

Patient Payment Responsibility: Real-World Perspectives

As patients continue to shoulder greater financial responsibility for their health care, the desire for meaningful pricing information is increasing. Although transparency of a hospital's charges can be useful, it also frequently fails to reflect what is top of mind for the patient—out-of-pocket expense. In this HFMA Executive Roundtable, sponsored by Emdeon, financial executives share their thoughts on effective strategies for determining and communicating patient payment responsibility prior to service, with particular focus on practical challenges as well as opportunities.

What are some of the benefits associated with providing estimates of payment responsibility prior to service?

Phillip Hardin: Growing numbers of uninsured or underinsured and trends toward high deductibles mean consumers are more concerned these days regarding cost burdens associated with their health care. Providers are facing increased requests from patients to understand their fee structures, particularly as self-pay patients seek the best value among competitors. Given this retail environment, it becomes important for providers to not only communicate potential financial responsibility prior to service but also ensure this communication is consistent.

Setting payment expectations from the outset with patients is increasingly necessary to improve collections. If you look at most hospitals, typically the self-pay component may be only 5 percent to 6 percent of total net revenue, but it's driving 16 percent to 17 percent of the outstanding accounts receivable, resulting in self-pay having a disproportional impact on the cash flows and financial performance of the facility.

Patrick O'Connor: From a customer service standpoint, reducing the element of surprise in billing and collecting is important. When we present an estimate to a patient, there is an opportunity for discussion of financial need and our charity care program. We have a very liberal charity care process: If your income meets certain guidelines, then the hospital will waive the balance up to the total charge. All we require is completion of an application and attestation of financial need.

In the past, patients might not have found out about these services or been aware of their eligibility for them until months after treatment. With up-front discussions, patients' concerns are eased from the outset that they won't be facing a bill beyond their means to pay. Also, they won't be as likely to postpone care when they know they have a financial resource to help them.

Since moving this discussion to the front end of patient interactions, we've seen the adoption rate for our financial assistance program quintuple over the past two years. This shift also helps the hospital, as accounts eligible for charity care are less likely to end up being mistaken for bad debt.

Rodney McCoy: Ensuring completeness and accuracy of the patient's billing information is eased for the provider when financial communications occur prior to service. A lot of issues that impede cash flow coming out of patient access are due to bad data, such as inaccurate mailing addresses or incomplete eligibility or financial assistance information. If you can get this information up front, then you have time to make sure everything is correct prior to the patient receiving service. When you are not able to receive this information until the day of the procedure, you are far less likely to identify a need to obtain or verify information—much less collect payment—while the patient is still on site. And after service is provided, it is far more difficult to locate patients and have these communications.

What are some of the key challenges that providers face when determining an estimate of patient payment responsibility in advance of non-emergency service?

Hardin: Obtaining key information for arriving at a successful estimate can be difficult for hospitals. A variety of information needs to be combined: data from the charge-master, the hospital's own retail price, or a contracted rate with a payer; eligibility and benefit information for that particular patient; and information relating to the actual treatment or procedure. So a lot of the processes involved in gathering this information—even though they are there—are not necessarily available at the right time or integrated into the workflow in a way that influences the financial estimate.

Tony Morrison: Understanding the differences in treatments or procedures and potential for extenuating or complicating factors that can affect billing is definitely a challenge. We have a registered nurse who assists in building our price quotes, and that has really helped this aspect. A lot of times, patients will call and say, “I’m having X test done,” and it’s simply not enough information for us to build an accurate quote. So in these instances, clinical staff will often offer to call the physician’s office for clarification of the procedure for a more accurate quote.

With so much disparate information that has to be managed, how does your organization cope from a practical standpoint?

Morrison: One way is by prioritizing efforts. Our organization mainly focuses on providing advance estimates for labor and delivery patients as well as responding to individual requests from those seeking elective procedures. Our verification staff will call the insurer or go online to

verify benefit coverage. As soon as status and coverage are determined, then the information is shared with our financial counselors who begin the personalized process of calculating what the patient’s out-of-pocket expense would be.

Another strategy that has been successful for us is centralizing our process. Our price quotes all are managed through our billing office. Also, we bring the hospital and clinics together in one billing; not a lot of organizations can do that. The benefit to this centralization is that when somebody comes in for a procedure and asks for a price quote, we can communicate with that person consistently and even include some of the physician fees. Of course, there are instances of professional fees outside of our organization where we can’t provide a price quote. We let the patients know to contact these physicians directly, especially when there is potential for large expense associated with the procedure, such as when an anesthesiologist or a radiologist will be significantly involved.

McCoy: We’ve had a preservice unit for two years. Staff receives reports that identify scheduled procedures. When patients have a fairly significant liability, such as \$500 or more, we’ll contact them in advance.

Also, we are trying to take better advantage of patient presence when they are visiting physicians with offices located on our campus. When these patients need to be scheduled for a treatment or procedure at the hospital, we want them to be able to come over from the physician’s appointment to meet with a representative at a one-stop registration and preservice shop here in the hospital. That way, on the day of service, all that would be needed is for the patient to head directly to where they are scheduled. The process might be a little fragmented right now. But we feel if we can have that direct interaction, then we’ll get one person performing functions that probably three or four people are having to perform right now. It makes a lot more sense and will ultimately be easier for the patient as well as those providing treatment.

Penny Nydegger: We’re working on centralizing processes. We’re implementing a full-fledged preservice center, which is a combination of preregistration and insurance verification. Within that department, we’re going to place a medical records coder, who will assist with verifying and clarifying physicians’ orders, ensuring appropriate use of ICD-9 and CPT codes, and supporting insurance verification. The insurance verification staff, who are now moving to preregistration, will be doing any precertification that is necessary. With this structure in place, it will now be possible for one call to be made to discuss a patient’s financial responsibility instead of multiple calls from within our system.

Participants in this HFMA Roundtable:

Philip Hardin is executive vice president of provider services, Emdeon, Nashville, Tenn.

Suzanne Lestina, CHFP, CPC, is manager of PFS/revenue cycle, Healthcare Financial Management Association, Westchester, Ill.

Rodney McCoy, CPA, is director of patient access services, St. Dominic’s Hospital, Jackson, Miss.

Tony Morrison is director of patient financial services, Sanford Health, Sioux Falls, S.D.

Penny Nydegger is director of patient access, BroMenn Healthcare System, Normal, Ill.

Patrick O’Connor, MBA, RN, is executive director of revenue cycle, Lake Forest Hospital, Lake Forest, Ill.

We did a pilot of our preservice center in March of last year and then examined MRIs. For 31 days in March, we saw a 96 percent decrease in discharged/not final billed. This is an extremely important point: When you're thinking about preservice, it's not just about getting the money from the patient. It's also making sure the bill goes out correctly and getting the money from the insurance company.

O'Connor: I think you can't underestimate the importance of technology. With the tools today, we're able to access information and pull it together quickly. First, we verify if the patient is eligible for that service and that date of service. If the patient is eligible for services, we take the contract we have with the particular insurer and will use the contracted rates for the procedure as well as information from our chargemaster. We typically go online to retrieve the insurers' data, since many of them will provide eligibility, unmet deductible, and co-insurance information in an automated fashion. Then it is simply a matter of hitting a print button to provide a copy of the estimate to the patient.

The nice part is having a printed estimate for reference. That way, with copy in hand, we're able to walk through the estimate with the patient and say, "These are the benefits according to your insurance company. There will be a balance due estimated at 'X.' How would you like to pay for that?"

What advice would you offer other providers looking to provide patients with advanced estimates of financial responsibility?

Morrison: Knowing your contracted rates is key. Your charges really don't tell the whole story, the contracted rate does. Patients aren't concerned with what is being charged for the procedure so much as the expected out-of-pocket portion that they will be responsible for based on the contracted rate. Having the necessary contract information current and easily accessible for staff is important.

Hardin: The patient financial management team must work closely with IT so they can agree on what the objectives are and what data need to be accessed. Regarding advanced estimates, in order for up-front collection strategies to work, there is a need to integrate information with the patient accounting system. Retail payment capabilities, such as online payment, require highly integrated data. Therefore, it's important that various teams work together.

Nydegger: It's important to recognize that providing estimates requires both a change in culture and processes. We've worked hard to educate everyone that assisting patients so they reach financial clearance is not only part of

our mission but also key to financing our future. In terms of addressing processes, our approach has been gradual and has been aided considerably with adopting appropriate technology. We have improved point-of-service collections by 40 percent since we started providing estimates two years ago.

Our processes were somewhat splintered at first, so when we had the opportunity to design and implement a new system, we looked for a pricing tool that would be flexible. We met weekly with staff to go over current processes, with an eye toward keeping what worked from the old way and designing and inserting new processes or capabilities as needed. Working with representatives from patient access, managed care, patient accounts, health information management, and clinical areas, we defined our goals and set associated time lines. Staff were required to report on progress each week.

Just some of the activities that have been undertaken include rewriting job descriptions, developing new financial assistance tools, streamlining our documentation and communications, and implementing an electronic orders management tool, payment segmentation tool, and estimator. Thanks to such efforts, we are moving from a decentralized precertification division that was five to seven days out in completing precertification to a fully cross-trained preregistration division that will now be four weeks out.

Specifically, what types of strategies are helpful when working with health plans to improve the process of determining and communicating patient payment responsibility in advance of service?

Nydegger: When working with health plans, it helps to take the time to understand their processes and anticipate opportunities to support them. As I mentioned, we're still moving the patient's financial responsibility to the front end.



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However, already we've discovered the benefit of using a coder to manage medical necessity and drop in the appropriate codes right away. It then makes our phone calls to the insurance company much more effective. It's a far more efficient process when you can call the insurance company for precertification with a code.

Suzanne Lestina: Simplifying contract language is important, and then you need to work together internally to determine access to that contract information. Staff cannot calculate patients' financial responsibilities if they don't know how the payer is going to apply the discount—percentage of charges, per diem, case rate, etc.

Also, the key is to work with the payer to determine how eligibility and benefit information will be shared. Will access be by electronic means, phone, web portal, a combination of these options, or all of these? Will the information provided be group benefits versus individual? Clarity on your information needs and expectations is important.

Morrison: We have a lot of hoops to jump through just to get to the benefit information, which is sometimes difficult. Our experience shows you really need to get it by electronic means, not by waiting on the phone for the next representative.

How can hospitals help ensure that their staff are communicating payment responsibility clearly, compassionately, and effectively?

Nydegger: Every single person who gets preregistered should be handled in the exact same way, whatever the balance is. The goal, especially within financial assistance, should be to treat people with respect and to treat them as kindly as possible. We try to communicate to patients that

on the date of service, we want to be done with the financial arrangements so that they can focus solely on getting well.

McCoy: In our collection efforts, we don't strong-arm anyone. We work as hard as we can with individual patients, understanding their needs and these economic times. We put a great deal of effort into providing them with financial counseling and assisting in accessing any financial support that might be available to them.

Hardin: To the extent you can set expectations up front and give patients a piece of paper—some sort of takeaway that says what you expect the outcome of the financial encounter to look like—you begin to create a high-integrity financial relationship with that patient. Then as you follow up with clear and correct billing on the back end, you increase the likelihood of payment.

Morrison: Identification of self-pay and asking for payment up front is a complete change in mindset for an organization. So you can't minimize the importance of gaining staff buy-in. Training on processes and procedures with a focus on scripting is usually a given. But it also helps to communicate with patient access staff how important their role is in the overall picture. Share with employees some key numbers, such as the amount of the organization's money that ends up in a bad debt status, the number of accounts that haven't been appropriately categorized as charity care, and the added expense associated with difficulty collecting money after the point of service. When you start to provide actual numbers, it is easier for staff to truly understand the importance of appropriately calculating and communicating patient financial responsibility; you need to share with them the financial impact of *not* making these efforts.



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