REPORT

The 2024 State of Payer Enrollment and Credentialing

Medallion

Medallion

ACKNOWLEDGMENTS

2024 survey methodology

Medallion conducted the 2024 State of Enrollment and Credentialing survey within the United States from January 11 through February 2, 2024. A randomly selected sample of healthcare organizations was invited to participate across provider groups, hospitals and health systems, payers, and virtual-first companies. In total, 347 respondents completed the survey.

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INTRODUCTION

Current state of payer enrollment and credentialing

Automation is no longer a futuristic concept — it's here. It’s rapidly reshaping how we approach healthcare, from patient care to administrative tasks.

We're on the brink of a new era, filled with new opportunities from AI-enabled chatbots to GenAI, promising to do things differently, faster and with remarkable precision. And with this shift comes excitement and caution, putting healthcare leaders at a critical crossroads.

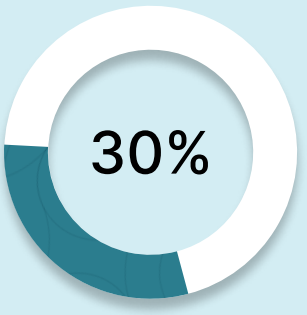
The question that hasn't been asked enough through this change is: How are healthcare organizations prioritizing automation and actively shaping their future with it? How are enrollment and credentialing teams feeling? Where can they get the most out of using automation?

To find out, we surveyed nearly 350 healthcare specialists, managers, directors and C-suite executives at the beginning of this year. In this survey, participants were asked questions about their role, business, and what they hope to evolve in their operations.

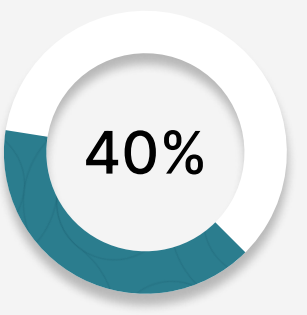
The responses to this survey reveal a glimpse into what's plaguing today's healthcare operations team while optimistically looking ahead to a future where innovative and efficient practices are embraced.

WHERE ARE WE NOW?

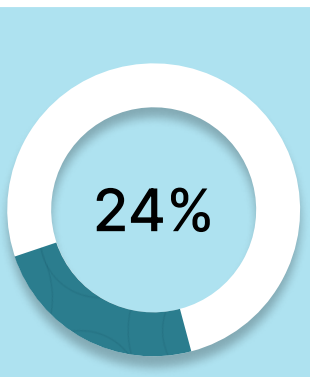
As we dive into the landscape of automation adoption, a clear picture emerges



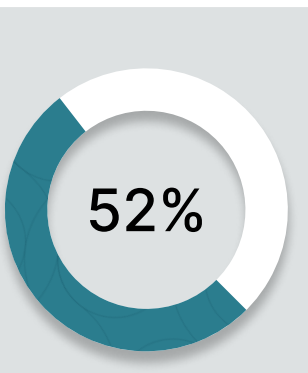
respondents say **gathering requirements from providers** is the most significant payer enrollment challenge.



. . . yet those surveyed say their **enrollment workflows are mostly manual**.

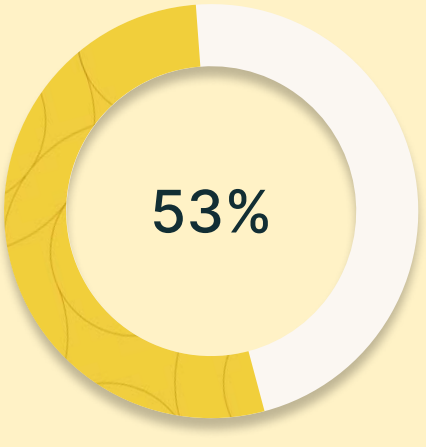


respondents say **gathering requirements from payers** is the most significant credentialing challenge.



. . . yet those surveyed say their **credentialing workflows are entirely manual**.

Despite these challenges, optimism and a desire for enrollment and credentialing automation is strong:



of healthcare professionals say automating and creating more efficient processes are top priorities this year.

CHAPTER 1

The state of payer enrollment and credentialing teams

Across the nation, healthcare professionals are grappling with an escalating crisis of burnout and uneven operational demands, exacerbating the urgent need for solutions that address this pressing challenge. **Despite increased awareness and widespread calls for action, the crisis only intensifies.**

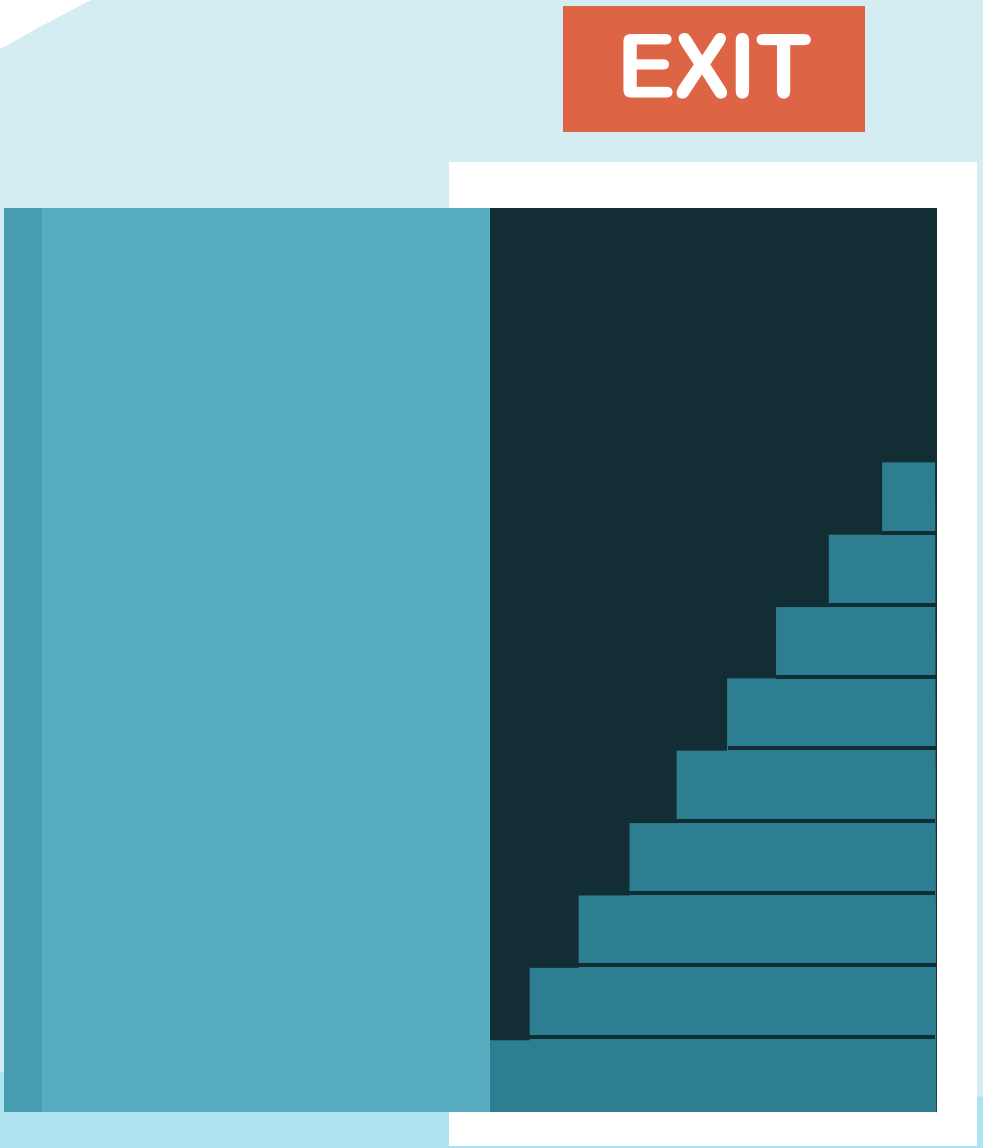
CHAPTER 1

Turnover

The healthcare industry has historically faced challenges with staffing and turnover due to long hours, pay and erratic work schedules. Then, the pandemic happened and left the industry with a situation that has only intensified recently, leading to turnover rates in 2022 ranging from 19.5% at hospitals to 65% for at-home care providers.

This widespread turnover imposes financial and logistical burdens on healthcare organizations and significantly strains their operational capacity as they manage rising outpatient volumes.

This shift has placed unprecedented pressure on enrollment and credentialing teams, an essential yet often undervalued function of healthcare operations experiencing turnover and staffing challenges.



The responses to the survey support this idea. **A striking 57% of respondents report they've experienced turnover and staffing challenges over the past year,** underscoring the pervasive nature of the issue.

The turnover rate among enrollment and credentialing teams is higher compared to other healthcare professions, such as nurse practitioners (15.3%), certified nurse assistants (35.5%), and physician assistants (10.7%), signaling a critical stress point within healthcare operations and pointing to the broader implications for healthcare delivery and patient care continuity.

Turnover and staffing challenges experienced

57%
Enrollment and credentialing teams

35.5%
Certified nurse assistants

15.3%
Nurse practitioners

10.7%
Physician assistants

Has your team experienced any employee turnover in the last 12 months? N=297

CHAPTER 1

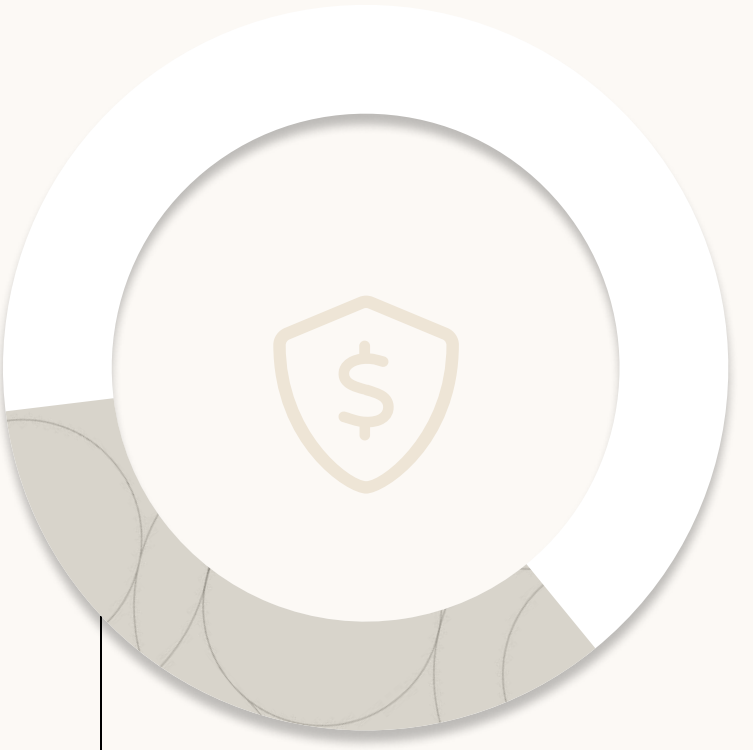
Under pressure

The last couple of years have been difficult financially for many healthcare organizations. As costs continue to accelerate at incredible rates, it's expected that 2024 is likely to bring continued financial challenges. Enrollment and credentialing teams are further burdened by the dual mandate to control costs, manage growing patient demands, and accomplish more with already stretched-thin resources.

A significant 45% of respondents say their staffing levels are "inappropriately" low, and interestingly, 34% recognize the need to cut headcount expenses, acknowledging that there is some struggle to balance efficiency with financial prudence.

45% of respondents say their **staffing levels are "inappropriately" low**

Do you feel your enrollment or credentialing team is appropriately staffed? N=297



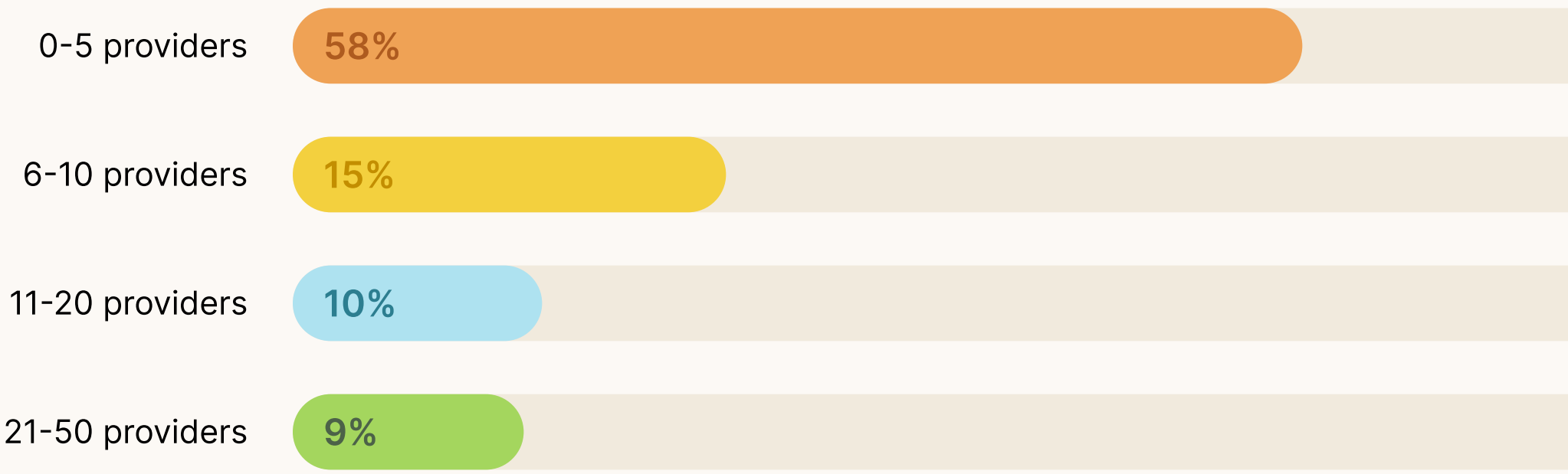
34% of respondents recognize **the need to cut headcount expenses**

Is your organization facing financial pressure to reduce headcount expenditure? N=297

While no doubt balancing the imperative to reduce costs with the equally critical mission of ensuring high-quality patient care presents a significant challenge, this data also speaks to something that has dominated discussions this year more than ever before: Automation and technology are not just strategic avenues to streamline expenses, but they are essential to the fundamental reimagining of how to maintain and elevate the quality of care in a rapidly changing healthcare landscape and foster optimism for the future of healthcare operations.

The survey also uncovered a nuanced growth trajectory within these organizations. While most (58%) report modest hiring rates of 0 to 5 providers monthly, a closer look reveals a broader growth spectrum. A noteworthy industry segment is pushing boundaries, with aggressive hiring practices that suggest an undercurrent of optimism and ambition despite the prevailing challenges.

Providers hired per month



On average, how many providers does your organization hire each month? N=297

CHAPTER 2

The state of payer enrollment

Payer enrollment teams are feeling the strain, with nearly half reporting revenue losses at the organizational level tied to sluggish enrollment processes. **With many teams still relying on manual workflows, this isn’t necessarily surprising, but it uncovers an incredible opportunity for automation to alleviate this burden.**

CHAPTER 2

What can be improved?

Alleviating workflow pain

The ripple effects of turnover and resource constraints are felt within payer enrollment processes. The existing long timelines for payers to process claims and remit reimbursements — often stretch between 90 to 120 days — and are fueled by slow enrollment workflows.

Nearly **40% of healthcare professionals reported moderate reliance on manual processes in their workflows**.

What percentage of your enrollment workflows are managed manually without automation or tools? N=224

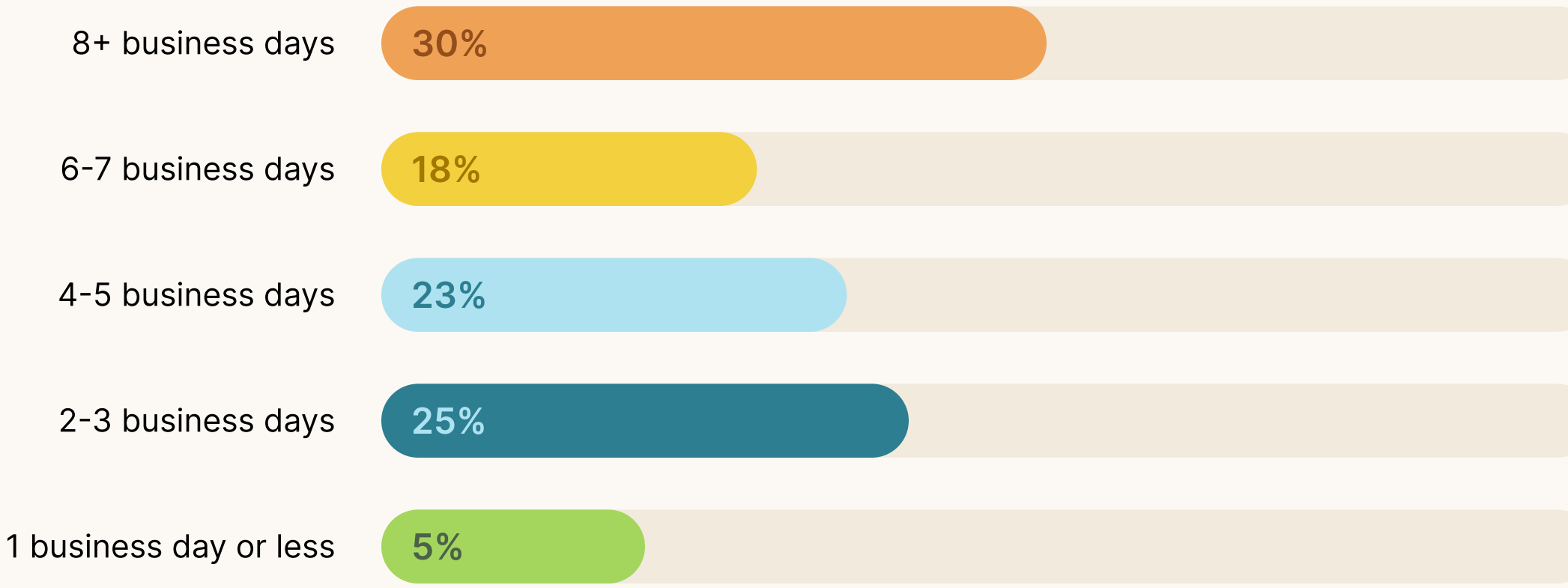
Given those numbers, it's perhaps no surprise that over half of respondents say automating and creating more efficient processes are top priorities for their organizations in 2024. Why?

The enrollment process involves gathering information from providers to fill out and complete applications. It consists in staying on top of evolving requirements by insurance payers and adhering to those rules. The process also includes physically submitting or mailing applications.

It involves internal/external communication of application or enrollment status (per provider) and following up with payers by phone, email or fax.

The responses to this survey support the idea that these time-consuming workflows that go hand-in-hand with payer enrollment add up. Nearly **30% of respondents say they spend over eight business days on provider information gathering** for payer enrollment.

Days spent gathering provider information

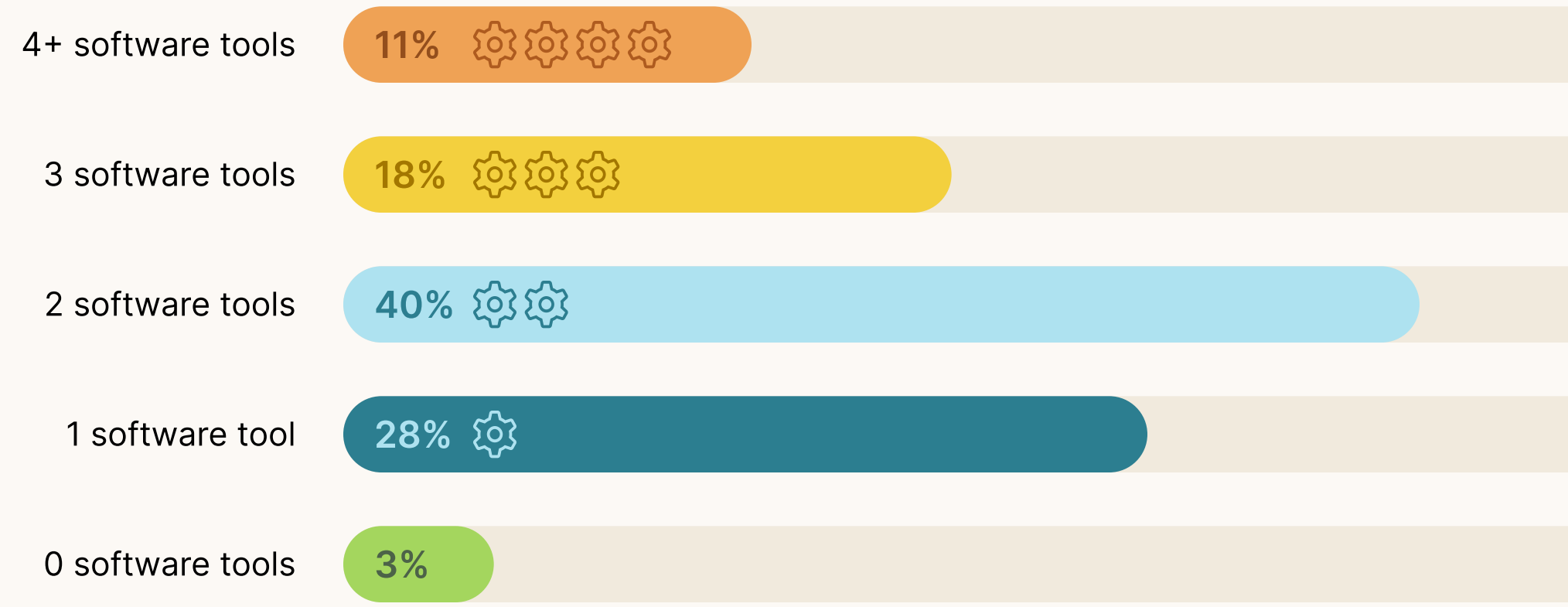


How long does it typically take to gather all required information from a provider to complete a payer enrollment application on their behalf? N=224

And, when resource capacity is top of mind for healthcare executives, the emphasis shifts to not just managing but innovating within these constraints, finding ways to stretch their existing personnel without compromising on the quality of care or operational efficiency.

The survey results agree — and highlight a clear trend: **enrollment teams are on the hunt for efficiencies**, with **40% of respondents relying on two separate software tools** to alleviate some of this workflow burden.

Software tools used by enrollment teams



How long does it typically take to gather all required information from a provider to complete a payer enrollment application on their behalf? N=224

It should be noted that relying on multiple tools can complicate workflows and outcomes. Firstly, juggling multiple tools amplifies compliance risks, as scattered data can lead to inconsistencies. It can also silo data, complicating the seamless integration of information and increasing the complexity of training and support for various systems.

Working with different tools also creates inefficiencies and redundancies, with teams often entering the same information multiple times across various platforms — and across different timeframes — as **57% of survey respondents often or sometimes request additional information from a provider after starting an enrollment application**.

Frequency when asking for additional information from providers

5%
Never

21%
Rarely

36%
Sometimes

21%
Often

17%
Always

How often do you request additional information from a provider after starting an enrollment application?
N=224

This back-and-forth prolongs the timeline for completing enrollments and adds to the daily workload and stress of enrollment teams who navigate these inefficiencies.

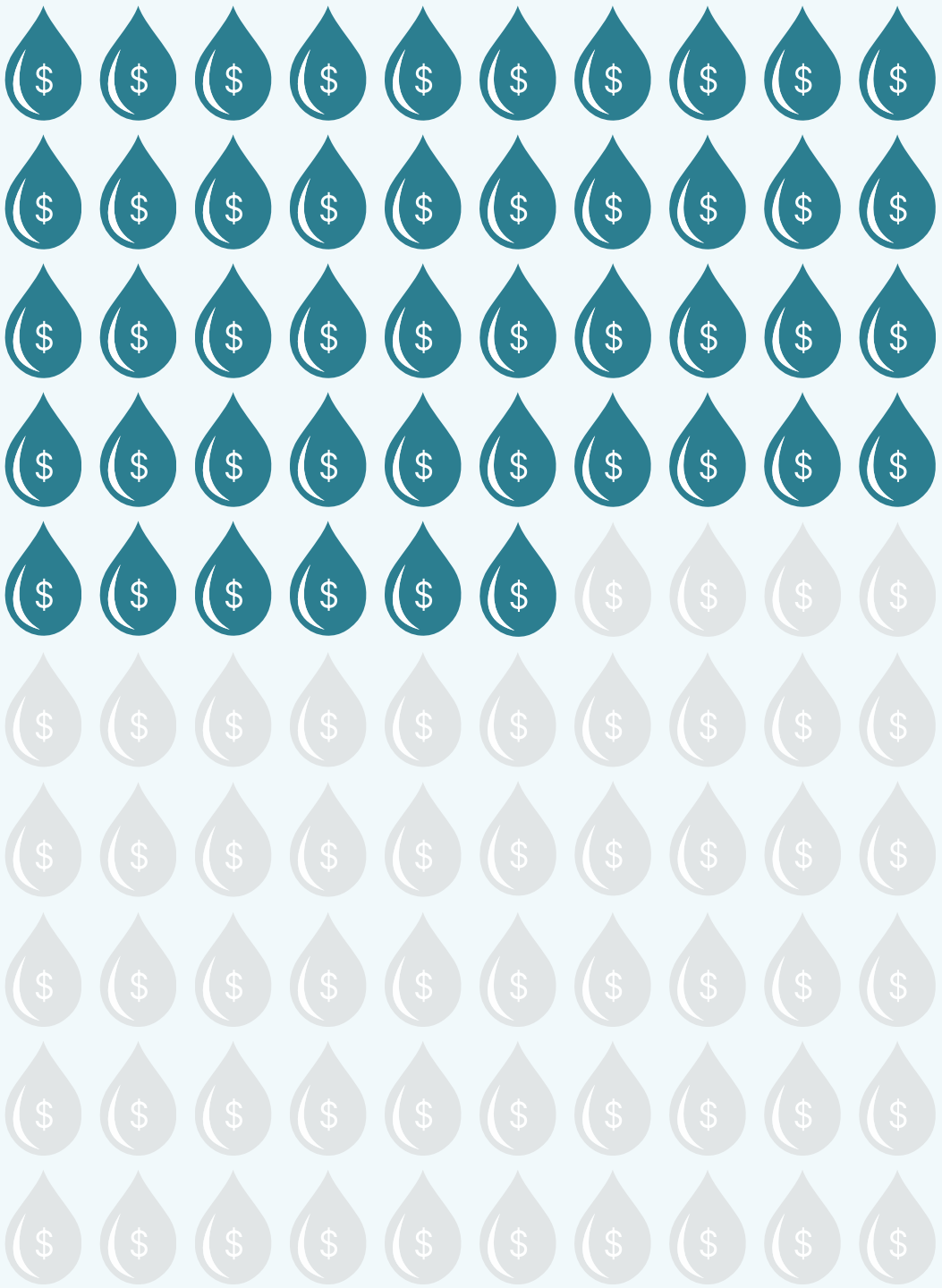
This finding is a call to action. A shift toward integration and efficiency can free enrollment teams to focus on the strategic aspects of their roles, enhancing the overall quality of care coordination and support to healthcare providers.

Plugging revenue leaks

Another critical factor to consider is that manual work comes at a price. **46% of respondents report revenue impacts to their healthcare organization due to unoptimized enrollment workflows and slow turnaround times**.

Healthcare organizations losing revenue due to slow enrollment and credentialing turnaround times

Yes No



Is your organization losing revenue due to slow enrollment turnaround times? N=297

This finding highlights a critical pain point: Inefficient workflows and delays in credentialing and enrollment directly hit the bottom line.

There are several reasons for revenue impact, but delays extend the revenue cycle, leading to deferred reimbursements and impacting cash flow. Why?

Manual processes increase the time it takes providers to get paid for services they deliver to patients. And providers need to be enrolled with a health plan or in-network with a payer organization, or an organization will have to write off expenditures. So, during this waiting period, a provider can see patients. However, they will not generate revenue for the organization, leaving it at a deficit to cover the provider's expense.

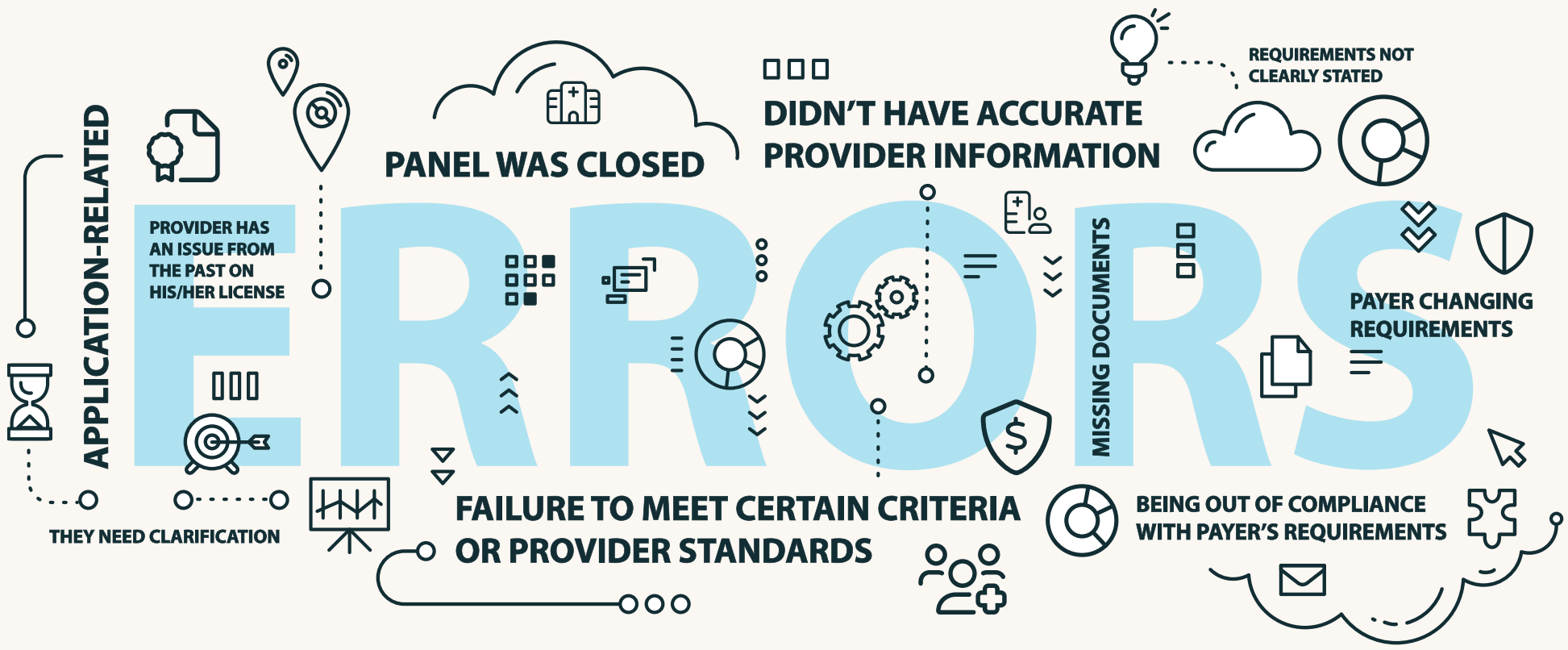
Each day, when there is a delay in this — where a provider cannot bill for services — there's lost revenue for both providers and the organization. An outside study from Merritt Hawkins showed that a provider generates $10,122 on average per day for their facility, so delays can be incredibly costly for healthcare organizations — mainly as there are compliance risks associated with enrollment delays that can result in penalties or fines.

The Healthcare Financial Management Association states that increasing revenue is the number one priority for most healthcare organizations in 2024, but improving the patient experience is also essential. Enrollment delays also impact this — they create the inability to quickly onboard providers, which may affect provider-patient satisfaction and retention — and should also be taken into account.

So, a sluggish pace in enrollment workflows is more than just an inconvenience; it's a significant obstacle to achieving financial sustainability, greater organizational goals and operational efficiency for healthcare teams.

Eliminating errors

Among our respondents, **131 pinpointed errors, compliance issues, and inaccurate information as the leading causes of enrollment application denials**. It's complex to lay the blame solely at the feet of manual workflows. Yet, it's evident that these processes significantly contribute to the challenges at hand, especially in ensuring applications are correctly completed from the start.



The reality for enrollment teams is often a frustrating cycle of discover-and-correct: errors typically go unnoticed until a denial comes through, sometimes over 30 days after submission. This cycle represents a significant loss of time while underscoring the critical need for precision from the outset.

Whether it's applying to the correct section, having accurate group and provider information ready, or selecting the appropriate section of the payer application based on the provider's specialty, automation can streamline data entry to reduce delays and inaccuracies, making a tangible difference in the efficiency of enrollment processes and, ultimately, in the overall quality of care provided.

CHAPTER 3

The state of credentialing

As the demand for healthcare services outpaces the supply of providers, **the need for simpler credentialing processes becomes apparent, allowing providers to focus more on care and less on paperwork.**

CHAPTER 3

Opportunities for change

Credentialing is an extensive and essential process that verifies a healthcare provider's qualifications and history to get in-network status with health plans and payer organizations.

It’s a process that involves several steps but typically includes three main phases:

1

Gathering data and documents for potential providers

2

Verifying provider information and completing primary source verifications

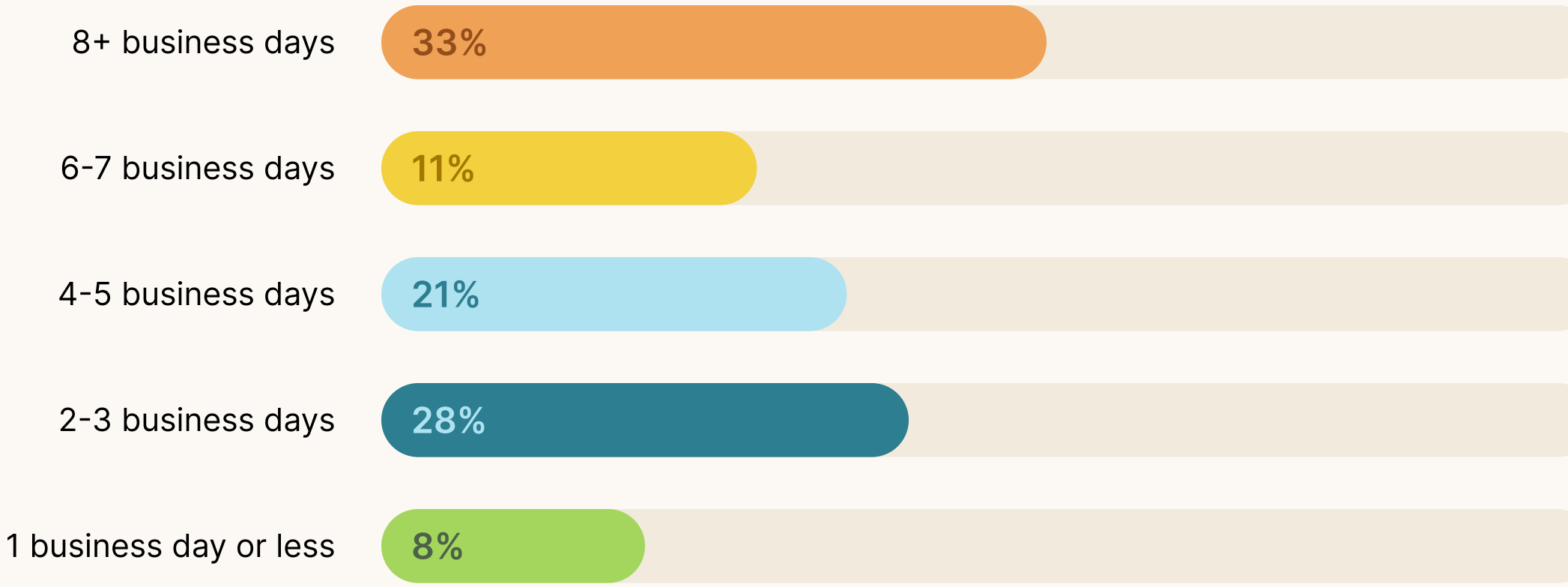
3

Credentialing the provider

Organizations must complete these steps for every provider employed at an organization and with every contracted payer to ensure that providers can see patients and that the organization complies with regulatory bodies' rules.

But as the survey data supports, navigating credentialing feels more like a marathon than a sprint, as **33% of respondents say they spend eight or more business days simply gathering the required information from providers to begin the credentialing process**, adding to cost and resource strains for healthcare organizations.

Time spent collecting information

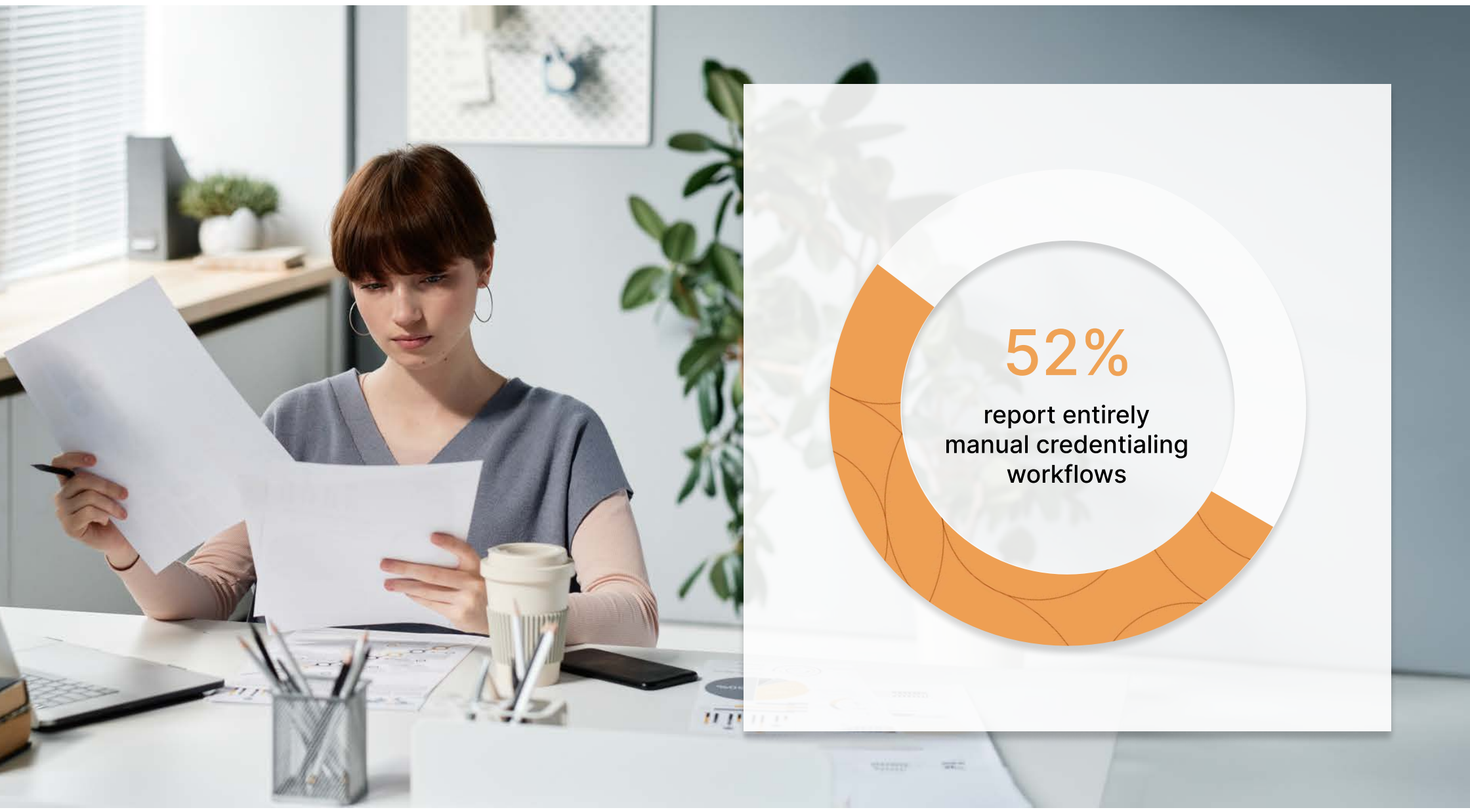


How much time do you typically need to gather all required information from providers for direct payer credentialing? N=266

Data collection and workflows

During this phase, the credentialing specialist — or person appointed — collects information and documents related to the provider from various sources. The required information includes the provider's education, license, work history, National Provider Identification number, fellowships, liability coverage, eligibility for state regulatory requirements and board certifications.

Given that surveyed organizations report spending eight or more business days on gathering provider information alone, it’s no surprise that **52% report having entirely manual credentialing workflows**.



What percentage of your credentialing workflows are managed manually without automation or tools? N=266

Imagine every step of the provider credentialing process being handled with spreadsheets, paper trails and phone calls. It's the reality for the survey respondents and likely for many healthcare teams, where 'entirely manual' means every piece of information is gathered manually through forms and emails. Verifications are conducted through one-by-one online portals, credentialing files are generated by manually assembling documents, and committee approvals are managed by hand. In such setups, the dedication of healthcare teams shines through as they meticulously manage these tasks; however, manual processes can lead to significant delays and the potential for error.

Provider onboarding and profile completion

Primary source verifications

File creation

Committee file review and approval

File completion and roster submission

Recredentialing and monitoring

Verifications

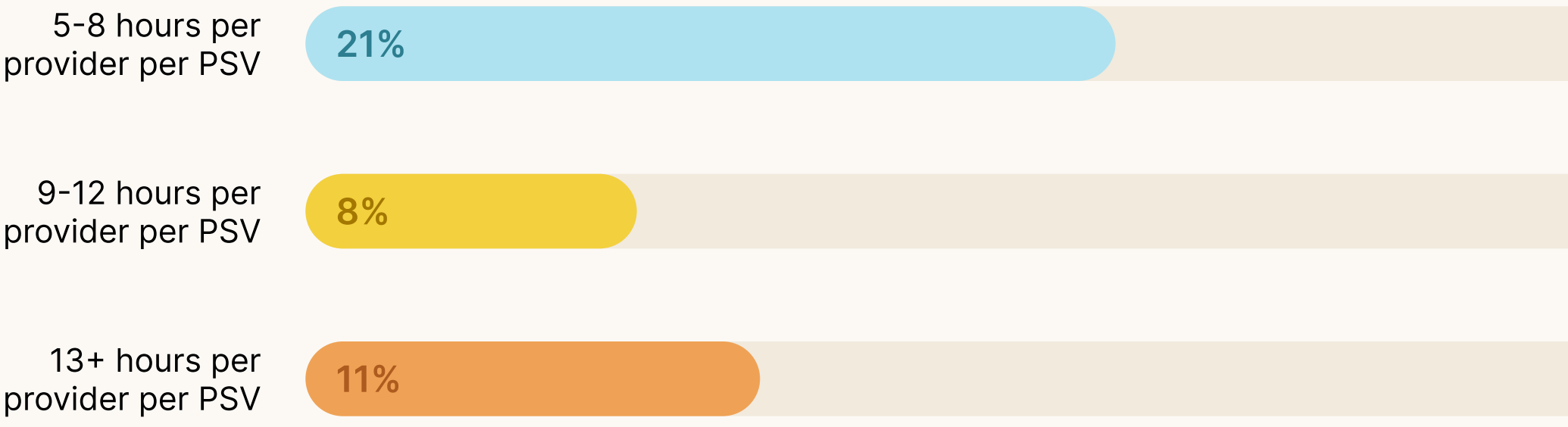
The overarching process of credentialing in healthcare is a complex one. Outside of this survey, verifying a provider's credentials takes time. Every action requires confirmation of a long list of credentials, making it crucial to pay attention to details to protect patients from harm. Missing a step or overlooking any information can put healthcare organizations and providers at risk of fines, penalties, or lawsuits.

As WorkWeek puts it: "Relying on manual processes to tackle it all "requires too many man hours, causes frustration, and results in compliance issues if your team misses something."

On the other hand, organizations that employ providers who have been vetted and appropriately qualified can protect themselves in case of an accident. Running primary source verifications that comply with the regulations can help reduce the risk of malpractice or negligence. Since the average malpractice claim costs $300,000, organizations must take all necessary steps to prevent such incidents.

It's evident that vetting providers are critical, and as this survey suggests, it requires a significant amount of time from credentialing teams. Perhaps one of the more interesting outcomes of the survey is that around **60% of respondents spend more than half a business day per provider on primary source verifications** involving various types of verifications, such as NPI, DEA, Medicare Opt-Out, NPDB, and more.

Time spent on PSVs

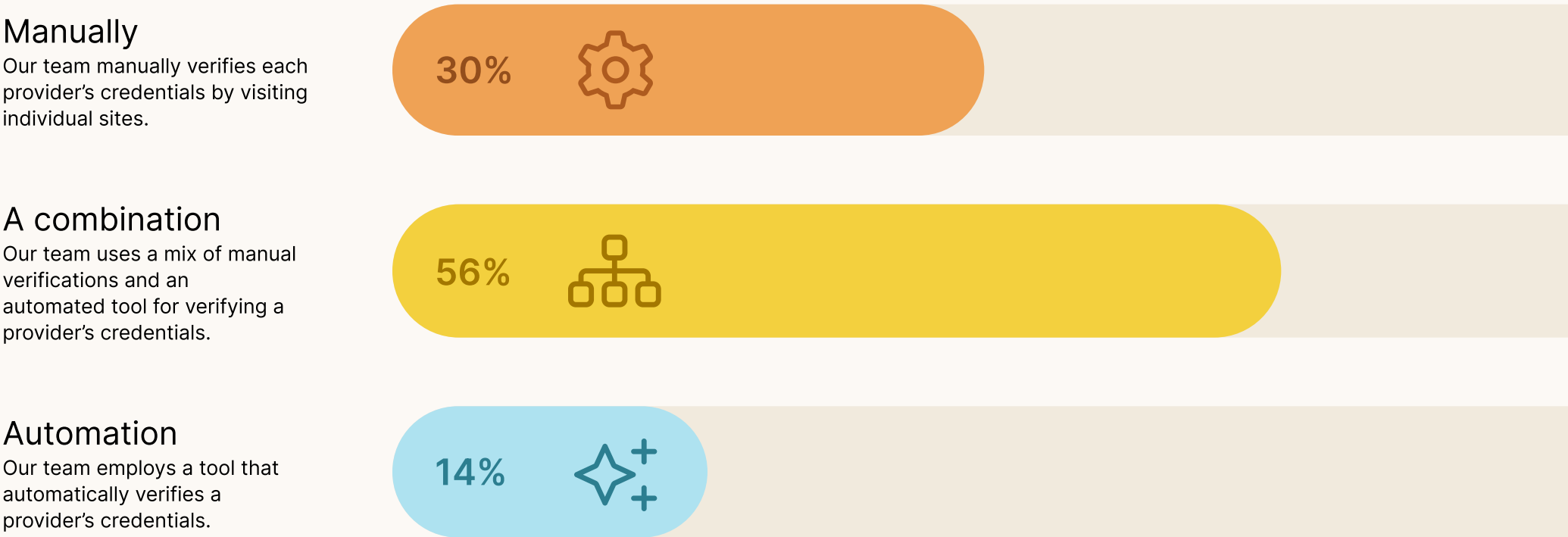


How long does it usually take to complete primary source verifications before creating a credentialing file? N=266

Or, to put it another way, credentialing teams are wasting one to two days per provider on just a single part of the credentialing process.

But that comes as no surprise as **30% of respondents say they manually verify each provider's credentials by visiting individual sites**. On a promising note and an indication of the industry's willingness to automate, **56% use some mix of manual verifications and an automated tool**.

Completion method for primary source verifications



How does your team complete primary source verifications? N=266

The meticulous nature of verifying each provider's credentials by hand is costly in terms of time and money and carries a hidden toll. While indispensable, this relentless pursuit of accuracy often leads to burnout among dedicated staff who find themselves caught in a cycle of repetitive, detail-oriented tasks. And according to a report by the AMA in 2020, the burnout from administrative hassles contributes to physician burnout and hinders timely patient care.

The financial implications are equally daunting, as each hour spent on manual verification diverts from patient care, innovation or other critical activities that could drive the organization forward — and the potential revenue loss illuminates the urgent need for change.

Credentialing’s visibility challenge

Because credentialing workflows are overwhelming, visibility into the process is painstaking. Even worse, visibility into the granular step-by-step details can become nearly impossible.

With 32% of survey respondents saying they have minimal to no visibility into their credentialing workflow, it becomes increasingly more work for healthcare leadership to sustain physician-growth models that accurately forecast when the organization will have a revenue impact.

Visibility, in this context, means having clear, accessible insights to track credentialing progress with real-time updates on each step from profile completion to verification; monitoring milestone completions like background checks or committee review dates, identifying bottlenecks with a clear understanding of what the hold-ups are, or notifications on changes in a provider's credentialing status, enabling timely updates to practice schedules and patient appointments.

The lack of such transparency can delay the onboarding of new providers and complicate interactions with insurance entities, ultimately impacting patient care.

How can credentialing teams hope to improve without clear insight into where things stand? In an environment where efficiency and responsiveness are paramount, this opacity hinders operational agility and affects the quality of patient care.

CHAPTER 3

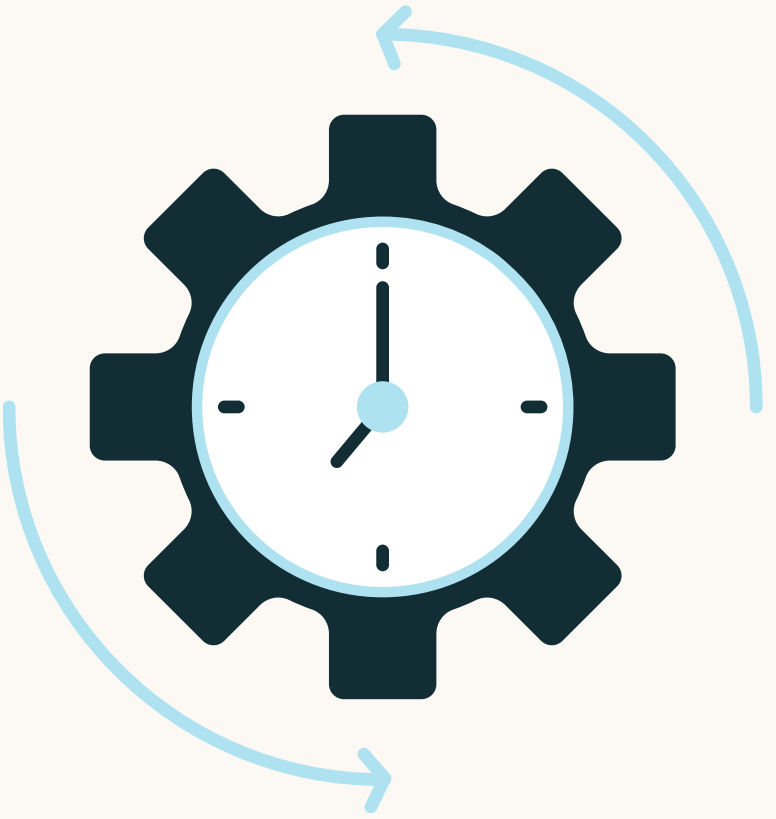
Seeking efficiency

Whether or not their workflows were automated, the survey responses shed light on the collective desire for change and efficiency within the credentialing process. When asked about their top credentialing priorities for 2024, participants echoed a unified call for enhancement:

"Getting my providers credentialed in a timely manner"

"Get a new credentialing system, increase automation"

"Credential providers faster"



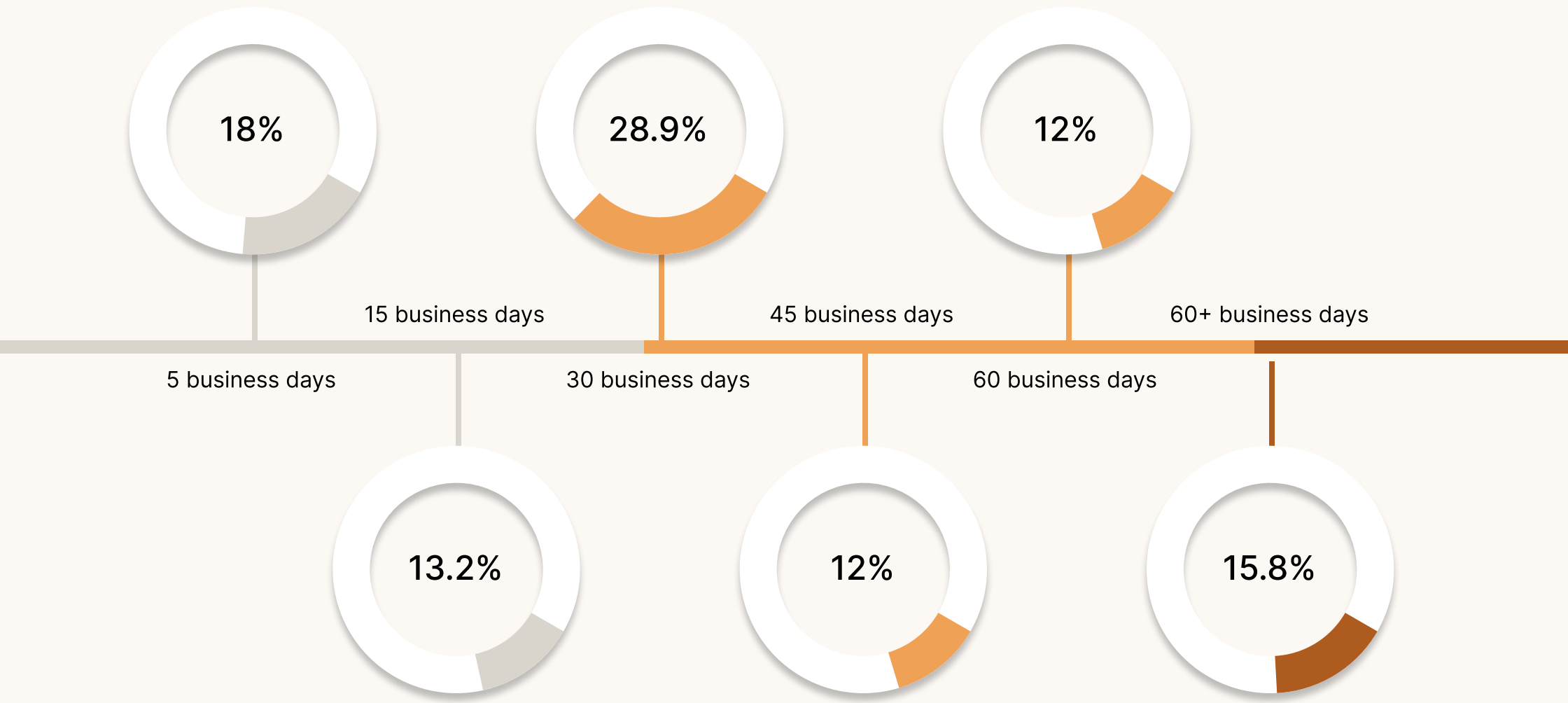
"Faster, more efficient credentialing"

"Have all new providers credentialed within 2 weeks of start date"

These responses underscore a pressing need within the community — a shift toward more streamlined, automated credentialing processes that make data collection, reporting and compliance monitoring less burdensome for providers and credentialing staff.

With **84% of credentialing teams experiencing turnaround times of 15 days or more**, the sense of urgency among these teams is palpable.

Average duration of credentialing process



What is the average total duration of the credentialing process in your organization, from the initial request to submitting your roster to a payer? N=266

Every day spent waiting on credentialing is when a provider isn't seeing patients. Revenue leakage from delayed patient care and missed reimbursement turns out to be an average of $10,000 each day for healthcare organizations — and as the healthcare industry at large continues to move into a new era of care, the efficiency question must be central to both meeting the operational goals of a healthcare organization and the broader mission of enhancing patient care through quicker provider readiness.

It's safe to say that in a landscape where efficiency equates to patient access and financial stability, the call for embracing technological solutions has never been more compelling.

CONCLUSION

State of the industry

As the industry looks forward and considers what the future of enrollment and credentialing looks like, **addressing the level of manual effort and resource strains that teams have faced — and will continue to face — must be considered.**

CONCLUSION

What comes next?

One of the goals of this survey was to shed light on how enrollment and credentialing professionals feel when it comes to their work and on what processes they spend the most time on. What we found is a world where healthcare teams navigate the complexities of enrollment and credentialing with dedication; the toll of manual processes is undeniable. With the U.S. healthcare sector spending over $800 billion annually on administrative costs, pushing for operational efficiency isn't just a goal; it's necessary for scaling and sustaining financial health. Here is where the power of automation can support teams and their organizations.

Leveling up teams and work

The heavy lifting of manual labor, compounded by staffing shortages and the quest for cost reduction, has placed an immense burden on enrollment and credentialing professionals. Yet, in these challenges lies an opportunity for transformation. Technology, automation and AI can simplify routine tasks, mirroring successes seen in other sectors.

There is accounts payable automation in finance, which automates routine steps like receiving invoices, coding, routing for approval, payment and reconciliation. However, accounts payable employees are still needed to manage exceptions, handle complex scenarios that require human judgment, ensure compliance with financial policies and maintain vendor relationships. There's machine learning, yet you still need engineers to select the appropriate algorithms, tune parameters, and ensure the model is trained on relevant, high-quality data.

It's the same for healthcare. Just as automation in accounts payable revolutionizes invoice processing while still valuing human oversight for complex decisions, similar innovations in healthcare promise to enhance efficiency without sacrificing the human touch.

Our takeaways

In a year that has tested the limits of healthcare organizations, our survey reveals an industry at a tipping point. The challenges of the pandemic, provider burnout, and workforce shortages have brought to light the critical inefficiencies of manual credentialing and enrollment processes.

It's clear: the time for change is now.

To work smarter *with* automation, organizations can find success in:

Reducing the reliance on manual processes in credentialing

Implementing automated solutions can significantly reduce the time and resources required for credentialing processes, thus increasing efficiency and accuracy.

Addressing variability and delays in credentialing

Automation can standardize processes to achieve consistent and efficient credentialing outcomes.

Streamlining enrollment workflows to increase revenue opportunities

Automation can optimize enrollment workflows to prevent financial losses and maintain operational momentum.

Embracing comprehensive technology solutions

Based on the data, the call for transparency, efficiency, and accuracy has never been louder.

Investing in and implementing end-to-end solutions that offer real-time tracking, automated verifications, and streamlined communication can reduce the administrative burden and pave the way for improved patient care and organizational growth.

Credentialing

Onboarding, instant primary source verifications, credential file generation, credential committee management, re-credentials, ongoing compliance monitoring, roster management, among others.

Enrollment

Onboarding, enrollment application tracking, provider tasking, automated payer follow up, demographic updates, revalidations.

Returning to the crossroads we discussed at the beginning of this report, the future of enrollment and credentialing is set for a pivotal shift — and the connection between AI, automation and human expertise is critical to this transformation.

The imperative of efficiency, transparency, and accuracy

Our findings underscore a collective desire for systems prioritizing transparency, accuracy, and efficiency. Solutions that automate primary source verifications instantly and offer comprehensive, real-time reporting capabilities can transform the credentialing landscape, offering organizations a clear competitive advantage.

Finally, efficiency is vital, but accuracy is equally important.

Solutions that reduce manual application errors, and offer quality assurance (QA) automation, supervised checkpoints, and can automatically map provider information to payer applications while providing speed, mitigate the risk of financial losses due to delays and foster a culture of accountability and continuous improvement.

The survey responses agree as both enrollment and credentialing teams rated automation and operational efficiency as the most important initiatives at their organizations.

Turning insights into action

The enthusiasm for change is not just a passing trend; it is genuine and deeply rooted. The survey data doesn't just hint at a willingness to adapt — it shines a light on a promising path forward, validating your readiness to embrace new ways of working.

By leveraging technology and investing in automation to amplify human capability and focusing on streamlining every step of the credentialing and enrollment journey, teams are not just preparing for the future but actively building it. With that in mind, we can ensure that our healthcare system is robust, responsive, and ready to deliver the best possible care to all who need it.

About Medallion

Medallion is the leading provider network management platform that unites provider operations and empowers end-to-end automation workflows for credentialing, enrollment, and monitoring. We free healthcare teams to focus on what matters by enabling healthcare organizations to quickly and accurately manage and grow their provider networks with our AI-powered automation technology. By automating burdensome administration workflows, we enable operations teams to better manage their provider networks, deliver superior care, speed up revenue paths, and elevate provider satisfaction levels.

To learn more about Medallion, visit medallion.co, or get in touch with a member of our team by scanning our QR code.

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