BENCHMARKING AND MEASURING FINANCIAL DATA

By Christina Moschella

THIS coming year, thousands of employees will have deductibles on their medical insurance coverage of $1,000 or more. In a recent article in the *Boston Globe,* Liz Kowalczyk wrote that several Massachusetts health insurers are seeking approval from the Division of Insurance to establish deductibles as high as $7,500 a year. Since the accounts receivable is most likely an organization's largest asset, a change in a reimbursement trend such as this could significantly alter the cash flow of your practice.

Managing, measuring, and interpreting financial information has always been one of the most important responsibilities of a practice manager. Now more than ever, managers must have reporting, collections, and monitoring procedures in place.

Briefly, the process requires:

- Establishing benchmarks by documenting goals – financial, administrative, and development.
- Collecting financial information that summarizes productivity, contractual adjustments, write offs, and accounts receivable data.
- Comparing percentages and ratios to benchmarks.
- Interpreting and monitoring data and statistics.

BENCHMARKING

Benchmarking is defined as "measuring your performance against that of best-in-class companies, determining how the best-in-class achieve those performance levels, and using the information as a basis for your own company's targets, strategies, and practices that lead to superior performance." (Pryor, 1989) In other words, it is the "search of industry's best practices that lead to superior performance." (Evans, Lindsay, 2002, p. 413)

Practice managers face the challenge of establishing benchmarks in an industry where variables such as the marketing mix and third-party reimbursement cuts are the norm. Such variations cause percentages and ratios to vary from practice to practice, region to region, and specialty to specialty. Even so, defining the "yardstick" is not impossible. Many practices measure against two benchmarks: 1) the current goals compared with prior period percentages and ratios, and 2) the current goals compared with industry benchmarks, such as those provided by associations.

To be effective, benchmarks should apply to all areas of your practice, such as financial, administrative, development, and productivity. These documented goals serve as improvement objectives.

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During the year, benchmarks provide a point of reference – a target. (Evans, Lindsay, 2002, p. 414)

COLLECTION MEASURES

The following calculations are fundamental, yet crucial measures of the financial status of your practice. (Tinsley, 37-48)

GROSS COLLECTION

$$\textbf{Gross Collection Percentage} = \frac{\textbf{Collections}}{\textbf{Gross Charges}}$$

The gross collection percentage, considered the most important measure, calculates the practice's production and actual cash collected. Consequently, review and compare gross collections on a monthly and year-to-year basis. In addition, your fee schedule and marketing mix affects this percentage; therefore, evaluate both periodically.

If the majority of your market mix is in managed care and you have a high gross collection percentage, it is an indication that your fee schedule may be too low. On the other hand, a practice with a large market mix of indemnity patients should expect a higher gross collection rate.

CONTRACTUAL ADJUSTMENTS

$$\textbf{Contractual Percentages} = \frac{\textbf{Contractual Adjustments}}{\textbf{Gross Charges}}$$

A contractual adjustment is the difference between what a physician charges and what the insurance carrier allows. The ideal measure is to account for each market mix's contractual adjustment. In addition, preparing and reviewing a managed care comparison spreadsheet – comparing the fee schedule of the practice with the allowed schedule of managed care provider – is recommended.

Including bad debt with contractual adjustments, a common

mistake, inflates the percentage. For the most part, contractual adjustments have a corresponding payment from an insurance company or a statement that services are covered. Bad debts are fees that are determined to be uncollectible. As a rule of thumb, if you could have received money from an insurance company and you did not because of an error, such as untimely filing, consider it a bad debt adjustment, not a contractual adjustment.

EXCEPTIONS

Academic medical centers and nonprofit community health centers usually include the bad debt related to treating indigent patients under contractual adjustments.

In addition, generally included in contractual adjustments are write offs such as professional courtesies, financial hardships, and small automatic write offs. (Note: Before you establish a practice policy regarding automatic write offs and adjustments, e.g. for balances under $1, make certain that the amount being automatically written off or adjusted is lower than the lowest coinsurance or copay due from any carrier, especially Medicare. The "most favored nation clause" allows the insurance company or Federal agency to pay at the lowest charge that the practice bills to any patient.)

NET COLLECTION PERCENTAGE

$$\textbf{Net Collection Percentage} = \frac{\textbf{Collections}}{\textbf{Charges Minus Contractual Adjustments}}$$

(Net Collection Percentage is also known as "expected amount.")

Net collection percentage is especially helpful in projecting cash flow. Bad debt is not included in the above "expected amount." For this percentage, always consider the general benchmark to be greater than 90%. If that is not the case, check for an increase in the aged receivables or for errors with contractual adjustment write offs.

ACCOUNTS RECEIVABLE RATIO

$$\textbf{Accounts Receivable Ratio} = \frac{\textbf{Current Accounts Receivable Balance}}{\textbf{Average Monthly Gross Production}}$$

"A good benchmark for most medical practices is to keep receivables more than 90 days old at less than 15 to 20 percent of the total amount of accounts receivable." (Tinsley, p.47-48) The accounts receivable ratio measures the reasonableness of the current accounts receivable balance. The following is a general guideline.

PRACTICE	RATIO
Income mainly received from office work	Between 1.0 and 2.0
Surgical practices or other significant focus on hospital services	Between 2.0 and 3.0

The accounts receivable ratio should never exceed three times the average monthly gross production. (Tinsley, p. 48) (Note: For more detailed ratios, consult surveys published by MGMA.)

MEASURING, INTERPRETING, AND MONITORING

Continually compare and monitor percentages and ratios to prior periods and benchmarks. Immediately investigate poor statistics.

The interpretation of financial data is complicated by variables such as changes in the market mix, the financial stability of insurance companies, and adjustments in Federal and state fee allowances. Because your market mix plays such a key role in the interpretation of the numbers, it is important that you keep up-to-date on the insurance industry and the local economy. For example, is an insurance company in danger of bankruptcy? Has a large company in your area closed, thus effecting employees'/patients' coverage? Is the state cutting back on Medicaid? Is there a trend towards higher deductibles?

CONCLUSION

Measuring and interpreting financial information in the medical field is difficult. The process requires establishing reports that allow you to constantly compare with the organization's and industry's benchmarks. The challenge of interpreting percentages and ratios requires strong analytical skills— both objective and subjective.

SOURCES:

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CHRISTINA MOSCHELLA is a consultant, specializing in HIPAA and compliance issues, management, and medical audits. She has published and lectured on physician practice management topics for several years.