

BLACK BOOK RESEARCH

2027 BUDGET AND RENEWAL DECISIONS

Hospital Revenue Cycle Accountability

Survey priorities and seven board review areas

PREPARED FOR

**Hospital Boards and Trustees
Health System RCM Executives
CIOs and CFOs**

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REPORT NAVIGATION

Contents and purpose

Hospital boards need a consistent way to judge whether a revenue cycle arrangement produces a verifiable financial benefit, maintains service and preserves the ability to change course. This report brings the common survey material and all seven subject briefs into one sequence for the 2027 budget cycle.

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How to use the report

Read the executive summary and survey foundation first. The seven subject chapters then connect the common renewal priorities to definitions, supporting records and recommended decisions. The closing governance section supplies an executive responsibility matrix, a suggested 90-day review sequence and a board checklist.

RCM means revenue cycle management. The scope is hospital administrative revenue cycle work, including outsourced and co-sourced arrangements. The report does not evaluate clinical AI, rank named vendors or prescribe a universal contract score.

Source keys S0-S7 identify the eight Black Book documents listed on page 26. Recommendations for board use are identified in the relevant sections.

SHARED SURVEY AND SEVEN SUBJECT AREAS

Executive summary

The central board question is whether the hospital can connect the complete cost of an RCM arrangement to cash received, operating performance and the patient billing experience. Renewal, consolidation and automation decisions should be assessed against that same evidence standard.

The supplied renewal brief reports the highest Essential information ratings for net financial benefit after all relevant costs at **97%**, time from service to collected cash at **96%**, and full cost to collect at **95%**. These figures describe the importance of receiving verifiable information before renewal. They do not measure the performance of the arrangements themselves. [S1, p 2]

Operating evidence gives those financial claims context. The reported ratings include preventable denial losses at **88%**, posted underpayment recoveries at **85%**, unresolved accounts at **80%**, rework at **73%**, complex-exception resolution at **71%**, and patient billing complaints at **70%**. The remaining measures address automation benefit pass-through, the cost of changing the arrangement and assigned-team turnover. [S1, pp 2-3]

What the seven reviews contribute

Subject	Conclusion for board review
Renewal	Require a complete benefit case supported by twelve clearly defined measures.
Outsourcing costs	Compare the vendor price with the full cost of transition, retained work and continuing operation.
Consolidation	Test service coverage, cash continuity, specialist capability and future flexibility before changing the provider structure.
Reporting	Connect each material claim to a hospital record, a reconciliation and an accountable owner.
Rural contracting	Match scope, retained local knowledge and transition arrangements to the hospital's operating needs.
Automation costs	Budget implementation and the continuing review, maintenance and replacement work.
Administrative workload	Assess the full workflow and staff group, including new checking and correction tasks.

Recommended board action. Ask the CFO, CIO and RCM leader to submit one reconciled evidence packet for each material renewal or change proposal. It should contain a documented baseline, the full cost comparison, service and patient measures, unresolved exceptions, and a recommendation with owners and review dates.

Interpretation: The percentages are attributed to the Black Book subject briefs and describe the importance of receiving renewal information. They do not measure vendor performance or financial outcomes. The research basis and reporting limits are explained on page 5. Sources: S0-S7.

POPULATION AND UNIT OF ANALYSIS

The common survey foundation

The source documents describe a common cohort of **207 provider-employed U.S. hospital and health system leaders representing distinct contracting organizations**. A multi-hospital system counts once when it is the contracting organization; its individual facilities are not separate responses. The seven briefs reuse this common population. [S1-S7, p 4]

Reported organization profile

Contracting organization	Count	Share
Multi-hospital systems with centralized or coordinated RCM contracting	79	38%
Standalone general acute-care hospitals with at least 100 staffed beds	74	36%
Standalone general acute-care hospitals with fewer than 100 staffed beds including critical access hospitals	41	20%
Standalone specialty hospitals	13	6%
Total	207	100%

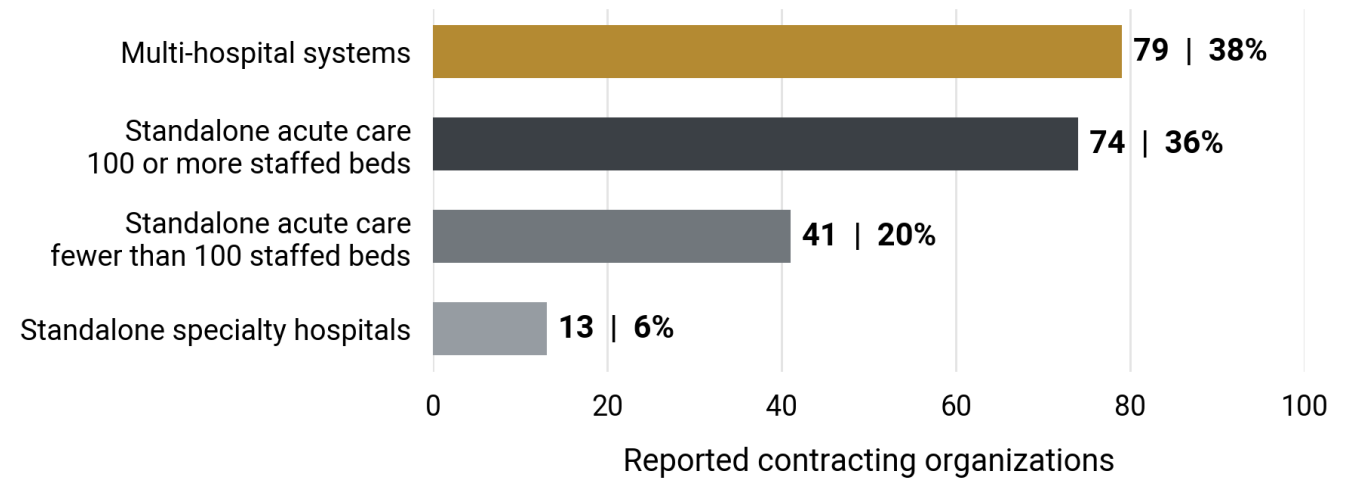


Figure 1 Organization profile reported in all seven briefs. Shares are rounded; the small-hospital category is not a verified rural subgroup. Source: S1-S7, p 4.

Respondent eligibility

The described main cohort requires direct responsibility for financial approval, renewal, performance review, operational oversight or escalation of an active outsourced or co-sourced hospital RCM agreement operating for at least six months. Respondents also need access to relevant financial or operating information. [S0, Respondents]

For this study, broad managed services means an end-to-end agreement or coverage of at least three predefined RCM functional domains with cross-functional accountability. Vendor employees, consultants, software-only customers, payers and independent practices, laboratories or ambulatory surgery centers are outside the described main cohort. These are study definitions, not universal industry classifications. [S0, Primary and supplemental cohorts]

SUBJECT 1

Renewal accountability

Renewal review begins with the financial result the hospital retains and the evidence needed to explain it. The twelve source-reported priorities provide a common agenda for management and trustees. They cover cash value, revenue leakage, operating execution, patient billing and the practical consequences of continuing or changing the arrangement. [S1, pp 2-4]

Twelve source reported renewal priorities

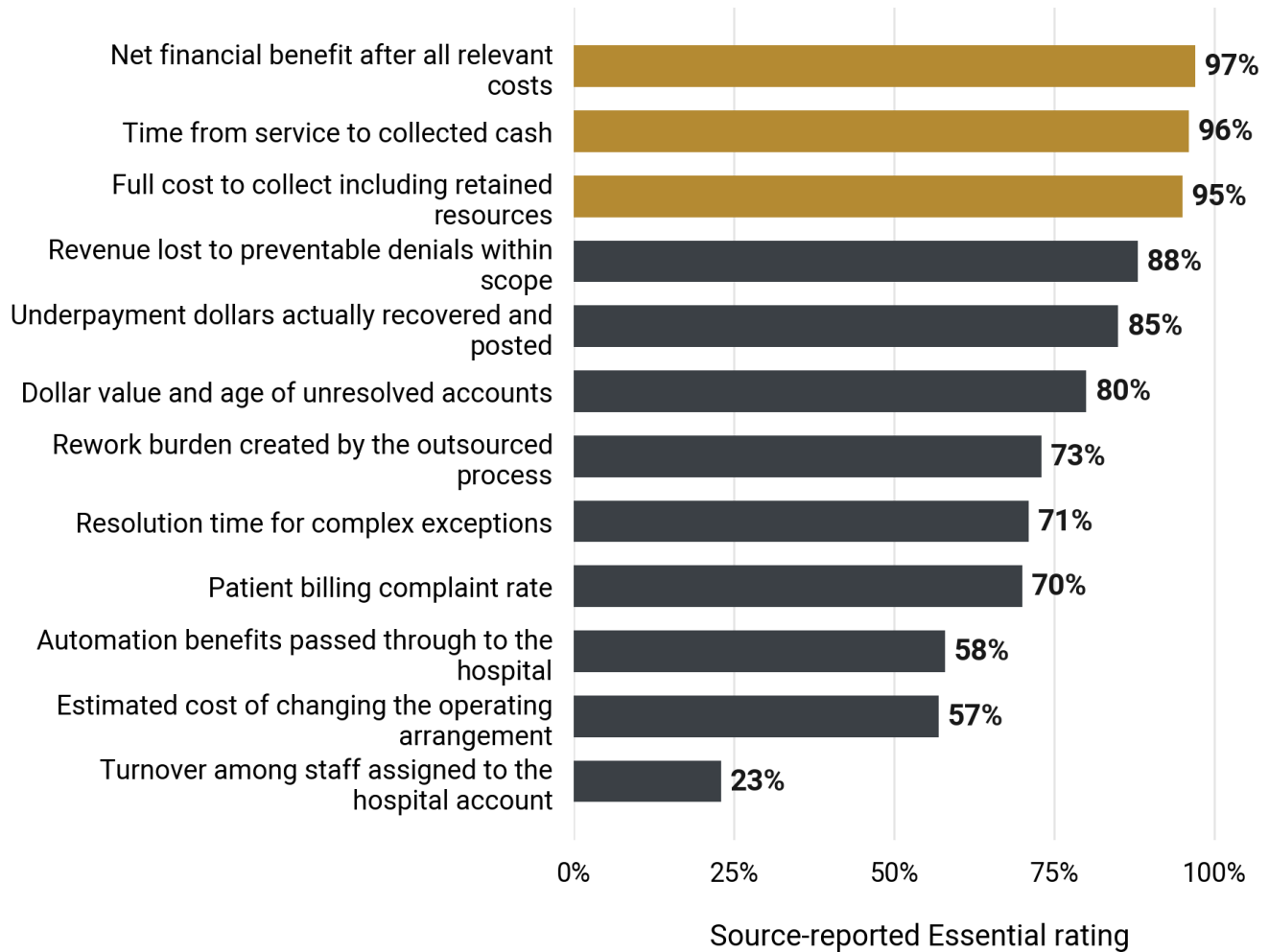


Figure 2 Importance of receiving verifiable information before renewal. Overall cohort reported as 207; item bases are unspecified. Ratings are independent and are not outcome or failure rates. Gold identifies the three largest reported values, without a statistical significance claim. Source: S1, p 2. Methodology and interpretation appear on page 5.

Implication for the decision

The financial priorities should be read with the operating measures. Faster cash can coexist with a growing unresolved backlog, and reported savings can coexist with more retained hospital effort. A lower Essential share does not justify omitting a locally material measure. The board should select evidence according to the service scope, contract risks and hospital circumstances.

The following measurement guide consolidates S0’s detailed definitions with S1, p 3. Suggested executive ownership is a governance recommendation, not a survey result.

SUBJECT 1 CONTINUED

Financial value and cash timing

1 Net financial benefit after all relevant costs

Source-reported Essential rating 97%. Compare incremental cash realization and operating cost reductions attributable to the arrangement with a documented baseline or alternative. Include vendor charges, retained hospital resources, technology and transition spending over a common time horizon.

Supporting records. The CFO should reconcile a benefit ledger to cash postings, general-ledger expenses, baseline assumptions and attribution adjustments. Separate changes in volume, payer mix, pricing and unrelated initiatives. Total collections less vendor fees does not establish incremental benefit, and the same receipt or saving should be counted only once.

2 Time from service to collected cash

Source-reported Essential rating 96%. Use median calendar days from a predefined service or discharge date to the first posted cash receipt for comparable accounts. Review time to final settlement and the age and value of unpaid accounts alongside the paid-account measure.

Supporting records. The RCM leader should provide account-level service, discharge and receipt dates, payer and service classifications, and payment allocations. Fix date conventions and distinguish payer, patient and partial payments. This measure is different from net days in accounts receivable; limiting the calculation to paid accounts can conceal unresolved work.

3 Full cost to collect including retained resources

Source-reported Essential rating 95%. Divide all relevant revenue cycle operating costs by patient service cash collected for the same covered scope and reporting period. Include vendor fees, hospital labor, oversight, technology and allocated support under a consistent allocation policy.

Supporting records. Finance should reconcile vendor invoices, payroll allocations, technology expenses and cash postings. Specify the treatment of transition and exceptional costs. Cash collections and net patient revenue are different denominators, so comparisons require a stated and stable convention.

4 Revenue lost to preventable denials within scope

Source-reported Essential rating 88%. Measure expected contractual reimbursement permanently lost after final appeals, recoveries and reversals for preventable denials traceable to contracted work. Show the amount and the relevant account or revenue base.

Supporting records. The RCM leader should link denial and appeal records to contractual reimbursement estimates, write-off reasons and root-cause reviews. A denial is not automatically a permanent loss or a vendor-caused failure; distinguish payer decisions, hospital dependencies and contracted responsibilities.

Sources: S0, measurement definitions; S1, pp 2-3. Methodology and interpretation appear on page 5.

SUBJECT 1 CONTINUED

Recovery and operating execution

5 Underpayment dollars actually recovered and posted

Source-reported Essential rating 85%. Count additional cash received and posted against validated underpaid claims, net of refunds, reversals and duplicate credits. Show recovery fees separately and the resulting net recovery benefit.

Supporting records. Finance and RCM should connect unique claim identifiers, original and corrected remittances, cash postings, recovery case records and fee invoices. Identified variances, appealed amounts and expected settlements remain distinct from recovered cash. Preserve the collection window and prevent duplicate attribution across programs.

6 Dollar value and age of unresolved accounts

Source-reported Essential rating 80%. Report open account counts and balances at a fixed date in consistent aging intervals. Identify whether the next action belongs to the vendor, the hospital or the payer.

Supporting records. The RCM leader should supply the receivables ledger, aging rules, workqueue extracts, valuation policy and account ownership. Identify whether balances are gross charges, net receivables or estimated collectible amounts. Transfers, valuation changes or a new aging origin can change the reported backlog without resolving an account.

7 Rework burden created by the outsourced process

Source-reported Essential rating 73%. Track unplanned repeat touches, corrections and hospital labor caused by errors or incomplete contracted work. Use frequency, hours and documented labor cost against a consistent claim or account volume base.

Supporting records. The RCM leader should assemble correction logs, returned-work records, task histories and time observations. Finance should validate labor-cost assumptions. Separate routine quality assurance from corrective work and assign causes; missing hospital information and payer changes can also contribute.

8 Resolution time for complex exceptions

Source-reported Essential rating 71%. Measure calendar time from first documented escalation to verified resolution for a defined complex case. Report the median, a tail measure and the age of cases still open, with an owner for each waiting stage.

Supporting records. Case definitions, timestamps, pause reasons, owners, closure evidence and unresolved-case logs support the result. Keep total elapsed time visible alongside any contractual clock that pauses for dependencies. A change in the definition of complexity can alter apparent performance.

Sources: S0, measurement definitions; S1, pp 2-3. Executive ownership is recommended. Methodology and interpretation appear on page 5.

SUBJECT 1 CONTINUED

Patients automation and continuity

9 Patient billing complaint rate

Source-reported Essential rating 70%. Count unique billed accounts with at least one qualifying billing complaint per 1,000 billed accounts in the defined cohort. Pair the rate with resolution time and repeat-contact frequency.

Supporting records. Deduplicate complaints across channels and link them to billed accounts, complaint classifications and resolution records. More accessible complaint channels can raise recorded rates. Distinguish service errors, coverage disputes and affordability concerns before assigning responsibility.

10 Automation benefits passed through to the hospital

Source-reported Essential rating 58%. Verify benefits received through fee reductions, credits, lower unit prices or demonstrably usable additional service capacity. Report financial amounts and capacity units separately after associated review and maintenance costs.

Supporting records. Finance, the CIO and the RCM leader should connect contract pricing, invoices, credits, comparable volumes, service performance and human-review costs. Task-time reductions do not automatically create cash savings; capacity is useful only when its availability and use are demonstrated.

11 Estimated cost of changing the operating arrangement

Source-reported Essential rating 57%. Estimate the prospective expense and implementation time for changing vendors or bringing work in-house. Include exit charges, data migration, transition staffing, knowledge transfer and temporary parallel operations.

Supporting records. Procurement, finance, IT and RCM should document contract terms, transition scope, staffing assumptions, data-export tests and migration estimates. Show ranges and dependencies. A temporary collection delay creates liquidity exposure that should be distinguished from expense and permanent revenue loss.

12 Turnover among staff assigned to the hospital account

Source-reported Essential rating 23%. Divide people leaving the assigned account team during the period by average assigned headcount. Distinguish departures, internal reassignments, key-role changes and contractor changes; report vacancy duration separately.

Supporting records. The RCM leader should review team rosters, assignment histories, staffing changes, training and coverage plans. Leaving an account differs from leaving an employer. Scope or team-size changes affect the ratio, and turnover alone does not establish poor service.

The complete cost measure and retained-work measures lead directly to the next review: whether the budget captures what the hospital must spend to obtain the promised service.

Sources: S0, measurement definitions; S1, pp 2-3. Methodology and interpretation appear on page 5.

SUBJECT 2

Outsourcing costs

The outsourcing cost review extends the common priorities for net financial benefit (97%), full cost to collect (95%) and rework (73%). These source-reported ratings support a complete cost comparison; they do not establish how often budgets omit costs or how large any overrun has been. [S2, p 2]

The eight categories below follow the supplied cost framework. Their order is a practical review sequence. A board should ask finance to connect each applicable category to the original estimate, actual expense and any approved change in scope.

Eight expenses to reconcile

Expense category	Evidence to request	Budget treatment to verify
Transition and onboarding	Setup invoices, implementation plan and mobilization records	Compare with the approved launch estimate.
Temporary parallel operations	Dates and costs of duplicate hospital and vendor activity	Identify the overlap period and its planned end.
Retained hospital oversight	Staff assignments, validation effort and escalation time	Include the hospital capacity still required.
Interfaces and integration maintenance	Connection inventory, support charges and maintenance work	Separate initial work from continuing expense.
Additional services and change orders	Signed changes, pricing and the work performed	Separate authorized expansion from unexpected charges.
Technology or data-access pass-through charges	License terms, invoices and actual use	Check the base fee for already included items.
Correction or repeat processing	Returned work, correction time and cause records	Identify hospital and provider resources consumed.
Prior-provider exit charges	Contract terms, settlement records and exit invoices	Include charges in the relevant transition comparison.

The source also identifies data migration and remediation, staff training, temporary replacement capacity and financing costs associated with documented collection delays. Their accounting treatment and inclusion in another category should be explicit. The collection delay itself is a timing exposure; it is not automatically an operating expense or a permanent loss. [S2, p 3]

Source: S2, pp 2-4. Evidence requests and budget checks operationalize the supplied categories; no category incidence, ranking or dollar estimate is reported.

SUBJECT 2 CONTINUED

Comparing the full financial result

Retain the estimate approved before implementation or a material renewal. Compare actual expense over the same elapsed period, facilities, functions and account population. A larger invoice may reflect approved scope growth; a smaller invoice may coexist with additional hospital labor. Both require an explanation before the board interprets the financial result.

Recommended cost classification

Classification	How it should appear in the review
Budgeted expense within estimate	Show the approved amount, actual amount and the remaining commitment for the same period.
Expense above estimate	Show the difference, cause, accountable owner and any change to the forecast.
Expense incurred without an estimate	Identify the missing allocation and why the cost was not in the approved case.
Authorized scope expansion	Present the additional services and approval separately from baseline variance.
Temporary collection delay	Show the timing and liquidity exposure separately from expense and permanent revenue loss.

Build one cost view across the organization

CFO responsibility. Reconcile vendor spending and retained hospital resources to the general ledger and staffing allocations. Record one-time transition costs, continuing operating costs and prospective exit estimates separately. Identify any financing expense without counting delayed collections as an additional expense.

CIO responsibility. Confirm the interfaces, software, data access, security and support work required to operate the contracted service. Identify which charges are included in the provider fee and which remain with the hospital.

RCM responsibility. Document the work still performed by hospital teams, including oversight, returned accounts, exceptions and corrections. Compare workload and cost using the same service scope and transaction period.

Questions for the board

1. Does the financial case remain favorable after all relevant hospital costs are included?
2. Which differences arise from performance, timing, incomplete estimates or an authorized change in services?
3. What evidence supports the proposed renewal price and the cost of the alternatives?

This reconciled cost view becomes the financial baseline for evaluating a different provider structure in the consolidation chapter.

Source: S2, pp 2-4, and S0, full cost to collect and net financial benefit definitions. The classifications and role assignments are recommended applications, not survey estimates.

SUBJECT 3

Provider consolidation

The common survey priorities for cash timing (**96%**), full cost to collect (**95%**) and the cost of changing the arrangement (**57%**) frame the consolidation decision. The supplied material does not report consolidation adoption rates or completed-transaction outcomes. [S3, p 2]

A proposal should identify the functions that will move and the benefit the hospital expects from that change. The ten considerations below turn a provider-count decision into a review of service coverage, cash, accountability and future flexibility.

Ten considerations before changing the provider structure

Consideration	Evidence required for the proposed change
Function coverage	Map contracted services, retained hospital work and unresolved service gaps.
Comparable performance	Compare like functions, account populations, definitions and periods.
Cash protection during transition	Document billing continuity, backlog ownership, cash monitoring and escalation.
One-time transition cost	Include migration, cutover and temporary duplicate operations.
Continuing cost after consolidation	Include provider fees, technology and retained hospital resources.
Specialist expertise	Identify who will perform complex and specialized work and how coverage will continue.
Accountability across handoffs	Assign ownership for transfers, exceptions and unresolved accounts.
Disruption at a single provider	Examine recovery arrangements and alternative operating capacity.
Usable data transfer	Test exports and preservation of account histories and work status.
Ability to change providers later	Specify exit assistance, expense, transition requirements and time.

The source also calls for attention to the proposed provider’s financial stability and the expertise the hospital must retain internally. Define those requirements before selecting the number of suppliers. [S3, p 3]

Source: S3, pp 2-4. These considerations are a decision framework, not a respondent-ranked list. Evidence requests consolidate the source guidance.

SUBJECT 3 CONTINUED

A decision case for consolidation

A consolidation case should state why the proposed arrangement is expected to improve cost, cash timing or service. That explanation should be specific enough to compare with continued use of the existing providers and with other feasible operating models.

Recommended proposal structure

Proposal component	What management should supply
Present operating model	Function map, provider responsibilities, retained staff and existing handoffs.
Proposed operating model	Functions moving, accountable provider, retained capability and unresolved dependencies.
Financial comparison	Common baseline, one-time transition costs, continuing costs and benefit attribution.
Transition readiness	Data-transfer evidence, migration plan, staffing coverage, backlog treatment and cash monitoring.
Continuity and future change	Recovery arrangements, alternative capacity, exit assistance and estimated time to transfer.
Post-implementation review	Review dates, actual costs, service results, unresolved issues and corrective-action owners.

Separate a proposal from a completed change

An organization considering consolidation does not supply evidence of a completed consolidation’s outcome. For an implemented change, record the time since cutover, transition costs still being absorbed and the documented financial result. Equivalent service scope and account populations are necessary for comparison. [S3, p 4]

CFO focus. Verify the full cost and cash assumptions. **CIO focus.** Demonstrate usable data transfer, access continuity and the technical dependencies of the proposed model. **RCM focus.** Establish who owns each account and specialist task during handoffs. **Board focus.** Require a clear rationale for the concentration of responsibilities and a practical response if service is disrupted.

Conditions for the board decision

The board can request conditions tied to evidence: reconcile a material cost assumption, demonstrate an export, assign an unresolved handoff, or complete a transition staffing plan before authorization. These are recommended review actions. The source package supplies no numerical pass score or universal threshold for approving consolidation.

The next chapter defines the reporting record that makes these cost and performance claims reviewable throughout the agreement.

Sources: S3, pp 2-4; S0, estimated change cost and operational continuity definitions. Proposal structure, ownership and authorization conditions are recommended applications.

SUBJECT 4

Reporting accountability

The source-reported priorities for net financial benefit (**97%**), full cost to collect (**95%**) and underpayment cash actually recovered (**85%**) place reconciliation at the center of the review. These are importance ratings. They do not show how many hospitals receive complete, incomplete or unverifiable evidence. [S4, p 2]

For each material claim, the hospital should be able to identify the record behind it, the comparison being made and the person responsible for resolving differences. The seven fields below provide a common structure for CFO, CIO and RCM submissions.

Seven fields for a reviewable evidence record

Field	Required content
Scope and owner	Contracted functions, covered facilities, accountable hospital owner and work or accounts outside scope.
Definition	Formula, numerator, denominator, exclusions and materiality threshold, preserved across periods.
Period and comparison	Reporting dates, prior result, target, baseline and adjustments for volume, payer mix or scope.
Source and reconciliation	Hospital source record, vendor report, reconciliation date and quantified unresolved differences.
Financial effect	Cash received, cost incurred or estimated exposure, with checks for duplicate benefit claims.
Exceptions	Missing information, unresolved cases, external dependencies and the effect on interpretation.
Action and follow-up	Corrective action, owner, due date, next review and evidence of closure.

Recommended reporting practice

Use the same record for a material measure at renewal and during subsequent performance reviews. Keep definitions and allocations stable, and explain changes before interpreting movements in results. A change in aging rules, account population or cost allocation can change the reported value without changing the underlying work. [S4, pp 2-3]

The board packet can summarize the measure and its evidence status, while the supporting record retains reconciliation details and exceptions. The accountable hospital executive should be identified even when the provider prepares the operational report.

Source: S4, pp 2-3, and S0, A practical evidence packet for board review. Reporting cadence and executive sign-off are recommended governance applications.

SUBJECT 4 CONTINUED

Classifying evidence and measuring gaps

Four substantive evidence categories

Evidence status	Meaning for the review	Recommended response
Fully provided and verifiable	The required information is available and can be checked against defined source records.	Record the reconciliation and remaining immaterial differences.
Partially provided	Some required information is missing or incomplete.	Identify the missing fields, owner and completion date.
Provided but not independently verifiable	Information is supplied but the hospital cannot substantiate it from the necessary records.	Request source access or a defined validation procedure.
Not provided	The required information is absent.	Record the decision impact and an escalation or delivery date.

Keep outside-scope and unable-to-assess responses separate. They do not automatically establish an evidence failure. Importance and availability are different questions, so a high Essential rating cannot be interpreted as a high rate of missing information. [S4, pp 3-4]

A defensible evidence gap calculation

To measure the gap among Essential raters, use matched answers from the same people and the same measure. The denominator is respondents who rate the information Essential and provide a substantive evidence-availability answer from a completed formal review. The numerator is those within that denominator reporting partial, unverifiable or absent information. State the valid base and exclusions.

The supplied package contains no such matched results. It therefore supports the calculation method, but not a numerical gap rate. Subtracting an evidence-availability percentage from an importance percentage based on different respondents would not produce a valid estimate. [S4, p 4]

Recommended executive accountability

The CFO should resolve cash and expense reconciliation; the CIO should establish access, interfaces and traceability of source data; and the RCM leader should validate workqueue, denial, complaint and exception records. Management should state how any unresolved evidence issue affects the decision and when the board will receive a resolution.

For rural organizations, this same reporting structure should be applied to the local service scope and retained capacity. The next chapter addresses those contracting decisions.

Source: S4, pp 2-4. Evidence categories and the matched-base method come from the source. Executive ownership and suggested responses are recommendations.

SUBJECT 5

Rural contracting

Rural contracting applies the common renewal priorities to the hospital’s service scope, cash continuity and local operating knowledge. The cited ratings for cash timing (96%), full cost (95%) and the estimated cost of changing the arrangement (57%) describe the broader cohort. They are not rural-specific estimates. [S5, p 2]

The six decisions below guide review of the proposed agreement and the hospital’s options if circumstances change. Each decision should have a hospital owner, a defined evidence request and a follow-up action.

Six decisions for a rural hospital board

Decision	Evidence and practical review
Choose the service scope	Compare full-service and selective outsourcing against actual functions. Assign responsibility at every handoff, including retained work.
Protect cash during transition	Require a collection-continuity plan, treatment of existing accounts and an escalation process for delayed work.
Preserve local operating knowledge	Identify required staff, payer knowledge, workflow expertise, coverage and knowledge transfer before changing roles.
Examine comparable rural experience	Review references with relevant service volume, scope and reimbursement circumstances, using comparable definitions.
Secure verifiable information	Establish access to cash postings, aging and exception logs, with an executive accountable for reconciliation.
Maintain a workable provider-change option	Assess data and knowledge transfer, exit charges, parallel operations, transition staffing and elapsed time.

Pricing at the hospital’s service volume and access to specialist support also belong in the review. They should be assessed against the contracted functions and retained hospital responsibilities. [S5, p 3]

Interpretation of the rural application

The reported organization profile includes 41 small standalone general acute-care hospitals, including critical access hospitals. That category cannot be treated as a verified rural subgroup. Rural-specific statistical conclusions require verified rural status and a clearly defined valid respondent base, neither of which is provided for this module. [S5, p 4]

Source: S5, pp 2-4. The six decisions are a practical framework and are not a measured ranking of rural respondent selections.

SUBJECT 5 CONTINUED

Matching the contract to local capacity

The board should be able to see which responsibilities transfer to the provider and which remain inside the hospital. A proposed service package should be evaluated against actual staffing, volumes, account characteristics and specialist needs. The purpose of the review is to make those operating requirements explicit before approval.

Recommended rural contracting evidence packet

Review area	Management should document
Local responsibilities	Named owners for payer relationships, missing information, complex exceptions, patient billing and provider oversight.
Reference comparability	Relevant service volume, functional scope, reimbursement circumstances, implementation conditions and measurement definitions.
Transition operations	Existing-account inventory, work allocation, collection monitoring, knowledge-transfer plan and escalation contacts.
Pricing and retained cost	Fee assumptions at the hospital’s expected volume, required local staffing, technology and specialist support.
Performance access	Hospital access to cash, aging, exception and complaint records with a defined reconciliation process.
Future change	Usable data export, transition assistance, expected staffing, expense, timetable and temporary duplicate operations.

Recommended discussion at the board table

Ask management to explain how service will continue if an account remains unresolved, a key local employee leaves or work needs to move to another provider. These are scenario questions for local planning. The supplied rural brief does not establish how often any of these events occurs.

The CFO should distinguish a temporary cash delay from expense and permanent loss. The CIO should establish usable access to records and the technical work needed for transfer. The RCM leader should preserve the operating knowledge and specialist coverage required for the contracted scope. The board should evaluate the arrangement and its alternatives on that common basis.

A workable future-change option requires both a financial estimate and an operational plan. An exit clause alone does not describe how accounts, people, data and ongoing collections will move. This is a practical inference from the transition requirements in the source framework.

Automation may form part of the service arrangement. The next review examines the complete budget for the administrative workflow, including the hospital work needed after deployment.

Source: S5, pp 2-4, supplemented by S0, change-of-arrangement cost definition. Evidence packet, scenario questions and role assignments are recommended applications.

SUBJECT 6

Automation costs

The automation cost review connects the source-reported priorities for net benefit (97%), complete cost (95%) and automation benefits received by the hospital (58%) to the 2027 budget. These ratings do not measure automation spending, savings, overruns or return on investment. [S6, p 2]

The supplied brief groups thirteen questionnaire expense candidates into ten budget categories. The underlying thirteen-item schedule is not reproduced in the package, so this report retains the ten presented groups and their stated components.

Ten categories for the automation budget

Budget category	What the review should capture
Licensing and usage	Software or model fees, consumption charges, billing units and transaction-volume effects.
Cloud hosting and storage	Hosting and retention expense, identifying what is included in another fee.
Hospital-system integration	Initial connections and the continuing work needed to maintain them.
Data preparation	Cleaning, mapping and remediation required for the specified workflow.
Validation before use	Testing, review and approval work before production activity begins.
Human review of outputs	Checking, exception handling and resolution of uncertain cases.
Security and access controls	Workflow-specific access administration, review and control maintenance.
Implementation support and training	External implementation or advisory assistance and participating staff training.
Monitoring maintenance and updates	Performance monitoring, application maintenance and testing changes, tracked separately within the group.
Replacement or migration	Data movement, application replacement and transition of the workflow.

Record one-time and continuing costs, who pays them and where they appear in the hospital or provider budget. Check hosting, integration and monitoring charges against the base fee before adding category totals. [S6, p 3]

Source: S6, pp 2-4. Categories are a budget review framework, not a ranking by reported frequency or dollar amount. Scope is administrative RCM automation.

SUBJECT 6 CONTINUED

Connecting automation expense to benefit

An automation budget should describe the same workflow and period as the benefit claim. A calculation that counts time saved in one task while omitting new review, correction and maintenance work gives an incomplete account of what the hospital receives.

Recommended benefit classification

Benefit claim	Evidence needed	How to present it
Lower fees or service prices	Contract provisions, invoices, credits and comparable service volumes	Recognized financial benefit after related hospital costs.
Additional cash realization	Account-level receipts, attribution and a documented comparison	Cash received, distinguished from identified or appealed amounts.
Reduced operating expense	Expense records, staffing or purchased-service changes and baseline	Expense reduction with timing and implementation costs.
Additional usable capacity	Measured available time, staffing use and maintained service quality	Capacity units and actual deployment; separate from cash savings.

Questions that the expense inventory cannot answer alone

The source expense question examines whether a cost occurred and whether it had an original budget allocation. Average spending, percentage overruns and realized return on investment require financial amounts and a documented comparison. The supplied attachments contain no results for those additional financial measures. [S6, p 4]

For each category, management should retain the original allocation, actual expense, forecast, service scope and any approved change. Human review and ongoing monitoring should remain visible even when they are delivered by existing staff. Check for costs already included in provider charges before aggregating them.

Recommended joint review by finance IT and RCM

The CFO should reconcile realized financial benefits and expense; the CIO should identify deployment, integration, data, access and maintenance requirements; and the RCM leader should confirm review intensity, exception handling, throughput and service quality. The board should receive both the financial result and the operating evidence that explains it.

The next chapter tests whether the remaining staff work is consistent with the automation benefit claim. It follows the same workflow and period rather than assuming that fewer manual steps necessarily reduce total administrative effort.

Sources: S6, pp 2-4; S0 and S1, automation benefits passed through to the hospital. Benefit classification and executive responsibilities are recommended applications.

SUBJECT 7

Administrative workload

The common renewal ratings for rework (73%), complex-exception resolution (71%) and patient billing complaints (70%) support a review of the work remaining after automation. They are not rates of workload increase, administrative burden or complaints caused by automation. [S7, p 2]

A reduction in manual entry can coexist with new checking, correction or supervision tasks. The eight measures below examine a defined workflow and staff group without assuming the direction of change. They are selected from a twelve-activity bank described in the source. [S7, p 3]

Eight measures of remaining administrative work

Measure	What to record	Supporting evidence
Duplicate entry	Repeat touches and time spent entering the same information	Task histories and observed processing time.
Review of automated outputs	Share reviewed and staff time used for checking or approval	Review queues, timestamps and review policy.
Correction of exceptions	Exception volume, correction time and cause	Exception logs and case-level correction records.
Response to automated alerts	Alert volume, review time and share requiring action	Alert logs and action or closure records.
Conflicting-output reconciliation	Effort to resolve disagreement with another system or record	Reconciliation cases and recorded staff effort.
Manual handoffs	Frequency and labor involved in transfers between teams	Workqueue histories and handoff records.
After-hours corrections	Correction work outside scheduled hours for the defined workflow	Work timestamps and documented staff time.
Workflow supervision	Oversight effort, ownership and required staff capacity	Assigned responsibilities and supervision records.

Also examine reopened accounts, downtime work, rule or prompt maintenance and retraining. Record whether each activity increased, decreased, stayed the same or could not be assessed. [S7, p 3]

Source: S7, pp 2-4. The eight measures form a framework, not a ranking of observed increases. Suggested supporting records translate the source measures into local data requests.

SUBJECT 7 CONTINUED

Evaluating workload change

A workload review should preserve the same workflow, staff group and comparable transaction volume before and after deployment. Record changes in case complexity, staffing and other operating conditions. A before-and-after difference alone does not establish that automation caused the change. [S7, p 4]

Recommended measurement protocol

Step	Required treatment
Define the population	Name the workflow, participating staff, facilities, functions and covered transactions.
Fix the comparison periods	Identify baseline and post-deployment windows and changes in service scope.
Record work and activity volume	Capture task counts, recorded time, exceptions and account or claim volume.
Preserve comparability	Explain changes in volume, case complexity, staffing, payer requirements or other initiatives.
Assess the whole workflow	Combine activity-level observations without double-counting the same staff time.
State the evidence basis	Separate measured records and observed time from staff or management assessments.
Connect to the budget	Translate documented resource changes into expense or capacity only when supported.

Use both activity and total workload measures

For local analysis, management can express staff minutes per comparable transaction alongside total hours for the defined group. This is a recommended normalization approach, not a result in the supplied survey. It helps distinguish an increase in work volume from an increase in effort for comparable work, while retaining the total staffing requirement.

The workload framework applies to respondents overseeing RCM workflows after at least three months of operational AI use. The accompanying brief provides eligibility criteria but no separate workload sample count or measured workload results. [S7, p 4]

What the board should ask management to explain

If one task decreases, identify whether effort moved to review, exceptions, handoffs or supervision. If total measured effort falls, explain whether the hospital realized an expense reduction, used the capacity elsewhere or retained unused capacity. Keep service quality, unresolved accounts and patient billing experience visible when interpreting the change.

Source: S7, pp 2-4, and S0, rework and automation benefit definitions. No measured workload change, nursing-workload finding, clinical outcome or labor-saving estimate is supplied.

BOARD IMPLEMENTATION

Executive accountability for board review

The seven subjects can be managed through one evidence packet. The recommended division of responsibility below keeps financial reconciliation, technical feasibility and operating performance connected while preserving a clear hospital owner for each decision.

Recommended responsibility matrix

Role	Primary responsibility	Evidence delivered to the board
Board or relevant committee	Set the decision standard, evaluate material exceptions and document authorization and follow-up.	Decision rationale, conditions, unresolved exposure and next review date.
CFO or finance executive	Own the complete cost and benefit comparison, cash reconciliation and financial assumptions.	Baseline, benefit ledger, vendor and retained costs, actual-to-budget comparison and liquidity assessment.
CIO or IT executive	Own the technical operating requirements, data access, integration, controls and transfer feasibility.	System dependencies, continuing IT cost, access and export evidence, support and continuity requirements.
RCM executive or leader	Own process scope, work ownership, service definitions and operating validation.	Denials, recoveries, aging, exceptions, rework, complaints, workload and transition readiness.
Procurement and contract support	Confirm service scope, pricing, obligations, change orders and practical exit assistance.	Contract inventory, fee provisions, approved changes, renewal timing and transition commitments.
Internal audit or independent validation function	Provide a defined review of selected material claims when requested.	Reconciliation findings, unresolved discrepancies and closure evidence.

Recommended decision record

For each material renewal, consolidation or automation investment, record the chosen option, the evidence relied on, alternatives considered, unresolved issues, conditions attached to authorization and the executive accountable for follow-through. Agree on the next review date and the evidence required to close each condition.

The source materials do not provide a universal pass score. Combining unlike measures into one unqualified total can obscure a material cost, reporting or service issue. Interpret the evidence against the hospital’s scope, baseline, contract terms and operating circumstances. [S0, Report application]

Governance recommendations synthesized from S0-S7. Role assignments are proposed responsibilities for local adoption; they are not findings about surveyed organizations or assertions about legal duties.

BOARD IMPLEMENTATION CONTINUED

A practical 90 day review sequence

The following schedule is a suggested management sequence for a material 2027 budget or renewal decision. Adjust it to the contract notice period, available records and the scale of the change. It is not a measured survey practice or a required timetable.

Period	Management work	Output for the review
Days 1-30	Define the agreement and baseline. Inventory provider and retained costs. Confirm source access, account populations and evidence owners.	Common scope and definitions, cost inventory, initial evidence status and issue list.
Days 31-60	Reconcile cash and expense. Test data access or transfer. Review exceptions, retained work and alternatives. Validate transition assumptions.	Reconciled benefit and cost case, service evidence, options comparison and corrective-action plan.
Days 61-90	Resolve material differences, finalize the proposal and record decision conditions. Agree on post-decision review and closure evidence.	Board packet, executive recommendation, decision record, named owners and follow-up dates.

Options the board may need to compare

Option	Evidence that should distinguish it
Renew	Verified ongoing benefit, acceptable service evidence and a documented basis for continuation.
Renew with revised terms	Defined pricing, scope, reporting or operating changes tied to specific issues.
Consolidate providers	A credible service and financial case with workable transition, continuity and exit arrangements.
Change provider or bring work in-house	A feasible alternative operating model, itemized transition cost, retained capability and cash-continuity plan.
Defer pending defined evidence	The missing information, effect of delay, responsible owner and time-bound decision path.

Management should compare feasible options using the same scope and time horizon. A choice can be conditional on a defined action, such as reconciling a cost, validating an export or completing a staffing plan. The board should record why the selected evidence is sufficient for the particular decision.

Suggested schedule and option framework derived from the evidence, transition and financial review principles in S0-S7. These are governance recommendations, not survey outcomes.

BOARD IMPLEMENTATION CONTINUED

Board review checklist

Use this checklist to organize the submission for a material RCM renewal, consolidation or automation proposal. Record the result, evidence location and unresolved action for each applicable item; assign an executive and due date when further work is required.

Review item	Evidence to locate	Suggested lead
Scope and baseline are defined	Functions, facilities, accounts, period and documented comparison.	CFO and RCM
Net benefit is reconciled	Incremental cash, expense changes, relevant costs and attribution.	CFO
Complete costs are included	Provider fees, retained work, technology, transition and authorized changes.	CFO and CIO
Cash timing includes unpaid work	Receipt timing, final settlement and unresolved account aging.	RCM
Revenue recovery is substantiated	Preventable denial losses and underpayment cash actually posted.	CFO and RCM
Service and patient effects are visible	Rework, complex exceptions, complaint rates and closure evidence.	RCM
Material claims are verifiable	Hospital source records, reconciliations and evidence-status classification.	CFO and CIO
Provider structure and local fit are tested	Function coverage, specialist needs, retained knowledge and comparable references.	RCM
Transition and future change are workable	Data access or transfer, staffing, exit expense and cash continuity.	CIO and RCM
Automation has a complete budget	Ten applicable cost groups, financial benefit and continuing human work.	CFO and CIO
Workload claims use comparable evidence	Defined staff group, task and total effort, volume and case complexity.	RCM
Decision conditions are assigned	Chosen option, unresolved issues, executive owners and next review.	Board and executives

Recommended closing questions

Can management trace the financial case to hospital records? Are remaining differences material to this decision? Does the proposed model have the people, data and transition capacity required to work? What evidence will the board receive next to confirm that the decision is delivering the expected result?

Checklist synthesized from S0-S7. It is intended for local use and does not supply thresholds, grades or conclusions about any particular hospital or vendor.

REFERENCE MEASURES

Six additional board measures

Six further measures extend the twelve rated priorities to an eighteen-measure framework. The source report provides no Essential percentages for these six. Their absence from the twelve rated rows does not establish that they are unimportant or fall below a known threshold. [S0, Additional measures]

Achievement of contractual service levels

Track the share of agreed targets met during the period and the severity and recurrence of breaches. Retain target definitions and underlying records. An average service score can hide a material failure in a particular function.

Cash forecast accuracy

Compare a forecast fixed before the reporting period with actual cash receipts for the same scope and period. Show directional bias and absolute error, and explain changes in volume, payer mix or service scope.

Audit and repayment exposure

Distinguish confirmed amounts, open claims and estimates relating to substantiated audit findings or repayment obligations attributable to contracted work. Establish the cause before assigning responsibility to a provider.

Unplanned charges and out of scope fees

Record additional charges beyond the agreed baseline in dollars and as a share of total service spending. Identify authorized service expansion separately from avoidable or unexplained surprises.

Operational continuity

Measure the duration of interruptions to critical contracted workflows and retain recovery evidence. A period without an interruption does not, by itself, establish that recovery arrangements have been tested.

Accuracy and reconcilability of financial reporting

Track the share of reported financial values reconciled to hospital source records without an unresolved discrepancy. Define materiality and the review period before measuring the result.

Source: S0, additional measures and measurement definitions. Select measures according to the agreement scope and the decision under review.

SOURCE REGISTER

Sources

The source keys below identify the Black Book Research documents supporting the report. Page references in citations refer to the individual subject briefs. The research basis and interpretation are described on page 5.

Key	Black Book source	Support
S0	2027 Hospital Revenue Cycle Accountability Survey Series Research report	Study description, organization profile, measurement definitions and additional measures.
S1	12 Numbers Hospital Boards Should Review Before Renewing an RCM Outsourcing Contract Subject brief 01	pp 2-3: twelve ratings and definitions. p 4: population and interpretation.
S2	8 RCM Outsourcing Costs Hospital Budgets Can Miss Subject brief 02	pp 2-4: shared priorities, expense categories and cost comparison.
S3	10 Priorities for Consolidating RCM Service Providers Subject brief 03	pp 2-4: shared priorities, provider structure and decision considerations.
S4	RCM Reporting Accountability Subject brief 04	pp 2-4: supporting records, evidence status and measurement of information gaps.
S5	6 RCM Contracting Decisions for Rural Hospitals Subject brief 05	pp 2-4: local operating requirements, six contracting decisions and subgroup limits.
S6	10 RCM Automation Costs for the 2027 Budget Subject brief 06	pp 2-4: cost groups, budget treatment and benefit distinctions.
S7	8 Measures of Administrative Workload After Automation Subject brief 07	pp 2-4: activity measures, eligibility and interpretation.

The seven subject briefs share the reported cohort and renewal priorities. Their cost categories, operating measures and governance guidance are identified separately from the twelve percentages.

Black Book Research
research@blackbookmarketresearch.com | 800-863-7590
blackbookmarketresearch.com