ADVANCED REVCYCLE

INDUSTRY OUTLOOK WHITE PAPER

Automations & AI to Out-Innovate Payors

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EXECUTIVE SUMMARY

Payors — especially Medicare Advantage and large commercial plans — are increasingly deploying automated algorithms and AI at scale to screen, delay, and deny home health and hospice claims. Providers must respond not just by "adding AI" to old workflows, but by broadening what counts as Revenue Cycle Management (RCM): from pre-registration and pre-coding through care documentation, claim assembly, adjudication, appeals, and patient collections. When RCM is widened and instrumented with smart automations plus human oversight, agencies flatten recurring bumps in the claims pipeline and turn a jagged, delay-prone flow into a near-linear claim throughput.

THE PROBLEM: PAYORS' AUTOMATION IS SHIFTING THE PLAYING FIELD

Recent industry reporting and regulatory activity documents a clear trend: payors are using AI, rules engines, and automated prior authorization/claims-review systems that can generate large volumes of denials or delays, and in some cases reject claims at machine speed. Providers report increased denials, and industry groups and regulators are raising alarms about care and payment impacts. Lawsuits and regulator inquiries have also drawn attention to automated claim-handling systems. These payor-side advances make it essential that provider-side RCM adopt a far broader, proactive posture rather than wait to "fight" denials after they occur.

Why this matters for home health & hospice in 2025:

- Home health and hospice claims depend on precise clinical documentation where the consequences of small documentation or coding gaps can have a negative ballooning effect.
- Workforce shortages make manual rework unsustainable.
- CMS audits are escalating.

EVIDENCE & KEY INDUSTRY SIGNALS

The most immediate friction points for revenue cycle performance in post-acute care are now concentrated in home health and hospice. Data across Medicare audits, medical-review programs, and provider benchmarking reveal that documentation completeness, plan-of-care compliance, and physician certification accuracy remain the most common sources of denial and delay. As payors increase their use of automated pre- and post-adjudication algorithms, these longstanding weaknesses have become amplified.

Selected findings (2020–2025):

- **Hospice improper payment rate – 12.0%:**

  CMS CERT and related audit cycles (covering claims submitted between 2020 and 2022) reported an average improper payment rate of roughly 12 percent for hospice claims. The top drivers were missing or incomplete physician certification and recertification forms, election statements, and documentation gaps establishing medical necessity. (CMS CERT Program; AAPC Audit Summaries)

EVIDENCE & KEY INDUSTRY SIGNALS (CONTINUED)

Selected findings (2020–2025):

- **Home Health medical-review outcomes:**

  Targeted Probe and Educate (TPE) and Medicare Administrative Contractor (MAC) reviews consistently show that among claims selected for review, 40 to 50 percent fail to fully support medical necessity or the required plan-of-care and face-to-face encounter documentation. (CG S and Palmetto MAC reports 2022–2024)

- **Audit appeal success and persistence:**

  Hospice and home-health agencies often report high success rates in individual appeal cases, yet those same audits frequently lead to extended or repeat TPE review cycles. Even overturned denials may trigger sustained scrutiny as payors refine their AI-driven audit selection criteria. (Alliance for Care at Home Survey 2023; MAC Audit Reports)

RE-DEFINING RCM FOR HOME HEALTH & HOSPICE

To stay in front of payor automation, agencies must expand RCM upstream and downstream. Traditional RCM often focuses on coding → claim submission → payment → collections. The expanded RCM should include:

1. **Pre-registration & eligibility intelligence**
2. **Pre-coding & clinician decision support**
3. **Clinical documentation engineering**
4. **Automated claim assembly with payor-specific profiles**
5. **Real-time payor response monitoring**
6. **Appeal orchestration and automation**
7. **Patient financial engagement & collections**
8. **Feedback loops to care teams**

This end-to-end scope turns RCM into a continuous control system that anticipates payor rules rather than reactively litigating denials.

HOW AI & AUTOMATION SHOULD BE APPLIED

Principles:

Human-in-the-loop

Automation augments, not replaces, clinical judgment for edge cases

Explainability & Audit Trails

Systems must log decisions and supporting evidence for appeals and regulators

Data Hygiene First

AI only works if inputs are clean and standardized.

Payor-profiled Logic

Different payors have distinct rules. Treat each payor as a unique “micro workflow.”

Continuous Larning + Governance

Automation augments, not replaces, clinical judgment for edge cases

ORGANIZATIONAL AND OPERATIONAL CHANGES REQUIRED

Technology must be paired with changes to people and processes:

- **Cross-functional teams:** clinical, coding, RCM and financial leadership working in sprint cycles to close recurring denial causes.
- **SLA and KPI overhaul:** Move beyond AR days and denial rate to upstream KPIs — e.g., "percent of claims meeting pre-submission validation," "time from visit to claim-ready," and "appeal success rate by payor."
- **Training & change management:** Clinician-facing nudges must be designed to minimize workflow friction.
- **Governance & model monitoring:** Establish model performance thresholds, bias checks, and human review triggers.

TECH STACK BLUEPRINT

1. **Data hub** — ingest EHR, billing, and external payor feeds.
2. **Rules engine & payor profile store** — codify payor-specific checks.
3. **NLP & ML layer** — for notes extraction, denial classification, predictive scoring.
4. **API & integration layer** — connect to payors, clearinghouses, and patient-facing portals.
5. **Analytics & feedback loop** — dashboards exposing root causes, payor trends, clinical documentation gaps.

QUICK WINS (90–180 DAYS)

1. **Run a denial-root-cause sprint:** Identify top 3 denial reasons and design interventions.
2. **Implement pre-submission validation** for the highest-volume claim type to catch common edits.
3. **Create automated appeal templates** for top 2 overturnable denials and measure time-to-submission improvements.
4. **Stand up payor profiles** for your top 5 payors.

LONGER-TERM STRATEGIC PLAYS (6–24 MONTHS)

- **Build an AI-driven claims defense platform** that continuously learns which evidence items the payors' systems respond to.
- **Partner with RCM Specialists** to leverage scale to improve payor rules and performance.
- **Lobby and compliance readiness:** participate in industry advocacy to shape regulations on automated denial explainability and safe automated adjudication.
- **Continuous payor watch** to monitor new payor rules and emergent algorithmic patterns and encode changes into your payor profiles within days, not months.

RISKS, MITIGATIONS & REGULATORY CONSIDERATIONS

RISK
Over-reliance on opaque AI may create appeal weaknesses or regulatory exposure.

MITIGATION
Insist on explainable models and maintain human oversight.

RISK
False positives by payor AI may increase patient harm and provider reimbursement volatility.

MITIGATION
Rapid appeals orchestration, legal review for systemic denials, and public reporting where appropriate.

RISK
Data privacy and security.

MITIGATION
HIPAA-compliant architecture, role-based access, encryption, and vendor attestations.

MEASUREMENT FRAMEWORKS — KPIs TO TRACK

- Pre-submission validation pass rate
- Claim first-pass acceptance rate by payor
- Denial rate by root cause
- Time from service date to claim-ready
- Appeal submission time and overturn rate
- Days in AR and net collections rate
- Patient financial consent and collection success rate

OUR CALLING AT ADVANCED REVCYCLE

Advanced RevCycle is well positioned to lead agencies through this transition by combining home health/hospice domain expertise with automation and AI capabilities. Those who move quickly will reduce denials, shorten cycles, and protect mission.

Selected data points:

- Hospice improper payment rate: CMS CERT and related analyses reported an estimated hospice improper payment rate of ~12.0% (reporting years around 2020–2022), with documentation (physician certification/recertification, election forms, medical necessity) the leading causes. (CMS CERT; AAPC analysis; industry audits).
- Home health medical-review findings: Medicare MAC and targeted probe-and-educate (TPE) activity for home health shows that among *claims selected for review*, a large share fail to support medical necessity or required certification/plan-of-care documentation (examples of reviewed-claim failure rates in MAC/TPE reports commonly range from ~40%–50% for flagged claims). (MAC medical review / TPE reports).
- Claims denial & rework: Industry analyses and provider benchmarking indicate that a meaningful share of home health claims are initially denied or delayed (estimates vary; industry sources cite initial denial/delay in the ~15–25% range for many agencies), and a substantial portion of denied claims are not resubmitted, representing revenue leakage. (Industry benchmarking reports; HFMA commentary).
- Audit and review outcomes: Provider surveys and audit reports (including hospice audit survey results) show high variability in overturn rates—many agencies report high appeal success in individual audits, but audits can still trigger sustained TPE or probe activity even after overturns. (Alliance for Care at Home hospice audit survey; MAC reports).