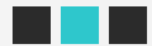
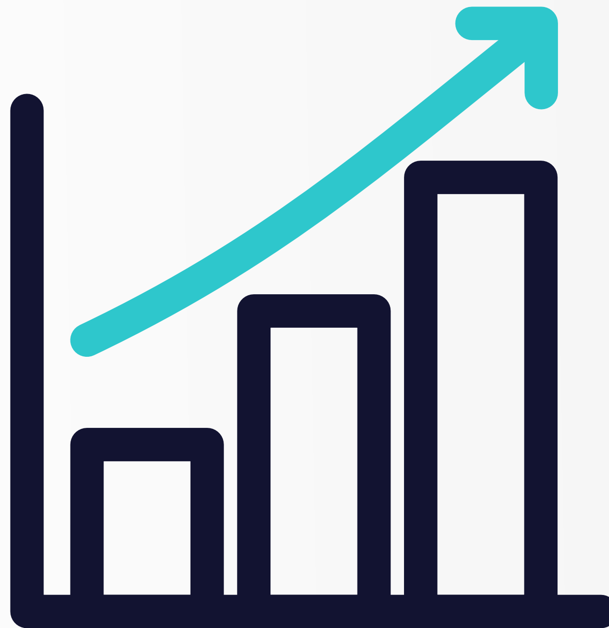


Revenue Cycle Operations, KPIs and Metrics

How Can Community Health Center Leaders Calculate Success? Best Practices for Measuring Results and Increasing Reimbursements.



PREPARED BY

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Introduction

We've all heard Peter Drucker's immortal words: "If you can't measure it, you can't improve it." Being able to measure your health center's metrics is the first step to following FQHC best practices in revenue cycle management.

To truly reduce costs, streamline operations, and increase reimbursements, FQHCs need to analyze more than just the top line of their financial reports and beyond the bottom line on their bank statements. Many FQHC accounting departments are stuck in a cycle of checking only the basics and losing out on lucrative, actionable insights.

In this white paper, you will learn more about the metrics that you should be tracking, the calculations that power the metrics, and best practices to improve your metrics.

What billing metrics should we measure?

FQHC Billing Metrics, or Key Performance Indicators (KPIs), help health centers understand their revenue cycle and provide insights to increase collections.

Monitoring your FQHC's financial performance while providing exceptional patient care is vital to your success. By routinely monitoring your revenue cycle metrics you can ensure that your FQHC collects what is federally guaranteed to Section 330 grant recipients.

There are many ways to analyze FQHC billing and collections data but the following seven KPIs are most closely correlated with your financial performance:

- Percentage of A/R Older than 60 Days
- Days in A/R
- Average Collections Per Visit
- Average Reimbursement Per Paid Visit
- First Pass Resolution Rate (FPRR)
- Gross Collection Rate (GCR)
- Net Collection Rate (NCR)
- Contractual Variance

A proactive approach to monitoring these metrics is to review them at month's end and compare them to the averages from the most recent quarter. Single data points without comparison don't provide many insights.

How can we calculate key FQHC billing metrics or KPIs?

1. Percentage of A/R older than 60 days

How effective are you at converting billed visits into paid visits?

This metric highlights the effectiveness and efficiency of your billing operations in getting you paid as quickly as possible. A significant sum of money over 60 days can signify charge lag issues, an increase in rejections from the claim scrubber and first-pass denials from the payer, bad write-off procedures, or poor collections processes in general.

- Percentage of A/R Over 60 Days = Total Balance Aged Greater Than 60 Days / Total A/R Balance for All Ages

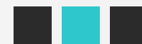
You can and should use the same calculation for percentages over 90 and 120 days for the total view of your A/R

2. Days in A/R

Accounts receivable (A/R) measures how long it takes for a service to be paid. Knowing your days in A/R is vital for understanding your budget and determining when you have the funds to pay for operating expenses.

Days in AR = Total AR / Average Daily Charges (90-day average)

This metric should be reviewed every month to make sure you aren't experiencing any problems with collections.



3. Average Collection per Visit and Average Reimbursement per Paid Visit

Average reimbursement per paid visit = When insurance pays a claim, how much do you receive on average?
Average collection per visit = total money received by insurance divided by the total number of patient visits in that insurance category.

Why does it matter?

Knowing the amount, you collect on an average visit is a good way to measure your FQHC against the industry standard and compare it to other payers. Average Collection per Visit = Total Reimbursements / Total Visits (for a specific time period)
Average Reimbursement per Paid Visit = Total Reimbursements / Total PAID Visits (for a specific time period)
You will be able to determine which payers reimburse at the highest rates and the difference between the two rates is an opportunity for increasing your collections.

4. First-pass resolution rate (FPRR)

Your first pass resolution rate (FPRR) is the percentage of claims that are paid after being submitted a single time. This metric tells you how effective your revenue cycle management (RCM) process is. If your center struggles with a low FPRR, focus on insurance verification, billing, and coding to create a more effective RCM.

- FPRR = # of Claims Paid on First Pass / Total # of Claims Submitted (for a specific time period)

NOTE: 29% of all visits are denied at first-pass submission. When this occurs, the cost of appealing and getting the visit paid increases from $6.50 to $31.50 per claim/visit. This significantly decreases your staff productivity and net revenue.

5. Gross collection rate (GCR)

A high gross collection rate (GCR) indicates your fees are close to the payer's rates, and how well your FQHC is doing at collections. However, a higher rate does not necessarily mean your FQHC makes more money.

- GCR = Total Payments / Charges *100% (for a specific time period)

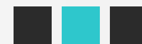
Every FQHC will have a different GCR because each sets a unique fee schedule, therefore this metric is best monitored internally rather than compared with industry benchmarks or other practices.

6. Net collection rate (NCR)

This easy-to-calculate metric reflects how effective your FQHC is in collecting the reimbursement you are allowed. FQHCs calculate their NCR to see how much revenue is lost due to factors such as uncollectible debt, or other non-contractual adjustments.

- NCR = (Payments / (Charges – Contractual Adjustments)) * 100%

This metric can be used to compare to other FQHCs. If your NCR is lower than 90-100% after write-offs, you should consider an audit of billing practices.
CAUTION: Because FQHCs may receive MORE in collections than they bill in charges it can skew the NCR calculations.



7. Contractual Variance

Contractual Variance is the amount you are receiving below the amount you contracted with your payers. This can be affected by how your biller submits the claim, among other reasons. Improper submission of a claim can still be paid, but there is a chance that it will be underpaid.

- Contractual Variance = Contracted Rate (based on your fee schedule) Minus the ERA Allowed Amount

Your practice should have analytics that shows you where your expected payment amount (per the fee schedule) is less than what was received from the insurance company.

Knowing how to calculate Days in Accounts Receivable grants actionable insight into billing efficiency.

Your Average Days in Accounts Receivable or “Days in A/R” is the average time that it takes for a service to be paid by a responsible party. This metric can describe either the insurance payments or patient payments. The reason practices should know how to calculate days in A/R is so they can quantify the efficiency of their billing operation.

When calculated correctly, the Days in A/R formula yields a number that signifies a value for days. Use the following metrics as guideposts:

- A/R Less than 35 – Excellent
- A/R 35 to 50 – Good
- A/R Greater than 50 – Poor

Note that specialty and payer mix can impact these numbers.

Calculating Days in A/R

First, you’ll need to calculate your FQHC’s average daily charges:

- Add all of the charges posted for a given period: 3 months, 6 months, 12 months (to increase accuracy use the exact number of days you are open in a calendar year)
- Divide the total charges by the total number of days in the selected period (e.g., 30 days, 90 days, 120 days, etc.)

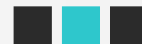
Next, calculate the days in accounts receivable by dividing the total receivables by the average daily charges.

NOTE: Be sure to look at each financial class and payer separately. It isn’t reasonable to expect self-pay accounts to have the same Days in A/R as Medicare.

3 pro tips for calculating your average days in accounts receivable.

Learn how to calculate days in A/R like the pros using these 3 tips.

1. Calculate days in accounts receivable - all payers individually.
2. Understand your percentage of A/R over 90 and 120 days.
3. Remember to incorporate collections account amounts in your formula.



Make sure you know your days in accounts receivable for all payers individually.

It is essential to know both your average days in accounts receivable across all payers as well as broken down for specific payers. By identifying payers with higher-than-average days in A/R, you may be able to spot some inefficiencies in your billing process for that payer and take steps to reduce the amount of time that it takes to get paid.

Old aging buckets- the percentage of A/R over 90 and 120 days

Monitoring the percentage of A/R that has aged beyond 90 and 120 days is an important factor in measuring the capability of your practice to get paid in a timely manner. This percentage indicates the percentage of receivables that are older than 90 and 120 days of the total current receivables. The actual age of the medical claim should be used as a base for your calculations (e.g., date of service) to achieve an accurate number and get a holistic of your revenue cycle operations.

NCR Grades

Interpret your Net Collection Rate using our scoring rubric.

95% + = Great work! Check your write-offs and adjustments to make sure they are accurate.

90% – 94% = Keep doing what you're doing, it's working! Verify write-offs.

85%-89% = Things are going well but there's room to improve!

< 85% = Money is left on the table. You may want help to find those funds.

There are a number of reasons your NCR can plunge below 90%.

More about the Net Collection Rate

Understanding the net collection rate gives FQHCs a better grasp of how effective they are in collecting money that's owed. This easy-to-calculate metric provides useful insights into how your center is truly performing. Read on to understand how to calculate your own net collection rate and how it impacts your revenue cycle.

This metric can also be used to limit revenue loss based on factors like uncollectible debt, untimely filing, and other non-contractual adjustments.

Along with days in accounts receivable and denial rates, the net collection rate is key to developing a clear understanding of your overall revenue cycle.

Measuring Effectiveness

As an FQHC your contract adjustments could include some anomalies.

If a dollar or more has been received by third-party insurance you can use this measurement as a way to gauge effectiveness in converting billed visits to paid visits.

When to use it

If your adjustments are skewing your NCR results, consider using the number of paid claims versus unpaid claims. This simple ratio measures effectiveness.

Calculate Your Net Collection Rate

Start by dividing payments (net of credits) by charges (net of approved contractual adjustments) for the time period that you want to monitor. Then multiply by 100 to get the percentage value. Payments need to match with their originating charges for the most accurate calculations.

Measure Your Performance

Keep your reporting consistent by basing your calculation on a time period of at least one year. Consider using a rolling 12-month schedule to calculate your net collection rate. As with all billing indicators, performance will be influenced by payer mix and specialty.

The Medical Group Management Association (MGMA) recommends a net collection of **95%** or higher. A net collection below 95% shows room for improvement and is often an indicator of poor performance. It is possible to score higher than 95% with expert oversight and by accurately determining charge value.

Charge value is calculated as charges minus your contractual adjustments. This metric reveals how much revenue is lost due to factors such as uncollectible bad debt, untimely filing, and other non-contractual adjustments.

Additional Factors to Consider

As with all billing indicators, performance as measured by the adjusted collection rate also will be influenced by your FQHC's particular payer mix and specialty, as well as the level of automation in your billing and collection cycles. Other considerations to be aware of include applying inappropriate write-offs to charges and not having access to all fee schedules for your payers.

The net collection rate can be measured monthly, quarterly, semi-annually, or annually. The longer the time frame, the more data you'll have to provide an accurate assessment of your FQHC's performance.

Avoiding Denials

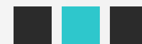
Knowing how to reduce claim denials can help your FQHC avoid the constant headaches of denied claims that negatively affect your FQHC's revenue, cash flow, and efficiency.

On average almost $15,000 per year, **per physician/provider,** is spent on investigating, appealing, and reworking denied claims!

Let that sink in for a moment. 1/3 of all claims are denied during the first submission. The cost goes from $6.50 to $31.50!

It can be difficult to know exactly what the payers are thinking with their constantly changing rules and regulations, but you *can* remove some of the guesswork. This quick guide will help you and your team know how to reduce or prevent claim denials.

The following FQHC billing mistakes are common causes of claim denials and knowing how to address them will create a positive impact on your center's bottom line.



Missing a Timely Filing Deadline

With all the complexity in the medical billing landscape, some denials due to human error are inevitable. The one type that is inexcusable, though, is a denial based on a failure to file in time. This is better known as the "timely filing rule." FQHCs know that missing this deadline creates a situation where money could be lost forever.
Train your team and reinforce that no claim should ever be late. Start by creating an easy-to-see reminder in your front office to help your staff avoid claims lost due to timely filing. Reminders for individual payers can also be posted or distributed in an easy-to-read document throughout the practice.

Missing claim information

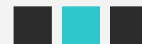
The ever-increasing amount of data points required for a claim to be accepted by a payer equates to a greater potential for information being omitted. Top-performing health centers are checking their claims, generally with software, to be sure the claims include the patient's information, diagnosis codes, CPT codes, and anything else needed to get the claim processed.
Just because the fields on the claim are populated doesn't ensure it will be processed by the payer, though.

Clerical Coding or Insurance Verification Issues

Even if most of your payers accept electronic claims, a few still may require manual submissions. This can cause issues if you're primarily used to submitting electronic claims. Any messy or illegible print claims may become problematic for payers who scan them into their systems upon receipt. Make sure your billers always look over claims and confirm they're readable before sending them off. This is especially important for those payers who are more demanding than others. A helpful tip is to group transactions by payers if you need to find out which ones are denying claims more frequently.
Not verifying the correct insurance coverage is one of the more common mistakes that cause claim denials. Insurance information is constantly changing whether at the insured level or for the insurer. It is important that the provider verify eligibility each and every time services are provided. This should become second nature for your staff, given the number of times a patient may change insurance providers throughout their visits.

For most health centers, eligibility rejections and denials are the number one reason for payment delays and labor overruns. Knowing how to reduce eligibility rejections and denials is an important first step to enact cost-saving measures at your practice.

A survey cited by Becker's Hospital CFO Report agreed with the findings that almost 24% of all denials are due to eligibility. The cost of correcting claims is steep. The American Medical Association published an article in JAMA that priced insurance follow-up for registration issues at a little under $19 per claim. This means centers that reduce their eligibility denial count by 5 per day can save almost $100 per day in administrative costs.
The best way to prevent eligibility rejections and denials is to practice proactive front desk management to stop them from occurring in the first place. A few simple workflow changes are all it takes to affect the accuracy of your claims.



Educate all staff about the revenue cycle.

Making sure the practice is paid for the work it does is everyone's responsibility. However, some front desk personnel can operate under the assumption that denied claims have nothing to do with them. Educate front desk staff about the claims process, so they understand that incorrect information leads to denied claims – and that denied claims lead to disgruntled patients, more work, and potentially less revenue for everyone's paycheck.

Share denial statistics.

Consider making denials an ongoing topic of discussion during team meetings. Share claim rejection and denial rates and set goals for improvement. If staff is making a concerted effort to increase accuracy, the results will be apparent in a short amount of time – usually within a month or two.

Hold front desk staff accountable for registration errors.

If your FQHC has a paper registration process, it is critically important to confirm all demographic and insurance information against the patient ID and insurance card. Some offices choose to scan IDs and cards for later reference. However, scans should not negate responsibility for obtaining correct information. We suggest having front desk personnel initial every page of the registration packet to verify it has been checked for completeness and accuracy.

Confirm address and insurance information at every visit.

People move to a new house and switch jobs regularly. Two simple questions can make a big difference:

- Are you still on XXXX Street?
- Are you still with XXXX insurance?

A quick confirmation of information with established patients can dramatically decrease denials. Specialties such as allergy and psychiatry, which see patients often, must ask these questions every time because once a claim is denied, there could be several claims in adjudication that will soon be denied as well. A denial domino effect can quickly develop.

Use technology whenever possible.

Thoroughly audit how insurance is verified. Scrutinize when phone calls are required because they are the most expensive and time-consuming of all the ways to check coverage. Many free benefit look-up tools get the job done but consider using one system, like MedClarity, that can meet all your needs. The time saved switching from one system to another may then be re-purposed for more impactful tasks. Another advantage of using technology is running batch checks and having the option to automate when checks are performed.

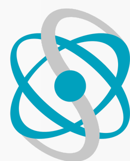
Knowing how to reduce eligibility rejections and denials boils down to attention to detail.

The saying, “garbage in, garbage out,” 100% applies to medical billing. In some circumstances, all it takes to receive a denied claim is a missing middle initial or forgetting to add a suffix to a name such as “Sr.” or “III.” Names, numbers, and other identifying information need to be submitted onto claims exactly as they appear on the insurance card. Attention to detail at the front desk is one of the most essential attributes to look for when hiring front desk staff.

In general, the front desk is not always seen as a mission-critical position. The truth, though, is that the front desk is a pivotal position in the office. They are the first to greet patients, collect balances owed to the organization, confirm all required patient information is complete and correct, and must know how to reduce eligibility rejections and denials. Organizations that acknowledge the importance of an experienced and efficient front desk employee will be best positioned to reap the rewards of cleaner claims and decreased denials.

About the author

Jayson Meyer is the Founder and CEO of Synergy Billing, which he founded in 2006 to provide revenue cycle management exclusively to Federally Qualified Health Centers. He is widely recognized as one of the nation's leading experts on revenue cycle management for Community Health Centers. The Synergy Billing campus at The Fountainhead in Holly Hill (FL) now is home to what is believed to be the largest concentration of FQHC RCM experts in the country. Jayson is in demand as a public speaker and has received numerous awards for his entrepreneurship and success.



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Final Thoughts

The best offense is a good defense.

“Billing and collections aren’t a fun topic. Sometimes you don’t know there is a problem. Once things become urgent it can be extremely stressful and even put your job in jeopardy.”

Most FQHCs struggle to collect money. Synergy Billing works exclusively with community health centers. We offer a complimentary revenue cycle analysis that will provide you with a revenue proforma and staffing model for your billing operations. Contact us today to get started.

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