WHITE PAPER:

# What do you have to lose (and gain)?

## The True Cost of Lax Inventory Management with Outsourced Vendors: Cash, Cost, and Patient Trust

A Fresh Look at the 10–20% of Revenue Processed by Outsourced Partners

WAYSTAR

## Introduction

Today's revenue cycle increasingly relies on external business partners to process collections. Passing accounts back and forth from business office to outsource partner has always had data integration challenges. When the volume and value of accounts sent to third parties was limited to a small percentage of revenue and even less in cash, the process inefficiencies were insignificant enough to ignore. No longer. Now, with the percentage of revenue involved often above 20%, the costs and risks in the accepted "good enough" process are becoming too big to ignore.

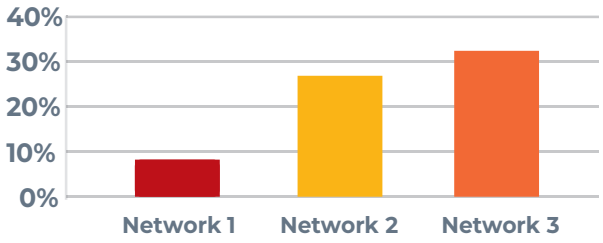
In an analysis of three different healthcare systems, inventory integrity issues between the provider's business office team and their vendor partners affected 20 to 30% of patient accounts sent to outsource teams. The recovery impact is sizable, with many of these affected accounts being stalled or completely missing. In addition, the hidden costs may be even greater than once thought.

These data issues lead to process issues that erode a patient's confidence in the financial relationship between patient and provider, which leads to more inbound calls, bill questions, complaints, and other costly forms of rework and administration. Consumer research has shown that only one in three patients evaluated their last hospital financial interaction as completely satisfying, and among those with balances over $100, the percentage fell to under one in four. An astonishing 50% of those surveyed consumers who had a balance due of over $100 will call into the business office to resolve issues.

## The data

In a recent Waystar inventory analysis of three hospital networks, account-level reconciliation found that an average of 23 percent of accounts had some form of account inconsistency. Effectively, 23 in 100 accounts being worked by organizations outside the business office had a data issue. The best of the three was running 8%, or one in every twelve accounts had an issue. The worst was over 30% or roughly one in every three accounts. None of these scenarios are acceptable.

**PERCENTAGE OF ACCOUNTS WITH RECONCILIATION ISSUES**




Reconciliation issues include a myriad of problems: Accounts can have balance mismatches between the vendor and the hospital patient accounting system. For Network 3, 22% of the errors were in accounts that the hospital thought were with agencies but in fact were not. An additional 10% of their errors were the exact opposite—they were with an agency but closed in the hospital system. For Network 2, 24% had location issues of one form or another, and 3% had issues with balance mismatches.

The three health systems included in this analysis represented a range of operational types and structures. All were over $1 billion in net patient revenue and multi-facility. Two were on Epic, and the third had several different systems in their various regions. All utilized third parties for patient-pay active A/R and bad debt, with several also using vendors for insurance follow-up on denials and underpayments.

## The implications of inventory reconciliation issues

Breakdown in inventory integrity is an insidious issue because it has negative effects on key operating imperatives. It raises operating costs, reduces recoveries, and erodes trust among vendors, business office teams, and patients. Data inconsistencies will infiltrate vendor invoices. For example, an account inadvertently placed with two vendors at the same time will trigger two commissions when the patient makes a payment. The hospital is effectively due to pay both partners for a single payment. Invoice inconsistencies tend to run 3 to 7%. Finding the double commissioning is a manual spreadsheet audit process, like looking for the needle in the haystack.

The recovery impact is also significant. For accounts that fail to place, commonly caused by missing files, broken recall rules, or failed file loads, the patient will not be engaged to resolve the balance and the cash will never be collected. Network 3, noted earlier, is, by definition, missing 22% of their return because the accounts are missing. It is routine to find upward of 20% of accounts lost in some black accounting hole. The time taken to find the account (if it is ever discovered) reduces potential recovery rates. Patients tend to pay a higher percentage of their balance the sooner they are engaged. In a recent analysis of a national sample pf patient bills by Waystar, a thirtyday delay in patient billing led to a yield reduction of over 30%.

Accounts on payment plans are another tangential point of performance leakage from poor inventory management. While not lost—an account is known to be at vendor—data around payment activity, or lack thereof, is often missing allowing accounts to become nonperforming without any repercussion. One organization in this sample discovered that 36% of their accounts on payment plans at their vendors were nonperforming and really were lost in the process. The accounts were nominally on a plan but simply nonperforming. Standard location and balance “checks” of inventory review processes would never discover the issue—no flag for nonrecovery would be set.

Beyond the direct cash and cost issues, patient experience implications will further raise costs as well as lower satisfaction scores. A single bill leads to calls and letters from multiple organizations, often with different names. For accounts lost in placement black holes, a patient hears nothing for months and months and then faces frantic collection calls and letters demanding payment. Who wouldn’t call to get more background? In a Waystar survey of consumer satisfaction with hospital billing processes, less than a third of respondents gave their experience a top rating on a 1 to 5 scale, with more than half giving a rating of 3 or poorer.

Ultimately, with what can feel like a nonstop series of complaints, issues, and frustrating discussions, provider and vendor emotions unravel and energy wanes. Providers know that the vendor invoices are in error, that there are accounts missing, but solving this puzzle is simply too hard. Performance management conversations become data reconciliation wrestling matches as opposed to collaboration. For providers using multiple vendors in a given stage for “competition,” the issues and frustration can double. Slowly but surely, trust and empathy fall by the wayside.

## Root causes

The core challenge is that an account is suddenly resident and being adjusted in two separate IT systems that have infrequent data exchanges and where the information is limited to account-level financial adjustments. On one side is the hospital’s patient accounting system, which is the system of record. On the other is the IT system of the business process outsourcer. While it is easy to assume that because it is computer-to-computer the exchange is error proof; that is wrong. The intermittent and narrowness of the data exchange leaves lots of room for cracks when dealing with tens and hundreds of thousands of accounts.

Some issues occur immediately at the assignment of the account to a vendor. The hospital patient accounting system might fail to generate a daily placement file, or the file they do generate has integrity issues, meaning it won’t properly load. Another cause is that the hospital patient accounting system might have a selection issue such that while the system has the account as a patient balance, it fails to load it into a placement file. Many times, a file will be picked up by the intended recipient—either the hospital or their vendor partner—but fail to be processed, almost like a bag of groceries that sits in the car and never gets brought into the kitchen.

Assuming the account has made it to the outsource partner, the daily effort to engage the patient begins. On a daily basis, hundreds of detailed activities need to be connected to the patient account, adjusting balances and timing and responsibilities. Checks are received and the provider is told it is "paid in full" only to discover a week later that the check didn't clear. Patients ask questions and need more information, so requests to provider teams are made via phone, email, or fax. Many times, insurance will be discovered and a new payer bill needs to be generated out of the hospital billing system. Postdischarge, patients file bankruptcy, or die, or seek charity classification. Over 10% of patient accounts sent to a third party will need some form of exceptional processing along the lines of these issues.

With all the activity, accounts are moving around vendor workflow systems, being tagged for future follow-up, or awaiting additional information. A missed note here, a failure to update a status flag there, and slowly but surely in creep account status disconnects. The issues grow unnoticed because the standard connectivity between hospital systems and their vendor partners focus on financial changes and not activity or status. So if the account is awaiting some follow-up by some party but there is no financial trigger, no one is the wiser.

The problem is not avoided when a new "modern" patient accounting systems is installed, because the root of the problem is in the communication between systems and their respective limitations and data philosophies. Because a health system utilizes multiple vendors and each vendor has their own technology infrastructure, it is not a simple single-system integration problem. The hospital system is piped into five, ten, even fifteen different vendor systems, each with their own data structures, definitions, and operating routines. Compounding the problem, everyone is constantly going through IT updates.

## "Non-solution" solutions

The prevailing, historic approach to this issue is to play ostrich—bury our heads in the sand and hope nothing bad happens. This approach might have been acceptable when only a handful of patients had payment responsibility and the portion ever sent to a third party for collection was a miniscule portion of a health system's patient community. All of these are no longer the norm. Moreover, with CFPB, IRS Form 990, 501r regulations, and general attention on patient medical debt, the exposure from gaps and miscommunication is increasing dramatically. Next up is the supersized Excel spreadsheet process, comparing inventory and invoice lists every month. On one side is the patient accounting data and the other the matching list from each vendor. Sort and compare; sort and compare.

Given the burden, many organizations simply reconcile a sample from the total inventory and, as long as the error percentage seems in line, consider the status quo acceptable. It also doesn't solve the hidden challenge of accounts lost in the black holes of "awaiting approval."

Another approach to solving this problem is to foist the issue on the hospital's vendor partners. Hospital teams ask their vendors to identify issues and update all the databases. Aside from what is a possible data control risk, vendors and providers have different incentives and, in many situations, are on opposite sides of the issues. One last strategy is the periodic clean-up consulting project. Internal data teams or consultant teams are formed to compare and correct inventory gaps. These efforts tend to be initiated around patient accounting system transitions where inventory is going to be migrated. If the inventory reconciliation problem is anticipated to be monumental, many health systems will simply not migrate old inventory, and the solution is to assume the problem away with time—a nonsolution solution or a temporary patch at best.

## Sustainable and financially viable solutions

What is emerging as a sustainable approach to inventory integrity is specialized vendor management platforms—extensions of patient accounting systems that manage and monitor the flow of accounts to and from the vendors using both financial and activity data on a highly frequent basis.

These technologies employ rules engines and database integration technology to monitor hospital and vendor data nightly and surface gaps for review. Critically, if the system is going to address the root causes of reconciliation gaps, the file structures need to include both financial transaction data and collection activity data. Without the latter, it is impossible to truly diagnose process gaps and disconnects. Better solutions categorize the issues and create work lists or queues of like issues that can be reviewed by specialists in a time-efficient and focused manner. Ultimately, the process can move from fixing individual account issues to naming the 20% of causes that lead to 80% of the problem and taking prevention steps.

Admittedly, a technology platform approach is an investment, financially and operationally. Financially, these platforms are an incremental budget item. Operationally, there is the resource investment to deploy and the commitment to stay engaged. Deployment starts with a onetime inventory clean-up project, usually led by the technology vendor who will have a structured process for reconciling and identifying gaps. Once clean, the tighter data integration from the technology will surface issues early and enable provider teams to resolve gaps in smaller, more digestible work efforts—not a monumental list of problems seen monthly, but a short list each week and flagged by type.

Case studies suggest the return can yield multiples of the cost, not including the benefits in patient satisfaction and trust between vendors and business office teams. Sustained performance improvement is in the millions of dollars in improved recovery against a cost in the hundreds of thousands.

## ABOUT WAYSTAR

*Waystar simplifies and unifies the healthcare revenue cycle with innovative, cloud-based technology. Together, our technology, data and client support streamline workflows and improve financials for our clients, so they can focus on their patients.*