FINANCE COMMITTEE AGENDA

Date: September 13, 2018
Time: 11:00 am
Location: 125 Worth Street, Board Room

Call to Order — Bernard Rosen
Adoption of the July 19, 2018 Minutes

I. Senior Vice President's Report — John Ulberg

II. Financial Reports Status
- Key Indicators — Krista Olson
- Cash Receipts and Disbursements — Michline Farag

III. Information Items
- Payor Mix — Krista Olson
- Huron Revenue Cycle Update — John Ulberg

Old Business
New Business — Bernard Rosen
Adjournment

MINUTES

Finance Committee **Meeting Date: July 19, 2018**

Board of Directors
The meeting of the Finance Committee of the Board of Directors was held on July 19, 2018 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES
COMMITTEE MEMBERS
Bernard Rosen
Gordon Campbell
Dr. Mitchell Katz
Mark Page
Emily Youssouf

OTHER MEMBER
Josephine Bolus

OTHER ATTENDEES
T. Cosgrave, Cerner
J. DeGeorge, Office of the State Comptroller
M. Dolan, DC 37
W. Huang, OMB
A. Lin, DC 37
F. Leonard, OMB
A. Mirdita, PAGNY

HHC STAFF
P. Albertson, Vice President, Supply Chain
E. Barlis, CFO, Jacobi/NCB
E. Casey, Central Office
E. Coleman, CFO, Metropolitan
F. Covino, Senior Assistant Vice President, Corporate Budget
L. DeHart, Assistant Vice President, Corporate Reimbursement Services
B. deLuna, Press Secretary
M. Farag, Corporate Budget Director, Corporate Budget
M. Figueroa, CFO, Harlem
R. Fischer, CFO, Bellevue
B. Foley, Senior Vice President, Acute Care
R. Malone, CFO, Queens
K. Mendez, Senior Vice President/Chief Nursing Officer, Central Office
K. Olson, Assistant Vice President, Corporate Budget

A. Pai, Central Finance
J. Reyes, Senior Director, Medical & Professional Affairs
K. Park, CFO, Coney Island
A. Saul, CFO, Kings County
B. Stacey, CFO, Lincoln
C. Telano, Senior Assistant Vice President/Chief Internal Auditor
LR Tulloff, Facilities Development
J. Ulberg, Senior Vice President/CFO, Corporate Finance
J. Weinman, Corporate Comptroller, Corporate Finance

CALL TO ORDER **BERNARD ROSEN**

Mr. Bernard Rosen called the meeting to order at 10:01 am. The minutes of the May 22, 2018 meeting were approved as submitted.

SENIOR VICE PRESIDENT'S REPORT **JOHN ULBERG**

Mr. Ulberg began his report noting that at the end of June, the cash balance was about $725 million which includes a City payment of $200 million and supplemental payments of $300 million. Mr. Ulberg noted that he, Linda DeHart, and other Finance staff have Friday calls with the State and OMB about streamlining the flow of funds. Mr. Gordon Campbell asked about the monies owed to the City, in terms of the amounts and for what years. Mr. Fred Covino noted that, in prior years, with the delay in receipt of supplemental payments, there were delays in City payments. There is approximately $290 million for FY15 due to the City, there are also some outstanding health insurance payments for prior years. Mr. Campbell asked if there were no outstanding payments for FY 16 through FY 18, and Mr. Covino confirmed none other than the health insurance payments. Ms. Josephine Bolus asked if there were any impacts from the settlement for nurses reported in the news last night. Mr. Covino noted that the physically taxing settlement will be paid by the City as it is related to collective bargaining. Ms. Bolus asked if there was an amount available, and Mr. Covino noted that follow-up would occur to determine that number. Utilization trends have not changed and continue to show declines, and headcount is holding steady at about 44,450 full time employees (FTEs). Ms. Emily Youssouf asked if the headcount figure included part-time employees and consultants. Mr. Covino noted that it includes part-time staff, temp staff, and IT consultants, but not consultants like those who are working on the year-end audit. Mr. Campbell asked if there was still a vacancy control board process in place, and Mr. Covino confirmed there was, with physicians, nursing, and nursing support positions being automatically approved. Mr. Campbell noted that at the Board meeting next week that there would be an update on nurse staffing.

Mr. Ulberg continued his reporting on looking at next year and finalizing budgets with the facilities. He noted that the execution of the budget is critical, with a disciplined implementation of approved business plans. A workplan process is being implemented that requires details on operationalization to achieve the $1.6 billion gap closing plan. Mr. Ulberg reported that Health + Hospitals is participating, through Dr. Katz, in the State's indigent care workgroup. The workgroup was initiated by the Governor's Office and the Legislature, with the first meeting focused on defining the scope of work, and there are three more meetings expected to take place in the fall. Ms. Youssouf asked about the participation in the workgroup, and whether each hospital system was included. Mr. Ulberg confirmed that hospital systems, advocacy groups, health plans, hospital associations, and the State Department of Health were included. Ms. Youssouf asked if the DSH funds would be distributed more favorably to hospitals that are public. Dr. Katz noted that he stated at the workgroup that disproportionate meant systems that treated a disproportionate share of Medicaid and uninsured patients; in California, disproportionate meant disproportionate. Dr. Katz continued that the State is concerned that any system is seen as losing something. In California, a hospital may go to the governor and state that they are closing, and the governor may not see that as an issue; in New York, there is a different consideration, particularly for a list of distressed hospitals that may not be serving a disproportionate share of Medicaid and uninsured patients. At the workgroup, Dr. Katz raised the issue of a hospital that may be in financial trouble, but not due to treating uninsured and Medicaid patients, but because it is not run well. The purpose of disproportionate hospital payments should be for those systems that are serving a disproportionate number of uninsured and Medicaid patients. Mr. Mark Page asked about the proportionate funds Health + Hospitals receives, what was the structural connection of the workgroup to what Health + Hospitals will receive. Dr. Katz noted that he raised this issue at the workgroup in terms of what success would look like in terms of

outcomes, and that the State responded that they were not prepared to answer the question and that more information will come later. Dr. Katz asked the State if this was a consensus process, a voting process, what were the rules of engagement for the workgroup; Mr. Katz noted that the State did not provide an answer at the meeting. Mr. Page noted that these types of forums can steer off into the wilderness without concrete outcomes. Mr. Ulberg noted that one strategy could be to memorialize the recommendations and draft legislation for adoption. With no further questions, the report was concluded.

KEY INDICATORS REPORT **KRISTA OLSON**

Ms. Krista Olson began the utilization report reporting through May 2018. Starting with acute care hospitals, ambulatory care visits are down by 1.1% against last year, compared to 1.5% from the May meeting. Utilization is trending up against earlier in the fiscal year. Dr. Katz noted the impact of adding doctors in ambulatory care in hospitals and Gotham clinics. Ms. Youssouf asked about Woodhull decreases, and Ms. Olson noted that the number of vacancies had an impact. Dr. Katz noted that a physician was hired as the new ambulatory care director; she is a Bellevue trainee who currently works at Gouverneur. Acute Inpatient discharges are down by 2.8% with the largest decline at Metropolitan. However, Metropolitan has seen a large increase in observation stays which are counted as outpatient that offsets a significant portion of the decline from a workload perspective. Mr. Campbell requested clarification on where acute and ambulatory visits were captured, and Ms. Olson noted that visits included emergency department and ambulatory care, and inpatient numbers were captured in discharges. Mr. Campbell requested headers in the report moving forward.

Ms. Olson continued her report on the average length of stay which is a half-day greater at Health + Hospitals overall, compared to the city-wide average, when adjusting for case mix. Mr. Rosen asked if the expected average length of stay was adjusted. Ms. Olson noted that the average length of stay was calculated by dividing the number of days by discharges, and excludes psych and rehab. The reasons for the higher length of stay are likely a combination of differences, in the patients served, documentation and coding differences, and discharge planning processes. Ms. Bolus asked about the clients who were staying in the system and not being discharged and how they were affecting the length of stay numbers. Ms. Olson noted that the metric only counted patients who were discharged. If there are patients who were discharged and who had a long length of stay, it is generally noted as a driver in a report. Mr. Campbell asked if there were “expected” targets for visits and discharges like there is for average length of stay. Ms. Olson noted that the Strategic Planning Committee did have different metrics around targets. Dr. Katz noted that when Health + Hospitals implements cost accounting, that there may be more available data that facilitates capturing that. He added that the case mix index (CMI) is not reflective of the Health + Hospitals population, as the CMI suggests the system is serving a healthy population. Coding is an example of a driver of how data looks, such as mortality rates and how much Health + Hospitals gets paid. For example, a patient may have pneumonia, but it is pneumonia with other conditions, and the other conditions and severity may not be captured. Ms. Youssouf asked if this was being addressed. Dr. Katz confirmed it was, and the system is not currently coding how sick patients are. There is a new Coder Academy being implemented, available to approximately 160 coders. As agreed to with the unions, staff will be training on their own time, but Health + Hospitals is paying for the training. Approximately 120 staff signed up for it, and about 97 attended the kick-off event. It is on-line CUNY learning targeted for working staff. If a certificate is earned, better pay may be an outcome. Mr. Rosen noted that the average length of stay did not look terrible, and Dr. Katz agreed, and that as more observation is used, that will push up the average length of stay, and noted that the industry wide average was closer to four. Mr. Rosen noted that his Finance Committee predecessor claimed that the length of stay was huge. Mr. Covino noted that the

metric had been calculated differently in prior years. Mr. Page also noted that the length of stay has been decreasing across the industry.

Ms. Youssouf asked if visits should have been increasing as discharges are decreasing, and Ms. Olson noted that the due to the relative small number of discharges when compared to the volume of visits, that it may not be fully visible in that metric. Dr. Katz noted that discharge volume has a bigger effect on length of stay compared to number of outpatient visits. Ms. Olson continued her reporting with the case mix index increasing by 3.4%, and Mr. Covino noted that was an increase of 12% over prior years. Diagnostic and Treatment Center visits continue to decline, down by 5.4% compared to this time last year. Dr. Katz noted that the numbers are reflective of the number of providers. For example, East New York has 1.5 providers versus 4.5 providers, and Dr. Ted Long's hiring will make a difference. Long-term care days are down by 2.3% compared with last year, primarily at Coler and Henry J. Carter. For Carter, the decline is in LTAC services. Gouverneur Skilled Nursing Facility days increased by 10.1%. With no further questions, the report was concluded.

CASH RECEIPTS & DISBURSEMENTS REPORT **MICHLINE FARAG**

Ms. Michline Farag began her reporting on global full-time equivalents (GFTEs). For Global FTEs, Health + Hospitals is down 1,040 GFTEs since the start of FY18 through May. Mr. Campbell asked about the changes in headcount numbers in facilities compared to those noted in Central Office, and Mr. Covino noted that with the centralization and shared services initiatives such as accounts payable and payroll functions, that there are a shift in numbers as to where staff are allocated.

For FY18 through May budget numbers, receipts came in $113.3 million better than budgeted, and disbursements are $28.7 million better than projected. Ms. Youssouf asked if better meant that the system was spending less, and Ms. Farag confirmed that it was. Ms. Farag continued her report discussing the comparison of FY18 actuals to FY17 actuals through May. For direct patient care receipts, Health + Hospitals is doing better through May compared to last fiscal year. Inpatient receipts are up $118.2 million, and outpatient receipts are $49.2 million higher. Overall receipts in FY18 through May are $28 million higher than last year. This is due to increased patient care revenue and Disproportionate Share Hospital/Upper Payment Limit (DSH/UPL) payment which is $122 million higher than last fiscal year, offset by the Value Based Payment/Quality Improvement Program (VBP/QIP) payment in FY17 in the Grants line. There will be a VBP/QIP FY18 payment in FY19.

In terms of total cash disbursements, Health + Hospitals is $340.8 million higher than last fiscal year partly due to a payment made to the City in the first quarter of FY18 for FY17 obligations as well as $331.7 million higher in fringe retiree health and pension payments made in FY18. This was offset by PS underspending of $162.7 million. Mr. Rosen asked if there was an additional pension payment, and Mr. Covino answered that Health + Hospitals caught up on payments this year compared to this time last year. Ms. Farag continued her report for FY18 through May actual receipts and disbursements against budget. Receipts are $113 million better than budgeted, the majority of which is in patient care receipts - $83.7 million better in patient care receipts. For cash disbursements, Health + Hospitals is $28.7 million less than budgeted due to PS and associated fringe. With no further questions, the report was concluded.

CANTEEN RESOLUTION **PAUL ALBERTSON**

Mr. Paul Albertson presented a resolution to authorize the New York City Health and Hospitals Corporation (the "System") to execute an agreement with Compass Group USA doing business as Canteen ("Canteen") to provide vending services for the System's acute care, post-acute care and corporate facilities with an initial term of five years and two five-year options to renew solely exercisable by the System. Canteen will pay the System a signing bonus of $250,000 and a commission of 30.8% on annual sales up to $3,999,999 and commission of 40% on annual sales in excess of $4,000,000. Mr. Albertson provided an overview of the current vending arrangement within Health + Hospitals. There are 485 snack and beverage vending machines throughout facilities, stocked with items that meet the NYC Healthy Food and Beverage Standards. The current vending arrangement was implemented in 2005, and is constrained by several issues, including the commission structure. The machines only accept cash. There is not a wide variety of items. The machines do not have Health + Hospitals branding, and do not have the capacity for online reporting for sales, maintenance, and other issues. Vending services went through a Request for Proposal (RFP) process, including posting in the City Record and disseminated to thirty-two known vending companies of which nine were certified as Minority and Women-Owned Business Enterprises (MWBE). A pre-proposers conference was held, and site visits were conducted at six facilities.

Five proposals were received, and three vendors were invited to present to the selection committee. The financial impact of the proposals varied from net revenue of $1 million to $3.4 million. Canteen scored the highest for proposal and presentation, and is the sole vendor to meet our MWBE goals through the Gilly subcontractor. Canteen's proposal is highlighted by its financial proposal, exceptional references including CUNY and NYU, and the service level agreements for preventative maintenance and on-call service. The evaluation committee had broad representation, chaired by Mercedes Redwood who is a registered dietician. Committee members were included from Finance and facilities. Canteen was the highest rated proposer following vendor presentations and a second round scoring. An application to enter contract was presented and approved by the Contract Review Committee at its June 2018 meeting.

Approval is being sought to enter into contract with Canteen for the Health + Hospitals vending machine program. The contract would be five years with two five-year renewal options. It includes installation of all new NYC Health + Hospitals branded vending machines, stocked with items in compliance with NYC Healthy Food and Beverage Standards. The vendor would work with facilities to optimize machine locations. The vending machines will include integrated technology for transparency, reporting, and auditing. The arrangement includes a $250,000 signing bonus for Health + Hospitals with a 30.8% commission on annual sales up to $3,999,999 and 40% over $4 million. The total projected revenue for the first five years and the two renewal periods are estimated at approximately $11.4 million. Ms. Youssouf asked about the estimates, if the prior vendor lacked the capacity for robust accounting in terms of the volume of products sold. Mr. Albertson noted that the projections were modeled on prior vendor dollars, as well as walk-through assessments and projections of foot traffic. Ms. Bolus asked if Health + Hospitals would do its own assessment of the machines, and Mr. Albertson confirmed there was a review. Mr. Campbell asked if the revenue projections were Health + Hospitals; and if the other proposing vendors had less or more projected revenue. 10.47 Mr. Albertson noted that these were Health + Hospital projections, based on projected volume and the commission structure, and that the other vendors had less projected revenue. Mr. Campbell asked if there would be additional machines throughout the facilities, and Mr. Albertson answered that the number would be determined with facility staff. Mr. Rosen asked who owns the actual machines, and Mr. Albertson confirmed the vendor did. Mr. Page asked if the current vendor bid, and Mr. Albertson confirmed the vendor

had. Mr. Page asked about if the service was not optimal, if the renewal term had to be pursued, and Mr. Albertson confirmed that the renewal did not have to be implemented. Ms. Bolus noted that it would be an incentive for healthier choices to have water be the least expensive drink available, and to work with nutritionists to ensure that healthier snacks were the least expensive option. Mr. Albertson noted that Ms. Redwood is a registered dietitian and lead the selection committee, and that all the snacks and beverages in the machines would meet the NYC Healthy Food and Beverage Standards. Ms. Youssouf requested an update after a year of implementation on revenue projections from the machines. The resolution was brought for motion, seconded, and the motion carried.

ACCUITY RESOLUTION **BOB MELICAN**

Mr. Bob Melican presented a resolution to authorize the New York City Health and Hospitals Corporation (the "System") to execute an agreement with Accuity Delivery Systems ("Accuity") to provide medical coding optimization services for the System's acute care facilities over a term of approximately two years to expire with the conclusion of FY 2020 with total amount not to exceed $25,364,000. Mr. Melican provided an overview of the coding work within Health + Hospitals. The coding and documentation work is in transition throughout the system. There are three key initiatives currently in place. Epic implementation throughout the system and 3M computer assisted coding are changing the process of capturing codes. The Huron engagement is providing ongoing physician education to improve the quality of clinical documentation. A Coder Academy is starting August 6, focused on improving coder skills. The Accuity contract will be a short-term bridge for a unified Health + Hospitals coding and documentation environment. Health + Hospitals will achieve self-sufficiency from Accuity by June 2020.

A RFP for Coding Optimization services was issued in April 2017 with four proposals received. Accuity was selected in June 2017 as part of the corporate-wide transformation initiative process. Accuity's model of cases reviews by a physician coder and a Clinical Documentation Improvement Specialist (CDIS) was key to the selection. A pilot began in September 2017 at Queens and Elmhurst, with an expansion in March 2018 to Bellevue, Lincoln, and Jacobi. The pilot phase for the five facilities will end August 2018. There is a projected cost of $5 million, and a projected net revenue of $15 million. The request is to roll-out this work to the remaining six acute facilities in September 2018 with a projected 8,505 cases per month at full operation with FY19 and FY20 projections of $75 million in net revenue.

Accuity's model includes a team comprised of a physician, coder, and CDIS who review Health + Hospital's coding and documentation in the EMR before final billing. Accuity is only reviewing cases with a revenue opportunity. Ms. Youssouf asked who is deciding which cases. Mr. Melican noted that the excluded cases are those with low opportunity due to reimbursement methodology such as psychiatry, rehab, and simple newborn cases, as well as severity of illness of four as those are already at the highest level. Mr. Melican noted that MetroPlus cases were under consideration for inclusion, and Committee members concurred that was a great idea. The Accuity work focused on a coding change or a query change, such as diabetes. Accuity sends a note to the physician inquiring if diabetes was present throughout the case, and askes the attending physician to review the case and document accordingly if diabetes was present so that Accuity could document diabetes as a secondary condition. Ms. Bolus asked how long a review took. Mr. Melican noted that coding changes happen within 24 hours, and documentation changes with the query option allow attending physicians up to ten days to respond back. Dr. Katz shared a story that a doctor flagged for him after a town hall meeting. The doctor had been with Health + Hospitals for twelve years, and came from a private hospital. At that private

hospital, the doctor had weekly sit downs about coding improvements and coding charts. The doctor noted that, in the twelve years, no one at Health + Hospitals had done this with her. Dr. Katz noted that multiple strategies around coding should be pursued. Mr. Campbell noted that there are teachable moments throughout the work, and what would the feedback loop be. Mr. Melican noted that the Accuity work includes meeting with each facility Chief Medical Officer and department heads, and that two months after the launch of the work, Accuity comes back to meet with leads about observations and lessons learned. Dr. Katz noted that Epic implementation will facilitate better coding as well because it's easier in that environment than in Quadramed as it takes time to populate each diagnosis Mr. Ulberg noted that as he has been doing his site visits, he has observed that revenue cycle work is a team sport, and the Accuity model supports that approach. Ms. Youssouf asked where Accuity had worked before. Mr. Melican noted that the vendor has worked with Montefiore, Mt. Sinai, and New York Presbyterian. Ms. Youssouf noted that as a public corporation, Health + Hospitals sometimes gets assigned a C or D team from vendors, and requested that the project have an A-team from Accuity assigned. Mr. Page noted that this initiative was important and a cost-effective measure. He asked if there was a need for incremental staff resources, what will this work mean for a doctor, in terms of what incremental time the doctor will need to focus on this work. Dr. Katz agreed, and noted that the doctor time issue has not been fully figured out; hiring doctors is being pursued. Mr. Rosen asked if the current coding system would stay in place, and that the Accuity team supplements that work. Mr. Melican confirmed the time frame was 24 hours for coding changes, and up to ten days for query changes. Mr. Page asked if the doctor will still need to look at records. Dr. Katz noted that the work will be real time efforts. Mr. Campbell noted that there may be a series of pilots to look at efficiencies and to identify different initiatives to implement. Dr. Katz confirmed there would be a variety of efforts. Ms. Youssouf asked if there was an overlap with Huron work. Mr. Melican relayed that the coding and documentation work was a three-pronged approach – the Huron CDI work, the Epic and 3M software work, and the Accuity work. Dr. Katz raised the analogy of a toolbox with different tools – the coding and documentation work was being addressed through different initiatives. Ms. Youssouf asked about how the work would be judged for effectiveness. Mr. Covino noted that results would be monitored against projections. Mr. Rosen asked where the firm was located, and Mr. Melican noted New York City. Mr. Campbell requested more information about achieving self-sufficiency by 2020, and Mr. Melican answered that a worklpan could be shared. The resolution was brought for motion, seconded, and the motion carried.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss, Mr. Rosen adjourned the meeting at 11:09 am.

KEY INDICATORS

FISCAL YEAR 2018 UTILIZATION

Year to Date
June 2018

	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES						
	FY 18	FY 17	VAR %	FY 18	FY 17	VAR %	ACTUAL	EXPECTED	FY 18	FY 17
Acute										
Bellevue	559,655	573,177	-2.4%	21,619	22,128	-2.3%	5.8	5.2	1.3028	1.2508
Coney Island	313,007	309,878	1.0%	13,494	13,744	-1.8%	6.4	5.2	1.0424	1.0079
Elmhurst	573,593	566,375	1.3%	18,132	17,870	1.5%	5.9	5.0	1.0510	1.0107
Harlem	299,570	298,570	0.3%	10,916	11,760	-7.2%	5.5	4.6	1.0052	0.9365
Jacobi	395,913	407,909	-2.9%	18,168	18,042	0.7%	5.4	5.4	1.1300	1.1037
Kings County	640,164	659,571	-2.9%	17,923	19,191	-6.6%	6.2	5.0	1.0527	1.0371
Lincoln	508,971	525,662	-3.2%	20,804	21,505	-3.3%	4.4	4.8	1.0165	0.9641
Metropolitan	357,536	367,213	-2.6%	7,732	9,228	-16.2%	4.7	4.8	0.9963	0.9675
North Central Bronx	204,554	203,189	0.7%	6,782	6,679	1.5%	4.0	4.1	0.7195	0.7026
Queens	405,580	387,512	4.7%	13,070	12,700	2.9%	4.3	4.8	0.8956	0.8128
Woodhull	398,329	434,325	-8.3%	10,123	10,507	-3.7%	5.1	4.7	0.9184	0.9370
Acute Total	**4,656,872**	**4,733,381**	**-1.6%**	**158,763**	**163,354**	**-2.8%**	**5.4**	**4.9**	**1.0483**	**1.0096**
Gotham	VISITS									
Belvis DTC	49,479	49,887	-0.8%							
Cumberland DTC	68,115	62,999	8.1%							
East New York	69,552	76,805	-9.4%							
Gouverneur DTC	213,873	231,494	-7.6%							
Morrisania DTC	71,578	80,019	-10.5%							
Renaissance	33,110	34,235	-3.3%							
Gotham Total	**505,707**	**535,439**	**-5.6%**							
Post Acute Care				DAYS						
Coler				249,492	269,118	-7.3%				
Gouverneur SNF				90,009	81,378	10.6%				
H.J. Carter				110,544	114,759	-3.7%				
McKinney				113,887	112,500	1.2%				
Seaview				108,267	109,300	-0.9%				
Post Acute Care Total				**672,199**	**687,055**	**-2.2%**				
Discharges/CMI-- All Acutes				**158,763**	**163,354**	**-2.8%**			**1.0483**	**1.0096**
Visits -- All DTCs & Acutes	**5,162,579**	**5,268,820**	**-2.0%**							
Days-- All SNFs				**672,199**	**687,055**	**-2.2%**				

Utilization

Discharges: exclude psych and rehab

Visits: Beginning with the November 2015 Board Report, FY17 and FY18 utilization is now based on date of service, and includes open visits. HIV counseling visits that are no longer billable have been excluded. Visits continue to include Clinics, Emergency Department and Ambulatory Surgery.
LTC: SNF and Acute days

Average Length of Stay(LOS)

Previous LOS calculations excluded one-day stays and outliers. Expected length of stay was based on H+H system average adjusted for case-mix.
As of September 2017, Actual LOS includes all stays, regardless of length.
Calculation is as follows:
Actual: days divided by discharges; excludes psych and rehab
Expected: Expected Length of Stay based on New York City SPARCS data, using facility specific case-mix

All Payor CMI

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

KEY INDICATORS

FISCAL YEAR 2018 BUDGET PERFORMANCE ($s in 000s)

Year to Date
June 2018

	GLOBAL FTEs		RECEIPTS		DISBURSEMENTS		BUDGET VARIANCE	
	Jun 17	Jun 18*	actual	better / (worse)	actual	better / (worse)	better / (worse)	
Acute								
Bellevue	5,497	5,443	$817,551	$25,959	$889,317	($4,745)	$21,214	1.3%
Coney Island	3,038	2,946	345,507	36,244	455,694	1,429	37,673	4.9%
Elmhurst	4,182	4,136	591,401	47,603	629,131	1,533	49,136	4.2%
Harlem	2,914	2,845	358,081	(7,742)	421,768	5,514	(2,228)	-0.3%
Jacobi	3,969	3,827	587,569	24,163	642,527	5,724	29,887	2.5%
Kings County	5,091	4,985	702,594	27,125	800,935	1,266	28,391	1.9%
Lincoln	3,994	3,864	516,072	6,830	564,473	5,313	12,143	1.1%
Metropolitan	2,463	2,354	293,737	(6,229)	348,131	9,009	2,780	0.4%
North Central Bronx	1,351	1,360	180,991	5,818	206,705	(1,568)	4,250	1.1%
Queens	2,795	2,644	410,646	37,164	410,912	2,230	39,394	5.0%
Woodhull	2,853	2,743	393,550	(21,113)	431,256	15,926	(5,187)	-0.6%
Acute Total	38,146	37,146	$5,197,699	$175,822	$5,800,849	$41,631	$217,453	2.0%
Gotham								
Belvis DTC	128	132	$16,228	($655)	$18,581	($1,211)	($1,866)	-5.4%
Cumberland DTC	200	189	22,484	632	31,361	(740)	(108)	-0.2%
East New York	207	200	26,697	3,764	24,879	494	4,258	8.8%
Gouverneur DTC	448	451	57,184	7,225	64,542	(124)	7,101	6.2%
Morrisania DTC	232	210	28,552	961	29,698	154	1,115	1.9%
Renaissance	166	151	10,311	(2,305)	21,186	352	(1,953)	-5.7%
Gotham Total	1,381	1,332	$161,456	$9,622	$190,247	($1,075)	$8,547	2.5%
Post Acute Care								
Coler	1,077	973	$73,779	($773)	$131,576	$4,305	$3,532	1.7%
Gouverneur SNF	362	379	35,790	1,163	52,537	945	2,108	2.4%
H.J. Carter	900	777	134,045	(2,505)	123,973	2,267	(238)	-0.1%
McKinney	439	435	40,589	(2,445)	50,339	1,837	(608)	-0.6%
Seaview	532	498	39,273	(7,834)	60,141	(136)	(7,970)	-7.4%
Post Acute Care Total	3,310	3,061	$323,476	($12,394)	$418,566	$9,218	($3,176)	-0.4%
Central Office	1,022	1,146	$1,415,206	$7,992	$628,845	$4,314	$12,306	0.6%
At Home	398	430	$36,551	($14,295)	$56,858	($7,218)	($21,513)	-21.4%
Enterprise IT/Epic	1,157	1,263	$0	($8)	$237,340	$7,939	$7,931	3.2%
GRAND TOTAL	**45,414**	**44,379**	**$7,134,388**	**$166,739**	**$7,332,705**	**$54,810**	**$221,549**	**1.5%**

*Actual Global FTEs have dropped by 5,030 since November 2015.

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

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

NYC Health + Hospitals
Cash Receipts and Disbursements (CRD)
Fiscal Year 2018 vs Fiscal Year 2017 (in 000's)
TOTAL CORPORATION

	Fiscal Year To Date June 2018		
	actual 2018	**actual 2017**	**better / (worse)**
Cash Receipts			
Inpatient			
Medicaid Fee for Service	$695,618	$712,666	(17,048)
Medicaid Managed Care	863,886	776,502	87,384
Medicare	488,469	494,392	(5,923)
Medicare Managed Care	343,824	340,652	3,172
Other	258,449	249,196	9,253
Total Inpatient	2,650,246	2,573,408	76,839
Outpatient			
Medicaid Fee for Service	142,281	133,793	8,489
Medicaid Managed Care	354,625	339,833	14,792
Medicare	81,437	68,058	13,380
Medicare Managed Care	100,293	92,149	8,143
Other	154,288	155,592	(1,304)
Total Outpatient	832,924	789,424	43,499
Total Direct Patient Care Revenue	3,483,170	3,362,832	120,338
Risk Pools	347,167	323,322	23,845
Total Patient Care Revenue	3,830,337	3,686,154	144,183
All Other			
Pools	316,193	308,747	7,446
DSH / UPL	1,956,527	1,658,489	298,037
Grants, Intracity, Tax Levy	844,175	1,015,716	(171,541)
Appeals & Settlements	75,106	76,217	(1,111)
Misc / Capital Reimb	112,050	66,775	45,275
Total All Other	3,304,051	3,125,944	178,107
Total Cash Receipts	**$7,134,388**	**$6,812,098**	**$322,290**
Cash Disbursements			
PS	$2,645,168	$2,792,696	$147,528
Fringe Benefits	1,513,763	1,322,999	(190,764)
OTPS	1,512,921	1,510,126	(2,795)
City Payments	454,432	32,022	(422,410)
Affiliation	1,105,964	1,073,757	(32,207)
HHC Bonds Debt	100,458	87,560	(12,898)
Total Cash Disbursements	**$7,332,705**	**$6,819,160**	**($513,546)**
Receipts over/(under) Disbursements	**($198,317)**	**($7,062)**	**($191,255)**

NYC Health + Hospitals
Actual vs Budget Report
Fiscal Year 2018 (in 000's)
TOTAL CORPORATION

	Fiscal Year To Date June 2018		
	actual 2018	**budget 2018**	**better / (worse)**
Cash Receipts			
Inpatient			
Medicaid Fee for Service	$695,618	$704,017	(8,399)
Medicaid Managed Care	863,886	768,810	95,077
Medicare	488,469	502,028	(13,558)
Medicare Managed Care	343,824	328,237	15,587
Other	258,449	253,166	5,283
Total Inpatient	2,650,246	2,556,257	93,989
Outpatient			
Medicaid Fee for Service	142,281	135,543	6,738
Medicaid Managed Care	354,625	371,968	(17,343)
Medicare	81,437	82,854	(1,417)
Medicare Managed Care	100,293	100,294	(2)
Other	154,288	153,813	475
Total Outpatient	832,924	844,472	(11,549)
Total Direct Patient Care Revenue	3,483,170	3,400,729	82,440
Risk Pools	347,167	284,072	63,095
Total Patient Care Revenue	3,830,337	3,684,802	145,536
All Other			
Pools	316,193	322,602	(6,409)
DSH / UPL	1,956,527	1,956,043	484
Grants, Intracity, Tax Levy	844,175	849,351	(5,176)
Appeals & Settlements	75,106	49,045	26,061
Misc / Capital Reimb	112,050	105,806	6,244
Total All Other	3,304,051	3,282,847	21,204
Total Cash Receipts	**$7,134,388**	**$6,967,649**	**$166,739**
Cash Disbursements			
PS	$2,645,168	$2,671,244	$26,076
Fringe Benefits	1,513,763	1,524,089	10,327
OTPS	1,512,921	1,528,112	15,192
City Payments	454,432	454,432	0
Affiliation	1,105,964	1,106,234	270
HHC Bonds Debt	100,458	103,404	2,946
Total Cash Disbursements	**$7,332,705**	**$7,387,515**	**$54,810**
Receipts over/(under) Disbursements	**($198,317)**	**($419,866)**	**$221,549**

NEW YORK CITY HEALTH + HOSPITALS
INPATIENT PAYOR MIX
Fiscal Year 2018 4th Quarter Report

INPATIENT: Percentage of Total Discharges For Each Facility

	Bellevue	Coney	Elmhurst	Harlem	Jacobi	Kings	Lincoln	Metropolitan	NCB	Queens	Woodhull	Corporate Total
Medicaid Total												
2018	**63.0**	**54.4**	**62.7**	**62.9**	**57.6**	**59.8**	**65.4**	**71.5**	**66.2**	**63.1**	**67.5**	**62.5**
2017	**61.0**	**53.8**	**63.8**	**63.4**	**57.3**	**61.0**	**66.5**	**69.2**	**65.2**	**63.2**	**67.9**	**62.5**
Medicaid												
2018	25.2	18.7	21.7	16.3	15.6	20.2	16.4	20.7	16.2	24.7	22.2	20.1
2017	23.8	19.2	22.2	18.0	14.9	20.5	17.0	21.5	15.8	25.0	19.4	20.0
Medicaid Plans												
2018	37.8	35.8	41.0	46.6	42.0	39.7	49.1	50.8	50.0	38.3	45.3	42.4
2017	37.2	34.6	41.6	45.4	42.4	40.5	49.5	47.7	49.4	38.2	48.5	42.5
Medicare Total												
2018	**18.7**	**36.8**	**23.1**	**22.7**	**25.1**	**22.2**	**24.6**	**19.0**	**20.7**	**24.9**	**22.3**	**23.6**
2017	**18.4**	**37.1**	**22.9**	**23.8**	**24.2**	**20.3**	**24.0**	**20.4**	**20.3**	**25.6**	**22.2**	**23.2**
Medicare												
2018	9.5	25.8	11.1	9.9	12.4	10.3	7.3	7.8	9.2	11.1	9.1	11.1
2017	9.7	26.5	11.3	10.1	12.5	9.9	7.7	9.2	9.9	11.9	9.5	11.4
Medicare Plans												
2018	9.3	11.1	12.0	12.8	12.7	11.9	17.3	11.2	11.6	13.8	13.2	12.4
2017	8.7	10.6	11.6	13.7	11.7	10.4	16.3	11.3	10.4	13.7	12.7	11.8
Commercial												
2018	**10.7**	**7.0**	**8.9**	**8.3**	**12.5**	**12.0**	**7.9**	**5.9**	**8.5**	**8.7**	**7.2**	**9.3**
2017	**10.4**	**7.2**	**8.7**	**8.5**	**12.6**	**12.0**	**7.3**	**5.5**	**8.9**	**8.8**	**6.9**	**9.2**
Other												
2018	**1.9**	**0.1**	**0.9**	**0.1**	**0.3**	**0.2**	**0.2**	**0.2**	**0.1**	**0.3**	**0.0**	**0.5**
2017	**3.4**	**0.1**	**1.0**	**0.2**	**0.2**	**0.2**	**0.3**	**0.1**	**0.1**	**0.3**	**0.1**	**0.8**
Uninsured												
2018	**5.7**	**1.6**	**4.4**	**6.0**	**4.5**	**5.7**	**1.9**	**3.4**	**4.5**	**3.1**	**2.9**	**4.1**
2017	**6.7**	**1.8**	**3.5**	**4.2**	**5.7**	**6.5**	**2.0**	**4.8**	**5.5**	**2.2**	**2.9**	**4.4**

FY18 run on 8/20/2018

FY17 run on 8/21/2017

Note: All numbers are percentages.

Medicaid Plans: Medicaid Managed Care

Medicare Plans: Medicare Advantage Plans

Commercial Plans: Commercial Plans, Child Health Plus, and Blue Cross

Other: Federal, State & City agencies, Uniformed Services and Prisoners No-Fault, Worker's Comp

NEW YORK CITY HEALTH + HOSPITALS
OUTPATIENT ADULT PAYOR MIX
Fiscal Year 2018 4th Quarter Report

OUTPATIENT ADULT (Excluding Emergency Room Visits): Percentage of Total Visits For Each Facility

	Bellevue	Coney	Elmhurst	Harlem	Jacobi	Kings	Lincoln	Metropolitan	NCB	Queens	Woodhull	Belvis	Cumberland	East New York	Gouverneur	Morrisania	Renaissance	Corporate Total
Medicaid Total																		
2018	**40.6**	**36.8**	**39.4**	**47.8**	**46.6**	**47.4**	**47.4**	**44.6**	**51.3**	**38.3**	**41.5**	**52.1**	**43.2**	**56.4**	**37.4**	**52.5**	**45.8**	**43.5**
2017	**38.1**	**36.6**	**39.3**	**46.9**	**46.3**	**47.2**	**46.5**	**44.0**	**51.5**	**38.1**	**42.0**	**50.7**	**44.9**	**55.8**	**37.2**	**52.8**	**44.0**	**43.1**
Medicaid																		
2018	7.5	8.8	5.8	6.4	8.4	8.9	9.4	7.6	7.0	8.2	3.4	4.1	4.8	7.8	5.8	4.5	5.3	7.3
2017	5.8	8.3	7.1	6.9	7.3	8.8	7.5	6.6	6.8	8.3	3.9	3.2	4.2	8.0	6.4	4.9	4.5	6.9
Medicaid Plans																		
2018	33.1	28.0	33.6	41.4	38.2	38.5	38.0	37.0	44.3	30.1	38.2	48.0	38.4	48.6	31.6	47.9	40.5	36.3
2017	32.3	28.2	32.2	40.0	39.0	38.4	39.1	37.4	44.7	29.8	38.1	47.5	40.6	47.8	30.8	47.8	39.4	36.1
Medicare Total																		
2018	**19.1**	**21.3**	**15.6**	**20.9**	**21.7**	**16.9**	**21.6**	**20.8**	**18.2**	**20.9**	**21.8**	**12.7**	**13.8**	**17.8**	**26.3**	**14.7**	**17.4**	**19.7**
2017	**19.4**	**21.4**	**15.7**	**22.1**	**21.4**	**16.4**	**22.0**	**21.0**	**17.3**	**20.5**	**20.6**	**15.0**	**14.3**	**17.5**	**25.3**	**14.4**	**18.5**	**19.6**
Medicare																		
2018	8.3	10.9	5.7	8.9	8.1	7.9	6.0	6.8	6.1	6.3	6.0	3.1	4.8	7.6	9.0	3.4	6.7	7.3
2017	8.5	11.5	6.1	9.8	8.4	8.0	6.5	7.6	6.0	6.7	6.4	3.2	5.1	7.8	9.0	3.8	7.0	7.6
Medicare Plans																		
2018	10.7	10.4	10.0	12.0	13.6	9.1	15.6	14.0	12.1	14.6	15.9	9.6	9.0	10.3	17.2	11.3	10.7	12.4
2017	10.9	9.9	9.6	12.2	13.0	8.4	15.5	13.3	11.3	13.8	14.2	11.8	9.2	9.7	16.3	10.6	11.4	12.0
Commercial																		
2018	**13.2**	**7.2**	**6.0**	**12.3**	**10.9**	**14.8**	**15.1**	**8.7**	**9.4**	**6.9**	**10.0**	**10.7**	**12.1**	**12.5**	**11.0**	**14.0**	**13.6**	**10.9**
2017	**13.2**	**8.1**	**5.6**	**11.8**	**11.0**	**14.5**	**14.4**	**8.0**	**10.2**	**7.2**	**9.8**	**9.9**	**13.2**	**12.7**	**10.7**	**12.4**	**13.1**	**10.8**
Other																		
2018	**2.2**	**0.6**	**1.7**	**0.5**	**1.7**	**0.4**	**0.7**	**0.2**	**0.8**	**0.6**	**0.5**	**0.0**	**0.3**	**0.0**	**0.9**	**0.0**	**0.1**	**0.9**
2017	**2.4**	**0.6**	**2.0**	**0.5**	**1.7**	**0.4**	**0.7**	**0.2**	**0.9**	**0.4**	**0.5**	**0.0**	**0.2**	**0.0**	**0.9**	**0.0**	**0.1**	**0.9**
Uninsured																		
2018	**24.9**	**34.1**	**37.3**	**18.6**	**19.1**	**20.5**	**15.2**	**25.7**	**20.3**	**33.3**	**26.1**	**24.5**	**30.5**	**13.3**	**24.4**	**18.8**	**23.1**	**25.0**
2017	**26.9**	**33.3**	**37.3**	**18.7**	**19.6**	**21.5**	**16.3**	**26.9**	**20.1**	**33.9**	**27.1**	**24.4**	**27.5**	**14.0**	**25.9**	**20.4**	**24.5**	**25.6**

EMERGENCY DEPARTMENT ADULT: Percentage of Total Visits For Each Facility

ED Uninsured																		
2018	**32.2**	**27.5**	**38.4**	**20.9**	**24.1**	**28.1**	**23.0**	**27.2**	**23.4**	**27.8**	**26.0**							**27.4**
2017	**33.2**	**28.6**	**38.7**	**20.0**	**27.1**	**28.4**	**21.6**	**27.5**	**26.2**	**28.8**	**27.9**							**28.0**

FY18 run on 8/20/2018
FY17 run on 8/21/2018

Note: All numbers are percentages.
Adult visits defined by age of patient >= 19 at time of visit.

Medicaid Plans: Medicaid Managed Care
Medicare Plans: Medicare Advantage Plans
Commercial Plans: Commercial Plans, Child Health Plus, and Blue Cross
Other: Federal, State & City agencies, Uniformed Services and Prisoners
No-Fault, Worker's Comp

NEW YORK CITY HEALTH + HOSPITALS
OUTPATIENT PEDIATRICS PAYOR MIX
Fiscal Year 2018 4th Quarter Report

OUTPATIENT PEDIATRIC (Excluding Emergency Room Visits): Percentage of Total Visits For Each Facility

	Bellevue	Coney	Elmhurst	Harlem	Jacobi	Kings	Lincoln	Metropolitan	NCB	Queens	Woodhull	Belvis	Cumberland	East New York	Gouverneur	Morrisania	Renaissance	Corporate Total
Medicaid Total																		
2018	**83.3**	**81.1**	**81.8**	**84.6**	**76.0**	**73.4**	**83.3**	**90.0**	**78.3**	**70.9**	**81.4**	**88.9**	**79.7**	**80.0**	**82.4**	**86.5**	**74.1**	**80.5**
2017	**81.8**	**77.3**	**80.8**	**83.3**	**76.2**	**73.7**	**84.6**	**89.9**	**77.1**	**69.6**	**79.2**	**88.4**	**80.4**	**77.9**	**82.4**	**82.8**	**73.9**	**79.7**
Medicaid																		
2018	4.0	9.0	2.7	3.6	6.0	4.4	3.6	1.5	4.6	5.3	2.6	5.6	3.5	7.8	5.3	3.8	4.7	4.3
2017	4.0	10.4	3.4	4.3	5.4	5.4	3.2	2.2	5.3	7.7	3.8	4.2	4.3	6.4	7.1	3.7	5.0	4.8
Medicaid Plans																		
2018	79.3	72.1	79.1	81.0	70.0	69.1	79.6	88.5	73.7	65.6	78.8	83.3	76.2	72.2	77.1	82.7	69.4	76.2
2017	77.8	66.9	77.4	79.0	70.8	68.3	81.4	87.7	71.8	61.9	75.4	84.3	76.1	71.5	75.3	79.1	68.9	74.9
Commercial Total																		
2018	**12.9**	**14.3**	**11.1**	**11.7**	**17.7**	**18.1**	**14.1**	**7.1**	**17.4**	**18.5**	**12.2**	**8.7**	**12.1**	**13.8**	**14.5**	**9.3**	**13.8**	**13.7**
2017	**13.0**	**16.9**	**10.2**	**12.3**	**17.6**	**17.7**	**12.6**	**6.9**	**17.5**	**18.1**	**12.4**	**8.9**	**11.0**	**13.1**	**13.9**	**8.9**	**12.1**	**13.5**
Child Health Plus																		
2018	4.7	5.1	6.8	3.1	4.8	6.8	8.7	4.0	3.8	7.5	5.6	5.3	5.3	5.9	5.7	4.2	3.6	5.7
2017	4.5	5.5	6.0	3.2	4.1	6.4	6.6	3.7	3.3	6.7	4.9	5.1	4.6	4.8	5.5	4.0	2.8	5.0
Non-CHP Plans																		
2018	8.2	9.2	4.2	8.6	12.9	11.3	5.4	3.1	13.6	11.0	6.7	3.3	6.8	7.9	8.8	5.0	10.2	8.1
2017	8.5	11.4	4.2	9.2	13.5	11.3	6.0	3.3	14.2	11.5	7.6	3.8	6.4	8.3	8.4	5.0	9.2	8.5
Other																		
2018	**0.2**	**0.3**	**0.2**	**0.3**	**0.9**	**0.2**	**0.4**	**0.0**	**0.1**	**0.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**
2017	**0.2**	**0.4**	**0.2**	**0.3**	**0.7**	**0.3**	**0.5**	**0.0**	**0.3**	**0.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**
Uninsured																		
2018	**3.7**	**4.3**	**6.9**	**3.4**	**5.3**	**8.2**	**2.2**	**2.8**	**4.2**	**10.3**	**6.3**	**2.5**	**8.3**	**6.3**	**3.1**	**4.3**	**12.1**	**5.5**
2017	**5.0**	**5.4**	**8.7**	**4.0**	**5.4**	**8.3**	**2.3**	**3.1**	**5.1**	**12.0**	**8.3**	**2.7**	**8.6**	**9.0**	**3.7**	**8.3**	**14.1**	**6.6**

EMERGENCY DEPARTMENT PEDIATRIC: Percentage of Total Visits For Each Facility

ED Uninsured																		
2018	**11.9**	**11.4**	**7.3**	**10.8**	**14.9**	**14.2**	**12.9**	**10.9**	**10.1**	**12.0**	**12.3**							**11.7**
2017	**17.1**	**11.5**	**9.0**	**10.8**	**15.7**	**14.7**	**14.1**	**9.9**	**13.7**	**11.7**	**12.9**							**12.8**

FY18 run on 8/20/2018

FY17 run on 8/21/2018

Note: All numbers are percentages.

Adult visits defined by age of patient >= 19 at time of visit.

Medicaid Plans: Medicaid Managed Care

Medicare Plans: Medicare Advantage Plans

Commercial Plans: Commercial Plans, Child Health Plus, and Blue Cross

Other: Federal, State & City agencies, Uniformed Services and Prisoners

No-Fault, Worker's Comp

Revenue Cycle Optimization
Presentation to Finance Committee
John Ulberg

September 13, 2018

PROJECT STREAM OBJECTIVES

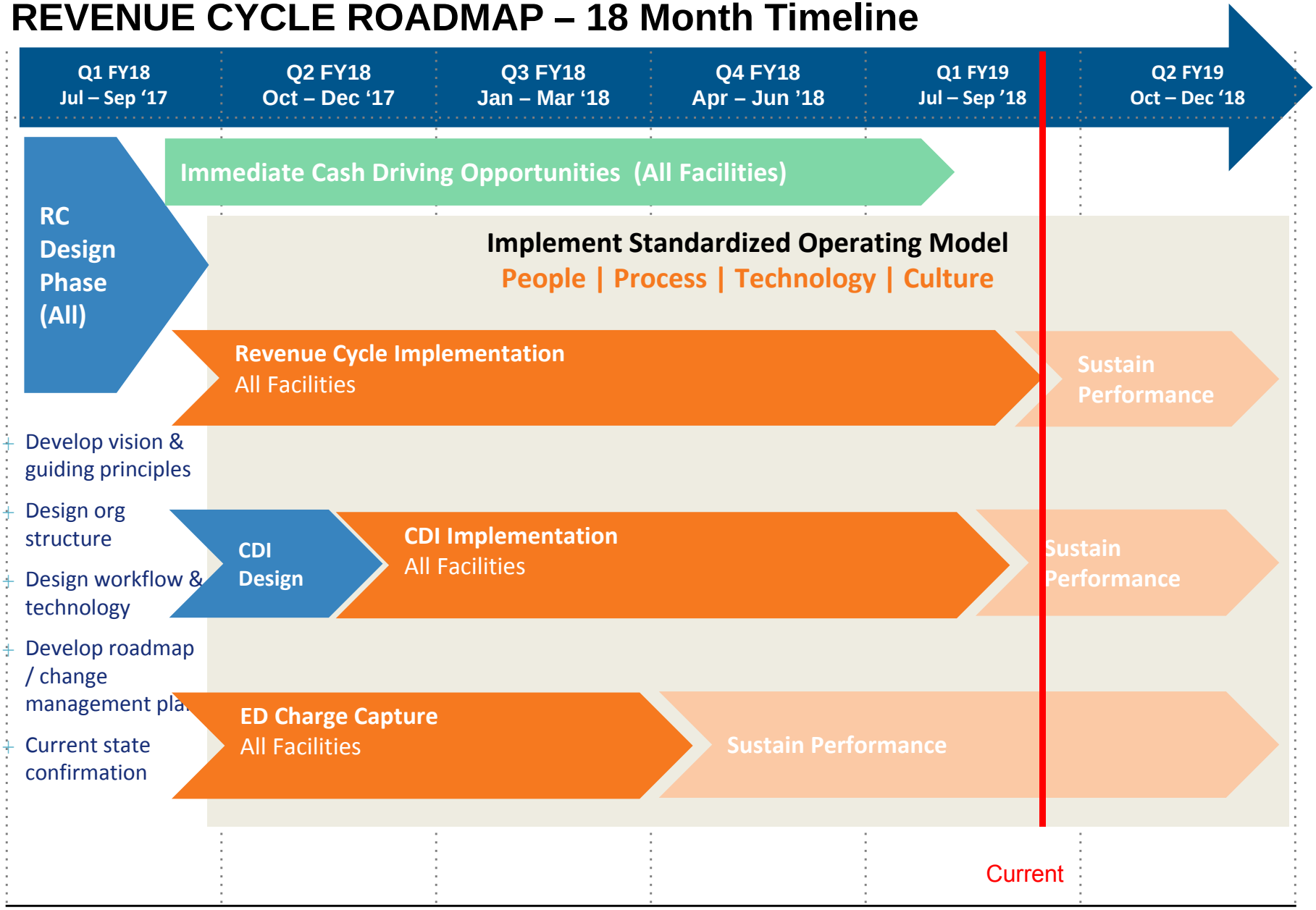
STREAM: Success Through Revenue Enhancement Activities & Maximization

- Create a best practice, standardized revenue cycle operating model
- Design operating model to prepare for upcoming conversion to Epic
- Implement automated workflow and comprehensive revenue cycle reporting
- Develop a comprehensive Inpatient Clinical Documentation Improvement (CDI) Program
- Implement an Emergency Department charge capture program
- Achieve and sustain significant financial results

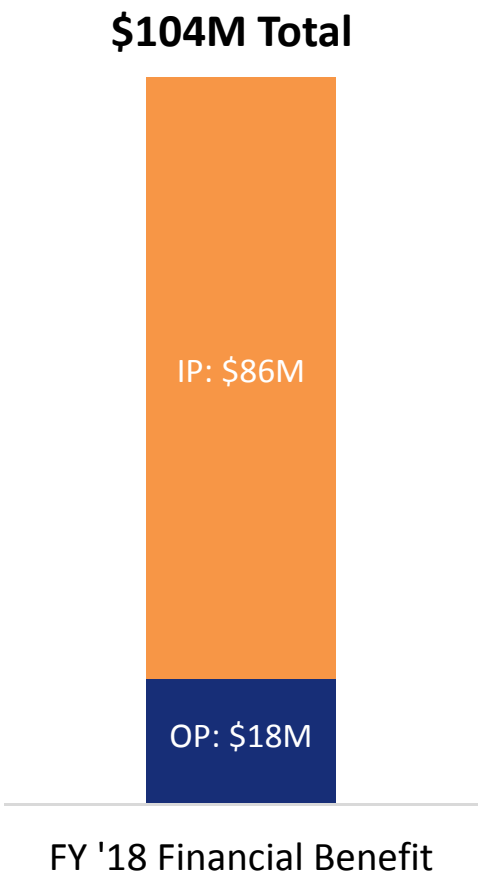
Assessment Findings – Financial Opportunity Sources		
Key Benefit Source	**Low Opportunity**	**High Opportunity**
Recurring Revenue Cycle Improvement	**$90 million**	**$210 million**
Recurring Clinical Documentation Improvement (CDI)	**$40 million**	**$80 million**
NYC Health + Hospitals Total Annual, Recurring Benefit	**$130 million to $290 million**	
One-Time Cash Flow Opportunity	**$30 million**	**$50 million**
NYC Health + Hospitals Total One-Time Cash Flow Benefit	**$30 million to $50 million**	

IMPLEMENTATION TIMELINE

REVENUE CYCLE ROADMAP – 18 Month Timeline



PROJECT RESULTS



IP Financial Results ($86M)

- IP volumes have decreased by 1.6%, while cash is up 2.2% in FY ‘18 vs. FY ‘17
- Collecting $457 more per IP admission (3.8%) in FY’18 vs. FY’17 adjusted for environmental factors
- CDI program is generating more than $3M per month through improved clinical documentation leading to appropriate DRG capture
- Improved rate for securing authorizations for IP admissions by 31 percentage points on average per facility (from 63% to 94%)
- Improved sponsorship (Medicaid, etc.) screening by 16 percentage points for inpatients while in-house (from 74% to 90%)
- Reduced backlog of A/R follow-up by $160M for high dollar (mainly IP) accounts

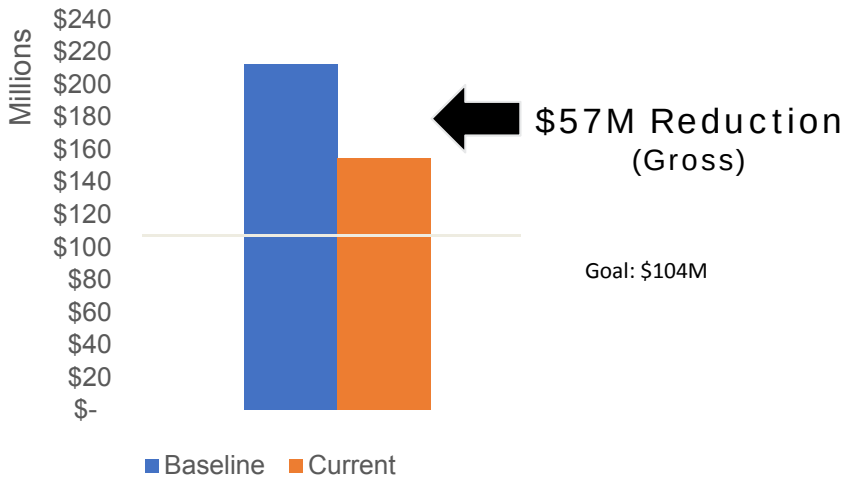
OP Financial Results ($18M)

- OP cash has increased by 1.2%, while volumes have decreased by 2.0%
- Capturing additional charges in the ED generating $1.5M net revenue per month
- Improved rate for securing authorizations for elective services by 13 percentage points (from 81% to 94%)
- A/R follow-up has been stagnant due to being under resourced
- Opportunity remains to increase ongoing OP cash collections

Note: Financial benefit likely includes overlap of other H+H revenue cycle initiatives
Improvements include CMI increases driven by Huron CDI initiative, Accuity, and other non-project related environmental changes

KEY METRIC IMPROVEMENTS

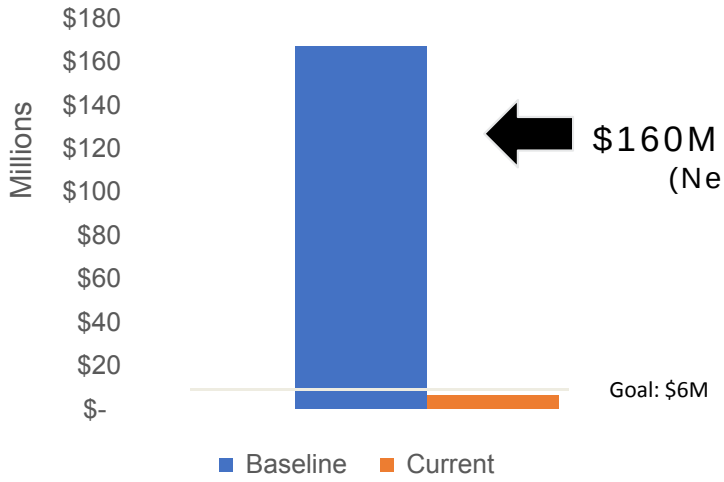
Billing Backlog
(All Facilities)



$57M Reduction
(Gross)

Goal: $104M

$10K+ A/R Follow-up Backlog
(All Facilities)

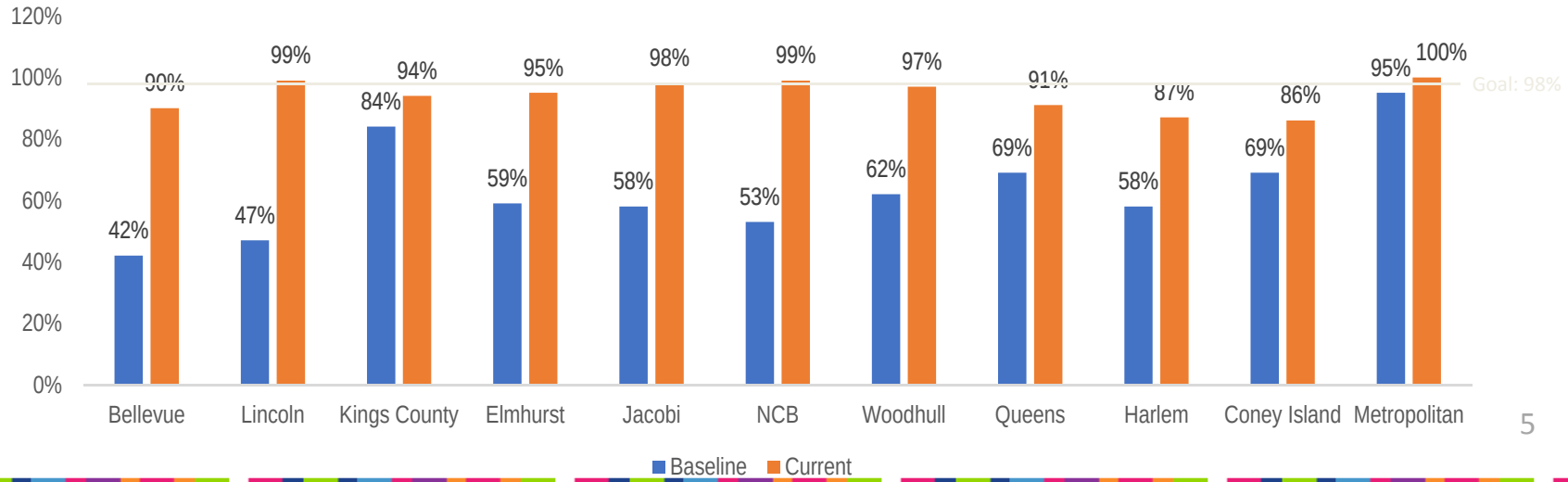


$160M Reduction
(Net/Gross)

Goal: $6M

31% Increase
(On Average
Per Facility)

Inpatient Verification/Authorization Rate



PROJECT ACTIVITIES

- The primary focus of the implementation to-date has been standardizing and modernizing the revenue cycle functions at the 11 acute facilities ("live" at all facilities by the end of June 2018)

Scope: RC Functions	RC Transformation Activities & Objectives	
▪ **Insurance Verification**	▪ Standard org, process, tools, reporting	▪ Reporting through Huron RCA
▪ **Financial Counseling (IP)**	▪ Preparation for Epic conversion	▪ New leadership meeting structure
▪ **Billing**	▪ Staff re-organization & job title changes	▪ Drive accountability w/ metrics
▪ **Insured Follow-up**	▪ New staff roles and priorities	▪ Staff & leadership training
▪ **Denial Management**	▪ Optimized process & communication	

- Implemented and trained over 1,200 users on Huron's Revenue Cycle technology
- Initial strategies to bring the A/R to "current" have been launched
  - Engaged specialty A/R secondary business office to work un-addressed claims
  - Analyzing and segmenting A/R for bulk negotiations and clean-up
- To right-size the revenue cycle operation, Project STREAM has hired and onboarded 278 of 392 approved positions
  - CDI – 37 of 42
  - HCIs and Sr HCIs – 161 of 181
  - Clerks – 71 of 74
  - Temporary HCIs – 57 of 89
- Assisted in onboarding Chief Revenue Cycle officer and recruitment for other key central leadership positions
- Promoted long-term sustainability through implementation of a new accountability structure and performance management goals at the facilities and with Revenue Management

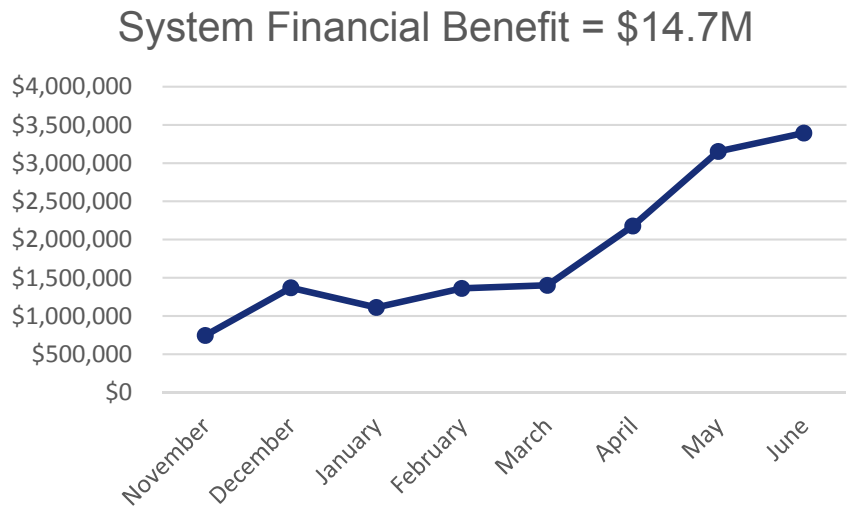
CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

The objective of the CDI initiative is to achieve accurate, complete, compliant, and appropriate documentation. Achieving these goal will facilitate appropriate reimbursement, accurate CMI, and improved quality metrics.

- **Education of CDI Specialists (CDI)** – Completed class room training and over 750 hours of mentoring to improve CDI's identification of query opportunities.
  - Competency scores improved 15 points from initial assessment

- **Staff Alignment –** Hired new staff to cover high opportunity discharges previously being missed. Prioritized work in the Huron CDI tool to focus effort on highest opportunity accounts first. Will continue to focus on ramping-up new staff to improve review rate.
  - Increased total review volume from 1,850 to 3,200 discharges

- **Physician Engagement –** Identified Physician Advisors at all facilities and leveraged their sponsorship to improve physician engagement and begin physician education.
  - 7 facilities achieving 90% Physician Response Rate goal



ED CHARGE CAPTURE

The objective of the ED Charge Capture initiative is to improve clinical documentation and charge capture processes to support accurate, timely, and complete reimbursement for ED services performed

Implementation Progress

- Provided HIM education covering ED coding best practices to all 11 acute facility HIM teams and supplemental coding vendors
- Performed ED nursing education on clinical documentation components related to bedside procedures, E&M criteria, and infusion stop times
- Completed post-education account reviews and held re-education sessions for both HIM and Nursing
- Established two ED Charge Capture champions per facility to assist with the newly implemented accountability structure

Actual Revenue Increases To Date (Jan 18 - June 18)	
Facility	**Net Revenue Increase**
Bellevue	$ 1,140,521
Coney Island	$ 877,932
Elmhurst	$ 423,604
Harlem	$ 789,512
Jacobi	$ 1,037,236
Kings County	$ 234,293
Lincoln	$ 1,202,318
Metropolitan	$ 477,710
N. Central Bronx	$ 701,663
Queens	$ 771,141
Woodhull	$ 543,050
Total	**$ 8,198,980**

REVENUE CYCLE REPORTING

Implemented automated reporting for the acute facilities providing visibility into revenue cycle performance:

- Monthly, weekly, and daily analytics and reporting designed for every level
- Incorporates goals and benchmarks to achieve leading practice performance
- Guides users through interactive problem-solving steps to isolate root cause issues through drill-down capabilities
- Simplifies data analysis to provide easy visibility into financial and operational trends to quickly identify top areas of opportunity
- Provides facility performance comparisons and enterprise wide management tools for metrics such as:
  - A/R Days
  - Cash Collections
  - 91+ DFD Agings
  - Insurance Verification Rates
  - Financial Counseling Screening
  - Billing Backlogs
  - A/R Follow-up Backlogs

REVENUE MANAGEMENT PRIORITIES

TRAINING

ENHANCED AUTOMATION

STANDARD POLICIES AND PROCESSES

ONGOING COMMUNICATION

IMPROVED REVENUE PERFORMANCE & EXCELLENT PATIENT FINANCIAL EXPERIENCE