Prodigal

Why Context Matters in Healthcare Receivables

Achieving RCM Operations Improvements

Table of Contents

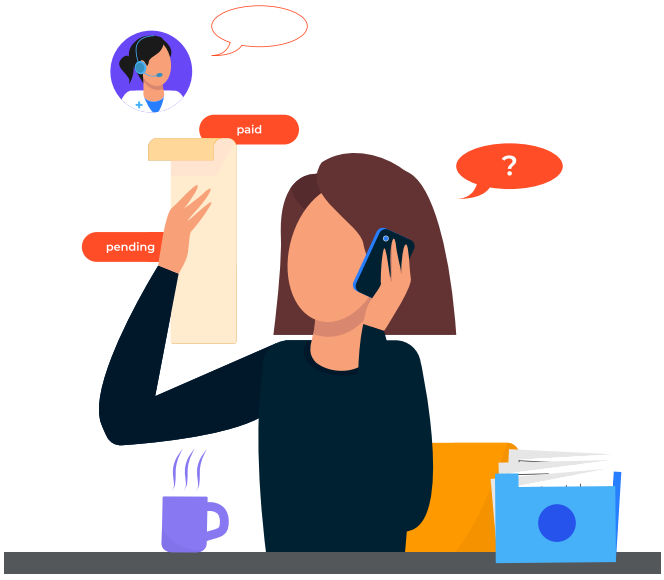
Executive Summary

Healthcare revenue cycles are deeply painful for all parties. Aside from the high pressure of healthcare and the patient-provider-plan dynamic writ large, there's the constant fear of wasted resources and lost revenue — and rightly so; denied claims submissions are just the tip of the iceberg, with over $125 billion lost each year.

Such pains necessitate improvement. And the timing is nigh. **By 2019, EHR adoption was over 98 percent.**[1] With these investments, organizations reflected their commitment to care outcomes and value-based reimbursement. As naturally follows a major operational undertaking of this type, other resource requirements and opportunities soon came into focus. Specifically, to address the major pitfalls of a complicated revenue retrieval cycle that EHR simply cannot solve — and to keep up with shifts to remote work and even remote medicine — providers have invested significant resources both in staffing RCM administrative functions (whether in-house or outsourced) and in process automation solutions.

Those investments should pay off long-term — and yet, healthcare institutions still face **major challenges to revenue capture and operations.**[2] It's not just the process, but the manner of service: institutions are likely to encounter poor QA in the patient contact center, low margins and wasted headcount (all three interconnected).

Inevitably, these faults cause a shake: a decidedly negative experience for the patient. Billings cycle agents lose opportunities to flex their empathy skills and develop the strong relationships required in patient servicing, the immediate victims of unproductive (or nonexistent) contextual workflows.



And patients lose access to the type of agent empathy such context can facilitate. Meanwhile, revenue cycle leaders lose out on new opportunities to improve patient servicing, and therefore, revenue capture.

These problem types can overwhelm even the most organized, process-oriented revenue cycle management teams. While they search for procedural solutions in coding, payments automation, claims grouping and more, *a major data source remains relatively unexplored:* **patient financial servicing interactions.**

[1] *RevCycleIntelligence. (2019, June 26). After EHRs, providers invest in revenue cycle management for Success. RevCycleIntelligence. Retrieved March 2, 2022, from https://revcycleintelligence.com/news/after-ehrs-providers-invest-in-revenue-cycle-management-for-success*

[2] *RevCycleIntelligence. (2022, Feb 3). Remote Work Propels Electronic Claims Management Adoption. Retrieved March 2, 2022, from https://revcycleintelligence.com/news/remote-work-propels-electronic-claims-management-adoption*

By accessing the specific context provided by stronger patient conversation analytics, RCM functions can move past the generic improvements and toward true productivity gains and more meaningful patient experiences. Ultimately, despite the many challenges of medical billings and collections and their effects on RCM, there are no aspects of the financial cycle that lie beyond the positive impact of accurate, relevant patient context.

Tim Haag

President, State Collection Service, Inc.

> “Prodigal has an impressive automation platform that instantly offers a positive ROI. We look forward to adding AI capabilities at State with Prodigal.

Revenue Cycle Management Costs and Improvements

One of the biggest costs in RCM lies in the billings and collections cycle and the many processes and people required to enact and operate the payments machine. That cycle begins way back at intake and runs through coding and down into collections (eventually). Today, every aspect of healthcare administrative cost is growing — far, far outpacing healthcare spending or physician growth over the last several decades.

But while hospitals and healthcare systems spend on administration, trying to not only keep up, but crack the code, bad debt continues to plague their revenue.

According to a 2018 survey of hospital leaders by healthcare IT company Dorado, while 36% of respondents shared that bad debt at their organization adds up to over $10 million, **half of respondents said only about 10% of their debt was recoverable.[3]**

Bad debt could be caused by any number of process failures or major healthcare shifts (in regulations, in patient influx, etc.). At the time of the survey, just **17% of respondents blamed patient delinquency, while 11% of leaders who responded said ineffective, facility-specific RCM processes were a major cause, 10% cited industry-wide RCM complexities, and 1% cited a high poverty rate.**

Whatever the exact cause, ballooning administrative costs don't seem to predict winning strategies for handling this recoverability aspect of the revenue cycle. Meanwhile, automation and staffing investments keep coming.

The result: almost all hospitals and healthcare systems and providers suffer the same frustrating revenue fate: **extremely low-margin operations — and low profitability.**

Further examining some of the causes of low margins and lost revenue opportunity can bring us closer to determining a theoretical — and practical — recoverability solution.

[3]Sage Growth Partners. (2018, June 27). Bad debt exceeds $10M at a third of organizations, but lack of confidence exists in how much is recoverable. Bad Debt Exceeds $10M at a Third of Organizations, But Lack of Confidence Exists in How Much is Recoverable. Retrieved March 2, 2022, from https://www.prnewswire.com/news-releases/bad-debt-exceeds-10m-at-a-third-of-organizations-but-lack-of-confidence-exists-in-how-much-is-recoverable-300667889.html

Quality Assurance In the Contact Center

Every RCM leader is familiar with the many issues in charge capture, coding and claims submission. Codes are wildly specific: A simple typo can lead to a cascade of long-term communication between payer, provider and plan. The corrective process is an extended one, if it exists at all. And who reviews each call or conversation to ensure not only compliance and corrective action, but also overarching quality of services?

This lack of quality assurance can also lead to a longer-term concern: a greater reliance on collections, i.e., the claim might still be in limbo and the bill will remain unpaid, pushing administrative costs further down the line — to agencies or in-house agents, who themselves create new demand for contact center quality assurance.

All the while, both inside and outside of collections, productivity concerns abound.

So, how do you solve for poor QA, thereby increasing productivity and managing away from opportunity costs? It's as simple as one little idea: **data accuracy.**

Analysis ≠ Accurate Context

Today's quality assurance efforts in RCM are largely focused on patient access and coding, and rightly so, as errors here propagate into longer A/R cycles and eventually lead to collections. But QA isn't just for the patient access side of RCM events.

Learning how to deliver the highest quality information and service depends on the data. Is the call and note data robust enough to detail short- and long-term trends? Are your QA team members searching for the right language markers? How does a QA team member ensure that agents are entering information correctly in the future, once they've identified an error from the past? Most importantly, is the data actually **accurate?**

Typically, a leader would hire a speech analyst to fine-tune all of the voice data that enters the RCM purview. But that has its accuracy drawbacks — and they're mostly context-related.

Even with the most stringent of analysis methodologies, a speech analyst will always miss some context and come to the table with some contextual biases of their own.

Additionally, hiring the right analysts to regularly review content and surface necessary changes is a productivity nightmare, and regardless of their skill, they cannot account for in-call, real-time QA triggers. They play catchup.

So, a speech analyst is not the solution to accuracy, context, or accurate context. **Instead, continual learning is required.** Pattern recognition in the data must be used as feedback to make improvements to the analysis model in order to reach true accuracy.

With trust in the accuracy of the data established, revenue cycle managers and A/R leaders begin working toward contextually-informed improvements that support both productivity and costs recovered.

As an example, should a contact center leader clearly identify a trend in time of day for accepted payments within a certain age range of patients, they might craft a workflow that ensures patients in that range are contacted only at the right time of day, cutting wasted time waiting for a phone call to go unanswered, or a claim to go unpaid.

In fact, A/R teams could achieve any of their major productivity objectives through identifying trends and optimizing workflows.

All that time, money and energy saved by agents allows leaders to take one of two massive opportunities:

1. Reduce headcount
2. Redistribute talent to difficult-to-fill roles.

Both are worthy goals, and both save costs long-term.

So, we've solved for poor QA in the contact center, via an accurate model that facilitates contextual improvements. But poor QA isn't the only cause of hampered operating margins.

Relationship Management

Regardless of how QA contributes to the revenue cycle, medical services are especially prone to a longer time between service delivery and payment receipt. This lag time has long been a natural consequence of the insurance system: with so many moving parts and players, it's no wonder that RCM leaders have been trying to find ways to incorporate electronic payments at the point of care wherever and whenever possible.

Even as ops teams race to keep up with the demand for self-pay solutions, patient deductibles and out-of-pocket expenses are rising, making providers more reliant on each patient's current financial health. Installment-based payment plans and increased time until insurance payback are just two reasons for the frequent interaction/long cycle nature of healthcare payments — or, put another way, the high-touch/low-yield reality of medical billing.

The point is, the healthcare payments process is complicated. As deductibles shift and reliance on the patient increases, complications frequently fall into the realm of financial hardship. Given the sensitive and often immediate nature of healthcare, all agents must assume that the patients from whom they elicit payments are under stress — financial or otherwise. This stress calls for advanced relationship management. Without it, revenue is lost and operating margins sink.

What does advanced relationship management look like?

Firstly, it requires productivity improvements, which, as we know, depend largely on QA and training, but also on tools. Productivity improvements can be realized through context, as agents are often the victims of nonexistent or incorrect contextual workflows that limit their ability to connect with the end payer in a meaningful, immediate way.

In other words, agents lack the context to offer empathy in RCM interactions; the consumer ends up confused and ultimately dissatisfied. And we know from the **2021 Healthcare Consumer Experience Study** from Cedar that **dissatisfaction significantly impacts patients' likelihood to pay.[4]**

[4]Rodriguez, S. ([2021], December [29]). Consumers don't pay patient financial responsibility after bad experience. RevCycleIntelligence. Retrieved March [2], [2022], from https://revcycleintelligence.com/news/consumers-dont-pay-patient-financial-responsibility-after-bad-experience

[5]Ibid.

We can only imagine that's increased during COVID: Because so many relationships between provider and patient are no longer in-office interactions, the care provider or staff rarely has the time or audience attention to effectively explain. Moreover, as Sarai Rodriguez put it for Revcycle Intelligence, "Thirty-seven percent of patients will not pay their bill if they cannot understand the administrative experience, highlighting the need for better communication and bill transparency during their healthcare billing and payment experience."[5]

That's right: over a third of patients will not pay patient responsibility if the patient financial experience (PFX) is bad. It's up to the agent to make it better.

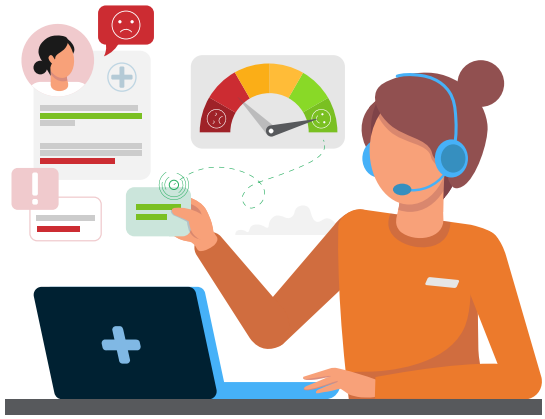
With strong relationship management, even a low-touch relationship should lead to high yield in payments. But in today's payment collection centers, the opposite occurs. The interaction/payment ratio negatively impacts operating margins through productivity lost. Tack on the value of health system reputation and how PFX impacts image, and you can see that losses come from all ends of the revenue cycle.

Empathetic Interaction First

As mentioned in the introduction to this paper, the **patient financial experience** can only be improved with accurate information about **patient financial interactions.** It seems obvious, and yet, so few revenue cycle management organizations have been able to realize the full power of that information when it comes to relationship management.

We suggest beginning with empathy. That's what patients deserve, and they have shown time and time again that it's also what they desire.

Given accurate interaction data in the right model, leaders could examine any number of markers of empathy and enumerate impact. If they had the tools to examine open-ended conversations and could attribute the impact of the conversation on revenue capture or payments, they might, for example, see a sudden surge in stressful conversations related to potential loss of employment. Knowing that this fear existed among patients, they could both:



1. Identify calls on which this stress was met with less-than-empathetic responses and retrain, and
2. Create real-time notifications or workflows associated with stress indicators.

Both of these changes would create a cascade of benefits, from productivity gains to major patient experience improvements.

And those improvements might manifest as higher quality scores, a lower percentage of collections spent on RCM, and even a shortened average time spent in Accounts Receivable.

Bottom line: Operating with empathy has unintended positive effects, which comes as a surprise to no one. But the ability to respond with empathy is often out of a leader's hands — unless they have accurate patient financial interaction data.

Now we've seen how QA and relationship management can impact the revenue cycle, and how patient interaction data can affect each. But can we really control for one of the most challenging aspects of healthcare?

Facing Growing Complexity

Change is constant, in healthcare as in the rest of the economic landscape. Data balloons and regulations shift. New vendors and competitors emerge and subside. What is it then, specifically, that adds to the complexity of healthcare in a way that reduces operating margins?

First, as any Accounts Receivable management group understands, the role of regulators is a big one. They're setting the pace, moving as quickly as possible to catch compliance issues and transgressions in the data. They scrutinize interactions using the best tools, including future- focused AI. Not only that, but they'll produce new regulations, too. It's a classic hacker vs. infosec faceoff — only in healthcare, the creators of the regulations are like the hackers, producing the zero day exploits, and operations leaders are like the infosec teams, desperate to keep up.

Take the No Surprises Act as an example. Of course, organizations had ample preparation time to design the right workflows for maintaining compliance prior to the Act taking effect.

However, now that it's in play, the real test begins. The bodies monitoring compliance will review each act of balance billing in greater detail than the system managing it can supply, and the next go around, the system will need to supply more detail.

It's not only this type of compliance to and fro that causes continuous growth in complexity (and therefore, reduced operating margins). It's also the dynamic nature of public health — illustrated by the type of changes that, try as we might, we cannot fully account for until they occur, such as the coronavirus pandemic.

Consider the case of a patient sent to a collections agent due to their receipt of a free vaccine. The patient is charged because the hospital is charging for COVID administration fees; but due to the misunderstanding, the patient is less likely to pay (as the Cedar survey reveals).

The loss to the revenue team manifests in extended recoverability time and more touches. And it's all due to a small change in an already difficult-to-decipher process — the type of change that's nearly impossible to anticipate.

The pandemic has led to other complexities within the healthcare payments ecosystem, too, such as an influx of patients with longer-term stays, an increase in coding errors, a backlog of patients with surplus income from lowered or waived interest, and the Great Resignation making it impossible to keep collections centers fully staffed. The list goes on and on, but the concept is concrete: shifts to the healthcare economic ecosystem are hard to predict and never-ending, often leading to organization-level losses.

Naturally, we cannot limit the dynamic nature of public health, nor can we limit a system's complexity by adding superfluous information to it. So, what can revenue functions actually control? **Their approach to context provision.**

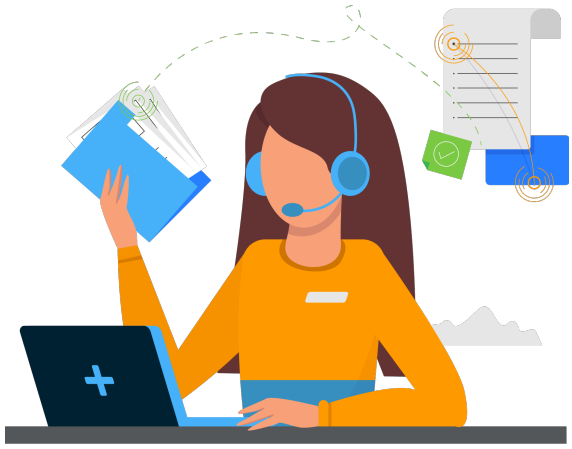
Consider Optio Solutions, a leading Accounts Receivables management agency managing first and third-party portfolios. Processing their call recordings at scale was one challenge, processing all of them accurately and flagging the issues in a way that simplified, rather than complicated, the process, was another entirely. With a commitment to improving the flow of call review, Optio recognized the importance of context provision: it could simplify flow by serving up compliance insights at the review level, without a search process that depended on QA knowledge of the compliance issues at hand. That sort of context provision led to 100 percent of calls reviewed with 100 percent compliance coverage — in 35% less time. Simplification, unlocked.

Knowing More is Doing More: Improving RCM Functions with Context

An improved RCM function is one that recovers more payments, ultimately generating less bad debt and running at a lower cost, leading to higher profitability. Additionally, any internal improvements to revenue cycles should be likewise felt by the patients — their experience affects the improvements, and vice versa.

Getting there is complicated, but every journey is made easier with a guiding light. In healthcare RCM, as in so many other data-soaked fields, that guiding light is one simple concept: **accurate context.**

Accuracy alone isn't enough. While a one-hundred percent correct transcript and set of call notes for every call is a noble goal, achieving it won't propel revenue centers to the forefront of productivity gains and patient relationship management. For that, leaders must put in place a plan for directing the information to the right users, at the right times. That's what real context means — it's not just about understanding that which is around you, but also providing that which is around you with some parameters, namely time, space, and function.



With these two elements in place, revenue leaders can improve QA and productivity, better forge and manage relationships, and yes, even simplify in the most complex of ecosystems.

The insight into RCM functions that revenue cycle leaders can gain from real patient conversations is invaluable, even when we can quantify it. Used correctly, this insight will improve productivity, reduce operating margins, help recapture revenue in a long cycle, improve relationships, and bolster reputation — for the RCM function within the organization and for the organization within the entire healthcare landscape.

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Want to get more insights?

Email: learn-more@prodigaltech.com

Phone: (650)-802-7795

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