State of New York
Office of the State Comptroller
Division of Management Audit and State Financial Services

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

VERIFICATION AND MONITORING OF AFFILIATION CONTRACTS

REPORT 98-N-3

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and
State Financial Services

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Dr. Louis R. Marcos
President
New York City Health and Hospitals Corporation
125 Worth Street
New York, NY 10013

Dear Dr. Marcos:

The following is our audit report on the Health and Hospitals Corporation's verification and monitoring of affiliation contracts.

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution; Article II, Section 8 of the State Finance Law; and Article III of the General Municipal Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

January 12, 2000

Executive Summary

New York City Health and Hospitals Corporation Verification and Monitoring of Affiliation Contracts

Scope of Audit

In the early 1960s, the New York City Department of Hospitals began affiliating its individual hospitals with local medical schools and their teaching hospitals via contracts, to provide clinical and support services to patients at the municipal hospitals, improve patient care, attract quality medical staff, and retain the municipal hospitals' accreditation. Established in 1970, the Health and Hospitals Corporation (HHC) took over the responsibility of managing the municipal hospitals, including the relationships with the affiliates. Affiliation contracts had traditionally based reimbursement to affiliates on the actual cost of services provided, without regard to performance. In the mid 1990s, HHC began negotiations with the affiliates to initiate a performance-based contract in which reimbursement is based mainly on productivity (workload) by the affiliate, using a nationally-recognized methodology called the Relative Value Unit (RVU) method to measure productivity. The performance-based contract also calls for the affiliate to comply with 24 specific performance indicators that assess the quality of care, quality of service, and the provider's competency and qualifications. The affiliate is subject to financial penalties if certain performance indicators are not met.

We selected three hospitals for our audit--Hospitals A and B, which have performance-based contracts, and Hospital C, which has a cost-based contract. Because of confidentiality restrictions, the names of the hospitals cannot be disclosed.

Our audit addressed the following question relating to HHC's affiliation contracts for the contract period July 1, 1997 through June 30, 1998:

- Is HHC ensuring that performance-based contracts are being implemented and that affiliates are complying with the terms of their affiliation contracts?

Audit Observations and Conclusions

HHC has made considerable progress in managing and reducing the costs of its affiliation contracts. Longstanding problems, such as lack of accountability and monitoring, are being addressed. Nevertheless, we found that most of the HHC acute care facilities and their affiliates have not fully implemented the performance-based contract. In addition, we found insufficient monitoring over the implementation of certain aspects of the affiliation contract. We also noted instances of non-compliance with certain performance indicators and instances where there was insufficient documentation to provide reasonable assurance that affiliate employees were working and providing the required contractual services.

HHC did not meet the established target dates by which all of its facilities would implement the performance-based contract. We reviewed the status of contract implementation among the 11 acute care facilities and found wide variation in the degree of implementation. Not all of the acute care facilities have formally entered into the performance-based contracts with their affiliates. In addition, as of May 1999, only three acute care hospitals had fully implemented the performance-based contracts by utilizing the RVU method as the basis for contract reimbursement. HHC is therefore not yet achieving the full benefits, such as cost savings and increased quality of care, that the performance-based contract is intended to provide. (See pp. 5-6)

At Hospitals A and B, there is insufficient monitoring over the implementation of certain aspects of the affiliation contract. For example, none of the performance indicator results and workload statistics are verified by the affiliation contract manager at the facility level or by HHC to ensure that they are accurate and reliable. (See p. 9)

Due to provisions in the New York State Public Health Law restricting access to confidential and privileged information, we performed a limited review of only 4 of the 24 performance indicators at Hospitals A and B. We found that the affiliates did not always meet the goals of the performance indicators we verified, and that the affiliates were not fined the proper amount called for in the contract for non-compliance. Because of the lack of compliance with these performance indicators, there is reduced assurance that proper patient care was provided. (See pp. 11-14)

In addition, in some cases there was insufficient documentation to provide reasonable assurance that contract payments for affiliate employees were accurate at Hospitals A and C. For example, at Hospital C, time records did not show the dates and times that affiliate employees worked; therefore, we could not verify that these employees fulfilled their contractual obligations. (See pp. 15-18)

We made 12 recommendations to address the conditions we identified in this report.

Comments of HHC Officials

In their response to our draft report, HHC officials agreed with most of our recommendations and reported the steps they are taking to implement them. HHC officials also stated that the report is misleading and inaccurate in some of its assumptions and conclusions. According to HHC officials, the audit occurred too early in the shift to performance-based contracts. HHC's complete response to the draft report is included as Appendix B. We have prepared an Appendix C, containing State Comptroller's Notes, which addresses comments made by HHC officials in their response.

Contents

Introduction

Background

In the early 1960s, the New York City Department of Hospitals began affiliating its municipal hospitals with local medical schools and their teaching hospitals. The purpose of these affiliations was to provide clinical and support services to patients at the municipal hospitals, improve patient care, attract quality medical staff, and retain the municipal hospitals' accreditation. To accomplish these objectives, the management and provision of certain clinical and support services were delegated to the affiliates, which were then reimbursed for related costs.

The Health and Hospitals Corporation (HHC), established in 1970, assumed responsibility for managing the municipal hospitals, including the relationships with the affiliates. HHC hospitals provide comprehensive medical, mental health, and substance abuse services to all patients regardless of their ability to pay. HHC operates 11 acute care hospitals, two long-term care hospitals, and four diagnostic and treatment centers.

Beginning in fiscal year 1983, HHC entered into formal contracts with the affiliates to tighten control over its facilities. These contracts, which were boiler plate in nature, placed primary responsibility for managing and operating the hospitals with HHC and each hospital's executive director. In 1990, HHC attempted to hold the affiliates more accountable for the services provided by requiring them to adhere to several indicators that assess the quality of care, quality of service, and physician's competency and qualifications. These affiliation contracts required HHC to reimburse the affiliates based on costs; that is, the salaries and fringe benefits of the affiliates' employees (doctors, nurses, etc.) who provided services at HHC facilities, without regard to performance. Our prior audits and the New York City Comptroller's Office audits of these affiliation contracts found significant problems relating to the affiliates' compliance with provisions of the contracts, lack of accountability by the affiliates, and inadequate HHC monitoring of the affiliates.

In the mid 1990s, HHC began negotiations with the affiliates to initiate a performance-based contract in which reimbursement is based mainly on productivity (workload) by the affiliate, using a nationally recognized methodology called the Relative Value Unit (RVU) method to measure productivity. The Radiology, Anesthesiology and Pathology departments would still be reimbursed on actual costs, which according to HHC officials, is the most effective way of controlling costs for these three departments. The performance-based contract, which is boiler plate in nature, also calls for the affiliate to comply with 24 specific corporate-

wide performance indicators. In addition, the affiliate would be subject to financial penalties if certain performance indicators are not met.

According to an HHC official, the performance-based contract is a mechanism to improve the municipal hospitals' competitive position in the New York metropolitan health care environment. As part of an overall strategy, HHC chose to pay for market productivity at market salaries and to more closely align workload standards to staffing needs. HHC officials indicated that the performance-based contract instituted an improved system of measuring and monitoring affiliate performance. The primary benefits of this contract are to provide increased collaboration between affiliates and facilities; increased emphasis on quality through performance indicators that measure quality of care, quality of service, and provider's competency and qualifications; and increased accountability for affiliate performance by paying for service based on quantity and quality of workload. HHC reported that corporate-wide, affiliation contract costs were $505 million in fiscal year 1996 with a projected amount of $453 million for fiscal year 2000, a reduction of $52 million over the five years.

Audit Scope, Objectives and Methodology

We audited the affiliation contracts at selected acute care facilities for the contract period July 1, 1997 through June 30, 1998. The objectives of our performance audit were to determine the implementation status of the performance-based affiliation contract, to evaluate the effectiveness of HHC's monitoring of compliance with certain aspects of the affiliation contract, to determine whether the affiliate met the goals of certain performance indicators, and to verify the accuracy of the contract reimbursements that should be paid to the affiliate.

We selected three hospitals for our audit -- Hospitals A and B, which have entered into the performance-based contract, and Hospital C, which was still using a cost-based contract. As part of the affiliation contract, HHC paid Hospital A's affiliate $48.3 million for fiscal year 1998. For the same year, it paid $54.5 million to Hospital B's affiliate, and paid $13.3 million to Hospital C's affiliate. We selected Hospital A because, even though it did not use the RVU method for reimbursement, the affiliate was supposed to be reimbursed based on equivalent workloads of the hospital's departments. We selected Hospital B because it used the RVU method as a basis for contract reimbursement for our audit period. We selected Hospital C because it used a cost-based contract which was last negotiated in 1991 and renewed periodically. Reimbursement to Hospital C's affiliate was based on actual costs without regard to performance.

At Hospital A, to verify the accuracy of the reimbursement claims for the workload departments, we reconciled their workload statistics to the monthly summary reports. For the Radiology, Anesthesia and Pathology departments that are reimbursed on actual costs, we selected a judgmental sample of 30 affiliate employees to determine if they worked and provided the required services. At Hospital C, which is still on a cost-based contract, we selected four random samples of 33 affiliate employees and verified their time records and work schedules. We also compared both the hospital's and the affiliate's payrolls to determine if there was any dual employment for our sampled employees.

Our audit scope was limited by the following:

- Due to various provisions of the New York State Public Health law that restrict access to confidential and privileged information, HHC allowed us to audit only four of the 24 performance indicators: Residency Program Accreditation, New York State Department of Health (DOH) Mandatory Training, Delinquent Medical Records, and Undictated Operative Reports. Our audit of the four performance indicators was done at only Hospitals A and B because Hospital C did not have the performance-based contract in place. Our review was further limited because we could not verify the reported results for the DOH Mandatory Training performance indicator because our access to physicians' personnel files was restricted by law. Moreover, we could not verify the reported results for the Delinquent Medical Records and Undictated Operative Reports performance indicators against Medicaid patients' medical records. Even though the law allowed us access to Medicaid patients' medical records, neither Hospital A or B was able to readily identify the entire Medicaid patient population for audit testing of the results for these two indicators.

- At Hospital A, we could not verify the reported workload statistics against Medicaid patients' medical records because the hospital stated that it could not provide us with their medical records without incurring a massive amount of programming at great expense to the hospital. For the Radiology, Anesthesiology and Pathology departments, in which reimbursement is based on actual costs subject to a contract limit, we were severely limited in the amount of audit testing we could perform because of considerable delays of up to five months by Hospital A and its affiliate in providing supporting documentation.

- At Hospital B, due to the independent audit of the affiliation contract by the affiliate's auditors that was being conducted at the

time of our audit, HHC officials requested that we not audit the contract reimbursements made to the affiliate.

Except for the effects of the limitations of access to records imposed by the law and HHC, we conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of HHC which are included within the audit scope. Further, these standards require that we understand HHC's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations which are included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach to select activities for audit. We focus our audit efforts on those activities we have identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. We devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of HHC Officials to Audit

We provided preliminary copies of the matters contained in this report to HHC officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters contained in HHC's response.

Within 90 days after the final release of this report, we request that the President of the Health and Hospitals Corporation report to the State Comptroller, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Implementation Status of the Performance-Based Affiliation Contract

HHC, through its Office of Professional Services and Affiliations (OPSA), is responsible for overseeing the implementation of the performance-based contracts with the affiliate hospitals. These contracts call for the affiliate to comply with 24 performance indicators, with resulting penalties for non-compliance. In addition, the performance-based contract specifies that the majority of the contract services provided by the affiliate are to be paid to the affiliate based on the RVU method. This method, initially developed for the Medicare program, measures the workload utilized in providing health care services per patient encounter. RVUs account for a patient's severity of illness, the length of time a provider renders care, and the intensity of care rendered by a provider. Payments are computed by determining the RVUs for each service and applying a pre-determined RVU price.

According to HHC officials, the implementation of the RVU-based payment methodology required the updating of existing information systems at each facility and the development of new procedures, both corporate-wide and facility specific. This process required technical changes to data systems, development of forms and reports, new methods of coordination between departments, and training of employees at all levels of HHC. An implementation plan was designed by OPSA, with some components handled centrally and some at the facility level. In 1997, HHC began entering into the performance-based affiliation contracts with various non-profit metropolitan hospitals, medical schools and their teaching hospitals, and physician-owned professional corporations.

Our audit found that HHC did not meet the established target dates by which all of its facilities would implement the performance-based contracts. We reviewed the status of contract implementation among the 11 acute care facilities and found wide variation in the degree of implementation. Not all of the acute care facilities have formally entered into the performance-based contracts with their affiliates. In addition, as of May 1999, only three acute care hospitals had fully implemented the performance-based contracts by utilizing the RVU method as the basis for contract reimbursement for our audit period. However, most hospitals have to some degree used productivity as a factor in calculating reimbursement to their affiliates.

For the eight acute care facilities that have not implemented the RVU method, we noted the following:

- Four hospitals, including Hospital C, do not have the performance-based contract in place. Hospital C's affiliation contract reimbursement is still on a cost-basis. According to HHC officials, the other three hospitals and their affiliates have mutually agreed to continue to operate under the terms and conditions of an interim agreement (referred to as "deal points"), which reflects the understanding of the parties regarding the principal terms of the performance-based contract that the parties intend to enter into.

- Even though one hospital has a signed performance-based contract for the period January 1, 1997 through June 30, 1999, it has been paying its affiliate based on employees' salaries. HHC officials stated that while full implementation of an RVU model has not occurred, the hospital compensated its affiliate for a level of staffing that is appropriate to the service needs of the facility.

- Two hospitals which have the performance-based contract in place did not use the RVU method for reimbursement for the audit period. They were paying their affiliates a fixed amount based on an expected level of productivity up to their contractual limit.

- One hospital entered into the performance-based contract effective July 1998, which was after our audit scope period.

HHC officials indicated that some of the delays are the result of training issues of the employees, affiliate and HHC system modifications, and the integration that is required to obtain the data needed to determine the productivity bases for the services provided. They further explained that there is a "phasing in" of the implementation of the RVU-based payments. HHC officials also indicated that "the facilities are capturing RVU data, but what is limiting HHC's ability to pay the affiliates is the time needed to ensure the accuracy of the RVU data." However, by not having the performance-based contract fully implemented at all acute care facilities, HHC is not achieving the full benefits, such as cost savings and increased quality of care, that this type of contract is intended to provide.

Recommendation

1. Closely monitor and ensure full implementation of the new performance-based contract at all acute care facilities as it relates to the use of the RVU method as the basis of contract reimbursement to the affiliates. Establish new target dates for implementation and monitor against these dates.

   (HHC officials agreed with this recommendation, indicating that target dates were set in Spring 1998 but facilities were unable to achieve them because of the complexity of the system.)

Monitoring of Compliance with Contract Terms

OPSA is responsible for the corporate-wide monitoring of the affiliation contracts. Each facility is supposed to have an affiliation contract manager whose function is to monitor affiliation contract activities to ensure contract compliance at the facility, to serve as a liaison with the affiliate and HHC's central office, and to facilitate resolution of contract issues. The affiliation contract manager prepares a quarterly report on the affiliate's compliance with the performance indicators. The performance indicator results are then submitted to OPSA, which on a semi-annual basis, compiles the results for all of the HHC facilities and submits a report to the HHC's Board of Directors (Board) on affiliate compliance with performance indicators.

We found that at Hospitals A and B, there is insufficient monitoring of performance indicators and workload statistics. As a result, there is reduced assurance that the affiliates are providing the necessary services as required in the contract, and receiving the proper reimbursement.

The performance indicator results and workload statistics are compiled either by hospital or affiliate staff. However, neither the affiliation contract manager at the facility level nor OPSA staff verify the results to ensure that they are accurate and reliable. In response to our draft report, HHC officials stated that the facility's respective departments are responsible for the verification and accuracy of the data. However, we maintain that there should be independent verification of the performance indicator data and workload statistics.

Recommendations

2. Require the affiliation contract manager or OPSA to verify, on a test basis, the performance indicator results and workload statistics.

   (HHC officials disagreed with this recommendation, stating that there are multiple systems in place to cross-check performance indicator data and that it is not OPSA's function to serve as the Corporation's auditor. HHC officials also stated that external auditors will verify the performance indicator data. While the use of external auditors to verify performance indicator data is, in part, responsive to the intent of our recommendation, we believe that, as a minimum, HHC officials have the responsibility to routinely verify, on an independent basis, the accuracy of performance indicator and workload statistics data. If, as stated by HHC officials, it is not the function of OPSA to verify the data, then we suggest that periodic verification be done by the affiliation contract manager.)

3. Recommendation deleted.

4. Recommendation deleted.

Verification of Contract Terms

We attempted to verify whether the terms of the hospitals' affiliation contracts were complied with in two areas: whether the goals of the performance indicators were met by the affiliates and whether the contract reimbursements to the affiliates were accurate. As indicated in the Audit Scope, Objectives and Methodology section of our report, our access to certain records related to these two areas was restricted by law and by HHC. As a result, our audit testing in these areas was limited. However, we were able to determine that the affiliates did not always meet the goals of certain performance indicators, and in some cases there was insufficient documentation to provide assurance that contract payments were accurate.

Performance Indicators

The performance-based contract specifies 24 corporate-wide performance indicators that assess the quality of care, quality of service, and the provider's competency and qualifications. The affiliate is required to meet the goals of these indicators within certain time frames. Failure to comply with certain indicators would result in financial penalties to the affiliate.

Due to provisions in the State Public Health Law restricting access to confidential and privileged information, we performed a limited review of only four of the 24 performance indicators at Hospitals A and B: NYS Department of Health (DOH) Mandatory Training, Delinquent Medical Records, Undictated Operative Reports, and the Residency Accreditation Program, to determine if the two hospitals met the goals of these four indicators, and if they did not, were the appropriate penalties levied against the affiliates.

We found that Hospitals A and B did not always meet the goals of the various performance indicators we verified, and that the affiliates were not fined the proper amount called for in the contract. At Hospital A, three of the four performance indicator goals were not met. Hospital B reported that it met all four performance indicators. However, we determined that it did not meet the goal of 100 percent compliance for the NYS DOH Mandatory Training indicator. Because of the lack of compliance with these performance indicators, there is less assurance that proper patient care was provided.

NYS DOH Mandatory Training

The contract definition for this performance indicator is that "providers" will complete the NYS DOH Mandatory Training during each fiscal year

of the contract term. Providers, as defined in HHC's Affiliation Contract Manual (Manual), include physicians and non-physicians such as lab technicians. To achieve compliance with this indicator, all of the affiliate's providers must complete the mandatory training if the health and safety of patients and employees are to be protected at the facility. The mandated training involves fire/life safety practices, general safety, risk management, patients' rights, infection control, and professional misconduct.

We found that the affiliates for both Hospitals A and B do not report on the mandatory training for non-physician providers. They report only on the training for physicians. Therefore, any result that these affiliates report to HHC in regard to this performance indicator would be incomplete. An OPSA official told us that during contract negotiations, both parties were clear that the term "provider" referred only to physicians and dentists and that this understanding would be clarified in the next revision of the Manual. We believe that the term "provider" should also be clearly defined in future contracts.

Hospital A reported that only 1,389 of the 2,128 affiliate physicians had received the mandatory DOH training in the 1998 fiscal year, resulting in a non-compliance rate of 35 percent. As a result, there is a significant risk that the safety and health of Hospital A's patients may be compromised. The hospital fined its affiliate $2,000 for non-compliance with this indicator, but the contract calls for a penalty of $8,000. In response to our preliminary audit findings, an OPSA official stated that the contract provision describing the amount of penalty to impose on the affiliate is confusing, and noted that HHC "will make sure that the contract is clear in the next negotiation." The affiliation contract manager pointed out that the medical director who had assumed responsibility for ensuring compliance had resigned and that the position was vacant for a short time at the end of fiscal year 1998.

In response to our draft report, HHC officials stated that Hospital A will impose additional fines of $6,000 on the affiliate.

Hospital B's affiliate reported that it had achieved 100 percent compliance with this indicator. However, it failed to report that a non-physician provider had not completed the mandatory training, which resulted in preventing the affiliate from being in full compliance.

Undictated Operative Reports

The contract definition for this performance indicator requires that no more than two percent per quarter, and not to exceed nine operative

reports per quarter, will remain undictated 24 hours post-surgery. The purpose of this performance indicator is to ensure that surgical procedures are recorded promptly. It is expected that medical records will be more complete and accurate if physicians document procedures immediately after they perform them. Therefore, failure to meet this performance indicator would have a significant effect on the quality of patient care.

Hospital A reported 11, 32, 38, and 27 undictated operative reports in the four quarterly reports for fiscal year 1998, exceeding the benchmark of nine for each quarter, indicating that the affiliate had not complied with this performance indicator. As a result, there is a significant risk that patient care is being compromised. Because the number of undictated reports did not exceed two percent in each quarter, Hospital A officials incorrectly concluded that the affiliate had complied, and did not penalize the affiliate. Attachment D of the contract stipulates a financial penalty of $5,000 per quarter for non-compliance. According to this provision, the affiliate should be penalized $20,000 for fiscal year 1998.

In response to our preliminary audit findings, Hospital A officials acknowledged that the threshold measures had been misinterpreted, and said that the affiliate has been levied the appropriate fines.

Delinquent Medical Records

Delinquent Medical Records are charts that remain incomplete for reasons within the physicians' control for longer than 30 days after a patient is discharged. They include patient information on discharge diagnosis, length of stay, and procedures delivered that are needed for billing third-party payers. Therefore, prompt third-party payments are directly dependent upon how quickly medical charts for discharged patients are completed. In addition, a large number of delinquent medical records may affect the appropriate delivery of follow-up medical care.

Attachment D of the affiliation contract defines the performance indicator for Delinquent Medical Records as the following: "No more than 5 percent of inpatient charts will be delinquent beyond 30 days of a patient's discharge, based on the calculated monthly average of discharges for that specific month."

Hospital A's affiliate failed to comply with this performance indicator for each of the four quarters in fiscal year 1998, with non-compliance rates of 17.5 percent, 20.6 percent, 25.5 percent, and 31.3 percent. The affiliate's failure to comply with this indicator increases the risk that the patients are not receiving proper medical care. Also, the hospital levied a $5,000 fine against the affiliate for the third and fourth quarters of fiscal

year 1998. However, it did not penalize the affiliate an additional $10,000 for the first two quarters, as required. In response to our preliminary audit findings, the hospital and OPSA officials asserted that in terms of applying financial penalties to the affiliate, Attachment D of the contract refers to calendar year 1998, not fiscal year 1998. However, it is evident to us that Attachment D refers to fiscal year 1998, since it clearly indicates that the formal review of the performance indicators begins in July 1997, that the affiliation contract is for fiscal year 1998, and that the performance indicator results are reported by quarter for fiscal year 1998, beginning on July 1, 1997.

Recommendations

5. Clarify contract requirements by defining the term "provider" in the affiliation contract, particularly as it relates to the performance indicator for NYS DOH Mandatory Training, and by specifying whether financial penalties should be imposed on a fiscal year or calendar year basis.

   (HHC officials agreed with this recommendation, stating that future contracts starting in fiscal year 2000 will be revised to clarify these changes.)

6. Ensure that Hospital A's affiliate complies with the following performance indicators: NYS DOH Mandatory Training, Delinquent Medical Records, and Undictated Operative Reports.

   (HHC officials agreed with this recommendation stating that Hospital A will conduct joint meetings with the facility Medical Director and affiliate representatives; implement specific performance improvement plans; hold meetings with non-compliant services; and implement suspension policy.)

7. Fine Hospital A's affiliate the required amount of financial penalties for non-compliance with the following performance indicators: NYS DOH Mandatory Training, Delinquent Medical Records, and Undictated Operative Reports.

   (HHC officials agreed with this recommendation. However, HHC officials still need to clarify whether financial penalties should be imposed on a fiscal year or calendar year basis.)

Contract Reimbursement Costs

Hospital C

During our audit period, Hospital C was still using the cost-based contract that was negotiated in 1991 and which has been renewed periodically. The affiliate is reimbursed based on the personal service costs of its employees. For the fiscal 1998 contract year, the affiliate was paid $13.3 million. In December 1997 and June 1998, a total of 145 and 147 affiliate employees, respectively, worked at Hospital C. To verify, on a test basis, the validity of the personal service costs, we selected four random samples totaling 33 affiliate employees who worked at the hospital during the months of December 1997 and June 1998. We found that controls were not adequate to ensure that affiliate employees were paid only for time worked.

In response to our draft report, HHC officials stated that the problems identified at Hospital C have been known to the Corporation for a long time. They further added that their recognition of these inherent deficiencies in the old "cost-based" contracts was a major reason for HHC moving to performance-based affiliation agreements.

1. Time Records

We requested supporting documentation that would help us determine whether the employees had worked and provided the required services. We found the following:

- The affiliate employees' time records, which are prepared on a monthly basis, do not show the dates and time worked. They report only the time that the employee is off (e.g., vacation, sick leave). Therefore, we could not verify if the affiliate employees actually worked at the hospital in accordance with the contract.

- 17 of 33 sampled employees did not appear on the work schedules for December 1997 and June 1998. Therefore, there is a possibility that these doctors were paid but did not work. As mentioned previously, employee time records provided insufficient evidence to support if they worked at all.

2. Dual Employment

For each of the 33 sampled employees, we examined Hospital C's payroll records for the respective payroll periods to determine whether the affiliate employees were also being paid by the hospital. We found that three

affiliate doctors had been paid by both the affiliate and the hospital for the two bi-weekly payroll periods in December 1997. However, there was no written authorization for their dual employment. During our audit, Hospital officials contended that the required authorization for these three doctors to have dual employment was not necessary because they were not providing any medical services at the affiliate's facility. This position is incorrect as HHC's policy, which requires written authorization for dual employment, does not provide for any exceptions. The policy also states that any employee who violates this regulation may be subject to disciplinary action with a penalty up to, and including, termination from both jobs. With regard to these three doctors, we found the following:

- One doctor, who had a full-time equivalent (FTE) status of 1.05 (indicating more than full-time) on the affiliate's payroll, was paid $8,720 for December 1997. He was also paid $4,591 for working 20 hours a week in the same month (.53 FTE) on Hospital C's payroll.

- One doctor, who had a .80 FTE status on the affiliate's payroll, was paid $2,750 for December 1997. She was also paid $15,037 by Hospital C as a full-time employee (1.0 FTE) for the same pay periods.

- One doctor, with a .5 FTE status, was paid $3,443 by the affiliate. She also had a .5 FTE status on Hospital C's payroll and was paid $4,887 for the same pay periods. We found that she had charged four hours of sick leave on her affiliate's time record for both December 16, 1997 and December 23, 1997. However, she also worked 4 hours and 3 and 3/4 hours, respectively, on the same days for the hospital.

In addition, these three doctors did not appear on the affiliate's department work schedule for December 1997. Therefore, we do not know whether they worked or when they worked. There is the risk that these employees could have been overpaid by the affiliate or the hospital for the same hours they worked during the month of December 1997.

3. Floor Checks

As part of its monitoring efforts, Hospital C performed seven floor checks of the affiliate employees who worked at the hospital during fiscal year 1998. However, the last floor check was performed in February 1998, almost four months before the end of the fiscal year. We also noted that all of the floor checks had been completed before 5 p.m., and that none

had been conducted during the 12 a.m. to 8 a.m. shift or on the weekends, which are periods susceptible to time and attendance abuses.

Only 51 of the 175 affiliate doctors were floor-checked during fiscal year 1998, an average of just seven doctors per floor check. The floor checks revealed that nine doctors could not be found. We were told that these doctors received verbal counseling. However, there was no evidence that Hospital C officials followed up to determine whether the doctors had legitimate reasons for being absent. If they did not, then the doctors were overpaid.

Hospital A

Hospital A entered into a performance-based affiliation contract with its affiliate for the period July 1997 through June 2000. This contract is primarily performance-based; that is, reimbursements are based primarily upon productivity (workload). However, reimbursement for the Radiology, Anesthesiology and Pathology departments is based on actual costs, subject to a contract limit. For fiscal year 1998, Hospital A paid its affiliate $48.3 million for those departments that were reimbursed on workload and actual costs. This amount includes grants, which we did not review. In this regard, we noted the following.

1. Workload Departments

For fiscal year 1998, contract payment calculations for the 16 workload departments were computed by multiplying the number of units of service by the agreed-upon unit cost for each department. Salaries of Hospital A's physicians and residents were then deducted to arrive at the amount that should be reimbursed to the affiliate. For this year, the hospital paid $23.8 million ($54 million less the offset costs of $30.2 million for its doctors and residents) to the affiliate. We compared the workload departments' units of service reported for fiscal year 1998 with the monthly summary statistics, and found no exceptions. However, we were unable to verify the workload departments' units of service to original source documents (patient medical records). Hospital A's officials were unable to provide us with the medical records of Medicaid patients (the only ones we were allowed to examine) because they explained that it would be time consuming to re-create the patient listing. A patient's medical record would have provided evidence that service had been provided. We also compared the hospital's doctors' and residents' costs to the hospital's payroll registers to ensure the proper offset was made. We found no exceptions.

2. Radiology, Anesthesiology and Pathology Departments

The affiliate was paid $13.2 million for the affiliate employees' salaries in these cost-based departments. This amount excludes fringe benefit and overhead costs. During fiscal year 1998, approximately 325 affiliate employees worked at Hospital A in the Radiology, Anesthesiology and Pathology departments. We selected a judgmental sample of 30 of these employees from the affiliate's annual payroll listing, and sought to determine whether they had worked and provided the required services during December 1997 and June 1998. The 30 sampled employees were on the December 1997 payroll register; just 28 employees appeared on the June 1998 payroll. Our review of the employee time records found that the supervisors' signatures were missing on 12 time records, and that one sampled employee signed herself as her supervisor on two time records.

Recommendations

8. Require the affiliate employees working at Hospital C to record the dates and time worked on their time records in accordance with the Hospital's time and attendance record-keeping policy.

   (HHC officials agreed with this recommendation, stating that Hospital C's Finance Department will work closely with its affiliate to develop a standardized reconciliation procedure for time and attendance recordkeeping.)

9. Determine whether the 17 affiliate employees cited in the report worked at Hospital C in accordance with the contract. If they did not, take appropriate action.

   (HHC officials agreed with this recommendation, indicating that an adjustment will be made to the fiscal year 2000 contract by the amount of one discrepancy found in the affiliate employee work schedules.)

Recommendations (Cont.'d)

10. Ensure there is proper authorization for the dual employment of the three affiliate doctors who were on both Hospital C's and the affiliate's payrolls.

11. Determine whether the three affiliate employees who had dual employment with Hospital C and its affiliate had been overpaid for the same hours worked at both institutions.

    (HHC officials disagreed with recommendations 10 and 11. In response to our draft report, HHC officials stated that dual employment is not an accurate characterization for these three doctors. They explained that a unique payroll formula is in place, in which "Hospital C's Affiliate pays a supplemental salary which is designed to raise the annual salaries of the physicians to be compatible with industry standards." However, we find such an arrangement problematic. First, the arrangement is undocumented, and therefore unverifiable. Second, Hospital C's and the affiliate's payroll records misrepresent the number of hours that these employees work. If this arrangement is to continue, HHC officials should formalize it and appropriately reimburse the employees.)

12. Perform periodic floor checks at Hospital C and ensure that a representative number of affiliate doctors are verified during all shifts, including weekends.

13. Document any follow-up and corrective action on affiliate employees not found during a floor check.

    (HHC officials agreed with recommendations 12 and 13. They further stated that floor checks will be performed on a quarterly basis and conducted on a department sample basis.)

14. Ensure that Hospital A affiliate employees' time records are authorized by their supervisors.

    (HHC officials agreed with this recommendation, stating that the affiliate administrator will verify that time sheets are signed by the appropriate individuals.)

Major Contributors to This Report

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Luis R. Marcos, M.D.
President

October 7, 1999

Mr. Kevin M. McClune
Audit Director
Office of the New York State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Re: New York City Health and Hospitals Corporation
Verification and Monitoring of Affiliation Contracts - 98-N-3

Dear Mr. McClune:

Thank you for the opportunity to respond to your draft audit report regarding the above-captioned subject.

To effectively compete in the current dynamic healthcare environment, three years ago HHC embarked on developing a business model with our affiliates that would provide full accountability for medical services rendered while improving the quality and timeliness of those services. This was a radical departure from the previous agreements. HHC has successfully taken on the daunting task of dismantling a 30 year old business model and restructuring over $535 million in affiliation contracts. Where payments to affiliates were once based only on staffing levels, we developed a comprehensive payment system which links compensation to performance. The Corporation has effectively reduced the cost of these contracts by over $100 million since Fiscal Year 1995 while, at the same time, significantly increasing the performance level and accountability of our affiliates. Moreover, the Corporation accomplished this monumental feat in only three years in an environment that has been difficult for the entire healthcare industry.

In general, the report is grossly misleading and inaccurate in its assumptions and conclusions. As we informed Deputy State Comptroller Robert H. Attmore during his visit to HHC on March 13, 1997, and as discussed with the principals in the Audit Department during audit planning and at the Entrance Conference on April 23, 1998, it is far too early in this monumental shift to conduct the audit testing anticipated. However, the audit proceeded on the erroneous assumption that on day one of the new contracts all provisions of the new agreements would be fully implemented with little or no transition. The auditors failed to account for the start up necessary to develop massive new systems of data collection and new operational processes and procedures. In fact, HHC and our affiliate partners have performed remarkably well in such a short period of time. We acknowledge that there are issues that require additional work and

* Note 1

that the transition may not have been flawless, but HHC moved these agreements forward, continuing to make them stronger, finding new partners where necessary, and redefining existing partnerships.

Reading the draft report, one gets the mistaken impression that HHC failed, that the quality of care has been diminished, and that little or no improvements have been made. This is simply not the case. Further, the draft audit report implies that HHC was less than cooperative during this audit. In fact, the staff at our facilities and the Office of Professional Services & Affiliations dedicated a great deal of time and effort to educating the auditors as to the intricacies of the new performance-based arrangements and providing the requested data. The auditors were aware that the laws and regulations promulgated by NYS, to which HHC is obligated to adhere, prohibited us from providing certain patient-specific documents to which they refer.

Although the auditors performed very limited testing, they nonetheless made some rather broad and misleading conclusions. For example, the audit report states that HHC is not achieving the full benefits, such as cost savings and improved quality of care, that the performance-based contract was intended to provide. A full assessment of the facts reveals otherwise and we believe that this statement is irresponsible, shortsighted and clearly misrepresents the current status of our agreements.

Further, the auditors' use of a few undictated operative reports and a few incomplete medical records as evidence of compromised care is erroneous and demonstrates a lack of understanding as to the goals and function of these indicators. These particular Performance Indicators (PIs) are not quality of care indicators but rather documentation requirements, and it is puzzling that these few findings resulted in the mistaken conclusion of poor patient care.

The most critical error in the conclusion of the report is the failure to acknowledge that the new performance-based contracts provided for a phase-in of the RVU methodology. Facilities have appropriately calculated payment based on visit equivalents and work load, while developing the databases to ensure payment is accurately consistent with RVU data. This was the responsible action for HHC to take, yet the auditors mistakenly indicate that we have been negligent.

Although we have made tremendous strides in progressing these new agreements, we realize we have more work to do. Our solid business plan has thus far been well executed, and we continue to make additional improvements. Our newest contracts included new Performance Indicators to further improve the quality and timeliness of medical care to our patients and provide additional monitoring tools.

* Note 2

* Note 3

* Note 4

* Note 5

* Note 6

* Note 1

*See State Comptroller's Notes, Appendix C

It is clear that the auditors' report has not presented a fair and balanced assessment of this contract process. HHC has achieved a great deal through skillful negotiations and through persistence in developing and maintaining a productive relationship with our staff and affiliates. Our accomplishments thus far and our outstanding results are proof that we are on the right course.

* Note 1

Attachment 1 is the Corporation's detailed response to the issues in the audit report. **Attachment 2** is the Audit Implementation Plan for the recommendations outlined in the report.

If you have any questions regarding our response, please call Mr. Alex Scoufaras, Corporate Director, Internal Audits, at 212-730-3123.

Sincerely,

Luis R. Marcos by ESTC

Luis R. Marcos, M.D.

LRM:cg
Enclosures

c: Senior Vice Presidents
Executive Directors
Linda Landesman, Dr. PH, MSW, Ass't Vice Pres., Professional Services & Affiliations
Alex Scoufaras, Corporate Director, Internal Audits

*See State Comptroller's Notes, Appendix C

ATTACHEMENT 1

OPSA's DETAILED RESPONSE

HHC RESPONSE TO: Report 98-N-3 New York City Health and Hospitals Corporation Verification and Monitoring of Affiliation Contracts

BACKGROUND

The Background section describes an overview of the Health and Hospitals Corporation (HHC) and a historical perspective that led to the new performance-based Affiliation contracts. In our response to the preliminary report, we described how HHC initiated performance-based contracts as a mechanism to improve their competitive position in the New York metropolitan health care environment. As part of our overall strategy, the Corporation chose to pay for market productivity at market salaries and to more closely align workload standards to staffing needs. Since FY95, when HHC embarked on performance-based contracts, the Corporation instituted an improved system of measuring and monitoring Affiliate performance while achieving an annual savings of $100 million and a cumulative savings of $277 million over FY95 spending. More important, after 30 years of doing business with Affiliates in a manner that resulted in much criticism, HHC is now acting prudently. In addition to making Affiliates more accountable through new systems of measuring the quality of performance, HHC has made great strides in building confidence in a new payment system by making sure that we base payments on correct data. HHC has made substantial gains toward fully implementing a lofty and complex program that involves updating and modifying huge systems and altering the behavior of thousands of HHC employees and Affiliate employees.

HHC improved the contracts through increased (1) collaboration between affiliates and facilities; (2) emphasis on quality through performance indicators that measure quality of care, service, and providers; (3) responsiveness to market forces by requiring that providers achieve linguistic and cultural competency; (4) HHC power over business decisions through penalties for inappropriate referrals out of the system; (5) central monitoring through annexes and worksheets which allow the creation of a database, and; (6) accountability for affiliate performance by tying payments to performance, including financial penalties for nonperformance of quality care

IMPLEMENTATION

The RVU reimbursement system is only one component of the performance-based affiliation contracts, and as such, a discussion about the implementation status should include the other components. The comprehensive transformation of the Affiliation agreements required the establishment or modification of processes for monitoring compliance with many contract terms. These terms included a new payment system, a revised audit process, quality-based performance indicators, terms that have financial implication (i.e., unapproved transfers and referrals of patients, third party payer denials, and research), and terms that have no financial impact (credentialing and recredentialing of staff, cultural and linguistic competency, provider qualifications, assignment schedules, accreditation of training programs, affirmative action reports, and departmental evaluations). Since the auditor's report is prepared on an "exception basis" and only highlights those areas needing improvement, it fails to acknowledge the accomplishments made in implementing these contract components. We are puzzled at a

* Note 7

recommendation that is so broad as to infer that implementation of these other components has not been achieved.

More important, this report is misguided in stating that HHC hasn't achieved the full benefit of cost savings and increased quality of care because we haven't fully implemented an RVU payment methodology. While one could argue that additional savings might be achieved through a theoretical reduction in reimbursement if workload decreases, the contracts guarantee payment for a minimum level of staffing in order to assure that we maintain quality patient care. While achieving a cumulative savings of $277 million since FY95, the Corporation has maintained the level of staffing necessary to ensure compliance with regulatory and resident supervision requirements. Coterminous with these changes, there has been additional independent verification of improvement in the quality of care, by the Corporation's high marks during the Joint Commission of Healthcare Organizations' accreditation process.

* Note 4

This report is inaccurate in stating that four hospitals do not have performance-based contracts in place. Three of the identified hospitals do have contracts which are in fact performance-based. The terms and conditions of the interim agreements (i.e. deal points) constitute contracts in and of themselves as a matter of law.

* Note 8

Although Affiliate payments are eventually based on reimbursement for Relative Value Units (RVUs), the report fails to state that the contracts provide that nine of the facilities are to capture baseline workload data in order to calculate the price of the RVUs **prior** to paying their Affiliates based on RVUs. There are three categories in which the RVU-based compensation models fall. The contracts for six (6) of the facilities require a visit equivalent adjustment to compensation, prior to the collection of baseline data and payment calculated using RVUs. The contracts for three of the facilities require a deferred base period prior to the calculation of RVU price and payments based on RVUs. At one (1) facility, the contract requires a baseline period to establish the RVU price and then payment calculated using RVUs. At one (1) facility, the contract requires payment based on RVUs without this transition. The report incorrectly reported the number of hospitals paying their Affiliates based on RVUs. A third hospital based payments on RVU data from the beginning of its contract. Further, as required by contract, three hospitals (including the hospital whose agreement didn't start until July 1998) have adjusted payments based on visits and discharges and are capturing and reporting data that will be used for the calculation of the RVU price. Finally, another hospital, whose contract calls for a deferred baseline, has been capturing and reporting RVU data, as required. This information was provided to the auditors.

* Note 9

* Note 10

The statement that one hospital has been paying its affiliate based on employee salaries doesn't reflect their achievement in tying Affiliate payment to performance. This hospital compensated its Affiliate for a level of staffing that is appropriate to the service needs of the facility while saving 25.7% or $14.5 million in the four years since FY95. The Affiliate was forced to "right size" the staff and by FY97 had cut 23% or 148 Full Time Equivalents over FY95. Contrary to the statement in the report that the Corporation has not fully achieved the

* Note 11

*See State Comptroller's Notes, Appendix C

cost savings benefits of these contracts, this Affiliate received appropriate reimbursement for maintaining a level of providers necessary to meet regulatory and accreditation standards at the hospital.

HHC negotiated variable categories of performance-based contracts because the success of basing payment on workload is dependent upon assuring both facility and Affiliate that the RVU data is accurate enough to calculate payment. This transformation of the Corporation's data systems has been an intricate process where tremendous strides have been made as detailed in the sections below.

While OPSA is globally responsible for assessing overall implementation of the contracts and reporting such to the Board of Directors, the onus of implementing and monitoring these contracts rest with the facilities on a daily basis. The following describes the tremendous advancements that have been made in the implementation of an RVU payment methodology.

CORPORATE WIDE ACTIVITIES

RVU Data Systems: The full implementation of an RVU-based payment methodology required the updating of existing information systems at each facility and the development of new procedures, both Corporate-wide and facility-specific. This tedious, labor-intensive process required technical changes to data systems, development of forms and reports, new methods of coordination between departments, and training of employees at all levels of the Corporation. An implementation plan was designed by the Office of Professional Services and Affiliations (OPSA), with some components handled centrally and some at the facility. OPSA monitored the progress of each facility and provided guidance where facilities fell behind target.

Corporate activities first centered upon reconfiguring the SMS financial systems to capture, record, and report on RVU data for both the inpatient and outpatient settings. Without these modifications, RVU implementation could not go forward. The patient visit and registration system also were upgraded at the facilities so that specific provider, diagnosis, and procedure data could be captured. The databases were updated to identify RVU/ CPT-4 codes. The computerized systems were modified to allow the capture of RVUs by service.

Simultaneously, reports were developed to analyze both inpatient and outpatient RVU activity. Both Central Office and the facilities had to create programs to produce reports organized by service, by provider, by RVU type (Evaluation and Management Codes or Procedure), and to identify data errors. The Corporation hired an outside vendor to 1) work with the Medical Records departments at each facility to develop outpatient specific forms, and 2) train facility staff and providers to use the new forms and the new reporting systems.

The Office of Professional Services and Affiliations developed an assessment tool and conducted a survey to evaluate RVU readiness at each facility. Once the facilities responded to the survey, OPSA conducted site visits to discuss a timetable for full implementation of the RVU

system. A copy of the site visit timetable was sent to each Network Senior Vice President. Each facility committed their staff to meeting this timetable. OPSA continued to discuss these implementation issues with facilities on an ongoing basis. While a timetable was established in the spring of 1998, the facilities, in some cases, have been unable to achieve these deadlines because of the complexity of the systems involved.

Operational Manual: Historically, the Corporation had never produced a manual to guide facilities in monitoring the Affiliation contracts. OPSA, the first to recognize the need for Corporate-wide direction, developed an Operational Manual which was initially distributed to all facilities and Affiliates in September 1997. The manual was subsequently revised and redistributed in October 1998. The manual, which was meant to provide guidance in operationalizing these complex agreements, covered the following:

- Responsibilities of Corporate and Facility staff;
- RVU data collection;
- Affiliate compensation and an overview of the payment process, including recalculation of payment, monthly expense reporting, and approval of documents;
- The audit process;
- Assessing compliance with performance indicators and impediments;
- Ensuring compliance with other contract terms; and
- Annexes and related reports required by the contract.

RVU Booklet: Because of the need to educate more than 10, 000 Corporate and Affiliate employees about the new payment system, OPSA developed an RVU booklet, entitled "Implementing the HHC Affiliation Contracts - Capturing Provider Data." This booklet serves as a quick reference guide to CPT-4 codes, RVUs and data reporting requirements. Initially, 13,000 copies of the handbook were distributed to affiliate providers and facility staff to guide them in the procedures of documenting provider activity for purposes of implementing the new affiliation agreements. Subsequent distributions have occurred each year, when a new group of residents and attendings are hired.

Document Development and Training: Prior to these contracts, all reporting on Affiliate activity was done through annexes where the data was typed directly onto the annex sheet. OPSA revised these annexes to include the capture of information that was more relevant to monitoring the new performance-based contracts. OPSA then developed a comprehensive set of computer-driven worksheets to facilitate the reporting of both business and operational terms and RVU data. Prior to this effort, all monitoring information was reported in a format which made tracking Affiliate compliance tedious, time consuming, and hard to quantify. The new annex documents report on staffing, residency and training programs, compliance with performance indicators and other terms, and research activities. The financial documents were developed with input from reimbursement, budgets, data, audits, legal, and each facility. The financial documents include 1) calculation of payment, 2) calculation of RVU price, 3) monthly fee statements, and 4) recalculation of affiliate payment. To facilitate accurate completion of these

new worksheets, a series of Corporate-wide training sessions was conducted for all facilities/Affiliates and individual sessions were also held with each facility/Affiliate. Additional training has also been provided when new staff was hired and/or questions arose.

Ongoing Monitoring of RVU Implementation: Once the initial site visits were concluded, OPSA conducted periodic phone follow-up with each facility in addition to regular liaison contact. OPSA staff inquired about progress in implementing each of the tasks agreed to in the initial RVU readiness site visits. Progress reports were shared with Senior Network leadership. In addition, the facility reports to OPSA on the status of RVU implementation at the monthly contract managers' meetings.

FACILITY SPECIFIC ACTIVITIES

Facilities are responsible for operationalizing the various components of the new performance-based contracts. Following the lead of Central Office, each facility had to make the RVU-workload data collection process operational, establish procedures for monitoring affiliate activities and monitor compliance with the terms of the contract, work with their Affiliate in the reconciliation of RVU data, track submission of RVU-BASED reports and review these reports before they were submitted to Central Office. The following identifies the variety of tasks that each facility has undertaken in order to fully implement an RVU-based payment methodology: 1) assess and upgrade system requirements (hardware, software, staffing, and training needs); 2) identify and assign staff responsibilities (number and skills needed to manage contract, skills needed to comply with contract, define roles, organize coordination and train; 3) system development (build structure for database; format data; design forms that are department specific; develop procedures for data collection, storage, and retrieval; develop formats for report; train both facility and affiliate staff; assess data; revise data where errors are identified); 4) system usage (institute procedures to monitor and evaluate affiliate workload, to complete financial worksheets and reconcile payment documents.

To ensure that data was accurate, facilities had to also ensure the following: 1) the input forms were available for all workload-based services; 2) the forms were designed to capture data accurately and completely; 3) providers were trained to use the forms and document accurate CPT-4 codes; 4) the codes selected by the providers were correct and accurately reflects services in patient charts; 5) data entry clerks were trained on inputting the forms; 6) data inputted by the clerks was complete and accurate; 7) data recorded in the facility database (e.g., CADCARS) was transmitted to the Corporation's financial systems completely and accurately; and 8) data reports accurately reflected workload, as verified by hospital utilization and/or faculty practice information systems.

In order to insure that Affiliate payment was correctly calculated, facilities had to insure that 1) the doctor master database containing provider information was accurate, complete and up-to-date; 2) outpatient visits were "closed" on a timely basis; 3) data systems assigned each physician to the correct service; 4) reports were organized by service within the appropriate

department classifications as indicated by the agreements; 5) procedures to check the RVU reports against other Corporate documents to ensure that the RVU data were accurate and complete; 6) data was entered by facility staff accurately and completely; 7) the process to correct data errors was effective; 8) discrepancies concerning data were resolved so that both Affiliate and facility agreed that the RVU data was correct; and 9) everyone who needed to be trained received training.

DEVELOPMENT OF PERFORMANCE INDICATORS

The implementation of the new performance-based Affiliation agreements required the revision of numerous other systems, in addition to a new payment methodology. OPSA developed and effectuated a new method of reporting and monitoring staffing, residency and training programs, compliance with performance indicators and other contract terms, and research activities. OPSA defined and described methods for measuring twenty-four new performance indicators in the first wave of negotiations and has added an additional 10 quality indicators for all contracts when they were or will be renegotiated for FY2000 and beyond.

VERIFICATION OF PERFORMANCE INDICATORS AND WORKLOAD STATISTICS

The auditors' statement that monitoring is not adequate does not reflect the processes that have been established to manage these new contracts. Since Fiscal Year 1996, the Health and Hospitals Corporation moved from a strong central office structure to a decentralized, Network dominated model. The result of this Corporate restructuring has been the shifting of day to day responsibility to the networks and facilities. The obligation for establishing the systems required by the new Affiliation contracts and verifying the results of these systems belongs to the Networks. The first level of review is done by the facility/Network in cooperation with the Affiliate. In addition to the review conducted by the contract manager and other facility staff, this information is also cross checked with other data reported to the Corporation, (data gathered through the quality assurance and the strategic planning processes). Finally, the Corporation has contracted for another review by the independent auditors hired to conduct an unbiased examination of the Affiliation contracts.

* Note 12

COMPLIANCE WITH LAWS, RULES AND REGULATIONS

Residency Program Accreditation: The State Comptroller's Office has misinterpreted this performance indicator and confused the monitoring of the Part 405 requirement ("Bell regulations") with an assessment of "maintaining Residency Review Committee (RRC) accreditation unless voluntarily withdrawn." This Performance Indicator, as agreed to in the Affiliation contracts, is measured by assessing "the percentage of programs that have RRC accreditation." Part 405 compliance is outside the scope of the intent and measurement of this performance indicator.

* Note 13

As was shared with the auditors, the facility has other internal checks and balances for

*See State Comptroller's Notes, Appendix C

Bell 405 compliance and thus there was no need to duplicate monitoring through a performance indicator. As the Controller's Office noted in its report, the RRC provided full accreditation at both facilities that it audited. Since these hospitals have assigned high level administrators in conjunction with Chiefs of Service to monitor and respond to 405 concerns, the auditors were invited, during a 4/22/99 preliminary exit conference, to assess hospital monitoring and compliance by interviewing those responsible. To our knowledge, the auditors didn't meet with the hospital personnel responsible for monitoring and reporting on Part 405 Bell compliance.

MONITORING NON-WORKLOAD DEPARTMENTS

The auditors suggest that the facility conduct periodic floor checks to verify that services are indeed being provided. The contracts do not include monitoring through floor checks because the Corporation believes that while floor checks may demonstrate that a provider is on site, they do not guarantee that the provider is delivering services. This decision to remove floor checks as a monitoring tool was based on the fact that workload and non-workload services are now closely interwoven. As example, efficiency in performing surgical procedures is dependent on the services of the department of anesthesiology. Because payment is tied to services provided, there is a built in incentive for the Affiliate to maintain adequate staffing levels in all departments for work to flow smoothly. If the Corporation was not receiving the services it had contracted for, this would be reflected in the overall performance of the Affiliate. Further, in implementing the new performance-based agreements, the facility has required that hospital administrators internally supervise and manage work schedules and ensure that adequate levels of service and quality of care are being provided. Monitoring of non-workload services is now the responsibility of personnel who administer hospital services, not the contract manager. The auditors declined the opportunity to speak directly with the administrative staff responsible for this monitoring.

* Note 14

PERFORMANCE INDICATORS

HHC was fully cooperative in providing access to all records requested by the auditors. Long before the auditors began their fieldwork, the attorneys of both HHC and the NYS Comptroller's Office agreed in writing that all but four performance indicators would be excluded from the audit. Further, it should be noted that access to physicians' personnel files was not possible because the confidentiality of such files is protected by law, and the auditors were fully aware of that fact when they made decisions about the scope and content of the audit.

* Note 3

The report states that "because of lack of compliance with these performance indicators, there is less assurance that proper patient care was provided." On a semiannual basis, OPSA develops a comprehensive detailed report assessing Affiliate compliance with performance indicators and other contract terms and presents the detailed findings to Network leadership and the HHC Board of Directors. These reports allow the Board to understand the longitudinal performance of each facility against itself and against all other facilities in the Corporation. This detailed analysis allows both the leadership of the facilities and the governance of the board to

*See State Comptroller's Notes, Appendix C

focus attention on areas where improvement is needed. Where performance thresholds have not been met, progressive improvement has been evident over the course of these contracts.

Specific comments about each PI follow:

NYS DOH Mandatory Training: The auditor's report states that the term "provider," as defined in the HHC Affiliation Contract Manual, includes physicians and non-physicians. While the manual does include three definitions for three types of "providers," during the negotiations, both parties were clear that for purposes of monitoring the contract, the PI was intended to only measure the training of physician providers. We will clarify this in the next revision of the Contract Manual.

With regard to the decision to limit the fine to $2000, since the contract calls for mandatory training to be reviewed annually, the Corporation cannot assess Affiliate performance or require payment of a penalty for non-performance on a quarterly basis. Because of the ambiguity and the operational reality that you can't accurately measure compliance with this PI on a quarterly basis, we will make sure that this contract is clearly written when we renegotiate it.

Delinquent Medical Records: The audit report is incorrect in its reading of Attachment C of the contract for hospital A. All of the contracts provide for a period in which the facility and Affiliate are given time to establish appropriate measurement of the performance indicators before financial penalties are assessed. While all the hospitals assessed performance from the first day of the contract, financial penalties were not imposed until several quarters later. Attachment C of the hospital A contract details the threshold for Delinquent Medical Records as <10% the 1st through 3rd Quarters of **calendar** year 1998, and that the threshold for the 4th Quarter of **calendar** year 1998 was <7%. While other Affiliate contracts, which were negotiated later, established thresholds using the HHC fiscal year not the calendar year, this hospital monitored their contract as it was written.

* Note 15

COST-BASED CONTRACT

The problems identified at hospital C have been known to the Corporation for a long time. Our recognition of these inherent deficiencies in the old "cost-based" contracts was a major reason for HHC moving to performance-based Affiliation agreements. The Corporation is close to implementing a comprehensive performance-based agreement between hospital C and its current Affiliate. When this new agreement is in place, the concerns expressed by the auditors about the processes at this facility will be remedied.

*See State Comptroller's Notes, Appendix C

ATTACHEMENT 1

HOSPITAL A's DETAILED RESPONSE

Hospital A has reviewed the draft audit report, dated September 7, 1999 on the New York City Health and Hospitals Corporation Verification and Monitoring of Affiliation Contracts conducted by the Office of the State Comptroller. This document will respond to specific items but will first address the general tone of the audit.

The audit team arrived at Hospital A on October 15, 1998. The original team consisted of Albert Kee, Robert Tabi, Howard Feigenbaum, and Karl Koller. A meeting was held to provide the auditors with a general overview of Hospital A's Affiliation contract. Hospital A's, Chief Financial Officer, led the meeting. He outlined the interim method of reimbursement to the affiliate through visit equivalent workload, end of year pricing, and resident and Doctor's Council subtractors. He also described the complicated process of converting from a contract that reimbursed the affiliate for salaries based on services provided, to a productivity model. The team was directed to a large room with several desks, chairs, and telephones, where they remained for the next seven months. Hospital A cooperated in all aspects of the audit. Numerous documents were requested and provided including:

* Note 16

- Copies of all invoices and reconciliation documents
- Several memorandums that explained adjustments to the invoices and payment methodology
- Physician schedules (These were provided early in the audit process, returned to the Affiliation Contract Manager, requested again at a later date, and provided)
- Annex F (Performance Indicator Reports) for all quarters in fiscal year 1998 indicating compliance levels for the four indicators under review
- Back-up provided by each department for the same indicators
- Affiliate audit report for the year ending June 30, 1998
- Copies of all letters denoting status of Residency Program Accreditation
- Payroll registers from the affiliate for radiology, anesthesiology, and pathology staff
- Personnel Services Expense Report for Attendings and Residents on the HHC payroll

In addition, several hours were spent explaining, in detail:

- The payment methodology
- A description of each performance indicator, the process of developing collection methodology, and what that methodology entailed

These two items were explained several more times when Arthur Liebowitz joined the team.

The following response addresses specific items in the report.

Audit Observations and Conclusions:

- **"At Hospitals A and B, there is inadequate monitoring over the implementation of certain aspects of the affiliation contract. For example, none of the performance indicator results and workload statistics are verified by the affiliation contract manager at the facility level or by HHC to ensure that they**

*See State Comptroller's Notes, Appendix C

are accurate and reliable. In addition, the affiliation contract manager performs no ongoing monitoring to ensure that affiliate employees are actually working and providing the contractual services."

Monitoring of Compliance with Contract Terms:
"However, neither the affiliation contract manager at the facility level nor OPSA staff verify the results to ensure that they are accurate and reliable."

The following was explicitly explained to the auditors on more than one occasion:

During the first several months of implementation of the productivity-based contract, Hospital A individuals and/or teams required to report on each performance indicator met with the Affiliation Contract Manager to review the specific requirements of data capture. The team worked together to develop a methodology for collection and identified appropriate hospital staff to monitor the indicator and report quarterly. Several of the indicators are also reported to the HHC Board of Directors Quality Council. Modifications to collection criteria were modified as necessary to comply with contractual stipulations.

* Note 17

The reports are forwarded to my office quarterly. The report is accompanied by department specific compliance data. The department specific data is compared to the summary report to ensure consistency; when inconsistent, the reporter is contacted for clarification or correction. Full back-up documentation is maintained within the designated department for future review/verification as necessary. As explained to the auditors, the full back-up is not kept in the Affiliation Contract Manager's office, due to space constraints. It is fully expected that hospital department directors and their staff can be held accountable for ensuring submission of accurate reports.

* Note 17

Undictated Operative Reports and Delinquent Medical Records: Mr. Liebowitz, auditor, interviewed Hospital A's Medical Records Director who reviewed the process of data collection on two of the performance indicators: undictated operative reports and delinquent medical records. She produced back-up documentation for the quarters reviewed, listing specific cases by physician with dates. Medical record numbers were listed for undictated operative reports.

* Note 18

As noted in the draft report, the threshold measure for undictated operative reports was misinterpreted. The affiliate has since been levied the appropriate fine.

The Department of Health Mandatory Training and Residency Program Accreditation indicators are collected by the Medical Staff Office who reports to Hospital A's Medical Director.

Mandatory DOH Training:
The data for DOH training is collected through two methodologies:

1. Physicians who complete the process by studying a hard copy manual, submit an attestation to the department head; these are forwarded to the Medical Staff Office.
2. A list of physicians who complete the process through the computer module is generated by the MIS Department.
   The two lists are merged into one by the Medical Staff Office who generates reports for the affiliation contract and for the HHC Board Report.

Residency Program Accreditation:

The benchmark for Residency Program Accreditation specifically states: "Residency programs will maintain RRC accreditation unless voluntarily withdrawn. This is applicable only for those items under physician control. For example, disapproval due to inadequate supervision is an item under physician control." The measurement indicator is the percentage of programs that have RRC accreditation.

* Note 13

As stated previously, the Affiliation Contract Manager provided copies of all letters denoting Residency Program Accreditation status to the auditors. Each residency program has a program director that, in coordination with the Department Chairman, prepares reports and coordinates with the appropriate hospital administrator to correct specific deficiencies. As the indicator specifies maintenance of accreditation status only, and all residency programs at our facility have maintained their accreditation, there has been no need to monitor the process further. The auditors were advised to speak directly to those responsible for 405 compliance for additional information regarding monitoring of the accreditation process, but chose not to.

* Note 13

Again, as explained to the audit team, administrative and medical staff from Hospital A and the Affiliate has worked together since implementation of the productivity model in formal team meetings to operationalize the contract and identify ways to improve quality of patient care. Results of performance indicator reports are shared with the school's administration to develop plans of correction. The issues are addressed at senior administration levels, multidisciplinary clinical service lines meetings, and quality council sessions.

- **"Also, the hospital levied a $5,000 fine against the affiliate for the third and fourth quarters of fiscal year 1998 (delinquent medical records). However, it did not penalize the affiliate an additional $10,000 for the first two quarters, as required."**

As explained to the auditors, fines were not levied against the affiliate during the first two quarters for two reasons:

1. The headings on Attachment D of the contract identify quarters by calendar year (ex. "first quarter 1998), not fiscal year
2. As agreed to during negotiation of the contract, the Affiliation Contract Manager spent the first several months of implementation of the contract,

* Note 15

coordinating the data collection process for all the performance indicators so that any penalties for non-compliance could be based on reliable data.

- **"In addition, in some cases there was insufficient documentation to provide assurance that contract payments for affiliate employees were accurate at Hospitals A and C."**

In addition to monthly invoices (which are prepared jointly by Hospital A and the Affiliate), detailed memorandums explaining changes in payments as well as a detailed grid of all payments were furnished to the audit team. Explanations for items not understood by the team were also provided on numerous occasions.

* Note 19

Audit Scope, Objectives and Methodology:

- **"We selected Hospital A because, even though it did not use the RVU method for reimbursement, the affiliate was paid a fixed amount tied to an expected level of productivity of the hospital's departments."**

The Affiliate was not paid a fixed amount for productivity. Payments to the Affiliate were based on visit equivalent workload.

* Note 20

- **"Even though the law allowed us access to Medicaid patients' medical records, neither Hospital A or B was able to provide us any of their medical records for these two indicators (Delinquent Medical Records and Undictated Operative Reports)."**

During Mr. Liebowitz' interview with the Director of Medical Records, it was explained that data for incomplete medical records is collected by physician and does not include the medical record number. While the data for undictated operative reports did include medical record numbers, Mr. Liebowitz did not request any medical records for review of this indicator.

* Note 18

- **"At Hospital A, we could not verify the reported workload statistics against Medicaid patients' medical records because the hospital could not provide us with their medical records."**

As explained to the auditors, the reports used to generate workload data for visit equivalent workload reports, as currently configured, do not include individual patient payer class. To do so would require a massive amount of programming at great expense to the hospital. In addition, the request-to-production process is extremely lengthy. The auditors accepted our explanation without question and did not request the information again.

* Note 21

- **"For the Radiology, Anesthesiology, and Pathology departments, in which reimbursement is based on actual costs subject to a contract limit, we were severely limited in the amount of audit testing we could perform because of considerable delays of up to five months by Hospital A and its affiliate in providing supporting documentation."**

As explained to the auditors, detailed financial information could not be provided until the reconciliation process for payment was completed. Reconciliation of payment was not completed until March 16, 1999. At that time, supporting documentation was gathered and provided to the audit team.

*
Note
22

ATTACHEMENT 1

HOSPITAL B's DETAILED RESPONSE

HOSPITAL B
COMMENTS ON NYS COMPTROLLER'S AUDIT OF HHC
VERIFICATION AND MONITORING OF AFFILIATION CONTRACTS

I. VERIFICATION OF PERFORMANCE INDICATOR RESULTS

The report states that none of the performance indicator results and workload statistics are verified by the Affiliation Contract Manager. The role of the Contract Manager at Hospital B is to manage the overall Performance Indicator reporting process, including developing and implementing assessment methods for each indicator, and ensuring the requirements of the Affiliation Contract are met. It is the responsibility of HHC staff in the operating areas to verify performance indicator results. In addition, HHC Quality Assurance staff are responsible for monitoring and reporting on many of these indicators. Hospital B has also established an internal audit process on the Performance Indicator results which is conducted by the Quality Assurance department at the Hospital. In addition to Hospital B's verification efforts, HHC has contracted with an external agency to verify PI data.

II. ACCESS TO MEDICAL RECORDS

The auditors were not denied access to medical records for verification of the undictated operative reports and delinquent medical record indicators. It was suggested that they review Chart Deficiency Module of the Intellus Medical Record tracking system. This system produces reports which identify charts which are delinquent. The availability of an electronic reporting system to track this indicator negates the need for a medical record review. The auditors accepted this method of verifying the results of this indicator. The auditors were also given an automated report which reported on undictated operative reports. They accepted this method of verifying this indicator. Both delinquent medical records and undicatated operative reports are also reported to the HHC Board on a quarterly basis.

III. RESIDENCY PROGRAM ACCREDITATION

The AED for Quality Assurance is responsible for monitoring Bell Commission requirements. The Affiliation Contract Manager is responsible for assessing whether all residency programs have full accreditation. The auditors were provided with documentation verifying that the Affiliation complied with this indicator. The auditors additional comments go beyond the scope of the PI process and therefore are inappropriate.

IV. MONITORING PROVISION OF CONTRACTUAL SERVICES

There is extensive monitoring of Affiliate performance through the quarterly Performance Indicator reporting. Hospital B verifies that the Affiliate is providing required contract services by reviewing their performance on a number of indicators which measure quality of and access to care. The suggestion of floor checks to monitor performance of the Affiliate is not useful.

ATTACHMENT 2

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AUDIT IMPLEMENTATION PLAN

Audit Title: *Verification and Monitoring of the Affiliation Contract* *Date:* *October 1, 1999* *Audit Agency:* *NYS Comptroller's Office*

Agency: *NYC Health and Hospitals Corporation OPSA* *Audit Date:* *October 1998 - April 1999* *Audit Number:* *98-N-3* *OMB Control:* _____

RECOMMENDATIONS WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 7, Recommendation 1 1. Closely monitor and ensure implementation of the new performance-based contract at all acute care facilities, including these of the RVU method, as the basis of contract reimbursement to the affiliates. Consider establishing target dates for implementation.	Continue the processes we have in place, including RVU readiness surveys, monthly Contract Manager reports, reports to facility leadership. Target dates were set in Spring 1998 but facilities have been unable to achieve them because of the complexity of the system.	Ongoing	Ensure continued monitoring.
Page 14, Recommendation 5 5. Clarify contract requirements by defining the term provider in the Affiliation Contract, particularly as it relates to the performance indicators for NYS DOH Mandatory Training, and by specifying whether financial penalties should be imposed on a fiscal year or calendar year basis.	Future contracts will be revised to clarify these changes.	Commencing FY 2000	Ensure clarity in future contracts.

PART C

AUDIT COORDINATION AND REVIEW
AUDIT IMPLEMENTATION PLAN

Audit Title: *Verification and Monitoring of Affiliation Contracts* *Date:* *October 1, 1999* *Audit Agency:* *NYS Comptroller's Office*

Agency: *NYC Health and Hospitals Corporation OPSA* *Audit Date:* *October 1998 - April 1999* *Audit Number:* *98-N-3* *OMB Control:* _____

RECOMMENDATIONS WITH WHICH THE AGENCY DISAGREES AND DOES NOT INTEND TO IMPLEMENT	REASONS FOR DISAGREEMENTS AND REFUSAL TO IMPLEMENT
Page 10, Recommendation 2 Require the affiliation Contract Manager or OPSA to verify, on a test basis, the performance indicator results and workload statistics.	There are multiple systems already in place to cross-check performance indicator data, which the facility will continue to use. It is not OPSA's function to serve as the Corporation's auditor. The external auditors will verify the performance indicator data.
Page 10, Recommendation 3 Require the affiliation Contract Manager to document any follow-up action to correct any non-compliance with the laws, including those related to inadequate supervision and resident work hours.	This is the responsibility of the Medical Director in cooperation with high level administrative staff at each facility, not the Contract Manager.

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Agency: *NYC Health & Hospitals Corporation HOSPITAL A* *Audit Date:* *October 1998 - April 1999* *Audit Number:* *98-N-3* *OMB Control:* _____

RECOMMENDATIONS TO WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 10, Recommendation 4 4. Verify that Affiliate's employees are actually providing the contractual services in the departments where reimbursement is based on actual costs. A useful monitoring tool would be the use of random floor checks.	Reimbursement to non-work load based departments, such as laboratories, radiology and anesthesia, is paid on a "fixed payment" schedule and is based on "actual costs up to a fiscal year contractual limit." The Hospital has an administrator who supervises the department heads. The department heads are directly responsible for staffing/scheduling/productivity and performance. Monitoring employees' time and attendance is a routine part of their job and the job of supervisors' staff who report to them. Thus, floor checks are not necessary.	Ongoing	Ensure the appropriateness of staffing productivity and overall performance.
Page 14, Recommendation 6 6. Ensure that Hospital A's Affiliate complies with the following Performance Indicators (PIs): NYS DOH Mandatory Training, Delinquent Medical Records, and Undictated Operative Reports.	Conduct joint meetings with the facility Medical Director and NYU representatives; implement specific performance improvement plans; hold meetings with non-compliant services; implement suspension policy.	Ongoing	Ensure monitoring of PIs and thresholds.

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RECOMMENDATIONS TO WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 14, Recommendation 7 **7A.** Fine Hospital A's Affiliate the required amount of financial penalties for non-compliance with the following PIs: NYS DOH Mandatory Training.	The Affiliation Contract Manager will impose additional fines of $6,000 for failure of the Affiliate to meet the training PI.	Fiscal Year 2000	$6,000 will be recouped from Affiliate. Encourages the Affiliate to meet PI thresholds.
Page 14, Recommendation 7 **7B.** Fine Hospital A's Affiliate the required amount of financial penalties for non-compliance with the following PIs: Delinquent Medical Records and Undictated Operative Reports.	The Affiliation Contract Manager has imposed financial penalties for failure of the Affiliate to meet the PIs for Delinquent Medical Records and Undictated Operative Reports.	January 1998 and Ongoing	Fines imposed and recouped from Affiliate. Encourages the Affiliate to meet PI thresholds.
Page 18, Recommendation 14 **14.** Ensure that Hospital A Affiliate's employees' time records are authorized by their supervisors.	The Affiliate has distributed a memorandum to the Chiefs of Services notifying them of their responsibility for verifying and signing time sheets. The Affiliate administrator will verify that time sheets are signed by appropriate individual.	9/24/99	Ensure that time records are authorized by supervisors.

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Agency: *NYC Health and Hospitals Corporation HOSPITAL B*

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RECOMMENDATIONS WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 10, Recommendation 2 2. Require the Affiliation Contract Manager or OPSA to verify, on a test basis, the performance indicator results and workload statistics.	The Affiliation Contract Manager does verify statistics. PI results are monitored and reported by administrative staff responsible for operational departments. They are also monitored by Hospital Quality Management Director and the results are reported to the HHC Board of Directors.	Ongoing	Monitor performance and verify the accuracy of statistics.
Page 10, Recommendation 4 4. Verify that Affiliate's employees are actually providing the contractual services in the departments where reimbursement is based on actual costs. A useful monitoring tool would be the use of random floor checks.	Reimbursement to non-work load based departments, such as labs, radiology and anesthesia is paid on a "fixed payment" schedule and is based on actual costs up to a fiscal year contractual limit. The hospital has an administrator who supervises the department heads. The department heads are directly responsible for staffing/ scheduling/productivity and performance. Monitoring employees' time and attendance is a routine part of their job and the job of supervisory staff who report to them. Thus, floor checks are not necessary.	Ongoing	Ensure the appropriateness of staffing productivity and overall performance.

PART C

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Agency: *NYC Health and Hospitals Corporation HOSPITAL B* *Audit Date:* *October 1998 - April 1999* *Audit Number:* *98-N-3* *OMB Control:* _____

RECOMMENDATIONS WITH WHICH THE AGENCY DISAGREES AND DOES NOT INTEND TO IMPLEMENT	REASONS FOR DISAGREEMENTS AND REFUSAL TO IMPLEMENT
Page 10, Recommendation 3 Require the affiliation contract manager to document any follow-up action to correct any non-compliance with the laws, including those related to inadequate supervision and resident work hours.	The AED for Quality Assurance is responsible for monitoring Bell Commission requirements. This is beyond the scope of the Affiliation Contract Manager's duties.

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RECOMMENDATIONS TO WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 10, Recommendation 4			
4. Verify that Affiliate's employees are actually providing the contractual services in the departments where reimbursement is based on actual costs. A useful monitoring tool would be the use of random floor checks.	1. Floor checks will be performed on a quarterly basis up to the date of implementation of the new Performance-Based Contracts (PBC). Floor checks will be conducted on a department sample basis.	10/1/99	Ensure Affiliate employees are providing contractual services through the use of floor checks.
	2. Reimbursement to non-work load departments, such as laboratories, radiology and anesthesia, will be paid on a "fixed payment" schedule and is based on "actual costs up to a Fiscal Year contractual limit." The Hospital has an administrator who supervises the department heads. The department heads are responsible for staffing/scheduling/productivity and performance. Monitoring employees' time and attendance is a routine part of their job and the job of supervisors' staff who report to them. Thus, floor checks are not necessary for the PBC.	Upon implementation of PBC.	Ensure the appropriateness of staffing productivity and overall performance.

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Agency: *NYC Health & Hospitals Corporation HOSPITAL C* *Audit Date:* *October 1998 - April 1999* *Audit Number:* *98-N-3* *OMB Control:* _____

RECOMMENDATIONS TO WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 8, Recommendation 8 8. Require the Affiliate employee working at Hospital C to record the dates and time worked on their time records in accordance with the Hospital's time and attendance record-keeping policy.	Hospital C's Finance Department will work closely with its Affiliate to develop a standardized reconciliation procedure for time and attendance record-keeping. The new procedure will be implemented and remain in effect until the date of implementation of the new Performance-Based Contracts (PBC).	11/1/99	Ensure that the Affiliate employees practice time and attendance record-keeping procedures.
Page 18, Recommendation 9 9. Determine whether the 17 Affiliate employees cited in the report worked at Hospital C in accordance with the contract. If they did not, take appropriate action.	1. Hospital C's Finance Department performed a reconciliation review of the Affiliate employees' work schedules, quarterly expense reports and monthly expense reports. 2. Adjustment will be made to the Fiscal Year 2000 Annex D, ***Maximum Allowable Cash and Spending Rate***, by the amount of one discrepancy found in Affiliate employee work schedules.	7/16/99 In Fiscal Year 2000.	Determine discrepancies in work schedules for Affiliate employees. Recoup monies for overpayments made to employees.

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RECOMMENDATIONS TO WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION/ TARGET DATES	PROGRAM IMPROVEMENTS/ DOLLARS SAVINGS/INCREASED REVENUE WITH TIMETABLE
Page 18, Recommendation 12 12. Perform periodic floor checks at Hospital C and ensure that a representative number of Affiliate doctors are verified during all shifts, including weekends.	Floor checks will be performed on a quarterly basis up to the date of implementation of the new Performance-Based Contracts (PBC). Floor checks will be conducted on a department sample basis.	10/1/99	Ensure Affiliate employees are providing contractual services through the use of floor checks.
Page 18, Recommendation 13 13. Document any follow up and corrective action on Affiliate employees not found during a floor check.	Hospital C's Finance Department will work closely with the Affiliate to implement corrective action and follow up for the Affiliate employees not found during a floor check. This will be performed up to the date of implementation of the new PBC.	10/1/99	Ensure that the Affiliate implements corrective action and follow up for those employees not found during floor checks. Ensure the provision of contractual services.

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OMB Control: _____

RECOMMENDATIONS WITH WHICH THE AGENCY DISAGREES AND DOES NOT INTEND TO IMPLEMENT	REASONS FOR DISAGREEMENTS AND REFUSAL TO IMPLEMENT
Page 18, Recommendation 10 **10.** Ensure there is proper authorization for the dual employment of the three Affiliate doctors who were on both Hospital C's and the Affiliate's payroll.	Dual employment of the three Affiliate employees cited in the audit report is not an accurate characterization by the auditors. A unique payroll formula is in place between Hospital C and its Affiliate. Hospital C pays the salary for Clinical Services provided under the Affiliation Agreement. Hospital C's Affiliate pays a supplemental salary which is designed to raise the annual salaries of the physicians to be compatible with industry standards. Hospital C's Contract Managers authorize clinical privileges at Kings County Hospital only.
Page 18, Recommendation 11 **11.** Determine whether the three Affiliate employees who had dual employment with Hospital C and its Affiliate had been overpaid for the same hours worked at both institutions.	See ***Reasons for Disagreement and Refusal to Implement*** cited above in Recommendation No. 10.

State Comptroller's Notes

3. We do not agree with HHC officials that our audit was undertaken too early in the shift to performance-based contracts with the affiliates, that the audit proceeded on the erroneous assumption that all provisions of the new contracts would be implemented with little or no transition, and that we failed to account for the start up necessary to develop new data collection systems and operational procedures. As stated in our report, HHC began entering into the performance-based affiliation contracts with various non-profit metropolitan hospitals, medical schools and their teaching hospitals in 1997. Our audit was primarily conducted during the latter part of 1998 and 1999. We took account of the fact that contracts had phase-in periods. For example, Hospital A's 1997-98 fiscal year contract calls for a six-month phase-in period (July 1, 1997 through December 31, 1997) before the RVU method of payment could be implemented. Further, on page 5 of our report, we noted that the implementation of the RVU-based payment methodology required updating of existing information systems at each facility and the development of new procedures. As acknowledged by HHC officials in their response to our report, additional work needs to be done and the transition to performance-based contracts was not flawless. Consequently, we believe that our audit is timely and provides valuable input to HHC officials during the transition to performance-based affiliation contracts.

2. Our report does not state or imply that HHC failed, that the quality of care has been diminished and that little or no improvement has been made. We have concluded that delayed implementation of the performance-based contracts precludes HHC from achieving the full benefits, in terms of cost savings and increased quality of care, that the performance-based contracts are intended to provide.

3. Our audit experienced delays at several junctures. For example, HHC officials did not inform us of the restrictions contained in the New York State Public Health Law concerning access to confidential and privileged information until May 28, 1998, almost four weeks after the opening conference for the audit. As a result, our audit was delayed for five months between June and October 1998 while legal counsels for HHC and OSC negotiated a memorandum of understanding concerning confidential material, which was consummated effective December 21, 1998. Additionally, Hospital A did not provide us with the affiliate and facility payroll records we requested until five months after we requested them in November 1998.

4. As stated in the Scope, Objectives and Methodology section of our report, an audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider in the circumstances. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations. Further, as stated in State Comptroller's Note 2, we concluded that delayed implementation of the performance-based affiliation contracts precludes HHC from achieving the full benefits of the contracts.

5. We did not make any conclusions with respect to poor patient care. We identified non-compliance with three of four performance indicators at Hospital A and with one of four performance indicators at Hospital B. We stated that because of a lack of compliance with these performance indicators,

there is less assurance that proper patient care was provided. It should be noted that the four performance indicators we reviewed are listed in the affiliation contract under the heading "Quality of Care Measures to be Assessed by the Hospital."

6. Contrary to the assertion by HHC officials, we were aware and did recognize in our report on page 6 that the new performance-based contracts provided for a phase-in of the RVU methodology.

7. We have modified recommendation 1 to focus on the implementation of the RVU method as the basis of contract reimbursement to the affiliates.

8. In our judgment, our report accurately reflects the situation regarding the implementation of the new performance-based contracts by the four hospitals. Hospital C does not have a performance-based contract in place and the other three hospitals are operating under an interim agreement, which reflects the understanding of the parties regarding the principal terms of the performance-based contract that the parties intend to enter into.

9. Although not stated in the report, we were aware that certain facilities were to capture baseline workload data prior to paying their affiliates based on RVUs. However, the underlying issue which we reported on is the timeliness with which the facilities were transitioning to the RVU methodology for paying their affiliates. As of May 1999, only 3 of 11 HHC acute care facilities were using the RVU method of reimbursement.

10. We modified page five of our report to state that three acute care hospitals were using the RVU method of reimbursement.

11. The point we make in our report is that, while this hospital has signed a performance-based contract with its affiliate, it is not reimbursing the affiliate based on RVUs.

12. In our judgment, procedures would be improved if there were independent verification of the performance indicators and workload statistics. We suggest that this be done by the affiliation contract manager or OPSA on a test basis.

13. We have amended our report by deleting the section titled Compliance with Laws, Rules and Regulations, which dealt with Part 405 of the New York State Department of Health's rules and regulations. We also deleted recommendation 3.

14. We have amended our report by deleting the section titled Cost-Based Reimbursement Departments, which dealt with hospital departments not reimbursed based on RVUs. We also deleted recommendation 4.

15. As acknowledged to us by HHC officials, the word "calendar" does not appear in Attachment D of Hospital A's affiliation contract. Based on our reading of the contract, we maintain that Attachment D refers to the 1998 fiscal year, since it clearly indicates that the formal review of the performance indicators begins in July 1997, that the affiliation contract is for fiscal year 1998, and that the

performance indicator results are reported by quarter for the 1998 fiscal year, beginning on July 1, 1997. Our recommendation 5 addresses this matter by recommending that HHC officials clarify certain contract terms such as specifying whether financial penalties should be imposed on a fiscal year or calendar year basis.

16. Not all documents were provided to us on a timely basis. For example, we requested the Personal Services Expense Report for HHC Attendings and Residents and the affiliate payroll registers for the Radiology, Anesthesiology and Pathology departments on November 19, 1998. Hospital A provided these records to us on April 20, 1999 and May 6, 1999, respectively.

17. Hospital A's response describes the process that is followed for collecting and disseminating performance indicator data. As stated by Hospital A, "It is fully expected that hospital department directors and their staff can be held accountable for ensuring submission of accurate reports." We maintain that HHC officials should independently verify the accuracy and reliability of the data.

18. The documents referred to by Hospital A did not identify the Medicaid patient population that we needed for our audit testing.

19. Hospital A's response does not address our findings pertaining to insufficient documentation. We concluded that the affiliate employees' time records were not properly approved.

20. We amended our report to state that Hospital A's affiliate was reimbursed based upon visit equivalent workload.

21. We amended our report to state that Hospital A could not provide us with the Medicaid patients' medical records because of the need for a massive amount of programming at great expense to the hospital.

22. Hospital A provided us with the supporting documentation for the reconciliation on April 20, 1999 and May 6, 1999, not March 16, 1999 as stated.