



Understanding Your True Cost to Collect



This project is a collaborative effort by ARC Group Associates and the Healthcare Financial Management Association.

As the processes associated with recovering appropriate payment from patients and payers grow increasingly complex, providers are discovering that identifying the actual costs associated with collections is even more important. After all, the greater the cost-efficiency in recovering revenue, the more opportunity the provider will have to invest that revenue elsewhere in mission-focused services.

It's no wonder then that many providers are beginning to keep a closer eye on their cost to collect and relying on its use among key performance indicators. If not on a provider's radar today, clearly it soon will be.

Broad executive leadership is beginning to take increased notice of the measure:

[Cost to collect] is one of the great "unsung" revenue cycle performance indicators...In many organizations, revenue cycle departments represent a large number of FTEs. And revenue cycle employees are sometimes eligible for incentive compensation that others don't

receive. Consequently, that can make the revenue cycle a big target. Having an indicator that can demonstrate whether the revenue cycle operation as a whole is doing its job quantifies the value of the revenue cycle function itself.¹

Understanding the cost differential during the revenue cycle stages and the fully loaded costs for each stage of the adjudication process helps hospital executives to make clearer decisions about increasing or decreasing technology, staff, or outsourcing services.

The overall cost to collect is typically reported between 2 and 3 percent for the business office. However, the fully loaded cost to collect may be much higher from strictly a business office perspective, not including any other revenue cycle departmental cost. More specifically, on an activity-based level, what does it cost to collect a cleanly billed Medicare claim or a workman's comp claim at day one versus a claim that is over 90 days old or a denied Medicaid account? Today the industry is not tracking cost to collect metrics at this

¹ Hammer, D. "Performance is Reality: How Is Your Revenue Cycle Holding Up," *hfm*, July 2005, p. 52

level and cannot accurately determine how these costs differ. For hospital executives to make cost-effective decisions on purchasing new technology and services or to insource or outsource specific groups of claims or functions, these metrics need to be tracked similar to other key performance indicators. The industry needs to develop benchmarks in order make the collection effort both cost and results effective.

More specifically, the following are just some of the key insights that cost to collect may reveal about a healthcare organization's revenue cycle performance:

Level of collection efficiency. Cost-to-collect percentages generally increase over the life of a claim. A claim that is brought to zero within 60 days generally costs less than a claim that is brought to zero after 120 days because fewer resources are spent over the life of the claim.

Appropriate use of automation. As a claim ages, the hospital's ability to collect on it generally decreases. Automation and implementation of associated business office standards for quality often are fundamental to fast turnaround.

How Well Are You Capturing Cost to Collect?

To find out how well you understand your organization's cost to collect, consider the following questions.

- What is my hospital's definition of its costs?
- Do we determine cost to collect by department or activity?
- How do we determine our hard vs. soft costs when identifying all cost associated with revenue capture across the revenue cycle?
- Can we determine cost by payer (Medicare)?
- Can we determine cost by type of service (inpatient/outpatient)?
- Can we determine cost during the various stages of the collection process (before and after final bill activities, on the first day in accounts receivable vs. after 90 days in A/R)?

Effectiveness of billing processes. The "cleaner" a claim, the fewer the resources that need to be expended to collect on it.

Accuracy in claims prioritization. The more timely a claim is adjudicated (within payer requirements), the greater the collection rate. Failure to properly prioritize by discharge date can drive up collection costs substantially.

Need for capital investment. An investment in people, process, or technology typically lowers cost to collect as a percentage over time because of increased quality or efficiency in performing revenue cycle functions.

Effectiveness of decision making. Identifying the organization's true cost to collect enables staff to make improved decisions in relation to ROI. Examples where the information can be particularly useful include deciding whether to purchase software, add additional staff, or move a revenue cycle function such as the business office or IT offsite.

"Ideal" Cost to Collect

Most healthcare finance managers can rattle off their organization's cost to collect as a percentage of operating costs and rate of return, but those numbers require context if they are to have any value.

"When you see an organization's collection numbers, it's important to know what they put into that," says Aaron Crane, CFO of Salem Hospital, Salem, Ore. "One organization might be collecting a lot but spending a lot to get that, while another might collect less but be getting a better return for what they spend."

While experts typically recommend that organizations maintain a cost to collect of no more than 2 percent or 3 percent, a 2 percent cost to collect may not necessarily indicate a greater level of efficiency than that of an organization with even a 5 percent or higher cost to collect.

The reason is that most organizations only include the departmental budget of the business office in their cost to collect, but after that, items counted in this figure

can vary widely. For greatest accuracy when calculating cost to collect, financial executives would need to examine all costs related to revenue capture across their hospital and entire revenue cycle:

Staff

- Salaries, overtime, temporary staff
- Consultants
- Benefits (medical, social security, unemployment), bonuses or incentive pay
- Turnover cost
- Staff training and benefits

Human Resources

- Recruiting and advertising expense
- Other department costs on the budget

Technology

- Hardware, maintenance
- Software (even if paid through the capital budget or some other funding source outside the revenue cycle departments)
- Programming support
- Support personnel assigned to the revenue cycle to assist with the revenue capture process
- Other IT costs as they relate to the collection process

Telecommunications

- Hardware, maintenance
- Software
- Programming support

Telecommunications services

- Local and long distance service
- Call center number for patients

Overhead

- Office space, general building operations
- Utilities (allocated by department)
- Human resources support
- Occupancy/real estate tax

Other department costs

- Supplies (minor equipment and maintenance, postage, copier and printer costs, furniture)
- Education (travel, dues, and subscriptions)
- Professional fees for outsourced billing, printing, or collections
- Other bolt-on technologies that help improve collections

What's On the Horizon?

As interest in collection costs continues to grow, experts anticipate greater access to benchmarking information and enhancements in monitoring cost to collect from year to year. Many organizations are looking to technology to assist them in calculating and comparing their collections performance and associated costs.

“We’re going to continue to automate the process as much as we can,” says Keith Eggert, FHFMA, vice president, revenue management, Orlando Regional Healthcare, Orlando. “We need to work smarter, harder, and more efficiently in all areas of the revenue cycle.”

Greatest expectations focus on technology that would allow providers to include or exclude different components affecting cost to collect. Such capabilities would make benchmarking easier by enabling organizations to easily create cost-to-collect formulas that are similar to those used by their counterparts.

“Without a list of recommended exclusions or inclusions, we need to find other ways to fine-tune our calculations within our organization to make them more consistent,” says Ryan Thompson, director, revenue service, for Catholic Healthcare West, Pasadena, Calif. “I think technology solutions will help us.”

Regardless of where cost are allocated in the organization, if those costs are a function in the collection process within the revenue cycle or outside of the revenue cycle they need to be counted into the fully loaded cost to collect. Many of these costs today are not truly accounted for in terms of a departmental budget. Instead, they often are wrapped into overhead or a capital budget process. It is important to understand where costs are being allocated to accurately calculate fully loaded cost to collect.

Whether and to what extent these items are included can vary widely not only from organization to organization, but even from facility to facility within a single organization.

The General Accounting Office discovered such a situation when it conducted a July 2004 study of collection costs at Veterans Administration facilities. Facilities were so inconsistent with one another that the GAO tasked the secretary of the VA with issuing guidance for a standard and consistent method of accounting for costs associated with collecting payments from veterans and private health insurers.²

The Veterans Health Administration responded with a directive listing those processes fundamental to billing and collections (see “Determining Cost to Collect at the VA”), stating that the decision support system would be used to provide the base cost information in developing the cost to collect. To date, however, it has not issued any guidelines more specific than that.

Challenges in Comparing Collection Costs

Although cost to collect can be a vital indicator of an organization’s revenue cycle efficiency, lack of an industry standard can make comparison challenging.

Determining Cost to Collect at the VA

In July 2004, the GAO recommended that the Veterans Affairs Secretary provide guidance for standardizing cost-to-collect methodologies throughout the VA’s facilities. The VA responded with a list of processes deemed fundamental to billing and collections, but to date, more specific guidelines have not been issued.

I. Intake

1. Patient registration
2. Insurance identification
3. Insurance verification
4. Preregistration

II. Utilization Review

5. Precertification and certification
6. Continued stay reviews
7. Medical appeals

III. Coding

8. Inpatient coding
9. Professional fee coding
10. Outpatient coding

IV. Billing

11. Claims validation
12. Revenue cycle bill generation
13. Third-party claims

V. Collections

14. Revenue cycle accounts receivable activity
15. Payment processing (including agent cashier time)
16. Austin Automation Center chargeback for LBX (lockbox, first-party)
17. AAC chargeback for consolidated copayment processing
18. First-party customer service
19. Collections correspondence and inquiry
20. Referral of indebtedness
21. Third-party technical appeals for underpayments and denials
22. Utilization review appeals denials for medical reasons

VI. Other Support Functions

23. Compliance activity
24. Travel related to revenue cycle
25. Training related to revenue cycle
26. Direct supervision of revenue cycle
VA Medical Center and Veterans Integrated Services Networks
27. Business implementation manager costs

Source: Veterans Affairs, “VHA Directive 2004-068: Reporting Medical Care Cost Funds Cost to Collect,” http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1206

“In health care, we’re accustomed to accurately benchmarking against other known entities, but that’s not really possible with cost to collect,” says Keith Eggert, FHFMA, vice president, revenue management, Orlando Regional Healthcare, Orlando. “There’s too much variation in what organizations put in, even if they’re otherwise similar.”

Some hospitals have based their calculations on the cost-to-collect definition published in *Hospital Accounts Receivable Analysis*, which is produced by Aspen Publishing. *HARA* generally pegs the cost to collect at 2 to 3 cents on the dollar. Yet this is a general number from surveyed respondents and is not a true activities-based cost analysis. And operational differences between organizations mean that the *HARA* list won’t work for everyone.

“The *HARA* list includes patient access—registration and admitting—but not patient scheduling,” says Roland Funsten, assistant vice president, revenue cycle operations, for St. Vincent Hospital, Indianapolis. “In some organizations, patient scheduling may report to another area, but in ours, it reports to patient access. That makes it part of the revenue cycle and therefore a major part of our cost to collect.”

Also to be noted is the relative cost of those elements within the cost to collect. “Your cost to collect may be a certain dollar amount, but you also have to consider how much you are paying for different elements within that,” says Ryan Thompson, director, revenue service, for Catholic Healthcare West, Pasadena, Calif. “You could have a cost to collect that seems high, but it’s because you purchased a new software system that will save you money later, but have the current depreciation expense to include in the cost. On the other hand, you could have a cost to collect that seems low, but you’re using software that’s 10 or 15 years old and not as efficient as it could be. Additionally, depreciation and other expenses such as lease/rent and utilities may not be consistently included in the applicable cost center’s expenses.”

Such factors often are important considerations, and benchmarking clearly needs to recognize business environment. A provider may have a legitimate need

What Do Other Industries Do?

One growing trend in health care has been to benchmark performance in various areas against companies in other industries, such as airlines or technology companies. However, in the case of cost to collect, this option is not realistic because of the unique challenges presented by health care’s payment system.

“Our billing processes are not as straightforward as in other industries, where you have a set price per hour or per product,” says Wah-Chung Hsu, senior vice president and chief financial officer for Kingston Regional Health Care System, Lake Katrine, N.Y. “We have different processes and software depending on who the payer is: Medicare, Medicaid, all the different commercial payers that have different payment arrangements in their contracts. Then there are acquisition and license fees for all of those, preauthorizations and pre-verifications, and the IT support needed to keep them all running.

“Other types of businesses also have a greater guarantee of getting paid,” Hsu adds. “When a customer comes to you to purchase a product or service, it’s usually safe to assume they have the money to pay for it. With health care, though, that’s not always the case. All of these issues are going to give healthcare organizations a much higher and more complex cost to collect than organizations in other industries.”

for more headcount or greater reliance on outsourcing than its peers, for example, when unrelated duties are being performed by business office and admissions personnel or when a backlog of accounts is being worked on.

In addition, factors such as a hospital’s patient population or payer mix also can affect cost to collect. “It can take a lot of resources to get payment

on self-pay accounts, if you get paid at all,” Salem’s Crane notes. “But with Medicare, if you submit a clean claim, you get paid pretty quickly. Commercial payers are somewhere in between. So you may have a higher or lower cost to collect based simply on your combination of those.”

Practical Use of Cost to Collect

Despite such limitations, measuring and comparing cost to collect can be key to effectively analyzing revenue cycle performance. Cost variances from year to year or with competitors often signal opportunities where process changes can lead to significant savings. By including a variety of indirect costs along with the direct costs in cost to collect, hospitals can get a clearer picture of what it is truly costing them to obtain payments, and if necessary, identify those steps of the process where costs can be reduced.

Because of the challenges associated with comparing cost-to-collect rates with other organizations, many providers find the simplest way to find value in the metric is by tracking cost to collect within their own facilities over time.

That’s what Bert Fish Medical Center in New Smyrna Beach, Fla., does. “We track our cost to collect over the years, just to make sure it’s staying relatively flat,” says Timothy A. Drury, FHFMA, CFO. “If it changed, we would need to look at the different components of that number and see where costs were going up.”

Also, reasonable benchmarks can be developed by focusing extensively on the context in which the number is to be used. As an example, the context for cost to collect might be defined as costs associated with the business office producing and collecting claims. The provider would then define the scope of these functional areas, such as the costs involved with the

Exhibit 1: Why Is an Aggregate Estimate of Collection Cost Misleading?

	Hospital
Gross Charges	\$250,000,000
Net Patient Revenue	\$87,500,000
Net Patient Revenue %	90%
Cash Collections	\$78,700,000
Business Office Departmental	\$1,967,500
Cost to Collect	2.5%
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50% of Cash Collected w/ little Expense	\$39,350,000
Remaining Cash to Collect	\$39,350,000
Business Office Departmental	\$1,967,500
EDI Expense to Collect these dollars	\$100,000
Revised Cost to Collect	\$1,867,500
Actual Departmental Cost to Collect on Remaining Cash Collections	4.75%

When calculating collection costs, many hospitals simply consider high-level numbers in aggregate. In this example, the hospital has gross revenue of \$250 million with net patient revenue of \$87.5 million. If the hospital collects 90 percent of its net patient revenue, that would be \$78.5 million. The cost of collections departmentally in its business office is \$2 million, which would result in an aggregate cost of 2.5 percent.

Too often, facilities do not calculate cost to collect beyond this point—which can be misleading. A more accurate analysis would be to separate out all claims that are collected without human intervention. In this example, assume 50 percent of the claims were paid cleanly with little to no cost or involvement from business office staff (other than expense related to electronic data interchange), yielding a cost of about .25 percent. The cost to collect for the remaining 50 percent of the inventory after netting out related EDI expenses increases notably—to 4.75 percent!

business office, pre-bill fixes for edit failures, bill production, collection follow up, business office denial management, bad-debt placement, contract management, and patient financial services software. The next step would be to produce several ratios, such as cost per dollar collected, cost per discharge or outpatient service, cost per claim (including a determination of how charity, bad debt, and secondary insurance is counted).

By contacting similar organizations interested in comparison and providing a detailed spreadsheet on how to calculate the number and define each cost category, a useful evaluation is possible.

Scott Johnston, a member of HFMA's PFS Forum and former HFMA technical director, supports this method and advises those using it to prioritize efforts. "My experience has shown that the top 80 percent of costs in the business office are labor and benefits, purchased good and services, and information services. Thus, I would look at these first."

Johnston says he finds these expenses are among the easiest to track since they generally fall under the PFS director's control and can be found as part of the annual budgeting process.

"Once I have gathered this information, I can trend my internal costs over a time period against other key benchmarks," says Johnston. "For example, I would use days in A/R, staff turnover, ROI of new software, technology or process changes, and denial management."

Better Management

Cost to collect is a critical revenue cycle efficiency indicator and ultimately can be used to provide the organization with information needed for better management. A detailed and inclusive cost-to-collect formula often is invaluable when it comes to identifying a cause if the cost-to-collect ratio starts to rise.

"If cost to collect starts going up, we need to find out where," says Bert Fish Medical Center's Drury. "Right now, we contract out our professional fees billing because our software can't handle it, but if the costs for that started going too high, we'd have

to identify the reason. Is it something we're doing on our end? Are the vendors expenses going up? Would it be cheaper for us to purchase new software and train staff? With a good cost-to-collect formula, it shouldn't be too hard to figure out."

Front-end process are important to include in the cost-to-collect ratio, especially in this era of increasingly high copayments and consumer-directed health plans. The reason is that the more time that passes following the patient's discharge, the cost to collect on that account continues to go up while the chance of actually collecting payment goes down. Therefore, any payment that can be collected early in the patient encounter is more valuable in the long term.

"One of the most expensive components, outside of staff salaries, is collection agency expenses," says St. Vincent's Funsten. "When you have to send an account to a collection agency, you lose some of that cash. And if you start getting higher recoveries, your expenses go up even further. So then you need to ask whether you're turning accounts over too quickly and there's more you could be doing in-house."

Just as a hospital will use benchmarking data such as denial rates by category as a means to learn to reduce denials and spend fewer resources getting claims paid, there are similar opportunities with cost to collect. There are benchmarks that tell how much of a hospital's A/R should be over 90 days. Currently the industry cannot determine the true cost to collect on their aged claims. The industry cannot determine how much it costs to collect on claims once they age past 90 days, for instance. If a facility has outsourced some or all of its aged financial classes, the facility cannot evaluate whether the outsourcing partner being used is providing a net return in comparison to internal cost.

We need to develop such benchmarks and metrics to help us understand the differential costs by financial class and age of collecting claims. Then we can make better decisions. By understanding the costs not only in the aggregate, but also for different stages in a claims life cycle, the cost effectiveness of the decisions we make regarding such things as staffing, technology, training and outsourcing can be more accurate.



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HFMA is the nation's leading membership organization for more than 33,000 healthcare financial management professionals employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include CEO, CFO, controller, patient accounts manager, accountant, and consultant. HFMA offers educational and professional development opportunities, information on key issues, technical data, and networking opportunities in order to give members practical tools and ideas that will increase their performance. For more information, visit HFMA's web site at www.hfma.org.

About ARC Group Associates

ARC Group Associates, Inc. has been in the revenue cycle business since 1991 and is currently leading the way to establish a nationwide standardized cost to collect methodology in the healthcare industry. ARC Group is helping some of the nation's premier health systems and hospitals understand and improve their overall cost to collect in an effort to achieve a cost efficient revenue cycle process. ARC partners with healthcare providers onsite or offsite utilizing your systems to deliver sustainable change. Solutions include managing an entire business process (patient access, the business office, denials, underpayments and day one low dollar accounts) and projects (system conversions, aged A/R and retrospective underpayments).

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