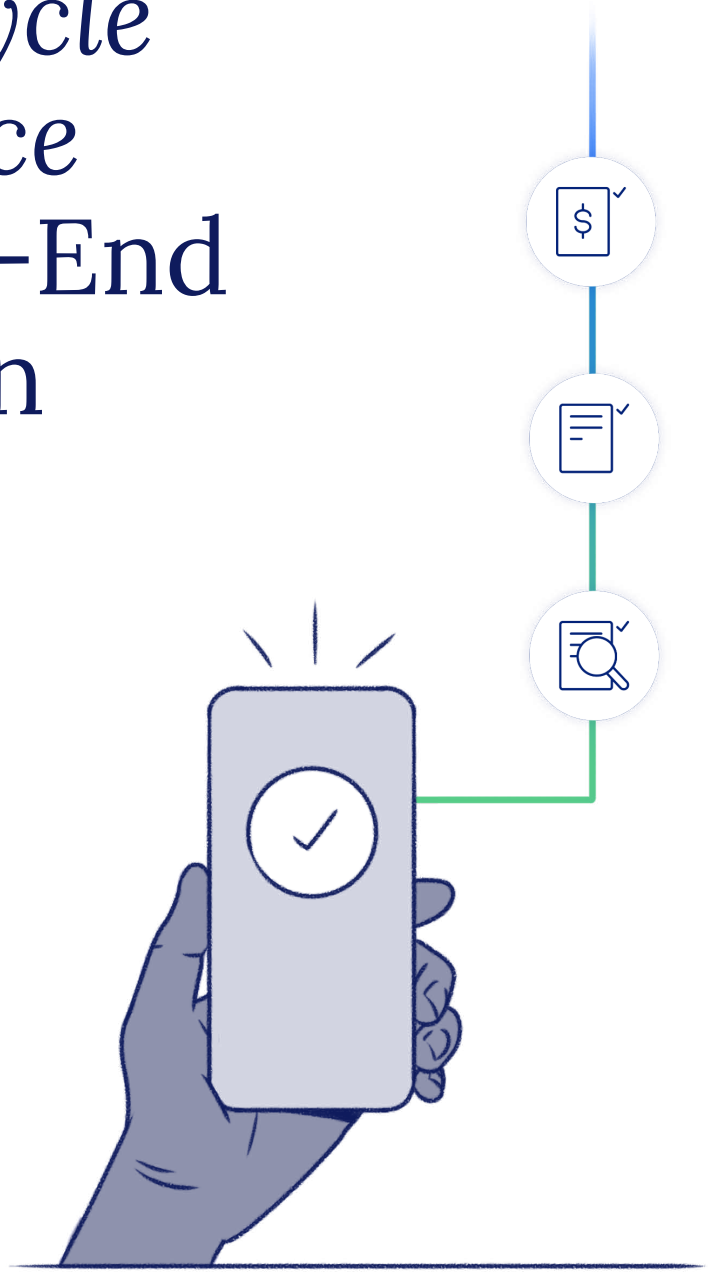
notable

Transform *Revenue Cycle Performance* with Front-End Automation



In today's economic environment, health systems can't afford the increased denials and prolonged accounts receivable days caused by inaccurate registration data. It's clear that the path ahead to financial recovery is dependent on improved revenue cycle efficiency, but many health systems rely on human labor-intensive and lengthy processes that impact patient access and ultimately, inhibit revenue capture. As staff shortages persist and labor costs increase, reviewing and correcting patient data on the back end is not feasible.

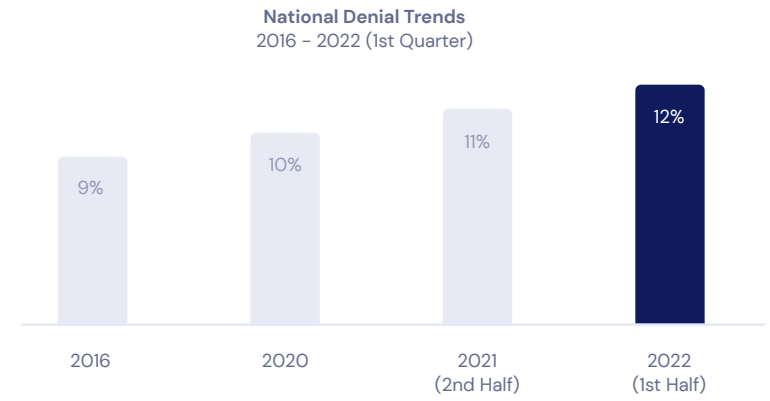
To succeed, revenue cycle leaders need to transform the first interaction many patients have in their care experience into a competitive differentiator, manage ever-changing payer rules, and navigate an exacerbated workforce shortage – all in an extraordinary inflationary environment.

As revenue cycle leaders look ahead, they need a new way–intelligent automation–to navigate rising front-end denials, increasing prior authorization burden, and growing patient financial responsibility.

Challenge #1: Rising front-end denials

Denials continue to rise for health systems. Since 2016, the average denial rate has increased by a third, with 12% of claims denied upon initial submission in 2022.[1]

Denials have been on the rise for the past six years[1]



Nearly half of denials are caused by front-end revenue cycle errors, which are largely preventable.[1] These front-end denials often result from a combination of issues, including:

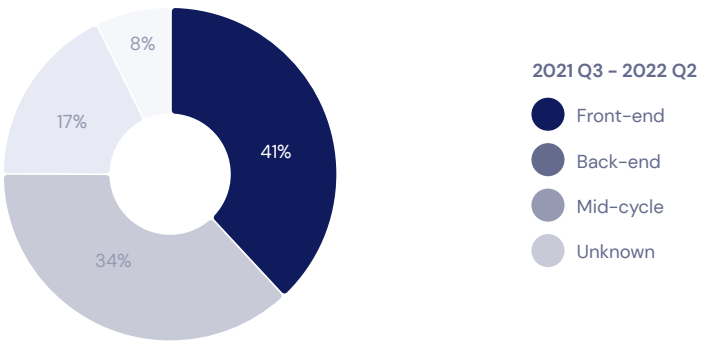
- **High staff attrition:** With the increasingly competitive labor market, it has been challenging for revenue cycle leaders to recruit and retain qualified staff. Experienced staff may be leaving the healthcare industry to pursue higher-paying and lower-stress roles in other industries, such as retail and service. When staff are hired, they may require comprehensive education and ongoing training to meet the job qualifications.

- **Reliance on manual processes:** Even when organizations are using technology in an attempt to optimize processes, staff continue to depend on labor-intensive and repetitive workflows to review and correct data.

- **Limited resources across the revenue cycle:** Only 18% of denials are unavoidable, with the balance either unequivocally avoidable (31%) or situationally avoidable (51%).[1] With short-staffed teams facing increased claims volume, the continued reliance on manual workflows increases the risk of errors – and those errors are caught later in the process (if at all).

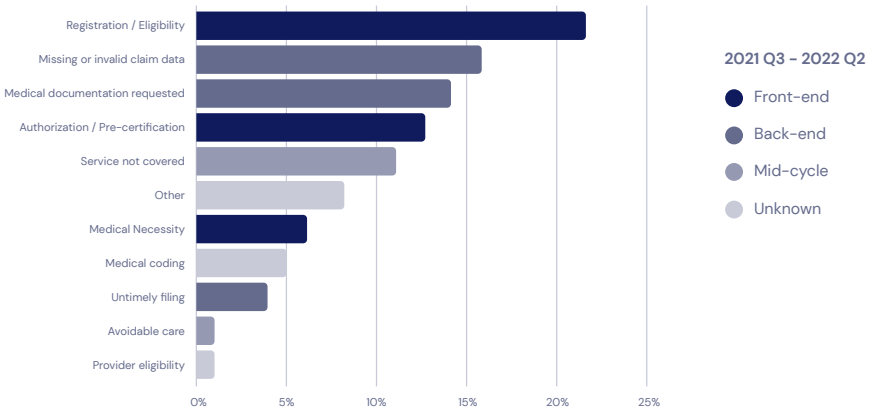
- **Increased denials backlog:** Many organizations do not have denial prevention strategies for the front end and mid-cycle. By addressing the symptoms that result in denials – rather than the causes – denials continue to present challenges, which in turn, affect filing deadlines.

Nearly half of denials are caused by front end revenue cycle issues[1]



The primary driver of denials continues to be registration and eligibility-related errors. While registration and eligibility-related denials aren't a new challenge for health systems, the current labor market has created additional burdens for organizations with suboptimal processes.

Registration and eligibility-related errors result in 22% of denials[1]



Staffing shortages have been exacerbated by increased competition for specialized talent. According to an MGMA survey, better pay/benefits at another organization was the top cause (59%) of medical practice staff turnover in 2021, followed by burnout (21%).[2] In addition, many patient access staff desire remote job opportunities instead of in-person work.[2] This has led to persistent workforce shortages, with one in four revenue cycle leaders reporting they need to hire more than 20 employees to fully staff their department.[3] As a result, health systems have fewer qualified staff to manage the complexity of denials.

Prevention is the key to avoiding revenue loss. About eight out of ten denials are preventable and 70 – 82% of claims can be overturned. Yet, six out of ten denials are never worked due to lack of time or knowledge. The cost for working denials ranges from $25 to over $100, depending on the care setting.[4] The opportunity is ripe for health systems to increase revenue capture, while decreasing time to payment and the resources needed to collect.

Challenge #2: Increasing prior authorization burden

Many organizations are challenged by the growing administrative burden of prior authorizations as a result of increasing authorization volumes and requirements. Inpatient prior authorization denials are a key driver for the dollar value of denials increasing from 1.5% to 2.5% of gross revenue in August 2022.[5] Nearly all practices have experienced a year-over-year increase in prior authorization requirements since 2016.[6] In 2022, about eight out of ten practices reported that their prior authorization requirements increased in the past 12 months.[6]

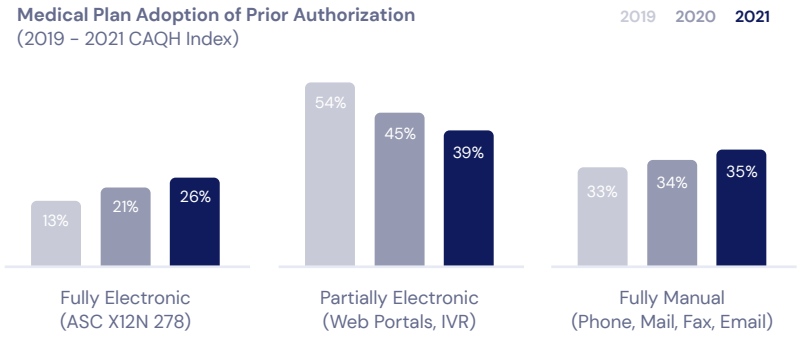
The most significant challenges associated with increased prior authorization requirements include:

- Increased time spent by staff to secure prior authorizations. With staffing shortages at record levels, this burden places further pressures on already-limited staff capacity.
- Lack of or slow response from payers for approvals
- Lack of automation in payers' prior authorization processes
- Delays in patient care due to lack of prior authorization[3]

Lengthy prior authorizations shape patient outcomes and revenue leakage. For example, a delayed or denied prior authorization can result in last-minute cancellations for procedures. Nearly all physicians (93%) report the prior authorization process delays patient access to necessary care and 82% report the prior authorization process can lead to patients abandoning the recommended course of treatment.[7]

However, only 26% of prior authorization transactions in 2021 were fully automated according to the Council for Affordable Quality Healthcare.[8] If all prior authorization transactions were to be automated, the industry is estimated to save $437 million annually.

EDI automation standards are not being adopted[8]



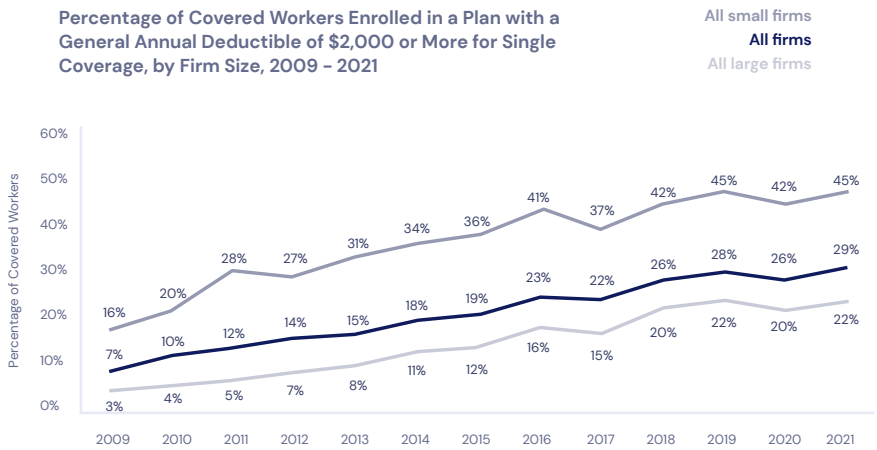
Challenge #3: Growing patient financial responsibility

Shifts in payer mix have resulted in patients becoming a more significant driver of a health system's financial health. As patient financial responsibility grows, health systems need to simplify the payment experience to increase point-of-service collections.

Higher premiums are becoming more prevalent. On average, covered workers contribute 28% of the premium for family coverage, which represents a 78% increase since 2008.[9]

The financial reality of patient deductibles is also stark. High deductible health plans (HDHP) represented 30% of total enrollment distribution for covered workers, with an average deductible of $1,434 in 2021 – a 92% increase since 2011.[9] The percentage of covered workers with an annual deductible of $2,000 or more has grown from 22% to 29% over the past five years.[9]

Financial liabilities are climbing[9]



Two-thirds of patients report that their financial situation makes it difficult to pay medical bills on time.[10] For health systems, this is reflected in the persistent struggle to collect payments from patients who cannot or will not make timely payments. According to a survey conducted by HFMA, about 70% of revenue cycle leaders reported a growing number of patient liabilities going to collections or write-offs.[11] Eight out of ten respondents reported greater lag time to collect from patients.

Today, it costs four times more to collect from a patient than from an insurance company.[12] With about 30% of practices' income coming directly from patients,[13] delivering an exceptional patient financial experience is a business imperative to maintain the health of the organization. According to original research conducted by Notable, patient-provided feedback indicates that providers need to simplify payment processes.[14] Since patients do not distinguish their financial interactions with their provider from their clinical or experiential ones, a poor patient access experience can prompt them to seek care elsewhere. More than half (56%) of patients would consider switching providers for a better healthcare payment experience.[4]

Common approaches to driving revenue cycle progress

Health systems have used different approaches to address these revenue cycle challenges, with varying levels of success.

Attracting and retaining top talent

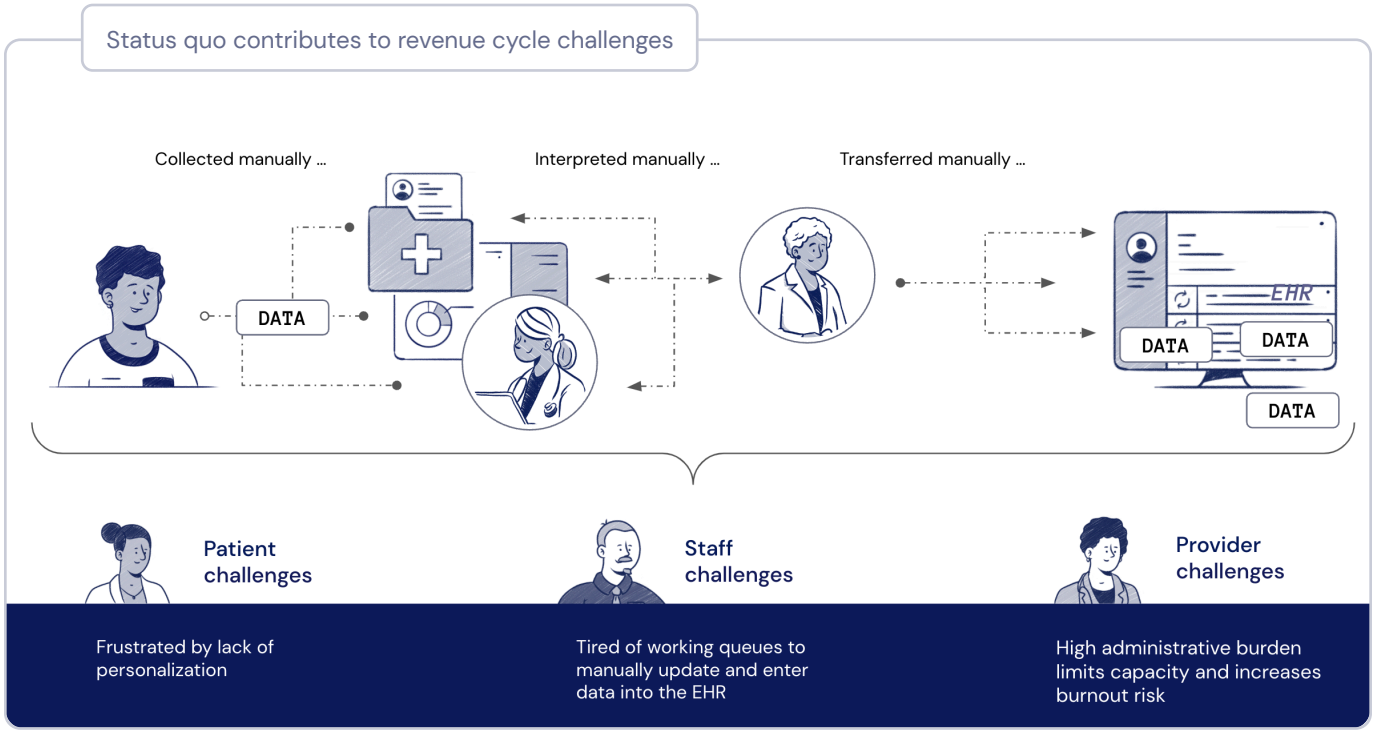
Many organizations have implemented higher salaries, more comprehensive benefits, flexible schedules, remote work opportunities, or a combination of multiple tactics. According to an MGMA survey, 56% of respondents reported raising wages has been the best tactic to address staffing shortages.[15] 29% of respondents reported providing a flexible schedule, including the opportunity for remote work, was the most effective tactic in the tight market for talent. These examples underscore the industry's tendency to focus on the symptom, rather than the underlying cause. Addressing current work backlogs with more people may provide relief in the short-term, but can obscure the source of the challenge: unsustainable administrative burden due to repetitive manual workflows.

Outsourcing revenue cycle

Outsourcing some or all processes to third-party vendors removes control over the revenue cycle – at substantial costs to the health system. The reality is that many organizations still need to retain employees to work complex denials and manage patient collections. The lack of synchronization and the quality of provider-vendor communication can also be an issue. In addition, the vendors that provide revenue cycle outsourcing services still face a significant amount of administrative burden – which ultimately impacts both the patient's financial experience and the organization's ability to collect.

Buying point solutions and leveraging native EHR solutions

Many health systems have purchased point solutions and/or EHR-based solutions to address each revenue cycle challenge. Since each solution has a limited scope of impact, this requires teams to implement, maintain, and optimize multiple technologies for comprehensive coverage. For example, organizations may have separate solutions for eligibility, coverage discovery, payment estimation, prior authorization management, payment plans, and more. Although these solutions may address their intended area, they often fall short of consumer expectations, have overlapping features, lack full integration into the revenue cycle ecosystem, and create additional downstream workflows for staff to manage. Even EHR-based tools require staff to manually QA information or re-enter into discrete fields in the EHR. In addition to high implementation and maintenance fees, organizations need to settle for lengthy implementation timelines and plan for significant internal IT resource allocation.



Even with these point solutions, revenue cycle processes remain saturated with manual workflows that frustrate all stakeholders – patients, staff, and providers.

For **patients**, the repetition of providing the same information multiple times to a staff member when they schedule the appointment, arrive for the visit, and receive the bill is the result of ineffective processes and communication breakdowns, which increase the risk for errors.

For **staff**, the volume of work is so high that they need to multitask to levels that increase their likelihood of making mistakes or letting errors persist even if they are flagged. This is further compounded by manual, paper-based processes that cannot be scaled using status quo approaches.

For **providers**, these innate system and workflow inefficiencies translate into lack of payment in a timely manner for the care they have delivered.

Addressing each component of the revenue cycle separately does not support a long-term strategy to improve financial performance. Revenue cycle leaders need to investigate how they can better leverage their current resources to perform at top-of-license, gather all the data needed to submit a clean claim without relying on disparate systems, and cohesively improve processes to decrease or eliminate redundant, labor-intensive, and manual tasks.

Pursuing intelligent automation

Intelligent automation integrates seamlessly with source systems and exponentially increases staff capacity, resulting in higher accuracy and faster payment. By using intelligent automation to power the front-end revenue cycle, health systems can collect all of the registration information needed for appropriate reimbursement without needing to hire additional staff. Patients are guided through the personalized financial experience they expect and staff are freed up to focus on high-value, meaningful work that only they can do.

Keys to transforming front-end revenue cycle performance

When identifying solutions to addressing these revenue cycle challenges, leaders should consider the following three keys to success.

Solve the core problem

Typical approaches to revenue cycle improvement – such as outsourcing to vendors, purchasing technology point solutions, and relying on EHR-based solutions – will always fall short of expected outcomes because they fail to address the underlying challenge of repetitive manual workflows.

Implement a cohesive solution

A constellation of point solutions often results in limited impact and disjointed experiences for every stakeholder – patients, staff, and providers. An enterprise-wide approach to patient access should include a broad range of capabilities on a common platform – including registration, scheduling, referrals, and prior authorizations – to best serve the end-to-end needs of every stakeholder.

Iterate and scale

A digital workforce is scalable and allows health systems to grow patient volume, without hiring more staff or depending on additional vendors.

Finding the right partner to improve revenue cycle performance

Measure what matters

Start by defining the outcomes the team wants to achieve. Choosing the right metrics will enable teams to quantify and track the impact of the initiative. Consider both operational and business metrics, such as:

Operational metrics

- Time per registration
- Registration quality
- Percentage of registrations completed without staff rework
- Percentage of insurance plans selected accurately without staff rework
- Clean prior authorizations submitted without staff rework
- Authorization turnaround time

Business metrics

- Point-of-service collections
- Denials and write-offs
- Patient satisfaction
- Staff engagement
- FTE capacity

After selecting the right metrics, it is critical to define the desired amount and time associated with each metric. Aligning on these outcomes will fuel a sense of urgency and purpose.

Example outcomes include:

- Increase copayment collections by 300% within one year
- Decrease eligibility- and registration-related denials by 50% in 3 months
- Increase average patient satisfaction rating to 91% in 4 weeks

Evaluation criteria

Selecting the right revenue cycle partner for the organization's needs can be challenging. With so many options available, accurately assessing the real benefits and potential pitfalls of each option is critical.

Selecting the wrong partner will have long-lasting implications for all stakeholders. Patients, staff, and providers may already be conditioned by previous efforts to expect frustrations with any new technology. The consequences of the wrong choice are high.

The following questions can help guide teams in evaluating the best partner to achieve a high-performing and patient-centered revenue cycle:

Patient Experience

- How does the solution extract the patient's insurance information and select the right plan?
- What percentage of patients complete the entire registration experience using the solution?
- How is the patient's financial responsibility communicated to them?
- What is the patient's payment experience?
- What percentage of patients pay for their care using the solution?
- How does the solution deliver a personalized patient experience?
- How does the patient experience differ for new vs. existing patients?

Staff Experience

- How does the solution's accuracy compare to current staff performance?
- Which workflows are fully automated by the solution?
- Which workflows do staff need to manage on the backend?
- Do staff need to manage separate dashboards outside of the EHR? How does reporting work?
- Do staff need to transcribe PDFs into the EHR?

Integrations

- What is the integration methodology?
- Does the solution automatically enter and update data into the right EHR fields?
- How does the solution update EHR fields that are not exposed via traditional APIs?
- How does the solution validate that the data is correct? Is this done in real-time?
- How long does it take to set up integrations?
- If the EHR updates a field, what is the process and expected turnaround time for the solution to test and reintegrate?

Implementations

- How long did the solution's last implementation with a similarly-sized provider take?
- What are the engineering resources required on the provider's side?
- What does the support infrastructure look like post-deployment?

By assessing potential solutions based on their responses to these questions, leaders are better equipped to choose the right partner for improving revenue cycle efficiency while growing the topline.

Care New England

Care New England reports a 55% reduction in authorization-related write-offs

Care New England (CNE) is Rhode Island's second-largest hospital system. CNE has six operating units, including Butler Hospital, Women & Infants Hospital, Kent Hospital, the VNA of Care New England, the Providence Center, and the Care New England Medical Group.

CNE recognized an opportunity for automation as a way to increase productivity without hiring additional staff or incurring costs. During a process improvement review, CNE estimated each Notice of Admission (NOA) or authorization took about 15 minutes to complete, and that they would need to hire an additional 14 FTEs to keep pace with the amount of work. The average turnaround time for submitting a prior authorization to getting a patient scheduled was nearly 10 days, resulting in patient and provider frustration.

Today, CNE utilizes intelligent automation to improve revenue cycle performance. For example, Notable executes NOAs into the payer portal with patent information and ensures the data is submitted accurately and on time. Since deploying Notable, CNE has saved over 2,000 hours of NOA- and prior authorization-related work, which translates to an estimated $644,000 cost savings in less than 12 months.

Back-end-related staff time savings has also been recognized. There is a significant decrease in hours spent on claims appeals and follow-up on denials for missed, late, or inaccurate notification and authorization. CNE has reallocated staff time to high-value initiatives, including time consuming federal requirements related to the No Surprises Act. Additionally, CNE reduced staff overtime due to the significant volume decrease of work offloaded to Notable. The volume shift has also allowed CNE to operate more efficiently if staff are ill or out of the office.

Since deploying Notable, CNE reports a 98% success rate for NOAs and 83% for prior authorizations, respectively. In the month of October 2022 alone, CNE reported outstanding benchmark performance: Just 1% of prior authorizations resulted in a write off – significantly lower than the industry standard of 10-13%.[16] This elevated productivity can be attributed to improved speed, accuracy, and reliability through intelligent automation.

With Notable, revenue cycle leaders can allocate precious staffing resources to the highest impact areas and reduce rework caused by human errors. As a result, CNE improves revenue cycle performance by reducing denials and write-offs, ultimately ensuring the patient receives timely, quality care.

"We have two different EMRs. We have different systems that staff need to interact with on a daily basis, along with following specific rules that vary by payer. With Notable, we were able to standardize and remove the margin for human error, things as simple as mistakenly faxing to the wrong number. Our process is more accurate and reliable because Notable is following steps coded into an automated workflow. There is no guesswork."

Krysten Blanchette, VP of Revenue Cycle
Care New England

Since deploying Notable to power Intelligent Authorizations, CNE reports:

Increased staff capacity

55%

Reduction in authorization-related write-offs

2,841

Hours saved for staff

Improved accuracy

83%

Prior authorization clean submission rate

98%

NOA success rate

Better revenue cycle performance

$644k

Projected write-off and cost savings within 12 months

80%

Reduction in authorization turaround time

Austin Regional Clinic

Austin Regional Clinic powers 78% touchless registrations in the front-end of the revenue cycle

Austin Regional Clinic (ARC) is an independent physician-owned, multispeciality clinic serving over 540,000 patients across 33 locations throughout the greater Austin area. Using Notable, ARC is powering a touchless patient registration experience, a critical step in patient financial clearance within the revenue cycle. This consists of automating various pre-visit workflows like new patient pre-visit registration, demographic verification, payer/plan matching, and RTE.

While ARC has one of the highest Epic MyChart activation rates in the country, only 20-25% of established patients complete their pre-visit registration through MyChart, and even those often require additional manual touch. ARC partnered with Notable to redefine the registration process to improve the patient experience while also decreasing denials driven by inaccurate registration data.

Since deploying Notable, 78% of registrations are completely touchless, minimizing workqueue volume and outbound phone calls for front desk and call center staff. In just three months since launching Notable, ARC has seen a 50% reduction in eligibility and registration-related denials on applicable claims.

Because much of registration relies on patient-provided information, inaccurate registration data is common and staff often have to manually intervene to correct inaccuracies or omissions. In order to drive high-fidelity information capture, Notable has created what ARC leaders call "easy buttons," or specific customizations based on claim rules. These take the form of questions patients must answer in order to move on to the next step, and auto-population of certain fields based on existing registration data to reduce the amount of data entry required by a patient.

By pursuing a touchless state on the front-end, ARC can impact the back-end, like resolving revenue cycle issues upstream with complete and correct rules-based registration. By partnering with Notable, ARC realized immediate results with long-term impact for patients, providers, and staff alike.

"Getting patient access workflows right is key to revenue cycle management. We partnered with Notable because they share our deliberate focus on improving patient, provider, and staff experience and engagement, as well as their expertise in both front-end and back-end workflows to holistically address suboptimal processes, such as patient registration."

Lucy Sumner,
VP of Revenue Cycle
Austin Regional Clinic

Modernize patient access with Notable

Health systems chose Notable as their intelligent automation partner to strengthen the front end of their revenue cycles with higher accuracy and faster payment, without additional headcount. With intelligent automation, error-proof patient access that eliminates downstream rework is a reality – increasing the capacity of staff and improving the overall financial performance of health systems.

With Notable's intelligent automation, health systems can automate front-end processes to eliminate back-end administrative burden. In doing so, organizations remove patient and staff hassles that compromise quality, impact reliability, and escalate cost.

- **Expand access** by guiding patients through a personalized registration process that is designed to optimize engagement, accelerate payments, and drive revenue cycle efficiency with high-fidelity data
- **Eliminate administrative burden** by using digital assistants to perform revenue cycle workflows on behalf of staff
- **Improve revenue cycle performance at scale** by preventing denials at their source with a digital workforce that is faster and more reliable than humans

"Like many health systems, our staffing needs exceeded our ability to hire. Notable has helped fill in these gaps and safeguard precious time and resources. We're saving 3,500+ hours for the front desk, which has increased employee and job satisfaction, and will ultimately help us do the same – or more work – without hiring more staff."

Chris Knight, CFO
Reid Health

"Our partnership with Notable has enabled us to meet patients where they are, to redirect staff resources into other areas, and to really lift some of the administrative burden that we have characteristically faced. We've seen a 50% reduction in claim denials, and patient engagement is much higher as a result."

Lucy Sumner, VP of Revenue Cycle
Austin Regional Clinic

To learn more about how Notable can power revenue cycle performance for your organization, request a personalized demo.

Leading providers use Notable to *transform* revenue cycle performance

55%
reduction in authorization-related write offs

Care New England

50%
decrease in eligibility and registration-related denials

Austin Regional Clinic

300%
increase in co-payment collections

Intermountain Healthcare

91%
prior authorization success rate

Fort HealthCare

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