Examining 2019 Revenue Cycle Benchmarks

Six insights from our 2019 Hospital Revenue Cycle Benchmarking Survey

Highlights

- **While 2019 performance exhibits noteworthy improvements, the effort is associated with rising costs.** For the first time since 2013, median cost to collect has increased to 3.3% net patient revenue. Going forward, providers must sustain performance gains while keeping costs in check.

- **Clinical denials emerge as the most significant denials challenge.** Whereas historical denials have derived from one subset of the payer population, today's providers must contend with medical necessity denials across all payer categories. This development emphasizes the importance of a robust clinical denials defense infrastructure.

- **Access the latest benchmarks to evaluate your revenue cycle and identify opportunities for improvement.** The Hospital Revenue Cycle Benchmark Generator has been updated with 2019 data from 97 facilities. Hospitals can compare their performance against national benchmarks or against a cohort with similar characteristics.

Background

Advisory Board's Hospital Revenue Cycle Benchmarking Initiative has assessed performance biennially since 2006, providing metrics that span patient access, mid-cycle, and the business office. This publication features our early impressions of 2019 revenue cycle benchmarks with a focus on cost-to-collect, patient access, and denials management and mitigation. For a more detailed analysis, view our on-demand webconference presentation, Your First Look at Our 2019 Revenue Cycle Benchmarks, or see our Hospital Revenue Cycle Benchmark Generator on **advisory.com/rcbenchmarks**.

Key insights

There has been an undeniable improvement in patient access performance.

As hospitals prioritize the patient financial experience, 2019 benchmarks indicate improvement in key patient access metrics. Insurance verification and point-of-service collection rates climbed across all performer levels. While providers should be pleased with this improvement, performance on price estimates, third-party funding conversion, and charity care indicate there is still work to be done in patient access.

Today's providers must prioritize a clinical denials defense infrastructure.

Despite efforts to drive down denials, clinical denials remain a challenge. Today's providers fight medical necessity denials across all payer categories, emphasizing the importance of clinical denials defense mechanisms (such as physician advisors). Our data suggests that organizations with effective physician advisor programs report lower medical necessity denials and lower bad debt.

CFOs are turning their attention back to the revenue cycle as a critical source of growth.

While historical trends indicated systems were delegating revenue cycle oversight to the VP or Director level, 2019 data suggests C-suite executives are reclaiming revenue cycle oversight.
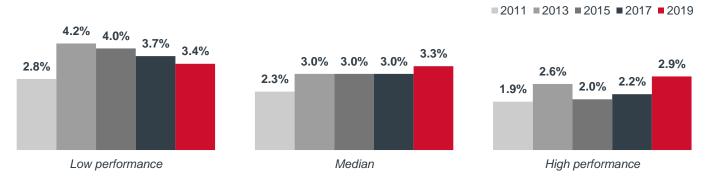
Source: Hospital Revenue Cycle Benchmarking Survey.

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Cost to collect up again

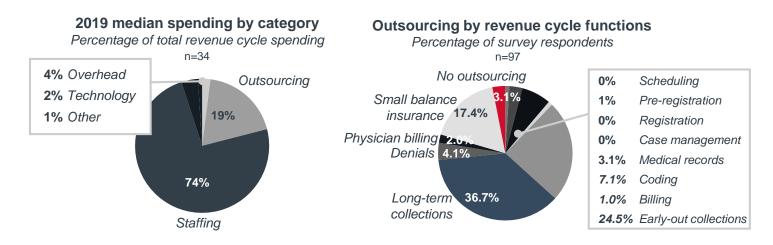## Does the additional spending yield better performance?

After years of a relatively flat performance, the median cost to collect has increased to 3.3% net patient revenue. The chart below details historical cost to collect trends for low, median, and high performers.[1]

Full cost to collect
Percentage of net patient revenue
n=51 (2011), n=31 (2013), n=59 (2015), n=48 (2017), n=26 (2019)

Legend: 2011 | 2013 | 2015 | 2017 | 2019

Low performance: 2.8%, 4.2%, 4.0%, 3.7%, 3.4%

Median: 2.3%, 3.0%, 3.0%, 3.0%, 3.3%

High performance: 1.9%, 2.6%, 2.0%, 2.2%, 2.9%

When we asked respondents *where* the additional dollars were going, we saw the largest categorical increases in outsourcing and staffing. The median performer spends 74% of their revenue cycle spending on staffing costs, 19% on outsourcing, 4% on overhead, 2% on technology and 1% on other expenses.

2019 median spending by category
Percentage of total revenue cycle spending
n=34

- 4% Overhead
- 2% Technology
- 1% Other

Outsourcing 19%
Staffing 74%

Outsourcing by revenue cycle functions
Percentage of survey respondents
n=97

No outsourcing 3.1%
Small balance insurance 17.4%
Physician billing 2.0%
Denials 4.1%
Long-term collections 36.7%

- 0% Scheduling
- 1% Pre-registration
- 0% Registration
- 0% Case management
- 3.1% Medical records
- 7.1% Coding
- 1.0% Billing
- 24.5% Early-out collections

Revenue cycle functions that demonstrated an increased likelihood of outsourcing include small balance insurance and early-out and long-term collections. In contrast, denials management and billing are less likely to be outsourced than in 2017. Since the recent influx of denied claims, it's possible that providers have shifted these functions in-house to exert more control over their day-to-day operation.

Top five areas of outsourcing change[2]

1. Small balance insurance (+10.2%)
2. Denials (-7.4%)
3. Long-term collections (+5.8%)
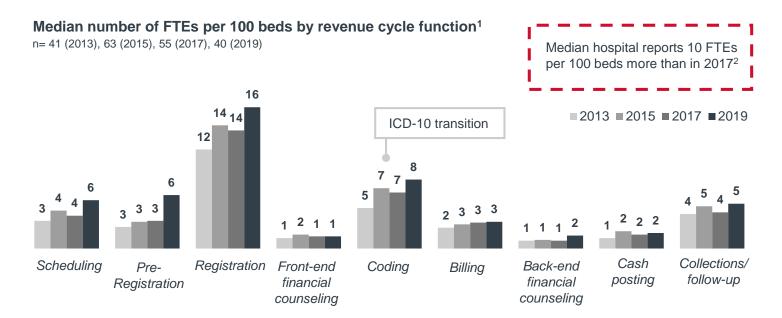4. Billing (-4.0%)
5. Early-out collections (+2.9%)

1. Low, median, and high performance categories correspond to 25th, 50th, and 75th percentiles.
2. Change in outsourcing frequency between 2017 and 2019.

Source: Hospital Revenue Cycle Benchmarking Survey.

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We're continuing to add staff

Growth most apparent in patient access

Since the introduction of managed care, health care administrative job growth has dramatically outpaced that of clinical staff. External analysis of data from the Bureau of Labor Statistics suggests that while the number of physicians in the United States from 1975-2010 has kept roughly in pace with population growth, the number of health care administrators has increased 3,200 percent for the same time period.
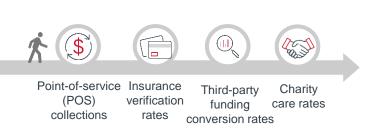
Revenue cycle is not immune to this growth. All functions reported a growth in staffing, with patient access functions demonstrating the largest increase. Today's median hospital reports 10 FTEs per 100 beds more than in our 2017 survey.

Median number of FTEs per 100 beds by revenue cycle function[1]
n= 41 (2013), 63 (2015), 55 (2017), 40 (2019)

Median hospital reports 10 FTEs per 100 beds more than in 2017[2]

ICD-10 transition

■ 2013 ■ 2015 ■ 2017 ■ 2019

Scheduling: 3, 4, 4, 6
Pre-Registration: 3, 3, 3, 6
Registration: 12, 14, 14, 16
Front-end financial counseling: 1, 2, 1, 1
Coding: 5, 7, 7, 8
Billing: 2, 3, 3, 3
Back-end financial counseling: 1, 1, 1, 2
Cash posting: 1, 2, 2, 2
Collections/follow-up: 4, 5, 4, 5

As illustrated in the chart above, patient access functions such as scheduling, pre-registration, and registration exhibited the largest increase in staffing levels compared from 2017. Fortunately, this increase is accompanied by improvement in key metrics such as point-of-service collections and insurance verification rates.

While providers should be pleased with their progress, performance on price estimate generation, third-party funding conversion, and charity care rates indicate there is still work to be done in patient access. For more information, visit **www.advisory.com/rcbenchmarks**.

Key metrics surveyed in patient access

Point-of-service (POS) collections   Insurance verification rates   Third-party funding conversion rates   Charity care rates

Metric	Median performance	Change from 2017
Point-of-service collections (as a percentage of NPR)	1.0% NPR	▲ + 0.2%
Insurance verification rate	98%	▲ + 4.3%
Third-party funding conversion rate	34%	*Metric new to 2019*
Charity care (as a percentage of NPR)	2.7%	▼ -2.2%

1. Median FTE per 100 beds in case management is 10, medical records is 8.
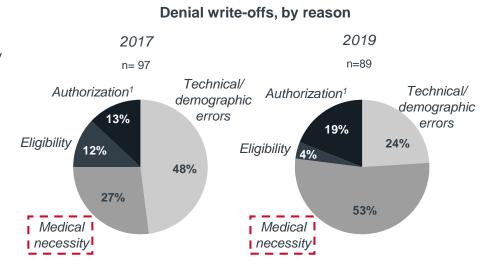2. Excludes case management and medical record staffing.

Source: Hospital Revenue Cycle Benchmarking Survey.

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Medical necessity a rising concern

Largest categorical growth observed in a decade

The majority of our provider membership continues to identify denials management and mitigation as a key revenue cycle priority. While 2019 benchmarks suggest a drop in overall denial write-offs, data on the reason for initial and denial write-offs identify an important shift since 2017 benchmarks.

In 2017, technical and demographic denials were the prominent challenge. However, it seems most providers have gotten ahold over these billing errors, demonstrated by a decrease in the percentage of technical denials. That established, the technical denial challenge has been replaced by a clinical crisis, with medical necessity denials exhibiting the largest categorical growth in over decade of benchmarking.

Denial write-offs, by reason

2017
n= 97

Authorization[1]   Technical/demographic errors
13%
Eligibility   48%
12%
27%
Medical necessity

2019
n=89

Authorization[1]   Technical/demographic errors
19%
Eligibility   24%
4%
53%
Medical necessity

Going forward, providers will need to fight medical necessity denials via a robust clinical defense infrastructure. One helpful feature is an active physician advisor program. When we asked survey respondents to self-identify the efficacy of their program, we found organizations who believe their physician advisor programs work well report fewer medical necessity initial and denial write-offs, as well as lower bad debt as a percentage of net patient revenue.

Key physician advisor responsibilities

Identify governmental audit risks (MACs, RACs)

Remove revenue cycle burdens from hospitalists

Understand specific clinical requirements for delivering care under different contracts

Strengthen communication with payer's clinical decision makers

Act as physician champion for revenue cycle team

DATA SPOTLIGHT

Organizations who believe their physician advisor programs work **"very well"** report:[1,2,3]

50% fewer medical necessity initial denials

33% fewer medical necessity denial write-offs

Effective programs report lower bad debt
Average bad debt as a percentage of NPR

n=29

Improvement required   8.6%

Working well or very well   4.9%

p= 0.0706

1. When compared to organizations who described their program as "working well", "some improvement required", or "major improvement required."
2. Statistically significant performance difference confirmed at a 95% confidence level via Student's T-test, p=0.0489 for medical necessity initial denials and p=.000008 for medical necessity denial write-offs.
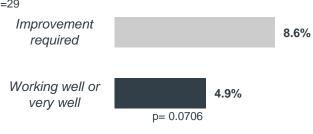3. Physician advisor programs who report "working very well" amount to a relatively even split between in-house and outsourced programs.

Source: Hospital Revenue Cycle Benchmarking Survey.

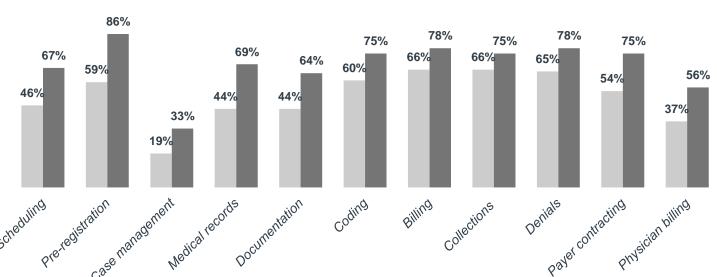advisory.com

CFOs resume additional revenue cycle oversight

C-suite turns to revenue cycle as critical lever for growth

The final section of our survey asked respondents to describe their organizational structure. Respondents were asked to identify which revenue cycle functions were overseen at the C-suite level. In our 2015 and 2017 surveys, many members indicated that CFOs were divesting oversight of these functions down to the VP or Director. In 2019, however, the opposite appears to be true.

Health system respondents suggested their executive leadership is stepping back into revenue cycle, as all functions are more likely to report directly to the CFO or CRO. In the absence of growth from traditional components of the business (new revenue streams, for example), it seems CFOs are turning to revenue cycle as a lever for growth.

Revenue cycle functions reporting directly to the CFO[1]

Percentage of survey respondents a part of a health system

n= 68 (2017), 37 (2019)   ■ 2017   ■ 2019

	Scheduling	Pre-registration	Case management	Medical records	Documentation	Coding	Billing	Collections	Denials	Payer contracting	Physician billing
2017	46%	59%	19%	44%	44%	60%	66%	66%	65%	54%	37%
2019	67%	86%	33%	69%	64%	75%	78%	75%	78%	75%	56%

Methodology

This research note presents a sample of results from the 2019 Hospital Revenue Cycle Benchmarking Initiative, which incorporates an online survey of 97 hospitals conducted from March to September 2019. The cohort is limited to acute care hospitals and presents a diverse sampling in terms of bed size, region, and system affiliation. The majority of participants (95%) have a not-for-profit status. Results reflect the most recent 12-month period. Low, median, and high performance quartiles are defined as the 25th, 50th, and 75th percentiles, respectively.

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Related Resources

To explore these topics in more depth, access the following related resources:

Webconference: Your First Look at Our 2019 Revenue Cycle Benchmarks
https://www.advisory.com/research/revenue-cycle-advancement-center/events/webconferences/2019/your-first-look-at-our-2019-revenue-cycle-benchmarks/ondemand

1. Data limited to hospitals in a health system.