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WHITE PAPER

Financial Health Check: 5 Key Metrics for your Accounts Receivable

Healthcare financial operations in the new normal

From preventable denials to unnecessary write-offs and bad debts, improper management of accounts receivable (AR) is a recipe for disaster, leading to poor cash flow and lost revenue. Although hospitals and health systems have struggled with AR challenges for decades, disruptions due to the Covid-19 pandemic have illuminated vulnerabilities in the process that impact providers' revenue each day.

Since March 2020, healthcare organizations nationwide have asked staff to work from home, significantly affecting or delaying millions of dollars in daily receivables. Quickly deploying and adapting to digital tools and processes became vital to survival, and to ensure service continuity at a time of unprecedented disruption. As providers now turn their focus towards post-pandemic recovery, business offices will likely continue to operate remotely, with new challenges and opportunities of a digital AR environment.

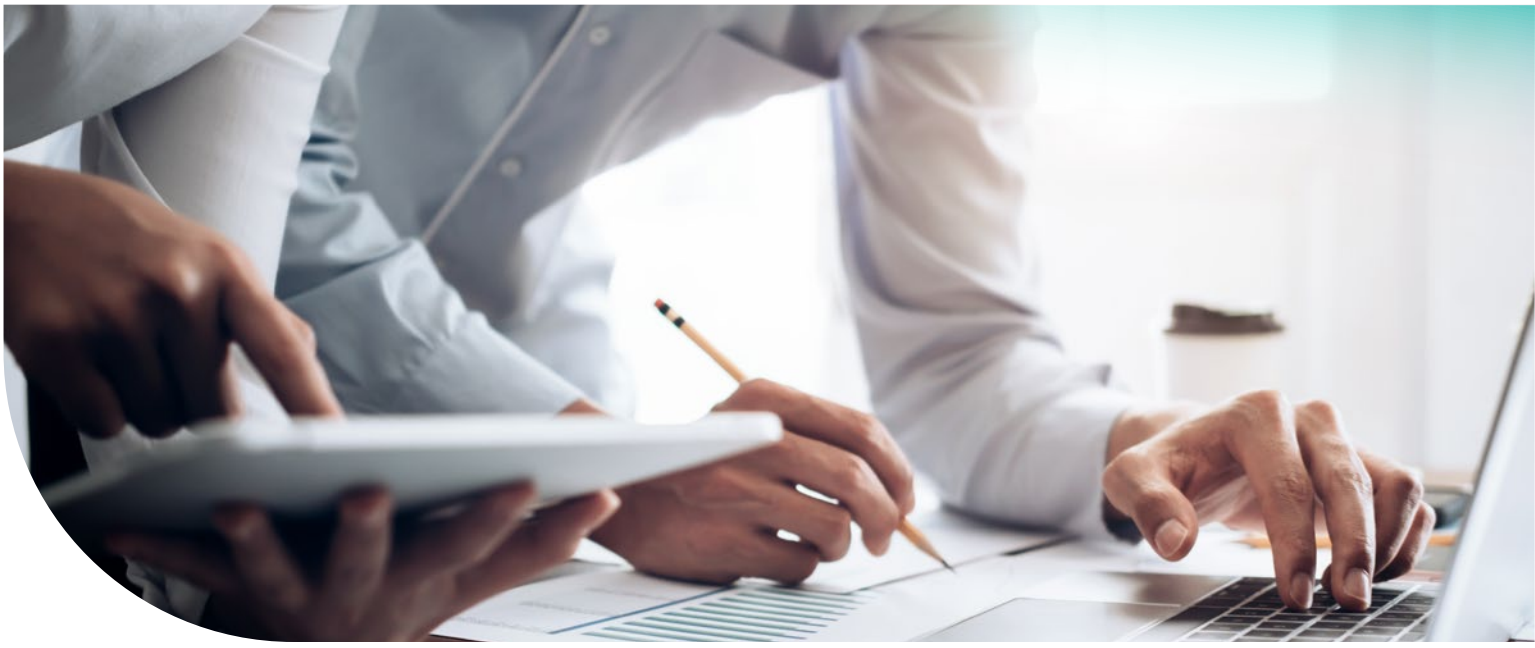
In today's increasingly digital-first world, healthcare providers have greater access to more data than ever before, with real-time reporting that enable better informed decisions regarding the organization's financial health. Advanced data and analysis allow organizations to quickly identify and assess anomalies and trends, both positive and negative, and address them accordingly. However, as the Covid-19 pandemic uncovered, many healthcare organizations are still unable to harness that data or take full advantage of the digital capabilities available to them.

Leveraging AR data

To use AR data in any kind of meaningful and impactful way, it needs to be presented in context. Asked if your AR indicates a healthy financial organization, for example, it's not enough to say "our AR is low" or "our AR is $XX" with no way to tell if that's good or bad. Additionally, benchmarking only against your organization's own AR performance may not help you prepare for the future. It could give you retrospective trend data — but without capturing accurate performance indicators, continuous financial improvement will be an uphill, if not impossible, task.

In this whitepaper, you'll gain an insight into key AR benchmarks and best practices to determine the financial health of your organization. It is important to remember there is no one-size-fits-all approach to benchmarking, as the unique environment, location, patient population and designation of your healthcare organization need to be taken into account when considering the application of these metrics. However, knowing these benchmarks is a fundamental first step that will help you:

- Future-proof your AR processes and harness available data to make informed decisions
- Plan for contingencies and better prepare your organization for the next disruption
- Prioritize areas that can yield the biggest impact to maximize collections and minimize revenue leaks



Key AR metrics to determine your organization's financial health

1 | Net days in AR

Arguably the most important metric to determine the financial health of your organization, net days in AR serves as a trending indicator of overall AR performance. This measure — the average number of days it takes to collect the payments due for services rendered — should be monitored monthly.

To calculate days in AR:

Total charges for the last 6 months / number of days in the last 6 months = average daily charges

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Total AR / average daily charges = days in AR

As a best practice, net days in AR should be between 35 and 40 days. This indicates an effective collections process, although other factors such as complex claims involving non-health payers may impact the days in AR.

Therefore, health providers should drill down into this data by looking at days in AR by financial class: claims involving self-pay, motor vehicle accident (MVA) insurance, workers' compensation (WC), and Veterans' Administration (VA). By separating these financial classes and monitoring trends over time, you will gain better visibility into the performance of all available revenue streams — as well as any bottlenecks that arise due to inefficient processes.

Best practice:

35-40 days in AR indicates a high-performing, effective collection process.

Key takeaway:

Drill down into days in AR by financial class, including self-pay, MVA, WC and VA, which quickly tells you if and where there is a problem.

2 Days discharged not final billed

Discharged not final billed (DNFB) is a valuable metric that not only indicates revenue cycle performance, but it also helps identify issues in the receivable process. Ineffective management of DNFB can lead to mounting AR days, frustrated employees, and disrupted cash flow.

Most healthcare providers aim to keep DNFB low; between 3 and 5 days is ideal. If your DNFB is consistently above 5 days, it is an immediate red flag that is indicative of a systemic issue that may include:

- Coding and billing challenges
- Staffing shortages
- Late charges

Additionally, it is also important to monitor your organization's trending DNFB data over time. Start from a 5-day benchmark — if the trend spikes suddenly or drops too low, it immediately tells you there is a problem.

Best practice:

3-5 days in DNFB is ideal.

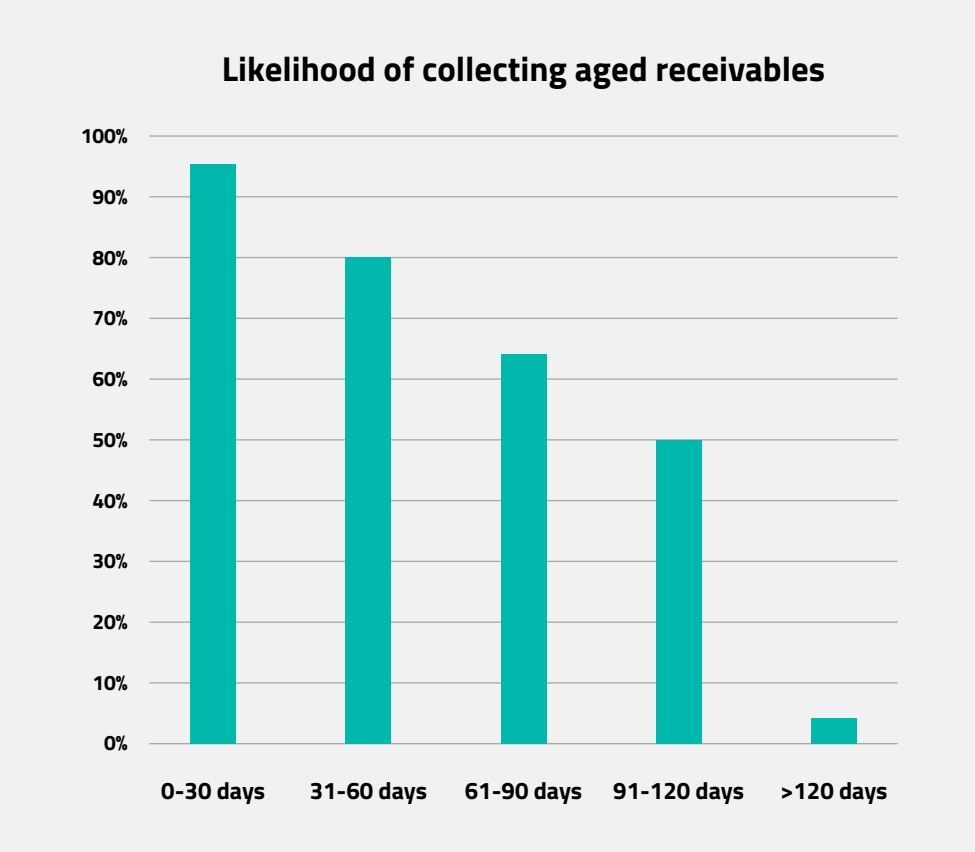
Key takeaway:

Have a mechanism in place to monitor DNFB and to flag issues that arise.

DNFBs consistently over 5 days indicate a larger problem with coding and billing.

3 | Aged AR as a percentage of total AR

The likelihood of collecting the full amount significantly decreases the longer these claims remain in AR. The aged AR metric indicates the collectability of these receivables, while serving as a performance indicator of revenue cycle effectiveness at liquidating AR.



At most healthcare organizations, AR is monitored in 30-day increments. As a general rule, receivables under 90 days are still highly collectible, while 90 days and above generally indicates a degrading receivable with a lower probability of collecting the full amount.

Aged AR should be measured as a percentage in what is referred to by "buckets" relative to your total AR. Depending on your payer mix — whether your organization sees a significant amount of complex claims that take longer to adjudicate, experiences high denial rates or manages a disproportionate share of self-pay patients — the >90 days bucket should make up no more than 25% of your total AR. Without the complexity that come with MVA, WC and VA claims, your organization should see less than 15% of AR over 90 days.

Best practice:

No more than 25% of your AR should be >90 days.

Key takeaway:

Collectability significantly decreases the longer the account ages. It is essential to coordinate and follow up on accounts before it reaches 90 days.

Denials are a significant reason for aged AR, so you should monitor denial codes that come back with technical denials. If 25-30% of denials are due to coding issues, address the coding and documentation process.

4 Number of touches per claim

Getting claims paid depends on your team's efforts in coordinating, following up and moving the claim along the relevant workflows. However, just because claims are "touched" frequently, doesn't mean the work has been effective.

To determine if your revenue cycle processes are efficient, monitor the number of touches on successfully adjudicated claims. This gives you an average benchmark and provides visibility into anomalies, such as drawn-out cases that require too many touches before the claim is reimbursed.

It's also important to monitor the number of claims that have been untouched for more than 30 days, which should be less than 5% of total claims. This performance indicator is crucial in driving payments and keeping aged AR low.

Best practice:

Claims untouched for 30+ days should make up less than 5% of total claims.

Key takeaway:

Creating a cadence in working outstanding accounts receivable will drive payments and prevent aging, but it's vital to do so effectively. Monitor the number of touches on successfully adjudicated claims to determine the efficiency of your collection process.

5 | Bad debt

Bad debt refers to patient debt that is considered unrecoverable. In 2017, hospitals and health systems nationwide wrote off over $55 billion, or 2% of gross revenue, in bad debt[1]— and that was before Covid-19 contributed to the rising number of uninsured and under-insured patients.

This metric indicates the healthcare organization's ability to collect accounts and identify payer sources for those who cannot pay their bills. Like the days in AR indicator, bad debt should be separated and monitored by financial class and at times it may be necessary to drill down to the payer level. Understanding and managing your receivable by financial class will give you a more accurate prediction of financial performance and bad debt reserve for each category.

[1] Bad Debt Expense Benchmarks. HFMA, 2017.

Best practice:

Reserve a percentage of bad debt by each financial class.

Key takeaway:

Lowering previous indicators such as aged AR will result in lower bad debt. Successfully predicting your bad debt reserve by financial class will hone your ability to identify problem areas and deploy targeted collection strategies.

Key metrics for complex claims

1 | Denials

Denials are a constant source of risk for healthcare providers. A denied claim is not just an interruption in cash flow, but also an increase in manual effort as staff needs to dedicate added time to investigate, appeal, and track each claim. Denied claims are, on average, four times more expensive to process than the initial claim[2].

Thus, it is not only important to monitor denial rates over time — including the percentage of denials to total revenue in each financial class — it is essential to track the reason for denials, as well as each successful appeal. This creates a feedback loop to prevent similar denials, while providing actionable insights that providers can leverage to appeal future cases. In light of continually changing standards, regulations, and reasons claims are denied by payers, providers should adopt a holistic and preventive denials management strategy to reduce claim denials and increase clean claims.

[2] HFMA, 2017.

However, for most healthcare providers, this is a moving target. The increasing volume and complexity of denials means hospitals and health systems must allocate resources to the denials that have the highest likelihood of being overturned and recognize that, at some point, the continued pursuit may not be the most effective use of their internal resources. In those instances it may make more sense to engage a specialized RCM partner who can provide a dedicated, skilled team of trained professionals to investigating, advocating and adjudicating these more complex claim denials, which ensures the success of your overall denial management and prevention strategies.

Key takeaway:

Track and monitor the reason for each denial and successful appeal.

Engage specialized resources to investigate each denial.

2 Specialized liability claims

The specialized revenue cycle only makes up a small percentage of total patient encounters, which means providers often ignore the metrics associated with liabilities involving MVA, WC and VA. Representing up to $50 billion in annual gross healthcare spend, it can be an impactful revenue stream and performance indicator — especially if your benchmarks are out of line.

The ratio of your specialized revenue cycle depends on your organization's environment and patient population, but if your organization is not seeing 3-5% of patient visits to the emergency department related to MVA, WC and/or VA, you need to ask if your registration process is missing these patients. Not capturing 1-2% of the patient population can impact the rest of your AR metrics as these misidentified accounts age through the receivable. This makes finding coverage from a suitable third-party payer a challenge, which eventually results in bad debt.

Questions to ask:

1. **Are you capturing all of your liability claims?**
2. **Are you successful in finding coverage from the third-party payers on those claims?**
3. **What is the percentage of untouched claims in these financial classes?**
4. **What percentage of aged receivable is >90 in these financial classes?**
5. **What is the coordination of benefits denial rate for these liability claims?**

To ensure your organization accurately captures these patient encounters, you need a comprehensive patient screening process with mechanisms in place to capture 100%, or as close to 100% as possible, of the patient population. Unlike the rigid, obligatory set of questions due to the limitations of registration software, employing patient advocates with a "human" touch is key to successfully uncovering hidden coverage options.

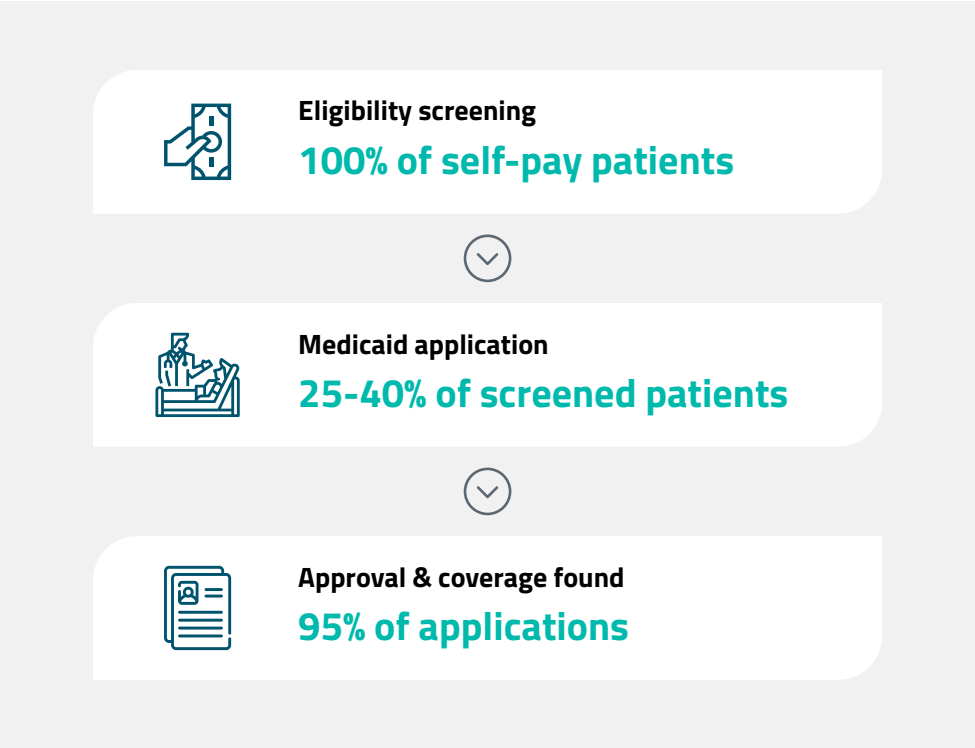
3 | Medicaid enrollment

Patients who are uninsured and qualify for Medicaid often have limited knowledge of how to enroll for coverage. In a recent survey, 40% of patients said they would have not found coverage without help, while 12% of patients — nearly five million people — tried to find help for enrollment but did not get it[3]. By employing on-site patient advocates, healthcare providers can help a significant portion of patients find and secure suitable coverage to maximize reimbursement and reduce bad debt.

Whether your organization does this internally or outsources to a specialized RCM partner, you should screen 100% of self-pay patients to identify Medicaid coverage eligibility. Of these, 25-40% of patients screened should result in an application. With the expertise and experience of dedicated resources, the success rate of applications should be 95% or greater.

[3] Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need. Kaiser family Foundation, 2021.

Another important metric to consider is the time it takes for an application to be approved. To optimize your ability to recover on an approved application, 45 days is a good benchmark to aim for.



Putting metrics into practice

Knowing these key benchmarks is the first step to improving the financial health of your organization. To put them into practice, it is essential to apply them consistently across your AR processes, as well as to communicate clear goals to the rest of your organization.

An important point to note is that these benchmarks are not solely the purview of the CFO. To ensure success, every individual involved in the RCM process must understand the impact of their work. Making this connection — between how their work affects AR metrics and performance, and therefore the organization's financial health — is key to a culture of continuous improvement and a positive financial outcome.

90%+
average collections of pursuable charges

400+
hospitals served

1M+
claims processed annually

$500M+
payments facilitated annually

Why Kemberton?

When you partner with Kemberton, our team of complex coverage experts takes on your most difficult revenue while your internal team focuses on the traditional revenue cycle.

We have already brought in hundreds of millions of dollars in lost revenue for our clients — and that is just the beginning. The results we have been able to achieve include a 3-5x improvement in total specialized revenue cycle reimbursements and A/R days, with dramatic impacts on cash flow and bad debt performance.

From workers' compensation to auto insurance, complex denials and the full range of specialized revenue cycle sources, Kemberton is the only one-stop shop for enterprise class specialized revenue cycle outsourcing services.

With personalized advocacy at the center of everything we do, our experts help patients navigate through the labyrinth of payers and benefits to resolve complex medical coverage challenges in the most compassionate way possible. Powered by a state-of-the-art rules-based workflow automation platform, Kemberton is able to maximize advocates' productivity and provide you with complete visibility and transparency into our revenue recovery processes by utilizing robust, real-time dashboards.

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