

WHITE PAPER

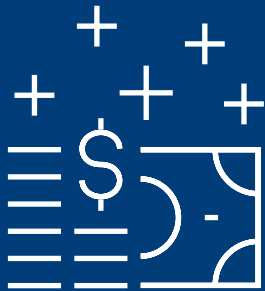
3 Strategies to Ensure a Smoother, More Connected Revenue Cycle

The revenue cycle is not a set of standalone departments – it's a tightly connected chain. And when one link fails, the impact reverberates throughout. What happens during patient registration doesn't stay at the front desk; it follows the claim all the way to payment. When things go wrong, they show up as claims denials, delayed A/R, and frustrated patients.

Many initial denials can be traced back to the very first interaction with the patient, where small data capture mistakes – like a mistyped birth date or an outdated insurance plan – silently set the stage for delayed billing and revenue disruption down the line.

As pressures mount across staffing due to payer complexity and operational inefficiency, forward-thinking organizations are recognizing the need to close these gaps across the revenue cycle. They are shifting from siloed approaches to systemic ones that connect data, processes, and people at every phase of the revenue cycle.

Automation and other best practices aren't just “nice to have” anymore. They're essential for preventing backlog, optimizing A/R, and sustaining financial stability. Whether you're running a small ambulatory practice or a hospital within a nationwide health system, the need to streamline and connect every step of the cycle continues to rise.



Did You Know?

25% of providers¹ say timely reimbursements and payments are their top revenue cycle priorities.

Let's break down three ways that RCM interconnectivity and smarter strategies can transform outcomes.

1. "Claims Denials: Causes, Impact, and AI-Enabled Prevention Strategies," Inovalon, October 2024, <https://www.inovalon.com/resource/claims-denials-causes-impact-and-ai-enabled-prevention-strategies/>

#1: Improve Data Collection at Patient Registration

Patient registration is the first mile of the revenue cycle – and where organizations often fall behind. With 67%¹ of providers [attributing denials to insurance eligibility and benefits verification](#), it's clear that bad data at intake creates big problems downstream.

The beginning of a patient encounter sets the foundation for the rest of the financial experience, including claim generation and adjudication. When a patient schedules an appointment, it's critical to ensure they have accurate, up-to-date information in order to financially clear the patient before care is delivered. That means confirming patient demographics, validating insurance coverage, and clearly understanding the benefits tied to that plan.

When this process breaks down, the effects are felt later. Delayed A/R is one of the most common results, especially when there aren't practices in place to capture accurate information upfront. For example, if a patient shares incorrect or outdated coverage and staff doesn't catch it, the claim is sent to the wrong insurer. When the denial comes back, the billing team is forced into manual rework, reaching out to the patient to track down the correct information or billing them directly in hopes they respond.

Even when front desk staff ask the right questions, patients might unintentionally provide inaccurate details. In some cases, they don't realize their plan has changed since their last visit, which is why having the right technology to verify details is essential.

However, revenue cycle software alone isn't enough. There must also be an organization-wide commitment to RCM best practices. It's up to your team to prioritize proactive verification and communicate clearly with patients by asking if their insurance or demographic details have changed. Staff should be trained and empowered to verify information in real time – which is what today's technology enables.

Optimizing data collection at the front desk isn't just about speed or convenience. It's about setting the financial health of the revenue cycle on the right path from the very beginning. When organizations get registration right, they avoid the boomerang of bad data and create a smoother journey from appointment to payment.

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How healthcare teams are closing the gaps

Solutions such as Inovalon's [Eligibility Verification Pro™](#) are helping providers validate addresses, verify insurance, and even uncover other sources of coverage through coordination of benefits.

"You'd be surprised how often patients return with terminated insurance," said Dr. Ernesto Sarduy, CEO of [South Florida Psychiatry](#), a behavioral health provider in Miami. "If we don't catch that upfront, we risk losing revenue for months of care. With Inovalon, we're catching it early."

[Face Rock Enterprises](#), a tribal health organization, reduced eligibility errors for its clients from 70–80% to 2–6% in just three months using solutions such as Inovalon's [Insurance Discovery™](#).

#2: Reduce Claims Denials and Delayed A/R

While optimizing data collection and validation on the front-end can mitigate reimbursement delays downstream, healthcare organizations still need to apply best practices throughout their revenue cycle.

One of the most important practices is targeting a first-pass acceptance rate in the high 90s. With claims denials on the rise, achieving this rate may be challenging – which is where software for claims scrubbing, tracking, and RCM analytics come in. These can all help improve a good revenue cycle into a highly efficient, strong-performing process.

Another way to offset denials and increase accuracy is applying custom business rules to claims workflows, which can be set for specific payer requirements or staff workflows. Instead of staff members manually fixing common errors claim by claim, custom rules help flag and correct them automatically, saving time and reducing mistakes, while helping your revenue cycle run smoother.

Simpler operations for faster billing

For HMG Healthcare, automated claims workflows [shortened submission time from 15 to 9 days](#). Using Inovalon's [Claims Management Medicare Pro™](#) and [Claims Management Pro™](#), this skilled nursing provider eliminated the need for billing staff to visit multiple sites and complete multiple form downloads to submit each claim. As a result, the billing department spends far less time getting claims out the door.

While greater efficiency makes a big impact for post-acute organizations, it's also significant in acute settings.

“My priority was to constantly look for more efficient workflows, processes, and technology to take the manual pieces out,” said Rachel Dallmann, former Revenue Cycle Director and current Senior Vice President of Clinical Operations at [Phelps Memorial Health Center](#), which reduced its A/R days from the 90s to the 30s with Inovalon solutions. “The more we can decrease the amount of manual intervention, the better.”

“Best practice is to not only have a claims scrubbing component to identify potential loopholes that could result in a denial, but to apply this knowledge to future claims submissions to protect revenue integrity,” said Kem Tolliver, President of Medical Revenue Cycle Specialists, an Inovalon partner who helps providers [strengthen their revenue cycles](#).

Empower staff with specialization and smarter workflows

While having the right solutions in your arsenal is critical to improving first-pass acceptance rate, revenue cycle staff also play a crucial role in reducing delayed A/R and increasing A/R efficiency. When organizations reduce the volume of claims coming back from payers for minor errors (e.g., inaccurate information and coding errors), their revenue cycle staff has the capacity to tackle more complex claim denials to recoup revenue.

Healthcare providers can also improve revenue cycle efficiency by having staff specialize in a type of rejected or denied claim. That person becomes the internal expert on that specific type of denial and can make the best decision on whether the organization should appeal it. Team members can also specialize by payer or site of care if organizations notice that some payers are rejecting or denying more claims than others, or some of their care sites are getting more denials.

The revenue cycle management transformation at Phelps Memorial Health Center featured a shift to proactive, tech-enabled workflows that ensured cleaner data, less manual rework, happier patients, and a faster path from care to payment.

“We collected demographic information from our systems before the patient even got here,” Dallmann explained. “That minimized the interaction with our team in admissions, which increases patient satisfaction because they are no longer sitting there having to go through all their information when they were just here a month ago.”

#3: Prioritize Patient Collections

Traditionally, payers have been the primary source of aging A/R and non-payment in healthcare. But the financial landscape is shifting. As patients take on a greater share of their healthcare costs, providers must evolve their revenue cycle strategies to reflect this new reality. Many organizations still focus almost exclusively on payers, leaving the patient piece underdeveloped or entirely unaddressed. That gap can be costly.

Patients now expect the same convenience and flexibility they experience in retail and banking – and providers that meet those expectations are more likely to get paid. Offering a variety of payment options is a strategic advantage for organizations of all types. Different patient populations may have different preferences. Some may want to pay online, through patient portals, or via secure links sent by text or email. While others may prefer mailed paper statements. Healthcare organizations that want to reduce patient A/R need to serve both ends of the spectrum.

Even when providers mail paper statements, relying solely on the address returned in an eligibility check can lead to missed bills. Patients often forget to update their address when they change insurance. As part of the access process, organizations should tap into postal databases to ensure billing information is accurate from the start.

When it comes to receiving reimbursement from patients, one of the most impactful approaches is keeping a card on file. Inovalon's [Patient Payment Management](#)™ provides this ability, which can significantly reduce delays in receiving patient payments. In many cases, providers face a lengthy wait after a clinical encounter to collect from patients. First, the payer must adjudicate the claim. Then, the provider sends a bill to the patient. Often, follow-up is needed to prompt payment. A card on file, and a payment plan the patient agrees to, work together to eliminate this delay.

With patient permission, front desk staff can securely collect a credit or debit card number during check-in. The card isn't charged immediately – it's held until after the claim is processed and the patient's balance is known. At that point, the balance can be charged automatically, or a text-to-pay notification can be sent. Both options streamline payment, reduce manual billing tasks, and improve the patient financial experience.

Turn payment touchpoints into revenue, efficiency, and trust

The benefits of better financial engagement strategies go beyond faster payments. With the right solutions in place, providers can ease administrative burdens on staff, simplify the patient experience, and accelerate revenue collection all at once.

Interim Healthcare, which provides home health and hospice services, [reduced its statement processing time by 97%](#), from 32 hours per month to less than one hour using Inovalon's [Patient Statement Management™](#). "We're not just improving cash flow – we're creating a better experience for our patients," said Katie Spencer, Director of Revenue. "They know what to expect. We're transparent. We've made it easy."

Lakeland Mental Health Center saw similar efficiency gains after moving from a clunky, unreliable system to Patient Payment Management. The shift significantly reduced follow-up needs and payment delays by giving clients the flexibility to pay anytime – early mornings, after business hours, or on weekends. The software also allows clients to set up convenient payment plans, further reducing friction for staff and patients.

The Power of a Connected Revenue Cycle

The revenue cycle doesn't function in a silo, and success doesn't happen in one department alone. It's the result of coordinated, connected action across patient access, billing, claims, and collections. When every phase communicates and reinforces the others, revenue flows more smoothly, and both staff and patients benefit.

Each of the strategies outlined plays a distinct role in building a revenue cycle that is not only efficient but resilient. They work best when implemented together, forming a system where good data in leads to faster payments out, and where both payer and patient responsibilities are handled with precision and care.

Technology is a key enabler, but process and culture must evolve alongside it. From validating insurance in real time to automating claim edits and offering patients modern payment options, the organizations seeing real gains are those that have committed to making every step in the cycle work together.

Ready to See the Big Picture and Connect Your Entire Workflow?

Expand your visibility and control with software that connects all of your revenue cycle, from eligibility checks to claims processing and faster reimbursement.

Explore Our RCM Solutions

About us

Inovalon is a leading provider of cloud-based SaaS solutions empowering data-driven healthcare. The Inovalon ONE® Platform brings together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated cloud-based platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by over 50,000 active, licensed customers.

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