FEATURE STORY

5 KPIs That Require Revenue Cycle Managers' Attention

Devendra Saharia
Revenue cycle management literature is replete with methods for measuring team performance, whether in patient access, health information management (HIM), patient accounting, or physician practice areas. Various articles within *hfm* alone have listed more than 300 key performance indicators (KPIs) within revenue cycle management, not including the critical measures involved in contract negotiation and general accounting. These KPIs are all important indicators of an organization’s health—but the volume can overwhelm the management team.

The best way to address this challenge is to limit the in-depth review of KPIs to those that fall outside acceptable value ranges.

In the current environment, with implementation of the Affordable Care Act (ACA) and the transition to value-based pricing well underway, the following five KPIs, in particular, warrant the attention of the revenue cycle management team because of the extent of their potential impact on accounts receivable (A/R) and cash flow.

### Cash Ratio

The cash ratio (cash collected as a percentage of net revenue) is the first and best KPI to monitor for success because it represents an objective standard that serves as a sentinel for performance issues. This measure does not represent the monthly collection goal, however. Monthly cash goals should include cash expected from trended net revenue figures (generally the...
monthly average of last 90 days of net revenue) and shortfalls in collections from previous periods that are expected to be recovered in this period.

Whether net revenue is tracked monthly or bimonthly or trended, the cash ratio over time should be between 97.5 and 103.5 percent in any given month—and trending to 100 percent of expected cash, as Zane Newitt and Brian Robertson indicate in a toolbox published in the May 2007 issue of *hfm*.a

There are many variations in cash goal-setting; what is most important is to understand the underlying drivers of good or bad performance and to act on the results of the cash ratio each month. To understand the variances involved, it is important to monitor trends by tracking daily cash against monthly targets and to respond immediately to cash shortfalls as they occur in any given month.

**Key concept No. 1.** Trended A/R performance (opening balance, new charges, adjustments, and cash) by payer will help disclose problems early.

**Key concept No. 2.** Cash targets should reflect booked net revenue, valid shortfalls in previous months’ collections, and expected shortfalls in current-month insurance payments resulting from extraordinary circumstances outside the control of revenue cycle management. State budget shortfalls are an example of such circumstances.

**Medicare Billed A/R over 30 Days**

The revenue cycle management team should examine the trend in Medicare inpatient A/R aged greater than 30 days from discharge as a percentage of total Medicare A/R. If the trend regarding this measure shows an increase or stagnation at a level over 5 percent, the organization may need to address a number of issues. Net days receivable outstanding for Medicare A/R should not exceed 22 days overall, according to Robertson and Newitt.

For many hospitals, Medicare (traditional Medicare, not the managed care replacement plans) is one of the largest payers. Any issues that cause delays in processing Medicare claims therefore are likely to have an immediate and measurable impact on a hospital’s cash flow. When Medicare A/R over 30 days is greater than 5 percent of total Medicare A/R, the revenue cycle management team should examine causes of the delays, denials, or suspended accounts.

It is important to ensure the billing profile contains clear and correct rules for managing charges according to Medicare rules. Most governmental billing will be quickly adjudicated (if not paid) within a few weeks of submission. Attaining a 95 percent clean-claims rate for bills sent to Medicare (and other governmental payers) is a reasonable goal for a high-performing manager.

A short-term task force should be established to identify and correct all issues relating to delayed or rejected Medicare claims. The task force should be charged with ensuring clean inputs and resolving throughput errors quickly.

The goal should be to correct errors in as timely a manner as possible, with a clear benefit to be gained from making corrections on the day of billing. Claims processing and payment can be unnecessarily delayed if the organization tends not to review claims until after they are accepted by Medicare or, worse, until it receives return-to-provider (RTP) reports.

**Key concept No. 1.** Hospitals should have processes and technology in place to address standard Medicare billing routines in an efficient and timely manner (daily—before submission).

**Key concept No. 2.** Processes and supporting technology also should be in place to assist in fixing Medicare RTP issues in real time. A recommended target is to limit RTP rejections to no more than 3 percent of claims with an RTP report.

---
Key concept No. 3. Developing best practices regarding clean claim submission to Medicare will help ensure a compliant posture within the organization, and a clear profile with Medicare.

Third-Party Aging over 90 Days
The key components affecting the cash ratio include billing input and throughput, payer response, and both internal and outsourced productivity relating to A/R workflows. A/R management is dynamic, but clear performance indicators begin to show after 90 days, making it useful to review billed A/R aged over 90 days from discharge as a percentage of total billed A/R. For the average business office, this measure may be 22 to 25 percent, but for a high-performing business office, it will be less than 17 percent.

Revenue cycle managers should watch for declining performance from nongovernmental payers where net insurance cash falls below projections, where patient coinsurance and deductibles are rising, and where unresolved accounts are increasing. Based on the best-practice measure cited by Newitt and Robertson, the revenue cycle management team should consider intervening when this KPI is stagnant and higher than 20 percent, depending on factors such as the type of hospital and its case mix.

Efforts to manage this nongovernmental KPI include various audits of the A/R by groups of accounts; by service type, payer, and balance range; and by account activity. The revenue cycle management team should look for underpayment or adjustment trends by service line to determine whether major payers or employers have changed how they pay for treatment. These basic audits may include:

> Open insurance balances with payments but no adjustments
> Open insurance balances with adjustments but no payments
> Open insurance balances with adjustments and payments

The team also should monitor shifts in case mix, level of care, and treatment setting (inpatient versus outpatient, for example) and whether length of stay has been reduced to determine the extent that these variables contribute to changes in A/R aging.\(^b\)

Key concept No. 1. Managing volumes of accounts is critical to success; a Pareto Analysis—i.e., applying the 80/20 rule—could help highlight problem accounts that the hospital might consider outsourcing to alleviate the burden on internal staff who have too many competing priorities to address these problems.

Key concept No. 2. The revenue cycle management team should ascertain the extent to which out-of-pocket values (e.g., copays, coinsurance amounts, and deductibles) per case might be increasing, both for newly obtained ACA policies and existing policies from major employers. This analysis will anticipate the growth in self-pay A/R and help establish the priority for increased point-of-service collection efforts, including improved quality of preregistration, additional tools for patient balance estimation, and enhanced training for registrars regarding collections.

Bad Debt Expense
In states with expanded Medicaid (post-ACA implementation), the revenue cycle management team should watch for bad debt expense that is increasing or stagnant and over 3 percent of total gross revenues. The team also should monitor charity care levels after Medicaid expansion; there should be a drop in charity care due to the transfer of patients from “uninsured” to Medicaid-eligible (eligible for presumptive coverage as well as expanded coverage), and from uninsured to ACA-insured. Charity care in most non-safety-net hospitals should not exceed 2 percent of gross A/R.

True self-pay accounts—where patients have no insurance at the time of final billing—also should decline significantly. A recent study by the Colorado Hospital Association showed a

\(^b\) See, for example, Osten, J., “Leave No Money on the Table,” \(hfm\), March 2011.
25 percent decrease in self-pay accounts as a result of enrollment in both Medicaid (Colorado is an expansion state) and newly purchased ACA insurance policies. In states where the Medicaid program has not been expanded, the key values will be the traditional ones—rising bad debt and bad debt costs, increased charity care, lower point-of-service collections, and lower overall self-pay collections from all sources.

An increase in presumptive Medicaid classes of patients should help decrease both charity care and bad debt, as these patients are reclassified from self-pay to Medicaid. Every state has the opportunity to work with uninsured poor populations to determine who might be presumptively eligible for Medicaid, and this effort will have an immediate impact on self-pay A/R for hospitals in the state. As the accounts migrate from self-pay to other payer types, the hospital should be able to reduce its allowance for doubtful accounts proportionately.

**Key concept No. 1.** Expanded Medicaid populations should have a measurable impact on both charity care and bad debt. If a hospital’s state has chosen to expand its Medicaid program under the ACA and the hospital does not see an increase in Medicaid volumes and a decrease in both bad debt and charity care, its revenue cycle leaders should launch an investigation.

**Key concept No. 2.** The team should monitor the growth of the self-pay population, in terms of both the number of accounts and actual dollars involved. Many recent studies have projected a growth trend for the self-pay population of up to 200 percent of its current level (from about 10 percent to more than 30 percent of revenues).

**Customer Experience**

Key components of the value-based pricing mechanism for Medicare DRG reimbursement are the HCAHPS questionnaires, which measure patient satisfaction. The revenue cycle management team should ensure that the overall goals of the hospital’s revenue integrity program are clearly defined and easy to achieve so the clinical teams can focus a high percentage of their efforts on delivering exemplary patient care and providing high-quality clinical documentation.

HCAHPS responders (patients and their families) are contacted within weeks of their discharge, so the on-site experience, including patient access and financial counseling services, will have a measurable impact on the hospital’s value-based purchasing scores (and thus on the hospital’s future Medicare payments).

Patients want to know what they will be expected to pay for the services they receive. The prevailing practice has been to avoid talking about the patient’s financial responsibility until late in the revenue cycle. Reports show, however, that effective up-front financial counseling actually promotes rather than negatively influences patient satisfaction.

At the highest level, excellent financial counselors have a clear understanding of what patients want from the hospital and are able to inform patients of the hospital’s expectation for payment in clear and simple language, up front and in writing.

Now is a good time, in light of the IRS’s soon-to-be implemented 501(r) regulations regarding financial assistance and billing and collections requirements for providers, to review all financial counseling policies, especially those that relate to patient balances, charity care, and “amount generally billed” discounts.

Again, clarity in communicating with patients is key. Hospitals should have a clearly written, board-approved policy and should share it with patients in the appropriate forums—including via brochures, the organization’s website, and Facebook—to give patients many opportunities to read about and respond to financial policies. Finally, seamless management of the financial policies requires coordination with vendors.

---

c. See, for example, Bohnsack, J., and Hawig, S., “Choosing the Right Strategy for POS Collections,” *hfm*, September 2012.

d. For details on the IRS Section 501(r) requirements, see, Hearle, K., “Preparing for Section 501(r),” *hfm*, June 2014.
Key concept No. 1. Clinical teams should be free of unnecessary charge capture burdens so they can address patient and documentation issues without distraction.

Key concept No. 2. Hospitals should have trained financial counseling staff equipped with the proper tools to help patients clearly understand their financial responsibilities at the time of registration.

Key concept No. 3. Hospitals can promote patient satisfaction by providing patients with easy access to online payments.

A Dynamic Process
It is incumbent on revenue cycle leaders to observe the many seemingly discrete moving parts in the process of managing the business of health care. The journey starts with the first step: opening the discussion with the managers involved in each process and framing the discussion in terms of measuring and improving process. The revenue cycle management team then should not only define, but also consistently refine the KPIs that are to be measured. The issues won’t be the same every month, and in fact, it is best not to focus on only a few KPIs over time. As the team reviews the values to be monitored, its members should commit themselves to the task and strive to reach consensus on how to manage the issues.

As the revenue cycle management team grows, and as processes improve, it should continuously examine the big picture to look for important variances and decide where to focus its efforts each month or quarter. Success also will depend, of course, on the extent to which leaders demand accountability for performance and reward results.

About the author

Devendra Saharia is CEO, AGS Health, Inc., New York, and a member of HFMA’s New Jersey Chapter (devendra.saharia@agshealth.com).