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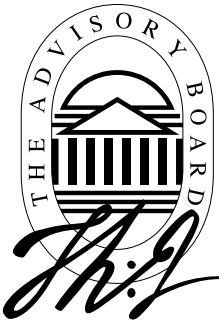

Assessing Revenue Cycle Performance

Findings from the 2006 Member Survey of Revenue Cycle Operations

- Demographics and Organizational Structure
- Collections and Uncompensated Care
- Revenue Cycle Costs and Staff Productivity
- Comparative Averages

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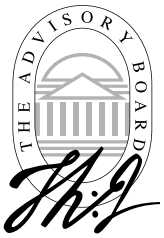

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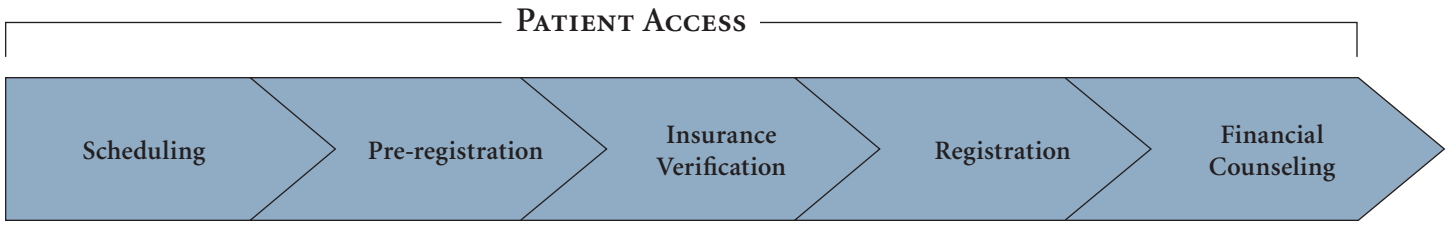

Benchmarking Guide Introduction

The origin of this book dates to August 2005, when the Financial Leadership Council launched an 85-question member survey of revenue cycle operations. At the time, we were unsure how the membership would respond to what we believed was the onerous task of collecting revenue cycle operational information from several departments scattered throughout most hospitals. The result, however, was a statistically significant, diverse swath of the Council membership. And the data set—which revealed a strikingly large variance between hospitals in cost to collect—became the foundation for the 2006 study entitled *Maximizing Revenue Cycle Margins: Best Practices for Advancing Operational Efficiency.*

Before we had finished collecting the 2005 surveys, we received dozens of requests for even more performance benchmarks, on a far broader range of revenue cycle topics. The industry suffered from a dearth of standards surrounding the definitions of operational metrics, making comparative benchmarks either unhelpful or non-existent. The Council's 2006 member survey sought to change that.

A Comprehensive Survey

In June 2006, we launched the survey soliciting the data included in this book (a reproduction of that survey is included in the appendix starting on page 53). The survey asked for 320 distinct data points and questions, most of which were routinely tracked by hospital finance departments. In the document, we asked for data pertaining only to individual hospitals (although we have been able to include system-specific data as well) and included a list of standardized definitions in order to ensure like comparisons between institutions. Those definitions can be found on page 2. We also sought to make our survey comprehensive and exhaustive, including as part of the revenue cycle not only the commonly tracked patient access and business office departments, but also the less frequently included case management and medical records functions. It is the Council's policy that any department that directly impacts or processes actual claims should be included as part of the hospital revenue cycle.

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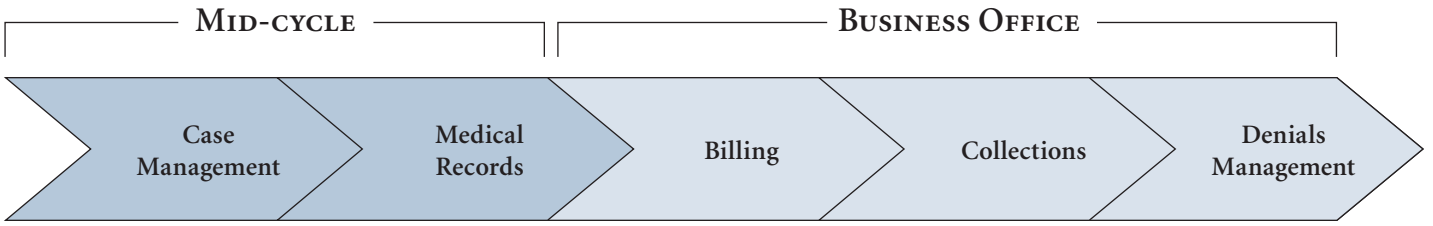

How to Use This Guide

This benchmarking guide has been divided into four principal sections: Demographics and Organizational Structure; Collections and Uncompensated Care; Revenue Cycle Costs and Staff Productivity; and Comparative Averages. Departmental data may be found in all sections. For quick reference, the Table of Contents lists specific metrics included in the chapters.

Demographics and Organizational Structure. The first section provides an overview of the survey and the cohort that provided data, with a snapshot demographic profile of the "typical" hospital included. The chapter then moves into the organization of the revenue cycle, answering a number of questions: On average, who has control? What operations are centralized? How quickly does staff turn over? How is case management structured?

Collections and Uncompensated Care. This guide's second and largest chapter focuses on the revenue cycle's principal objective: augmenting cash collections. We look at recovery rates by payer and patient type and delve into the two most-commonly tracked performance measures of collections, AR days and bad debt, and how they relate to other performance metrics. The chapter also examines performance of collection agencies, point-of-service collection efforts, and the causes of denials.

Revenue Cycle Costs and Staff Productivity. Previous Council research unearthed large opportunities for hospitals to reduce cost to collect. This year's data reinforces those ideas, with hospitals reporting significant variances in cost performance. This guide delves into the source of those costs, focusing on resource allocation and staff productivity medians for all revenue cycle departments.

Comparative Averages. One of the most common complaints against existing revenue cycle medians is the inability to benchmark against similarly structured institutions. In this section, we have disaggregated four characteristics that hospitals typically use as fundamental differentiators—system affiliation, net patient revenue level (and by extension, bed size), payer mix, and inpatient-outpatient mix—and listed their respective means.

Members are encouraged to contact Christopher Kerns at 202-266-6148 or kernsc@advisory.com, with questions and feedback about this material.

Financial Leadership Council
February 2007

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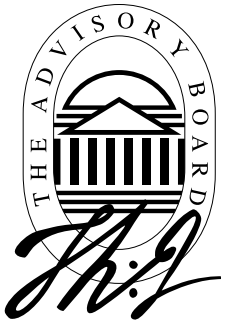


Demographics and Organizational Structure

Definitions List

The following definitions were included in the 2006 Member Survey of Revenue Cycle Operations. This list standardizes definitions of functions that are often ambiguously defined between hospitals. Note that for the purposes of this book, "patient access" and "business office" are synonymous with groups of functions often respectively labeled "front office" and "back office."

Revenue Cycle Terminology

Billing	Department responsible for bill preparation and distribution
Business Office	All in-house functions related to billing and collections
Collections	In-house department charged with following up on claims, managing denials, and posting cash
Coding	Translating transcribed documentation into the appropriate ICD-9 codes and/or feeding them into an electronic grouper designed to assign DRGs
Financial Counselors	Responsible for developing payment plans and special arrangements for self-pay patients; can act on both the Patient Access and Business Office sides
First-Pass yield	The percentage of claims that arrive in the Business Office error-free
Mid-cycle	All revenue-cycle functions that generally occur between the Patient Access and Business Office segments; usually includes case management, coding/HIM, medical records, and utilization review
Medical Records	All coding and transcription functions that take place during and after case management
Medical Transcribers	Responsible for turning physician documentation into readable and reproducible (digital) files
Patient Access	All in-house functions related to scheduling, pre-registration, registration, and admission
Pre-registration	Responsible for collecting patient information and/or often verifying insurance prior to patient visit
Registration	Responsible for collecting patient information and admitting at the time of patient visit
Scheduling	Charged with scheduling appointments and coordinating with physician offices
Self-Pay	All claims and revenue stemming from patient obligations
Outsourcing	Any external service contracted by the hospital to perform a revenue-cycle function
Utilization Review	Responsible for monitoring the appropriateness of medical procedures; often outsourced; generally makes determinations based on physician documentation

2006 Survey in Brief

The 2006 Member Survey was sent to all Financial Leadership Council members and requested 320 distinct data points. The Council received 73 responses as of press time. The survey sought to examine all aspects of the revenue cycle. To that end, we included functions that are frequently not included as part of the revenue cycle, such as case management and coding. But it is the position of the Financial Leadership Council that all activities that directly impact the processing of actual registrations or claims should be considered revenue cycle functions. The included functions, and their respective groupings (as defined in this book), are listed below.

Three Distinct Revenue Cycle Fields

Patient Access

- Scheduling
- Pre-registration
- Insurance Verification
- Registration
- Financial Counseling

Mid-cycle

- Case Management
- Utilization Review
- Coding
- Medical Transcription

Business Office

- Billing
- Collections
- Denials Management
- Financial Counseling

n=73

2005 Survey in Brief

Goal: To provide tangible benchmarks pertaining to the revenue cycle's organizational structure and resource allocation

Structure: 85 questions, sent to the entire Financial Leadership Council membership

Patient Access

- Total costs
- FTE allocation/turnover
- Registration rate
- Insurance verifications
- POS collections

Business Office

- Total costs
- FTE allocation/turnover
- Self-pay rates
- Outsourced costs

Organizational Structure

- CFO control
- Revenue cycle officers
- Systems vs. independents

Responses: 33 full responses, 50 partial responses

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Your "Typical" Peer

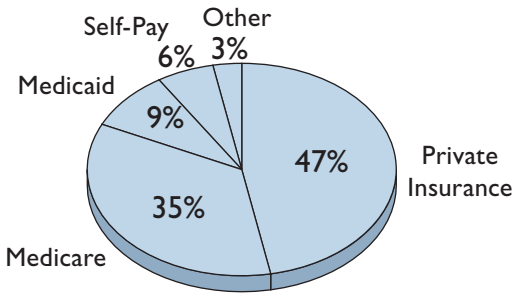
Below is a profile of the "average" hospital that participated in the 2006 Member Survey. With respect to net patient revenue, bed size, AR days, and bad debt, the survey data is similar to that of other national means and medians. For a more detailed account of medians in registrations, claims, total revenue and cash, please turn to pages 6 and 7. Data regarding recovery rates by payer mix can be found on pages 18 and 19. A discussion on AR days and bad debt performance can be found beginning on page 22.

Matching National Averages

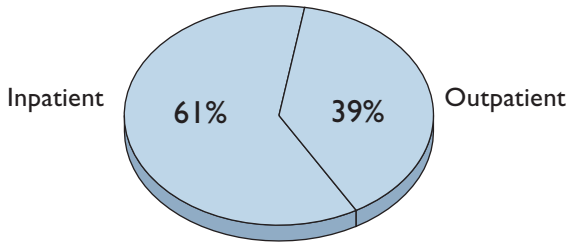
Percentage of Net Patient Revenue

Survey Means

Payer Mix



Patient Mix



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Survey Average Hospital

- 323 beds
- $386 M in annual net patient revenue
- 52.6 days in AR
- 14.0 days in DNFB
- Bad debt equal to 5.4 percent of net patient revenue

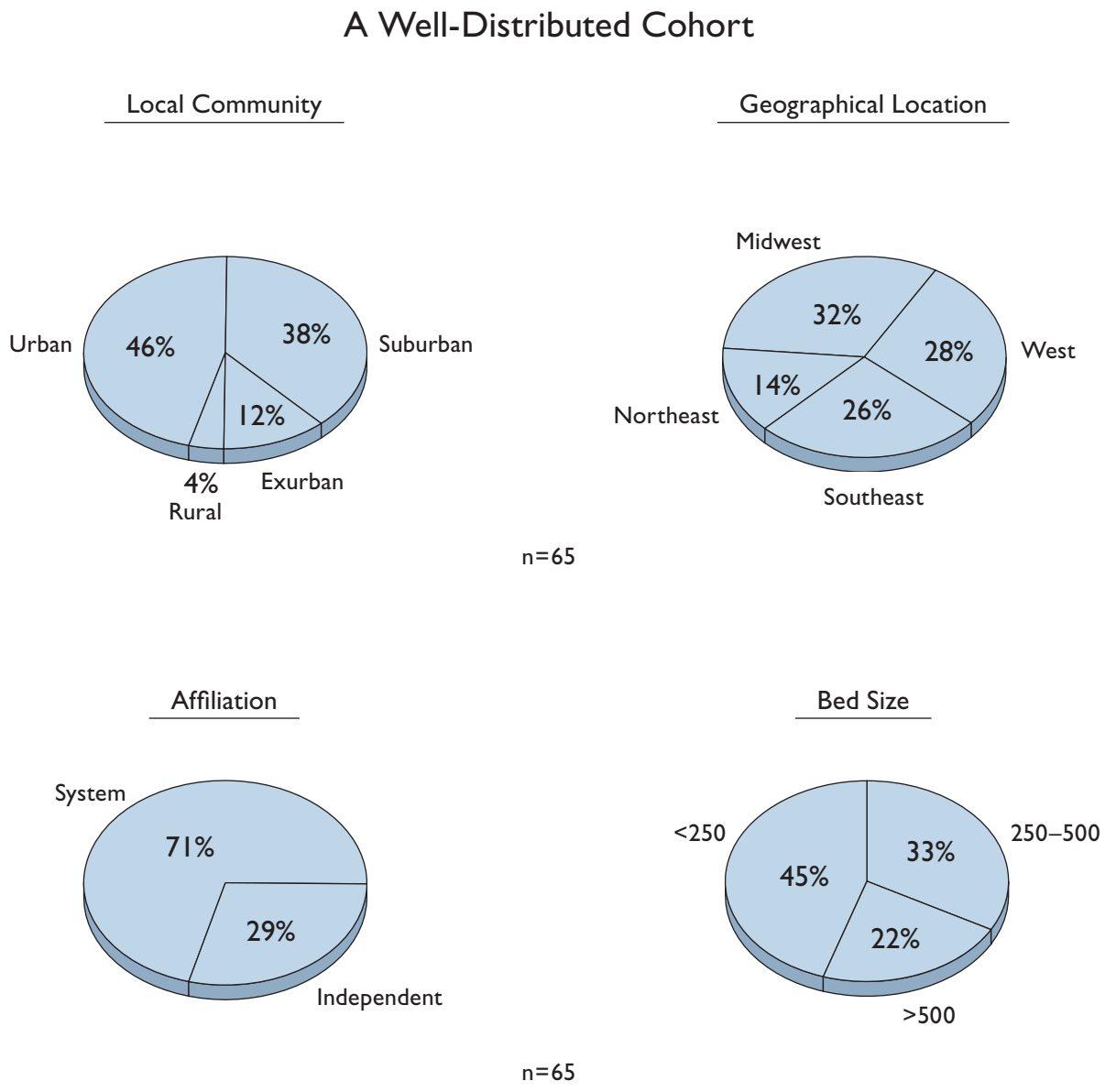
Moody's 2006 Not-for-Profit Healthcare Medians

- 343 beds
- $317 M in annual net patient revenue
- 49.0 days in AR
- Bad debt equal to 5.9 percent of net patient revenue

Source: Moody's Investor Service; Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Demographic Snapshot

The demographic profile represented in the survey also conforms to other national medians, although this year's survey cohort is slightly overrepresented in the Midwest region of the United States. Note, however, that the Council found no relationships with revenue cycle performance for either geographical location or community type. For comparative medians of institutions of various sizes, system affiliation, patient mix, or Medicare mix, please see Chapter IV, starting on page 47.

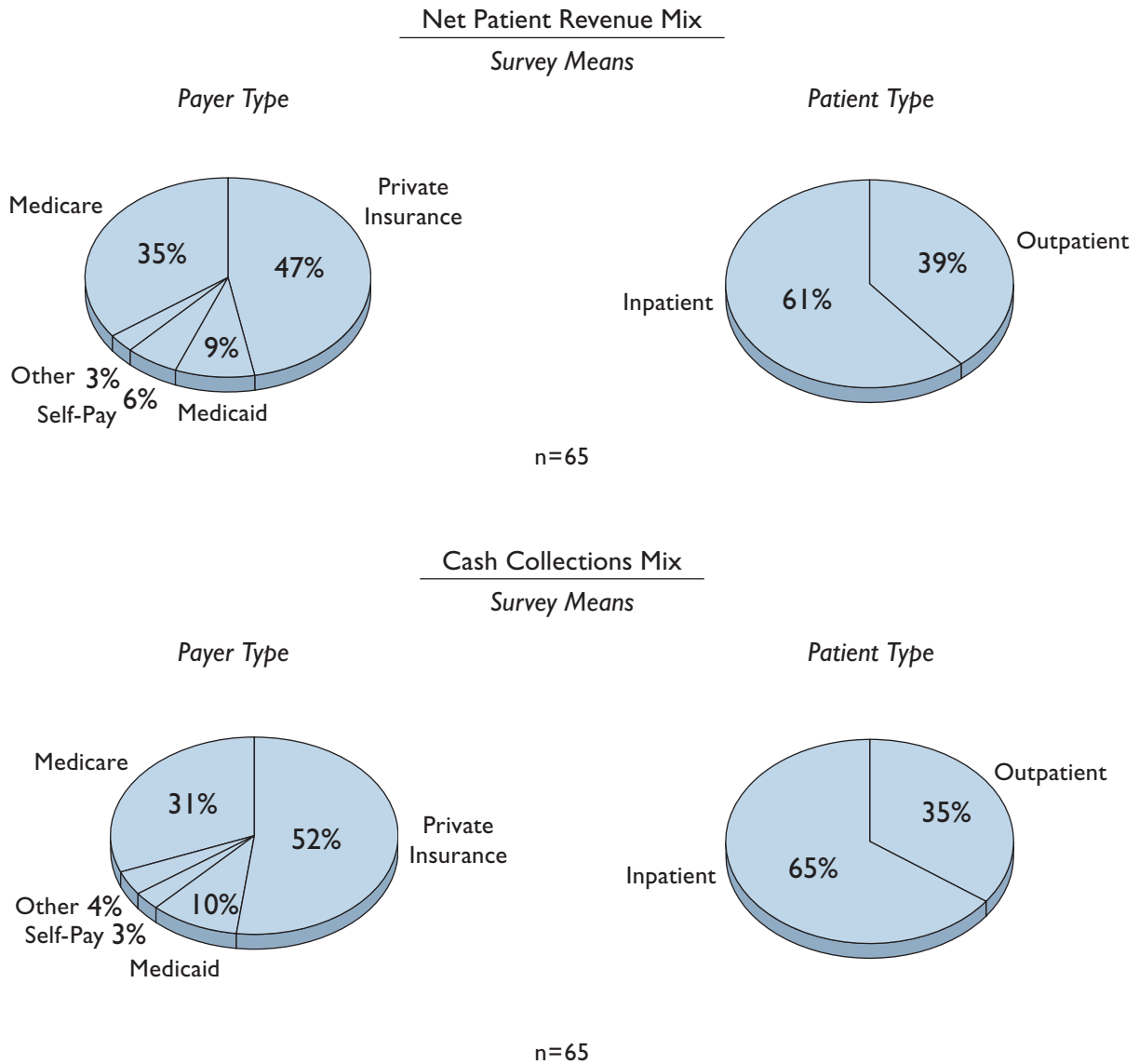


Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Who Pays Us?

The cross-subsidy revenue management model is clearly visible in the differences between revenue mix and cash postings. Private insurance accounts for a majority of all cash collected by hospitals, but less than half of stated net patient revenue. Inpatient claims also appear to be easier sources of collection than their outpatient counterparts, accounting for a greater share of cash collections than net patient revenue.

Private Insurance and Inpatient Claims Dominate

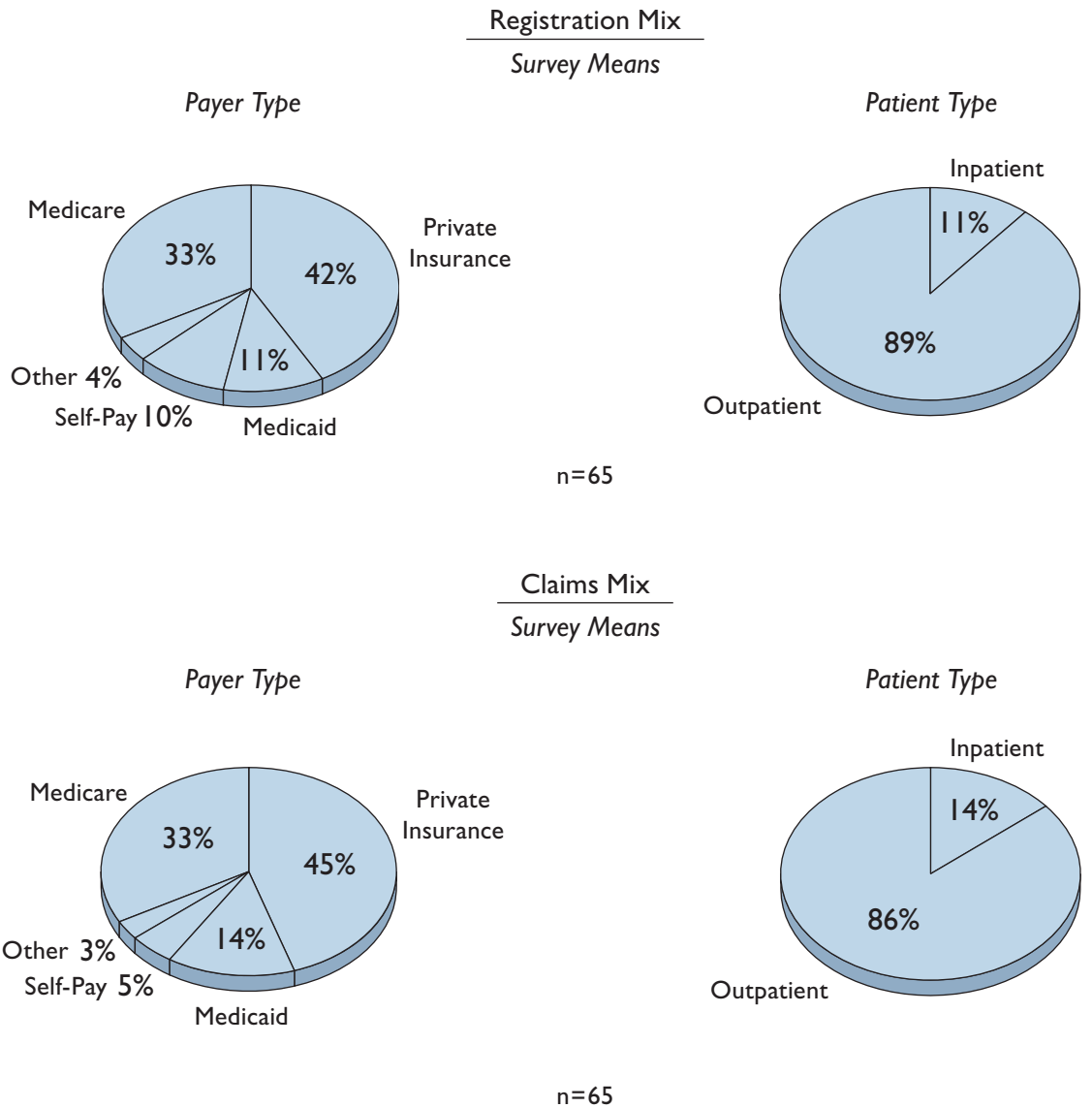


Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Who Visits Us?

Although representing fewer than 40 percent of net patient revenue, outpatient claims account for nearly nine out of every 10 hospital visits. A large disparity exists in the relative share of self-pay between registrations and claims, indicating the filters of charity care and post-admission Medicaid enrollments. For a more-detailed analysis on the self-pay patient population, please turn to pages 18 and 19 for a discussion on self-pay recovery rates, and page 31 for a breakdown of partially insured versus uninsured self-pay patients.

Outpatient Visits Represent Vast Majority



Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Territorial Stability

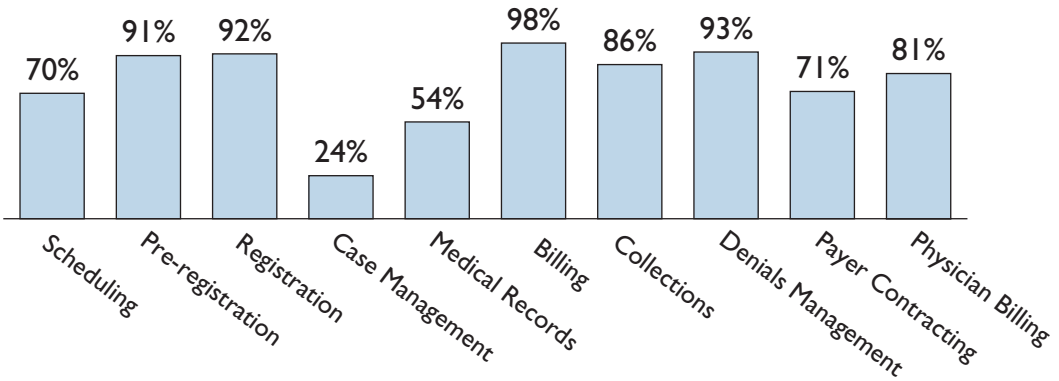
Chief financial officers have gained widespread control over nearly all revenue cycle functions, although case management still lies largely within the clinical realm, and finance's control over medical records is far from universal. The data differ little from that collected in 2005, but note that control over case management is up a few percentage points.

CFOs Have Widespread Revenue Cycle Control

Functions Reporting to the CFO

Percentage of Survey Respondents

2006



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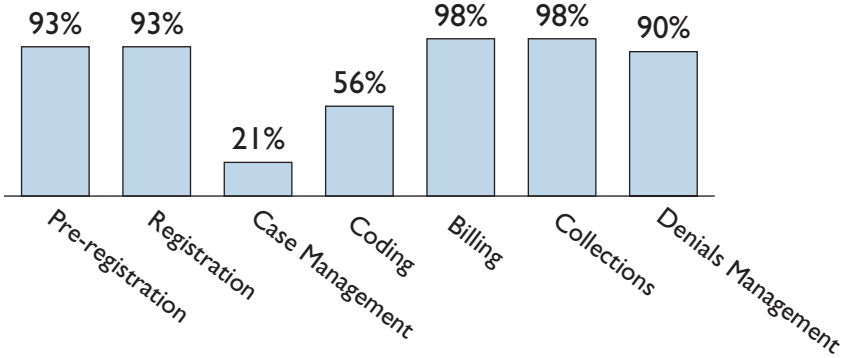
2005



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Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations; Financial Leadership Council 2005 Member Survey of Revenue Cycle Operations.

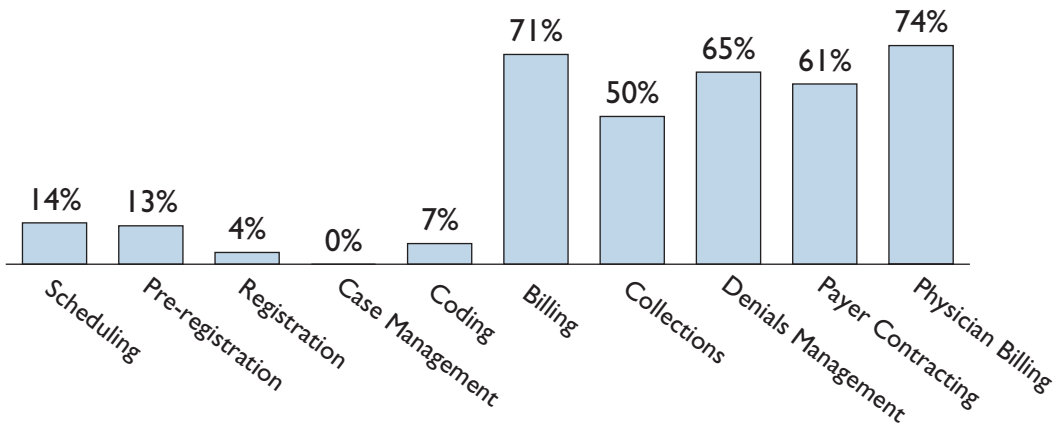
Engineering Economies of Scale

Economies of scale and the capacity for operational consolidation are often cited as the primary advantage of creating multi-hospital systems. Health systems that centralize at least one function frequently centralize business office (back end) operations, but leave most patient access functions organized at the local level, although some examples have shown that economies of scale can be generated through centralization of scheduling and insurance verification.

Centralization Concentrated at Back End

Centralized Functions

Percentage of System Respondents That Have Centralized Business Office Relationships



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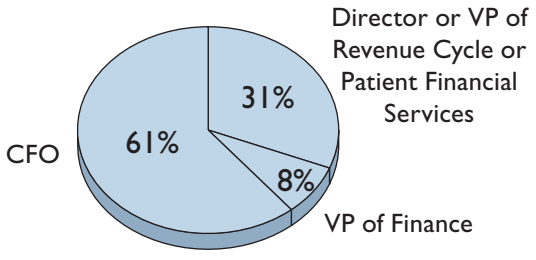
What's in a Name?

Title of Senior Revenue Cycle Executive

Percentage of Respondents



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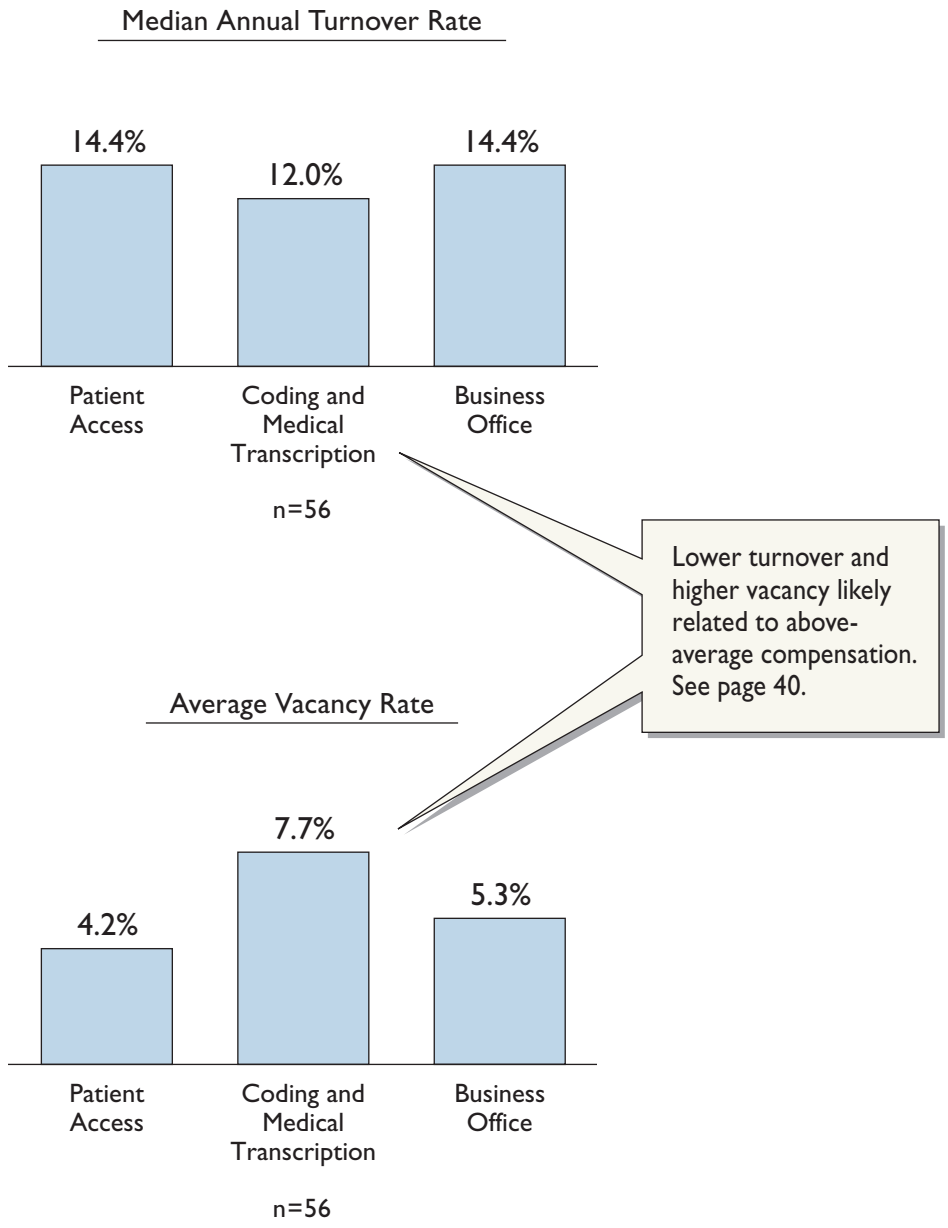
Three-fifths of those surveyed reported that the title of the most senior revenue cycle executive at their hospital is chief financial officer, indicating the high priority revenue cycle operations continue to have among CFOs. Most of the remainder devolved revenue cycle authority to directors or vice presidents of either revenue cycle or patient financial services (considered synonymous for the purposes of this guide). A small minority vested revenue cycle control in the hands of a vice president of finance.

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Staff Retention Rates

Median turnover and vacancy rates for patient access and business office staff are in line with those of other hospital departments. The mid-cycle functions of coding and medical transcription, however, have slightly lower-than-average turnover, and higher-than-average vacancy rates, reflecting the widespread notion that qualified medical records staff are in relatively short supply. A constrained supply probably partially explains the high salaries paid to coders and medical transcribers relative to other departments in the revenue cycle (see page 40).

Turnover and Vacancy Rates High but Stable



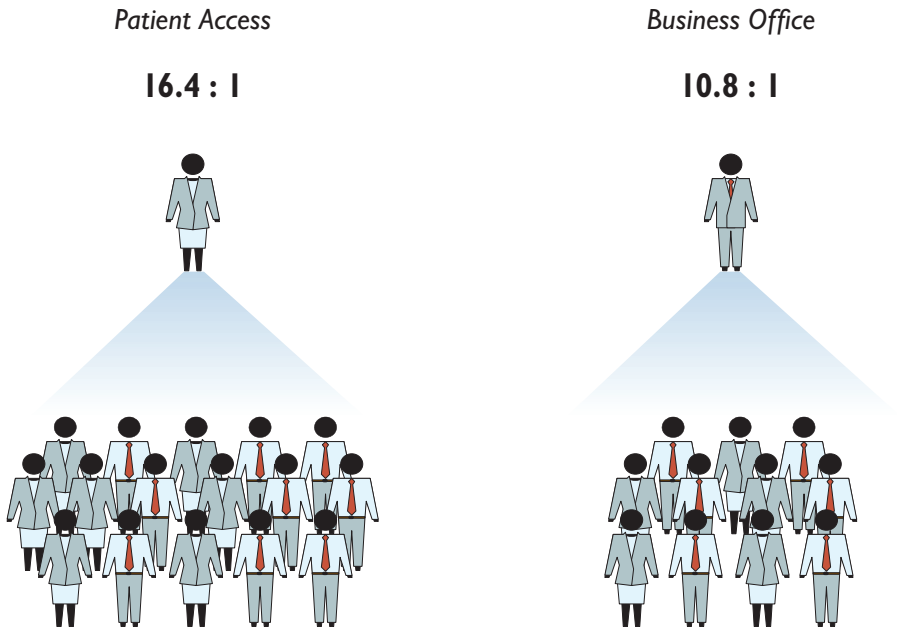
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Management Staffing Ratios

Below are the ratios of staff to managers for the two largest segments of the revenue cycle: patient access and the business office. Patient access managers tend to oversee more staff than their business office counterparts, possibly because business office staff tend to have a greater level of compartmentalization by payer.

Patient Access Managers Oversee More Staff

Staff to Supervisor Ratios



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Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

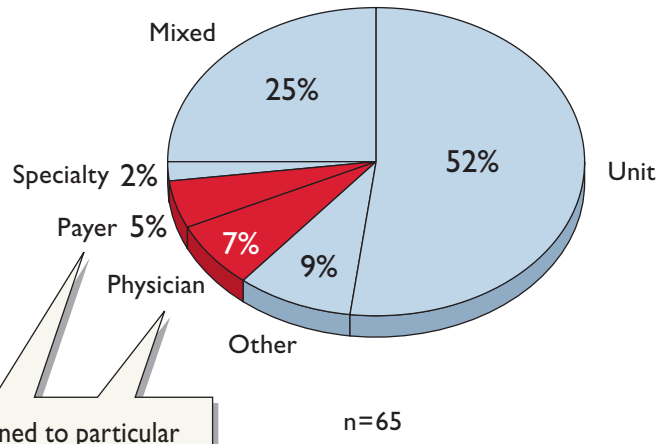
Organizing Case Management

The traditional unit-based model of case management continues to dominate at most hospitals and health systems. Models organized around payers and physicians have been shown to be effective in reducing denials and underpayments, but account for the models at only 12 percent of surveyed hospitals, possibly because they are thought to be more expensive. Data analysis, however, did not reveal any correlation between high overall revenue cycle costs and case management models organized around physicians or payers.

Unit-Based Model Still Dominant

Case Management Model Type

Percentage of Respondents



Case managers assigned to particular physicians or patients of specific payer types; models have been shown to be successful at reducing denials and underpayments by improving physician documentation, although anecdotal evidence shows them to be more expensive than other models

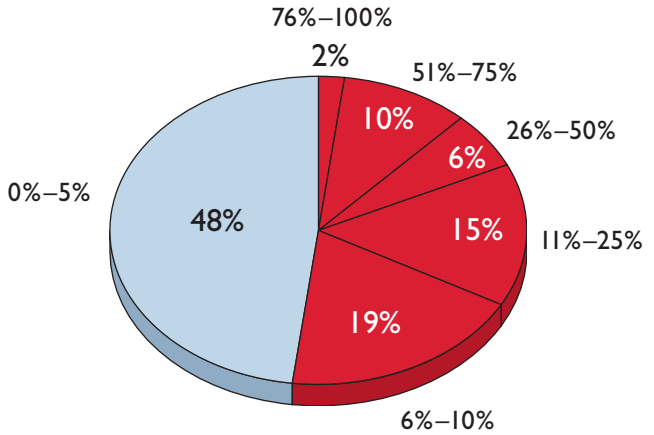
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Charts Rife with Errors

A plurality of hospitals report physician documentation error rates at 5 percent or below. But a full third of hospitals experience documentation error rates in excess of 10 percent, indicating the significant revenue opportunities that remain in improving documentation and charge capture.

Physician Documentation Continues to Be Problematic

Percentage of Charts With at Least One Documentation Error That Could Have Impacted Charge Capture



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Physician Advisor

Most hospitals (83 percent) reported having assigned at least one physician advisor to assist in case management. The advisors act as liaisons between case managers and physicians, and their job is to resolve communication problems and other ongoing disputes regarding documentation and charge capture. Although 29 percent of hospitals that deploy physician advisors reported assigning between two and 10 advisors, the remaining 71 percent assigned just one.

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

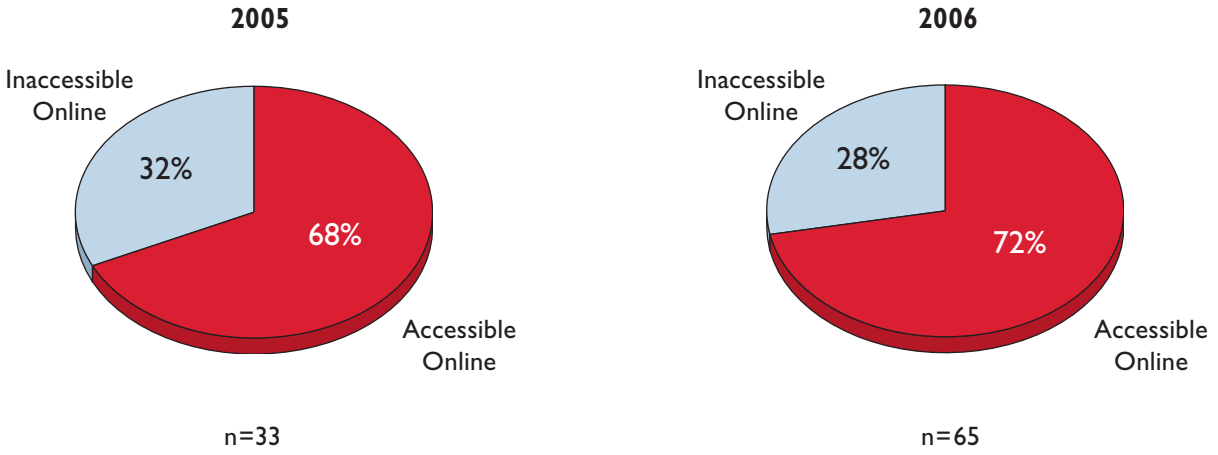
Accessing Insurance Verification Online

Survey respondents reported that, on average, 72 percent of payers are accessible online for the purposes of insurance verification. This compares with 68 percent reported in 2005 (albeit with a significantly smaller cohort in the prior year). Of those hospitals that have access to online insurance verification, greater than two-thirds employ both electronic intermediaries and direct payer access to verify insurance, while the remainder is split nearly evenly between exclusive direct payer access and intermediary access.

Leveraging the Internet to Verify Insurance

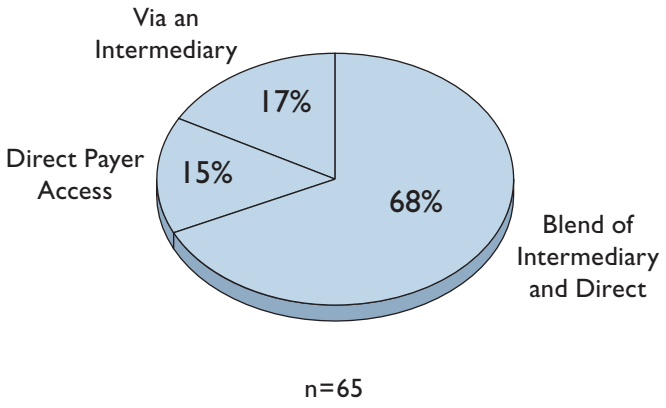
Percentage of Payers Accessible via Online Insurance Verification

Percentage of Respondents



Means of Accessing Online Insurance Verification Information

Percentage of Respondents



Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations; Financial Leadership Council 2005 Member Survey of Revenue Cycle Operations.

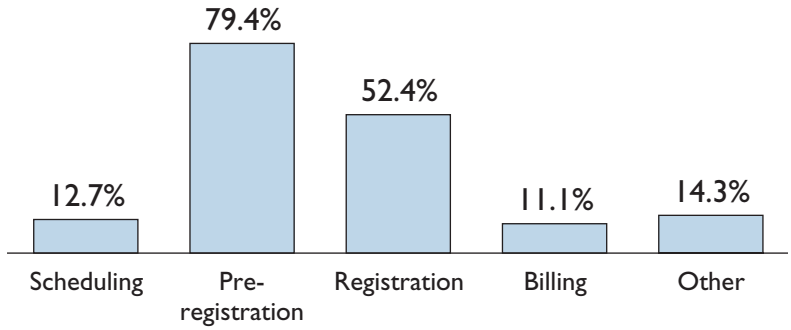
Verifying Insurance and Securing Authorization

Pre-registration and registration remain the most popular departments for verifying primary insurance. A number of hospitals also attempt to verify insurance at the time of scheduling, and even as far down the line as the business office. Pre-registration is also clearly the preferred choice for authorizations, but given that its popularity is limited to less than half the survey cohort, initial authorization procedures are far from standardized. Also note that 13.1 percent of respondents reported that they do not secure initial authorizations at any point in the hospital.

Pre-registration the Primary Source of Verification

Functional Areas Where Primary Insurance Is Verified

Percentage of Respondents



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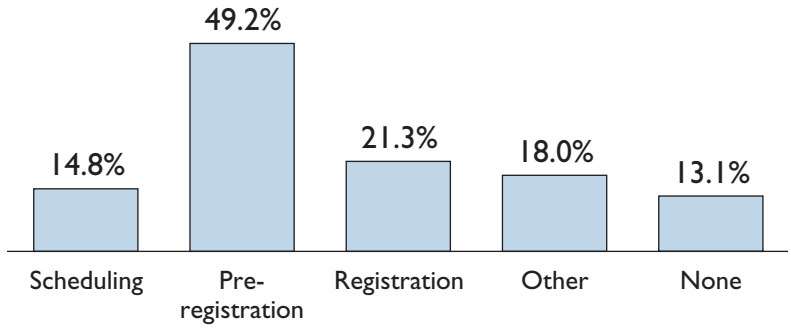
Functional Areas Where Initial Authorization Is Secured

Percentage of Survey Respondents



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Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

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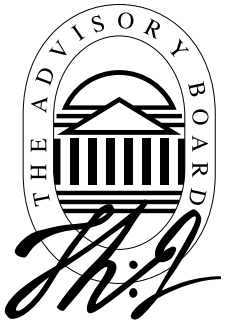


Collections and Uncompensated Care

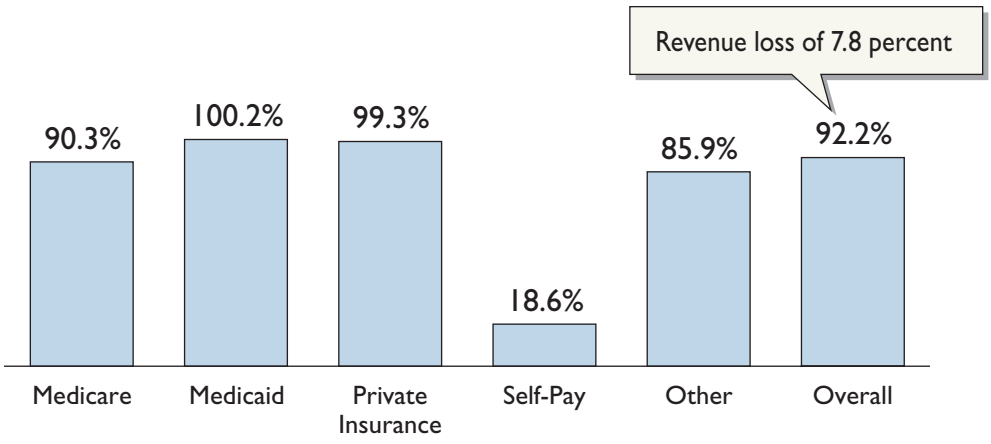
Collection Performance

Overall, hospitals collect in cash 92.2 percent of their posted net patient revenue. Self-pay suffers from the lowest recovery rates, with roughly 80 percent of self-pay collections coming from patients with some form of insurance (see page 31). Relatively high recovery rates of private insurance and Medicaid relative to Medicare suggest three implications: (1) denials of private-insurance claims are written off as contractual allowances of gross charges, accounting for a high overall recovery rate; (2) many patients initially classified as self-pay eventually become qualified for Medicaid, which explains the latter's recovery rate greater than 100 percent; (3) Medicare denials are more difficult to bury in contractuals, explaining the relatively lower recovery rate.

Self-Pay and Medicare Shortfalls

Recovery Rates

Cash Posted as a Percentage of Net Patient Revenue, by Payer Type



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Contribution to Revenue Loss

Percentage of Total Net Patient Revenue

Self-Pay	3.92%
Medicare	3.29%
Private Insurance	0.32%
Other	0.25%
Medicaid	(0.02%)
Total	**7.8%**

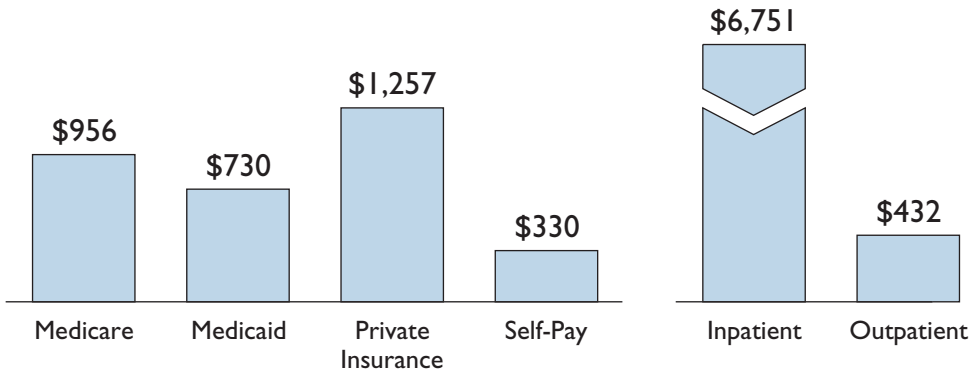
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Collection Efficiency

Unsurprisingly, self-pay generates the smallest amount of cash per claim. But Medicaid also brings in a smaller amount of cash per claim than Medicare or private insurance. And as shown on page 43, FTEs devoted to Medicaid claims process fewer claims per FTE than they do for other third-party payers. But the efficiency of collection—that is, the ease of collecting on a processed claim—can be represented in dollars collected per claim per FTE. On this measure, Medicaid claims are most efficient, explaining why many hospitals are willing to devote a relatively large number of FTEs to their collection.

Medicaid Claims Small, but Lucrative

Median Cash Collected per Claim



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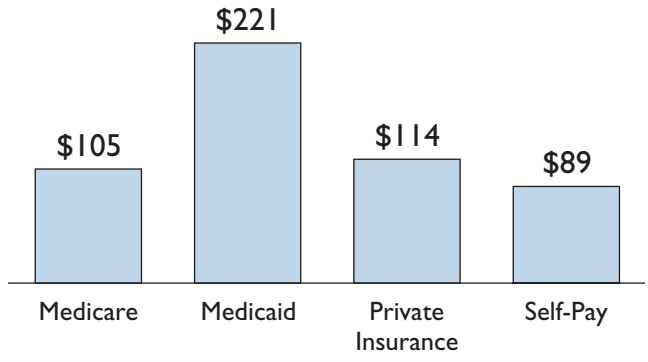
Median Collection Efficiency by Payer

Dollars Collected per Claim per FTE



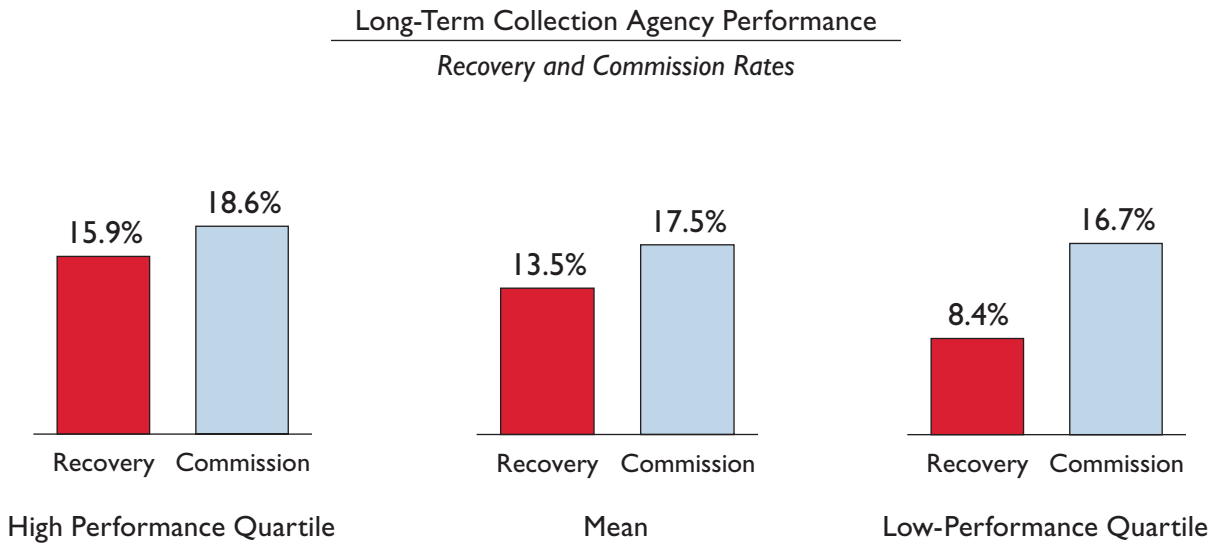
n=65

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Assessing Long-Term Collection Agencies

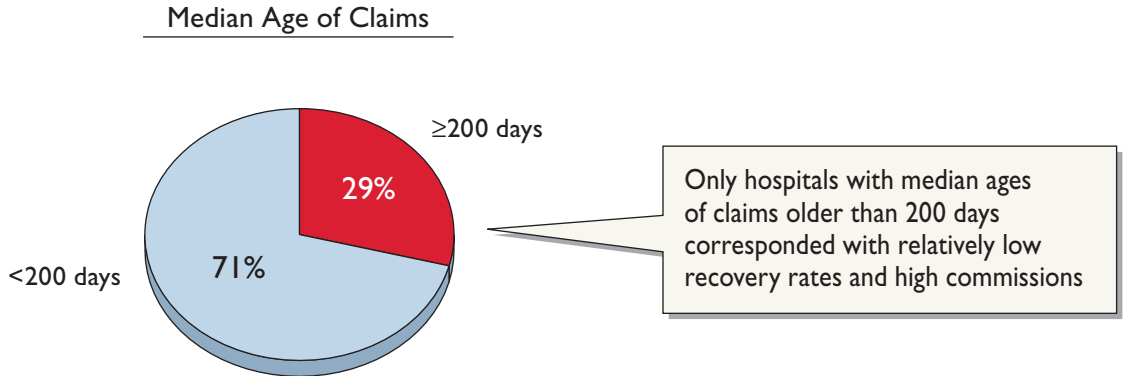
Average commissions paid to long-term collections agencies varied surprisingly little relative to the variance in recovery rates. In interviews, a common explanation cited for the wide variance in recovery rates was the range in the age of claims sent to collection agencies. But survey analysis revealed that only hospitals with median ages of claims older than 200 days corresponded with low recovery rates and high commissions relative to their peers—and such hospitals accounted for 29 percent of the cohort. For the majority of hospitals with median ages of claims younger than 200 days, the Council found no relationship between age, recovery rate, and commission.

Wide Variability in Collections Agency Performance Persists



Median Age of Claim: 140 days

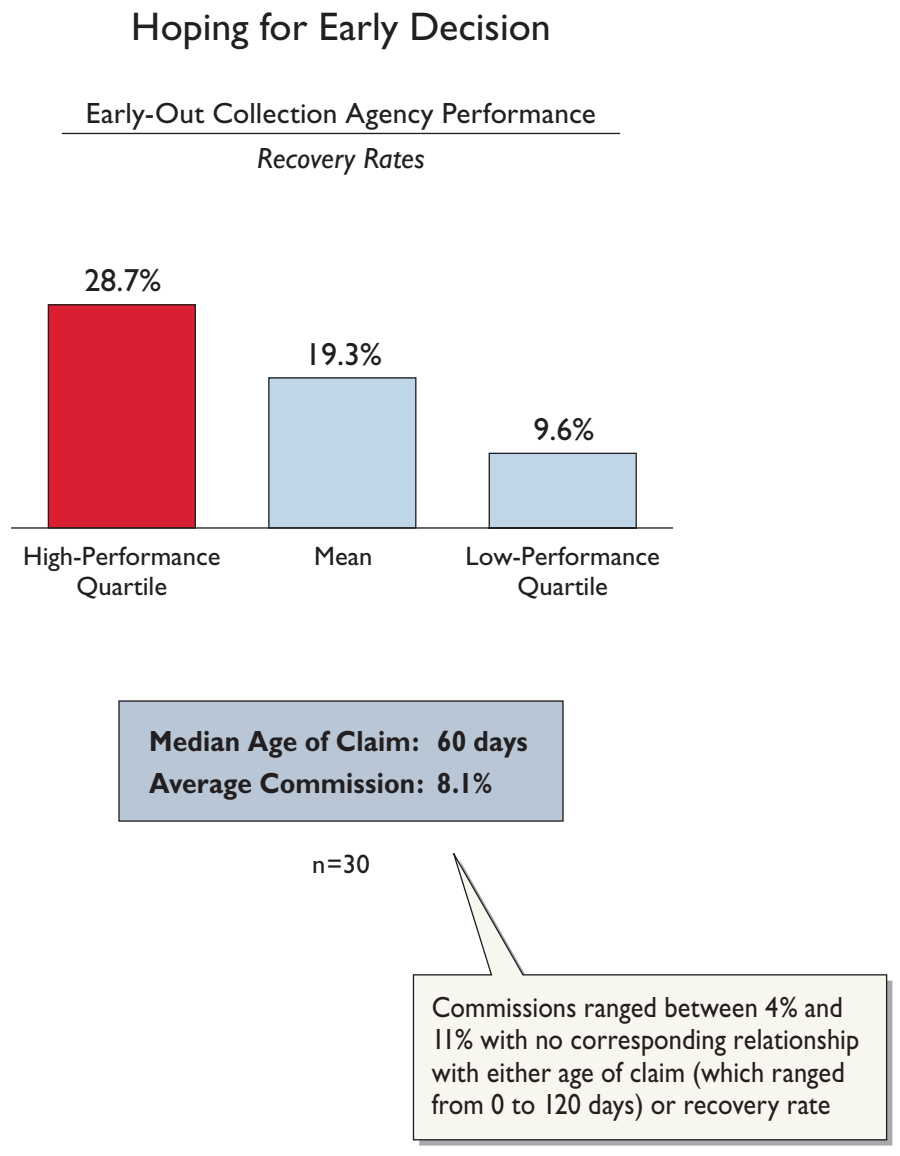
n=51



Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Assessing Early-Out Collection Agencies

Average recovery rates from early-out collection agencies were understandably higher than those of their long-term counterparts (probably owing to the exceptional difference in median ages of claims). But while commissions varied even less than they did for long-term collection agencies, recovery rates varied by a wider margin. And the Council found no corresponding relationship between recovery rates and commission with respect to median age of claim.

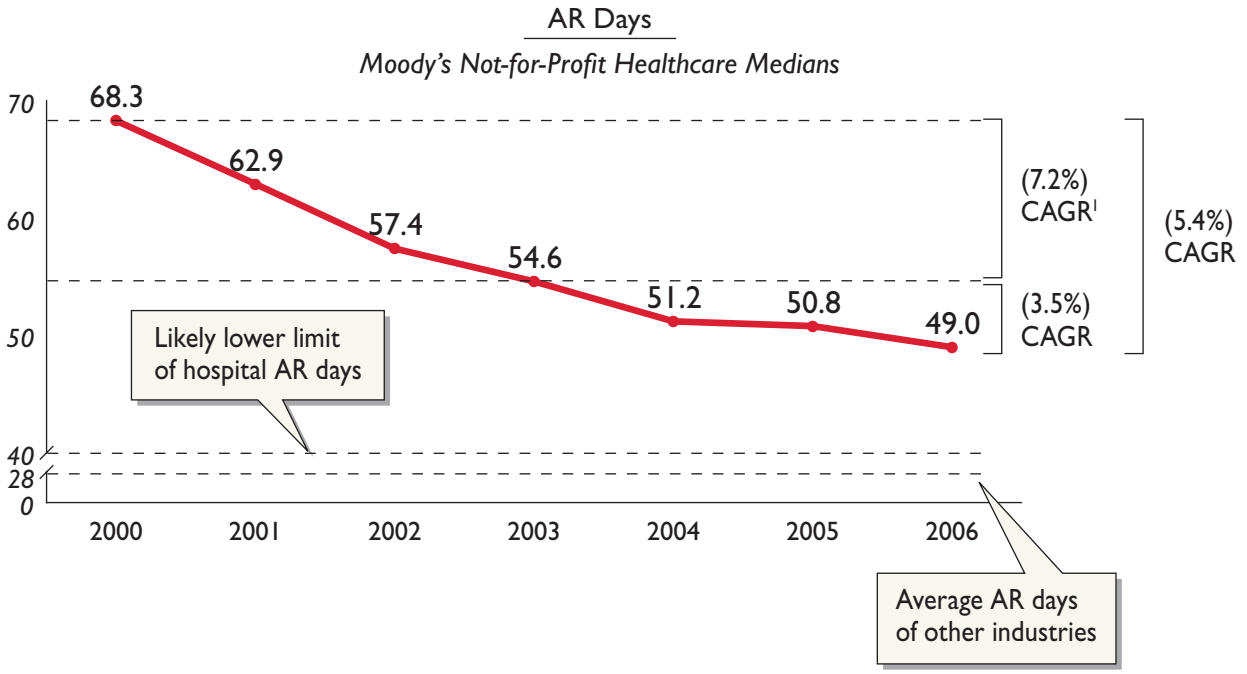


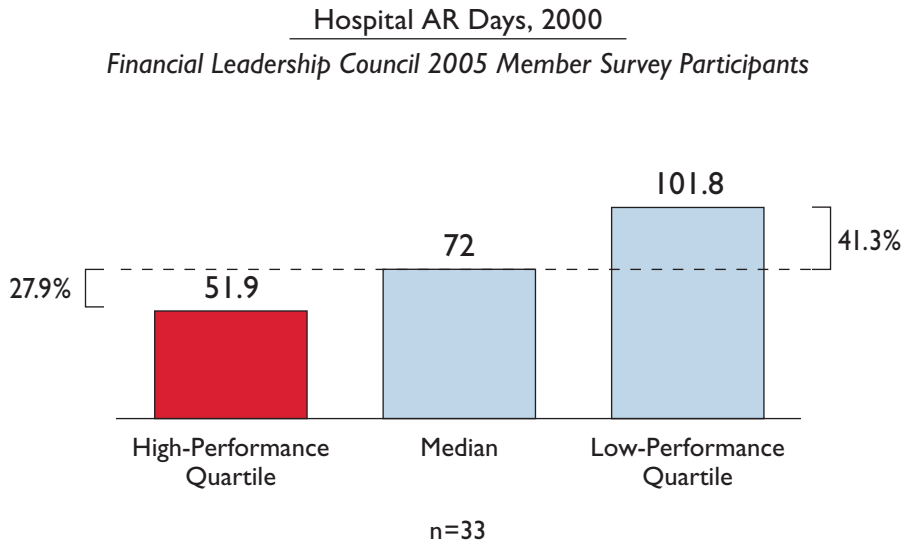
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Diminishing Returns on Gains in AR Days

Over the past six years, hospitals have made significant progress in their efforts to reduce AR days via a relentless focus on collections. But as an industry, most of the low-hanging fruit has been garnered. Marginal improvements in AR days are getting smaller. And the exceptional complexity of the hospital revenue cycle ensures that hospitals are unlikely to approach the average AR days figure of other industries. The Financial Leadership Council estimates that 40 days are the likely lower limit of hospitals AR days median performance.

Focus on Collections Bears Fruit





[1] Compound annual growth rate.

Source: Moody's Investor Service; Financial Leadership Council 2005 Member Survey of Revenue Cycle Operations; Financial Leadership Council analysis of Financial Compass data.

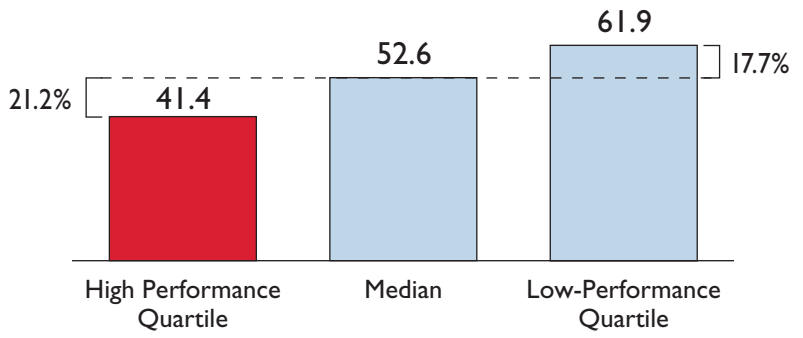
Variance in AR Days Performance Narrows Further

AR days continued to improve in 2006, with the survey's median AR days dropping from 53.2 days in 2005 to 52.6 days. The poor-performance quartile experienced the greatest gains with a reduction in median AR days of 5.6. The variance between median and low performers has also continued to narrow with the variance between median and low performers narrowing from 26 percent last year to slightly below 18 percent this year.

Don't Mind the Gap

AR Days, 2006

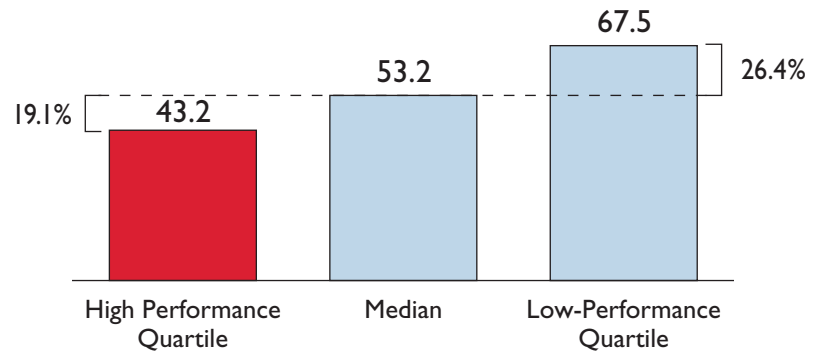
Financial Leadership Council Member Survey Participants



n=60

AR Days, 2005

Financial Leadership Council Member Survey Participants



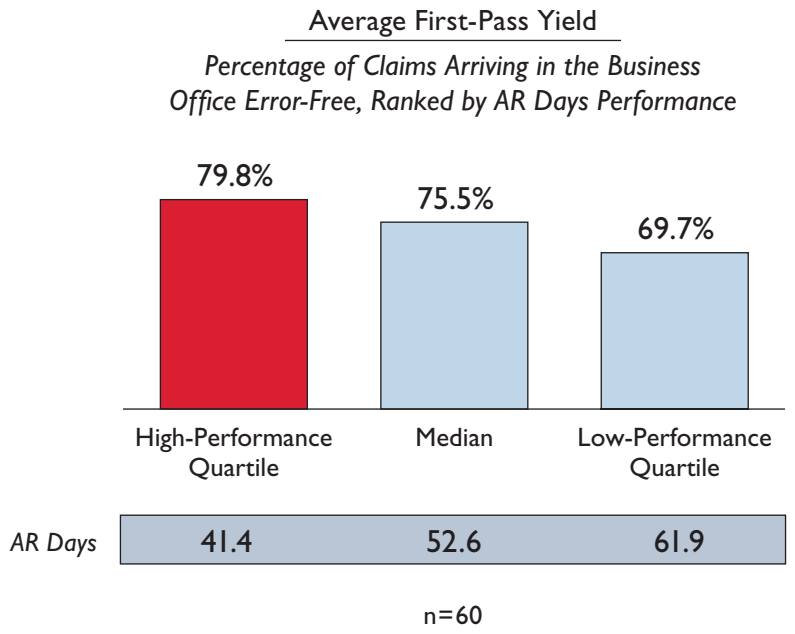
n=33

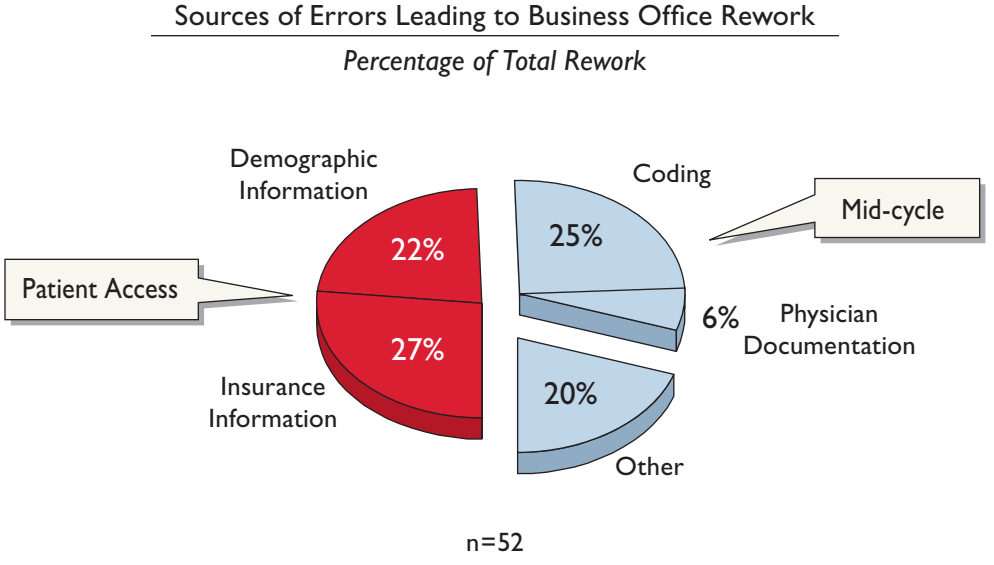
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations; Financial Leadership Council 2005 Member Survey of Revenue Cycle Operations.

Significant Variance in Error Rates

First-pass yield, defined as the percentage of claims that arrive in the business office error-free, varied significantly between solid and poor performers as ranked by AR days performance. Half of the errors leading to rework originated in the patient access departments. About a third of all business office rework was caused by errors in the mid-cycle functions of coding and physician documentation. The remaining fifth of errors occurred during unspecified portions of the revenue cycle.

Focusing on the First Pass



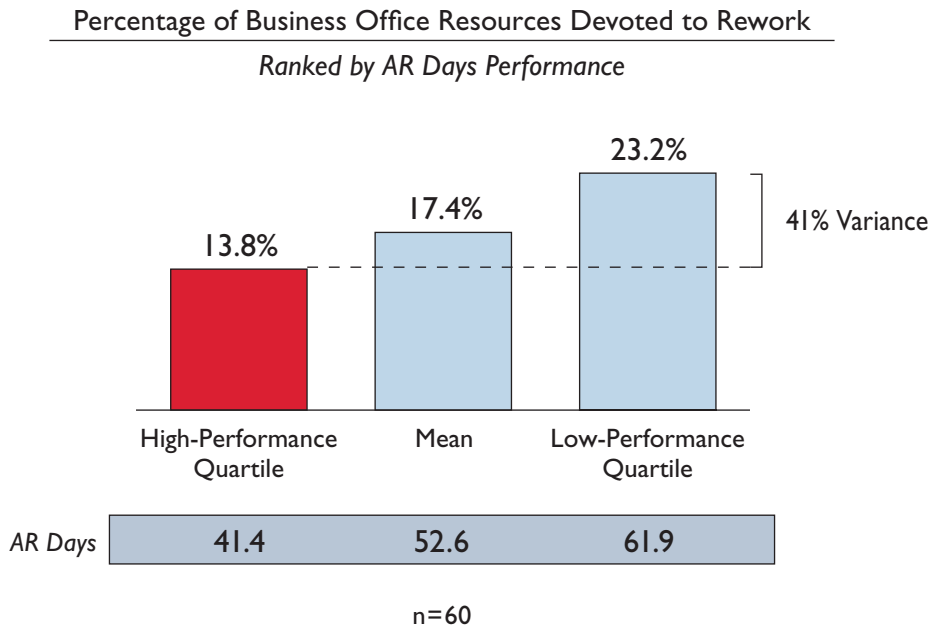


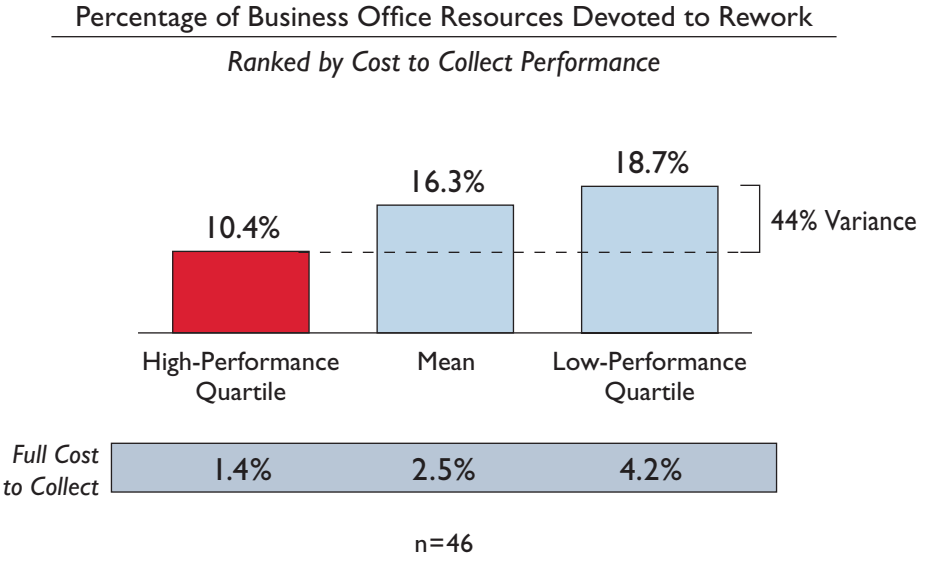
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Rework a Key Source of Performance Shortfalls

Top revenue cycle performers, ranked by both cost to collect (profiled on pages 36 and 37) and AR days, spent a significantly smaller percentage of their business office resources on reworking errors in claims. Poor performers in rankings for both metrics devoted greater than 40 percent more of their resources to rework relative to their high-performance peers. The data bear out the hypothesis that business office rework has a significant impact on both the efficacy and efficiency of the hospital revenue cycle.

Déjà Vu?





Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

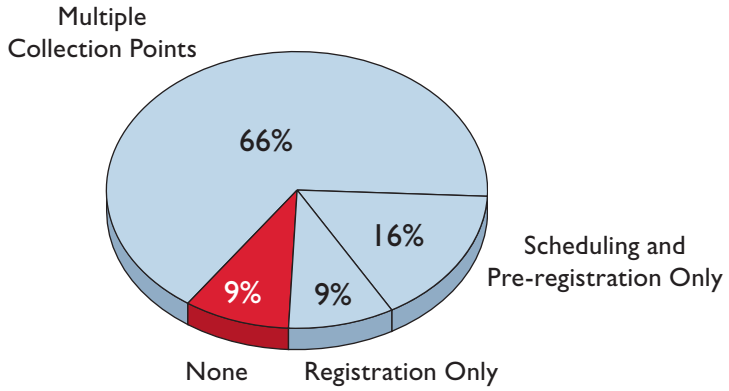
A Wide Range in POS Collections for Scheduled Visits

Although the vast majority of hospitals attempted point-of-service collections, with two-thirds of participants having collected from the patient at multiple points, there was a significant difference in performance. Top performers collected close to 7 percent of patient obligations compared to the poor performers who struggled to collect even 1 percent.

The Difference Between Doing and Succeeding

Point-of-Service Collection Practices for Scheduled Visits

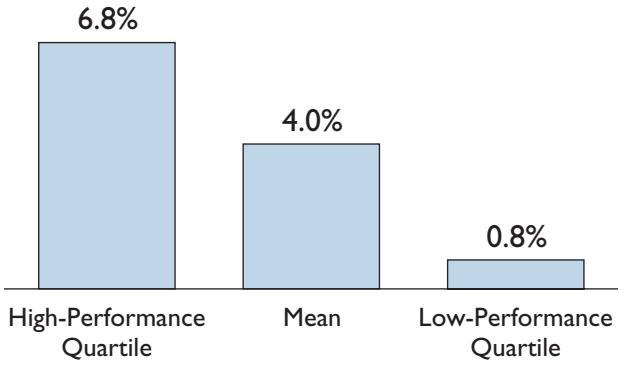
Percentage of Respondents



n=63

POS Collection Efficacy

Percentage of Total Patient Obligations Collected at Point of Service



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Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

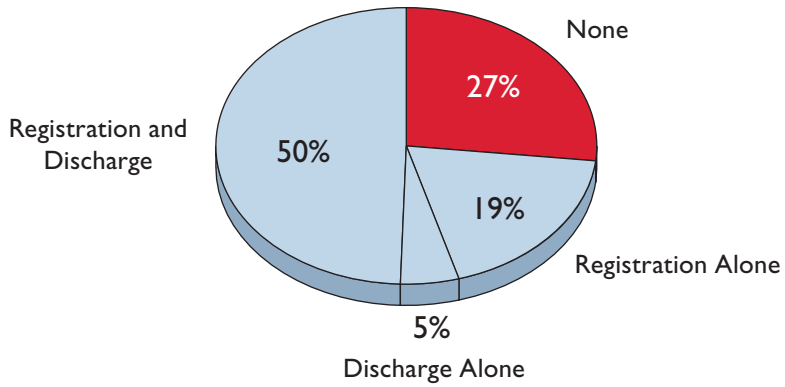
No Consensus in POS Collection Practices for Unscheduled Visits

Point-of-service collection efforts for unscheduled visits have not gained the same traction as POS collections for scheduled visits. Although nearly 70 percent of hospitals attempted POS collections during the registration process, and more than half tried to recover patient obligations at the time of patient discharge, greater than a quarter of hospitals surveyed did not attempt to collect for unscheduled visits compared to just below 10 percent of hospitals for scheduled visits.

Some Aren't Even Trying

Point-of-Service Collections for Unscheduled Visits

Percentage of Respondents



n=65

Unsynchronized Systems

"We're doing a pretty good job of collecting copays at the point of service. Patients have come to expect it and we can determine the correct copay without too much difficulty. But we're struggling with deductibles and co-insurance. We can identify what the deductible is, theoretically, but we're not so good at determining what portion of it the patient has already paid. If patients have been to physicians' offices or imaging centers the same day they come to us, we may have no way of knowing what's left to charge them."

Hospital CFO

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

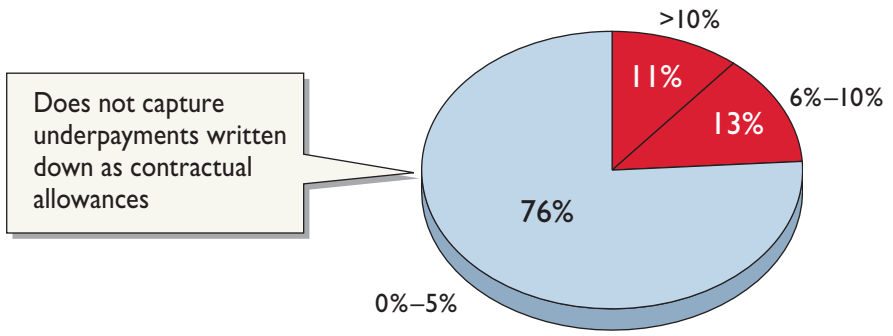
Dramatic Differences in Denials

Although a majority (76 percent) of hospitals reported initial denial rates below 5 percent of outstanding AR, a significant subset of hospitals reported initial denial rates well above 10 percent of outstanding AR. It must be noted, however, that initial denials are notoriously difficult to track; an undisclosed and often untracked number of underpayments are written down as contractual allowances and are not included in the initial-denials number. Write-offs resulting from denials mirrored the performance of initial denials, with a large performance gap between high and low performers.

Strong Overall Denials Performance?

Initial Denials, 2006

Percentage of Outstanding AR



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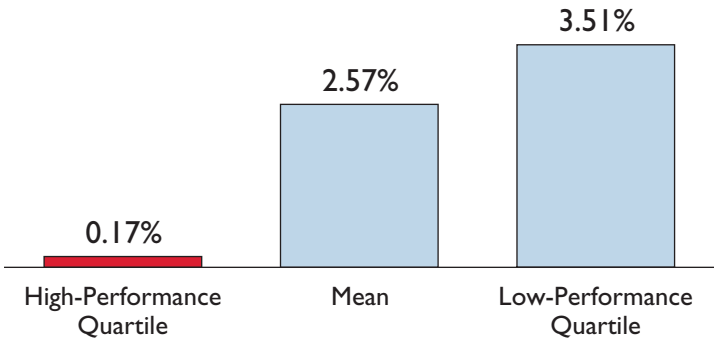
Denials Write-Offs, 2006

Percentage of Net Patient Revenue



n=48

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

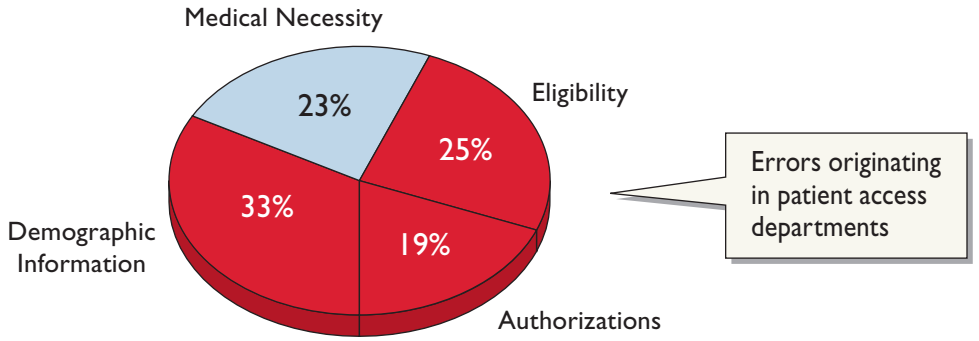
Source of Denials

A breakdown of the sources of errors leading to denials highlights the importance of the front office; with three-fourths of denials having originated from errors in patient eligibility, lack of authorizations, and inaccuracies in demographic information. The lower two charts show, as expected, managed care and outpatients are driving the majority of the denials, although they roughly mirror the sources of total cash collections (detailed on page 6).

Where Hospitals Stumble

Source of Errors Leading to Denials

Percentage of Total Denials



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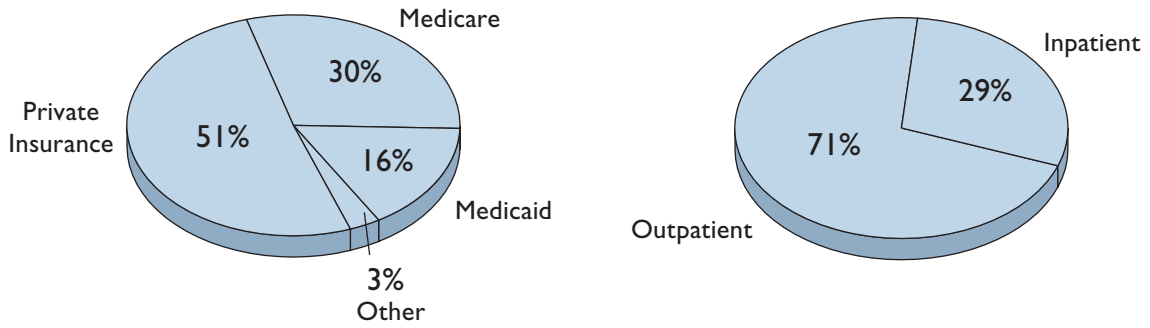
Types of Denied Claims

Percentage of Total Denials

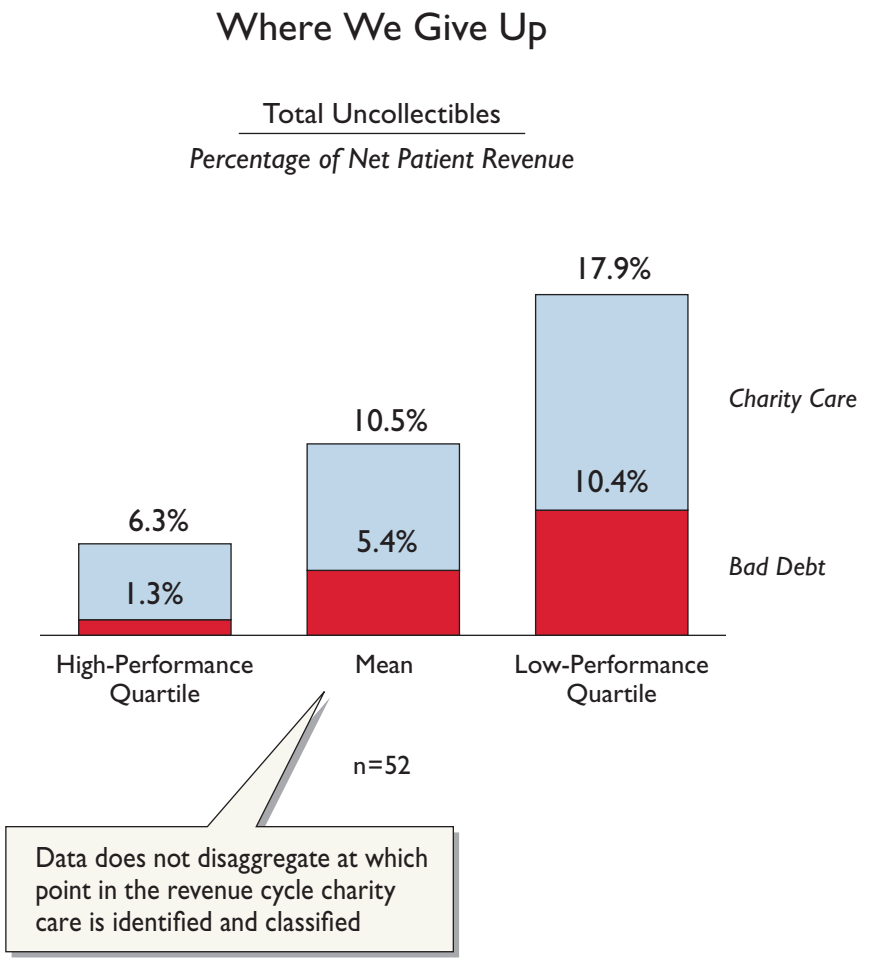


n=54

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Wide Variance in Uncollectibles Performance

The last stop for a claim that has been denied without a successful appeal, or a self-pay account on which hope for collection has been abandoned, is bad debt. A common suspicion among revenue cycle executives is that hospitals with low levels of bad debt are simply reclassifying bad debt claims as charity care. But the data below show that high levels of charity care correspond with high levels of bad debt. When ranked by bad debt performance, performance in total uncollectibles (bad debt plus charity care) mirrored performance in bad debt.

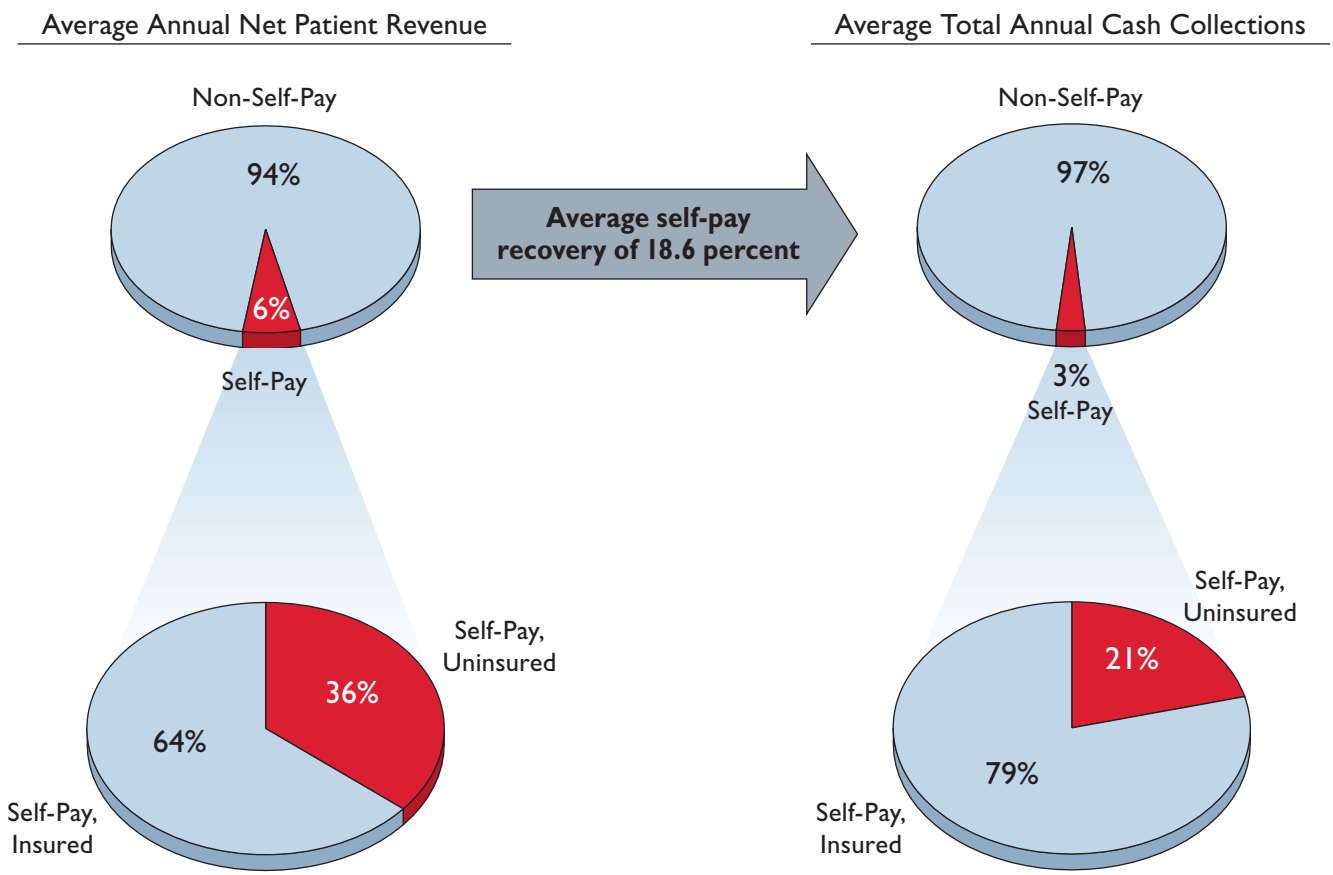


Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Insured Versus Uninsured Self-Pay

Self-pay accounts have notoriously low recovery rates, as we have seen on page 18, and are associated with high levels of bad debt. But most of the 18.6 percent recovery hospitals are receiving, on average, is not coming from the truly uninsured population. The charts on this page show that the uninsured account for about a third of net patient revenue booked as self-pay, but only about a fifth of the cash actually posted from self-pay accounts. The Council estimates that a sizeable number of uninsured self-pay accounts eventually become transferred to Medicaid (explaining Medicaid's high recovery rate). But many more are eventually written off as bad debt.

Who Pays for Self-Pay?



n=45

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Relating Bad Debt

Below is a list of hospital metrics associated with bad debt performance. After ranking hospitals by bad debt performance quartiles, the Council analyzed hospital performance in other areas within the corresponding quartiles. It is perhaps unsurprising that high levels of bad debt correspond with relatively large outpatient and self-pay net patient revenue, because such claims are riskiest. But the relationship between strong performance in bad debt and strong performance in both AR days and cost to collect is startling. Many executives assume that hospitals must essentially trade off low AR days for relatively high bad debt, for example. The relationships between solid performance in all three major performance metrics indicates an opportunity for hospitals to improve revenue cycle performance across the board.

Metrics Showing Relationships with Bad Debt

Related Performance Metrics, Ranked by Bad Debt Performance

Metric	High-Performance Quartile	Mean	Low-Performance Quartile
Bad Debt	**1.3%**	**5.4%**	**10.4%**
AR Days	52.3 days	53.2 days	59.1 days
Adjusted Cost to Collect	2.0%	2.2%	3.1%
Self-Pay Percentage of Total Revenue	4.2%	5.5%	7.9%
Inpatient Percentage of Total Revenue	74.3%	64.6%	56.0%
Medicare Percentage of Total Revenue	35.2%	34.3%	30.8%

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Relating AR Days

Below is a list of hospital metrics associated with AR days performance. After ranking hospitals by AR days performance quartiles, the Council analyzed hospital performance in other areas within the corresponding quartiles. Again, note that solid performers in AR days matched with strong performance in both bad debt and cost to collect. Hospitals landing in the high-performance AR days quartile also posted strong showings in first-pass yield and business office rework, indicating the utmost importance of accuracy in the patient access departments. The slightly higher level of Medicare revenue for strong performers (also weakly apparent when ranked by bad debt) is probably associated with the relatively simple billing process and quick turnaround time for Medicare reimbursement (14 days, on average).

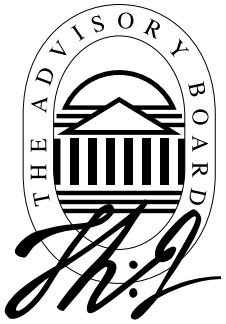
Metrics Showing Relationships with AR Days

Related Performance Metrics, Ranked by AR Days Performance

Metric	High-Performance Quartile	Mean	Low-Performance Quartile
AR Days	**36.4 days**	**52.6 days**	**69.1 days**
Bad Debt	4.8%	6.3%	6.6%
Full Cost to Collect	2.1%	2.5%	3.4%
First-Pass Yield	79.8%	75.5%	69.7%
Percentage of Business Office Resources Devoted to Rework	13.8%	17.4%	23.2%
Medicare Percentage of Total Revenue	36.4%	35.2%	34.9%

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

III

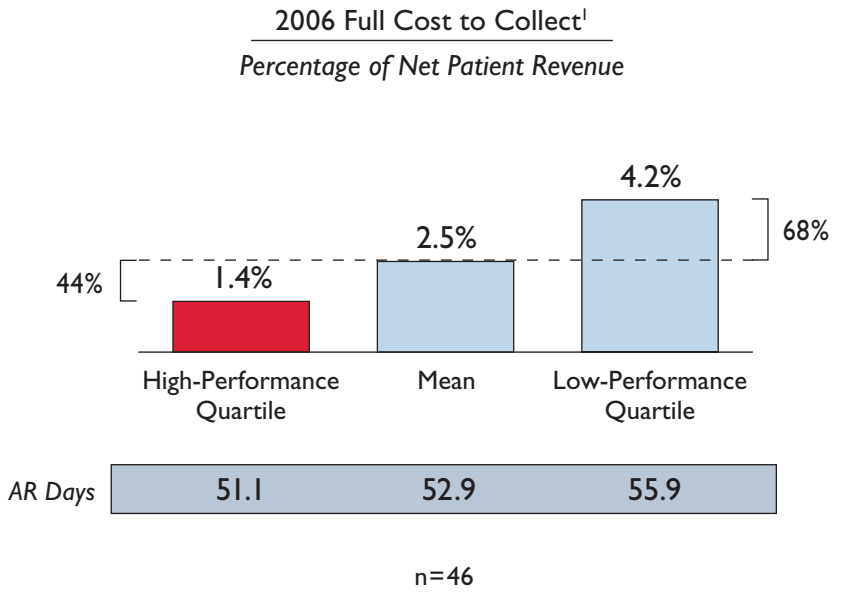


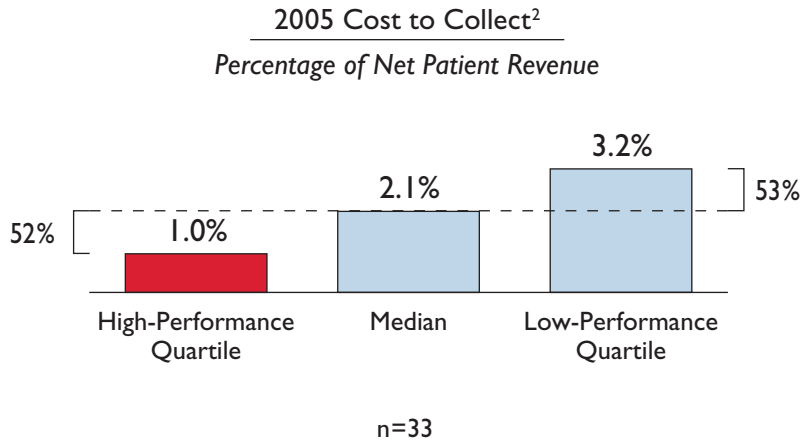
Revenue Cycle Costs and Staff Productivity

A Costly Revenue Cycle

In 2005, the Council measured the costs of salaries and benefits, outsourcing, and overhead (which included both technology and space) as a percentage of net patient revenue. In 2006, we expanded our scope to include the mid-cycle functions as well, which explains the overall increase in cost to collect depicted below. We also tracked costs more discretely, by measuring on-site and off-site outsourcing for specific functions, and separating costs for technology and space. But similar to last year's data, this year's results showed an enormous variance between hospitals in cost performance. In fact, cost to collect once again showed the greatest variance of any major performance metric.

Significant Variance in Collection Costs





[1] The 2006 Cost to Collect figure is the sum of the staffing, technology, overhead and outsourcing costs associated with all functional areas of the revenue cycle (including patient access, mid-cycle, and business office), expressed as a fraction of annual net patient revenue.

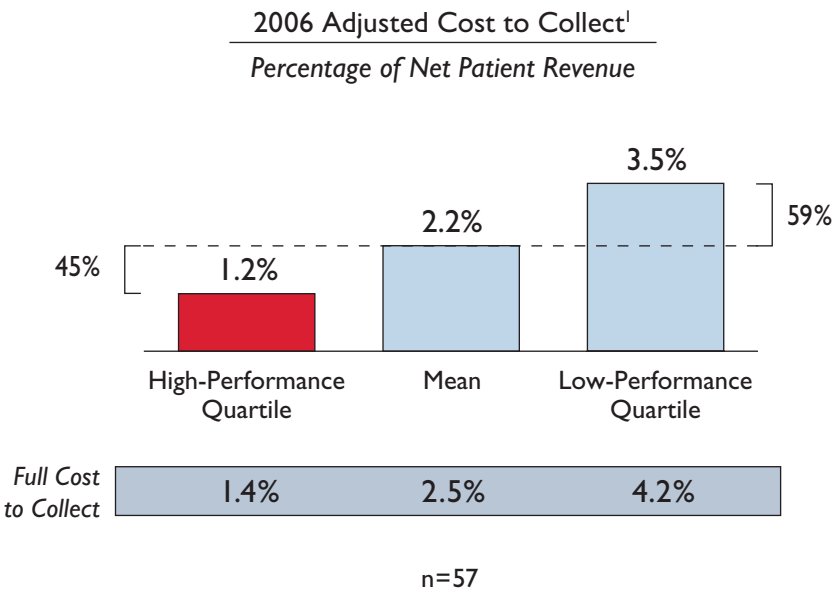
[2] The 2005 Cost to Collect figure is the sum of the staffing, overhead, and outsourcing costs associated only with patient access and business office, expressed as a fraction of annual net patient revenue.

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations; Financial Leadership Council 2005 Member Survey of Revenue Cycle Operations.

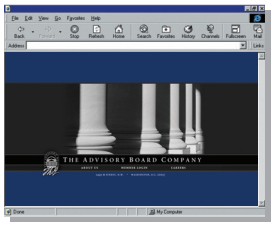
A More Palatable Measure of Cost?

The Council understands that not all institutions may wish to include case management and utilization review in their revenue cycle performance metrics, especially given the large salaries paid to case managers relative to other revenue cycle departments. Although the Council believes such costs should be included in revenue cycle performance measures, we have included an adjusted cost to collect that includes coding and medical transcription, but specifically excludes case management and utilization review. Note, however, that the variance between performance quartiles remains virtually unchanged from the full cost to collect data.

Cost to Collect Excluding Case Management



Tracking Cost to Collect



Looking for a clearer picture of what revenue cycle costs the Council believes every hospital should track? Log on to Advisory.com and check out the Council's 2006 publication *Maximizing Revenue Cycle Margins*. Download "Tool #1: Revenue Cycle Cost Worksheet," for a comprehensive list of revenue cycle costs. Hard copies of all Council books are available to members in unlimited quantities.

[1] Adjusted cost to collect excludes case management and utilization review costs.

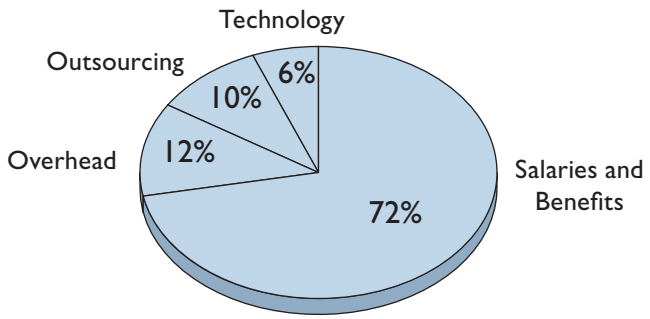
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Cost Allocation by Resource Type

Perhaps unsurprisingly, salaries and benefits account for the vast majority of revenue cycle costs, although the Council suspects that technology and overhead costs are actually a greater percentage of the total (because those costs are often not directly or properly allocated to revenue cycle operations). Outsourcing costs account for a tenth of the total; note that outsourcing costs do not include collection agency commissions, which are generally assessed as a percentage of recovery (see page 20 and 21 for more detail). Also not that only about a quarter of respondents indicated they employ both on-site and off-site outsourcing.

Spending to Collect

Percentage of Total Revenue Costs



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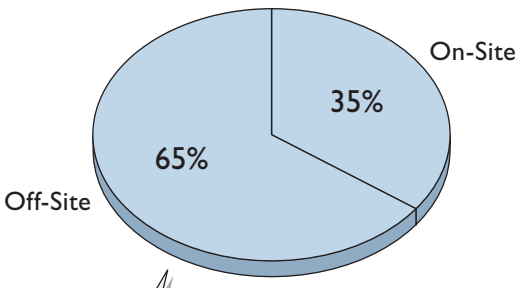
Outsourcing Costs

Percentage of Outsourcing Costs



Only 24 percent of respondents reported using both on-site and off-site outsourcing

Most Commonly Outsourced Functions

1. Coding
2. Medical Transcription
3. Billing
4. Collections
5. Scheduling

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

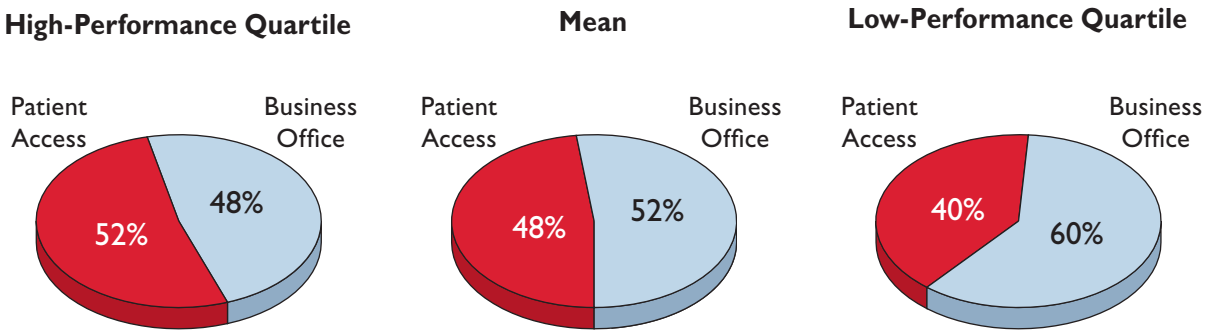
Resource Allocation by Functional Area

Reinforcing data collected in 2005, this year's survey revealed that low-cost revenue cycle operations devote a disproportionately large share of resources to patient access operations. This year's data also reveal that hospitals in the high-performance (low-cost) quartile also allocate a relatively greater amount of resources to the mid-cycle functions of coding, medical transcription, case management, and utilization review.

Patient Access Versus Business Office

Revenue Cycle Resource Allocation, Excluding Mid-cycle

Percentage of Revenue Cycle Costs,[1] Ranked by Full Cost to Collect



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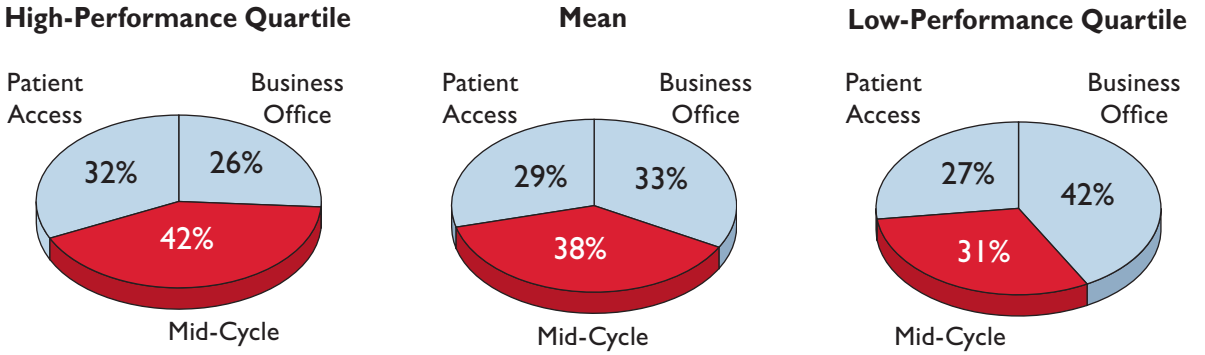
Revenue Cycle Resource Allocation, Including Mid-cycle



n=46

[1] Costs exclude all mid-cycle costs.

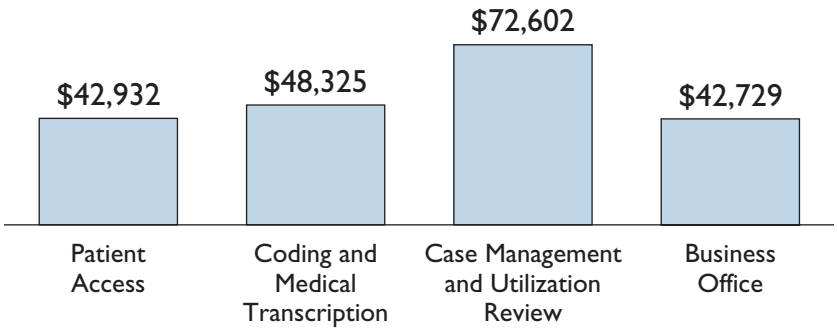
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Revenue Cycle Staffing Costs

If the per-FTE costs below seem larger than expected, note that the figures below include both salaries and benefits, and the figures in the second chart include all departmental costs, including technology, overhead, and outsourcing. Patient access and business office staff enjoy nearly identical compensation while coders and medical transcribers can command a slight premium (which is potentially related to the low turnover and high vacancy rates detailed on page 10). Because case managers generally are nurses, their total compensation is in line with other nursing staff.

Wide Departmental Variances

Average Total Salary and Benefit Costs per FTE



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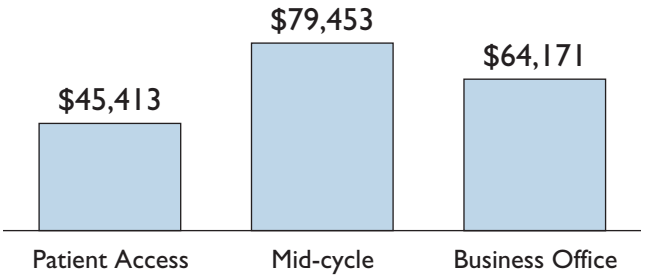
Average Total Costs per FTE

Includes Salaries/Benefits, Technology, Overhead, and Outsourcing



n=46

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Revenue Cycle Staff Productivity

The table below provides annual productivity benchmarks for the standard work units typically assigned to each of the functions listed. Please note that the figures regarding financial counselors do not reflect the number of registrations or claims actually processed by the counselors; rather, they reflect the number of registrations and claims processed by the hospital for every financial counselor FTE employed.

New Benchmarks for Standard Tasks

Median Annual Work Units per FTE

Function	Median
Patient Access	
Registrations per Scheduler	28,472
Registrations per Pre-registrar	33,304
Registrations per Registrar	6,250
Total Hospital Registrations per Financial Counselor	65,479
Total Hospital Claims per Financial Counselor	83,333
Registrations per Patient Access FTE	4,308
Mid-cycle	
Registrations per Coder	20,833
Claims per Coder	19,411
Business Office	
Cash Posted per Biller	$29,133,778
Claims per Biller	29,864
Cash Posted per Collector	$15,849,748
Claims per Collector	14,646
Cash Posted per Business Office FTE	$7,105,263
Claims per Business Office FTE	7,169

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

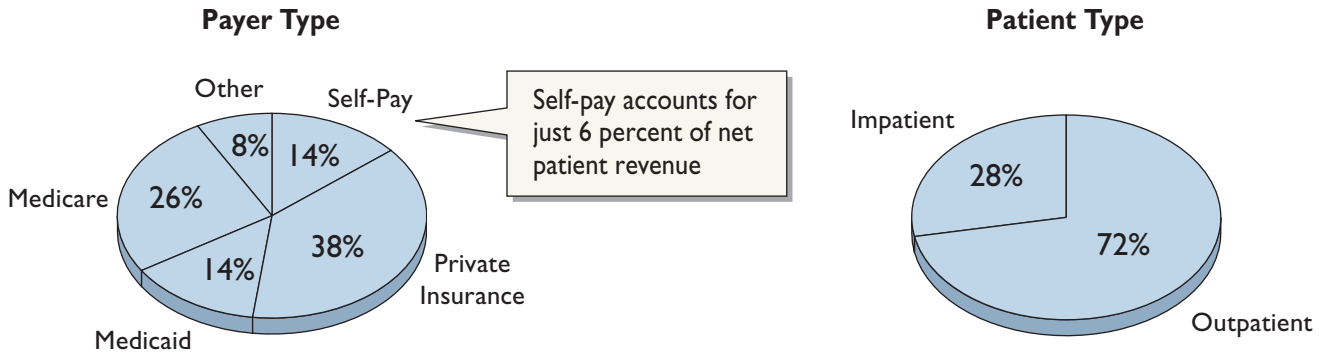
Business Office Resource Allocation

The next two pages focus specifically on productivity benchmarks within the business office itself. The data below show that self-pay and outpatient claims consumed a disproportionate share of business office resources relative to their share of either net patient revenue or cash collections (see page 6). The variance in cost to collect for these two claim types relative to their peers was especially significant, underscoring potential opportunities for cost savings or productivity enhancements.

Private Insurance and Outpatient Claims Dominate

Business Office Resources

Average Percentage of Business Office Resources



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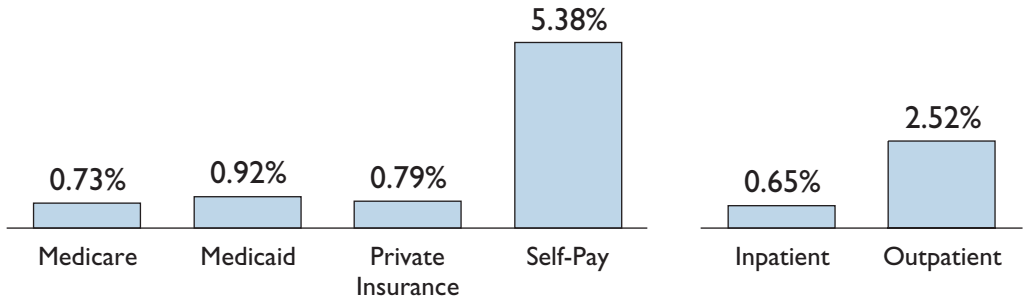
Business Office Collection Costs

Median Percentage of Payer-Specific Cash Collections, by Payer and Patient Claim Type



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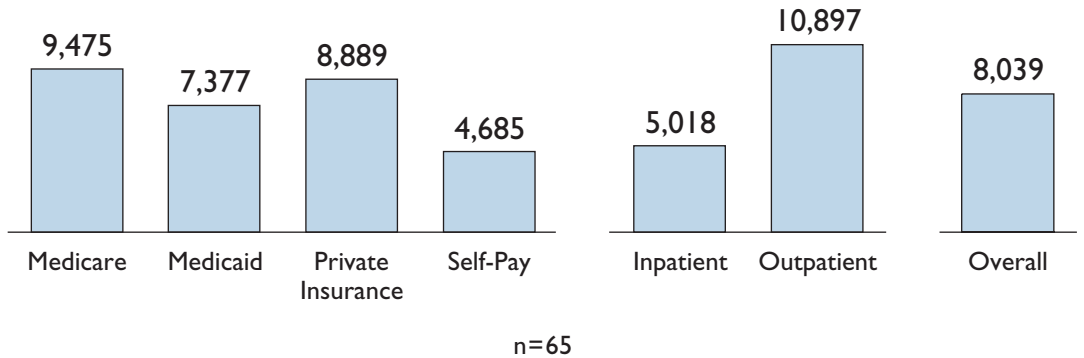
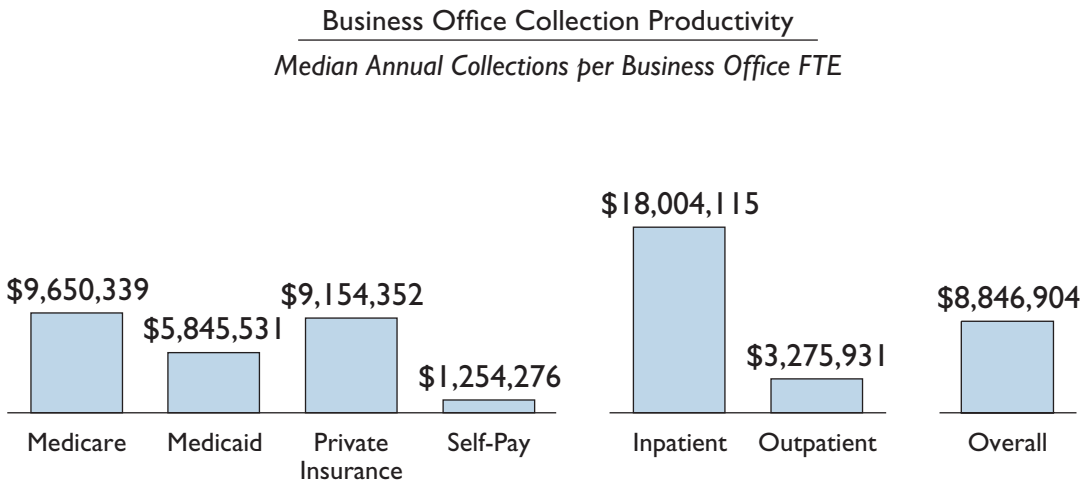
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Business Office Productivity

In terms of claims processed per FTE, the low productivity numbers for self-pay are unsurprising, given the often-cumbersome nature of processing such claims. And although Medicaid reimbursement is relatively low, its high collection efficiency (ease of collection from processed claims, profiled on page 19) may explain its relatively low claims-processing productivity: hospitals have added staff to the business office to enroll patients and collect from Medicaid.

Significant Variance in Claims-Processing Productivity





Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Relating Cost to Collect

Below is a list of hospital metrics associated with performance on full cost to collect. After ranking hospitals by cost-to-collect performance quartiles, the Council analyzed hospital performance in other areas within the corresponding quartiles. Uncoincidentally, hospitals with low costs to collect (the high-performance quartile), devoted a relatively greater share of resources to patient access and a relatively smaller share of business office resources to rework. (Also note that low levels of rework also correspond with strong AR days performance, as detailed on pages 24 and 25.) Unsurprisingly, hospitals with relatively low costs to collect also had a smaller portion of net patient revenue stemming from self-pay. Those same hospitals also devoted a relatively larger share of business office resources to collecting from self-pay patients. Finally, again note the corresponding relationships between strong cost-to-collect performance and high performance in both AR days and bad debt.

Metrics Showing Relationships with Cost to Collect

Related Performance Metrics, Ranked by Cost to Collect

Metric	High-Performance Quartile	Mean	Low-Performance Quartile
Full Cost to Collect	**1.4%**	**2.5%**	**4.2%**
AR Days	51.1 days	52.9 days	55.9 days
Bad Debt	4.6%	6.0%	7.3%
Patient Access Percentage of Total Revenue Cycle Costs[1]	52.5%	47.7%	41.3%
Percentage of Business Office Resources Devoted to Rework	10.4%	16.3%	18.7%
Self-Pay Percentage of Total Revenue	3.6%	6.1%	7.2%
Self-Pay Percentage of Business Office Resources	14.9%	11.5%	9.2%

[1] Excludes mid-cycle costs.

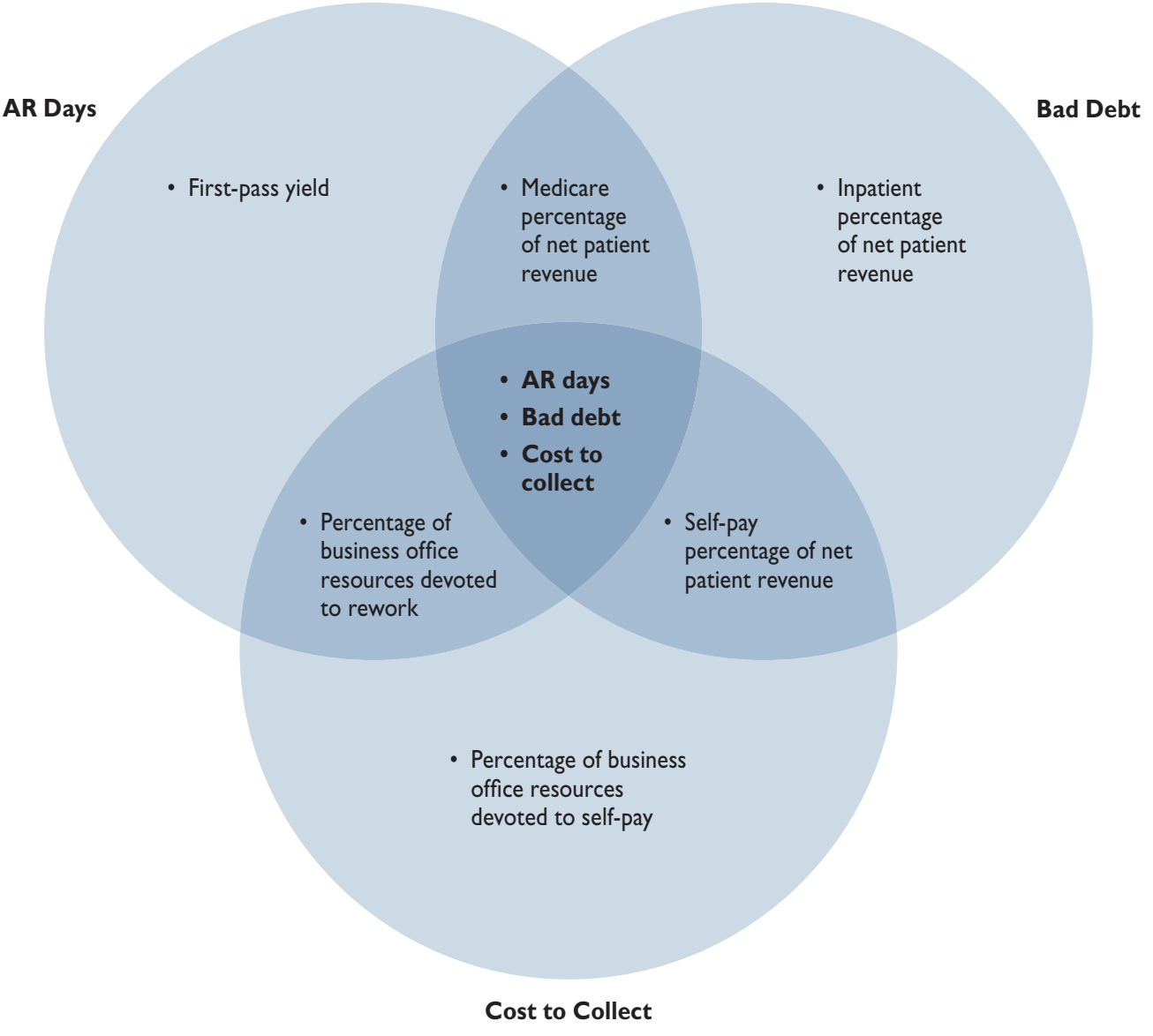
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Aggregating Performance Relationships

This guide has focused on three particular performance metrics: AR days, bad debt, and cost to collect. For each metric we have illustrated six attributes that the survey data suggest are associated with performance. On this page, we have outlined how those relationships overlap. A charge often laid against these revenue cycle performance metrics is that they work at cross purposes: strong performance in one area will mean poor performance in another. The diagram below shows emphatically that such an assumption is false, and that revenue cycle performance can be augmented in all key areas without necessarily sacrificing performance elsewhere. Although bad debt seems beholden to the largest number of uncontrollable factors, its relationship with AR days and cost to collect—which are associated with several controllable factors—indicates opportunities for improvement are still possible.

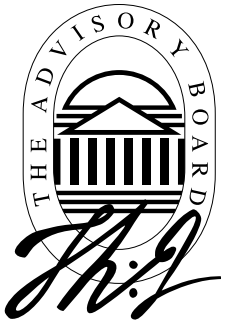
The Interplay of Performance Metrics

Factors Showing Relationships with Major Revenue Cycle Performance Metrics



Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

IV

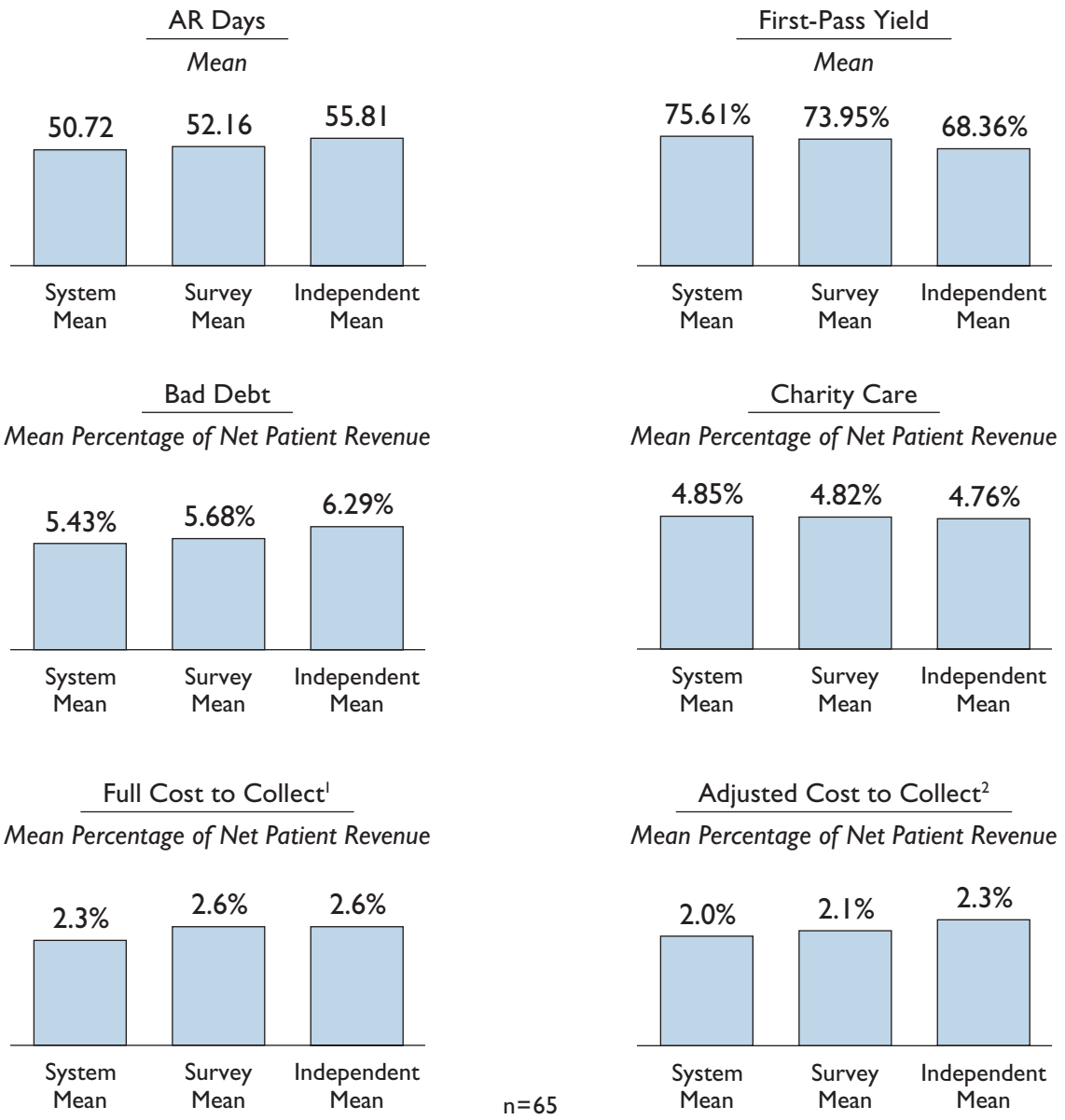


Comparative Averages

Systems Versus Independents

The next few pages provide survey means for six common performance indicators, divided by characteristics that hospitals often cite as fundamentally vital—and often uncontrollable—variables that affect performance. These pages should provide for greater "apples-to-apples" comparisons. On this page, we have listed survey averages for hospitals affiliated with systems, independent institutions, and the overall survey cohort. In every category, systems tend to perform fundamentally better, but only marginally so. Although system hospitals tended to dominate overall top-quartile performance in the three major revenue cycle performance metrics (AR days, bad debt and cost to collect), both systems and independents were fairly evenly distributed in all other quartiles.

Systems Win—But Just Barely



[1] Full Cost to Collect includes staffing, technology, overhead, and outsourcing costs associated with all functional areas of the revenue cycle.

[2] Adjusted Cost to Collect excludes case management and utilization review.

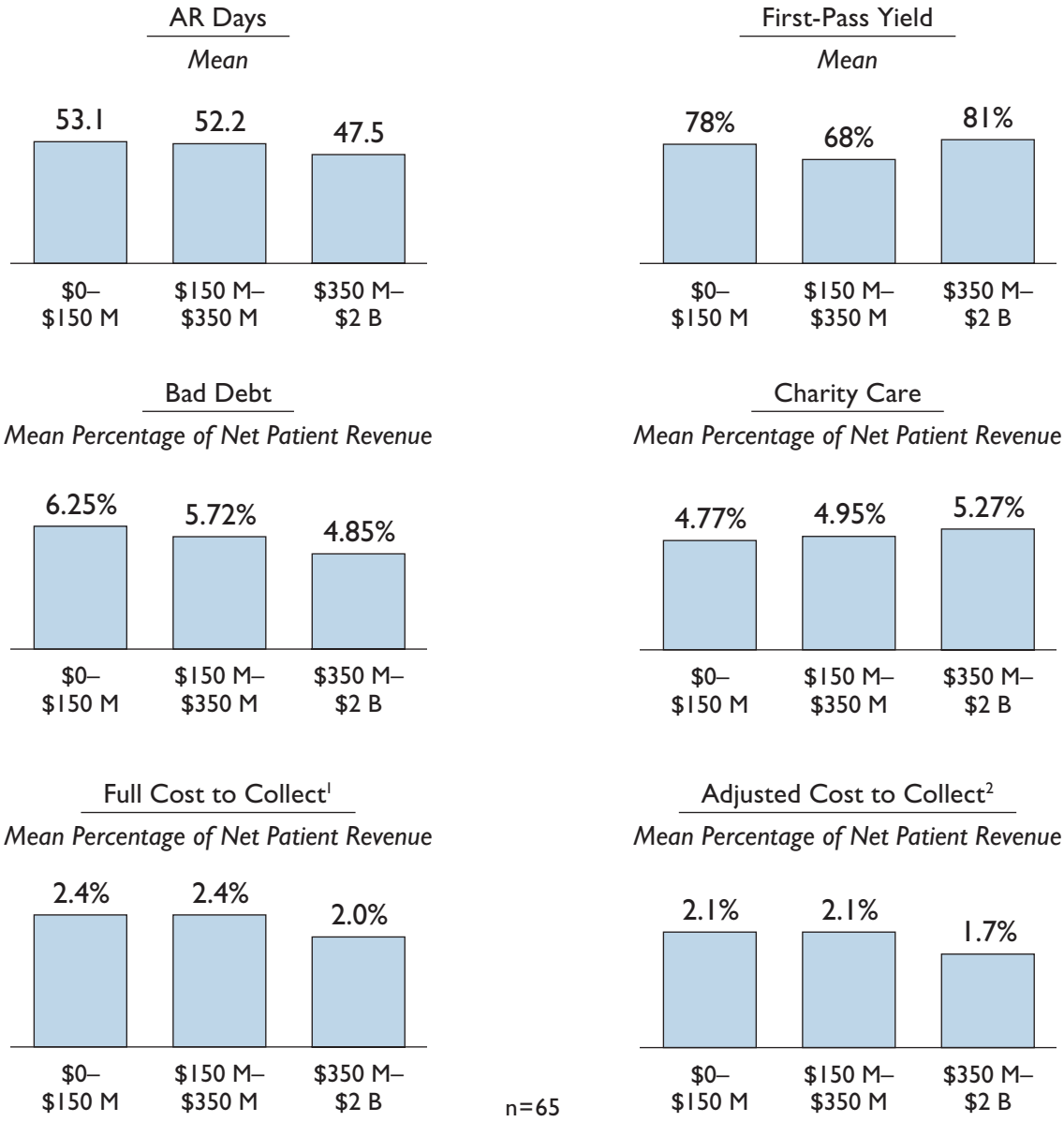
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Size Does Matter—Sometimes

For the purposes of this analysis, net patient revenue was used a proxy for hospital size. On this score, larger hospitals do tend to reap the benefits of economies of scale, enjoying stronger performance in AR days, bad debt, and cost to collect, and boasting slightly more generous charity care. But note that a hospital's size appears to have limited bearing on its ability to process claims accurately, as evidenced by the first-pass yield data.

Hospital Size Driving Some Performance Measures

Performance Means Segmented by Annual Net Patient Revenue Range



[1] Full Cost to Collect includes staffing, technology, overhead, and outsourcing costs associated with all functional areas of the revenue cycle.

[2] Adjusted Cost to Collect excludes case management and utilization review.

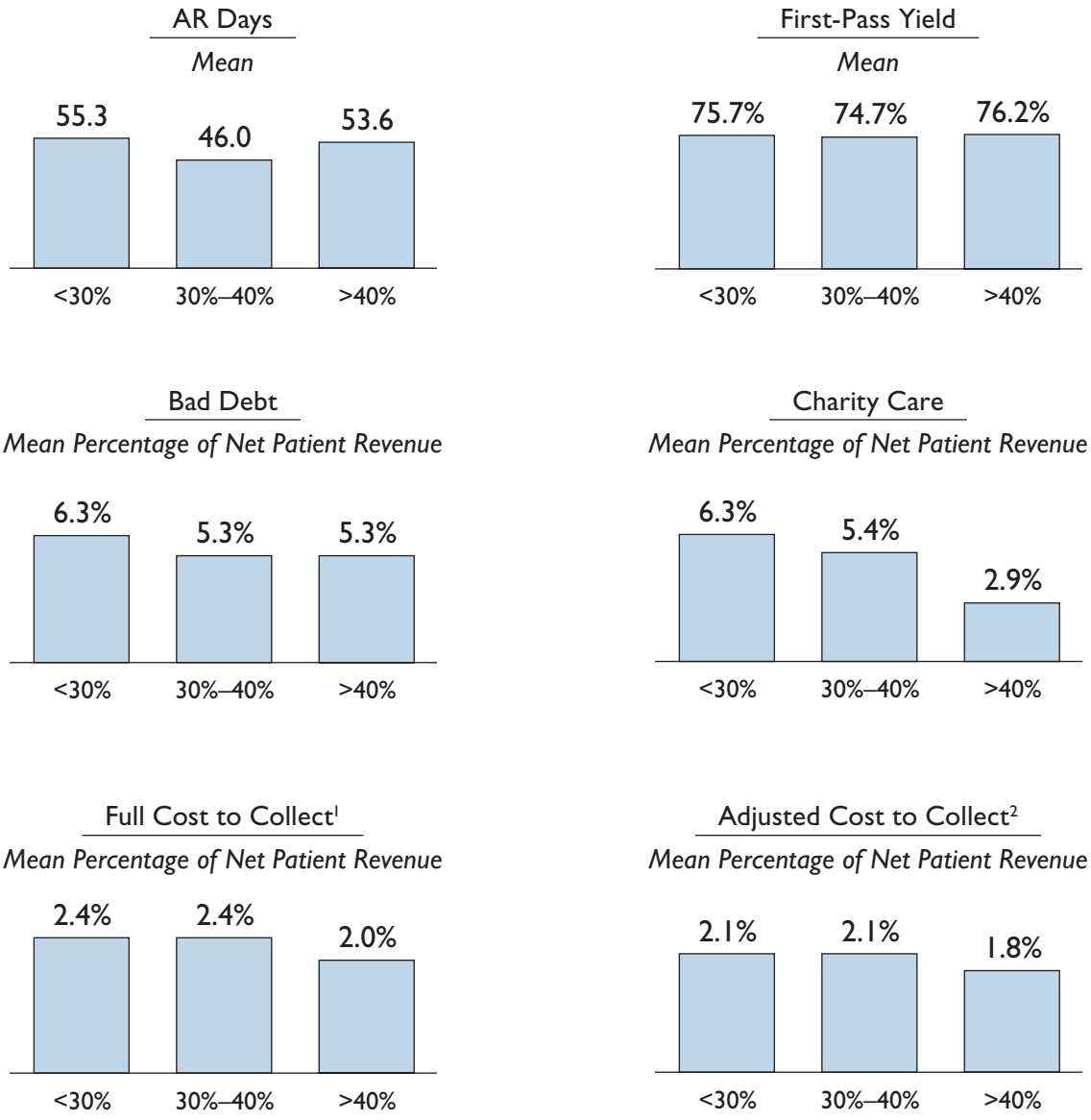
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Evaluating the Impact of Medicare

Hospital executives often charge that a payer mix heavy on Medicare will lead to a more efficient revenue cycle because Medicare claims have a standardized reimbursement process and enjoy rapid turnaround times relative to other payers. Survey analysis indicates this is not necessarily true. Although hospitals with a large Medicare mix do not have to devote as much net patient revenue to charity care, Medicare mix appears to have a limited but notable influence on performance in AR days, first-pass yield, bad debt, and cost to collect.

Limited Revenue Cycle Benefit

Performance Means Segmented by Medicare Percentage of Net Patient Revenue



n=65

[1] Full Cost to Collect includes staffing, technology, overhead, and outsourcing costs associated with all functional areas of the revenue cycle.

[2] Adjusted Cost to Collect excludes case management and utilization review.

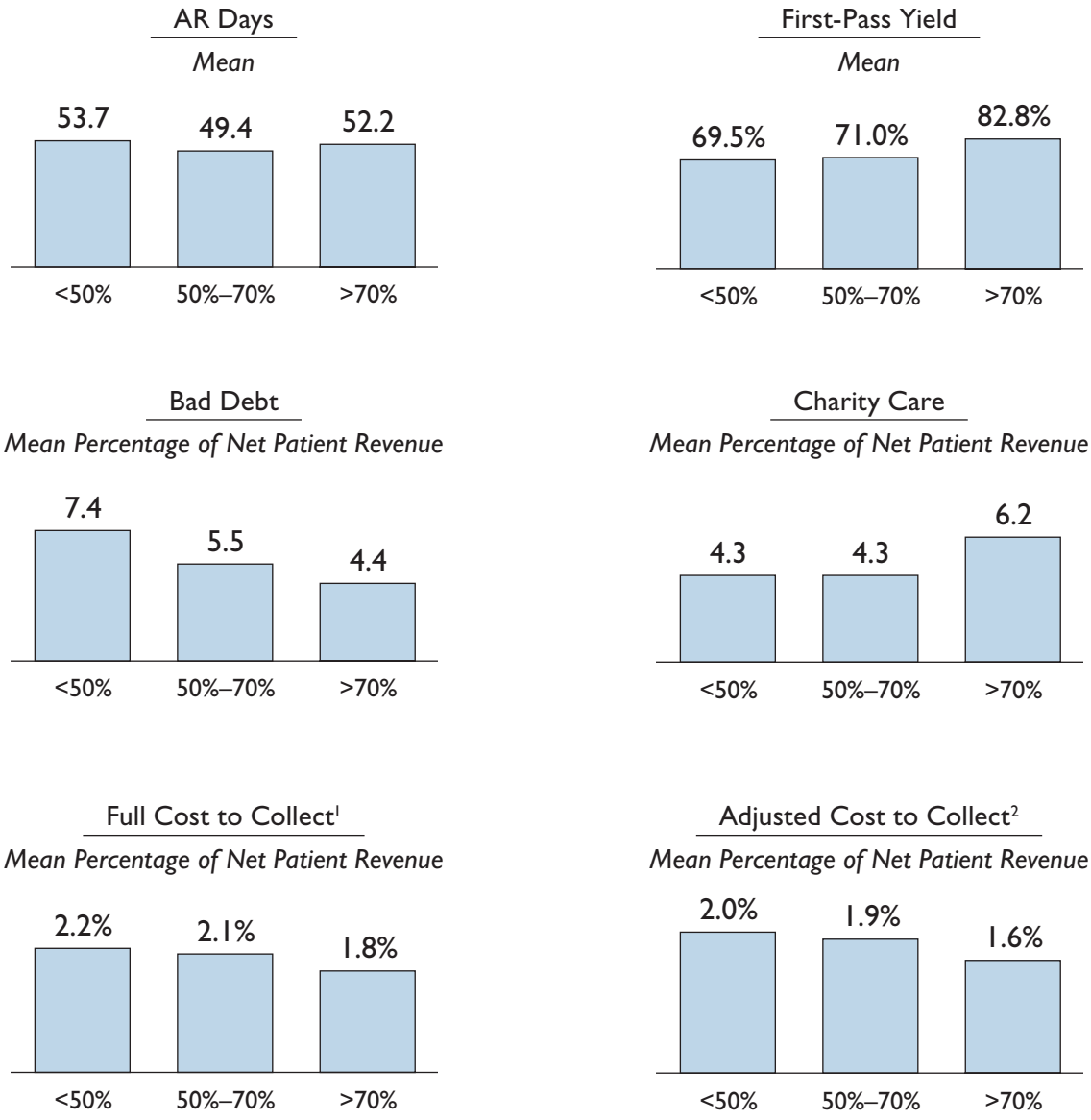
Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Evaluating the Impact of Patient Mix

Inpatient-outpatient mix, however, does appear to have a large impact on revenue cycle performance. Although inpatients have little impact on AR days performance, they are associated with strong performance in bad debt and cost to collect, and tend to be related to higher first-pass yields. Although such claims are more complex than their outpatient counterparts, they are far more lucrative per claim, and a larger inpatient mix means that hospitals can devote a relatively greater share of resources to ensuring they are processed accurately and efficiently.

Inpatients Enhancing Performance

Performance Means Segmented by Inpatient Percentage of Net Patient Revenue



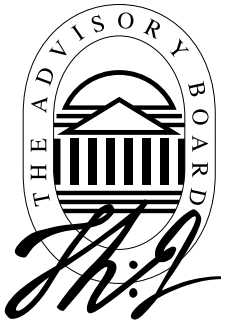
n=65

[1] Full Cost to Collect includes staffing, technology, overhead and outsourcing costs associated with all functional areas of the revenue cycle.

[2] Adjusted Cost to Collect excludes case management and utilization review.

Source: Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Appendix



2006 Member Survey of Revenue Cycle Operations

The following pages contain the text for all questions included in the 2006 Member Survey of Revenue Cycle Operations (although the formatting has changed). The definitions list on page 2 of this book also was included in the original survey document. The Council collected data from July 1, 2006, through December 31, 2006. Please note that while most data were self-reported by hospitals, numerous follow-up interviews were conducted to confirm accuracy.

Financial Leadership Council Member Survey

Hospital Name: _____

Location: _____

Contact Person: _____

Phone Number: _____

E-mail: _____

Instructions:

- Please limit your responses to data concerning a single hospital. If your hospital is part of a larger system using a number of centralized functions, please allocate resources attributable to your hospital only. Rough estimates are perfectly acceptable.
- Please answer the following questions with the most recent information you have available. For questions that ask for annual data, please supply information for the most recent completed fiscal year.
- If you are unable to obtain specific figures for any given question or worksheet, please estimate using your best judgment.

Chapter 1: Background

1. **Please denote your institution's affiliation status:**
   - ❍ Independent/Stand-Alone?
   - ❍ Part of a multi-hospital, regional, or national health system?
2. **How would you characterize your hospital's local community?**
   - ❍ (A) urban
   - ❍ (B) suburban
   - ❍ (C) exurban
   - ❍ (D) rural
3. **What are your hospital's annual total point-of-service collections?** $_____
4. **What percentage of cash collected from patient obligation comes from POS collections?** _____%

Please list the following:

Staffed Beds	_____ **Beds**	
Annual Registrations	_____ **Registrations**	
% Medicare	_____ %	Inpatient _____ %
% Medicaid	_____ %	Outpatient _____%
% Managed care/commercial	_____ %	**Total 100%**
% Self-pay	_____ %	
% Other	_____ %	
Total	**100%**	
Annual Claims	_____ **Claims**	
% Medicare	_____ %	Inpatient _____ %
% Medicaid	_____ %	Outpatient _____%
% Managed care/commercial	_____ %	**Total 100%**
% Self-pay	_____ %	
% Other	_____ %	
Total	**100%**	
Annual Net Patient Revenue	$ _____	
% Medicare	_____ %	Inpatient _____ %
% Medicaid	_____ %	Outpatient _____%
% Managed care/commercial	_____ %	**Total 100%**
% Self-pay	_____ %	
Self-pay, insured, patient balance _____ %		
Self-pay, uninsured _____ %		
% Other	_____ %	
Total	**100%**	
Annual Cash Posted	$ _____	
% Medicare	_____ %	Inpatient _____ %
% Medicaid	_____ %	Outpatient _____%
% Managed care/commercial	_____ %	**Total 100%**
% Self-pay	_____ %	
Self-pay, insured, patient balance _____ %		
Self-pay, uninsured _____ %		
% Other	_____ %	
Total	**100%**	
Bad Debt (% of net revenue)	_____ **%**	
Charity Care (% of net revenue)	_____ **%**	
Initial Denials (% of Outstanding AR)	_____ **%**	
Denial Write-Offs (% of net revenue)	_____ **%**	
DNFB (discharged not final bill)	**$** _____	

Chapter 2: Patient Access

Please list the number of FTEs devoted to the following operations:

Please only include those FTEs who spend at least 50% of their time performing labor relevant to the revenue cycle. Include Financial Counselors only if they mostly act in Patient Access.

Function	Total FTEs	*Monthly* Turnover Rate	*Monthly* Vacancy Rate	Supervisor FTEs Only
Scheduling	_____ FTEs	_____ %	_____ %	_____ FTEs
Pre-registration	_____ FTEs	_____ %	_____ %	_____ FTEs
Registration	_____ FTEs	_____ %	_____ %	_____ FTEs
Financial Counseling	_____ FTEs	_____ %	_____ %	_____ FTEs
Total	_____ FTEs	_____ %	_____ %	_____ FTEs

Please list the *annual* costs associated with each of the following functions:

Please allocate only those technology and overhead costs that apply specifically to the revenue cycle; if such costs are not currently defined, allocate using your best judgment. If you are unable to allocate dollar amounts for the individual departments, you may estimate using the percentage boxes. Include Financial Counselors only if they act primarily in Patient Access.

Function	Total In-House Patient Access Salary and Benefit Costs[1]		Total Patient Access Technology Costs[2]		Other Patient Access Overhead Costs (space, office materials, etc.)[2]	
Scheduling	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Pre-registration	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Registration	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Financial Counseling	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Total	$ _____	100%	$ _____	100%	$ _____	100%

Please list the following Patient Access outsourcing costs:

Function	Total On-Site Patient Access Outsourcing Labor Costs		Other Patient Access Outsourced-Service Costs	
Scheduling	$ _____	_____ %	$ _____	_____ %
Pre-registration	$ _____	_____ %	$ _____	_____ %
Registration	$ _____	_____ %	$ _____	_____ %
Financial Counseling	$ _____	_____ %	$ _____	_____ %
Total	**$ _____**	**100%**	**$ _____**	**100%**

[1] Include only those employees directly employed by the hospital.

[2] Include only annual operational and depreciation costs; do not include capital expenditures.

Operations

When does your hospital verify a patient's primary insurance?

❍ (A) Scheduling

❍ (B) Pre-registration

❍ (C) Registration

❍ (D) Billing

❍ (E) Other _____

If you have access to online insurance-verification tools, how does your system access the information?

❍ (A) We do not use online insurance-verification tools

❍ (B) Directly through the payers

❍ (C) Via an intermediary

❍ (D) Blend of direct-to-payer and intermediary access

For what percentage of payers do you use your online verification tool? _____%

At what point does your hospital engage in point-of-service collections for *scheduled* visits?

❍ (A) Scheduling/Pre-registration

❍ (B) Registration

❍ (C) Discharge

❍ (D) More than one of the above

❍ (E) None of the above

At what point does your hospital engage in point-of-service collections for *unscheduled* visits?

❍ (A) Scheduling/Pre-registration

❍ (B) Registration

❍ (C) Discharge

❍ (D) More than one of the above

❍ (E) None of the above

Which department is primarily responsible for securing initial authorizations?

❍ (A) Scheduling

❍ (B) Pre-registration

❍ (C) Registration

❍ (D) Other _____

❍ (E) None of the above

Chapter 3: Mid-cycle

Please list the number of FTEs devoted to the following operations:

Please only include those FTEs who spend at least 50% of their time performing labor relevant to the revenue cycle.

Function	Total FTEs	*Monthly* Turnover Rate	*Monthly* Vacancy Rate	Supervisor FTEs Only
Coders	_____ FTEs	_____ %	_____ %	_____ FTEs
Medical Transcription	_____ FTEs	_____ %	_____ %	_____ FTEs
Case Management	_____ FTEs	_____ %	_____ %	_____ FTEs
Utilization Review	_____ FTEs	_____ %	_____ %	_____ FTEs
Other Functions	_____ FTEs	_____ %	_____ %	_____ FTEs
Total	**_____ FTEs**	**_____ %**	**_____ %**	**_____ FTEs**

Please list the *annual* costs associated with each of the following functions:

Please allocate only those technology and overhead costs that apply specifically to the revenue cycle; if such costs are not currently defined, allocate using your best judgment. If you are unable to allocate dollar amounts for the individual departments, you may estimate using the percentage boxes.

Function	Total In-House Mid-cycle Salary and Benefit Costs[1]		Total Mid-cycle Technology Costs[2]		Other Mid-cycle Overhead Costs (space, office materials, etc.)[2]	
Coders	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Medical Transcription	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Case Management	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Utilization Review	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Other Functions	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Total	**$ _____**	**100%**	**$ _____**	**100%**	**$ _____**	**100%**

Please list the following Mid-cycle outsourcing costs:

Function	Total On-Site Mid-cycle Outsourcing Labor Costs		Other Mid-cycle Outsourced-Service Costs	
Coders	$ _____	_____ %	$ _____	_____ %
Medical Transcription	$ _____	_____ %	$ _____	_____ %
Case Management	$ _____	_____ %	$ _____	_____ %
Utilization Review	$ _____	_____ %	$ _____	_____ %
Other Functions	$ _____	_____ %	$ _____	_____ %
Total	**$ _____**	**100%**	**$ _____**	**100%**

[1] Include only those employees directly employed by the hospital.

[2] Include only annual operational and depreciation costs; do not include capital expenditures.

What is the case management model employed at your institution?

❍ (A) Unit-based

❍ (B) Physician-based

❍ (C) Payer-based

❍ (D) Specialty-based

❍ (E) Mixed

❍ (F) Other

In the last year, what percentage of charts had at least one documentation error/problem that could have impacted accurate charge capture?

❍ (A) 0%–5%

❍ (B) 6%–10%

❍ (C) 11%–25%

❍ (D) 26%–50%

❍ (E) 51%–75%

❍ (F) 76%–100%

Chapter 4: Business Office

Please list the number of FTEs devoted to the following operations:

Please only include those FTEs who spend at least 50% of their time performing labor relevant to the revenue cycle. Include Financial Counselors only if they act primarily in the Business Office. **Note:** Include denials and underpayment follow-up operations in Collections FTEs.

Function	Total FTEs	*Monthly* Turnover Rate	*Monthly* Vacancy Rate	Supervisor FTEs Only
Billing	_____ FTEs	_____ %	_____ %	_____ FTEs
Collections	_____ FTEs	_____ %	_____ %	_____ FTEs
Financial Counseling	_____ FTEs	_____ %	_____ %	_____ FTEs
Total	**_____ FTEs**	**_____ %**	**_____ %**	**_____ FTEs**

Please list the *annual* costs associated with each of the following functions:

Please allocate only those technology and overhead costs that apply specifically to the revenue cycle; if such costs are not currently defined, allocate using your best judgment. If you are unable to allocate dollar amounts for the individual departments, you may estimate using the percentage boxes. Include Financial Counselors only if they act primarily in the Business Office.

Function	Total In-House Business Office Salary and Benefit Costs[1]		Total Business Office Technology Costs[2]		Other Business Office Overhead Costs (space, office materials, etc.)[2]	
Billing	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Collections	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Financial Counseling	$ _____	_____ %	$ _____	_____ %	$ _____	_____ %
Total	$ _____	100%	$ _____	100%	$ _____	100%

Please list the following Business Office outsourcing costs:

Function	Total On-Site Business Office Outsourcing Labor Costs		Other Business Office Outsourced-Service Costs	
Billing	$ _____	_____ %	$ _____	_____ %
Collections (early-out)	$ _____	_____ %	$ _____	_____ %
Collections (long-term)	$ _____	_____ %	$ _____	_____ %
Total	$ _____	**100%**	$ _____	**100%**

Please supply the following information regarding outsourced collections agencies:

Agency Type	Average Age of Claim When Sent to Collection Agency	Average Collection Agency Commission	Average Recovery Rate
Early Out Collections	_____ days	_____ %	_____ %
Long-Term Collections	_____ days	_____ %	_____ %

Operations

How are billing operations ordered at your hospital?

❍ (A) By patient

❍ (B) By payer

How are your hospital's collections primarily organized?

❍ (A) By patient

❍ (B) By payer

Please list what Business Office information system(s) your hospital uses:

[1] Include only those employees directly employed by the hospital.

[2] Include only annual operational and depreciation costs; do not include capital expenditures.

What is the first-pass yield of claims (the percentage of claims that arrive in the Business Office without errors)? _____%

Please list or estimate the percentage of Business Office resources devoted the following types of claims:

% Medicare	_____ %	Inpatient	_____ %
% Medicaid	_____ %	Outpatient	_____ %
% Managed care/commercial	_____ %	**Total**	**100%**
% Self-pay	_____ %		
% Other	_____ %		
Total	**100%**		

Please list or estimate the percentage of Business Office resources or time devoted reworking claims prior to their initial submission (i.e., returned by claims scrubber, not by payer): _____%

Please list or estimate what percentage of claims reworked prior to initial submission (i.e., returned by claims scrubber, not by payer) are attributable to the following reasons:

Demographic errors (name, address, social security number, etc.)	_____ %
Improper insurance information	_____ %
Improper coding	_____ %
Physician documentation errors	_____ %
Other	_____ %
Total	**100%**

Please list or estimate what percentage of denials (claims rejected by payer) are attributable to the following reasons:

Demographic/technical errors	_____ %
Medical necessity	_____ %
Eligibility	_____ %
Authorization	_____ %
Total	**100%**

Please list or estimate what percentage of denials (claims rejected by payer) relate to the following types of claims:

% Medicare	_____ %	Inpatient	_____ %
% Medicaid	_____ %	Outpatient	_____ %
% Managed care/commercial	_____ %	**Total**	**100%**
% Self-pay	_____ %		
% Other	_____ %		
Total	**100%**		

Please use this space for any clarifications, comments or suggestions you may have regarding questions in this chapter.

Chapter 5: Organizational Structure

For each of the following functions, please list the principal C-suite executive to which each reports:

Scheduling:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Pre-registration:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Registration:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Collections:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Case Management:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Medical Records:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Billing:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Denial/ Underpayment Recovery:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Payer Contracting:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Physician Billing/ Practice Management:
- ❍ CEO
- ❍ COO
- ❍ CFO
- ❍ CMO
- ❍ CNO
- ❍ CIO

Please list the title of the most senior revenue cycle officer in the organization:

Which of the following functions report to the officer named above?

- ❍ Scheduling
- ❍ Pre-registration
- ❍ Registration
- ❍ Case Management
- ❍ Medical Records/HIM/Coding
- ❍ Billing
- ❍ Collections
- ❍ Denial/Underpayment Recovery
- ❍ Payer Contracting
- ❍ Physician Billing/Practice Management

Which executive does the most senior revenue cycle officer report to?

❍ CEO

❍ COO

❍ CFO

❍ CMO

❍ CNO

❍ CIO

Which of the following functions are centralized within your local hospital?

❍ Scheduling

❍ Pre-registration

❍ Registration

❍ Medical Records/HIM/Coding

❍ Billing

❍ Collections

If your hospital or health system has a relationship with a centralized business office (CBO), please answer the following questions.

Where is each the following functions located (and at the local level, under whose authority)?

Scheduling:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Insurance Verification:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Registration:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Physician Billing/ Practice Management:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Case Management:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

HIM/Coding:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Billing:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Collections:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Denial/Underpayment Recovery:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Payer Contracting:
❍ local hospital (CFO)
❍ local hospital (non-CFO)
❍ system CBO

Please use this space for any clarifications, comments or suggestions you may have regarding questions in this chapter.