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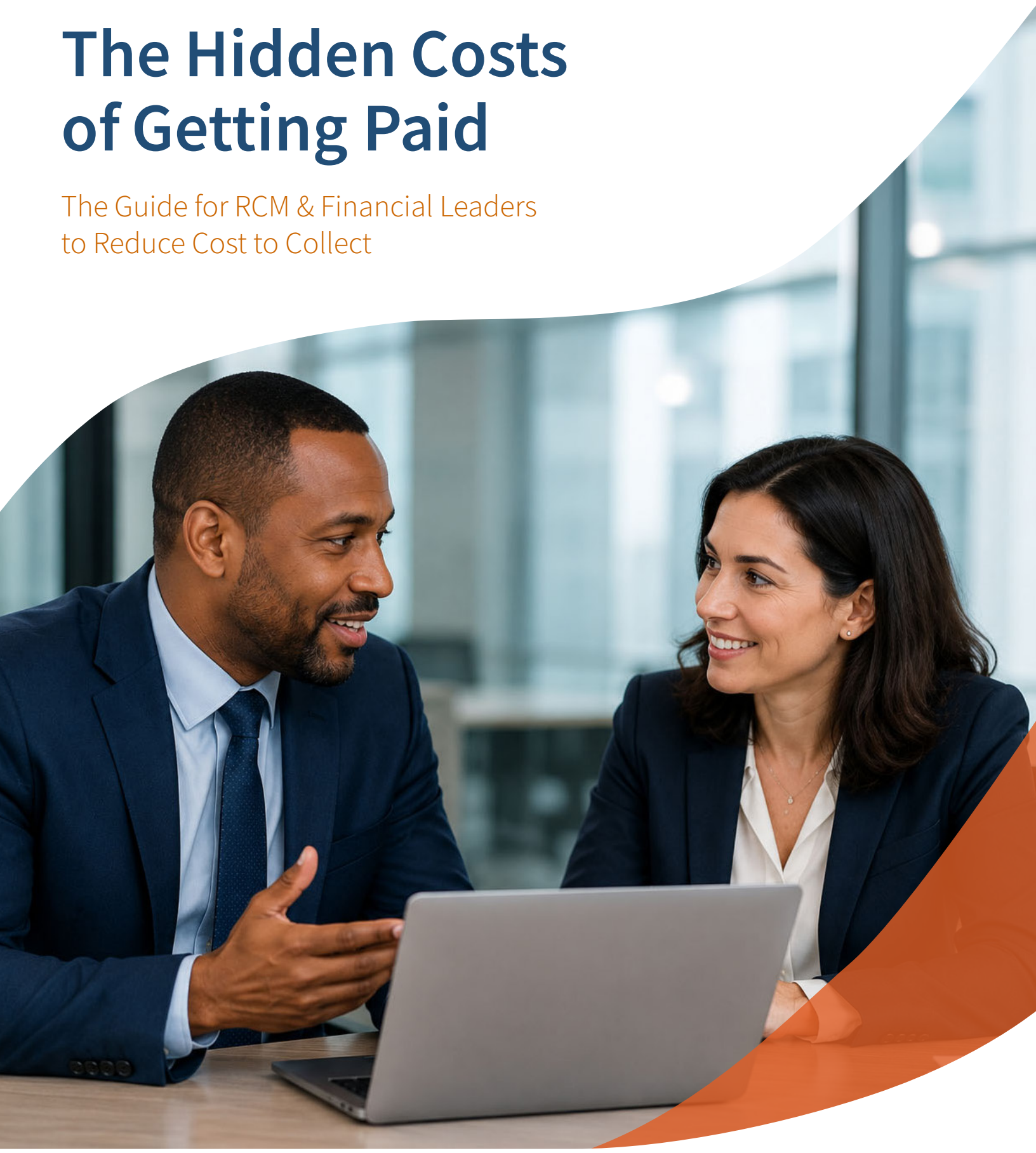
The Hidden Costs of Getting Paid

The Guide for RCM & Financial Leaders to Reduce Cost to Collect



Executive Summary

Most revenue cycle conversations start with denials or days in A/R. Those numbers matter, but they only tell you what happened after the fact. They don't tell you how much labor it took to get there — and for most organizations, that unmeasured labor is now one of the largest controllable costs on the income statement.

Claim Errors

Providers say claim errors are rising and clean claims are getting harder to submit, not easier — 54% report more errors this year, and 68% say clean claim submission is more difficult than a year ago.

Collections Spend

U.S. hospitals spent an estimated $43 billion in 2025 on billing and collections, with roughly $18 billion of that spent specifically overturning claim denials.

Denial Rates

41% of providers now report denial rates of 10% or higher — a figure that has climbed every year since 2022.

Hospital Survival

More than 40% of rural hospitals are operating at a loss, and 417 are now considered vulnerable to closure — margin pressure that makes every dollar of avoidable administrative cost a survival issue, not a line item.

Labor Savings

The industry could still capture roughly $21 billion in savings simply by finishing the move from manual to electronic workflows — savings sitting in labor, not technology.

The real cost-to-collect problem isn't denials or A/R days. It's the unmeasured human labor behind every claim — the eligibility checks, the callbacks, the resubmissions, the rework — most of which is never tied back to whether it actually produced a payment.

Why Your Current Metrics Don't Show the Real Cost

CFOs and RCM leaders have spent decades managing revenue cycle performance with a familiar set of numbers: days in A/R, net collection rate, clean claim rate, denial rate. These are the metrics every board deck and benchmarking report is built around.

They are also, by design, lagging indicators. They tell you the result of the work. They say nothing about the work itself.

Days in A/R

HFMA holds net A/R days below 50, with 30–40 days considered strong. It tells you how fast money moves, not how many people it took to move it.

Net Collection Rate

HFMA's MAP Keys set a 95%+ target for what's actually collected against what's owed. A practice can hit that number and still be burning enormous labor to get there.

Clean Claim Rate

Even a "clean" claim can require staff intervention before submission. It measures the paperwork, not the touches behind it.

Denial Rate

It tells you a claim was rejected — not that it took five or six follow-ups and resubmissions to eventually get paid.

This is the visibility gap. Leaders know work happened. Very few can say whether that work created value.

The Anatomy of Cost to Collect

Every paid claim is the product of a chain of human effort — most of it invisible to standard reporting.

Typical Claim Management Process

- Eligibility and benefits verification before the visit
- Prior authorization request and follow-up
- Charge entry and coding
- Claim submission and clearinghouse status checks
- Denial or rejection review
- Payer phone calls and portal research
- Claim correction and resubmission
- Payment posting and reconciliation
- Patient billing and collections follow-up

Every one of those steps involves a person doing work, and every touch has a cost.

Industry cost analyses put labor at roughly 90% of the total expense of processing a claim — which means cost to collect is, overwhelmingly, a labor-efficiency problem before it's anything else.

The touch is only "worth" its cost if it moves the claim closer to payment. When it doesn't, the organization has spent real dollars — staff time, benefits, overhead — and gotten a claim that's exactly where it started.

The Hidden Cost Categories

A diagnostic taxonomy — most RCM leaders will recognize their own organization somewhere in this list.

Rework from preventable upstream errors

- Half of providers now cite missing or inaccurate claims data as the leading driver of denials — up from the year before.
- Prior authorization issues remain a top denial trigger for roughly a third of providers; physicians and staff report spending upwards of 13 hours a week on prior authorization, with the large majority reporting related burnout.
- Common root causes: eligibility not verified, authorization not checked, wrong payer on file, coding or modifier errors, incomplete registration data.

Non-actionable follow-up

- In MedEvolve's touch-level analysis across tens of millions of revenue cycle interactions, avoidable, non-actionable touches — work that consumes staff time without ever changing a claim's outcome — have consistently represented 65% to 85% of measured revenue cycle activity.
- A team can touch a claim status update, log it, and move on, having accomplished nothing but the appearance of productivity.

Denial-driven cost

- 41% of providers report denial rates of 10% or higher, a share that has grown every year since 2022.
- Private payers deny an estimated 15% of claims on first submission, and every denial triggers its own rework cycle.
- Not all denial cost is even recoverable — an estimated 90% of denied claims are never appealed at all, often because the manual cost of investigating and appealing exceeds the claim's value.
- In rural and community hospitals specifically, MedEvolve's analysis found at least 63% of claim touches represent wasted effort tied to inefficiency and payer friction — a drain rural providers, on thin cash reserves, can least afford.

Outsourced & offshore inefficiency

- Many organizations outsource all or part of the back office, assuming that removes the cost-to-collect problem. It typically just relocates it.
- Outsourced RCM partners are commonly measured on activity — claims touched, calls made — rather than on whether that activity produced payment.
- Without structured, outcome-linked touch data, there's no way to know whether an outsourcing arrangement is reducing cost to collect or just moving the same inefficiency somewhere less visible.

Why This Stays Invisible

This isn't a failure of effort.

It's a structural gap in the tools the industry has used for decades.

RCM Headwinds:

- EMR and practice management systems were built to process transactions — schedule the visit, submit the claim, post the payment — not to classify whether a human touch moved a claim toward resolution.
- Standard reporting shows claim status, denial codes, and A/R aging. It does not connect a specific staff action to a specific financial outcome.
- There is no feedback loop from action to outcome: a rep can work forty claims a day and no system will show whether those touches produced five dollars or five hundred thousand.
- Even with heavy investment in automation, meaningful savings remain on the table: the most recent CAQH Index puts additional achievable savings from further automation at roughly $21 billion, on top of the more than $258 billion already avoided through electronic workflows.

The result: organizations can be sophisticated about measuring outcomes and completely blind to the work that produced them.

Benchmarks: What "Good" Looks Like

Directional targets, pulled from published industry benchmarks and MedEvolve's touch-level dataset. Use these to see where your organization sits today — not as a scorecard to chase in isolation.

Metric	What "good" looks like	What's typical today
Cost to collect	At or below 2% of net patient revenue	Widely cited range of 2–4%; above 4% is an urgent signal
Net days in A/R	30–40 days	Many organizations run well above the 50-day caution line
Net collection rate	95% or higher	Broad samples often land in the 90–94% range
Denial rate	Well below 10%	41% of providers report 10%+, and rising
Non-actionable touch rate	As close to zero as workflow allows	65–85% of touches drive no financial outcome

The pattern across every one of these benchmarks is the same: the gap between "typical" and "good" is rarely a technology gap. It's a visibility gap. Organizations that can't see which touches are non-actionable can't systematically close the distance between where they are and where the benchmark says they should be.

A Framework for Reducing It: See It. Fix It. Prevent It.

Reducing cost to collect isn't a single initiative — it's an operating discipline, and it works the same way regardless of which systems sit underneath it.

1

See It

You can't manage a cost you can't measure. Start by classifying every touch in the revenue cycle — not just what happened, but whether it moved the claim toward payment. This turns "our team is busy" into a specific, dollarized picture of where effort is and isn't producing revenue.

2

Fix It

Once non-actionable and denial-driven work is visible, prioritize it. Route staff to touches that are actually actionable. Trace recurring denials back to their root cause - a payer, a modifier, an eligibility gap — instead of re-treating the same symptom claim by claim. This is where automation and workflow orchestration earn their return: not by removing people, but by removing the waste around them.

3

Prevent It

The highest-leverage fix happens upstream, before a claim is ever touched by a biller. Feed what you learn about denial and rework patterns back into eligibility, authorization, and coding workflows so the same avoidable error stops recurring. This is the step that actually bends the cost curve down over time, rather than just working through today's backlog.

This sequence is deliberately vendor-agnostic. Whatever platforms sit underneath your revenue cycle, the discipline is the same: visibility before action, action before automation, and a closed loop back to prevention.

Illustrative Example

The following is a composite example built from the pattern of results MedEvolve customers have reported publicly - rather than a specific client's confidential figures.

A mid-size behavioral health organization began measuring touches at the individual claim level for the first time. Within roughly a year of establishing that visibility and acting on it, the organization saw:

Touches Per Visit

Touches per visit down 21%, translating to an estimated $700,000 in annual labor cost savings

Removing Manual Intervention

Roughly $3.3 million a month in claims that no longer required A/R team attention at all, because they were resolving without manual intervention

Denial Reduction Savings

A 65% reduction in a specific denial-driven rework category, worth an estimated $275,000 in annual savings

Reduce Avoidable Write-offs

Avoidable write-offs tied to prior-authorization denials down 75%, and timely-filing denials down 92%

None of this required replacing the underlying billing system. It required knowing — claim by claim, touch by touch — which work was producing payment and which wasn't, and redirecting effort accordingly.

Next Steps

Every organization is already paying a version of this cost today. The only question is whether it's currently measured.

1

Audit your current metrics

If your reporting stops at denial rate, A/R days, and clean claim rate, you have an outcomes view but not an effort view.

2

Pick one category to instrument first

Denial-driven rework and non-actionable follow-up are usually the fastest to quantify and the most convincing to a board or ownership group.

3

Set a baseline before you set a target

You can't responsibly commit to "reduce cost to collect by X%" without first knowing what today's number actually is at the touch level.

> ***"We now have staff all over the country with complete visibility into their work. We use the data to incentivize our staff and create friendly competition, which has been a huge motivator."***

— K. Kelly, President, Strategic Practice Solutions

> ***"The power of the revenue-cycle-focused data intelligence gave us the ability to quickly identify issues and use workflow to find specific examples and resolve cases fast."***

— R. Koehn, Sr. Director of Revenue Optimization, Metropolitan Anesthesia Consultants

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