The State of Payer Reimbursement in 2024

It’s Time to Stop Living in Denials

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In 2024, the intricate balance between financial sustainability and patient care has become trickier than ever. As economic uncertainties and staffing shortages plague today's healthcare leaders, many are going back to basics, looking to increase efficiencies and streamline revenue cycle operations as a foundation of their operational success.

But are providers expecting enough from their revenue cycle and practice management systems?

According to a new study conducted by Sage Growth Partners, **just 25% of respondents are confident they're receiving every dollar they've earned from payers through their medical billing process, while just 35% consider themselves "very satisfied" with their revenue cycle** management solutions. Only 20% consider themselves "very satisfied" with their denial management process.

This spells out a broken system—or, one that falls well short of helping practices ensure they're getting every penny of revenue they need to deliver quality care, according to this group of 84 practice leaders and administrators.

Not to mention, more than one third of respondents say they spend more than 41% of their time thinking about the state of their revenue cycle—in other words, nearly three and a half hours a day. Practices are investing significant amounts of time into their revenue cycle, and that time is not just limited to billing staff.

With shifting payer requirements and other challenges impacting returns, it's no wonder leaders are looking for ways to optimize their revenue cycle. Solutions that employ automation and AI will be critical to updating today's RCM processes to help ensure practices get paid more efficiently and accurately from the payers.

01

Level setting: The state of revenue cycle in 2024

A snapshot of revenue cycle in today's strained healthcare environment

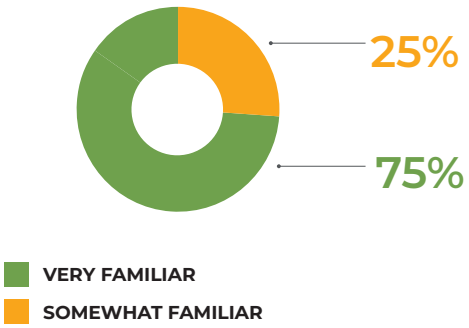
The healthcare revenue cycle is notoriously complex, and recently, organizations across healthcare have been even more compelled to optimize their revenue cycle strategies. Ongoing complexity in payer rules, escalating cost pressures, and a strapped labor market exacerbate fragmented systems—resulting in the near-critical need for solutions that increase both data transparency and automation.

Sage Growth Partners surveyed 84 practice leaders and administrators to dig into their experiences and pain points when it comes to optimizing their revenue collection. The group, who is highly familiar with revenue cycle management, represents a wide swath of the market. More than half of respondents (55%) are employed in single-specialty physician practices, while 44% work at multi-specialty practices. The challenges identified in the study also represent a range of practice sizes, from 10-20 billable providers to over 200.

Respondent Overview

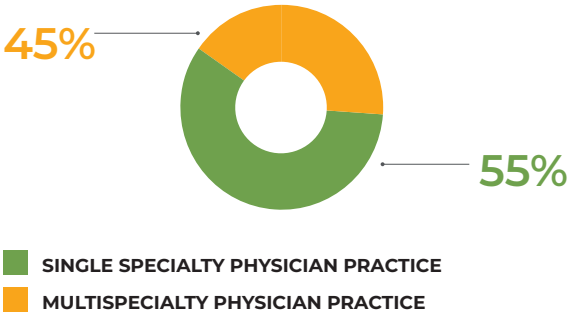
Respondents

Familiarity

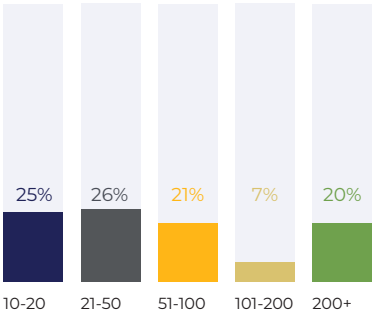


Organization Overview

Types of Organization



Billable Providers

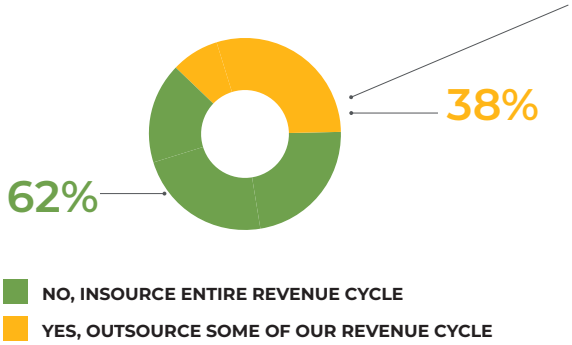


Thirty percent of respondents said their billing department employs between five and 10 people, while 27% employ between 11 and 20. Twenty-four percent of respondents said their billing teams have more than 30 employees. When it comes to remote work, 74% said they have billing staff work remotely, while 25% say their staff is in the office. The average (mean) total number of staff who work remotely is about 50%. **As a result, practices need better tools for managing remote staff**. One in four respondents said their staff spends too much time on revenue cycle management, and more than one in five said that their lack of tools that provide insight on staff productivity is a challenge.

When it came to whether or not respondents managed the full revenue cycle process in-house, 62% of respondents said they insource the entire revenue cycle. Thirty-eight percent of respondents said they outsource parts of their process, with bill collection (63%) as the most commonly outsourced part of their revenue cycle. Forty-seven percent said they outsource coding and documentation, along with claims scrubbing and payment posting, while 44% outsource their denials management processes.

How Revenue Cycle is Managed

Outsource or Insource?



Which part(s) are outsourced?

63%	Bill Collection	22%	Charge Management
47%	Coding & Documentation	19%	Registration, Enrollment, and Eligibility Checking
47%	Claims Scrubbing	19%	Charge Entry
47%	Payment Posting	9%	Prior Authorizations
44%	Denials Management	6%	Scheduling
44%	Work Rejections & Denials	19%	Other
38%	Claims Status Checking		
31%	Batching & Submitting Claims		

The survey also asked respondents how much time they spend thinking about their revenue cycle management processes. According to respondents, 34% of them spend more than 41% of their time thinking about their revenue cycle—further illustrating the critical role revenue cycle management plays in a highly successful practice, and the level of concern practice leaders have with it.

Today's practice management integrations leave much to be desired

Today's practice management systems are expected to do a lot of heavy lifting by practice management leaders. And although there are some things PM systems do well...others, not so much.

For instance, when it comes to managing the revenue cycle, only 20% of respondents say they are "very satisfied" with their PM's ability to manage denials, and only 35% are very satisfied with the PM's revenue cycle capabilities as a whole, highlighting the question: **just how much money are today's practices leaving on the table?**

Level of Satisfaction with Components of Practice Management System

Denial Management	Analytics and Reporting	Data Extraction	User Interface and Usability	Revenue Cycle Management	Claims Tracking
20% are "very satisfied" with their denial management	27% are "very satisfied" with their analytics and reporting	35% are "very satisfied" with their ability to extract data	33% are "very satisfied" with their user interface and usability	35% are "very satisfied" with their revenue cycle management system	37% are "very satisfied" with their ability to track claims

02

The best it can be: Attitudes toward current RCM processes

Although respondents say they're satisfied with current processes, challenging payer rules and mismanagement of denials continue to affect reimbursement rates

All respondents reported being familiar or highly familiar with their revenue cycle, but very few feel they're getting every penny they've earned from their payer partners. In fact, just 25% say they are confident they're receiving every dollar they can from each submitted claim.

And, just 31% feel strongly they have the data insights needed to identify patterns in claim denials. This is concerning, since understanding these patterns are key to collecting every dollar earned.

How much do you agree with the following statements about your revenue cycle?

	Disagree		Neutral			Agree	
	Strongly Disagree	2	3	Neutral	5	6	Strongly Agree
I am confident my organization is receiving every dollar earned from each claim submitted	12%	10%	15%	15%	23%	**23%**	**2%**
My organization has real-time access to the data needed to identify patterns in claims	7%	8%	11%	15%	27%	**20%**	**11%**
I would be comfortable using AI to improve the revenue cycle management process	4%	4%	6%	23%	13%	**30%**	**21%**

Given the concerns with optimal revenue collection, it's not surprising respondents were hesitant to categorize their revenue cycle as top tier—just 30% described their process as "excellent" or "market leading," while 46% said they consider their revenue cycle management process "good." These responses continue to illustrate how pervasive concerns over revenue cycle are throughout the industry today—while also highlighting the need for continued education around the value of automation and data transparency.

Strong opinions about friction with payers also say a lot about practice leaders' overall attitudes towards RCM. **Changing payer rules (62%) and difficult payer relationships (45%) were far and away the top two challenges that respondents named when it comes to managing revenue**. Furthermore, for the 44% of respondents who said their ability to manage and collect revenue over the past three years has gotten harder—a concerning trend in and of itself—the overwhelming majority named payer obstacles as the leading reason for the increased challenges. Visibility into the changing payer rules and workflows that automate claims to match those rules is not just nice-to-have, but critical to changing the story of frustrating provider-payer relationships.

03

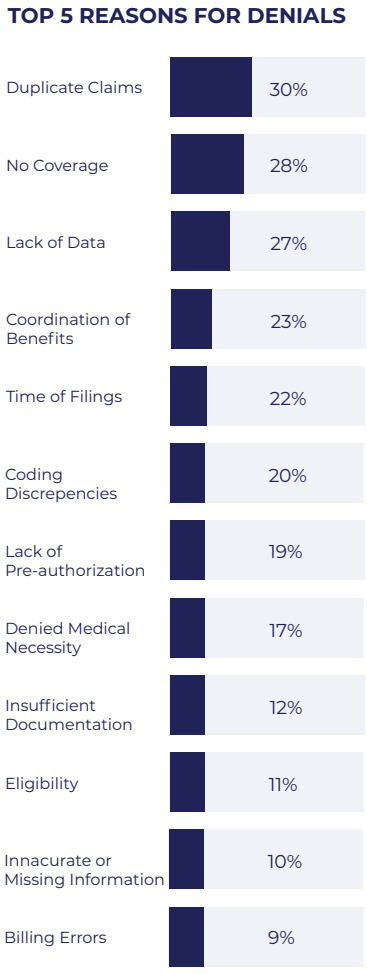
The root of the issue: Unpacking claims, denials, and payment posting

How today's methods for claim submissions are leaving dollars on the table

When digging deeper into the revenue cycle management process, respondents revealed a contradiction; **even though 75% of respondents were highly familiar with their RCM process, only 31% of respondents felt they had an accurate view of their claims and denials process, making it nearly impossible to gauge bottlenecks and potential money lost**. Yet, 51% of respondents said they'd be comfortable exploring artificial intelligence as a way to improve their revenue cycle, showcasing the desire for increased efficiency and automation—and a recognition that today's claims and denial processes aren't as good as they could be.

The top five reasons for denials came down to duplicate claims (30%), lack of coverage (28%) and missing data (27%), coordination of benefits (23%), and timely filings (22%). Intelligent automation of claim submission with rules-based, customizable software can eliminate errors before they happen—and also increase timeliness by reducing workflow friction and focusing billers only on the claims that truly need attention.

Top Reasons for Denials



All you need to know about claims scrubbing—and what's missing in clearinghouse and PM system scrubbers

When respondents were asked about the presence of a claims scrubber in their submission process:

- **40% said they use their clearinghouse's claim scrubber**
- **37% said they use one embedded in their practice management system**
- **12% use a third party**
- **11% of respondents don't use one**

When asked to rank critical components of timely payment in order of importance, 63% of respondents said claim submission is a key part of the reimbursement process. For those looking to increase speed of payments, a claims scrubber that validates claims prior to submission is critical to optimizing the process, since it prevents denials before they are even set in motion.

Given the challenges with changing payer rules explored above, it's also important for claims scrubbers to automate payer-specific and specialty specific claim edits—as well as practice-specific and claim structure edits—to efficiently prevent denials. However, these features are missing in PM system and clearinghouse scrubbers, despite the critical functionality they provide.

It's important to note too that the right claims scrubber has trickle-down effects for productivity across the practice, allowing billers to focus their attention only on problematic claims and to complete all parts of their job more efficiently. Today's latest RCM technologies offer just that; for instance, after one practice with 10 locations across the Midwest implemented Encoda's rules-based software engine, they went from posting 28% of their charges within one day of service to posting 89% of their charges within one day.

A journey through claim denials

Just how common are denials for today's medical practice leaders? According to respondents, 40% say their denial rate is between 10% and 30%. When digging in deeper:

- 29% say **10% to 20%** of their denied claims are due to incomplete coding
- 55% claim that **more than 75%** of their denied claims are followed up on...
- Yet a majority of respondents (73%) said **only 75% or less** of their denied claims are paid after resubmission

Even after resubmissions, it's most common to still have just **51% to 75%** of claims approved (30% of respondents), resulting in a quarter—and up to half—of resubmitted claims essentially going nowhere despite the effort.

04

Time's up: What's next for RCM

The latest in RCM technology is helping practices get all they can from the payers—as quickly as possible

With today's claims and denials processes leaving money on the table for practice leaders, the need for more efficient solutions—and data insights—is clear. For practices to receive the most accurate and timely payments from payers, ensuring the claim is right the first time is critical—along with leveraging the solutions that can make that happen.

According to **76%** of survey respondents, the ability to validate claims to help prevent rejections or denials before submission would be extremely valuable. However, even with technology that allows for claims validation prior to submission, it's the fragmented claims management processes that further prevent claims from being correct. More often than not, practice billing staff work on claims in multiple places, such as their own billing system and the EDI or payer portal. **75%** of respondents would see extreme value in having a single interface to be able to work all claims in one work queue.

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Finally, transparency into the claims status at the payer level is increasingly concerning. All too often, "stuck" claims are not only unrealized, but it's also difficult to understand how to fix them. Many of these are claims that fall off the practice's radar and may or may not get paid in the end. Three quarters of our survey respondents would find extreme value in having a solution to automatically monitor each payer to ensure no claim is left behind and unpaid.

Encoda is a healthcare reimbursement software engine that bridges the gaps between practice management systems, clearinghouses, and payers to simplify the complexity of medical billing. With Encoda, practices can validate the accuracy of claims prior to submission, lessening the chances of denials while saving both time and resources. By having all claims in one intuitive work queue, users no longer have to deal with disparate systems and siloed workflows. For the minority of respondents who felt their ability to collect and manage revenue had become easier over the past three years, improved tools and workflow were named as the number one reason for that improvement.

Conclusion

It's clear—current solutions for maximizing payer reimbursement are falling short. Methods that employ practice management systems, clearinghouses and payer portals leave much to be desired from practices investing time and resources into their billing processes. However, today's new technologies have been proven to streamline billers' work and increase automation and transparency, while allowing practices to accomplish more with less. In other words, practices that don't settle for the current fragmented set of tools will be able to cost-effectively collect the most revenue in the shortest time possible.

About the Study

Encoda commissioned Sage Growth Partners, a healthcare consultancy, to conduct a survey of 84 practice leaders and administrators between January and February 2024. Respondents included practice administrators and managers, C-suite leaders, RCM and billing directors, and other key titles familiar with the billing process at single-specialty and multi-specialty practices.

About Encoda

Encoda is the leading claims and denials software solution that acts as the connective tissue between practice management systems, clearinghouses and payers. In turn, we give practices greater visibility into their claims data, allowing them to address denials and post payments more efficiently—and more profitably.

Drawing from 30 years' experience developing and implementing revenue cycle software solutions, the team at Encoda is dedicated to revolutionizing healthcare reimbursement automation. And by doing so, Encoda is enabling customers to grow their businesses while significantly reducing back-office resources.

Today, Encoda realizes the true intention of healthcare reimbursement by enabling our clients to collect the most amount of money, in the shortest amount of time, as cost effectively as possible. How do we do that? By using our customizable, rules-based solution to bridge the workflow gaps between payers, clearinghouses, and practice management systems—allowing our customers to get every penny possible from the payers.

To learn more, visit encoda.com or contact info@encoda.com.