While delivering quality care is always the top priority, efficient revenue cycle management is critical to making sure the door stays open to patients in need. Medical practices can streamline RCM processes with effective changes to workflow and smart introductions of management systems.

Keep these methods in mind to simplify patient billing and payment collection—and ultimately increase the bottom line.

1. Take advantage of technology

In an increasingly digital world, the healthcare industry risks falling behind the curve and running into manual complications when medical practices fail to adopt new technologies. There are numerous ways for practices to leverage technology, such as automating medical forms and simplifying payment processing with electronic admittance advice. Digital payments methods can also streamline processes through easy access to billing, balance inquiries and payment options.

3 steps to gaining physician and staff buy-in and building trust

Just as consumers demand transparency around healthcare quality and costs, physicians need transparency, too—on how well they are performing compared with their peers, the trends that put financials at greatest risk, and the impact of a staff member’s daily tasks and time spent.

It’s clear that when it comes to transparency, you need a strategy that takes into account physicians’ needs, the demands on their time, and their ability to act on the information. There are three things to consider in developing a meaningful approach to understanding where all your time and money is going, where to look first, and what to do next.

STEP 1: Build a data narrative.

If we asked you to tell us two things you could do today to improve net revenue, would you know what to say?

Physician practices have greater access to data than ever before, but to avoid data overload, practice leaders must tell a story with their data that compels physicians to action. Start by determining the problem your practice most wishes to solve, such as the practice’s no-show rate or average reimbursement per visit. Then, develop “data snapshots” that illustrate, at a glance:

- Extent to which this problem impacts your practice
- Any surprises that have been uncovered with data (e.g., Does the problem affect one group of patients more than others?)
- How your practice’s performance in this area compares with others of the same size and type
- The action steps that could make a difference, including communication strategies to those patients with the highest no-show rates

The narrative you build should be highly visual—but keep it simple. Focus on just one or two charts that convey the information you most want to impart to physicians, and use callouts to draw attention to key statistics. When it comes to presenting your call to action, consider framing your solution as a question (“What if we did this?”). One strategic storyteller has found this approach invites collaboration, builds engagement and credibility, and makes the audience more likely to take part in the problem-solving journey.
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STEP 2: Use quality data to thrive, not just survive.

Access to data can create constructive conversation, but key performance indicators (KPIs)—metrics that enable organizations to gauge how well they are meeting their goals—will determine next steps.

It's no secret that reimbursements are declining. But with quality measures, consumerism, security, compliance, a constantly shifting payer space and more, it's not shocking that most physicians are in survival mode. If we keep our doors open, we're fine.

Let's say you only have two minutes before your next case to review your current financial performance. With established KPIs and a clear data story, you should be able to identify improvement needs quickly—without manual investigations, trend analysis or guessing.

Surviving versus thriving with benchmark data requires physician practices to consider what benchmarks are most meaningful for their organization. In our experience, it is most impactful for physicians to know:

- How their performance compares with that of practices of the same specialty, in the same region, and of similar size
- What performance looks like at both the group level and by individual physician
Practice leaders also should take a close look at what is driving care activity. One data point that is sure to attract physicians’ attention: comparing the types of visits and procedures performed this year with those performed a year ago. This comparison data can also provide insight into revenue risk.

For example, if Level 3 and Level 4 visits have increased, make sure your practice is taking a close look at the denials received for these visits. Some practices struggle to provide the appropriate documentation to support Level 3 and Level 4 visits. If this is true for your practice, investment in coding education and expertise could help your practice mitigate the reimbursement risk associated with these visits. Incorporating the evaluation and management benchmarks for your specialty will help you quickly understand your potential risk related to medical necessity denials.

Another area physician practices are beginning to examine is the shift in their payer mix and how that affects their gross collection rate (GCR) and cash flow over time. For example, if the percentage of patients covered by Payer X, which has a GCR of 40 percent, is declining, and if the percentage covered under Medicare, which has a GCR of 32 percent, is increasing, pressures on cash flow will tighten. Depending on the size of the organization, the impact could be material.

**Smart KPIs—Key performance indicators that are associated with a national or regional benchmark—will save you time and instantly alert you to red flags. Standard benchmarks to get you started include:**

- Clean claim pass rate >97%
- First Pass Denials Rate: <5%
- A/R Red Flags (Insurance): >20% over 60 days
- Unreconciled Appointments: > <5%
- Net Collection Rate: >95%
- Bad Debt Write-Offs: <1% net revenue
- Avoidable Write-Offs: <1% net revenue

MedEvolve is able to provide benchmarks that are tailored to your practice’s specialty.

**STEP 3: Take emotion out of the analysis.**

As patient financial responsibility grows, so does a need to balance patient engagement with smart business practices. In an era of high deductibles, it’s more critical than ever that physician practices collect payment upfront. Today, consumer spending on healthcare premiums and out-of-pocket costs totals nearly 12 percent of median income, according to a 2018 Commonwealth Fund report. Yet some staff are still reluctant to push for payment prior to or at the point of service—and physicians are reluctant to push them to do so. As a result, 81 percent face challenges communicating patients’ out-of-pocket responsibility for care, according to Black Book research. Meanwhile, 83 percent of physician practices say slow payment from patients with high-deductible plans is their top collection challenge.
While it can be uncomfortable for some staff to have these discussions at patient scheduling, registration, or check-in, it’s also necessary. One study shows 68 percent of patients with medical bills that are $500 or less do not pay their total out-of-pocket portion for care. The longer these bills age, the less likely physician practices will be to recover payment. MedEvolve has found that when a patient balance has aged greater than two months, the provider will collect less than 20 percent of what is owed. Access to data that can change the way you communicate with patients and hold them responsible for their out-of-pocket costs is critical at a time when an increasing percentage of payment is coming from consumers. You are delivering a service—and you have a right to get paid for the work you are doing.

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Ask yourself:

- How many patients in the past year have led to bad debt write-offs—and how many of these patients are scheduled to be seen in the coming months?
- What percentage of the patients your practice will see this month have a prior unpaid balance? Did your scheduling staff secure a payment prior to booking their next appointment?

**Premium and Deductible Costs Amounted to Nearly 12 Percent of Median Income in 2017**

*Combined employee premium contribution and deductible as share of median income*

![Graph showing premium and deductible costs as a percentage of median income.]


One Way to Ensure Payment: Enact a Credit-Card-on-File Policy

Keeping the patient’s credit card on file with consent to charge up to an agreed-upon amount when the balance becomes the patient’s responsibility will boost collection rates and reduce days in A/R.

This is an instance where a data-driven narrative can help take the emotion out of the analysis by focusing on the business case for collections at the point of care.

We’ve found that one of the data points most likely to catch physicians’ attention is their practice’s net collection ratio. This is calculated by dividing the practice’s collections by its net charges. Ideally, a practice’s net collection ratio should fall between 96 to 100 percent after write-offs. When the net collection ratio is lower, this indicates a potential problem with the physician group’s revenue cycle related to avoidable write-offs such as denials or bad debt.

In the example below, a practice’s net collection ratio averaged 83.4 percent. The primary culprit: the practice struggled to collect the balance due from patients after insurance had covered its portion. Additionally, the practice struggled with effective A/R follow-up on aged insurance claims and overturning denials—many of which would have been preventable with better financial clearance processes in place prior to service being delivered.

**QUICK TIP:** Real-time eligibility checks in your practice management system can draw unexpected value when it comes to verifying patient demographics. Returned mail from bad addresses can be as high as 15 percent. With postage as high as $.50 per billing statement, the ability to verify addresses prior to mailings could save hundreds of dollars a month.
Taking a deep dive into collections data and sharing it in a meaningful way with physicians and staff is vital to a physician practice’s ability to survive in a transformative healthcare environment. With information in hand, practice leaders can use data to educate their teams on:

- How the practice’s point-of-service collection rate compares with that of other practices of the same type and size
- The impact low collection rates have on the organization’s financial health and its ability to provide service for those in need

Increasing Collections at the Point of Care


“Running a patient estimator during the scheduling or preregistration process and securing financial sponsorship prior to service will strengthen financial outcomes for any provider.”
Quick answers, more money, better patient experience

*Very few practices today are working as smart as they could be.*

- Do you have access to month-end reporting the day after close?
- Can you review and assess your practice’s financial status in five minutes?
- Do you know where your organization is losing money?

Most executives don’t have time or resources to analyze data, uncover root causes, and identify opportunities to take action.

So, what if someone could do that work for you?

We were tired of the silos - so we built a tool that does all three. Our RCM Scorecard provides an executive level view of what’s REALLY going on in your financial department - at all times.

The MedEvolve RCM Scorecard answers the following questions with little to no effort from you or your team:

- Who is doing what and how efficiently?
- Where is your money? Where is cash opportunity?
- What are the gaps in your workflow?
- How can you improve cashflow, workflow? And prioritize?

More importantly, we tell you what to do with that information.

**Build a smarter practice over a cup of coffee.**

Take 3 minutes to learn more: [connect.medevolve.com/data-transparency](http://connect.medevolve.com/data-transparency)