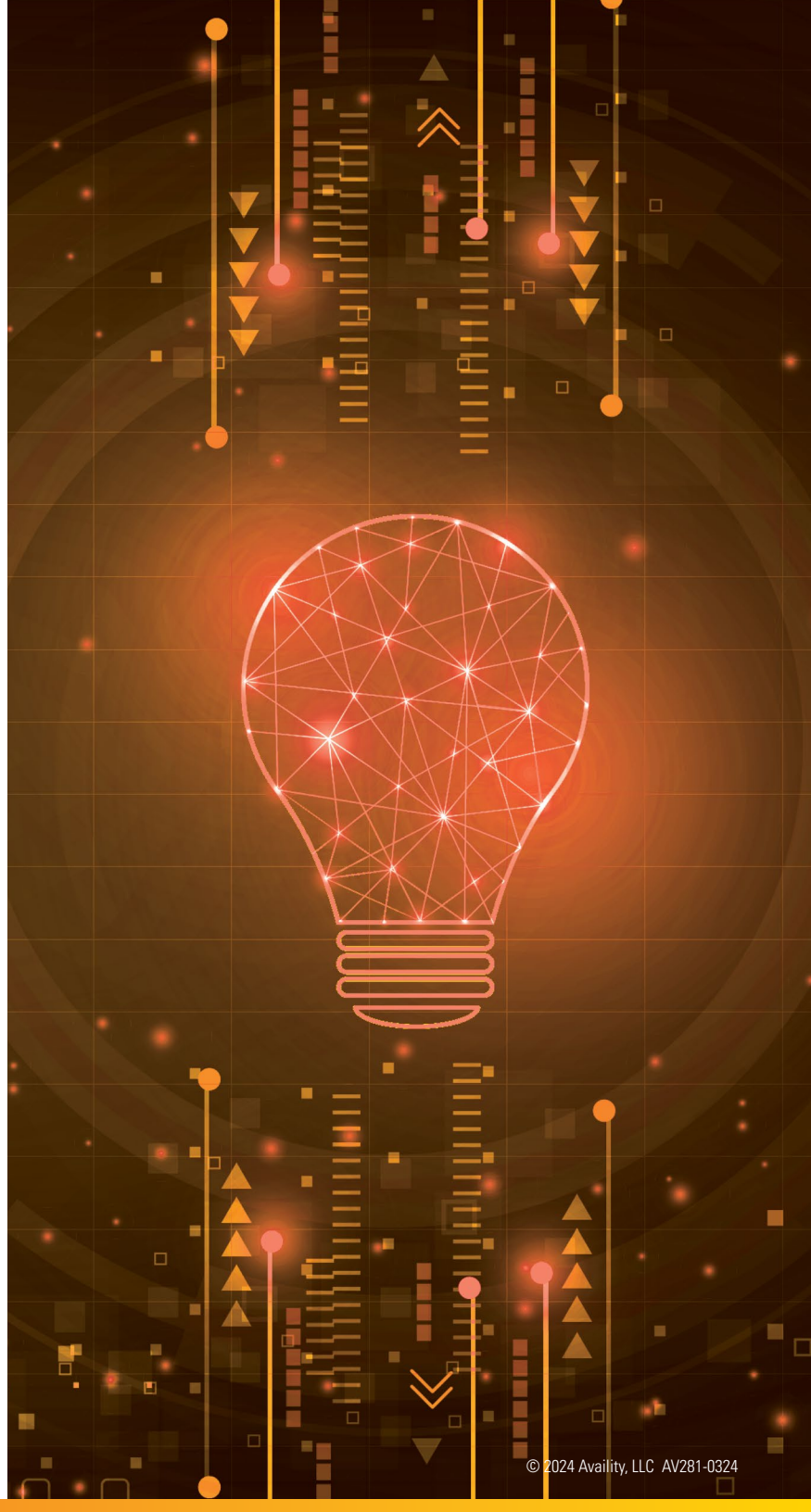
Availity®

Availity 2024
Revenue Cycle Management Buyer's Guide

About Availity

Availity is the trusted partner for organizations seeking to realize the greatest value from clinical, administrative, and financial data. Positioned at the nexus of provider, health plan, and consumer health information, Availity develops scalable, innovative solutions for healthcare data acquisition, standardization, transparency, automation, and exchange among health plans, providers, and technology partners. As one of the nation's largest health information networks, Availity facilitates billions of clinical, administrative, and financial transactions annually. Our suite of dynamic products, built on a powerful, intelligent platform, enables real-time collaboration for success in a competitive, value-based care environment.



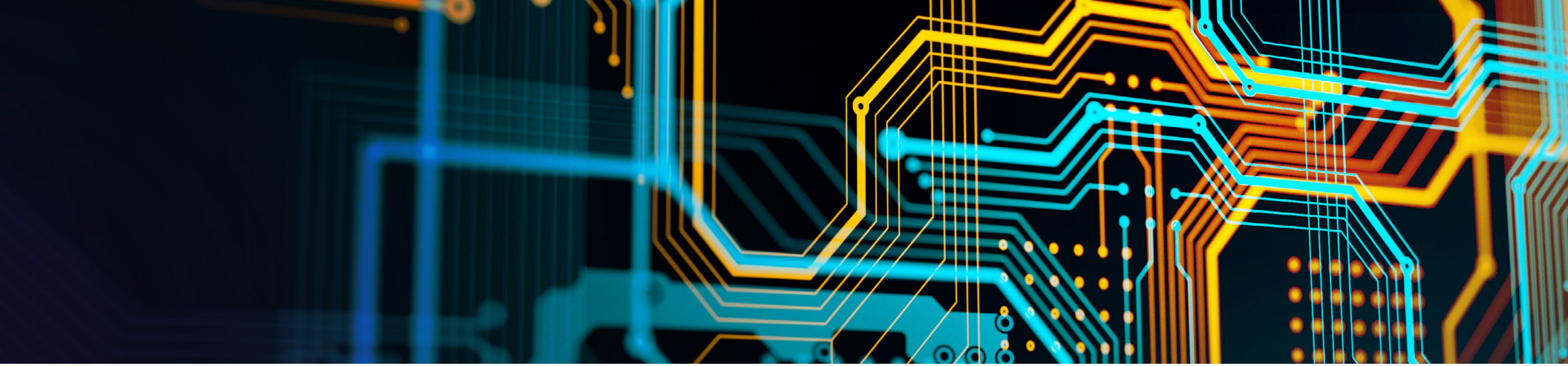


Table of Contents

Executive Summary

Synergizing Success: The Critical Role of RCM in Healthcare Excellence

Revenue cycle management (RCM) is the heart of every practice, hospital, and health system. When it's healthy and humming, it feeds every corner of the organization—from the front desk and the executive office to every function. When it's unhealthy and struggling, alarming symptoms appear everywhere—chronic operational inefficiencies, financial instability, burned-out staff, and frustrated patients.

RCM Renaissance

Not too long ago, RCM was strictly a back-office function populated by coders and billing staff surrounded by phones, faxes, and sheaves of paper. If you were front-office staff, it was a bit of a mystery figuring out what those folks did exactly.

Those days are long gone.

Today's modern RCM ecosystem is an intricate web connecting many operational facets: patient registration, claims processing, and denials and appeals management. Individually, these elements are critical, and their collective functionality determines the efficiency and success of the entire revenue cycle. Optimal performance demands a synergistic approach where these diverse components seamlessly interact.

The RCM Imperative

Patient care is the focal point of healthcare, but RCM forms its foundational business strategy. For healthcare executives, focusing on operational aspects such as coding accuracy and technological efficacy in payment systems is essential. Optimizing these components is not just a task—it's a strategic imperative. Getting the revenue cycle right allows more people and resources to be deployed in service of patient care.

Each element of the revenue cycle, from eligibility verification to claims adjudication, plays a vital role. A bottleneck in any part, such as a denied claim or delayed authorization approval, will have cascading effects on patients, providers, and health plans. These elements are not just independent cogs but integral to the collective strength and efficiency of the revenue cycle.

Next-Level RCM: Driving Financial Health through Digital Integration and AI

A sophisticated RCM strategy is crucial to enable providers to focus on patient care, which bolsters reimbursement in value-based care models. Advanced RCM practices go beyond minimizing revenue leakage and enhancing cash flow; they involve integrating end-to-end digital solutions and leveraging AI and automation.

Comprehensive digital platforms offer real-time data analytics and integrated communication channels, providing a holistic view of the revenue cycle and enabling data-driven decision-making. The future of healthcare finance will increasingly rely on AI not only for operational efficiency but also for maintaining a competitive advantage.

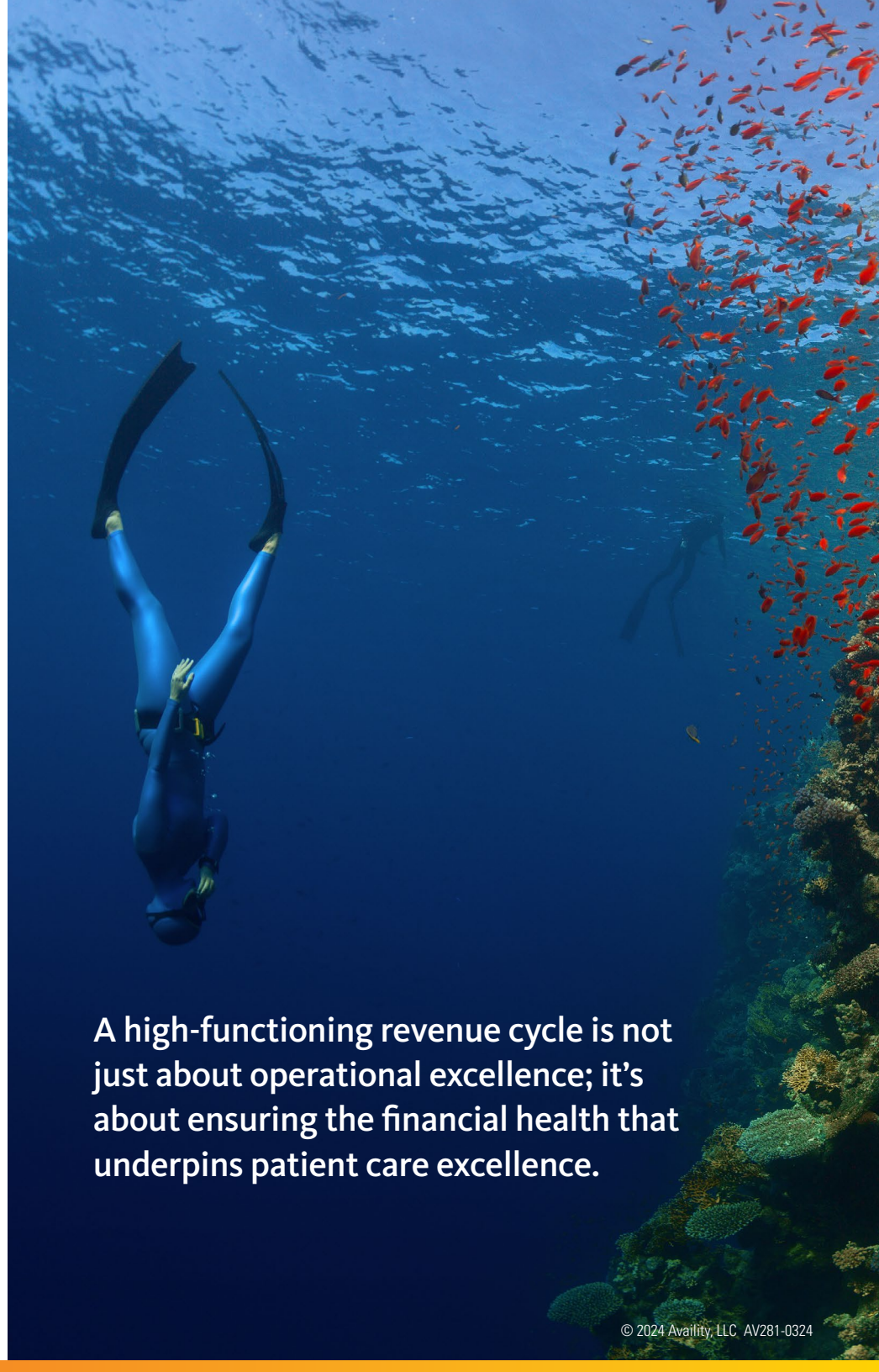
RCM Deep Dive

Availity developed the 2024 RCM Buyer's Guide to empower revenue cycle leaders to make informed decisions about their technology investments, operational strategies, and business goals. This guide will take providers step by step across the RCM lifecycle—pre-service, post-service, and post-adjudication—and identify the challenges and opportunities of each area.

We'll also take a deep dive into Availity Essentials Pro, our flagship, end-to-end revenue cycle platform solution. As the nation's largest real-time health information network, Availity processes more than 11 billion transactions every year.

For more than 20 years, Availity has delivered innovative and reliable solutions that empower provider organizations to meet their operational and patient care goals. Our mission is anchored by deep industry knowledge, tailored to the unique needs of your organization, and underpinned by a steadfast commitment to treating each of our customers as a distinct and collaborative partner.

A high-functioning revenue cycle is not just about operational excellence; it's about ensuring the financial health that underpins patient care excellence. As healthcare continues to evolve, the integration of digital platforms and AI in RCM will be pivotal in navigating this complex landscape. The essence of RCM lies in its ability to adapt and innovate, ensuring healthcare organizations not only survive but thrive in this dynamic environment.



Chapter 1

Optimizing Pre-Service Components for a Robust Revenue Cycle

Key Takeaways

- **Importance of Pre-Service Processes:** The critical role of eligibility, prior authorizations, and patient financial clearance in establishing a resilient and efficient revenue cycle.
- **Benefits of Automation and Integration:** How automation within the EHR can significantly improve workflow efficiency, reduce denials, and enhance financial performance.
- **Advancing Patient Financial Clearance:** Exploring sophisticated tools for patient financial clearance that integrate demographic, coverage, and patient responsibility information.

How one large health system streamlined its eligibility and benefits process with Availity's Advanced Real-Time Eligibility solution.

Learn More

Pre-service tasks—insurance eligibility verification, securing prior authorizations, and clarifying patient financial obligations, are fundamental in establishing a ***resilient and efficient revenue cycle***—sets the stage for both financial health and enhanced patient experience. In the modern healthcare landscape, mastering these components is imperative.

Top 5 Mistakes in Eligibility and Benefits Verification

Identifying and rectifying common mistakes in eligibility and benefits verification can save significant administrative time and resources:

1. **Service-Type Specific E&B Checks:** Perform E&B checks across all relevant service types to avoid missed co-pays, communicate patient responsibility, and reduce patient frustration.

2. **Overlooking Self-Pay Patients:** Check for potential coverage in self-pay patients to increase the likelihood of payer billing and patient satisfaction.

3. **Final E&B Checks Pre-Claim Submission:** Conduct a final eligibility check before claim submission to match patient's benefits information with the health plan's records.

4. **Inefficient Vendor Relationships:** Providers who utilize vendors that do not source the most reliable information can lead to denials and additional back-office work.

5. **Centralizing E&B Information:** Utilize technology solutions that integrate E&B information directly into your EHR, PMS, or HIS, avoiding workflow inefficiencies and information silos.

Streamlining Pre-Service Processes

The integration of comprehensive pre-service tools can ensure a seamless journey from initial patient interaction, thereby solidifying the organization's financial foundation and fostering a sustainable healthcare delivery system.

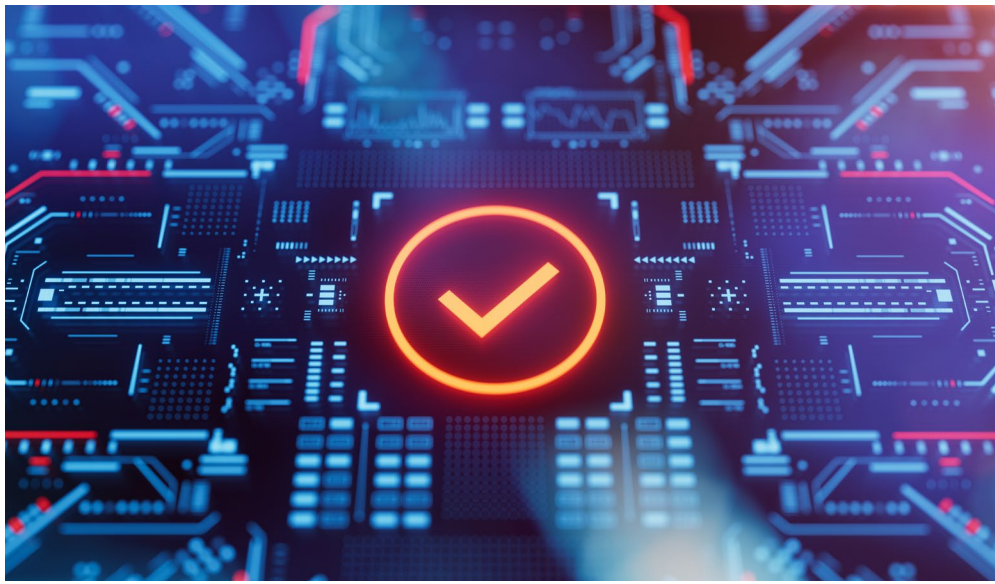
Automating Prior Authorizations: According to the American Medical Association, prior-authorization denials on inpatient accounts are a key driver behind the dollar value of denials increasing to 2.5% of gross revenue in August 2022 from 1.5% of gross revenue in January 2021.1 Identifying and addressing the root cause of authorization-related denials is critical to improving financial performance.

For example, many provider organizations rely heavily on phone and fax machines to process prior authorizations. CAQH estimates that the majority of providers continue to manually prior authorization requests.2 This forces staff to leave their primary workflow—the EHR. This is often a significant drag on productivity for hospitals and health systems processing a high volume of prior authorizations and referrals.

Leveraging direct integrations with EHR systems and connections with health plans nationwide can significantly streamline the prior authorization process. Automating these tasks for fast and accurate submissions, including determining authorization necessity and clinical documentation attachment, is vital.

Other benefits of automation and direct connections to health plans include:

- Automated queries to the health plan to determine if authorization is required, eliminating unnecessary tasks if it's not.
- Auto-population of prior authorization forms for fast submission with minimal or no human intervention.
- Provider staff receiving up-to-date authorization status information directly in the EHR workflow, eliminating calls to the health plan or visits to the portal.
- Improved reporting and analytics free up staff time to focus on high value activities



Efficient Coverage Discovery: Identifying insurance coverage—particularly when not immediately apparent, or with ancillary services where patients don't see regiatration, like labs, ERs, or imaging—is a critical pre-service task. Tools that efficiently search for active coverage across multiple payer sources and automatically update EHR systems with relevant payer and plan codes can greatly enhance workflow efficiency and patient record accuracy.

- **Reduce bad debt and lost revenue:** Provider organizations are more likely to collect their full payment and less likely to have to write off bad debt charges when patients have active insurance coverage.
- **Streamline registration and pre-service activities:** As with many aspects of the revenue cycle, tools that allow provider staff to stay within established EHR workflows are imperitive.
- **Improve patient data accuracy:** Digital tools that identify coverage for a patient automatically post back to the EHR with the related payer and plan codes, triggering customized workflows to keep the patient record up to date.

Advancing Patient Financial Clearance: Sophisticated tools for patient financial clearance remove the guesswork from patient estimations and coverage screening. Integrated demographic, coverage, and patient responsibility information, combined with government mandate compliance and price transparency tools, are essential for tailoring workflows to specific organizational needs.

Comprehensive Eligibility and Benefits Management

Addressing front-end gaps in the revenue cycle can mitigate issues related to claim denials and patient payments. Accessing comprehensive eligibility and benefits information within user interfaces and through real-time EHR integrations is critical.

Conclusion

A robust pre-service strategy is integral to a healthy revenue cycle. Embracing technological solutions and best practices in pre-service components streamlines operations and positions healthcare organizations for financial success and improved patient experiences.

Chapter 2

Achieving Powerful Post-Service Claims Management

Key Takeaways

- **High Cost of Manual Processes:** The costs of manually driven claims management are high, including the cost of paper, equipment, postage, and inefficient communication methods.
- **Inefficiencies and Duplication in Manual Claims:** A common cycle of inefficiency leads to delays, duplications, and denials, exacerbating costs and operational inefficiencies for both providers and health plans.
- **Benefits of Electronic Claims Processing:** Shift toward electronic claims processing for increased efficiency, improved claim accuracy, and faster payment processes.

Mercy Medical Center saves time and money, sends cleaner claims, with integrated workflows and expert implementation.

Learn More

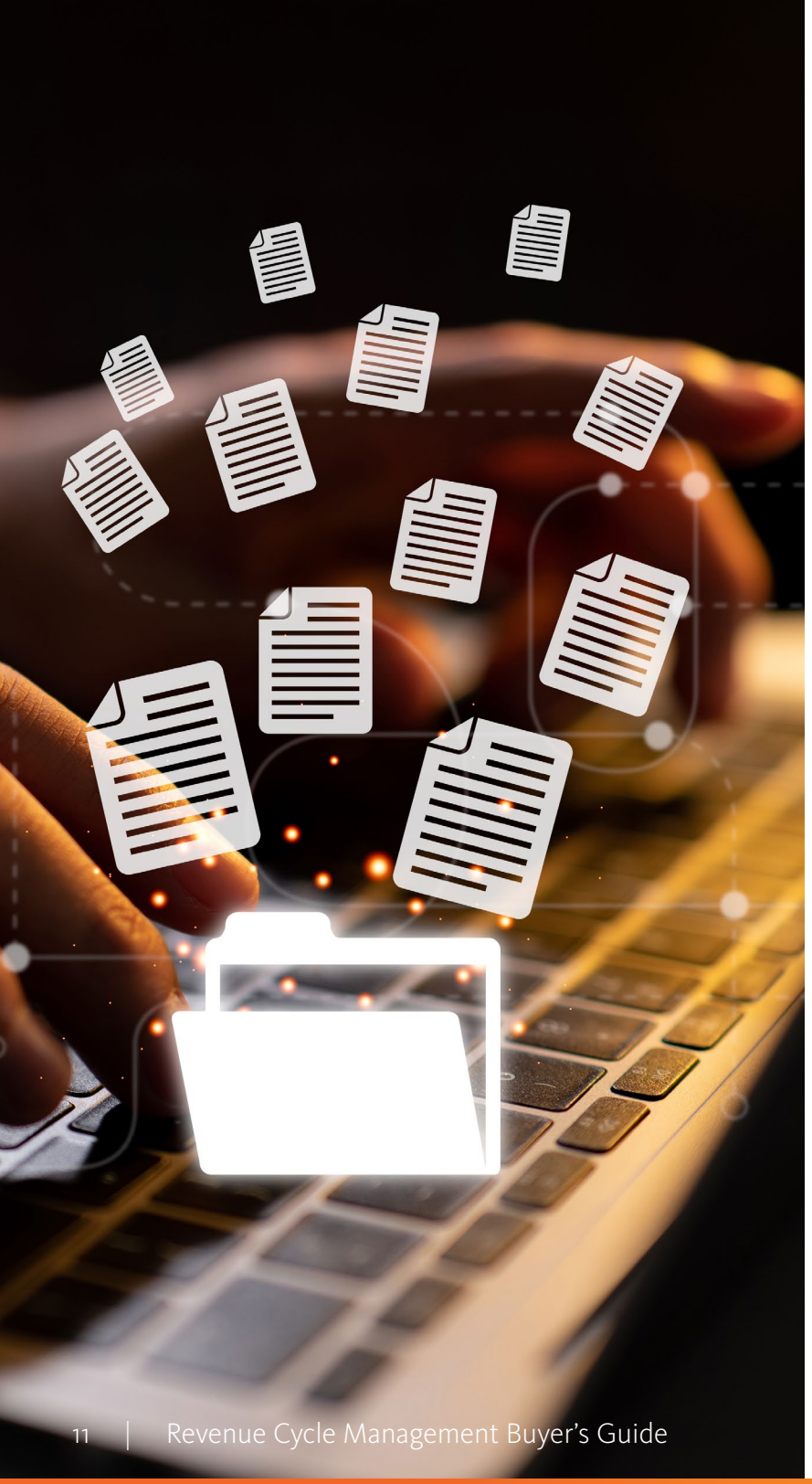
We can do almost anything electronically these days, even a process as complex as securing a mortgage loan on a house. Yet, people can't visit a doctor or have a surgery without slow, error-prone manual processes and a mountain of paper. It comes at a steep cost. ***The healthcare industry loses ~$20B annually from manual processes***, which doesn't even account for the cost of paper, equipment, postage, and phone/fax lines.

Cascading effects of manual claims processes

Consider a typical scenario. A provider submits a claim and then has no idea what happens from there. If there's no word in a couple of weeks, they follow up. On the payer side, incoming paper documents get scanned and indexed and may not be accessible immediately. When the provider calls to check the status, if the payer representative doesn't identify the right claim, the provider proceeds to submit the claim again. When the original claim is identified, the provider now has duplicate claims, which causes a denial by the payer, leading to an appeal. It can be a vicious cycle.

In parallel, infrastructure costs continue to increase. In addition to paper, equipment and supplies, postage costs are also increasing. Medical claims must be mailed at the higher first-class postage rate due to HIPAA requirements. At 10,000 claims a month, that adds up to $72,000 a year just for postage. One more cost for payers and providers is maintaining physical office space for printing and mailing claims, even after many staff shifted to remote work during the pandemic.

In reality, no one wants to manage claims by fax and mail, because it's not efficient, it costs more and it's difficult to process for all stakeholders. Making the shift to electronic processes reduces the workload and speeds the payment process for everyone.



Steps to take now to reduce paper processing

Across the industry, some components of payment process, such as eligibility and benefit verification, have achieved higher electronic adoption rates. On the other hand, only 29% of attachments and 31% of prior authorizations were processed electronically.[3] Given that technology is available, there are immediate steps provider revenue cycle teams can take to reduce manual processing:

1. **Actively maintain payer and plan profiles:** It's important to do a thorough review of all payer and plan profiles on a regular basis. Oftentimes, organizations will discover that a payer or health plan identified in their system as only accepting paper claims can now accept electronic claims. Or there may have been an error in the original setup. In either case, consistent review and cleanup of the system will keep better pace with payer updates and enable more claims to be submitted electronically. When the average cost of submitting a manual claim is $7.19[4] the savings add up.
2. **Edit claims before submission:** Editing is one of the most critical components of claims processing that prevents denials and reduces manual rework. Using flexible, HIPAA-compliant editing tools, providers can complete eligibility and network checks, confirm that all data required is entered accurately, and account for custom requirements for special circumstances. By focusing on claim edits up front, providers can submit more clean claims, requiring less manual intervention downstream.

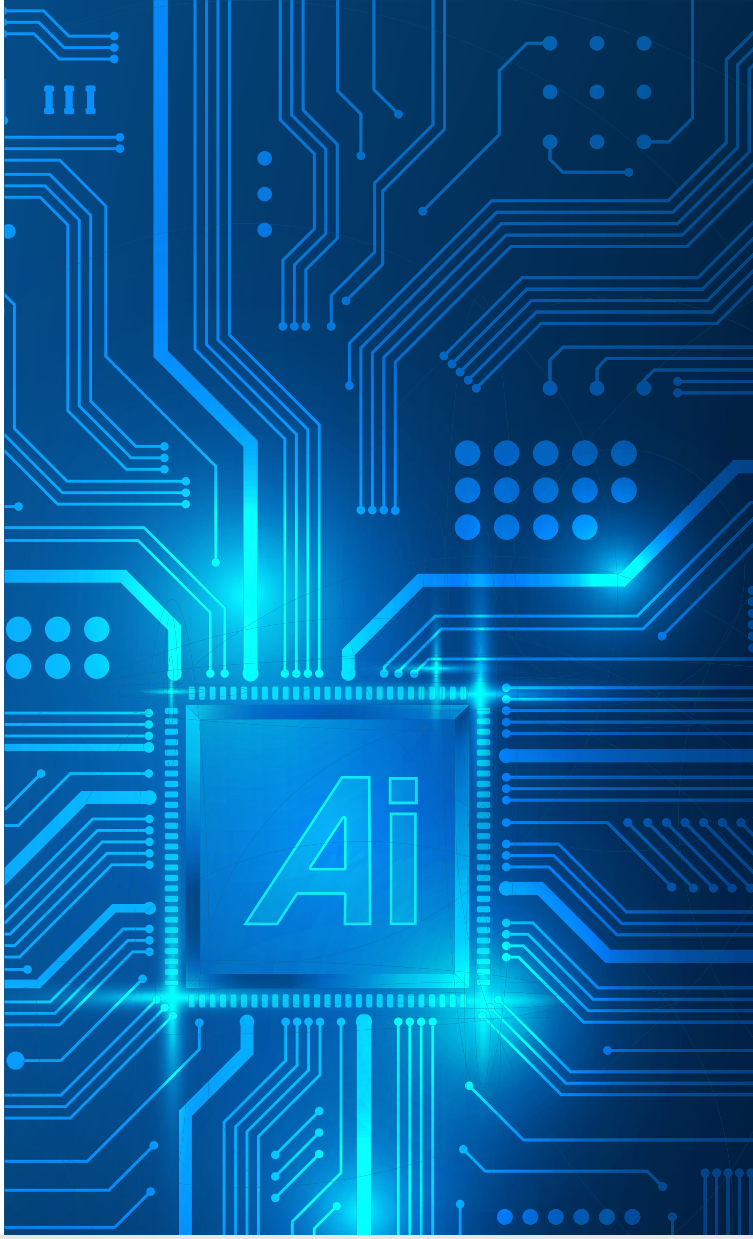
3. **Submit attachments up front:** The need for additional information to process a claim, in the form of a medical attachment, is one of the largest causes of payment delays and denials. In addition, it is one of the least adopted electronic transactions, resulting in nearly 80% of medical attachments being sent manually via fax or mail. Instead, use existing technology to identify and submit unsolicited attachments up front. This can be accomplished via secure file transfer from within the EHR workflow, which can marry the claim and the documentation together and send them to the payer as a complete package. One health system reduced attachment-related denials by 88% and saved 1,200 hours of rework in just three months. The cost savings are significant – each electronically submitted attachment saves $3.10 over sending a paper copy.[5]
4. **More electronic processing means more visibility:** An important outcome of shifting more claims to electronic processing is the increase in visibility. It's critical at every step in the process for providers and payers to understand the status of a claim: when it was received by the payer, if more information is needed, if the medical attachment was received, if it has been paid, etc. Manual claim status inquiries, typically done by phone, cost a whopping $12.12/ inquiry more than checking electronically. Eliminating manual inquiries could save a provider 22 minutes per inquiry. Industry-wide, removing manual inquiries could reduce waste by $3.1B annually.[6]

Make Paper Fly Away for Cleaner Claims Processing

It's time for the healthcare industry to let go of paper and fax machines – every other industry is far ahead of us. While there will always be some level of paper-based processing, the proportion can be reduced dramatically with collaboration among industry stakeholders and higher adoption of existing technology. Healthcare providers that have made the shift have gained a 75% reduction in staff time dedicated to managing paper claims and an 80% reduction in in-house paper claim volume. Let's move forward with electronic claims processing that is not only less costly, but also results in faster payment for providers and faster account resolution for patients.

Chapter 3

AI in the Revenue Cycle—A Use Case for Denial Prevention



Key Takeaways

- **AI Transformation:** AI tools providing a proactive approach to prevent denials—saving time and reducing the financial burden on healthcare systems.
- **Prevention vs. Management:** Predictive editing, powered by AI, identifies and corrects potential denials before they occur, offering a significant improvement over traditional, retrospective claim editing methods.
- **Better Performance:** Implementing AI for predictive editing in the revenue cycle can lead to substantial savings by reducing administrative costs associated with claim reworks and denials, enhancing overall revenue cycle performance, and allowing healthcare providers to focus more on patient care rather than administrative tasks.

Proving the value of AI in accelerating the revenue cycle. Proof of concept accurately predicts $848 million in denied claims.

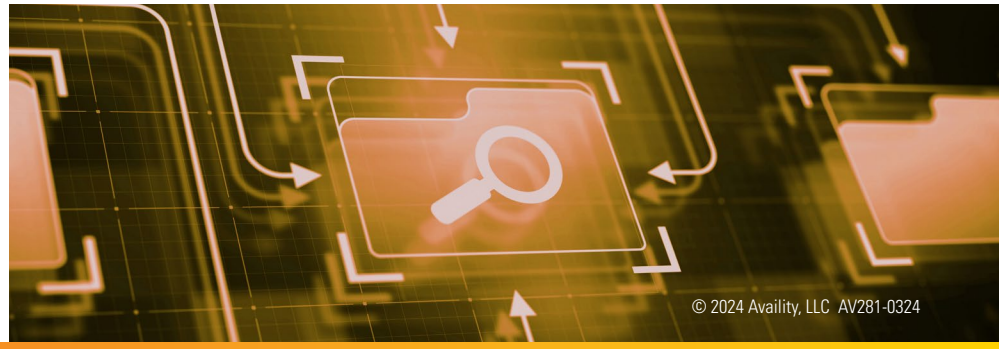
Learn More

Artificial intelligence (AI) has been healthcare's next big thing for years. While AI's application in clinical care and pharmaceuticals has received the most buzz, the technology's potential impact on the **$43 billion** spent each year on healthcare's revenue cycle could be equally transformative.

However, the value of the unpaid claim and the time it takes to rework it are only part of the overall impact on a health system's bottom line. Many provider organizations invest too heavily in reactive solutions—point technologies, staffing surges, and complex appeal processes. These tools may help "manage" denials, but true cost savings lie in prevention.

Tools with AI capabilities address many of the time-consuming, resource-intensive, and costly processes associated with claims editing and denial management. But the true value of this technology is its ability to analyze claims for errors before routing them to the payer. Many systems offer packaged or custom edits to claims before submission, but these edits are built retrospectively, requiring costly analysis to determine the root cause of the denials, and ongoing maintenance as payers' adjudication rules shift in response to external forces. Telehealth claims adjudication, for example, changed rapidly during the early days of the COVID-19 pandemic.

The ideal system would analyze claims from multiple providers, going to multiple payers, and spot trends that will likely lead to denials. Applying AI to the constantly changing stream of data removes the manual writing and maintenance of edits and allows health systems to react to changes more quickly – before the claims are submitted and a new batch of denials has to be analyzed.



The Potential of Predictive Editing

Providers want more effective ways to identify and prevent denied claims so they can reduce administrative rework and lost revenue associated with them.

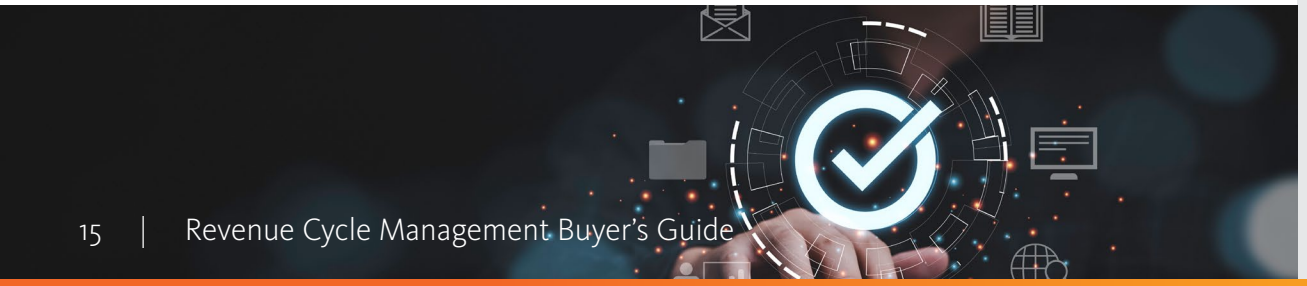
Predictive editing uses an AI algorithm that focuses on the subset of denials that are most likely to be avoidable and correctable. The algorithm's predictive capabilities lie in its ability to analyze claims data across a broad network of provider organizations, as well as policies specific to individual health plans.

The solution will return the predicted Claim Adjustment Reason and Remark (CARC & RARC) if the likelihood of denials is very high; the model only returns edit errors when there is 98 percent confidence that the claim will be denied.

As a result, providers can:

- Reduce the administrative cost of reworking claims and improve revenue cycle performance.
- Increase edit coverage by capturing complex, payer-specific edit scenarios that are beyond the scope of traditional front-end edit engines.
- Reduce the administrative effort of maintaining manual rules.
- Allow providers to save on implementation costs because predictive editing can be used within the provider's existing edit/error management tools.

The path toward a sustainable and healthy revenue cycle requires tools, insights, and analytics to help providers submit claims right the first time. Artificial intelligence and machine learning tools have the potential to move your organization from costly denial management to streamlined denial prevention.



Proof of Concept—Predictive Editing

Two large health systems participated in a proof-of-concept analysis of one year's claim data. The Predictive Editing AI was trained using data from 100 million professional claims with 176 million claim lines.

$45B
Claims billed amount

98%
Prediction precision on claim lines and denial reasons

$828.8M
Predicted denials that paid after correcting identified errors before submitting to payers

Participant feedback:

> "The analysis was accurate and identified areas our organization can improve upon immediately."

> "We're ready to put this into place immediately."

Chapter 4

Reporting and Analytics

Key Takeaways

- **Importance of Real-Time Claim Tracking:** Track claims in near real-time to swiftly identify and rectify issues, thereby reducing delayed payments and denials.
- **Streamlining Remittance Processing and Patient Payments:** Highlights the significance of receiving Electronic Remittance Advice (ERA) in formats that allow automatic posting.
- **Leveraging Advanced Analytics and Reporting:** Emphasizes the role of advanced analytics tools in providing real-time data visualization and custom reporting, crucial for gaining insights into various aspects of the revenue cycle.

Analytics and reporting in the post-adjudication phase of the healthcare revenue cycle are vital for optimizing financial performance and operational efficiency. This phase involves several key elements.

1. **Claim Status and Tracking:** It's essential to track claims in real time to determine where they are in the adjudication lifecycle. Integrating claim status data with practice management systems or EHRs can enhance the clarity and efficiency of this process. Real-time tracking allows for immediate identification and rectification of any issues, thereby reducing the risk of delayed payments and denials.

2. **Remittance Processing:** The ability to receive Electronic Remittance Advice (ERA) files in formats that facilitate automatic posting to practice management systems is crucial. This not only streamlines the process but also reduces manual labor and the potential for errors.

3. **Patient Statements and Payments:** The integration of electronic statements and payment processes into the workflow is another critical aspect. This includes setting up payment plans and processing various forms of payment, which can significantly improve the patient financial experience and streamline the billing process.

4. **Analytics and Reporting:** Leveraging advanced analytics tools is fundamental in this stage. These tools allow healthcare providers to visualize data in real-time, building custom reports that offer deep insights into various aspects of the revenue cycle such as claim errors, status, remittances, denials, and more. This level of detail is instrumental in identifying areas for improvement and making informed decisions to enhance overall revenue cycle performance.

Effective use of analytics in revenue cycle management is a key driver of success. Many healthcare organizations traditionally rely on tools like Excel for managing metrics, but this approach often leads to fragmented and manually tracked key performance indicators (KPIs), data integrity issues, and inefficient use of staff time. Transitioning to more advanced business intelligence solutions is therefore recommended. These solutions enable comprehensive benchmarking and reporting across the organization, offering a cohesive view of the entire revenue cycle workflow. This integrated approach significantly enhances decision-making capabilities, improves patient experiences, and demonstrates the impact of revenue cycle management on organizational success.

In summary, the post-adjudication phase of the healthcare revenue cycle, enhanced by sophisticated analytics and reporting tools, is crucial for ensuring that healthcare providers are reimbursed accurately and efficiently. This phase allows organizations to identify opportunities for improvement, streamline their processes, and make data-driven decisions that ultimately contribute to their financial health and operational excellence.

Chapter 5

The Availity Essentials Pro Advantage

Key Takeaways

- **Get to Know 'Pro':** Availity Essentials Pro is an end-to-end RCM platform designed to streamline processes, enhance efficiencies, and optimize financial outcomes.
- **Advanced Features:** Availity Essentials Pro includes advanced features such as real-time eligibility and benefits verification, predictive editing using AI for claim error identification, and robust analytics for informed decision-making.
- **Partnership:** Availity Essentials Pro represents a strategic ally for healthcare providers, emphasizing adaptability across various settings and dedication to maximizing revenue, positioning itself as essential for navigating modern healthcare complexities.

With decades of revenue cycle management expertise and 15+ years of Epic integration, we value long-term relationships over short-term gains. We're a revenue cycle management partner focused on YOUR revenue. Our dedicated provider leadership team has over a century of combined experience.

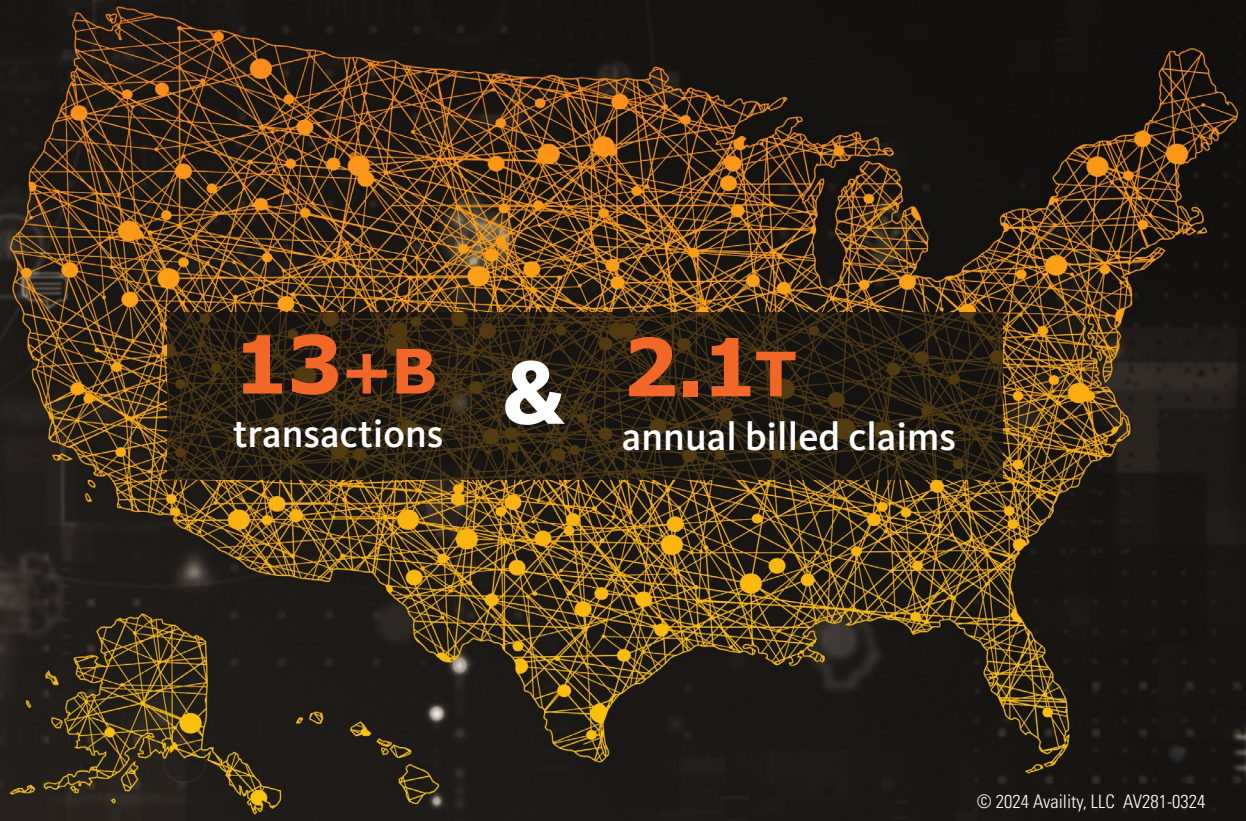
Learn More

In the rapidly evolving landscape of healthcare, providers face increasingly complex challenges in managing their revenue cycles. The key to navigating this intricate environment is leveraging advanced technological solutions that streamline processes, enhance efficiency, and optimize financial outcomes.

Availity Essentials Pro, our premier end-to-end revenue cycle solution, stands at the forefront of this transformation, offering an array of tools and features designed to meet the diverse needs of hospitals and physician practices.

Availity is the destination where providers connect with their payers to get the answers they need to focus on patient care. Availity simplifies how payers and providers exchange information, from the first check of a patient's eligibility through final resolution of reimbursement.

- **117M**
  Covered lives carried exclusively through Availity
- **1.5M+**
  Daily logins
- **1.5M+**
  Providers on Platform



Comprehensive Revenue Cycle Management

Availity Essentials Pro serves more 2 million providers from hospitals, health systems, and group practices, emphasizing our adaptability across various healthcare settings. This solution is tailored for proactive organizations dedicated to maximizing their revenue for services rendered. In an industry where every penny counts, Availity Essentials Pro emerges as a strategic ally for healthcare providers.

Addressing Customer Pain Points with Precision

Availity Essentials Pro meticulously addresses critical pain points in the healthcare revenue cycle:

- **Pre-service Denial Management:** The platform provides enhanced data to frontline staff, mitigating downstream data issues and denials. This proactive approach ensures a smoother, more accurate pre-service experience.
- **Post-service Claims Management:** Availity Essentials Pro equips providers with robust tools to manage their revenue cycle effectively. This includes reducing errors, consolidating processes, and driving process improvements.
- **Vendor Complexity and Integration:** The solution addresses the challenge of working with multiple, non-integrated vendors by offering a unified platform that streamlines vendor interactions and data flow.
- **Expanded Solutions for RCM Power Users:** Going beyond traditional RCM tools, Availity Essentials Pro offers advanced claim edits, denial prevention strategies, and comprehensive remittance solutions.

Enhancing Pre-Service Data Quality and Claims Management

The platform delivers critical payer and patient data, reducing manual processes and increasing claim quality. Key features include:

- **Eligibility and Benefits Verification:** Real-time checks of eligibility, co-pays, deductibles, and coinsurance.
- **Patient Engagement Tools:** A branded online statement and payment platform enhance patient communication and financial interactions.
- **Self-Pay Eligibility Verification:** Identification of potential coverage options under Medicaid and major health plans.
- **Claims Submission and Error Management:** Standard and non-HIPAA format submissions with real-time notification, detailed tracking, and an intuitive error management system.
- Post-service claims management is fortified with tools that prevent errors, boost staff productivity, and offer insightful analytics.
- **Claims Submission:** Capabilities for submitting individual or batch claims with real-time tracking and notifications.
- **Denial Prevention and Management:** Tools for addressing the root causes of denials, including front-end claims editing and customizable payer-specific edits, supported by integrated appeals workflows.

Robust Analytics and Reporting for Informed Decision-Making

The platform's analytics and reporting capabilities allow for real-time data visualization, helping providers track trends and make data-driven decisions. This includes integrated status, payment, claim details, and historical information.

Advanced Features for Enhanced RCM Power

Availity Essentials Pro stands out with additional features:

- **Predictive Editing:** Utilizing AI to pre-emptively identify and rectify claim errors.
- **Comprehensive Claims Processing Options:** Including Drop-to-Paper, Workers' Compensation, and Dental claim processing.
- **EOB to ERA Conversion and Remit Reconciliation:** Streamlining the remittance process for enhanced efficiency.

A Partnership for Optimized Revenue Cycle Management

Availity Essentials Pro is more than a solution; it's a partnership for healthcare providers seeking to navigate the complexities of modern healthcare. Its comprehensive suite of tools, combined with a commitment to innovation and customer support, positions Availity Essentials Pro as a pivotal resource in the journey towards optimized revenue cycle management. In an era where efficiency, accuracy, and financial performance are paramount, Availity Essentials Pro emerges as an essential ally for healthcare providers.

Availity Support and Success Management

Success Manager

Dedicated Success Managers proactively build, maintain, and expand relationships to ensure client success.

- Single escalation point of contact
- Success planning
- Ongoing training
- Operational Meetings/ Strategic Meetings

Business Analysts

Experienced business analysts partner with Success Manager to resolve complex issues and improve outcomes.

- Understand your specific business needs
- Analyze issues and identify opportunities

Contact Center

Experienced, U.S.-based contact center associates available from 8:00 AM ET to 7:00 PM ET.

- Integrated smart eTicketing
- ASA of <30s
- 24x7x365 critical support

Chapter 6

An Epic Integration

Key Takeaways

- **Seamless Integration:** Learn about how Availity's integration into Epic enhances provider efficiency.
- **Impact on Patient Outcomes:** Learn how the information exchange between payers and providers facilitated by the Availity-Epic alignment improves patient outcomes and reduces administrative burdens and health costs.
- **Key Considerations:** Guidance on evaluating vendor integration capabilities, optimizing end-user workflows, and the necessity of an effective change management.

Case Study

How a large Texas-based health system leveraged Availity Essentials Pro's best-in-class Epic integration to achieve more in less time.

Learn More

Built on a 15-year foundation of deep integration and real-time data exchange, the relationship between Availity and Epic is the best-kept secret in health IT. In fact, Availity's pre- and post-service revenue cycle integration is so seamless that providers working in Epic likely don't realize that they are using Availity!

Information exchange between payers and providers at the point of care makes a measurable difference in-patient outcomes and lower health costs. The alignment between Availity and Epic fosters a more robust, data-driven approach to improving patient health, facilitate timely access to appropriate care, and eliminating administrative burdens.

Additionally, Availity is part of Epic's Garden Plot as the integrated RTE vendor and claims clearinghouse. Introduced in March 2022, Garden Plot gives small practices streamlined access to Epic and Availity with minimal overhead.

Today, Availity's integration into Epic for end-to-end revenue cycle is used by more than 145 hospitals, health systems, and group practices across the nation, representing 112 million covered lived and 12 billion transactions every year.

Are Your Ready for an Epic Integration—3 Questions to Ask

If you are an Epic shop and considering a new RCM solution there are many questions to consider before moving forward. Here are just a few:

1. Are you working with the right RCM vendor?

Epic continues to gain share of the $31 billion electronic medical record (EMR) market, and many RCM vendors tout their ability to integrate with the Epic system. As you evaluate RCM solutions for your healthcare organization, clarify how each vendor "defines" integration to ensure your expectations are aligned. Do they handle both HB and PB claims, and can they offer advanced claim status or electronic attachments? Do they offer hospital-specific editing packages, and can they integrate claim status, attachments, or advanced eligibility options? You should also use the vendor's customer references as an opportunity to ask in-depth questions about the implementation and ongoing support. Pay particular attention to how well the vendor and Epic work together to address issues. An RCM implementation team with extensive Epic experience is better able to get in front of common issues and address them before they cause major project delays.

2. Does your vendor understand optimizing workflows from the end-users' perspective?

Integrating your RCM solution with Epic represents an opportunity to automate many manual processes around eligibility and benefits, claim scrubbing, claim submission, and claim status. But to lay the groundwork, an RCM vendor shouldn't rely solely on handbooks or process documents to evaluate workflow. Instead, members of your RCM vendor's team need to sit down with your employees to see how they do their jobs and where their pain points are to identify opportunities where automation can streamline tasks. Look for a demonstrated track record working with customers to integrate RCM in ways that truly let you optimize workflows in Epic and keep your teams doing the majority or all of their work on Epic screens—not switching between systems.

3. Do you have a change management plan in place for an Epic integration?

Change management is the critical component for a successful RCM implementation, but many hospitals and physician practices don't make it a priority, which can lead to issues with morale among staff and slower-than-expected user adoption. Having a plan in place to communicate with staff about the project, its purpose, and milestones can help you get in front of employee concerns. Also, make sure there are extensive training resources available to minimize productivity issues during and after the transition.

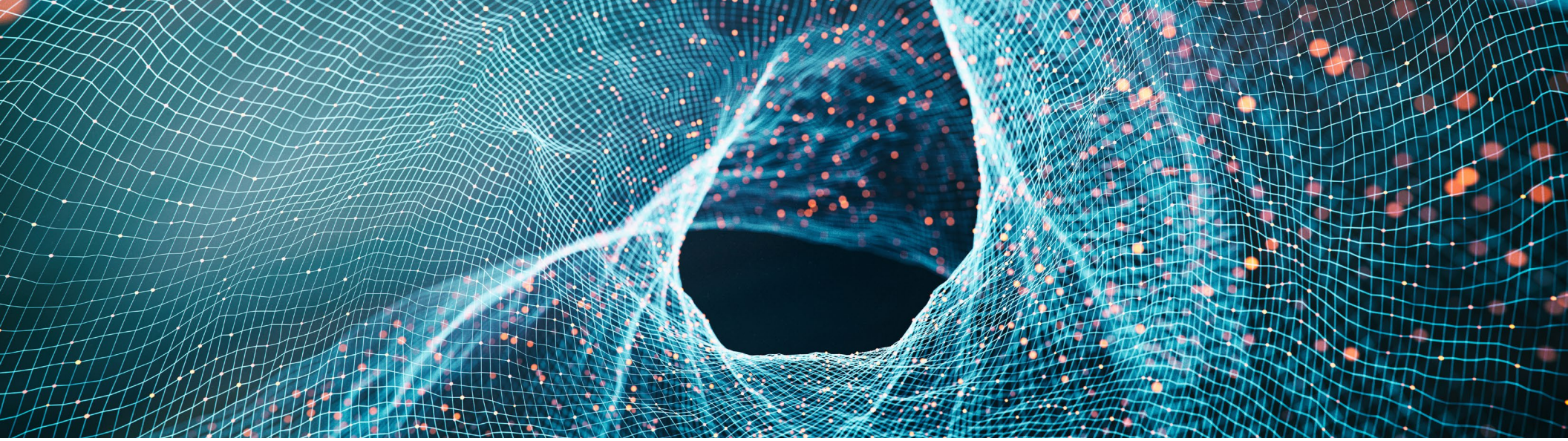
Conclusion

The Availity 2024 Revenue Cycle Management Buyer's Guide was created as an indispensable resource for provider organizations seeking to enhance their RCM processes and workflows. This guide explored the nuances of the modern RCM environment, from optimizing pre-service components and mastering post-service claims management to leveraging advanced technologies like AI and analytics for denial prevention and operational excellence.

Key takeaways included the importance of integrating digital solutions across the RCM lifecycle to improve operational efficiency, financial health, and patient satisfaction. The Buyer's Guide emphasizes the critical role of pre-service processes in setting the stage for a healthy revenue cycle, the transformative potential of AI in preventing denials and streamlining claims management, and the indispensable insights provided by analytics in driving decision-making and strategic planning.

Availity's Essentials is a comprehensive solution tailored to meet the evolving demands of healthcare providers, offering end-to-end capabilities that span eligibility verification, claims submission, and advanced analytics. The integration with Epic showcases a seamless synergy between technology and workflow, underscoring the potential for improved efficiency and outcomes.

As healthcare continues to advance towards a more digital, data-driven era, the insights and strategies presented in Buyer's Guide offers a roadmap for organizations to navigate the complexities of the modern revenue cycle. By prioritizing technological integration, data transparency, and patient-centered processes, healthcare providers can not only achieve operational excellence but also enhance the overall quality of care delivered to their patients.



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Appendix

Meet the Team

With decades of revenue cycle management expertise and 15+ years of Epic integration, we value long-term relationships over short-term gains. We're a revenue cycle management partner focused on your revenue. Our dedicated provider leadership team has over a century of combined experience.

If you are interested in learning more about how Availity Essentials Pro can transform your revenue cycle, reach out to one of our experts today.

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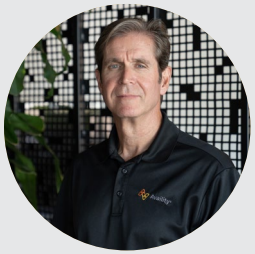

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"For more than 20 years, Availity has delivered innovative and consistent solutions that empower provider organizations to meet their operational and patient care goals. Our mission is anchored by deep industry knowledge, tailored to the unique needs of your organization, and underpinned by a steadfast commitment to treating each of our customers as a distinct and collaborative partner."

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