

Establishing Financing Options for Self-Pay Patients

Transactions with self-pay patients are taking on greater importance to hospitals' revenue cycles as a result of the growing number of uninsured and increasing popularity of consumer-directed health plans with high deductibles. As such, hospitals may find themselves exploring payment options, such as financing, to better serve this particular patient population. What will you need to know before pursuing such arrangements? HFMA, with sponsorship from GE Healthcare Financial Services, convened a group of senior healthcare finance executives in New York who shared the following perspectives on planning and implementing financing programs for self-pay patients.

Do you currently have patient financing programs to help with self-pay collections? If so, please describe the options you offer.

McNiff: We establish payment arrangements for patients and maintain them ourselves. Installment payments are worked out with patients based on what they can afford, taking our financial aid and charitable care policies into consideration. If a patient misses payments, the account goes to an outside agency to manage.

Shanahan: We also manage this internally. Self-pay patients meet with a financial counselor and discuss payment options. As part of that process, we determine whether the patient can qualify for Medicaid or other assistance programs.

Batheja: We have a similar arrangement as well as a sliding scale for inpatient and outpatient services. We try to limit our payment plans to three to six months. Before we classify a patient's account as delinquent, we call the patient to see if modifying the payment arrangements would help.

Maher: We have some patients with a limited ability to pay who want a payment plan with low monthly payments extended over five years. Those accounts are managed externally.

Coyle: As a skilled nursing facility, we have to screen patients up front to determine their level of assets and how quickly they will convert to Medicaid status. Once a patient is admitted, if we have collection problems, we often have to turn the account over to an attorney or an agency.

Batheja: We don't always have the luxury of doing that pre-admission due diligence when patients are being transferred to the nursing home from an acute care hospital bed.

What considerations go into your decisions about when financing is appropriate?

Maher: Decisions are based on the patient's income, ability to pay, and whether the patient is willing to work with us. There are no hard-and-fast rules; this is done on a case-by-case basis. We do a lot of work up front with charity care and Medicaid eligibility screenings, so we have a lot of financial information on hand to guide us.

Coyle: We avoid setting up financing arrangements when we can because of the risk that patients' assets will be depleted or directed elsewhere. We take a close look at prospects for Medicaid eligibility for patients who are unable to pay.

McNiff: Given our history of community involvement and the culture we are operating in, we don't even charge patients interest. We work with people and do the best we can with the income they have. Once a payment program is established, which may involve a sliding fee scale or other reduced charges, patients usually make a commitment to pay. I would say that 90 percent to 95 percent of our installments are maintained and paid. Patients realize and appreciate that accommodations are being made for them.

How and when do you communicate your financing options to patients? Are you estimating patient responsibility up front?

Barton: With elective procedures, we contact patients when the procedure is scheduled. For patients who come in through the ED [emergency department], the communication has to take place on the back end, after they are already in house, which is always a struggle.

McNiff: Payment for emergency department services is a big issue for the healthcare industry. We've set up a discharge desk in an effort to collect some payment before patients leave the hospital. It's very important to establish a process where nurses and other clinicians mention payment arrangements to patients and give them a flyer instructing them to stop and talk with a financial counselor before they leave. In areas where we have a strong structure in place, we do very well in collecting from patients. If clinicians don't buy into this process, though, collections are lower.

Nobile: We have signage about payment arrangements at the patient registration desk, and we provide flyers about the availability of financial counselors as well.

Batheja: We have signs in the registration areas that have been translated into the four primary languages spoken by residents of our service area. We also have notices in

our patient handbooks. For our self-pay patients, we've just partnered with a niche collection agency that's energetic about pursuing accounts with small balances. The larger accounts have been easier for us to monitor. This new approach seems to be working for small accounts, which collectively represent a significant part of our ED business.

McNiff: We need to distinguish between insured patients coming through the ED—who are responsible for copays and deductibles—and uninsured patients. It's almost as tough, if not tougher, to collect the copay and deductible from insured patients than to work out a payment plan with uninsured patients. Given the increasing popularity of consumer-driven plans with high deductibles, how do we change patients' attitudes about their responsibility for their part of the bill?

Then there are the patients who might be Medicaid-eligible but instead are receiving charity care because of all the pressure to increase the amount of charity care we provide.

Barton: We want to make sure that we're classifying accounts appropriately as charity care write-offs rather than bad debt. Due diligence in identifying a patient's ability or lack of ability to pay is very important.

How have your efforts affected self-pay recoveries? In other words, how do you evaluate the effectiveness of your financing program?

McNiff: We have established history of the characteristics of our typical self-pay population and we benchmark against previous results. We have a good process in place, including a predictive dialer. We do precollection work. Telephone outreach is a big part of this—it's more effective than sending bills. What we usually find through doing telephone outreach is that many patients have insurance but they came through a registration area where the insurance information was not collected.

Batheja: We use outside vendors for self-pay collections. We monitor what they turn into insurance, liquidation rates, close-out rates, and what's being closed out and why. We also plan to take it a step further by doing a product- and service-line-specific bad debt analysis.

Maher: We look at historic information to help us focus on accounts we should pursue rather than wasting time on those that are unlikely to be paid.

PARTICIPANTS:

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McNiff: The leading trend in this area is to have accounts analyzed at the time of initial registration and assess their payment prospects then. This is the system that vendors are marketing now. Also, it's important to have a good audit done for charity purposes, to establish that due diligence has been done and an account may properly be classified as charity care.

Coyle: Recoveries are difficult and time-consuming once they get to the legal stage. We perceive it as a failure when we have to go that route. We do all we can to stop it before it gets that far.

For those who have looked into financing programs, what are some of the most important features of a successful financing program? What are some key concerns?

Batheja: We have been perceived as a community-based provider that offers no-interest loans. A financing program would in essence be seen as a credit card with a "hard collect." At the end of the day, that is a significant concern. We decided not to pursue a financing program at this time.

Maher: Patients do have an expectation that they shouldn't have to pay interest on their hospital bills.

Batheja: Yes. If my direct competitors in the immediate area were charging interest, that would be a different story. But they're not and that doesn't appear soon to change.

What about insured patients who want alternatives for being able to pay, for example, a \$2,000 deductible?

Batheja: When it comes to the underinsured population, we know that we are usually at the bottom of the priority list after rent, food, children's clothes, and whatever else. But we usually have an ongoing relationship with patients and their families so we know we can count on getting our monthly \$50 payment from them.

Maher: I think patients who use a credit card to pay hospital bills would find other financing devices appealing. It could be almost like a healthcare line of credit.

McNiff: It would be a better option than dealing with an outside agency to pursue payment for a deductible.

Barton: It would be perceived more positively by the community.

Holland: If we're talking about the underinsured or the working uninsured, and we're talking about a credit card with a reasonable interest rate, do you have concerns about how those monies will be collected, particularly for hospitals that are concerned about maintaining their tax-exempt status?

Barton: Absolutely.

Holland: But there's nothing inherently wrong about a credit card, as long as it doesn't have a staggeringly high interest rate. It can still fit with your mission and your interest in demonstrating community benefit, is that right?

Batheja: Yes. Coming directly from the vendor makes it more acceptable.

Have you had any patient complaints about your current collection methods or your payment policies?

McNiff: We have very few complaints from patients regarding self-pay collections. If anything, we get positive feedback. Patients appreciate the option to work out extended payment arrangements.

Within your organization, who would be a key part of decision-making about the structure and implementation of financing programs?

Coyle: In a nursing home scenario, it would be the admissions director and the Medicaid coordinator. We would want them to be involved up front.

Batheja: We would want the Administration, Public Relations, and the medical staff to be involved.



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McNiff: Physicians would need to be involved up front. If the hospital starts charging interest and the physicians don't, patients are going to start complaining to the physicians about the change in hospital policies. And then the physicians are going to start calling us.

How would you handle the public relations aspects of making a change like this? How would you prepare the community for these new financing options?

Gavis: You would have to present it as a new benefit, as a positive thing.

Shanahan: Financial counselors should present the information to patients on a one-to-one basis, using handouts as a supplement.

Is there a benefit to offering any new financing program to physicians so they can introduce it at the same time the hospital does?

Barton: Yes. That would be a key to the success of a new financing program. The doctor has the one-on-one relationship with the patient. If you could package the pathology, radiology, and emergency department physician charges into a single financing program, then that would be ideal.

McNiff: We are not seeing many patients with high-deductible health plans yet.

Manuel: All of the hospitals and physician groups I've talked with are saying the same thing. But they are also saying that they don't know how to prepare for an

influx of patients with high-deductible health plans, if it does happen. Is anyone here starting to make contingency plans in the event that the trend accelerates in the next two to three years?

McNiff: We've added staff making outbound calls to make more contacts with patients. We've also talked with financing companies, and we're in the middle of discussions with a couple of banks. But we're more concerned about another trend in our area—small, local employers that are dropping their insurance coverage because they know providers that offer charity care will serve as a safety net. Overall, I would say that preparing for a deluge in high-deductible health plans is not at the top of our priority list.

Batheja: All the work we have done on our front-end processes to try to capture patients when they come in the door and check for Medicaid eligibility has helped prepare us for any increase in self-pay patients.

Holland: Does anyone get complaints from self-pay patients when the actual cost of a procedure is higher than the pre-procedure estimates?

Barton: If the procedure turns out to be complicated and a \$2,000 bill turns into an \$8,000 bill, then that creates some public relations challenges.

McNiff: We discuss deductibles and copayments for elective procedures with patients in advance. If a patient does not want to pay in advance or at the time of service, then the alternative is to delay the procedure. That's their financing option at this point.

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