

Healthcare reimbursement is facing some of the biggest changes – and challenges – of the past 50 years.

While in many ways this evolution is a good thing, it does require organizations to fundamentally rethink their revenue cycle. In fact, many providers who have relied on a tried and true method of getting paid – see the patient, code the visit, submit a claim and receive payment from the insurance company for services provided – are having to reconsider their approach.

Traditional payment models are slowly but surely being replaced as the patient becomes a more integral part of the payment picture due to the advent of high-deductible health plans (HDHPs), increasing co-pays and an overall shift to greater patient responsibility. The days when a health insurance payment covered the majority of the patient's bill are fading, replaced by a blended reimbursement model in which the patient is responsible for paying a larger portion of charges.

While some practices have begun laying the groundwork for a blended model, others have not started to address the growing importance of patient payment. Underscoring this is a recent Capario poll, which revealed that only 23 percent of practices participating in the poll currently require payment beyond co-pays at the time of service. On the other hand, 19 percent don't currently have a process in place to take patient payments and 34 percent are not sure of the impact of increased patient responsibility.¹

How concerned is your practice about patient pay responsibility?



23%

Not concerned. We're ready!



74%

Very concerned. We're not ready.



19%

Do not have a patient payment policy in place.¹

*Percentages not intended to total 100%

Although it will take some time to become an industry-wide standard, the shift toward blended reimbursement is beginning and now is the time to prepare for this new paradigm. The following white paper discusses the ever increasing role of the patient in healthcare payment and offers best practices to get ready for new reimbursement models that share responsibility across payers and patients.

The evolving reimbursement dialogue

Over the past decade, discussions about the increasing cost of healthcare have grown louder, creating a national awareness about the cost of care. Fueled by the fact that national health expenditures accounted for 17.2 percent of the Gross Domestic Product (GDP) in 2012 and are projected to grow to 19.9 percent by 2022², this new consciousness is driving changes in payment methodologies that help lower the cost while also improving care quality.

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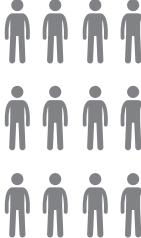
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Among the changes are those from the Affordable Care Act and the subsequent creation of accountable care organizations (ACOs) to better coordinate care and reward providers for outcomes rather than service volume. As a result, quality-based payments that incentivize providers to both control costs and improve quality are becoming a more regular part of total reimbursement.

Amidst the talk about the need to reward value versus volume, discussions about the increasing role of health savings accounts and HDHPs – where patients pay a lower

premium yet bear a larger portion of the healthcare bill – have increased along with enrollment. An estimated 15.5 million people are covered under these plans, which have experienced an annual growth rate of approximately 15 percent over the last several years.³ The accelerated growth indicates that employers are attracted to this model as a way to stem their rising costs and push a degree of responsibility back to the employee.

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For example, the percentage of employers offering only high-deductible plans in 2013 was 31 percent higher than in 2012, while 44 percent were considering only HDHPs in 2014.⁴

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Emerging reimbursement models

As healthcare continues to evolve, three main reimbursement models are taking shape. The first – traditional fee-for-service – has been around for years. In this model, a provider sees the patient, delivers care, submits the bill to the payer and is reimbursed based on contracted rates for volumes of service, regardless of the impact on the patient's health. There is little financial incentive for the provider to monitor care quality, outcomes or overall cost; instead, the practice is focused on the number of patients moving through and charges for services provided.

Contrary to the traditional approach, value-based reimbursement methodologies reward clinical outcomes as driven by treatment efficacy and efficiency. In these models, providers still may be paid fee-for-service for some portion of the payment and are incented with bonus payments tied to reduced costs and enhanced quality outcomes. This reimbursement model is used in ACOs, risk-based care agreements and other value-driven models. It often includes bundled payments, where payers replace separate payments to each provider with a bundled payment based on quality of care. The provider organization then has the burden of “unbundling” the payment to distribute it accordingly to those involved in care delivery.

In the context of both fee-for-service and value-based reimbursement, a third model is coming to light. This “new world” reimbursement approach encompasses a blend of payments from the payer and the patient. Practices may experience this model whether they are continuing to focus on traditional volume-based reimbursement or shift their thinking to value-based payment. This is creating a new reality in which providers have to manage billing and payment collection from both payer and patient. As such, the need to pay attention to the patient portion of payment is becoming paramount.

Best practices for boosting patient payment

The inevitable transition to a blended model is smoother with the right technology, people and processes to drive patient payment. The following best practices help providers sharpen their focus on patient responsibility and, ultimately, improve financial performance.

1. Get a handle on the current situation.

Regardless of whether an organization is pursuing a value-based model or keeping with the fee-for-service approach, practices should monitor what percentage of their reimbursement is from payers and what amount is from patients to identify trends and create forecasts. For example, a practice might retroactively view three years of data to assess growth in patient responsibility and write offs. This analysis could reveal an increase in patient payment by 20 percent. Industry trends show the amount could be closer to 50 percent in five years, indicating the need to develop strategies to improve the payment processes before the percentage grows.

2. Streamline financial clearance. To maximize the payer portion of the payment, practices should consistently verify eligibility for all patients before their visit. This establishes a revenue safety net, ensuring the practice capitalizes on payer payments as part of the overall reimbursement equation. While eligibility verification can be done manually, an automated verification tool can not only improve the efficiency of the process but also accuracy, making certain that patients are properly cleared before coming onsite to the practice. To help patients better understand their coverage, practices may want to print the results of eligibility verification, and present it to the patient upon his or her arrival.

3. Offer payment estimates. Shifting patient payment conversations earlier in the patient encounter can increase the likelihood of payment and also improve patient satisfaction. A key component of these conversations is the patient estimate. Rather than waiting until a payer payment is received 30 to 60 days after the patient is seen to share information with the patient about his or her responsibility, consider leveraging estimation tools to predict what the patient will be responsible for and present that amount during the visit. By using real-time technology to establish the patient's co-payment and co-insurance amounts as well as any unmet deductibles, organizations can create a clear estimate about the patient's expected payment based on what the payer has paid historically. This creates transparency with patients for a better financial experience, increasing the likelihood that those patients will pay their bill.

4. Craft a well-defined policy. Creating a patient financial policy can foster consistent, compassionate and comprehensive financial conversations. Within the policy, practices should define the financial information that should be presented to the patient during the visit, how that information should be communicated and the types of payment plans available. To ensure the policy is consistently followed, practices should train those who work directly with patients to be sure they understand the increasing burden patients face and are comfortable with having financial conversations with patients. Use of scripting and role playing can be beneficial to increase staff comfort levels when communicating financial policies and available payment options. As a byproduct, this policy also identifies internal processes that may need to be reworked to support estimations and payment plans.

5. Facilitate transactions. Having the tools in place to collect from patients when they are ready and able to pay helps increase the likelihood of patient payment. Ideally, practices should collect patient payments at the point of service; however when this is not possible, organizations should produce an estimate and have a defined process for collecting payment after the patient leaves the office. To improve payment rates, practices should use multiple communication channels to reach the consumer and offer more consumer-friendly payment methods such as online or telephone payments using a credit card.

6. Have a plan for delinquent payments.

If a patient is not paying, whether due to insufficient resources or simply a lack of commitment to settle financial obligations, practices need to have a plan in place for following up. This may involve reaching out to the patient and offering a payment plan or helping the patient transition into charity care, if criteria is met. Practices should also develop a protocol for improving collections on delinquent patient accounts. For example, this may include sending three statements over 60 days, followed by a letter and a phone call. Practices may want to consider employing automated tools that can create, manage and monitor work queues and route delinquent accounts into a work queue so that staff can focus on those that are likely to transition into payment versus bad debt.

Preparing for the Future

National dialogue about the cost of healthcare is reaching a crescendo, and consumers are becoming increasingly more sensitive to the issue. HDHPs are changing consumer philosophy about when to see a physician, as patients experience higher out-of-pocket payments with the average in-network deductible nearly doubling in the last five years, rising to \$1,230 in 2013.⁵

As patients have more financial stake in their care, they are seeking out organizations that offer a more consumer-focused experience. For the revenue cycle, this translates into the need for greater transparency in the form of upfront estimates, payment plans and direct communication with staff about payment responsibilities. As a blended reimbursement model becomes the norm, practices can no longer afford unfocused attempts at patient payment collection. The opportunity lies in preparing now for the certain move to greater patient responsibility coupled with the increasing demand for a more transparent process. Targeted efforts focused on increasing communication with patients can better support a revenue cycle that relies more on payment at the time of service in order to maintain fiscal health.

High-deductible health plans are changing consumer philosophy

about when to see a physician as patients experience higher out-of-pocket payments with the average in-network deductible nearly doubling in the last five years, rising to \$1,230 in 2013.⁵

1 Capario "Revenue Opportunity: Creating Success for Your Practice" May 2014.

2 Centers for Medicare & Medicaid Services, "NHE Fact Sheet," <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>.

3 Americas Health Insurance Plans, January 2013 Census Report, <http://www.ahip.org/HSA2013/>.

4 PwC, 2013 Health and Well-being Touchstone Survey, http://www.pwc.com/en_US/us/health-industries/behind-the-numbers/assets/medical-cost-trend-behind-the-numbers-2014.pdf.

5 McKinsey & Co. Overhauling the US health care payment system, June 2007; The Advisory Board Company, Financial Leadership Council. 2007. Cultivating the Self-Pay Discipline.

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