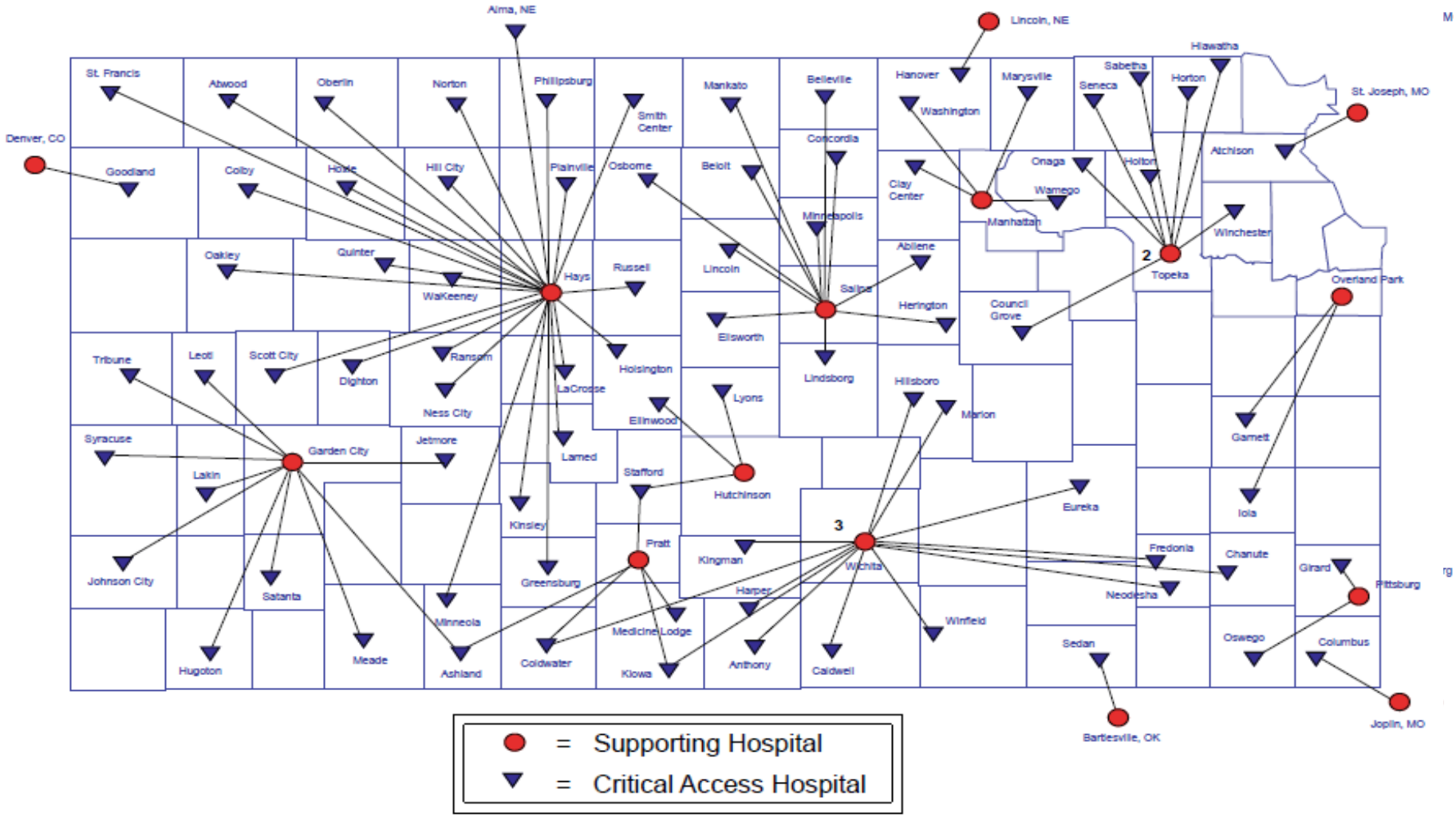
CAH Revenue Cycle Assessment Project 2012

Our Mission: To protect and improve the health and environment of all Kansans.


KANSAS

We gotta lotta CAHS!



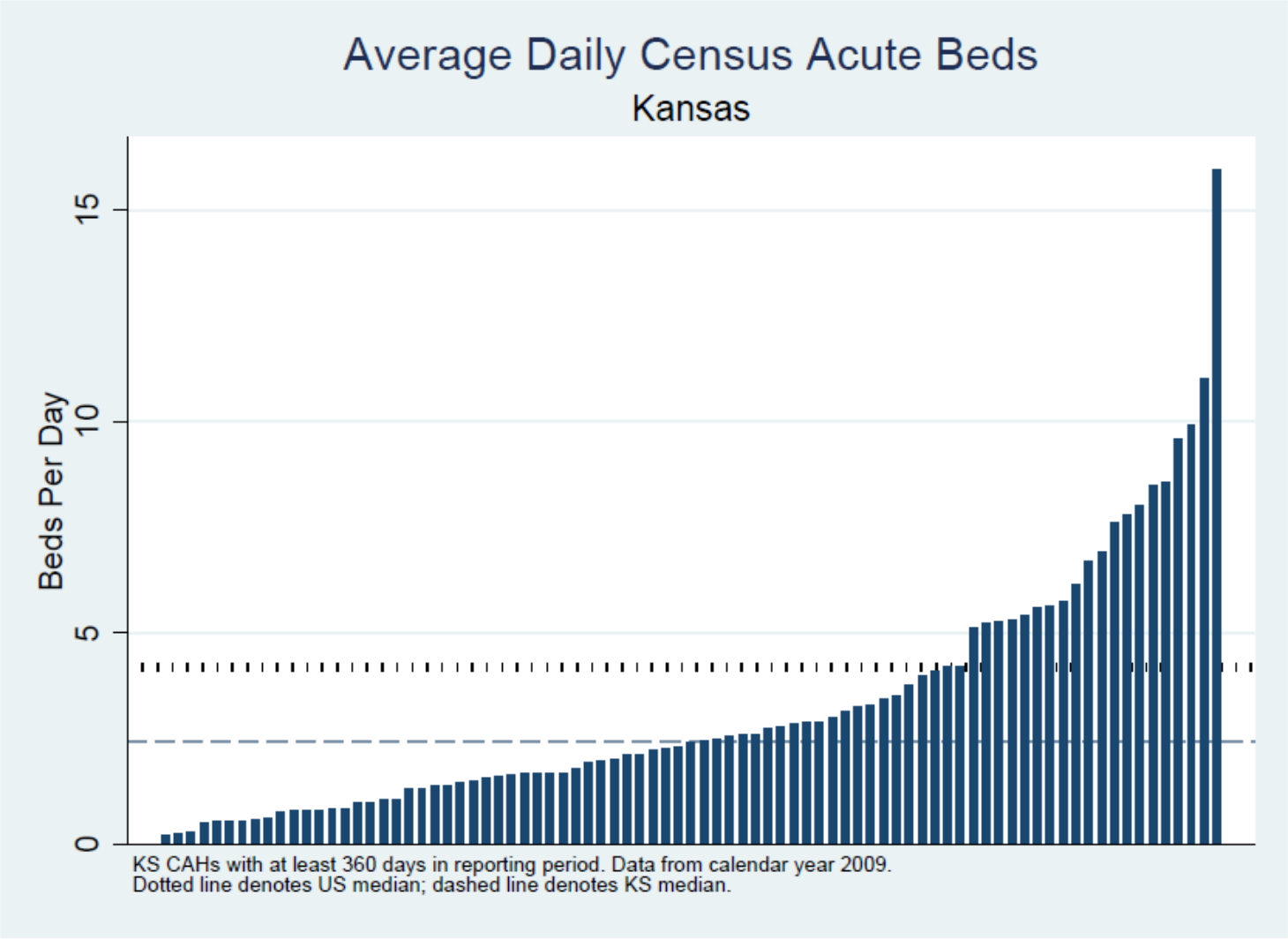
How did CAHs in KS compare to the US in 2010?

CAHs in KS and US - 2010: Summary

- Compared to the US, a higher percentage of CAHs in Kansas:
  - Have lower net patient revenue
  - Are government owned
  - Provide LTC
  - Operate a RHC

CAHs in KS and US – 2010 Summary

- Compared to the US, CAHs in KS:
  - Are less profitable
  - Are less liquid
  - Have less debt and are less able to service debt
  - Have lower proportion of outpatient revenue, patient deductions, and Medicare revenue per day
  - Have higher Medicare payer mix and outpatient cost to charge
  - Have much older age of plant
  - Have lower ADC acute but higher ADC swing beds


Average Daily Census Acute Beds
Kansas
Beds Per Day
0
5
10
15
KS CAHs with at least 360 days in reporting period. Data from calendar year 2009.
Dotted line denotes US median; dashed line denotes KS median.

How did KS financial performance compare to benchmark?

How does *KS*'s financial performance in 2009 compare to benchmark?

Benchmarks are a key component of many performance measurement systems because they help identify good financial performance and provide specific targets for improvement. Benchmarks for five indicators were created from a survey of CAH CEOs and CFOs. Medians change over time but benchmarks provide a constant basis on which to judge financial performance and condition. *For more information see the Benchmark section in the CAH Financial Indicator Report.*

Your 2009 Performance Compared to Benchmarks

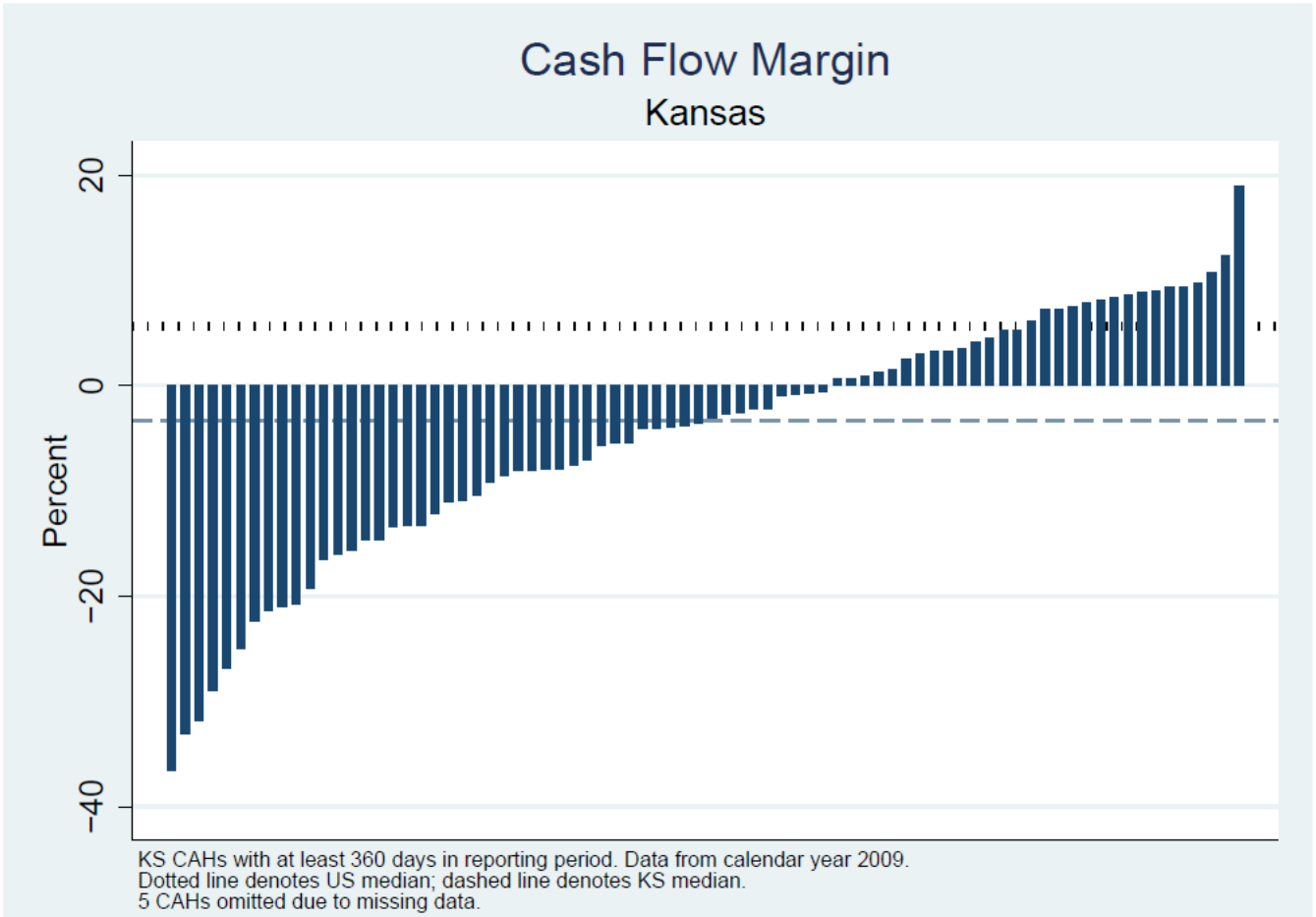
		Percent of CAHs Meeting Benchmark	
Indicator	*Benchmark*	*KS*	*Nation*
Cash Flow Margin (percent)	5	23.1%	53.5%
Days Cash on Hand (days)	60	46.3%	52.8%
Debt Service Coverage (times)	3	25.0%	42.3%
LT Debt to Capitalization† (percent)	25	58.4%	47.4%
Medicare O/P Cost to Charge† (times)	.55	45.0%	68.3%

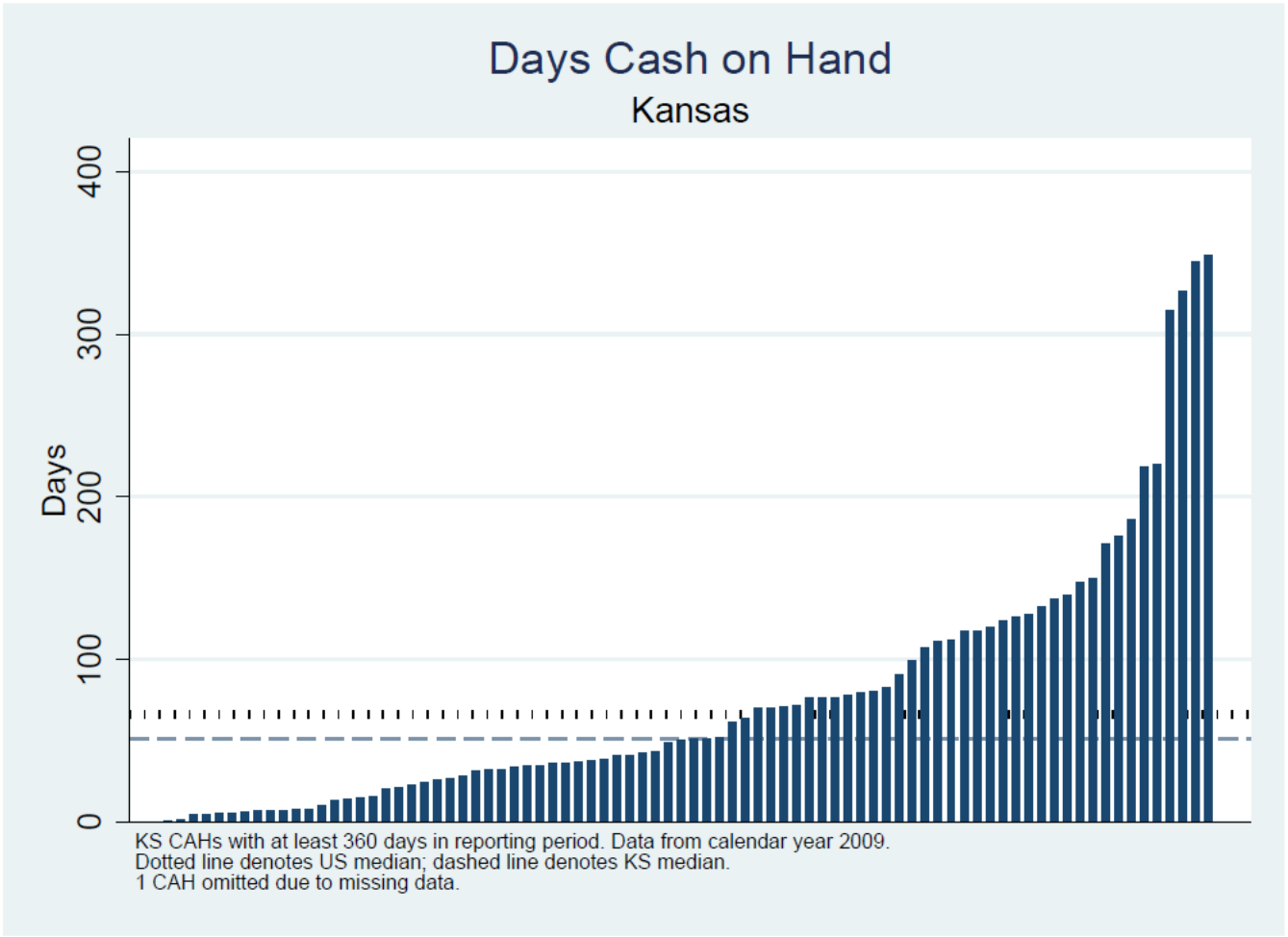
† For these ratios, lower values are associated with better financial performance.

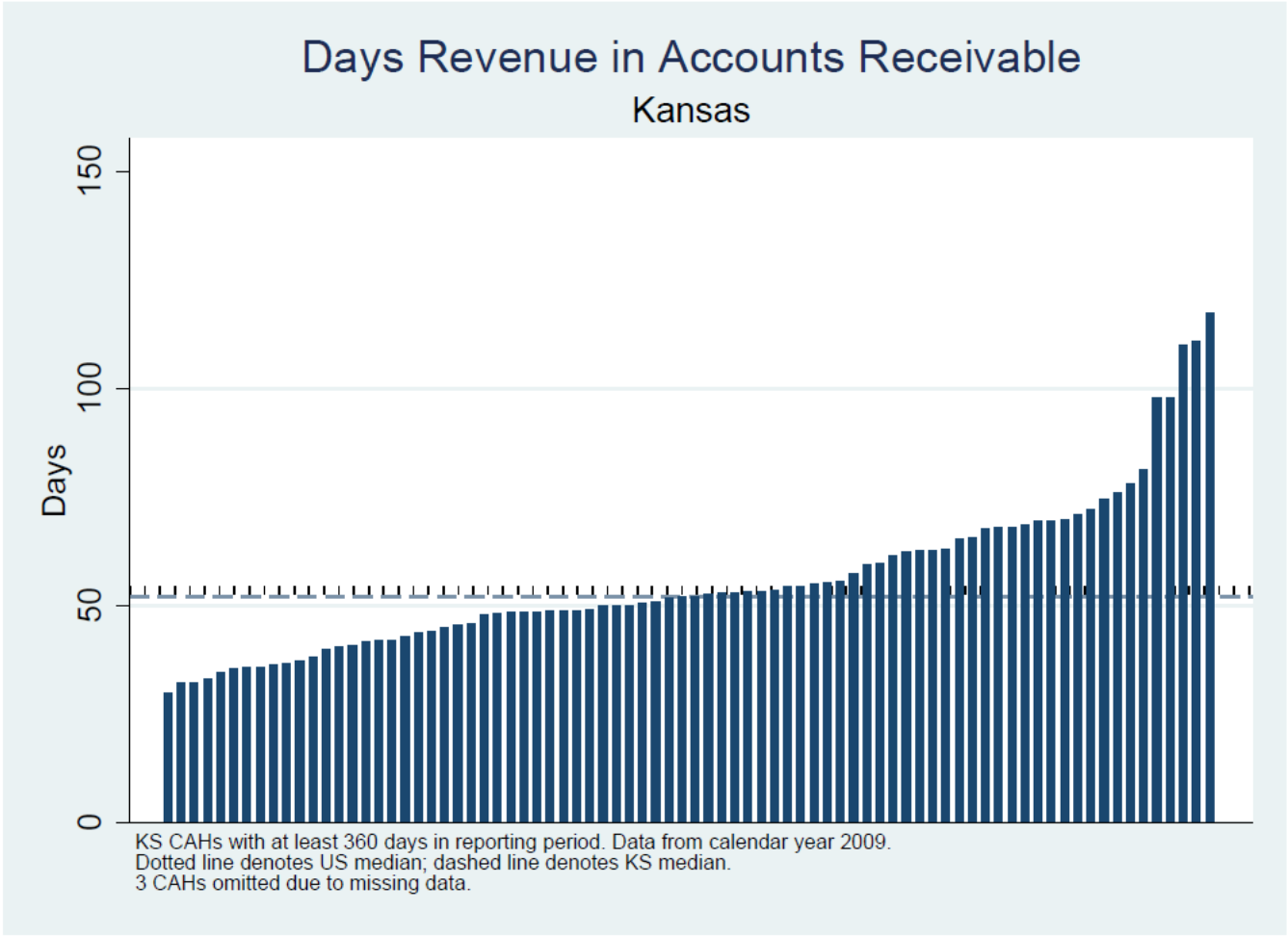
CAHs in KS and US - 2010

Indicator:	KS median	US median
Profitability:		
Total margin	-2%	2%
Cash flow margin	-6%	6%
Return on equity	-3%	5%
Operating margin	-9%	1%
Liquidity:		
Current ratio	2.2	2.3
Days cash on hand	49	66
Days revenue in accounts receivable	54	53

*Red: worse performance than U.S. median
Blue: better performance than U.S. median


Cash Flow Margin
Kansas
Percent
20
0
−20
−40
KS CAHs with at least 360 days in reporting period. Data from calendar year 2009.
Dotted line denotes US median; dashed line denotes KS median.
5 CAHs omitted due to missing data.


Days Cash on Hand
Kansas
Days
0
100
200
300
400
KS CAHs with at least 360 days in reporting period. Data from calendar year 2009.
Dotted line denotes US median; dashed line denotes KS median.
1 CAH omitted due to missing data.


Days Revenue in Accounts Receivable
Kansas
Days
0
50
100
150
KS CAHs with at least 360 days in reporting period. Data from calendar year 2009.
Dotted line denotes US median; dashed line denotes KS median.
3 CAHs omitted due to missing data.

State Report for KS

For the CAHs in KS, what is the current risk of financial distress compared to all CAHs?
A well-functioning prediction model can be used by administrators and boards as an early warning system so that remedial action may be taken before financial distress occurs. The model uses financial performance variables (current profitability, reinvestment, and hospital size) and market characteristics variables (competition, economic status, and market size) to predict financial distress (equity decline, unprofitability, and closure) two years later.

Risk of Financial Distress

	Number (Percent) of CAHs	
Risk	KS	US
Low	22 (27%)	813 (63%)
Mid-Low	24 (29%)	232 (18%)
Mid-High	17 (21%)	119 (9%)
High	19 (23%)	124 (10%)

In short…

- **50%** of our CAHs fall short in achieving 4 of the 5 Flex Monitoring Team national performance benchmarks

- **44%** of Kansas' CAHs are at high risk of financial distress.

Kansas
Department of Health and Environment

What's the matter with Kansas???

Kansas
Department of Health and Environment

We asked some experts. This one believed it was a talent and leadership issue:

"*The big thing is lack of engaged networks, engaged CEOs, engaged boards…..do not see the big picture*."

" *What I do know is Kansas may not want to know, or* ***they may not even have a clue*** *with what is going on*…"

OUCH.

Kansas
Department of Health and Environment

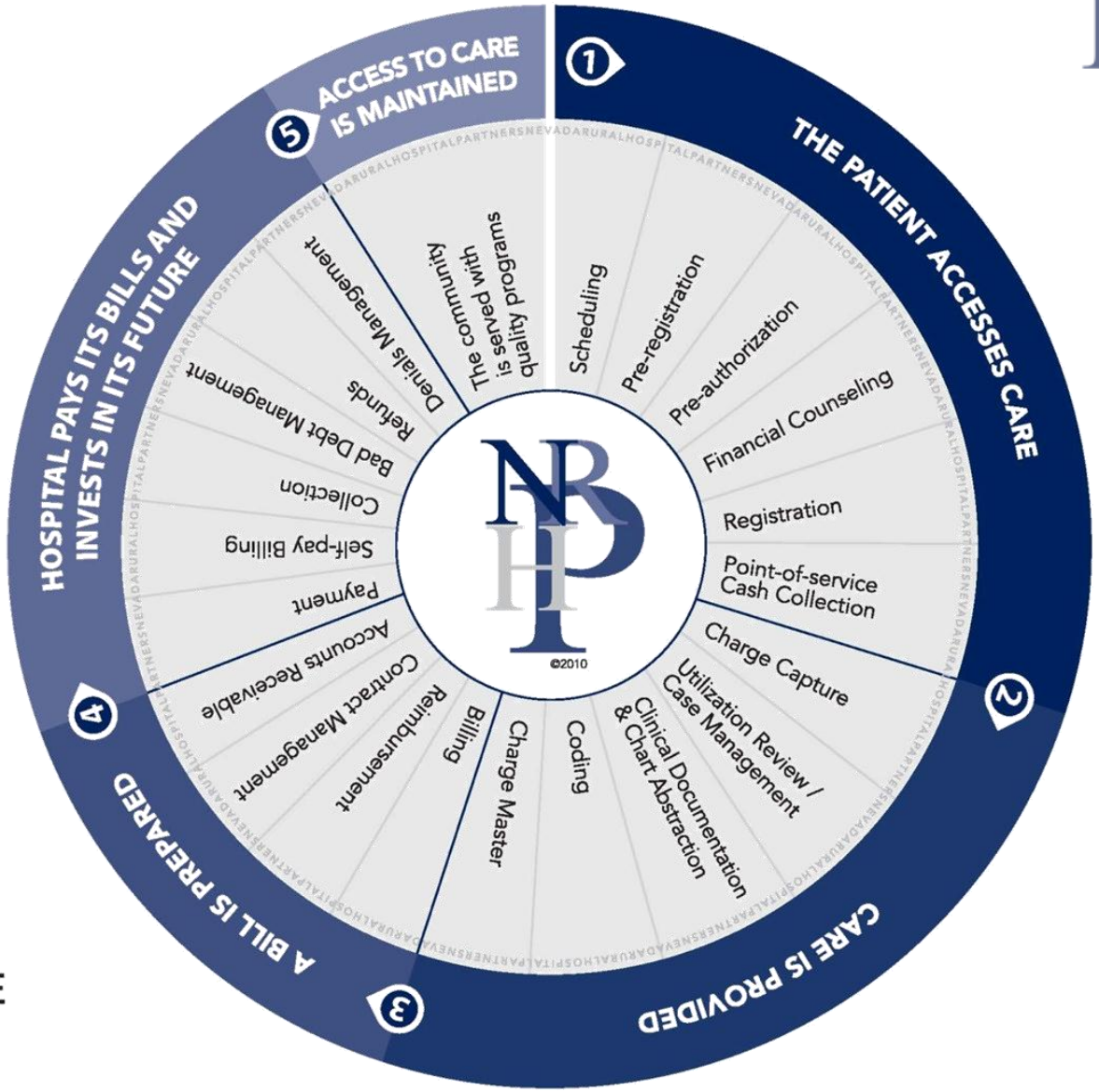
Others were more gentle…

- **"Well, it *could* be a structural cause…"**
- "KS has about 20 more CAHs (than a neighboring state that is performing better) and all of those additional 20 are stinkers - their ADC is one or less and they are located within 35 miles of another CAH or hospital. "
- "Almost all KS CAHs have both swing beds and an RHC, leading to lower margins ."
- "There are a lot of really old people. Approximately 50 percent of KS CAHS have Medicare payer mix exceeding 85 %. The only way to change the mix is to enlarge the size of the pie -- **recruit new patients. How are you going to do that?"**

While the structural theory has lots of truth and is morbidly fascinating, it is also unchangable.

- How do we know what to do when we don't know what's wrong?
- TASC and ORHP were telling us to focus on Revenue Cycle Management.

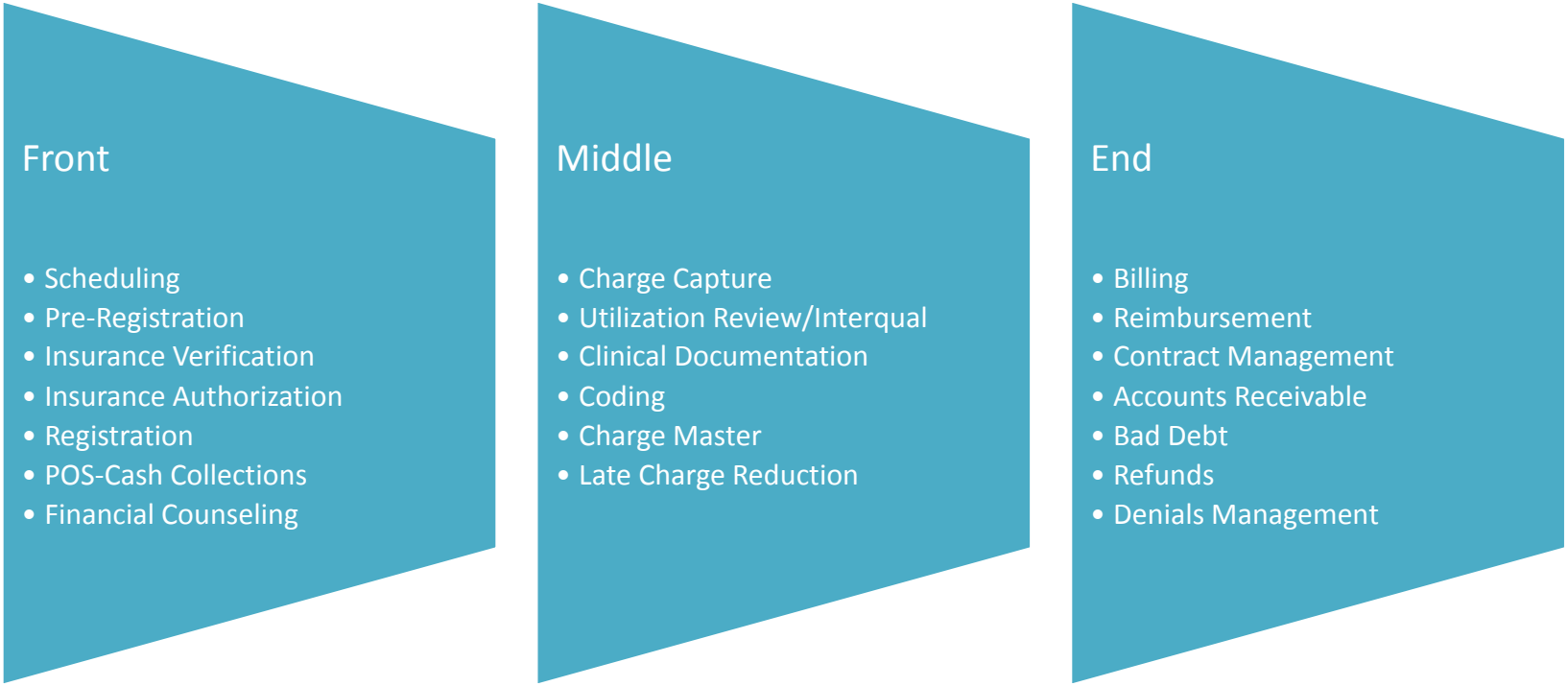
- *"Uh, OK, what is it and how do we do it?"*



NRHP
REVENUE CYCLE
IMPROVEMENT
PROGRAM

What is Revenue Cycle?

- A means to improve hospital revenue and reimbursement by streamlining workflow, processes, and education in the following areas:



Whatever we decided to do had to meet several criteria:

- Provide ***baseline information*** on individual and aggregate hospital revenue cycle management processes,
- Provide information to help KS FLEX determine ***meaningful future programming,***
- Be ***useful*** to participating CAHS,
- ***Be available to all 83 CAHS at no additional cost to them,***
- ***Be available to roll out in the next couple of months.***
- ***NRHP's RevCat met all those criteria, plus they were able to take us on immediately, meet our timeline and be flexible to our evolving needs.***

To our CAHS…

- "The Revenue Cycle Assessment Tool is completed on-line and then evaluated by staff at NRHP. ***It measures revenue cycle practices in your hospital against revenue cycle best practices.*** This will provide a ***gap analysis*** for each hospital, indicating where your hospital diverges from best practices, and an aggregate gap analysis for our state. Using the aggregate findings, the Kansas Flex program will work to create meaningful workshops directly addressing primary gaps."

Progress to date

- 31 CAHs signed on to participate (37%)
- 29 completed surveys (35%)
- All have received their individual hospital gap analysis.
- We expect the aggregate report in late June.
- We intend to run another session of Rev Cat after releasing that report to our State Network Council.
- We intend to offer intensive programming to CAHs that both completed the survey and are ready to commit.

Summary of Preliminary Findings

- **Areas of Strength**
  - Billing and Coding, including Utilization Review
  - Chargemaster (CDM) and Charge Capture
  - Charity Care and Self-Pay Account Management
- **Areas for Improvement**
  - **Denials and Third Party Payer Management**
  - **Front-End Patient Processes, including Financial Counseling and Point of Service Collections**
  - **Charge Audit**
  - **Quality Assurance/Improvement Activities**

- **Immediate financial impact/”low hanging fruit”**
- **Enhancement of revenue cycle processes with potential financial impact**
- **Quality assurance monitoring and improvement with potential financial impact**
- **Compliance related issues with potential penalty and fine avoidance**
- **Compliance related issues with financial return**

Classification of Opportunity

Kansas - Preliminary RevCat Results

- Point of Service Collections
- Benefits and Eligibility Verification
- Scheduling and Pre-Registration
- Financial Counseling
- Charity Care
- Self Pay Management
- Billing Staffing Levels

Revenue Cycle Process Enhancement with Potential Financial Return

Next grant year

- We anticipate developing financial improvement collaboratives for hospitals,
- including setting performance improvement goals,
- doing intensive interventions,
- requiring consistent, timely data reporting and
- doing re-testing to evaluate the impact of adopting recommendations.

Upcoming Programming for Revenue Cycle Management Improvement

A. Year-long Revenue Cycle Improvement Curriculum

- Three 3 - month long courses, each on a revenue cycle process identified in aggregate gap analysis.
- 2 webinars + one face-to-face workshop (at SNC?)
- Pre-test, post-test and re-test to see what you're learning and what're you're implementing at home.
- Audience: CEOs, CFOs, Business Office, QI Manager

B. Intensive Improvement Collaboratives

- **Objective = concretely improving hospitals' financial performance.**

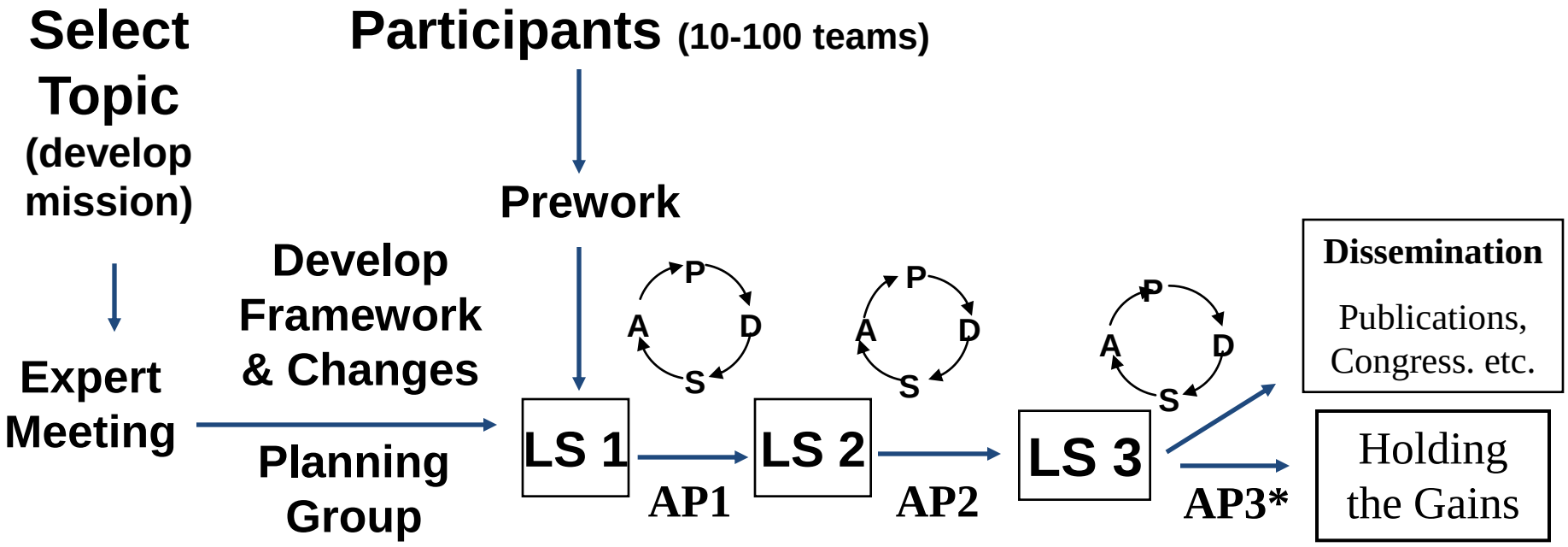
- **Aimed at hospitals interested in and ready to improve financial performance, *that have completed the Revenue Cycle Assessment Tool.***

Characteristics of Collaboratives

- Designed to help organizations close that gap by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements.
- Intensive short-term (6- to 15-month)
- Brings together teams from different hospitals to work on improvement in a focused topic area.
- In-hospitals teams are multidisciplinary.
- Performance is REPORTED regularly to track and measure results.
- Team sends members to attend Learning Sessions (face-to-face meetings over the course of the Collaborative), to share with other hospitals.

IHI Breakthrough Series

(6 to 18 months time frame)



LS – Learning Session

AP – Action Period

Supports

Email (listserv) Phone Conferences

Visits Assessments

Monthly Team Reports

*AP3 –continue reporting data as needed to document success

Questions

www.kdheks.gov

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