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healthcare financial management association



Revenue Cycle Strategies and Technologies for Serving the Uninsured

The numbers are all too familiar: More than 46 million people lack health insurance, a number that has increased by more than 7 million since 2000, according to most recent Census figures.¹

Another 16 million people in the United States are underinsured and therefore cannot protect themselves against catastrophic healthcare expenses.² And a recent survey by *Consumer Reports* concluded that 24 percent of the U.S. population has health insurance coverage that only marginally covers their healthcare needs.³

It should therefore come as no surprise that hospitals are seeing increasing levels of self-pay activity and greater needs to provide uncompensated care.

What do such dynamics mean for today's hospital leaders?

Many healthcare executives need to take a fresh look at core concepts of charity care and bad debt and explore revenue cycle processes and technologies to better serve the needs of those without coverage or who lack adequate coverage.

Increasingly, hospitals are shifting from a self-pay management style that was concentrated on the back end of the revenue cycle to a more proactive front-end stance. They are reviewing and updating their charity care policies to be sure they are identifying all patients who could be eligible for charity care and are strictly following these policies. Hospitals also are rethinking essential processes related to the front-end revenue cycle management of self-pay and charity care patients, and they are looking to optimize handling of early-out collections.

To provide guidance in these areas, HFMA presents the following discussion, sponsored by National Patient Account Services (NPAS) and SearchAmerica. The discussion highlights themes presented at More Margin for Your Mission, an educational event held by NPAS and SearchAmerica in May 2008, which explored strategies and technologies for optimizing payment and account resolution for self-pay patients and those eligible for charity care.

Speakers

Shari Bailey, vice president of Verité Healthcare Consulting, Hamilton, Ohio.

Cindy Price, chief operating officer for HCA-Shared Services, Houston, Texas.

Steven G. Johnson, chief technology officer and vice president for product development, SearchAmerica, Maple Grove, Minn.

Joe Shutts, chief operating officer of National Patient Account Services, Louisville, Ky.

Garett Jackson, CFO of HCA National Patient Account Services, Louisville, Ky.

Changing Service Needs

Demands on technology, process, and staff resulting from increasing numbers within the self-pay population, including both uninsured and underinsured patients, are forcing hospitals to improve their management of self-pay accounts receivable. Just some of the trends affecting financial service delivery include:

Growing use of HSAs. The rise of health savings accounts (HSAs) is prompting hospitals to modify registration, collections at the time of service, and billing and collections. HSAs complicate the management of accounts receivable in several ways: not providing clear guidance about whether a portion of payment may be collected at the time of service, shifting more of the responsibility for payment to the patient, offering different ways of paying claims, and reducing the amount of money that is available for prompt payment.⁴

Of 2.5 million health reimbursement accounts in 2005, 1 million were HSAs.⁵ In 2006, the proportion of employees in private industry who had access to an HSA was 6 percent,⁶ and according to the Foundation for Agency Management Excellence, up to 32 percent of employees were expected to add an HSA to their benefits in that year.⁷

Increased importance of charity care determination. Also fundamental for addressing uninsured and underinsured patient populations is the careful delineation of charity care from bad debt. Charity care consumes resources and—given rising demand and public scrutiny—must be managed ever more wisely. Hospitals therefore need to know what portion of patients qualify for charity care because of an inability to pay and what portion may be classified as bad debt because of an unwillingness to pay. What's more, high levels of bad debt can lead to lower cash flow from operations and affect credit ratings, thus affecting the hospital's ability to serve its community. Therefore, it is imperative for hospitals to review and determine whether patients qualify under charity care guidelines or have access to third-party sources such as Medicaid.

Following standard practice five years ago, hospitals would identify charity care on the basis of information supplied by the patient. That process is cumbersome and time-consuming, however, because in most cases, patients do not provide the information promptly. As a result, pending accounts often would remain in accounts receivable for 60 to 120 days. In the meantime, patients without the ability to pay would continue to be billed, unnecessarily utilizing hospital resources and increasing the potential for poor community relations. If charity care patients are identified at the time of service, collection activities are more productive and better targeted.

"HFMA's Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Care Providers" helps hospitals streamline the charity care process.⁸ The statement allows hospitals to use external sources, such as credit reports, to validate that a patient may be classified for charity care and to verify data "to the extent practical." Many facilities have rigorous

procedures for determining which patients qualify for charity care. However, the statement, among various provisions, notes that a *single element* of information may be enough to make a *reasonable* determination of eligibility. The determination of charity care does not need to be so extensive that it eats up resources that could be used more productively to serve patients.

By singling out patients who are eligible for charity care at the time of service, a 22-hospital system in Ohio improved early-out collections by \$1.3 million. The system also sent 30 percent fewer accounts to debt service because it was better able to distinguish patients who had the ability to pay from those who did not.

Greater receivables volume and sensitivity regarding collections. When it comes to healthcare receivables, money later—if at all—is more and more often the case. According to the American Hospital Association, uncompensated care (including bad debt and charity) cost U.S. hospitals \$31.2 billion in 2006, representing 5.7 percent of annual hospital expenses, and an 8 percent increase from uncompensated care costs in 2005.⁹ What's more, the problem is only expected to worsen. The growing uninsured population as well as increases in deductibles, copayments, and coinsurance among policyholders are the primary causes for the increase in bad debt and why it's likely to continue to grow as healthcare costs continue to shift to the consumer.

At the same time, scrutiny is increasing on hospital's billing and collection practices. Three congressional committees have been investigating the billing and collection practices of hospitals, including the U.S. House of Representatives Energy and Commerce Subcommittee on Oversight and Investigations, which is focusing public attention on hospital charity care policies, hospital debt collection practices, the relationship between hospital charges and costs, and the public disclosure of hospital charges. In Illinois, the Attorney General and other groups have explored issues related to "price gouging" and "aggressive collection practices" aimed at the uninsured and suggested that hospitals have unwritten as well as written policies concerning billing and collections and that their policies are not applied consistently.¹⁰

Technologies for Addressing Self-Pay and Charity Care

Many hospitals are seeking technology solutions to address these changing service needs. Tools are available to help assess the ability of a patient to pay and automate charity care determination as well as third-party program eligibility. Functions hospitals are pursuing include:

Payment responsibility estimation. These tools respond to the need to learn not only if an insured patient has a deductible but

exactly what the level of the deductible is. Depending on the particular technology, payment responsibility estimation tools can be used to calculate what the patient will owe based on payer-specific contract rules and discounts, obtain benefit information about the remaining deductible, and create a patient-specific estimate that presents all underlying assumptions as well as caveats concerning contingencies, such as complications. Such abilities are increasingly important as individuals, particularly those participating in HSAs, are shouldering significantly higher deductibles than has been traditionally seen and are seeking competitive pricing information among hospitals.

Payment assessment. Payment assessment technology is designed to determine as early as possible whether a patient is able to pay his or her bill as well as how much the patient is likely to owe out of pocket. Such abilities are important for efficient point-of-service collections. Collection efforts on the back end are less effective and prolong the payment process.

In the ideal situation, the hospital and the patient will know during preregistration what the eventual out-of-pocket costs will be. Some technologies will also segment workflow by the likelihood of payment. A patient who is highly likely to pay will go through the normal billing cycle, for example. A patient who is moderately likely to pay will undergo focused collections, and one who is least likely to pay will be screened for Medicaid or charity care eligibility. Even more advanced segmentation strategies combine the probability of collection with the amount of the balance. (See "Using Credit Scoring to Segment Workflow" on page 7.)

Although a nine-hospital healthcare system in Illinois had a point-of-service collections process in place, it did not differentiate workflow based on the likelihood of payment. After instituting patient assessment technology, the hospital increased the average payment by 25 percent from patients highly likely to pay and by 20 percent from patients moderately likely to pay. The hospital also significantly reduced the effort directed at receiving payment from low-likelihood accounts, which saved resources.

Automated program screening. Screening and enrollment for third-party payment programs such as Medicaid, the State Children's Health Insurance Program, Healthy Families, Victims of Crime, and others are often time-consuming (taking as long as 90 days to determine eligibility) and have complex rules and requirements. Identifying patients as potential candidates for these programs is complicated by difficulty verifying the financial situation of the patient.

Automated program screening technology can, however, help identify likely program candidates at the point of registration or during preregistration and aid in preparation of paperwork.

Depending on the technology, such systems can use information from credit reports to substantiate a patient's income level, household size, and assets; screen to ascertain program eligibility; and prepopulate program applications. As a result, such technology can be useful to increase the efficiency of screening and enrolling patients eligible for aid programs.

Many patients seen in a large university hospital did not know if they were eligible for a healthcare financial assistance program because the state required patients to meet complex income and other eligibility requirements. Using an automated program screening tool, the hospital prepopulated and printed out application forms that incorporated the state's unique Medicaid requirements and accelerated Medicaid program approval by the state. The hospital also decreased the time and effort needed to qualify patients for Medicaid, and it automatically placed ineligible patients in the charity workflow process.

Automated charity care process. Hospitals are under intensified pressure to make their charity care policies straightforward, non-discriminatory, and transparent. Yet they are hampered by having to rely on patients for providing the necessary information, single out potential charity care cases early in the registration process, and eliminate or streamline time-consuming manual screening and enrollment. Automating the charity care process can allow the hospital to flag candidates for charity care during registration or preregistration. At the same time, automated tools are designed to verify the patient's income, household size, and assets and plug in the relevant items of information in the hospital's charity care application. Depending on the technology, these tools also can automatically calculate the number of patients who are approved for charity care as well as the appropriate discount, and they can help in monitoring the operation of the charity care program.

A five-hospital system in the Southeast was not able to include many deserving patients in its charity care program because patients were not able to meet paperwork requirements, including corroborating documentation such as pay stubs and income tax forms. By using industry source data to substantiate a patient's financial status, an automated charity care tool tripled the number of patients enrolled in charity care, dropped bad debt by 50 percent, and cut the time spent in charity care enrollment by more than half.

Reporting and analysis. Automated tools can simplify the complexity of the information collected about uninsured and underinsured patients so hospitals can monitor the revenue cycle,

analyze the workflow involved in clearing accounts, and measure progress toward goals. Reporting and analysis technologies provide a mechanism to track key performance indicators (KPI) and compare them to established targets so hospitals can incorporate predictive values in budgeting and measure return from investments in collections operations, such as focused collections.

Reporting and analysis systems can create KPI dashboards that compare actual versus target performance of collections management over time, such as the percentage of bad debt, to show how quickly bad debt is declining, how long accounts remain uncollected compared with the budget or predictions, and how many patients are receiving charity care each quarter or each month. Depending on the system, specific operations dashboards can show on a monthly and year-to-date basis how well the hospital is collecting payment from patients who are classified as highly likely to pay and how many patients are being approved for charity care. Scorecards can compare monthly performance against targets for patient accounting, revenue cycle outcomes (e.g., gross and net revenue, the percentage of net/gross revenue, cash collections and the percentage of cash/net revenue, and days of revenue outstanding) and patient registration (e.g., number of patient visits, accuracy of registration, and percentage of financial clearance). Scorecards also can illustrate performance by the type of patient account. For self-pay patients, the scorecards report the percentage of self-pay visits, net revenue from self-pay patients, and self-pay days of revenue outstanding. For charity care patients, they can report the total in charity care write-offs and the percentage of charity care/gross revenue.

Optimizing Front-End Self-Pay Processes

As described, integrated front-end eligibility software at the point of registration can be key for classifying patients upfront on the basis of their ability to pay. The registrar can then immediately determine the nature and amount of any copayment or deductible requirements or begin the application process for Medicaid or charity care and applicable financial aid programs.

Technology isn't enough, however. It's also important to have strong processes in place to monitor performance and resolve challenges as needed. A bad debt committee should be formed and meet weekly to review key self-pay management metrics, identify trends in how self-pay accounts are being handled, and develop associated strategies to improve front-end processes. Regular attendance should be requested of the CEO, CFO, chief nursing officer, case management director, patient access director, emergency department director, and the third-party eligibility vendor. Case management of self-pay should be as important as that of Medicare, Medicaid, or any other payer.

Among the metrics that should be examined are:

- › Front-end collection failures per registration. Registrars should be required to code why they did not collect cash up front so patient accounts directors can localize problems, such as patients who are not being appropriately routed in the emergency department.
- › Third-party eligibility conversion rate. The third-party eligibility conversion rate is used to detect the variables associated with a drop in an inpatient conversion rate.
- › Performance by financial class. A self-pay dashboard report by financial class can be used to examine collection efforts. For example, which collection efforts took place in each financial class or the actual success rate achieved for each financial class.
- › Emergency department screening performance. Important data include the number of patients who were not in need of emergency or urgent care, how many patients had a medical screening examination, how many patients were asked for payment, and how many patients stayed to receive payment.

While such activities require significant commitment of time and resources, many hospitals are finding them well worth the effort. Identifying opportunities to better determine and communicate appropriate patient financial responsibility at time of service improves the organization's ability to collect. The longer a hospital waits to collect, the more money it must spend on pursuit of follow-up correspondence and collection activities and the less likely the patient will be to pay as the bill is no longer top of mind. What's more, collection efforts on the back end prolong the payment process.

HFMA's benchmark conversion rate for self-pay copayments and deductibles in 0 to 30 days is 50 percent. A large centralized business office (CBO) in the Southwest with approximately 25 hospitals was only able to reach a conversion rate of 46 percent. The CBO instituted a medical screening and exam services program for its emergency departments (EDs). It began triaging all patients arriving in the ED as immediate or emergent, urgent or nonemergent, or nonurgent based on a nurse's examination. After a secondary screening to ensure accuracy, the patient is routed based on the severity of illness. Patients who are nonemergent and nonurgent within certain age limits are sent to the registration department for financial counseling. Those without insurance are screened using an automated front-end eligibility system to determine their qualification for charity or Medicaid. Those who do not qualify are asked for a facility fee before they receive further assistance. Those who do not pay are released to home. About 40 percent of the patients in the hospital's EDs are nonemergent or nonurgent, and 15 percent elect to stay for treatment. The program has been accepted by the state's department of insurance.

Internally Managing Back-End Collections

So what can hospitals do to improve the collection process when it reaches the back end? For both front- and back-end collections processes, generating economies of scale provides the largest opportunity to maximize performance. Use of a centralized business office (CBO) is a common approach to doing this. (Note that some hospitals may not be able to amass the needed volume, and should explore other options of optimization, such as outsourcing.) In most cases, the CBO or an external early-out agency will follow the same best practices mentioned below. Opportunities often arise in finding the right people, developing appropriate incentives for them by setting clear productivity and quality standards, and supporting them with communications and workflow tools.

Hiring and motivating CSPs. In the past, CBOs and hospitals primarily have looked for experienced individuals to take positions as customer service professionals (CSPs), agents, or collectors for the back office. However, these CBOs did not often find employees who were motivated or predisposed to do this type of work.

Many CBOs are now using interviewing guidelines that prescreen or test for behavioral characteristics to discover employees who will thrive in an environment like the back office. While these individuals need to be comfortable with structure and set goals, they also must have an aptitude for navigating the ever-changing social dynamics that come with dealing with the public. CBOs further motivate such individuals with training that emphasizes the value of the work they are doing and how their work fosters the overall mission and operation of the hospital and the delivery of patient care.

Successful CBOs are providing CSPs with feedback on their performance in real time, daily, or at least weekly, and they are holding supervisors and team leaders to the same metrics so all team members are focused on the same goals. Incentives should be easily understandable, measurable, and calculated. In most organizations, high-level KPIs or goals focus on global concerns such as cash, cost, compliance, and customer service. Measurements for CSPs are more granular and typically involve average payment size, amount of cash collected per scheduled hour, quality, and other factors that support the global goals. Measurements typically are weighted to balance efficiency and effectiveness.

Training CSPs. Dedicated training resources should aim to get new employees off to a successful start from the outset. Formal classroom instruction should teach employees how they will be expected to do their jobs. Many CBOs also provide trainees with side-by-side exposure to seasoned CSPs on the job so they can better learn how to hasten the management of an account as well as how to use scripting correctly. Trainees also may pick up bad habits, however. Upfront training should therefore concentrate on the essential aspects of the work and how it should be done.

Because the amount of cash collected is the principal way CSPs are graded, training should focus on negotiation techniques targeted at dealing with recalcitrant individuals and obtaining sensitive information, such as personal financial information, to close an account. Continuous coaching by supervisors should reinforce the principles taught in formal class training.

Measuring CSP productivity. Successful organizations provide CSPs with a set of standards they should be able to meet, such as the average number of accounts they are expected to work per day, the average cash they should be able to generate for each hour, the average balance size they collect per account, and the length of time they spend on the phone. These metrics are used not only by CSPs to keep themselves motivated and on track, but also by the CBO to track back-office performance. Efficiency measurements should include the percentage to goal for accounts worked and the conversion rate of promises for payment into cash (promises kept). Effectiveness measurements should include the average collection per scheduled hour and the average payment size.

Equally important is routine assessment of CSP time performing the collection task versus nonproductive time, such as vacation days, length and number of breaks (particularly unscheduled ones), and the length of time spent in such activities as training or quality reviews. The objective is to determine if back-office operations are running smoothly.

Measuring CSP quality. How CSPs perform their duties is just as important as what they do. Assessing quality involves listening to CSPs on the phone to monitor and provide feedback about performance. The quality of CSP calls typically is compared with a standard format based on the segmentation of the account, the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, and essential business steps that must be taken in the management of each account. A quality scorecard should be used to document critical error points made during a call, and the scorecard should be reviewed every month with each CSP. In addition, an audit of all back-office processes should be done regularly (quarterly, yearly, or semiannually) to uncover and improve any defects in departmental performance.



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Balanced scorecards track CSPs' performance in keeping with established incentives. A typical scorecard documents the percent to goal for accounts worked, percentage of promises kept, dollars collected per scheduled hour, and average collection size. It sets a minimum performance level for each of these efficiency and effectiveness measures and awards bonus payouts for performance excellence. Balanced scorecards for each unit present each of the above statistics as well as a unit performance index (UPI). The UPI can be set up similarly to the gross domestic product index where the later months are compared with the average, and each unit should strive to be above 1.000.

Supporting productivity. Automated telecommunications systems streamline back-office operations. A predictive dialer can be expensive and therefore may not be an option for smaller hospitals or CBOs. However, such technology allows CSPs to decrease their dialing time so they can spend more time talking. In addition, integrated voice response can automate call handling, which reduces the need for CSPs to complete simple tasks. Inbound call routing can identify callers based on the phone number or type of account and route calls to a CSP who is specially trained in handling the type of account. Call recording permits quality assessment of phone calls as well as a mechanism to report and validate customer complaints.

Automated workflow systems also can be useful. Functions may include providing workflow processes that change in response to "event drivers," displaying segmentation on the basis of the type of account, and measuring aging on the basis of the number of days since the last action was taken.

Many CBO employees are not used to having their performance measured at great length. However, a large hospital system's business office with more than 15,000 employees implemented comprehensive performance metrics in its self-pay early-out agency, which has about 600 employees. All of the business offices are required to take an annual employee satisfaction survey, and results are compared. The early-out agency was ranked the highest of 10 regional service centers despite the rigorous quality and measurement systems, indicating that staff will adapt and possibly thrive in a culture with minimally subjective performance criteria.

Outsourcing Early-Out Collections

While most hospitals manage the back office on their own, some are turning to vendors to act as an extended business office and handle early-out collections through letters, contacts, and rebilling. The decision to outsource often is partially driven by the desire to gain economies of scale and partially by the technology investments that may be necessary to properly execute the organization's strategy.

The phrase “champion-challenge” is commonly thought of in relation to Six Sigma organizations. The goal is to compare the current process “champion” with a new process “challenger” using statistically valid samples representative of the overall population. An early-out champion-challenge process took place in two centralized business offices (CBOs) comprising approximately 48 hospitals. An internal early-out agency was challenged by submitting 20 percent of the accounts from the 48 hospitals to a nationally recognized external vendor. The results after 12 months showed that the internal process provided 40 percent more netback per self-pay account than the external vendor. The CBOs have kept the challenger process in place and switch vendors regularly to ensure the internal champion continues to provide the service at a reasonable price with high netback.

Before pursuing such an option, the hospital should, of course, be sure external assistance is truly the most cost-effective and value-driven option. The hospital should determine the direct and indirect costs it incurs in early-out collections (for example, salaries and benefits for collections staff, credit scoring and screening resources, and communications) as well as the netback results of its efforts. The netback from early-out collections is calculated by dividing the total net cash obtained (less total direct

and indirect costs) by the gross balance (less adjustments and recalls). Also, a hospital should carefully compare netback per account statistics as well as other performance indicators from several vendors. Successful vendors are those that can get a better rate of netback per account than the hospital can internally or competitors.

It's also key to examine vendors' service policies and the structures in place to ensure these policies are followed. Collection vendors work on behalf of the hospital, and therefore they must have a clear customer-service focus and support and represent the hospital's mission whenever communicating with patients or their guarantors.

In terms of comparing capabilities, many hospitals are looking for vendors that can provide comprehensive reporting and analysis. The early-out collections vendor should provide information that helps a hospital identify gaps in the internal process, such as inaccurate addresses or phone numbers and the age of placement, and details about the overall portfolio (for example, balance size, patient type, financial class, and credit score). Above all, the vendor should give hospitals the kinds of information that will help them assess the vendor's performance, including work effort. The vendor, after all, is managing a portion of the hospital's business. The hospital should not have to manage the vendor's business.

Using Credit Scoring to Segment Workflow

For a scoring system to succeed, a hospital must decide how it will use credit scores to change collection workflow and which accounts will be scored, what will happen to the FTEs who had been managing the accounts, and how it will present the program to the board of directors for approval. (Note that credit score is not a FICO score, but rather a healthcare-specific credit score indicating likelihood for payment of healthcare debt.)

Balance size is a key driver of collection performance, because as balance size increases, the recovery rate decreases. Experience shows recovery rate often drops from about 35 percent to less than 15 percent when the balance increases from \$50 to \$200-\$300 for self-pay patients. The recovery rate also drops markedly as the age of the account rises and in relation to incorrect initial information. Recovery for organizations may be more than 50 percent within 0 to 30 days but less than 30 percent at 151 days. Similarly, recovery has been shown to drop from 45 percent or 50 percent to around 10 percent when an address or phone number is incorrect.

Recovery also declines in relation to credit-scoring ranges. A NPAS proprietary study shows that while more than 77 percent

of cash in high credit-scoring ranges is recovered on average, the number for low-scoring accounts is only about 7 percent. For self-pay patients, 40 percent of which have low credit scores, the rate of recovery was only slightly more than 3 percent. More work will not necessarily improve recovery rates for these self-pay accounts. In comparison with accounts that have credit scores of 900 or higher, the recovery rate drops by 42 percent for accounts with a credit score between 601 and 700 even though the number of units of work is the same. Thus, credit-scoring segmentation allows hospitals to reduce work effort and maintain or increase netback.

Note that in the future, hospitals may score accounts and value inventory including their allowances for bad debt, rather than applying a hindsight adjustment for bad debt write-offs. Medicare will not allow hospitals to charge off Medicare bad debt while there is any active or passive (secondary agency) collection activity. Hospitals therefore may be best served by using a scoring method to earmark low credit-scoring accounts as bad debt write-offs but continuing to work high credit-scoring accounts across all payers.

Technology capabilities also should be considered. At the least, an early-out collections vendor should have a two-way electronic interface into the hospital's patient accounting system. It should be able to display the productivity of CSPs, and it should have a mechanism for sending calls to a facility for review so the hospital can be sure the vendor is meeting customer service and mission standards.

Positioning for Success

The growing shift of financial responsibility to the consumer—whether due to lack of insurance or increases in deductibles, copays, and coinsurance among policyholders—is creating a need for hospitals to focus greater attention on self-pay functions of the revenue cycle and means for determining charity care eligibility. Fitch Ratings recently identified bad debt expense and accounts receivable reserving methodologies as among the most important issues for for-profit hospitals.¹¹

Endnotes

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As financial pressures continue to build and bad debt becomes harder to simply write off, those hospitals best positioned for success will have solid self-pay management processes in place that are strongly supported by technology and appropriately trained staff. Key will be focusing on front-end efforts to estimate and communicate patient financial responsibility, reviewing and updating charity care processes, and optimizing the handling of early-out collections.



National Patient Account Services (NPAS) is a division of HCA Healthcare that is recognized as one of the largest providers of early-out collection services in the hospital and surgery center industry. Established in 1980, NPAS serves over 200 hospitals in 25 states providing the highest netback possible for its clients. With more than \$5 billion in annual placements and 600 highly trained professionals, NPAS has been recognized for two years running as a "Best Places to Work" in their community, while providing award-winning customer service to hospital patients and guarantors. To discover how NPAS' expertise can seamlessly fit into your revenue cycle strategy, go to www.npasweb.com or call 866-882-3582.



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