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Combat Revenue Leakage

Strategies for Healthcare Providers to Optimize Revenue

Healthcare organizations spend too much time and effort on billing, and they lose money they should be capturing. Providers should embrace automation as they look to optimize their claims processes.

Many hospitals are dealing with sobering financial challenges. Most health systems, particularly nonprofit systems, manage with modest operating margins even in the best of times, and plenty of providers are still struggling after the COVID-19 pandemic.

The American Hospital Association released its annual "Costs of Caring" report in May 2024, which illustrated some of the hurdles for providers. For example, inflation grew more than two times faster than Medicare reimbursements between 2021 and 2023.

Hospitals continue to wrestle with staffing shortages, according to a Kaufman Hall report, and that has resulted in increased wage expenses and financial strain.

In fact, 85% of the survey respondents said wage and salary increases for clinical staff have exceeded 6%, with one-third (31%) reporting increases in excess of 11%. With these headwinds and other challenges, such as facility needs and rising expenses for cybersecurity, hospitals face a difficult road ahead.

That makes it crucial for hospitals to capture all potential revenue and reduce the inefficiencies in the revenue cycle management process – specifically the claims payment process, which may contribute significantly to overall revenue leakage.

In this white paper, experts from Zelis outline some of the common problems hospitals and other providers face and offer guidance for health systems on strategies to improve different aspects of revenue cycle management.

Timely billing starts before the point of care

Hospitals and providers need to engage in timely billing to help improve their cash flow, serve their patients, and prevent revenue leakage. After all, if providers get claims out the door faster, they will get revenue more quickly.

"Ensuring everything gets paid within a reasonable time frame also allows you to then bill the next responsible party, whether that's a secondary payer or the patient, in a timely manner," Stephanie Brookings, Director of Provider Enablement for Zelis, explains. "And then it also allows you time to be able to react if there is something wrong with the claim that you then need to refile and send back out."

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Brookings recommends simple office visits, including primary care visits, be coded and sent out the same day to ensure claim submissions are prompt. This helps avoid delaying the process – and delayed payments.

If there isn't an efficient process for managing claims, then problems can develop if several staff members are involved. This is especially true for complex procedures such as surgeries. Unclear and inefficient processes only lead to more delays and greater risks of losing revenue. The more people involved in the procedure, the more important the process.

"Everybody thinks they have a few days to do it," Brookings says. "But if we're allowing everyone to take their time, then it really does add to the length of the revenue cycle."

Healthcare organizations can spend a lot of time and money getting clinicians to move claims along, but providers really want to prioritize expediting processes as much as possible.

Those that do typically have not only stronger processes but also stronger metrics to measure how quickly providers are charting and coders are getting their documentation. That itself can offer valuable insights.

Avoid denied claims with a streamlined claims management process

Sending the claims promptly is only half the battle though. Many providers wrestle with the number of denials from payers, and that can be a significant source of revenue leakage.

"Once health systems and providers get the claims out, they need to ensure that the payer is dealing with the claims promptly," adds Karen Randolph, Strategic Sales Executive at Zelis.

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Premier reviewed claims from more than 500 acute care hospitals in 2022 and found that nearly 15% of claims submitted to private insurers for reimbursement were initially denied. More than half of those denials were eventually overturned, but providers spent nearly $20 billion pursuing those delays and denials across all types of payers. More than $10 billion was spent on claims that were incorrectly denied. Making matters worse, providers also have to track claims where there has been no answer from payers.

"Those non-responsive claims just fall into a black hole with the payer, if that follow-up isn't being done," Randolph says. "That is probably your most likely opportunity to lose that revenue because they're just sitting there lost in the shuffle. And they could just time out that way."

But before we cast all the blame on health plans, it's worth noting that the problem isn't only confined to payer challenges.

Sometimes providers are not monitoring claims when they have been sent to the payer or are not submitting claims according to the insurer's timeline.

"It's helpful to start with timely filing limits, which are rules that each payer puts in place of how long you have from the time of service to get the claim to them," Brookings says. "And if you exceed that timeframe, then they'll simply just deny it and they're not obligated to pay it. And then you're really stuck. You've lost the revenue, and you're not able to bill that to the patient. So that is a big, big area of risk for revenue leakage."

Automating this process with an end-to-end claims management solution is vital to solving these challenges. Automation helps reduce the amount of manual work, track the status of the claim, and cut back on the number of days a claim is in accounts receivable.

Healthcare organizations also run into situations where patients have more than one insurer, and the provider did not submit the claim to the primary insurance. That can lead to more delays.

"You want to make sure that you allow some breathing room if you do have those situations where you may be waiting on somebody," Brookings says. "Because if you miss that timely filing, it really is just an immediate out for health plans not to pay."

Gain a better understanding of payer policies

Responding to denied claims is vitally important but it is also reactive – often by necessity. Providers ultimately want to take a proactive approach to those situations, striving to stop the problem before it happens. But how can any provider manage that with the constantly shifting tide of payer policies?

Underscoring this challenge is the ongoing tension between payers and providers. The complexity of healthcare forces both parties to get lost in the minutiae, and the focus is pulled away from the main objective: Improving patient care. Just as providers want healthy patients, health plans want healthy members. How each party gets there is often where the tension lies.

Each payer comes with their own set of rules and regulations that providers must follow when submitting claims. And with hundreds of health plans nationwide, it's no surprise that providers struggle to keep up.

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"That's where some of the complexity also lies," Brookings says. "There are payers that want things documented a certain way and have certain requirements for following the care than other payers do. Sometimes it's really hard for providers to know what those are or learn about changes."

Providers looking to stem revenue leakage from denied claims need a good understanding why a claim was denied, and how to remediate in the future. The communications from payers can't be overlooked.

"We have to leave room in the revenue cycle for the possibility that a payer comes back and says, 'We're not paying you for this reason,'" Brookings adds. "The team needs to make that change."

Go digital to avoid paper delays

While each of these can have a tremendous influence on improving ROI and reducing revenue leakage, none address the elephant in the proverbial room: Paper.

The annual CAQH Index tracks the high costs and missed opportunities for healthcare organizations because administrative tasks aren't being handled electronically. The medical and dental industries could save $18 billion annually by automating more processes, according to the 2023 CAQH Index Report.

"Anything that you're looking at that is related to paper in the revenue cycle is a wasted effort at this point," says Brookings. "We really should be looking at digital workflows to get that information back as fast as we can."

A digital process for those payments fixes a host of the problems with traditional paper checks. For example, consider the time it takes to move a paper check through the organization and document that the payment has been received.

"A couple years ago the time it took them to get a paper check was 14 days on average," Randolph says. "Now it seems to be getting closer to 16 to 20 days. And that's just on average. Providers can bring it down to 24 to 48 hours just by going to electronic payments."

Organizations relying on paper often struggle to track and understand why claims have been denied payment. Healthcare organizations need an electronic process in their revenue cycle management to avoid missed communications involving denials and ensure they are making the best use of resources.

"Being able to capture that remit back from the payer in a digital way allows the provider to capture additional communication back from the payer in a way that's helpful for the team that has to do the follow-up for the insurance," Brookings shares.

Paper-based processes cause more than just lost time and money. Providers also have to worry about the risk of check fraud, which has become a growing problem. In 2022, financial institutions nationwide reported 680,000 suspicious activity reports related to check fraud, nearly twice as many as the year before, according to the Financial Crimes Enforcement Network.

How Zelis can help

Zelis sees across the financial experience to identify, optimize, and solve problems holistically with technology built by healthcare experts — driving real, measurable results and modernizing the healthcare financial experience for all.

The Zelis Payments Network is a critical part of a connected platform that bridges gaps in the healthcare financial system and aligns interests across healthcare insurers, providers, and consumers. This solution consolidates and accelerates electronic claim payments and remittances across more than 450 payers.

By reducing complexities and enhancing efficiency, Zelis supports healthcare providers in their mission to deliver exceptional care while maintaining financial health.

To learn more about Zelis Payments Network, visit Zelis.com.

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