FOCUSED KPI FOR CHC LEADERS

REVENUE CYCLE . CHC EXPERTISE
PEACE OF MIND

Agenda

- Intro
- The Landscape
- Billing vs. RCM
- Key Performance Indicator Defined
- Information Is Gold
  - Days in AR (DAR)
  - AR Aging
  - Blended Encounter Rate (BER)
  - Denial Rate
  - Net Collection Rate
  - Staffing
- Sample Dashboards
- Summary

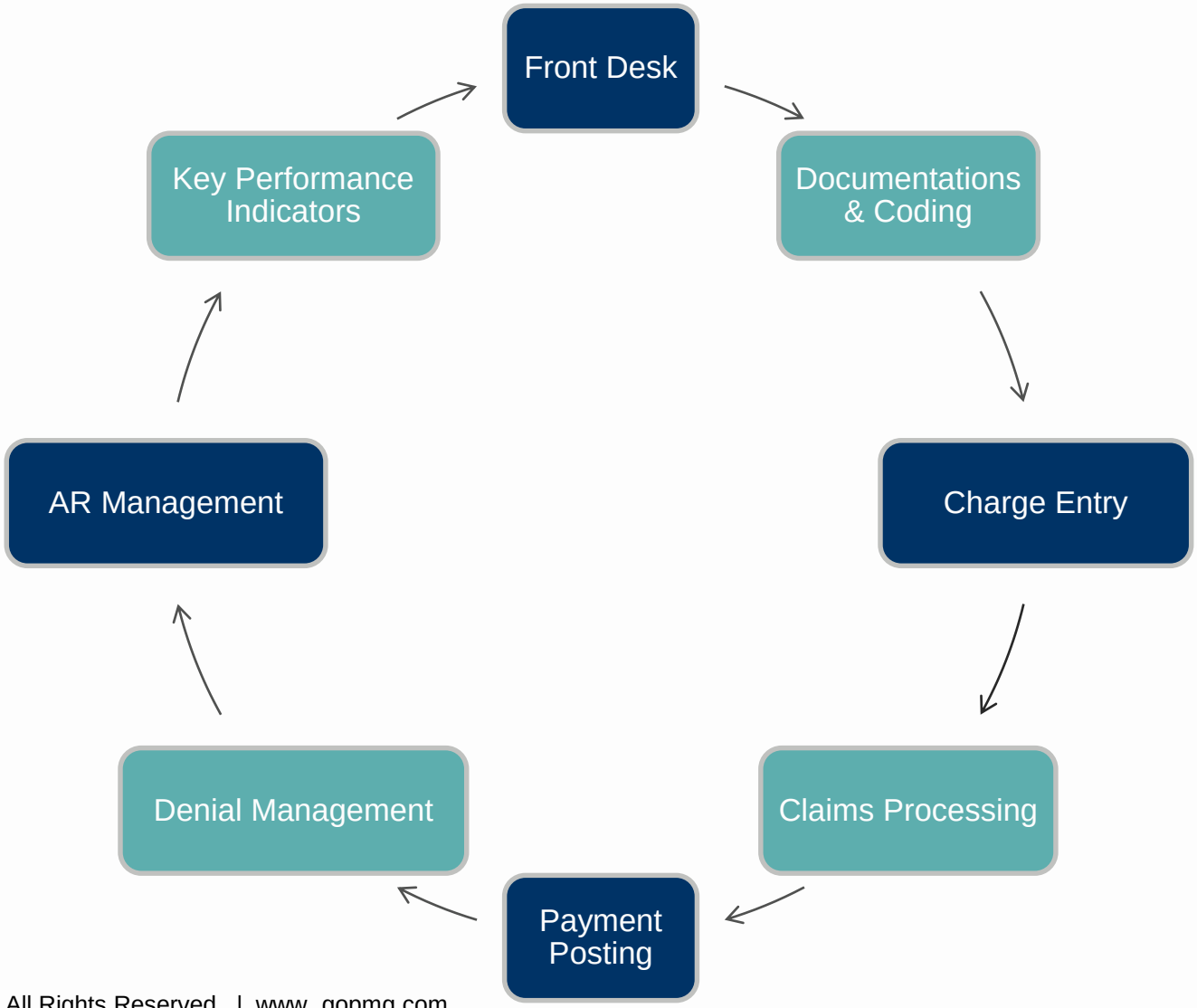
CHC Environment

- Expanding organizations… CHCs & Payers
- Expanding patient populations in need
- Staff recruitment & retention… a challenge
- Funding: more diversified & complex
- Operating under tight budget margins

Health Care Delivery System Future

- The Culture of Managed Care and Capitation
- Payment Reform
- Accountable Care Organizations/Communities (ACOs & ACCs)
- Care Coordination and Case Management
- Alternative Models of Care Delivery & Access

Revenue Cycle Processes & Audits

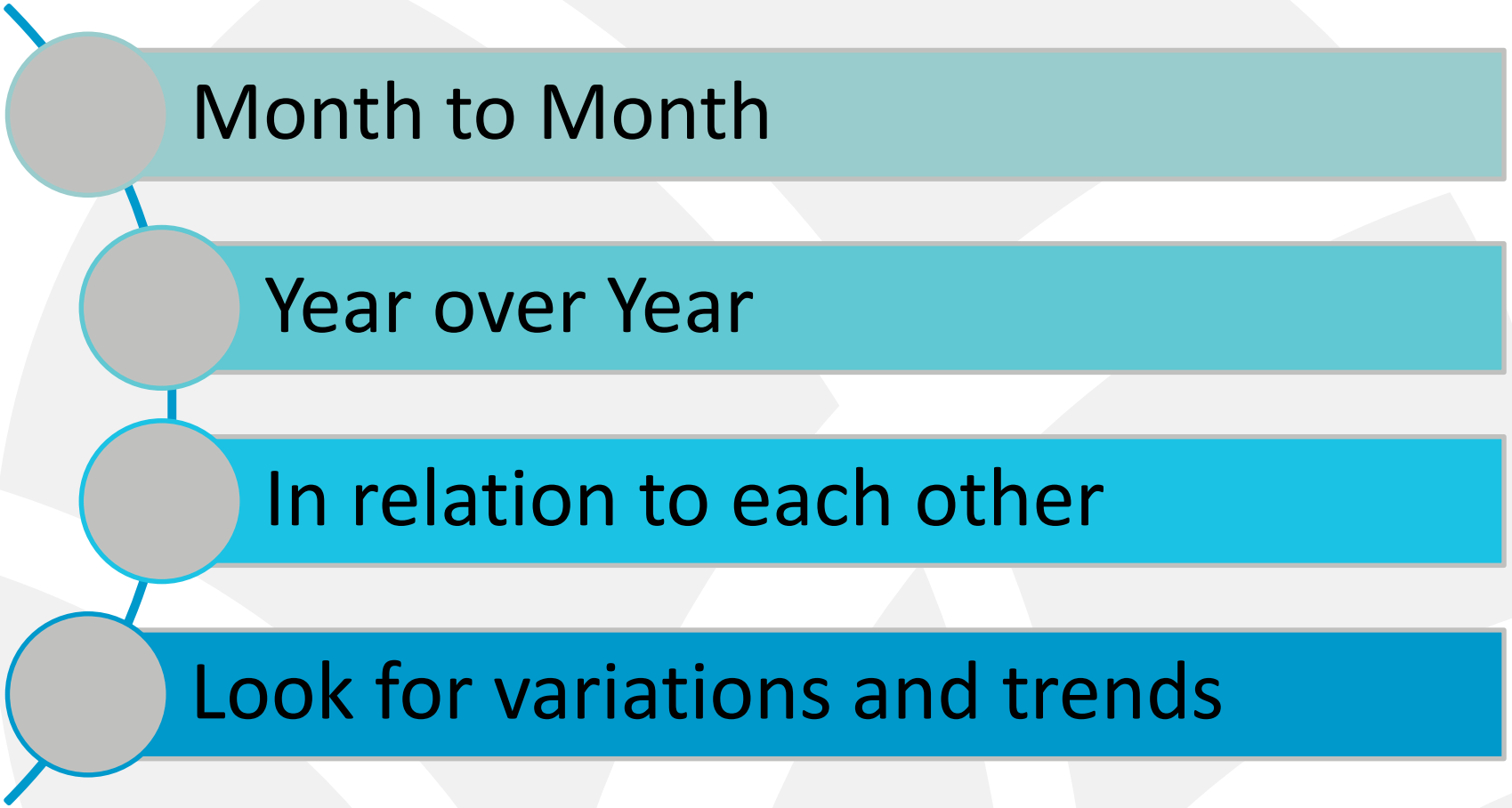


Key Performance Indicators: KPIs

KPI = A performance measurement

- Evaluate “success“ of a particular activity… e.g., RCM operations
- Success means what??
  - Achievement of some measure or a finite goal
  - Progress towards strategic/tactical goals
- What are the “right” KPIs?
  - What’s important?
  - Financial vs. Clinical performance… at cost of the other?
  - Target areas for improvement
  - Staff performance evaluated based on KPIs…
    - Alignment of interests

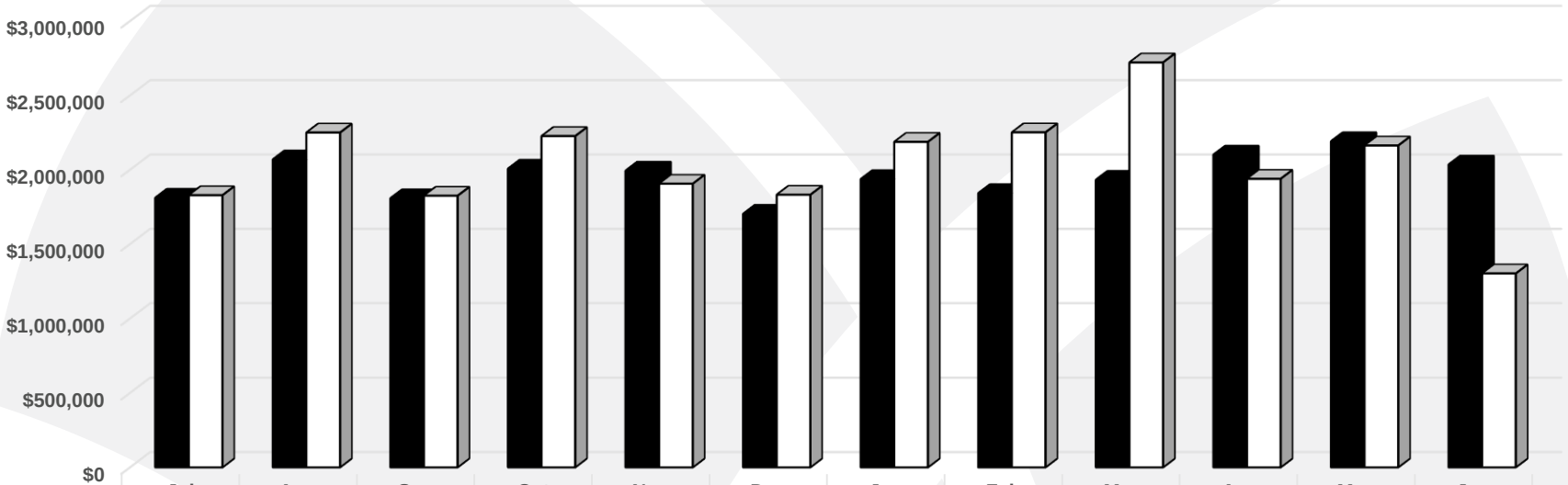
Compare Charges, Payments, Visits



Charges (Gross)

Fiscal Year Trending

4% uptick compared to same period last fiscal year



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
■FY18	$1,811,387	$2,069,157	$1,807,851	$2,006,979	$1,993,702	$1,703,565	$1,936,823	$1,842,518	$1,932,181	$2,101,370	$2,191,569	$2,034,558
□FY19	$1,828,520	$2,250,034	$1,825,076	$2,226,337	$1,905,799	$1,831,752	$2,187,296	$2,251,447	$2,721,586	$1,938,839	$2,163,075	$1,302,545

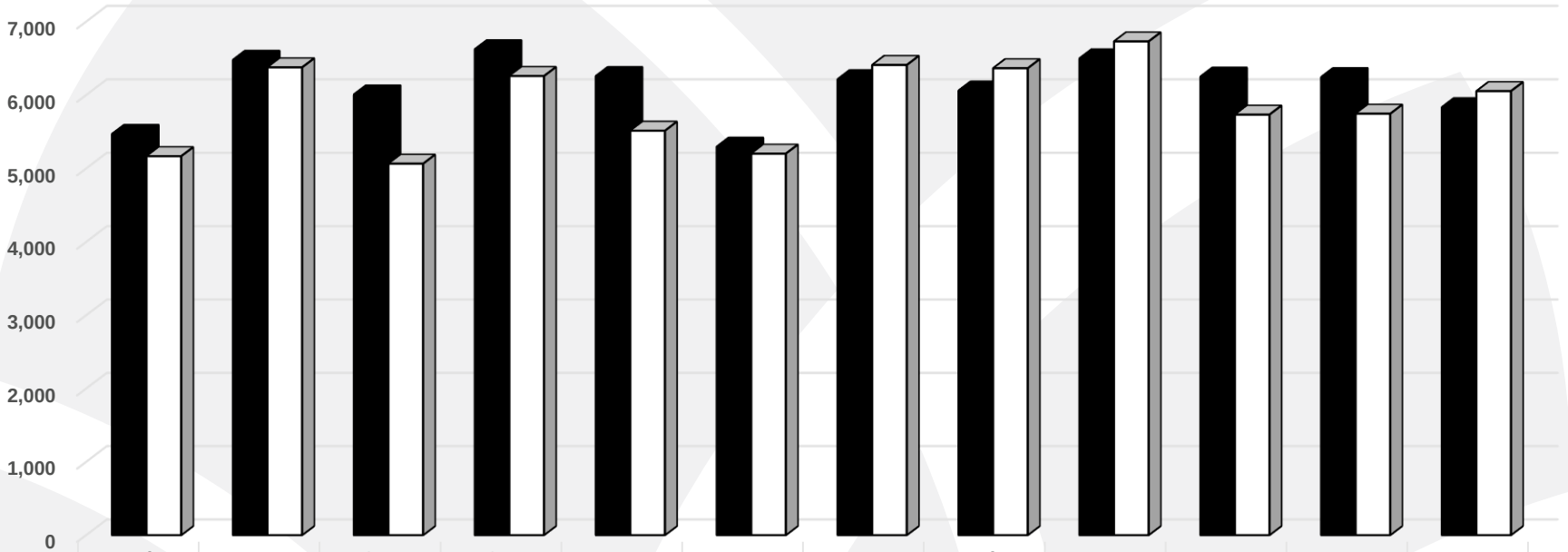
Charges:

- Monitor provider productivity and the ‘level’ of services provided
- Do not really predict payment directly in the CHC (due to PPS rate)
- Used to trend provider activity & monitor unexpected highs/ lows

Encounters

Trending by Fiscal Year

- Down 4% compared to same period last fiscal year.
- ↑ encounters should align ↑ charges



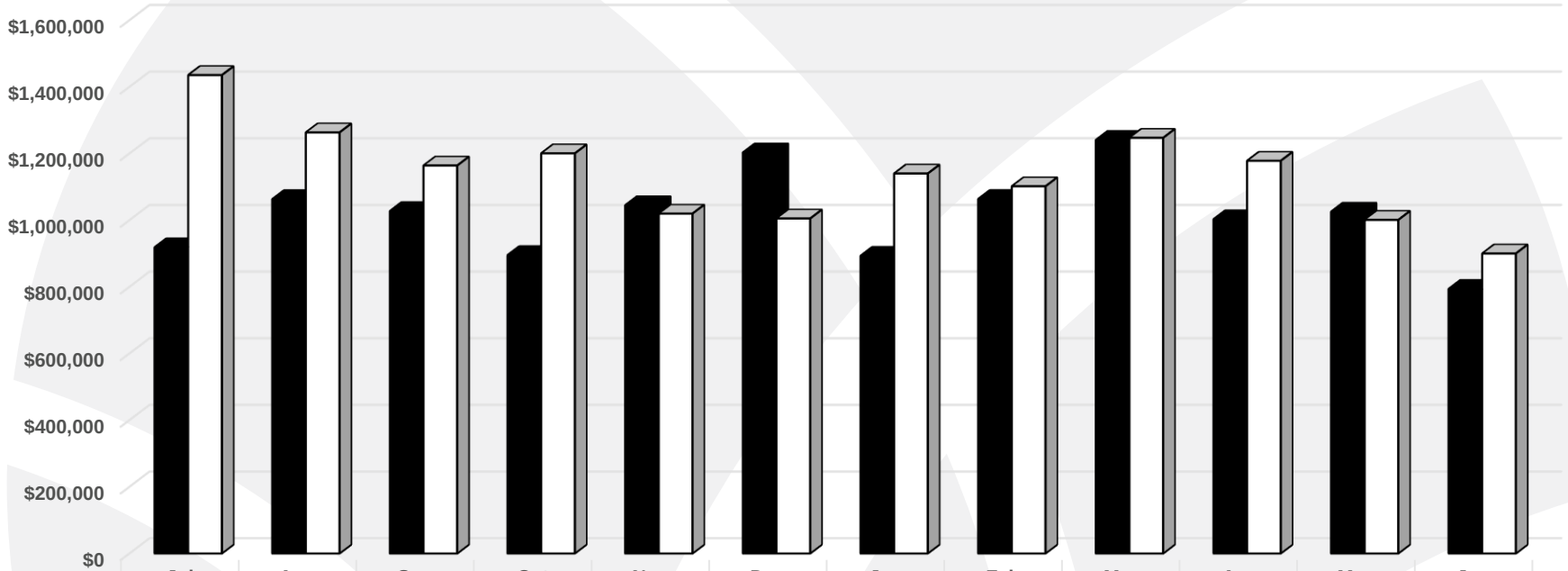
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
■FY18	5,470	6,479	6,008	6,623	6,258	5,296	6,215	6,060	6,499	6,250	6,244	5,834
□FY19	5,167	6,377	5,065	6,259	5,514	5,202	6,410	6,365	6,730	5,733	5,746	6,053

Monitor provider productivity… forecast future staffing needs

Payments

Fiscal Year Trending

↑ 4% compared to same period last fiscal year.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY18	$918,713	$1,063,193	$1,027,437	$895,238	$1,044,925	$1,203,028	$892,974	$1,063,755	$1,240,786	$1,002,760	$1,025,430	$793,854
FY19	$1,435,341	$1,263,398	$1,163,988	$1,200,563	$1,019,690	$1,005,043	$1,140,004	$1,101,765	$1,247,062	$1,178,169	$1,000,957	$900,074

Monthly reconciliation: payments received vs. posted

Why Not Just One?

- KPI often use overlapping data elements
- No one KPI should be used in isolation
- Understand the relation of one to another
- How are they related?
  - Days in AR (DAR) & Blended Encounter Rate (BER)
  - AR Aging & Blended Encounter Rate
  - Staffing Levels & Billing Expense

Days in AR (DAR)

- DAR: Average total days to collect a claim
- DAR indicates days' worth of charges outstanding
- Calculating DAR

Total AR ÷ Average Day's Charges

Days in AR (DAR)

- What is a day?
  - One day's worth of charges… E.g., $1,000/day
  - Calculation: Total Charges ÷ number of days
    - 365 days at $1,000/day = $365,000
    - DAR = $45,000 ÷ $1,000 = 45 days

Days in AR (DAR) - Example

Data

- Annual Charges = $13,563,875
- Total AR = $2,465,985

Calculations

- Average Day's Charges

  $13,563,875 ÷ 365 = $37,161

- DAR Calculation

  $2,465,985 ÷ $37,161 = 66.3 Days

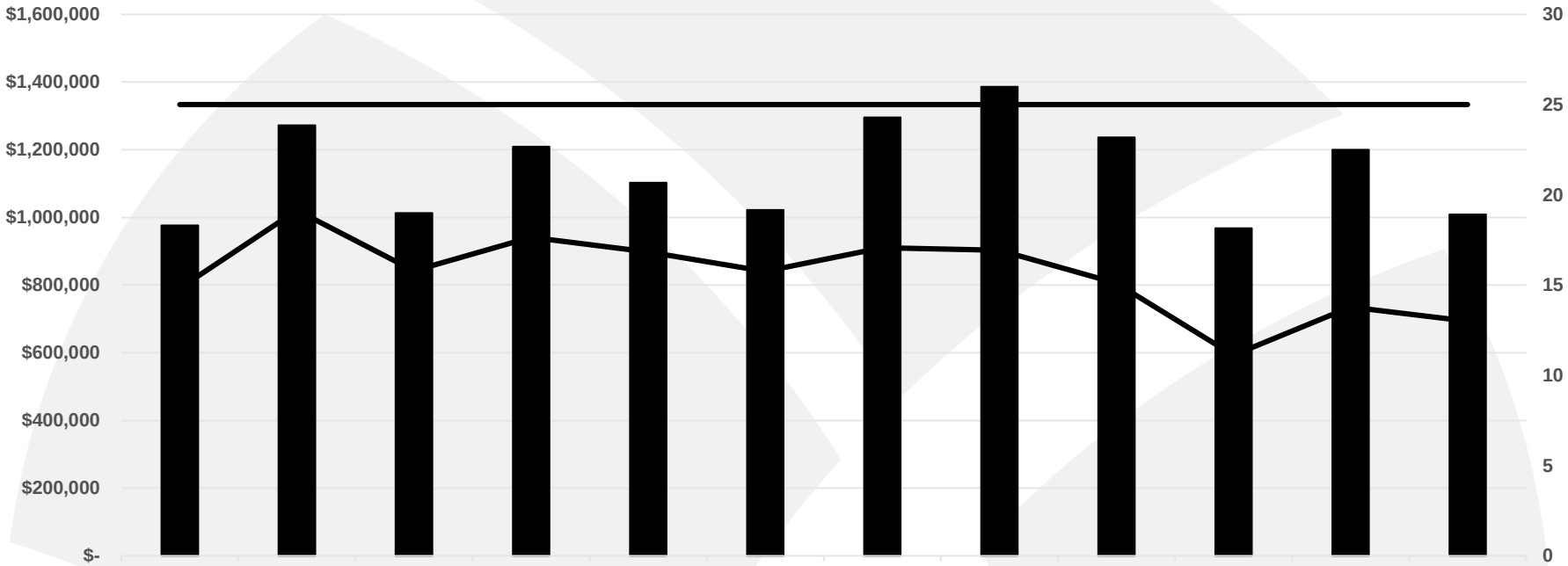
Performance Benchmarks for DAR

< 39	• Very Good Performance
40 - 59	• Average Performance
> 60	• Below Average Performance

DAR: 3rd Party, Contributing Factors

Payer	Provider	Reason	Total $	Days
Medicaid Dental	Dr. Jones	Not linked to Dental NPI	$ 64,379.09	2.1
	Dr. Smith	Not linked to Dental NPI	$ 11,122.75	0.4
	Dr. Pepper	Not linked to Dental NPI	$ 6,467.00	0.2
Medicaid MCO	Dr. Medd	Provider non par	$ 39,287.39	1.3
Medicare	All	Cost Report Hold	$ 212,773.96	6.8
Highmark	Dr. Billings	New claim format not accepted	$ 13,465.72	0.4
Commercial	All	Service not in contract (CPT 99460, 99462)	$ 7,777.00	0.2
Total Contributing Factors			**$ 355,272.91**	**11.4**

AR Days – Third Party



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Balance	$976,315	$1,272,139	$1,013,351	$1,208,886	$1,102,532	$1,021,823	$1,295,208	$1,386,080	$1,236,611	$968,380	$1,200,206	$1,008,987
Days in AR	15	19	16	18	17	16	17	17	15	11	14	13
Target	25	25	25	25	25	25	25	25	25	25	25	25

- Days of AR (DAR) = AR ÷ Average Daily Charge
- A.K.A., Days Sales Outstanding (DSO)
- Find AR projects to rapidly diminish DAR

Percent of AR > 90 Days

- Percent of AR > 90 days as percent of total AR
- Conveys ability to collect claims in timely manner
- Older the claim, the less likely to pay

AR > 90 days ÷ Total AR

AR > 90 Days - Example

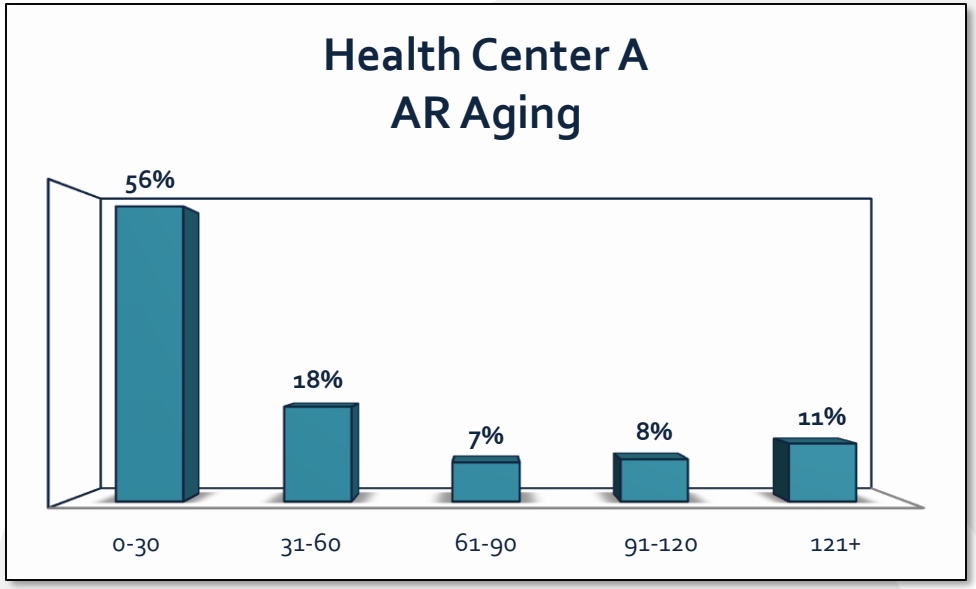
Data

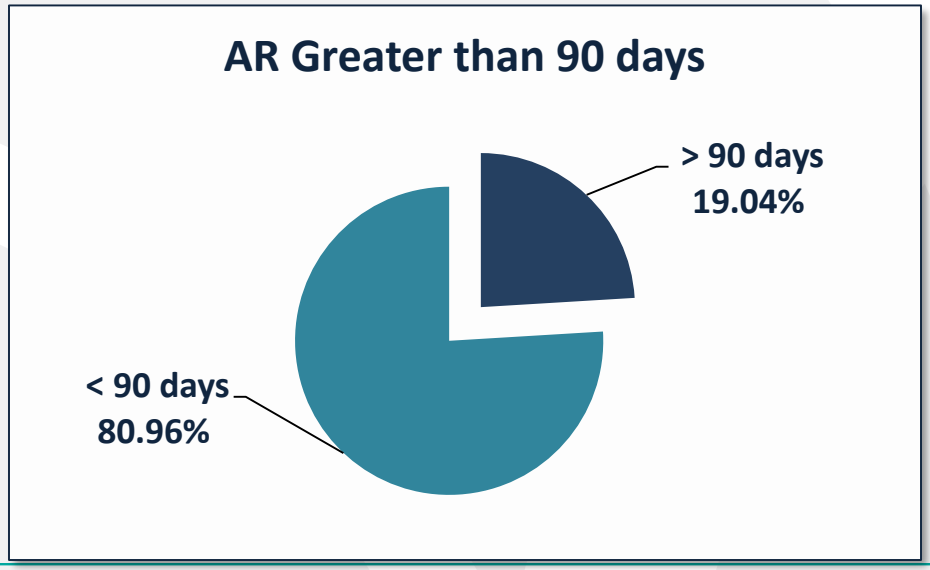
- Total AR = $2,465,985
- AR > 90 Days = $665,816

Calculations

- $665,816 ÷ $2,465,985 = 27%

AR Aging Overview



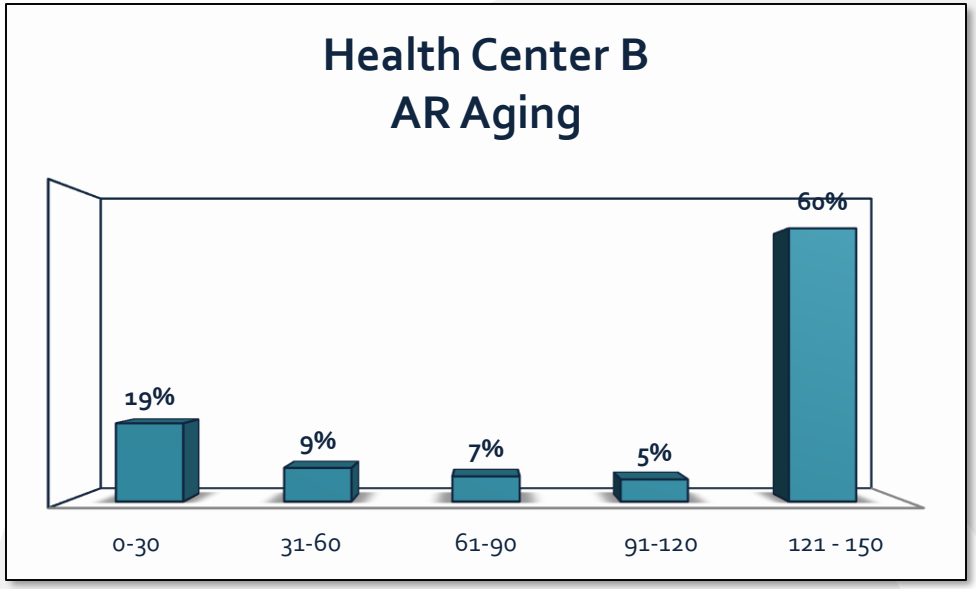


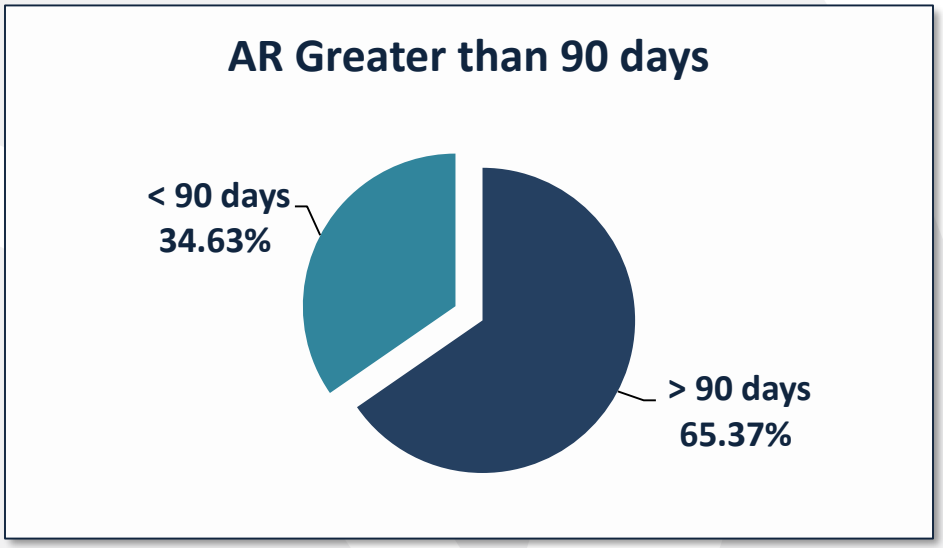
> 90 days "at risk" for: timely filing & uncollectible

Goal: < 20% @ > 90 days

Red Flag: >25%

AR Aging Overview





> 90 days "at risk" for: timely filing & uncollectible

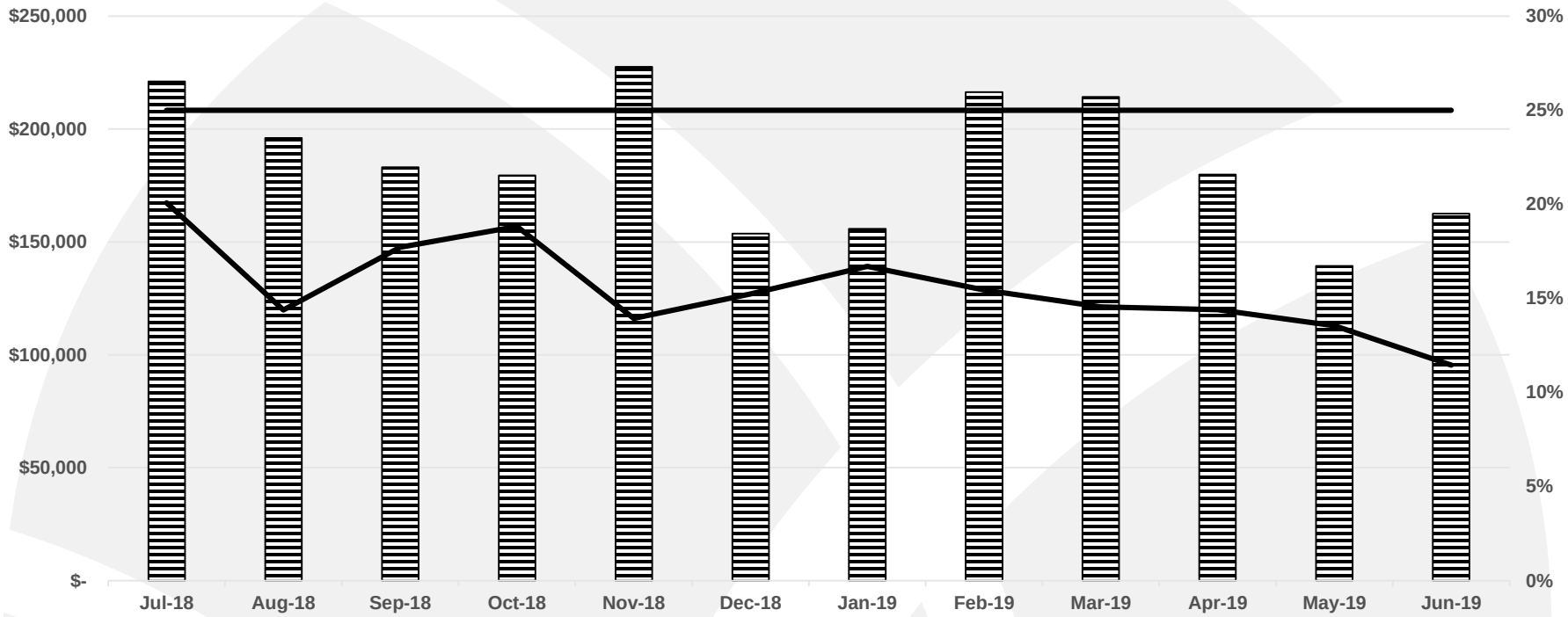
Goal: < 20% @ > 90 days

Red Flag: >25%

Performance Benchmark AR > 90 Days

< 25%	• Very Good Performance
30-40%	• Average Performance
> 40 %	• Below Average Performance

AR > 90 Days – Third Party



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Balance	$221,045	$195,994	$183,072	$179,505	$227,581	$153,707	$155,761	$216,359	$214,179	$179,838	$139,394	$162,517
%	20%	14%	18%	19%	14%	15%	17%	15%	15%	14%	14%	11%
Target	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%

- AR Over 90 Days: ‘At risk’ of being uncollectable
- Monitor >90 Days

Percent of AR > 90 Days

Contributing Factors in setting benchmarks

- Payer Mix
- Check Write Schedule
- Self Pay Collection Policy
- Credentialing

Payments per Encounter

- Average payment for each visit
- Blends all payers
- Estimates cash collections independent of productivity fluctuations

Total Payments ÷ Number of Visits

Blended Encounter Rate

$$\frac{\text{Total Payments}}{\text{Total Visits}} = \$ \text{ BER}$$

Payments per Encounter

Considerations

- Data from most recent 6 months to one year
- Significant one-time events effect visits or payments?

Average Charge Per Encounter

Significant increase/decrease… why?

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY18 Monthly	$331.15	$319.36	$300.91	$303.03	$318.58	$321.67	$311.64	$304.05	$297.30	$336.22	$350.99	$348.74
FY19 Monthly	$353.88	$352.84	$360.33	$355.70	$345.63	$352.12	$341.23	$353.72	$404.40	$338.19	$376.45	$215.19
FY18 YTD	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95	$319.95
FY19 YTD	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96	$345.96

- Should be fairly steady
- Significant changes: PM/EMR issues? Provider coding? Other?
- Warning sign unless expected du (e.g., fee schedule change)

Blended Encounter Rate (BER)… What is it?

- Average payment per visit/encounter
- How to calculate:

Total Payments ÷ Total Visits = Blended Encounter Rate*

vs. (different than knowing) Medicaid or Medicare Rate

*Visits = Encounters = Single patient face-to-face service with core provider

Blended Encounter Rate BER… 2017 UDS Data

- Average payment per visit/encounter
- How to calculate:
  - 2017 National UDS 5, #34 less #29 (Total Visits) 104,090,709*
  - 2017 National UDS 9D, Line 14 Collection $17,410,822,396*
  - **2017 National Blended Encounter Rate: $167.27/visit***

  - 2017 NC UDS 5, #34 less #29 (Total Visits) 1,740,159**
  - 2017 NC UDS 9D, Line 14 Collection $241,471,779**
  - **2017 NC Blended Encounter Rate: $138.76****

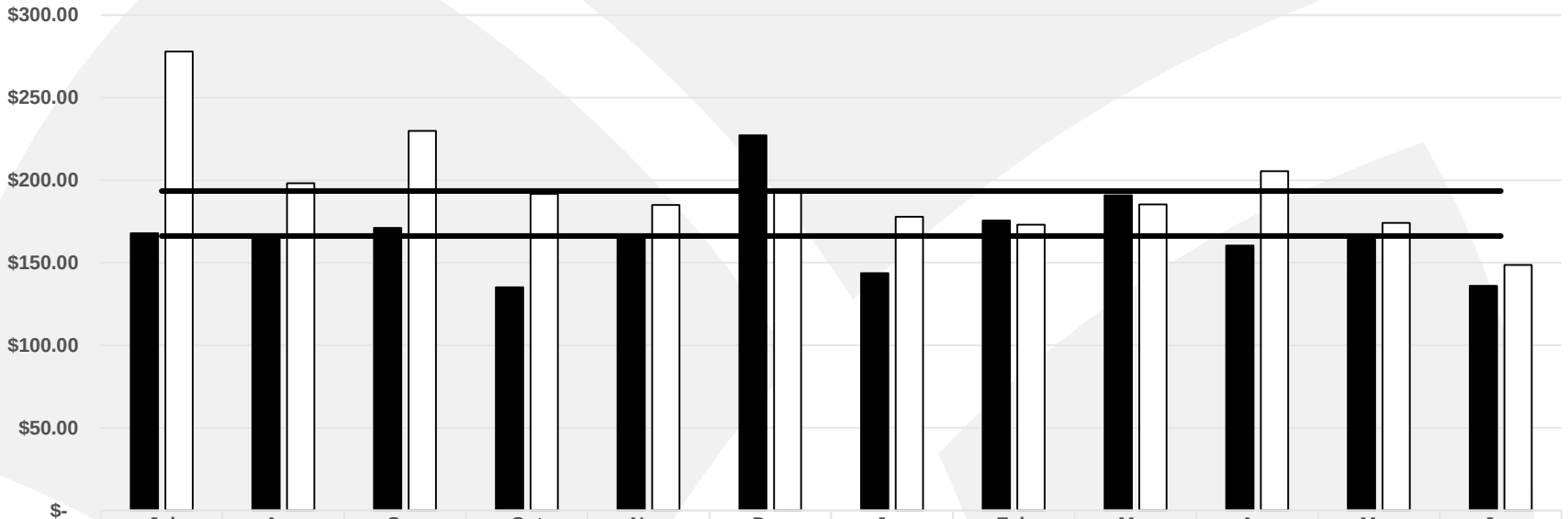
* http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=

** http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=NC

Blended Encounter Rate

(Average Payment Per Encounter)

Blended encounter rate up 8% compared to FY2018.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY18 Monthly	$167.95	$164.10	$171.01	$135.17	$166.97	$227.16	$143.68	$175.54	$190.92	$160.44	$164.23	$136.07
FY19 Monthly	$277.79	$198.12	$229.81	$191.81	$184.93	$193.20	$177.85	$173.10	$185.30	$205.51	$174.20	$148.70
FY18 YTD	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20	$166.20
FY19 YTD	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37	$193.37

- BER above/below anticipated PPS? (80% Medicare)
- Off target… someone need know why

Payment P⁴Y… What is it?

- Average payment per patient per year ***(PPPPY… P⁴Y)***
- How to calculate:

Total Payments ÷ Total Patients = Payments P⁴Y*

**Patients = Total UDS Patients, excluding "Enabling Services"*

Blended P⁴Y… 2017 UDS Data

- Average payment per PATIENT per year (P⁴Y)
- How to calculate:
  - 2017 National UDS 5, Lines 15,19,20-22,&22d (Grand Total) 32,581,498*
  - 2017 National UDS 9, Line 14B Collection $17,410,822,396*
  - **2017 National Payments P⁴Y: $534.38***

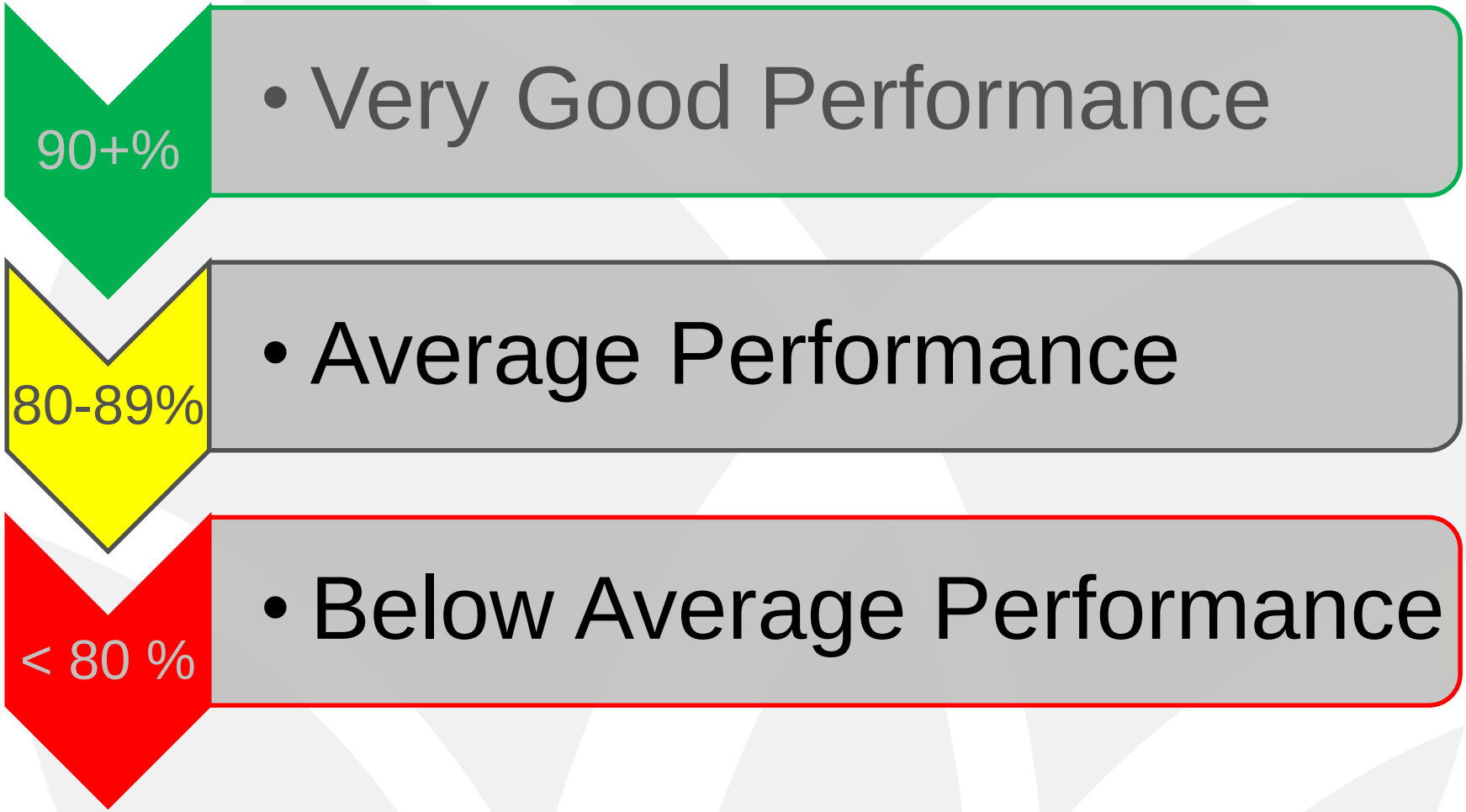
  - 2017 NC UDS 5, Lines 15,19, 20-22, & 22d (Total Patients) 596,360**
  - 2017 NC UDS 9D, Line 14 Collection $241,471,779**
  - **2017 NC Payments P⁴Y: $404.91****

**Patients = Total UDS Patients, excluding "Enabling Services"*

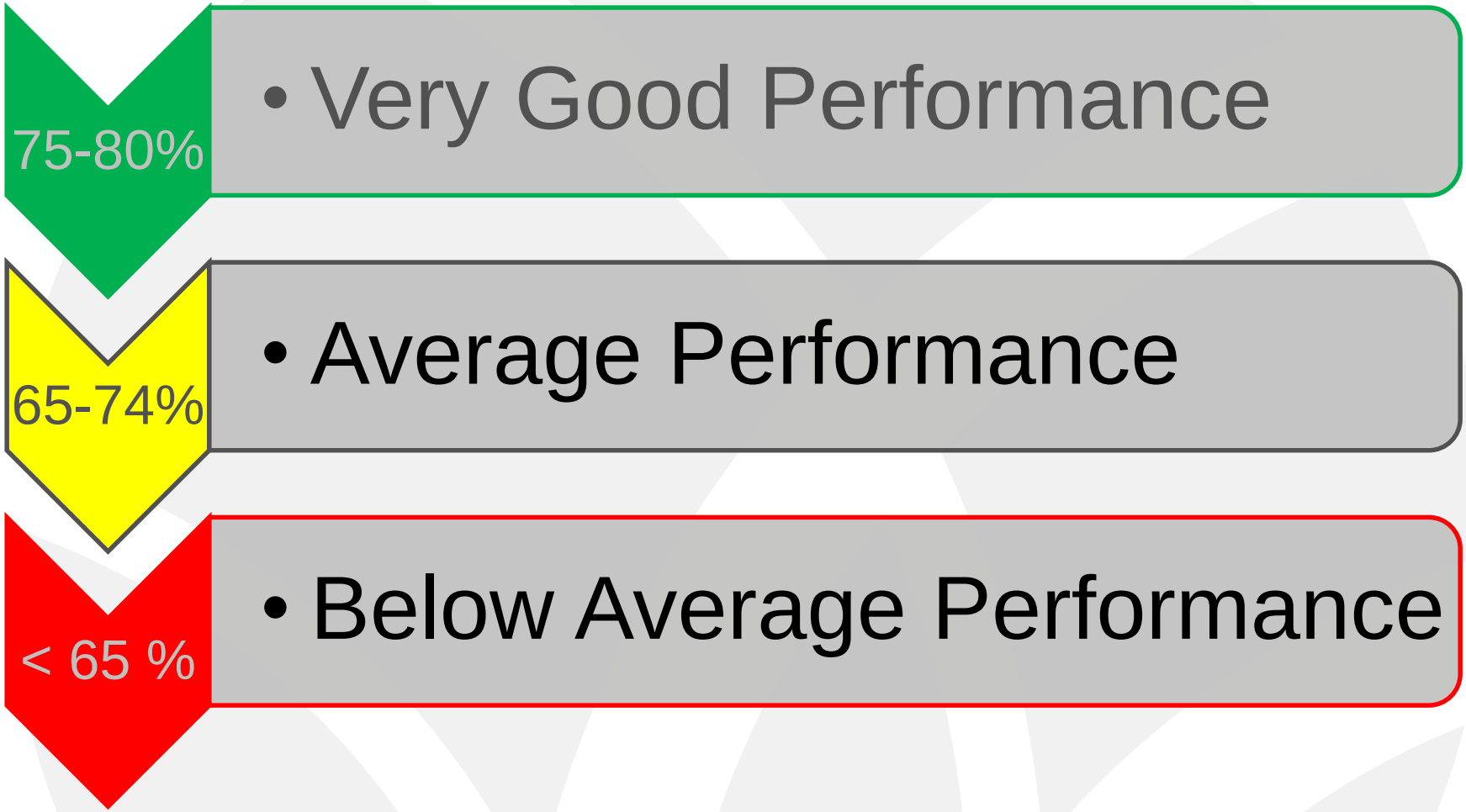
*http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=

**http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=NC

MEDICAID Blended Encounter Rate



MEDICARE Blended Encounter Rate



Denials: What do we do with them?

Denials

Positively impacting KPIs

- Reduce DAR: Get claims paid more quickly
- Reduce Age of AR: Get claims paid more quickly
- Increase BER: Get more claims paid

Denials by Location

Site C – Always highest denial volume
NOTE: 57% of Site C- Clinic Medical denials due to Registration.

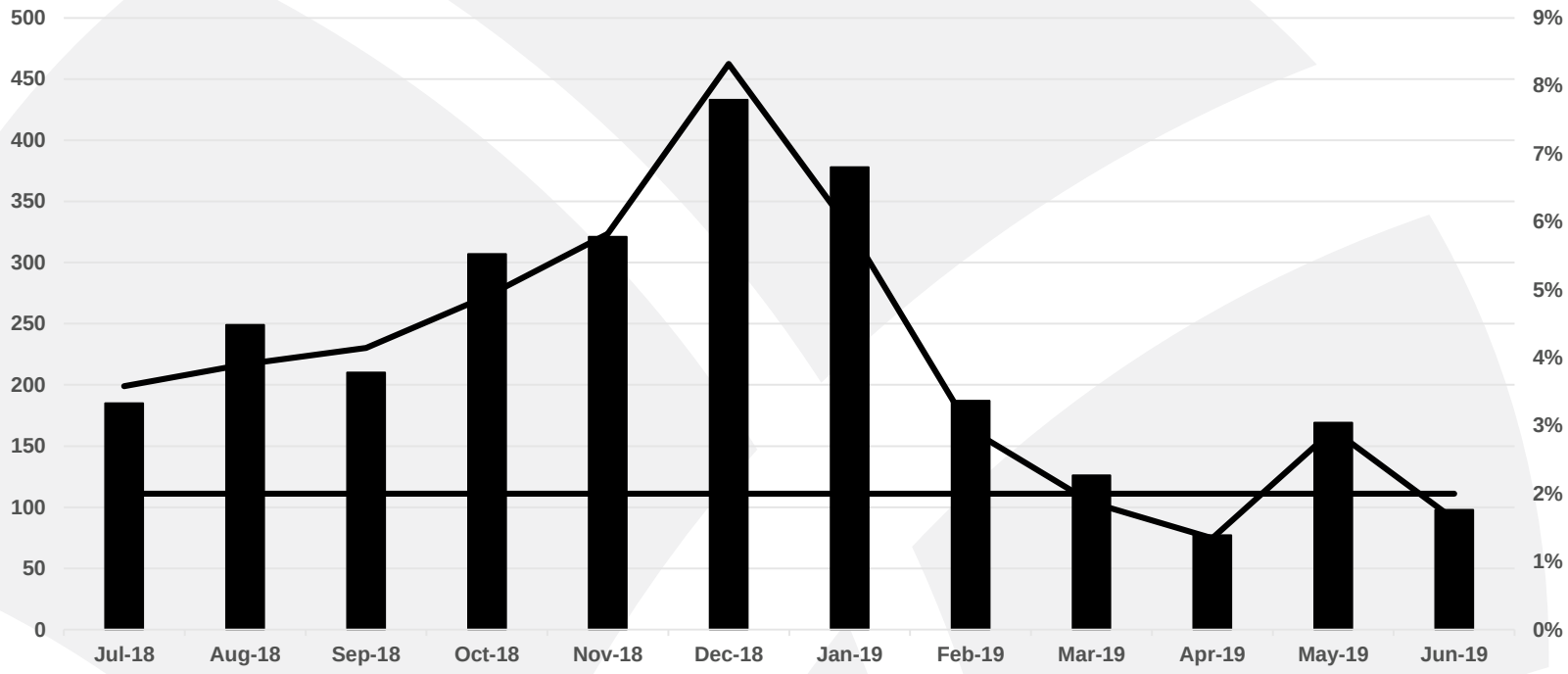
Location	Coding	Documentation Required	Non Covered Benefit - Patient Responsibility	Provider Credentialing	Referral Authorization	Registration	Grand Total
Site A - Clinic							0
Site B - Behavioral Health				3		14	17
Site C - Clinic Medical	37	6	13	5		81	142
Site D- Clinic	34		2	5		7	48
Site F - Mobile Van	5	1	2	1		2	11
Site H - Clinic	12		7	6		76	101
Site I - Pediatric Clinic	1		2			38	41
Site J - Clinic	9			2		4	15
Site L - Clinic Medical	9	4	2	1		72	88
Grand Total	**107**	**11**	**28**	**23**	**0**	**294**	**463**

Denials by Location… why?

- Provider enrollment denials (e.g., failure to revalidate)
- Dental coding denials (Need coding training?)
- Registration denials (Staff not correctly checking patient eligibility?)

Denial Rate – Front End

Trending



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Front End Denials	185	249	210	307	321	433	378	187	126	77	169	98
Front End Denial Rate	4%	4%	4%	5%	6%	8%	6%	3%	2%	1%	3%	2%
Goal	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%

General denial info helpful, “actionable data” desired

Coding Denials

65% of Coding denials due to Diagnosis/Procedure mismatch
NOTE: 92% of these, corrected & rebilled within the same month

Reason	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total
Diagnosis/Procedure conflict	24	12	4	8	17	27	13	13	11	4	12	19	164
CPT/Modifier conflict	5		3	2	3	2	4	2	3	3	13	20	60
Non Emergency service	1	1	1	1						1	2	1	8
CPT/Patient Age conflict		2		1	2								5
NDC # needed				1	2	1							4
Diagnosis/ Patient Age conflict		1	1				1		1		3	1	8
Diagnosis/Patient Gender conflict						1		1					2
Included service							1						1
Provider - 'New Patient' conflict	1												1

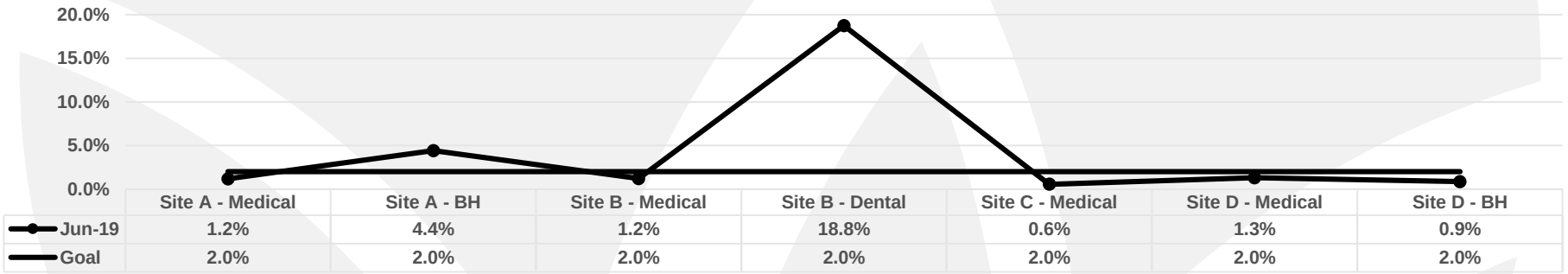
Actionable data idea:

- Subcategory, coding denials summarize coding errors/feedback
- Use data for training and other tool creation

Registration Denials

Location

Processed Period	Site A - Medical	Site A - BH	Site B - Medical	Site B - Dental	Site C - Medical	Site D - Medical	Site D - BH
Jul-18	3.7%	1.8%	0.9%	0.0%	2.5%	2.6%	1.3%
Aug-18	2.8%	2.8%	5.4%	4.8%	4.1%	2.7%	3.2%
Sep-18	3.1%	25.8%	1.9%	0.0%	2.9%	3.7%	6.8%
Oct-18	3.4%	6.5%	3.6%	1.1%	3.6%	5.6%	2.1%
Nov-18	5.3%	7.4%	3.0%	5.4%	5.6%	4.9%	4.1%
Dec-18	8.2%	1.6%	3.5%	1.6%	6.5%	10.8%	6.6%
Jan-19	4.9%	0.5%	2.9%	0.0%	6.1%	7.8%	4.6%
Feb-19	2.9%	1.2%	2.7%	6.8%	1.9%	2.9%	2.1%
Mar-19	1.3%	2.9%	0.8%	3.7%	1.5%	2.3%	1.3%
Apr-19	1.1%	0.5%	0.3%	2.2%	0.8%	1.5%	1.9%
May-19	1.1%	1.7%	2.9%	2.3%	0.7%	1.7%	0.7%
Jun-19	1.2%	4.4%	1.2%	18.8%	0.6%	1.3%	0.9%
Total	3.1%	4.2%	2.5%	2.9%	3.1%	3.8%	2.7%
Goal	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%



Registration Denials

Reasons

40% of Registration denials due to Medicaid MCOs vs. straight Medicaid
NOTE: 57% submitted to correct carrier within the processed month

Reason	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total
Other Insurance Primary	28	41	42	72	79	136	79	39	36	22	29	22	625
Covered under Managed Care Plan	42	92	91	95	93	198	190	50	32	16	33	21	953
Coverage termed	37	54	45	58	42	43	67	49	19	14	23	21	472
Patient not on file	33	25	5	23	48	15	9	17	13	9	16	37	250
Requirements not met	0	0	0	0	0	0	5	2	2	2	0	2	13
Prior to coverage	6	4	4	0	10	3	4	13	10	1	17	2	74
Date of death precedes DOS	0	0	0	0	0	0	1	0	0	0	0	0	1
Name/number mismatch	0	0	0	0	0	0	0	0	0	0	0	0	0
Not eligible on date of service	0	2	0	8	0	3	0	0	0	0	0	0	13

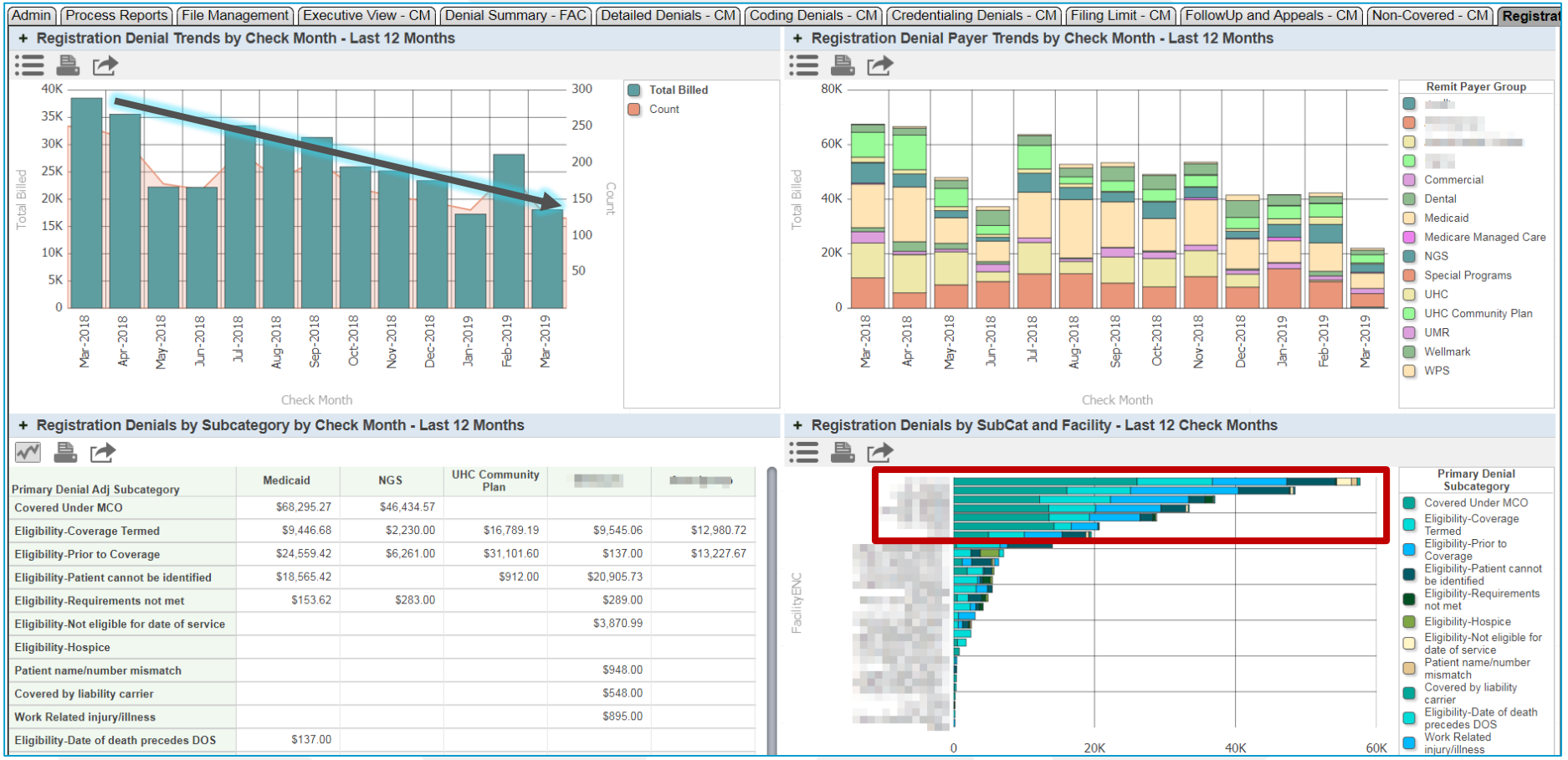
Educate/Improve front desk knowledge with these data

Denial Data

Top 10 Denials by Code (accounts for 92% of all denials)

CARC	Code	Claims	% total	Billed	Paid
COB13	Included Service-Previously Paid	7,266	31.32%	$671,334.30	$0.00
CO16	Appeal/Follow Up Needed	4,744	20.45%	$403,217.11	$0.00
COA1	Appeal/Follow Up Needed	3,046	13.13%	$391,335.65	$0.00
CO119	Benefit Max Reached/Exceeded	2,566	11.06%	$223,683.41	$83.77
CO29	Processing-Filing Limit	1,308	5.64%	$210,082.42	$0.00
CO11	Diagnosis/Procedure Conflict	1,281	5.52%	$141,421.02	$0.00
CO35	Benefit Max Reached/Exceeded	506	2.18%	$22,698.41	$0.00
CO4	CPT/Modifier conflict	319	1.38%	$30,277.70	$0.00
CO125	Submission error	319	1.38%	$47,601.42	$0.00
Grand Total		**21355**	**92%**	**$ 2,141,651.44**	**$ 83.77**

Registration Denial Trending



Primary Denial Adj Subcategory	Medicaid	NGS	UHC Community Plan	[redacted]	[redacted]
Covered Under MCO	$68,295.27	$46,434.57			
Eligibility-Coverage Termed	$9,446.68	$2,230.00	$16,789.19	$9,545.06	$12,980.72
Eligibility-Prior to Coverage	$24,559.42	$6,261.00	$31,101.60	$137.00	$13,227.67
Eligibility-Patient cannot be identified	$18,565.42		$912.00	$20,905.73	
Eligibility-Requirements not met	$153.62	$283.00		$289.00	
Eligibility-Not eligible for date of service				$3,870.99	
Eligibility-Hospice					
Patient name/number mismatch				$948.00	
Covered by liability carrier				$548.00	
Work Related injury/illness				$895.00	
Eligibility-Date of death precedes DOS	$137.00				

Denial Rate

< 6%

- Very Good Performance

6-15%

- Average Performance

< 15%

- Below Average Performance

Net Collection Rate (NCR)

Of the money to be collected… how much actually was?

Assumptions:

- 80% Payment percentage across all payers
- Average monthly charge: $4,000,000
- Anticipated payments: 80% of $4M or $3.2M

Net Collection Rate (NCR) Calculation:

- If $3M collected vs. $3.2M, NCR = 93.75% ($3M ÷ $3.2M)
- If $2.5M collected vs. $3.2M, NCR = 78.13% ($2.5 ÷ $3.2M)

Net Collection Rate

90%+

- Very Good Performance

80-89%

- Average Performance

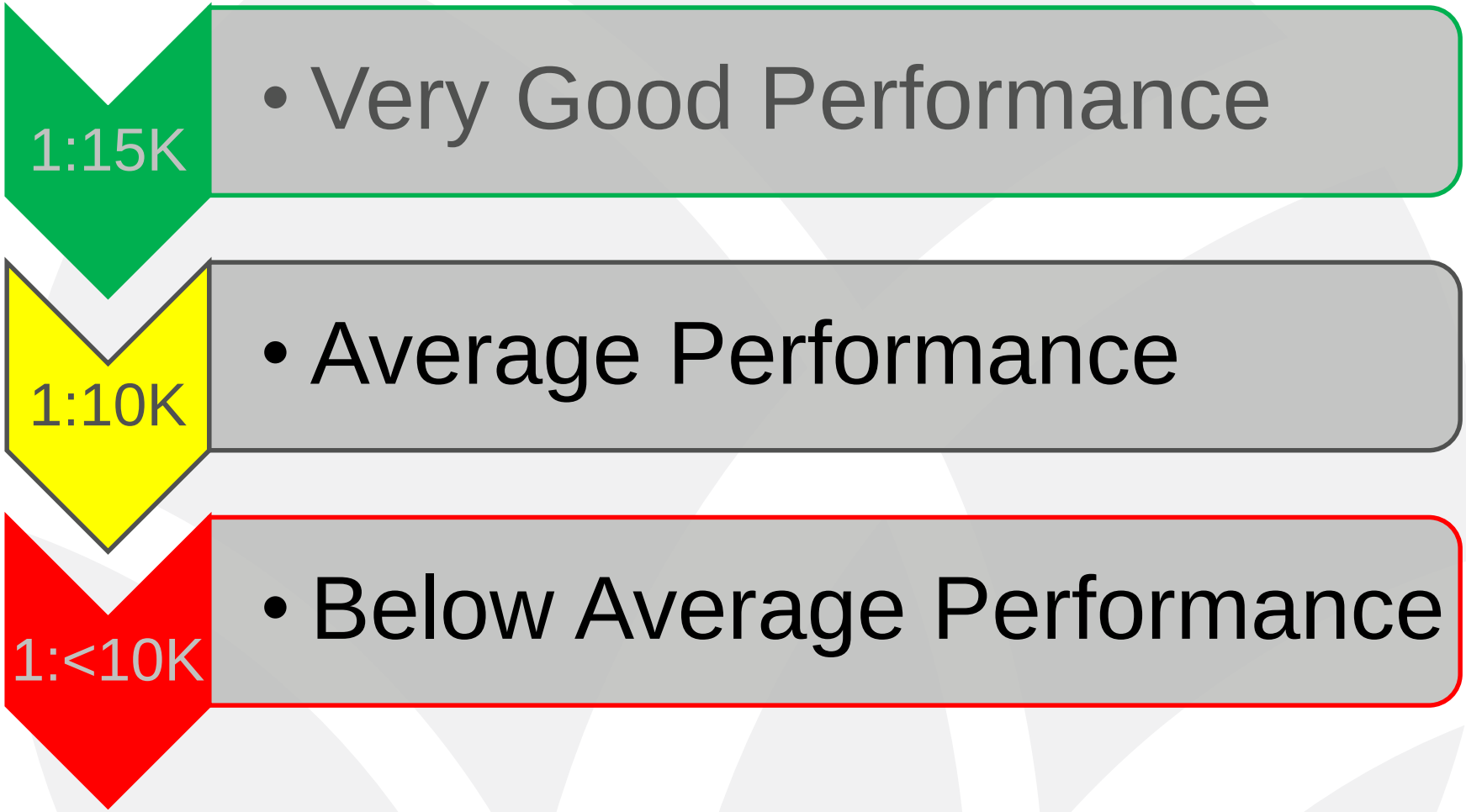
< 80%

- Below Average Performance

Staffing

- Ratio of 1:12,000… 1 FTE to 12,000… 3rd party only
  - E.g., 60,000 visits but 20% Self Pay… 48,000 third party
- Charge Entry & Pay Post = 18%-28% of billing process
- Auto Charge Capture/Pay Post, 20% increase for each
- E.g., Automated charge capture
  - 20% of 12,000 = 2,400
  - New FTE target – 14,400
- PMG FTE targets 20,000+
- Historic PMG staff person… 32,000 visits
  - Across 3 clients
  - 18 DAR

RCM FTEs to Encounters Ratio



Sample Data

Dashboards Available to Your CHC… Right now!

Revenue Health Systems - DMS

Practice: [▾]

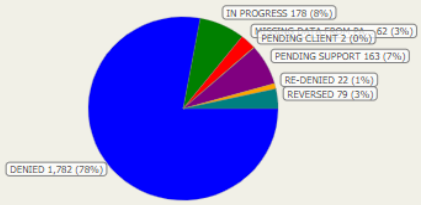
| Worklist Home | Search | Reporting |

Hide Dashboard

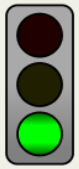
Totals for Pending Claims

# Claims:	2,369
$ Claims:	$558,814.72
Age (Svc Date):	188 Days
Age (Worklist):	6 Days
Age (System):	10 Days

Pending Claim Status Distribution



30-Day Rolling Re-Denial Rate



0.49 %

Pending Worklists

◉ Actionable ○ Non-Actionable ○ Both

Print to PDF | Export to CSV

Team	Worklist	# Claims	$ Claims	Age (Svc Date)	Age (Worklist)	Age (System)	# Re-denied	
PMG Account Management	Filing Limit Denials	126	35928.75	514	11	11	13	Reassign
	On Hold-Known Issues	1	550.00	71	8	42	1	Reassign
	Pending Support Actionable	174	43548.82	146	8	25	1	Reassign
PMGi Denial Resolution	Commercial	484	89276.37	235	7	7	2	Reassign
	Commercial SysOverflow_001	198	37953.59	375	4	4	0	Reassign
	Dental	311	103023.42	125	6	10	0	Reassign
	Medicaid	137	28817.07	242	6	9	4	Reassign
	Medicaid Managed Care	463	116564.58	143	4	11	0	Reassign
	Medicaid Managed Care SysOverflow_001	193	46422.22	98	5	6	0	Reassign
	Medicare	16	6028.41	126	13	15	0	Reassign
	Medicare Managed Care	40	7359.36	78	10	11	0	Reassign
	Returned Items	2	260.00	88	8	31	0	Reassign
	Unassigned	224	43082.13	199	4	10	1	Reassign

- How many claims (and $) are pending additional action?
- Of the open claims, most recent action taken?
- How successful in positively adjudicating claims? (Rolling Re-Denial Rate)

Finance Dashboard - EPIC

Finance Dashboard

Outstanding Insurance Debits - Current Financial Class

Data collected: Wed 8/7 05:52 AM

Current Financial Class	Outstanding (Denied)	Outstanding (Suspended NRP)	Outstanding (Others)	Total Outstanding	Overposted	Total Insurance Balance
Blue Cross	0	0	1,284	1,284	0	1,284
Other	0	0	1,115	1,115	0	1,115
Commercial	51,749	0	334,311	386,059	-502	385,558
Medicare	35,607	0	351,212	386,819	-850	385,969
Medicaid	106,339	0	249,438	355,778	-1,826	353,951
Self-pay	0	0	0	0	-1,005	-1,005
Totals	**193,695**	**0**	**937,360**	**1,131,055**	**-4,183**	**1,126,872**

Claims Outstanding - Original Financial Class

Data collected: Wed 8/7 05:52 AM

Original Financial Class	0 to 30	31 to 60	61 to 90	91 to 120	Over 120	Total
Blue Cross	127	465	444	248	0	1,284
Commercial	145,112	56,363	37,187	32,135	82,757	353,554
Medicare	155,605	79,887	52,764	26,596	54,363	369,215
Medicaid	158,259	30,338	30,838	17,295	47,596	284,326
Self-pay	0	0	55	0	172	227
Totals	**459,103**	**167,053**	**121,289**	**76,274**	**184,888**	**1,008,606**

Claims Outstanding - Current Financial Class

Data collected: Wed 8/7 05:52 AM

Current Financial Class	0 to 30	31 to 60	61 to 90	91 to 120	Over 120	Totals
Blue Cross	127	465	444	248	0	1,284
Commercial	145,322	56,483	36,491	31,912	82,503	352,711
Medicare	153,482	73,891	44,961	21,332	47,943	341,609
Medicaid	160,172	36,213	39,393	22,781	54,443	313,002
Totals	**459,103**	**167,053**	**121,289**	**76,274**	**184,888**	**1,008,606**

- Current claim volume & balance of open A/R by current financial class?
- Origin of current open A/R? Balances moving from insurance to patient?
- How old balances? Original or current financial class is aging?

Finance Dashboard – EPIC

Finance Dashboard

PB Projected Monthly Summary

	Yesterday	MTD	Proj Monthly	Daily Average
Charges	93,388	384,200	1,985,031	67,741
Payments	-15,690	-42,119	-217,612	-22,332
Adjustments	-38,303	-145,731	-752,946	-41,870
Payment Reversals	0	0	0	0
Bad Debt	0	0	0	0
AR Net	**39,395**	**196,350**	**1,014,473**	**3,539**

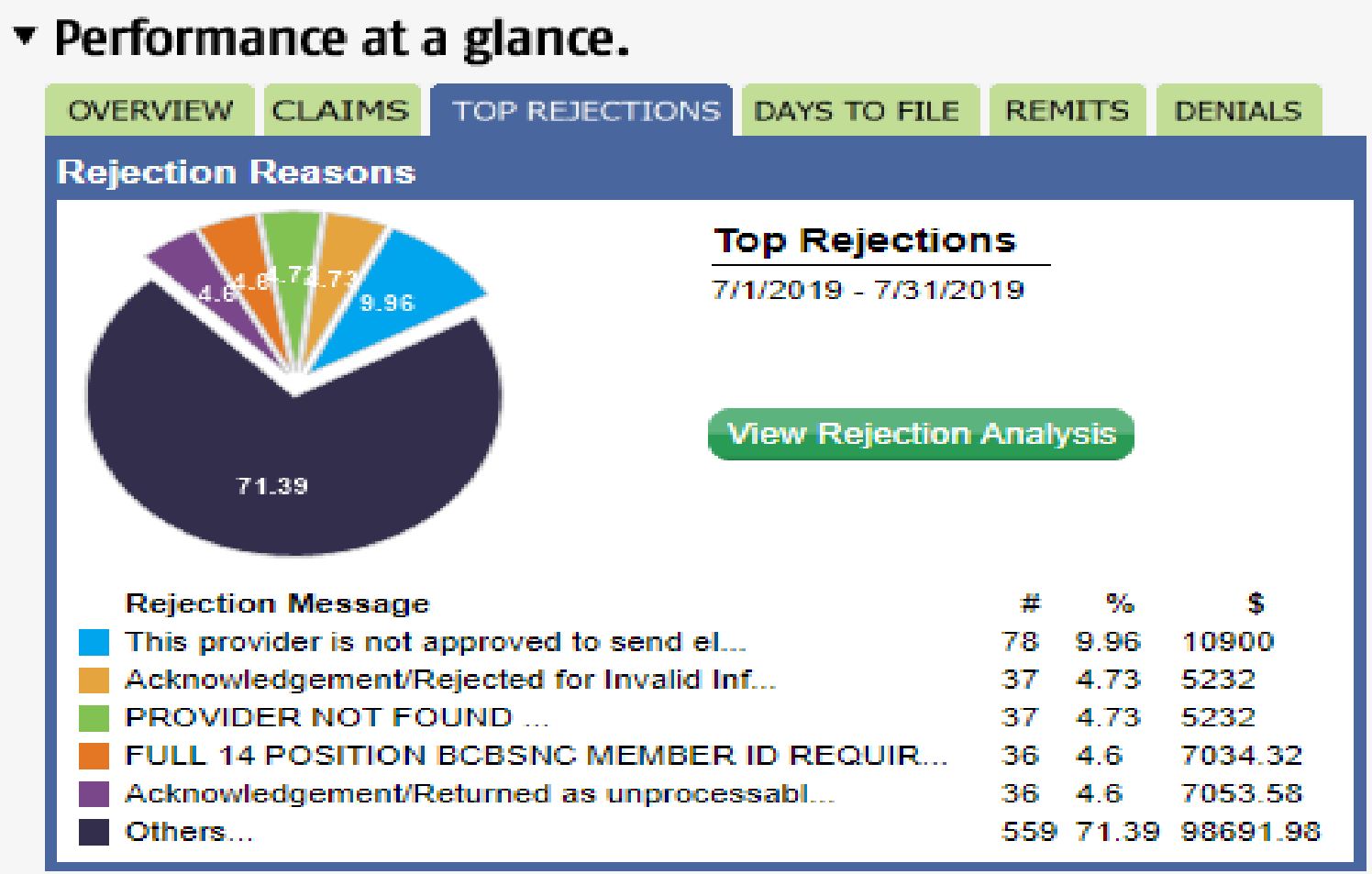
PB Watch List

Data collected: Wed 8/7 05:52 AM

	Avg Age	Amount
Pending Payments & Remittance		
PB Payment Batches	5	64
PB Insurance Remittance (Loaded Not Processed)	1	37,225
PB Insurance Remittance (Processed Not Accepted)	1	0
Pending Adjustments & Refunds		
Adjustments	106	14
Other Activity		
Insurance Balance but No Claim Status		2,609

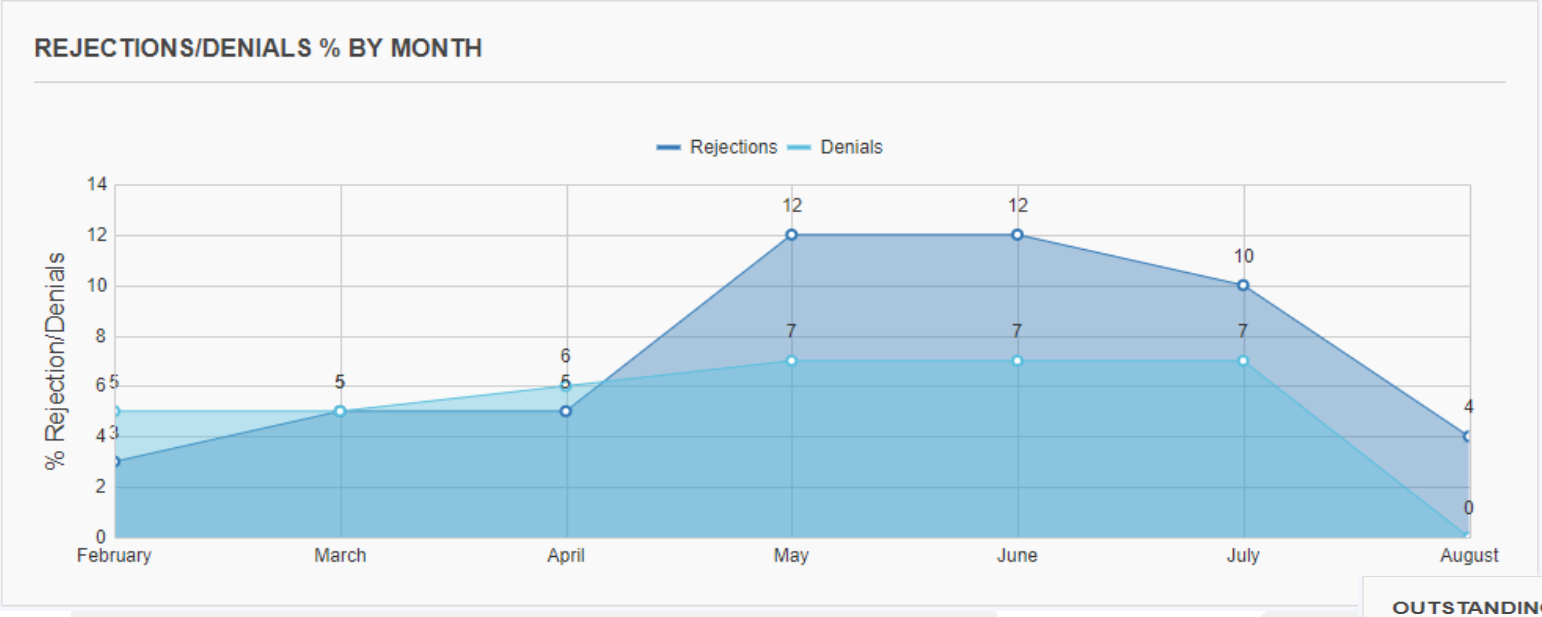
- How do yesterday's transactions compare to daily average?
- How does monthly projected averages compare to expectations?
- How many (& $) of pending transactions (unposted batches)?

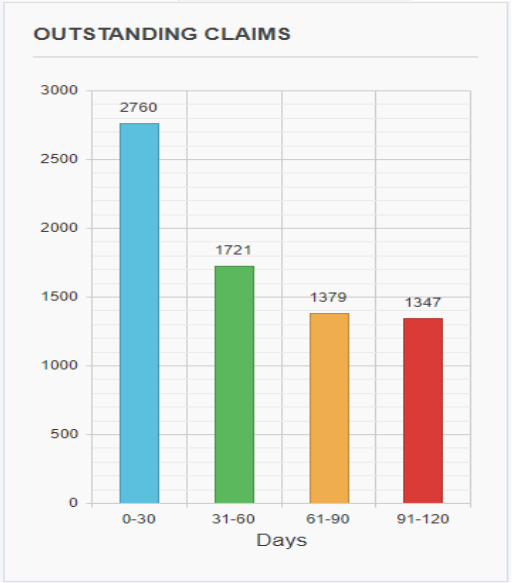
Trizetto - Top Rejections



- What are the most frequent rejection reasons?
  - Preventable? System issue?
- Value of A/R held up by these rejections? Top priority to resolve?

ClaimRemedi – Rejections/Denials





- Trending of rejections & denials… Improving?
- Age of current open claims hitting a clearinghouse edit?

PayerPath – Claim Summary

- What is ‘pass’ vs. our ‘fail’ rate?
- Top edit errors causing claim failures?
- Claims pending transmission? Held why?

Summary

- Capture data daily
- Report monthly
- Measure always
- Set your goals before you start

Questions?