The Ultimate Guide to RCM Metrics: Measuring Success and Identifying Areas for Improvement

Healthcare organizations aiming to optimize their financial performance prioritize efficient Revenue Cycle Management (RCM). Recognizing its pivotal role in ensuring financial stability, 40% of healthcare providers channel investments toward Backend RCM automation, according to a report from HFMA and Eliciting Insights.

Central to the success of RCM automation is the meticulous measurement of Key Performance Indicators (KPIs). These metrics provide invaluable insights into various components of the revenue cycle, enabling organizations to identify strengths, capitalize on advantages, and enhance their financial well-being.

This Ultimate Guide to RCM Metrics serves as a roadmap for healthcare organizations seeking to enhance financial performance, optimize operational efficiency, and ensure sustained success in an ever-evolving healthcare ecosystem. Through an integrated approach to RCM measurement and analysis, organizations can unlock untapped potential, foster innovation, and deliver superior patient care while achieving financial excellence.

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Introduction

A streamlined process that includes multiple steps, such as patient registration, appointment scheduling, claim submission, and reimbursement, is essential for effective RCM in the healthcare industry. Each of these phases offers chances to maximize revenue and avoid dangers that could impair financial performance.

KPIs help organizations measure their performance, spot bottlenecks, and make targeted improvements by serving as benchmarks for assessing the efficacy and efficiency of each step.

Although revenue cycle management can be laborious and time-consuming, minor issues can result in significant losses—up to hundreds of thousands of dollars annually—if improper supervision is not provided. At Jindal Healthcare, we are here to help you understand the crucial metrics and provide helpful tips for how to use RCMs to pinpoint areas that still need work.

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Key RCM Success Factors

Several critical areas are positively affected by an efficient RCM program:

a) **Enhance Revenue Capture:** Streamline procedures to perfect revenue capture. Monitoring revenue KPIs can shorten reimbursement cycles and decrease denials.

b) **Improve Operational Efficiency:** Organizations can find inefficiencies and bottlenecks in their revenue cycle processes. Tracking KPIs makes it possible to make focused interventions to raise operational effectiveness.

c) **Enhance Patient Experience:** The patient experience can be improved by examining specific KPIs, such as billing transparency metrics and patient satisfaction scores. This will enable businesses to improve patient loyalty and satisfaction.

d) **Mitigate Financial Risks:** Organizations can proactively find and address potential financial risks before they escalate by keeping an eye on KPIs that measure claim denials, days sales outstanding (DSO), and other financial indicators.

e) **Optimize Resource Allocation:** By highlighting areas of underperformance or overperformance, KPIs can help healthcare organizations make well-informed decisions and distribute resources accordingly.

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Core RCM Metrics

While several KPIs can offer insightful information about different sides of the revenue cycle, some metrics are especially important for evaluating and enhancing RCM performance. Here are some crucial KPIs that healthcare institutions ought to check.

a) **Days in Accounts Receivable:** How long does it typically take a healthcare facility to get paid for the services given? A high DSO can have a detrimental effect on cash flow since it shows inefficiencies in the revenue cycle process.

b) **Claim Denial Rate:** The percentage of claims that payers reject. By watching this KPI, organizations can reduce denials and increase reimbursement rates by showing common denial causes and putting corrective measures in place.

c) **Revenue Cycle Length:** This metric tracks the average time it takes for a healthcare organization to complete the entire revenue cycle, from patient registration to final payment collection. A shorter revenue cycle length shows greater efficiency and faster revenue realization.

d) **Percentage of Net Collection:** The percentage of total billed charges collected after deducting contractual adjustments and writeoffs. A high percentage of the net collection indicates effective revenue capture and

e) **First-Pass Claim Rate:** Measures the percentage of claims accepted by payers upon first submission, without requiring rework or resubmission. A high first-pass claim rate indicates efficient billing processes and reduces the risk of delayed or denied payments.

f) **Accounts Receivable Aging:** Based on the length of time accounts receivable have been outstanding, this metric typically divides them into buckets such as 0-30 days, 31-60 days, 61-90 days, and over 90 days. Monitoring AR Aging helps identify overdue accounts and prioritize collection efforts.

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How These Metrics Reflect a Practice's Health

Precise financial reporting offers vital information about the financial stability of medical practices. They provide a thorough understanding of the revenue cycle, which facilitates performance evaluation, pinpoints areas for development, and guides decision-making that can grow the company. Typical contents of these reports include:

a) **Collection rate:** A comparison between the total amount billed and the amount of money collected. This indicator shows how well the practice converts billed services into actual income.

b) **Denial Rate:** This shows the number of claims that insurance payers rejected in a given period. A high denial rate could be a sign of a problem with the insurance verification process, coding errors, or documentation.

c) **Clean Claims Rate:** The percentage of claims that are neither denied nor rejected. A high clean claims rate indicates that the practice has a precise and efficient billing system.

d) **Charge lag days:** How long it takes for charges to be made and recorded in the system, following the provision of services. Charges should be made that same day or the following day. This metric indicates the charge capture workflow's health and areas needing improvement.

e) **Days in receivables outstanding:** This metric illustrates the amount of time outstanding funds are held in accounts receivable before ultimate collection. A practice search for efficiencies if the number is high. A low number denotes a wellmanaged billing and collections process

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Utilizing RCM Metrics
for Improvement

What is the most effective way to assess a practice's performance if it has recently made efforts to optimize the revenue cycle? Creating a dashboard with essential performance metrics can help identify what is and is not working in the revenue cycle and provide guidance on how to address common issues. Take these key performance indicators into consideration when creating a revenue cycle dashboard:

a) **Days in receivables outstanding:** This is the best measure of practice billing performance (DRO). A DRO of between 30 and 40 days is ideal, the lower the number, the better, as it suggests that revenue cycle operations are functioning well. When a DRO continuously exceeds 60 days, it should raise concerns.

   When it comes to collecting unpaid balances, 60 is the new 90 — and the longer bills are unpaid, the less likely it is that they will be paid.

   Enhance outcomes by being meticulous with time-of-service collection and aiming for accuracy at every stage of the revenue cycle. It is crucial to remember that the DRO can increase due to uncontrollable circumstances like handling difficult payers or having many patients on payment plans. However, this does not imply that the revenue cycle management is flawed.

b) **Receivables outstanding over 120 days:** The aged trial balance report is another excellent way to evaluate successful revenue cycle management in healthcare. While it is possible to measure success using any aging categories, focus on the receivables over 120 days. Aim to have less than 10% of receivables over 120 days. If you hit the 20% mark, take a serious look at the collection process.

Like other DRO measurements, factors outside of a practice's control can have an impact on the numbers. The best way to reduce receivables outstanding over 120 days is to collect payment at the time of service and be diligent about following up on unpaid balances.

c) **Net collections rate:** Also known as the adjusted collection rate, this percentage shows net collections compared to the number allowed by insurance companies. It also reveals how much revenue the practice is losing to overwhelming debt or poor billing practices.

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Implementing a Successful RCM Measurement Strategy

To effectively measure KPIs for a successful RCM, healthcare organizations should follow these best practices:

a) Define Clear Objectives: Clearly define the objectives and goals of RCM performance, ensuring alignment with the organization's overall financial and operational objectives.

b) Select Relevant KPIs: Select KPIs that are relevant to the organization's specific needs and priorities, considering factors such as specialty, payer mix, and revenue cycle workflows.

c) Establish Baselines and Targets: Establish baseline performance metrics for selected KPIs and set realistic targets for improvement based on industry benchmarks and organizational goals.

d) Implement Robust Data Collection and Analysis Processes: Implement robust data collection processes to ensure the accurate and timely capture of relevant performance metrics. Leverage healthcare analytics tools and reporting systems to analyze data and generate actionable insights.

e) Monitor Performance Continuously: Monitor the KPIs' performance regularly to track progress, identify trends, and detect anomalies that may require corrective action. Regularly review them with key stakeholders to drive accountability and foster a culture of continuous improvement.

f) Iterate and Adapt: Continuously iterate and adapt RCM processes and strategies based on insights gleaned from KPI measurement efforts. Use data-driven learning to identify opportunities for optimization and implement targeted interventions to drive improvement.

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Case Studies

Medical Clinic, a mid-sized family practice with three physicians, faced mounting challenges with its RCM processes. Manual claim submissions led to errors and denials, extending collection times, and impacting cash flow. Frustrated by a lack of transparency, both staff and physicians felt uncertain about the clinic's financial performance.

The Challenge:

• High denial rates due to manual coding errors and incomplete
  claim submissions.

• Lengthy claim processing times, which cause slow reimbursements.

• Limited visibility into key RCM metrics, hindering proactive
  improvement strategies.

• Low staff morale due to cumbersome manual processes and unclear
  financial performance

The Solution:

The Medical Clinic partnered with a healthcare revenue cycle management service provider to implement a data-driven approach. The new system offered several key features:

• **Electronic Health Record (EHR) Integration:** Eliminated manual data
  entry, reduced errors, and streamlined claim submissions.

• **Automated Coding and Scrubbing:** Ensured accurate coding based on the
  latest guidelines, which minimized claim denials due to coding errors.

• **Real-time Claim Status Tracking:** Provided instant updates on claim
  status, allowing staff to address any issues and expedite
  reimbursements proactively.

• **Comprehensive Reporting and Analytics:** The RCM service provided
  detailed reports on key metrics like clean claim rate, days in AR, and
  collection rate.

These reports offered valuable insights into the clinic's RCM performance.

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The transition to the new RCM system involved comprehensive training for staff on claim submission procedures and reporting tools. The clinic also established clear communication channels to ensure collaboration between RCM specialists and clinic staff.

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Using RCM Automation to Streamline Workflow

Reducing receivables, expediting payment, and streamlining revenue cycle management are all made possible by automation. Robotic process automation (RPA) can be used to automate any type of repetitive task, including revenue cycle steps.

RPA replicates laborious manual processes with software-script bots. Tasks like prior authorization, patient registration, eligibility verification, claims submission, denied claims, and collections—all of which do not require human decision-making—are among the error-prone jobs that RPA excels at.

RPA can help analyze a health insurance claim in 12 seconds, whereas human workers take 85 seconds — and still, RPA is more accurate, according to a study. So, if possible, automate every part of the medical claims and billing process with an all-in-one billing solution.

The positive impact of automation on RCM and practice performance cannot be understated. By eliminating manual errors, claims go through faster, cash flow improves, and the practice becomes healthier and more productive. When the practice team spends less time on paperwork, they can focus on the patient experience, which further supports revenue growth.

The fundamentals of revenue cycle management and sound monetary management will never change if patient eligibility information is confirmed, and a clean claim is created, and submitted to the appropriate payer. Nonetheless, there are numerous chances to maximize every revenue cycle stage and avoid making revenue mistakes.

Increasing staff training, automating revenue cycle management, and making investments in medical billing and payment systems that simplify the entire process can all contribute to better cash flow and financial health.

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Conclusion

Therefore, healthcare organizations can improve their operational efficiency, financial performance, and patient experience by measuring KPIs for successful Revenue Cycle Management. With KPIs, organizations can drive positive outcomes by identifying areas for improvement and implementing targeted interventions.

Healthcare organizations' can thrive in the increasingly competitive healthcare landscape and achieve sustainable RCM success by implementing robust processes for data collection, analysis, and monitoring.

Jindal Healthcare is a leading name in Revenue Cycle Management backed by the $100 Billion OP Jindal Group. With over two decades of expertise in business process outsourcing, we specialize in maximizing healthcare providers' revenues so they can reinvest in and focus on elevating patient care standards. Our approach integrates cutting-edge HealthX AI technology with human insight to drive optimization, automation, and process enhancement. From End-to-End Revenue Cycle Management to Practice Management Solutions, Prior Authorization support, Coding Management, and Analytics, we offer a comprehensive suite of services. Experience unparalleled revenue growth, cost reduction, and operational efficiency with Jindal Healthcare - your trusted partner in healthcare revenue optimization.