



End-to-End Solutions

The Necessity for Change and Reasons to
Outsource Your Revenue Cycle



Listen carefully to anyone who has something to say about healthcare, and you will hear a “change” cliché. Change is the only constant. Change is inevitable, growth is optional. Change = opportunity.

We’ve probably all used trite euphemisms to try to articulate the reality and prevalence of interruption and disruption in healthcare. You may even confess to rolling your eyes a little at a headline like “[Forget Amazon and Google—Apple could bring in \\$300B a year in healthcare by 2027.](#)” Yet in truth, only those healthcare organizations who have deliberately anticipated “what’s next” will be ready for—and at the forefront of—the new models, technologies and paradigms we’ll use to attract patients, deliver care, or capture revenue.

Cliché or not, change often springs from pain points, and that’s precisely why end-to-end revenue cycle outsourcing provides an optimal solution for many challenges that hospital and physician group leaders face when creating strategies to achieve financial goals, focus on value-based care initiatives, and deliver a positive patient experience.

Citing responses to a recent [survey conducted by Black Book Market Research](#) on views of outsourcing and new industry statistics from [Kaufman Hall’s 2018 State of Consumerism report](#), we ask the question: *Is your organization on track for meeting the expectations of patient consumers and achieving financial goals?*



Margins are Tightening

A daily look at the current top headlines of renowned publication, “Becker’s Hospital CFO Report,” drives the dire state of healthcare affairs home.

“Cash-strapped California hospital to close ER, become long-term care facility.”

“Temple University Health System considers shedding hospitals to strengthen finances.”

“Outdated patient billing is hurting hospitals and healthcare providers.”

That’s not even to mention the long list of hospital bankruptcies that have forced major labor reductions and closures across the U.S. this year alone. There is an increase of pressure on hospitals to reduce inpatient volumes and readmission rates as a result of the shift to value-based care.

The growing concern is that expenses are projected to outpace revenue growth, and by 2022 the average hospital’s **costs must be reduced by 24% to simply break even.** The importance of reducing costs and ensuring payer claim reimbursements through accurate and specific coding and collecting every dollar of patient responsibility has to be prioritized.



But how? The burning question in the minds of many revenue cycle leaders is whether perceived loss of control associated with outsourcing revenue cycle operations is greater or less than the value of taking this step. Arguably, decreasing cost to collect, improving productivity with proven staffing models, increasing overall financial performance and gaining access to otherwise out-of-reach technology that puts your patients first are all attractive outcomes.

What tips the scale in favor of taking the leap with an outsourcing partner, though, is a plan to mitigate the biggest perceived risks. Here are a few ways that taking the outsourcing step can become a very comfortable choice.

Potential outsource partners should demonstrate measurable value through a thorough Service Level Agreement (SLA). First, current performance should be benchmarked. Then performance improvements can be projected. Service level metrics should align with the organization's goals. Transparency is key—on your part—and on the part of the potential partner. Finding a partner who records, monitors and analyzes 100% of patient interactions, and offers real-time dashboards that show the status of your claims, backlogs and A/R balances gives you visibility into revenue cycle performance.



Increased Patient Responsibility

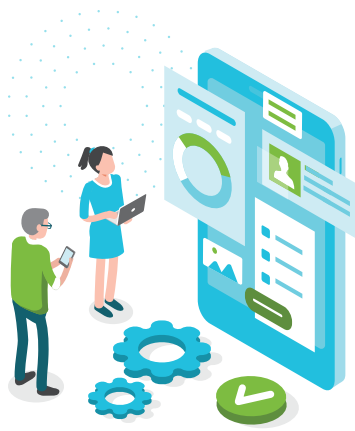
Healthcare affordability is the top concern for Americans today. Ten years ago, the majority of healthcare payments in hospitals came from insurance payers, but today the percentage of [patient payments has increased from 5% to around 35%](#). This number will only continue to grow.

Medical bills are the biggest cause of U.S. bankruptcies with estimates [citing 877,000 patients](#) filing bankruptcy each year.

In 2017, [Debt.org found](#) that people aged 55 and older account for 20% of total filings. That number has doubled since 1994. Even with assistance from Medicare, the average 65-year-old couple faces \$275,000 in medical bills during retirement.

Providers know that it is imperative to provide cost-effective care and there is a heightened focus on patient outcomes—and the *patient experience*—but that’s if the patients walk through the doors to their appointments. A percentage of Americans are forgoing medical procedures or recommended testing and making the decision on the basis of cost. 46% of employers took steps to reduce cost growth in 2018, such as offering lower-cost, high-deductible health plans. *The average deductible has **climbed to over \$3000**, the average American can’t afford an unexpected expense **of \$400** without the assistance of a payment plan.*

It’s no wonder then that patients are demanding to know what their out of pocket costs are in advance of receiving care, **but only 10%** of healthcare organizations are transparently posting pricing for services. Patients also want to understand their medical bills, but providing customer-friendly billing statements is something that **less than 50%** of organizations have implemented or are piloting.



Why isn't this more of a priority?

64% of survey respondents identified using digital tools to engage consumers as a high priority for their organizations; only 23% said they had strong capabilities to do so, but that is still a sizable change from 14% in 2017.

Implementing and successfully running an effective patient pay program requires a delicate balance between deploying a host of tools and technologies along with a strong customer service component. Not all patients will or want to pay the same way. The days of sending a bill and receiving a check a week later are mostly over.

From the first point of patient contact, engaging the patient on their terms and asking about their preferred communication style, to advising what to expect regarding billing options, makes the entire clinical and revenue cycle process easier from beginning to end.

Patient communication preferences are duly important when considering [regulatory acts like the Telephone Consumer Protection Act \(TCPA\)](#), which limits the use of automatic dialing systems, prerecorded voice messages, SMS text messages and faxes. Your organization must ask patients how and when they wish to be contacted in order to avoid costly violations.

The goal is to create a better patient financial engagement, where the patient is personalized, the decisions are outcome-based, and the process is optimized. Patient pay programs are commonly outsourced because of their complexities, the technology, and the expertise required to create those desired outcomes in your patients. Adhering to *their* preferences and providing constant education by answering *their* questions is paramount to ensuring that payment is received.

Accountable Care Functions and the Impact on Technology

It is interesting that 85% of healthcare organizations are looking to replace their revenue cycle management systems to accommodate the needs of value-based reimbursement models. While you are focusing on bringing about this shift from fee for service payment models to new alternative payment models, outsourcing revenue cycle functions can alleviate a lot of stress and create peace of mind.

There are so many technology options competing for available budgeted dollars and resources to deploy and support them: patient pay technologies to increase collections, price transparency tools, AI and chat bots, updating EHR, and/or patient accounting technologies.

Currently, 94% of hospitals are reimbursed under a mix of value-based care and fee-for-service contracts.



Change from the traditional IT functions of revenue cycle management has become commonplace as value-based care puts the emphasis on clinical outcomes for reimbursement. However, technology alone cannot be not the answer. Despite which technological solutions and features integrate financial and clinical data for alternative payment models and quality reporting, there will still be a need for *people*—medical coders, in particular, who understand and deliver Hierarchical Condition Category coding (HCC). Outsourcing to accurately monitor and optimize risk-based codes is an effective balance instead of solely relying on technology to try and do it all.

Traditionally, common areas of revenue cycle outsourcing include coding, patient pay programs, denial management and insurance A/R follow up. Looking at solutions for automation, some leaders intend to only outsource as they work through a system conversion or until they can build the technology in house. For instance, when asking providers about outsourcing to automate claims management processes, only 44% reported using a vendor solution, while another 18% built an in house system, and the remaining providers were either unsure or used a completely manual claim follow up system.



Managing Staffing and Freeing Up Resources

80% of hospital leaders are vetting or considering end to end revenue cycle management by 2019.

98% of surveyed hospital leaders are considering some outsourcing of both revenue cycle management functions and some clinical functions such as imaging centers.



This leaves barely 2% of hospital leaders who **will not** consider outsourcing end-to-end revenue cycle management due to the anticipated reaction—internally and externally—from the community, staff and physicians the organization serves and employs.

As stated earlier, changes are difficult, but take in the global picture and what is best for the organizational needs on the whole. Reducing administrative headaches such as training, benefits, and staff turnover are all alleviated when you open up to end-to-end revenue cycle outsourcing. Additional benefits include an increased return on your investment in cost to collect.

Shifting existing staff to an outsource partner, or “re-badging,” can be a win-win.

Re-badging is exactly as it sounds. Your business office employees or coders discontinue employment with your care organization and begin employment with the outsource partner. While this happens, staff members maintain their same role with their new employer. In this scenario, the logistics can be complex, and planning is key. Attention to space requirements, timelines, messaging, corporate culture as well as benefits comparisons is required. And, in truth, some employees may choose not to make the shift.

Another option is reallocating your internal resources: **59% of medical providers and 86% of hospitals surveyed stated plans to eliminate some revenue cycle management functions**, i.e., medical billing processes that are resource-intensive, error prone, manual and back-end.

Particularly if your organization is growing, there may be additional positions for tenured staff as business needs shift. Onsite staff whose jobs are being assumed are reallocated to other departments within the organization, and the outsource partner takes on the business office functions.

We know it's sensitive to talk about, but the hard reality of outsourcing is that current positions within your organization may be consolidated or eliminated altogether. Sometimes it's the only option for your organization to achieve your goals—whether it's cost reduction or performance improvement or both. Your current employees would be notified, and the outsource partner would replace the business of running revenue cycle and operations with its own staff.

The outsourcing option is often the “best for business” decision—one that will put the healthcare organization in a good position to deliver the best patient care within an ever-changing regulatory and consumer-driven environment.



Rise of Consumerism

Patients want transparent and clear information—and more—convenient personalized communication and financial channels to improve their healthcare experience.

From Kaufman Hall's State of Consumerism report, researchers took a step outside of asking providers their thoughts and analyzed healthcare organizations websites to examine their customer friendly functions.

Customers are increasingly searching online for information about their healthcare providers; here are some findings:



Easy-to-find contact information: Most organizations (81%) provided contact information on the main landing page, and the remaining 19% had it available within less than five clicks



Self-scheduling: 28% of organizations had self-scheduling available either on the landing page or within less than five clicks, while 34% had it available only through a patient portal, and 37% had no self scheduling available at all



Virtual visits: The majority of organizations—74%—did not provide access to virtual visits on their website, while 5% had them available only through a patient portal; 21% had them available on the main landing page or within less than five clicks



Price estimators: 21% of organizations had a price estimator on the landing page or within less than five clicks, while 17% had them available through a patient portal; 61% of organizations had no price estimator on their website



Posted wait times for emergency or urgent care and/or check-in services: Wait times or check-in for emergency or urgent care were only available at 22% of organizations

These results magnify the view that organizations need to take a more comprehensive, strategic approach to consumerism. In order to develop an effective game plan for fulfilling changing consumer expectations, healthcare leaders need to start with a solid understanding of who their consumers are, including their healthcare needs and behaviors, how they enter provider systems, and whether they ultimately remain loyal to the organization or seek future care elsewhere.

Where do you even begin?

Look at the cost of the service compared to the value of the partner services when selecting an end-to-end revenue cycle management partner. Providing real value means more than simply reducing days in A/R and claim denial rates or increasing payments. There are aspects of finding the ideal outsource partner that have nothing to do with cost. The right fit can't be measured only with money—integrity, transparency, culture, communication and honesty are important for your employees and for the well-being of your patients. A sincere approach with a committed partner will create many positive changes.



The Bottom Line

Healthcare leaders are vetting end-to-end RCM outsourcing as a go-to solution to progress forward and make positive changes—namely improving the patient experience. An outsource partner has the technology and expertise to manage your revenue cycle seamlessly, while you focus on your organization’s expertise: clinical care.

You need only to read an article or two on Apple’s foray into healthcare to understand that the ability to change is more than just plodding along and hoping that you can do enough here and there to stay relevant. Consumerism means anticipating patient demands and investing in the necessary technological advancements for your healthcare organization, so you keep your patients happy and loyal—it’s as simple as that.

What’s not simple is revenue cycle management—it’s complicated and intense. Partner with an outsource firm who has experience and has demonstrated time and again with similar clients to you that they have the ability to stay relevant by making changes—even if those changes are difficult.





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