

RivetHealth.com

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**How World Class Practices Manage Cash  
Flow and Patient Collections**

# Objectives & Learnings

By the end of the presentation you should have a better understanding of the evolving patient financial landscape. If I do my job right, you'll know a bit more about pending and final legislative changes and how to tackle these obstacles.



# Andrew Harding

## Vice President of Customer Success

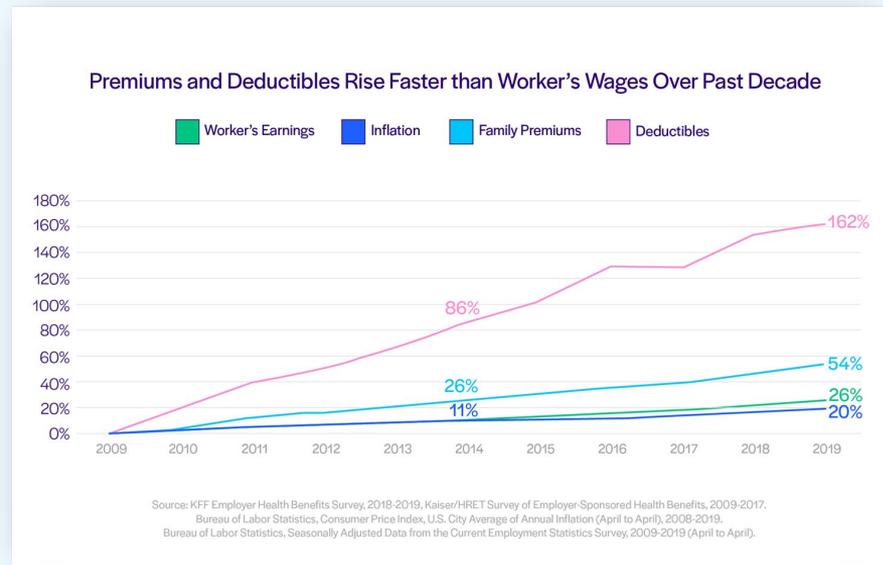
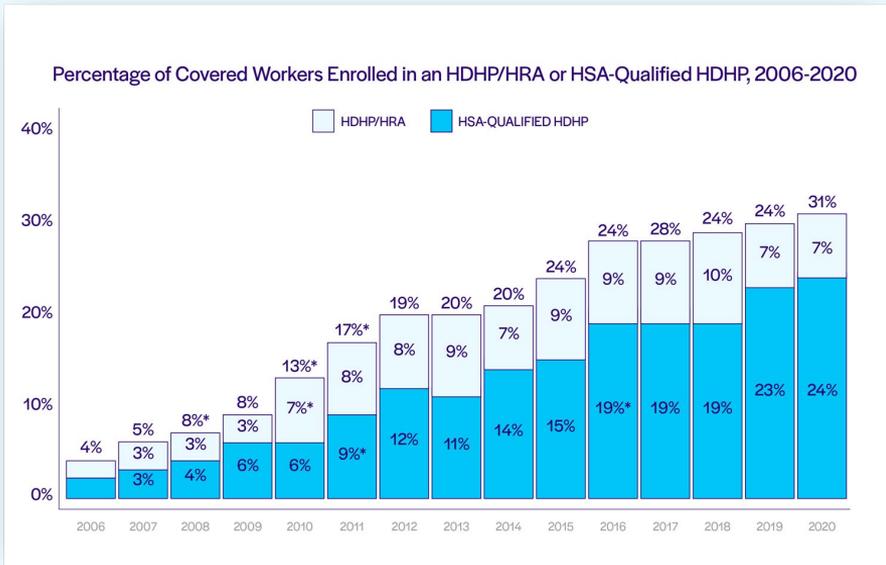
Andrew is the Vice President of customer success at Rivet. His primary function is supporting Rivet's customer in learning, implementation and adoption of Rivet from patient cost transparency to navigating the waters of insurance contracts. He brings over a decade of revenue cycle experience to support process and organizational change.

# Agenda

1. Why financially clearing patients up front makes sense
2. Benefits and tips for upfront collections
3. Communicating patient costs
4. Compliance with the No Surprises Act and Good faith estimates

Why?

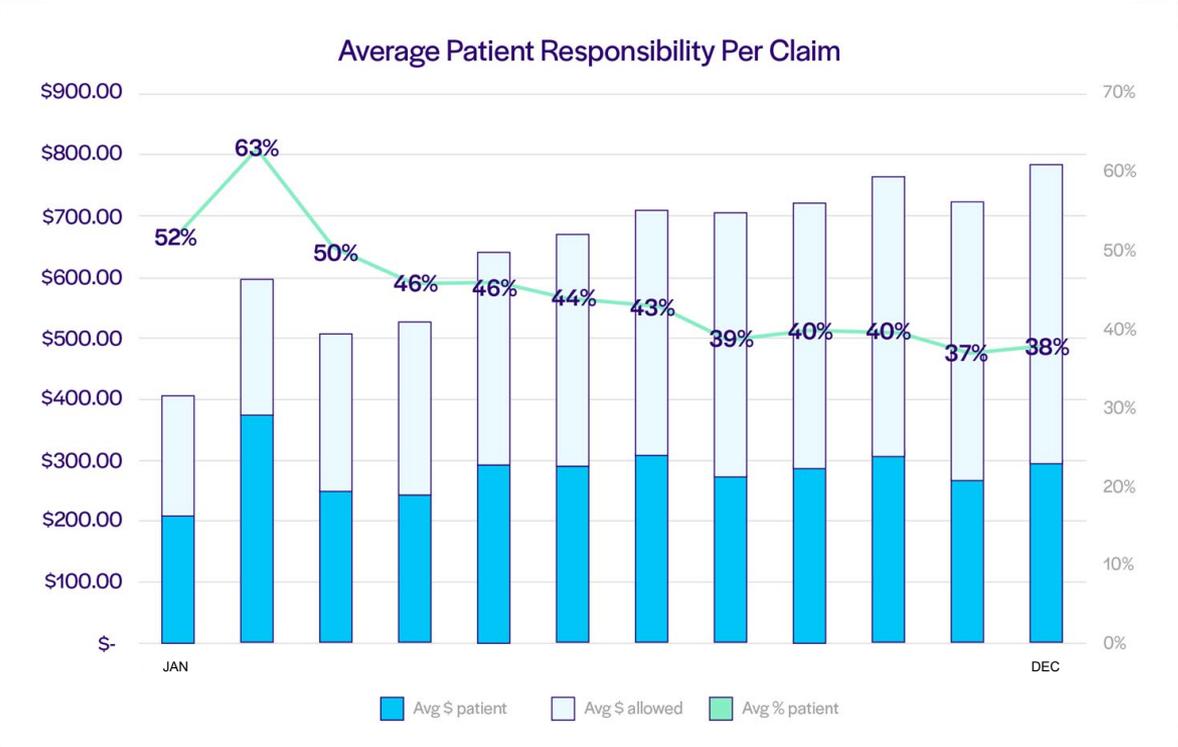
# Insurance is cyclical - but it changes



- Deductibles and OOP reset
- “Visit limitations” can reset
- More of the visit going to patient liability

- New employers/plans
- High \$ procedure pushed to less stressful time
- Maximizing amount of “benefit time”

# Patients own a lot of the bill



# Poll Question #1

What percent of your A/R is patients?

1. 0-10%
2. 10-20%
3. 20-30%
4. 30-40%
5. 40-50%

# 83%

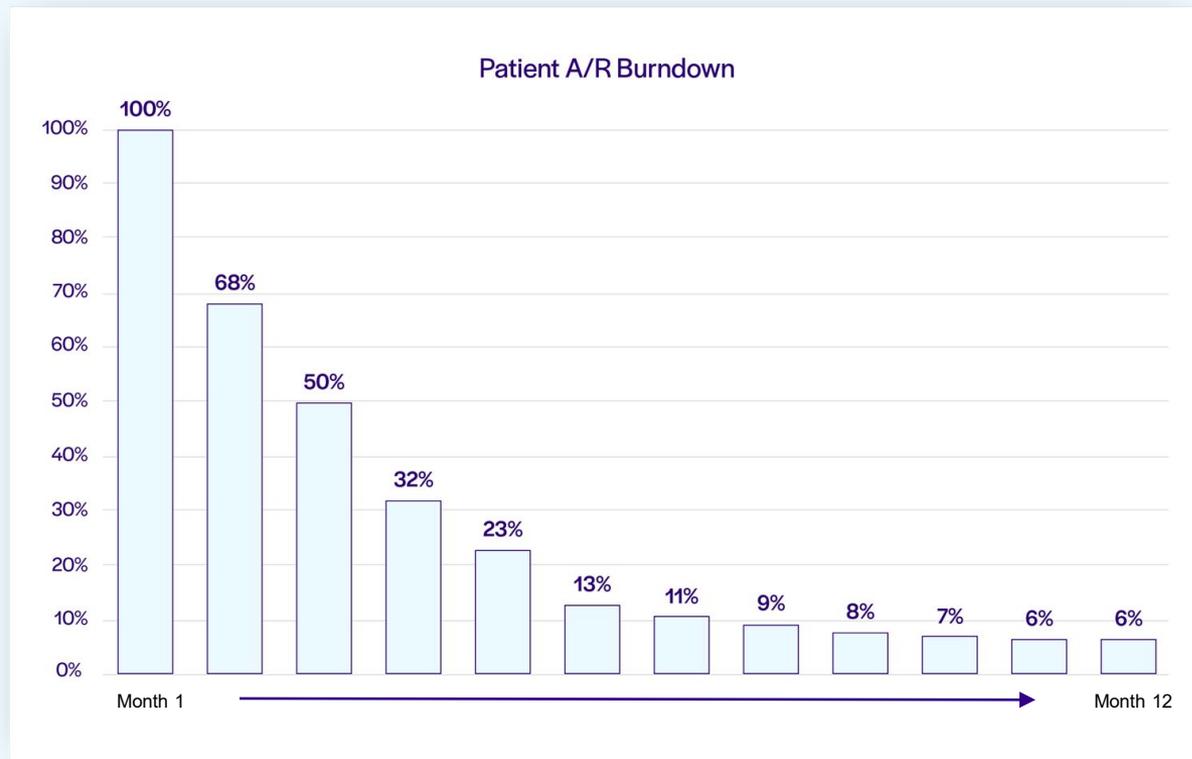
of Physician Practices under five practitioners said the slow payment of high-deductible plan patients are their top collection challenge

# 67%

of Americans are either very worried or somewhat worried about unexpected medical bills

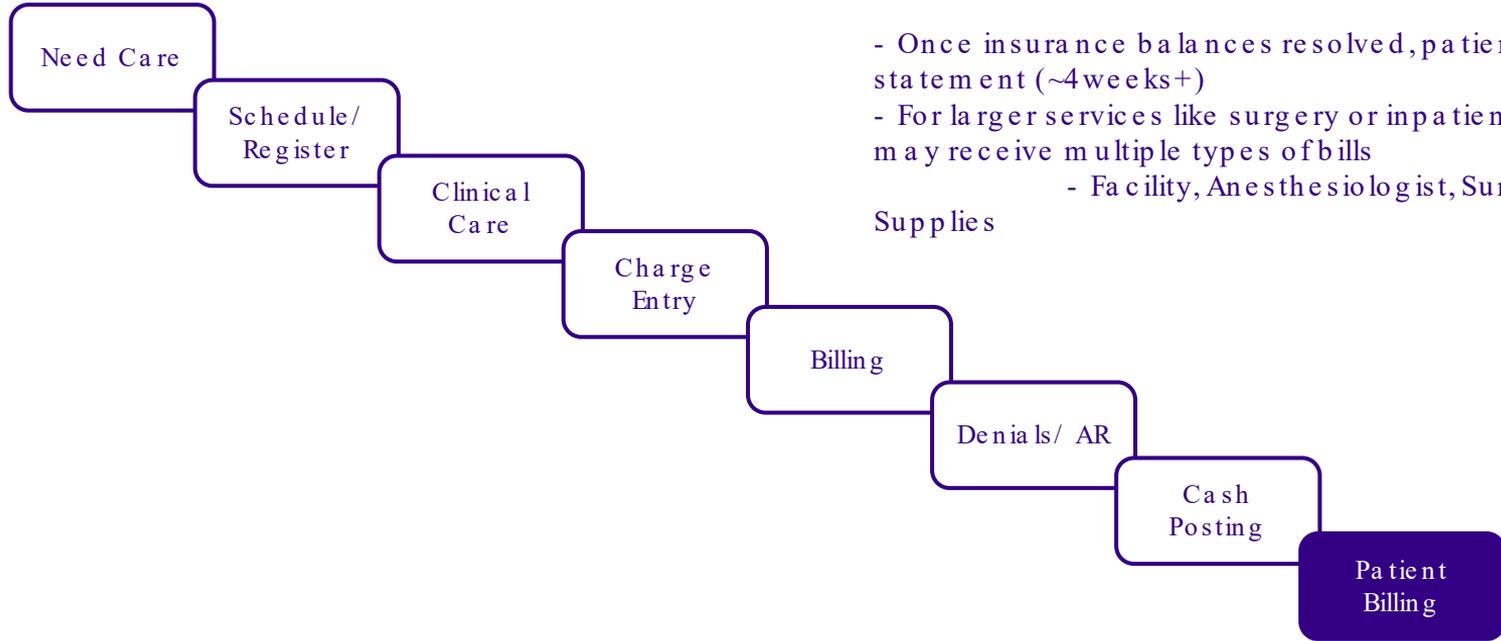
- 4x harder to collect from patients over payers
- Aged patient balances large component of open A/R
- Difficulty in patient collections creates additional complexity in financial models
- Patients as consumers

And it takes a while to collect



# Benefits and tips for upfront collections

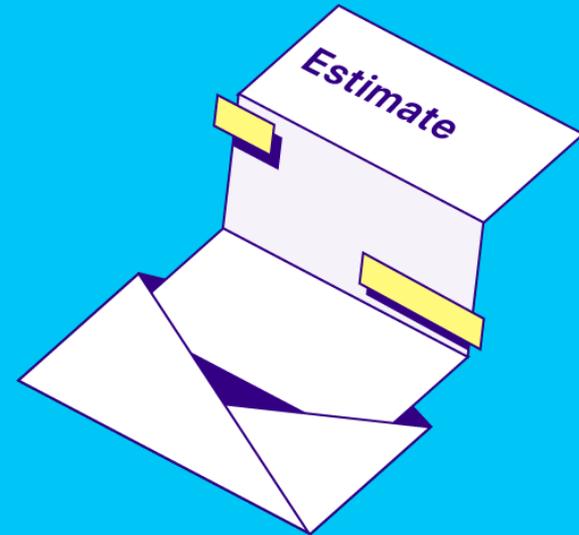
# The problem in revenue cycle



- Once insurance balances resolved, patient receives statement (~4 weeks+)
- For larger services like surgery or inpatient stays, may receive multiple types of bills
  - Facility, Anesthesiologist, Surgeon, Supplies

# Patient Cost Estimates (secret sauce)

- Move the cost conversation up front
- Use either your actual contracted rates, or analytics from remittance data (payment data)
- Pair scheduled services with benefits & eligibility
- Clear and transparent patient responsibility
- Patient-friendly delivery
- Establish payment baseline
  - Flat fee, %, or payment in full



## Poll Question #2

**Do you collect from patients upfront?**

- 1. Yes**
- 2. No**

# Gotchas

1. Choosing the right fee schedule
2. Benefit attribution
3. Coverage guidelines
4. Guarantor vs. patient
5. Previous balance history
6. Other provider charges



# Communicating costs

# The communication crisis



- Text/SMS messages
- Online portal
- “Touchless” check-in
- At-home document completion
- Kiosks
- Self-serve options
- -----
- Paper based statements
- Phone calls

# Communicate balances early on

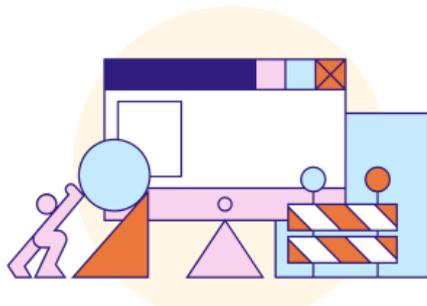
- Communicate costs prior to service
  - Transparency enhances patient experience
- Communicate payment policies (payment in full, payment plan)
- If a patient is concerned about the cost pre-service, that would not change post-service



# Successful delivery



Get necessary consent,  
and determine patient  
preferences



Understand the difference  
between marketing, financial  
and clinical (HIPAA)



Be a solution - answers  
for questions patients  
may have

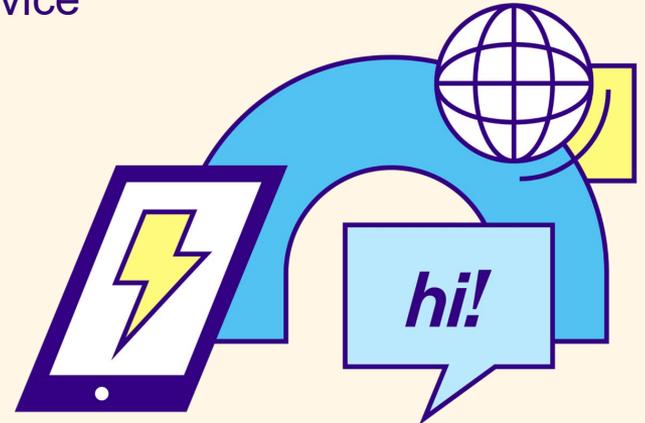
# Make it easy to pay

Modern payments are so easy,  
incorporate these!

- ✓ Mobilepay
- ✓ Web-pay
- ✓ Flexible cards  
(HSA/FSA, Debit, Credit)
- ✓ Card-on-file auto payments
- ✓ Patient driven payment plans

Provide multiple avenues  
for a patient to pay

- ✓ Phone line
- ✓ Portal/web based/mobile
- ✓ Point of service



# Know what you can/cannot do

## Fair Debt Collections Practices Act

- + When and where you can try and collect
- + How aggressive you can be

## Telephone Consumer Protection Act

- + Documented consent
- + Ability to be excluded from SMS/Text

## HIPAA

- + Balance reporting and patient adequate collection efforts
- + Protection of data

## Internal financial policies

- + Statement and notification requirements
- + Balance write-offs and adjustments
- + Process of collections

# Good Faith Estimates

# Good Faith Estimates

## Self-pay/Uninsured Patients

**All providers** (doctors, hospitals, ASCs, MRI places, everyone!) must provide a good faith estimate of the expected charges to any self-pay or uninsured patient.

## Timing

The estimate must be provided no later than **3 business days** after the service is scheduled  
(if it's scheduled at least 10 days out)  
**OR** no later than **1 business day** if the service is scheduled in less than 10 days.

*Estimate must be provided in “clear and understandable language.”*

## Poll Question #2

**What does your office currently do for good faith estimates?**

- 1. Use software**
- 2. In-house spreadsheets/word docs**
- 3. No current process**
- 4. Other**

# The Good Faith Estimate must include . . .

## Estimate Info

- Patient name and date of birth
- Description of the primary item or service in clear and understandable language (*and if applicable, the date the primary item or service is scheduled*)
- Items and services reasonably expected to be furnished for the period of care
- CPT codes
- ICD-10 codes
- Expected charges
- Names of providers and facilities
- Tax ID Number
- National Provider Identifier
- Estimates for any services that might be provided in conjunction with the primary service. (labwork, hospital, anesthesia) Enforcement won't be until 2023.

# Convening Provider/ Co-provider/ Co-facility

GFE

Multiple providers/ facilities in conjunction with primary service must provide a combined GFE.

1

You have no later than 1 business day after scheduling a appointment to contact co-provider/ facility about expected charge.

2023

No one has a system in place, so this will be enforced at the “discretion” of HHS until 2023.

If...

If an uninsured or self-pay individual does NOT receive a combined GFE, they may ask the convening provider/ facility to furnish one.

\*

HHS encourages including a range of expected charges for items or services expected to be provided and billed by co-providers & co-facilities.

# The Good Faith Estimate must include . . .

## Disclaimer Info

- State that the good faith estimate is an estimate and subject to change
- State that there may be additional items or services not contained in good faith estimate
- State their right to initiate the patient-provider dispute resolution process
  - And state how they can initiate this process (e.g., Call this number. . .)
- State that the good faith estimate is not a contract

# CMS Good Faith Estimate Examples

OMB Control Number [XXXX-XXXX]  
ExpirationDate [MM/DD/YYYY]

**[NAME OF PROVIDER OR FACILITY]**

**Good Faith Estimate for Health Care Items and Services**

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: ____/____/____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: <input type="checkbox"/> By mail <input type="checkbox"/> By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

1

OMB Control Number [XXXX-XXXX]  
ExpirationDate [MM/DD/YYYY]

If scheduled, list the date(s) the Primary Service or Item will be provided:

Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
<b>Total Estimated Cost: \$</b>	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are recurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

2

OMB Control Number [XXXX-XXXX]  
ExpirationDate [MM/DD/YYYY]

**[Provider/Facility 1] Estimate**

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

**Details of Services and Items for [Provider/Facility 1]**

Service/Item	Address where service/item will be provided [Street, City, State, ZIP]	Diagnosis Code [ICD code]	Service Code [Service Code Type/Service Code Number]	Quantity	Expected Cost

**Total Expected Charges from [Provider/Facility 1] \$**

Additional Health Care Provider/Facility Notes

3

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OMB Control Number [XXXX-XXXX]  
ExpirationDate [MM/DD/YYYY]

**[Provider/Facility 2] Estimate**

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

**Details of Services and Items for [Provider/Facility 2]**

Service/Item	Address where service/item will be provided [Street, City, State, ZIP]	Diagnosis Code [ICD code]	Service Code [Service Code Type/Service Code Number]	Quantity	Expected Cost

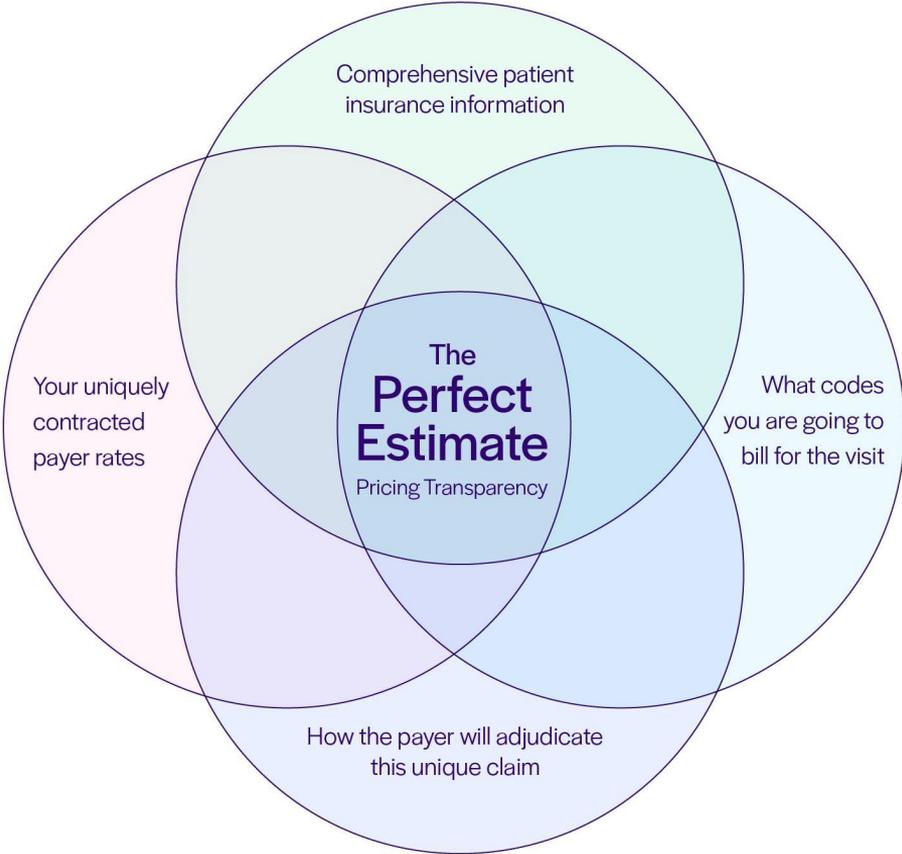
**Total Expected Charges from [Provider/Facility 2] \$**

Additional Health Care Provider/Facility Notes

4

# GFEs in Rivet

## The Necessary Ingredients to Achieve Perfect Cost Estimation



# Contacts



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