARY

RESOLUTION AUTHORIZING A MEDICAL TRAINING AGREEMENT WITH ST. GEORGE'S UNIVERSITY

BACKGROUND: St. George's University ("SGU") is a 40 year old medical school based in Grenada which has grown to have more than 7,700 students, most of whom come from the United States. New York City Health and Hospitals Corporation (the "System") has had a system-wide relationship with SGU since 2007 by which the System's facilities participate in the medical training of SGU third and fourth year medical students. The relationship has been helpful to the System because SGU students have assisted in the operation of the System's facilities (under appropriate supervision) and many of them have come to work within the System after they graduated. For the SGU students, the training they receive at the System's facilities has been an essential and necessary part of their medical education.

The System has long-term medical affiliations with NYU and Mt. Sinai both of which operate prestigious medical schools. An important part of that relationship is that those affiliates' students also rotate through the System's facilities as part of their education. Such arrangements have generally co-existed with the SGU program and will continue to do so. The System hospitals with doctors supplied by NYU or Mt. Saini will continue to have most of their students drawn from those two academic medical institutions.

Despite the benefit the System derived from the 2007 contract with SGU, a careful analysis of the program has indicated that SGU must increase its fees to the System and the System must have the ability to limit the number of students it sends to rotate through the System's facilities. In FY 2016, SGU paid to the System a total of approximately $9,433,138 including both a fee per facility and a weekly rotation fee based on 380 students participating in the SGU program at the System's facilities. The System has determined that a renewal of the SGU agreement would be acceptable only if the payments were increased, the System were to gain the ability to reduce the number of students and exercise control of the program from the System's Central Office rather having such control distributed to the individual facilities.

NEED: The United States needs more doctors than are currently graduated from U.S. based medical schools and there are more students qualified to train to be doctors in the United States then there are slots for them at U.S. based medical schools. Accordingly, a number of medical schools have developed in the Caribbean to fill the gaps.

PROGRAM: SGU is responsible for the administration of the Program, including the curriculum content, the requirements of matriculation, grading, graduation and faculty appointments. SGU shall provide a Director of Medical Education, Clerkship Director and Clerkship Coordinator to ensure that the Program is properly administered with the necessary support for the students and the NYC Health + Hospital staff. The System is responsible for accommodating the rotation of SGU students through the System facilities, giving them access to the System's patients

under appropriate System staff supervision and participating in the clinical training and education of the SGU students.

FINANCIAL TERMS: SGU will pay an annual fee to the System of $500,000 for each System facility with 24 or more SGU students. For facilities with 12 to 23 students, the fee will be not less than $250,000 which shall increase by $20,000 per student over 12 and up to 23 students. It is not anticipated that facilities will have fewer than 12 students but if this should be the case, the parties will discuss an equitable reduction of the fee provided that the fee for NYC Health + Hospitals/Metropolitan which falls into this category shall generate an annual fee of $200,000. These facility fees are anticipated to generate approximately $3,200,000 annually.

SGU will also pay a weekly fee of $575 for each student that rotates through the System facilities. These rotation fees are anticipated to generate approximately $8,905,600.

The fees payable by SGU to the System will increase by 3% annually.

The total anticipated SGU annual revenue will be approximately $12,105,600. In FY 2016, the last year for which full figures are available, the comparable annual revenue was $9,433,138. Thus the proposed contract will increase the revenue from SGU by approximately 28%.

SCHOLARSHIPS: SGU will award two full scholarships per participating System facility to students who pledge to work within the System after graduation. This represents a doubling of the number of such scholarships over that previously awarded.

EXCLUSIVITY: As with the prior SGU agreement, the System will not allow students from other foreign medical schools to train at the System's facilities without the approval of SGU.

RIGHT OF FIRST REFUSAL: The System will give to SGU a right of first refusal to make a new medical training agreement with a foreign medical school.

RIGHT OF TERMINATION: The Corporation and SGU shall each have the right to terminate the agreement on six months' notice.

SYSTEM RIGHT TO REDUCE THE NUMBER OF STUDENTS: The System shall have the right to require a reduction of the total number of students on six months' notice provided that if SGU is not able, following good faith efforts, to place any students who would lose their slots in the System's facilities in other medical facilities to continue their training, then the System shall continue the training of such students for up to another six months. Initially SGU will be able to send 380 students as is currently the case.

RESOLUTION

Authorizing New York City Health and Hospitals Corporation (the "System") to execute an agreement with Huron Consulting Group Inc. ("Huron") to provide a Revenue Cycle Optimization Program for the entire System over a 2-year period, yielding estimated ongoing enhanced annual revenue range between $130 and $290 million, and a one-time annual revenue recovery range between $30 and $50 million, for an estimated total compensation to Huron, not to exceed $37 million based on the achievement of program milestones.

WHEREAS, as part of the System's ongoing transformation it is necessary to optimize and improve revenue cycle operations and performance to ensure the ongoing financial health of the System; and

WHEREAS, an assessment by Huron of current performance indicates an opportunity for a range of revenue recovery between $70 – 150 million in FY 18, with an ongoing revenue recovery range between $130 and $290 million annually; and

WHEREAS, Huron was prequalified through an open competitive process to provide training, process re-design, implementation and establish governance and quality control structures in the area of Revenue Cycle from among six pre-qualified consultants; and

WHEREAS, Huron is considered the industry leader in revenue cycle performance improvement consulting with a track record of improving revenue at major health systems across the nation and has done considerable prior work for health systems in New York City; and

WHEREAS, the proposed contract for Huron's services will be managed jointly by the Senior Vice President for Acute and Ambulatory Care Services and the Senior Vice President for Finance/Chief Financial Officer who shall share responsibility for ensuring that the work of Huron is properly coordinated.

NOW THEREFORE BE IT:

RESOLVED, that New York City Health and Hospitals Corporation be and hereby is authorized to enter into a contract with Huron Consulting Group Inc., to provide Revenue Cycle optimization services over a 24 month period for an amount not to exceed $37 million based on the achievement of program milestones.

EXECUTIVE SUMMARY
RESOLUTION TO AUTHORIZE CONTRACT
WITH HURON CONSULTING GROUP

BACKGROUND: The purpose of this engagement will be to optimize the Revenue Cycle for New York City Health and Hospitals. Revenue Cycle refers to the process of collecting revenue for patient care. It is a "cycle" because it involves the journey of a patient bill through multiple stages from pre-authorization, before the patient arrives, to collection, after the patient has been discharged. At Health and Hospitals, approximately $3.1 billion in net patient service revenue go through this process every year, and the accuracy and dependability of people, processes and systems can have a very significant impact on the overall financial performance of the organization.

Major health systems including NY Presbyterian, Mt Sinai and NorthWell have engaged revenue cycle consulting groups for large scale turnaround projects involving the re-alignment of financial services processes to ensure optimal revenue collection.

It should be noted that in May 2017 the Board of Directors authorized Health and Hospitals to embark on a program for the installation of the Epic Revenue Cycle modules including implementation, configuration and installation of the software modules; the necessary hardware; as well as software and hardware maintenance. This project addressed the IT system that will be used for an optimal revenue cycle process.

NEED: Due to flaws in coding, billing, collection and management of denials of claims by third party payors, the System currently is not able to collect enough of the revenue available to compensate for care provided to patients with insurance. It is essential that the System optimize its revenue, within regulatory bounds, to finance its operations. We anticipate ongoing enhanced annual revenue between the range of $130 and $290 million, and a one-time annual revenue recovery between the range of $30 and $50 million.

PROCUREMENT: NYC Health + Hospitals issued a Request for Proposals to identify and pre-qualify consultants within fifteen different scopes of work all of which relate to the Transformation of the System now underway. From the many proposals received, generally 5 – 7 vendors within each scope of work were selected by Selection Committees that evaluated the vendors based on written submissions. The Contract Review Committee reviewed the pre-qualification procedure used and the pre-qualification selections made and approved of both. Pursuant to a written procedure proposed by the SVP/Chief Financial Officer and the SVP/Chief Transformation Officer and accepted by the Interim President applicable to all work orders for particular Transformation services using firms pre-qualified as described above, the proposed consulting services were described to six firms prequalified to perform Revenue Cycle related training, process design and implementation of governance and quality control structures. Huron was one of such firms. The six firms made competing proposals including cost proposals. A Selection Committee evaluated the proposals, scored them and on the basis of both

price and appropriateness, selected Huron. In accordance with the adopted procedure, that selection and the cost of the contract was presented to an Approval Committee that must approve all Transformation consulting contracts using the pre-qualified pool of consultants. The Approval Committee consists of the Interim President, SVP/Chief Financial Officer and the SVP/Chief Transformation Officer. The Approval Committee approved the selection of Huron. Being as the contract price exceeds the Board's threshold for review, the contract is being presented to the Board of Directors for approval.

TERMS: The System will pay an amount not to exceed $37 million, inclusive of expenses, over a two year period. Payments will be tied to the achievement of identified milestones critical to the success of the project and the realization of the projected revenue enhancements.

NYC HEALTH+ HOSPITALS

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Keith Tallbe
Associate Counsel, Director of Procurement
Legal Affairs, Supply Chain Services

31590A

TO: Mitchell Jacobs, Director
Procurement System Operations
Division of Materials Management

FROM: Keith Tallbe KT

DATE: April 4, 2017

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Huron Consulting Services LLC,** has submitted to the Supply Chain Diversity Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Central Office

Contract Number: _____

Project: Consulting Services for Transformation

Submitted by: Division of Materials Management

EEO STATUS:

1. [X] Approved

2. [ ] Conditionally Approved with follow-up review and monitoring

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

KT:srf

Revenue Cycle Optimization

July 12, 2017

REVENUE CYCLE OPTIMIZATION

INTRODUCTION

- Revenue cycle describes the process of collecting revenue for patient care. Approximately $3.1 billion in net patient service revenue are affected by revenue cycle annually at Health and Hospitals.

- Major health systems including NY Presbyterian, Mt Sinai, and Northwell have employed revenue cycle optimization as a key financial strategy to increase revenue.

- After a competitive bid process, Huron Consulting was chosen from among six pre-qualified consultants to perform a 4 week assessment of revenue cycle operations at NYC Health and Hospitals.

- The assessment shows that optimization of revenue cycle processes at Health and Hospitals will require a major turnaround project to achieve sustainable results.

- A successful turnaround project of Health and Hospital's revenue cycle operations will yield additional revenue in the range of $130 - $290 million annually.

ASSESSMENT FINDINGS

SUMMARY ASSESSMENT FINDINGS

Despite motivated and dedicated individuals, inadequate staffing, fragmented technology, and disjointed processes have led to significant opportunities for standardization and improved financial performance.

	Rating	Findings
People		+ Revenue cycle operating model creates lack of accountability and alignment between system and local priorities + Divisions between inpatient and outpatient operating model lead to poor A/R coverage + Lack of staffing in key functions + Lack of performance standards causes inefficient and unpredictable operations
Process		+ Significant manual, paper-based processes lead to an inability to track end-to-end performance and create potential process black holes + Lack of focus on outpatient receivables leads to low collectability + Lack of up-front clearance and focus on patient throughput leads to lower sponsorship + Inconsistent charge capture and CDI workflows across facilities
Tools		+ Available technology including staff workdrivers are not leveraged to potential + Many key revenue cycle metrics are either not available, not produced timely, or not trusted by local facilities due to data integrity concerns + Lack of automation leads to manual, high cost-to-collect processes
Culture		+ Facility leadership demonstrated a high commitment to mission to serve patients and a desire for change + Budget constraints create a culture of hesitation to make bold organizational changes + Communication and operating expectations between corporate and facilities showed a lack of accountability and alignment

ASSESSMENT FINDINGS

FINANCIAL OPPORTUNITY SOURCES

Financial Opportunity Sources		
Key Benefit Source	**Low Opportunity**	**High Opportunity**
Recurring Revenue Cycle Improvement + Reduction in administrative and bad debt write-offs + Reduction in adjustments for A/R cleanup of unworked populations + Decreased aged receivable leading to avoidable write-offs + Solidified charge capture processes[1]	**$100 million**	**$230 million**
Recurring Clinical Documentation Improvement (CDI)[2] + Increased accuracy/thoroughness of clinical documentation + Increased representation of patient acuity and quality	**$30 million**	**$60 million**
NYC Health + Hospitals Total Annual, Recurring Benefit	**$130 million to $290 million**	
One-Time Cash Flow Opportunity + Reduction in billing backlogs + Reduction in 90+ Days from Discharge/Service (DFD/S) agings + Improved denials management and resolution processes	**$30 million**	**$50 million**
NYC Health + Hospitals Total One-Time Cash Flow Benefit	**$30 million to $50 million**	

[1] Charge capture range is pending completion of detailed charge analysis
[2] CDI opportunity range is pending completion of medical record chart reviews

IMPLEMENTATION APPROACH

PERFORMANCE IMPROVEMENT APPROACH - SINGLE ACUTE CARE FACILITY

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12

Implement Revenue Cycle Enhancements

- Restructure revenue cycle organization
- Implement automated workflow and technology improvements
- Side-by-side staff and management training
- Roll out comprehensive revenue cycle reporting & analytics
- Implement meeting & accountability structure

★ Go-Live
Huron RC Technology
Workflow & Analytics

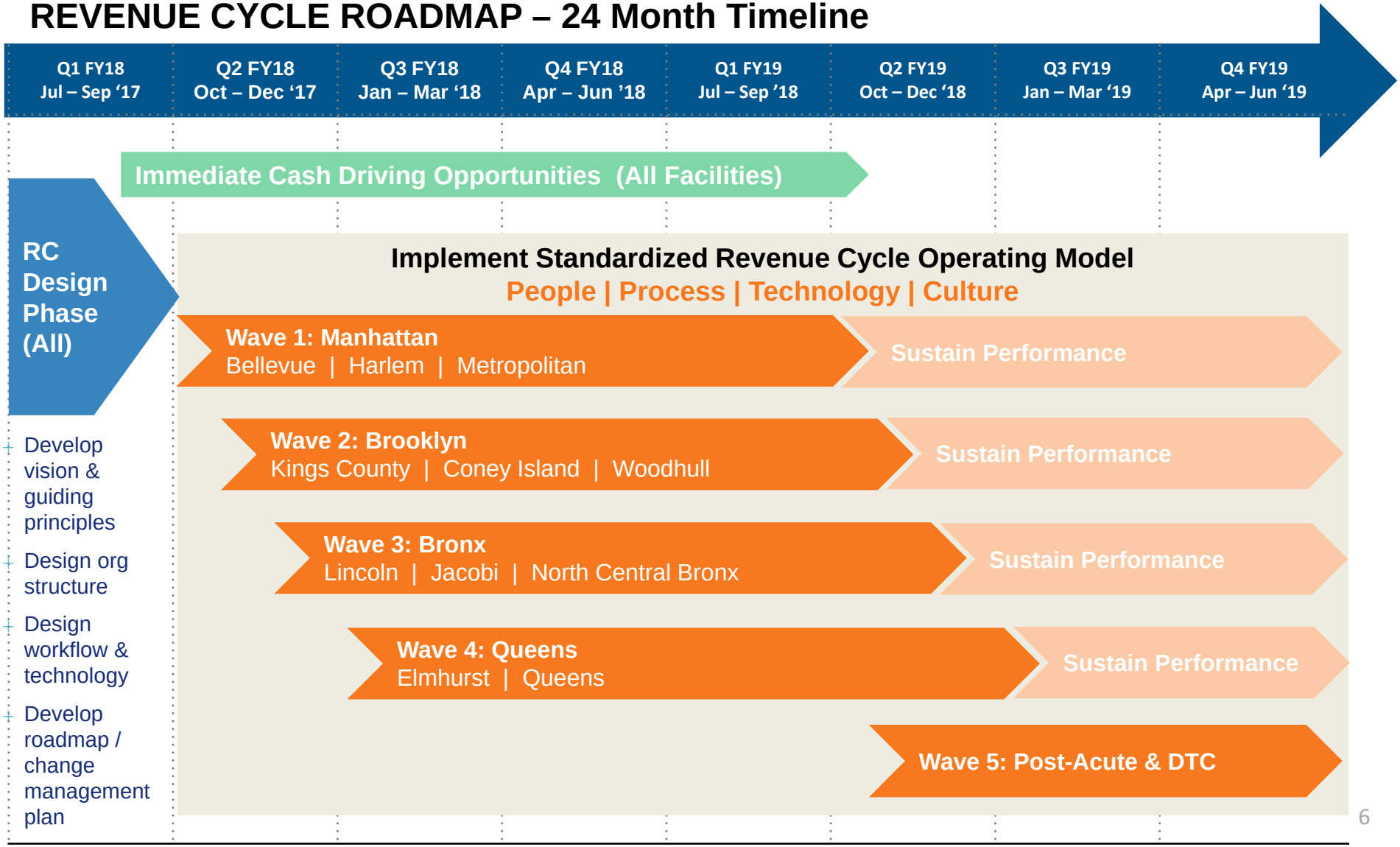
Achieve Results and Transition

- Achieve metric performance goals
- Transition detailed day-to-day support to NYCH+H leadership
- Measure financial benefit
- Provide continued improvement recommendations

Realize Financial Benefit

IMPLEMENTATION APPROACH

REVENUE CYCLE ROADMAP – 24 Month Timeline



PROPOSAL

Resourcing

- Comprehensive implementation across **21 entities** (11 hospitals, 5 post-acute care facilities, and 5 diagnostic treatment centers)
- **24-month duration**
- **150,000+ consulting hours** with peak staffing of approximately **65 dedicated onsite consultants** plus additional resources supporting remotely

Investment

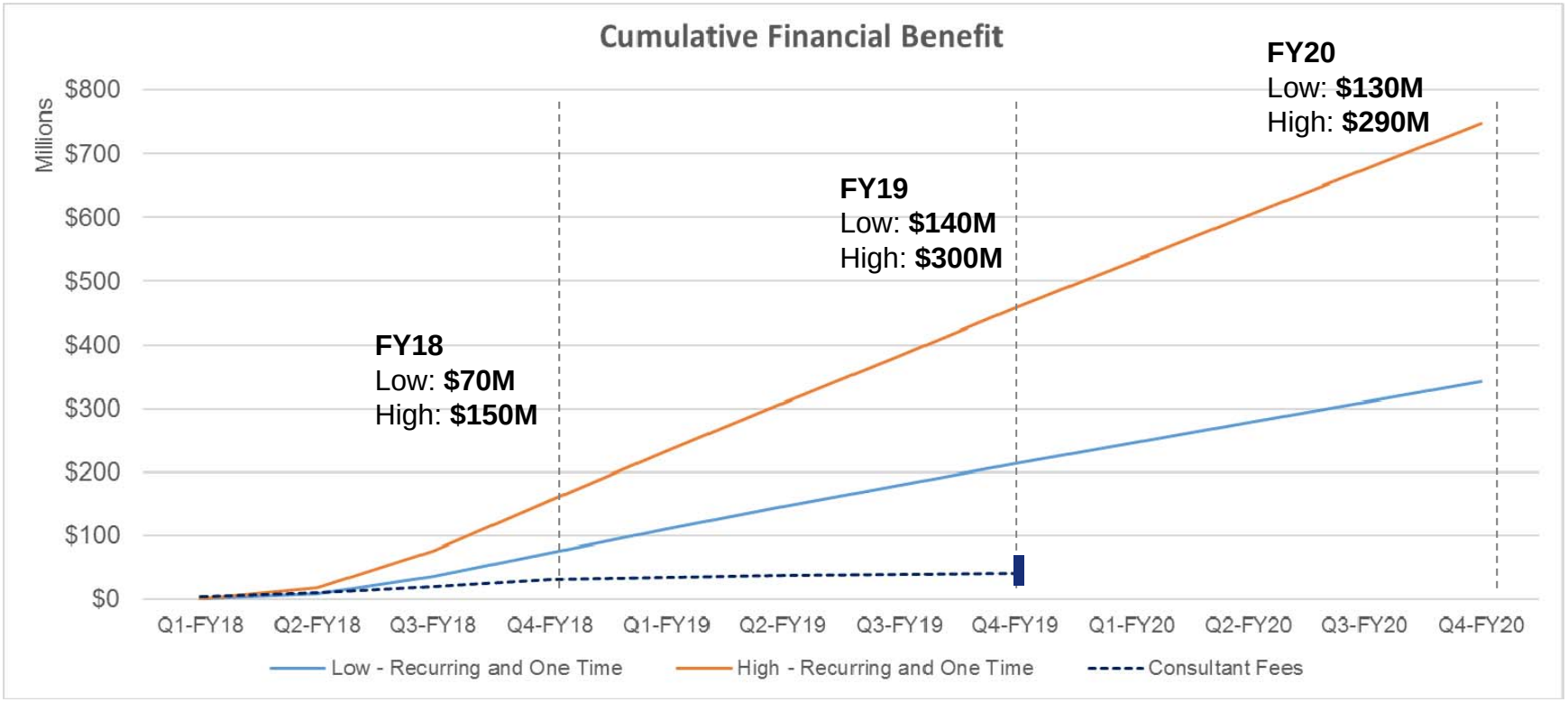
- **Fixed fee arrangement based on achievement of milestones where consultant fees and out of pocket expenses not to exceed $37 million**
- Recurring ROI equals 5.7:1 of annual recurring financial benefit versus total fees. **3-year cumulative ROI equals 17.2:1+**
- The engagement is projected to **break even by month 8** of implementation (cumulative financial benefit exceeds total fees)
- Cost per entity is less than $2 million

+ ROI and calculation based on mid-point benefit projection

FINANCIAL BENEFIT

THREE YEAR SUMMARY

- Opportunity exists to improve cash flow by **$340M - $740M or more over the next three years**
- The engagement is projected to **break even by month 8** of implementation (cumulative financial benefit exceeds total fees)



[1]Financial opportunity was based upon NYC Health + Hospitals' net patient service revenue excluding MetroPlus, DSH, and UPL ($3.1B)
[2]Financial opportunity excludes potential interest earnings and takes into account a ramp-up of annual, recurring benefit in the first year
[3]At midpoint benefit

NYC HEALTH+ HOSPITALS

HURON QUALIFICATIONS

Huron has 25 years of experience partnering with a broad range of clients as depicted below. In the last 18 months, Huron has driven over $1 billion in recurring financial benefit for 34 clients. They have achieved the low end of the estimated benefit range for 94% of these clients and exceeded the high end for 61%.

Public Systems Experience	Multi-hospital Health Systems Experience
Riverside University Health System SF Health Network – San Francisco Department of Public Health Greenville Health System KootenaiHealth Salinas Valley Memorial Healthcare System	Department of Veterans Affairs Intermountain Healthcare UNC Health Care Trinity Health Northwestern Medicine
New York Market Experience	**Epic Experience**
NewYork-Presbyterian Mount Sinai Northwell Health The Brooklyn Hospital Center – Keeping Brooklyn Healthy	Rush University Medical Center Partners Healthcare OHSU UC Health The University of Kansas Health System

RESOLUTION

Adopting a Second Revised Statement of Board Policy for the Review and Authorization of Procurement Matters ("Second Revised Statement") by the Board of Directors (the "Board") of New York City Health and Hospitals Corporation (the "System") in the form attached that shall be effective as of August 1, 2017 shall be binding upon all employees and officers of the System and directing the President of the System to prepare and adopt a revision of Operating Procedure 100-05 to implement such Second Revised Statement.

WHEREAS, at its September 22, 2011 meeting, the Board adopted a Revised Statement of Policy for the Review and Authorization of Procurement Matters by the Board of Directors; and

WHEREAS, the current Revised Statement of Policy for the Review and Authorization of Procurement Matters by the Board of Directors reflects a decentralized, network model, containing processes and roles that are no longer present in the System; and

WHEREAS, since September 22, 2011 procurement functions have been centralized into the division of Supply Chain Services; and

WHEREAS, the Board wishes to update its prior Revised Statement of Policy for the Review and Authorization of Procurement Matters by the Board of Directors to reflect the changes that have occurred in the System and to provide for further efficiencies in the System's procurement functions to ensure its financial wellbeing; and

WHEREAS, the proposed Second Revised Statement maintains the Board's oversight of the System's significant contracting activity, and requires the Board's authorizations for certain procurement transactions before they are concluded; and

WHEREAS, the New York State Public Authorities Accountability Act requires that entities such as the System have in place written policies regulating its procurement activities and the Board intends that the adoption of the Second Revised Statement of Policy and Operating Procedure 100-05 be in satisfaction of such requirement.

NOW THEREFORE, be it

RESOLVED, that the Board of the New York City Health and Hospitals Corporation hereby adopts the Second Revised Statement of Policy for the Review and Authorization of Procurement Matters by the Board of Directors in the form attached hereto that shall be binding upon all employees and officers of the System and that shall be effective as of August 1, 2017 and directing the President of New York City Health and Hospitals Corporation to prepare and adopt a revision of Operating Procedure 100-05 to implement such Second Revised Statement.

EXECUTIVE SUMMARY

RESOLUTION TO ADOPT A SECOND REVISED STATEMENT OF BOARD POLICY FOR THE REVIEW AND AUTHORIZATION OF PROCUREMENT MATTERS

BACKGROUND: New York City Health and Hospitals Corporation (the "System"), as part of its efforts to leverage its purchasing ability and promote standardization, has centralized its procurement functions into a single office, Supply Chain Services, and implemented modern best practices in supply chain management to achieve costs savings while ensuring quality of goods and services and bettering patient experiences and outcomes, while increasing internal controls, accountability and visibility in the procurement process.

NEED: The Board's current statement of policy regarding procurement, adopted in 2011, does not reflect the centralization of procurement functions in the Office of Supply Chain Services that has been achieved and it gives certain responsibilities regarding procurement to persons holding certain offices that no longer exist. Furthermore, as the System has come under increased pressure to reduce its costs through efficiencies, it is necessary to develop additional ways to streamline its procurement processes while maintaining appropriate controls and Board oversight which are not possible under the current Board Statement of Policy. Thus, it is necessary to revise the Board Statement of Policy and to adopt an updated version.

PROPOSAL: The proposed Second Revised Statement of Policy for the Review and Authorization Matters by the System's Board of Directors increases the threshold for the Board's review of procurement matters from $3 Million to $5 Million and it applies the same dollar standard to trigger the requirement of the review of affiliation agreements. More important, whereas the previous Statement of Board Policy had specified many of the terms of the System's Operating Procedure for Procurement, OP 100-5, the proposed Statement of Policy leaves to the System's President to implement such Second Revised Statement of Board Policy and gives to the President the responsibility and authority to adopt a revised OP 100-5. This change brings OP 100-5 into line with the other Operating Procedures of the System to give the President authority over their adoption and this change will enable the President to adopt a new OP 100-5 that makes the changes to the existing OP 100-5 necessary to reflect the centralized procurement system now in place, to reflect other changes in the System since 2011 and to make possible further efficiencies in the System's procurement practices that are not possible under the current Board Statement of Policy.

LEGAL REQUIREMENT: The New York State Public Authorities Accountability Act requires that entities such as the System have in place written policies regulating its procurement activities and the Board intends that the adoption of the Second Revised Statement of Policy and Operating Procedure 100-05 be in satisfaction of such requirement.

NYC HEALTH+ HOSPITALS

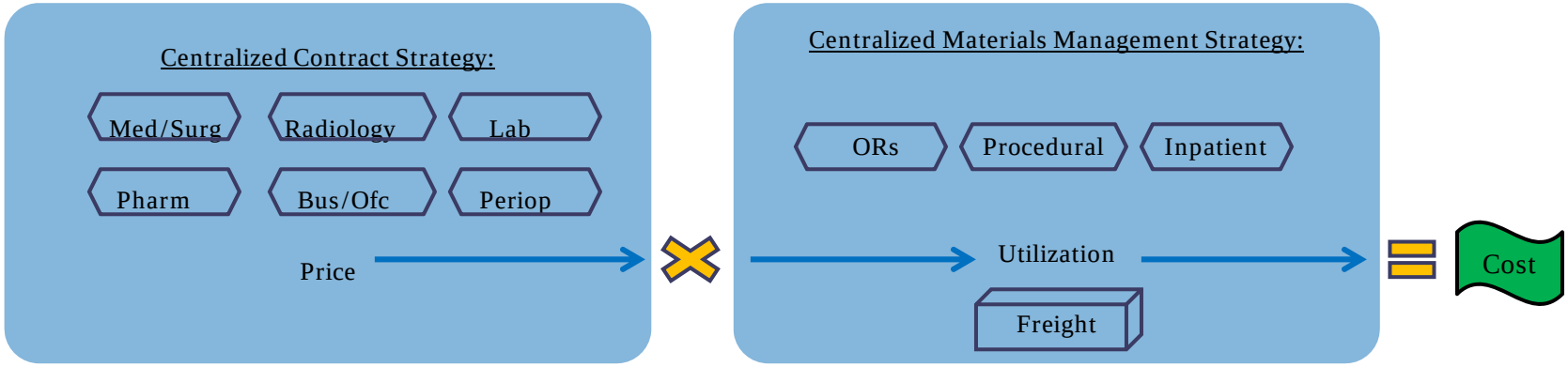
Centralized Procurement

Supply Chain Services Update,
Revision of
Board Procurement Policy Statement
and Operating Procedure 100-05

July 12, 2017

NYC HEALTH+ HOSPITALS

Supply Chain Strategy on a Page



Centralized Technology:

o Single Virtual Item Master

o Contracts Stored in Contract Center, Enterprise Wide

Centralized Purchasing Team:

o Standard Work Across Buyers

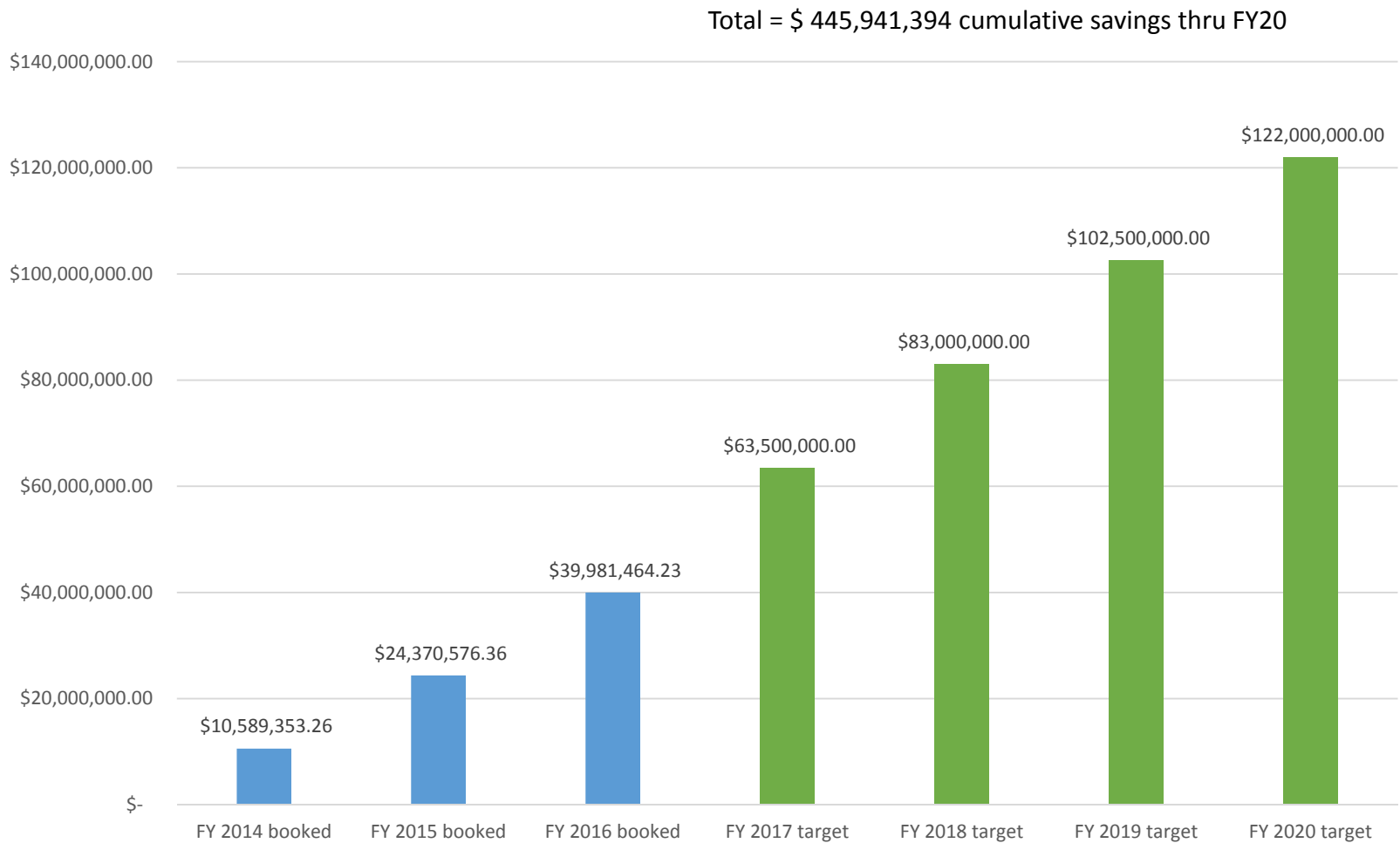
o IDN Status (stop local contracting)

o Visibility to All Contracts

o Integrate Capital PO Process

o Item Requires Action Form

Supply Chain will deliver $446M in value



NYC HEALTH+ HOSPITALS

Supply Chain Services FY18-19 Plans: Enterprise Resource Planning (ERP) System Inventory Management Just-In-Time (JIT) Delivery and Low Unit of Measure (LUM)

Stockless Requisition (JIT-LUM)

Changing OP 100-05 Requires Changing Board's Procurement Policy Statement

The current Operating Procedure for Procurement (100-5) needs to be revised

It was written to reflect the decentralized NYC Health + Hospitals network model

The Operating Procedure has processes that are no longer accurate

Normally the President, in concert with Senior Staff, implements OP revisions

The difference with existing OP, is in 2013, the Board adopted a Procurement Policy Statement, which essentially contains the entire OP 100-05

To enable the President to adopt a revised OP, the Board is asked to adopt a revised Policy Statement.

Supply Chain Services: Centralized and Transforming

OP Revised September 2013

Centralized October 2013

Transforming

Future State: Complete Transformation

Network and Facility based Contracting Model

Enterprise Contracting Model

+ Professional Sourcing Staff
+ Standardize work
+ Work with IT and OFD
+ Assume Affiliations and Outsourced Services

All NYC H+H Contracting

Many smaller contracts

Fewer but larger contracts

Transforming OP 100-05: Modernized Contracting

Uniform Contracting:

- All procurement falls under Supply Chain Services and Office of Legal Affairs authority

Flexible contracting:

- Allow for combining procurement methods
- Value based purchasing
- Contract extensions and renewals

Sensible Contracting:

- Apply due diligence standard to contracts less than 1 million
- Raise CRC threshold from 100K to 1 million
- Raise Board threshold from 3 million to 5 million

Transforming OP 100-05: Increased Controls

Supply Chain Manual: A document jointly approved by Supply Chain Services (SCS) and Office of Legal Affairs (OLA) with detailed procedures, processes, controls.

Contract Control Sheet: An auditable control for every contract detailing its procurement history and requiring SCS and OLA sign off for each contract. No contract number can be assigned without.

Departmental Audits: Review of every transaction between $100K and $1M that is not procured by traditional methods by non-sourcing personnel; summarized monthly; provided to Internal Audits Office.

Internal Audits Review: Performed semi-annual; reported to the Audit Committee.

NYC HEALTH+ HOSPITALS

Board Approval at Other NY Area Hospitals

Hospital	Board Approval Requirement
NYU	> $5 million
Northwell	No board review Reviews contracts for service/capital > $10M with President
Presby	Materiality
Mt Sinai	No board approval except for large construction projects

Revising OP 100-05 Requires Revising Board Procurement Policy Statement

September 2013 Statement:

It is a shortened version of OP 100-05 including all methods and limits

Proposed Statement:

Only include those matters that must be reviewed by Board

Enables President to revise OP 100-05 to meet operational state

STATEMENT OF POLICY
FOR THE REVIEW AND AUTHORIZATION OF PROCUREMENT MATTERS BY THE BOARD OF DIRECTORS OF NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

I. POLICY PURPOSES AND GOALS

This Statement of Policy sets forth the requirements of the Board of Directors (the "Board") of New York City Health and Hospitals Corporation ("NYC Health + Hospitals") for those procurement matters of NYC Health + Hospitals that must receive prior Board authorization. This statement of policy shall be binding upon all officers and employees of NYC Health + Hospitals.

In adopting this Statement of Policy, the Board wishes to preserve NYC Health + Hospitals' financial wellbeing while maintaining its efficient operations. The intent of this Statement of Policy is to ensure that the Board is informed of the Corporation's significant contracting activity and that it reviews and authorizes certain procurement transactions before they are concluded.

II. GENERAL STATEMENT

In general, and subject only to the specific exceptions noted below, any financial commitment by NYC Health + Hospitals in excess of $5 million for the procurement of goods or services, including affiliation contracts under which NYC Health + Hospitals will pay for others to provide clinical services, requires the Board's prior authorization regardless of the procurement method used. Further, the following require the Board's prior approval regardless of the amount of money involved: (a) all leases, licenses and other agreements for the disposition or acquisition of real property rights; and (b) all contracts for the services of auditors engaged to report on any aspect of the conduct of the business of NYC Health + Hospitals. This Statement of Policy shall not be interpreted to relieve NYC Health + Hospitals from making presentations to the Board and, when appropriate receiving the approval of, or authorization from, the Board regarding non-procurement related matters such as those pertaining to strategic planning, medical and professional affairs, etc. consistent with NYC Health + Hospitals' past practice and existing Operating Procedures. The Board acknowledges that MetroPlus Health Plan, Inc.'s certificate of incorporation imposes certain requirements for the approval by NYC Health + Hospitals' Board of certain contracts and it is not intended that this Statement of Policy alter in any way such requirements.

In adopting this Statement of Policy, the Board intends to change the current practices of the Corporation in three ways. First, the threshold for the requirement for Board approval for general contracts is increased from $3 million to $5 million. Second, the structure for reporting on contracts below the threshold for presentation to the Board is strengthened. Third, this Statement of Policy, recognizing the centralization of the procurement function within the Office of Supply Chain Services and the increased professionalism of the operation, leaves to the oversight of the President and the Vice

President responsible for Supply Chain Services the task of adopting suitable rules and procedures for the procurement of those goods and services below the threshold for presentation to the Board rather than directing them here.

III. PROCUREMENT MATTERS NOT REQUIRING ANY APPROVAL OF THE BOARD

The procurement matters not requiring prior authorization by the Board are: (i) grant-funded contracts under which the entity providing the goods or services is specified in the grant by the funder; (ii) purchases of goods (such as medical/surgical supplies, pharmaceuticals, all manner of supplies and equipment and utilities used in the ordinary course of the Corporation's business) regardless of the dollar value of such purchases; and (iii) contracts for the maintenance of NYC Health + Hospitals' equipment or related components when the contract is a renewal or replacement of an existing contract with the same vendor and for a scope of maintenance services substantially the same as in the previous contract.

IV. PROCUREMENT MATTERS REQUIRING ONLY THE BOARD'S PRIOR AUTHORIZATION FOR THE RIGHT TO EXPEND FUNDS BUT NOT FOR THE ACTUAL CONTRACT

Construction contracts governed by the New York State General Municipal Law for "Construction Projects" that will cost more than $5 million require prior authorization of the Board only for the right to expend the needed funds. Once the Board has approved the right to expend the funds, Board authorization shall not be required for the awarding of a contract, selection of the contracting party or any aspect of the procurement process.

For the purposes of this Statement of Policy, a "Construction Project" shall refer to the totality of the work and materials needed to complete a capital improvement or addition to one of the Corporation's facilities and shall include all elements that are planned, budgeted or contracted together. The object of such definition is to afford the Board the opportunity to consider such projects as a single endeavor and determine if the overall effort is worthy and properly funded. That a single entity will oversee or coordinate the entire effort will render the entire effort a single Construction Project. The President shall make such additional related rules regarding Construction Projects as necessary through a revised Operating Procedure 100-5 to be adopted.

Requests to the Board for authorization to expend funds for procurement purposes under this Section IV, shall set forth the spending authority requested, the purpose for which the expenditure is to be made, the procurement method to be used and the source of the funds to be expended.

V. CONTRACT REVIEW COMMITTEE

The Contract Review Committee (CRC) shall be a management committee constituted by the President with one voting member appointed by the Chairperson of the Board. The CRC shall review all contracts that require Board authorization prior to the award of a contract except for leases, licenses and other agreements for the disposition or acquisition of real property rights.

VI. OPERATING PROCEDURE

The President shall adopt a revised Operating Procedure 100-5 to provide a consistent method for ensuring compliance with this Statement of Policy and with best practices with regard to procurement contracts and authorizations of the right to expend funds for procurement purposes in cases where the authorization of the Board is not required by this Statement of Policy.

VII. CONTRACT REPORTS

The President shall provide the Board with reports and such reports shall include matters that the President deems appropriate as well as those matters requested by the Board. The Board believes that the development of an effective reporting structure is an essential tool to assure effective Board governance especially for matters that will not be presented to the Board for authorization.

The Board may select any contract or vendor for review in the course of its duties regardless of whether such contract is subject to Board approval under this Statement of Policy.

VIII. PRESIDENT'S AUTHORITY

The procedures outlined in this Statement of Policy shall be followed in all but exceptional cases, such as emergencies, where the President, or his/her designee, determines in writing to make an exception from the established procedure. The President shall report any such exception to the Board at the meeting immediately following such exception when the exception concerns a matter that would otherwise have been subject to Board approval under this Statement of Policy. The President may take to the Board for prior authorization or as an informational item, any transaction or expenditure that, irrespective of this Statement of Policy, the President determines merits the attention of the Board.

STATEMENT OF POLICY
FOR THE REVIEW AND AUTHORIZATION OF PROCUREMENT
MATTERS BY THE BOARD OF DIRECTORS OF
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

I. POLICY PURPOSES AND GOALS

This Statement of Policy sets forth the requirements of the Board of Directors (the "Board") of New York City Health and Hospitals Corporation ~~(the "Corporation~~("NYC Health + Hospitals") for those procurement matters of ~~the Corporation~~NYC Health + Hospitals that must receive prior Board authorization~~ and for the manner of presentation of certain procurement matters for which prior authorization is mandated.~~. This statement of policy shall be binding upon all officers and employees of ~~the Corporation and shall be implemented by the President of the Corporation by the adoption of appropriately detailed Operating Procedures~~NYC Health + Hospitals.

In adopting this Statement of Policy, the Board wishes to preserve ~~the Corporation's~~NYC Health + Hospitals' financial wellbeing while maintaining its efficient operations. The intent of this Statement of Policy is to ensure that the Board is informed of the Corporation's significant contracting activity and that it reviews and authorizes certain procurement transactions before they are concluded.

II. GENERAL STATEMENT

In general, and subject only to the specific exceptions noted below, any financial commitment ~~expenditure of funds~~ by ~~the Corporation~~NYC Health + Hospitals in excess of $~~3~~5 million for the procurement of ~~of: (i) Construction Services for "Construction Projects," as defined below in Section IV; (ii) equipment; (iii) professional services and non-professional services; and (iv) any other expenditure of funds by the Corporation to procure~~ goods or services, including affiliation contracts under which NYC Health + Hospitals will pay for others to provide clinical services, ~~irrespective of how classified require~~requires the Board's prior authorization regardless of the procurement method used. Further, the following require the Board's prior approval regardless of the amount of money involved: (a) all leases, licenses and other agreements for the disposition or acquisition of real property rights; and (b) all contracts for the services of auditors engaged to report on any aspect of the conduct of the business of ~~the Corporation~~NYC Health + Hospitals~~; and (c) all affiliation contracts under which NYC Health + Hospitals will pay for the purchase of~~others to provide ~~clinical services~~. This Statement of Policy shall not be interpreted to relieve ~~the officers of the Corporation~~NYC Health + Hospitals from making presentations to the Board and, when appropriate receiving the approval of, or authorization from, the Board regarding non-procurement related matters such as those pertaining to strategic planning, medical and professional affairs, etc. consistent with ~~the Corporation's~~NYC Health + Hospitals' past practice and existing Operating Procedures. ~~The Board recognizes the need to adopt new policies to govern the Corporation's banking and financing activities and that will be addressed in a separate document.~~ The Board acknowledges that MetroPlus Health Plan, Inc.'s certificate of incorporation ~~requires~~

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imposes certain requirements for the approval by ~~the HHC's~~NYC Health + Hospitals' Board of ~~all~~certain contracts ~~having an annual expense of $1 million or more~~ and it is not intended that this Statement of Policy ~~relax~~alter in any way such ~~more restrictive rule~~requirements.

In adopting this Statement of Policy, the Board intends to change the current practices of the Corporation in ~~two key~~three ways. First, the ~~Board shall be informed about all contract spending and not just individual contracts that require Board approval. Second, as set forth in the chart appearing at the end of this Statement of Policy and explained in the following paragraphs, certain transactions of lower dollar value will no longer be presented to the Board for authorization while others of higher dollar value that had previously not required Board authorization will, in the future, require such authorization.~~

~~Currently, the~~ threshold for ~~having to obtain Board authorization for transactions varies greatly depending upon the size of the contract, the nature of the goods or services purchased and the method for selecting vendors. For example, for non-recurring goods or services purchased by competitive bids, the current threshold is $1 million while there is no approval required for purchases of recurring goods or services made using competitive bidding. There is no approval needed for purchases made off of City, State, or Federal contracts or using group purchasing organizations, while professional service contracts in excess of $50,000 require Board approval.~~

~~The new policy will increase the threshold with the result that a category of transactions previously presented to the Board for authorization will no longer be subject to such a~~ the requirement~~. But the new, higher~~ for Board approval for general contracts is increased from $3 million ~~threshold will be applied without many of the exceptions that had complicated the former policy. While in the past, construction contracts, City, State, and Federal contracts and contracts made using group purchasing arrangements had not been brought to the Board, now they will be submitted for authorization if they exceed $3 million in value and if they are for Construction~~to $5 million. Second, the structure for reporting on contracts below the threshold for presentation to the Board is strengthened. Third, this Statement of Policy, recognizing the ~~greatly increased~~ centralization of the procurement function within the Office of Supply Chain Services~~, equipment and either professional or non-professional services. The reason that construction contracts had not been brought to the Board before is because the General Municipal Law strictly regulates the process by which such contracts are awarded and mandates the award to the low bidder. The reasoning had been that, because the Board could have no role in choosing the vendor (the law dictated the award to the low bidder), it could have no meaningful role in any part of the process. Similarly, with the use of group purchasing organizations, the list of vendors has already been vetted by the group purchasing organization. When the Corporation uses such a vendor, there is already assurance that the Corporation is getting a good price by benefiting from volume discounts and that the vendor is a~~ and the increased professionalism of the operation, leaves to the oversight of the President and the Vice President responsible ~~party. Thus, again, the choice of the vendor seemed not to be subject to debate.~~

~~Thus, while some transactions will be removed from Board consideration, others will be added with the aim being to shift the Board's focus to transactions of higher dollar value.~~

~~In implementing the changes required by this Statement of~~ for Supply Chain Services the task of adopting suitable rules and procedures for the procurement of those goods and services below the threshold for presentation to the Board rather than directing them here. ~~As indicated below numerous important principles established in the Board Policy, the Board wishes Management to err in favor of presenting matters to the Board for authorization in any cases of any doubt whether Board authorization is required and it shall be the responsibility of management to inform the Board of any cases where there is doubt as to whether the authorization of the Board is required. adopted in September 2011 continue in effect.~~

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III. PROCUREMENT MATTERS NOT REQUIRING ANY APPROVAL OF THE BOARD

The procurement matters not requiring prior authorization by the Board are: (i) grant-funded contracts under which the entity providing the goods or services is ~~listed on~~specified in the grant by the ~~third party~~funder; (ii) ~~contracts that do not involve any expenditure of funds; (iii)~~ purchases of goods (such as medical/surgical supplies, pharmaceuticals ~~and~~, all manner of ~~other~~ supplies and equipment and utilities used in the ordinary course of the Corporation's business) regardless of the dollar value of such purchases; and (ii~~i~~~~v~~) contracts for the maintenance of ~~any of our computer systems~~NYC Health + Hospitals' equipment or related components when the contract is a renewal or replacement of an existing contract with the same vendor and for a scope of maintenance services substantially the same as in the previous contract ~~and (v) those procurement transactions, other than those pertaining to real estate, audit services or clinical services, for less than $35 million~~.

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IV. PROCUREMENT MATTERS REQUIRING ONLY THE BOARD'S PRIOR AUTHORIZATION FOR THE RIGHT TO EXPEND FUNDS BUT NOT FOR THE ACTUAL CONTRACT

Construction contracts governed by the NYS General Municipal Law for "Construction Projects" that will cost more than $~~3~~5 million ~~and contracts for services made through group purchasing agreements including contracts made through City, State or Federal group purchasing agreements~~ require prior authorization of the Board only for the right to expend the needed funds. Once the Board has approved the right to expend the funds, Board authorization shall not be required for the awarding of a contract, selection of the contracting party or any aspect of the procurement process.

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For the purposes of this Statement of Policy, a "Construction Project" shall refer to the totality of the work and materials needed to complete a capital improvement or addition

to one of the Corporation's facilities and shall include all elements that are planned, budgeted or contracted together. The object of such definition is to afford the Board the opportunity to consider such projects as a single endeavor and determine if the overall effort is worthy and properly funded. That a single entity will oversee or coordinate the entire effort will render the entire effort a single Construction Project. The President shall make such additional related rules regarding Construction Projects as necessary ~~more fully define "Construction Project" as necessary~~ through a revised Operating Procedure 100-5 to be adopted.

V. CONTRACT REVIEW COMMITTEE

The Contract Review Committee (CRC) shall be a management committee constituted by the President with one voting member appointed by the Chairperson of the Board. The CRC shall review all contracts that require Board authorization prior to the award of a contract except for leases, licenses and other agreements for the disposition or acquisition of real property rights.

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~~V. PROCESS FOR MATTERS REQUIRING BOARD APPROVAL PRIOR TO CONTRACTING~~

~~For procurement matters requiring the Board's authorization prior to contracting under the general rule of Section II, the prior approval and report of the Contract Review Committee, described below shall be required. For all real estate matters, the Office of Facilities Development shall continue to present all proposed transactions as in the past with the addition of regular briefings of matters not ready for presentation but in earlier stages of development.~~

~~VI. PROCESS FOR OBTAINING BOARD AUTHORIZATION WHERE ONLY AUTHORIZATION FOR THE RIGHT TO EXPEND FUNDS IS REQUIRED BUT NOT FOR THE ACTUAL CONTRACT~~

~~The President shall adopt a revised Operating Procedure 100-5 to provide for presentations~~Requests to the Board ~~of requests~~ for authorization to expend funds for procurement purposes under this Section IV, ~~above, setting~~shall set forth the spending authority requested, the purpose for which the expenditure is to be made, the procurement method to be used and the source of the funds to be expended. ~~The President shall approve a standard reporting format to be used.~~

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~~VII. CONTRACT REVIEW COMMITTEE~~

~~The Contract Review Committee (CRC) shall be a management committee constituted by the President with one voting member appointed by the Chairperson of the Board. The CRC shall review all contracts that require Board authorization prior to the award of a contract. The purpose of such reviews is to ensure that:~~

i. The proper procurement methodology was followed;
ii. The contract is ready to be executed;
iii. The required expenditure has budget authorization from Corporate Finance;
iv. The selection process was fair and impartial; and
v. In accordance with applicable Operating Procedures all contract negotiation processes were followed, all standard contract forms were used and that all vendor responsibility investigatory procedures were appropriately followed.

The CRC shall forward to the Board reports of all contracts requiring prior Board authorization. The President shall approve a standard reporting format to be used.

VIII. APPROVAL OF PROCUREMENT CONTRACTS AND THE RIGHT TO EXPEND FUNDS BELOW THE THRESHOLD FOR BOARD AUTHORIZATION

V. CONTRACT REVIEW COMMITTEE

The Contract Review Committee (CRC) shall be a management committee constituted by the President with one voting member appointed by the Chairperson of the Board. The CRC shall review all contracts that require Board authorization prior to the award of a contract except for leases, licenses and other agreements for the disposition or acquisition of real property rights.

VI. OPERATING PROCEDURE

The President shall adopt a revised Operating Procedure 100-5 to provide a consistent method for ensuring compliance with relevant Operating Proceduresthis Statement of Policy and with best practices with regard to procurement contracts and authorizations of the right to expend funds for procurement purposes in cases where the authorization of the Board is not required by this Statement of Policy.

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IXVII. CONTRACT REPORTS

The President shall provide the Board with reports and prepared annually showing the total contract spending by the Corporation organized by vendor listing the largest vendors accounting for approximately 80% of the Corporation's purchasing by contracting amount. Ssuch reports shall include such other matters that as the President deems appropriate as well as nd those matters requested by the Board. The Board believes that the development of an effective reporting structure is an essential tool to assure effective Board governance especially for matters that will not longer be presented to the Board for authorization. The format for such reports shall be determined by the President in consultation with the Board but, in any case, such report shall indicate the general subject of the contracts outstanding with the listed vendors and the expiration dates of each.

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~~Upon presentation of such annual contracting report,~~T ~~t~~he Board may select any contract or vendor for review in the course of its duties~~of the following twelve months~~ regardless of whether such contract is subject to Board approval under this Statement of Policy.~~ When a contract term will expire during the twelve months following the presentation of the annual report, the Board may determine that it wishes not only to review the contract but also to make any renewal of the contract subject to the Board's prior approval.~~

~~X~~VIII. PRESIDENT'S AUTHORITY

The procedures outlined in this Statement of Policy shall be followed in all but exceptional cases, such as emergencies, where the President, or his/her designee, determines in writing to ~~deviate~~make an exception from the established procedure. The President shall report any such ~~deviation~~exception to the Board at the meeting immediately following such ~~deviation~~exception when the exception concerns a matter that would otherwise have been subject to Board approval under this Statement of Policy. The President may take to the Board for prior authorization or as an informational item, any transaction or expenditure that, irrespective of ~~of the monetary thresholds established in~~ this Statement of Policy, the President determines merits the attention of the Board. ~~While the President shall have the sole authority to create a revised Operating Procedure 100-5 to implement this Statement of Policy, he shall present such Operating Procedures to the Board for the information of the Board and he shall not thereafter modify Operating Procedure 100-5 without similarly informing the Board of the proposed modification.~~

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Type of Expenditure	Procurement Method(s)	Approval/Report Current	Approval/Report Under New Structure
Construction	Competitively Bid	No Board Approval	Board Approval for Spending > $3M & Reports on Total Spending & Major Contracts **
Professional Services including outside auditors	RFP, Negotiated Acquisition or Sole Source	Board Approval of all Contracts > $50,000	Board Approval of Contracts > $3M & Reports & of all contracts for outside auditors**
Professional Services and non-Prof Services incl. Info. Tech Services	City, State, Federal, Group Purchase Organization	No Board Approval	Board Approval of Contracts > $3M except renewals of IT maint. contracts w/same vendor for substantially same scope; & Reports **
Non-Prof Services incl. Information. Technology Services	Competitively Bid	Board Approval of Non-Recurring > $1M; no Board Approval for Recurring Contracts	Board Approval of Contracts > $3M & Reports **
Medical, Capital & Information Technology Equipment	Competitively Bid	Board Approval of all Purchases > $1M	Board Approval of Contracts > $3M & Reports **
Medical, Capital & Information Technology Equipment	City, State, Federal, Group Purchase Organization	No Board Approval	Board Approval of Contracts > $3M & Reports **
Goods for Routine Operations	Competitively Bid	Board approval of non-recurring > $1M but for Pharmaceutical, Manf. only Distrib. Medically nec. goods; no Board Approval for Recurring Contracts	No Board approval; Reports **
Goods for Routine Operations	City, State, Federal, Group Purchase Organization	No Board Approval	No Board Approval; Reports **
If Provider of Goods/ Services Named in Grant Contract; or if No Spending Required	All Methods	No Board Approval	No Board Approval
Real Estate	All Methods	Board Approval of all Agreements	Board Approval of all Agreements
Affiliation Contracts	Sole Source	Board Approval of all Agreements	Board Approval of all Agreements
MetroPlus	All Contracts	Based on MetroPlus' own rules, HHC Board Approval for Contracts w/annual spend > $1M	Based on MetroPlus' own rules, HHC Board Approval for Contracts w/annual spend > $1M

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~~With all of the above, both before and after, the President may deviate from the requirement for approval in emergencies. With all the above, both before and after, the President may request approval when not required.~~