Financial Leadership Council

The Advisory Board Company

2011 Revenue Cycle Benchmarking Results

Industry Benchmarks and Performance Standards

- Finance Program Characteristics and Organizational Structure
- Collections and Uncompensated Care
- Revenue Cycle Costs and Staff Productivity

Financial Leadership Council

Project Director
Hamza Hasan

Project Editor
Mina Khosravi Egan

Design Consultant
Dustin Almond

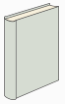
Managing Director
Josh Gray

Table of Contents

Available Within Your Financial Leadership Council Membership

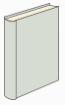
Over the past several years, the Financial Leadership Council has developed numerous resources to assist program leaders in boosting revenue cycle performance. The most relevant resources are outlined on the right. All of these resources are available in unlimited quantities through the Financial Leadership Council membership.

Best Practice Support for Superior Revenue Cycle Performance



Optimizing Front Office Performance (21762)
Best Practices for Securing Coverage and Maximizing Patient Collections

- Ensuring Informed Financial Consent
- Optimizing Payment Options
- Enhancing Staff Effectiveness
- Maximizing ED Collections
- Next-Generation POS Analytics



Best-in-Class Clinical Documentation Improvement Programs (21259)
Blueprint for Maximizing Revenue Capture

- Program Staffing and Oversight
- Defining Program Objectives
- Instilling Staff Accountability
- Improving Physician Compliance

Analytic Support for the Revenue Cycle

Medicare Financial Benchmark Generator

This tool provides user-defined, peer-group benchmarks for key inpatient utilization and financial metrics. Performance quartiles and institution-specific data for annual Medicare discharges support benchmarking and opportunity assessment.

Complication and Comorbidity Coding Analyzer

This tool pinpoints areas where your hospital's MS-DRG coding reflects a substantially higher or lower level of acuity than a self-identified peer group, and quantifies the revenue differentials associated with coding acuity variances.

To Order Via Advisory.com

To order copies of these and other Financial Leadership Council presentations, please visit our website: www.advisory.com/flc/publications

To Access Data and Analytic Tools

To access these and other Financial Leadership Council tools, please visit our website: www.advisory.com/flc/tools

Beyond the Financial Leadership Council

In addition to the resources available through the Financial Leadership Council membership, The Advisory Board Company offers **a comprehensive set of revenue cycle solutions.**

Preparing for an Uncertain Financial Future

The Advisory Board's performance technology collaboratives combine proprietary business intelligence technology with best-in-class process support to help your organization reach a new level of revenue cycle performance—from patient access to the business office. Together, ***Payment Navigation Compass*** and ***Payment Integrity Compass*** provide a unified solution for maximizing point-of-service collections, preventing initial denials, streamlining backend denials workflow, aggressively recovering underpayments, and maximizing yield from all payers and contracts:

- **Precise Patient Obligation Estimates** to allow collection of full financial obligation at or before point of service
- **Advanced Workflow Functionality** to boost collector agility and coordinate seamlessly across departments to overturn more denials and increase underpayments recovery
- **Sophisticated Contract Analysis and Modeling** to arm staff with data and scenario analysis to level the playing field with payers, improve negotiations and increase contract yield
- **Best Practice Process Support** to streamline processes across the revenue cycle and maximize productivity

ICD-10: (Much) More Than Coding and IT

A Special Invitation for Chief Financial Officers

At the most progressive health care organizations, planning efforts are capitalizing on the unique opportunity the transition to ICD-10 represents for elevating revenue cycle and other practice areas to next generation performance.

In conversations with more than 500 health system executives, the Advisory Board has identified a set of best practices that we believe can help organizations take best advantage of the ICD-10 transition to safeguard revenue and boost performance. Our goal across 2011 is to share the approaches that we have seen work at these leading institutions in order to help prepare organizations for the challenges ahead.

If you are interested in requesting an Advisory Board expert to come onsite for a 90-minute Executive Briefing, please email us at Beyond@advisory.com.

Contact Us

For additional information please visit our website:
www.advisory.com
or email us at
Beyond@advisory.com

A Message from the Council

In 2005 the Financial Leadership Council launched its first survey of revenue cycle operations. At the time, we were unsure of how the membership would respond to the labor-intensive task of collecting revenue cycle operational information across multiple departments. We were gratified that many members chose to participate and found the results helpful.

Even before we had finished collecting the 2005 surveys, we received dozens of requests to broaden this effort and cover a wider range of revenue cycle topics. In response, the Council launched two more comprehensive surveys in 2006 and 2008. The 2008 results were published in our book *Revenue Cycle Performance Assessment.* The expanded survey consisted of 320 distinct data points and questions, most of which are routinely tracked by hospital finance departments. The survey included 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 belief that any department that directly impacts or processes actual claims should be considered part of the hospital revenue cycle.

Given the high demand and interest from the membership in updated benchmarks, the Financial Leadership Council launched a fourth revenue cycle operations survey in early 2011. This publication presents the full results from our 2011 revenue cycle benchmarking initiative. While the survey participants have varied from year to year, we present comparative data where they highlight notable industry trends.

Members are encouraged to contact Hamza Hasan at 202-266-6540 or hasanh@advisory.com with questions and feedback about this material.

Financial Leadership Council
June 2011

Executive Summary

As with previous benchmarking studies, this guide has been divided into three principal sections: Finance Program Characteristics and Organizational Structure, Collections and Uncompensated Care, and Revenue Cycle Costs and Staff Productivity. Departmental data may be found in all sections. For quick reference, the Table of Contents on page three lists specific metrics included in the chapters.

Finance Program Characteristics 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.

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 delve into the two most-commonly tracked performance measures of collections, AR days and bad debt. 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. The guide delves into the source of those variances, focusing on resource allocation for all revenue cycle departments.

Unless otherwise indicated, all figures in this publication are from the Council's 2011 survey, which includes data from fiscal year 2010.

Finance Program Characteristics and Organizational Structure

Definitions List

The following definitions were included in the 2011 Financial Leadership Council Revenue Cycle Survey. This list standardizes definitions of functions that are often ambiguously defined between hospitals. Note that for the purposes of this publication, "patient access" and "business office" are synonymous with groups of functions labeled "front office" and "back office" respectively.

Revenue Cycle Terminology

Billing	Department responsible for bill preparation and distribution
Business Office	All in-house functions related to post-discharge billing and collections
Collections	In-house department charged with following up on claims, managing denials, and posting cash
Coding	Staff responsible for translating transcribed documentation into the appropriate ICD-9 codes and/or feeding them into an electronic grouper designed to assign DRGs
Financial Counselors	Staff responsible for developing payment plans and special arrangements for self-pay patients; including 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
Patient Access	All in-house functions related to patient scheduling, pre-registration, registration, and admission
Pre-registration	Staff responsible for collecting patient information and/or verifying insurance prior to patient visit
Registration	Staff responsible for collecting patient information and admitting at the time of patient visit
Scheduling	Staff responsible for scheduling appointments and coordinating with physician offices
Self-Pay	All claims and revenue stemming from patient obligations, including after-insurance obligations
Outsourcing	Any external service contracted by the hospital to perform a revenue cycle function
Early-Out Collections	Usage of a collections agency that takes self-pay accounts on Day 1 of the billing cycle and follows through the billing process on behalf of the hospital
Long-Term Collections	Usage of a collections agency that assumes responsibility for collecting on self-pay accounts, typically 90–120 days into the billing cycle

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Survey Structure

The 2011 Revenue Cycle Survey sought to examine all aspects of the revenue cycle, including case management and coding. Although mid-cycle operations are often not considered part of the revenue cycle, it is the Council's belief that all activities directly impacting the processing of registrations and claims should be considered revenue cycle functions. The included functions, and their respective groupings (as defined in the book), are listed here. As with previous survey iterations, institutions were asked to report data from their most recently completed fiscal year. In addition to defining current performance benchmarks, the survey was intended to provide trended data on revenue cycle performance using historical survey findings.

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

Survey of Revenue Cycle Operations

- **Goal: To provide benchmarks pertaining to the revenue cycle's organizational structure, resource allocation, and current performance**
- Consisted of 50 questions
- Received 50 full and an additional 48 partial responses

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

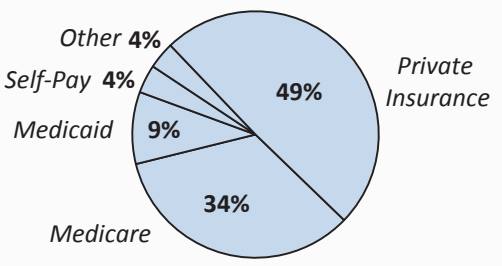
Survey Cohort Averages

At right is a profile of the "average" hospital that participated in the 2011 Revenue Cycle Survey. With respect to net patient revenue, bed size, AR days, and bed debt, the survey data is similar to that of other national means and medians. Data regarding recovery rates by payer type is listed on page 20. A discussion on AR days and bad debt performance is illustrated on page 27 and page 36 respectively.

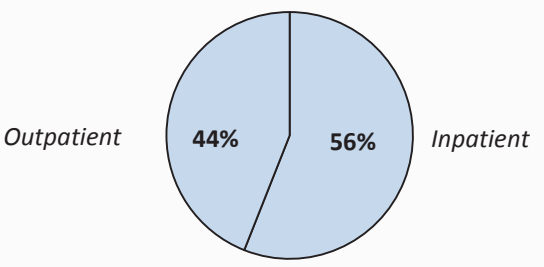
Your "Typical" Peer

Percentage of Net Patient Revenue
Survey Means

Payer Mix
n = 72



Patient Mix
n = 79



Average Survey Respondent

- 406 beds
- $452 M in annual net patient revenue
- 44.8 days in AR
- Bad debt equal to 5.6% of net patient revenue

Moody's 2009 Not-for-Profit Healthcare Medians[1]

- 399 beds
- $446 M in annual net patient revenue
- 45.2 days in AR
- Bad debt equal to 6.1% of net patient revenue

1. Freestanding hospitals and single-state healthcare systems.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

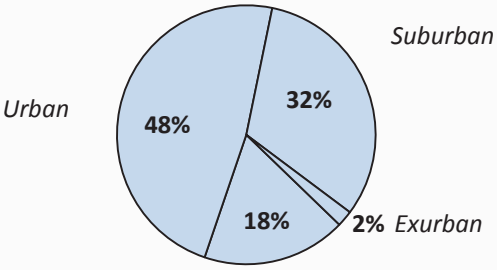
Survey Cohort Profiles

The profile of the 2011 survey cohort conforms to national medians, although the midwest region of the country is slightly over-represented. Note, however, that the Council found no relationships between revenue cycle performance and either geographical location or community setting.

A Well-Distributed Cohort

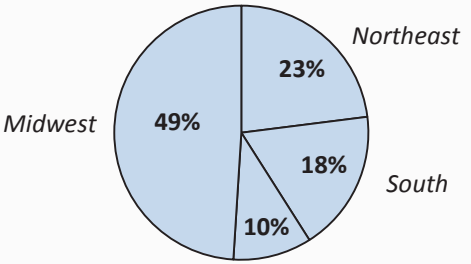
Local Community

n = 98



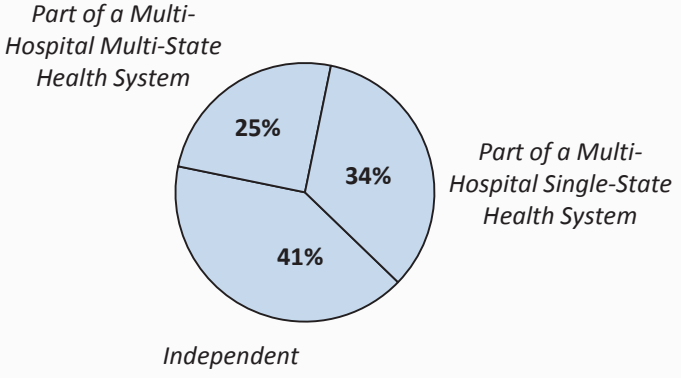
Geographical Location

n = 98



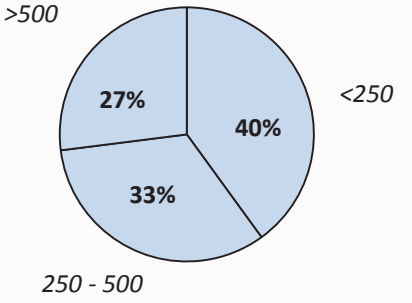
Affiliation

n = 98



Bed Size

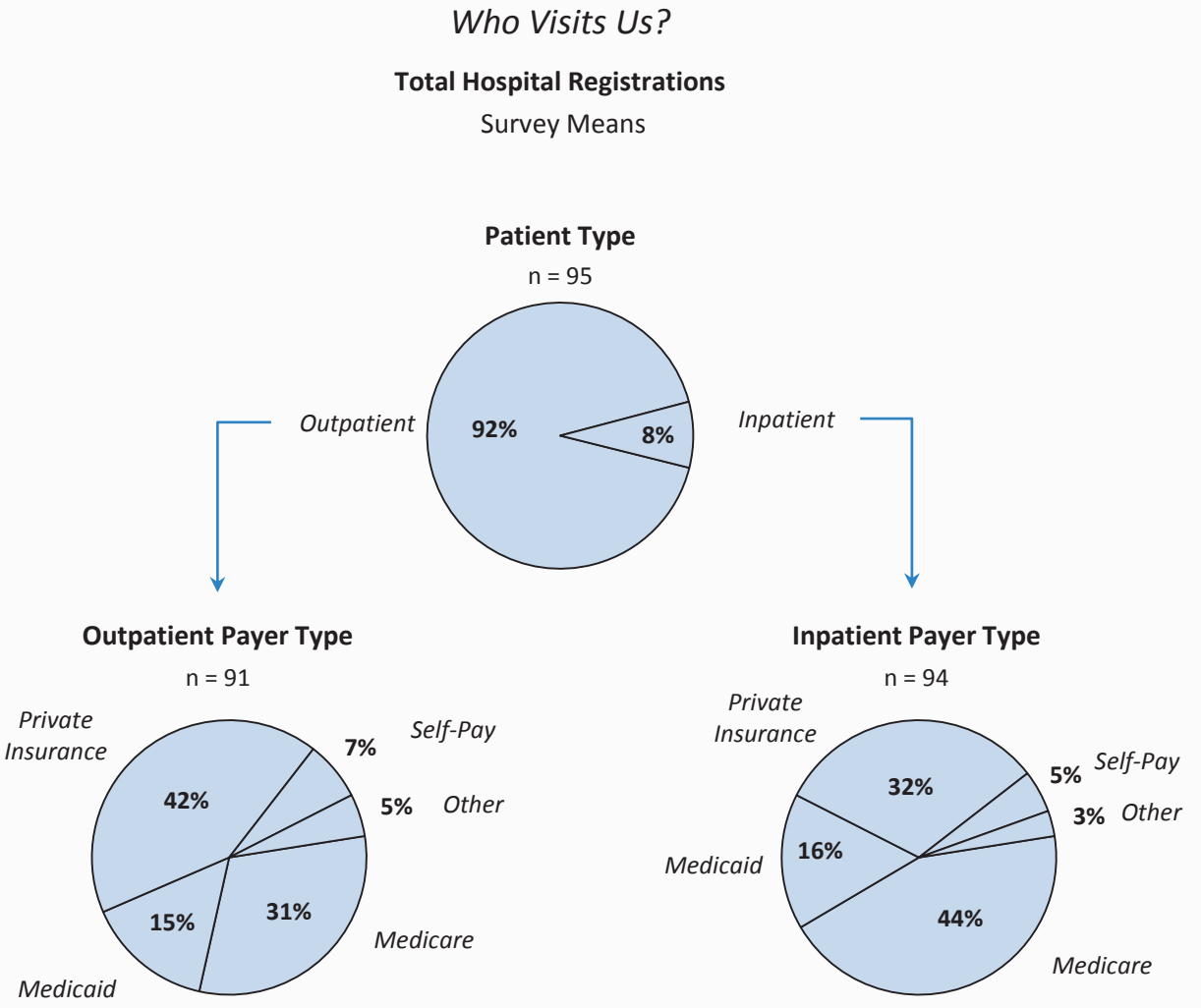
n = 98



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Registration Mix by Patient and Payer Type

Outpatient registrations comprise the overwhelming majority of registrations, accounting for nine out of ten hospital visits. Medicare registrations comprise a plurality of inpatient admissions, though they are outnumbered by patients with private insurance in the outpatient care area.



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Claims Mix by Patient and Payer Type

The overall distribution of claims largely mirrors patient registrations. For a more detailed analysis of the self-pay population, please turn to pages 21 – 22 for a discussion of self-pay recovery rates.

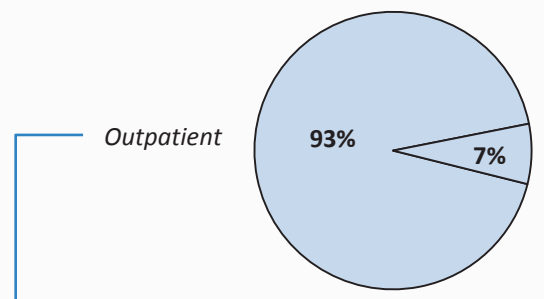
Who Pays Us?

Total Hospital Claims

Survey Means

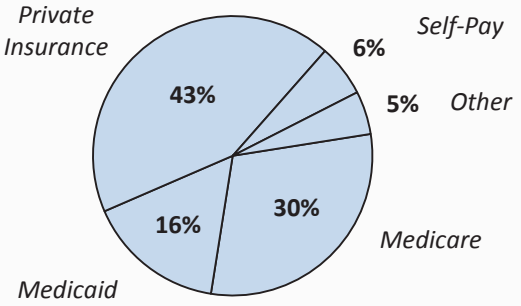
Patient Type

n = 83



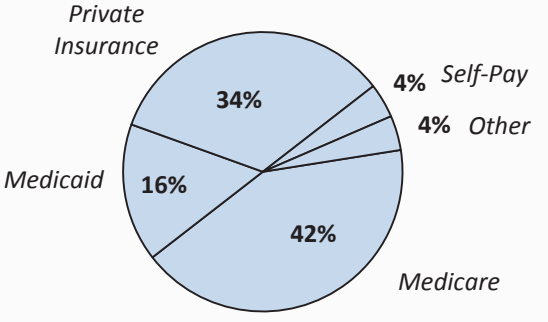
Outpatient Payer Type

n = 77



Inpatient Payer Type

n = 77



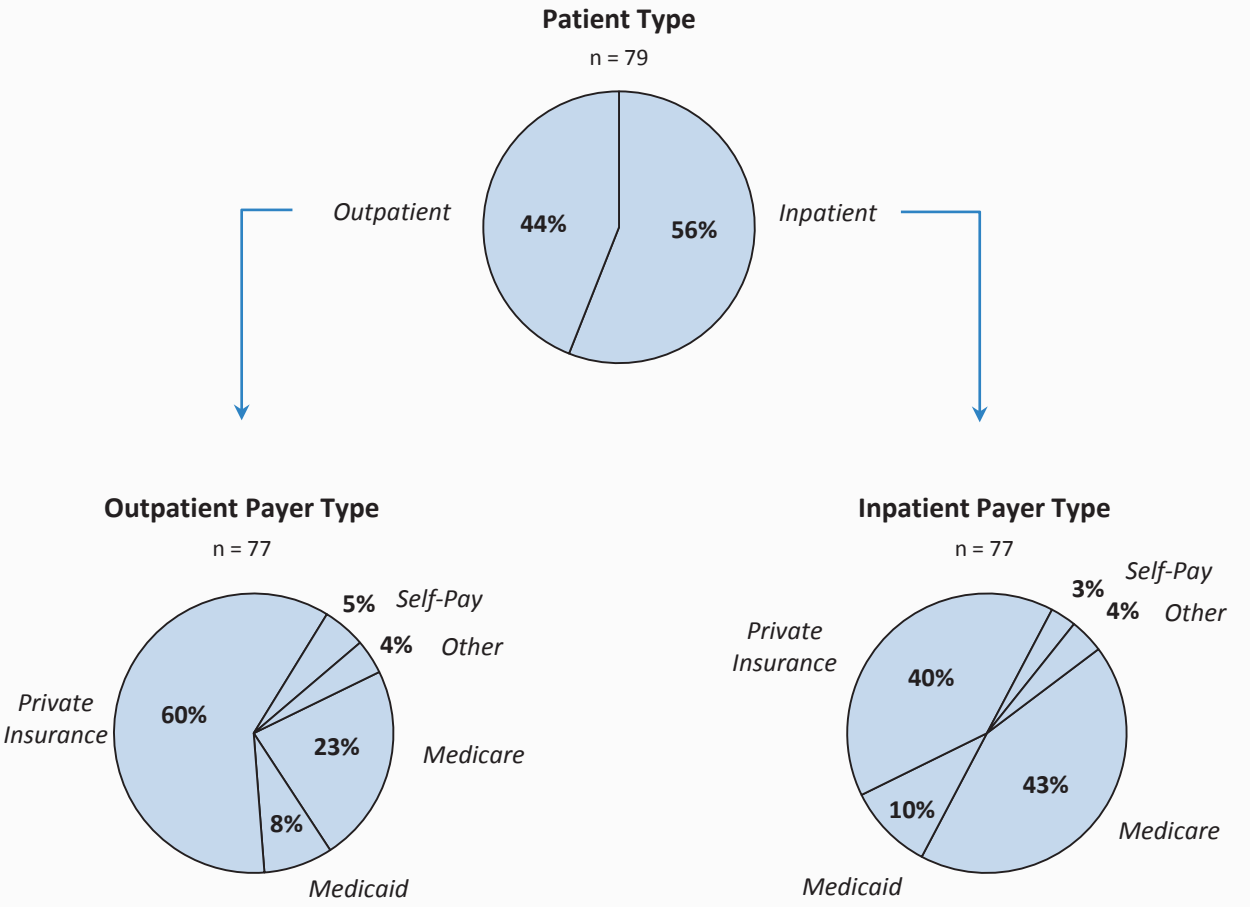
Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Revenue by Patient and Payer Type

Despite accounting for over 90 percent of registrations, outpatient claims comprise less than 45 percent of total hospital net patient revenue. Note also the disparity between privately insured patient registrations relative to net patient revenue—particularly in the outpatient setting. This is consistent with findings from our 2006 and 2008 surveys.

Who Pays Us?

Net Patient Revenue
Survey Means



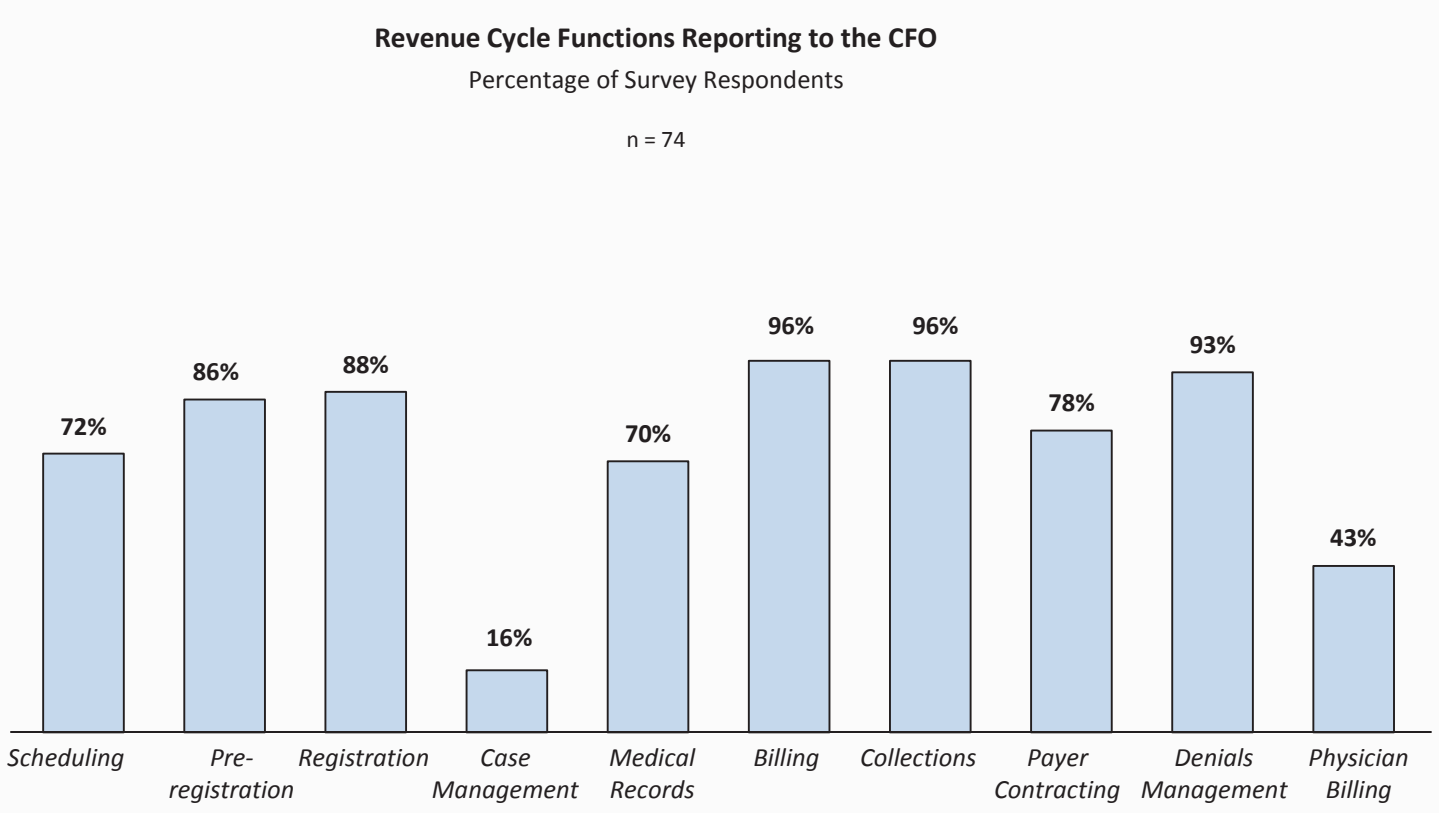
Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Finance's Control Over Revenue Cycle Operations

Since the last Revenue Cycle Survey, the CFO's control over revenue cycle operations has continued to grow. While business office functions have traditionally been controlled by the finance department, front office functions are now increasingly within the CFO's purview. CFO oversight of case management remains relatively low, though slightly higher than in the 2008 survey results.

The percentage of respondents reporting that physician billing falls under the CFO's control has declined over the past three years. The Council suspects that an increasing number of physician billing operations are outsourced or controlled by a separate organization, usually in the form of a Physician-Hospital Organization (PHO).

CFOs Have Widespread Revenue Cycle Control



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Case Management Structures

Case management structures remain diverse. Although the traditional unit-based case management model is most common in the inpatient setting, models centered around physicians and payers have increased since the 2008 survey.

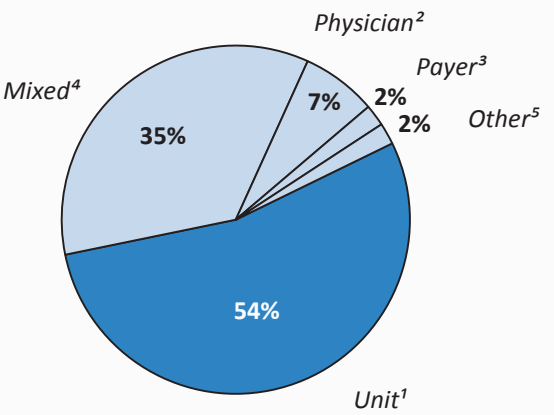
Prior Council research has found models organized around physicians and payers to be effective at reducing denials and underpayments, but these are often thought to be more expensive. With the advent of accountable care and the transition to ICD-10 coding, the Council suspects that the prevalence of these models will likely continue to grow. Another trend observed by the Council is an increase in ED-based case managers. These staff assist physicians in making patient status determinations and establishing medical necessity for inpatient admissions.

Diversity in Case Management Models

Case Management Model Type

Percentage of Survey Respondents

n = 84



1. Unit based: case managers are assigned to a group or department of physicians, working with all physicians within that group.
2. Physician based: case managers are assigned to specific high-volume physicians (i.e., paired with specific physicians).
3. Payer-based: case managers are assigned to specific payers and only manage patients that are tied to those payers.
4. Mixed: one or more of the above case management models are utilized within the facility.
5. Other: a case management model other than ones described above is utilized within the facility.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

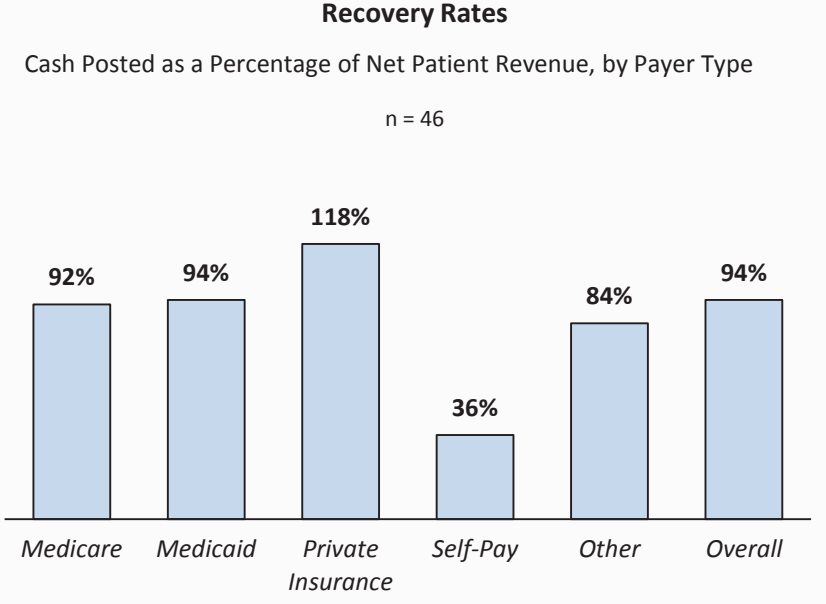
Collections and Uncompensated Care

Recovery Rates by Payer Type

Overall, hospitals collect 94 percent of their total net patient revenue in cash. Unsurprisingly, self-pay suffers from the largest short-falls. Recovery rates for Medicare and Medicaid were 92 percent and 94 percent respectively, largely mirroring 2008 survey results. The relatively low collections from government payers and self-pay were balanced by significantly higher rates from private payers.

Respondents indicating private payer recovery rates above 100 percent offer a variety of explanations for cash collections exceeding net revenue. Many point to the time lag between booking net revenue and posting cash, along with a renewed focus on aggressively collecting on the prior year's claims. Others have won lump sum settlements on underpayment appeals from 2010 contract compliance reviews. Finally, a small but growing number of hospitals are employing collection agencies to focus on small balance commercial claims, further boosting commercial recovery rates.

Self-Pay Shortfalls



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Long-Term Self-Pay Collection Agency Performance

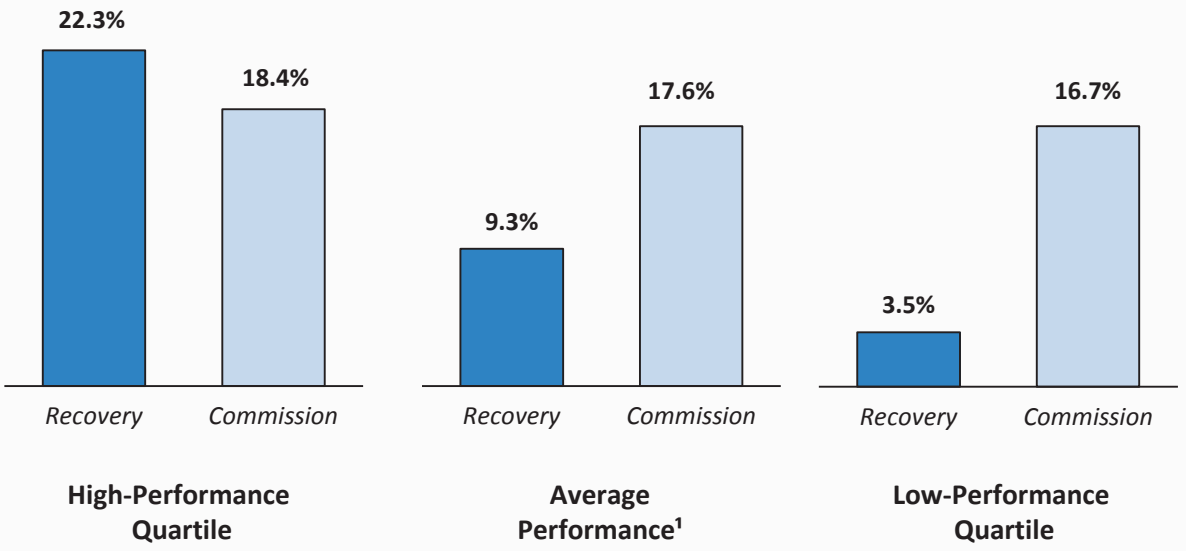
Average commission rates paid to collections agencies varied little compared to wide differences in reported recovery rates. Recovery rates for the high-performance quartile were 22.3 percent, much higher than the 12.0 percent in the 2008 survey results.

Wide Variability in Collections Agency Performance Persists

Long-Term Collection Agency Performance, Ranked by Recovery Rate

Recovery and Commission Rate

n = 68



1. Average performance refers to the mean performance of hospitals in the middle two quartiles.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Early-Out Self-Pay Collection Agency Performance

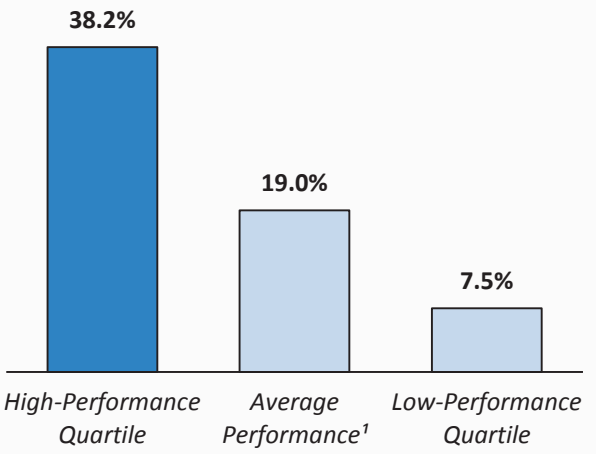
As expected, average recovery rates from early-out collections were substantially higher than those of their long-term counterparts (probably owing to the difference in the median age of claims). Between the 2008 and 2011 surveys, the variance between high-performance and low-performance quartiles increased dramatically. Recovery rates for average performers remained fairly consistent relative to 2008 survey performance, while the bottom quartile worsened.

Greater Variability in Performance

Early-Out Collection Agency Performance

Recovery Rates

n = 34



Median Age of Claim: 50 days
Average Commission: 7.5%

1. Average performance refers to the mean performance of hospitals in the middle two quartiles.

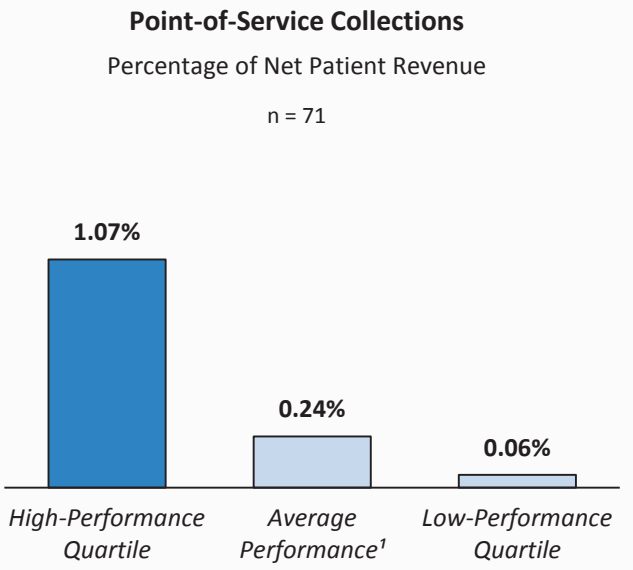
Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Point-of-Service Collections

Point-of-service collections remain a struggle for many hospitals across the country, with the high-performing quartile just exceeding 1 percent of net patient revenue through up-front patient collections.

Prior Council research indicates that top performing programs consistently provide complete patient obligation estimates prior to service and attempt to make collections multiple times before care is delivered. Hospitals achieving best-in-class performance can collect 1.8 percent or higher of total net patient revenue through up-front patient collections.

Up-front Collections Remain a Struggle



1. Average performance refers to the mean performance of hospitals in the middle two quartiles.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Insurance Eligibility Verification

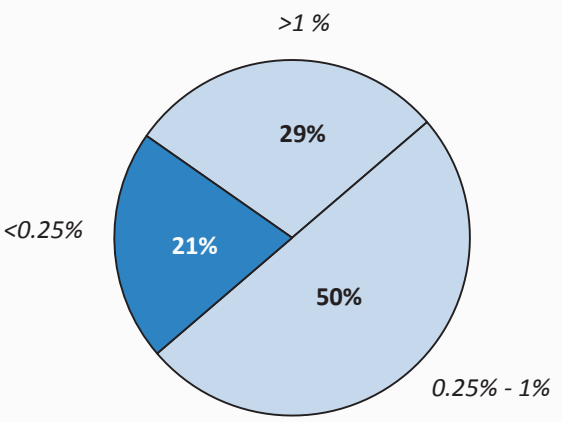
Despite struggles with point-of-service collections, members report strong performance at insurance verification and authorization-related write-offs. High performers regularly verify insurance for 99 percent of pre-registered patients, compared with 92 percent for average performers.

Preventing Downstream Errors

Authorization and Eligibility Denials Rate

Percentage of Net Patient Revenue

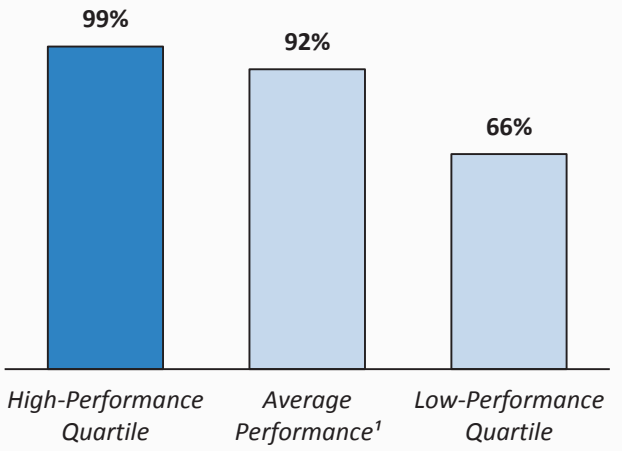
n = 38



Insurance Verification Rate

Percentage of Pre-Registered Patients Whose Insurance Is Verified

n = 71



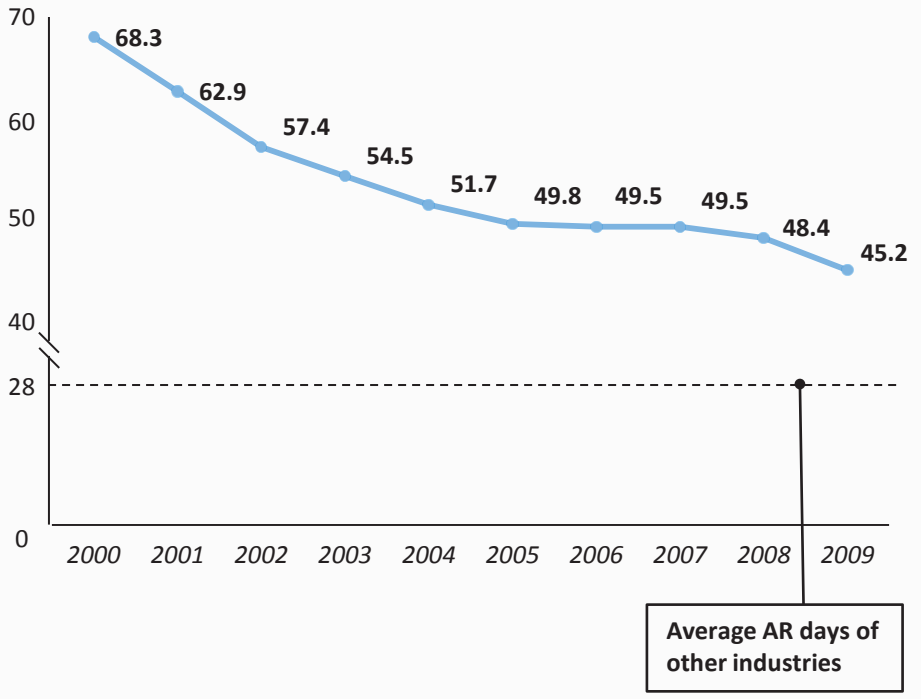
1. Average performance refers to the mean performance of hospitals in the middle two quartiles.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

AR Days: Improvements Over Time

Over the past ten years, Moody's data indicates hospitals have made exceptionally strong progress in their efforts to reduce Accounts Receivable (AR) days via a concerted focus on increasing collections. The most dramatic improvement occurred between 2000 and 2005, with a 27 percent decrease in AR days. Between 2005 and 2008, AR reductions slowed down considerably, averaging about 1 percent per year. A larger reduction—6.6 percent—occurred in 2009, although it is not clear whether this level of improvement can be sustained moving forward.

Moody's Median AR Days



Source: Moody's Investor Service, *Not-for-Profit Healthcare Medians*.

Historical AR Days

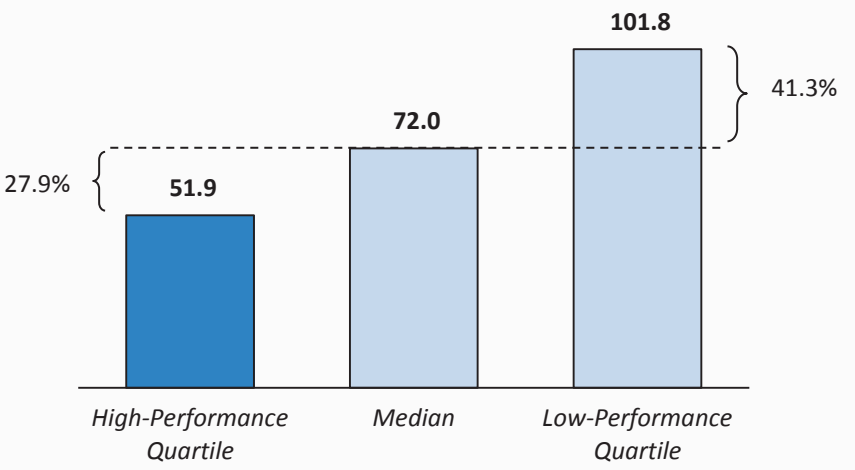
In 2005, the Council asked survey respondents for their AR days from the year 2000. A significant disparity between high and low performers existed; as shown over the next few pages, this disparity of 50 days between the top and bottom quartile has been dramatically reduced in recent years.

A Reminder of Past Performance

Hospital AR Days, 2000

Financial Leadership Council 2005 Member Survey Participants

n = 35

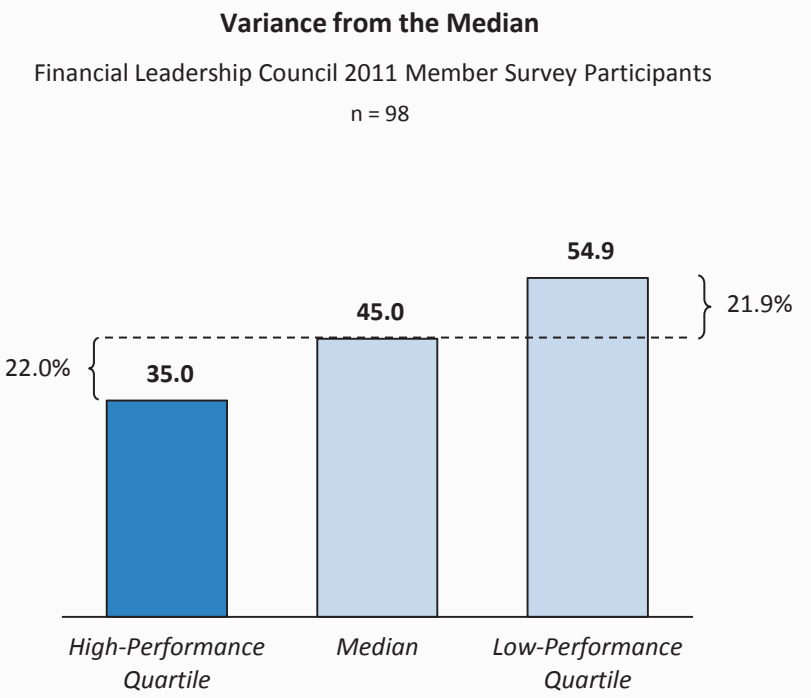


Source: Financial Leadership Council 2005 Member Survey of Revenue Cycle Operations.

AR Days: Current Performance

AR days continued to improve in the 2011 survey, with survey median AR days dropping to 45.0 days from 49.0 days in the 2008 survey. The high-performance quartile saw the most significant gain, with an average decrease of 7.2 days. Over the past decade, the range in AR days between the top quartile and the bottom quartile has narrowed considerably, dropping from 50 days in 2000 to 20 days in the 2011 survey.

Improvement in Absolute Performance, but Variation Persists



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

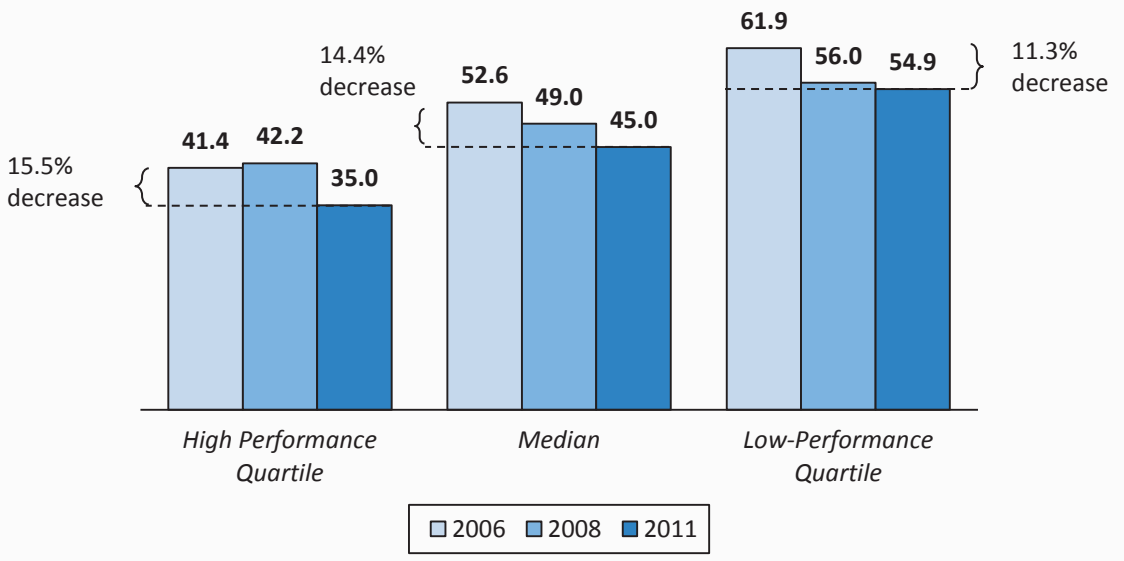
Trending AR Days

Over the past three years, AR days have improved across all performance categories, particularly for those in the top quartile. Persistent variation shows that average and bottom quartile programs still have ample room to improve.

Dramatic Improvements Across the Board

2006 – 2011 AR Days

Financial Leadership Council Member Survey Participants

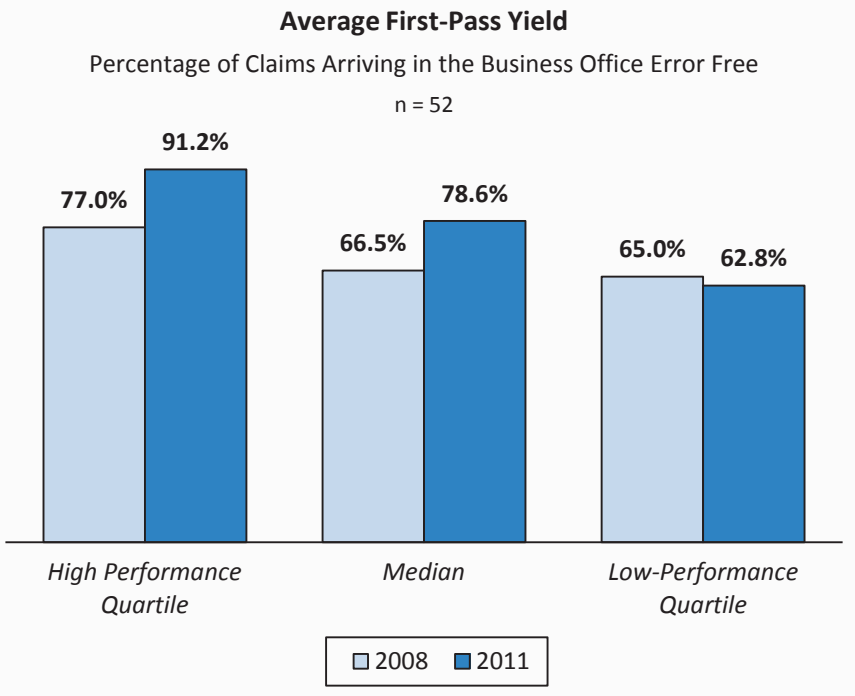


Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey; Financial Leadership Council 2008 Member Survey of Revenue Cycle Operations; Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

First-Pass Yield

First-pass yield, defined as the percentage of claims that arrive in the business office error free, increased in variation between the 2008 survey and the 2011 survey, particularly at the median and for the high-performance quartile. Higher first-pass yield was associated with slightly lower AR days in the 2011 survey cohort.

Focusing on the First-Pass



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey; Financial Leadership Council 2008 Member Survey of Revenue Cycle Operations.

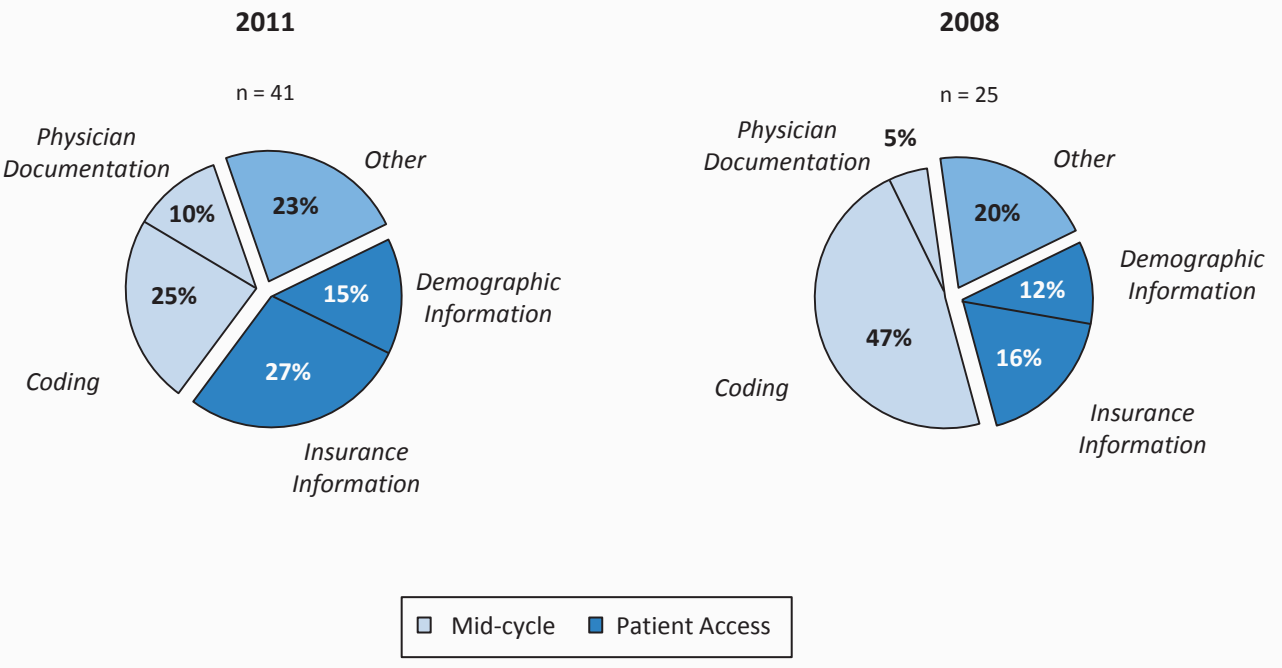
Identifying Sources of Errors

Just one-third of revenue cycle errors originated in the mid-cycle in the 2011 survey, compared to more than half in the 2008 survey, indicating an overall improvement in documentation and coding performance across the industry. However, Council research has found that insufficient documentation commonly results in under-coding—a major source of underpayments. Recognizing this issue, many hospitals are launching or improving Clinical Documentation Improvement (CDI) programs to identify and pursue revenue capture enhancement opportunities. The pay-off between average and best-in-class CDI performance is significant, potentially reaching seven figures for a medium-sized hospital.[1]

Patient Access a Growing Problem

Sources of Errors Leading to Business Office Rework

Percentage of Total Rework



1. See Financial Leadership Council publication *Best-in-Class Clinical Documentation Improvement Programs.*

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey; Financial Leadership Council 2008 Member Survey of Revenue Cycle Operations.

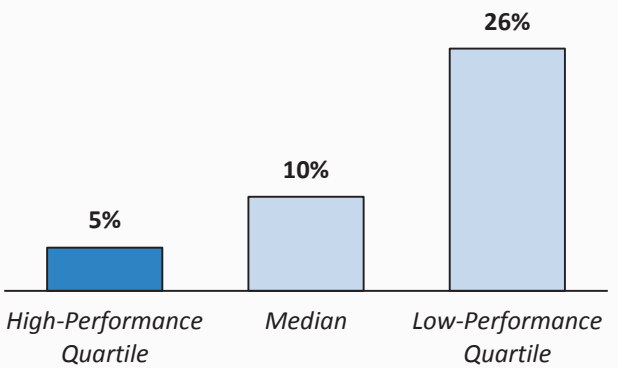
Business Office Rework Rates

Resources devoted to reworking claims in the business office varied significantly by quartile, with the low-performing quartile devoting five times as many resources to rework than the high-performance quartile. Prior Council research has shown that higher levels of rework are associated with higher cost to collect and greater AR days.

Fixing Things on the Back-End

Percentage of Business Office Resources Devoted to Rework

n = 45



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Initial Denials & Write-Offs

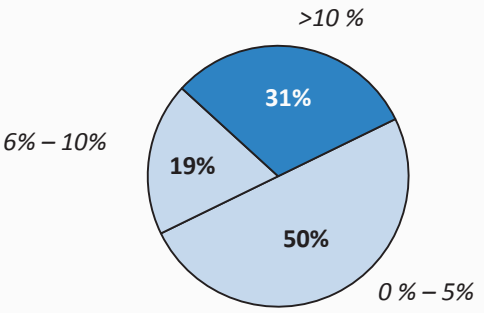
Revenue cycle performance on initial denials remains an area of concern for many hospitals. Hospitals with initial denials greater than 10 percent increased from 11 percent in 2006 to 31 percent in 2011. Initial denials, however, are notoriously difficult to track, as a large portion of underpayments are written off as contractual allowances and not included in the initial denials figures.

Dramatic Improvements at the Bottom

Initial Denials

Percentage of Outstanding AR

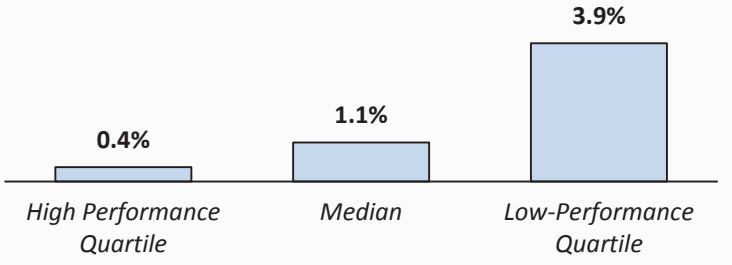
n = 36



Denial Write-Offs

Percentage of Net Patient Revenue

n = 72



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey; Financial Leadership Council 2006 Member Survey of Revenue Cycle Operations.

Sources of Initial Denials

The graphs on the right highlight the breakdown of initial denials by payer mix, patient mix, and their original sources of errors. Nearly half of all initially denied claims are attributed to private insurers, while almost two-thirds of errors leading to initial denials are traced back to the front office.

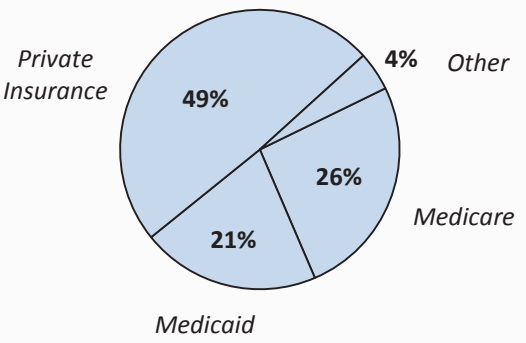
Where Hospitals Struggle

Types of Initially Denied Claims

Percentage of Total Denials

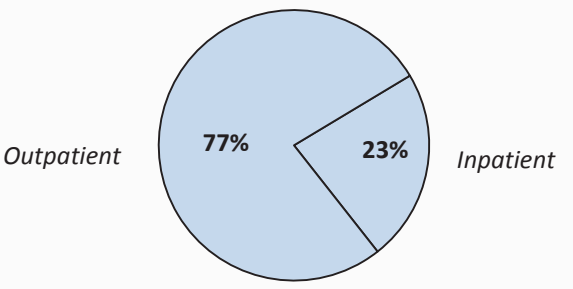
Payer Mix

n = 46



Patient Type

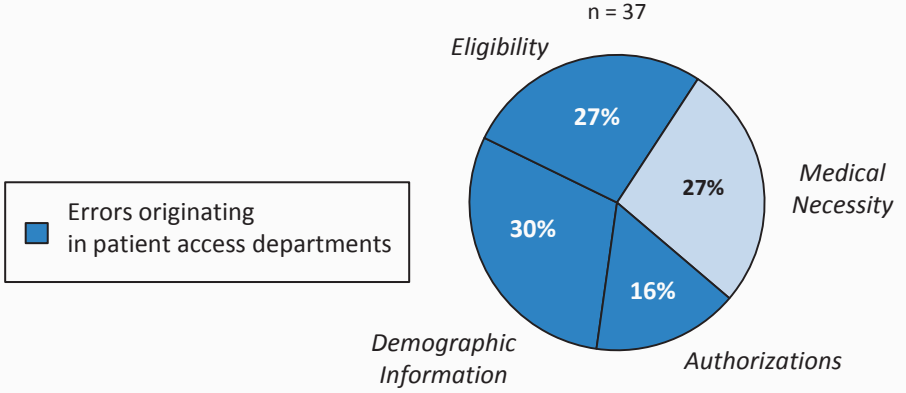
n = 44



Sources of Errors Leading to Initial Denials

Percentage of Initial Denials

n = 37



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Sources of Denials Write-Offs

Although the payer and patient breakdowns of denials write-offs largely mirror those of initial denials, the sources of errors leading to denied claims are more heavily weighted toward medical necessity and authorizations. This suggests that providers have greater success appealing denials caused by eligibility and demographic information errors.

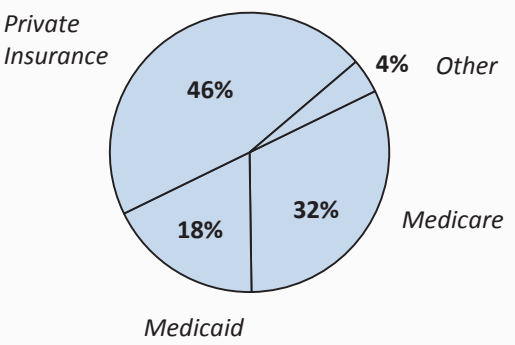
Where Hospitals Lose Out

Types of Claims Written Off

Percentage of Denial Write-Offs

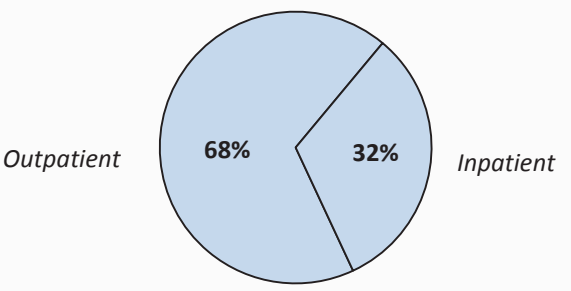
Payer Mix

n = 46



Patient Type

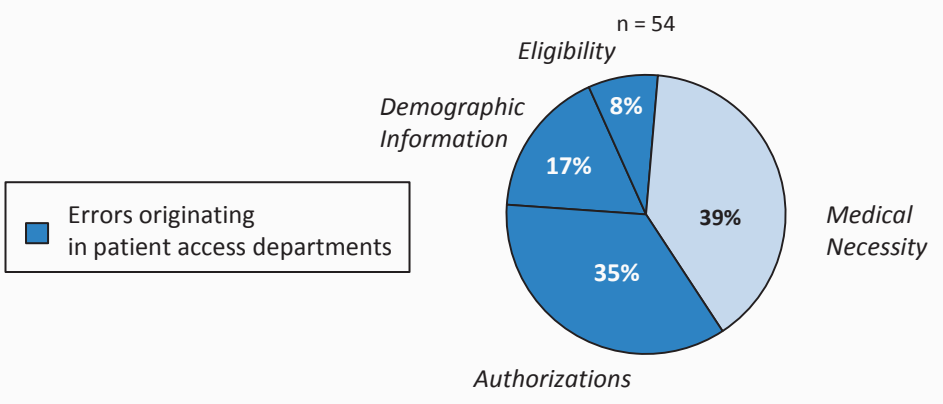
n = 44



Sources of Errors Leading to Denial Write-Offs

Percentage of Denial Write-Offs

n = 54



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Discharged Not Final Billed[1]

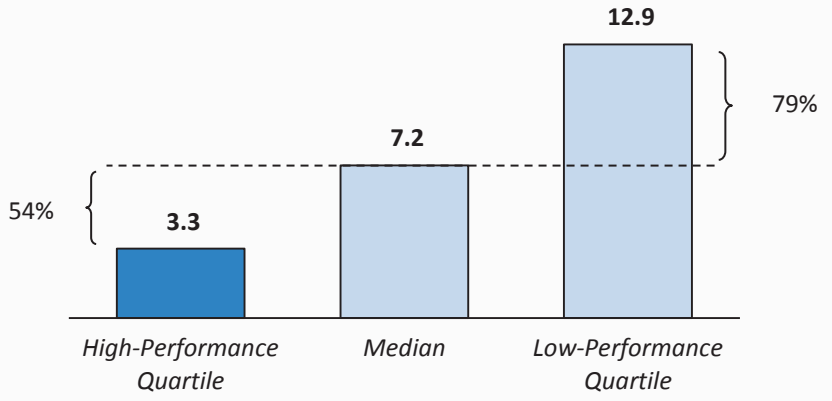
The median age of claims that are discharged but not final billed totaled just over 7 days. Low performers, however, required nearly 13 days to bill claims after the patient has been discharged, a 79 percent increase above those at the median.

Wide Disparity in Performance

Discharged Not Final Billed (DNFB)

Total Number of Days

n = 76



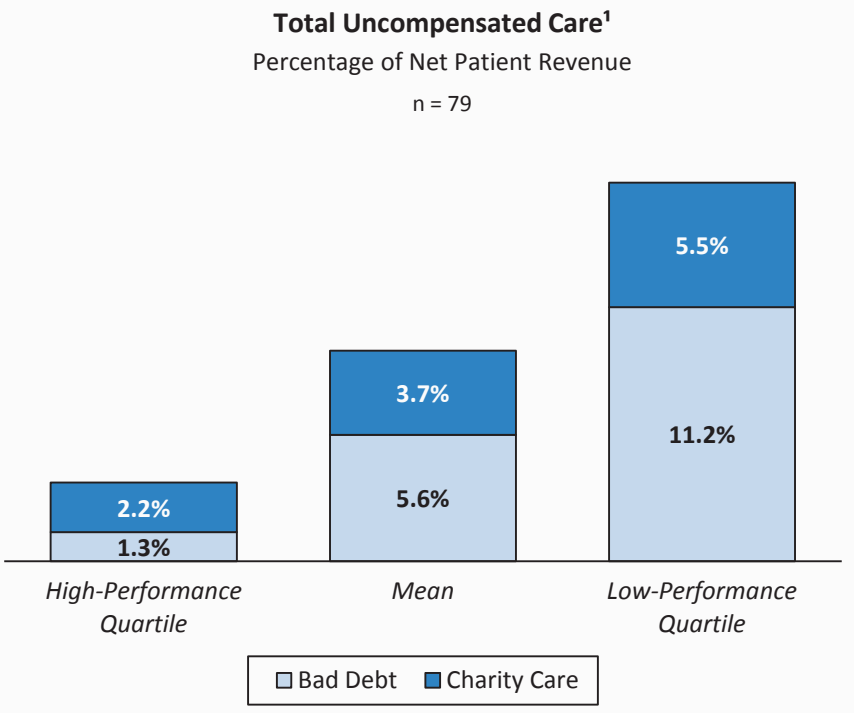
1. Discharged Not Final Billed refers to the time between the patient being discharged from the hospital and the billing department submitting that claim for payment.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Lost Revenue

The final stop for a denied claim, or a self-pay claim with no hope for collection, 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. In general, though, the data shows that high levels of charity care correspond with high levels of bad debt.

Variance in Uncompensated Care Performance



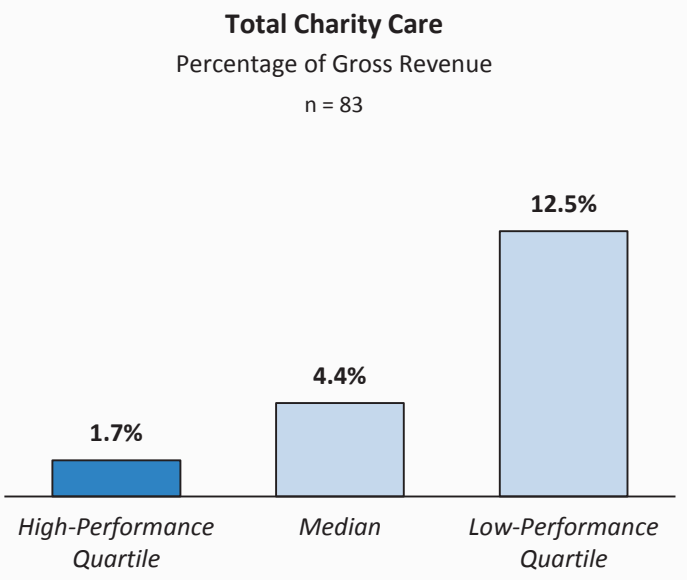
1. Ranked by bad debt performance.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Charity Care Commitments

Charity care adjustments varied significantly across the survey cohort. Many community hospitals serving large indigent communities provide significantly higher levels of charity care, approaching 15 percent of gross revenue. At the other end of the spectrum, for hospitals located in areas with a favorable payer mix and higher income levels, charity care levels of under 2 percent of gross revenue are typical.

Variance in Charity Care Adjustments



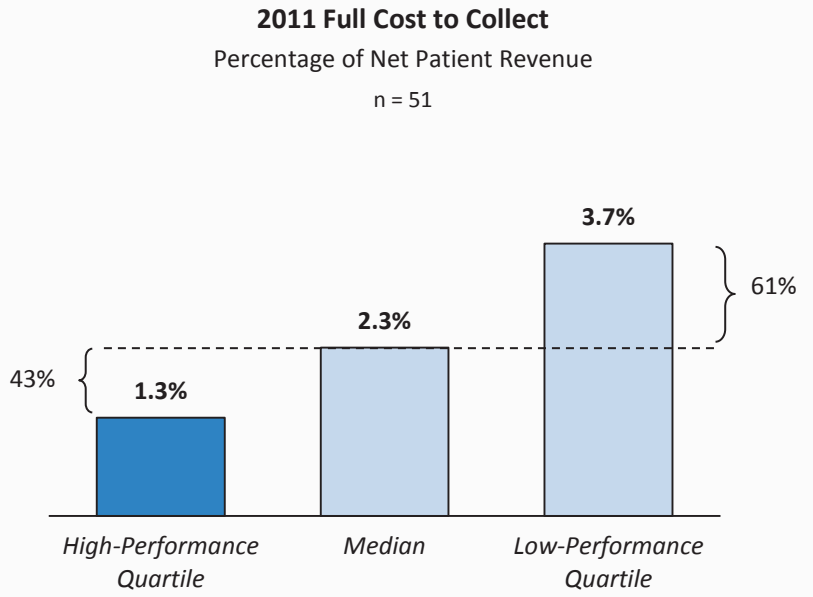
Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Revenue Cycle Costs and Staff Productivity

Cost to Collect

The Council defines cost to collect as including all operational and depreciation costs including staff salaries and benefits, technology solutions, outsourcing costs, and overhead costs (both technology and space) for all stages of the revenue cycle, including the mid-cycle. In previous survey iterations, cost to collect data presented the greatest variance between the median and high- and low-performing quartiles. Although cost to collect continues to vary significantly, the 2011 survey data variance from the median for both high and low-performance quartiles narrowed considerably.

Significant Variance in Collection Costs



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Spending by Cost Type

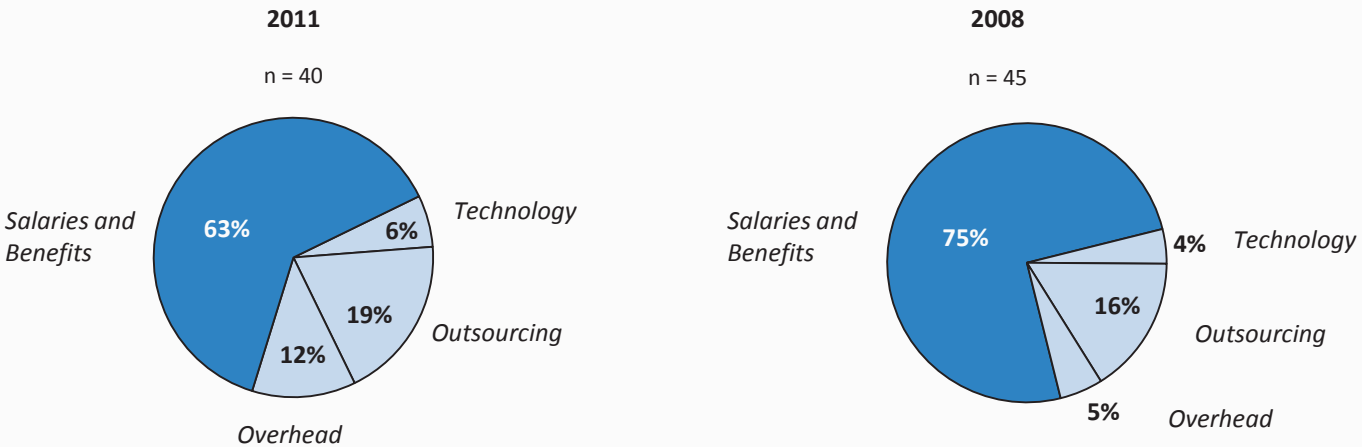
The proportion of revenue cycle costs devoted to salaries and benefits has decreased from 75 percent in the 2008 survey to 63 percent in the 2011 survey, while technology, outsourcing and overhead costs registered increases.

Although the factors driving these changes are not entirely clear, the Council suspects that three factors maybe driving these changes. First, over the past three years, many hospitals have instituted hiring freezes and have allowed FTE numbers to decline through attrition. Second, increased reliance on technology platforms, particularly new patient access solutions, clinical documentation improvement systems, and revenue cycle technology solutions could be reducing required staffing levels. Finally, after a slowdown forced by the economic crisis of 2008, a number of hospitals have commenced capital projects. The increase in overhead costs likely reflects the increase in capital spending on revenue cycle functions.

Salaries and Benefits Costs Decreasing

Revenue Cycle Cost Spending

Percentage of Total Revenue Cycle Costs



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey; Financial Leadership Council 2008 Member Survey of Revenue Cycle Operations.

Revenue Cycle Outsourcing

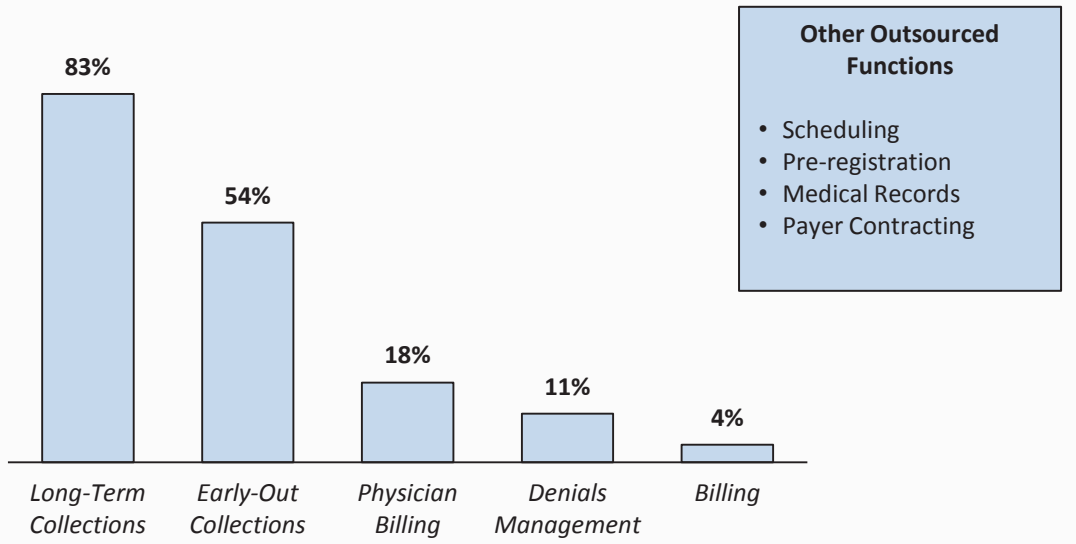
As shown on the previous page, outsourcing costs account for nearly a fifth of all revenue cycle costs, growing from 10 percent of total revenue cycle costs in 2006 to 16 percent in the 2008 survey, and reaching 19 percent in the 2011 survey. This page lists the most frequently outsourced revenue cycle operations. Although collections rank as the most frequently outsourced functions, they are usually not included in outsourcing costs, as collection agency commissions are typically assessed as a percentage of recoveries.

Outsourcing Concentrated at Back-End

Frequently Outsourced Revenue Cycle Functions

Percentage of Survey Respondents

n = 92



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Spending by Functional Area

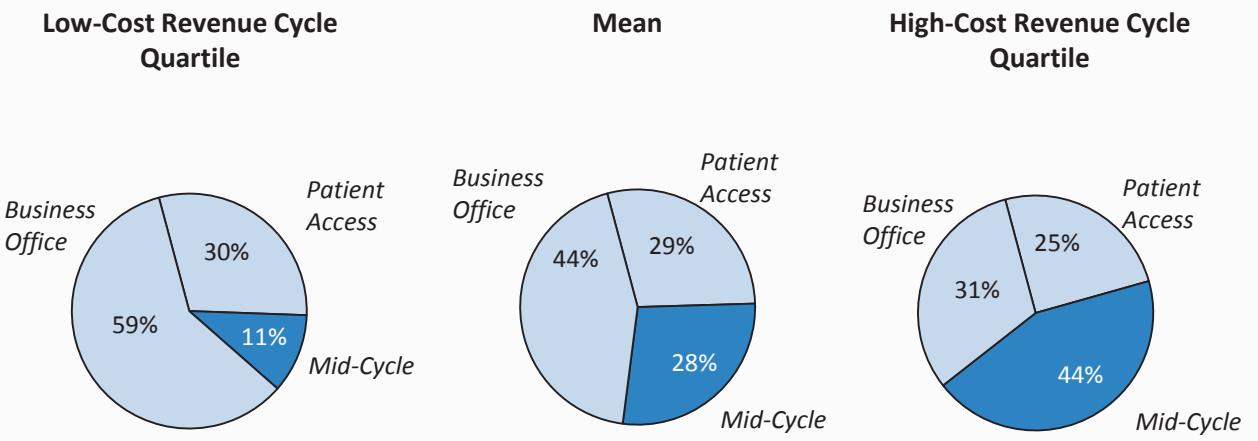
When segmented by functional area and ranked by cost to collect, high-cost revenue cycle operations devote a substantially larger portion of their resources to mid-cycle operations than their low-cost counterparts. Many progressive hospitals have devoted significant resources to clinical documentation improvement and coding. Although faced with higher costs, Council research has shown that increased mid-cycle resourcing can dramatically boost revenue cycle margins. Patient access costs, however, remain more consistent regardless of overall cost performance.

Higher Spending Correlated with Increased Mid-Cycle Expense

Revenue Cycle Cost Spending

Percentage of Total Revenue Costs, Ranked by Cost to Collect

n = 34



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

Revenue Cycle Staff Productivity

The table at right provides annual productivity benchmarks for standard work units typically assigned to each of the functions listed. These numbers vary widely based on usage of technology, payer mix, and service line supported. Consequently, they are best considered directional indicators of workforce productivity, rather than actionable benchmarks for staff. Many of these benchmarks have increased dramatically since the 2008 survey; the Council suspects that growth in the use of technology platforms is a key factor in driving improved productivity.

Benchmarks for Standard Tasks

Function	2011 Median
Patient Access	
Registrations per Scheduler	42,749
Registrations per Pre-registrar	57,423
Registrations per Registrar	11,802
Total Hospital Registrations per Financial Counselor	70,834
Total Hospitals Claims per Financial Counselor	80,540
Mid-Cycle	
Registrations per Coder	32,967
Claims per Coder	35,009
Business Office	
Cash Posted per Cash Poster	$96,894,998
Claims per Biller	39,141
Cash Posted per Collections/Follow-up FTE	$51,209,723
Claims per Collections/Follow-up FTE	59,001

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey.

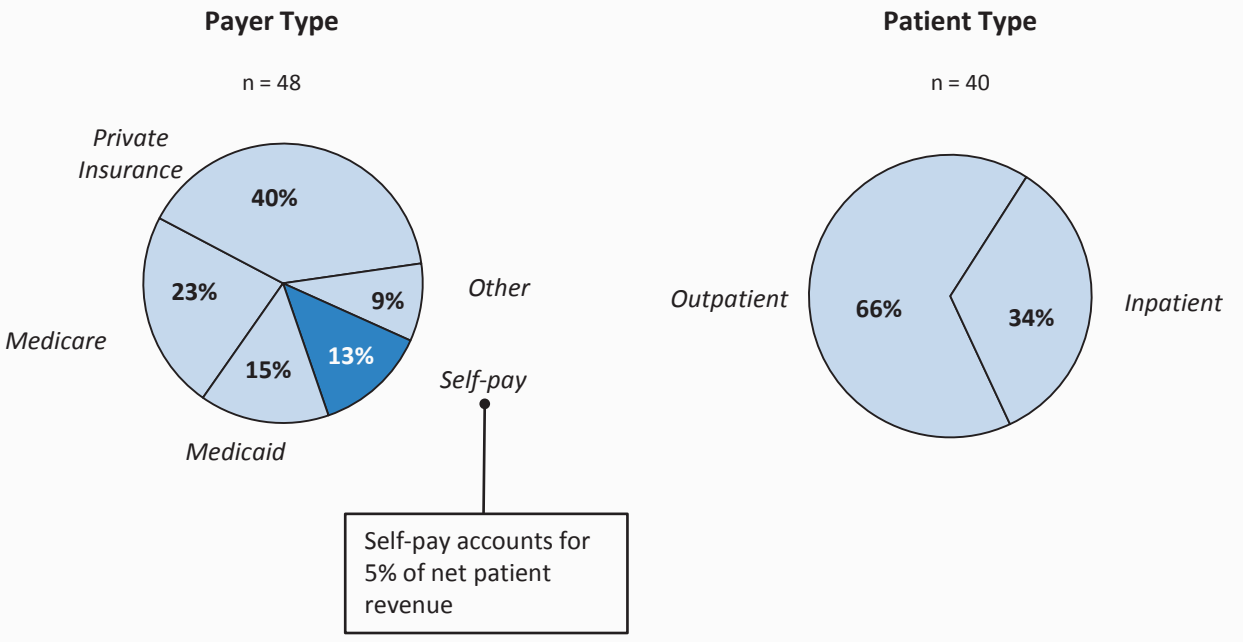
Resource Distribution at the Back-End

Unsurprisingly, 2011 survey data shows that self-pay, Medicaid, and outpatient claims consume a disproportionate share of business office resources relative to their share of either net patient revenue or cash collections. The variance in cost to collect for these types of claims relative to others highlights the potential opportunities for cost savings or productivity enhancements.

Benchmarks by Payer and Patient Type

Business Office Resource Distribution

Average Percentage of Business Office Resources



Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey

Revenue Cycle Performance Dashboard

Pictured at right is a dashboard outlining quartile performance for key revenue cycle metrics. The identity of specific hospitals within each category varies; for example, a hospital demonstrating top quartile for AR may not be in the top quartile for cost to collect. That said, a number of hospitals in the survey cohort achieved strong performance across categories.

Snapshot of Key Metrics

	High-Performance Quartile	Average Performance Quartile	Low-Performance Quartile
First-Pass Yield	91.2%	78.6%	62.8%
Cost to Collect[1]	1.3%	2.3%	3.7%
AR Days	35.0	45.0	54.9
Bad Debt	1.3%	5.6%	11.2%
Denial Write-Offs	0.4%	1.1%	3.9%

1. Cost to collect quartiles may vary depending on the degree of revenue cycle investments.

Source: Financial Leadership Council 2011 Revenue Cycle Benchmarking Survey

Appendix

2011 Revenue Cycle Benchmarking Survey

The following pages contain the text for all questions included in the 2011 Revenue Cycle Benchmarking Survey. Respondents were given the option of either completing the survey online or completing an Excel-based version. The survey remained open from January to May 2011. Please note that while all data was self-reported by hospitals, follow-up interviews were conducted to verify data accuracy.

Organizational Structure:

Please denote your hospital's affiliation status:
- ❑ Independent/Stand-alone
- ❑ Part of a multi-hospital, single state system
- ❑ Part of a multi-hospital, multi-state system

Please indicate your hospital's teaching status:
- ❑ Community
- ❑ Teaching
- ❑ Academic Medical Center

How would you characterize your hospital's local community?
- ❑ Urban
- ❑ Suburban
- ❑ Exurban
- ❑ Rural

How would you characterize your hospital's tax status?
- ❑ For-profit
- ❑ Non-profit

What functions within your hospital's revenue cycle are outsourced:
Note: Please check all that apply
- ❑ Scheduling
- ❑ Pre-registration
- ❑ Registration
- ❑ Medical records
- ❑ Billing
- ❑ Collections (early-out)
- ❑ Collections (long-term)
- ❑ Payer contracting
- ❑ Denial/Underpayment recovery
- ❑ Physician billing
- ❑ None of the above

Please indicate whether your hospital's CFO is the principal C-suite executive overseeing each of the following revenue cycle functions:
Note: Please check all that apply
- ❑ Scheduling
- ❑ Pre-registration
- ❑ Registration
- ❑ Case management
- ❑ Medical records
- ❑ Billing
- ❑ Collections
- ❑ Payer contracting
- ❑ Denial/Underpayment recovery
- ❑ Physician billing/Practice management
- ❑ None of the above

Does your hospital's revenue cycle department handle revenue cycle functions for the following physician practice groups?
Note: Please check all that apply
- ❑ Employed physicians
- ❑ Other affiliated physicians (co-managed practices, etc)
- ❑ Independent physicians
- ❑ None of the above

2011 Revenue Cycle Benchmarking Survey

General Revenue Cycle Performance

Hospital bed size_____

Reminder: Answer the following questions for the ***most recently completed fiscal year at your hospital***

Total number of registrations

Inpatient _____

Outpatient _____

Payer Mix for inpatient registrations:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

Payer Mix for outpatient registration:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

Total number of claims

Inpatient _____

Outpatient _____

Payer Mix for inpatient claims:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

Payer Mix for outpatient claims:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

Total net patient revenue:

Inpatient $_____

Outpatient $_____

Payer Mix for inpatient net patient revenue:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

2011 Revenue Cycle Benchmarking Survey

Payer Mix for outpatient net patient revenue:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

Net AR days: _____
Gross AR Days: _____
Cash Posted: $_____

Payer mix for cash posted:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

Uncollectible Account Information

Bad Debt (% of Net Revenue)	____%
Charity Care (% of Net Revenue)	____%
Charity Care (% of Net Revenue)	____%
Initial Denials (% of Net Outstanding AR)	____%
Denial Write-Offs (% of Net Revenue)	____%

Patient Access and the Mid-cycle

Please indicate your hospital's total annual point-of-service collections:
$_____

Please estimate your front office staff's insurance verification rate in the most recently completed fiscal year:
Note: insurance verification rate refers to the percentage of pre-registered, insured patients verified through eligibility processes, solutions, or vendors
_____*%*

Please estimate your front office staff's authorization/eligibility write-offs in the most recently completed fiscal year:
Note: Authorization/eligibility write-offs refer to payer denial write-offs associated with patient authorization and eligibility, as a percentage of Net Patient Revenue
_____*%*

What is the case-management model employed at your hospital?

- ❑ Unit-based
- ❑ Physician-based
- ❑ Payer-based
- ❑ Specialty-based
- ❑ Mixed
- ❑ Other

2011 Revenue Cycle Benchmarking Survey

Cost to Collect

Please estimate your revenue cycle department's full cost to collect, as a percentage of net patient revenue:
Note: 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
_____*%*

Please estimate the percentage of your hospital's total revenue cycle costs that were spent in the following areas during the most recently completed fiscal year:
Please enter percentages as whole numbers. For technology costs, only include annual operational and depreciation costs; do not include capital expenditures. Do not use the percent sign. Answers must sum to 100.
a. Technology _____%
b. Outsourcing _____%
c. Overhead _____%
d. Salaries and benefits _____%

Please estimate the percentage of your hospital's total revenue cycle costs that were spent in each of the following functional areas during the most recently completed fiscal year:
Please enter percentages as whole numbers. Do not use the percent sign. Answers must sum to 100.
a. Patient access _____%
b. Mid-cycle _____%
c. Business office _____%

Please indicate the number of FTEs employed in each of the following areas of your revenue cycle:
Note: Do not include outsourced employees in the figure for total FTEs

Function	Total FTEs
Scheduling	_____
Pre-registration	_____
Registration	_____
Financial Counseling	_____
Coding	_____
Billing	_____
Cash Posters	_____
Collections/Follow-Up	_____

Business Office

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

Please indicate your hospital's first-pass yield of claims in the most recently completed fiscal year?
Note: first-pass yield refers to the percentage of claims that arrive in the business office error free
_____%

2011 Revenue Cycle Benchmarking Survey

DNFB (Discharged not final billed)
$_____
_____ days

Please estimate the percentage of your hospital's business office resources that are devoted to the following types of claims:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

% Inpatient	____%
% Outpatient	____%
Total	100%

Please estimate the percentage of your hospital's business office resources that were devoted to reworking claims prior to their initial submission in the most recently completed fiscal year:
_____%

Please indicate the percentage of claims reworked prior to initial submission that were attributable to the following reasons in the most recently completed fiscal year:

Demographic Errors (name, address, SSN)	____%
Improper Insurance Information	____%
Improper Coding	____%
Physician Documentation	____%
Other	____%
Total	100%

Please estimate the percentage of **initial denials** that were attributable to the following reasons in the most recently completed fiscal year:

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

Please estimate the percentage of **initial denials** that were related to the following types of claims in the most recently completed fiscal year:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

% Inpatient	____%
% Outpatient	____%
Total	100%

Please estimate the percentage of **denial write-offs** that were attributable to the following reasons in the most recently completed fiscal year:

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

2011 Revenue Cycle Benchmarking Survey

Please estimate the percentage of **denial write-offs** that were related to the following types of claims in the most recently completed fiscal year:

% Medicare	____%
% Medicaid	____%
% Commercial Insurance	____%
% Self-pay	____%
% Other	____%
Total	100%

% Inpatient	____%
% Outpatient	____%
Total	100%

The Advisory Board Company • Financial Leadership Council

2445 M Street, NW • Washington DC 20037
Telephone: 202-266-5600 • Facsimile: 202-266-5700 • www.advisory.com