Early Impressions: 2017 Hospital Revenue Cycle Benchmarks

First Take on 2016-17 Performance for Finance Leaders

Highlights

- **Across-the-board improvement in AR days suggests new standard for operational efficiency.** After a steady rise in net AR days observed from 2011 to 2015, the median number of days for hospitals to collect payment in our cohort is the lowest of the decade—41 days. The gap between high, median, and low performers remains constant.
- **Denial write-offs represent a growing source of revenue leakage.** Denial write-offs, as a percentage of net patient revenue, have been growing steadily in recent years, with the median hospital writing off roughly 2.1% of net patient revenue, double the rate from 2011. At the same time, the gap between best and worst performers has widened by 65% over the past four years.
- **Access the latest benchmarks to evaluate your revenue cycle and identify opportunities for improvement.** The Hospital Revenue Cycle Benchmark Generator has been updated with 2017 data from over 300 organizations. Hospitals can compare their performance against national benchmarks or a cohort with similar characteristics.

Background

The Hospital Revenue Cycle Benchmarking Initiative has assessed performance biennially since 2006, providing metrics that span patient access, mid-cycle, and business office. This research note features our early impressions of 2017 revenue cycle benchmarks with a focus on accounts receivable, denials, cost-to-collect, and bad debt. For a more detailed review of results and analysis of historical trends, see our Hospital Revenue Cycle Benchmark Generator on advisory.com or join our webconference Latest Trends in Hospital Revenue Cycle Performance: Findings from the 2017 Hospital Revenue Cycle Benchmarking Survey on September 13. Register on advisory.com; webconference will be available on demand after September 13.

Key Insights

There is significant opportunity to reduce bad debt, despite growing patient financial obligations

Hospitals with the lowest levels of bad debt in our survey have seemingly already reaped all the gains from the coverage expansion and are seeing their levels of bad debt creep up slightly. The rest of hospitals, however, still have room to reduce their bad debt by at least 1% to 2% of net patient revenue.

Hospitals are holding collection costs at bay

Cost-to-collect benchmarks have hovered around 3.0% of net patient revenue since 2013. While low performers have reduced their collection costs slightly, high performers have given up some of their recent gains. Unfortunately, it is difficult to unpack this metric, but significant investments in staffing and technology could have offset recent gains in operational efficiency.

Hospitals should revisit documentation and coding strategies given uptick in Medicare denials

After a marked increase in commercial denials from 2011 to 2015, public payer denials have risen in the last two years (38% growth in share of the total). While the threat from commercial insurers has not receded, hospitals will need to increase their focus on the main drivers of Medicare denials, e.g. medical necessity and authorization.

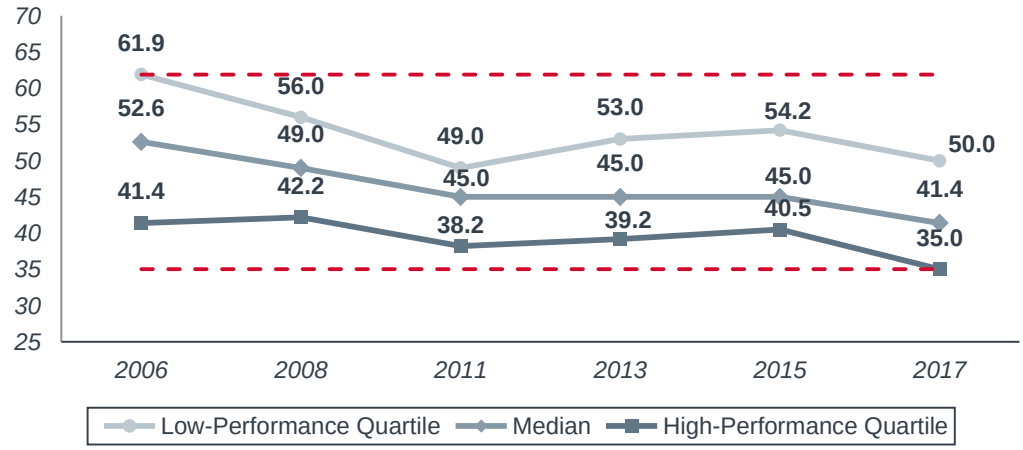
Net AR Days: Drop Suggests New Baseline for Revenue Cycle Efficiency

Since 2015, hospitals have dramatically increased their operational efficiency. The strongest performers have reduced days in AR by 13%, while median performers have achieved a 9% decline. Both high (35 days) and median (41.4 days) cohorts are enjoying their best performance in a decade.

While it is difficult to pinpoint the exact reasons for the improvement, recent conversations with hospital finance executives suggest that it could be a payoff from the significant investments in automation, introducing a new industry standard for AR.

Trended Net AR Days from 2006 to 2017

n=60 (2006); n=35 (2008); n=98 (2011); n=47 (2013); n=58 (2015); n=154 (2017)

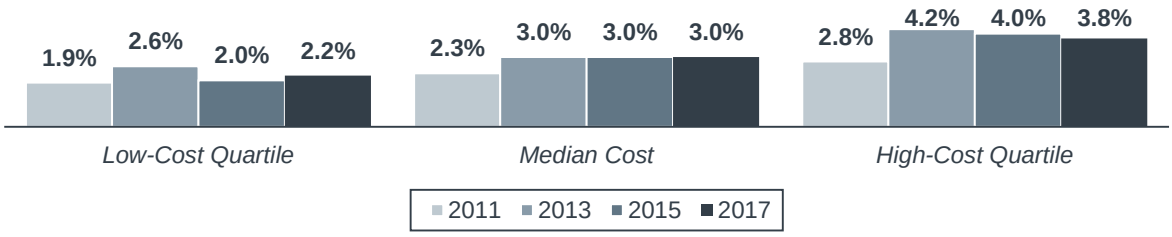


Cost to Collect: Performance Remains Flat

Little appears to have changed in cost-to-collect over the past four years. While the poorest performing organizations have slightly reduced their cost-to-collect as a percentage of net patient revenue (by 0.2 percentage points), the median has remained stable at 3.0%.

Trended Full Cost to Collect from 2011 to 2017

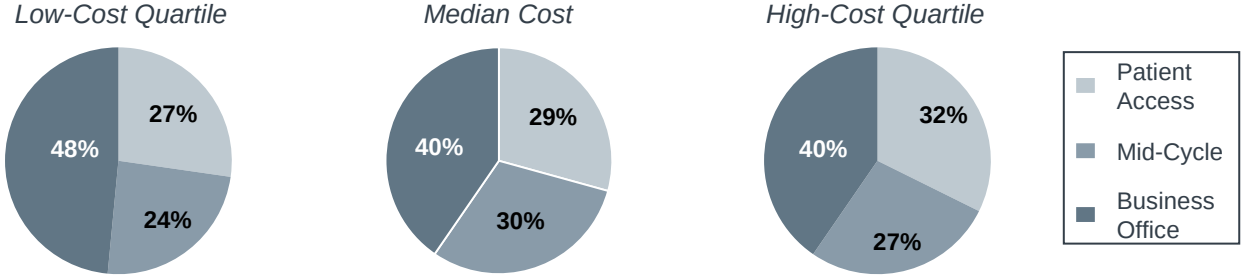
n=51 (2011); n=31 (2013); n=59 (2015); n=48 (2017)



However, recent improvements in accounts receivable and other revenue cycle metrics suggest that more granularity is needed when evaluating cost-to-collect. We introduced a new metric in 2017 to examine collection costs by area (patient access, mid-cycle, and business office). Early analysis shows that hospitals with lower cost-to-collect currently allocate slightly more resources to the business office.

Allocation of Costs by Overall Cost-to-Collect Quartiles

n=36 (2017)

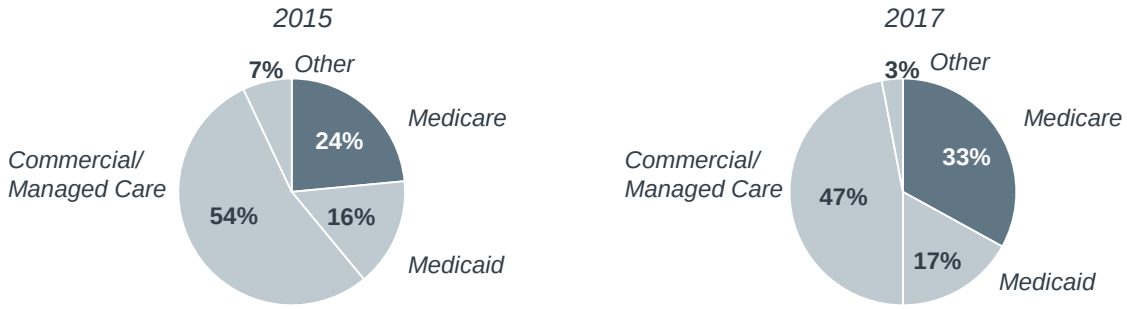


Denials: A Growing Battlefield Between Public and Private Payer Claims

From 2011 to 2015, commercial claims emerged as the top source of initial denials for hospitals. While this still holds true, the most recent data indicates that public payers are also increasing their scrutiny of claims. The proportion of total initial denials attributed to Medicare claims increased 38% over the past two years and the proportion of write-offs increased 34%—in both cases outpacing the growth in the share of total registrations from Medicare patients in the cohort.

Initial Denials

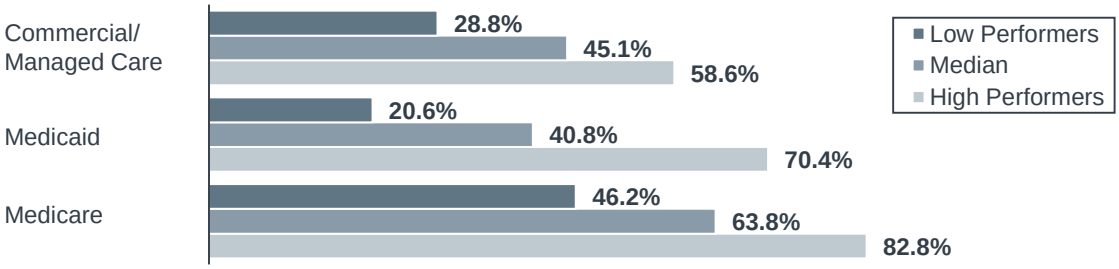
n=106 (2015); n=116 (2017)



As CMS continues to cut reimbursement on multiple fronts, hospitals must reeducate staff on coding and documentation of common Medicare denials, e.g. medical necessity and authorization, while still maintaining focus on commercial payers. The pressure on the business office is likely to intensify as the sheer number of appeals increases. But despite the increase in Medicare denials, appeals are likely to be successful: the median hospital in our sample reports a 63% success rate on Medicare appeals, the highest of all payers.

Appeal Success Rate for Denials

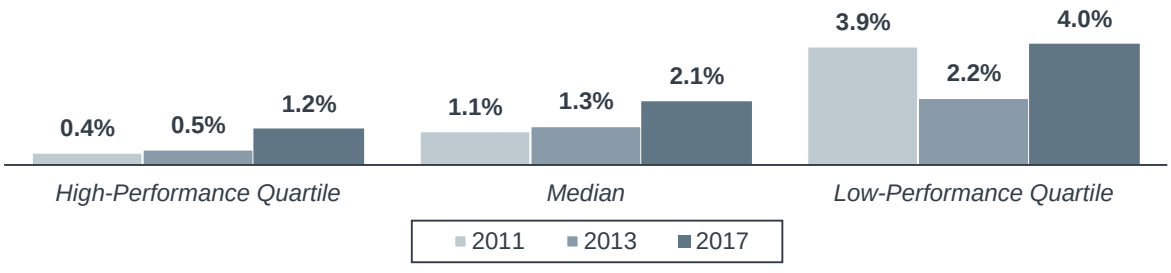
n=63 (2017)



The increased scrutiny from Medicare, coupled with the established threat from commercial insurers, has resulted in significantly higher write-offs as a percentage of net patient revenue than in previous years. Even high performing organizations report writing off 1.2% of their net patient revenue, the equivalent of median levels in 2011-2013. We will likely see this trend intensify as RAC audits resume and commercial payers continue to face margin pressures.

Denial Write-Offs as a Percentage of Net Patient Revenue

n=72 (2011); n=33 (2013); n=56 (2017)

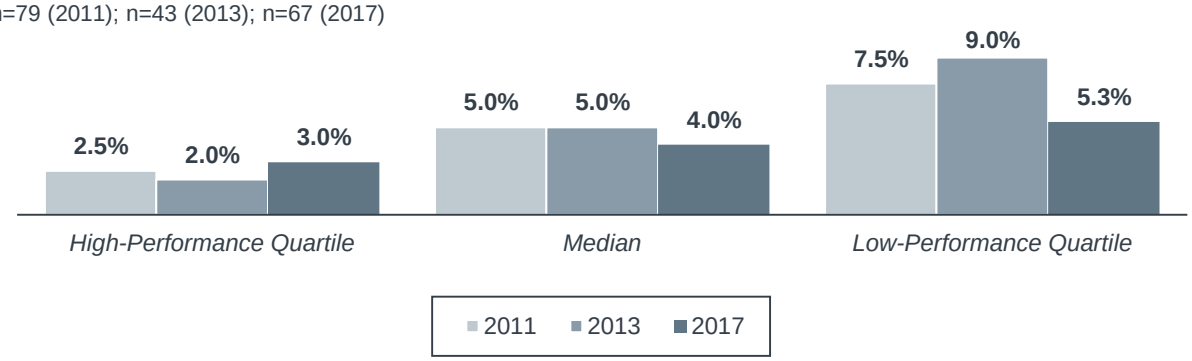


Bad Debt: A Leveling Point for High Performers?

Our survey indicates that the majority of hospitals have seen improvements in bad debt since 2011, likely as a result of the coverage expansion. Median performers have reduced their bad debt by 20% and low performers by 30%. Hospitals with the lowest levels of bad debt, however, appear to have seen a regression to previous years.

Bad Debt as a Percentage of Net Patient Revenue

n=79 (2011); n=43 (2013); n=67 (2017)



It is possible that best performers achieved all of the gains from coverage expansion by 2015, and since then, the growth in high deductible health plans and patient financial obligations has eroded those gains—effectively redefining best performance. This is in line with previous Advisory Board research, indicating that hospital revenue losses tied to the growth in bad debt (from higher patient financial obligations) and reduced DSH payments have nearly eroded the savings achieved from 2014 to 2016 from the decline in uncompensated care, due to the lower number of uninsured patients.

Methodology

This research note presents a sample of results from the 2017 Hospital Revenue Cycle Benchmarking Initiative, which incorporates data from two sources: an online survey of acute care hospitals conducted from March to June 2017 (n=90) and Advisory Board Technology proprietary data (n=297). 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 (96%) 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.

The information in this note is accurate as of its publishing date but is subject to change. If a change should occur, an updated note will be published.

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Related Resources

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

Webconference: Latest Trends in Hospital Revenue Cycle Performance
https://www.advisory.com/research/financial-leadership-council/events/webconferences/2017/latest-trends-in-hospital-revenue-cycle-performance

Hospital Revenue Cycle Benchmark Generator
https://www.advisory.com/navigator

Revenue Cycle Maturity Model
https://www.advisory.com/revcyclematuritymodel