



CLINICAL PROCESS OUTSOURCING: HOW HEALTH SYSTEMS SCALE CLINICAL CAPACITY WITHOUT COMPROMISING CARE QUALITY

Abstract

Health systems are navigating pressures on two fronts that aggravate each other. Even as the clinical demand is rising, the workforce available to meet it is not growing to match. The gap between what institutions can sustain and what patients, payers, and regulators expect has been growing, and it requires an immediate solution. Clinical process outsourcing (CPO) has emerged as the leading solution. It extends clinical and administrative capacity through specialised external partners rather than attempting to close the gap through internal hiring that the talent market cannot support. Health system leaders are looking for solutions that allow them to outsource in a way that scales operations without eroding the care quality those operations exist to serve.



Administrative work now accounts for more than 40% of total operational costs in a hospital (Brighton Health Plan Solutions). It is clearly not producing proportional value. In most institutions, it is absorbing clinical staff time, delaying patient access, and generating errors that propagate into the revenue cycle. Over 77% of global healthcare leaders report that staff shortages are already causing delays in patient care and limiting access to preventive services.

More than 6.5 million healthcare

professionals are projected to leave their roles in the coming year, with only 1.9 million entering to replace them (HR Healthcare). The WHO estimates a global shortfall of 11 million healthcare workers by 2030. Within the administrative tier specifically, a shortage of 30,000 to 50,000 certified medical coders in the US alone makes in-house coding operations increasingly difficult for mid-size health systems to staff and sustain.

Revenue cycle pressure compounds the staffing problem, with 73% of physician

practices reporting increased claim denial rates compared to 2023. This growth is driven by payer-side AI deployment, rising prior authorisation complexity, and coding requirements that have grown more granular with every ICD-10 revision cycle.

There are a few cyclic causes that fuel the issues while also feeding off them:

- Administrative backlogs consume clinical staff time
- Staff burnout accelerates attrition
- Attrition leaves administrative queues understaffed

Distinguishing clinical expertise from commodity BPO

CPO refers specifically to administrative functions that require clinical knowledge, prior authorisation review against clinical criteria, coding that requires understanding of diagnosis and treatment context, utilisation management decisions, clinical documentation review, and telehealth support that operates within

clinical protocols.

The clinical knowledge requirement is what separates CPO from commodity data entry or scheduling services. These tasks have clinically adjacent functions where domain expertise determines outcome quality.

This also explains why healthcare institutions are increasingly partnering with vendors who deploy credentialed clinical professionals, such as registered nurses, certified coders, and licensed clinical staff, in distributed, technology-enabled delivery models rather than simply offshoring administrative volume.

The clinical process outsourcing (CPO) service landscape

The functions commonly delivered under clinical process outsourcing span the full clinical-administrative boundary. The most common include:

Medical billing and coding

Medical billing and coding represents 32% of healthcare BPO revenue and is the largest single segment, covering charge entry, claims submission, denial management, and appeals (Stealth Agents).

Prior authorisation and verification

In prior authorisation and insurance verification, specialist staff process requests faster and with greater consistency than generalist internal teams.

Revenue cycle management

End-to-end outsourcing in revenue cycle management grew 18% in 2025 as more health systems transferred the entire AR cycle to specialised vendors rather than managing escalating complexity in-house.

Clinical documentation review

External teams audit the completeness and accuracy of documentation before it reaches coding and billing.

Patient engagement and access operations

Patient scheduling, recall management, and telehealth support are high-volume patient-facing functions that affect access,

throughput, and satisfaction without requiring on-site delivery.

Referral management involves tracking, communicating, and closing referral loops. This function directly affects care continuity but consumes significant administrative bandwidth.

The relative scale of these functions varies by institution type. A multi-site hospital network may outsource end-to-end revenue cycle management and coding. A specialist practice may outsource only prior authorisation and patient recall. Data-driven outsourcing services are better at delivering functions requiring specialised expertise and high throughput.



Data-driven outsourcing: how technology amplifies CPO

Clinical process outsourcing is a technology-enabled service model in which the human expertise of clinical professionals is amplified by purpose-built analytical infrastructure that most individual health systems could not build or maintain independently. AI-powered coding assistance has

become standard practice at leading CPO vendors. Natural language processing tools that review clinical documentation and suggest ICD-10-CM and CPT codes improved coding accuracy, reducing the time experienced coders spend on chart review while maintaining quality

on complex cases. Peer-reviewed studies show AI-assisted coding achieving high accuracy with much faster processing. This combination makes outsourcing economically viable for mid-size hospitals that previously lacked the scale to justify specialised coding teams.

Beyond medical coding, CPO providers integrate predictive models across key operational workflows:

- Predictive models for healthcare decision support are increasingly integrated into CPO workflows beyond coding.
- Prior authorisation prediction tools flag the requests that are likely to be denied based on payer-specific patterns, allowing outsourced teams to pre-

emptively address documentation gaps before submission.

- Denial prediction models applied at the claim level prioritise rework queues by probability of recovery.
- Utilisation management teams supported by predictive analytics can identify patients at high readmission risk and surface them for proactive care coordination.

Automated claims processing using RPA

reduced claim submission turnaround times at major CPO vendors, handling high-volume rules-based tasks like eligibility checks, prior authorisation tracking, and payment posting. The result is that human clinical staff, on both the outsourced and in-house sides, concentrate on the cases where judgment, communication, and exception-handling are required, rather than on process steps that can be executed with greater speed and accuracy by automation.



Quality considerations

Any arrangement where a third party manages clinical-adjacent processes introduces a principal-agent problem: the vendor's incentives are not automatically aligned with the institution's care quality commitments.

When prior authorisation is handled by specialists who do not juggle other responsibilities, requests are processed faster, which means patients receive care decisions faster. When credentialed experts

handle coding and are supported by AI tools, documentation accuracy improves. This means fewer denials and fewer billing disputes. When dedicated teams with structured follow-up protocols manage patient recall, the gaps in preventive care close and recall rates improve.

The institutions most resistant to CPO on care quality grounds are often the ones where understaffing is already degrading

quality. Retaining these functions in-house often provides a false sense of control while locking institutions into lower operational quality at a higher cost.

CPO improves care-adjacent outcomes when the vendor has genuine clinical expertise, when service-level agreements specify quality metrics alongside the throughput, and when the health system maintains active oversight of performance.



Compliance considerations: protecting the patient

About 78% of health systems cite HIPAA compliance as the most important factor when evaluating a CPO partner (Stealth Agents). It trumps cost, service quality, and geography. Healthcare data suffered 714 major breaches in 2025, with 23% originating from business associates and subcontractors. So it is safe to conclude that the concerns of the healthcare enterprises are not unfounded.

Any CPO vendor that handles protected health information is a potential point of

entry for attackers, and the institution that contracted with them remains accountable for the breach under HIPAA regardless of where the failure originated.

The minimum compliance infrastructure for a credible CPO partner includes a signed Business Associate Agreement, SOC 2 Type II certification, HIPAA-specific security policies, annual third-party penetration testing, and documented employee training programmes. These are

the baseline requirements.

Beyond HIPAA, state-level data residency requirements are becoming an ongoing compliance consideration. California, Texas, and New York have enacted legislation restricting the transfer of certain categories of patient data to offshore locations. Health systems operating across multiple states must track these evolving requirements and ensure vendor contracts allocate compliance responsibility explicitly.

The operational risks to address

Three risks that tend to be underweighted in the commercial enthusiasm for cost savings are:

Knowledge transfer and institutional memory

When coding nuances, payer-specific rules, and documentation quirks reside with the vendor's team rather than the institution's staff, a deteriorating or exiting vendor relationship creates operational risk. Regular knowledge transfer protocols and documentation of payer-

specific requirements maintained on the institution's side mitigate this risk, but they require deliberate investment.

Exit provisions and data return

Contracts negotiated primarily on entry terms may lead to undesirable results later. Clear SLAs with performance penalties, defined transition procedures, and unambiguous data return timelines should be negotiated before the relationship starts.

Sub-contractor visibility

Many CPO vendors deliver through sub-contracted components. The institution may have conducted thorough due diligence on the primary vendor while having limited visibility into the security posture and compliance practices of the sub-contractors who handle parts of the work. Contractual rights to audit sub-contractor arrangements, or requirements for the vendor to disclose and warrant sub-contractor compliance, are not standard terms, but they are worth negotiating.

End note

Clinical process outsourcing is, for most health systems, a structural necessity. The realities of the workforce do not favour building all capabilities in-house. Sometimes, the talent is not available, the coding complexity is increasing, and the administrative burden on clinical staff is

already affecting care throughput. While clinical process outsourcing does not eliminate these pressures, it redirects them toward partners who are better equipped in specialisation, scale, and technology. Forward-looking health systems choose

[data-driven outsourcing service partners](#), specify quality metrics in contracts, maintain active oversight of vendor performance, invest in knowledge transfer, and select partners with genuine clinical credentials.

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For more information, contact infosysbpm@infosys.com

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