Key Performance Indicators (KPI) For Peak Financial Performance

Cash flow is just one factor in the financial health of a health care organization. To determine how effective your revenue cycle process is, there are other important metrics that should be measured and monitored.

Management should determine what the Key Performance Indicators (KPI) are for their organizations and monitor them on monthly basis.

In most cases, many of these metrics can obtained directly from your PM/billing system. A standard set of monthly management reports should be identified and consistently run at each month-end.

The monthly results should be reported and compared to prior months and year-to-date. They should also be compared to benchmarks and goals set by the organization, as appropriate.

Summary of Key Performance Indicators (KPI)

1. **Total charges overall and by provider**
2. **Total new and established patient visits**
3. **Days in accounts receivable (A/R)**
4. **Aged accounts receivable (A/R)**
5. **Collection rate/ratio**
6. **Claims denial rate**
7. **Payer ratio**

Once your organization has determined what KPIs to measure, it may be helpful to meet with your PM vendor and/or IT support to determine which reports to run and how best to obtain this information from your system.

KPI #1 – Total charges overall and by provider

Total monthly charges will be reported in most PM systems as long as each month's activity is formally closed at month-end. If the internal files of your PM system have been set up properly, total charges by provider should also be available.

Tracking total monthly charges is one of the best measures of the overall productivity of the organization and is the leading indicator of cash flow for the following month. Variations in total charges from month to month should be analyzed and the reasons for those variations explained.

Tracking total charges by provider is very helpful in monitoring the relative productivity of the clinic providers. If internal benchmarks for charges by provider have been established, the monthly management reports should also compare the actual results to those benchmarks.

KPI #2 - Total new and established patient visits

Although it is not considered a metric for the effectiveness of your revenue cycle and billing process, tracking new and established patient visits on a consistent and comparative basis will help your organization project both current and future demand for services.

Most organizations have internal benchmarks for monthly visit volumes and use benchmarking reports to discuss marketing strategies and make important management decisions if goals are not being achieved.

KPI #3 – Days in accounts receivable (A/R)

Days in accounts receivable measures how long it takes for a service to be paid. It is perhaps the single most important revenue cycle metric.

There are three simple steps to calculating days in A/R:

Step 1: Determine the total amount of the organization's accounts receivable. Subtract from that total any credits/funds owed by the clinic to others.

Step 2: Determine the average daily charge by dividing the total charges for the past 12 months by 365 days. This measure should be recalculated on a quarterly basis to account for any changes in volume and/or productivity.

Step 3: Divide the total AR (Step 1) by the average daily charge amount (Step 2).

The formula looks like this:

Total current A/R minus credits divided by the average daily charge amount = Days in A/R

On average, an A/R greater than 50 days generally indicates the need for improvement. Practices typically see A/R of 35 – 50 days. Top performing practices typically see A/R of less than 35 days.

Some organizations prefer to track this A/R metric in average months rather than average days. Monthly charges are typically already tracked and easy to compute. If average monthly charges are divided into the total A/R, the industry benchmark is 1.5 Months in A/R or less.

Remember to recalculate your organization's average daily or average monthly charges at least quarterly to account for fluctuations in the demand for services (up or down).

Measuring and monitoring days in A/R can help signal several areas of underperformance that should be watched including:

- Payer specific delays
- Delays in follow-up on the A/R by the billing team

Payer specific delays means that the overall days in A/R may average 45 days depending upon the payer, but Medicaid claims might average 75 days and warn of a problem that needs attention.

Delays in follow-up on the A/R by the billing team are common. A/R follow-up is often the area of least attention (after charge entry, claim submission and payment posting) when staffing is limited or the organization has not established structured procedures.

KPI #4 – Aged accounts receivable (A/R)

This KPI is an equally important measure to days in A/R because good overall days in A/R can hide elevated amount in the older aging buckets (e.g., 90 – 120 days or older).

Tracking the aged accounts receivable monthly will help the organization determine if it is receiving timely payment. This report is a standard report in most PM systems and should be run overall and by payer, including patient pay.

Once the total dollars in A/R by month have been determined (0 – 30, 30 – 60, 60 – 90, 90 – 120, 120+), divide the total for each month by the total A/R to determine the percentage of A/R in each bucket.

On average, if a practice has more than 20% of the total A/R 90 days or older, it signals a problem. The detail of the accounts in the over 90 day A/R should be printed so that the source and nature of the accounts can be analyzed and action taken.

The longer a receivable remains on the books, the more likely it will be uncollected and turn into a bad debt.

Important tip: Make sure that your aged A/R reports are run based on the date of service (DOS) and NOT on the date last submitted. Otherwise, if a claim is "re-aged" to "zero" every time it is resubmitted or moved to another payer, the organization will have a falsely positive impression of performance.

KPI #5 – Collection rate

There are several ways to analyze your organization's percentage of collected revenue. Some organizations make the comparison to the fee that was charged (**Gross collection rate**) while others calculate the adjusted (**Net collection rate**) based on the organization's contractual fee schedule with the payers. Many organizations do both calculations, which we recommend.

1) **Calculating the Gross collection rate:**

To calculate the organization's overall gross collection rate, at month-end, take the total payments received for the month and divide that by the sum of the total payments plus total adjustments (i.e. the charge associated with those payments.

The formula looks like this:

Monthly payments divided by monthly payments + the adjustments on those payments = **Gross collection rate**

Example:
If an organization collects $75,000 in total payments for a given month and the total adjustments for that month are $50,000, then the **Gross collection rate** for the month will be 60%.

When this calculation is done by payer type, it will show who your best payers are and which your lowest reimbursing payers are. This information may then be useful for negotiating higher reimbursements with selected payers.

2) Calculating the Net collection rate:

In order to effectively calculate your organization's net collection rate, it is helpful to have a PM system that allows you to enter the contracted rates for each payer.

When the contracted payer information is readily available, the Net collection rate is an excellent measure of the clinic's effectiveness in collecting all legitimate reimbursement.

Despite what one would believe, payers do not always pay the amount that they agreed to pay based on their contract and fee schedule with the organization.

This metric is also helpful in identifying how much revenue is lost due to uncollectible bad debt, untimely filing or other non-contractual adjustments.

The formula looks like this:

Monthly payments divided by charges (net of approved contractual adjustments).

Some PM systems can't match payments with their originating charges. If this is the case, the calculation should be done on data dating back 4 – 6 months, giving the majority of the claims ample time to clear.

Example: Net collection ratio for a 3 month period

Total payments for the 3 month period = $475,000
Total payments for the 3 month period = $856,000
Total write-offs for the 3 month period = $360,000

$475,000 divided by ($856,000 – $360,000) = 95.8% Net collection ratio

Most practices average between 95 – 99%. A Net collection ratio below 95% usually signals a problem somewhere in your organization's revenue cycle.

KPI #6 – Claims denial rate

The denial rate is the percentage of claims denied by payers. The lower this number, the better your cash flow will be.

Medicare and most payers have over 200 reasons why claims are denied or rejected. While most organizations think that the majority of claims are denied due to coding errors, the top reasons are actually due to front-end work flow failures.

(See Chris' slide for Common reasons for claim denial)

Automating aspects of the billing process can dramatically lower the denial rate. Unfortunately, not all billing systems have the ability to obtain denial information in a meaningful way. Clinics that don't track denials could be losing over 20% of their revenue.

Even if your PM system does not track your denials and the reasons for those denials, you can set up a spreadsheet and track the type and frequency of your denials and address those errors with the appropriate personnel.

How to calculate your denial rate

Using a designated period of time (monthly or at least quarterly), total the dollar amount of claims denied by the payers. Then divide that sum by the total dollar amount of claims submitted for that same period.

Denial rates of less than 5% indicate a strong, effective RCM process. Many practices average between 5 – 10%, and a denial rate of greater than 10% signals problems in your RCM process.

To fully understand what is driving your denial rate, you should do a denial rate analysis by payer, provider, remark code and category. Most clearing houses can provide these more detailed breakdowns.

Denial rate is one of the most crucial areas to focus on in advance of the transition to ICD-10. **According to CMS, in the early stages of ICD-10 implementation, denial rates will increase by 100 – 200%!**

Practices will need to establish effective processes for appealing these claims or risk putting the financial health of their organizations at risk.

Using Your KPI for Process Improvement

Once your organization has identified what KPI to track and how to obtain that information, it is important to know the steps to take when there are unfavorable KPI results.

KPI #1 and 2 – Relating total charges by month to total visits, overall and by provider

There should be a direct correlation each month between the number of patient s seen and the total charges billed. While the mix and type of visits may vary, there should still be a fairly predictable increase in charges in those months with increased patient visits.

When charges do not reflect the variations in visit month to month, possible reasons may include providers not completing their charges in a timely way, providers not charging patients for certain services or charges missed entirely.

The daily charge reconciliation process should be helpful in identifying weaknesses in the charge capture process but tracking these metrics by physician may also reveal a particular provider who is delinquent in submitting charges.

KPI #3, #4 and #6– Days in A/R, Aged A/R and Denial rate

These three KPIs are all directly affected by the "cleanliness" of the claims going out to the payers. The more effort that is put forth in obtaining accurate and complete information from the patients on the "front-end", the less the effort that will required on the "back-end."

Well-run billing offices review and edit (reject) charges *before* they are sent to the clearing house or directly to the payer. Encouraging internal rejections (and having a system for correction) is an industry best practice.

A high internal claims rejection rate will typically result in a lower denial rate – and thus, improved cash flow.

If the clearing house or claims scrubber in your PM system detects errors, such as your coder using an improper modifier, the payback will be two=fold: a denial will be prevented and a delay will be avoided in posting the paid claim.

There also needs to be a good, effective process established internally for the reasons for rejection and denial to be shared with both front office staff and providers so that those errors can be corrected and reduced.

KPI #5 – Gross and Net Collection rates

As we discussed, the **Gross collection rate** is a metric that is directly related to the contractual fee schedules established with your various payers. Depending upon the payer and the state in which you operate, those rates may or may not be negotiable.

To ensure that your organization is receiving the amounts from each payer that have been agreed to in your contract, load each payer's fee schedule into your PM system.

If your billing system cannot accommodate that information, identify your top 10 – 20 CPT codes billed to the payers and create a spreadsheet with those codes and the amounts expected from each payer.

As payments are received, post the amounts paid to the spread sheet and compare to the expected reimbursement. If there is a discrepancy, the payer should be contacted.

The **Net collection ratio** is much more dependent on the effectiveness of your billing team. If the Net collection ratio for your organization falls below 95%, one of the key areas to investigate is "write-offs."

Most PM systems will have a special "adjudication report" that provides all of the detail on the write-offs that have been done. Writing off a claim is certainly less work than correcting and/or appealing a claim but is certainly not in the best interest of the organization.

Summary of best practices for monitoring RCM metrics;

- Hold monthly revenue cycle team meetings
- Track and monitor Key Performance Indicators (KPI)
- Benchmark against industry standards and internally to trends over time
- Use a dashboard to manage and measure revenue cycle improvement and goals.

Ongoing monitoring of these key metrics is essential to improved revenue cycle performance. With the right tools and information, your organization can experience fewer denials, faster payment and greater profitability.

In summary, management must focus on each part of the revenue cycle process to ensure that value is delivered consistently and that revenue is maximized. KPI tracking and process improvement will contribute greatly to the success of the revenue cycle.

Implementing these best practices will have a positive impact on your organization and the communities that you serve.