

NAVIGATING THE MAZE OF HEALTH CARE FINANCES: A REVENUE CYCLE PERSPECTIVE

The Problem

The harms of medical debt are well-documented and resonate with people nationwide, regardless of background. While medical debt [disproportionately harms some communities more than others](#), most people know a neighbor, friend, or family member contending with unaffordable medical bills. We see their stories in the media, person after person struggling with the myriad harms of medical bills—missing from the story, however, are the experiences of the workforce tasked with producing these bills and collecting revenue to keep health systems running. With their close proximity to the problem, what important insights can they provide and what role can they take in potential solutions?

Known as ‘[revenue cycle management \(RCM\)](#),’ health care medical billing workers confront long hours, manage complex contractual obligations, navigate layers of government regulation, and must keep up with an onslaught of evolving software (and now artificial intelligence, or AI) solutions. In a recent survey of health care executives, 67 percent [reported](#) an increased rate of claim denials, while 63 percent reported increased outsourcing of functions including revenue cycle. A separate [survey](#) indicates typical RCM staff turnover is anywhere between 11-40%. With such high turnover rates, existing staff must manage recurrent vacancies and onboarding new staff into a complex work environment—meaning staff are always changing, having to learn intricate systems and norms while also managing intense pressure to meet the revenue needs of health care systems. Simply put, the burden and burnout now endemic to the health care field extends from physicians, nurses, and other health care workers to the “behind the scenes” workforce critical to keeping the system functioning.

We wanted to get a fuller picture of the challenges faced by people working at every level within the health care system. After interviewing beneficiaries, we felt conversations with revenue cycle management members would provide critical detail into what happens during the billing process—what are the steps in creating a bill? Where are there opportunities for intervening before a bill becomes a debt? What are the pain points they experience? —and we are grateful to them for sharing their time. We held a total of eight conversations: five revenue cycle leaders from five different states (two non-profit hospitals, one for-profit skilled nursing facility, one large physician group, and one solo mental health practice) and three key informants (an RCM software vendor, a community-based organization, and a government regulation expert). Together, these conversations signal a need to better understand the challenges this workforce confronts and bring their perspective into the conversations about the harms of medical debt.

We need solutions that focus on implementing medical billing processes that better meet patient needs while also fulfilling revenue responsibilities. Looking forward, hospitals and health systems can take meaningful steps to support revenue cycle staff, bolster patient knowledge about cost-sharing (including through trusted community partners), and share feedback with policymakers so that reforms can be effectively managed and implemented. At the same time, there are clear steps that federal policymakers can take to improve the medical billing process while reducing the potential for medical debt—including ensuring patients have access to comprehensive, high-quality coverage that truly protects them medically and financially.

Our Findings

We identified multiple themes in our conversations, ranging from workflow to workforce challenges. RCM professionals were forthcoming with their frustrations as well as their ideas for addressing those challenges, which we explore more below.

When asked about their pain points, participants uniformly highlighted the difficulty of working with commercial insurers and navigating government requirements. Specifically, participants cited the stress of navigating insurance denials, prior authorizations, and other barriers that require manual effort to reconcile; additionally, the lack of standardized approaches across contracts and multiple software platforms leads to confusion, delays in payment, and stretch the medical billing workforce beyond capacity. Finally, in states with evolving regulatory environments focused on increasing access to financial assistance and reducing delays in access to care, there was support for capturing more eligible patients for assistance. However, leaders expressed concern about implementation and meeting

deadlines for these changes, particularly those that create new steps in the registration and discharge workflows.

When asked about the challenges patients face, participants discussed the lack of awareness and understanding of health insurance, particularly their financial responsibilities related to out-of-pocket expenses. Additionally, they highlighted the hesitancy of patients to engage with financial counselors and medical billing staff until late in the process.

Key Themes in Depth

The following key themes emerged from our conversations:

- Commercial insurers must be better collaborators.
- The shifting regulatory landscape does not fully appreciate current workforce challenges.
- There is a communication mismatch between medical billing staff and patients.
- (Under)-Insurance literacy harms patients and providers.

Commercial Insurers must be better collaborators

Every revenue cycle leader we spoke with highlighted how challenging it can be to work with commercial insurers. They see insurers as quick to deny and delay, muddying the waters and creating barriers for bill resolution. Critically, continued back and forth with insurers delays documenting a patient's balance, meaning patients must wait to get a complete understanding of what they owe after insurance is applied. Additionally, the proliferation in complexity and number of insurance contracts means medical billers are tasked with tracking differing billing deadlines and software platforms. If a medical biller is working with five different insurance companies, they are also working within five different software platforms. While most of this work is automated, medical billers spend a great deal of time manually addressing issues when claims fall through the cracks—much to the frustration of both staff and patients. Participants felt strongly that spending all their time resolving these transactional issues takes away from their capacity to work with patients struggling with affordability. Finally, they also commented on the challenges posed by changing insurance products, namely the growing shift of the [cost-sharing burden](#) onto patients. Participants highlighted how these changes lead to more patient engagement on the billing side, not less,

as well as a growing landscape of RCM products designed to “solve” for these shifts in financial responsibility. These experiences highlight how the broken health care finance system is drowning both patients and the health care workforce in administrative burden—so what should be done?

- **Commercial insurers need to be more accountable to health care providers.** When insurers deny care ([sometimes automatically](#)) or require [excessive prior authorizations](#), they create additional manual work for medical billing staff to resolve. The back and forth between billing staff and insurers is time-intensive and harmful to patients, taking away staff’s ability to work through affordability issues. As one medical billing leader for a physician group noted, “we throw just a ton of resources fighting these commercial payers...on the commercial payer side, yeah, we’re continually battling some of the larger payers, which just takes an astronomical amount of resources on our side on the back end of the process”.
- **Commercial insurers often change the requirements and systems without notification and planning, creating delays in payment and confusion.** Medical billing professionals comment that insurers are inconsistent and switch up software platforms and practices without regard to how that affects patient billing. This can lead to delays in payment and is particularly stressful for small provider groups and individual practitioners. As noted by a medical billing leader for a mental health center, “one week you’re sending claims to this address or electronic address, the next week it’s somewhere entirely different, and they’ve not notified us or anything”. While remaining nimble is important, insurers must give medical billing staff enough time to understand and adjust to changes.
- **Shifts in the health insurance landscape have made it more likely for insured patients to need financial assistance.** Traditionally, many providers did not consider that insured patients may also require financial assistance. This may be in part due to assumptions about affordability (if someone is insured they must be able to pay their bill) and the way the insurance billing process is structured. Insured patients are not typically presumptively screened at registration because there is not a self-pay balance until further down the medical billing process when insurance is applied. Data shows an [increasing number of people unable to meet their deductibles and out-of-pocket responsibilities](#) with incomes that would often make them eligible for financial assistance.

INSIGHT FROM REVENUE CYCLE LEADERS

“I think right now our health systems and our revenue cycles are taking a lot of hits on the backs of our payers and so our payers are not good friends with us... if we weren't pushing so many resources and expenses to just get money from our commercial payers, we maybe would have more resources to help our folks get on some of these charity care programs and those types of things. So, it is very costly for us.”

MEDICAL BILLING LEADER, NONPROFIT HOSPITAL

The shifting regulatory landscape does not fully appreciate current workforce challenges.

Many states are addressing medical debt through [new requirements for hospitals related to medical billing and debt collection](#). These range from changes to financial assistance eligibility standards, requiring financial assistance to be offered earlier, to creating preconditions that must be met before engaging in [extraordinary collection actions](#) (ECAs). Many of these changes are intended to tighten up broad federal standards, but operationalizing them can be challenging for medical billing staff. Our participants shared that revenue-cycle workflow can be very tight and extremely complex, and implementing regulatory changes in workflow without ample time or understanding can have deleterious effects. Culturally, revenue cycle environments are rule and performance-oriented—this culture can, at times, feel in conflict with mission-focused goals to deliver care in the context of financial assistance and affordability. Approaching these necessary changes with an understanding of the complexity of the work can go a long way in ensuring successful implementation.

- **New and changing regulatory standards require increased staff capacity at a time when the workforce is declining.** The medical billing workforce, like the clinical workforce, is stressed and struggling with burnout and high turnover. Training new staff in complex systems that require interfacing with multiple vendors is challenging and time-consuming. Each contract has a different set of requirements, data exchange platform and timeline for prior authorization, submitting claims, coding, and reimbursement. These new regulatory standards are incredibly important, and more work should be done to include revenue cycle professionals in the design and rulemaking process to make sure these changes are implemented successfully.

INSIGHT FROM REVENUE CYCLE LEADERS

“I feel like once a patient leaves a facility, it’s really difficult to track them down as is. And if you’re adding, you know an additional requirement on the billing team that’s going to become very cumbersome. And most of the RCM billing teams are already understaffed as is.”

MEDICAL BILLING LEADER, FOR PROFIT SKILLED NURSING FACILITY

- **Unclear requirements for reporting lead to barriers to accessing financial assistance.** Federal regulations ([501r](#)) alongside other cost reporting requirements can lead to different interpretations and practices, particularly as it relates to requiring an asset test for patients and patient notification about their financial assistance status. As noted by one billing leader for a nonprofit hospital, “we tried to move to a one-page Charity Care application, and we were told by our auditors we could not because these were required questions that we have to ask. So that’s what we do.” This difference in interpretation and practice also means a patient may find themselves declared eligible for financial assistance at one provider, while they’re denied at the provider down the street.
- **The shifting regulatory environment and lack of clarity around implementation has led to the growth of RCM products—many of which muddy the financial assistance eligibility process and shift the burden to patients.** The RCM leaders we spoke with noted these software tools may include screening criteria that are unnecessary in screening for financial assistance eligibility. Including criteria like [propensity to pay](#) (assessing someone’s credit footprint and likelihood of making payments) means these tools may be used inappropriately and unfairly deny someone financial assistance. The sole criteria when screening for financial assistance eligibility should be income. Ultimately these RCM tools are designed for multiple purposes, including for use in the debt collection process and if not adjusted, may not be well-suited to screening for financial assistance eligibility. Further, all informants highlighted the shift in the health insurance landscape that challenges traditional pathways for financial assistance.

There is a communication mismatch between medical billing staff and patients.

When asked specifically about barriers to financial assistance, leaders commented that they felt they were doing their best to communicate the availability of financial assistance but that some patients were reluctant to pursue it or avoided any conversation about financial responsibility. Non-hospital revenue cycle professionals noted they have generous financial assistance for patients when they reach out to call centers. [Federal law requires](#) nonprofit hospitals to offer a financial assistance policy but leaves the details of that policy up to the individual hospital; many for-profit hospitals also offer financial assistance. Physician groups have their own approach to financial assistance that is voluntary and varies. From the medical billing staff perspective, financial assistance opportunities exist and are plentiful, but patients do not know about or will not engage with them. While for revenue cycle staff this is something they encounter daily, it is [not a typical experience for the patient](#) who may be under duress and confused about their financial responsibility and/or their eligibility for financial help. Closing this communication gap is core to any work on medical debt.

- **Hospital financial assistance is available, but many patients are apprehensive about forms or think the assistance is not for them.** Leaders communicated frustration that more patients do not pursue financial assistance when unable to pay; additionally, when patients are approached, they are hesitant to share needed information to access financial assistance for which they are eligible. One billing leader for a nonprofit hospital commented, “we have it all over the place but a lot of times it’s we have a patient that’s getting to their fourth or fifth statement and we’re getting ready to send them to collections and then that’s when we get them to actually call us up and say, ‘Hey, wait a minute. You’re sending me to collections. Don’t do that.’ Or we’ve already sent them to collections, and now they’re calling us up and you know, so we make attempts, we try to call these patients and try to work with them, but we need to get them to engage with us. And they don’t often do that.”
- **For financial help with physician bills, patients need to reach out.** The patient must take the initiative if they are unable to pay their bills. Of those interviewed, hospitals were the only settings that presumptively screen for financial assistance. As one physician group leader noted, “it’s listed all over our patient statements. So, it’s clearly in black and white on the very front of the patient statement. You know, if you need any assistance, financial assistance, whatever type of assistance, please call us and then we just walk through the process with them.”

INSIGHT FROM REVENUE CYCLE LEADERS

“When I was younger, and I was first having to break the bad news to people about their bills and deductibles and people would come at me and they’d come at me like I was a debt collector and that I was ruining their life. And as a young person, I would get my back up. And I really was like, I’d push back and be like, “Well, you owe this.” And then I learned the hard way that I have to approach these clients completely different and because then they’d get angry and they wouldn’t pay, or they’d complain to their clinician and you know, I was getting made to feel like I was a monster. And I was like, I don’t want to do this. But then when I shifted to a more gentler approach and more of an educating approach instead of just saying, “you owe this.” And this is why, I kind of, you know, apologize for the system while I’m talking to people and I’m like, “I’m really sorry that it is like this. But you know this is how it works and unfortunately your provider is a person in business, and this is their livelihood.” So, you know, I just tried to take a more sympathetic approach rather than, like, people would come at me angry, and I’d go back angry too. This is like, you know, 15 years ago. Now, if they’re angry, I just turn the other way and say, “I understand this, this does suck.”

MEDICAL BILLING LEADER, SOLO PRACTITIONER/MENTAL HEALTH CLINIC

Key informants further illustrate the disconnect in patient communication. Community-based partners are often frustrated with a lack of response and ease in ushering eligible people into financial assistance programs. There is a general perception that these programs are intentionally hidden from view and are difficult to access. These barriers include burdensome applications that require unnecessary information requests, lack of online applications, low eligibility thresholds, and excluded services/physicians. A community based-organization informant commented, “FAP documentation is burdensome. It’s a lot to put on a patient that might not be medically literate.”

Insurance complexity harms patients and providers

All revenue cycle leaders commented on the increasing trend of high deductible health plans (HDHPs). Data continues to show that patients are struggling with self-pay balances, especially when their responsibility is over \$500. According to [Kodiak Solutions](#), hospitals, health systems and physicians are collecting just under half (47.6%) what patients owe them. Importantly, 53% of provider bad debt in 2023 was from patients with some form of health insurance.

- **For solo provider medical billers, a pain point is the collection of out-of-pocket costs that are unexpected for patients.** One participant highlighted that patients were largely unaware of how their insurance worked and when billed for high out-of-pocket costs (deductibles, etc.), would be overwhelmed and frustrated. This participant at times had to include the clinician in bill collection efforts because the collection of funds was so closely tied to provider income. Small and solo practitioners are particularly vulnerable and exposed to risk when insurance plans are unaffordable. The participant noted, “with the deductibles and cost sharing, it’s the insurance companies’ way of dumping the bad debt onto the clinicians, which (for) a private practice clinician, that’s their livelihood, that hurts them.”

INSIGHT FROM REVENUE CYCLE LEADERS

“The uptick in out-of-pocket costs going to the client is ridiculous...I’m seeing deductibles that were last year \$1,500 to \$2,000, now jumped to \$4,000. And for a client to meet that with strictly mental health treatment is pretty tough. So, then you end up basically being a cash-pay client when you think you’re going through your insurance, but your insurance is like, well, “no, this is how it’s going to be. You’re going to have to pay this much out of pocket.” And I find that the biggest complaint that I have about it from a patient perspective is they’re not educated about how deductibles work.”

MEDICAL BILLING LEADER, SOLO PRACTITIONERS/MENTAL HEALTH CENTER

- **Patient literacy is lacking. Many patients are angry at the provider for their high out-of-pocket expenses that they did not fully anticipate as part of their insurance plan.** Health insurance is intensely complex, with each plan seemingly having numerous loopholes for what is and isn’t covered. Additionally, more and more people are [enrolling in high deductible health plans](#), many of whom are unaware of the extent of the financial risk they’re taking on. One participant commented that regardless of health plan, patients do not understand how the various financial responsibilities interact or don’t, leaving people frustrated that they are paying premiums, deductibles, co-pays and co-insurance all at the same time. “It is baffling for anyone even if you have a PhD,” commented a regulatory expert.

INSIGHT FROM REVENUE CYCLE LEADERS

“It’s awful. And, you know, people come back, come at me very angry. You know, I’m the person that they think well, you billed me. You’re supposed to bill my insurance. Well, I’m sorry to say I did bill, your insurance and then a lot of times they really like—I struggled for years at how to explain how deductibles work into like plain English.”

MEDICAL BILLING LEADER, SOLO PRACTITIONERS/MENTAL HEALTH CENTER

What Can I Do?

Hospitals are designed to improve people’s health. While they cannot solve every financial challenge for every patient, they can take steps to mitigate as much harm as possible. Doing things like working to ensure they’re providing patient-friendly financing options, conducting warm hand-offs to social service supports who can address other needs, and creating a safe environment to ask about financial assistance are all steps that will help tamp down patient fears about medical bills. Ultimately, the medical billing process is fraught with complexity for both patient and provider—billing departments face high [staff turnover rates](#) and are burdened with an [increasing volume of insurance denials](#), while patients [make difficult sacrifices or avoid needed care altogether](#) in an effort to avoid medical debt. There are opportunities, however, to streamline some of these functions and improve patient quality of care while better-aligning medical billing with with social determinants of health (SDOH) organizational strategies.

Hospitals Should Consider

We offer a non-exhaustive list of potential solutions for hospitals below. We recognize that hospitals and providers are stretched thin in providing care to their communities while also balancing their financial needs and other administrative burdens; these solutions are designed to be “win-wins” for everyone, as they help reduce unnecessary administrative burdens while creating a healthier, more collaborative environment for the patient-provider relationship. These potential solutions include:

- Hospitals working with federal regulators to address the high rates of insurance denials while enforcing prior authorization timelines to protect patients from long waits for care. Additionally, hospitals could collectively pressure CMS to enforce standardizing the billing process from coding to timelines for claims.

- Health systems reviewing their revenue cycle workforce capacity—including gauging their level of burnout and ideas for solutions. This feedback should be used to develop a plan of action for addressing challenges. For this to be successful, health systems must focus on creating a safe environment for staff feedback.
- Hospitals creating space for cross-departmental collaboration that supports mission alignment, including ‘connecting the dots’ on social determinants of health and health equity initiatives. Additionally, cross-training staff within the billing department can make staff nimble when clogs in the workflow create administrative burden.
- Simplifying financial assistance to reduce burden on medical billers and patients. Hospitals should revise their financial assistance policy to include insured people in eligibility criteria, especially for people earning below 400% FPL. Additionally, they should remove asset tests from applications as they are a barrier to people applying.
- Reaching out to CMS to clarify that asset tests are not necessary for cost reporting and other audit requirements.
- Hospitals investing in additional counselors to support insurance literacy and investing in community-based efforts to raise awareness and support campaigns that support individuals in plan selection. Accessing comprehensive insurance remains a challenge for many low and moderate-income people; hospitals can be allies in building awareness about being inadequately insured.
- Limiting the outsourcing of revenue cycle staff. Patients and community partners both noted feeling like they don’t have in-person connection with billing staff—ensuring there are some staff available at the facility is critical when patients are navigating care and complex financial assistance pathways. Additionally, consideration should be given to person-centered training for medical billing staff; medical billing professionals work day in and day out within these complex systems and it can be difficult to remember that is often not the case for patients. Helping medical billing professionals remember that context may help reduce burnout and create a more collaborative relationship between patient and staff.

It should be noted the health care financing system cannot be fixed by hospitals and providers alone—Congress must also address the issue of underinsurance and complexity. This includes funding health navigators, community health workers, and financial counselors to help with health insurance literacy in both selection and use of plans. Importantly, Congress must address the affordability of ACA plans, employer-sponsored insurance, and expand Medicaid in all states.

The work for affordable and comprehensive coverage includes improving benefit design, eliminating junk plans that mislead patients into thinking they have coverage and ensuring that patient networks are broad and accessible. It is paramount that Congress and the Administration take steps to simplify coverage and reduce out-of-pocket costs. This work includes but is not limited to:

- Implementing changes to short-term limited duration plans, known as junk plans, is essential as is ensuring the benefits plans include are comprehensive and easy to access without loopholes that exclude medically necessary services and pharmaceuticals.
- Simplifying out-of-pocket costs is important in reducing the administrative burden for both the patient and medical billing teams. One helpful change in addition to reducing deductibles would be the elimination of coinsurance; coinsurance is costly for patients and opaque. Additionally, Congress must protect low- and moderate-income workers from high deductible health plans (HDHP) that leave them exposed to high out-of-pocket costs.
- Finally, the Administration should launch a federal task force to study ways to simplify and standardize the actions that insurers take before paying claims that will reduce the administrative burden for patients and medical billing staff.

Methodology

Participants were asked questions designed to explore their experiences leading revenue cycle teams and their staff's experiences, with a focus on financial assistance. We asked participants about the pain points along the medical billing process and administering assistance. A round table setting allowed participants to react to one another's experiences and build on key themes. We then analyzed round table transcripts for overarching themes. In addition, we asked key informants in 1:1 conversations about the medical billing process for additional perspective. We are deeply grateful to our participants for their willingness to share their work experience and hope this brief helps continue a productive conversation around eliminating medical debt and improving access to care.