CHCCDP:

Are We Getting Our Money's Worth?

Monitoring the Use of Community Health Care Conversion Demonstration Project Funds

Commission on the Public's Health System

April 2003

CHCCDP, Are We Getting Our Money's Worth?, is dedicated to the memory of Marshall England, the former Chairperson of the Commission's board. Marshall's dedication to equity, justice, and the communities right to know, are the continuing guiding light for the work of the Commission on the Public's Health System.

The Commission on the Public's Health System was formed in 1991 out of a strong belief that decisions about health care must include public input and address the diverse needs of New York City communities.

The Commission remains committed to making sure that our public health system stays strong, that people have access to health services, and the public's voice on health care issues is heard.

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Table of Contents

Executive Summary

With 1.6 million uninsured city residents, New York City relies on the safety net to provide health care services. In addition, two million New Yorkers depend on Medicaid for their health care. Currently the Medicaid program is the subject of major proposed cuts and changes at the federal and state levels. If enacted, these proposals would greatly limit eligibility and benefits for low income residents and could greatly weaken the institutions that constitute the health care safety net. The city's proposed budget would make service cuts in public health programs and services. At a time when every level of government is under financial strain, all public funding resources need to be used wisely.

Many health care funding decisions are made on the basis of political judgment rather than on the basis of health care needs. The Community Health Care Conversion Demonstration Project (CHCCDP) is a prime example of just such a decision making process. Under this project, $1.25 billion of federal funds was committed to New York State hospitals to assist them in the transition to Medicaid managed care. Most other states applying for Medicaid managed care waivers chose to use savings from implementation of managed care to fund expansions of public insurance coverage. This was not the case in New York. In order to buy support for the waiver from several unions and hospital associations, the Governor agreed to use managed care savings for hospitals. CHCCDP was to fund hospitals for: expansion of primary care services; activities related to managed care readiness; and worker retraining.

Because of the political basis for the CHCCDP project's initial design, government agencies and elected officials did not build in the types of monitoring and accountability typical for government funding. Oversight of this project is minimal. The difficulty that the Commission had in gaining access to requested CHCCDP documents is one indication of the unwillingness of state government to be accountable for this program. The Commission strongly supports public accountability for public funding. Throughout the seven years that the Commission has been following CHCCDP plans and implementation, public accountability has been one of our major themes. This report was undertaken with the goal of shining a light on CHCCDP funded projects, and

using the review of this program to influence the final two years of funding.

Despite significant obstacles, the Commission along with others thanked and acknowledged throughout this report, was able to advocate for major changes in the program based on initial goals that were developed. With the New York City Task Force on Medicaid Managed Care, the Commission developed goals that included:

- Funding from the CHCCDP program should go directly to community-based health care providers. This was not accomplished.
- Hospitals receiving CHCCDP funding would expand primary care services and guarantee access to health care services for all residents, regardless of their ability to pay. This was partially accomplished.
- Worker retraining funds would be used to increase staffing for primary and ambulatory care services; would upgrade staff particularly for hard to fill positions; would provide foreign language and interpreter training and cultural competency. This was partially accomplished.

Achievements are described within the body of the report. Notable in the accomplishments was the federal agency's decision to require several improvements in the program. Tim Westmoreland, then heading the division at the agency formerly known as the Health Care Financing Administration (now known as CMS), required a re-review of the CHCCDP allocation formula for the funding of hospitals. He also required New York State to ask hospitals to provide information about their policies for providing care for the uninsured. Commission efforts to advocate for safety net providers (those institutions which provide services to low-income and uninsured populations) were successful in winning a change in the funding formula for CHCCDP, so that care for the uninsured has been given more weight. Another important success was convincing the State Health Department that data collected on hospital reporting forms, the Institutional Cost Report, was problematic, particularly as it related to outpatient self-pay data. The department agreed to make some corrections in this data.

In order to evaluate the CHCCDP program, the Commission requested from the state Health Department, the final reports for Cycle I funding for CHCCDP hospitals in New York City, along with the preliminary and final proposals for Cycles II and III, and site-visit reports prepared by state staff. Even after the documents were requested

under New York State's Freedom of Information Laws, yet the State Health Department resisted responding to these requests. Many of the documents were not received until an Article 78 law suit was filed.

Review of the information received from the State Health Department raised serious questions about the use of this public funding. Cycle I of CHCCDP funding ended in 2001, yet two years later, only two of the 44 city hospitals funded had submitted a Final Report as required by State Health. Eight hospitals in New York City received 25 percent of their Cycle II and III funding two years ago, but still have not submitted the final proposal for these two cycles. In addition, several hospitals used CHCCDP funding in questionable ways, including one hospital which spent available dollars meant for primary care and managed care to upgrade its computers for Y2K readiness. Another hospital used a portion of its grant to fund a clinic in an upscale community in Westchester. The worker retraining portions of hospital proposals are also problematic, since they are nearly identical for all of the voluntary hospitals, and also nearly identical for the public hospitals. This raises questions about whether these projects are designed to meet local needs. For at least three hospitals, serious problems were found in the Health Department's site visit reports, but there is no indication that these problems were pursued or resolved by state officials. Oversight by the federal agency in charge, the Center for Medicare and Medicaid Services, is not publicly known except for scant information in quarterly reports from the State Health Department.

The eleven public hospitals run by the Health and Hospitals Corporation have done a more thorough job of reporting on their spending of CHCCDP funds. This may be because their public status for all spending requires more public accountability. In Cycle I of this funding, the public hospitals made more of an effort to expand primary care services than the voluntary hospitals did; this is a prime goal of the Commission.

During the first three CHCCDP cycles New York City hospitals were allocated $648,364,165 of the total $750 million allocated statewide. As of February 2003, $500,048,220 has actually been paid to city hospitals. Two more cycles of funding, IV and V, will be available to complete the initial waiver-defined CHCCDP goals. The governor has recently negotiated two additional cycles of funding, totaling another $350

million. Despite strong efforts by the Commission and DC 37 to require the state to use these new funds for the same CHCCDP-related purposes, the governor received approval from the Center for Medicare and Medicaid services to have "flexibility" in the spending of these funds in Cycles VI and VII. Based on the newly negotiated waiver agreement, the governor can use these funds for worker retraining and retention, as well as for Graduate Medical Education.

Recommendations

With at least two more years of the initial CHCCDP program to go, and nearly $500 million still to be allocated, CHCCDP funding could be used by hospitals to undertake a meaningful restructuring of health care services for Medicaid and uninsured patients. In order for this to happen, the Commission on the Public's Health System recommends the following:

- An outside independent audit of the expenditure of CHCCDP funding to determine the effectiveness of this program. The audit could be undertaken by the New York State Comptroller's office which would have more access to all of the required documents.
- Serious consideration by all CHCCDP funded hospitals of the issues raised in this policy paper, with the idea that the proposal submitted by each hospital for the final two cycles of funding should match the goals set by the program, and the goals identified by the Commission and the Task Force.
- When the time comes to appropriate the final two cycles of CHCCDP funding, the state legislature should give serious thought to including language that would ensure better accountability for the expenditure of these funds. In addition, the legislature should consider the flexibility given to the governor for the spending of Cycles VI and VII of CHCCDP funds. These funds could perhaps be more appropriately utilized in continuing the goals set by the original CHCCDP program – expansion of primary care, managed care readiness, and worker retraining.
- The State Health Department must evaluate the effectiveness of their monitoring efforts.

- The Terms & Conditions of the federal waiver (Attachment J) required that the state reallocate unspent CHCCDP funds to the other hospitals. A time limit should be set for completing the spending of each Cycle's funding – perhaps an additional year. If the funds are not completely spent by that time, the funding should be reallocated. All of the $1.25 billion in federal dollars allocated for the CHCCDP program should be spent for the intended purpose.

Introduction

The Community Health Care Conversion Demonstration Project (CHCCDP, pronounced as CHIPDIP) is federal funding for hospitals in New York State to help them to transition to Medicaid managed care. This program is a part of the New York State federal waiver, named the Partnership Plan, that allows the state to require mandatory enrollment of Medicaid beneficiaries in managed care. Eligible hospitals would together receive $1.25 billion – or $250 million per year for five years. CHCCDP funds were to be used for expanding primary care, enhancing hospitals' readiness for managed care, and a designated 25 percent of the funds for worker retraining.

Most other states granted a Medicaid managed care waiver in the 1990's used the savings to expand health insurance coverage for their population. But New York chose not to expand coverage at the point that they applied for the waiver despite strong community advocacy efforts led by the New York City Task Force on Medicaid Managed Care (the Task Force).

Although the waiver request was submitted to the federal agency (then named the Health Care Financing Administration [HCFA] and now renamed the Center for Medicare and Medicaid Services [CMS]) in 1995, it was not approved until 1997. This delay was caused in part by heavy lobbying efforts by different constituencies for changes in the proposal. As finally approved in 1997, the waiver contained, among other changes, the CHCCDP funding. The governor agreed to include the CHCCDP funding to win support of hospital associations and unions for his waiver request. The hospitals had expressed concern about the impact of managed care on their bottom lines and wanted funding to offset losses from managed care reimbursement rates.

The Commission on the Public's Health System (Commission) assumed leadership on this issue in the Task Force based on concern about the continued viability of safety net providers and continuing access to care for the uninsured by these providers. Safety net providers include the public health and hospital system, some voluntary hospitals, and community-based health centers. The Commission and the Task Force worked to shape the parameters of the CHCCDP funding, before the waiver

was granted and throughout the course of this funding project. The Commission took very seriously the importance of assuring accountability for the spending of public funds and the need for public agencies to monitor this spending. The Commission also firmly believes that the public has the right to access and publicize information on public spending.

Because of the Commission's continuous and persistent advocacy regarding the implementation of the CHCCDP program and its funding, the program has changed over a period of years. A most notable success was an agreement to change the allocation formula for the distribution of CHCCDP funds in the last two of five years of funding. On the negative side, however, there have been gaps in enforcing requirements for accountability and monitoring of hospital care for the uninsured.

Information about spending under this program has not been readily available to the public. To date, three fifths of the $1.25 billion available for CHCCDP - or $750 million – has been allocated to 89 hospitals statewide. This report will evaluate how this extraordinary amount of public funding has been spent in the city hospitals receiving this funding. The 43 hospitals (in Cycle I it was 44 hospitals) in New York City have been allocated the lion share of the total funding – $214,880,767 of the $250 million statewide for Cycle I and $433,483,398 of the $500 million for Cycles II and III.

This report is not the first time that the Commission reviewed documents to analyze the spending of CHCCDP funding. In 1999, the Commission requested copies of Cycle I funding proposals for each of the New York City hospitals. Comments were submitted to the State Health Department on some glaring problems found during this review. For example, funding was allocated to Union Hospital in the Bronx, although that hospital was in the process of closing. In addition, several hospitals proposed to spend CHCCDP funds to assist their managed care organizations in doing outreach to potential enrollees. The Commission commented on this inappropriate use of funding, which was disallowed. In 2001, the Commission reviewed documents from the Health

and Hospitals Corporation on the spending of CHCCDP I funds.[1]

This report is also being prepared with the expectation of influencing hospital proposals for the spending of CHCCDP funds for Cycles IV and V. A review of documents from each of the hospitals in New York City reveal some serious problems with how some of these funds are being spent. The Commission expects that casting a certain amount of light on this issue could result in a more accountable process and more targeted proposals for spending of the final two years of CHCCDP funding.

Background & History of CHCCDP

Even before the CHCCDP program was devised, District Council 37 (which represents the public hospital employees) and its national union, AFSCME, had pressed the federal Health Care Financing Administration (HCFA) for several years. This effort was meant to insure that traditional safety net providers, including the public hospital system, be guaranteed a Medicaid funding stream to enable them to function effectively in a managed care environment and to retrain their workers for these changes. The union argued that without this assistance, Medicaid revenue reductions – through rate cuts and competition – would make it impossible for these institutions to adapt to changing conditions and maintain the necessary level of care for the poor and uninsured.[2]

However, CHCCDP as initially envisioned[3] by Local 1199, SEIU (representing workers primarily in private hospitals), would have provided $250 million per year, over five years, only to New York City's voluntary hospitals to assist them in transitioning to

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[1] Judy Wessler and Linda Ostreicher. *Sinking to the Bottom Line.* Commission on the Public's Health System. New York. May 2001.

[2] Stanley Hill, then Executive Director of DC 37. Correspondence with Helen Smits, Deputy Administrator, HCFA, April 28, 1995 and Alison Greene, Regional Director, DHHS, July 22, 1996.

[3] The description of the CHCCDP funding project is adapted from *Sinking to the Bottom Line,* a report by Judy Wessler, Linda Ostreicher, and the Commission on the Public's Health System. May 2001.

managed care for Medicaid patients. 1199's position was that there were two problems: 1) New York City's hospitals lacked the capacity to do the necessary restructuring within the time frame spelled out in the waiver; and 2) the change would have a deleterious impact on the institutions, on health care services, and on the labor force. 1199 maintained that because most of the city's voluntary hospitals have about 25% in Medicaid revenues, and the safety-net voluntaries have 70% Medicaid, there would be a tremendous impact on the work force. (There was no mention of how many uninsured patients are treated by these hospitals). As initially planned by 1199, CHCCDP funding was to be allocated specifically for capital and for retraining. 1199 wanted to see hospitals build new ambulatory care facilities and form partnerships with community centers. The union supported flexibility in the spending of the money, maintaining that the worker retraining money in the state's Health Care Reform Act was too restrictive, so this money could broaden what is allowed.

When pressured to support an expansion of facilities eligible for CHCCDP, 1199 first recommended an expansion of the dollars available so the public hospitals could also participate. But additional funds were not available, so 1199 had to agree to share the $1.25 billion dollars. The $250 million per year was a straight match of federal dollars for currently unmatched state spending on health care for the poor. As for allocating some of the funds to community-based safety net providers (rather than hospitals), an 1199 representative said that the union hoped that 1199 hospitals would choose to work with these facilities. District Council 37 proposed limiting the funding to safety net hospitals, like the public system, where 40 percent or more of the patients are on Medicaid or are uninsured. This was not done, but in the waiver agreement, to qualify for CHCCDP funding, hospitals had to have at least 5,000 inpatient discharges a year, of which at least 20 percent had to be Medicaid and uninsured inpatients.

District Council 37 also argued, along with the Commission and the Task Force, that to force the type of restructuring that CHCCDP was designed to encourage, funding levels should be based on outpatient – not inpatient – levels of services. These organizations also urged that the State be required to develop new data systems to make those calculations. The waiver required that the first year of CHCCDP funding be

based on inpatient discharges, but that the state work with HCFA to develop a new formula for Year 2 funding and beyond that incorporated outpatient data, and to develop more reliable ways of reporting outpatient data.

The Commission and Task Force argued for funding to go directly to community-based health care providers, which also needed to transition to managed care. They were unsuccessful in winning this argument, since the hospitals and their unions had initially obtained this money. However, the groups were successful in negotiating with the Health and Hospitals Corporation (HHC) to form the Community Health Partnership, under which HHC would receive the CHCCDP funds, set up a Core Group Task Force to work on proposals, and contract with community-based providers. Based on this agreement, and the strong support of District Council 37 and AFSCME, the Health and Hospitals Corporation was awarded $103 million in Year 1's $250 million allocation. However, when the time came for each public hospital to write its proposal, the commitment to contracting with community based providers waned.

The CHCCDP Formula

As noted above, to be eligible for funding under CHCCDP, hospitals had to maintain 5,000 discharges per year, of which 20% had to be Medicaid patients or persons with no insurance. In the first year, funding was allocated based on the number of inpatient discharges for these populations.

Partially because of the state's inaction, the first year of funding dragged on into more than two and one half years[4]. The Terms and Conditions of the waiver required that the state and HCFA work together on a new allocation formula for Cycles II and III of the CHCCDP funding that would incorporate ambulatory care data. (Because of the long delay, the state began referring to the time frame for CHCCDP in cycles rather than years). However, despite the initial concern that the available ambulatory care data was unreliable, new data collection methods were not developed.

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[4] The waiver required that CHCCDP funding to hospitals be tied to a phasing in of mandatory enrollment in managed care. Delays in the phasing of mandatory enrollment also contributed to the delay in CHCCDP funding.

Another contentious issue in the development of the formula was how to weight care for the uninsured. HCFA and the state combined data for care of Medicaid and uninsured patients. Advocates argued that care for uncovered patients should receive greater weight.

The state developed its own proposed Cycle II formula for the allocation of CHCCDP funds, which was submitted to HCFA in the middle of a presidential campaign, thus ensuring a political solution to a question of methodology. Despite strong efforts to change the state's proposed formula by the Commission, the Health and Hospitals Corporation, District Council 37, and AFSCME, it was approved by HCFA. After further efforts by the Commission and the Task Force, one concession was made: that the state's proposed formula would be applied to Cycles II and III of funding, but that the state would have to involve Medicaid advocates in the development of a funding formula for Cycles IV and V, thus leaving the door open to change.[5] HCFA also required that the State Health Department develop a proposal to monitor hospitals' provision of care for the medically indigent, including the uninsured.[6] The state's proposal for monitoring was approved by HCFA despite concerns raised by advocacy organizations, who felt the requirements were not strong enough.

Charts prepared by the Commission on the Public's Health System showed that under the state's inequitable formula for Cycles II and III, New York's safety net hospitals – both public and private – were losers. The big winners were institutions – primarily Academic Medical Centers – that provide minimal services to the uninsured. See Appendix A for Chart of Winners and Losers in CHCCDP.

In 2001, the Commission was contacted by the State Health Department to participate in a Task Force that would review and design a new methodology for allocation of funding for Cycles IV and V. After a meeting of the state Task Force –

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[5] Letter from Timothy Westmoreland, Director, Center for Medicaid and State Operations, HCFA to Judy Wessler, Director, Commission on the Public's Health System. November 29, 2000.

[6] Letter from Timothy Westmoreland, Director, HCFA to Dennis Whalen, NYSDOH. November 9, 2000.

which also included representatives of the Managed Care Task Force, the State Hospital Association, and the Greater New York Hospital Association -- the Commission submitted a proposal for a different method of distributing the funds.

Linda Ostreicher, then a member of the Commission's board, developed a proposal that would double the weighting for care of uninsured patients. The Commission's proposal grew from concern that under the existing arrangement, CHCCDP hospitals could be rewarded for providing more care for Medicaid patients while turning away the uninsured. The numbers of uninsured patients treated at HHC facilities was increasing, so that about one third of the total patient population at HHC were uninsured. Greater New York Hospital Association and the State Health Department, citing concerns similar to each other that CHCCDP was to focus on Medicaid, rejected the Commission's proposal.

In early 2002, the State Health Department reviewed the provision of hospital care to the uninsured and required certain hospitals to respond to an analysis showing that there was a large swing in the amount of this care provided at that hospital.[7] This review was based on data submitted by hospitals on a state required form, the Institutional Cost Report (ICR). Based on the state's review, and the hospitals' responses to the request for review of their data by the state, the State Health Department concluded that the voluntary hospitals were continuing to provide the same levels of uncompensated care for the uninsured. The Commission requested copies of the hospitals' responses and learned that some of the hospital responses recognized mistakes, errors, and problems in reporting care for the uninsured on their Institutional Cost Report. These responses reinforced concerns about the validity of this data that had been raised by DC 37, Health and Hospitals Corporation, the Commission, and the Task Force during the initial negotiations for the parameters of CHCCDP funding. The unreliability of ICR data, particularly as it relates to care for the uninsured, once again became a serious issue, but this time it was based on finding serious flaws in reported data.

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[7] Letter from Mark Van Guysling, New York State Department of Health to Judy Wessler, Director, Commission on the Public's Health System. March 1, 2002.

The Commission enlisted support, and the technical expertise, of the Health and Hospitals Corporation and others, to analyze the problems with ICR data reporting and to develop new proposals for distribution of CHCCDP funds that would assist safety net hospitals. Efforts were made to include voluntary safety net hospitals, but these efforts were not successful. The Commission, with HHC and others' support, developed and formally proposed to the State an alternative formula, to determine the distribution of the last two cycles of funding, that would prevent two major problems with the present system:

- **Medicaid beneficiaries can displace the uninsured.** Hospitals benefit financially from treating patients with Medicaid coverage, and lose money on patients with no coverage. The existing award formula allowed them to add together the sum of their Medicaid care and their care to the uninsured, and would allow a hospital that turned all uninsured patients away to receive the same award as a hospital which treated every uninsured patient who sought care. The Commission proposal would distinguish between the two groups, counting care for the uninsured as a separate factor from Medicaid care.
- **Inpatient care is given too much weight, in comparison to outpatient (clinic-based) care.** A major point of CHCCDP was to help hospitals shift the location of care from the hospital bed to the outpatient clinic, if they are to succeed at managed care. However, the existing award formula penalizes them for reducing their use of inpatient care, and fails to reward them for increasing outpatient care. Both types of care should be counted. The Commission's formula gives outpatient care an importance based on its actual role in hospital spending.

Using the hospital-reported problems with ICR data as a starting point, the experts did further analysis of other ICR data problems, particularly in the reporting of uncompensated outpatient care. Many questionable practices were identified and reported to the state. The Department of Health ultimately committed to cleaning up some of the "dirty data" issues that were identified. For example, Staten Island

University Hospital over-reported ambulatory care data, by counting visits that were not made to facilities listed on their hospital operating certificate. These visits went steadily up from 700,104 in 1996, to 1,045,256 in 1998, then down to 226,705 in 1999.[8] The Department of Health investigated this problem after it was pointed out to them. Large numbers of Home Health services (14 hospitals) and Home Dialysis services (9 hospitals) were also incorrectly reported as ambulatory care visits.[9]

By July 2002, the State Health Department had agreed to discuss alternatives for modifying the allocation formula.[10] Several new proposals for different methodologies for the allocation of CHCCDP funds were submitted. Finally, there was agreement that special recognition should be given to the provision of care for uninsured patients. Hospitals would receive a 25 percent increase for self-pay care, thus raising the amount of funding going to hospitals that provided more out- and inpatient services for people who have no health insurance.[11] District Council 37 and the Health and Hospitals Corporation contributed greatly to this positive outcome.

Overall, the work to improve the allocation formula for CHCCDP funding for the final two cycles of funding has been successful. The agreement by the state Health Department to clean up some of the hospitals' reported ICR data was a major victory. Before last year, the department had continually defended this data and was unwilling to admit that there were problems. Since this information is used for more than the calculation of CHCCDP allocations, this acknowledgment should have even broader implications for funding decisions.

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[8] Letter to Mark Van Guysling, New York State Department of Health from Judy Wessler, Director, Commission on the Public's Health System. October 11, 2002.

[9] Ibid.

[10] Letter from Mark Van Guysling, NYSDOH to Judy Wessler, Commission, July 19, 2002.

[11] Letter from Dennis Whalen, Executive Deputy Commission, New York State Department of Health to Michael Fiore, Director, Division of Integrated Health Systems, Centers for Medicare and Medicaid Services, requesting approval of changes in the CHCCDP formula. October 15, 2002.

In addition, after much effort, the State did agree to upweight the accounting for services provided for the uninsured. This new formula was submitted to CMS (the successor agency to the HCFA) and was approved by the federal agency. Giving extra weight for providing this care is an important principle, since it is the safety net hospitals – those that make themselves available to the entire community regardless of the ability to pay – that are the most financially vulnerable when economic and delivery systems change. This changed formula should also be used for the distribution of other funds, such as the Medical Indigent Pools under the State's Health Care Reform Act (HCRA).

Monitoring and Accountability for the Spending of CHCCDP Funds

When the Community Health Care Conversion Demonstration Project was approved by HCFA/Department of Health and Human Services, strong efforts were made to build in levels of accountability for the spending of these funds. Perhaps because of the political nature of these funds, federal and state government officials were reluctant to specify language that would strengthen government's ability to monitor spending. Advocates urged the New York State legislative staff to introduce language requiring some accountability for CHCCDP in the state authorization for the spending of these funds. In the past, the Assembly had often supported monitoring and accountability measures. For the CHCCDP program, however, legislative staff was not interested in discussing stronger legislative language.

The state's reporting to the federal agency, HCFA now named the Center for Medicare and Medicaid Services (CMS), on CHCCDP is contained in quarterly reports. Typically the section on CHCCDP is two-three pages long and contains information on the total dollar amount expended during each of the CHCCDP cycles. The number of completed site visits to hospitals is also reported. In the most recent quarterly, state staff reported on the department's monitoring of the requirement to provide medically necessary care (in one paragraph). This report also stated that the department had

reached an agreement on changes to the allocation formula.[12] It is the Commission's understanding that this is the extent of what is publicly available based on CMS' federal oversight on the New York State CHCCDP program. The federal agency may have been limited because of the way the Terms & Conditions were written.

As troubling as the lack of willingness to require legislative oversight of this program, was the extreme difficulty in obtaining documents from the State Health Department. It took approximately one year, even invoking the Freedom of Information Laws, to obtain some of the documents requested. When the state continued to delay release of these documents, the Commission on the Public's Health System, represented by the Urban Justice Center, filed an Article 78 legal action to require that they be produced. At that point (December 2002), some of the outstanding requests for documents went back to February 2002 and others to July 2002. Even as this report is being written in March 2003, the Commission has been unable to obtain the Final Reports for Cycle 1 funding, which started in1999 and ended sometime in 2001. It is unfortunate that these reports are not available, since although not descriptive, they do require some statistical information that is not available in reports that the Commission has been able to obtain to date.

Initial Guidance

The Terms and Conditions for CHCCDP appeared as Attachment (J) to the approval of the New York State Partnership Plan (the Medicaid managed care waiver), signed on July 15, 1997. This four page attachment contained one-and-one half pages of language related to how the program would be funded. The next full page outlined the criteria determining which hospitals would be eligible for CHCCDP funding. These criteria included: hospitals must have at least 5,000 discharges per year; at least 20 percent of total discharges must be Medicaid and self-pay patients; and finally the hospitals must certify that they would provide all medically necessary care to medically

[12] Letter from Kathleen Shure, State Department of Health to Cheryl Tarver, Center for Medicaid and State Operations, CMS. March 14, 2003. Quarterly Report: October 1, 2002-December 31, 2002.

indigent patients coming to the hospital for services. The last requirement regarding indigent care was a priority issue for the Commission. Hospitals also needed to agree to participate in the Partnership Plan and contract with Medicaid managed care organizations.

For the first year of CHCCDP funding, the allocation formula was determined based on a weighting of participating hospitals' Medicaid and self-pay inpatient discharges. The beginning of funding was tied to a phasing in of mandatory enrollment in managed care. Language about what would be approved and funded by the state was quite vague and included the following:

> Receipt of funding in any year is contingent on the eligible hospitals submitting an application to the State on an annual basis that details the restructuring goals of the upcoming year and accomplishments over the previous year, if applicable, including the activities outlined in item 9 below. Upon review of the applications, if the State determines that the hospitals have met their prior year restructuring goals and have appropriate goals for upcoming periods, hospitals will receive the full annual allocated amount, depending on available funds. Any funds not allocated to eligible hospitals, in whole or in part, as a result of failing to meet these requirements shall be reallocated to other eligible hospitals by the Commissioner....Funds distributed to eligible hospitals may be recouped by the Commissioner from such hospitals upon an audit finding that the expenditure of funds was not in keeping with the approved application for meeting CHCCDP goals.[13]

The Terms and Conditions also required that 60 days after approval of state legislation, the state would submit an amendment to the operating protocol that identified: which agency would be responsible for the program, the model application form, the amount of dollars each hospital would be receiving, the process for reviewing hospital proposals for funding, and the method for auditing the expenditure of these funds. (Sect. 8)

Finally, there was acknowledgment of the need to expand primary care and to restructure health facilities serving the poor. Attachment J of the Terms & Conditions stated that in reviewing applications, "the State will encourage hospitals to incorporate

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[13] Attachment J. NY Partnership Plan Terms and Conditions. July 15, 1997. DHHS/HCFA. Sect. 6

the following types of linkages into their restructuring plans: enhanced linkages to existing article 28 diagnostic and treatment centers....linkage with local health departments; establishment of new, hospital affiliated individual or physician primary care group practices in Federally-recognized medically underserved areas and health professional shortage areas".[14]

Despite the vagueness of this language, there was clarity on certain points:

- Twenty five percent of the allocated funding for each hospital was to be spent on worker retraining;
- The remaining 75 percent of the funding was to be spent within two general categories: expansion of primary care and managed care readiness;
- Each hospital was to be required to sign a certification statement that the hospital would provide care to the medically indigent (including the uninsured);
- The state was to develop an application form which hospitals were to file on an annual basis, with goals for the coming year's funding and a report on how the funding for the prior year was spent to meet those goals;
- Hospitals were encouraged, although not required, to work with diagnostic and treatment centers and the local department of public health to meet their goals;
- Unallocated funds were to be redistributed by the commissioner to other participating hospitals.

Clearly the language of the Terms & Conditions was vague on specific requirements of what should be funded under CHCCDP. Some of the requirements, although spelled out in the Terms & Conditions, were nonetheless not adhered to. For example, the state was required to work with the federal agency to develop a new methodology for allocation of funds which incorporated outpatient data. Instead of this cooperative development, the state delayed in developing a new formula and only turned to the federal agency when it was time to approve what the state had formulated by itself. Unfortunately the federal agency chose to approve this formula anyway, but did (at the urging of the Commission and others) place some additional requirements

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[14] Attachment J. Page 71.

on the state. These requirements included: going back to the Medicaid advocates for development of a new formula for Cycles IV and V; and requiring the state to monitor whether hospitals were providing services to the medically indigent, particularly the uninsured.

A Press Release from the Governor's office included the following description of CHCCDP: "...a five-cycle, $1.25 billion program directed to eligible hospitals with approved projects to retrain workers, increase their provision of primary care to the community, or make system changes necessary to participate more fully in managed care networks....The first grant cycle distributed previously totaled $250 million and supported a wide array of hospital projects aimed at meeting the health care needs of their communities. The funding enabled additional primary care services to be offered and it enabled hospitals to expand access to services through evening and weekend hours".[15]

Review of the Commission's Goal for the CHCCDP Funding

Review of the hospital CHCCDP documents was guided by two priorities:

- Was the funding used in a way that was consistent with the underlying goal of the program to help hospitals transition to Medicaid Managed Care? and;
- Were the hospitals' proposals consistent with the goals as defined by the Commission on the Public's Health System?

The Commission worked with the New York City Task Force, and others, on defining goals for the CHCCDP funding and program. Initially, the Commission and Task Force worked to have funding from the CHCCDP program go directly to community-based health care providers to expand primary care services, particularly in medically underserved neighborhoods. When it was realized that such funding would not be possible, we worked to ensure that a portion of the funding would flow through the hospitals receiving funding out to community-based providers. The goal was to ensure culturally and linguistically competent health care services in communities where

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[15] Http://www.state.ny.us/governor/press/year01/jan09_03_01.htm.

these services were needed.

The Commission also worked to ensure that hospitals receiving CHCCDP funding would guarantee access to health care services to all residents, regardless of their ability to pay. Other states used savings from managed care to expand insurance coverage to uninsured residents. This did not happen in New York. Instead, funding was only made available to hospitals, which is an unfortunate pattern that is often repeated in this state. The Commission, with others, advocated for requiring hospitals to sign a strong certification statement guaranteeing that they would provide medically necessary services for the uninsured. The certification that was included was weak. The Commission then urged the federal agency to require more reporting requirements on the actual provision of care for the uninsured.

The Commission supported worker retraining funds be allocated to training projects that would increase staffing for primary and ambulatory care services. Other important goals included: upgrading training for staff, particularly in hard to fill positions such as nursing; training to improve the skills of staff; foreign language and interpreter training; cultural competency; and other patient-centered training topics.

The Commission and Task Force supported a reworking of the allocation formula for distribution of CHCCDP funding, based on improved ambulatory care data and an increased weighting for care to the uninsured. Although we were unable to influence the formula for funding Cycles II and III, the Commission's comments on the formula convinced the federal oversight agency to require a reopening of the formula issue for Cycles IV and V.

The Commission strongly endorsed the need for accountability and oversight for the spending of public funds. Since there has been no public reporting or public involvement in the review or decisions of how CHCCDP funds should be spent, the Commission embarked on this study to review and analyze the appropriateness of a large portion of the $750 million of public funds, which has been spent.

What did New York State Require from Hospitals to Account for CHCCDP Funding?

Funding for the initial year of CHCCDP's five year funding, was based on an application to the State Health Department. Guidance for reporting requirements was sent to hospitals in February, 1999 for Cycle I funding. Less detail was required in Cycle I funding applications. New York City's phasing in of Medicaid Managed Care was somewhat delayed, so funding was slow, with hospitals in the city initially receiving 15% of their first cycle allocation between October 1, 1997 and December 31, 1998. The application for Cycle I required:[16]

- Project Summary (1 to 2 pages);
- Market Description (1 to 3 pages), including description of hospital catchment area and role of the facility in the community;
- Work Plan (4 to 8 pages), including a description of the goals for the project;
- Budget form that was attached, and a budget narrative; and
- Description of project management (1 page).

Funding for Cycles II and III was delivered in several phases and required:

- A Program Progress Report for each funded project that included: activities, expected outcome, completion date, and status of activities.
- An Expenditure Report.
- Budget Modification Request.
- **Cycle I Final Report,** 4 pages. (Emphasis deliberately added).[17]
- Written Directive for advance payment of 25% for the two years. This allocation was based on a very simplified application form.

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[16] Draft Chapter. Community Health Care Conversion Demonstration Project application guidelines. September 18, 1997. Division of Planning, Policy and Resource Development. New York State Department of Health.

[17] The Commission only learned that these reporting forms were required by reviewing the guidance package to hospitals. Only one of the hospitals' applications received initially from the State Department of Health contained this form. The reporting of care for the medically indigent form for each hospital was separately requested in a Freedom of Information Law request.

- Requirements for the second phase of 55% payment for the two year cycle, were contained in a letter and documents from Mary Ann Anglin, Director, Primary and Community Health Care Development Programs, New York State Department of Health, March 2001. This submission required workplans and budgets.
- A description of how the CHCCDP hospital intended to comply with the certification requirement that they provide "medically necessary" care to all indigent patients. Forms were included in the application requirement for reporting on the hospitals' policies and their monitoring activities.
- For the primary care/managed care component, hospitals had to include outcomes in terms of increased visits. Under managed care projects, outcomes also had to be quantified. Budget reporting forms were also included.
- For the worker retraining projects, there also needed to be a measurable outcome with estimates of numbers of people to enter training.
- The workplans required: the project name, expected outcome, and completion quarter.

Documents Received from the State Health Department

As noted above, the process of obtaining information from the State Health Department on hospital reports and applications for CHCCDP funding was long and drawn out. It was only when the Commission filed an Article 78 proceeding against the department that materials were received. Even so more than 13 months after the first request for information was made in February 2002, the Commission has not received all of the documents requested. The following charts display what has been received to date from the State Health Department for each of the New York City hospitals receiving CHCCDP funding. The Health and Hospitals Corporation facilities will be reported separately.

An X mark in the box signifies that the Commission received these documents from the State Department of Health. Dash marks (–) signify that these documents were not sent to the Commission. Regarding the site visits, it should be noted that not every hospital has been visited by staff of the State Health Department.

Bronx CHCCDP Hospitals

Hospital	Site Visit Report	Cycle I Final Report	Cycle I Summary Report[18]	Cycle II & III Final Application	Provision of Care to the Medically Indigent
Bronx Lebanon	X	–	X	X	X
Montefiore	X	–	X	X	X
Our Lady of Mercy	X	–	X	X	X
St. Barnabas	X	–	X	X[19]	X[20]

[18] Submitted as part of the Final Application for Cycle II and III funding. Many of these submissions offer the only information available on Cycle I, but were only one or two pages long with little information.

[19] Submitted 12/05/02, which was late in the application process. Received by CPHS February 7, 2003.

[20] Policy was submitted. But there was no Certification form.

Brooklyn CHCCDP Hospitals

Hospital	Site Visit Report	Cycle I Final Report	Cycle I Summary Report	Cycle II & III Final Application	Provision of Care to the Medically Indigent
Brookdale	X	–	Partial	X[21]	X
Brooklyn	X	–	X	X	X
Interfaith	X	–	X	X	X
Kingsbrook	X	–	–	–	Partial
Long Island College	–	–	X	X[22]	X
Lutheran	–	–	X	X	X
Maimonides	–	–	–	–	–
Methodist	X	X	–	–	X
Victory Memorial	X	–	X	X	X
SUNY Downstate	–	–	–	–	X
Wyckoff Heights	X	–	X	X	X

[21] Received by the State on August 29, 2002, and approved for funding on October 11, 2002. Received by the Commission on February 7, 2003.

[22] Received by the State on September 20, 2002, and approved for funding on November 1, 2002. Received by the Commission on February 7, 2003.

Manhattan CHCCDP Hospitals

Hospital	Site Visit Report	Cycle I Final Report	Cycle I Summary Report	Cycle II & III Final Application	Provision of Care to the Medically Indigent
Beth Israel	X	–	X	X[23]	X
Cabrini	X	–	–	–	–
Mt. Sinai	X	–	X	X	X
NY Eye & Ear	X	X[24]	–	–	– Cycle I funding only
NY Presbyterian	X	–	X	X	X
NYU Downtown	X	–	X	X	X
North General	X	–	X	X	X
St. Luke's Roosevelt	X	–	X	X[25]	X
St. Vincent's	X	–	X	X	X

[23] Received by the State on October 15, 2002, approved for funding November 15, 2002. Received by the Commission on February 7, 2003.

[24] This contract was terminated after Cycle I because the hospital did not continue to meet the trigger for funding of 5,000 discharges.

[25] Received by the State on November 2, 2002, and approved for funding on November 20, 2002. Received by the Commission on February 7, 2003.

Queens CHCCDP Hospitals

Hospital	Site Visit Report	Cycle 1 Final Report	Cycle 1 Summary Report	Cycle II & III Final Application	Provision of Care to the Medically Indigent
Catholic Med. Queens/Brooklyn	–	–	–	–	X
Episcopal Health Services	X	–	X	X	X
Flushing Hospital	–	–	–	–	X
Jamaica	–	–	X	X	X
NY Hospital, Queens	–	–	–	–	X
Peninsula	X	–	X	X	X

Staten Island CHCCDP Hospitals

Hospital	Site Visit Report	Cycle 1 Final Report	Cycle 1 Summary Report	Cycle II & III Final Application	Provision of Care to the Medically Indigent
Staten Island	X	–	–	X	X
St. Vincents & Bayley Seton	X	–	X	partial	X

These charts show clearly that there are many missing reports and documents. In correspondence, the State Health Department claims that they are not in possession of the missing documents. Yet, as will be shown below despite the absence of reports, funding has continued to flow to all of the hospitals that are eligible for Cycle II/III funding, despite the lack of reporting. Hospitals were allowed to submit a preliminary application and receive 25 percent of funding for the two cycles (II & III). It is possible that the State Health Department has additional documentation on the spending of these funds, but this information has not been made available to the Commission.

Health & Hospitals Corporation CHCCDP Hospitals[26]

Hospital	Site Visit Report	Cycle I Final Report[27]	Cycle I Summary Report	Cycle II & III Final Application	Provision of Care to the Medically Indigent[28]
Bellevue	X	X	X	X	partial
Coney Island	X	X	X	X	partial
Elmhurst	X	X	X	X	partial
Harlem	X	X	X	X	partial
Jacobi	X	X	X	X	partial
Kings County	X	X	X	X	partial
Lincoln	X	X	X	X	partial
Metropolitan	X	X	X	X	partial
North Central Bronx	X	X	X	X	partial
Queens	X	X	X	X	partial
Woodhull	X	X	X	X	partial

Review of the Hospital's Reports and Proposals for Spending of CHCCDP Funds.

An overall review of the listed documents revealed some very exciting projects funded that measurably increased access to primary care services, some contracting

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[26] The Health and Hospitals Corporation was responsible for submitting the reports and applications for all 11 of their hospitals, located in four boroughs. For that reason, the HHC hospitals are reported as a separate entity.

[27] These reports were received directly from the Health and Hospitals Corporation. In a legal brief, the State Health Department claimed that these are not the Final Summary Reports for Cycle I.

[28] Instead of HHC's policy for providing care to the medically indigent, other reports detailing the amounts and types of care were submitted. Yet a review of Cycle I Final Reports from HHC hospitals show a high percentage of services provided for the uninsured. For example, at Bellevue Hospital 29% of CHCCDP added primary care visits were made by uninsured patients. At Elmhurst, the number grew to 31%; 35% at Lincoln; 30% at North Central Bronx; and 55% at King County Hospital.

with community-based providers and community organizations, and some efforts to improve services and access to care generally. On the other hand, some hospitals provided very little information and it was quite difficult to assess how their CHCCDP monies were being spent. There were also some examples of spending on inappropriate projects that appeared to have no relevance to the stated goal of the CHCCDP project – to assist hospitals in transitioning to Medicaid managed care. Examples will be given of "good spending" as well as "bad and/or problematic spending" of these funds.

The Site Visit Report

The Commission reviewed 36 reports of site visits by the State Health Department staff to New York City CHCCDP hospitals, between June 2000 and June 2002. In all reports, a listing of the people who attended the site visit is indicated. Most of the reports were two to three pages long. In some cases, documents were cited as attached, but were not attached to the copies sent to the Commission. In some instances, the state team identified serious problems, but there is no indication that these problems were resolved, at least from the documents received by the Commission.

In addition, there is no evidence from these site visit reports that the Health Department did any independent review of what they were being told. On the contrary, it appears from these reports as if they accepted hospital claims at face value. In only a few of the site visit reports are concerns raised.

Cycle I Final Report

The Commission received only two of these Cycle I Final Reports officially from the State Department of Health. In a supplemental affidavit, Mary Ann Anglin asserted that the two Final Reports from Cycle I were the only such reports in their custody.[29]

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[29] Supplemental Affidavit. Mary Ann Anglin, Director of Primary Care and Community Health Care Development Programs, New York State Department of Health. February 28, 2003. Commission on the Public's Health System v. Antonia C. Novello and the New York State Department of Health.

There has been a continuing dispute about the availability of these reports, since funding under Cycle I began in 1999, it is hard to understand why each of the hospitals have not as yet completed this cycle and would not be able to complete this form. Some of the information required on the form for the Cycle I Final Report is not available from other sources, including quantifying the outcomes of activities funded by CHCCDP. For example, the Cycle I Final Report form requires:

- Worker retraining by employee category and by training type, such as clinical skills training, computer training, managed care training, workplace skills, development training.
- How many additional primary care visits occurred because of CHCCDP funding?
- The percentage of these visits by Medicaid patients?
- The percentage of these visits by uninsured patients?
- How many full time patient care providers were added?
- How many patient care hours per week were added?
- How many patient care exam rooms were added?
- How much other patient care clinic space was added?
- Check off of added, or expanded, services, including: primary care, dental, behavioral health care, etc?
- The number of collaborations with community health care providers, and the dollars allocated for this?
- The number of collaborations with human service organizations, and the dollars allocated for this?
- Improvements in operational efficiencies, such as average waiting time for a physical, waiting room time at an appointment, change in no show rate for an appointment, and change in emergency room utilization – all desired outcomes in preparation for managed care.
- Listing of other operational efficiencies and quantifying of improvements.[30]

Many of the categories of information listed on this form are relevant to the goals identified by the Commission and the Task Force as priorities for funding of CHCCDP

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[30] CHCCDP Cycle I Final Report, New York Methodist Hospital.

monies. Clearly, hospitals' failure to submit this form to the State Health Department, and the departments' negligence in requiring it, leaves a great gap in the ability to assess whether or not CHCCDP funded hospitals in New York City are meeting the goals of the program, or the goals of the Commission. It is important to note that within several of the hospital site visit reports, Health Department staff noted the need for these reports to be submitted.

Cycle I Summary Report

Cycle I Summary Reports are submitted as part of the Cycle II & III Final Applications for funding. The application form requests a "Summary of the restructuring accomplishments in Cycle I...Explain how the grant funds have been used to improve the ability of the hospital to meet the challenges of an evolving health care environment, in particular the move toward an environment of Medicaid Managed Care. When possible give quantitative measures."[31] Typically, hospital responses to this requirement have been 1-2 pages long, some with very little detail. None indicate how much money has been spent on the Cycle I listed projects. Although some of the hospitals listed exciting projects that addressed the goals set for CHCCDP, for the most part it was difficult to assess the value or the appropriateness of the dollars spent for these programs.

Cycle II & III Final Application

Cycle I lasted for over two and one half years. This extended period occurred because of delays in phasing in Medicaid managed care as well as a delay in the development, and approval of, a new funding formula. Because of this long delay, and the concern about getting additional funding to hospitals in an expedited manner, the State Health Department collapsed two funding cycles into one, Cycles II and III. In addition, hospitals were allowed to initially file an abbreviated preliminary application and on that basis were awarded an advance of 25% toward the total of the two cycles of funding. This funding was given to most hospitals in February or March, 2001.

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[31] CHCCDP Cycle II and III Final Application form.

Hospitals received another 55% of the funding at various times when they submitted their final applications.

Five hospitals received the advance and then did not submit a full application until after August 2002 – Beth Israel, Brookdale, Long Island College, St. Barnabas, and St. Lukes/Roosevelt. Nevertheless, all five of these hospitals received the initial 25% advance at the same time as the other hospitals, and more recently received their 55% second payment.

An additional eight hospitals, as of February 7, 2003, had still not yet submitted a Cycle II/III application – Cabrini, Catholic Medical Center of Brooklyn and Queens, Flushing Hospital, Maimonides, Methodist, New York Hospital Medical Center of Queens, Kingsbrook and SUNY/Downstate Medical Center. Yet, all of these hospitals received the 25% advance payment two years ago. As a result, no information was made available about the programs of any of these hospitals for Cycles I, II and III, except for Methodist Hospital, which submitted a Final Report for Cycle I, and Cabrini for which a site visit report was made available.

Overall, little information has been made available about the hospitals' programs and spending for Cycle I, although less detail was required during that Cycle. Only two Cycle I Final Reports are available from the State Health Department, with the explanation that the other reports do not exist. Although some information about Cycle I is required in the Cycle II and III applications, the typical one to two pages were submitted without much detail.

On the other hand, the Cycle II/III applications do require more back up details. Including: a summary of restructuring goals for the two-year cycle; detailed work plans, including expected outcomes and completion quarter; and a budget page for each project. The budget page requests details for personnel expenses, including the number of FTE's, and non-personnel expenses, including construction/renovation costs, equipment, supplies and contract. It is from this application, where the hospitals have completed them, that the reviewer is able to get a sense of the funded programs.

The Cycle II/III final application also required proposals for the Worker Retraining portion of the CHCCDP grants. This portion of the application (for most hospitals worth 25 percent of the total funding) were summarized for Cycle I and submitted separately

for Cycles II/III. The Health and Hospitals Corporation submitted the Worker Retraining proposals for all 11 public hospitals. For 21 of the voluntary hospitals, Local 1199/SEIU took over responsibility for the majority of the training and submitted the proposals for those hospitals. Among the voluntary hospitals, the worker retraining portion was often longer and more detailed than the portion submitted by the hospitals themselves about primary care/managed care.

Policies for Providing Care to the Medically Indigent

Because of strong advocacy efforts prior to approval of the Medicaid Managed Care waiver and throughout the course of this program, hospitals are required to certify that they will provide medically necessary services for the medically indigent – including the uninsured. Advocacy efforts prior to the approval of the funding formula for Cycles II and III led to a requirement, included on the certification form, that the Department of Health will:

-require that each CHCCDP eligible hospital submit a description of its policies and procedures, including monitoring activities, for ensuring compliance with providing medically necessary care to all indigent patients presenting themselves to the hospital for services;

-require that each hospital submit a report which provides detailed results of the monitoring activities;

-monitor each hospital's annually reported Medicaid and self-pay utilization for years within and preceding each award;

-require the hospital to explain any substantial reductions in either patient category; and

-require the hospital to submit a corrective action plan as a condition of on-going receipt of CHCCDP funds if it is determined that a change in submitted policies and procedures, and/or a failure in the hospital's monitoring system, contributed to a substantial reduction in Medicaid and/or self pay utilization.[32]

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[32] Community Health Care Conversion Demonstration Project - Cycles II and III. Certification to Provide Medically Necessary Care to Indigent Patients.

These requirements, if implemented, would be important in meeting the Commission's goal of ensuring access to services for the medically uninsured. Gathering information about the hospital's policies on treating the uninsured is a meaningful step toward understanding problems of access and barriers to access. All of the New York City hospitals receiving CHCCDP funds have made an effort to comply with these reporting requirements, as they relate to their policies, but they have not made the same effort in reporting the types of monitoring activities they will undertake.

Goals for CHCCDP-funded Hospitals

The evaluation of the hospitals' reports and applications (where available) is based on two sets of goals: the government CHCCDP goals; and the Commission/Task Force goals for this funding program.

- Government CHCCDP goals – were defined as expansion of primary care services, retraining of workers; and general activities to make hospitals managed care ready.
- Commission/Task Force goals – expansion of primary care services; contracting with community-based providers; providing culturally and linguistically competent services; ensuring access to services for the uninsured; worker retraining projects that would increase primary and ambulatory care staffing, upgrading training for staff particularly in hard to fill position, training in foreign language and interpreting skills.

Our evaluation of hospitals' CHCCDP expenditures is based on how they met both the Commission/Task Force and the government goals for this program. This information was pieced together from the documents provided by the State Health Department. There are probably significant holes in this report, due to the incompleteness of the documents provided. Three examples of problems identified in site visit reports are:

- St. Barnabas Hospital visited on 11/28/01 - Serious problems were found. The hospital was unable to provide visit data. Few worker retraining projects had begun, and reporting is an issue. The new MIS system was abandoned after the

hospital had reported that it was completed. The site visit team was scheduled to tour a new ambulatory care building under construction, but they were unable to make this visit. The site visit report ended with the statement that a follow-up site visit would be scheduled in the near future. If it was, the Commission was not given a copy of this report.

- Staten Island University Hospital visited on 6/20/01 - the report makes reference to several attachments which were not attached to the report sent to the Commission. Much hard work was needed by the hospital and DOH to straighten out problems in Cycle I funding. "There was an issue with the report that 90% of the funding had been expended by the hospital, while considerably less than 90% of the activity represented in the workplan had been accomplished." Reference is made to the problems being worked out. There is reference to an attachment for failed project/lessons learned for primary care, but this document is not attached. This is extraordinary in light of the fact that funding for Cycle II and III for this hospital increased dramatically.
- St Vincent's/Richmond and Bayley Seton Hospitals were visited on June 20, 2001. The site visit report notes that DOH auditors are looking at CHCCDP expenses for both of these hospitals, and that at that time the issue was not resolved.

Working within the limitations of this incomplete documentation, we have done our best to assess the CHCCDP expenditures of each hospital. Some portion of this funding appears to have been spent wisely, resulting in an increase in availability of primary care services; enhanced readiness for Medicaid managed care; and training of hospital workers to have the skills to provide services for Medicaid and uninsured patients and adjust to the new managed care environment.

Other funding was spent in a questionable manner, considering the underlying rationale for this program. Some examples are:

- One hospital, St. Vincent's/New York, spent all of its 3 cycles of funding meant for primary care/ managed care on an inpatient case management system.
- Another hospital, Brookdale, spent almost all of its non-training funds on upgrading its computer systems for Y2K readiness.

- Beth Israel spent a portion of their funds on a primary care clinic for Japanese patients located in Hartsdale. Hartsdale is known as a high income community in Westchester.
- Montefiore spent a portion of their funds at a hospital-affiliated HIP center, an HMO which only provides care for enrolled patients, not the uninsured.
- Some hospitals, such as Mt. Sinai, had very high salaries listed. Other hospitals had high administrative costs.
- A few hospitals expanded services and/or outreach/education for seniors. Seniors are generally not uninsured and even if they are dually eligible (for Medicare and Medicaid) they are not required to enroll in managed care.

The authors of this report are not expert in computer technology, so the various new and upgraded systems are not evaluated. However, it is hard to understand the expenditure of CHCCDP funds for Y2K readiness, which is the way that one hospital spent its' allocated funds.

Primary Care/Managed Care Charts

The hospital charts reporting on primary care and managed care readiness expenditures will be reported by boroughs, except in the case of the public system, the Health and Hospitals Corporation. HHC submitted one application for all 11 hospitals, so these hospitals will be reported separately, divided into the HHC networks in which they are located.

The worker retraining portion of the hospital applications will be presented in separate charts.

Where large dollar amount for projects were listed in the application, they will be included in these charts.

In the first column on the charts, the dollar figures signify:

- The total allocated dollar amount for Cycle I.
- The total allocated dollar amount for Cycle II and III.
- The total dollar amount drawn down by the hospital by February 13, 2003 for Cycles I, II, and III.

Bronx Hospitals - Primary Care/Managed Care

Hospital	Construction	Expansion primary care	Managed care readiness	Contracting/ working with CBO's	Cultural & Language Competence	Administrative	Other
Bronx Lebanon Cycle I, $10.6 mil. Cycle II/III, $20.9 mil. total drawn = $26,162,238	Hunts Point Avenue Clinic, Women's Health Center at hospital.		Call Center (4.6 mil), Standardized referral protocols, transportation network		Basic Spanish training.	MIS system with Montefiore Hospital (3 mil) Re-establish Office of Managed Care (3.2 mil)	"Bronx Care" marketing campaign, Patient Financial Investigation Unit (3.1 mil).
Montefiore Cycle I, 1.8 mil. Cycle II/III, $9.4 mil. total drawn = $9,383,664	New primary care exam rooms Relocated Comprehen. Family Care Center (7 mil), expanded peds ER. Expanded OB at Einstein	Increased nutritionists, social workers, & patient service reps. Expanded MMC/HIP center	Developed health education prog.		Spanish for health care workers. Cultural/diversity training.	Information Systems at HIP centers affiliated with the hospital.	
Our Lady of Mercy Cycle I, 2.2 mil Cycle II/III, 4.6 mil. total drawn = $5,720,094		Developed foster care extension clinic	Operations re-engineering assessment		Spanish for medical personnel	Lease cost for upgrade of information systems (3.5 mil)	
St. Barnabas Cycle I, 4 mi Cycle II/III, $14.2 mil. total drawn = $18,981,212	Mobile Mammography van. Renovation of off-site. Build new ambulatory Clinc	Expand Soundview Medicine Clinic, add primary care docs and staff				MIS system with hospital's PHSP, later abandoned.	

Brooklyn Hospitals - Primary Care/Managed Care

Hospital	Construction	Primary Care	Managed Care Readiness	Contracting/ Working with CBO	Cultural & Language Competence	Administrative	Other
Brookdale Cycle I, $4.1 mil. Cycle_II/III, 7.5 mil. total drawn = $9,340,514						Upgrade Computer Programs	Information Systems for Y2K readiness
Brooklyn Cycle I, $5.6 m., Cycle II/III, $10.5 m. total drawn = $12,959,278	Renovate family practice site - Caledonian renovate other hospital space	added 5 doctors to off-sites, 2.5 at hospital, dental expansion to off-sites.	computer system, patient processing enhancements	La Providencia Health Center		Consultant, managed care review. Created ED of managed care	Used consultant to manage projects. Utilization and revenue management task force.
Interfaith Cycle I, $7.1 m Cycle II/III, 11.3 m. total drawn = $14,664,050	Construct speciality clinic (5.6 mil.), 3 satellites		Date system network. ($3.6 mil)			Develop professional billing vehicle	
Long Island College Cycle I, $2.7 m Cycle II/III $4.5 mil. total drawn = $5,389,433	Renovate allergy clinic	added 4 primary care docs, expanded sessions by 40%. Expand OB to Saturdays	Transport system to off-site clinics	Uninsured contract w/CBO's, Parish Health Program w/ 4 CBO's. Provide midwife at Bed Stuy FHC.		Consultant to assess staff functioning. New computer systems.	Asthma & diabetes workshops
Lutheran Cycle I, $4.1 m Cycle II/III, $11.5 m. total drawn = $12,499,915		Convert part time to extension clinics for Russian & Arabic pop.	Same day appts.. Managed care college for docs	Partner w/5 FQHC'S	Pt. materials translated in Russian. Bilingual RN's for telephone advice line.	MIS expansion ($6.9 mil)	

NY Methodist (only Cycle I) Cycle I, $1.7 m Cycle II/III, $4.05 m total drawn = $2,582,992		Expand # exam rooms, visits, hours.	Case management program	Kensington part time clinic			
Victory Memorial Cycle I, $345,176 Cycle II/III, $1.6 m $1,730,216		Hired 2 docs to serve Medicaid and uninsured. Nurse Health Educator			Letters/other info translated to Russian, Chinese, Albanian		
Wyckoff Cycle I, $5.3 m Cycle II/III, $9.3 mil. total drawn = $11,876,000	Purchased mobile van. Renovate vacant building for women's health center.	Primary care evening clinics, hired staff. Expand outpatient OB.	Asthma awareness education, closed circuit TV system. Diabetes Center	Lyndon Baines Johnson Health Center, provide docs and midwives		Clinical manager system ($2 mil)	Advertising & Outreach

Manhattan Hospitals - Primary Care/Managed Care

Hospitals	Construction	Primary Care	Managed Care	Contracting/ Working w/CBO's	Cultural & Language Competence	Administrative	Other
Beth Israel Cycle I, $6.4 mil. Cycle II & III, $19.01 mil. total drawn = $20,319,259	?	5.6 added primary care docs to expand to evening and weekends at off-sites. Staff for Williamsburg clinic (since closed) Primary care expansion for Japanese Americans in Manhattan and Hartsdale (1.5 mil).	Expand Patient Education program. Management Services Organ. (MSO) set up (later disbanded). Expand managed care department.	MSO with Community Health Centers (FQHC), but it is not clear this is still in operation. Community collaborations for health promotion and disease prevention.	Establish translation service - language not specified. Hire culturally competent docs.	Computer and call systems.	Referral coordinators at Information Desk. Medical records upgrades.

Mt. Sinai Cycle I, $2.9 mil. Cycle II & III, $8.2 mil. total drawn = $8,961,084	Renovate & relocate Medicine/Pediatrics practice.	Expansion of evening or weekend peds clinics.	Hire consultant to plan readiness. Case and disease management for primary care practices. Call Center support.	Access to website for CAS Milbank-Dunleavy Center.	Spanish language training for docs.	Medical resource management education put on hold, Electronic medical records. Integrated registration hardware. Administrative oversight of grant = $500,000.	Patient/family education needs assessment, intranet website. Transportation services. Funding for REAP entitlement program.
NY Eye & Ear (Cycle I only) Cycle I, $665,827	Renovations	Added 1.5 docs and 1 PA, 80 hours per week and 6 exam rooms. General peds clinic established.	Managed care liaison handled 1500 managed care problems	1 expanded collaboration w/ community health provider and 1 w/ human service organization.		Telephone bank system, expand management for managed care.	
NY Presbyterian Cycle I, $9.8 mil. Cycle II & III, $14.09 mil. total drawn = $19,996,012	Newly constructed Rangel Health Clinic, w/clinic space for MIC program Renovate Morris Heights CHC birth center. Computer Lab. Delayed Morris Hts MIS, and renovation of clinics in Fort Washington area.	Staff for Rangel site. Expansion of birthing center and Women's Services at Morris Heights. Expansion of Fort Washington Practice. Broadway practice, expanded hours and added site. Mammography unit at community site.	Improve managed care readiness at other affiliates (not specified)	Contract w/ 2 CBOs (Alianza Dominica and Northern Manhattan Partnership), to train people as community health workers.	Interpreters for Associates in Internal Medicine practice (2.5 FTE).	Computer system, Web WebCIS. Computerized scheduling system. Telemedicine for case management.	Education & Outreach activities. Hired hospitalists to follow patients in hospital. Establish a Call Center.
NYU Downtown Cycle I, $1.7 mil. Cycle II & III, $4.01 mil total drawn = $4,597,649	Renovated space at hospital, 22 new exam rooms. Construct clinic on Lower East Side.	Added doc at Chinatown Clinic. Brooklyn Primary Care Center. Develop Elmhurst primary care center.	Consultant for OPD restructure. Project CARE, outreach & education.		Chinese language/ culture training.	Consultant analysis, primary care capacity.	Hired managed care coord. Add staff for credentialing docs. Electronic files

North General Cycle I, $2.7 mil. Cycle II & III, $4.9 mil. total drawn = $6,077,933	Construct UrgiCenter. Renovate space in school for school-based health clinic.	Expanded clinic hours to night and weekends for AIDS patients, also Paul Robeson Clinic (now closed). Acquired 5 Community Doc Practices.	Centralize oncolgy and expand cancer screening program. Add a patient health educator.	Relation with Morris Heights CHC, but this ended. Proposal to collaborate with Community Based provider to run hospital clinics.	Added costs for translation services and bilingual signage.	Consultant on restructuring ambulatory care. MIS system enhanced.	Develop Outreach & Health Education Dept.
St Lukes/ Roosevelt Cycle I, $6.5 mil. Cycle II & III, $12.7 mil. total drawn = $12,509,153		Hired staff for primary care network expansion. Expand staff for MIC project. 2 docs and other staff for 107th St. Site ($1.055 mil). Hired lots of staff for HIV/AIDS outpatient program ($5.7 mil)	Hired ER staff to educate patients about managed care. Expand staff in managed care dept. Staff for discharge planning.			Establish MSO, later disbanded.	Hire Community Health Planner and MCH coordinator.
St. Vincent's Cycle I, $2.8 mil. Cycle II & III, $5.9 mil. total drawn= $7,164,217					Foreign language training in Chinese and Spanish.		Hired Director, Manager and 24.5 case managers - at every inpatient nursing station, admitting office, and ER. ($4.024 mil).

Queens Hospitals – Primary Care/Managed Care

Hospitals	Construction	Expansion Primary Care	Managed Care	Contracting/ Working w/CBO's	Cultural/ Language Competence	Administrative	Other
Episcopal Health Services Cycle I $3,287,906, Cycle II & III, $5.2 mil total drawn= $6,865,034		Expansion of imaging services for OBS patients	Hired Medical management staff. Hired public relations staff. Educate community on managed care system.			Upgrade info systems. Implement MIS. Administrative oversight. Managed care contracting & provider recruitment ($884,300)	Consultant to assist in planning use of worker retraining money.
Jamaica Cycle I, $4.5 mil. Cycle II & III, $10.06 mil total drawn= $12,127,565	Women's Health Center relocation & expansion. Expansion of dental program. Relocate physician practices ($5.4 mil.)	New chronic disease management clinic at Ozone Park.	Link ER patients to primary care center. Develop patient education center.			Conduct employee survey.	Marketing to senior citizens. Hire family caregiver liaison. Consultant to ensure Y2K readiness.
Peninsula Cycle I, $417,762. Cycle II & III, $995,105 total drawn= $1,266,575	Construction of new pediatric unit. Gut renovation of specialty clinic areas.	Expansion of family health center, increases in clinic use. Develop prenatal care, but later abandoned. 3 PA's hired to expand ER triage.		Integration of services w/Addabbo Family Health Center (FQHC).		Health education and outreach focus on primary care and CHP.	Clinical pathway to lower ALOS. Consultant for patient satisfaction survey in ER.

Staten Island Hospitals - Primary Care/Managed Care

Hospitals	Construction	Expansion Primary Care	Managed Care	Contracting/ Working w/ CBO's	Cultural/ Language Competence	Administrative	Other
St. Vincents/ Baley Seton Cycle I, $2.5 mil. Cycle II & III, $5.6 mil. Total drawn: $2,280,110	Pediatric clinic renovated increasing # of examining rooms.	Took over full responsibility for Port Richmond clinic, which was shared with Staten Island Univ. Hospital. NP Urgent Care Unit established. Open clinic at Mariner's Harbor. Expansion of primary care in adult homes.	Computer system. Implement information system.		Expand translation service.	Refigure management practices. Improve management of contracts with MCO's.	Mind/Body Program - abandoned. Plan to extend efforts to serve underserved populations in Mariner's Harbor and Port Richmond areas.
Staten Island University Cycle I, $2.1 mil., Cycle II & III, $18.005 mil. Total drawn: $16,306,062	Bay St. Health renovation. Primary care dental service.		Community education and wellness ($3.2 mil). Expand managed care infrastructure. Pictorial Archiving System ($2.4 mil). Breast center expansion ($2.1 mil).		Foreign language interpreters. - 5.6 staff	Administrative overhead charged for each project.	No write up of projects or goals for Cycle I, II, III. Nothing re Cycle I. Primary care Gerontology service ($861,908). Quality assurance - primary care. ($1.7 mil)

Seven voluntary hospitals received funding in Cycle I/II/III, but have not submitted any documentation that could be used for summarizing their CHCCDP proposals. The hospitals, and their funding for these cycles are:

Hospital	Cycle I funding	Cycle II/III funding	Funding drawn by 2/13/03*
Cabrini	$ 564,877	$ 1,908,902	?
Kingbrook	$ 348,522	$ 1,131,934	$ 631,506
Maimonides	$2,157,947	$ 6,622,367	$3,381,950
SUNY Downstate	$1,808,877	$ 3,674,809	$2,365,804
Catholic Med. Center/Brook./Que	$7,532,570	$10,027,064	$7,515,923
Flushing	$1,992,013	$ 4,036,307	$2,603,489
NY Hospital Queens	$1,234,505	$ 3,313,728	$1,070,446

*Methodist Hospital is shown in the Brooklyn Hospital charts.

Health & Hospitals Corporation – Primary Care/Managed Care

Network/ Hospitals	Construction	Expansion Primary Care	Managed care readiness	Contracting/ working with CBO's	Cultural & Language Competence	Administrative	Other
South Manhattan/ Bellevue Cycle I, $10.3 mil. Cycle II & III, $16.3 mil. total drawn = $22,278,376	new clinic, 2 exam rooms. 2 new exam rooms Roberto Clemente. Bought 2 new patient vans. Renovate Judson Health Center.	3 new OB/GYN's, 2 new primary care docs Bellevue, 1 peds at Gouverneur. Upgraded Smith & Baruch Child Health Clinics. Expand indigent medication program. School based clinics at IS 51 and Thomas High School.	Pilot managed care facilitation unit. HIV services enhanced. Mental health initiatives, Gouverneur & hospital. Patient shuttle vans. Implement Advanced Open Access. Establish central scheduling office.	Pride Site I. Expanded service at Educational Alliance.	Enhanced Interpreter Services (TEMIS). Hire additional staff. Provide culturally competent health education.	MIS system, computerized record, registration, billing system. Managed care staff hired. Case management & ambulatory clerks hired. Hire staff to identify/verify insurance coverage.	Add community health educators.
North Manhattan/ Generations +/ Harlem Cycle I, $7.3 mil. Cycle II & III, $13.1 mil. total drawn = $16,983,525	Renovate 32 exam rooms & 24 consult rooms at Sydenham. Relocate/renovate Lenox Ave. Health Center. Renovate St. Nicholas Child Health Clinic	Add 5 OB/GYN provider. Add 1 primary care doc. Hire pediatric staff. Hire 3 docs for Renaissance. Staff for mobile van.	HIV services enhanced. Expand patient navigator system (6 staff). Hire 4 registration staff. Operate asthma van.			Computer record system. CHCCDP staff hired for oversight/ evaluation. Install PACS.	Pediatric Resource, recruit 25 senior volunteers to participate in program with families of children w/ special health needs.
North Manhattan/ Metropolitan Cycle I, $7.05 mil. Cycle II & III, $10.8 mil. total drawn = $14,931,208	Renovate primary care space at hospital. Renovate East Harlem & Riverside Child Health Clinics.	Expand hours at off-site clinics. Add 4 staff	Establish Urgi care center. HIV special services. Centralized appt. scheduling center. Develop case management.			Computer record system and other systems. Community health, managed care & patient relations staff expanded. Install PACS.	Community liaison worker to help patients preregister, schedule initial appts. Develop patient relations service.

North Manhattan/ Lincoln Cycle I, $12.7 mil, Cycle II & III, $22.3 mil. total drawn = $28,944,756	Women's Health clinic renovation.	New Bronx river Houses clinic, 8 exam rooms. Expand primary care clinic hours. Establish ambulatory cancer center.	Expand transport service. Establish telephone nurse triage. Established Urgi Care Center. Wellness program developed. Services enhanced for HIV and behavioral health. Expand financial counseling. Add ambulatory service staff.			Financial computer and other systems updated. Picture Archiving System installed (PACS). CHP administrator and staff hired.	Staff hired to increase outreach to CBO's. Operate asthma mobile van. Staff hired for patient education materials.
North Bronx/ Jacobi Cycle I, $9.4 mil. Cycle II & III, $15.7 mil. total drawn = $20,962,246	Renovate Glebe, Gunhill (?closed) & Monroe, Child Health Clinics. Acquire & renovate Tremont.	Add 26 staff for Tremont off site. Expand primary care hours at Jacobi.	HIV services enhanced. After hours physician telephone coverage. Hire staff for one stop registration area. Expand shuttle service. Develop network ambulatory call center.	Part-time primary care at Weinberg Mental Health Center.	Establish clinic for Kosovar refugee immigrants. Simultaneous interpreter services.	Computer record and other systems. PACS installed. CHP manager hired. Adminstrative and other staff for CHP oversight	Internet service and web access. Develop disease centers of excellence. Community Education and Referral Access.
North Bronx/ North Central Cycle I,$7.07 mil. Cycle II & III, $12.04 mil. total drawn = $15,921,003	Built new health center, 6 exam rooms.	Expand primary clinic hours at hospital.	Expanded shuttle service. HIV services enhanced. After hours telephone physician coverage.		Simultaneous interpreter services.	Computer record and other systems. CHP manager hired. Install PACS. Adminstrative staff for CHP oversight.	Staff hired to enhance community collaborations. Internet access and web services. Develop Disease Center of Excellence. Develop COBRA program for HIV services.

Queens/ Elmhurst Cycle I, $12.01 mil. Cycle II & III, $21.7 total drawn = $28,077,457		New primary care sites at Sunnyside & Corona. Expand women's and pediatric health service. Add Saturday & evening hours.	Patient shuttle service established. Enhanced HIV services. Patient navigation at Child Health Clinics. Integrate Behavioral health and primary care.	Mobile health service with Tzu Chi. Establish p/t clinic at Astoria MIC.		Computer record and other systems. CHP project staff hired. Staff to increase community providers credentialed at Elmhurst and Queens.	E-mail installed. Establish centralized call system.
Queens/ Queens Cycle I, $7.7 mil. Cycle II & III, $13.1 total drawn = $17,434,757	Renovate at hospital for 17 new exam rooms. Renovated 2 Family Health Services sites.	New primary care site at Springfield Gardens. and operate clinic at South Conduit. Add Saturday & Evening hours to pediatric clinic. Add staff to Drew Community clinic and primary care at hospital.	Centralized call center established. ER and clinic patients linked w/ primary care docs. Patient shuttle service established. Link ER & clinic patients w/ primary care providers.			Computer record and other systems. Staff to increase community provider credentialing. Staff to oversee CHP.	
North Brooklyn/ Woodhull Cycle I, $8.4 mil. Cycle II & III, $14.4 mil. total drawn = $19,577,842	Renovate 5 Child Health Clinics: Lafayette, Roosevelt, Williams, Wyckoff Gardens & Sumner Ave. Renovate Greenpoint Ave. clinic (7 new exam rooms)	Establish central appt. office. Renovate ambulatory care, 8 new exam rooms.	Renovate managed care office. Upgrade Nurse Triage Call Center.	Partnership w CBOs and schools to train culturally sensitive volunteers. Community outreach.		Computer record and other systems. Marketing campaign developed. Install PACS. CHP administrative oversight.	Internal PC linkages w/ off-site clinics. Hire 3 social workers to do assessments at off-site clinics.

Brooklyn/ Staten Island/ Kings County Cycle I, $16.1 mil. Cycle II & III, $22.6 total drawn = $32,444,836	Renovate space for Women's Health Service. Renovate East NY D&TC. Renovate Fifth Ave. FHC, St. George dental & Crown Height CHC.	Add 4 primary care docs. Upgrade 8 attendings to primary care docs. Staff hired to expand evening hours for onsite and offsite clinics.	Purchase patient shuttle van. Network wellness program developed. HIV & behavioral health integrated. Staff hired to expedite referrals between primary & specialty care. Hire nurses to provide case management in clinics. Establish Wellness Center.			Computer record and other systems. Staff hired to improve medical records system. Install PACS.	Hired 3 patient care representatives to help navigate. Hire staff person to collaborate with CBOs. Establish linkages w/ independent practitioners.
Brooklyn/ Staten Island/ Coney Island Cycle I, $6.0 mil. Cycle II & III, $11.4 mil. total drawn = $14,491,290	Renovate hospital primary care.	Open Flatlands extension clinic. Mobile van to visit schools. Expand behavioral health.	Hire infection control team to meet needs of sexual assault and needle stick patients.		ATT Translation services expanded, changed to New World Language Service. Directory signs in 5 languages. Educational materials in Russian, Urdu, Pakistani and Chinese.	Computer record and other systems. Media campaign. Install PACS. CHP staff for administra- tive oversight.	Improve medical records review.

The Health and Hospitals Corporation submitted one application for all eleven acute care facilities. In addition to the activities listed above, the central office of HHC will spend $10.7 million in Cycle II & III for a variety of activities, such as:

- Improve access to primary care services by development of Open Access and other ambulatory care restructuring.
- Technology program, including HIPAA issues, corporate internet, etc.
- Community Outreach/Health Promotion activities, including: creation and distribution of health promotion materials; managed care orientation video; utilization management program; managed care web-based instructional materials.
- Program Development and Analysis, including: technical assistance for managed care program development; strategic planning and corporate restructuring activities, mapping and database development; and auditing. But, Community Collaboration development was not as well developed.

Worker Retraining

The charts below will analyze information found in the Worker Retraining portion of the Cycle II/III grant applications. Data was reviewed from 32 hospitals in New York City – 11 public hospitals and 21 voluntary hospitals which are members of the League of Voluntary Hospitals and Homes of New York (League). All League hospitals used one identical format in the application process, while all HHC hospitals used another. Information common in both sets of applications were reviewed.

The Key to the review:

- Administration Personnel Cost – This is reported differently by League and HHC hospitals. In the HHC applications, this is the number that represents personnel costs for coordinating and monitoring the program. In the League hospitals' applications, it represents the total Administration personnel cost.
- Administration Non-Personnel Cost – In HHC applications, this refers to just the material/supply cost used for coordinating and monitoring the program, rather than the material/supply cost for the entire program. In League hospital applications, it seems to include all non-personnel cost.

- Total Replacement Cost – Salary for those workers who replace workers participating in training.
- Total Tuition – The total tuition cost for each training course.
- Total Material Cost – For HHC hospitals, this excludes material/supply cost for coordinating and monitoring the program. For League hospitals, this represents material/supply costs for the courses as well as for the administration of the program.
- Total Participants – Employees may participate in multiple training courses and some courses may have multiple sessions. This number reflects the number of training encounters, not the number of individual employees actually trained.
- RN Programs – League hospitals clearly separated non-RN training programs from RN programs. HHC facilities combined some of the non-RN training.
- A sampling of five (5) training courses were compared:
  1) Cultural Diversity/Cultural Competency;
  2) Foreign language training, including classes in American Sign Language.
  3) Customer Service/Customer Relations training.
  4) Managed Care training.
  5) Computer training.

Some Key Points from this review:

- $94.3 million was requested by these hospitals for Cycle II/III training: $50.8 million for League hospitals and $43.4 million for HHC hospitals. Of this amount, $45.2 million will be used for tuition, $24.7 million will be used for replacement costs, and $9.2 million for material/supply costs.
- During Cycle II/III, hospitals will offer 53,095 encounters for some kind of customer service training; 4,714 for foreign language training; 24,230 for cultural diversity/cultural competency training; 52,104 for computer training; and 15,671 for managed care training.
- Because League/1199 completed the League hospital applications, and HHC Central Office packaged the HHC hospital applications, the hospital applications are identical in many respects. Concern should be raised as to whether this

process comprised the customization of programs for each hospitals to meet its' individual need.

- The entire Administration, non-personnel costs for League hospitals, $1,185,495, appears to have gone to 1199/SEIU.
- In most cases, the material/supply costs financed hospital learning centers, which will hopefully exist beyond the CHCCDP program.
- During Cycle II/III period, the hospitals proposed to have 237,346 training encounters: 48,577 by League hospitals and 188,769 by HHC hospitals.
- During Cycle I, there were a total of 104,603 training encounters: 95,635 by HHC employees and 8,968 by League employees. No conclusion can be drawn about the success of Cycle I training without knowing what the goals were on each hospitals initial application.
- Some hospitals did not request funding for foreign language training for Cycle II/III: Peninsula; Queens; Mt. Sinai; Bellevue; Harlem; Our Lady of Mercy; Bronx Lebanon; Victory; Lutheran; Kings County and Coney Island Hospitals. Still others proposed limited foreign language training for as little as eight weeks. And still others limit foreign language training to Spanish, even though they are located in neighborhoods with patients who speak other primary languages.
- Woodhull Hospital describes a better than average attempt to provide foreign language training. The hospital identified medical interpreters and is making attempts to improve what they describe as their "Language Bank." They also described attempts to provide training for a dual handset telephone language system.
- Some of the classes seem to suggest that employees were inadequately trained to do their jobs in the first place. In areas that present great risk to patients, training should be ongoing with or without grant monies, such as: teaching Operating Room prep skills to technicians and nurses; enhanced sterilization skills to central supply staff; or proper food handling techniques to dietary staff.
- Many hospitals do a good job of offering upgrades for nursing staff; either for selected employees to become LPN's or for LPN's to become RN's.
- St Barnabas Hospital reports in-house training for which they charged only replacement cost. Is there verification of this training?

THE CITY OF NEW YORK TOTALS						
	QUEENS	MANHATTAN	BRONX	BROOKLYN	STATEN ISLAND	GRAND TOTAL
CYCLE II & III						
Total Budget	$ 12,662,111.00	$ 26,316,681.00	$ 24,855,794.00	$ 25,987,623.00	$ 4,501,453.00	$ 94,323,662.00
Administration Personnel Cost	$ 1,062,617.00	$ 2,335,883.00	$ 2,083,704.00	$ 2,016,247.00	$ 346,612.00	$ 7,845,063.00
Administration Non-Personnel Cost	$ 203,595.00	$ 425,862.00	$ 402,328.00	$ 440,131.00	$ 103,533.00	$ 1,575,449.00
Total Administration	$ 1,266,213.00	$ 2,589,516.00	$ 2,485,581.00	$ 2,456,378.00	$ 450,145.00	$ 9,247,833.00
Total Replacement Cost	$ 3,452,140.00	$ 6,660,849.07	$ 7,754,315.88	$ 5,346,297.15	$ 1,551,529.32	$ 24,765,131.42
Total Tuition	$ 5,574,435.00	$ 13,004,274.84	$ 10,391,057.70	$ 13,767,432.63	$ 2,475,195.98	$ 45,212,396.15
Total Material/Supply Cost	$ 1,717,961.00	$ 2,793,489.99	$ 2,318,925.01	$ 2,576,635.27	$ 24,582.50	$ 9,431,593.77
Non Administrative Personnel Cost	$ 651,362.00	$ 1,268,149.00	$ 1,865,966.00	$ 1,903,935.00	N/A	$ 5,689,412.00
Total Participants	21687	68,651	54,201	90,844	1963	237,346
Non-Rn Programs	7959	7,674	9,363	12,466	873	38,335
Cultural Diversity Training	700	3,153	8,327	12,000	N/A	24,180
Foreign Language Training	800	755	1,685	1,265	N/A	4,505
Customer Service Training	1475	18,133	9,726	23,560	N/A	52,894
Managed Care Training	3170	1,600	1,484	9,417	N/A	15,671
Computer Training	2606	13,220	14,988	19,548	300	50,662
Rn Programs	770	1,438	1,749	4,732	1090	9,779
Cultural Diversity Training	N/A	-	50	N/A	N/A	50
Foreign Language Training	N/A	44	125	40	N/A	209
Computer Training	N/A	155	587	700	N/A	1,442
Managed Care Training	N/A	-	N/A	N/A	N/A	-
Customer Service Training	N/A	-	N/A	200	N/A	200
CYCLE I						
Total Completed Training	12,841	26,818	19,718	45,188	38	104,603
Cultural Diversity Training	-	792	297	5,286	0	6,375
Foreign Language Training	-	66	207	243	6	522
Managed Care Training	580	652	1,717	8,561	0	11,510
Customer Service Training	4,814	10,429	8,510	19,610	0	43,363
Computer Training	1,064	2,187	1,643	2,686	0	7,580

THE BOROUGH OF THE BRONX							
PAGE 1	MONTEFIORE	ST. BARNABAS*	OUR LADY OF MERCY	BX. LEBANANON	LINCOLN	N. CENTRAL BX	JACOBI
					HHC	HHC	HHC
CYCLE II & III							
Total Budget	**$ 2,360,183.00**	**$ 3,558,892.00**	**$ 1,167,683.00**	**$ 5,229,998.00**	**$ 5,589,564.00**	**$ 3,011,268.00**	**$ 3,938,206.00**
Administration Personnel Cost	$ 181,734.00	$ 274,035.00	$ 89,912.00	$ 402,710.00	$ 445,365.00	$ 301,127.00	$ 388,821.00
Administration Non-personnel Cost	$ 54,734.00	$ 81,855.00	$ 26,857.00	$ 120,290.00	$ 113,592.00	$ -	$ 5,000.00
Total Administration Cost	$ 236,018.00	$ 355,890.00	$ 116,768.00	$ 523,000.00	$ 558,957.00	$ 301,127.00	$ 393,821.00
Total Replacement Cost	$ 308,750.00	$ 1,677,598.88	$ 304,430.00	$ 2,613,862.00	$ 848,016.00	$ 692,109.00	$ 1,309,550.00
Total Tuition	$ 1,642,378.00	$ 1,420,351.70	$ 643,992.00	$ 1,851,688.00	$ 2,654,189.00	$ 824,994.00	$ 1,353,465.00
Total Materia/ Supply Cost	$ 173,037.00	$ 105,050.41	$ 102,491.60	$ 241,492.00	$ 990,000.00	$ 415,988.00	$ 290,856.00
Non Administrative Personnel Cost	N/A	N/A	N/A	N/A	$ 538,402.00	$ 777,050.00	$ 550,514.00
Total Particpants	**6,352**	**1,816**	**824**	**2,120**	**20,033**	**8038**	**15018**
Non-Rn Programs	5,238	1,591	799	1,735	N/A	N/A	N/A
Cultural Diversity Training	200	N/A	N/A	N/A	3,794	1242	3091
Foreign Language Training	285	50	N/A	N/A	250	500	600
Customer Service Training	500	775	337	N/A	3,794	1728	2592
Managed Care Training	284	N/A	N/A	N/A	1,200	N/A	0
Computer Training	1,000	385	200	120	1,775	3776	7732
Rn Programs	1,114	225	25	385	N/A	N/A	N/A
Cultural Diversity Training	50	N/A	N/A	N/A	N/A	N/A	N/A
Foreign Language Training	125	N/A	N/A	N/A	N/A	N/A	N/A
Computer Training	437	N/A	N/A	150	N/A	N/A	N/A
Managed Care Training	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Customer Service Training	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CYCLE I							
Total Completed Training	**891**	**N/A**	**20**	**2,158**	**6,203**	**3380**	**7066**
Cultural Diversity Training	-	N/A	0		297	0	0
Foreign Language Training	88	N/A	0	119	-	0	0
Managed Care Training	-	N/A	0	378	603	270	466
Customer Service Training	309	N/A	0	713	2,892	1082	3514
Computer Training	12	N/A	0	644	242	235	510

*$480,450 of this amount will be allocated to train 650 non-unionized employess.

THE BOROUGH OF THE BRONX	
PAGE 2	TOTAL
CYCLE II & III	
Total Budget	$ 24,855,794.00
Administration Personnel Cost	$ 2,083,704.00
Administration Non-personnel Cost	$ 402,328.00
Total Administration Cost	$ 2,485,581.00
Total Replacement Cost	$ 7,754,315.88
Total Tuition	$ 10,391,057.70
Total Materia/ Supply Cost	$ 2,318,915.01
Non Administrative Personnel Cost	$ 1,865,966.00
Total Particpants	54,201
Non-Rn Programs	9,363
Cultural Diversity Training	8,327
Foreign Language Training	1,685
Customer Service Training	9,726
Managed Care Training	1,484
Computer Training	14,988
Rn Programs	1,749
Cultural Diversity Training	50
Foreign Language Training	125
Computer Training	587
Managed Care Training	N/A
Customer Service Training	N/A
CYCLE I	
Total Completed Training	19,718
Cultural Diversity Training	297
Foreign Language Training	207
Managed Care Training	1,717
Customer Service Training	8,510
Computer Training	1,643

*$480,450 of this amount will be allocated to train 650 non-unionized employess.

THE BOROUGH OF BROOKLYN PAGE 1	LONG ISLAND	INTERFAITH	VICTORY	BROOKDALE	LUTHERAN	BROOKLYN	WYCKOFF
CYCLE II & III							
Total Budget	**$ 1,123,325.00**	**$ 2,830,028.00**	**$ 163,909.00**	**$ 1,893,811.00**	**$ 2,884,832.00**	**$ 2,635,449.00**	**$ 2,325,060.00**
Administration Personnel Cost	$ 86,496.00	$ 217,912.00	$ 12,621.00	$ 145,823.00	$ 222,132.00	$ 202,930.00	$ 179,030.00
Administration Non-Personnel Cost	$ 25,836.00	$ 65,091.00	$ 3,770.00	$ 43,558.00	$ 66,351.00	$ 60,615.00	$ 53,476.00
Total Administration Cost	$ 112,332.00	$ 283,003.00	$ 16,391.00	$ 189,381.00	$ 288,483.00	$ 263,545.00	$ 232,506.00
Total Replacement Cost	$ 50,607.00	$ 302,692.50	$ 89,353.13	$ 285,330.00	$ 928,129.10	$ 1,217,700.42	$ 973,000.00
Total Tuition	$ 957,867.40	$ 1,717,659.63	$ 56,325.00	$ 1,368,683.00	$ 1,633,990.00	$ 1,016,338.60	$ 1,119,554.00
Total Material/Supply	$ 2,518.40	$ 526,672.12	$ 1,839.87	$ 50,417.00	$ 34,229.90	$ 92,864.98	$ -
Non-Administrative Personnel Cost	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Participants	**4085**	**2,031**	**165**	**2699**	**4100**	**1631**	**971**
Non-Rn Programs	3543	1,516	15	2059	3740	726	867
Cultural Diversity Training	N/A		N/A	N/A	3000	N/A	N/A
Foreign Language Training	118*	136*	N/A	5	N/A	10	150
Customer Service Training	2300	500	N/A	1000	N/A	N/A	N/A
Managed Care Training	200	14	N/A	N/A	N/A	N/A	3
Computer Training	200	400	N/A	300	200	300	105
Rn-Programs	542	2,031	150	640	360	905	104
Cultural Diversity Training	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Foreign Language Training	N/A	*307	N/A	40	N/A	N/A	N/A
Computer Training	N/A	N/A	N/A	100	N/A	600	N/A
Managed Care Training	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Customer Service Training	N/A	N/A	N/A	200	N/A	N/A	N/A
CYCLE I							
Total Completed Training	**34**	**580**	**-**	**N/A**	**577**	**54**	**357**
Cultural Diversity Training	0	483	-	N/A	0	0	0
Foreign Language Training	0	-	-	N/A	0	0	0
Managed Care Training	0	-	-	N/A	0	0	0
Customer Service Training	0	-	-	N/A	0	0	0
Computer Training	0	91	-	N/A	0	0	183

THE BOROUGH OF BROOKLYN PAGE 2	KINGS COUNTY HHC	CONEY ISLAND HHC	WOODHULL HHC	TOTAL
CYCLE II & III				
Total Budget	**$ 5,653,799.00**	**$ 2,862,437.00**	**$ 3,614,973.00**	**$ 25,987,623.00**
Administration Personnel Cost	$ 430,000.00	$ 254,840.00	$ 264,463.00	**$ 2,016,247.00**
Administration Non-Personnel Cost	$ 41,003.00	$ 31,403.00	$ 49,028.00	**$ 440,131.00**
Total Administration Cost	$ 471,003.00	$ 286,243.00	$ 313,491.00	**$ 2,456,378.00**
Total Replacement Cost	$ 1,050,000.00	$ 75,000.00	$ 374,485.00	**$ 5,346,297.15**
Total Tuition	$ 2,556,796.00	$ 1,095,053.00	$ 2,245,166.00	**$ 13,767,432.63**
Total Material/Supply	$ 1,190,000.00	$ 327,638.00	$ 350,455.00	**$ 2,576,635.27**
Non-Administrative Personnel Cost	$ 386,000.00	$ 1,078,503.00	$ 439,432.00	**$ 1,903,935.00**
Total Participants	**30,109**	**20,602**	**24,451**	**90844**
Non-Rn Programs	N/A	N/A	N/A	**12466**
Cultural Diversity Training	2,500	3,000	3,500	**12000**
Foreign Language Training	-	-	1,100	**1265**
Customer Service Training	7,000	6,760	6,000	**23560**
Managed Care Training	7,000	1,200	1,000	**9417**
Computer Training	6,010	7,023	5,010	**19548**
Rn-Programs	N/A	N/A	N/A	**4732**
Cultural Diversity Training	N/A	N/A	N/A	**N/A**
Foreign Language Training	N/A	N/A	N/A	**40**
Computer Training	N/A	N/A	N/A	**700**
Managed Care Training	N/A	N/A	N/A	**N/A**
Customer Service Training	N/A	N/A	N/A	**200**
CYCLE I				
Total Completed Training	**27,511**	**9,377**	**6,698**	**45188**
Cultural Diversity Training	4,737	66	-	**5286**
Foreign Language Training	-	-	243	**243**
Managed Care Training	7,283	-	1,278	**8561**
Customer Service Training	10,666	5,506	3,438	**19610**
Computer Training	1,379	823	210	**2686**

THE BOROUGH OF MANHATTAN							
PAGE 1							
	N. GENERAL	ST. VINCENT'S	BETH ISRAEL	MT. SINAI	ST. LUKE'S	NY PRESBYTERIAN*	NY PRESBYTERIAN**
CYCLE II & III							
Total Budget	**$ 1,226,783.00**	**$ 1,475,787.00**	**$ 4,754,109.00**	**$ 2,072,258.00**	**$ 3,198,077.00**	**$ 1,062,903.00**	**$ 2,461,623.00**
Adminisration Personnel cost	$ 94,462.00	$ 246,252.00	$ 366,066.00	$ 159,564.00	$ 246,252.00	$ 106,290.00	$ 189,545.00
Administration Non-personnel cost	$ 28,216.00	$ 73,556.00	$ 109,344.00	$ 47,662.00	$ 73,556.00	$ -	$ 56,617.00
Total Administration Cost	$ 122,678.00	$ 147,579.00	$ 475,410.00	$ 207,226.00	$ 319,808.00	$ 106,290.00	$ 246,162.00
Total Replacement Cost	$ 608,473.00	$ 594,392.50	$ 1,942,309.07	$ 1,042,805.00	$ 815,646.60	$ -	$ 719,336.90
Total Tuition	$ 490,832.00	$ 625,016.00	$ 2,217,117.00	$ 740,479.00	$ 1,744,395.84	$ 941,703.00	$ 1,177,344.00
Total Material/ Supply Cost	$ 4,800.00	$ 108,799.50	$ 119,272.33	$ 81,747.00	$ 318,226.06	$ 14,910.00	$ 318,780.10
Non-Administrative Personnel Cost	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Participants	**1214**	**916**	**1842**	**2319**	**1478**	**2140**	**1343**
Non-Rn Programs	1136	913	1453	2113	945	N/A	1114
Cultural Diversity	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Foreign Language	85	150	100	N/A	40	N/A	80
Customer Service	1000	N/A	300	N/A	130	1000	700
Managed Care Training	N/A		N/A	N/A	N/A	100	N/A
Computer Training	N/A	140	400	1900	80	700	100
Rn Programs	78	3	389	206	533	N/A	229
Cultural Diversity	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Foreign Language	N/A	N/A	44	N/A	N/A	N/A	N/A
Computer Training	N/A	N/A	95	N/A	N/A	N/A	60
Managed Care Training	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Customer Service	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CYCLE I							
Total Completed Training	**6**	**548**	**623**	**1020**	**N/A**	**N/A**	**418**
Cultural Diversity Training	0	0	0	0	N/A	N/A	N/A
Foreign Language Training	0	15	41	0	N/A	N/A	N/A
Managed Care Training	0	0	0	32	N/A	N/A	N/A
Customer Service Training	0	0	10	0	N/A	N/A	N/A
Computer Training	0	0	120	0	N/A	N/A	N/A

* New York Presbyterian non-unionized workforce.

**New York Prebyterian unionized workforce.

THE BOROUGH OF MANHATTAN				
PAGE 2				
	BELLEVUE	HARLEM	METROPOLITAN	TOTAL
	HHC	HHC	HHC	
CYCLE II & III				
Total Budget	**$ 4,077,233.00**	**$ 3,280,517.00**	**$ 2,707,391.00**	**$ 26,316,681.00**
Adminisration Personnel Cost	$ 337,690.00	$ 327,533.00	$ 262,229.00	**$ 2,335,883.00**
Administration Non-personnel Cost	$ 28,400.00	$ -	$ 8,511.00	**$ 425,862.00**
Total Administration Cost	$ 366,090.00	$ 327,533.00	$ 270,740.00	**$ 2,589,516.00**
Total Replacement Cost	$ 88,400.00	$ 485,062.00	$ 364,424.00	**$ 6,660,849.07**
Total Tuition	$ 2,160,691.00	$ 1,581,672.00	$ 1,325,025.00	**$ 13,004,274.84**
Total Material/ Supply Cost	$ 911,600.00	$ 496,555.00	$ 418,800.00	**$ 2,793,489.99**
Non-Administrative Personnel Cost	$ 550,052.00	$ 389,695.00	$ 328,402.00	**$ 1,268,149.00**
Total Participants	**27,729**	**17,566**	**12,104**	**68651**
Non-Rn Programs	N/A	N/A	N/A	**7674**
Cultural Diversity	50	1,000	2,103	**3153**
Foreign Language	N/A	N/A	300	**755**
Customer Service	10,000	2,900	2,103	**18133**
Managed Care Training	-	N/A	1,500	**1600**
Computer Training	3,150	4,850	1,900	**13220**
Rn Programs	N/A	N/A	N/A	**1438**
Cultural Diversity	N/A	N/A	N/A	**0**
Foreign Language	N/A	N/A	N/A	**44**
Computer Training	N/A	N/A	N/A	**155**
Managed Care Training	N/A	N/A	N/A	**0**
Customer Service	N/A	N/A	N/A	**0**
CYCLE I				
Total Completed Training	**5,622**	**9,304**	**9,277**	**26818**
Cultural Diversity Training	-	-	792	**792**
Foreign Language Training	-	10	-	**66**
Managed Care Training	182	-	438	**652**
Customer Service Training	3,173	4,471	2,775	**10429**
Computer Training	-	1,072	995	**2187**

* New York Presbyterian non-unionized workforce.

**New York Prebyterian unionized workforce.

THE BOROUGH OF QUEENS						
	JAMAICA	EPISCOPAL	PENINSULA	QUEENS HHC	ELMHURST HHC	TOTAL
CYCLE II & III						
Total Budget	**$ 2,515,285.00**	**$ 1,323,347.00**	**$ 99,511.00**	**$ 3,284,857.00**	**$ 5,439,111.00**	**$ 12,662,111.00**
Administration Personnel Cost	$ 193,677.00	$ 101,898.00	$ 7,662.00	$ 216,710.00	$ 542,670.00	**$ 1,062,617.00**
Administration Non-Personnel Cost	$ 57,852.00	$ 30,437.00	$ 2,289.00	$ 111,776.00	$ 1,241.00	**$ 203,595.00**
Total Administration	$ 251,529.00	$ 132,336.00	$ 9,951.00	$ 328,486.00	$ 543,911.00	**$ 1,266,213.00**
Total Replacement Cost	$ 585,560.00	$ 760,808.00	$ 30,537.00	$ 815,554.00	$ 1,259,681.00	**$ 3,452,140.00**
Total Tuition	$ 1,668,205.00	$ 430,106.00	$ 50,844.00	$ 1,453,421.00	$ 1,971,859.00	**$ 5,574,435.00**
Total Material/Supply Cost	$ 9,990.00	$ 98.00	$ 8,179.00	$ 447,018.00	$ 1,252,676.00	**$ 1,717,961.00**
Non Administrative Personnel Cost	N/A	N/A	N/A	$ 240,378.00	$ 410,984.00	**$ 651,362.00**
Total Participants	**6917**	**1440**	**211**	**5,750**	**7,369**	**21687**
Non-Rn Programs	6483	1315	161	N/A	N/A	**7959**
Cultural Diversity Training	N/A		50	325	325	**700**
Foreign Language Training	200	75	N/A	N/A	525	**800**
Customer Service Training	400	500	N/A	400	175	**1475**
Managed Care Training	1000	20	N/A	900	1,250	**3170**
Computer Training	400	N/A	N/A	802	1,404	**2606**
Rn Programs	434	125	211	N/A	N/A	**770**
Cultural Diversity Training	N/A	N/A	N/A	N/A	N/A	**N/A**
Foreign Language Training	N/A	N/A	N/A	N/A	N/A	**N/A**
Computer Training	N/A	N/A	N/A	N/A	N/A	**N/A**
Managed Care Training	N/A	N/A	N/A	N/A	N/A	**N/A**
Customer Service Training	N/A	N/A	N/A	N/A	N/A	**N/A**
CYCLE I						
Total Completed Training	**1,588**	**47**	**9**	**4,608**	**6,589**	**12,841**
Cultural Diversity Training	-	-	-	-	-	**-**
Foreign Language Training	-	-	-	-	-	**-**
Managed Care Training	-	-	-	580	-	**580**
Customer Service Training	-	-	-	1,750	3,064	**4,814**
Computer Training	115	-	-	388	561	**1,064**

THE BOROUGH OF STATEN ISLAND		
	STATEN ISLAND	TOTAL
CYCLE II & III		
Total Budget	$ 4,501,453.00	**$ 4,501,453.00**
Administration Personnel Cost	$ 346,612.00	**$ 346,612.00**
Administration Non-Personnel Cost	$ 103,533.00	**$ 103,533.00**
Total Administration Cost	$ 450,145.00	**$ 450,145.00**
Total Replacement Cost	$ 1,551,529.32	**$ 1,551,529.32**
Total Tuition	$ 2,475,195.98	**$ 2,475,195.98**
Total Material/Supply Cost	$ 24,582.50	**$ 24,582.50**
Non-Administrative Personnel Cost	N/A	**N/A**
Total Participants	**1963**	**1963**
Non-Rn Programs	873	**873**
Cultural Diversity Training	N/A	**N/A**
Foreign Language Training	N/A	**N/A**
Customer Service Training	N/A	**N/A**
Managed Care Training	N/A	**N/A**
Computer Training	300	**300**
Rn Programs	1090	**1090**
Cultural Diversity Training	N/A	**N/A**
Foreign Language Training	N/A	**N/A**
Customer Service Training	N/A	**N/A**
Managed Care Training	N/A	**N/A**
Computer Training	N/A	**N/A**
CYCLE I		
Total Completed Training	**38**	**38**
Cultural Diversity Training	0	**0**
Foreign Language Training	6	**6**
Managed Care Training	0	**0**
Customer Service Training	0	**0**
Computer Training	0	**0**

Hospital Policies for Treating the Uninsured.

A requirement of Cycle II/III funding was the hospital submission of a description of their policies and procedures for providing care to all indigent patients. Hospitals were also required to include a description of their monitoring procedures and submit a report of the results of this monitoring.

The hospitals' Cycle II/III applications did not include the information to meet the medically indigent care requirement. A separate Freedom of Information request to the State Health Department did result in the Commission's receiving the hospitals submissions on indigent care. Some hospitals submitted detailed policies and procedures, others complied with a one to two paragraph description. Only two hospitals met the requirement of submitting their policies on monitoring of access to medically necessary care for the uninsured.

Some of the hospitals submitted detailed policies on access to care for the uninsured, including sliding fee scales. Others however, only submitted their Emergency Medical Treatment and Active Labor Act (EMTALA) policies. EMTALA is a federal law requiring hospitals with Emergency Departments to provide medical screening for all patients arriving at their Emergency Rooms, and treatment if the patient is found to have an emergency condition.[33]

Clearly access policies that only cover care in the Emergency Room should be a violation of the Certification language required for CHCCDP funding. The certification language reads, in part: "presenting themselves to the hospital for services." This form says nothing about limiting access to care for emergencies. Limiting the provision of care to the Emergency Room is also not in keeping with the intent of the Medicaid managed care waiver and CHCCDP, which is intended to move patients into primary care services.

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[33] 42 U.S.C.A. Sect. 1395dd.

Uninsured Policies at CHCCDP Hospitals

Bronx CHCCDP Hospitals

Hospitals	EMTALA	Clinic Policy	Fee Scale Attached	Comments
Bronx Lebanon	X	–	–	
Montefiore	–	X	–	Good statements re doesn't limit any services to patients, or on the ability to pay. But doesn't explain access or fees. No monitoring plan.
Our Lady of Mercy	–	X	–	Screening for eligibility for uncompensated care, payment schedule arranged. Sliding fee scale for clinic patients, but not attached. No monitoring plan.
St Barnabas	–	X	–	Statement - treat all in need of health care services, irrespective of patient's ability to pay. Monitoring - by Medical Director who will conduct monthly reviews to ensure that no patients are turned away. Method not explained No monitoring plan.

Brooklyn CHCCDP Hospitals

Hospitals	EMTALA	Clinic Policy	Fee Scale Attached	Comments
Brookdale	–	X	–	Two paragraphs submitted. No patient is ever turned away because of inability to pay. A special sliding scale of fees based on income has been established. No monitoring plan.
Brooklyn	–	X	–	"Hospital provides various levels of free service and charity care through formalized policies which recognize the financial resources of the patients served." No fee scale attached. "In monitoring the level of free service and charity care provided the hospital maintains separate categories of these allowances on a monthly basis." No monitoring plan.

Interfaith	–	X	–	One paragraph - "Our policies provide for care to all patients regardless of ability to pay." Participation in Hill Burton. No fee scale attached. No monitoring plan.
Kingsbrook	–	–	–	Nothing submitted.
Long Island College	X - prepared by GNYHA	X	–	Patients who are uninsured are advised of sliding fee scale and counseled by credit registrar. Patients seen in Emergency: "If patient has no primary care practitioner or is uninsured, they should be referred to the appropriate practices." No fee scale attached. No monitoring plan.
Lutheran	X - "Lutheran does not admit or discharge patients based on their ability to pay."	X	–	From Hospital Manual: Hill Burton sign attached. "Clinical care is based on identified patient healthcare needs, not on financial criteria." No fee scale attached. No monitoring plan.
Maimonides	–	X	X	"Evaluate for Sliding Scale eligibility all patients with significant self-pay liabilities who express inability to meet their financial obligation" The fee scale is not for inpatient, ambulatory surgery, or in Emergency. Ancillary services charged at sliding scale percentage rate that corresponds to the clinic visit. Pay at time that service is rendered. Have sliding scale program application. The sliding scale is attached, but difficult to read. Patients pay a percentage of charge, but charge not identified. No monitoring plan.
Methodist	X	–	X	Nothing about clinic policy. No fee scale attached. No monitoring plan.
Victory Memorial	–	X	X	One page. See patient regardless of ability to pay the approved and posted surcharge. For the sliding scale, patients are "asked to pay $40 for complete medical evaluation." All inclusive payment for physician visit. No monitoring plan.
Wyckoff	–	–	X	Two paragraphs. Hill Burton uncompensated services. Application. For income up to 200% of FPL, free of charge. No monitoring plan.

Manhattan CHCCDP Hospitals

Hospitals	EMTALA Policy	Clinic Policy	Fee Scale Attached	Comments
Beth Israel	X	X	X	Phillips Ambulatory Care Sliding Fee Scale. People referred to financial counselor. "Sliding fee scale discount will apply to Teaching Practices and associated ancillary charges." Fee scale = up to about 25% of poverty level, patient pays 25% of cost, but doesn't say 25% of what. Patient is expected to pay in full at time of service. No monitoring plan.
Cabrini	–	–	–	Nothing submitted.
Mt. Sinai	X	X	–	There is a review of non-emergency admissions. For patients under the care of Mt. Sinai doctors the attending doctor is asked to sign a Physician Financial Guarantee, if willing. No fee scale is attached. No monitoring plan.
NY Ear & Ear	–	–	–	The hospital did not receive Cycle II/III funding so is not required to submit their policy.
NY Presbyterian	–	X	X	The sliding scale is for clinic patients only, but not for emergency, psychiatric, substance abuse, or inpatient care. To get on the scale, a patient must provide documents, if not they pay top of scale = $165. Must pay at time of visit, but there are exceptions. Scale = up to 100% of poverty, $40, up to 150% of poverty, $50. No monitoring plan.
NYU Downtown	–	X	X	All patients must be treated and/or appropriately referred regardless of their financial ability to afford medical services. For elective admissions, with under poverty level income, patient is eligible to have cost adjusted. For ambulatory, adjusted based on sliding scale, up to 75% of charges. No monitoring plan.
North General	–	X	–	Will serve patients with or without coverage and refer for Medicaid application. No fee scale attached. No monitoring plan.
St. Lukes/Roosevelt	X	X	X	Sliding scale= up to 100% poverty, $50. Up to 133%, $65. Up to 185%, $125. No monitoring plan.
St. Vincents/New York	–	X	X	Mission statement to provide care regardless of ability to pay. Sliding scale = below 100% of poverty, 100% write off. Up to 110%, 90% write off. At 190% of poverty, a 10% write-off. No monitoring plan.

Queens CHCCDP Hospitals

Hospitals	EMTALA	Clinic Policy	Fee Scale Attached	Comments
Catholic Med. Center/Queens/Brooklyn	–	–	–	Nothing submitted.
Episcopal	X	X	–	Two paragraphs re EMTALA. Admission irrespective of financial resources. Hospital has program to provide medications to patients who can't afford to purchase. Sliding fee scale for outpatients, no attached. Hospital inpatient care is monitored by case managers.
Flushing	–	–	–	Nothing submitted.
Jamaica	–	X	–	Two paragraphs. Treats all patients regardless of ability to pay. Sliding scale of fees, not attached. No monitoring plan.
NY Hospital Queens	–	–	–	Nothing submitted.
Peninsula	X	–	–	No fee scale attached. Statistical reporting on monthly basis on Medicaid, Bad Debt and Charity Care.

Staten Island CHCCDP Hospitals

Hospitals	EMTALA	Clinic Policy	Fee Scale Attached	Comments
St. Vincents/Bayley Seton	–	X	–	Use Hill-Burton for ambulatory care clinics, not used in Emergency. Applications are distributed. There is a financial screening procedure and payment policy. No fee scale attached. No monitoring plan.
Staten Island University	–	X	X	Policy = patients are expected to pay for non-emergency services at time rendered. If not able to pay in full are eligible for sliding scale. If patient doesn't have appropriate documents to report income and unable to pay, appointment will be rescheduled. The sliding scale is for clinic visit and any routing ancillary testing. There are different fees for different services - up to 100% of poverty level = Med/Surg, $35. Mental health $20. MRI, $300, etc.

Conclusion

There is an unfortunate pattern in New York State in which available public monies are used to fund hospitals to provide care for low income communities, rather than using these funds to expand public insurance coverage. Health care funding decisions in this state are highly politicized. Funding decisions are often based on political muscle rather than on the health care needs of the population. Nevertheless, consistent and forceful advocacy by community organizations, aided by the public hospital union and some health care providers, did manage to influence some of the decisions made about the CHCCDP program.

Some government grants for health care include some type of requirement that hospitals receiving funds provide services to the medically indigent. Yet there is almost never strong language to require this care, nor is there effective oversight, monitoring or accountability to ensure that health care services are actually provided, particularly for the uninsured.

This was certainly the case with the Community Health Care Conversion Demonstration Project. $1.25 billion was committed to fund hospitals for a period of five years to help them transition to Medicaid managed care. Three of the five years of funding for CHCCDP hospitals in New York City, or $648,364,165, has been allocated. Of these funds, $500,048,220 had been paid to these hospitals by February 2003.

Public accountability for the expenditure of these federal funds has been all but non-existent. Even when the Commission attempted to obtain information through formal channels, the Freedom of Information Laws, access was made very difficult. Because the State Department of Health, the designated oversight agency and keeper of the records, resisted the normal channels for responding the Commission had to file a law suit to compel production of these documents. Even with the law suit filed, the Commission has not received all of the necessary information to complete this evaluation as fully as we had planned.

Despite these obstacles, enough information was received to provide some evaluation of the way that CHCCDP funding has been used by city hospitals. Based on

the information available, the Commission can conclude that some portion of CHCCDP funds was used to expand primary care services, assist hospitals in becoming managed care ready, and provide some relevant training to hospital care workers. But it is almost impossible to determine what proportion of the funding was spent in accordance with the CHCCDP requirements contained in the Terms & Conditions, Attachment J, of the federal approval of the state's Medicaid managed care waiver. Assuredly, the benefits in no way equal the over $500 million that has already gone to hospitals in the city.

The amount of detail submitted by the Health and Hospitals Corporation, on behalf of its eleven acute care hospitals, far exceeds the information submitted by the voluntary hospitals. Although the Commission does not agree with some of the use of CHCCDP funds by the HHC, there is at least enough information available to draw this conclusion. Perhaps as a public corporation, the HHC is more accustomed to reporting for use of public funding.

Although some of the hospitals appear to have fulfilled the official CHCCDP goals at least partially, a number of the goals for CHCCDP that were set by the Commission and the Task Force have not been met. There has been very little in the way of contracting, or even working, with community based health care providers. This part of the safety net has essentially been left out of the CHCCDP program. With the changing populations in many communities in the city, and the large number of new immigrants moving into many neighborhoods, it is unfortunate that more hospitals did not use CHCCDP funding to move their institutions toward more culturally and linguistically competent care and services. There are also communities in which primary care access is not at the level that it could and should be, yet in Cycle II and III, only a small portion of the overall funds were used to expand primary care services. With severe shortages of certain health professionals, it is unfortunate that more of the retraining funds were not used to upgrade workers for these new careers. A large amount of CHCCDP dollars were used for computer and information systems, including MIS, billing and medical records. Some of these costly projects were not successful and were ultimately abandoned. Others may have been useful to the hospital, yet were only marginally related to CHCCDP goals.

Two more cycles of CHCCDP funding will be available for hospitals. This means there is still an opportunity to use these funds productively to improve the number and quality of resources available.

For the 1.6 million residents of New York City who have no health insurance, a more serious effort is needed to review and enforce the CHCCDP requirement that hospitals receiving these funds provide access to services for the uninsured. Although almost all of the hospitals made available their policies on access to services for the uninsured, many of these policies serve as a serious barrier to care, particularly for low income individuals and families. The Commission will undertake a more comprehensive review of these stated policies to understand how consistent they are with the laws, rules and regulations governing non-profits. The fact that very few of the hospitals submitted a monitoring plan to review how they accomplish, or not, access to care, is very troubling. Even fewer of the hospitals submitted the results of their monitoring – another requirement for CHCCDP funding.

There could have been four more years of funding, since the governor's office lobbied to extend the CHCCDP program for an additional two years. However, the governor requested and received federal approval to dedicate the additional $350 million for Cycles VI and VII to Worker Retraining and Retention, and Graduate Medical Education. This appears to be much the same purposes found in the January 2002 amendment to the state's Health Care Reform Act, for which the governor appropriated the proceeds of the Empire Blue Cross conversion to for-profit status. Much of these proceeds, unless a law suit overturns the gubernatorial and legislative decision, will be used for salary increases for health care workers. Efforts by the Commission, DC 37, and others to convince the federal agency, CMS, to maintain the initial purposes for CHCCDP funding during the extra two years were unsuccessful.

Recommendations

Cycles IV and V CHCCDP funding, the last two years of funding for the stated CHCCDP purposes, could be used to make a tremendous difference in primary care, managed care readiness, and worker retraining for managed care. Some steps need to

be taken before the Commission could view CHCCDP a success in meeting the important goals initially set for this funding. With almost $500 million remaining to be allocated, and the current cycle's funding still being spent, funded hospitals could accomplish much and could turn what has been called a "slush fund for hospitals" into a meaningful restructuring of health care services.

In order to accomplish this turn-around, the Commission on the Public's Health System recommends the following:

- An outside, independent audit of the expenditure of CHCCDP funding to determine the effectiveness of this program. This audit could be undertaken by the New York State Comptroller's office, as that office has the capacity to send in a team of professionals to evaluate this program. It is unfortunate that this has not already been undertaken. It would be important for this audit to review and determine whether there were any improprieties in the expenditure of these funds, and a requirement to follow-up on the issues identified in state Site Visit Reports, as well as the questions raised in this paper.
- Serious consideration by all CHCCDP funded hospitals of the issues raised in this policy paper, with the idea that the proposal submitted by each hospital for the final two cycles of funding should match the goals set by the program, and the goals identified by the Commission and the Task Force. Certainly, there should be more of an effort to reach out to community-based health care providers to develop working relationships and ensure the continued viability of these important health care resources.
- When the time comes to appropriate the final two cycles of CHCCDP funding, the state legislature should give serious thought to including language that would ensure better accountability for expenditure of these funds. In addition, the legislature should consider the flexibility given to the governor for the spending of Cycles VI and VII of CHCCDP funds. These funds could perhaps be more appropriately utilized in continuing the goals set by the original CHCCDP program – expansion of primary care, managed care readiness, and worker retraining.

- The State Health Department must evaluate the effectiveness of their monitoring efforts. Based on the Commission's review of this program to date, the department is deficient in requiring accountability from hospitals receiving CHCCDP funding. The very fact that eight hospitals in New York City received 25 percent of their funding for Cycles II and III and as of February 2003 had not yet submitted their final application for funding, is extraordinarily troubling. Another round of site visits should be undertaken by department staff, but this time there should be some independent fact-checking on hospitals' claims. Additionally, the department's claim that only two of the New York City CHCCDP funded hospitals have submitted Final Reports for Cycle I funding is outrageous. Hospitals that do not complete their reporting requirements for a cycle should lose a portion of the next cycle funding.
- The Terms & Conditions of the federal waiver required that the state reallocate unspent CHCCDP funds. A time limit should be set for completing the spending of each Cycle's funding – perhaps an additional year. If the funds are not completely spent by that time, the funding should be reallocated. All of the $1.25 billion in federal dollars allocated for the CHCCDP program should be spent for the intended purpose.

Percent of Self Pay Cases — Calendar Year 1998 Discharges
CHCCDP First Year Dollar Allocation

Hospitals	#of Self Pay Cases	Self Pay Percent	Total # of Cases	CHCCDP 1 Allocation	CHCCDP 1 Revised	CHCCDP 2 Proposed	Winner(+) Loser (-)
Bronx Voluntary							
Bronx Lebanon- Concourse	4,520	22.8%	19,836	8,861,483	10,614,896	10,483,34	-
Bronx Lebanon-Fulton	790	15.2%	5,194				
Montefiore — Weiler Hospital	213	1.3%	16,706	2,067,053	1,855,780	5,046,145	++
Montefiore — Moses	443	1.6%	27,466				
Our Lady of Mercy	714	4.2%	17,008	2,285,548	2,233,629	2,365,516	+
St. Barnabas Hospital	1,356	8.2%	16,578	3,660,323	4,073,335	4,770,985	++
Union Hospital of the Bronx	15	9.7%	154	5,179,414	1,104,322	0	
Westchester Square Medical	178	2.8%	6,334	----------			
Bronx Public Hospitals							
Jacobi Medical	4,002	21.0%	19,102	10,101,936	9,414,184	7,449,173	--
Lincoln Medical	3,056	15.4%	19,887	11,406,354	12,727,495	10,973,906	--
North Central Bronx Hospital	2,263	20.3%	11,167	7,766,587	7,077,479	6,117,567	--

Source of Data: NYSDOH SPARCS
Computations by: CPHIVS, Health and Hospitals Corporation
CHCCDP Allocation: Governor Pataki Press Release, July 16, 1997
CHCCDP Allocation: Year 1 Revised & Year 2, HCFA Fax
Charts Prepared by: Commission on the Public's Health System
December 15, 1999
Revised December 5, 2000

Hospitals	#of Self Pay Cases	Self Pay Percent	Total # of Cases	CHCCDP 1 Allocation	CHCCDP 1 Revised	CHCCDP 2 Proposed	Winner (+) Loser (-)
Brooklyn Voluntary							
Brookdale Hospital Medical Center	233	1.0%	23,322	4,896,875	4,155,712	4,142,164	-
Interfaith Medical Center at Jewish	243	8.5%	2,858	6,063,906	7,104,517	6,022,561	-
Interfaith Medical Center at St. Johns	279	8.2%	3,419				
Kingsbrook Jewish Medical Center	111	2.0%	5,611	396,980	353,223	635,405	++
Long Island College Hospital	381	1.8%	20,809	2,679,275	2,273,755	2,541,343	-
Lutheran Medical Center	1,484	7.6%	19,418	3,964,479	4,140,727	6,132,085	++
Maimonides Medical Center	659	2.1%	31,979	2,262,917	2,187,058	3,289,414	++
New York Community Hospital	108	2.2%	4,849	----------			
New York Methodist Hospital	----	0.0%	26,563	2,083,963	1,768,207	1,780,192	-
State University of Brooklyn	510	6.9%	7,355	1,613,179	1,833,279	1,758,591	-
The Brooklyn Hospital Center-Downtown	2	0.0%	18,247	4,656,937	5,647,813	5,150,626	-
The Brooklyn Hospital - Caledonia	-----	0.0%	4,021				
Victory Memorial Hospital	294	3.4%	8,634	406,737	345,176	979,265	++
Wyckoff Heights Medical Center	1,632	9.5%	17,139	6,315,375	5,359,516	4,344,655	--
Catholic Med Center at St. Marys	1,560	15.0%	10,426	2,056,063	3,285,194	5,451,684	++
Brooklyn Public Hospitals							
Coney Island Hospital	3,381	19.5%	17,316	5,670,903	6,003,590	5,518,722	--
Kings County Hospital Center	5,956	25.6%	23,294	12,674,947	16,162,556	11,548,664	--
Woodhull Medical Center	5,096	30.5%	16,713	8,566,045	8,490,786	7,366,378	--

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Manhattan Voluntary							
Beth Israel/North Div.	105	1.5%	6,783	6,828,439	6,468,741	9,994,578	++
Beth Israel/Petrie Div.	1,169	3.4%	34,725				
Cabrini Medical Center	191	2.1%	8,992	674,601	572,497	978,528	+
Lenox Hill	1,385	4.8%	29,078	----------			
Mount Sinai	871	1.9%	46,259	3,478,024	2,951,611	4,277,577	++
New York Hospital	1,714	4.9%	35,259	2,571,301	*		
New York Downtown	89	10.6%	842	2,011,729	1,757,976	2,032,902	+
New York Eye & Ear	123	7.6%	1,621	665,827		0	
North General	33	0.7%	4,953	2,954,806	2,726,577	2,539,322	--
New York University Medical Ctr.	404	1.8%	21,858	----------			
Presbyterian	1,694	4.7%	36,253	5,365,269	9,816,809	7,525,528*	--
Presbyterian/Allen Pavillion	474	3.9%	12,009				
Roosevelt/St. Luke's Roosevelt	1,025	4.4%	23,154	7,545,920	6,529,800	6,622,291	--
St. Luke's/St. L Roosevelt	686	4.1%	16,808				
St. Vincent's of NY	2,524	11.2%	22,599	3,145,516	2,863,191	2,933,688	--
MANHATTAN PUBLIC HOSPITALS							
Bellevue Hospital	3,273	15.8%	20,676	10,143,004	10,395,295	8,087,767	--
Harlem Hospital	1,822	15.1%	12,037	7,001,441	7,303,742	6,720,789	--
Metropolitan	2,391	17.2%	13,920	8,627,221	7,057,897	5,399,604	--

Source of Data: NYSDOH SPARCS
*Separate awards to New York Hospital, Presbyterian, & Allen are combined for Year 2.
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Queens Voluntary Hospitals							
Catholic Med. at Mary Immaculate	1,454	16.1%	9,041	3,241,466			
Catholic Med. at St. John	1,544	10.0%	15,464				
Jamaica Hospital	2,117	9.9%	21,482	4,869,924	4,592,972	4,603,361	-
Long Island Jewish	327	1.2%	27,351	----------			
New York Med Center of Queens	678	2.8%	24,343	1,221,826	1,251,159	1,839,613	+
North Shore at Forest Hills	32	0.3%	9,921				
Parkway Hospital	173	2.2%	7,700	----------			
Peninsula Hospital	46	1.0%	4,440	474,937	417,762	501,622	+
St. John's Episcopal at South Shore	1,173	15.9%	10,791				
Western Queens Community	58	2.3%	2,486	562,722			
Queens Public Hospitals							
City Hospital at Elmhurst	5,679	25.1%	22,622	10,783,014	12,018,082	11,173,332	-
Queens Hospital Center	2,301	18.3%	12,543	8,236,372	7,796,233	6,541,873	--

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