overcoming 4 common revenue cycle benchmarking myths

Once you cut through some myths, you’ll see that comparing revenue cycle performance with peers doesn’t have to be painful.

As shrinking payments and healthcare reform initiatives continue to pressure the revenue cycle, many hospitals and health systems aim to improve their performance by benchmarking against their peers.

To succeed in these revenue cycle benchmarking efforts, leaders need timely and comparable performance information that is clear and consistent. They also need to understand which peers can help them answer the most critical questions about their performance.

All too often, however, the whole concept of benchmarking with peers can seem impractical when faced with day-to-day priorities or it can morph into something overly complex given the relative payoff. With this in mind, what follows is an exploration of several “myths” that can get in the way of effective performance comparisons and advice from the field for establishing a meaningful—and practical—revenue cycle benchmarking program at your organization.

**Myth 1: Only Benchmark If You’re Not Improving**

When an organization has a long history of a certain level of performance and is finally able to eke out improvement, it seems like the last thing that it should spend any energy on is benchmarking, right?

Not quite. Yes, looking at performance over time is a good foundation for understanding what is “normal” or “high” performance for your organization. But it doesn’t take into account other factors that may be at play. Has the payment environment gotten more complex over the past few years? Are consumers paying for greater portions of their care than in the past? By examining performance solely against previous levels, you aren’t getting the full picture.

Checking revenue cycle performance against others is important to understanding how performance ability may be affected by what is happening in
the industry at large. Consider for a moment a situation where you slightly reduce days in accounts receivable (A/R). This achievement, although positive, may not seem like much. But it can quickly take on much greater significance once you recognize that you have achieved this shift at a time when most other organizations are struggling just to maintain status quo or are even seeing their days climb. By knowing how your performance compares with others in the industry, you get a much deeper understanding of where your strengths and opportunities lie.

Also, benchmarking against others can be useful in that it provides a reality check for the goals you may set. Knowing that you are at a higher level of performance than experienced in the past isn’t enough. How confident are you that the positive movement can be maintained? Benchmarking helps leaders better understand true improvement potential so they can create achievable stretch goals to move performance from good to great.

Meaningful targets are at the crux of staff’s trust in the process and commitment to performance improvement. “If you are just doing your own benchmarking against past performance and not comparing yourself with peers across the industry, sometimes you can lose that motivation to push yourself further,” notes Bethany Sexton, vice president of the revenue cycle at MultiCare Health System, a not-for-profit, five-hospital system based in Tacoma, Wash.

At MultiCare, leaders set an aggressive goal of bringing the system’s point-of-service (POS) cash collections to 2 percent of net revenue. It might have been easy for staff to slide back into old habits over time, but knowing that others had reached this goal kept the team motivated, says Sexton. Since setting the goal, MultiCare has achieved yearly improvements in its up-front collections, including close to a 5 percent boost in 2012. And staff can take comfort in knowing the organization won’t be pushing them beyond what is possible, recognizing that the goals set are attainable and will be adjusted if broader factors across the industry should impede POS collection ability.

**Myth 2: Benchmarking Is Useless When You’re Different**

Many revenue cycle leaders believe that their organizations are unique and therefore won’t benefit from peer-to-peer comparisons. Yet this view is often shortsighted.

“People get stuck because they think they have to find the exact match for themselves,” says
Diane Watkins, vice president of the revenue cycle at Saint Luke’s Health System, a faith-based, not-for-profit system based in Kansas City, Mo. “But even if you are a little different and all of the characteristics don’t line up, you can still learn from comparing yourself with others.”

The truth is that even children’s hospitals and organizations with high Medicaid populations share the same revenue cycle processes and can benefit from benchmarking.

At MultiCare, Sexton doesn’t shy away from comparing the organization’s children’s hospital, Mary Bridge Children’s Hospital, with non-children’s hospitals or for-profit organizations. “We hold ourselves to a standard of performing like any for-profit organization,” she says.

A large group for comparison also has inherent advantages in terms of normalizing data and providing data consistency. Sexton says she actually prefers to keep her comparative group fairly broad, choosing peers based on payer mix and net patient revenue. “You don’t want to over-weight your peer group on certain characteristics,” Sexton says. “By leaving it a little broad, you can compare yourself to a larger group, and you will get a better result.”

**Myth 3: One Benchmark Fits All**

Wait a minute. What happened to that stuff about benchmarks being meaningful even when you’re different?

Large, broad peer groups can be valuable. But there are indeed times when more targeted selection of peers for comparison is necessary. When you benchmark your organization’s performance, the truth is that the peer groups you select won’t be one-size-fits-all. Your organization’s peers should change based on what you are measuring.

Take the example of religious affiliation and collection performance. The mission base of an organization will play little role when looking at metrics that track overall operational efficiency, such as aging and net days in A/R; broad peer groups with similar net revenue and payer mix will generally work well for comparison. However, a revenue cycle leader at a faith-based organization may want to select a narrower group of peers with similar affiliation when it comes to examining POS cash collection performance, as faith-based organizations frequently do not prioritize up-front collection the same way as for-profit peers do. With the POS collection metric, revenue cycle leaders at faith-based organizations will be best served by selecting peer groups with similar collection philosophies.

In the same way, revenue cycle leaders at rural critical access hospitals shouldn’t expect to have the same efficiencies or economies of scale as large, urban not-for-profit teaching hospitals. Also, rural hospitals won’t have the same targets as urban medical centers because payer mix, patient population, and services offered tend to be very different.

In addition, regional peer groups can help hospitals gauge performance when local issues make national comparisons less valuable. One example of this can be seen in Illinois, where the state’s Medicaid payments are lagging. Because of this payment challenge, Illinois hospitals don’t really benefit from measuring their performance for aging receivables against national benchmarks. Revenue cycle leaders at these hospitals can tell a much more meaningful—and positive—story by taking a regional view.

The bottom line for benchmarking? The metrics being studied should drive which demographics (such as net patient revenue, bed size, and organization type) define your peer group.

**Myth 4: Benchmarking Just Opens You Up to Greater Scrutiny from Your Boss or (Gulp) the Entire C-Suite**

This one isn’t exactly false. Sure, scrutiny probably won’t intensify. But it won’t go away either. Your boss (and his or her boss and so forth) will continue to be concerned about performance. That’s just the way it goes.
Sometimes, a regional peer group can provide the best insight into a hospital’s performance. A good example is a hospital in Illinois, which, like its peers, is coping with lagging Medicaid payments from the state. To get a clearer view of its performance, this hospital should compare its performance regionally, rather than nationally, for the net days in A/R and the aged A/R over 90 days. Medicaid indicators. Although the median net days in A/R for hospitals with similar net patient revenue and annual self-pay percentages nationwide is roughly 55, the median net days in A/R for hospitals in the region is much higher, between 60 and 80. This indicates that the sample hospital is actually performing in line with its peers. For aged A/R, the national median shows that roughly 40 percent of Medicaid traditional receivables are older than 90 days. Regionally, the median jumps to more than 60 percent. So nationally, the sample hospital is underperforming, but regionally, it is outperforming its peers.
That said, with benchmarking, you often have an opportunity to shift the nature of performance-focused conversations. By comparing organizational performance with that of peers, revenue cycle directors often discover that their organizations are facing the same struggles as others. (“Yes, our denials have increased substantially over the past three years. But so have everyone else’s. So let’s talk about what’s driving that, and what we can and can’t control in addressing the challenge.”)

“Benchmarking is good offense, but it is also good defense,” says Jho Outlaw, executive director of the revenue cycle at Providence Hospitals, Columbia, S.C.

Comparison also can be useful when making a case for dedicating more resources in an area or answering questions from the C-suite or outside consultants about the value of FTE levels or use of outsourced services.

As an example, Outlaw notes that comparative data was useful to demonstrate to her C-suite that her organization had a significantly lower cost to collect than its peers, which helped make a case for ROI when FTEs were somewhat higher in one area.

Benchmarking can also give insight when solid processes are in place yet performance on a particular metric isn’t as strong as expected. Outlaw describes such an instance, noting it came about during her normal benchmarking processes as she was slicing data by peer group.

Outlaw’s default benchmarking peer group includes organizations with a similar payer mix and bed size. When reviewing a key metric such as aged A/R, Outlaw slices the comparative data at least three ways: She compares the data for her entire system with data for like-sized systems. She breaks the data down by facility to compare performance at each one with others of similar size. And then she compares her system’s aged

### ORGANIZATIONS OF THE SAME TYPE WILL WORK BEST AS DEFAULT PEER GROUPS

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<tr>
<th>2012 MAP App Data</th>
<th>Median</th>
<th>Top Quartile</th>
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<tr>
<td><strong>Point-of-Service Cash Collections</strong></td>
<td></td>
<td></td>
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<td>Critical Access Hospital</td>
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<tr>
<td><strong>Cost to Collect, Without IT</strong></td>
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<tr>
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<td>Rural Hospital</td>
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<td>Not-for-Profit Teaching Hospital</td>
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<td><strong>Bad Debt</strong></td>
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<tr>
<td>Not-for-Profit Teaching Hospital</td>
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Source: HFMA’s MAP App, 2012 (based on HFMA’s MAP keys).

This chart shows the significant differences that can exist between critical access, rural, and not-for-profit teaching hospitals nationwide. Rural hospitals often do a better job at establishing policies to collect up front, compared with critical access and not-for-profit teaching hospitals. The chart also shows meaningful differences in cost to collect without IT and bad debt.
A/R with that of all hospitals nationwide. Occasionally, she also reviews metrics by region.

Recently, when denials as a percentage of net revenue grew without clear reason, Outlaw checked regional data—which showed that denials were up across the Southeast. This finding suggested there was an issue with payers in her region, rather than the front end of her healthcare system’s revenue cycle.

**Getting Started: Six Tips on Selecting Peers**

So now that you know the truth about benchmarking, you have a good foundation for moving forward. To select an appropriate peer group for benchmarking, consider this advice.

**Create a default peer group that includes providers of the same type with similar net revenue.**

Performance can vary significantly by provider type and size. Take HFMA’s POS Cash Collections MAP key, for example. Among critical access hospitals, the top quartile of performers collects about 7 percent up front. Among not-for-profit teaching hospitals, the top quartile’s POS collections more than double that percentage. The best results will come from choosing peer organizations that generally mirror your own.

**Don’t get too narrow.** Revenue cycle leaders can get bogged down by thinking they must select the “perfect” group. For many organizations, broader is better. Aim to have at least a dozen—if not several dozen—hospitals in your peer group.

**Make sure the organizations you select are your true peers.** Know which organizations are at the top quartile and top decile, but ask yourself, are they truly competition? Would your leadership agree? Would your revenue cycle team agree? Also, be realistic. If your organization is operating below the median on a metric, don’t measure your performance against the top decile. Having a sense of which organizations are generally like yours and perform at similar levels will allow you to set practical, achievable goals.

**Once you identify an area of opportunity, drill down in your data.** For example, if benchmarking reveals that your net days are going up, you can look at your days in discharged not final billed (DNFB) and days in final billed not submitted to payer (FBNS) to see if it is taking longer to get a bill out the door. Then you can drill down and examine aging by payer. If peer groups are performing better than your organization, then you should conduct a root cause analysis.

**Revise metrics to make them more measurable.** At Saint Luke’s Health System, the central business office has changed how it measures patient cash collections from absolute dollar amounts to patient cash as a percentage of net patient revenue. This new metric allows the revenue cycle team to compare its performance with others.

**Review peer groups annually.** It’s good practice to assess your peer groups once a year, even if you don’t make many changes. This yearly review can help provide perspective if shifts are taking place in the industry that may become factors in performance potential.

**It Shouldn’t Be Painful—Really**

Benchmarking performance shouldn’t be an impractical or hopelessly complex exercise. Rather, it should make your management efforts easier. It provides a shortcut to better understand your organization’s strengths and opportunities and makes it easier to identify where you may need resources, where your efforts are making a difference, and where your attention is likely to result in the greatest payoff. Just remember to keep things practical. Despite what you may have heard out there, finding useful peer groups for comparison shouldn’t be painful—really.

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