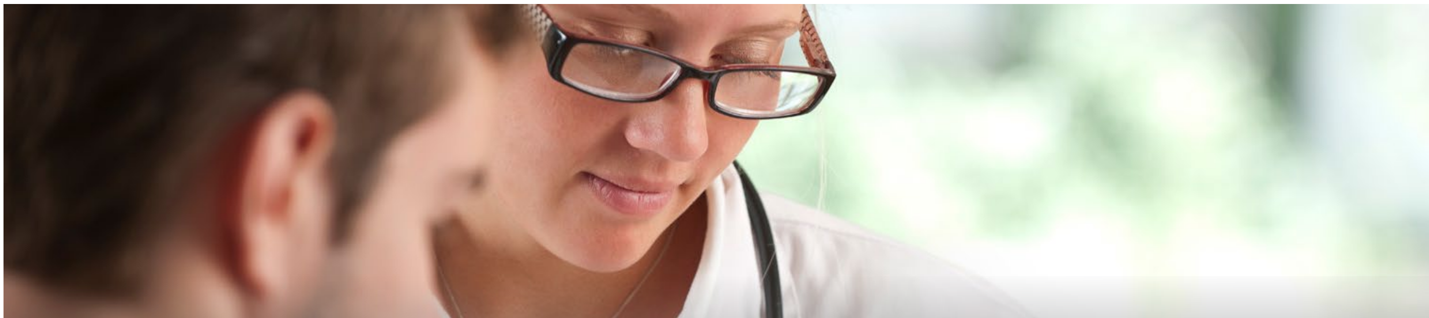

Streamlining Patient Payment for Better Revenue Cycle Management

The importance of a payment assurance strategy

Healthcare providers need to rethink their current patient payment collections strategy, thanks to two recent phenomena: high-deductible plans that are shifting a greater portion of the bill to the patient, and an increase in the number of patients struggling to pay those higher bills.

A recent study found that 68 percent of patients failed to pay off medical bill balances in 2016, up from 53 percent in 2015 and 49 percent in 2014. By 2020, this number is expected to climb to 95 percent.[1] In addition, a Kaiser Family Foundation poll found that 45 percent of Americans would have difficulty paying an unplanned $500 medical bill.[2]

As greater financial responsibility shifts to patients and the cost of healthcare rises, patients have become more consumer-oriented with their healthcare decisions. They have access to information they didn't have 15 years ago and are shopping around for high-quality, lower-cost care — all in the expectation that healthcare providers should act more like retailers.

In this new landscape, healthcare providers must actively engage patients in a new manner — one that is more purposeful, deliberate and customer-friendly. Providers can accomplish this by establishing a *payment assurance strategy.*

A solid payment assurance strategy helps healthcare providers securely and efficiently collect payments while improving the patient experience and ensuring a positive financial outcome for providers. This strategy also helps providers to:

- More quickly collect the out-of-pocket expenses from patients with high-deductible plans
- Increase billing transparency, which decreases patient frustration
- Navigate the rise of consumerism and attract more patients

Key takeaways

Healthcare providers should establish a payment assurance strategy that better engages patients – nine out of 10 patients want to know their responsibility upfront.[3]

Once an unpaid bill goes to collections, the chance of collecting decreases significantly.

Some under-equipped revenue cycle teams are applying up to 40 processes per patient payment.

Patients are the new payers

The average health insurance premium for family coverage has increased 83 percent over the last 12 years. This has corresponded with a 72 percent increase in patient responsibility. By 2024, it is estimated that nearly one out every five dollars will be spent on healthcare in the U.S. Although patients are spending more than ever, they rarely know their responsibility upfront. Yet nine out of 10 consumers want that information, especially since they now approach healthcare as more of a retail exchange, shopping with price and quality in mind.[4]

Providers are challenged not only to provide this transparency and quality, but also to offer integrated solutions that make it easy for patients to pay. Patients who know their financial responsibility upfront and have an easy way to pay are more likely to pay. Achieving these goals, however, requires providers to rethink the way they bill for healthcare services and how they engage with the patient along the patient journey.

Many providers still have a business-to-business mindset around billables and receivables, given the historic insurance carrier and provider payment structure. While providers have contracts with these carriers, they don't have contracts with consumers. Because of high-deductible insurance plans, 10 to 20 percent of accounts receivables are now coming directly from consumers, who may take 90 days to pay, if they pay at all.

While providers cannot create the same contract structure they have with carriers, they can create a payment assurance strategy that mimics the retail model that patients are already demanding as consumers.

Leveraging tools and training around eligibility and estimations

"The idea that patients aren't willing to pay upfront is a myth, but just like every other industry, you have to provide an itemized bill," said Peter Wheeler, senior vice president of healthcare and insurance vertical for KeyBank's Enterprise Commercial Payments. According to a McKinsey survey of retail healthcare consumers, more than 50 percent of patients would be willing to pay at least $200 at the point of service if they had a good-faith estimate and were given a good accounting of what they were paying for (18 percent would be willing to pay regardless of the amount).[5]

Providers should engage patients from the initial visit and eligibility verification, to estimating their out-of-pocket expenses, to the final follow-up. First, providers need the right tools to estimate and collect upfront payments. They also need to train (or retrain) patient-facing staff. "Today's front-end staff [members] have more demands on them than before and require a different skill set and script around how to obtain payment from the patient," said Wheeler. Staff members may be asked to do things they haven't done before, such as collecting much larger amounts of money upfront.

Providers need to formalize training in a classroom-like setting so the staff can practice the ask and execution of payment collection. "Dedicating four to six hours of training on how to collect without fear will pay big dividends," Wheeler said. "A refresher training three months later can serve as a checkpoint on the level of success thus far."

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– Peter Wheeler, senior vice president of healthcare and insurance vertical KeyBank Enterprise Commercial Payment

Avoiding the BAI shock

Many providers mistakenly believe that the customer experience ends when the patient leaves the office. Receiving the final bill weeks later, however, is a vital part of the overall customer experience. For patients who have paid very little (or nothing at all) upfront and do not know the balance after insurance (BAI), this can be a very negative experience. Even if a patient received quality care, a shocking and/or confusing final bill can ruin the customer experience.

In fact, an unexpected BAI runs counter to the retail model experience patients want. “When people don’t understand their bill, they tend to either pay slowly, or they don’t pay at all,” Wheeler said. Paying a bill also requires an additional step after the fact, whether it is calling the provider, sending in a check or a credit card form, or using a patient portal. And once an unpaid bill goes to collections, the chance of collecting decreases significantly.

Having conversations upfront with patients around eligibility and estimation helps prevent BAI shock. Providers also need to offer myriad payment options and ideally give patients the ability to access their information in a portal or on a mobile device. For large balances, providers need to offer payment plan choices that consumers can easily review on their mobile device.

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Case Study: Ogden Clinic

When consumer billing exceeded 20 percent of total revenue for Ogden Clinic, the Northern Utah physicians practice worked with KeyBank to integrate a patient revenue cycle solution into its practice-management system. The goal was to identify a patient payment portal that:

- Verifies benefits and notifies patients of past due balances
- Asks patients for a credit card to keep on file
- Charges the BAI five days after claim processes
- Allows patients to make other payment arrangements if needed

The patient adoption rate for keeping a credit card on file is 68 percent, and Ogden Clinic has seen a 36 percent reduction in eligibility denials since deploying an integrated collection system.

Read the full case study here.

Taking inventory and building the strategy

Before deploying new tools, providers should take inventory of their current resources to discern what tools they are underutilizing. They may also discover deficiencies in staff training on certain tools. Providers often have multiple vendor partners and systems, which can result in an unwieldy, poorly integrated infrastructure. In fact, KeyBank discovered that some revenue cycle teams are applying as many as 40 processes just to complete one patient payment. It's essential to discover these gaps and deficiencies in order to streamline the process.

While the chief financial officer and revenue cycle director may lead the strategic process, they need to engage and involve the staff members who will be using the tools on a daily basis. In addition to the C-suite, the change-management team should include the following:

- Patient-access manager and business office manager
- Scheduling and insurance verification staff
- Registration, patient billing and cash posting staff
- IT manager

KeyBank recommends that providers tap an HR or training manager to facilitate a strategy-development kickoff call, where each team member can provide insight into the current process and guide the team on how to efficiently and effectively incorporate changes within the department. Having cross-department input drives enterprise-wide ownership of the initiative and its goals. As a trusted partner in helping numerous providers deploy payment assurance strategies, KeyBank can help facilitate these discussions.

Other considerations

Many providers are still using the same legacy banking infrastructure from 20 years ago – despite the great advances in technology and innovation. They need to address fundamental accounting changes as part of their payment assurance strategy. First, it's crucial to segregate accounts receivable and accounts payable. Having more patients as payers means there are more transactions than ever before, making it increasingly hard for accounting staff to reconcile.

Security, however, is perhaps the most important reason to segregate these two processes. Having a dedicated A/R account with the proper filters and blocks with a banking partner ensures that customer receipts stay secure. The same holds true for A/P transactions. Segregating A/P transactions not only helps facilitate secure payments to vendors, it also mitigates any risk associated with fraud.

The common denominator between these two accounts is patient refunds, which are typically low-dollar transactions paid via check. Deploying, managing and measuring a payment-assurance strategy will help mitigate the number of patient refunds. KeyBank developed its Auto Pay Collect (APC) to address this challenge. As part of the pre-encounter process, APC helps staff members secure a credit card upfront and save it in a PCI-compliant and secure fashion. With APC, the adjudication process takes place as it normally would with the insurer, and the BAI is processed on the card that is on file for the patient, without a paper bill ever being mailed.

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Measuring success and looking forward

A strategy is only as good as its return on investment; therefore, providers should measure the impact their payment assurance strategy is having on their revenue cycle. Healthcare Financial Management Association's (HFMA) MAP initiative provides a MAP App that allows providers to benchmark their revenue cycle performance against other hospitals and systems. This includes metrics for those in the 90th, 75th, 50th or 25th percentile for point-of-service collection. Providers should seek out these types of tools for measuring their strategy's impact.

Measuring can help providers course-correct and/or allocate more resources. It can also reaffirm that providers are on the right path, with a sound strategy that will allow them to thrive in the coming years as more and more patients are shouldering the cost of their healthcare.

A payment assurance strategy is about more than improving revenue cycle for providers. It's about helping providers become more like retailers – not just in how they charge consumers and collect money, but also in how they inspire loyalty and focus on customer experience. Patient loyalty is no longer a given for providers. They must compete to attract and retain patients. As we move to more of a fee-for-quality model, reimbursement agencies are starting to look at a number of different aspects on how to rate a provider – one is patient satisfaction. Dissatisfied patients can lead to lower patient satisfaction scores, which in turn can lead to reduced reimbursement rates. Satisfied customers who feel valued become return customers. This has always been the reality of retail, and now, it is the reality of healthcare as well.

To learn more about KeyBank's offerings in the healthcare industry, visit **key.com/healthcare.**

Sources:

[1]TransUnion, "Patients May be the New Payers, But Two in Three Do Not Pay Their Hospital Bills in Full," June 26, 2017.
[2]Kaiser Family Foundation, Bianca DiJulio, Ashley Kirzinger, Bryan Wu and Mollyann Brodie, "Data Note: Americans' Challenges with Health Care Costs," March 2, 2017.
[3]InstaMed, "Trends in Healthcare Payments Report: 2015."
[4]InstaMed, "Trends in Healthcare Payments Report: 2015."
[5]InstaMed, "Trends in Healthcare Payments Report: 2015."
[6]Thomas Pellathy and Shubham Singhal, "The next wave of change for US healthcare payments," McKinsey Quarterly, May 2010.