



Financial Leadership Council

Benchmarking Revenue Cycle Performance

Results from the 2015 Revenue Cycle Benchmarking Survey

Financial Leadership Council

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Overview of Benchmarking Revenue Cycle Performance

- Executive Summary
- Financial Leadership Council Key Findings
- Research Methodology

Executive Summary

Benchmarks Critical to Maximizing Revenue Cycle Performance

Revenue Cycle performance improvement continues to be a major priority for hospital finance departments, and data remains critical to this effort. Without relevant industry standards, leaders are forced to gauge performance by instinct or institutional precedent. This approach can overlook potential improvement areas or leave operations under-resourced. The purpose of this publication is to provide meaningful, actionable benchmarks for hospital Revenue Cycle departments.

This report features results from the 2015 Revenue Cycle Benchmarking Survey. It provides quartile rankings and data trends for key performance metrics, helping financial leaders better identify areas of low performance and high opportunity.

Navigating This Publication

The report has been divided into three sections, each targeting a specific area of revenue cycle operations and performance:

- **Benchmarking Cohort Demographics:** Presents a demographic snapshot of the survey cohort, as well as an overview of patient mix and case mix index.
- **Revenue Cycle Structure and Staffing:** Focuses on sources of revenue cycle costs, assessing structure and staffing by functional area and expense type.
- **Revenue Cycle Performance Metrics:** Analyzes performance on most important measures of revenue cycle performance from point-of-service collections through final appeals for denials and sources of cost and performance.

Read the Full Publication to Learn More

Benchmarking Revenue Cycle Performance provides comprehensive, industry-wide benchmarks to help leaders reliably compare revenue cycle productivity and more appropriately target improvement efforts.

Financial Leadership Council Key Findings

1. **Low performers consistently fall far behind top-performers**

Our research indicates the gap between high and low performers exceeds 100% for multiple metrics. We estimate a potential opportunity of \$3.4 million for point-of-service collections and \$8 million in cost to collect. Considering the already narrow operating margins for hospitals, low performers should at least aspire to meet median performance, if not better. **Page 20**

2. **AR performance losing steam**

After steady across-the-board improvements between 2006 and 2011, days in net accounts receivable (AR) has increased since 2013 at the top and bottom ends of the performance spectrum. However median performance has stayed fairly flat, suggesting that hospitals can stave off material AR declines through focused efforts. Our analysis indicates that improvement from low to median performance quartiles could yield a significant acceleration of cash, up to \$10.2 million **Page 25**

3. **Poor AR performance linked to cost inefficiency**

Organizations performing worst on AR generally have the highest cost to collect and spend more on salary and benefits than high performers. This high baseline level of spending can make improvements to AR performance difficult, as cash is already tied up in other, ostensibly ineffective, efforts. **Page 32**

4. **Ninety days an apparent stagnation point for AR**

Long-term AR management should be a concern for all organizations. Data indicates little improvement in AR between 90 and 120 days, regardless of performance quartile. Consider front-loading resources to prevent accounts from aging past 90 days. **Page 26**

5. **Coded, Not Final Billed a top priority for low performers**

For low performers it may be easier to drive improvements in unbilled AR by focusing on Coded, Not Final Billed rather than Discharged, Not Final Coded. Organizations with low performance today have a clear but attainable benchmark to pursue. **Page 24**

6. **Point-of-service collections opportunity remains despite recent gains**

Our latest data shows the largest increase in point-of-service collections as a percentage of net patient revenue seen in the last four years. High performers now collect over 1% of net patient revenue at point-of-service. Nevertheless, there is a significant gap between top-quartile and top-decline performers, indicating significant performance gains are possible. **Page 20**

7. **Commercial denials weakening payer cross-subsidy**

Many hospitals rely on commercial payments to offset the lower reimbursement from government payers. However, commercial denials, as a percentage of total denials, have increased, even as the volume of commercially insured patients has stayed constant in both inpatient and outpatient settings. **Page 28**

8. **Across-the-board decline in outsourcing**

Not only has overall revenue cycle spending on outsourcing decreased since 2013, but fewer hospitals report outsourcing for every function surveyed. This decline is significant but not universal, as hospitals still predominantly choose to outsource in specific areas, such as collections. **Page 14**

9. **CMI affected, but not limited, by hospital size**

Contrary to common belief, high performing small hospitals have a CMI nearly identical to median performing mid-sized hospitals. This trend also holds true for high performing mid-sized hospitals. **Page 12**

10. **Staffing upticks likely influenced by national health care trends**

High-deductible health plans and the ICD-10 transition are the probable causes for increases in financial counseling and coding staffing, respectively. While high-deductible health plans will likely demand more front-end staffing resources moving forward, future coder needs post-ICD-10 transition are yet to be determined. **Page 16**

Research Methodology

The 2015 Revenue Cycle Benchmarking Initiative combines data from two different sources: a 34-question survey administered via an online portal and data provided by The Advisory Board Company's Revenue Cycle Solutions Performance Technologies.

Survey questions examined all aspects of the revenue cycle. In addition to defining current performance benchmarks and performance-quartile breakdowns, this report compares current performance against historical survey findings.

Participants were asked to submit data from their hospital's most recently completed fiscal year. Ninety-nine percent of responses include data from fiscal year 2014. Hospitals that were part of a system employing centralized functions were asked to allocate and report resources attributable to individual facilities, with multi-hospital systems reporting data on multiple facilities.

Revenue Cycle Functions Analyzed



Patient Access

- Scheduling/Registration
- Financial clearance
- Pre-collections



Mid-cycle

- Case mix index
- Coding and documentation
- DNFC¹ performance



Business Office

- Billing
- Collections
- Denials management



Survey of Hospital Revenue Cycle Operations

- 2015 report is our fifth publication of this survey
- Provides hospital financial executives with a comprehensive set of revenue cycle performance benchmarks
- Seven new data points included in 2015 survey: Case Mix Index; Hospital Management of Physician Revenue Cycle; Minutes to Financially Clear a Patient; Coded, Not Final Billed; Accounts Receivable Over 90 Days; Accounts Receivable Greater Over 120 Days; Appeals Success Rate
- Received 92 survey responses (full and partial)
- Additional data was received from 428 members of the Advisory Board Company's Performance Technologies^{2,3}

1) Discharged, Not Final Coded.
2) Participating Performance Technologies include Revenue Optimization Compass, Revenue Cycle Compass, and Payment Integrity Compass.
3) Some members submitted data through both the survey and Performance Technology tools.

Source: 2015 Revenue Cycle Benchmarking Survey



Benchmarking Cohort Demographics

- Cohort Profile
- Patient Registrations by Care Setting and Payer Type
- Case Mix Index
- Revenue Cycle Costs by Expense Type
- Outsourced Revenue Cycle Functions

Cohort Profile

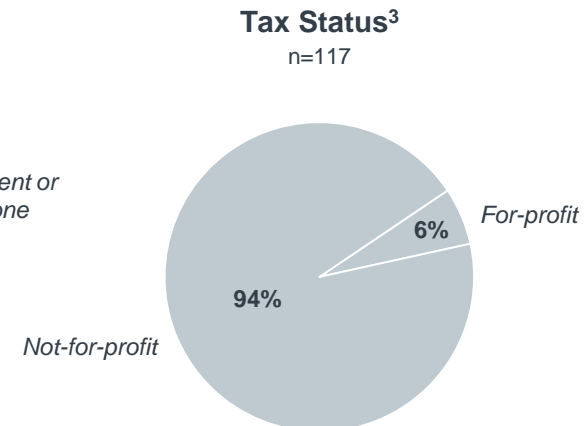
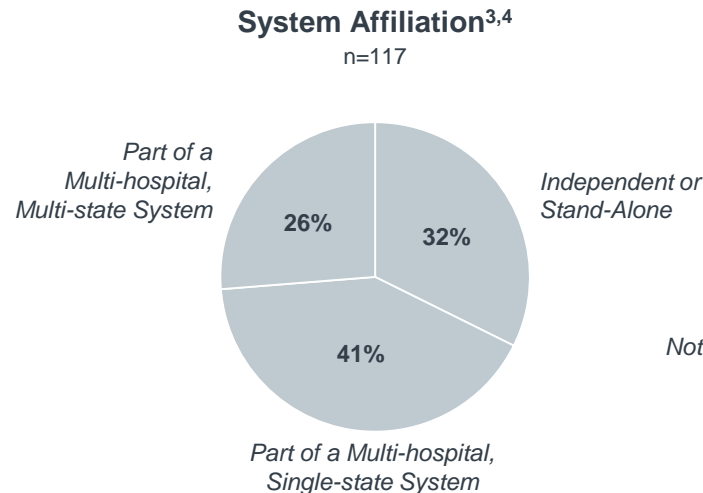
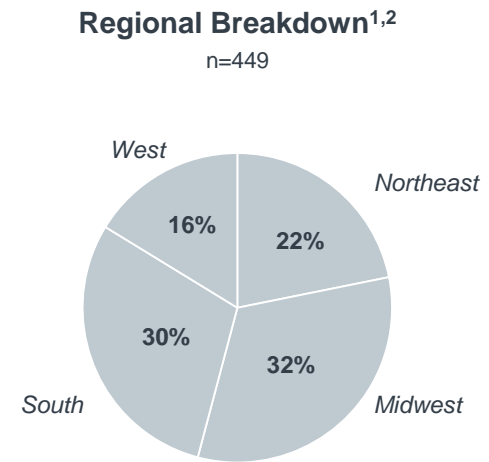
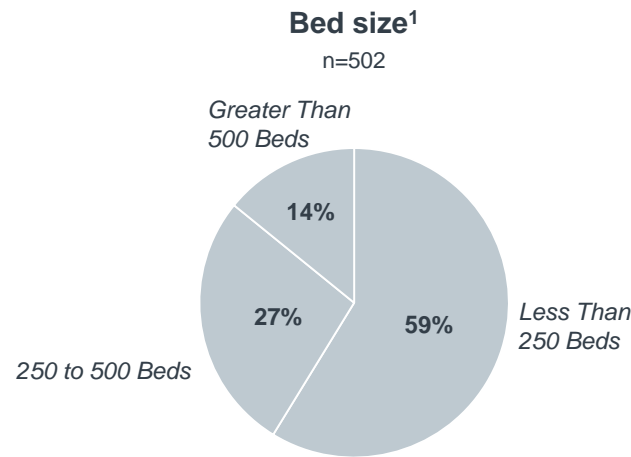
This year's cohort represents a diverse sampling for analysis and includes hospitals of varying size and scope. All institution types, regions, and affiliations are represented within the benchmarking cohort.

Hospitals in this analysis are characterized as acute care inpatient facilities, reimbursed under the Inpatient Prospective Payment System. The analysis does not include other hospital types such as children's, psychiatric, long-term care, and critical access hospitals.

The most significant change observed in this year's cohort is the increase in hospitals' reporting system affiliation. Only 32% of this year's participants reported independent status, down from 48% in the 2013 survey. While this may reflect changes in sampling from prior years, it is consistent with a broader national trend of consolidation.

One characteristic of the sample that differs from national representation is the lower overall presence of for-profit hospitals. Survey participants are almost entirely not-for-profit hospitals. Nationally, 21% of hospitals are for-profit.

Demographic Breakdown



1) Survey and Performance Technology data.
 2) Northeast region includes: CT, DE, MA, ME, NH, NJ, NY, PA, RI, VT; Southern region includes: AL, AR, FL, DC, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV; Midwest region includes: IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI; Western region includes: AK, AZ, CA, CO, ID, HI, MT, NV, NM, OR, UT, WA, WY.
 3) Survey data only.
 4) Percentages may not sum to 100 due to rounding.

Source: "Fast Facts on US Hospitals," American Hospital Association, <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml#community>; Source: 2015 Revenue Cycle Benchmarking Survey

Patient Registrations by Care Setting and Payer Type

This year's surveyed hospitals reported a distribution of patient registration by payer, similar to 2013. The only notable difference is a slight shift in outpatient registrations, with a small uptick in Medicare offset by a corresponding decline in Medicaid.

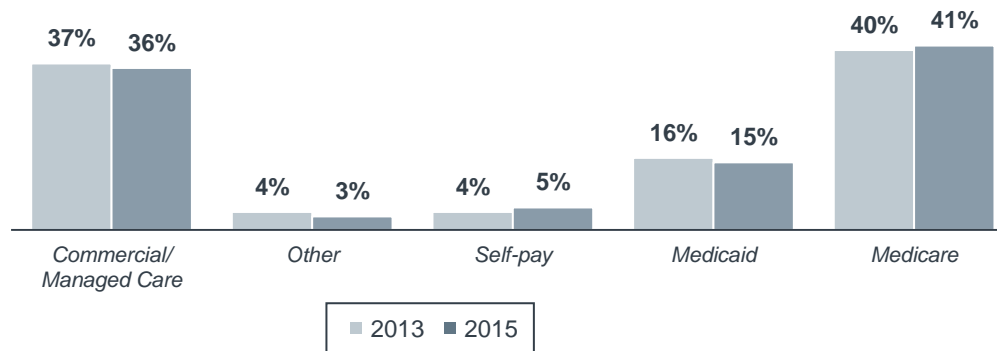
As the payer mix has remained constant at participating hospitals over the last two years, it is unlikely to play a significant role in changes to revenue cycle performance. Nevertheless, the increasing uptake of high-deductible health plans—reflected in the Commercial/Managed Care category—is likely to play an immediate role.

High Proportion of Medicare Registrations, Fewer Commercially Insured Patients

Inpatient Payer Type^{1,2}

Percentage of Inpatient Registrations

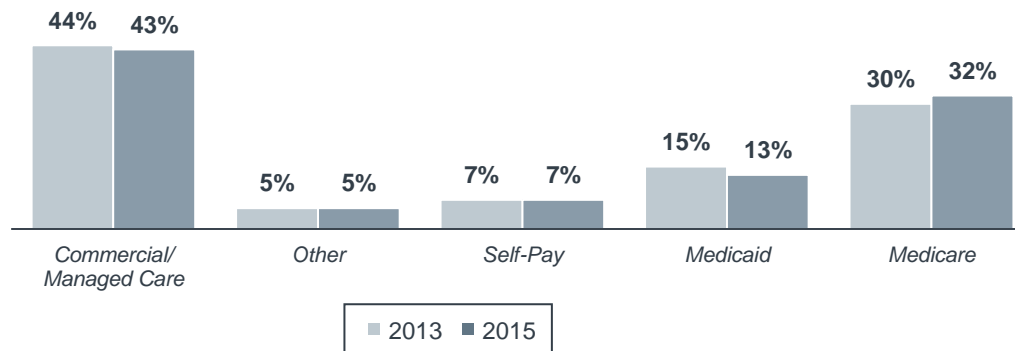
n=41 (2013); n=78 (2015)



Outpatient Payer Type^{1,2}

Percentage of Outpatient Registrations

n=42 (2013); n=77 (2015)



54%
Net patient revenue from inpatient setting

46%
Net patient revenue from outpatient setting

1) Survey data only.
2) Percentages may not add up to 100 due to rounding.

Source: 2015 Revenue Cycle Benchmarking Survey

Case Mix Index

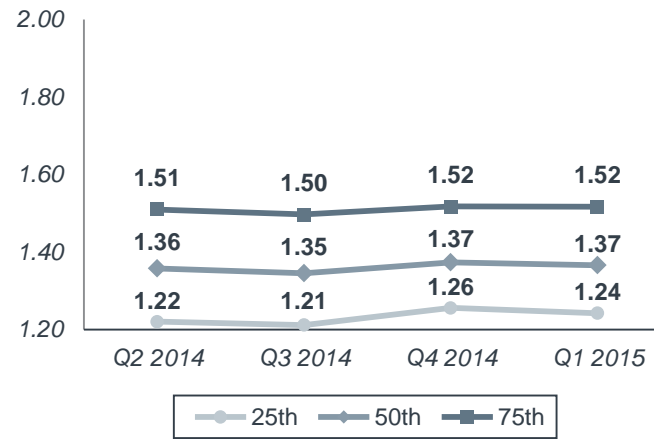
The 2015 survey is the first time that we have requested participants to report quarterly case mix index (CMI), a measure of relative resource utilization across the inpatient population.

Generally, case mix index increases as bed size increases, reflective of the higher proportion of complex cases treated at larger facilities. However, our survey reveals that while bed size is a contributing factor to CMI, it is not completely limiting at small to medium-sized hospitals. Top-quartile CMI at these facilities was often consistent with the profile of a larger organization. For example, high performers in the 0-250 bed group have a comparable CMI to median performance for 250-500 bed hospitals. Similarly, high performers for 250-500 bed hospitals have a nearly identical case mix index to median-performers at large, 500+ bed hospitals.

CMI Performance Influenced, but Not Completely Limited, by Bed Size

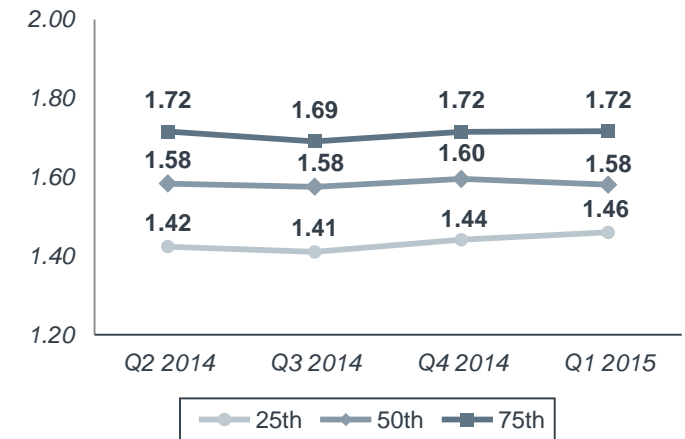
CMI, Hospitals 0-250 Beds¹

n=220



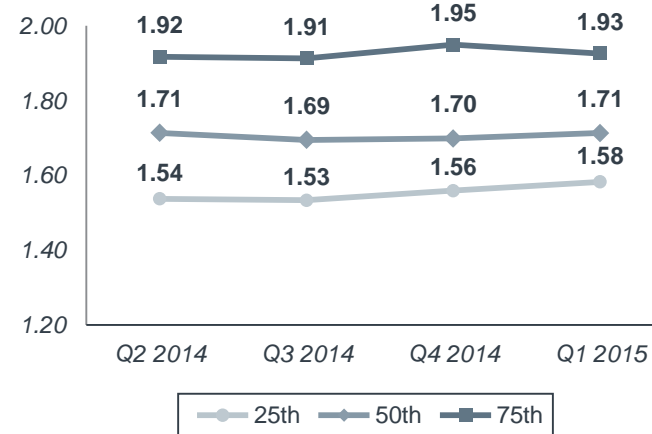
CMI, Hospitals 250-500 Beds¹

n=107



CMI, Hospitals 500+ Beds¹

n=49



1) Survey and Performance Technology data.

Source: 2015 Revenue Cycle Benchmarking Survey

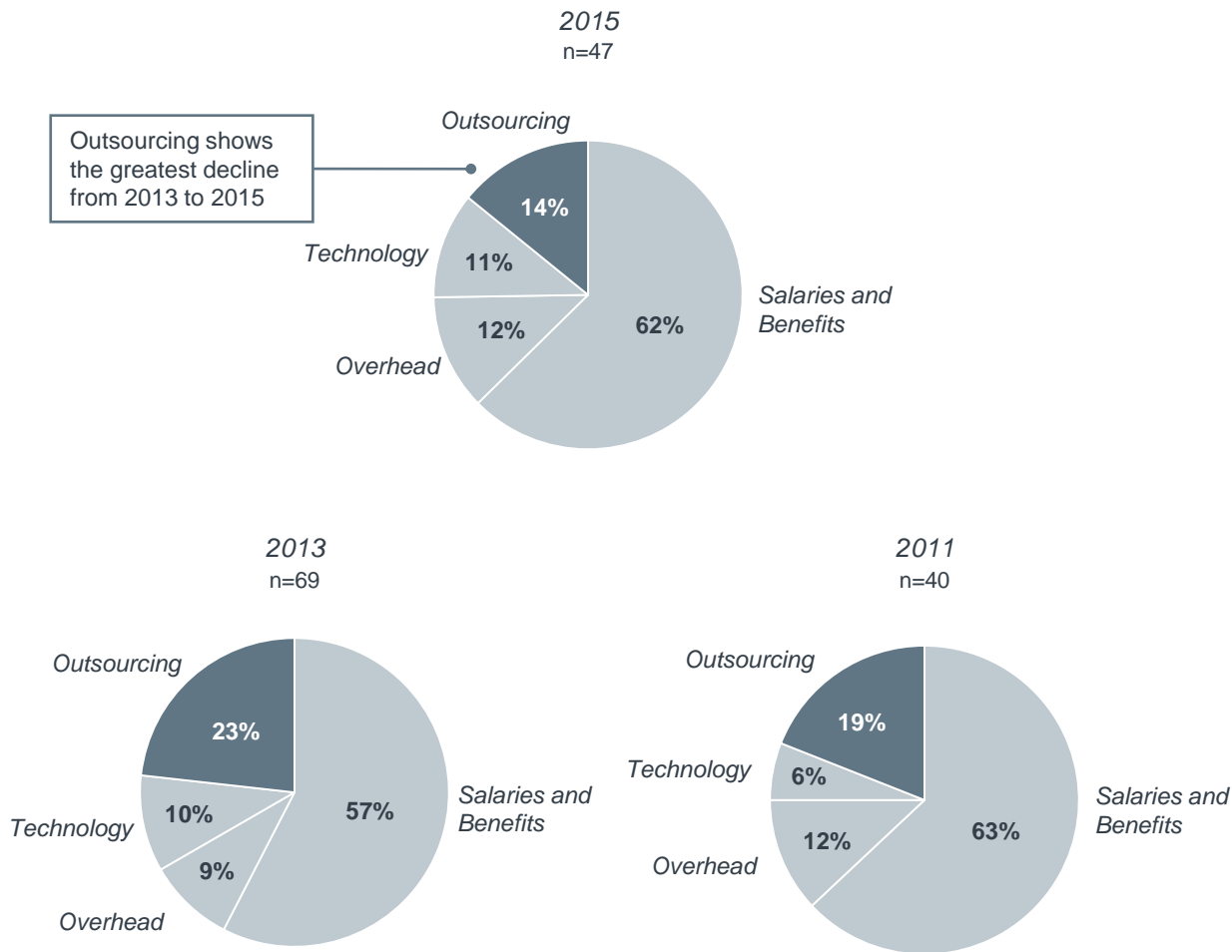
Revenue Cycle Costs by Expense Type

The distribution of revenue cycle expenses has changed significantly from our last survey in two notable areas: reduced outsourcing spending and a commensurate uptick in the overall proportion of spending on salaries and benefits. This trade-off suggests that hospitals are reallocating internal resources to areas previously outsourced. Spending on technology and overhead has increased slightly since 2013, also supporting a broader move to bring more revenue cycle functions in-house.

Moving forward, organizations will require better visibility into specific areas of spending that drive revenue cycle performance improvements. View our analysis on page 33 to see how spending varies between organizations with high and low accounts receivable performance.

Organizations Looking to Leverage Technology, Bring Services In-House

Average Revenue Cycle Spending by Expense Type^{1,2}



1) Survey data only.
2) Percentages may not sum to 100 due to rounding.

Source: 2015 Revenue Cycle Benchmarking Survey

Outsourced Revenue Cycle Functions

Our latest survey results indicate reduced revenue cycle outsourcing compared to the 2013 survey for all functions. After a small spike in 2013, outsourcing now appears to be more consistent with 2011 levels.

The sharpest outsourcing reduction observed is in long-term collections. This finding is not surprising considering the high cost and relatively low success rates of long-term collections overall, as discussed on page 26. Nevertheless, over two-thirds of all respondents still outsource this function.

A smaller, but notable shift is the decline in outsourced physician billing and practice management. Considering increases in both physician and hospital M&A¹ activity, this may reflect physician revenue cycle functions shifting toward consolidation rather than outsourced management or affiliation with hospital revenue cycles.

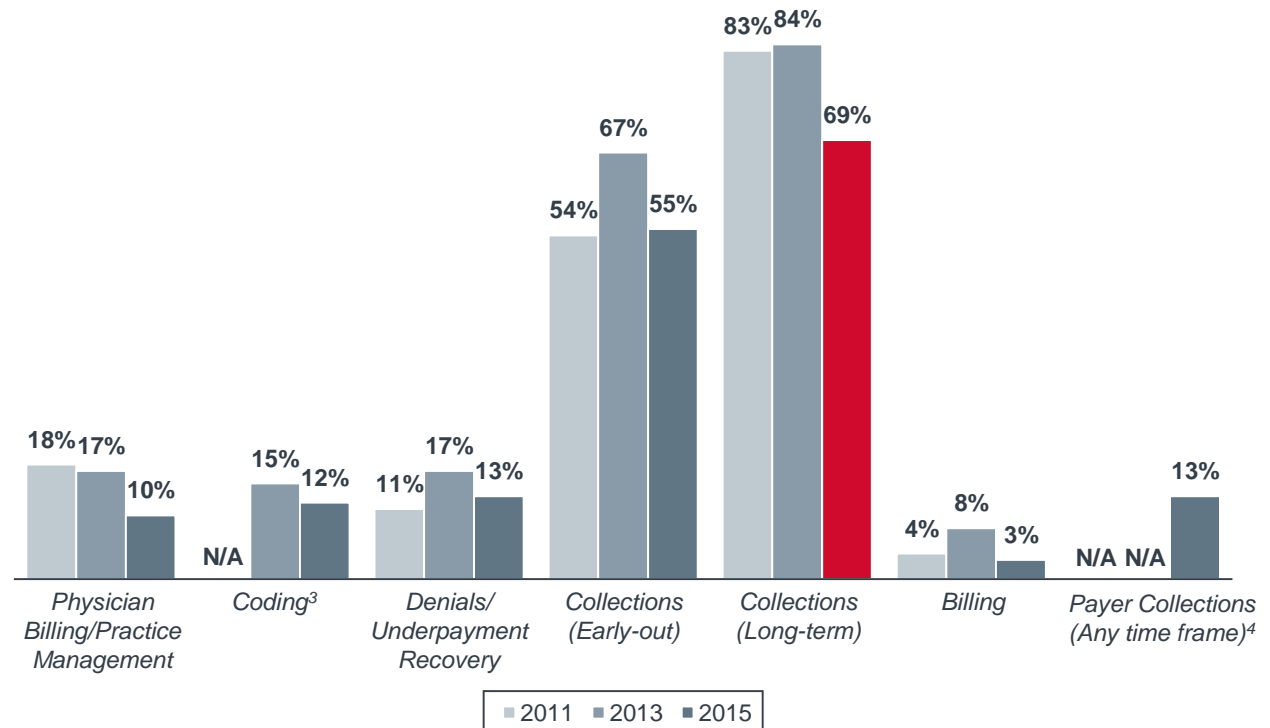
Newly tracked in 2015, a small but significant number of hospitals report outsourcing payer collections.

Outsourcing Decisions Reveal Changes and Challenges in Hospital Landscape

Outsourced Revenue Cycle Functions²

Percentage of Survey Respondents Outsourcing this Function

n=92 (2011); n=41 (2013); n=118 (2015)



1) Mergers and acquisitions.
 2) Survey data only.
 3) Survey option introduced in 2013.
 4) Survey option introduced in 2015.

Source: 2015 Revenue Cycle Benchmarking Survey



Revenue Cycle Structure and Staffing

The Composition of the Hospital Revenue Cycle Function

- Revenue Cycle Staffing
- Revenue Cycle Staffing by Bed Size
- Management of the Physician Revenue Cycle

Revenue Cycle Staffing

Our survey data reveals increased revenue cycle staffing, particularly in areas influenced by national health care changes: the transition to ICD-10, managing the needs of patients with HDHPs¹, and payer relations.

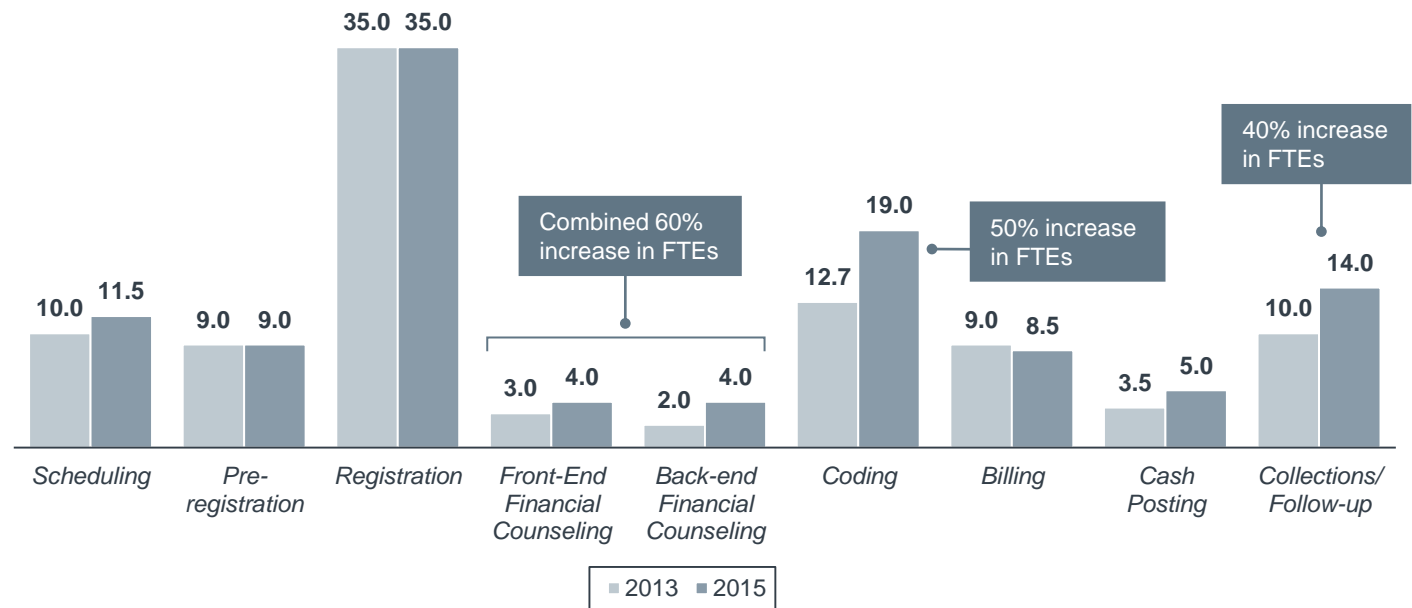
Organizations have increased their coding staff by 46%, likely in anticipation of the ICD-10 transition. However, it is unclear how long this uptick in staffing will remain. Productivity and accuracy of coding post-ICD-10 is likely to play a role in determining necessary staffing levels.

Providers have shifted more resources to front-end financial counseling functions likely as a response to the increase in potentially insurance-eligible patients and those who need assistance understanding financial obligations. The growth of patient debt and decreased emphasis on outsourcing are probable contributors to the staffing increase observed in collections/followup and back-end financial counseling.

Staffing Growth a Response to National Health Care Trends

Median Number of FTEs by Revenue Cycle Function^{2,3,4,5}

n=41 (2013); n=63 (2015)



1) High deductible health plans.
 2) The functions listed here represent the most common revenue cycle operational areas and are not intended to be exhaustive.
 3) Medians are based on members who reported having at least one FTE in each function.
 4) Percentage of members who answered the survey question for each FTE service in 2015: Scheduling (60%), Pre-registration (78%), Registration (90%), Front-End Financial Counseling (87%), Back-End Financial Counseling (49%), Coding (79%), Billing (98%), Cash Posting (97%), Collections/Followup (90%).
 5) All reported data for 2013 and 2015 exclude survey respondents who reported "0" employees for a particular function. The 2013 Revenue Cycle Benchmarking publication used a different calculation methodology. Thus, the 2015 survey will not match previous publications.

Source: 2015 Revenue Cycle Benchmarking Survey

Revenue Cycle Staffing by Bed Size

When examining revenue cycle FTEs¹ by bed size, we see a proportional increase in specific roles as the organization gets larger. This finding suggests that certain staffing functions, such as registration, coding, and collections, may be less scalable and simply require more FTEs at larger organizations.

Scheduling and pre-registration staffing appear to deviate from this trend. Though the median number of employees for these functions at 250-500 bed and 500+ bed institutions is nearly identical, data from survey respondents shows a wide range of scheduling and registration staffing levels across all bed-size groups. In this area, it appears that responding organizations have not identified a widely applicable staffing ratio.

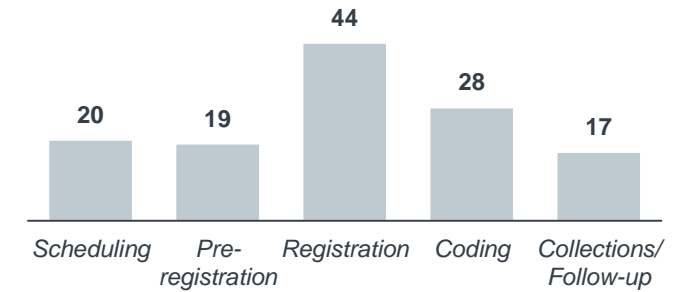
Achieving Scalable Efficiency Easier in Select Functions

Median Number of FTEs by Revenue Cycle Function²

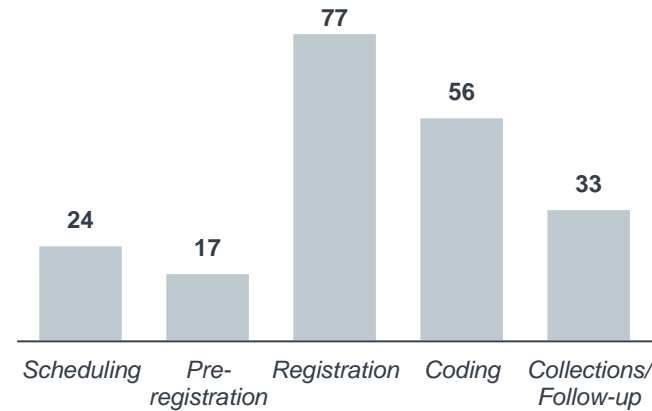
Fewer Than 250 Beds
n=24



250-500 Beds
n=20



More Than 500 Beds
n=16



1) Full-time employees.
2) Survey data only.

Source: 2015 Revenue Cycle Benchmarking Survey

Management of the Physician Revenue Cycle

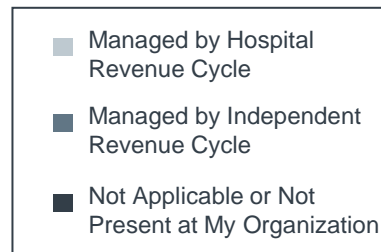
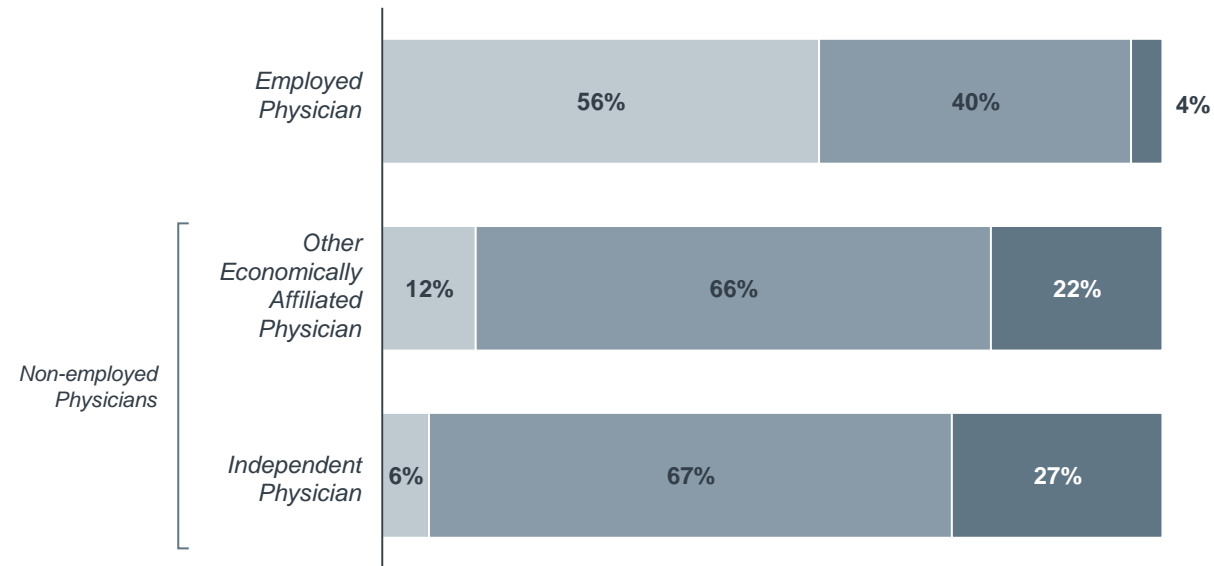
Over half of the surveyed organizations report managing their employed physicians' revenue cycle, taking advantage of existing hospital revenue cycle functions. However, the nuances of physician billing and collections are likely the reason a full 40% of organizations report management of the physician revenue cycle by a medical group, physician practice, or practice-only central billing office for employed physicians.

A small but notable portion of hospitals surveyed report the revenue cycle for non-employed physicians. At this stage, the Financial Leadership Council has limited insight into the specific motivations for these relationships. However, we will monitor this trend in future research to examine its long-term impact.

Few Hospitals Manage Revenue Cycle for Non-employed, Aligned Physicians

Hospital Management of Physician Revenue Cycle^{1,2}

n=108



1) Survey data only.
 2) Definitions: Managed by Hospital Revenue Cycle: i.e. traditional hospital function or hospital-controlled CBO; Managed by Independent Revenue Cycle: i.e., by medical group, physician practice, or practice-only CBO.

Source: 2015 Revenue Cycle Benchmarking Survey



Revenue Cycle Performance Metrics

Analysis of Key Revenue Cycle Benchmarks

- Point-of-Service Collections
- Point-of-Service Collections by Service Area
- Unbilled Accounts Receivable Days
- Discharged, Not Final Coded Days
- Drivers of Unbilled Accounts Receivable Days
- Trending Net Accounts Receivable Days
- Aged Accounts: AR Over 90 and AR Over 120 Days
- Self-Pay Collections: Early-Out and Long-Term
- Denials by Payer
- Denials by Reason
- Appeal Success for Denials
- Cost to Collect
- AR Performance by Cost to Collect
- Revenue Cycle Spending by Net AR Days Performance Group

Point-of-Service Collections

While hospital point-of-service (POS) collections have improved over the last five years, there appears to be significant opportunity for growth. Performers in the top quartile are collecting, on average, four times more than hospitals in the bottom quartile.¹ Despite this large discrepancy, the low performance quartile exhibited the largest growth since the 2013 survey; particularly impressive given relatively flat performance between 2011 and 2013.

For a hospital with median net patient revenue, moving from low to median-performance on POS collections could mean an increase of \$1.2 million. Those aspiring to move from low to high performance could see an increase as high as \$3.4 million.

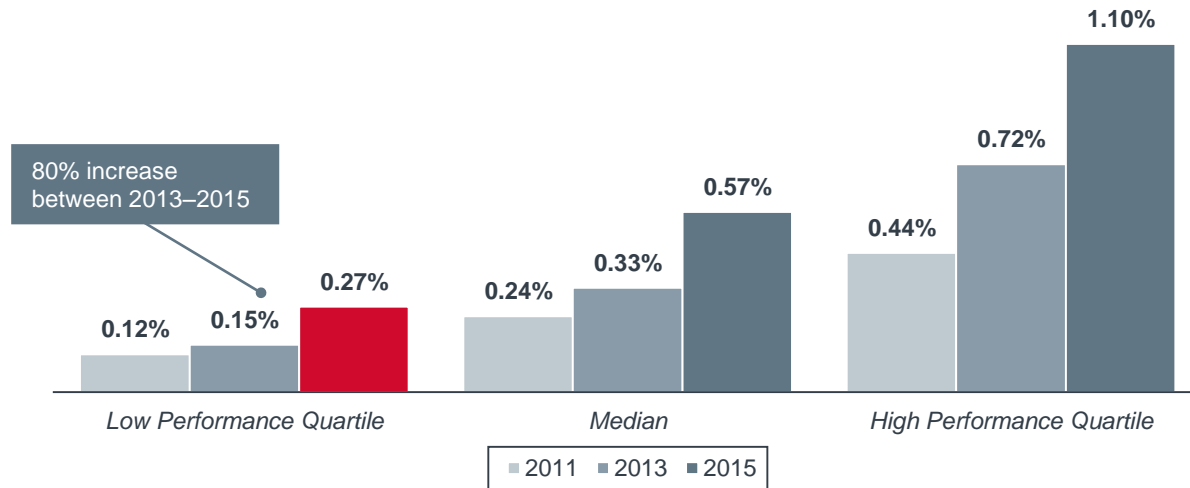
Importantly, our analysis indicates no correlation between hospital bed size and point-of-service collections as a percentage of net patient revenue, suggesting that high performance is attainable regardless of size.

Point-of-Service Collections Show Improvement After Slow Start

Point-of-Service Collections²

Percentage of Net Patient Revenue

n=72 (2011); n=38 (2013); n=54 (2015)



Financial Leadership Council Analysis
Point-of-Service Collections Opportunity by Performance Quartile³

\$1.2M	\$2.2M	\$3.4M
Difference in POS collections between median and low performing quartiles	Difference in POS collections between high and median performing quartiles	Difference in POS collections between high and low performing quartiles

1) When comparing total point-of-service collections as a percentage of net patient revenue.
 2) Assumes annual net patient revenue at the median for survey respondents of \$406,445,773.
 3) Survey data only.

Source: 2015 Revenue Cycle Benchmarking Survey

Point-of-Service Collections by Service Area

Inpatient and outpatient surgery represent the highest single category of dollars collected at the point-of-service across the cohort. While the emergency department and radiology also contribute significantly, the large contribution of ‘other services’ — including areas like lab, pharmacy, urgent care and other miscellaneous categories—cannot be ignored.

This year we also asked our members for data on time to financially clear a patient. Though high performers in the survey are clearing patients in 9.5 minutes, anecdotal evidence suggests faster performance is attainable for most through process improvements.

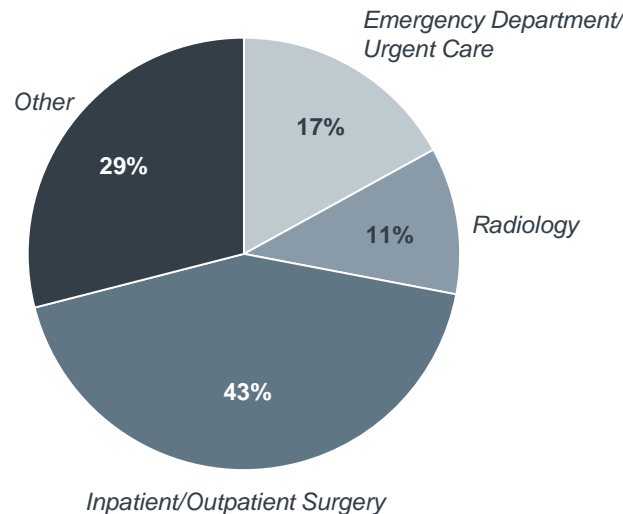
To achieve this goal, hospitals must focus on optimizing workflows and technology solutions. This enables patient access teams to prioritize a smaller number of more complex patient interactions.

Surgery Leading Source of Point-of-Service Collections

Point-of-Service Collections by Service Area^{1,2}

Percentage of Total Point-of-Service-Collections

n=80



Minutes to Financially Clear a Patient

- 25 Low-performing quartile
- 15 Median
- 9.5 High-performing quartile

\$1.8M

Cohort median for annual point-of-service collections

1) Survey data only.
2) This data is a composite group based on median performance across the survey cohort.

Source: 2015 Revenue Cycle Benchmarking Survey

Unbilled Accounts Receivable Days

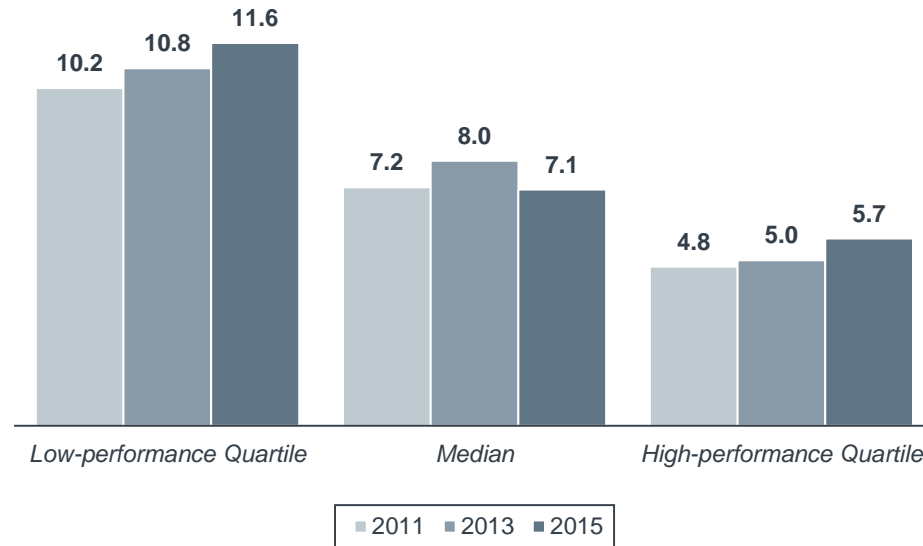
Days in unbilled accounts receivable (AR), commonly called discharged, not final billed (DNFB) days, has worsened over the past three surveys. This performance pattern indicates a deceleration of the billing process, a key challenge associated with improving AR performance. Our analysis indicates that contributing factors to AR management begin in-house. For organizations looking to improve AR days, DNFB improvement may be an easier starting point than working with payers after claims have been sent.

The analyses on the next two pages explore the underlying drivers of unbilled accounts receivable performance.

Low Performers Falling Behind on Unbilled Days

Unbilled Accounts Receivable Days¹

n=76 (2011) n=31 (2013); n=140 (2015)



\$19.5M
 Median value of total dollars in unbilled account status, 2015

1) Survey and Performance Technology Data.

Source: 2015 Revenue Cycle Benchmarking Survey

Discharged, Not Final Coded Days

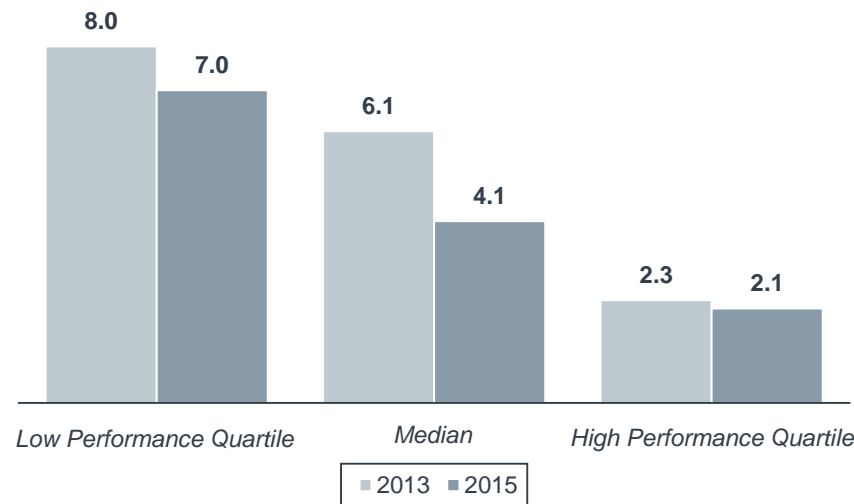
This year's data shows a modest improvement in discharged, not final coded (DNFC) days from previous years, particularly among low and median-performers. As noted on page 16, organizations appear to have increased coding staff in preparation for the ICD-10 transition. The associated benefit of the additional staff has likely been realized in terms of productivity gains, as the cohort improved overall performance compared to 2013 results.

DNFC is a valuable indicator to gauge efficiency—or inefficiency—in mid-cycle processes and operations. These numbers may also serve as a benchmark after the ICD-10 transition, as providers look to, at a minimum, match their previous DNFC performance.

Staffing Upticks Likely a Driver of Reduced DNFC Days

Discharged, Not Final Coded Days¹

n=28 (2013); n=130 (2015)



4.9
Difference between high and low performance quartiles for DNFC days

1) Survey and Performance Technology data.

Source: 2015 Revenue Cycle Benchmarking Survey

Drivers of Unbilled Accounts Receivable Days

This graphic compares organizations on the basis of unbilled AR performance, displaying the average contribution of days in discharged, not final coded (DNFC) and coded, not final billed (CNFB). Diagnosing the overall composition of unbilled AR performance is an essential first step to correcting bottlenecks. We recommend using these benchmarks to identify which aspect of unbilled AR warrants the most attention.

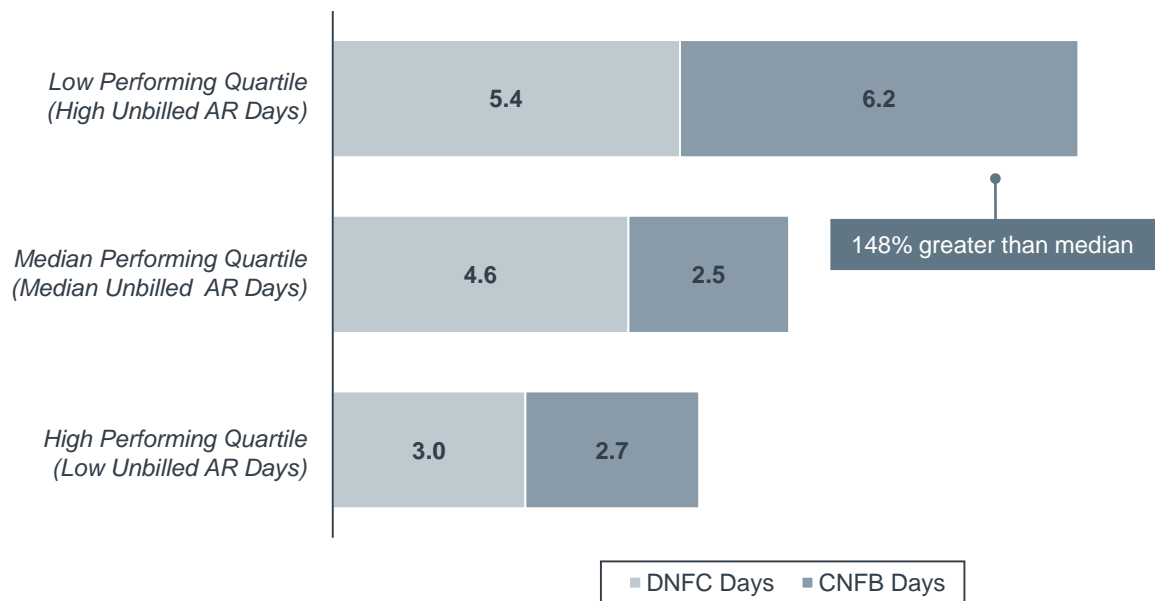
Roughly half the organizations in the cohort have converged on best-practice performance for CNFB, ranging between 2.5 and 2.7 days on average. These organizations should prioritize improvement in DNFC to drive down overall unbilled AR days.

Organizations in the low performing quartile should focus on improving CNFB days, which clearly lags behind median performance.

Cohort Converging on Best Practice for Coded, Not Final Billed

Performance Group Categories for Unbilled AR Days¹

n=126^{2,3}



1) Survey and Performance Technology data.
 2) 39 low days facilities; 46 middle days facilities; 41 high days facilities.
 3) Each group represents average performance for groups at the 5-33, 34-66, and 66-95 percentiles, respectively.

Source: 2015 Revenue Cycle Benchmarking Survey

Trending Net Accounts Receivable Days

Despite improvements over the past decade, performance on AR days has been gradually eroding since 2011. This is likely the result of a confluence of factors, including a toughening payer climate and a diversity of competing revenue cycle priorities.

The most notable declines in AR days can be seen in the low performing quartile. The gap between low and high performers was under 11 days in 2011, but has now widened to almost 14 days. The median's steady performance in AR days suggests it is possible to stave off performance declines.

The potential upside of improvement is sizeable. Financial Leadership Council analysis¹ shows an opportunity of \$15.3 million for low performance organizations seeking to pursue the path to high performance. Even those able to increase to median performance could see \$10.2 million in improved AR performance.

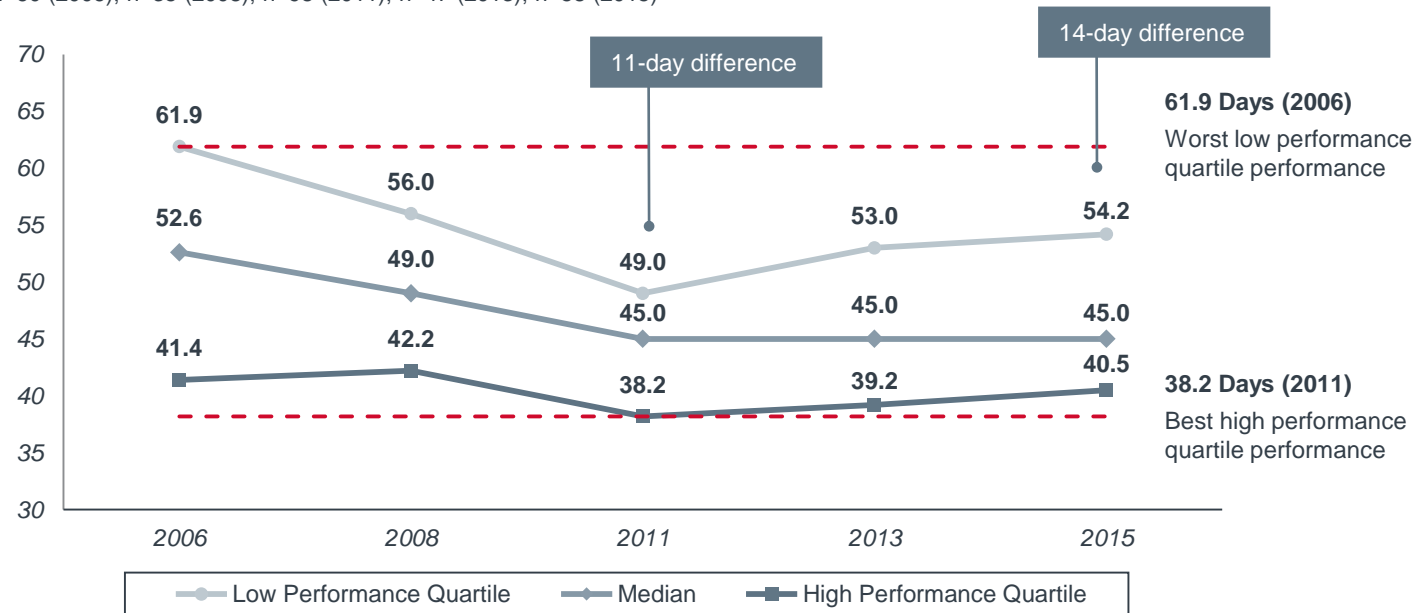
As best practices for AR reduction have changed little since 2011, organizations aiming to improve performance would benefit from a renewed focus on established AR management tactics.

Previous Gains Slowly Slipping

Trended Net AR Days from 2006 to 2015²

Revenue Cycle Benchmarking Survey Participants

n=60 (2006); n=35 (2008); n=98 (2011); n=47 (2013); n=58 (2015)



Financial Leadership Council Analysis: AR Cash Acceleration Potential¹

\$10.2M	\$5.0M	\$15.3M
Difference between median and low performing quartiles	Difference between high and median performing quartiles	Difference between high and low performing quartiles

1) Assumes cohort median for net patient revenue, \$406,445,773 averaged out over the course of a year (\$1,113,550 per day) and quartile performance shown on this page.
2) Survey data only.

Source: 2015 Revenue Cycle Benchmarking Survey

Aged Accounts: AR Over 90 Days and AR Over 120 Days

A surprisingly large proportion of accounts receivable remain uncollected at 90 days across all performance quartiles with a near 100% gap between high and low performers.

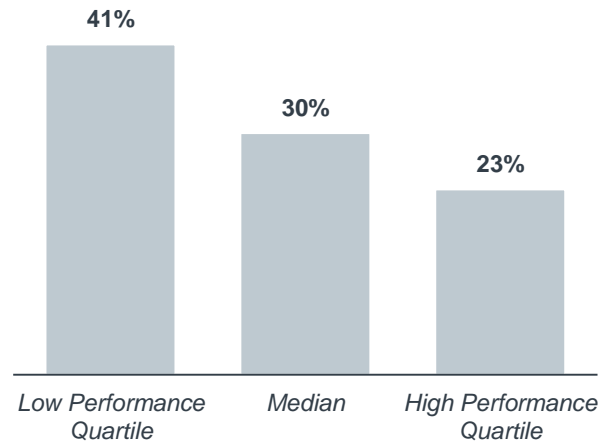
There is minimal improvement observed in AR performance after 90 days, as evidenced by the persistent collection gap present at 120 days.

It remains to be seen how aged AR performance may be impacted in the short to medium term. Two significant forces seem poised to play a role here; first, the recent transition to ICD-10 causing potential payer delays; second, the shift toward HDHPs that increases patient financial obligations, traditionally a leading cause of aged AR.

Ninety Days an Apparent Stagnation Point for AR

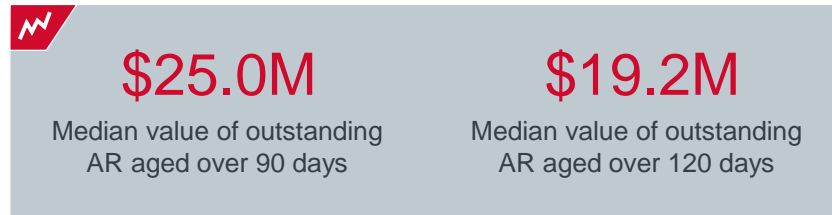
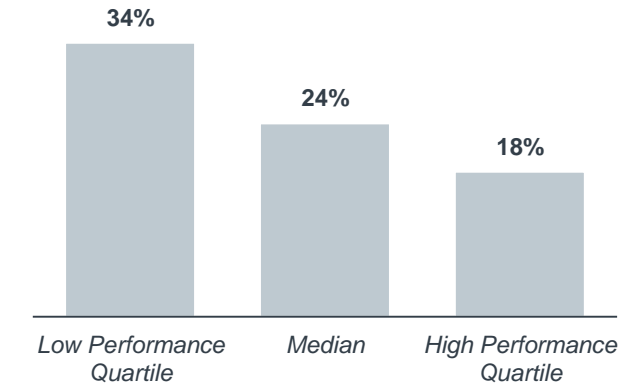
AR Over 90 Days As a Percentage of Total Billed AR¹

n=155



AR Over 120 Days As a Percentage of Total Billed AR¹

n=151



1) Survey and Performance Technology Data.

Source: 2015 Revenue Cycle Benchmarking Survey

Self-Pay Collections: Early-Out and Long-Term

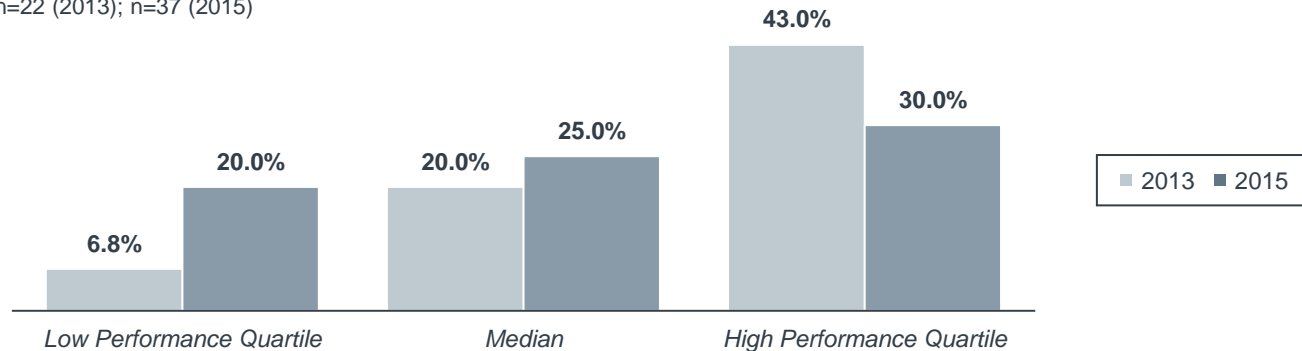
As highlighted on page 14, fewer organizations outsource collections today than in 2013. Based on the narrow difference in early-out recovery rate (top) observed between the median and high performance quartiles it appears that the industry may be converging on best practice. Given the recent increases in overall patient financial responsibility, historic early-out recovery rates of 43% may no longer be attainable.

Long-term collections (bottom) remain nearly unchanged from 2013. Performance between quartiles continues to be relatively close, with low overall success rates. This supports the commonly held belief that aged accounts are more difficult to collect regardless of the approach.

Early-Out Collections May Pay Off—Up to a Point

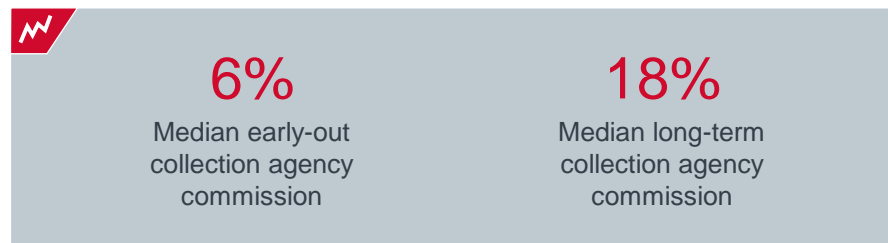
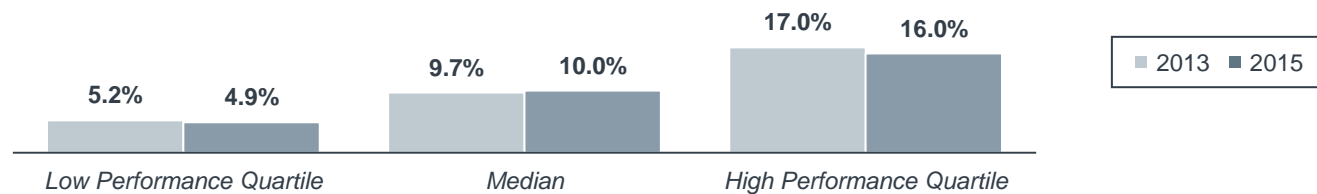
Early-Out Self-Pay Collection Agency Recovery Rate¹

n=22 (2013); n=37 (2015)



Long-Term Self-Pay Collection Agency Recovery Rate¹

n=32 (2013); n=52 (2015)



1) Survey data only.

Source: 2015 Revenue Cycle Benchmarking Survey

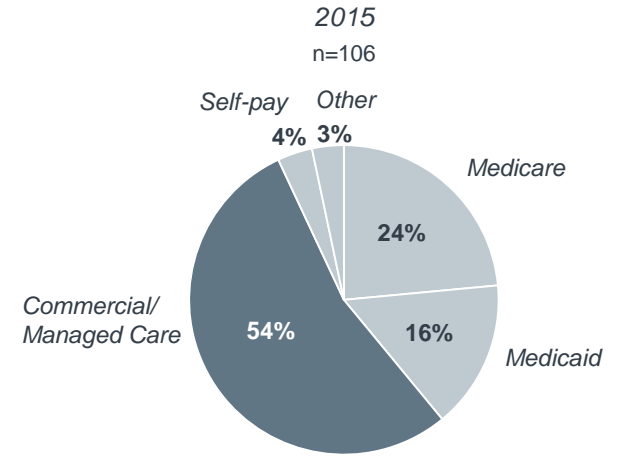
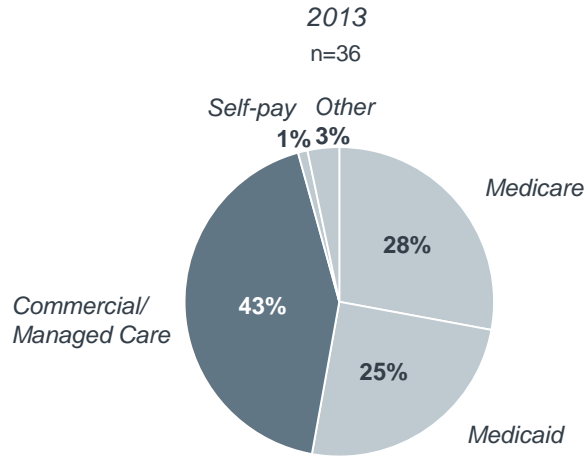
Denials by Payer

The growing proportion of commercial denials should pose a concern for hospitals that have historically relied on these payers to cross-subsidize lower reimbursing public payers. More than half of all denials are now attributable to commercial payers, much higher than reported 2013 rates. Anecdotal reports also suggest these payers carry more complex requirements than government payers, creating more work for denials follow-up teams.

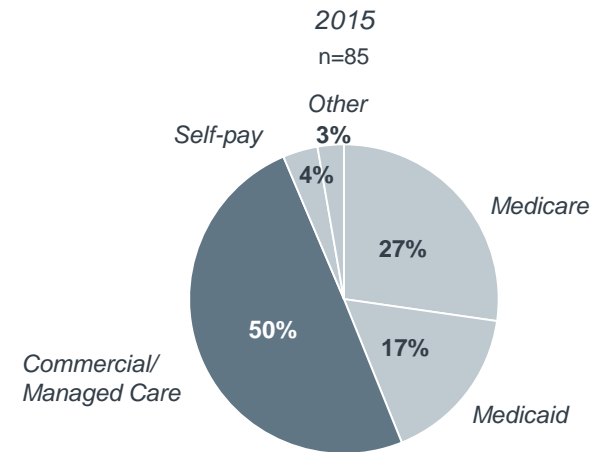
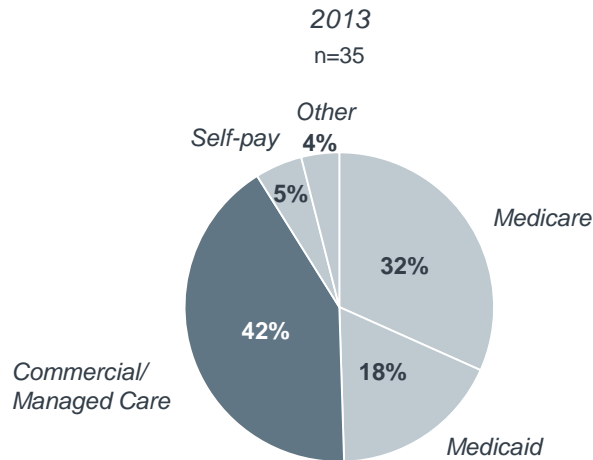
Denials from government payers have decreased, with survey participants reporting lower initial denial rates for both Medicare and Medicaid and lower Medicare denial write-offs.

Commercial Denials Write-Offs Impact Efficacy of Payer Cross-Subsidization

Initial Denials^{1,2}



Denials Write-Offs^{1,2}



1) Survey and Performance Technology data.
2) Sums may not equal 100 due to rounding.

Source: 2015 Revenue Cycle Benchmarking Survey

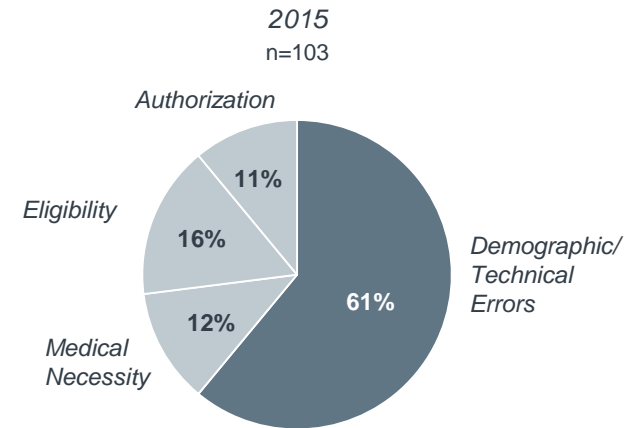
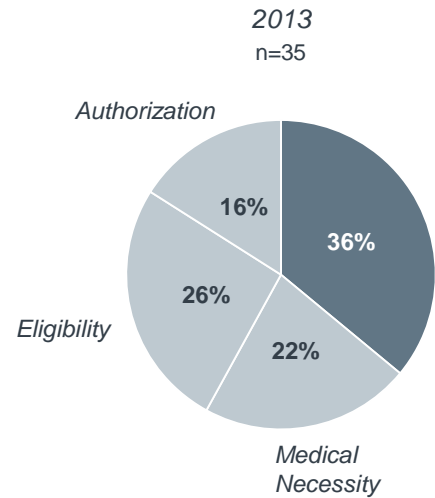
Denials by Reason

Demographic and technical errors are far and away the leading source of both initial denials and write offs reported in this year's survey. Perhaps most significant is the relative doubling of this category as a proportion of all denials since 2013. The upside of this finding is that most demographic/technical denials are avoidable, well within the control of hospital revenue cycle functions.

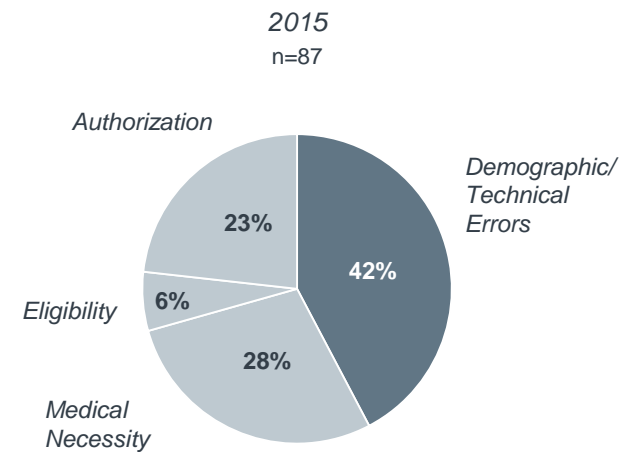
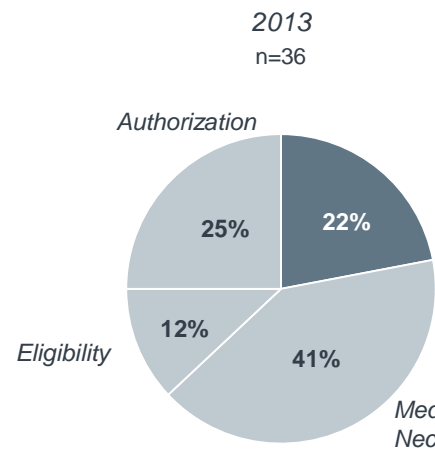
Considering the increase in overall commercial denials described on page 28, commercial payers are likely contributing significantly to the spike in demographic/technical denials seen between 2013 and 2015 representing a clear area of focus for providers.

Demographic and Technical Errors, Leading Cause of Rework

Initial Denials^{1,2}



Denials Write Offs^{1,2}



1) Survey and Performance Technology Data.
2) Percentages may not sum to 100 due to rounding..

Source: 2015 Revenue Cycle Benchmarking Survey

Appeal Success for Denials

This year's survey shows a wide performance gap in success rates when appealing denials. High performers successfully appeal denied claims two to three times more often than low performers across all payer types.

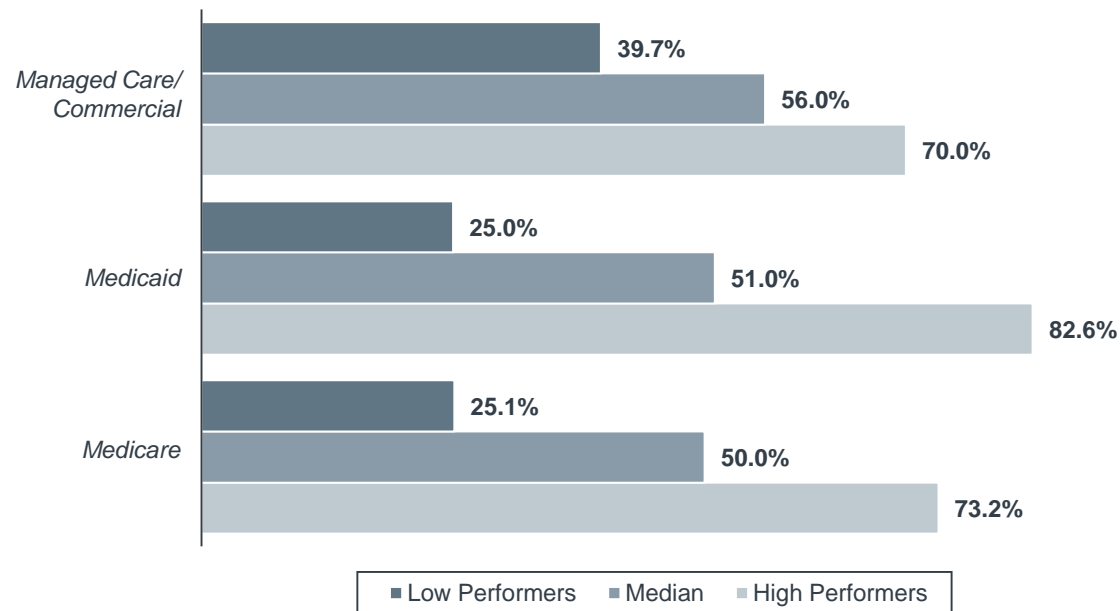
However, even high performers fail to overturn 17% to 27% of denials. Most organizations report appeals success rates of less than 60%, further indicating the need for improved denial management processes.

Many denials are considered preventable, particularly technical and demographic errors. Organizations should weigh increased investment in denial prevention efforts against the current costs of denials management. Given the relatively low appeals success rates across the cohort, improved denial prevention may reduce the need for appeals and likely trim overall cost to collect as well.

Examine Hidden Costs of Overturning Denials

Appeal Success for Denials¹

n=65



1) Survey and Performance Technology data.

Source: 2015 Revenue Cycle Benchmarking Survey

Cost to Collect

Controlling collection costs has proven to be a challenge for Financial Leadership Council members over the past four years. Collections costs decreased across all performance quartiles compared to 2013 levels, however only low-cost performers managed to reduce their costs to 2011 levels.

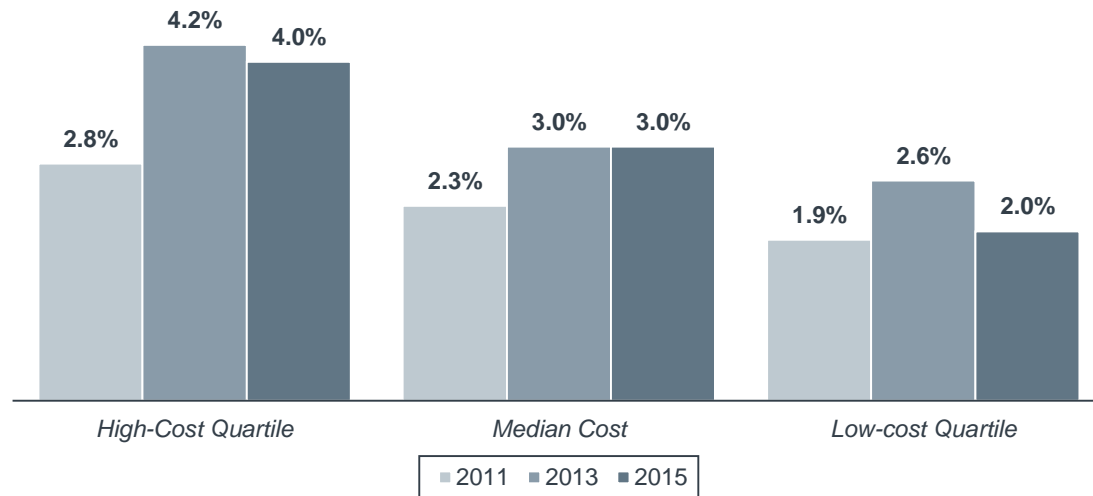
The difference in collections spending between the high- and low-cost quartiles has grown significantly since 2011, climbing from 47% to 100%. We recommend hospitals assess whether their own investment in cost to collect is paying off with high revenue cycle performance. The analysis on pages 32 and 33 provide two models of comparison to consider.

Spending Gap Doubled Since 2013

Full Cost to Collect¹

Percentage of Net Patient Revenue

n=51 (2011); n=31 (2013); n=59 (2015)



A Growing Gap in Cost to Collect

47%

Difference between high- and low-cost quartile in 2011

62%

Difference between high- and low-cost quartile in 2013

100%

Difference between high- and low-cost quartile in 2015

1) Survey data only.

Source: 2015 Revenue Cycle Benchmarking Survey

AR Performance by Cost-to-Collect

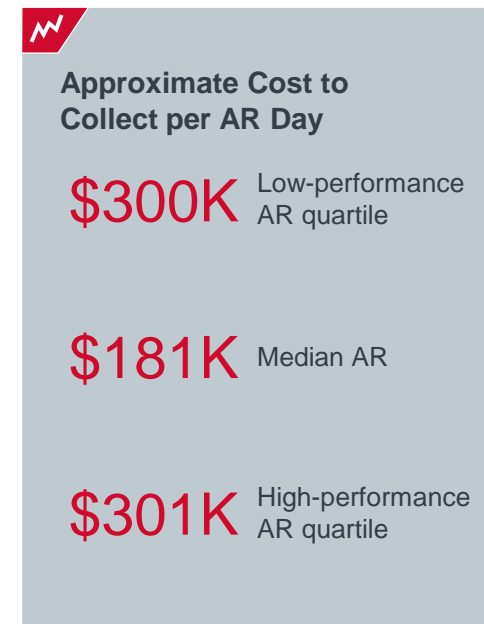
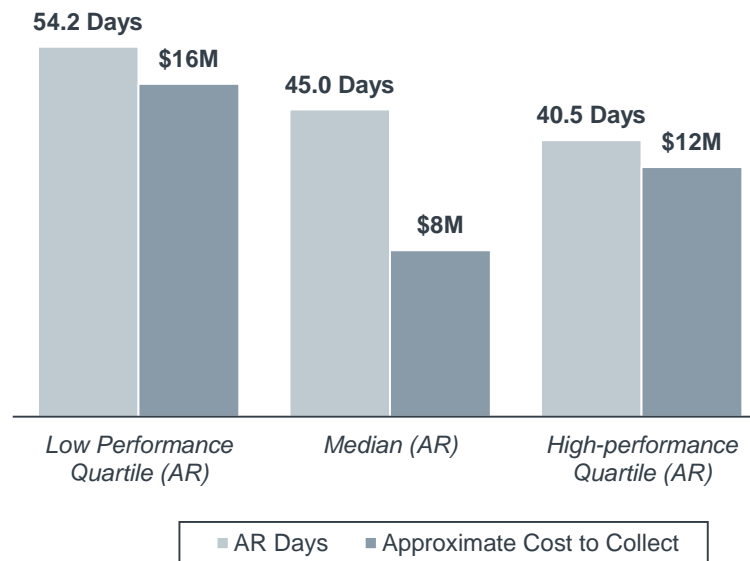
This graph shows the relative cost to collect by AR performance category.¹ There are two key takeaways from this data. First, low performing hospitals spend the most on cost to collect and also have the worst AR performance. Second, hospitals wishing to move from the median to high performing AR quartiles can expect to see substantially higher cost to collect. Our modeling indicates a \$5 million cash improvement for hospitals moving from median to high AR performance quartiles (page 24),² offset by an additional \$4 million in annual cost to collect.

If we consider costs in terms of dollars per AR day, it appears that median performance may be a relative “sweet spot” with a cost 40% lower than organizations in the low or high performing quartiles. Hospitals should weigh the relative merits of potentially losing out on additional cash associated with lower AR days versus increasing overall cost of collection, when evaluating the jump from median to high AR performance.

Poor Accounts Receivable Performance Linked to Cost Inefficiency

AR Performance Categories by Cost to Collect^{3,4}

Days in AR and Approximate Cost to Collect
n=38



1) Assumes cohort median for annual net patient revenue, \$406,445,773.
 2) Assumes cohort median for annual net patient revenue, \$406,445,773 divided by 365 (\$1,113,550).
 3) Survey data only.
 4) Cost to collect as a percentage of net patient revenue for low performing hospitals (AR days) was 4%, for median performing hospitals (AR days) was 2%, and for high performing hospitals (AR days) was 3%. The dollars reflect the cohort median for annual net patient revenue, \$406,445,773.

Source: 2015 Revenue Cycle Benchmarking Survey

Revenue Cycle Spending by Net AR Days Performance Group

Our data suggests that organizations with worse overall accounts receivable performance spend a higher proportion of their revenue cycle expenses on salaries and benefits. High-performing organizations appear to have more effective processes and/or staff productivity, spending roughly six percentage points less on salaries and benefits than low performers.

One possible explanation for this difference is the higher spending dedicated to overhead and technology at high performing organizations. Such investments may enable improvements in collection efficiency, reducing the spending requirement for staffing.

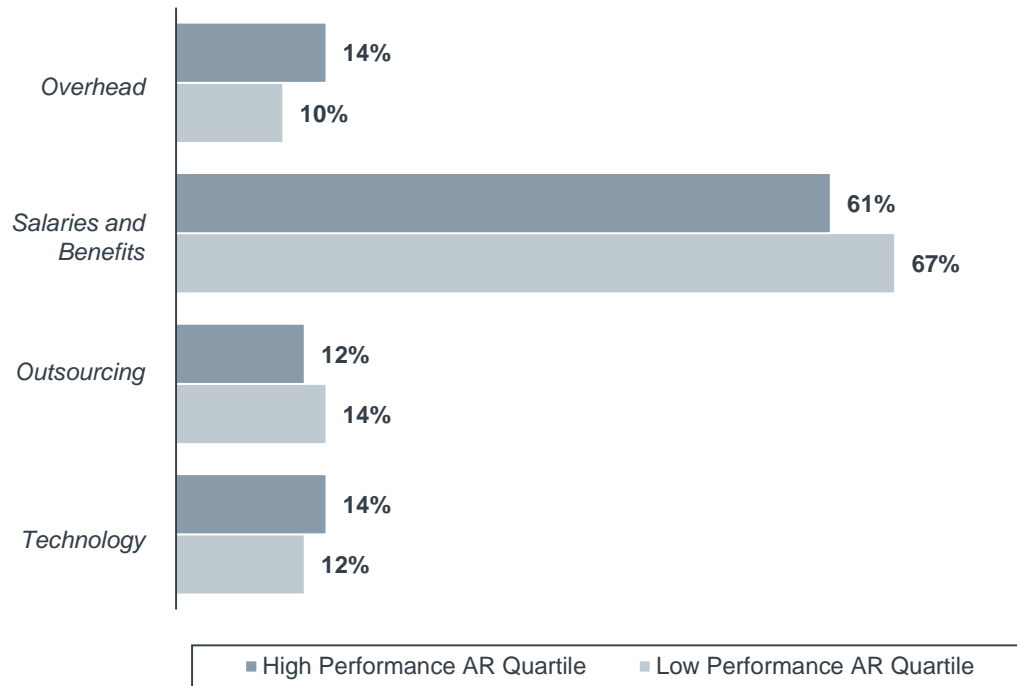
High-performers Spend Less on Staff

Revenue Cycle Expenses by Hospital AR Performance¹

Expense Type

n=47

2015



1) Survey data only.

Source: 2015 Revenue Cycle Benchmarking Survey



Appendix

- Revenue Cycle Definitions: Key Functions
- Revenue Cycle Definitions: Key Metrics
- Requested Data Points and Metric Calculations
- Revenue Cycle Performance Dashboard

Revenue Cycle Definitions: Key Functions

Term	Definition
Billing	Department responsible for bill preparation and distribution to responsible parties
Business Office	All in-house functions related to billing and collections
Coding	Department responsible for translating transcribed documentation into the appropriate ICD-10 codes and/or feeding them into an electronic grouper designed to assign DRGs
Collections	In-house department responsible for following up on claims, managing denials, and posting cash
Financial Counselors	Staff responsible for developing payment plans and special arrangements for self-pay patients; can operate on both the patient access and business office sides
Mid-cycle	All revenue-cycle functions that generally occur between the patient access and business office segments; usually includes case management, coding, medical records, and utilization review
Outsourcing	Any external service contracted by the hospital to perform a revenue cycle function
Patient Access	All in-house functions related to patient scheduling, pre-registration, registration, and admission
Pre-registration	Department responsible for collecting patient information and/or verifying insurance prior to patient visit
Registration	Department responsible for collecting patient information and admitting at the time of patient visit
Scheduling	Department responsible for scheduling appointments and coordinating with physician offices
Self-Pay	All claims and revenue stemming from patient obligations

Revenue Cycle Definitions: Key Metrics

Metric	Definition	Value
Appeal Success for Denials	Metric indicating a hospital's success in overturning denied claims	Indicator of opportunities for payer and provider relationship improvement
Case Mix Index	Metric representing the average diagnosis-related group (DRG) relative weight for a hospital	Indicator of the patient acuity and relative cost needed to treat the mix of patients in a hospital
Coded Not Final Billed (CNFB)	Days between the coding department completing coding of the record and the billing department submitting claim for payment	Indicator of efficiency in the back end of the revenue cycle
Cost to Collect	All operational and depreciation revenue cycle costs, including staff salaries and benefits, technology solutions, outsourcing costs, and overhead costs (space, office materials, etc.), not including capital expenditures	Indicator of the efficiency and productivity of the revenue cycle process
Discharged Not Final Billed (DNFB)	Days between the patient being discharged from the hospital and the billing department submitting the claim for payment, also called unbilled accounts receivable	Indicator of revenue cycle overall efficiency
Discharged Not Final Coded (DNFC)	Days between the patient being discharged from the hospital and the coding department completing coding of the record	Indicator of efficiency in the mid-cycle stage of the revenue cycle (documentation, capture, and coding)
Early-Out Collections	The use of an external collections agency that assumes responsibility for self-pay accounts on or near day one of the billing cycle and follows through the billing process on behalf of the hospital	Indicator of external collections agency's ability to collect self-pay claims 1 to 90 into the billing cycle
Long-Term Collections	The use of an external collections agency that assumes responsibility for self-pay accounts about 90 to 120 days into the billing cycle	Indicator of external collections agency's ability to collect self-pay claims 90 to 120 days into the billing cycle
Net Accounts Receivable Days	Metric indicating the time the time in days from billing to receiving payment for all accounts receivable	Indicator of revenue cycle's ability to liquidate accounts
Point-of-Service Collections	Collection of the portion of a bill that is likely to be the responsibility of the patient prior to the provision of services	Indicator of pre-service patient engagement and communication in the front office

Source: "Details for Title: Case Mix Index," CMS, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS022630.html>; "Evidenced-Based Revenue Cycle Improvement: An HFMA MAP Educational Program," Healthcare Financial Management Association, http://www.hfma-social.org/Education/117_Chapter%20Educational%20Program%20III.pdf; Source: 2015 Revenue Cycle Benchmarking Survey

Requested Data Points and Metric Calculations

Requested Data Points
#1 Net Inpatient Revenue
#2 Net Outpatient Revenue
#3 Average Daily Revenue
#4 Total Dollar Amount Collected at Point-of-Service
#5 Dollar Amount in Accounts Receivable
#6 Dollar Amount in Accounts Receivable Aged Over 90 Days
#7 Dollar Amount in Accounts Receivable Aged Over 120 Days
#8 Dollar Amount in Accounts Discharged Not Final Billed
#9 Dollar Amount in Accounts Discharged Not Final Coded
#10 Dollar Amount in Accounts Coded Not Final Billed

Metric	Calculation
Point of Service Collections as a Share of Total Net Patient Revenue	$\frac{\#4}{\#1+\#2}$
Share of Revenue: Inpatient	$\frac{\#1}{\#1+\#2}$
Share of Revenue: Outpatient	$\frac{\#2}{\#1+\#2}$
DNFB (Discharged Not Final Billed) Days	$\frac{\#8}{\#3}$
DNFC (Discharged Not Final Coded) Days	$\frac{\#9}{\#3}$
Coded Not Final Billed Days	$\frac{\#10}{\#3}$
AR Greater than 90 Days as a Share of Billed AR	$\frac{\#6}{\#5}$
AR Greater than 120 Days as a Share of Billed AR	$\frac{\#7}{\#5}$

Source: "Evidenced-Based Revenue Cycle Improvement: An HFMA MAP Educational Program," Healthcare Financial Management Association, http://www.hfmasocial.org/Education/117_Chapter%20Educational%20Program%20III.pdf; Source: 2015 Revenue Cycle Benchmarking Survey

Revenue Cycle Performance Dashboard

Snapshot of Key Metrics

	Low Performance Quartile	Median	High Performance Quartile
Appeal Success for Denials: Medicare	25.1%	50.0%	73.2%
Appeal Success for Denials: Medicaid	25.0%	51.0%	82.6%
Appeal Success for Denials: Managed Care/Commercial	39.7%	56.0%	70.0%
AR>90 as a Percentage of Total Billed AR	41%	30%	23%
AR>120 as a Percentage of Total Billed AR	34%	24%	18%
DNFB Days	11.6	7.1	5.7
DNFC Days	7.0	4.1	2.1
Early-Out Collections Recovery Rate	20.0%	25.0%	30.0%
Long-Term Collections Recovery Rate	4.9%	10.0%	16.0%
Net AR Days	54.2	45.0	40.5
POS Collections as a Percentage of Net Patient Revenue	0.27%	0.57%	1.10%

Source: 2015 Revenue Cycle Benchmarking Survey



2015 Revenue Cycle Benchmarking Survey

Survey Questions

2015 Survey of Hospital Revenue Cycle Operations

Welcome to the 2015 Revenue Cycle Benchmarking

This survey will provide benchmarks on hospital revenue cycle. Most of this survey asks for data from your organization's most recently completed fiscal year. Additionally, this survey is facility-specific. Please respond about only one facility within this survey. If you have multiple facilities, you may submit multiple surveys and a link is provided at the end to allow you to restart.

This survey should take no more than 15 minutes to complete. All individual responses will remain confidential and only be shared in aggregate.

Support from Your Performance Technology Team

Our team greatly values your membership in our Revenue Cycle Performance Technology. Some of the data we are seeking in this survey is already captured in one or more of your Performance Technology services. You will not be asked these questions and your survey will be slightly shorter. Your dedicated advisor will answer these questions for you once your survey is submitted.

Organizational Background Profile

Please provide information to help us classify your hospital across common identification characteristics.

1. What is the NPI for your hospital?

2. What is your hospital's affiliation status?

- Independent/Stand-Alone
- Part of a multi-hospital single-state system
- Part of a multi-hospital multi-state system

3. Which best characterizes your hospital's tax status?

- For-profit
- Non-profit

4. Much of this survey will ask you about the most recently completed fiscal year at your organization. Which fiscal year will you be responding about?

- FY 2014
- FY 2013

5. What functions within your hospital's revenue cycle are outsourced?

Please select all that apply. Outsourced functions are those that are paid for and administered by entities outside the revenue cycle department

- | | |
|---|--|
| <input type="checkbox"/> Scheduling | <input type="checkbox"/> Collections (early-out) |
| <input type="checkbox"/> Pre-registration | <input type="checkbox"/> Collections (long-term) |
| <input type="checkbox"/> Registration | <input type="checkbox"/> Payer Contracting |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Denial/Underpayment Recovery |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Physician Billing/Practice Management |
| <input type="checkbox"/> Coding | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Billing | |

6. Which types of physician groups exist at your organization? For physician groups at your organization, please specify how their revenue cycle is handled.

For complex organizations or where multiple types of practice group arrangements exist, please choose the option which best fits the majority of your physician groups

- Employed Physician
 - Managed by Hospital Revenue Cycle
 - Managed by Independent Revenue Cycle
 - Not Applicable or Not Present
- Other Economically-affiliated Physician
 - Managed by Hospital Revenue Cycle
 - Managed by Independent Revenue Cycle
 - Not Applicable or Not Present
- Independent Physician
 - Managed by Hospital Revenue Cycle
 - Managed by Independent Revenue Cycle
 - Not Applicable or Not Present

2015 Survey of Hospital Revenue Cycle Operations

Organizational Financial Profile

As a reminder, please answer the following questions with data for the **most recently completed fiscal year** at your hospital.

7. What was your organization's total number of registrations?
 - a. Outpatient: _____
 - b. Inpatient: _____
8. What was your organization's total net patient revenue?
 - a. Outpatient: _____
 - b. Inpatient: _____
9. What was your organization's payer mix for inpatient registrations?
Enter values as percentages; numbers should sum to 100%

Medicare	_____%
Medicaid	_____%
Managed/Care/Commercial	_____%
Self-Pay	_____%
Other	_____%
Total	100%

10. What was your organization's payer mix for outpatient registrations?
Enter values as percentages; numbers should sum to 100%

Medicare	_____%
Medicaid	_____%
Managed/Care/Commercial	_____%
Self-Pay	_____%
Other	_____%
Total	100%

11. What was your organization's case mix index (CMI)?
At a minimum, please provide CMI across the latest quarter (January, February, & March 2015); if historical data is available, provide CMI for the last four quarters starting with Q2-2014 (April, May, & June 2014).
 - a. Q1 2015: _____
 - b. Q4 2014: _____
 - c. Q3 2014: _____
 - d. Q2 2014: _____
12. What is the percentage of your dual-coded claims that contain a DRG shift?
Please enter a value between 0% and 100%.
 _____%

Back-End Revenue Cycle Profile

As a reminder, please answer the following questions with data for the **most recently completed fiscal year** at your hospital.

13. What is the total dollars in unbilled account status?
Exclude "in-house" accounts. Do not include accounts with administrative holds.
 - a. Discharged Not Final Coded (DNFC): \$ _____
 - b. Coded Not Final Billed: \$ _____
 - c. DNFC and Coded Not Final Billed Combined: \$ _____
Please include sum Discharged Not Final Billed (DNFB):
14. What is the total dollar amount of outstanding A/R?
Include Active status, billed, debit receivables; exclude "in-house" and DNFB.
 \$ _____
15. What is the total dollar amount of outstanding A/R?
Include Active status, billed, debit receivables; exclude "in-house" and DNFB.
 - a. Outstanding AR aged over 90 days (i.e., AR>90): _____
 - b. Outstanding AR aged over 120 days (i.e., AR>120): _____

2015 Survey of Hospital Revenue Cycle Operations

16. For each type of AR days, please provide your organization's average days in AR:
- Gross AR Days: Gross total days in accounts receivable: _____
 - Net AR Days: Net total days in accounts receivable: _____

17. What is your facility's average daily revenue?
\$ _____

Back-End Revenue Cycle Profile

As a reminder, please answer the following questions with data for the **most recently completed fiscal year** at your hospital.

18. Please estimate your revenue cycle department's full "cost to collect," as a percentage of net patient revenue:

Please include all operational and depreciation revenue cycle costs including staff salaries and benefits, technology solutions, outsourcing costs, and overhead costs (space, office materials, etc.). Do not include capital expenditures.

_____ %

19. Please estimate the percentage of your hospital's total revenue cycle costs spent in the following areas:

Answers must sum to 100%. For technology costs, include only annual operational and depreciation costs; do not include capital expenditures.

Technology	_____ %
Outsourcing	_____ %
Overhead	_____ %
Salaries and Benefits	_____ %
Total	100%

20. What best describes your contractual adjustment practices?

While there are many varied practices, please choose the one that best describes the practice for the majority of your billed payers.

- Net down all contractals at time of bill
- Net down all contractals at time of payment
- Net down Inpatient only at time of bill
- Net down Government payers at time of bill
- Other: _____

21. Please provide the following information regarding outsourced early-out collections:

Please enter all percentages as whole numbers. Early-out collections refers to the use of an external collections agency that assumes responsibility for self-pay accounts on Day 1 of the billing cycle.

- Average age of claim when set to collection agency: _____
- Average collection agency commission percentage: _____ %
- Average collection fee per account: \$ _____
- Average recovery rate: _____ %
- Average age for secondary transfer: _____

22. Please provide the following information regarding outsourced long-term collections:

Please enter all percentages as whole numbers. Long-term collections refers to the use of an external collections agency that assumes responsibility for self-pay accounts about 90-120 days into the billing cycle.

- Average age of claim when set to collection agency: _____
- Average collection agency commission percentage: _____ %
- Average collection fee per account: \$ _____
- Average recovery rate: _____ %

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23. Please indicate the number of FTEs employed in each of the following areas of your hospital revenue cycle:

Do not include outsourced employees in the figure for total FTEs.

- | | |
|---------------------------------------|--|
| <input type="text"/> Scheduling | <input type="text"/> Collections (early-out) |
| <input type="text"/> Pre-registration | <input type="text"/> Collections (long-term) |
| <input type="text"/> Registration | <input type="text"/> Payer Contracting |
| <input type="text"/> Case Management | <input type="text"/> Denial/Underpayment Recovery |
| <input type="text"/> Medical Records | <input type="text"/> Physician Billing/Practice Management |
| <input type="text"/> Coding | <input type="text"/> None of the above |
| <input type="text"/> Billing | |

Front-End Revenue Cycle Profile

As a reminder, please answer the following questions with data for the **most recently completed fiscal year** at your hospital.

24. Please indicate your hospital's Point-of-Service collection dollars:
Point-of-Service collection dollars refer to the collection of the portion of the bill that is likely to be the responsibility of the patient prior to the provision of services.

\$ _____

25. Please indicate the areas where your organization currently collects patient obligations at the point of service:

Please select all that apply.

- Emergency Department/Urgent Care
- Radiology
- Inpatient/Outpatient Surgery
- Other: _____
- My hospital does not collect patient obligations at the point of service in any of these areas

26. What percentage of your organization's total point-of-service collections are generated in each service area?

Please enter percentages as whole numbers; answers should sum to 100%.

Emergency Department/Urgent Care	_____ %
Radiology	_____ %
Inpatient/Outpatient Surgery	_____ %
Other	_____ %
Total	100%

27. What is the percentage of your organization's total point-of-service "collection opportunity" in each service area?

Collection opportunity" is the total portion of the bill that is likely to be the responsibility of the patient prior to the provision of services—this may not equal the actual point-of-service amount collected.

Emergency Department/Urgent Care	_____ %
Radiology	_____ %
Inpatient/Outpatient Surgery	_____ %
Other	_____ %

28. About how much time does it take for your organization's front-end teams to "financially clear" a patient?

Define "financially cleared" patients as those where your staff have verified eligibility, checked if an authorization is necessary (and if so, retrieved it and have it on file) calculated the financial responsibility, and collected the payment from the patient.

_____ minutes

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Denials Profile

As a reminder, please answer the following questions with data for the **most recently completed fiscal year** at your hospital.

29. Please provide the percentage of your total initial denials related to the following types of claims:

Answers must sum to 100%

Medicare	_____ %
Medicaid	_____ %
Managed/Care/Commercial	_____ %
Self-Pay	_____ %
Other	_____ %
Total	100%

30. Please provide the percent of initial denials related to types of claims:

Answers must sum to 100%

Inpatient	_____ %
Outpatient	_____ %
Total	100%

31. Please provide your hospital's appeal success rate for denials:

For each payer type, enter a success rate between 0% and 100%

- Medicare: _____ %
- Medicaid: _____ %
- Managed Care/Commercial: _____ %
- Self-Pay: _____ %
- Other: _____ %

32. Please provide the percentage of your total initial denials attributable to following reasons:

Answers must sum to 100%

Demographic/Technical Errors	_____ %
Medical Necessity	_____ %
Eligibility	_____ %
Authorization	_____ %
Total	100%

33. Please indicate the percentage of denial write-offs attributed to the following reasons:

Answers must sum to 100%

Demographic/Technical Errors	_____ %
Medical Necessity	_____ %
Eligibility	_____ %
Authorization	_____ %
Total	100%

34. Please estimate the percentage of denial write-offs related to the following type of claim:

Answers must sum to 100%

Medicare	_____ %
Medicaid	_____ %
Managed/Care/Commercial	_____ %
Self-Pay	_____ %
Other	_____ %
Total	100%

