STROUDWATER

TRANSFORM THE RURAL HEALTHCARE REVENUE CYCLE WITH DATA-DRIVEN DASHBOARDS

AGENDA

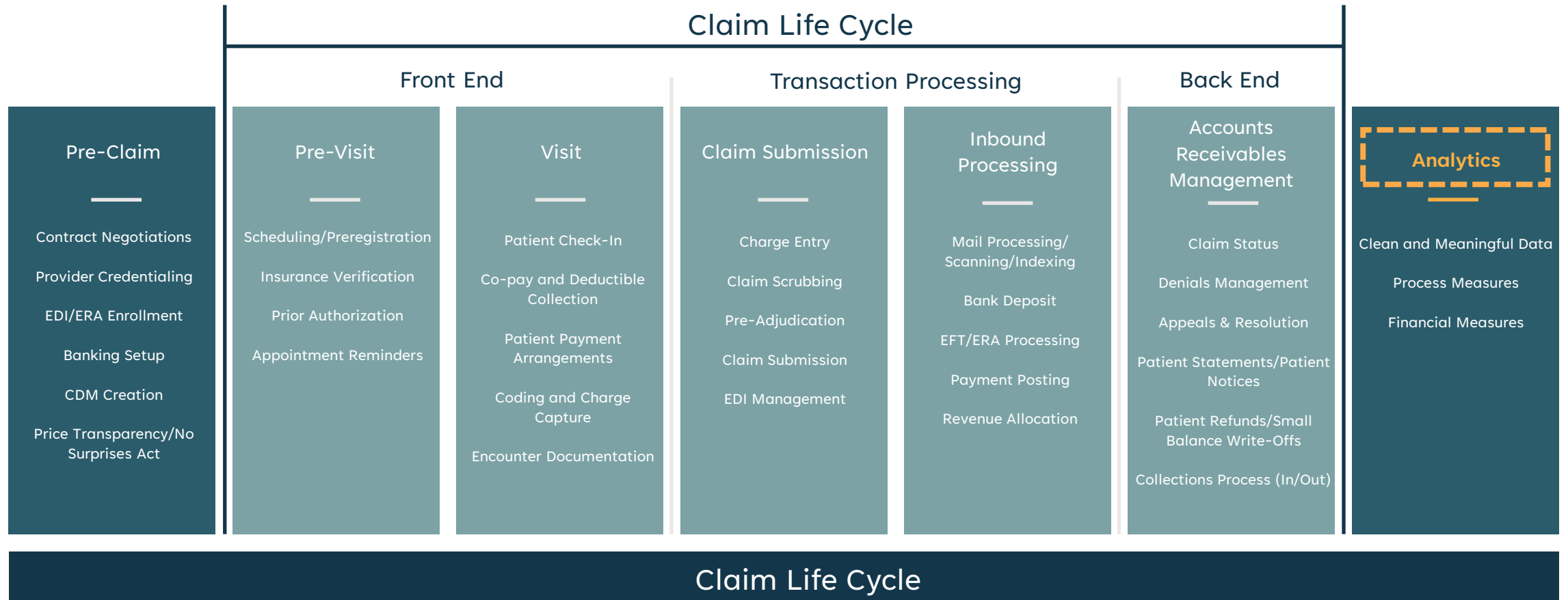The Foundation → How to Use the Data → What to Do with the Data → Call to Action

THE FOUNDATION

Revenue Cycle Management, KPIs, Dashboards

REVENUE CYCLE MANAGEMENT

Claim Life Cycle

	Front End		Transaction Processing		Back End	
Pre-Claim	**Pre-Visit**	**Visit**	**Claim Submission**	**Inbound Processing**	**Accounts Receivables Management**	**Analytics**
Contract Negotiations	Scheduling/Preregistration	Patient Check-In	Charge Entry	Mail Processing/ Scanning/Indexing	Claim Status	Clean and Meaningful Data
Provider Credentialing	Insurance Verification	Co-pay and Deductible Collection	Claim Scrubbing	Bank Deposit	Denials Management	Process Measures
EDI/ERA Enrollment	Prior Authorization	Patient Payment Arrangements	Pre-Adjudication	EFT/ERA Processing	Appeals & Resolution	Financial Measures
Banking Setup	Appointment Reminders	Coding and Charge Capture	Claim Submission	Payment Posting	Patient Statements/Patient Notices	
CDM Creation		Encounter Documentation	EDI Management	Revenue Allocation	Patient Refunds/Small Balance Write-Offs	
Price Transparency/No Surprises Act					Collections Process (In/Out)	

Claim Life Cycle

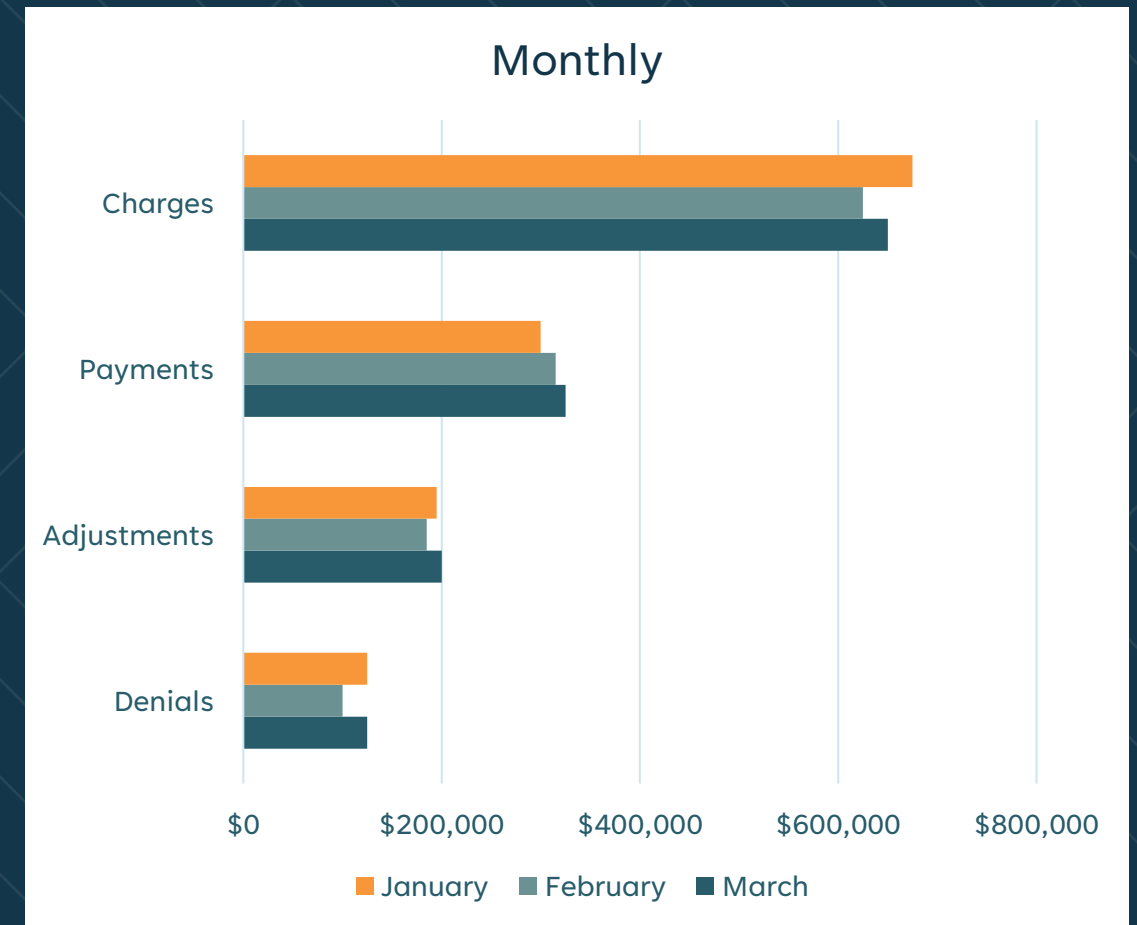| Month-End Closing	Cost Reporting	Compliance	Performance Management	IT & Quality

WHAT IS A KPI?

- Key Performance Indicator (KPI) is a measure of a specific item or objective over time
- Measures financial health, stability, and trajectory, and gives value for further decision-making
- Metric tied to at least one business goal
- Actionable, directional, accurate, and measurable

Monthly

Legend: January, February, March

Categories: Charges, Payments, Adjustments, Denials

X-axis: $0, $200,000, $400,000, $600,000, $800,000

WHAT IS THE PURPOSE OF KPIS?

» Trend internal processes to show improvement or opportunity

» Create targets for teams to strive for and milestones to gauge progress

» Help leaders across the organization make better decisions backed by data

» Recognize process breakdowns or opportunities for improvement

REPORTS TO MONITOR RCM KEY INDICATORS

Claim Life Cycle

Process Measures

› How is the ***AR Process*** performing?

Financial Measures

› How is the ***AR*** performing *financially*?

General Ledger/P&L

THE POWER OF KPI DASHBOARDS

Root Cause Analysis/Trend Identification

payor Relations and Communication

First Line of Defense/Protect the AR

KPI DASHBOARD

» Data populated monthly

» Red/yellow/green indicators of progress towards goal

» KPIs and goals established and published for the entire team to view

» Agreement on key areas to prioritize

Sample Hospital Name

	Goal	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Number of days in period		31	28	31	30	31
Cash Goal	100% of 3 mo pr net rev	$ 1,521,459	$ 1,642,907	$ 1,538,282	$ 1,391,683	$ 1,465,778
Cash Collections		$ 1,680,392	$ 1,489,575	$ 1,750,692	$ 883,753	$ 1,213,412
% of Cash Goal	100%	● 110%	● 91%	● 114%	● 64%	● 83%
Self- Pay Collections		$ 41,056	$ 30,111	$ 36,793	$ 38,555	$ 41,232
Total POS Cash Collections		$ 2,742	$ 8,920	$ 6,581	$ 7,256	$ 8,024
% of Total Self- Pay Collections	>15%	● 7%	● 30%	● 18%	● 19%	● 19%
Gross Patient Revenue		$ 14,227,967	$ 14,392,383	$ 15,564,350	$ 10,363,172	$ 12,582,223
Average Daily Revenue		$ 458,967	$ 514,014	$ 502,076	$ 345,439	$ 405,878
Total A/R (including inhouse and credit balances)		$ 26,355,787	$ 24,585,783	$ 20,033,445	$ 27,324,085	$ 24,631,255
Days in A/R - Gross	< 40	● 57.42	● 47.83	● 39.90	● 79.10	● 60.69
Insurance A/R $ > 90 Days		$ 5,109,800	$ 6,068,690	$ 2,826,451	$ 3,092,112	$ 3,109,442
% of Total A/R	< 15-20 %	● 19%	● 25%	● 14%	● 11%	● 13%
All A/R $ >90 days (includes Self-Pay)		$ 8,689,922	$ 8,710,464	$ 9,386,715		
% of Total A/R	< 20-25 %	● 33%	● 35%	● 47%	● 0%	● 0%
DNFB	< 5 Days	● 8.42	● 6.32	● 4.97	● 9.00	● 5.08
DNFC	< 3 Days	● 7.58	● 4.45	● 2.75	● 3.00	● 2.87
Gross Denials $ written off		$ 232,596	$ 97,506	$ 79,842	$ 65,525	$ 70,232
% of gross patient revenue	< 2%	● 2%	● 1%	● 1%	● 1%	● 1%
Bad Debt transfers		$ 789,093	$ 528,767	$ 759,585	$ 689,443	$ 712,357
% of bad debt gross patient revenue	< 8%	● 6%	● 4%	● 5%	● 7%	● 6%

IMPLEMENT A KPI DASHBOARD

» Track what matters

» Evaluate denial types, service lines, and payors

» Establish areas of concern

» Agree on key areas to prioritize

Clean Claims Analysis

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Claims for the period	5,712	5,998	6,297	6,612	5,290	4,232
Clean Claims	4,823	5,102	5,400	5,408	4,200	3,360
Clean Claim %	**84.4%**	**85.1%**	**85.7%**	**81.8%**	**79.4%**	**79.4%**
Denials	502	530	550	590	593	420
Denial %	**8.8%**	**8.8%**	**8.7%**	**8.9%**	**11.2%**	**9.9%**

Denial Write off Analysis

Denial Code	Category	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	6 month Trend Low	6 month Trend High
CD	Coding	1.79%	1.80%	1.68%	1.69%	1.58%	1.59%	1.58%	1.80%
DC	Duplicate Claim	0.25%	0.25%	0.25%	0.25%	0.24%	0.24%	0.24%	0.25%
MN	Medical Necessity	1.06%	1.07%	1.00%	1.00%	0.94%	0.94%	0.94%	1.07%
NC	Non-covered	2.49%	2.50%	2.34%	2.35%	2.36%	2.38%	2.34%	2.50%
OT	Other	0.30%	0.30%	0.30%	0.30%	0.31%	0.31%	0.30%	0.31%
PA	Prior Authorization	2.60%	2.61%	2.63%	2.46%	2.47%	2.31%	2.31%	2.63%
Total		**8.49%**	**8.53%**	**8.20%**	**8.06%**	**7.89%**	**7.76%**	**7.71%**	**8.55%**

HOW TO USE THE DATA

RCM Champion Team

TRADITIONAL PROCESSES LEAVE RCM ON AN ISLAND

Clinical

IT/System Config

Contracting

Registration

Coding

Billing

CDM

Financial/Marketing Decisions

All provide input to claim generation

Errors/Denials

RCM, "Billing"
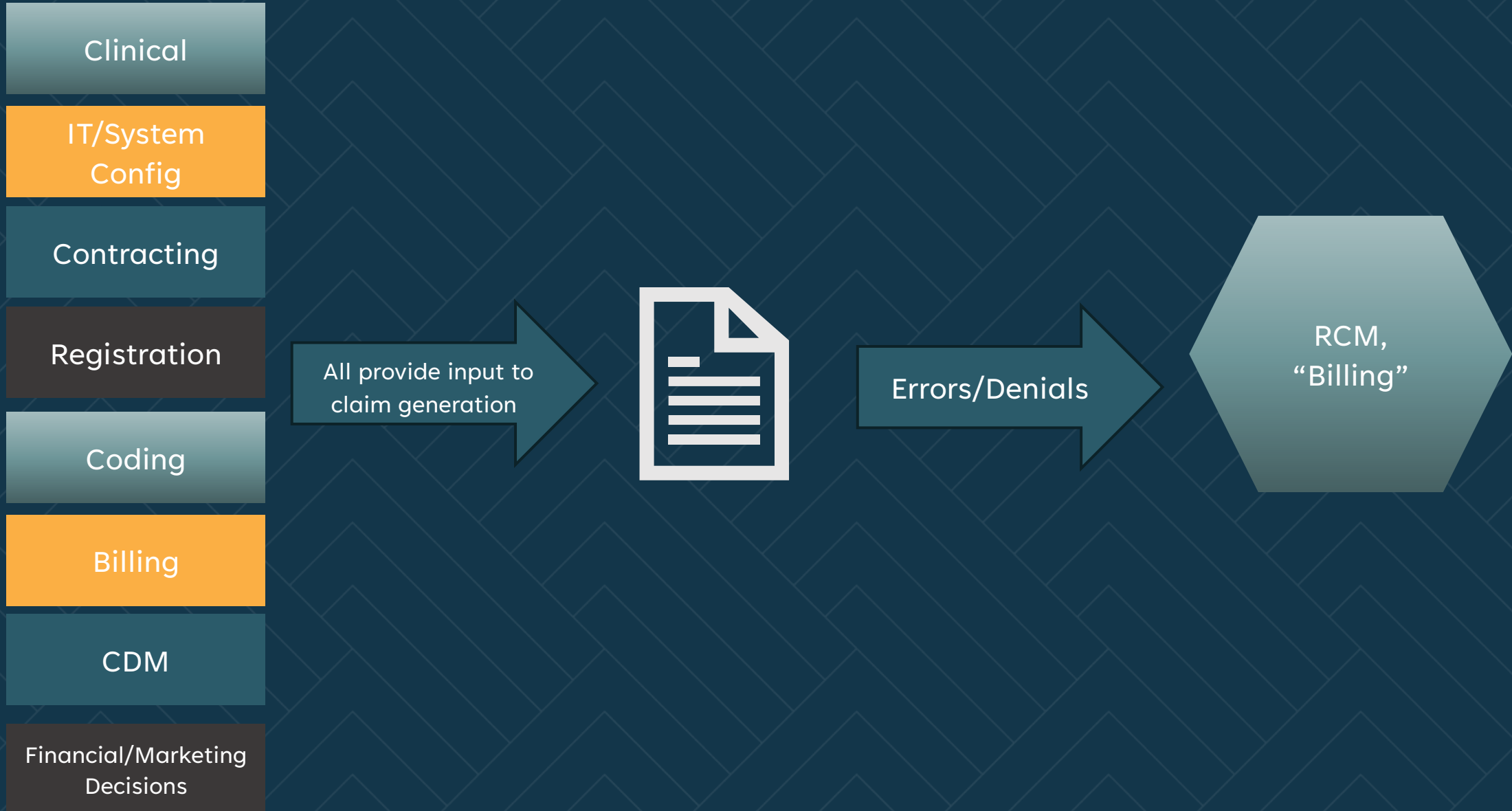
DEVELOP A MULTI-DISCIPLINARY APPROACH TO MONITORING KPIS

"RCM CHAMPION TEAM"

Involve Clinical

Medical Necessity, non-covered and payor policy

Involve Patient Access

Registration, eligibility, patient collections

Involve IT

System changes, updates, workflow decisions

Involve Finance

Impact of bad debt, write-offs, AR changes
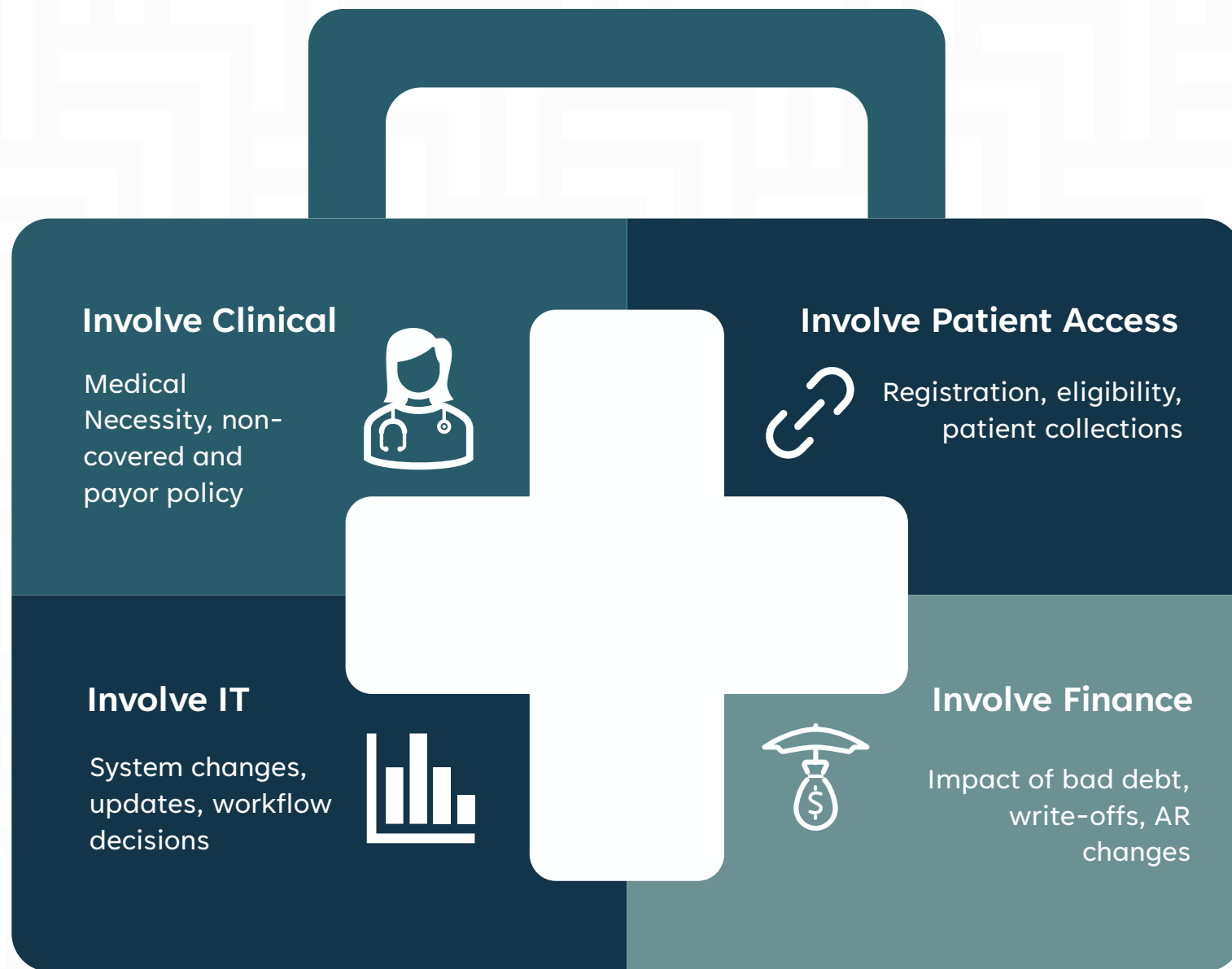
LEADERSHIP ENGAGEMENT

- *Strategic Alignment:* Ensures that revenue cycle decisions support the hospital's mission, boosting financial stability while maintaining a focus on patient care.

- *Resource Allocation:* Leaders effectively distribute resources to support revenue cycle management (RCM) systems, thereby enhancing billing, coding, and collection processes.

- *Staff Empowerment:* Involved leaders cultivate a culture of accountability, encouraging staff to improve through training and investment opportunities.

- *Data-Driven Decisions:* Leadership utilizes analytics to identify revenue loss, enabling timely adjustments in billing and contract negotiations.

- *Interdepartmental Collaboration*: Engaged leadership connects clinical and administrative teams, optimizing workflows from patient intake to payment.

- *Vendor Management:* Leadership oversees vendor contracts for RCM services to ensure cost-effectiveness and alignment with hospital objectives.

CROSS-FUNCTIONAL RCM INVOLVES ALL STAKEHOLDERS IN DATA AND DECISIONS

Clinical

IT/System Config

Contracting

Registration

Coding

Billing

CDM

Financial/Marketing Decisions

Provide KPIs, reporting, trends, and challenges seen

All provide input to in claim generation

Errors/Denials

RCM along with Cross-Functional Decision-makers (RCM Champions)

Provide support and guidance for adjusting policy or behaviors to improve performance

WHAT TO DO WITH THE DATA

Identify Problems and Address Root Causes

INVESTIGATE TRENDS AND ANOMALIES

Ask questions

Who, What, When, Where, Why, How
> *Ask Why THREE times*

Look at the information differently

Aging buckets that are increasing or decreasing
> *Is there a specific payor that stands out?*
> *Is this an annual trend for the payor?*

Don't just focus on financial areas

Sometimes you need to look at the ***entire*** process to identify the root cause
> *Have there been operational changes?*

The first answer isn't the only answer

Multiple factors are at play, which means there can be multiple answers

WHAT DO THE KPI METRICS SHOW?

Registration Rate
Frequent demographic/insurance denials
High registration edits before billing
High patient complaints about billing

Insurance Verification Rate
High denials for no eligibility on file
Staff bypassing verification steps
High write-offs for ineligible or non-covered

Point of Service Collections
No process or tracking mechanism for POS
High volume of accounts in collections
Staff discomfort in discussing payment options

Authorization Rate
High claim denials for auth not obtained
Frequent rescheduling or cancellations for no PA
Delays in care because staff missed PA

Discharged Not Final Billed
Billing delays over 5-7 days
Backlogs in coding or documentation review
Recurring delays tied to a department or physician

Charge Capture Accuracy
Large variances between expected /billed revenue
Frequent under-coding or missed ancillary services
High rate of late charges entered

WHAT DO THE KPI METRICS SHOW? (CONT.)

Coding Accuracy
- High external audit error rates or payment reviews
- Frequent rebills and corrected claims
- Over- and underuse of particular codes

CDI Response Rate
- Unanswered or delayed responses
- Repeated issues with particular providers
- Missed opportunities and timely denials

Days in AR
- Metrics above 60-65 (45-50 industry average)
- Swelling aging buckets beyond 90 and 120 days
- Backlogs in appeals and denial management

Claim Denial Rate
- Metrics above 10%
- Recurring denials for the same issues
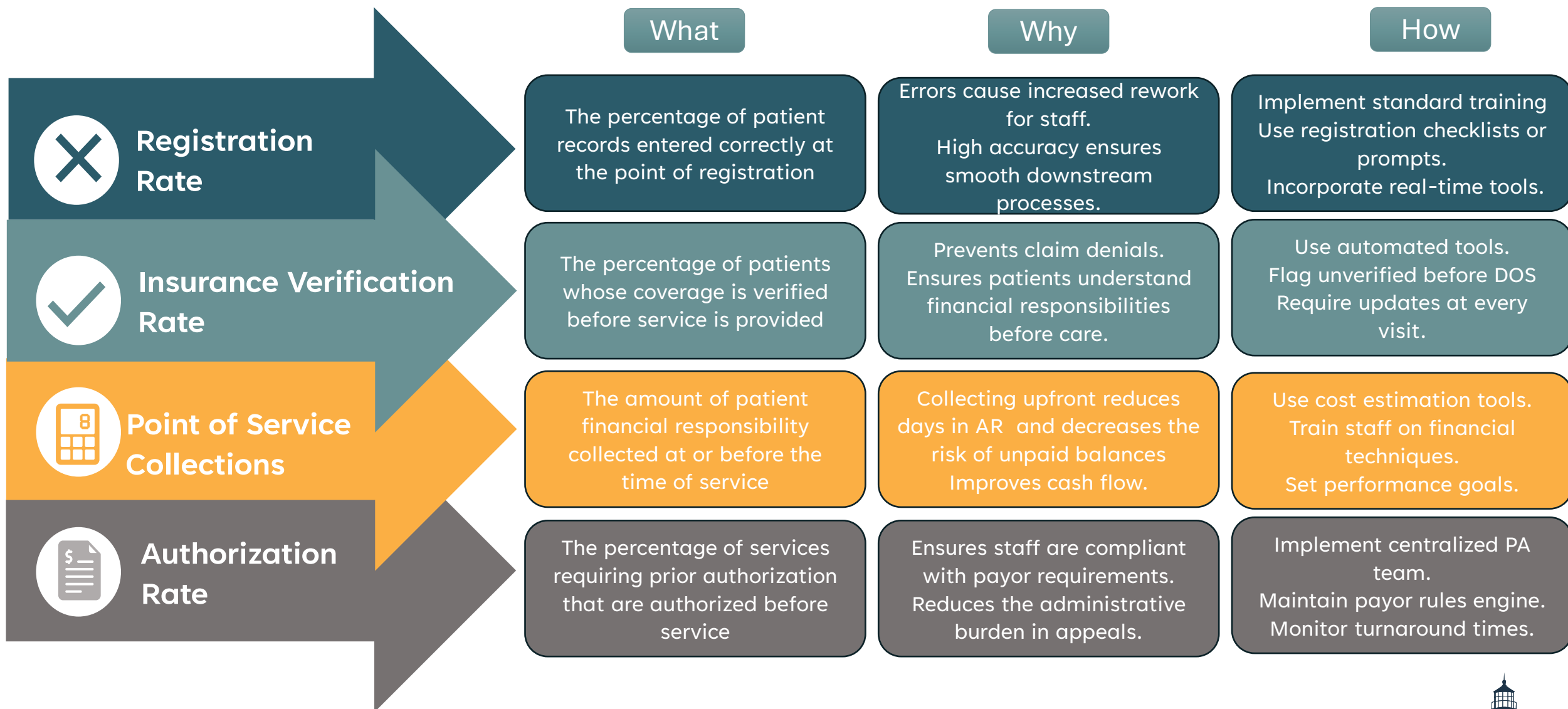- High volume of appeals and write-offs

Cash Collection Rate
- Net collections rate below 95-97%
- Large # of under/no payments without follow-up
- High variance between expected and actual collections

Bad Debt Rate
- Rising bad debt trend despite stable volume
- High write-offs on self-pay accounts
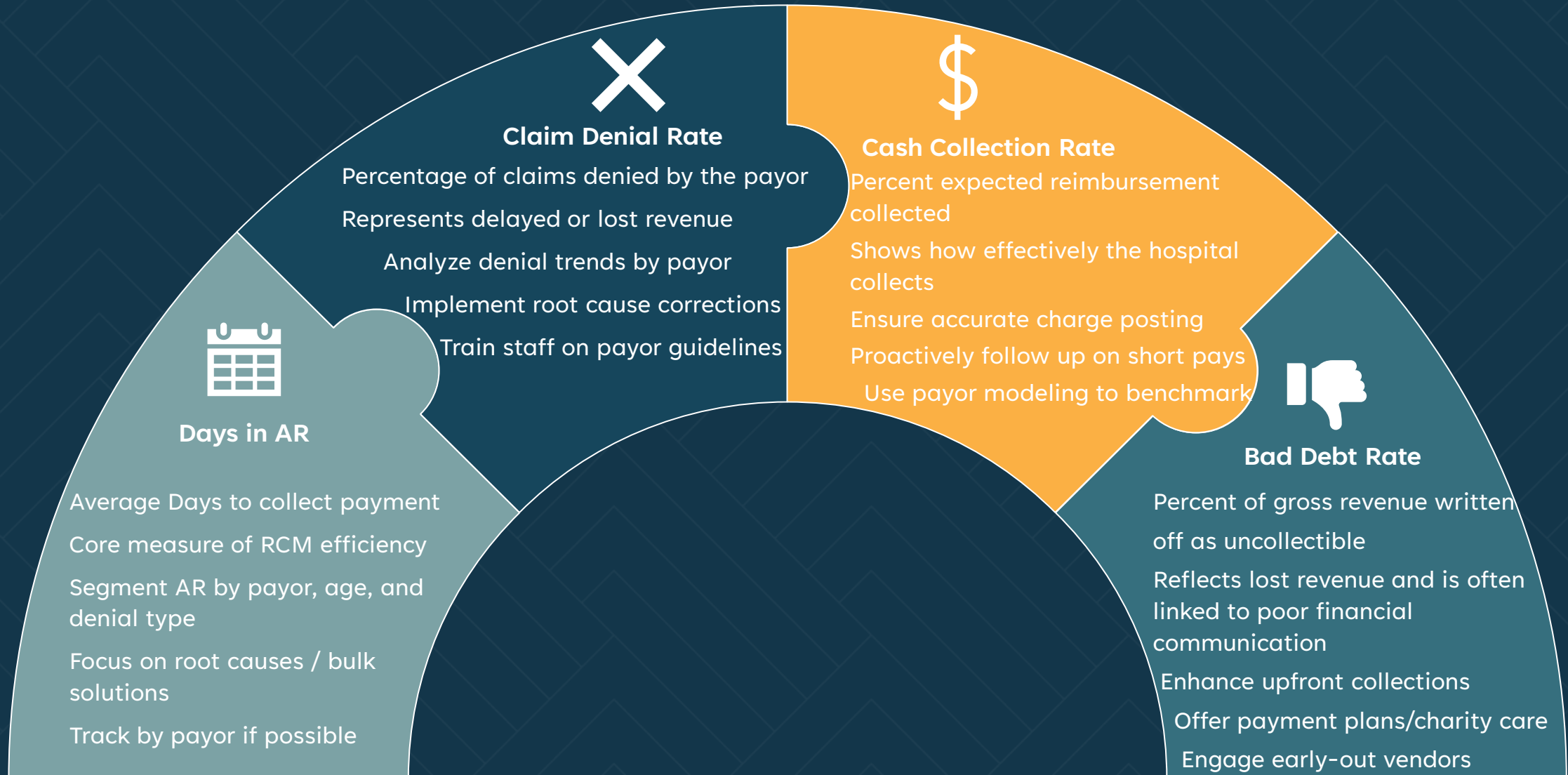- Minimal POS collections

FRONT END REVENUE CYCLE METRICS

	What	Why	How
Registration Rate	The percentage of patient records entered correctly at the point of registration	Errors cause increased rework for staff. High accuracy ensures smooth downstream processes.	Implement standard training Use registration checklists or prompts. Incorporate real-time tools.
Insurance Verification Rate	The percentage of patients whose coverage is verified before service is provided	Prevents claim denials. Ensures patients understand financial responsibilities before care.	Use automated tools. Flag unverified before DOS Require updates at every visit.
Point of Service Collections	The amount of patient financial responsibility collected at or before the time of service	Collecting upfront reduces days in AR and decreases the risk of unpaid balances Improves cash flow.	Use cost estimation tools. Train staff on financial techniques. Set performance goals.
Authorization Rate	The percentage of services requiring prior authorization that are authorized before service	Ensures staff are compliant with payor requirements. Reduces the administrative burden in appeals.	Implement centralized PA team. Maintain payor rules engine. Monitor turnaround times.

MIDDLE RCM METRICS

	DNFB	Charge Capture Accuracy	Coding Accuracy	CDI Response Rate
What	Total amount of patient accounts that are discharged but not billed	Completeness and correctness of clinical charges for services rendered	Percent of coded records that pass the audit without needing correction	Percent of CDI queries that are responded to by providers within a target timeframe
Why	High DNFB delays revenue	Inaccuracy leads to lost revenue and compliance risks	Accurate coding ensures proper reimbursement and supports compliance and quality reporting	Improves coding accuracy and reduces denials and unbilled charges
How	• Implement real-time CDI programs • Monitor chart completion • Enforce timely documentation • Set internal targets	• Automate charge capture • Conduct regular audits • Provide education to staff • Use daily reconciliations	• Offer continuing education • Perform regular audits • Promote CDI collaboration	• Educate providers on CDI impact • Integrate CDI tools into EMR • Set expectations with providers • Provide feedback for physician engagement

BACK-END RCM METRICS

Claim Denial Rate

Percentage of claims denied by the payor

Represents delayed or lost revenue

Analyze denial trends by payor

Implement root cause corrections

Train staff on payor guidelines

Cash Collection Rate

Percent expected reimbursement collected

Shows how effectively the hospital collects

Ensure accurate charge posting

Proactively follow up on short pays

Use payor modeling to benchmark

Days in AR

Average Days to collect payment

Core measure of RCM efficiency

Segment AR by payor, age, and denial type

Focus on root causes / bulk solutions

Track by payor if possible

Bad Debt Rate

Percent of gross revenue written off as uncollectible

Reflects lost revenue and is often linked to poor financial communication

Enhance upfront collections

Offer payment plans/charity care

Engage early-out vendors

VENDOR INVOLVEMENT WITH KPI SUCCESS

Implement regular vendor performance reviews

Confirm vendor is meeting expected service levels

Establish timelines for deliverables

Utilize analytics to review leakage points

Focus on actionable data

Understand gaps in performance and corrective action plans

Enhance vendor oversight and accountability

Review vendor work, clarify expectations, and set up appropriate cadence of communication

Establish points of contact and anticipated staff involvement

What types of items require immediate escalation to staff?

What is the expected response time from the vendor and staff on all items?
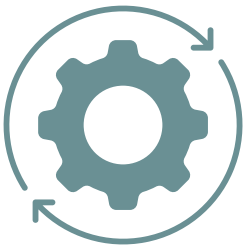
VALUE OF KPI WITHIN PAYOR CONTRACTING

Denial Reporting
- Dollar value to total billed
- Number of claims to claims submitted to the payor

Medical Necessity
- Medical records requests
- Appeals process

Prior Authorization
- Process, lag time, automation

Overall success of payor
- Financial health of the contract

CALL TO ACTION: **IN SUMMARY**

Develop and Monitor KPI Dashboards

Create an RCM Champion Team focused on addressing identified issues (not placing blame)

Drill into the data to strategically address Root Causes

Commit to continually learning and adapting to new, developing issues caused by outside parties

Q&A

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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THANK YOU!

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