



## WHITE PAPER

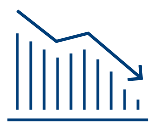
# Five Strategies for Software Vendors to Help Healthcare Customers Succeed

# Introduction

Complicated billing, unclear eligibility information, changing Medicare Beneficiary Identifiers (MBIs), endless payer logins, and denials stacking up – these are just a few of the pressing revenue cycle challenges providers are facing today. From the front office to the billing team, and all the way to the CFO, providers need a better way to manage intake, claims, patient payments, and reporting.

Enter: Software vendors like you, ready to turn an organization's top eligibility and claims challenges into stress-free processes. But, how are your solutions standing out in the market? To set yourself apart, you need more advanced features and easy-to-use software. Providers are looking for a true partner they can count on.

Here are five focus areas to make sure your product delivers on, so providers see your software as a trusted solution, not just another piece of their RCM toolbox.



## 1. Reduce financial burden

Tackle revenue cycle challenges at every part of the process, from the first eligibility check to the last payment.



## 2. Stay connected with payers

Be the expert on payer rules so your customers don't have to worry about keeping up with the latest changes.



## 3. Improve claims management

Fend off denials from adding to your customers' day; keep their focus on high-value tasks, not extra work.



## 4. Deliver revenue insights

Go beyond the immediate needs of the revenue cycle by delivering actionable insights that empower providers to work more proactively rather than reactively – in every step of the front- and back-end workflow.



## 5. Make payments as easy as possible

Bring patients and residents into the RCM process, too. Are your solutions solving for the payment options they need?

# Reduce Financial Burden

**Providers are feeling financial pressure from all sides.** As they struggle to keep pace with labor, inflation, and operating expenses, the need to also improve revenue spreads them thin. Small billing teams in 1-2 doctor practices don't have enough hours in the day to do it all, and at mid-size and large organizations, even specialized staff are faced with looming financial challenges.

For example, labor remains the largest expense at hospitals,<sup>1</sup> with nurse salaries increasing as clinical leaders try to find and retain talent. Meanwhile, hospitals are also feeling the brunt of underpayments from Medicare and Medicaid, and their expenses are growing faster than inflation.<sup>1</sup>

This all adds up to one large burden. Mastering the revenue cycle isn't just about capturing payment or making it easier for billers to do more in their day; it's the lifeline many providers are relying on to keep their doors open – across care settings and different organization sizes.



## \$130

Billion in underpayments from Medicare and Medicaid.<sup>1</sup>



## 5.1%

The growth of total hospital expenses in 2024, significantly outpacing the overall inflation rate (2.9%).<sup>1</sup>



## #1

Labor remains the number one expense for hospitals.<sup>1</sup>

## How to help

Though claims management can have its challenges, it's typically easier to submit a claim and get reimbursed from a payer than to collect an outstanding balance from a patient. More importantly, it's much easier to master claims management on the back-end if your customers are set up for success on the front-end.

Delivering front-end solutions that can find all active coverage and flag when patient data has changed makes all the difference for your customers' revenue cycle.

Inovalon's Insurance Discovery<sup>™</sup> can find active coverage for Medicare, Medicaid, and commercial payers in just one search, with an average insurance identification hit rate of

## 43.04%

on uninsured accounts.<sup>2</sup>

1. "The Cost of Caring: Challenges Facing America's Hospitals in 2025," April 2025, American Hospital Association, <https://www.aha.org/costsofcaring>
2. Internal reporting, Inovalon, March 2025. Individual results may vary.

For example, finding secondary or even tertiary coverage in addition to the insurance information a person has shared means customers now have another avenue to collect revenue. Or, keeping patient data up to date by checking for changes to demographic details or even down to their [Medicare Beneficiary Identifier \(MBI\)](#) are just a couple of capabilities that can transform providers' revenue cycle.

When the front-end is working to verify every detail provided, and taking the extra step on customers' behalf to look for additional data points, the back-end runs much smoother. In fact, 67% of providers pinpoint front-end workflows as the top contributor to denials<sup>3</sup> – which are primarily caused by inaccurate or missing data about patient identification, demographic, insurance, or benefits gathered during registration<sup>3</sup> – so solving for front-end challenges can really set your solution apart.

## STRATEGY TWO

# Stay Connected With Payers

**Payer requirements are constantly changing.** It's a nearly impossible task for providers to keep up with every new claims submission requirement, which is why they need solutions that help ensure they're working in adherence to the most recent standards.

Some healthcare software vendors do this via customer newsletters or notifications, however, this leaves providers to determine any necessary process changes or training on new rules. Direct payer connections take away the guesswork. With product deployments that are in-step with payer changes, customers don't miss a beat; they can log off one day using one set of requirements, then get right back to mastering their claims the next day with software that's been updated to follow the latest requirements.

Inovalon is the first and largest Network Service Vendor (NSV) connected to Medicare. Our direct payer connections, running for over 20 years, have helped partners and thousands of customers protect their revenue by ensuring claims are created, submitted, and corrected according to the latest requirements.

This means:

- Pre-submission claims checks happen according to the latest rules
- Missing data or necessary corrections are flagged
- Most importantly, more peace of mind

With the right connections in place, customers can be confident in every claim – all thanks to a constantly updated rules engine.

3. "Claims Denials: Causes, Impact, and AI-Enabled Prevention Strategies," Inovalon, October 2024, <https://www.inovalon.com/resource/claims-denials-causes-impact-and-ai-enabled-prevention-strategies/>

# Improve Claims Management

**Perhaps your software already connects the front- and back-end, and payer rules are up to date. Now what?** Claims management is never fully mastered; not on the product side, and certainly not for billers who are working an endless amount of claims every day.

Plus, claims management often takes more than one touch. Denials are a top revenue cycle concern across care settings. They slow down the revenue cycle, cause frustration among billing teams and their leaders, and put earnings in jeopardy. Half of all hospitals recover less than 50% of initially denied claims and about a third of large hospitals (300+ beds) have 20+ full-time employees dedicated to managing claims denials.<sup>3</sup> Similarly, physician practices also need a full-time employee dedicated to appealing claims.<sup>3</sup>

This leaves money on the table and forces providers to allocate precious resources for fixing denials – which is why the best approach to solve for denials is prevention.

Improving claims management is not just about working more claims in a day or getting through each claim faster. The best claims management solutions help providers avoid denials before they even occur.

## 3 ways to reduce denials



### 1. Simplify your software

How many clicks does it take for your users to create and submit a claim? Consider how you can improve their experience. Whether you decide to integrate EHR and claims data or update product UI so more parts of the claims lifecycle can be worked in one screen, there are endless opportunities to make your product better – and sometimes, the best path forward is to partner with a vendor who can deliver your next deployment.



### 2. Make key details easy to see

With a truly connected revenue cycle, the front- and back-end don't just relay data to the other side – the data should pull through from registration to claims creation. This greatly reduces the risk of incorrectly re-entering data that was verified on the front-end when using it on the back-end, or for any details to be missed.



### 3. Monitor customer results

Enhancing your software capabilities is only half the battle. After deployments are released, make sure the expected value is realized. Customers may need training on new features or additional messaging to understand the tools now available to them. Or, your latest release could benefit from more development. Either way, customers' results will clearly show how well your release is working.

3. "Claims Denials: Causes, Impact, and AI-Enabled Prevention Strategies," Inovalon, October 2024, <https://www.inovalon.com/resource/claims-denials-causes-impact-and-ai-enabled-prevention-strategies/>

For one EHR vendor, for example, [partnering with Inovalon](#) to support their product development resulted in **customers' denial rates dropping to 2%<sup>4</sup>, well below the 7.66% national average<sup>5</sup>**. And for the product team, having a partner along the way was “like having night vision goggles.” They shared, “We used to stumble around in the dark [when trying to get enhancements out the door], but now we can see everything fast.”

## STRATEGY FOUR

# Deliver Revenue Insights

**Just as data can verify the customer value of your latest release, it can unlock unique opportunities for your customers, too.** Providers already have enough on their RCM to-do list to add reporting to the mix, so delivering the revenue cycle performance data they need can make your stance as a vendor much stronger.

Built-in [RCM analytics](#) empower providers to spend more time understanding their workflow opportunities, which can vary across each team from correcting a common-made mistake to lowering their denials or average days in A/R. They don't have to find or figure out the data for themselves; they can rely on your analytics to point them to their next revenue-driving opportunity.

Some of the top metrics providers want insight to include:

- **First-pass yield**

This measures the number of claims that are paid on first submission, which can help providers understand the revenue coming in the door in the shortest time possible (vs. their potential earnings of all claims submitted, of which some may be denied).

- **Denial rate**

This is the proportion of claims denied on first submission. The average claims denial rate for commercial plans is about 20%, while Medicare denials range between 6-9%.<sup>6</sup>

- **Gross days revenue outstanding (GRDO)**

This indicates how many days, on average, it would take to capture the full balance of all receivable accounts. GRDO is calculated by dividing gross A/R by average daily gross patient revenue.

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4. Average of customer results. Actual results may vary.

5. “Comprehensive Error Rate Testing (CERT),” CMS, January 2025, <https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert>

6. “Healthcare Denials Are Skyrocketing in 2025: Hidden Reasons Revealed”, <https://blog.healthjobsnationwide.com/healthcare-denials-are-skyrocketing-in-2025-hidden-reasons-revealed/>

# Make Payments as Easy as Possible

**Patients are more likely to pay their medical bills when they can clearly understand what's owed.** Their first indication of their balance shouldn't be the statement they get in the mail. Just like with claims management, patient payment begins in the front-end.

Having clear, up to date benefits information at the point of intake leads to less confusion when it's time to collect payments and empowers both sides of a provider's RCM team to educate patients along the way. Front office staff can communicate estimated out-of-pocket expenses, which gives the back-end team a starting point to continue the conversation with patients rather than sharing amounts and payment options for the first time.

This is another opportunity for your solutions to bring the revenue cycle together. With eligibility and insurance coverage details connected to back-end workflows, billers can see all the data they need – and easily share that with patients.

And to go a step further, considering adding [patient payment solutions](#) to your portfolio. Offer different payment capture methods to your customers so they can give patients the flexibility they desire to pay medical bills in the way that works best for them. Or, make it easier to engage patients in the final step of their care journey with clear patient statements.

This all helps increase customers' chances of capturing revenue, which is ultimately the main purpose of the revenue cycle.

## Summary

As the entire revenue cycle gets increasingly challenging for providers, they need tools they can count on now more than ever. Make sure your organization stands out as a trusted, must-have solution – and continue to enhance your product with a partner that delivers the speed, expertise, and capabilities your next release needs.

Explore how an Inovalon Strategic Partnership can help you cut development time, delight customers, and stand out in the market.

Discover Partnership Opportunities

## About us

Inovalon is a leading provider of cloud-based SaaS solutions empowering data-driven healthcare. The Inovalon ONE® Platform brings together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated cloud-based platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by over 50,000 active, licensed customers.

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