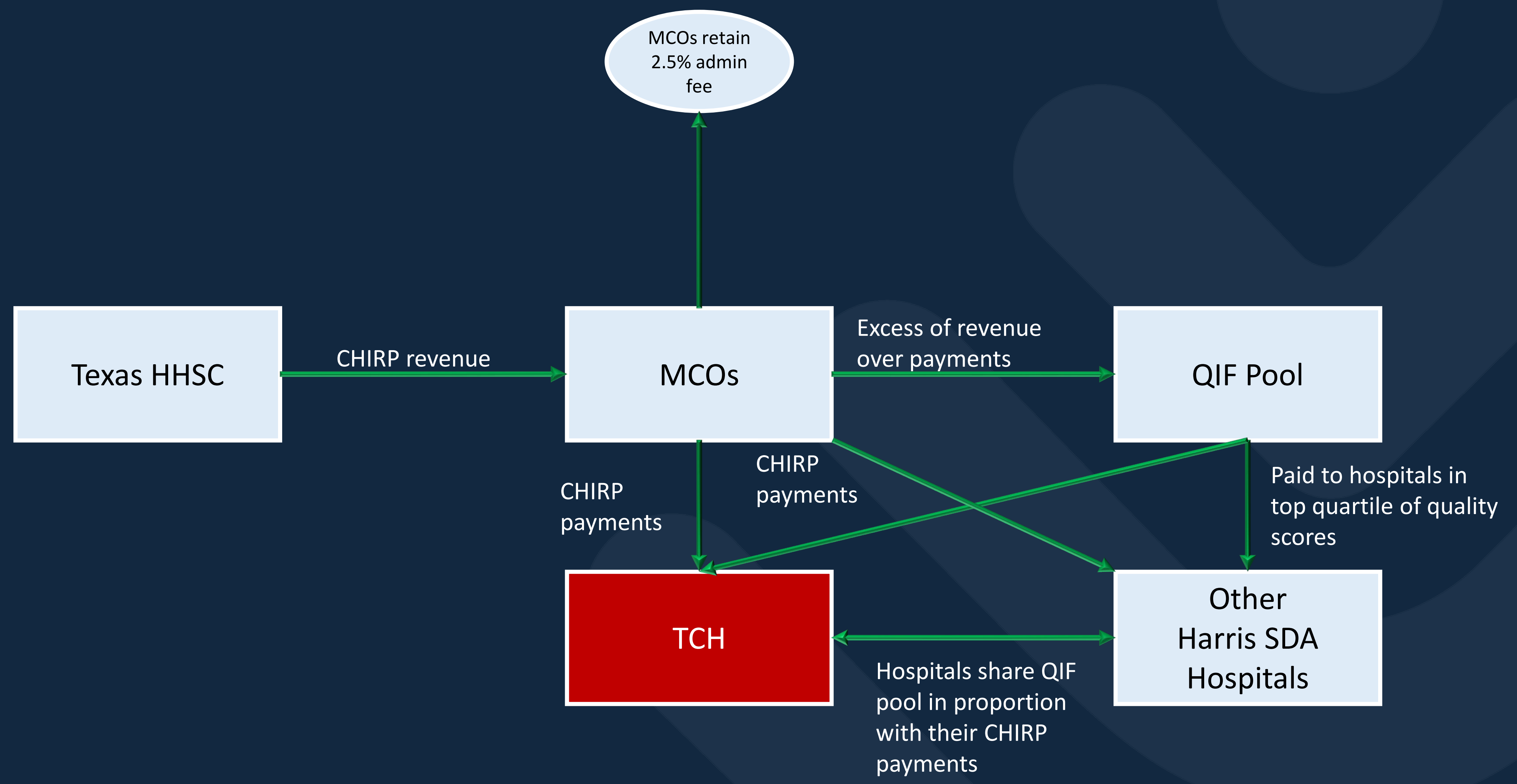
Texas DPP

Flow of Funds

August 1, 2024

Texas Children's®

DPP Funds Flow



Texas Children's

Supplemental Government Funding

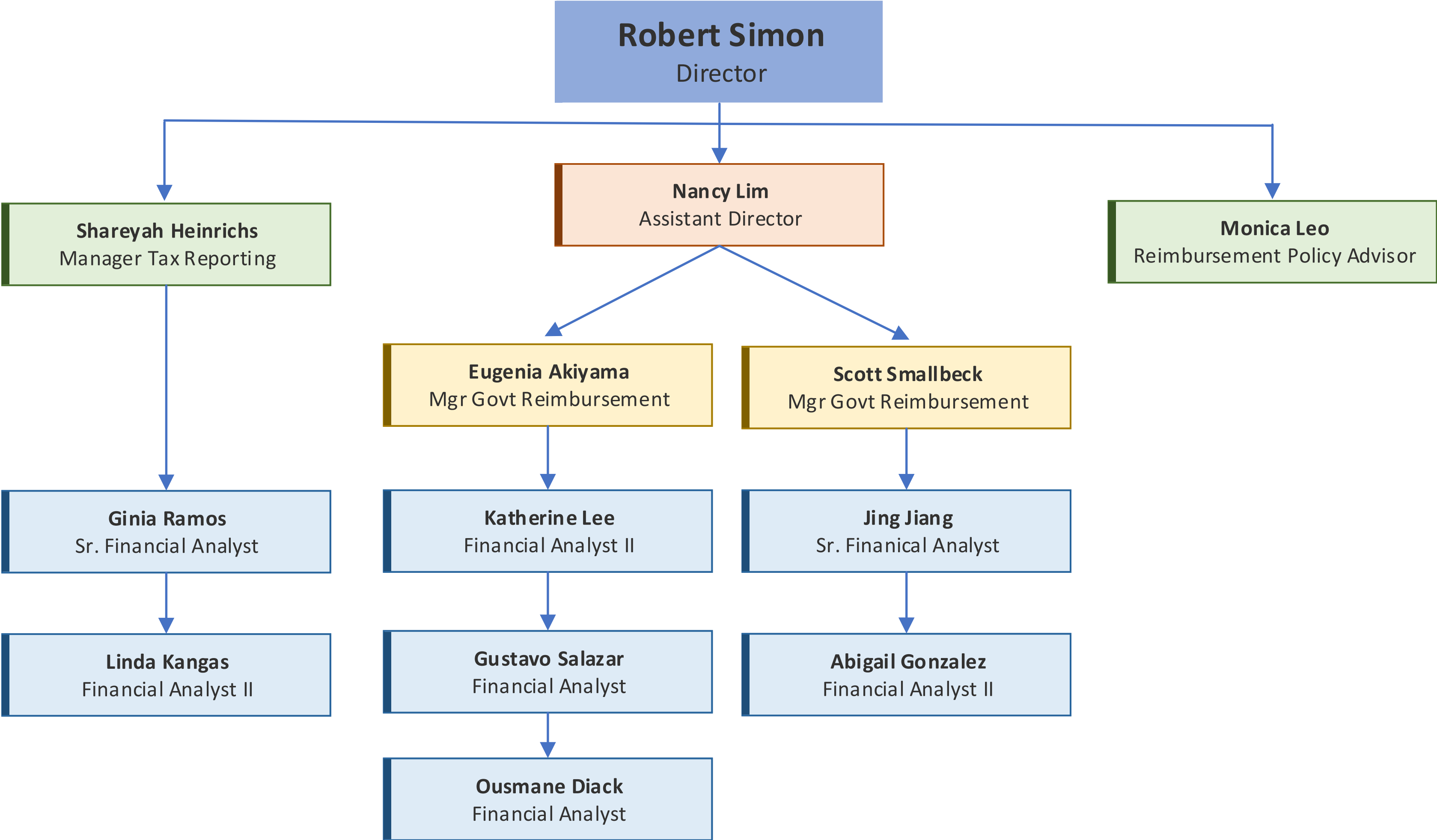
(dollars in thousands)

	FY21 Actual	FY22 Actual	FY23 Actual	FY24 Forecast	FY25 Forecast	FY26 Forecast
DSRIP	$ 28,968	$ 7,288	$ -	$ -	$ -	$ -
UC	40,516	51,522	65,627	60,000	35,159	35,283
UC (FY22)	-	-	782	-	-	-
UC (FY19)	-	(36,275)	(318)	-	-	-
UC (FY18)	(29,900)	4,057	-	-	-	-
Medicaid GME	-	-	30,293	63,161	88,862	30,000
HARP	-	-	93,750	50,976	128,813	60,000
Other govt funding	3,540	3,627	43	-	-	-
Medicaid and other supplemental revenue	**$ 43,124**	**$ 30,219**	**$ 190,177**	**$ 174,137**	**$ 252,834**	**$ 125,283**
UHRIP/CHIRP (in NPR)	$ 46,750	$ 268,870	$ 408,406	$ 441,848	$ 550,170	$ 568,675
QIF (in other operating revenue)	35,696	67,807	263,048	81,234	-	-
Directed Payment Program revenue	**$ 82,446**	**$ 336,677**	**$ 671,454**	**$ 523,082**	**$ 550,170**	**$ 568,675**
Total supplemental revenue	**$ 125,570**	**$ 366,896**	**$ 861,631**	**$ 697,219**	**$ 803,004**	**$ 693,958**
Expense associated with supplemental revenue	**$ (97,934)**	**$ (174,058)**	**$ (413,507)**	**$ (248,590)**	**$ (353,013)**	**$ (311,843)**
Total margin	**$ 27,636**	**$ 192,837**	**$ 448,124**	**$ 448,629**	**$ 449,991**	**$ 382,115**

Texas Children's Hospital

Government Reimbursement & Reporting

Organizational Chart



July 2024

CHA CFO Breakout

Session 1: Payor Challenges

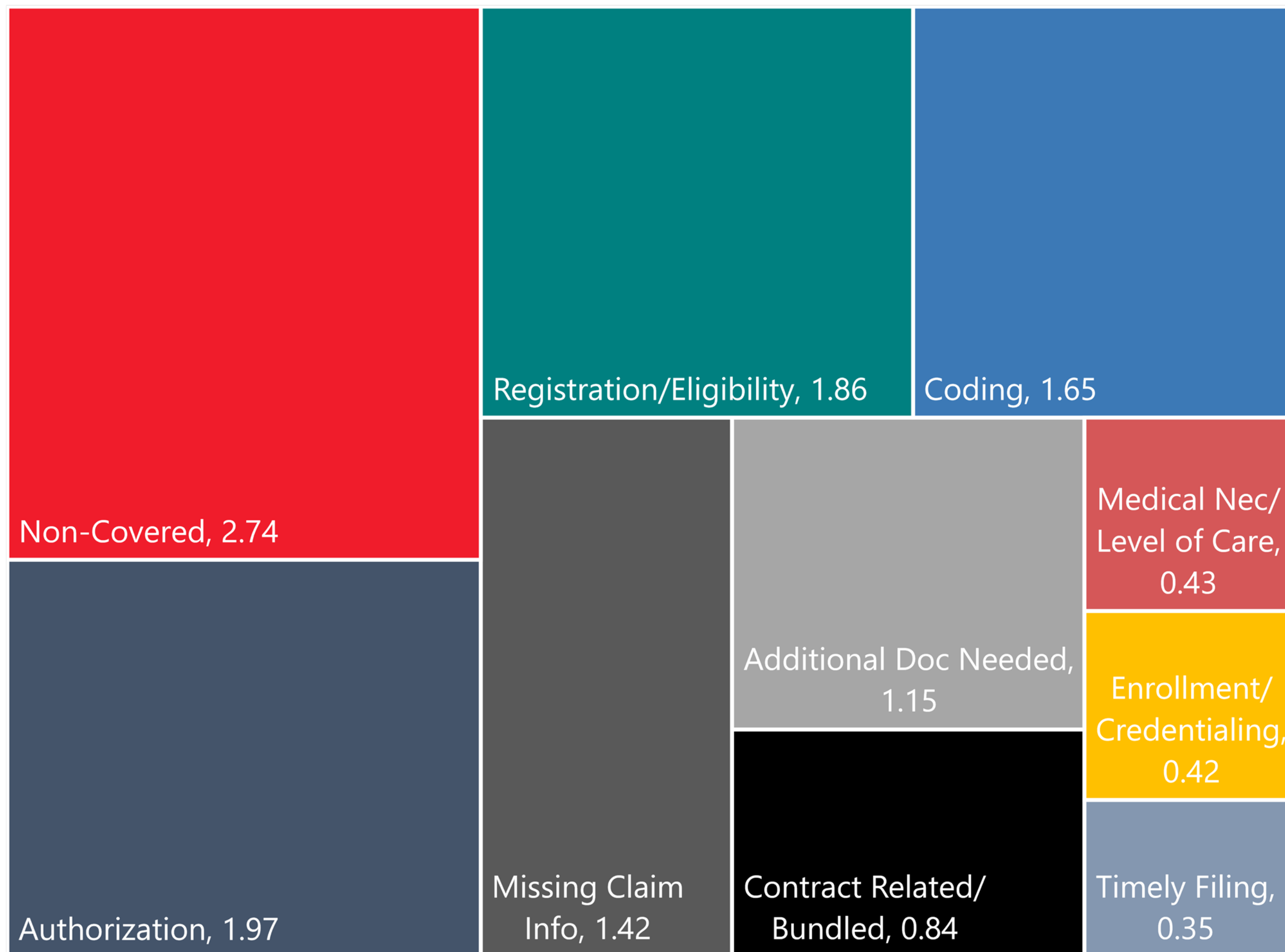
Agenda

Overall Denial Trends

Audits

Levels of Care

Overall Denial Trends



Source Data: Epic Denial Pulse – Hospital Billing as of 7/13/24
(Classification = Children's; Size = Small, Medium, Large, and Very Large; Region = Midwest, Northeast, South, and West)

What are the Top 3 denials where a combination of payor behavior, operational gaps, and contracting challenges have created a perfect storm?

Additional Documentation

On the surface a payor requests additional documentation, but ultimately they are going to use the documentation to subsequently deny for one of three: authorization, medical necessity, and/or investigational/experimental

Contract Related/Bundled

A payor is indicating that the specific revenue code/cpt-hcpcs charge line item is not separately reimbursable. Instead the payment for it is already part of a payment for a separate item. This is distinct and different from non-covered.

Non-Covered

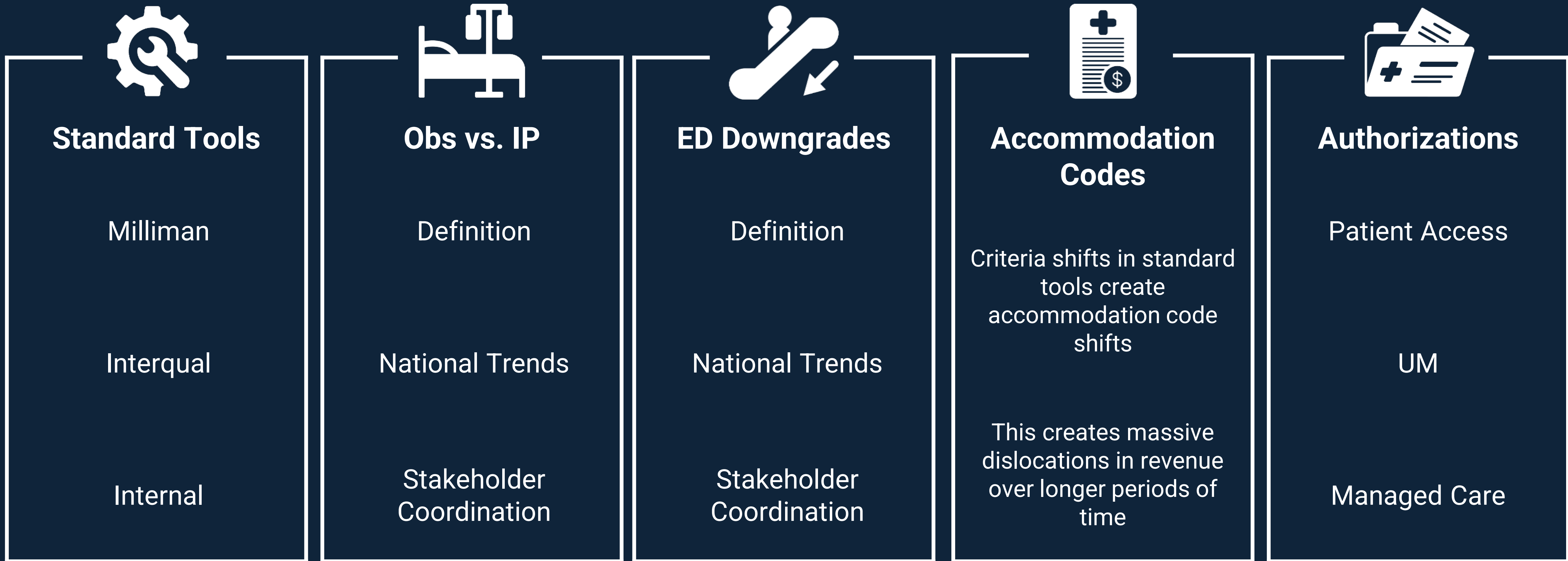
A payor is stating that a legitimate and separately reimbursable charge is not in the list of services that are payable

What are some tools to combat and overturn these denials?

Audits

	Pre-Payment Audits	Post-Payment Audits
Definition	Prior to payment, a denial is sent requesting additional documentation; post receipt of the documentation a payor will engage in a complete audit of the claim and the record to identify clinical and technical details	After a payment – within a certain amount of time – hopefully delineated in a contract – a payor will come back and request documentation to review claims often with a specific set of objectives (i.e. bundling, DRG downgrades, or line item denials)
Entity	Used to be primarily payor driven, now it is often outsourced to a 3rd party vendor	Often a 3rd party vendor
Impact	1. Delayed adjudication 2. Delayed payment 3. Higher AR days 4. Lower payments	1. Retrospective balance sheet hits 2. Larger refunds/recoupments 3. Lower payments
Tools to combat these audits	1. Track timelines to response – days to payment and days to response 2. Communicate consistently with payor network reps in JOC 3. Implement electronic exchange mechanisms to exchange records to more assiduously track timelines	1. Engage clinical leadership to help craft complex appeals for medical necessity 2. engage a complex appeals vendor to weave clinical and technical elements into a cohesive appeal 3. Legal arbitration

Levels of Care



Gene & Cell Therapies

New Gene therapies beyond Zolgensma changing the game

Developed therapies releasing more rapidly

Acquisition costs nearer to $3M per dose

Higher volumes of clinically eligible patients

Untimely reimbursement trends

Low or no margin on the therapy itself

Discussion:

Resourcing/ cost management strategies

Payer/Pricing strategies

Advocacy opportunities

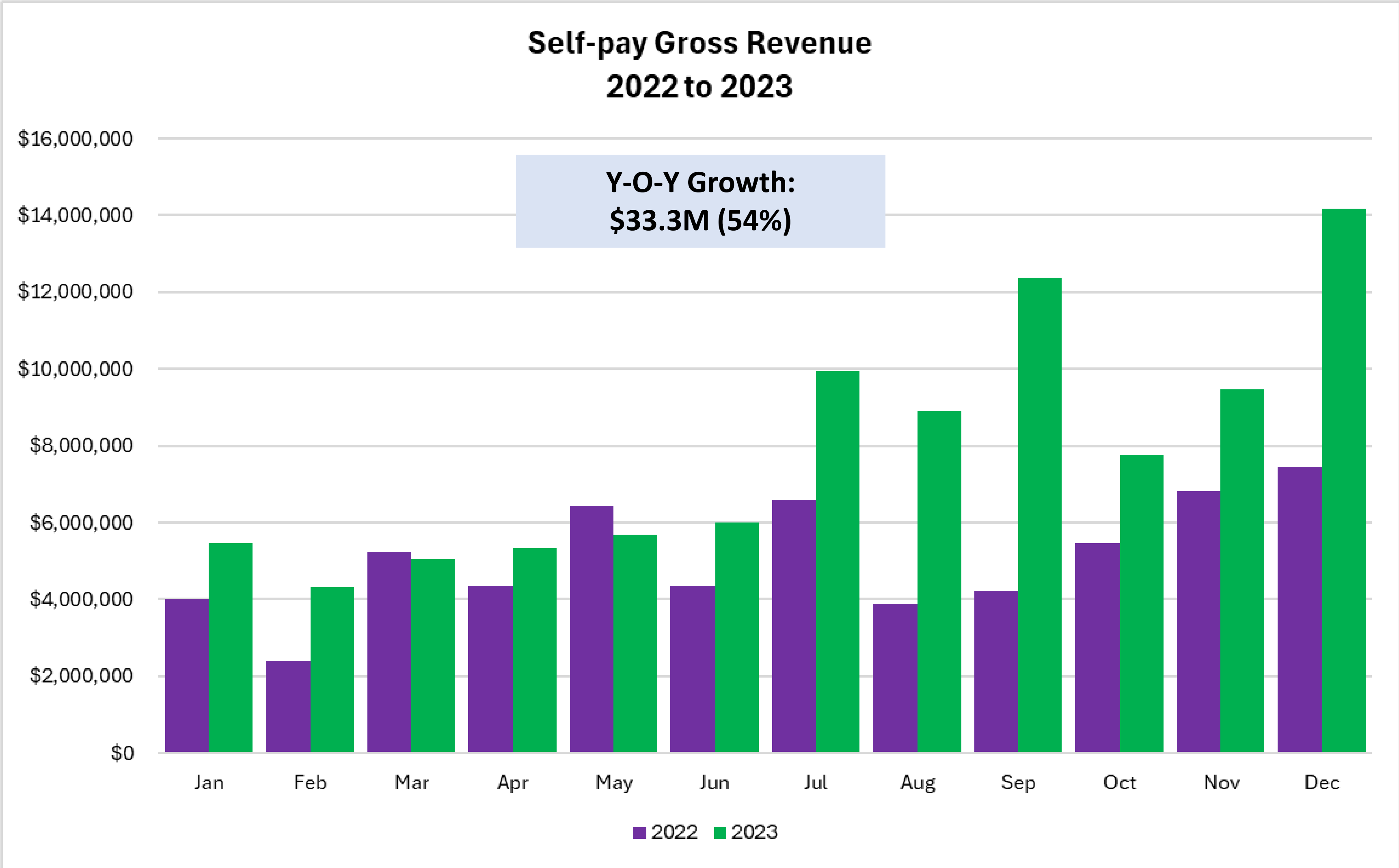
CHA CFO Breakout

Session 2: Revenue Cycle

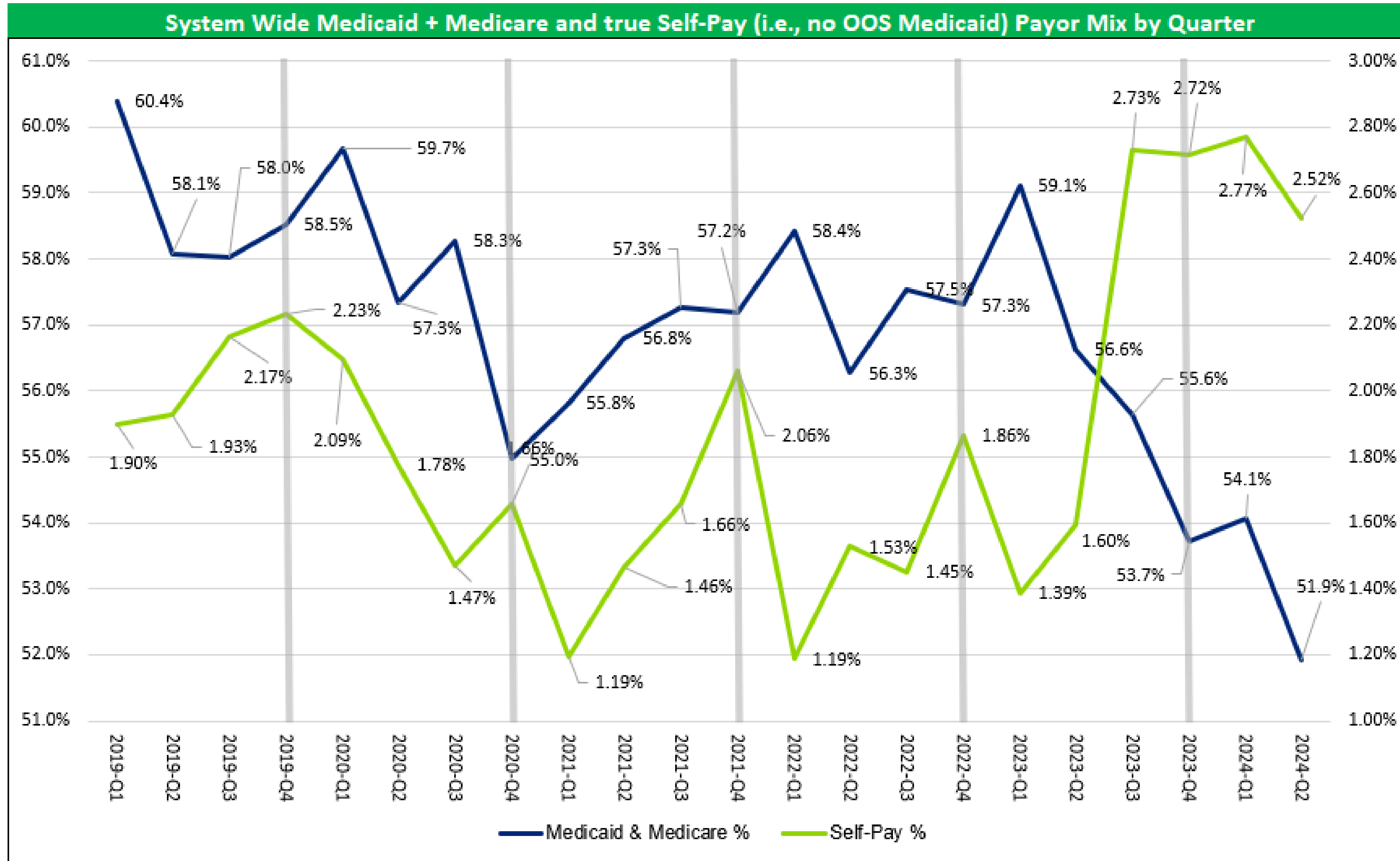
Background

- **April 2023:** Georgia Medicaid initiated the redetermination process
- **April 2023:** GA Medicaid enrollment: 2.5M members (source: kff.org)
- **July 2023**: Children's began to observe a significant increase in Self-pay gross revenue
- **February 2024**: As a result of the Change Healthcare cyber-attack, Children's lost the ability to produce and send patient statements
- **March 2024:** GA Medicaid enrollment: 2.0M members (source: kff.org)

Self-pay Gross Revenue (HB): 2022 – 2023



Self-pay & Medicaid Payer Mix Trends: 2019 - 2024



Rate Volume Mix Analysis - 2022 vs 2023

Top of House by Fin Class for 2022 vs 2023

Fin Class	2022 # of HARs	2022 Gross $	2022 $ / HAR	2023 # of HARs	2023 Gross $	2023 $ / HAR
CMO Medicaid	207,869	1,736,275,395	8,353	205,058	1,823,460,169	8,892
Commercial	1,641	14,040,133	8,556	1,078	7,895,790	7,324
Managed Care	179,146	1,719,551,991	9,599	184,909	1,921,879,791	10,394
Medicaid	41,729	761,976,744	18,260	42,387	835,099,742	19,702
Medicare	1,368	19,594,564	14,324	1,094	22,023,063	20,131
Out of State Medicaid	1,385	13,492,863	9,742	1,246	12,417,706	9,966
Self-Pay	9,860	61,289,559	6,216	15,163	94,541,594	6,235
Shared Service	80	6,602,081	82,526	116	7,960,640	68,626
Tricare	7,509	99,300,485	13,224	7,639	104,330,288	13,658
Grand Total	**450,587**	**4,432,123,815**	**9,836**	**458,690**	**4,829,608,783**	**10,529**
				Y-O-Y Gross $ Change	**397,484,969**	

Fin Class	Rate - Volume - Mix Analysis $: Rate	Volume	Mix	Total Var	Rate - Volume - Mix Analysis %: Rate	Volume	Mix	Tota Var
CMO Medicaid	85,639,792	(23,479,548)	25,024,529	*87,184,774*	21.55%	-5.91%	6.30%	21.93%
Commercial	461,160	(4,816,938)	(1,788,564)	*(6,144,342)*	0.12%	-1.21%	-0.45%	-1.55%
Managed Care	88,743,438	55,316,770	58,267,591	*202,327,800*	22.33%	13.92%	14.66%	50.90%
Medicaid	38,699,595	12,015,162	22,408,241	*73,122,998*	9.74%	3.02%	5.64%	18.40%
Medicare	*783,496*	*(3,924,642)*	*5,569,645*	*2,428,499*	0.20%	-0.99%	1.40%	0.61%
Out of State Medicaid	606,935	(1,354,157)	(327,935)	*(1,075,157)*	0.15%	-0.34%	-0.08%	-0.27%
Self-Pay	4,712,645	32,963,340	(4,423,950)	*33,252,035*	1.19%	8.29%	-1.11%	8.37%
Shared Service	478,651	2,970,936	(2,091,028)	*1,358,559*	0.12%	0.75%	-0.53%	0.34%
Tricare	5,050,982	1,719,145	(1,740,324)	*5,029,803*	1.27%	0.43%	-0.44%	1.27%
Grand Total	*225,591,381*	*79,703,807*	*92,189,781*	*397,484,969*	*56.75%*	*20.05%*	*23.19%*	*100.00%*

Self Pay Only by Base Class for 2022 vs 2023

FIN_CLASS: Self-Pay

Base Class	2022 # of HARs	2022 Gross $	2022 $ / HAR	2023 # of HARs	2023 Gross $	2023 $ / HAR
Ambulatory Surgery	279	3,142,334	11,263	362	4,236,395	11,703
Emergency	5,566	15,419,547	2,770	8,626	25,449,073	2,950
Inpatient	382	24,606,903	64,416	698	35,885,783	51,412
Outpatient	3,633	18,120,774	4,988	5,477	28,970,343	5,289
Grand Total	**9,860**	**61,289,559**	**6,216**	**15,163**	**94,541,594**	**6,235**
				Y-O-Y Gross $ Change	**33,252,035**	

Base Class	Rate - Volume - Mix Analysis $: Rate	Volume	Mix	Total Var	Rate - Volume - Mix Analysis %: Rate	Volume	Mix	Tota Var
Ambulatory Surgery	203,858	934,816	(44,613)	*1,094,061*	0.61%	2.81%	-0.13%	*3.29%*
Emergency	1,194,835	8,477,150	357,541	*10,029,526*	3.59%	25.49%	1.08%	*30.16%*
Inpatient	2,248,118	20,355,449	(11,324,686)	*11,278,880*	6.76%	61.22%	-34.06%	*33.92%*
Outpatient	1,365,916	9,197,552	286,100	*10,849,569*	4.11%	27.66%	0.86%	*32.63%*
Grand Total	*4,712,645*	*32,963,340*	*(4,423,950)*	*33,252,035*	*14.17%*	*99.13%*	*-13.30%*	*100.00%*

Volume is the key-driver for the significant increase in self-pay revenue between 2022 and 2023

Rate Volume Mix Analysis – 2023 vs 2024 Annualized

Top of House by Fin Class for 2023 vs 2024 (annualized)

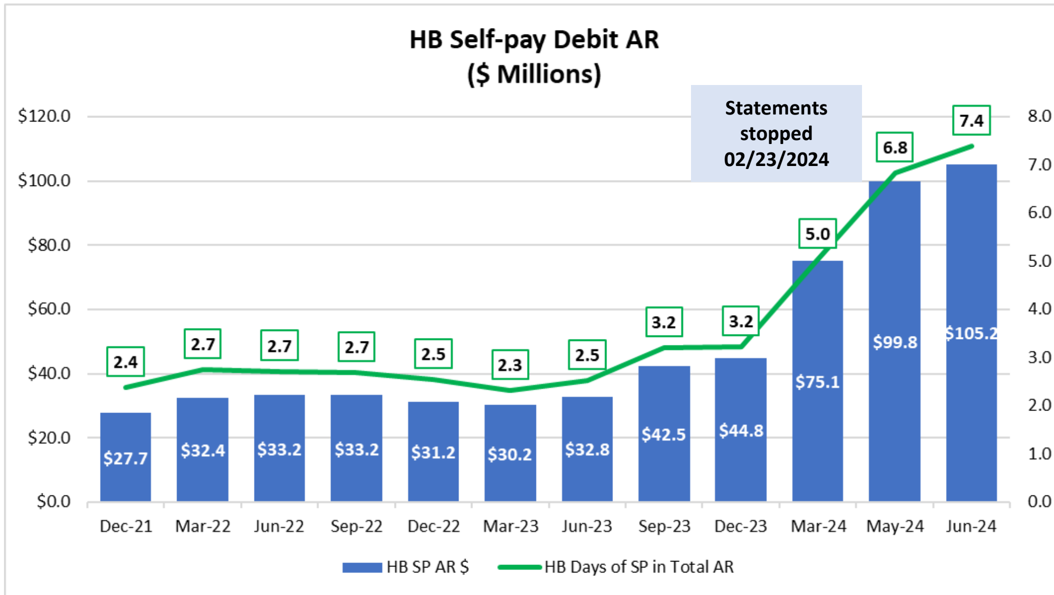
	2023			2024 YTD (Jan to Apr)			2024 Annualized			Rate - Volume - Mix Analysis $				Rate - Volume - Mix Analysis %			
Fin Class	# of HARs	Gross $	$ / HAR	# of HARs	Gross $	$ / HAR	# of HARs	Gross $	$ / HAR	Rate	Volume	Mix	Total Var	Rate	Volume	Mix	Tota Var
CMO Medicaid	205,058	1,823,460,169	8,892	64,853	590,099,499	9,099	194,559	1,770,298,496	9,099	82,179,690	(93,361,431)	(41,979,932)	*(53,161,673)*	15.7%	-17.8%	-8.0%	*-10.1%*
Commercial	1,078	7,895,790	7,324	658	6,482,073	9,851	1,974	19,446,219	9,851	686,780	6,562,735	4,300,914	*11,550,429*	0.1%	1.3%	0.8%	*2.2%*
Managed Care	184,909	1,921,879,791	10,394	65,278	735,573,801	11,268	195,834	2,206,721,402	11,268	96,682,946	113,550,648	74,608,018	*284,841,611*	18.4%	21.7%	14.2%	*54.3%*
Medicaid	42,387	835,099,742	19,702	15,975	350,768,577	21,957	47,925	1,052,305,732	21,957	44,849,892	109,108,509	63,247,589	*217,205,990*	8.6%	20.8%	12.1%	*41.4%*
Medicare	1,094	22,023,063	20,131	338	6,014,185	17,793	1,014	18,042,554	17,793	969,599	(1,610,462)	(3,339,646)	*(3,980,509)*	0.2%	-0.3%	-0.6%	*-0.8%*
Out of State Medicaid	1,246	12,417,706	9,966	280	2,477,249	8,847	840	7,431,748	8,847	397,646	(4,046,219)	(1,337,385)	*(4,985,958)*	0.1%	-0.8%	-0.3%	*-1.0%*
Self-Pay	15,163	94,541,594	6,235	6,807	44,725,210	6,570	20,421	134,175,630	6,570	6,047,953	32,783,730	802,352	*39,634,035*	1.2%	6.3%	0.2%	*7.6%*
Shared Service	116	7,960,640	68,626	37	6,532,384	176,551	111	19,597,152	176,551	361,832	(343,131)	11,617,812	*11,636,512*	0.1%	-0.1%	2.2%	*2.2%*
Tricare	7,639	104,330,288	13,658	2,541	42,012,877	16,534	7,623	126,038,632	16,534	4,945,309	(218,521)	16,981,557	*21,708,344*	0.9%	0.0%	3.2%	*4.1%*
Grand Total	**458,690**	**4,829,608,783**	**10,529**	**156,767**	**1,784,685,855**	**11,384**	**470,301**	**5,354,057,565**	**11,384**	235,213,472	122,253,783	166,981,527	*524,448,782*	*44.8%*	*23.3%*	*31.8%*	*100.0%*
							Y-O-Y Change	**524,448,782**									

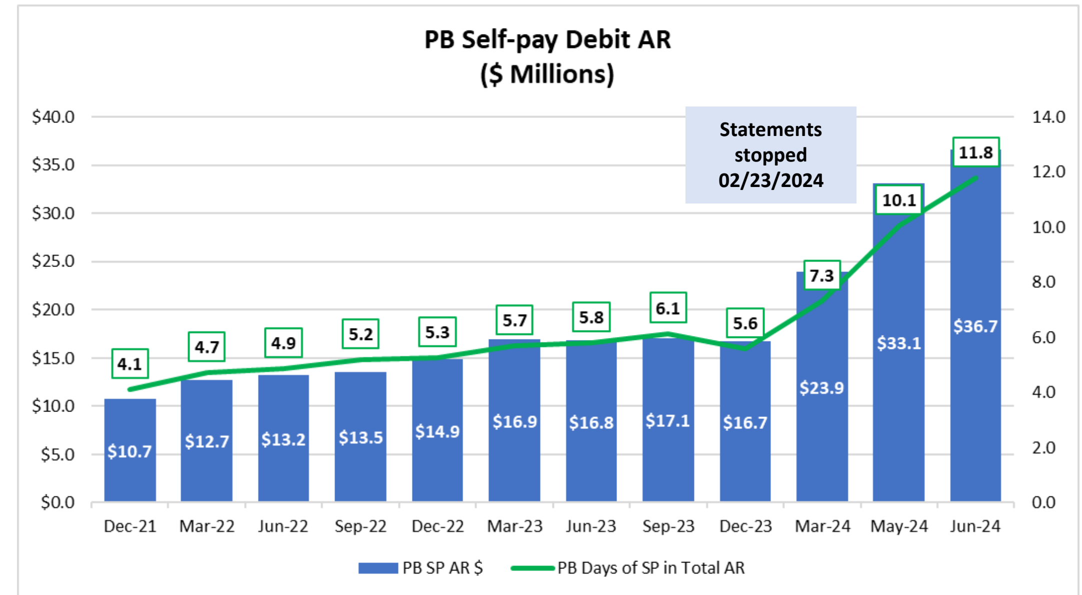
Self Pay Only by Base Class for 2023 vs 2024

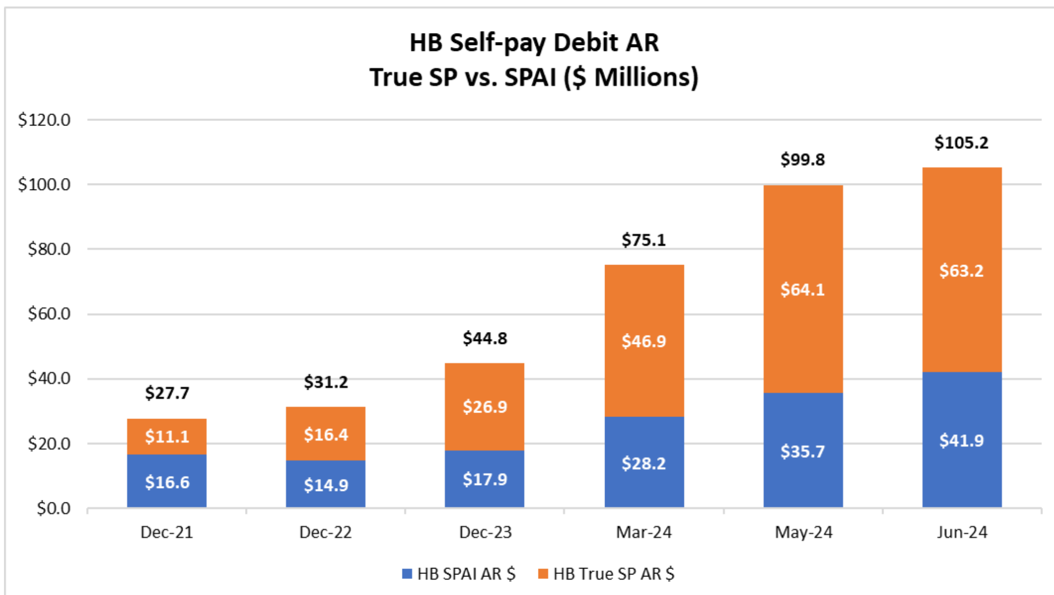
FIN_CLASS	Self-Pay			Self-Pay													
	2023			2024 YTD (Jan to Apr)			2024 Annualized			Rate - Volume - Mix Analysis $				Rate - Volume - Mix Analysis %			
Base Class	# of HARs	Gross $	$ / HAR	# of HARs	Gross $	$ / HAR	# of HARs	Gross $	$ / HAR	Rate	Volume	Mix	Total Var	Rate	Volume	Mix	Tota Var
Ambulatory Surgery	362	4,236,395	11,703	143	1,711,651	11,970	429	5,134,952	11,970	238,473	784,084	(124,000)	*898,557*	0.6%	2.0%	-0.3%	*2.3%*
Emergency	8,626	25,449,073	2,950	3,984	12,208,018	3,064	11,952	36,624,053	3,064	1,674,930	9,812,615	(312,565)	*11,174,980*	4.2%	24.8%	-0.8%	*28.2%*
Inpatient	698	35,885,783	51,412	286	16,050,209	56,120	858	48,150,627	56,120	2,095,308	8,225,968	1,943,568	*12,264,843*	5.3%	20.8%	4.9%	*30.9%*
Outpatient	5,477	28,970,343	5,289	2,394	14,755,333	6,163	7,182	44,265,998	6,163	1,804,471	9,018,520	4,472,664	*15,295,655*	4.6%	22.8%	11.3%	*38.6%*
Grand Total	**15,163**	**94,541,594**	**6,235**	**6,807**	**44,725,210**	**6,570**	**20,421**	**134,175,630**	**6,570**	*6,047,953*	*32,783,730*	*802,352*	*39,634,035*	*15.3%*	*82.7%*	*2.0%*	*100.0%*
							Y-O-Y Change	**39,634,035**									

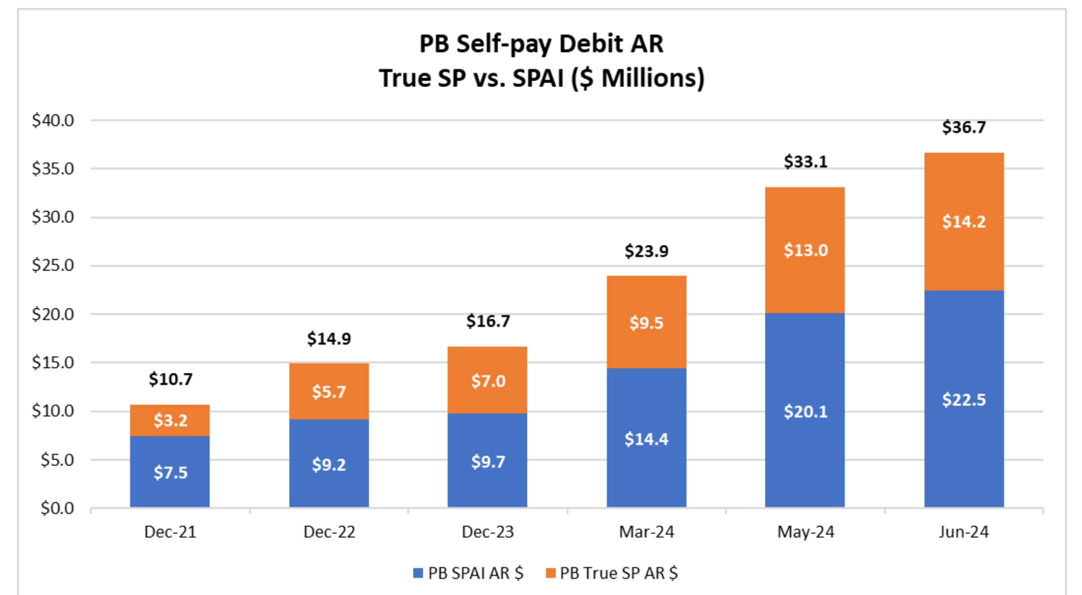
Volume is (still) the key-driver for the significant increase in self-pay revenue between 2023 and YTD 2024

Self-pay AR (HB & PB): 2021 – 2024

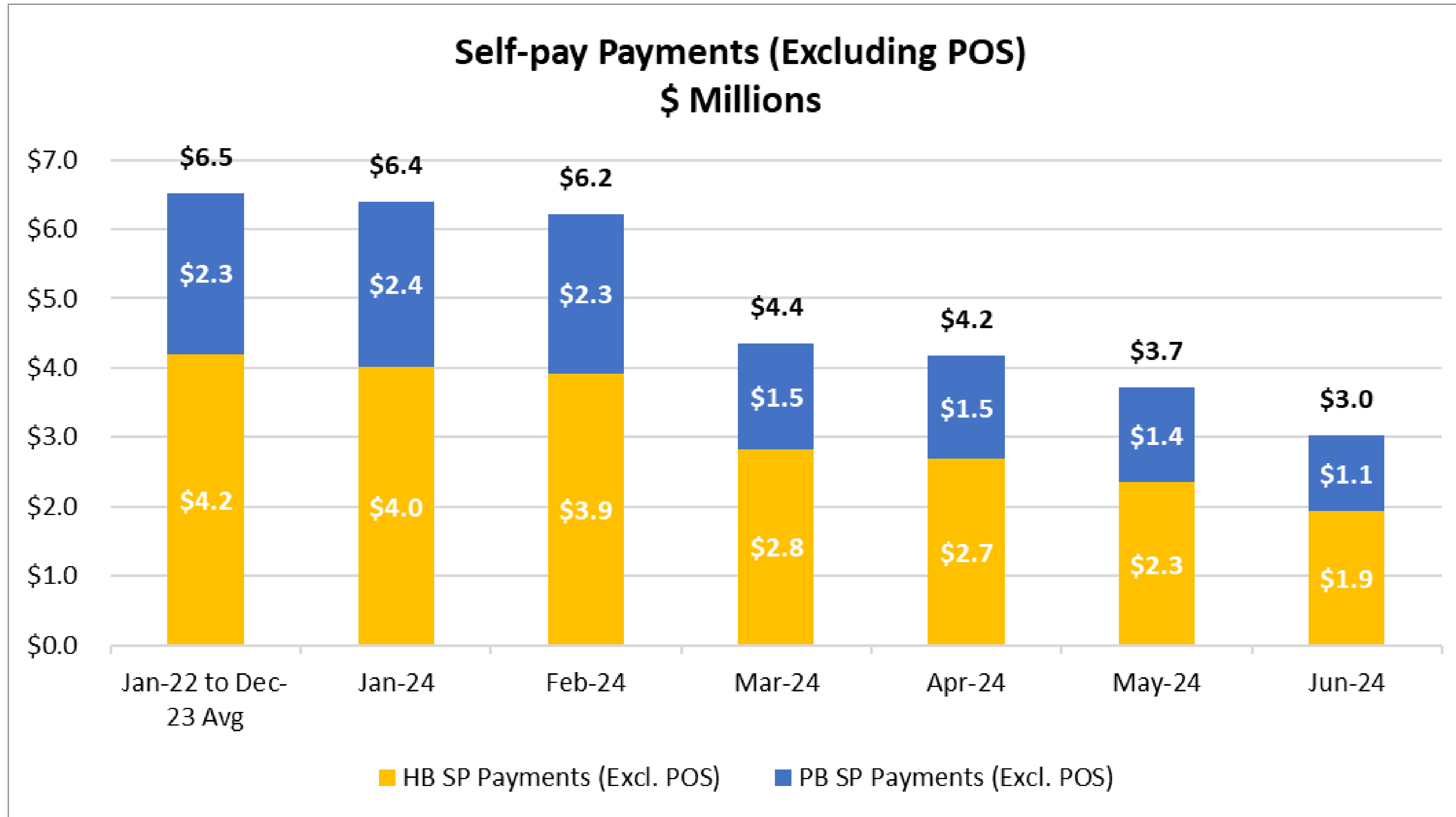








Self-pay Collections (HB & PB): 2022 – 2024



Cumulative YTD 2024 SP Collection difference: Actual monthly collections vs. Jan-22 to Dec-23 Average: **$11.2M**

Self-pay Actions Taken

Task	Details
Statements	• Pursuing vendor solution in addition to exploring Epic internal statement solution • IS&T completed internal statement setup within Epic; aggregating PB data cannot be achieved within Epic statement framework; issue will likely require vendor to format and produce statements.

Coverage Discovery	• Validated preliminary results from vendor:
	  • Coverage identified for 10% of self-pay accounts sent
	  • ~80% of coverage hits have been found to be valid; coverages added to accounts and billed
	• Discussed results with vendor and engaging with initial contractual discussions around cost
	• Assessing secondary vendor's results but initial review shows not as favorable as primary vendor

Presumptive Charity Assessment	• Vendor performed presumptive eligibility of large backload of guarantors with a self-pay balance. • Once data file is processed, scoping of presumptive charity for all self-pay AR can occur
Enrollment Outreach	• Repurposed Customer Service employees to contact likely disenrolled families and provide instructions to reenroll.

Out of State Medicaid Contracting Process Improvement

CHA Big 5 CFO Conference

August 1, 2024

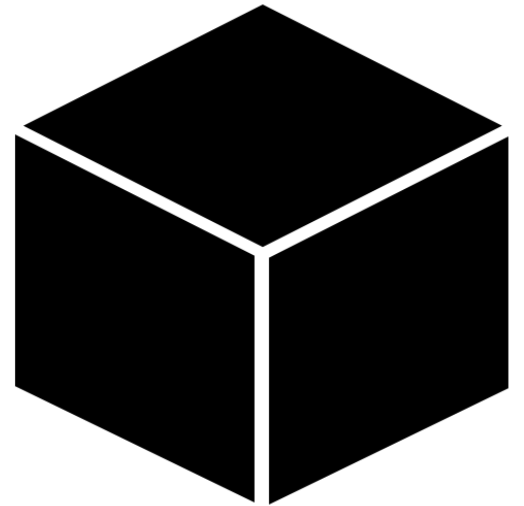
Boston Children's

Where the world comes for answers

Out of State Medicaid Contracting Process Improvement

Where we began (Fall 2017)

- No consistent approach to OOS Medicaid contracting
- No formal policy for OOS Medicaid contracting
- Unable to perform financial analysis
- No staff dedicated to OOS Medicaid contracting



Out of State Medicaid Contracting Process Improvement

Step 1: Determine Project Ownership

Senior leadership tasked the VPs of Government Relations and Enterprise Contracting with building consensus in the organization on how to improve this process and executing on that plan

- ➢ Hired two people on a consulting basis to assist with the work, each reporting to one of the VPs.
- ➢ Worked closely with physician leadership for over a year to build consensus and ensure that everyone had input.
- ➢ Established a steering committee of stakeholders – PFS, PO, Credentialing, OGC, etc.

Out of State Medicaid Contracting Process Improvement

Step 2: Establishing Physician Buy In

The President of the PO led several meetings establishing why change was needed to this process and engaging in discussions about what our policy should be. His credibility with this group was critical to our success.

- It was clear that any policy would be consistent with our mission and values and access to services would be determined by physicians.
- Established contracting standards for inside and outside our service area.
- Ensured that physicians had the final word by creating the Health Affairs Review Process (HARP).

Out of State Medicaid Contracting Process Improvement

Step 3: Create an Accurate and Timely Data Base

Most of OOS Medicaid payers who accessed us were unidentified in our system. They were put in an “all other payer” category. This made it impossible to identify the performance of our SCAs.

- Every payer needed to be identified in the system.
- Data base allowed us to see the financial impact of each individual case, down to the claims line level.
- Data was updated monthly and could be sorted by payer, geography, department, etc.
- This gave the process credibility with the physicians.

Out of State Medicaid Contracting Process Improvement

Step 4: Formalize the Policy

Working with the Office of General Counsel, we put this policy in writing.

- Helps ensure consistency in the future.
- Gives us supporting documentation, if the process is questioned.
- Helps address audit questions.
- OGC helped establish desired contract template language.

Out of State Medicaid Contracting Process Improvement

Step 5: Iterate for Continuous Process Improvement

- Moved SCA team from Enterprise Contracting to PFS.
- Hired someone with a nursing background onto the SCA team.
- Put in place full contracts with high volume payers – e.g. Centene.
- Identified that lack of credentialing resources often prevented physician payments. Moved to Hospital only payments whenever possible to lessen the credentialing burden. Payments are then shared with physicians.

Out of State Medicaid Contracting Process Improvement

A simplified view of the workflow & HARP

Potential Patient from non-contracted OOS payer is referred to BCH → Sent to Single Case Agreement team

Sent to Single Case Agreement team → Contracting standards met. Services are scheduled.

Sent to Single Case Agreement team → Contracting standards not met. Services are not scheduled.

Contracting standards not met. Services are not scheduled. → Physician can appeal to have services provided under certain conditions that are consistent with our mission. (HARP)

Physician can appeal to have services provided under certain conditions that are consistent with our mission. (HARP) → Physician reviews with Dept Chief

Physician reviews with Dept Chief → Chief appeals to EVP of Health Affairs who makes the exception decision

Chief appeals to EVP of Health Affairs who makes the exception decision → Services are scheduled.

Chief appeals to EVP of Health Affairs who makes the exception decision → Services are not scheduled.

Out of State Medicaid Contracting Process Improvement

Results

- Doubled the income as a percent of charges
- Clearly understand our performance
- Bring meaningful data to decision making
- Consistency in the process for who accesses BCH

Questions?

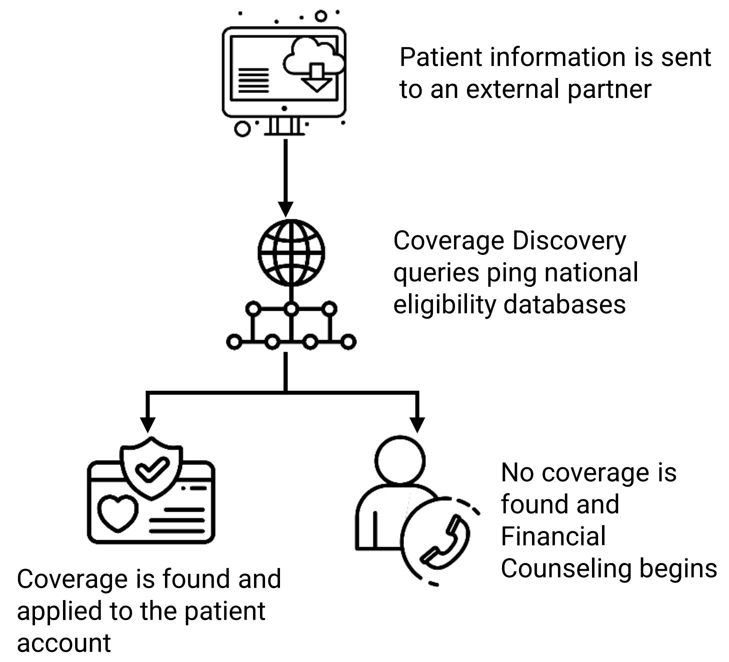
Public Health Emergency (PHE) Transition

With the end of the PHE in May 2023, the state ended auto-enrollment into the Medicaid program. This significantly pushed patients – who previously had coverage – into an uninsured status.

Levers to Convert Uninsured to Insured

Coverage Discovery

When patients present without insurance, the Revenue Cycle team leverages Coverage Discovery services to identify potential coverage.



Avenues for Financial Assistance

Pre-Visit Interventions

Families with financial assistance needs are referred to Financial Counseling prior to their appointment

Emergency Center (EC) Interventions

Families in the EC receive information for Medicaid and charity enrollment. Those needing support are contacted by Financial Counseling to discuss financial options

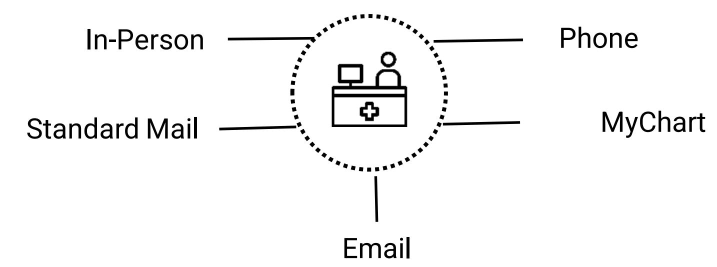
Inpatient Interventions

All admissions for patients lacking insurance coverage are screened by Financial Counseling to ensure appropriate coverage or charity is provided

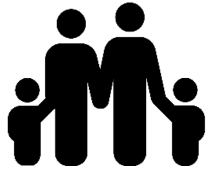
Mediums for Financial Assistance

There are multiple avenues through which a family, a provider, or other Texas Children's personnel can engage financial assistance services for prospective and existing patient families.

Options for families to work with Financial Counseling:



Thresholds for Financial Assistance



$26,500
Family of Four =
100% FPL

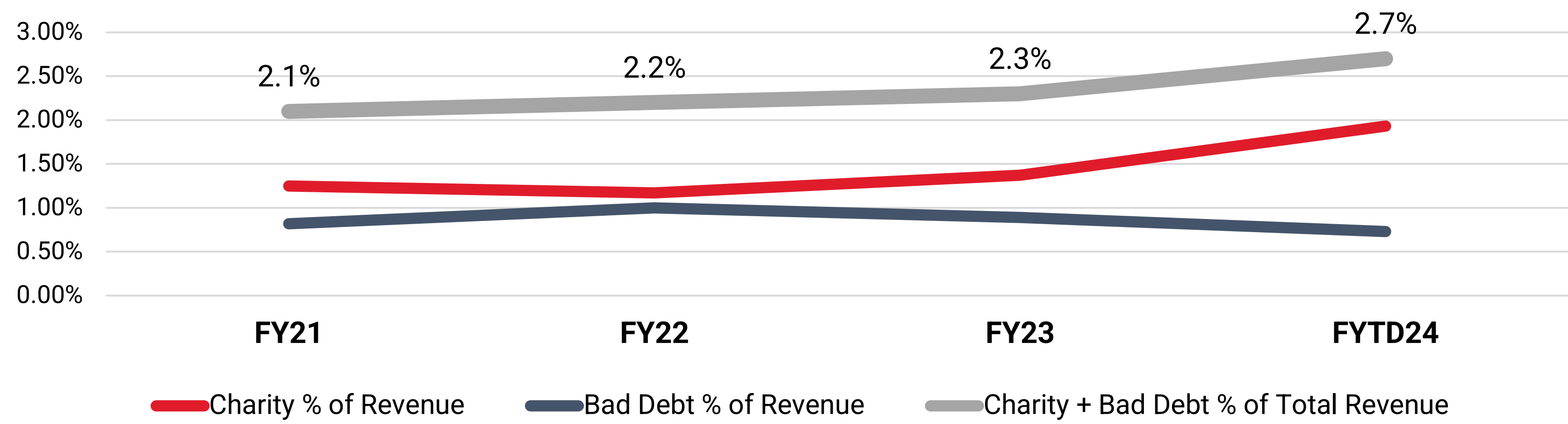
Post-Policy Impact Update

In 2022, the Texas Children's financial assistance policy was updated to increase the threshold to trigger financial assistance from a federal poverty limit (FPL) score of 200% to 250%. As a result, a compositional shift from bad debt to charity occurred, as intended and expected.

Impact on Charity and Bad Debt

The policy update is more appropriately qualifying patients for charity and reducing the impact of bad debt, concurrently.

Due to the growth of unfunded patients with the termination of the PHE, we are observing a disproportionate growth in the overall impact of care provided to unfunded patients, as shown by the ratio of total charity and bad debt amounts as a percentage of the total revenue.



Revenue Enhancement

Clinical Documentation Improvement

Care Transitions

Access & Clinic Optimization

Operating Room Optimization

TCHP Rate Relief

Expense Management

Labor - $83M

- Reduction in force
- Leveraging economies of scale
- Eliminating premium labor
- Flex to demand staffing

Non-Labor - $56M

- Optimization of supply and outsourced service contracts
- Elimination of discretionary spending
- Reduction in supplies
- Reduction in drug expense

BCM - $25M

- Reduction in force
- Leveraging economies of scale
- Practice plan restructure

Business Development

System-Wide

- Enhanced Mission Control & Transfer Operations
- NICU Community Hospital Partnerships
- MFM Second Opinion Network
- Concierge Pediatric Practice Development
- Center of Excellence & Service Line Outreach
  - Heart Center
  - Transplant Center
  - Cancer Center
  - Neurosciences Center
  - Orthopedics & Sports Medicine
  - Women's Services

Focused Austin Strategy

- Local Partnership Opportunities
- Specialty-Specific Outreach
  - Women's Services
  - Emergency Center & Urgent Care
  - Heart Center
- Develop Clinically Integrated Network

Texas Children's

PSO ICC Dashboard - Houston

CANCER CENTER

REPORTING TIMEFRAME

Month

- _FYTD
- Oct-23
- Nov-23
- Dec-23
- Jan-24

DEPARTMENT

Department

- MEDICAL
- HOSPITAL
- OBGYN
- OTHER
- RCM Administration
- SURGICAL

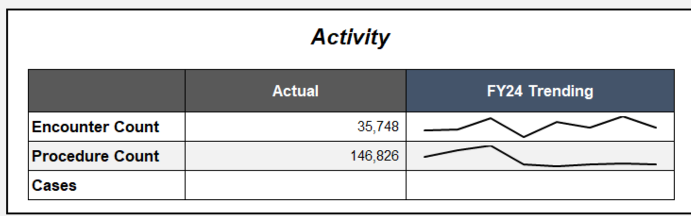
FINANCIAL DIVISION

Financial Division

- (All)
- ADOLESCENT MED
- ALLERGY/IMMUNOLOGY
- CANCER CENTER
- CARDIOLOGY

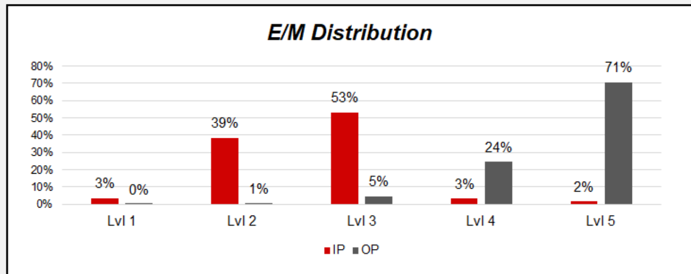
ACTIVITY

Activity



	Actual	FY24 Trending
Encounter Count	35,748	
Procedure Count	146,826	
Cases		

E/M Distribution



PENDING/MISSING CHARGES

Open Encounters

	Current Volume	≤ 7 Days	> 7 Days
FY23	54	0	54
FY24	385	48	337

Revenue

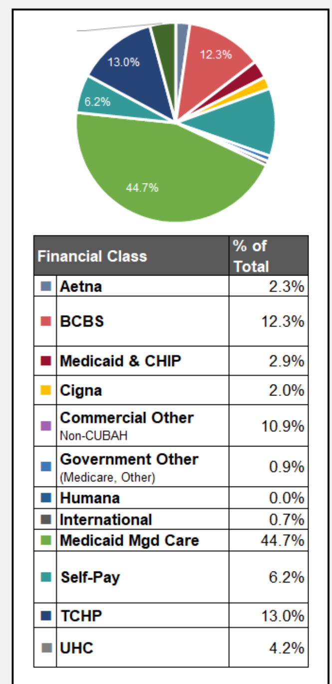
	Actual	Budget	FY24 Trending
Gross Patient Revenue	$ 32,366,633	$ 27,385,311	
Net Patient Revenue	$ 9,129,772	$ 9,480,357	
Other Operating Revenue	$ 28,872,658	$ 29,817,529	
Total Operating Revenue	$ 38,002,429	$ 39,297,886	

FINANCIALS

Expenses

	Actual	Budget	Δ	FY24 Trending
Salaries	$ -	$ -	$ -	
Benefits	$ -	$ -	$ -	
Professional Fees	$ 33,511,861	$ 35,392,033	$ 1,880,172	
Medical Claims	$ -	$ -	$ -	
Supplies	$ 3,738,529	$ 3,126,790	$ (611,739)	
Purchased Services	$ 1,542	$ 2,640	$ 1,098	
Utilities and Maintenance	$ 2,732	$ 5,456	$ 2,724	
General and Administrative	$ 747,761	$ 770,961	$ 23,200	
Depreciation	$ -	$ -	$ -	
Interest	$ -	$ -	$ -	
Total Operating Expenses	$ 38,002,429	$ 39,297,886	$ 1,295,457	

PAYOR MIX



Financial Class	% of Total
Aetna	2.3%
BCBS	12.3%
Medicaid & CHIP	2.9%
Cigna	2.0%
Commercial Other Non-CUBAH	10.9%
Government Other (Medicare, Other)	0.9%
Humana	0.0%
International	0.7%
Medicaid Mgd Care	44.7%
Self-Pay	6.2%
TCHP	13.0%
UHC	4.2%

PROVIDER PRODUCTIVITY

Clinical FTEs

Select Provider Type from Dropdown

All	FTEs	CFTEs	wRVUs	60th Percentile wRVU Benchmark
2023-10	133.7 FTEs	97.0 CFTEs	16,576.21	15,188.30
2023-11	135.4 FTEs	99.1 CFTEs	16,002.65	15,220.84
2023-12	136.4 FTEs	99.4 CFTEs	17,161.06	15,190.75
2024-01	137.8 FTEs	100.0 CFTEs	14,907.12	15,480.53
2024-02	134.6 FTEs	98.5 CFTEs	17,130.93	15,590.63
2024-03	133.1 FTEs	98.1 CFTEs	17,171.06	15,666.43
2024-04	131.5 FTEs	95.5 CFTEs	17,608.20	15,525.16
2024-05	130.9 FTEs	94.9 CFTEs	16,375.35	15,542.91

Template Utilization

	Scheduled Utilization	Completed Utilization	Completed/ Scheduled
2023-10	63.1%	55.4%	88%
2023-11	63.0%	54.7%	87%
2023-12	64.6%	56.9%	88%
2024-01	61.7%	53.5%	87%
2024-02	59.8%	52.2%	87%
2024-03	64.2%	57.5%	90%
2024-04	65.1%	57.5%	88%
2024-05	64.0%	56.7%	89%

wRVUs

	Actual	Budget	Δ	FY24 Trending
wRVU/RVG - Prov. Product.	132,932.6	123,051.4	9,881.2	
wRVU (ASA) - RCE	133,285.4			
Payment per wRVU - RCE	$ 79.76			

wRVU Impact from Code Changes

FYTD Impact	Month-End Impact	FY24 Trending
FY24	_FYTD	
+650.6	+845.5	

Detailed Dashboard Links

- Revenue Cycle Explorer Qlik Dashboard
- Revenue Cycle KPI Qlik Dashboard
- Financials Dashboard
- Provider Productivity Dashboard
- Open Encounters Qlik Dashboard
- Template Utilization Dashboard

BCM & TCH Funds Flow Diagram – PSO FY2023