

Average deductible for single coverage among covered workers

Source: Kaiser Family Foundation, 2017 Employer Health Benefits Survey



Buy Now, Pay

By Matt Seefeld

The new year is the opportune time not only to reflect, but also to engage in meaningful conversations about redesigning your whole approach to revenue cycle management (RCM). Those of us with time spent in the world of billing and payments are accustomed to revenue-cycle challenges, like spikes in denials or declining reimbursement rates. What we're less accustomed to is asking patients to pay a significant portion of their medical costs, especially when they least expect a bill.

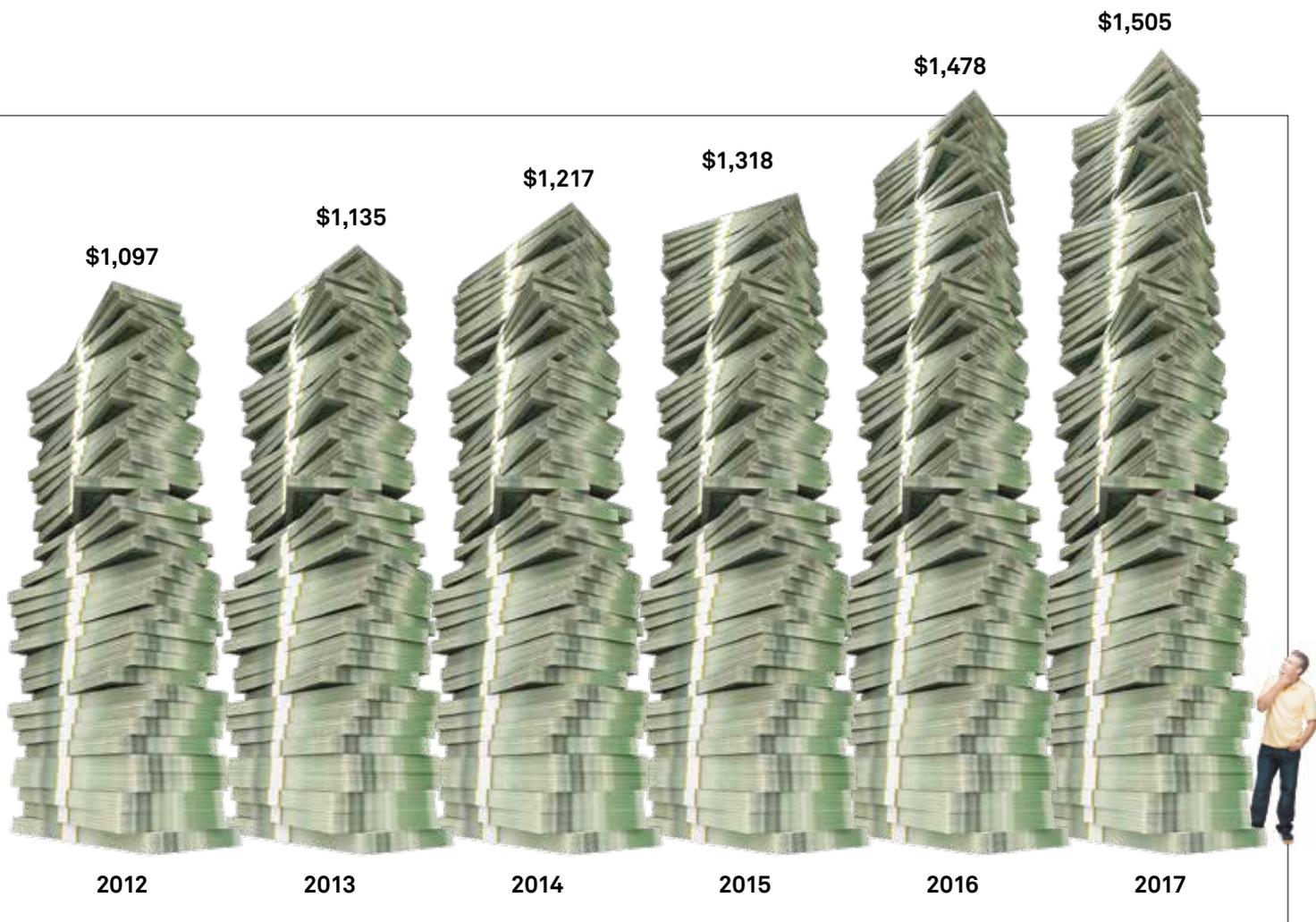
For most practices, that's about to change dramatically—if it hasn't already.

Patients are now the third largest payer, per a 2017 TransUnion analysis, which pointed out that as many as 68% of patients with bills of \$500 or less did not pay their balance. In addition, patients saw an increase in average out-of-pocket

costs by 11% in 2017 to \$1,813, from \$1,630 in the fourth quarter of the previous year.¹

These data points coincide with the growth of high-deductible health plans (HDHPs), with average annual deductibles as high as \$6,550 for individuals and \$13,100 for families.² According to a recent Kaiser/HRET Survey, 51% of covered workers in 2017 reported an annual deductible of \$1,000 or more for single coverage, up 34% from 2012.³

As a result, the once-rookie patient who defaulted on a medical bill is no longer an anomaly. What's possibly worse is many physicians don't even realize the extent of this problem because it hasn't caught up with them. We must understand how our outdated technologies, habits, and workflows are inconsistent with patient payment and billing trends.



Never

Redesign your RCM for patient-payment trends

How the System Broke Down

We need not look far to see how the surge in healthcare spending—which rose approximately \$933.5 billion between 1996 and 2013—directly correlates with a steady rise in prices for healthcare services.⁴

The problem is that many patients aren't used to paying large out-of-pocket sums for services such as elective surgery. Instead, they're frequently shocked at their medical bills or reluctant to pay them. Simultaneously, we haven't adjusted to the fact that so many of our dollars come from the patient. Because providers aren't accustomed to financing (the way hospitals are), the vicious cycle continues.

There are, however, opportunities to reverse this cycle—although practices aren't taking advantage of them. For example, a lot of groups still rely on basic mail or phone calls to reach patients, but there's no tracking and reporting on the hours involved in these efforts, which have a high failure rate.

By leveraging workforce automation and data analytics tools, you can get in front of problems in the revenue cycle, such as high rates of nonpayment for specific procedures. In doing so, you can ultimately reduce bad debt.

While administrative staff work hard, they're typically not trained to work the type of receivable that's coming to them when the patient is responsible for a large portion of a health-care bill. In some cases, a different personality type may be necessary for a staff member who is discussing financial issues with patients versus someone who is dealing with insurance companies.

Redesign RCM Workflows

Given these challenges, most medical groups would benefit from a complete redesign of their RCM systems and processes. While the idea of a redesign might sound complex and time consuming, it's really centered around taking a new

approach through appropriate work-force automation tools, deploying new payment strategies, and reliance on analytics or business intelligence.

To start, examine existing workflows and ask yourself whether they still make sense given the changing payments landscape. In a traditional workflow, a patient schedules an appointment, pays the insurance copay, and sees a physician before post-visit billing kicks in, a process that is still largely centered around sending periodic statements and collections.

But if patients are your top payers, this is not an effective long-term strategy. Below is how a redesigned workflow works, emphasizing the front end:

Pre-appointment. When a patient makes an appointment, immediately verify insurance eligibility, run a patient-estimator tool to review out-of-pocket costs, and collect outstanding balances and/or estimated balances. In addition, because patients value transparency—visibility across the end-to-end spectrum into their explanations of benefits (EOBs), payment expectations, payment submissions/approvals—be up front about costs before a service is rendered. Transparency is especially important to millennials, who are more likely than the general population to judge healthcare organizations by their billing practices, according to findings published by PricewaterhouseCoopers' (PwC's) Health Research Institute.⁵

Another key element of the pre-appointment workflow, which is designed to help prevent no-shows and optimize your schedule, is mobile text appointment reminders. These reminders allow the patient to confirm an appointment, cancel, or reschedule if necessary. This simple practice can have a big impact on your practice's productivity, efficiency, and bottom line.

Office visit. When the patient arrives, staff double-checks eligibility and other information and obtains the patient's cell phone number (for text reminders) and email addresses (for e-statements).

After reviewing out-of-pocket costs, collect outstanding balance and/or estimated balance.

Post-appointment. Because you complete so much of your financial legwork up front, you have much less work on the back end—and likely less money to collect (see “When Sending a Bill”).

Instead of spending hours cold-calling patients, the redesigned workflow relies on auto-dialer to make follow-up phone calls to collect remaining balances, freeing up valuable administration time. Analytics tools on the back end, too, allow you to continually measure results of these approaches, which is equally important, so you can adapt as this new patient-provider dynamic continues to evolve.

When Sending a Bill

- ▶ Offer multiple convenient payment methods, including online by credit card, to increase likelihood of receiving payment.
- ▶ Offer to enroll patients in a payment plan if they can't afford to pay their balance all at once.
- ▶ Make them feel empowered about paying their medical bills.

As recently as five or 10 years ago, you could easily glance at a spreadsheet and spot a problem from a mile away (e.g., accounts receivable [A/R] running 120 days on average). Today, the low-hanging fruit—the obvious, fixable problems—aren't there anymore. Isolating your biggest revenue-cycle pain points requires sophisticated tools that can comb through data and deliver actionable information in an easy to

understand and readily accessible format.

Measure Effectiveness

No single approach works the same way for every medical group. A behavioral health practice, for example, may see a patient who is more accustomed to paying a high copay than an elective surgical practice, which is accustomed to seeing other payers cover the lion's share of a standard procedure.

Continually measure and re-evaluate your RCM activities. Regularly communicate with your vendors, RCM consultants, or other partners about their goals, and whether one or more aspects of their approach could be improved.

For group practices to thrive, RCM needs to run like a well-oiled machine, sustaining the livelihood of provider groups that depend on timely payments. The fact that patients are responsible for a huge chunk of their healthcare expenses isn't an easy trend to accept. Nevertheless, you need to employ proactive tactics to ensure you're spending less time chasing payments and more time providing high-value, high-quality care. [GRU](#)

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