visitpay®

Dispelling the Myths of the Patient as Payer

A Guide for Empowered CFOs

A Patient Financial Health eBook

What's Inside

"The healthcare revenue cycle has changed very dramatically in the last five years. Consequently there are myths that are very strongly held by many of us. **By dispelling those myths, we get down to the real facts of what's really changed, and what's the truth."**

–Author David Kirshner

Introduction By David Kirshner

As patient financial responsibility continues to rise, elevating the consumer experience has become a hot topic for health systems. With the growing numbers of HDHPs, rising OOP expenses, and narrowing margins, health systems are reassessing their current systems and strategies. Part of this change involves challenging conventional wisdom: the strongly held beliefs that fall into the "but we've always done it this way" category.

Take, for instance, how your health system regards charity care. Or what measures it uses to understand the performance of the consumer revenue cycle. Or the belief that a software system built for process consistency within the health system will offer a world class consumer experience. Any of those sound familiar? If you're like most health systems, there's a good chance some of your traditional ways of doing things need revamping. The financial health of your system—and the ongoing loyalty of your patients—depends on it.

To help, we've taken a closer look at some of those strongly held beliefs, or myths. They're based on our experience talking with health systems and partners at VisitPay. Each myth includes a set of myth-busting facts that challenge conventional wisdom

In the end, we hope this will help inform how you interact with individual patients and their families. After all, a shift in thinking can make a difference for the success of your health system—and your patients.

David Kirshner

ABOUT THE AUTHOR

David Kirshner, MBA, CPA, served as SVP and CFO of the University of Rochester Medical Center. He helped engineer a remarkable financial turnaround for Boston Children's Hospital, the primary teaching affiliate of Harvard Medical School, where, as SVP, Treasurer and CFO, he worked extensively on revenue cycle reengineering and implementation and operation of Epic's revenue cycle applications.

MYTH 1:

Days-in-A/R Is the Health System CFO's Primary Focus in Measuring Revenue Cycle Performance

There shouldn't be a single metric that measures overall performance. Instead, **use the sum of several key dimensions to provide a more accurate view**.

MYTH 1

Healthcare Finance Is Multidimensional

Is “days in accounts receivable” the best and only metric to use when measuring revenue cycle performance in the health system? In the current financial healthcare environment, the idea of using a single dimension to understand the health of your accounts receivable needs to be reassessed.

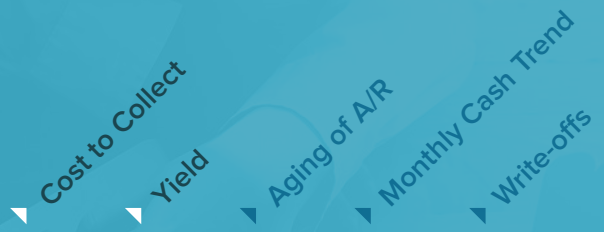
Embedded in this myth is the notion that a comprehensive view can be achieved by looking at one or two ratios. The reality is that as the nature of the revenue stream has changed, and as more and more patient payment responsibilities and obligations get billed, it has become much more important to advance and expand the number of variables that CFOs are trying to measure.

Days in A/R

CFOs and accountants are trained to measure the speed of the collection process as the primary indicator of performance. In other words, the faster the A/R is collected, the lower the days in A/R. CFOs measure the A/R days in both “gross” terms and “net” terms. And when you boil it down, the best revenue cycles are the ones that perform their tasks appropriately, quickly, analytically and efficiently—to a point where the days in accounts receivable are very low.

Many CFOs still regard days in A/R (DAR) or collection period as the number one ratio. But while DAR is an important metric to measure—it can literally be calculated right down to each payer and each insurance type – there are other dimensions that should also be examined. In isolation, days in A/R is just too limiting for today’s complex healthcare revenue cycle.

MYTH 1



5 Metrics to Watch

Here are five additional ratios and metrics that, when combined with days in A/R, offer CFOs a more comprehensive way to measure their health system's accounts receivable status.

1. Cost to Collect

Since economic and cost pressures on healthcare are a constant, the "cost to collect" metric has become critical. Cost to collect helps a CFO to understand and measure how well the revenue cycle is performing from the perspective of efficiency. CFOs look at the cost to collect as a question of how efficient the health system is while turning over the accounts receivable during its target collection period.

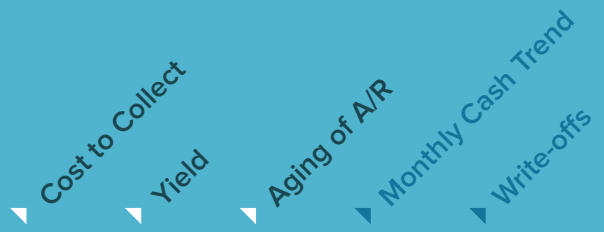
2. Yield

Yield is one of the most important KPIs or metrics. Think about yield as a farmer would regard a field of corn. After planting 100 seeds, the real question is how many of those seeds produce exactly the kind of result the farmer wants.

Using this analogy in accounts receivable or revenue cycle, you want to measure the operating statement relationship between the amount of cash collected, or net revenue that you generate, on the average charges that you billed.

It's not that health systems get paid as a percentage of charge, but that the overall question is how much can be yielded from each bill and charge that is generated. The relationship between your net revenue and your gross patient service revenue is the one that you want to focus on as a result of several important changes in the revenue stream for the healthcare enterprise.

MYTH 1



Yield, as CFOs currently think about it, is the composite of not only third-party insurance contracts and how those are performing in the revenue cycle but also increasingly patient-pay and patient-pay management. I advocate that CFOs separate these two things because they're very different revenue cycles. Here's why: If you only measure the third-party insurance, it's pretty much a function of how effective you are at processing claims: getting information on the front end and working your way through the entire cycle to the point where you have resolved and adjudicated the claim and payment has been received by the healthcare enterprise.

Improving yield in the patient-pay revenue cycle is VisitPay's specialty.

However, the patient-pay cycle is distinct. It is a hard one to measure if you don't use the yield statistics because the days in A/R may be quite long. It's here that CFOs need to focus and consider how different the patient-pay cycle is from the third-party insurance cycle stream versus the self-pay revenue cycle and stream.

3. Aging of Accounts Receivable

Aging of the accounts receivable refers to the time it takes to completely resolve a claim. The aging statistics are tried and true. For the revenue cycle, the typical trend is to view any claim over 180 days old as one that is in serious danger of not being collected. As a standard, the collectability concern with anything greater than 180 days is real—indicating that this ratio is very important to address.

Aging of accounts is usually viewed in 30-day buckets. If you start to see the aging of a hospital's accounts receivable go out to 210 days, that 's a red flag—the older the account gets, the worse it is. For third-party insurance, it's a highly accepted trend. However, on the patient-pay side, with the introduction of high-deductible health plans and other patient payment responsibilities, it's not unusual to see more aged, valid accounts receivable exist in our healthcare systems.

Applying a broad-brush to all aged receivables in the same way—using the typical aging statistics—is not a real measure of what's going on. A better way is to bifurcate between the third-party insurance and the patient-pay receivable, including patient payment obligation after insurance.

MYTH 1

4. Monthly Cash Trend

One of my all-time favorite ratios is monthly cash trend. It's a great one to use with Wall Street rating agency presentations when going out for bond issues. Monthly cash trend is a vivid measure because it's just an absolute dollar value to look at historically month-by-month.

Over the years, monthly cash trend has proven to be a wonderful ratio because it provides CFOs with three things:

1. The revenue cycle's operating improvement
2. The contracting improvements that are being achieved
3. The way in which the institution is capturing its charges

That's why patient-pay cash collections are absolutely a big part of this discussion now—for both third-party insurance and patient-pay. Patient care cash receipts are relatively easy to measure from most healthcare systems.

At the end of the day, CFOs care about the cash that's coming in every month—no matter what the source. CFOs will want to make sure that monthly cash trend is the fifth dimension in their best practice analysis.

MYTH 1

Cost to Collect
Yield
Aging of A/R
Monthly Cash Trend
Write-offs

5. Write-offs

Write-offs come in three primary forms:

Insurance Denials:

Most health systems today track denials by “reason code.” This enables revenue cycle leadership to remediate the causes of the denial including claims and coding edits used by third-party payers.

Charity Care:

Most systems use a credit scoring solution to classify patients who are truly indigent and unable to pay their obligations. CFOs record these write-offs in tax returns as evidence that they provide free care in accordance with our credit and collection policies, and with our charitable mission.

Bad Debt:

For patients scored with a propensity to pay their bills, this write-off typically reflects the unwillingness of the patient to resolve their obligation. I advocate that CFOs need to look at bad debt write-offs as a proportion of patient balances due, rather than the entire accounts receivable, to help them more accurately zero in on strategies to move the needle on this metric.

MYTH 1

Broaden Your Metrics—and Your Perspective

When CFOs consider other metrics to really understand how well they are doing when it comes to improving operating margins, there is a lot of focus on denials or write-offs that occur unnecessarily, perhaps due to administrative defects from the payer or one's own revenue cycle – things that make it impossible to know whether speed or costs was really a question. As a best practice, none of these metrics should stand alone.

Include all six of these major revenue cycle performance metrics in your dashboards—rather than rely solely on the one-dimensional view of days in A/R:

- **Days in A/R**
- **Cost to Collect**
- **Yield**
- **Aging of A/R**
- **Monthly Cash Trend**
- **Write-offs**

The VisitPay platform can help CFOs broaden this perspective using a combination of the six suggested ratios discussed.

Thoughtfully consider how different the patient-pay cycle is from the third-party insurance cycle stream versus the self-pay revenue cycle and stream. CFOs should segregate the patient-pay revenue cycle from the third-party cycle.

MYTH 1

The VisitPay system enables CFOs to accurately segregate the insurance versus patient obligation. The underlying data to move from a primary insurance source like Blue Cross Blue Shield, which will carry a deductible or coinsurance with it, will ultimately need to get calculated as a hybrid patient receivable.

The same segregation requirement also applies to patient obligation. On this point, the VisitPay system offers a robust set of tools and capabilities that can deliver a more intimate understanding of the patient obligation, and how to segregate and measure obligations with precision.

After working with the underlying revenue cycle systems like Epic, McKesson, Allscripts, and others around the country, my analysis is this is exactly what the VisitPay platform is geared to do across all the dimensions of the six main KPIs discussed.

The rating agencies were first to define credit ratios. When Moody's and Standard and Poor's scrutinized healthcare credit, they organized ratios into three buckets: liquidity, operating performance (that's your operating or operating cash flow margin), and capital structure. **What I'm advocating in today's myth-busting examination is very similar. In the same vein, the dynamic sum of six key performance indicators is better than just one.**

MYTH 2:

Charity Care and Traditional Collections Strategies Are Fit for Purpose for Consumer Payments

Is there a better course of action than **dismissing financially challenged patient accounts as bad debt write-offs**?

MYTH 2

Offering Consumers a New Way to Pay

Are charity care write-offs or aggressive collection practices sufficient to address the growing number of under-insured and insured patients who have large deductible and coinsurance payment responsibilities? Would having the ability to offer patients a different path—one where they are able to propose what they feel they can pay, based on a combination of discussion and analytics—be a more effective strategy?

Here's why these two ends of the spectrum may not serve the best interests of either the provider or the patient in the era of consumer-driven health plans.

The Charity Care Mandate

Most hospitals and employed physicians in the US are tax-exempt entities required to render urgent and emergent services to patients, regardless of a patient's ability to pay. Internal Revenue Code, Centers for Medicare and Medicaid, and common state regulations routinely require compliance with so-called "charity care" standards, including an upfront assessment of low-income status.

There is no denying that there's a moral imperative embedded in charity write-offs. Health systems play a key role within their community. Charity care is an important part of the mission and it's vital to the patients who truly need it. For the patients who are indigent or very unlikely to have any means to pay their medical costs, health systems may choose to not even bill the patient, opting instead to recognize the revenue generated as a "contra revenue," reporting it as "charity care."

Many leading health systems use a financial "scoring" methodology to identify patients who qualify for charity care under household income criteria. These scoring systems were initially designed to address the "propensity of a patient to pay" their bill, to support a charity care designation, or formally qualify for an uninsured discount.

Uninsured Discount

An uninsured discount policy is typically a clearly defined, documented business practice adopted by health systems to collect at least what the provider would have received from a third-party insurer – had the patient been insured. In general, co-payments, co-insurance or deductibles are not waived or discounted.

MYTH 2

Patients with "Propensity to Pay"

That then leaves the growing legion of insured patients who have a "propensity to pay" their responsibility for account balances that remain after the application of all insurance payments and contractual adjustments, in accordance with any remittance advice or "explanation of benefits" received from the insurer.

With mounting pressure to collect patient pay receivables over a timely period—ranging from 30 to 120 days—patient accounting professionals will often designate a patient balance that doesn't qualify for charity care or uninsured discount to an "early out" vendor. The rationale for this behavior is based on the belief that consumers with a "propensity to pay" are more likely to pay their bills while these bills are still fresh in their minds.

Collection Action

A health system gets more return when they collect from the patient with the threat of being sent to a bad debt collection agency after 120 days of written patient statements, a phone call, and a final collection notice. With consumer protection high on the list of priorities, however, many states have laws preventing healthcare providers from predatory behavior toward patients who don't pay their patient obligations.

Health systems today typically don't report patient bad debt to any credit bureau. This policy is not intended to restrict the hospital from taking this action in very specific cases; nor does it prevent the hospital and its agents from utilizing the services of a credit bureau to identify the credit rating of a patient with a view to determining the patient's "propensity to pay."

The result of traditional collection action is a very unhappy patient – one who feels harassed and with no choice. While very few patients are ever "happy" to pay their patient obligation, for many patients, setting an expectation up front and being given the benefit of more time, makes all the difference.

Why Consider New Patient Payment Programs as a Middle Ground?

Changing behavior is never easy. However, without exploring other patient payment options beyond charity care and traditional collection agencies, a health system might end up in a situation where they need to either be bailed out or face bankruptcy.

MYTH 2

Let's consider the following four facets of a Patient Payment Program for your organization:

1 Make It Easier to Have Difficult Financial Conversations

Determining a patient's hardship status can entail a difficult conversation that healthcare systems would rather not have. The aversion to having the initial difficult conversation is understandable. Without a reliable "propensity to pay" scoring methodology, determining who qualifies and who doesn't is a bit of a shot in the dark.

However, some health systems are starting to understand that when patients are allowed more time and options through payment plans or deferred payment options tailored to their unique circumstances, the system will recoup more of the value of the outstanding balance. Some patients might also prefer a prompt payment discount to resolve their obligations.

With a sophisticated Patient Payment Program, these conversations can be made easier. For example, patients can pay a portion of their bill through a set of self-selected options that are created by the provider health system.

These options give patients the opportunity to design a payment plan for themselves, based on the criteria set by the health system. The result is the patient can pay their bill off over a set period (e.g., 12 to 18 months). When offered the choice, patients have a vested interest in proactively managing these obligations – which gives patients who fall within the financial hardship category a better option.

Further, health systems are using advanced propensity to pay solutions to add intelligence to their early out relationships. The temptation with an "early out" vendor is to use it for all patient balances, including those that could be identified as the "cream of the crop." But this approach can be expensive and, with the advent of smart analytics solutions, is now unnecessary.

MYTH 2

2 Consumer-centric Health Systems Reduce Complexity for the Patient

Adopting a more consumer-focused portal brings a level of familiarity and ease into what has been perceived as a complex payment process in the healthcare sector. Providing a solution that looks, feels and behaves like any other consumer financial experience encourages engagement, and ultimately, improves patient payment yield.

Education of patients and clarity of options for insured patients with balances are becoming very important. Having revenue cycle and finance professionals be the only judge of payment terms isn't good enough anymore. To change behavior, the industry needs to create a new language – with personas and terms that are easily understood by the average consumer.

3 Measure Income Bands with Greater Granularity

The answer to the question of how best to recover a balance due from most insured patients depends on the health system's ability to match the consumer's needs and identify categories within which the patient can find him or herself.

For instance, patients in lower- to middle-level income buckets likely include those that want to pay something towards their bill. If a health system has the means to more accurately stratify and segment patients, the health system will have better visibility into who really qualifies to receive discounts and payment plans.

Using VisitPay's platform with sophisticated analytical scoring models and business rules, combined with both provider and patient input and third-party data resources, enables providers to more accurately identify a patient's ability and capacity to pay for medical services or qualify for charity or other financial assistance.

MYTH 2

4 Ensure Patients Are Aware of Alternative Options

When a patient visits a doctor or hospital and is asked for financial information, they are often given brochures offering them financial counseling, including the potential of charity care. In the future, health systems will instead be publishing options available for consumers to explore that include pre-payment, deferred payment plans, and financing. For the tax-exempt hospital revenue cycle, this is relatively new territory.

> Leading health systems with Patient Payment Programs supported by VisitPay are **already offering patients alternatives to straight payment plans**—giving them time and appropriate incentives to pay off their health obligation over a longer term.

Building a Patient-focused Revenue Cycle Strategy

It's not a coincidence that "patient-payment" or "patient-pay program" have emerged as new terms within the healthcare finance arena, which used to only refer to "self-pay" when referring to patient balances.

Patient-payment is a profoundly important part of revenue cycle strategy and execution, no matter what software system is being used. With so many insured patients presenting at the time of registration or service with unknown deductibles and coinsurance, patient-pay is the rule rather than the exception. Understanding what patient payment means for your health system and having a solution like VisitPay is fundamental in the new, consumer-driven revenue cycle.

MYTH 3:

The EMR System Alone Is a Sufficient Way to Engage Patients Financially

Optimizing consumer payment is not a job for the EMR system alone. Rather, it requires health systems to create a true consumer-first experience by employing smarter software, coupled with marketing and consumer finance know-how.

MYTH 3

The Challenge of Using Only the EMR to Optimize Consumer Financial Payments

It's no secret that patients have become vital payers for health systems. **Not only do over 40% of consumers today have a high deductible health plan, but almost half of adults in the country struggle to pay a significant unexpected bill of more than $400.** They're also likely to pay their medical bills last. Consequently, many health systems now budget annual increases of 6% to 7% in bad debt write-offs.

Understandably, many CFOs are turning first to EMR portal and revenue cycle software to address the challenge. Unfortunately, it's not enough to meet the varied expectations of the patient consumer.

As Atul Gawande wrote in *The New Yorker*[1]:

> *"Why can't our EMR systems be like our smartphones—flexible, easy, customizable? The answer is that the two systems have different purposes. Consumer technology is all about letting me be me. Technology for complex enterprises is about helping groups do what the members cannot easily do by themselves—work in coordination."*

[1]https://www.newyorker.com/magazine/2018/11/12/why-doctors-hate-their-computers

MYTH 3

Increasing the Value of an Existing EMR Investment

In a nutshell, Dr. Gawande's statement echoes the frustration that health system CFOs may feel about the investments they are making in EMR technology. The consumer plays an ever-growing role in healthcare. It's one of the reasons why CFOs can't always default to "Epic gets first right of refusal, and more functionality is coming in the next release" or "We already have it in Cerner."

Tackling the challenge of optimizing the payment of patient balances requires health systems to differentiate between standardizing workflow and the creation of a true consumer-grade experience. Their frustration lies in finding a suitable solution that combines the marketing and consumer finance know-how necessary to engage the consumer with the ability to tackle the complexities associated with healthcare billing.

Over the past decade, it's become pretty clear that investing and implementing an integrated, high caliber EMR-revenue cycle system like Epic is critical to optimizing compliant third-party insurance company reimbursement. For CFOs, such systems are a game changer because they enable the health system to manage the patient journey from the first clinical encounter through to resolution of the final bill. **An integrated EMR system marries both the clinical and the financial elements of the journey.**

What most CFOs have also learned is that no single vendor can solve every business problem. The best hope is to find a solution that leverages the EMR seamlessly—one that provides both provider and patient with an integrated view. Even if your system happens to have Hospital Billing (HB) and Physician Billing (PB), and you've also taken the step to upgrade to Epic's Single Business Office (SBO), integrating a solution that is attuned to consumer financing needs is a springboard to creating a self-service, digital patient billing experience.

MYTH 3

5 Ways VisitPay and EMR integration Can Optimize Consumer Financial Engagement

When it comes to paying out of pocket obligations, it's important to remember that patients are accustomed to seamless consumer finance experiences such as online shopping through Amazon. You're competing against the best user experience they've ever had.

Following are some points that summarize the differences between only using an EMR like Epic versus enhancing the EMR with a dedicated consumer platform like VisitPay. They help to illustrate the key areas where consumer credit is best addressed with a specialized partner.

1 Transparency of Patient Liability

Having transparency of patient liability is beneficial to both the patient and the health system. It is not that patients trust their insurer more than their provider, but seeing an accompanying EOB from the insurance company—which shows the patient what they owe and why—increases the credibility of the provider's statement. If the patient receives their EOB separately, they may not view both documents side-by-side.

EMR-ONLY APPROACH	IMPACT USING EMR + VISITPAY
Insurer's Explanation of Benefits (EOB) must be retrieved manually by the patient in a separate document/system	EOB is available online at the visit level regardless of insurer, making it easier for the patient to understand what they owe

MYTH 3

❷ Standard Billing vs. Patient-driven Workflows

To facilitate the needs of the patient as a payer it's critical to differentiate between patients. This ability is foundational to creating a consumer-friendly billing experience. While the EMR may not enable patient-driven financial workflows, VisitPay is built to bring them to life. This is an integration area where **VisitPay dovetails perfectly with the EMR, complementing it by enhancing the consumer channel, offering patients more opportunity to see the entire landscape of options** across the revenue cycle to settle a bill.

EMR-ONLY APPROACH	IMPACT USING EMR + VISITPAY
Patient Pay workflow focused on presumptive charity care designation, internal self-pay follow-up, collecting a digital payment and referral to early out programs	Propensity to Pay scoring built right into the workflow Payment plans are automated and provide tailored options for patients depending on their circumstances

❸ Enhanced Credit and Collection Policy

EMR-ONLY APPROACH	IMPACT USING EMR + VISITPAY
Policies reflect charity care standards and otherwise standard collection practices apply to all patients	Policies are informed by best practices of leading health systems reflecting consumer segmentations and preferences

For health systems using the EMR only, credit and collection policy capabilities go as far as determining how many statements a hospital will send and offer digital bill-payment options. In contrast, integrating VisitPay with the EMR enables a health system to bring to life sophisticated credit and collection policies in an online, self-service manner. **Creating a more sophisticated credit and collection policy enables a health system to encourage consumers to act in ways that work for both themselves and the health system**, and deliver remarkably better financial outcomes as a result.

MYTH 3

❹ Improve Provider Efficiency

Paying a middleman to make calls to accounts without any segmentation is a buckshot method of debt collection. **VisitPay will engage the consumer digitally, allowing the health system to manage patient obligations in alternative ways like early-out programs and collection agencies—thus saving contingency fees on accounts that are already highly likely to pay.**

An added benefit of insourcing through the VisitPay platform is the continuation of direct contact and engagement between the patient, who is a member of the community, and the health provider or system, who is both a stakeholder and a member of the community.

EMR-ONLY APPROACH	IMPACT USING EMR + VISITPAY
Consumers can pay their balances online. Patient pay balances are sent to early out vendors or multiple collection agencies who are paid a commission	Patient pay balances can be retained and actively managed on the health system's own branded portal and remain on the system's balance sheet or not with no impact on consumer experience

MYTH 3

EMR-ONLY APPROACH	IMPACT USING EMR + VISITPAY
Multiple EMRs and/or upgrades and migrations creates a fragmented consumer experience and over-statementing	Consumer has one monthly statement, normalized across the health system with a consolidated view of patient payment responsibility

5 One Comprehensive View of the Bill

At many health systems, patients are sent a new statement every time they have a visit and engage a new service. For a health system with multiple billing systems or systems that are migrating from one system to another, it's a significant technical, operational and design effort to consolidate bills. **With VisitPay, physician and hospital bills are organized in an integrated view for patients who receive a single consolidated statement once a month.**

Some hospitals and health systems use Epic Single Business Office, pulling the physician and the hospital bill into one picture. However, even then, the consumer may receive multiple statements a month depending on the number of visits and whether a single guarantor has multiple accounts. For consumers used to receiving a single statement each month that combines multiple transactions (on, say, a credit card bill) this experience can be disconcerting.

MYTH 3

Prognosis

Although most consumers want to pay what they owe for the care they receive, today's healthcare billing systems make patient payments painful. According to Forbes[2], patient payments account for 35% of some providers' revenue. The explosion in high deductible plans means patients face balances of $2,000 to $5,000 much more frequently than in the past.

Aside from a lack of ability to pay and low payment rates, these trends and changes in benefits structure could be initiating many thousands of inbound calls a month to a health system. **Patients need the ability to actively engage in the self-service of their financial responsibility.**

[2]https://www.forbes.com/sites/allbusiness/2017/06/28/what-we-can-all-do-about-rising-healthcare-costs/

Two Mythbuster Recommendations for CFOs

In addition to complementing your EMR with a consumer-focused platform like VisitPay, we also see two areas where our most successful health systems are focused:

1 Make Patient Satisfaction and Loyalty a Priority

How consumer-oriented are your patient billing services today? If patient loyalty translates into ongoing revenue for a hospital, shouldn't building loyalty be a primary goal of the CFO? Given the rise in high deductibles and expanding number of patient payment accounts, **long-term, low-interest payment options can no longer be the exception rather than the rule in healthcare**.

2 Reconsider Credit and Collection Policies

Offering flexible and easy-to-understand payment options makes patients feel the health system is on their side, helping meet their financial obligations within a workable time frame. **Giving patients more control over how to pay reduces anxiety, improves engagement, and builds confidence in the overall quality of care received**.

But behind the scenes CFOs need to rethink their consumer credit and collection policies. Treating everyone the same, regardless of financial situation, is not a recipe for building a successful financial relationship with people most likely to need help managing a bill.

VisitPay excels at helping systems tailor payment options and credit policies in ways that help find workable solutions for both the health system and the consumer. Leading health systems that integrate VisitPay's flexible and automated patient revenue cycle management solution with the EMR are seeing increases in total patient dollars of 30% or more. **Now, isn't that a better outcome than having to pay external agencies to make outbound calls that no one wants to receive?**

Conclusion

Dispelling the myths surrounding healthcare finance gets us down to the real facts of what's changed in the environment today. Becoming more aware of the importance of the consumer, you'll be better equipped to engage them through a new approach.

VisitPay is purpose-built to support health systems as they take the necessary next steps to broaden their approach around metrics, charity care, and software solutions. Designed by working closely with several large health systems, VisitPay is a powerful solution that simplifies the entire billing experience for patients and health systems for the good of everyone.

From enabling providers to more accurately identify a patient's ability and capacity to pay, to helping systems tailor payment options and credit policies in ways that help find workable solutions for both the health system and the consumer, to providing billing transparency and flexibility—VisitPay can help your organization engage patients, improve financial relationships, and drive yield.

Let's connect to discuss how VisitPay can help you improve the healthcare consumer's experience while simultaneously driving meaningful financial results.

VisitPay is a dedicated group of consumer finance people working for the good of the healthcare industry.

Our company was established after our founders discovered an entire industry that was using outdated and inadequate systems to manage patient revenue—leading to frustrated providers, dissatisfied and confused patients, and, ultimately, fewer payments. Something had to change.

So we decided to fix it. In doing so, we didn't only make patient billing easier, we rethought patient financial relationships from end to end.

Let's explore how your health system can rethink things, too. Whether you have a question or you'd like to schedule a demo to see VisitPay in action, we look forward to showing you how this powerful platform makes patient financial engagement easier than ever.

LEARN MORE:

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Thanks for reading.

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