

# THE BIG THREE: PATIENTS, PROVIDERS, AND PAYORS

LEVERAGING DATA TO OPTIMIZE FINANCIAL  
PERFORMANCE

# Speakers



## **Diana Richard**

AVP, National Accounts  
XiFin, Inc.

With 20 years of experience working in the diagnostics industry, Diana has an exceptional understanding of the market landscape. She has worked with numerous healthcare providers, helping them improve their revenue cycle management performance, explore financial process improvement opportunities, and develop strategic partnerships. Diana's previous roles include senior-level business development, client management, billing performance, internal auditor, and marketing. Diana holds a BA in Marketing as well as Economics from Francis Marion University.



## **Debbie Windsor**

VP, Market Access

Debbie has over two decades of experience in the healthcare industry, having held various sales, market access, and leadership roles in diagnostic, pharmaceutical, and medical device organizations. She is an established team leader with deep expertise in all facets of market access and reimbursement, including navigating medical policy and payer contracting. Her experience includes leadership roles at Mayo Collaborative Services, GeneDx, Exsome Diagnostics, and Quest Diagnostics. She holds a Master's in Healthcare Leadership from Capella University.



## **Stephanie Denham**

VP, Enterprise Clients  
XiFin, Inc

Stephanie has over 20 years of experience in healthcare revenue cycle management (RCM). As a Certified Public Accountant (CPA), she brings a strong financial foundation to strategic initiatives that improve client satisfaction by fostering strong partnerships with key stakeholders. She collaborates with cross-functional teams to deliver actionable insights, streamline workflows, and improve RCM outcomes. Prior to joining XiFin in 2018, Stephanie served as Director of Client Management at Change Healthcare (formerly McKesson).

# Overview



Value Creation Across Patients, Providers, and Payors

Financial Analytics to Identify Revenue Leakage

Enhancing Patient Engagement and Collections

Improving Provider Performance

Optimizing Payor Relationships and Reimbursement Outcomes

Key Takeaways

# VALUE CREATION ACROSS PATIENTS, PROVIDERS, AND PAYORS

# Common Barriers to RCM

**Complexity** - 58% of insured patients report problems using their health insurance, citing claims denials, billing confusion, and administrative complexity



**Resources** - ~70% of denied claims are eventually paid, but only after costly manual intervention and delay.



**Time**—>50% of RCM staff time is spent on rework for errors, denials, and follow-up

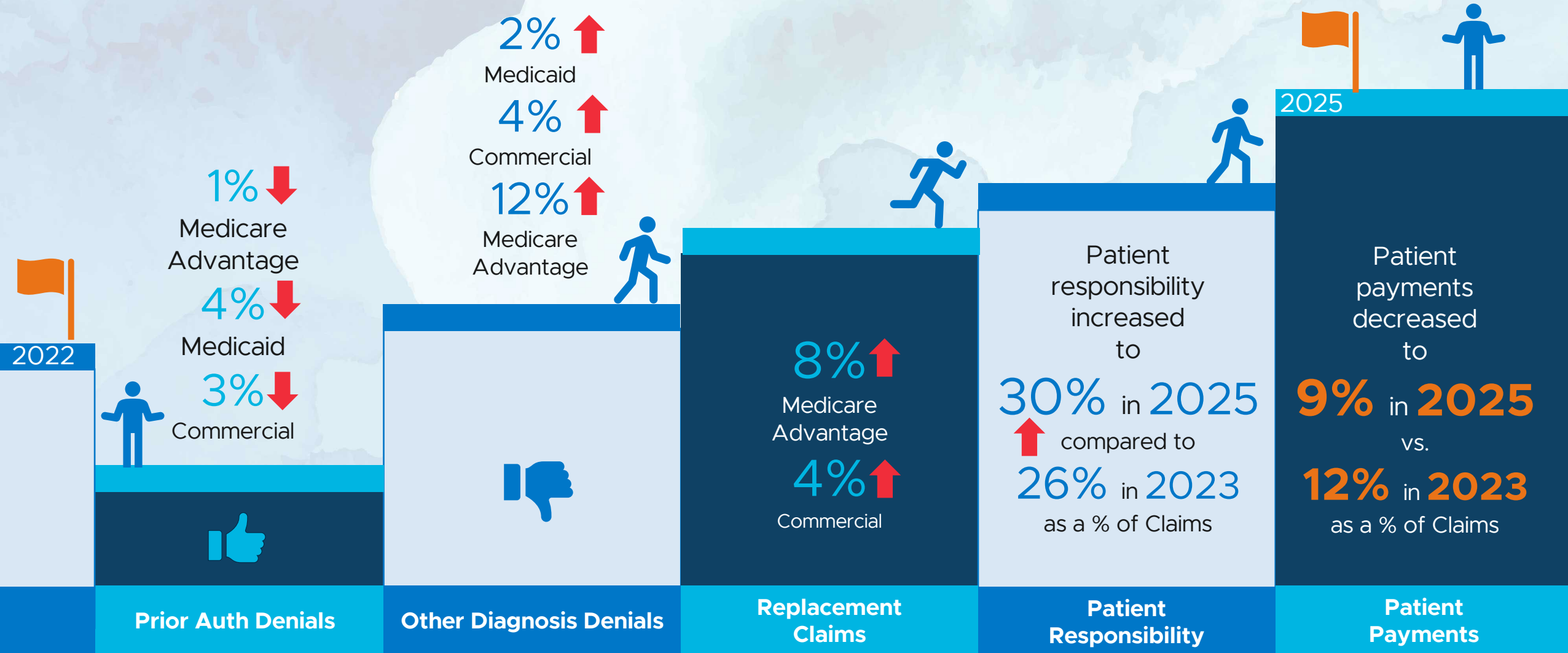


**Technology**—84% of health insurers now use AI/ML in daily operations, marking industry-wide transformation (NAIC, 2025)



# Key Factors Impacting Reimbursement

Analysis of Change From 2023 to 2025



# Patient Debt Spike: Credit Policy + Cost Shifts

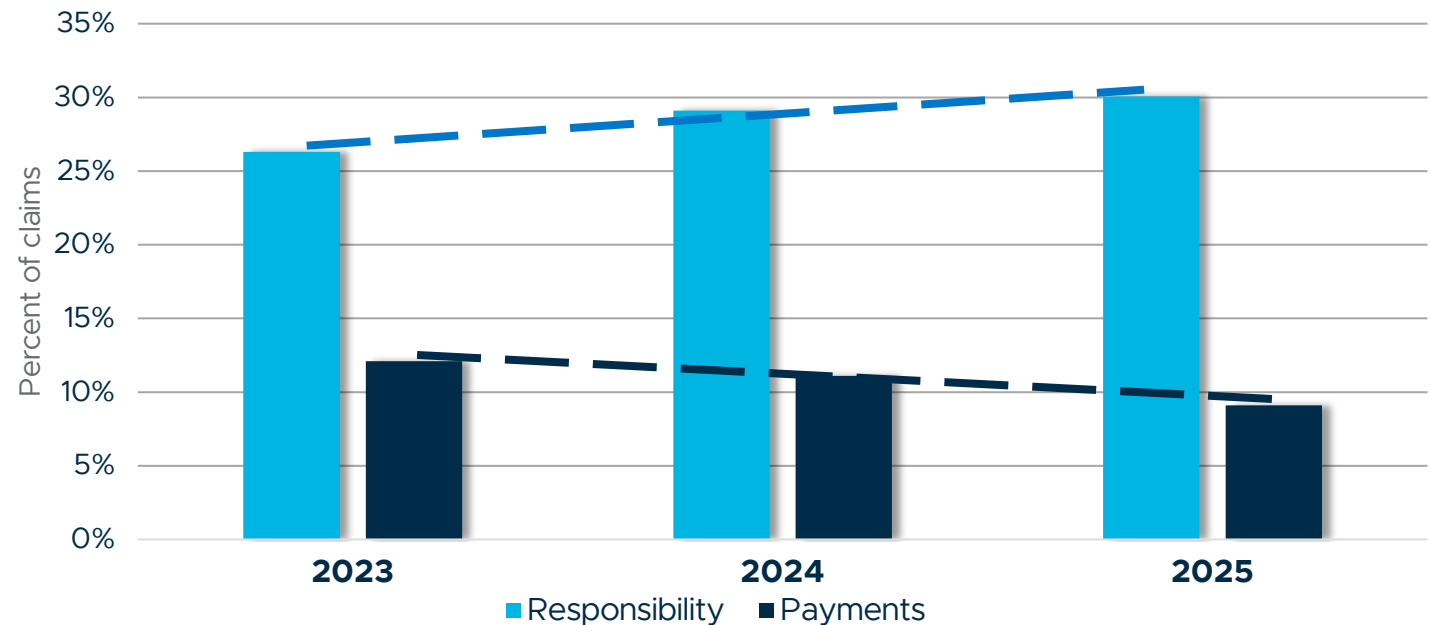
## AI-enabled First Patient Encounter:

- Provide accurate estimates of their out-of-pocket expenses
- Facilitate various kinds of payment types
- Work with providers to collect pre-payments
- Use patient welcome letters
- Offer digital statements and text payment reminders (35% of patients paying by text vs paper is achievable)
- Consider financial assistance programs
- Enable automatic text messaging with an opt-out

XiFin data shows:

- 26% of claims had a patient responsibility in 2023, growing to 29% in 2024, and hitting 30% in 2025.
- 12% of claims had patient payments in 2023, patient payments were represented in only 11% of claims in 2024, and in only 9% of claims in 2025

## Patient Responsibility vs Patient Payments



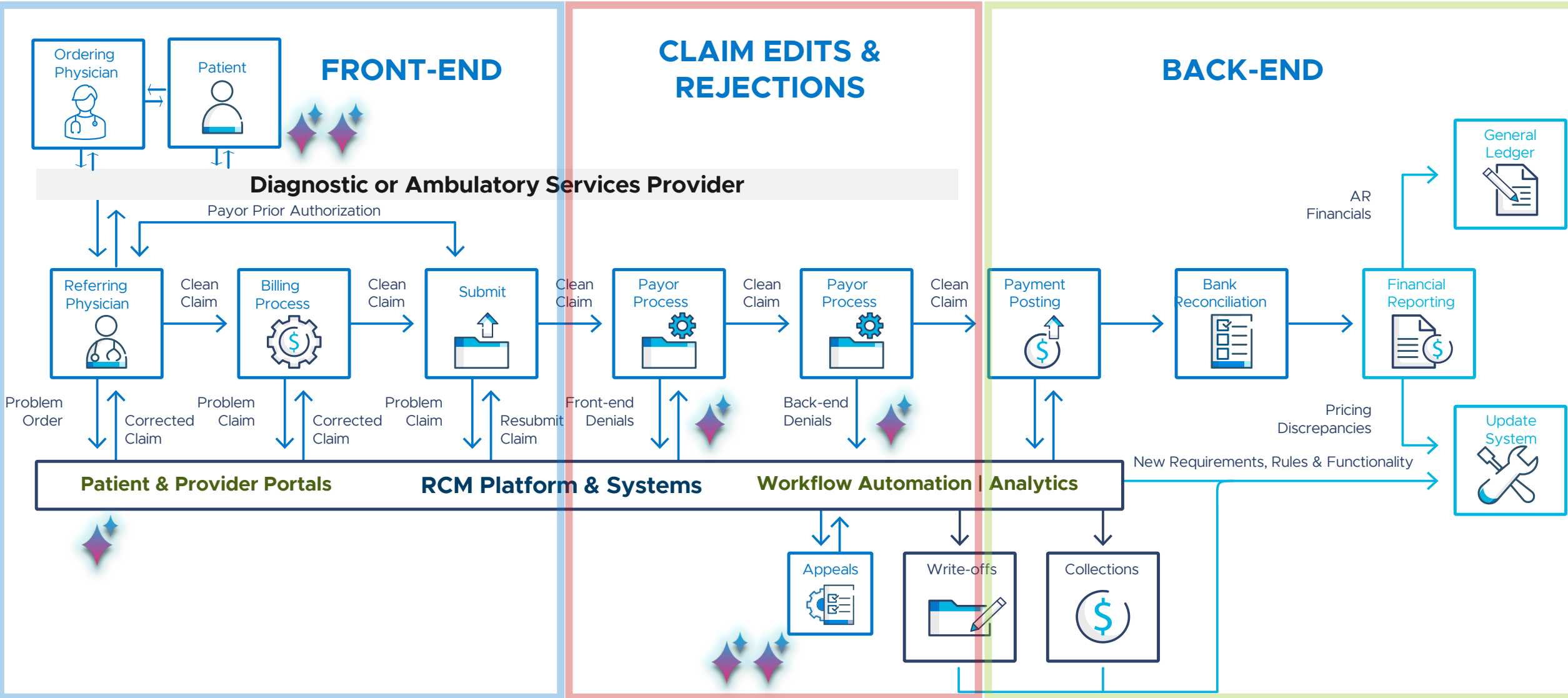
**As patients' out-of-pocket expenses rise, patient payments decline**

# Common Thread: Complexity Exceeds Manual Capacity

AI at the Edge of Revenue means applying AI principles to revenue-critical workflows

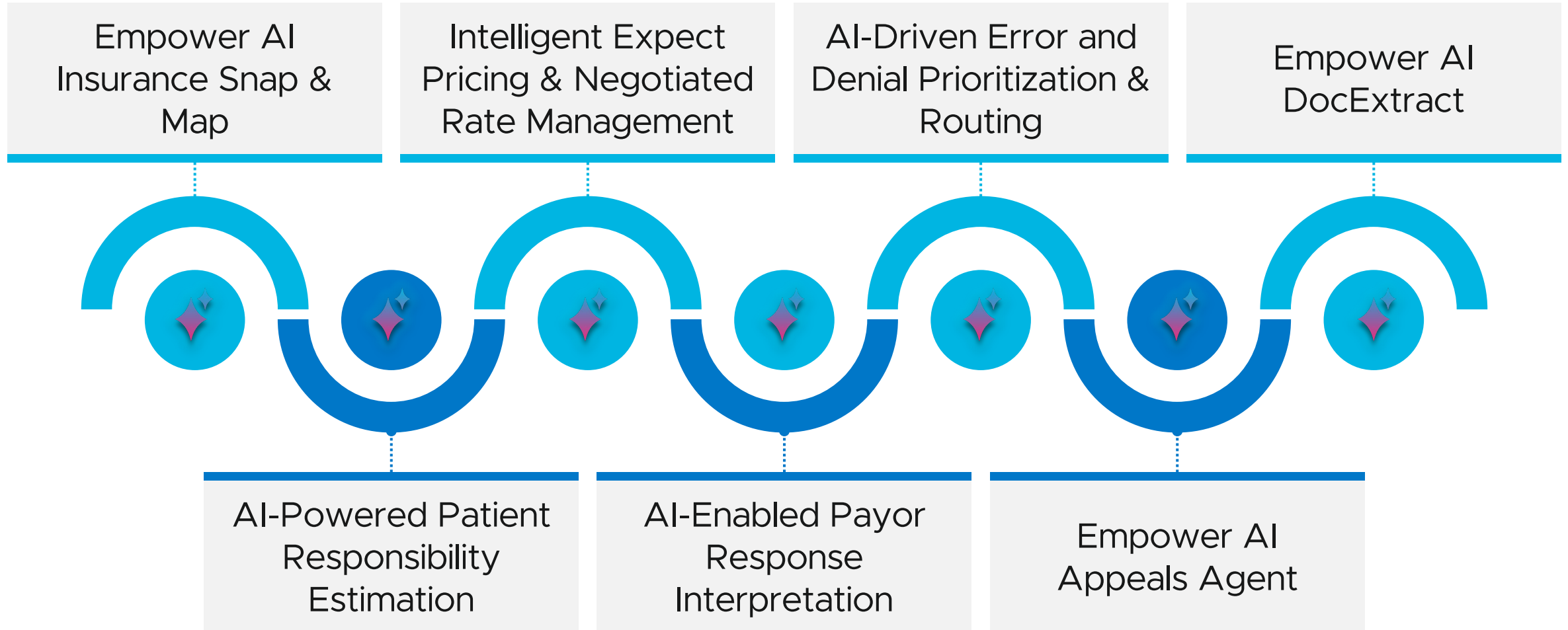
- The Illusion of Linear Scaling
  - Revenue cycle complexity was historically managed by adding staff, training, and policies
  - This approach only worked when rules were stable and complexity grew slowly
  - Today, that assumption no longer holds
- Why Traditional Fixes Fail
  - Payor rules, coding requirements, and policies now change too fast for manual processes
  - Human capacity scales linearly while complexity grows exponentially
  - Training, manual QA, and added headcount introduce lag, errors, and delayed revenue
- The Case for Intelligence at Scale
  - AI enables scale that matches complexity—not more people, but smarter systems
  - Can ingest and operationalize the full universe of payor rules
  - Learns from every denial, adapts in real time, and predicts issues before submission
  - Represents the only sustainable path forward for revenue operations

# Value Can Be Created at Every Stage in the RCM Process



# Making Revenue Cycle Management **Simply Smarter**

Driving a smarter, faster, more predictable revenue cycle with AI



# Optimizing Financial Performance Relies on Seamless Integration of All Three Phases of the RCM Process

The RCM process relies on seamless integration and optimization of all three phases:



Accurate data capture in the **front-end** ensures fewer downstream issues.



Efficient workflows in the **middle** reduce payor-related obstacles and streamline claim submissions.



Proactive strategies in the **back-end** lead to faster payments, improved patient satisfaction, and better financial performance.

Each stage benefits from robust data reporting, clear workflows, and leveraging technology to minimize inefficiencies.

# FINANCIAL ANALYTICS TO IDENTIFY REVENUE LEAKAGE

# Advanced Reporting: Your Checklist

Begin with the  
End in Mind



Use  
“Indicator”  
KPIs



Build the Story



Have a  
Conclusion



# Essential KPIs

## Patients

- Bad Debt
- Dunning Cycle success rates
- Collection Agency recovery

## Providers

- Data quality / clean claim submissions
- Payor and Test Mix (cherry picking)
- Profitability

## Payors

- Rejections and Denials
  - Impact of Payor Policy changes
- Expect Price Discrepancy



# ENHANCING PATIENT ENGAGEMENT AND COLLECTIONS

# Patients: What to Consider

## Engagement Strategy

- Patient Portal for payments and information updates
- Electronic billing



## Collection Strategy

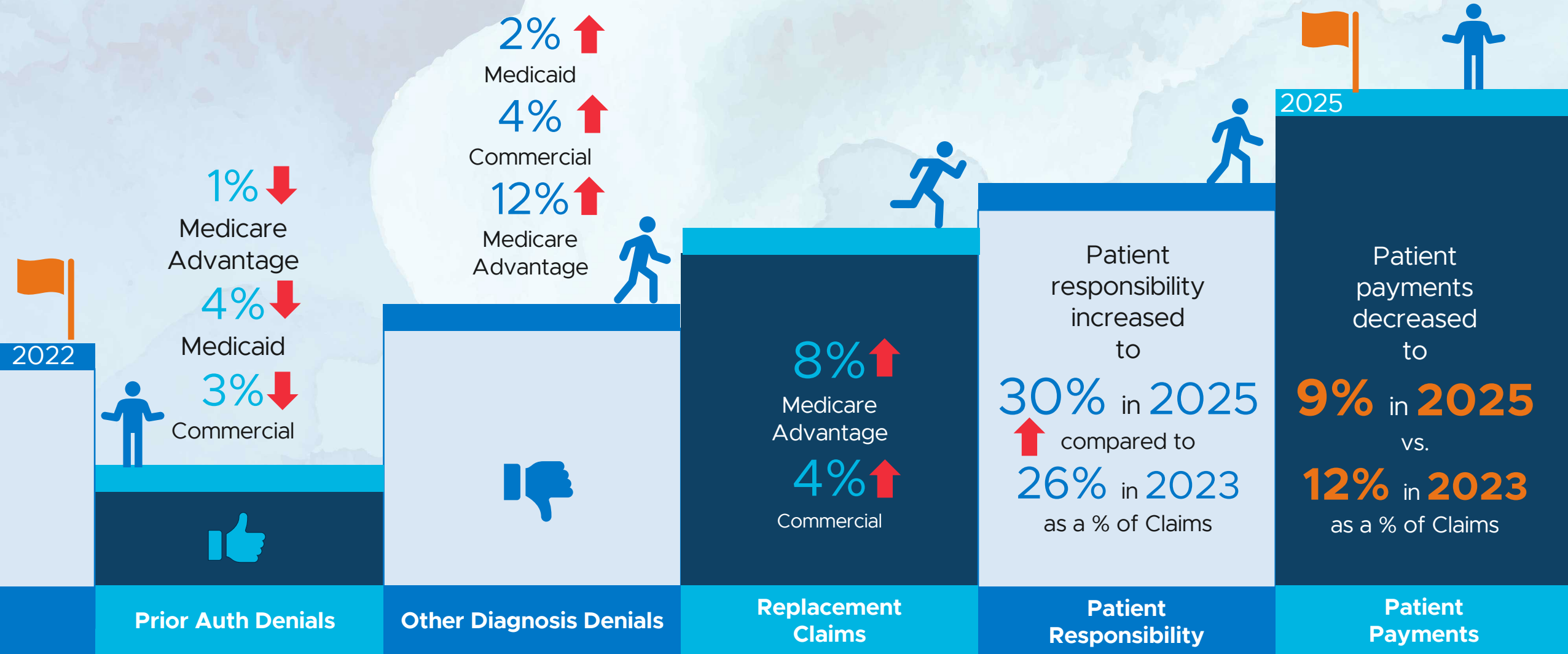
- POS Payment capture
- Payment plan structures
- Collection agency engagement



**Strategic Dunning**  
Timing and technology

# Key Factors Impacting Reimbursement

Analysis of Change From 2023 to 2025



# Evolving the Patient Experience

## Improving patient engagement reduces patient bad debt



### With Engagement Solutions, Patients Can:

- Make payments through online payment options and payment plans, accelerating collections
- Update documentation and insurance details, reducing patient and physician phone calls and improving satisfaction
- Receive estimated out-of-pocket expenses upfront, accelerating patient payments
- Access electronic statements, accelerating patient collections



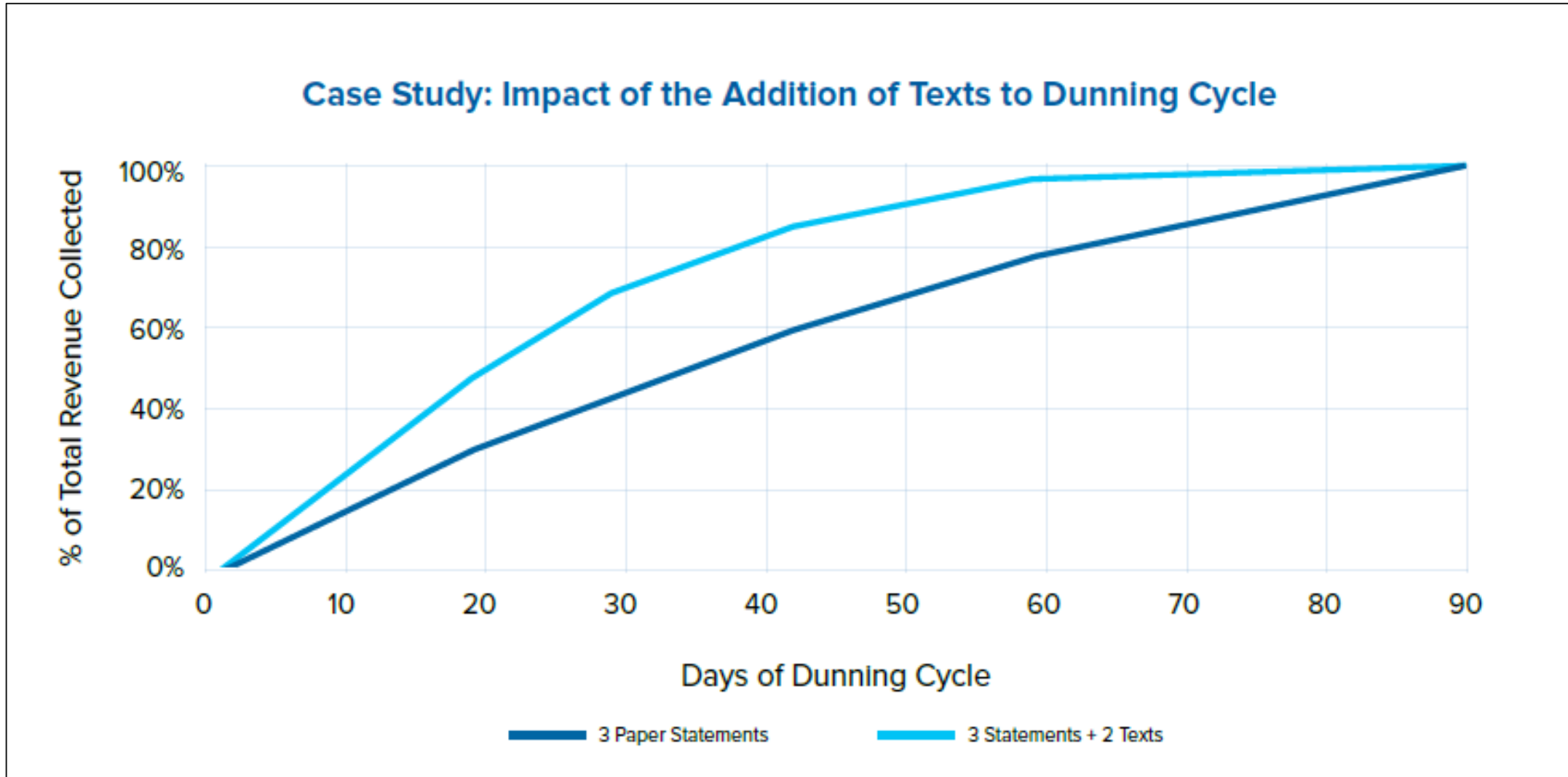
**Offer multiple options for your patients' communication preferences**

# Accelerating Patient Payments with SMS Texting

Meet patients where they are: on their phones to accelerate patient payments

<b>What</b>	Patients receive secure statement links via SMS text on their phones
<b>How</b>	<ul style="list-style-type: none"><li>▪ Automated texts during the dunning cycle</li><li>▪ Multiple reminder messages</li></ul>
<b>Why</b>	<ul style="list-style-type: none"><li>▪ Mobile-friendly statement and payment experience</li><li>▪ Mailed statements delay patient payments</li></ul>
<b>Value</b>	<ul style="list-style-type: none"><li>▪ Faster patient payments</li><li>▪ Lower printing and mailing costs</li><li>▪ Better patient engagement</li></ul>

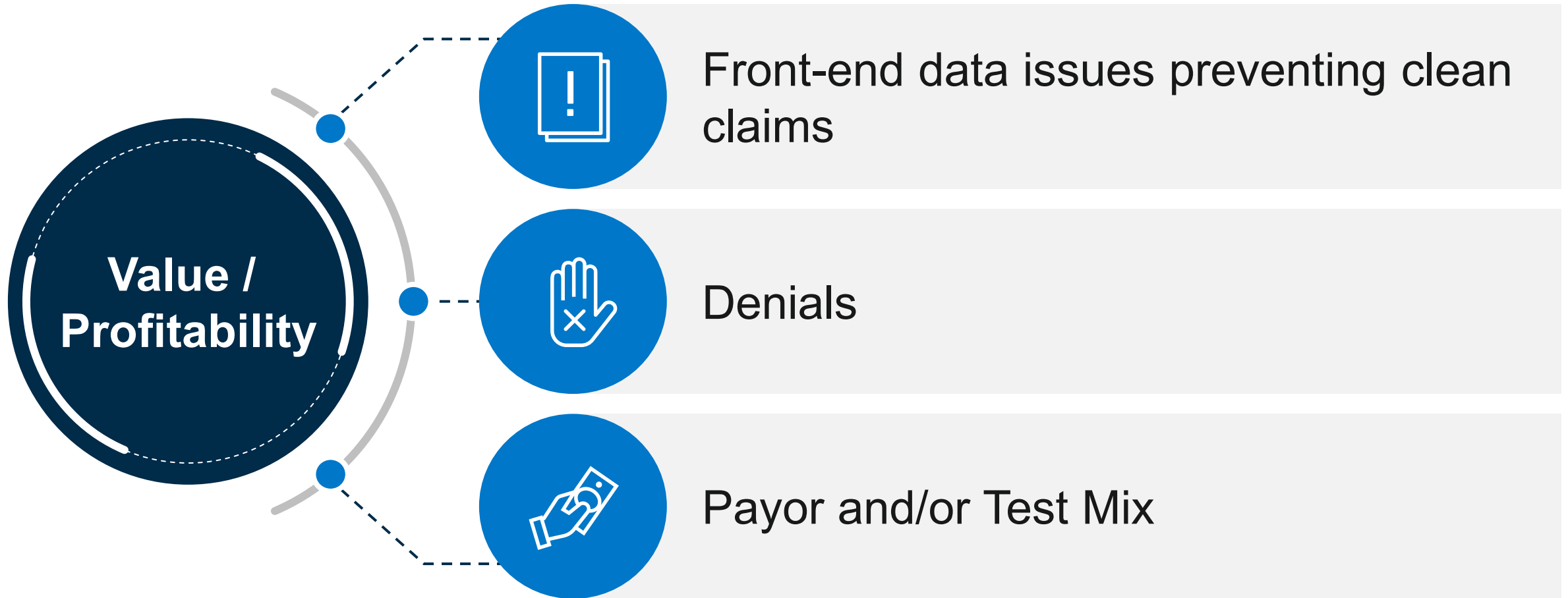
# Patient Example: Applied Analytics



# IMPROVING REFERRING/ORDERING PROVIDER PERFORMANCE

# Referring/Ordering Providers

## Key Considerations



# Measuring Underperforming Provider Clients

## Three Most Common Areas of Diluted Value



# Measuring Underperforming Provider Clients

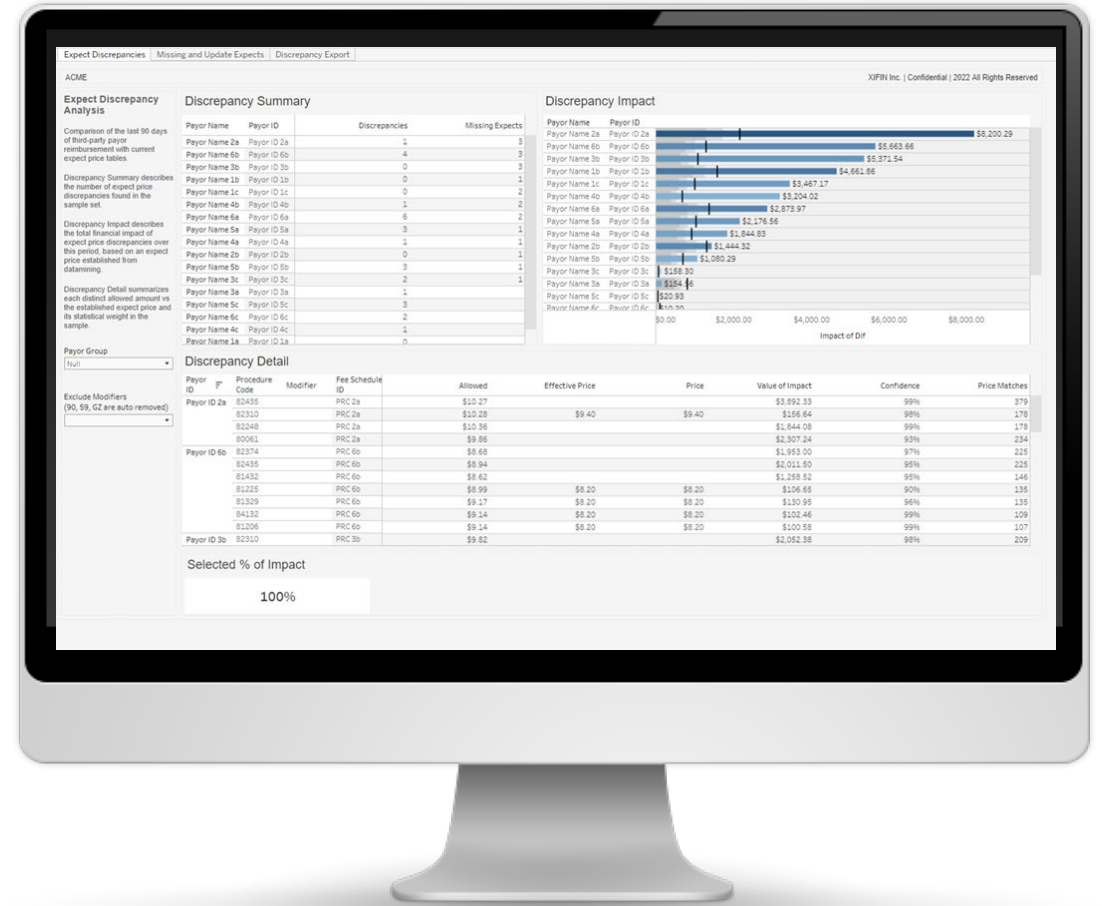
## Denial Trends



Denial follow-up can be costly if not automated, and can delay reimbursement



Review referring providers with highest denial rates to prevent or mitigate

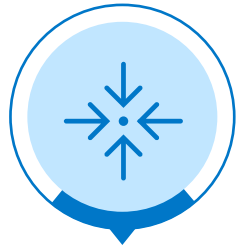


# Investing in Provider Engagement

**Building relationships and provider engagement pays off.  
An engaged provider is more likely to capture information correctly, which:**



Reduces patient  
billing confusion  
due to coding  
issues



Minimizes  
resubmission  
efforts



Increases claim  
accuracy and lab  
revenue



Enhances patient  
satisfaction and  
transparency



Reduces noise  
for physicians'  
offices

**That, in turn, accelerates reimbursement.**

# Measuring Provider Engagement Success

## Key Metrics and Indicators

### Error Reduction:

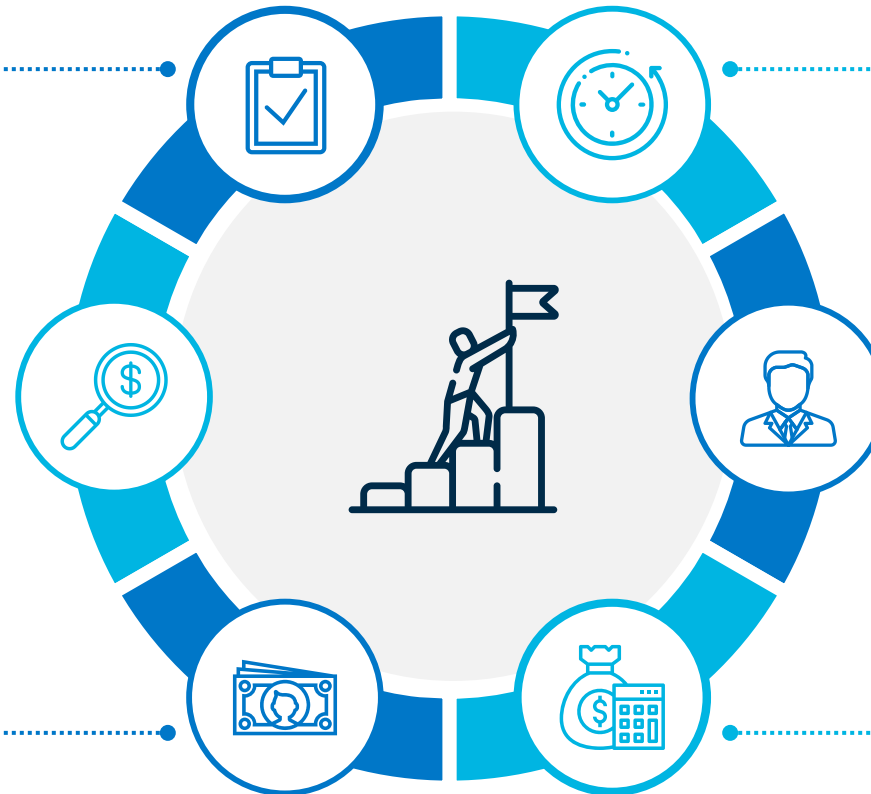
Monitor the reduction in billing errors over time with weekly analysis.

### Fixed Errors:

Track which specific errors are resolved through portal usage.

### Revenue Impact:

Measure additional revenue by preventing denials, underpayments, and missing payments.



### Process Efficiency:

Monitor improvements in operational efficiency.

### Client Engagement:

Track client ability to self-identify and resolve issues.

### Preventive Practices:

Client behavior changes inspired through portal usage to prevent errors.

# Ordering/Referring Provider Profitability Analysis



Payor mix changes, network status, modality shift in testing



Shift to self-pay or Medicaid



Prior authorization challenges and out-of-network status



Exception / Error processing

**Finance and RCM leaders need to understand the root causes of AR changes.**

- Where to start and how to determine the root cause and next best actions?
- Provider/Client profitability analysis: KPIs
  - Do you have clients that cost you money?
- Ordering patterns, types of test, ASP, and payor mix/payor mix changes.
- Modality shift in testing.

***Work with your sales team to educate underperforming client providers. It may even make sense to sever relationships in extreme cases.***

# Provider Engagement Success: MD Now®

## STI Screening at Urgent Care Centers



**Issue:** The client initially had around 10,000 billing errors per month across 91 locations.



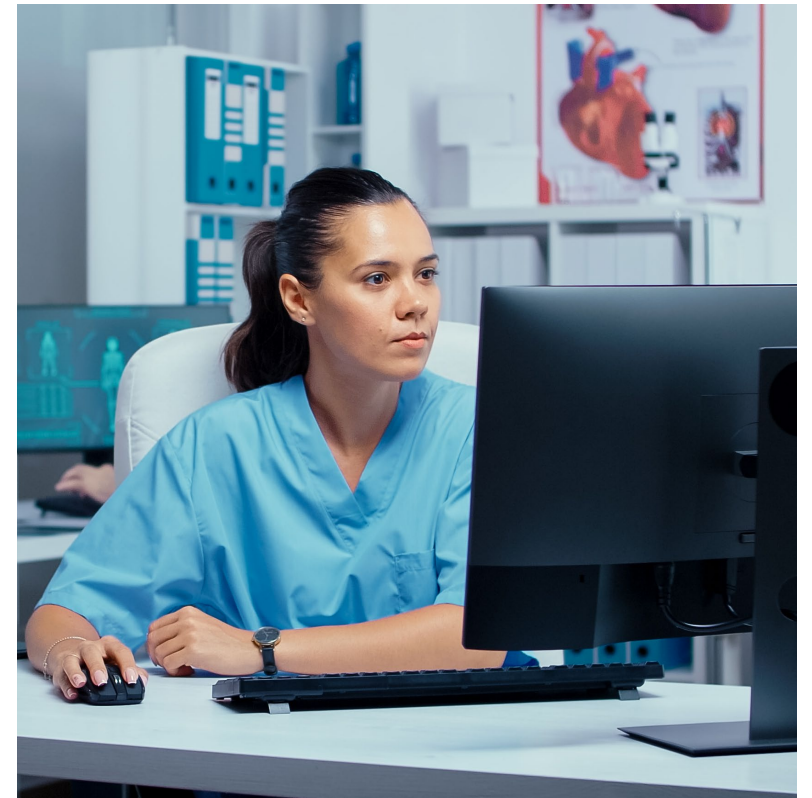
**Solution:** Through self-assessment capabilities provided through the XiFin® Empower Provider Portal, they identified and resolved the root causes of errors.



**Outcome:** Errors drastically reduced to an average of 145 per month across all 91 locations, less than two errors per location.



**Impact:** The self-assessment and corrective measures eliminated the need for additional staff or manual intervention and prevented future errors.



# Provider Engagement Success: BioReference Health

## Reducing Manual Entry and Errors



**Issue:** Manual, labor-intensive billing error resolution process led to 15,000 per two-week period. Resolution required delivering large packets of documents across the state and manual entry.



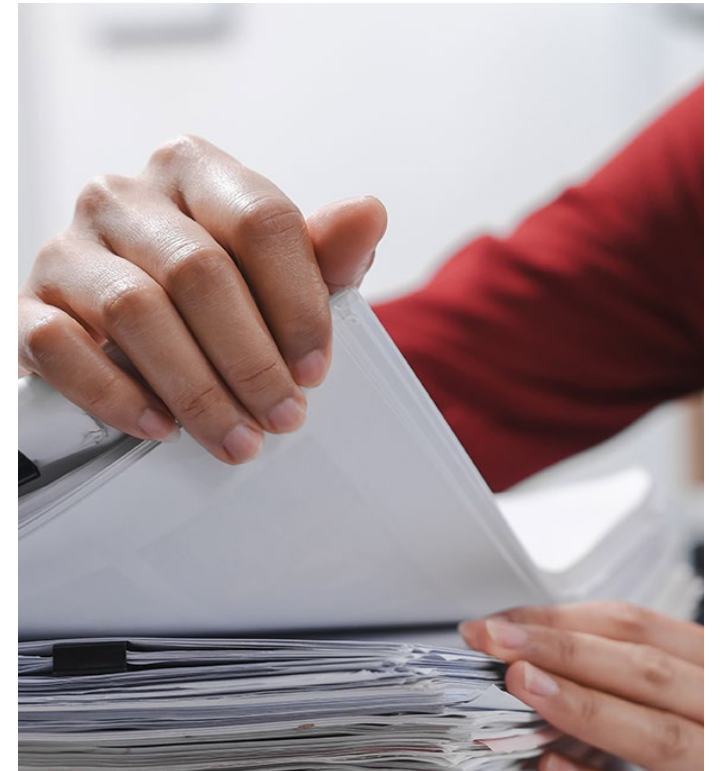
**Solution:** The XiFin® Empower Provider Portal enabled ordering providers to upload medical records electronically, securely, and in a fraction of the time it took by fax.



**Outcome:** The processing time for claims was reduced from over 120 days to less than 20 days, while avoiding timely filing issues. Unbillable rate fell from 29.1% to 9.2% (28.8).



**Impact:** The automated portal workflow drastically cut down on manual processes, helping the client avoid filing time limits, improve cash flow, and enhance overall efficiency.



# Provider Engagement Success: BioReference Health

## Additional Outcomes



Grew from 300 to more than 5,000 clients using the portal



Resolves DX errors at a 60% success rate (vs. 30% on spreadsheets)



Errors are now:

- 61% DX limitations (LC, no ABN)
- 11% Ordering physician mismatch
- 10% Missing DX
- Remainder largely demographic errors



Can hold back only problem tests—while allowing all other tests on the accession file



Leverages medical document access to:

- Navigate post-COVID audits
- Streamline prior authorization

# OPTIMIZING PAYOR RELATIONSHIPS AND REIMBURSEMENT OUTCOMES

# Payors: What to Consider

Published Policy

Actual Behavior:

- Incorrect Reimbursement
- Unexpected Denials



Expected Reimbursement

# Understanding Payor Behavior

## Payor Trend Analysis



### Payor reimbursement behavior is complicated and constantly changing:

- New products and plans
- In and out-of-network providers
- Policy evolution
- Service-level limited coverages



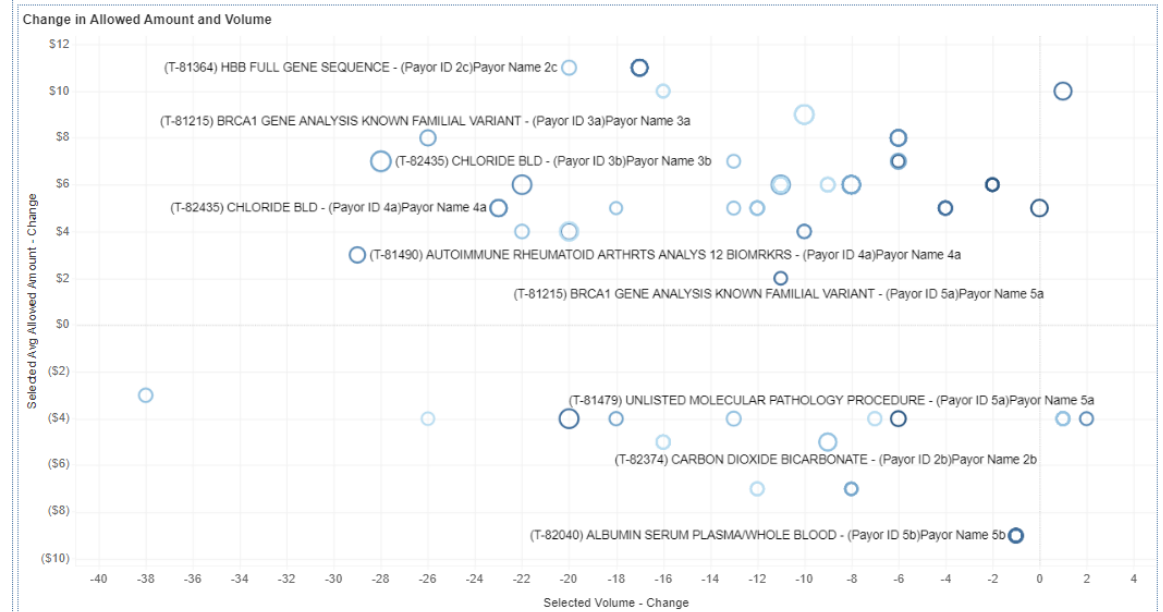
### These changes manifest in billing as:

- New denials
- Changes in denial rate
- Change in % reimbursement
- Change in time to payment

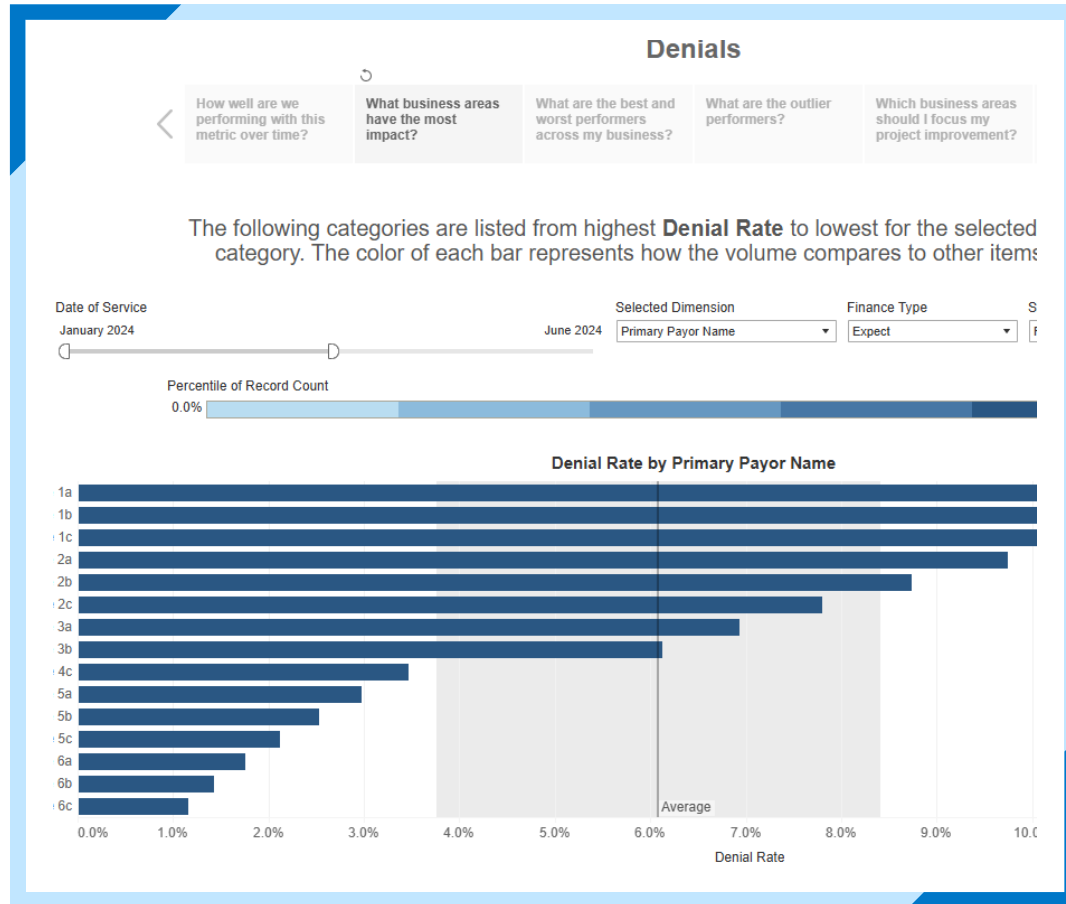


### Failure to quickly recognize and adapt workflow to payor reimbursement changes can result in:

- Costly appeals projects
- Bulk write-offs
- Patient billing – audit prevention



# Denial Trends by Payor



Implementation of new payor policies can often be identified in denial trend reports.



Monitoring reimbursement activities and KPIs in conjunction with denial activity can allow you to quickly identify trends and take action toward recovery.

# Discrepancy in Expect Pricing



An accurate picture of expected payor reimbursement is critical to many RCM and financial functions.



Consider both contracted and non-contracted health plans.



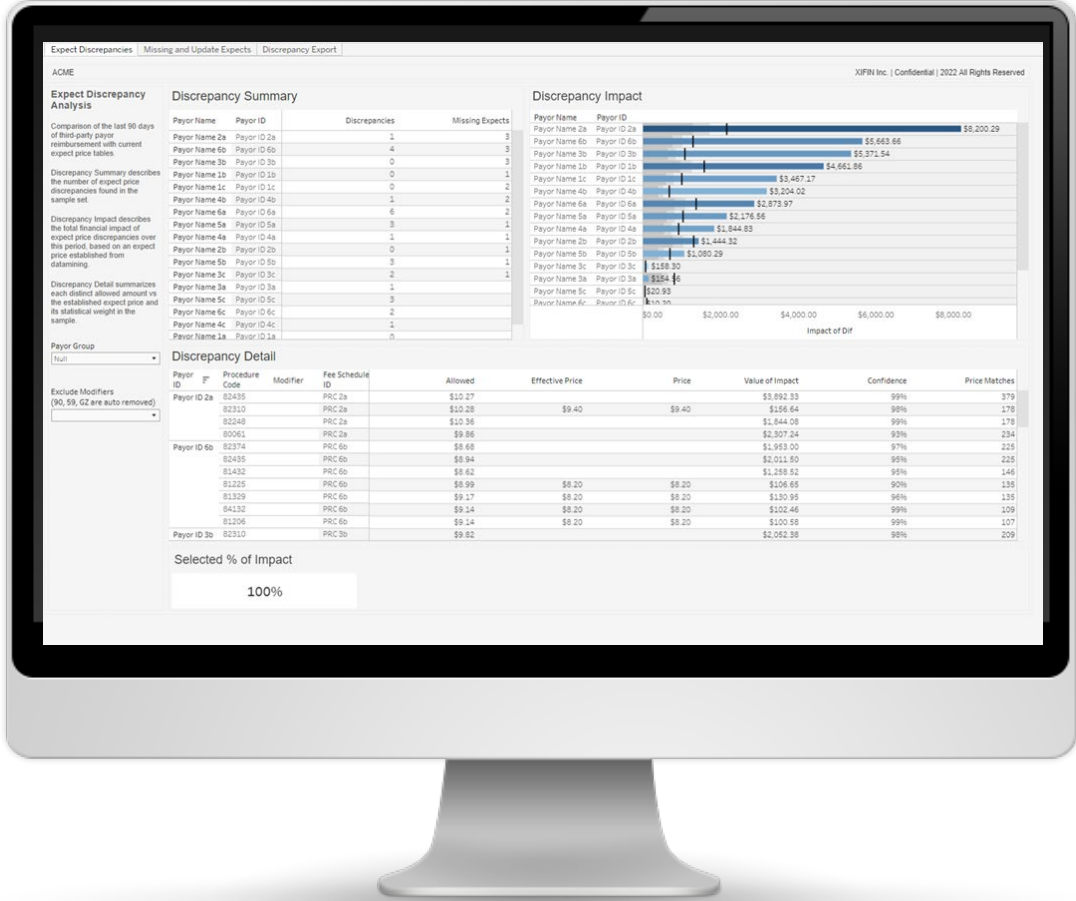
Are you receiving the appropriate reimbursement?



ML-based historic data modeling can assist with determining expected reimbursement.



Results may be driven into RCM configuration or determined in-line within the workflow.



# The Important Role of Market Access and Contracting Collaboration

Organizations that offer complex, often proprietary diagnostics and remote monitoring services share four common, frustrating challenges:



1 Achieving payor coverage



2 Understanding coding requirements



3 Securing reimbursement

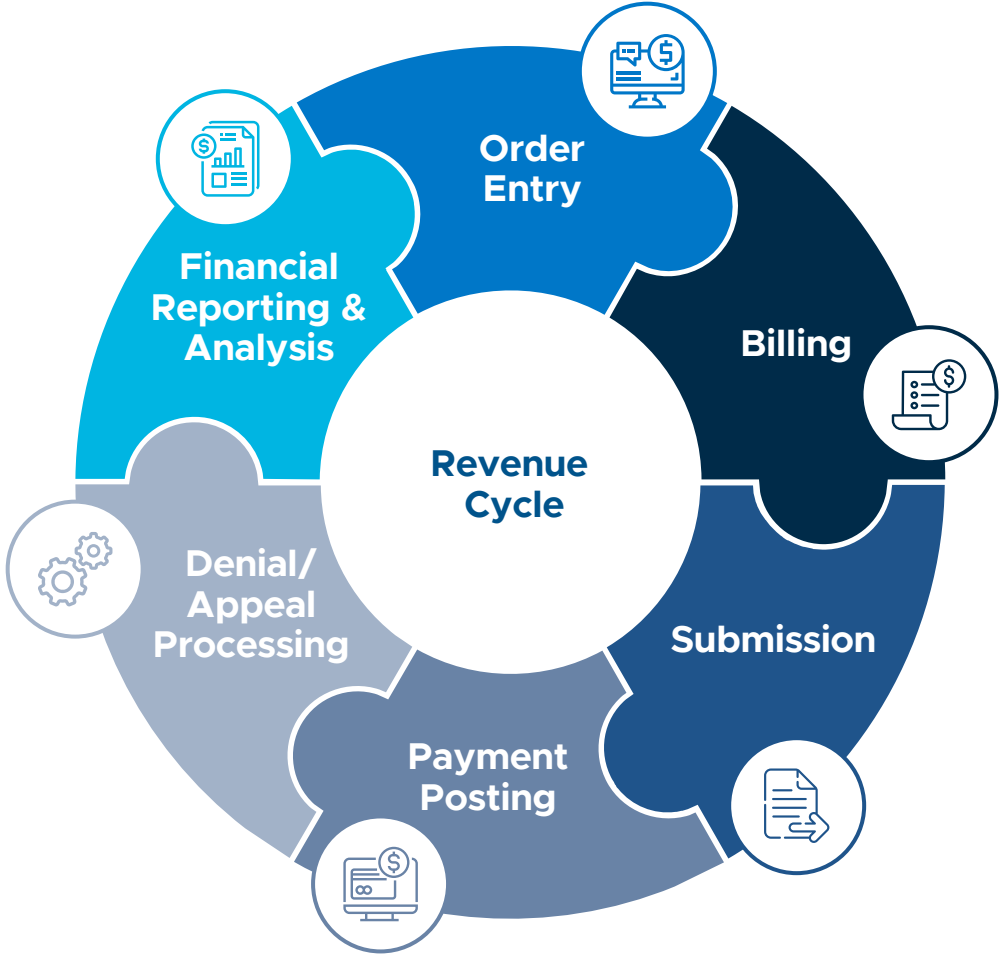


4 Staying compliant with evolving payor policies

**The best way to overcome these hurdles and achieve financial stability and sustainability is through collaboration between the market access, commercial (i.e., sales), and revenue cycle management (RCM) teams**

# Recommended Practices for Market Access

-  Analyze your payor mix
-  Understand the relevant medical policies
-  Know your prior authorization (PA) requirements
-  Work with your RCM partner to leverage their data resources and contacts
-  Meet regularly across teams to share data and trends to prioritize efforts



# KEY TAKEAWAYS

# Building Your Plan

As you build your plan for financial reporting, consider:



Stakeholders – Involve the right people and align to the right metrics



Systems – Ensure you're set up for accurate, timely reporting.



Cadence – Report with frequency that drives informed decision-making without overwhelming



Commitment – Cross-department collaboration to drive improvements

As you implement any process improvements or changes: Define, Measure, Analyze, Improve... and Control

# Questions?



# THANK YOU!

