

HFMA MAP Keys

Revenue Cycle Excellence

The industry standard for revenue cycle performance measurement. 29 strategic KPIs across 5 key areas with real-time visibility and actionable insights.

PA Patient Access

PA-1	Percentage of Patient Schedule Occupied	4	PA-2	Pre-Registration Rate	5
PA-3	Insurance Verification Rate	6	PA-4	Service Authorization Rate — IP/OBS	7
PA-5	Service Authorization Rate — Outpatient	8	PA-6	Conversion Rate — Uninsured to Third-Party	9
PA-7	Point-of-Service (POS) Cash Collections	10			

PB Pre-Billing

PB-1	Days in Total Discharged Not Final Billed (DNFB)	11	PB-2	Days in Final Billed Not Submitted to Payer (FBNS)	12
PB-3	Days in Total Discharged Not Submitted (DNSP)	13	PB-4	Total Charge Lag Days	14

CL Claims

CL-1	Clean Claim Rate	15	CL-2	Late Charges as a Percentage of Total Charges	16
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AR Account Resolution

AR-1	Aged A/R as % of Billed A/R	17	AR-2	Aged A/R as % of Billed A/R by Payer Group	18
AR-3	Aged A/R as % of Total A/R	19	AR-4	Aged A/R as % of Total A/R by Payer Group	20
AR-5	Remittance Denial Rate	21	AR-6	Denial Write-Offs as % of Net Patient Revenue	22
AR-7	Bad Debt	23	AR-8	Charity Care	24
AR-9	Net Days in Credit Balance	25			

FM Financial Management

FM-1	Net Days in Accounts Receivable (A/R)	26	FM-2	Cash Collection as % of Net Patient Revenue	27
FM-3	Uninsured Discounts	28	FM-4	Uncompensated Care	29
FM-5	Case Mix Index	30	FM-6	Cost to Collect	31
FM-7	Cost to Collect by Functional Area	32			

Use the HFMA content to understand **what to measure**. Use the CareCloud content to understand **how to operationalize it**.

Introduction and Data Sources

The MAP Keys are strategic key performance indicators (KPIs) that set the standard for revenue cycle excellence in the health care industry. Developed by industry leaders led by HFMA, these industry-standard metrics define the essentials of revenue cycle performance in clear, consistent, and unbiased terms.

These strategic keys apply to hospitals and systems, ambulatory providers, physician organizations, post-acute care, health systems and integrated delivery systems. There are **29 MAP Keys** for revenue cycle benchmarking divided into **5 major groups**: Patient Access, Pre-Billing, Claims, Account Resolution, and Financial Management.

How CareCloud Supports HFMA MAP Keys



Real-time KPI Visibility

MAP Key metrics are continuously tracked and visualized through dashboards, eliminating manual reporting and lagging indicators.



Automated Data Collection

Required MAP Key data is pulled directly from source systems such as EHRs, billing platforms, and general ledgers, reducing manual entry and reporting errors.



Standardized Benchmarking

Organizations can compare their MAP Key performance against HFMA-defined benchmarks across facilities, service lines, and time periods.



Advanced Insights & Alerts

Analytics identify trends, outliers, and performance risks early, enabling teams to take corrective action before revenue is impacted.

Percentage of Patient Schedule Occupied

PURPOSE

Identifies opportunity to maximize utilization of scheduled availability.

VALUE

Measures available capacity.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of patient slots occupied}}{\text{Number of patient slots available}} = \text{Source: Scheduling System}$$

POINTS OF CLARIFICATION

Number of Patient Slots Occupied

The slots reported should represent time attributed as available for professional and ancillary services provided to patients. Does not include slots blocked for non-patient activities.

INCLUDES:

- Overbooked slots
- May exceed 100% (overbooking)
- Slots designated as cancellations and no-shows are included in the "occupied" count unless these designations have been removed

EXCLUDES:

- Slots blocked for non-patient activities

Number of Patient Slots Available

INCLUDES:

- Actual number of available slots for use in reporting period
- Represent available time for patient services

⚡ CareCloud Enablement

Supported by CareCloud patient access and scheduling analytics, enabling real-time visibility into appointment utilization and capacity trends.

Pre-Registration Rate

PURPOSE

Trending indicator that patient access processes are timely and efficient.

VALUE

Indicates revenue cycle efficiency and effectiveness.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of patient encounters pre-registered}}{\text{Number of scheduled patient encounters}} = \text{Source: Patient Financial System}$$

POINTS OF CLARIFICATION

Number of Patient Encounters Pre-Registered

Total number of monthly encounters pre-registered prior to scheduled service. A successful pre-registration is defined as completion of at least all demographic and insurance data fields required for registration as defined by organizational policy.

INCLUDES:

- Outpatient encounters (recurring account counts as one encounter)
- Inpatient admissions and observation cases (if scheduled in advance)
- Urgent care appointments, if scheduled (provider option)
- Canceled pre-registrations

EXCLUDES:

- Unscheduled pre-admits, walk-ins, urgent care (if not scheduled) and Emergency encounters

Number of Scheduled Patient Encounters

Total number of monthly scheduled encounters. A "scheduled encounter" is defined as an encounter scheduled prior to service.

CareCloud Enablement

Supported by CareCloud pre-registration and eligibility automation tools that track completion rates and identify gaps prior to service.

Insurance Verification Rate

PURPOSE

Trending indicator that patient access functions are timely and efficient.

VALUE

Indicates revenue cycle process efficiency and effectiveness.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of verified encounters}}{\text{Number of registered encounters}} = \text{Source: Patient Financial System}$$

POINTS OF CLARIFICATION

Number of Verified Encounters

Total of monthly scheduled encounters that have been verified prior to or at time of service AND unscheduled verified encounters prior to final billing. A successful verification is defined by the individual organization policy.

INCLUDES:

- Outpatient encounters (recurring account counts as one encounter)
- Inpatient encounters
- Unscheduled book of business (walk-ins, emergency department, urgent care patients)

Number of Registered Encounters

Total number of registered encounters reported in same reporting month as numerator. No type of registered encounter is to be excluded from the total — ALL encounters should be included.

INCLUDES:

- Outpatient encounters
- Inpatient encounters

⚡ CareCloud Enablement

Supported by CareCloud insurance verification workflows that provide real-time eligibility status and verification tracking.

Service Authorization Rate — Inpatient and/or Observation

PURPOSE

Trending indicator that measures what is actually authorized versus the total population that requires authorization.

VALUE

Indicates revenue cycle process efficiency and effectiveness.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of IP/OBS encounters authorized}}{\text{Number of IP/OBS encounters requiring authorization}} = \text{Source: Patient Financial System}$$

POINTS OF CLARIFICATION

Number of IP/OBS Encounters Authorized

Total monthly number of inpatient (IP) and observation (OBS) encounters that have been authorized prior to claim release.

"Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. A retro-authorization should be counted if completed before claim is released to the payer.

Number of IP/OBS Encounters Requiring Authorization

Total monthly number of inpatient and observation encounters that require authorization prior to service.

"Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. The denominator data should be calculated as the numerator (number of authorized encounters) and the number of encounters that were denied due to a lack of authorization.

⚡ CareCloud Enablement

Real-time authorization tracking via CareCloud analytics helps monitor approval status and identify authorization risks before claim submission.

Service Authorization Rate — Outpatient Encounter

PURPOSE

Trending indicator that measures what is actually authorized versus the total population that requires authorization.

VALUE

Indicates revenue cycle process efficiency and effectiveness.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of outpatient encounters authorized}}{\text{Number of outpatient encounters requiring authorization}} = \text{Source: Patient Financial System}$$

POINTS OF CLARIFICATION

Number of Outpatient Encounters Authorized

Total monthly number of outpatient (OP) encounters that have been authorized prior to claim release. "Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. A retro-authorization should be counted if completed before claim is released to the payer. For purposes of these keys, authorization and referral approval are considered the same activity.

INCLUDES:

- Series accounts, initial encounter or subsequent encounter where a new authorization is required

EXCLUDES:

- Inpatient and observation encounters

Number of Outpatient Encounters Requiring Authorization

Total monthly number of outpatient encounters that require authorization prior to service.

⚡ CareCloud Enablement

Supported by CareCloud authorization management and analytics tools that track outpatient approvals and prevent avoidable denials.

Conversion Rate of Uninsured Patient to Third-Party Funding Source

PURPOSE

Trending indicator of qualifying uninsured patients for a third-party funding source.

VALUE

Indicates organization's ability to successfully secure funding for uninsured patients and improve patient satisfaction.

EQUATION AND DATA SOURCE

Total uninsured patients converted to third-party funding source

Total uninsured discharges and encounters

=

Source: Accounts Receivable

POINTS OF CLARIFICATION

Total Uninsured Patients Converted to Third-Party Funding Source

Total patient discharges and encounters approved in the reporting month.

INCLUDES:

- Inpatients converted at any time
- Outpatients converted after discharge, including ED
- Conversions of newborns from self-pay to Medicaid because mother has Medicaid
- Medicaid conversions where provider has received notification from Medicaid agency

EXCLUDES:

- Conversions awaiting Medicaid applications (pending approval status)

Total Uninsured Discharges and Encounters

The total number of uninsured discharges and encounters in the reporting month.

⚡ CareCloud Enablement

CareCloud analytics help identify uninsured patients and track successful conversions to third-party funding sources.

Point-of-Service (POS) Cash Collections

PURPOSE

Trending indicator of point-of-service collection efforts.

VALUE

Accelerates cash collections and may reduce collection costs.

EQUATION AND DATA SOURCE

$$\frac{\text{Patient POS payments}}{\text{Total self-pay cash collected}} = \text{Source: Accounts Receivable}$$

POINTS OF CLARIFICATION

Patient Point-of-Service (POS) Payments

Point-of-service payments are defined as:

- Patient cash (self-pay cash) for a current encounter which is collected prior to, at the time of service, and up to seven days after discharge
- Patient cash (self-pay cash) for a prior encounter which is collected prior to or at the time of a new service

INCLUDES:

- All posted POS payments, including undistributed payments (debit transactions only)
- Cash collected on prior encounters, including cash collected on bad debt accounts
- Pre-admit dollars captured in the month payment is posted

EXCLUDES:

- Refunds; cash refunded to the patient should not be considered
- Routine payment plan payments unless collected at time of service

⚡ CareCloud Enablement

Supported by CareCloud financial clearance and POS analytics to improve upfront collections and patient payment performance.

Days in Total Discharged Not Final Billed (DNFB)

PURPOSE

Trending indicator of claims generation process.

VALUE

Indicates RC performance and can identify performance issues impacting cash flow.

EQUATION AND DATA SOURCE

Gross dollars in discharged not final billed (DNFB)

=

Source: Unbilled A/R, Income Statement

Average daily gross patient service revenue

POINTS OF CLARIFICATION

Gross Dollars in Discharged Not Final Billed (DNFB)

Gross dollars in A/R for all patient accounts discharged but not yet final billed for the reporting month. Snapshot at month-end.

INCLUDES:

- Recurring accounts (interim bills)
- Accounts in suspense period
- Ambulatory services charged but not final billed

EXCLUDES:

- In-house accounts
- Accounts in FBNS status
- Late charge bills
- Rebills

⚡ CareCloud Enablement

CareCloud enables early identification of DNFB backlogs by monitoring unbilled accounts and highlighting workflow bottlenecks before they impact cash flow.

Days in Final Billed Not Submitted to Payer (FBNS)

PURPOSE

Trending indicator of claims impacted by payer/regulatory edits within claims processing tool.

VALUE

Track impact of internal/external requirements to clean claim production which impacts positive cash flow.

EQUATION AND DATA SOURCE

$$\frac{\text{Gross dollars in FBNS}}{\text{Average daily gross patient service revenue}} = \text{Source: Claims Processing Tool, Income Statement}$$

POINTS OF CLARIFICATION

Gross Dollars In Final Bill Not Submitted To Payer (FBNS)

Gross dollars from initial 837 claims held by edits in claims processing tool not yet sent to payer. Snapshot at 11:59pm on last day of month.

INCLUDES:

- Initial claims only
- All 837 claims
- Claims rejected during submission (not denied)

EXCLUDES:

- In-house accounts
- Accounts in DNFB
- Rebills and late charge bills

⚡ CareCloud Enablement

Claims performance is visualized through CareCloud dashboards, helping teams quickly identify held or edited claims before submission delays escalate.

Days in Total Discharged Not Submitted to Payer (DNSP)

PURPOSE

Trending indicator of claims generation and submission process.

VALUE

Indicates revenue cycle performance and can identify performance issues impacting cash flow.

EQUATION AND DATA SOURCE

Gross dollars in DNFB + gross dollars in FBNS

=

Source: KPI PB1 + PB2, Income Statement

Average daily gross patient service revenue

POINTS OF CLARIFICATION

Gross Dollars In DNFB + Gross Dollars In FBNS

Automatically combines DNFB dollars (PB-1) and FBNS dollars (PB-2) to calculate total dollars in claims discharged but not submitted to the payer.

INCLUDES:

- All accounts from PB-1 and PB-2

EXCLUDES:

- See PB-1 and PB-2 exclusions

⚡ CareCloud Enablement

CareCloud analytics consolidate DNFB and FBNS activity into a single view, enabling faster intervention across the full pre-billing workflow.

Total Charge Lag Days

PURPOSE

Trending indicator of charge capture workflow efficiency.

VALUE

Impacts cash flow.

EQUATION AND DATA SOURCE

Sum of days from revenue recognition (posting) less date of service

Sum count of Charge/CPT codes billed

=

Source: Patient Financial System

POINTS OF CLARIFICATION

Sum of Days From Revenue Recognition Date Less Date of Service

Number of days between date of service and date of revenue recognition (posting) for each charge code. This is a count of days, not total charges.

INCLUDES:

- Charges posted within the month
- Charge corrections and changed modifiers

EXCLUDES:

- Charges reclassified based on patient/insurance type change
- System-identified date changes from payer class change

⚡ CareCloud Enablement

CareCloud identifies charge lag trends by provider, department, and service date, supporting faster charge capture and fewer billing delays.

Clean Claim Rate

PURPOSE

Trending indicator of claims data quality as it impacts revenue cycle performance.

VALUE

Indicates quality of data collected and reported.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of claims that pass edits requiring no manual intervention}}{\text{Number of claims accepted into claims processing tool for billing}}$$

=

Source: Claims Processing Tool

POINTS OF CLARIFICATION

Number of Claims That Pass Edits Requiring No Manual Intervention

Aggregate daily total of claims in the processing tool requiring no manual intervention for reporting month the first time the claim is scrubbed.

INCLUDES:

- Primary, secondary and tertiary claims - all applicable 837 claim types

EXCLUDES:

- Claims 'warned' because intervention is required
- Claims directly submitted to third-party payer
- Claims 'warned' for print and hardcopy submission

⚡ CareCloud Enablement

CareCloud monitors clean claim performance in real time, enabling early detection of data quality issues that lead to rework or denials.

Late Charges as a Percentage of Total Charges

PURPOSE

Measure of revenue capture efficiency.

VALUE

Helps identify opportunities to improve revenue capture, reduce unnecessary cost, and accelerate cash flow.

EQUATION AND DATA SOURCE

Gross charges with post date >3 days from service date

—————
Total gross charges

=

Source: Patient Financial System

POINTS OF CLARIFICATION

Gross Charges With Post Date >3 Days From Service Date

Absolute value of debit and credit charges at transaction level with a post date greater than 3 days from the service date.

INCLUDES:

- Charges posted within the month
- Charge corrections as well as changed modifiers

EXCLUDES:

- Charges reclassified based on patient type/insurance type change
- System-identified date changes from payer class change

⚡ CareCloud Enablement

CareCloud dashboards highlight late charge patterns, helping teams address process gaps that delay revenue recognition.

Aged A/R as a Percentage of Billed A/R

PURPOSE

Trending indicator of receivable aging and collectability.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R.

EQUATION AND DATA SOURCE

0-30, 31-60, 61-90, 91-120, >120 days

Total billed A/R

=

Source: Aged Trial Balance

POINTS OF CLARIFICATION

Billed A/R By Aging Category (0-30, 31-60, 61-90, 91-120, >120 days)

Total billed A/R amount for all payers in each aging category, aged from discharge date (hospitals) or date of service (ambulatory). Buckets must sum to 100%.

INCLUDES:

- Only active billed debit balance accounts
- Series accounts/recurring accounts
- Accounts outsourced but not classified as bad debt

EXCLUDES:

- Active billed credit balance accounts
- DNFB accounts
- In-house accounts
- In-house interim-billed accounts

⚡ CareCloud Enablement

Executive dashboards powered by CareCloud provide real-time visibility into A/R aging trends, supporting faster decision-making and improved collections.

Aged A/R as a Percentage of Billed A/R by Payer Group

PURPOSE

Trending indicator of receivable collectability by payer group.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R by payer group.

EQUATION AND DATA SOURCE

0-30, 31-60, 61-90, 91-120, >120 days by payer group

Total billed A/R by payer group

=

Source: Aged Trial Balance

POINTS OF CLARIFICATION

Billed A/R By Payer Group By Aging Category

Total billed A/R amount by payer in each aging category, aged from discharge date (hospitals) or date of service (ambulatory). Aging buckets are mutually exclusive and must sum to 100%.

INCLUDES:

- Only active billed debit balance accounts
- Series accounts/recurring accounts
- Accounts outsourced but not classified as bad debt

EXCLUDES:

- Active billed credit balance accounts
- DNFB accounts
- In-house accounts
- In-house interim-billed accounts not billed at month-end

⚡ CareCloud Enablement

CareCloud analytics break down A/R performance by payer group, helping leaders identify payer-specific risks and prioritization opportunities.

Aged A/R as a Percentage of Total A/R

PURPOSE

Trending indicator of receivable aging and collectability.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R.

EQUATION AND DATA SOURCE

Unbilled, 0-30, 31-60, 61-90, 91-120, >120 days

Total A/R

=

Source: Aged Trial Balance

POINTS OF CLARIFICATION

Unbilled and Billed A/R By Aging Category

Total A/R amount for all payers in each aging category including in-house and DNFB, billed A/R by discharge date. Unbilled is defined as revenue in-house and discharged not final billed (DNFB).

INCLUDES:

- Only active debit balance accounts
- Series accounts/recurring accounts
- Accounts outsourced but not classified as bad debt

EXCLUDES:

- Active credit balance accounts

⚡ CareCloud Enablement

HFMA benchmarks enhanced with CareCloud analytics allow organizations to compare total A/R performance across time periods and organizational units.

Aged A/R as a Percentage of Total A/R by Payer Group

PURPOSE

Trending indicator of receivable collectability by payer group.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R by payer group.

EQUATION AND DATA SOURCE

Unbilled, 0-30, 31-60, 61-90, 91-120, >120 days by payer group

Total A/R by payer group

=

Source: Aged Trial Balance

POINTS OF CLARIFICATION

Unbilled and Billed A/R by Payer Group by Aging Category

Total A/R amount for all payers in each aging category including in-house and DNFB, billed A/R aged by discharge date. Aging buckets are mutually exclusive and must sum to 100%.

INCLUDES:

- Only active debit balance accounts
- Series accounts/recurring accounts
- Accounts outsourced but not classified as bad debt

EXCLUDES:

- Active credit balance accounts

⚡ CareCloud Enablement

CareCloud dashboards highlight payer-level aging patterns, supporting targeted follow-up and improved cash acceleration strategies.

Remittance Denial Rate

PURPOSE

Trending indicator of % of claims denied.

VALUE

Indicates provider's ability to comply with payer requirements and payers' ability to accurately pay the claim; efficiency and quality indicator.

EQUATION AND DATA SOURCE

Total number of claims denied

=

Source: Accounts Receivable, 835 Files and/or Paper Remittance

Total number of claims remitted

POINTS OF CLARIFICATION

Total Number of Claims Denied

Total claims adjudicated monthly at claim level. Denials are 'actionable denials' - those that may be addressed and corrected within the organization and may result in appropriate reimbursement.

INCLUDES:

- Only payments containing a denial code on remittance advice
- Both initial claim denials and subsequent appeal denials
- Zero payment and partial payment accounts with denial indicator

EXCLUDES:

- Denials for patient responsibility
- RAC recoupments
- Denials for duplicate claims
- Shadow/encounter claims

CareCloud Enablement

Predictive analytics within CareCloud help identify denial trends early, enabling corrective action before denial rates increase.

Denial Write-Offs as a Percentage of Net Patient Service Revenue

PURPOSE

Trending indicator of final disposition of lost reimbursement where all efforts of appeal have been exhausted or provider chooses to write off expected payment.

VALUE

Indicates provider's ability to comply with payer requirement and payer's ability to accurately pay the claim.

EQUATION AND DATA SOURCE

$$\frac{\text{Net dollars written off as denials}}{\text{Average monthly net patient service revenue}} = \text{Source: Patient Financial System, Income Statement}$$

POINTS OF CLARIFICATION

Net Dollars Written Off As Denials

Total dollars written off as a denial in the reporting month, net of recoveries.

INCLUDES:

- Denied RAC dollars from lost appeals or choosing not to appeal
- Dollars must be stated at net
- Only payments containing a denial code

EXCLUDES:

- Denials for plan excluded (non-covered) services
- Denials for patient responsibility

⚡ CareCloud Enablement

CareCloud reporting surfaces denial write-off patterns and root causes, supporting improved compliance and revenue protection.

Bad Debt

PURPOSE

Trending indicator of the effectiveness of collection efforts and financial counseling.

VALUE

Indicates organization's ability to collect accounts and identify payer sources for those who cannot meet financial obligations.

EQUATION AND DATA SOURCE

$$\frac{\text{Bad debt}}{\text{Gross patient service revenue}} = \text{Source: Income Statement}$$

POINTS OF CLARIFICATION

Bad Debt

Total bad debt deduction as shown on the income statement for the reporting month. This is not the amount written off from A/R. Also called 'Provision for Uncollectible Accounts' or 'Provision for Bad Debt.'

⚡ CareCloud Enablement

CareCloud analytics support executive monitoring of bad debt trends to guide financial counseling and payer strategy decisions.

Charity Care

PURPOSE

Trending indicator of the administration of the provider's financial assistance policy.

VALUE

Indicates services provided under the provider's financial assistance policy.

EQUATION AND DATA SOURCE

$$\frac{\text{Charity care}}{\text{Gross patient service revenue}} = \text{Source: Income Statement}$$

POINTS OF CLARIFICATION

Charity Care

Total charity care as shown on income statement for the reporting month, not the amount written off from A/R.

EXCLUDES:

- Community benefit amounts

⚡ CareCloud Enablement

CareCloud provides clear visibility into charity care trends to support policy oversight and financial planning.

Net Days in Credit Balance

PURPOSE

Trending indicator to accurately report account values, ensure compliance with regulatory requirements, and monitor overall payment system effectiveness.

VALUE

Indicates process failure in timely cash posting, incorrect posting or incorrect payment.

EQUATION AND DATA SOURCE

$$\frac{\text{Dollars in credit balance}}{\text{Average daily net patient service revenue}} = \text{Source: Aged Trial Balance, Income Statement}$$

POINTS OF CLARIFICATION

Dollars In Credit Balance

Any patient account with a credit balance at the account level, reported as the absolute value of the credit balance.

EXCLUDES:

- Pre-service deposits
- In-house (not discharged) accounts
- Undistributed cash clearing accounts

⚡ CareCloud Enablement

CareCloud dashboards help identify credit balance drivers and process failures impacting payment accuracy and compliance.

Net Days in Accounts Receivable (A/R)

PURPOSE

Trending indicator of overall A/R performance.

VALUE

Indicates revenue cycle (RC) efficiency.

EQUATION AND DATA SOURCE

Net A/R

Average daily net patient service revenue

=

Source: Balance Sheet, Income Statement

POINTS OF CLARIFICATION

Net A/R

Net A/R is the net patient receivable on the balance sheet. It is net of credit balances, allowances for uncollectible accounts, discounts for charity care, and contractual allowances for third-party payers.

INCLUDES:

- A/R outsourced but not classified as bad debt
- Medicare DSH payments
- Medicare IME paid on MS-DRG account basis
- A/R related to patient specific third-party settlements
- CAH payments and settlements

EXCLUDES:

- A/R related to non-patient specific third-party settlements
- Non-patient A/R

⚡ CareCloud Enablement

Executive dashboards powered by CareCloud track net days in A/R in real time, supporting proactive revenue cycle management.

ASC 606 Illustration: Gross vs. Net Revenue Recognition

A patient has \$24,000 in charges with a \$13,000 explicit price concession (contractual adjustment). The hospital expects to collect \$11,000.

Prior to Topic 606:

Item	Amount
Net Patient Service Revenue	\$11,000
Patient A/R	\$11,000

Under Topic 606:

Item	Amount
Net Patient Service Revenue	\$11,000
Patient A/R	\$11,000

Result: Same A/R under both methods when explicit price concessions are properly applied.

Cash Collection as a Percentage of Net Patient Service Revenue

PURPOSE

Trending indicator of revenue cycle ability to convert net patient services revenue to cash.

VALUE

Indicates fiscal integrity/financial health of the organization.

EQUATION AND DATA SOURCE

$$\frac{\text{Total patient service cash collected}}{\text{Average monthly net patient service revenue}} = \text{Source: General Ledger, Income Statement}$$

POINTS OF CLARIFICATION

Total Patient Service Cash Collected

Total patient service cash collected for the reporting month, net of refunds.

INCLUDES:

- All patient service payments posted to patient accounts
- Bad debt recoveries
- Medicare DSH payments
- Medicare IME payments

EXCLUDES:

- Remittances received but not deposited in bank
- Non-patient-related settlements/payments
- Non-patient cash (retail pharmacy, gift store, cafeteria)

⚡ CareCloud Enablement

CareCloud analytics connect cash collection performance to HFMA benchmarks, enabling leaders to monitor liquidity and financial health.

Uninsured Discounts

PURPOSE

Trending indicator of amounts not expected to be paid by uninsured patients.

VALUE

Indicates the portion of the self-pay gross revenue not included in cash, charity, or bad debt metrics.

EQUATION AND DATA SOURCE

Uninsured discounts (prior to charity care and bad debt)

Gross patient service revenue

=

Source: Accounts Receivable, Income Statement

POINTS OF CLARIFICATION

Uninsured Discounts

Total patient revenue reported at month-end as 'Uninsured Discounts' prior to transfer to bad debt, as shown on income statement for the reporting month.

INCLUDES:

- Any account registered without insurance, except where exclusions apply

EXCLUDES:

- Charity Care
- Bad Debt
- Discounts to self-pay balance after insurance payment
- Prompt-pay discounts

⚡ CareCloud Enablement

CareCloud reporting highlights uninsured discount trends to support pricing strategy and financial transparency.

Uncompensated Care

PURPOSE

Trending indicator of total amounts not collected from patients related to self-pay discounts, charity care, and bad debt combined.

VALUE

Indicates the portion of the self-pay gross revenue not included in cash, charity, or bad debt metrics.

EQUATION AND DATA SOURCE

$$\frac{\text{Uncompensated care}}{\text{Gross patient service revenue}} = \text{Source: KPI AR7 + AR8 + FM3, Income Statement}$$

POINTS OF CLARIFICATION

Uncompensated Care

Sum of uninsured discounts, charity care and bad debt for the reporting month.

⚡ CareCloud Enablement

CareCloud analytics consolidate uncompensated care metrics to support executive-level financial planning and reporting.

Case Mix Index

PURPOSE

Trending indicator of patient acuity, clinical documentation and coding.

VALUE

Supports appropriate reimbursement for services performed and accurate clinical reporting.

EQUATION AND DATA SOURCE

$$\frac{\text{Sum of relative weights for inpatients}}{\text{Number of discharged inpatients in the month}} = \text{Source: Encoder-Decision Support}$$

POINTS OF CLARIFICATION

Sum of Relative Weights for Inpatients

Sum of Medicare MS-DRG weights universally applied to all discharged inpatients for the reporting month. Only applicable to hospitals and hospital systems.

EXCLUDES:

- Normal newborns (UB 0170 or UB 0171)
- Medicare exempt units

⚡ CareCloud Enablement

CareCloud analytics enhance HFMA benchmarks by identifying case mix trends that impact reimbursement and clinical documentation quality.

Cost to Collect

PURPOSE

Trending indicator of operational performance.

VALUE

Indicates the efficiency and productivity of revenue cycle process.

EQUATION AND DATA SOURCE

$$\frac{\text{Total revenue cycle cost}}{\text{Total patient service cash collected}} = \text{Source: Income Statement, Balance Sheet}$$

POINTS OF CLARIFICATION

Revenue Cycle Cost

Revenue Cycle Costs include: Patient Access Expense (eligibility, scheduling, pre-registration, financial clearance), Patient Accounting Expense (billing, collections, denials), and HIM Expense (transcription, coding, CDI).

INCLUDES:

- Salaries and fringe benefits
- Subscription fees
- Outsourced arrangements
- Software maintenance fees
- Bolt-on application costs
- IT operational expenses for RC
- Record storage
- Contingency fees
- Transaction fees

EXCLUDES:

- IT 'hard' costs (hardware, licensing, servers)
- Lease/rent expenses
- Physical space costs
- Scheduling if performed by service departments

⚡ CareCloud Enablement

CareCloud dashboards help leaders analyze cost-to-collect performance across revenue cycle functions and time periods.

Cost to Collect by Functional Area

PURPOSE

Trending indicator of operational performance by functional area as reported in KPI FM-6.

VALUE

Indicates the efficiency and productivity of revenue cycle process by functional area.

EQUATION AND DATA SOURCE

Total x (x = each functional area) cost

=

Source: Income Statement, Balance Sheet

Total patient service cash collected

POINTS OF CLARIFICATION

Total x (x = each functional area) Cost

Breakdown of revenue cycle cost based on functional area. Functional areas include patient access, patient accounting, and HIM.

INCLUDES:

- See FM-6 inclusions broken down by functional area

EXCLUDES:

- See FM-6 exclusions

⚡ CareCloud Enablement

CareCloud provides functional-level cost insights to support operational efficiency and strategic resource allocation.

COMPLETE GUIDE

Ready to Transform Your Revenue Cycle Performance?

CareCloud brings HFMA MAP Keys to life with real-time analytics, automated data collection, and actionable insights.

[Request a Demo →](#)

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