Top KPIs Physician Practices Should be Monitoring

Seven Key Indicators of Practice Health in a Post Covid Environment

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Physician practices are facing unprecedented challenges. A recent MGMA Stat poll surveyed practice leaders to learn which challenges they are most concerned about. Taking the top spot at 58% was staffing, followed by revenue (27%), expenses (20%), technology (2%), and other (2%).[1] The first three challenges can be blamed, at least partially, on the pandemic—especially staffing. While most healthcare facilities are struggling with labor shortages, it is particularly challenging for smaller, independent practices that cannot compete with larger group practices and hospitals regarding wages and incentives.

The MGMA Stat poll also found that costs are rising faster than revenue for 90% of respondents. Besides inflation and the overall increase in the cost of goods, a large portion of the rising expenses is related to recruitment, incentives, and enhanced benefits.

The bottom-line impact of these challenges puts added pressure on practices that were already struggling to maintain financial viability before the pandemic. This means monitoring practice performance is more important than ever. Establishing and tracking key performance indicators (KPIs) is now critical to success. There are seven primary metrics practices should consider. The following guideline provides a list of the top KPIs, divided by front end and back end, that practice leaders should be tracking, along with industry best practices they should strive to achieve.

Point-of-Service (POS) and Cash Collections

Cash collection KPIs give practices a picture of how quickly they can "transfer net patient services revenue to cash."[2] This metric provides insight into the practice's financial viability. A poor POS or cash collection rate can lead to increased collection costs and bad debt write-offs. Collecting from patients at or before the time of service is more effective than trying to chase revenue on the back end.

How to Calculate

- **Cash collections as a percentage of net patient services rendered:** Divide total collected patient service cash (from the balance sheet) by the average monthly net patient services revenue (from the income statement).[3]
- **POS cash collections:** Divide POS payments by self-pay payments collected for a specific timeframe.[4]

POS and Cash Collection Benchmarks

- **Cash collections as a percent of net revenue:** 100% of monthly average net revenue for the preceding three months.[5]

Improving POS and Cash Collections

One of the best ways to improve POS and cash collections is to develop a more proactive patient collection strategy.[6] Just like with collection KPIs, it's important to have experienced staff at the front desk. It can be uncomfortable for less-experienced staff to have a financial conversation with patients. Regardless, practices should develop scripts to help guide staff through a more effective financial conversation. This can be as simple as "How would you like to pay today? We take cash, check, or credit card."

Generating patient payment estimations prior to the visit gives staff the opportunity to call the patient to help them understand their financial responsibility and to request payment before their appointment. While on the call, staff should suggest putting a credit or debit card on file to make future payments easier. For patients with outstanding balances, practices should consider offering flexible payment plan options.

While patient responsibility estimations are not always 100% accurate due to unknown co-insurance or other issues, they give practices the information they need to have that important conversation with patients. It also helps empower patients to make more informed decisions about how to pay for their care. This, in turn, can help improve the patient experience.

Charge Capture

Monitoring charge capture metrics helps practices understand their claim lag days and the potential for writing off late charges.[11] These write-offs can negatively impact a practice's financial performance.

How to Calculate

- **Charge lag time:** Average number of days from date of service to posting date[12]

Charge Capture Benchmarks

- **Complete/timeliness of charge capture:** 3 – 5 days after the date of service[13]
- **Late charges as a percentage of total charges:** ≤2% of all charges[14]

Improving Charge Capture

Setting goals for improving charge capture can vary based on specialty. For example, interventional radiology charge capture can be four to six days instead of the industry's benchmark of three to five days for primary care. According to Conifer Health, however, capturing 90% within the first month and achieving 100% within four days is possible regardless of specialty.

The most impactful step practices can take to improve charge capture is to require providers to complete charts within 24 to 48 hours of a visit, although adding one or two days may be appropriate if there is an interface. Another step is to emphasize to providers the need for them to respond to coder questions as quickly as possible. They need to understand that not doing so has a direct impact on charge capture and cash flow. Similarly, coders need to understand that it is not appropriate to just guess when it comes to a provider's illegible handwriting or incomplete notes. Making guesses to avoid having to disturb the provider will likely lead to more work in the future.

Another opportunity for improving charge capture is to use automation technology that continuously audits processes and flags potential issues so they can be quickly addressed before they have a chance to interrupt the revenue cycle. This can help reduce additional work for staff while also making them more productive.

Clean Claims Rate

Nowhere is GIGO (garbage in, garbage out) truer than in claims processing workflows. Ensuring claims are correct and complete upon first submission is critical to a practice's cash flow and bottom line. Top issues that lead to claim rejections and denials include missing or invalid claims date, prior authorization and precertification issues, and inaccurate eligibility verification information.[7] These three issues alone are responsible for more than half of all denials, and all are caused by inefficient workflows.

How to Calculate

- **Insurance verification rate:** Divide the total number of verified encounters by the total number of registered encounters.[8]
- **Clean claims rate:** Divide the total number of claims received by the payer and the total number of claims dropped.

Clean Claims Benchmarks

- **Insurance verification rate:** ≥98% of all registered patients[9]
- **Clean claims rate:** 98%[10]

Improving Clean Claim Rates

There are several things providers can do to improve clean claim rates. The first is to use automation technology to streamline the patient access process to ensure insurance coverage information and patient demographics are accurate and complete. It is also critical for practices to proactively identify if a service is covered under the patient's insurance plan, if the service is necessary, and if the service is bundled. Diagnosis and procedure codes can be correct but if these three elements aren't considered up front, it could still lead to reimbursement issues.

Initial Denial Rate

Payers are denying more claims than ever, about one in every ten claims submitted.[27] The cost to providers can be as high as 2% of net revenue. Three reasons for the increase, according to Modern Healthcare, are that payers are using more sophisticated algorithms to perform automated reviews, more complex criteria for claims submission and medical necessity, and more variables in their contracts such as medical necessity criteria and technical specifications.[28]

How to Calculate

- **Denied claim rate:** Divide the total dollar amount of denied claims by the total dollar amount of claims submitted in the same timeframe.[29]

Denial Rate Benchmarks

- **Industry average denial rate:** 5% – 10%[30]
- **Best practice for optimal performance:** <5%[31]
- **Ideal denial resolution rate:** 85% within 30 days[32]

Improving Denial Rates

Research shows that 40% of denials drive 80% of a practice's issues. Prevention requires that practices understand why claims have been denied—including at the payer level. Technologies like AI and machine learning are key. Along with 835 and 837 files, these technologies give practices the information they need to address issues at their root cause. They also add value by helping practices better understand which denials to work, which to drop, and what actions need to be taken to successfully appeal.

Technology can also automate the appeals process itself, which is especially useful for bulk denials from a single payer. Automating this process helps reduce payment delays and improve appeals success. These technologies can also reduce headcount while improving results. Existing staff can be reassigned to more strategic tasks like escalation.

While technology can improve denials processes, the best solution remains prevention. Just as with A/R and net collections, it all starts with collecting accurate, complete information up front and submitting the cleanest claims possible.

Practices can also leverage claim scrubbing tools that identify and flag potential issues before a claim reaches the payer's adjudication system. This provides the staff the ability to fix the problem before the claim has a chance to be rejected and reduce the total the errored claim would take to be paid.

Another way practices can improve their clean claim rate is to provide ongoing education for coding staff to help keep them up to date on ICD-10 changes. Staff also need to be made aware of how the quality of their work impacts the quality of the practice's bottom line. Using incentives for high-quality work can help. It might also help reduce turnover, which is so important with our post-Covid staffing shortage.

Days in A/R

Days in A/R is the average number of days it takes for a practice to be paid for services rendered. This calculation gives practice leaders insight into how well their revenue cycle is performing. A well-performing revenue cycle means better cash flow, lower collection costs, and less work for staff.

How to Calculate

- **Days in A/R:** Divide current receivables, net of credits by the practice's average daily charge amount.[15]
- **Net credits:** Subtract the current credit balance from total current receivables.[16]
- **Average daily charge amount:** Divide gross charges for the previous 12 months by 365.[17]
- **Net days in A/R:** Divide net A/R by average daily net patient service revenue.[18]

A/R Benchmarks

- **Optimal days in A/R:** 30-40 days[19]
- **A/R over 90 days:** <10%[20]
- **Service-to-bill rate:** <7 days[21]
- **Self-pay A/R over 90 days:** <30%[22]
- **Credit balances:** <1 day[23]

Improving A/R

While the AAFP suggests 30 to 40 days as optimal days in A/R, Conifer Health believes most practices should be able to achieve less than 30. This helps ensure optimal cash flow and consistent practice operations. Start by identifying what percentage of A/R is over 90 days and aim to achieve 90% in 90 days. Next, identify appeals that are not getting worked or denials that are not getting adjusted off. If the team is not set up by tasks, the priority should be as follows:

1. **Make all corrections** to get the claim out of the door in a timely manner.
2. **Make all transfers to the next responsible party** in order to get the balance back into the revenue cycle as quickly as possible.
3. **Take all adjustments and write-offs** to clear the way for workable A/R.
4. **Manage the denials appeals**.

It is important to understand how the COVID-19 pandemic has impacted payer lag times. According to Conifer Health research, lag time average for all payers prior to the pandemic was 20 business days. However, in 2022, appeal-to-adjudication lag times peaked at 75 business days, although it has since dropped to around 55-60 business days. The fact is that payers are facing staffing issues just as providers are, which makes it challenging for them to keep up.

One of the best strategies to reduce days in A/R and mitigate longer payer lag times is to amp up efforts to submit clean claims. At this time, there is no indication that staffing issues are going to go away any time soon. Making the claim submission and appeals process as error-free and efficient as possible is essential to achieving optimal days in A/R.

It is also important to note that some payers are just slower to pay regardless of the pandemic. This should be taken into consideration when evaluating A/R metrics as it can skew KPIs.

Net Adjusted Collection Rate

The net adjusted collection rate tells a practice which payer sources (including patients) are returning the greatest revenue. Having this information can help pinpoint opportunities for improvement. For example, if patient collections lag significantly behind other payer collections, practices may want to rethink their patient collection strategies.

How to Calculate

- **Net adjusted collection rate:** Divide payments (net of credits) by charges (net of approved contractual agreements) for a specific timeframe and multiply by 100.[24] (It is important that the calculation is based on matching payments to the associated charges.)

Collection Benchmarks

- **Net collection rate:** Minimum = 95%, optimal = 97% to 99%[25]
- **Bad debt (unnecessary write-offs) rate:** <3% of total expected collections[26]

Improving Net Adjusted Collection Rates

Achieving an optimal Net Adjusted Collection Rate is all about clean claims and data integrity. Spending a few extra days to collect complete and accurate information on the front end can save up to three months in A/R and significantly drive down the cost to collect. Keeping payer fee and reimbursement schedules on hand can help practices better understand what should have been paid, which can help prevent unnecessary write-offs.

It can also be helpful to remove the eligibility verification process from the front desk to the back office and to complete it prior to the time of service. This removes distractions from the front desk so staff can focus on patients and collecting patient payments.

When choosing where to assign staff, many practices put their lowest-paid person at the front desk. It would be much better if practices put their most experienced person at the front desk—someone with full knowledge of the collection process and how it impacts the revenue cycle. This person needs to be confident and able to have a productive conversation about what the patient owes and getting patients to pay.

Practices can also improve collections by making it easier for patients to pay. Offering patient responsibility estimates before the time of service allows patients to better plan for their care and gives staff the opportunity to ask for payment up front. Offering payment plans provides the patient options for meeting their financial obligations within their budgets, therefore increasing the likelihood of paying their balance in full.

Bad-Debt Rate

More than one in five physicians say that at least 10% of their patient accounts are impacted by debt.[33] Monitoring bad debt helps practices identify opportunities for process improvements, such as collecting more up front.

How to Calculate

- **Percentage of Bad Debt:** Divide total bad debt by total service revenue.[34]

Bad-Debt Benchmark

- **Bad-Debt Benchmark:** <5%[35]

Improving Bad-Debt Rates

While anything less than five percent is commonly considered a good bad-debt rate, Conifer Health suggests providers strive for three percent and many clients achieve as low as one percent. As with POS collections, practices can reduce write-offs by having a more formal process for collecting patient payments before the time of service. Practices should consider engaging patients sooner in the self-pay cycle. Studies show that most patients who plan to pay their medical bills start sending payments within the first statement cycle. This means that if a practice hasn't been paid within the first 60 days, chances of getting paid in full are greatly diminished.

Another great option is to engage early out vendors within 40 to 45 days. This way, the vendor can perform credit checks, determine which accounts to pursue first, and then begin the outbound calling. This is proven to deliver the best outcomes for collecting patient responsibility.

Practices may also want to do a credit check to determine a patient's propensity to pay. This helps practices pursue only those patients who are most likely to pay instead of chasing payment from patients who may not have the means.

Understanding patient communication preferences is also important for successful collections. Some people prefer text while others prefer emails or phone calls. Practices should require front desk staff to ask patients for their contact preferences when they check in. Once this information is on file, they can just verify it at future appointments.

Practices can also provide patient payment portals to make it easier for patients to pay. The URL for the portal should be printed on the statements where it is clearly visible. Adding a QR code to the statement is another great option.

Is Outsourcing the Answer?

For a growing number of physician practices, outsourcing all or a portion of their revenue cycle processes has become an attractive option for improving KPIs. There are many benefits outsourcers can deliver that practices might never be able to accomplish on their own. The following are just a few examples:

- Provide access to broader, multi-shore talent pools at lower costs
- Deliver training at scale, which improves work quality and clean-claim rates while reducing errors, denials, lingering days in A/R, and delayed reimbursement
- Offer access to a higher level of payer expertise
- Enable quicker and more proactive identification of payer trends for more timely intervention, facilitating faster, more accurate reimbursement
- Supply broader access to automation technology, enabling greater process consistency and efficiency
- Reduce IT infrastructure costs, as outsourcers can spread each investment across many clients

When choosing a partner, it is essential to remember that not all revenue cycle vendors deliver the same value. Those with the broadest experience and highest levels of expertise will provide a faster return on investment.

A New Approach

Physician practices are under more financial pressure than ever before. With ongoing staffing challenges, rising costs, and shrinking revenue, the focus should be on improving efficiencies. Establishing and tracking KPIs gives practices the insight they need to create a strategic path forward.

Key Takeaways

- Staffing challenges aren't going away anytime soon.
- Inflation and expenses will continue to be an issue.
- Even with these challenges, physician practices can grow revenue and protect their bottom line by improving operational performance.
- Top opportunities for improvement include:
  - Fewer days in A/R
  - Better collections
  - Fewer rejections and denials
  - More accurate coverage verification
  - Higher clean claims rate
  - More accurate and timely charge capture
  - Greater POS cash collections
  - Fewer bad debt write-offs
- Outsourcing can help practices achieve better KPIs and practice performance faster and with fewer resources.

These benchmarks are general guidelines but the numbers can vary based on a variety of factors, including specialty, geography, and payer mix. For example, some specialists experience more reimbursement-related issues due to medical necessity, prior authorization, and documentation requests. Other considerations for what to include or exclude can be found on the American Academy of Family Physicians website.[36]

Sources

1. https://www.mgma.com/data/data-stories/healthcare-in-2023-staffing-is-still-the-biggest-c
2. https://revcycleintelligence.com/news/breaking-down-the-top-5-healthcare-revenue-cycle-kpis
3. https://revcycleintelligence.com/news/breaking-down-the-top-5-healthcare-revenue-cycle-kpis
4. https://practolytics.com/blog/top-9-kpis-for-effective-revenue-cycle-management/
5. https://www.beckersasc.com/news-analysis/10-benchmarks-for-billing-and-collections.html
6. https://revcycleintelligence.com/news/3-patient-collections-best-practices-to-boost-the-bottom-line
7. http://cthima.org/wp-content/uploads/2018/12/CTHIMA-Payer-Denial-Trends-Rocky-Hill-Dist-12.13.2018.pdf
8. https://www.ruralcenter.org/sites/default/files/rhpi/help/4%20Patient%20Focused%20but%20Metrics%20Driven.pdf
9. https://healthitanalytics.com/news/using-business-intelligence-kpis-for-revenue-cycle-management
10. https://www.beckersasc.com/asc-coding-billing-and-collections/improving-asc-kpis-clean-claim-percentage-denial-rate-and-denial-reason-trending.html
11. https://healthitanalytics.com/news/using-business-intelligence-kpis-for-revenue-cycle-management
12. https://www.kareo.com/blog/article/benchmarks-your-medical-practice-vital-part-critical-practice-analysis
13. https://healthitanalytics.com/news/using-business-intelligence-kpis-for-revenue-cycle-management
14. https://healthitanalytics.com/news/using-business-intelligence-kpis-for-revenue-cycle-management
15. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
16. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
17. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
18. https://revcycleintelligence.com/news/breaking-down-the-top-5-healthcare-revenue-cycle-kpis
19. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
20. https://www.mgma.com/event-registration/mgma18-the-financial-conference/session-handouts/con301-keeping-score-utilizing-key-performance-ind
21. https://www.mgma.com/event-registration/mgma18-the-financial-conference/session-handouts/con301-keeping-score-utilizing-key-performance-ind
22. https://www.mgma.com/event-registration/mgma18-the-financial-conference/session-handouts/con301-keeping-score-utilizing-key-performance-ind
23. https://www.mgma.com/event-registration/mgma18-the-financial-conference/session-handouts/con301-keeping-score-utilizing-key-performance-ind
24. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
25. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
26. https://www.mgma.com/practice-resources/revenue-cycle/collection-challenges-growing-for-medical-practice
27. https://www.modernhealthcare.com/revenue-cycle/why-your-denials-are-skyrocketing-and-3-ways-hospitals-can-respond
28. https://www.modernhealthcare.com/revenue-cycle/why-your-denials-are-skyrocketing-and-3-ways-hospitals-can-respond
29. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
30. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
31. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf
32. https://www.mgma.com/event-registration/mgma18-the-financial-conference/session-handouts/con301-keeping-score-utilizing-key-performance-ind
33. https://www.medicaleconomics.com/view/practices-dealing-bad-debt-patients-struggle-medical-bills-study-shows
34. https://www.mdclarity.com/blog/revenue-cycle-metrics-rcm-kpis
35. https://www.kareo.com/blog/article/benchmarks-your-medical-practice-vital-part-critical-practice-analysis
36. https://www.aafp.org/dam/AAFP/documents/practice_management/admin_staffing/FiveKeyMetricsPresentation.pdf

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