

# Hospital Revenue Cycle Strategies for Turbulent Times

**T**he weakening economy presents many new challenges for today's hospital revenue cycle leaders, from increasing levels of self-pay and charity care activity to growing burdens of bad debt. With these dynamics in mind, the following HFMA Executive Roundtable, sponsored by Siemens, focuses on ways various organizations are responding to the day's shifting market dynamics as well as strategies for securing appropriate payment into the future.

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**Given trends toward high deductibles and increasing numbers of uninsured, many healthcare organizations are seeing growing levels of self-pay activity. What revenue cycle management strategies are you taking now or might you take in the future to address this activity?**

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**Mary Lee DeCoster:** As a safety net provider, we have a large self-pay population. Currently, about 18 percent of the patients who walk through the door have no insurance, and that number is continually increasing. To help meet these patients' needs, we have a very generous charity care program. Also, we rely on a tool that helps us verify eligibility for financial assistance and generates price estimates accordingly. If clinic patients say they are unable to pay and their need is not urgent or emergent, then we postpone service until payment is possible. We also work hard to qualify patients for Medicaid.

As for the future, we're considering purchasing a tool to aid with our collection strategies. It would help segment our self-pay portfolio, so we could more appropriately identify those accounts suitable for charity care as well as those where payment is likely to occur without any intervention. Such identification would then help us focus our efforts on those accounts that need it most.

**Mike Winiarski:** Strengthening financial assistance processes is important. We worked with our local Medicaid representatives to arrange for a Medicaid office right in the hospital. Also, we check to see if patients are eligible for free care through HCAP [the Hospital Care Assurance Program, Ohio's version of the Disproportionate Share Hospital Program]. But only people who are at or below federal poverty levels can qualify for HCAP, and it has been challenging to get patients to share their financial information.

In terms of securing payment, we're starting to use sophisticated processes for accounts with larger balances to differentiate those who are unable to pay—and might qualify for charity care—from those who are simply unwilling to pay. We're also starting to pursue collections more aggressively for the latter group.

Although we're pursuing this issue on several fronts, there hasn't been a lot of success so far. We're a community hospital, so there is hesitancy to pursue collections aggressively or ask for cash up front.

**Charles Shetler:** I've seen some indication of change in up-front collections. Some of our employed physicians recently approached us regarding our processes for patients who are uninsured but don't qualify for Medicaid. For those patients needing costly surgical or diagnostic procedures such as MRIs or CT scans, we typically review the medical necessity of the case and approve a 40 percent discount in advance of service. For routine services such as lab tests, this review traditionally has been done after service. Our physicians told us this approach needs to be examined because patients are not willing to take the risk of incurring medical bills they can't pay.

We realize that patients who have chronic conditions, such as diabetes, need lab tests to monitor their health and avoid complications that can land them in the emergency department or lead to inpatient admissions. So we asked the physicians if they would consider identifying self-pay patients who need help up front to enable us to determine if they qualify for financial assistance. We could then offer these patients a deeper discount for a set period of time. For example, we could approve a 50 percent discount on all care provided during a six-month period with an additional 10 percent discount if the patient pays in a certain

number of days. In exchange for making such a financial arrangement, we could then be more aggressive in our payment expectations.

To my surprise, the medical staff agreed to this approach. Of course, now I need to bring it to the board. In the past, some board members have been unwilling to take an aggressive stance with up-front collections.

**Bruce Burns:** You mentioned a six-month period for a discount. Our charity care policy includes a six-month authorization for services. We've done some utilization analysis and found that people are not abusing the system. And we know that six office visits are a lot less expensive than one visit to the emergency department.

**DeCoster:** Recognizing effects on utilization is what shaped our decision to be more generous with charity care in our clinics. If a patient doesn't have the clinic visit copayment on a given day, then the nurse consults with the clinic medical director. Together, they determine the medical necessity of the visit. For example, patients with diabetes who are at the clinic for a regular weekly visit and need their self-monitoring supplies will be seen, even if they don't have the copayment. Doing so keeps them out of the emergency department. It's better for us to absorb the loss for that clinic visit than an emergency department visit a few days later.

**Michael Bernick:** We serve only children and adolescents. Our board has directed us not to refuse care to any child.

#### Participants in this HFMA Roundtable:

**Michael Bernick** is vice president-finance and CFO, Southwest Mental Health Center, San Antonio, Texas.

**Bruce Burns** is senior vice president and CFO, Concord Hospital, Concord, N.H.

**Michael Calder** is CEO, LinkPlus Partner, LLC, San Diego Calif.; formerly senior vice president, finance-revenue cycle services, at Saint Vincent Catholic Medical Centers, New York.

**Sabbir Dadabhai** is vice president and CFO at Redlands Community Hospital, Redlands, Calif.

**Mary Lee DeCoster** is vice president, revenue cycle, at Maricopa Integrated Health System, Phoenix, Ariz.

**Mike Dewerff** is CFO, Buena Vista Regional Medical Center, Storm Lake, Iowa.

**David Hadley** is CFO, Via Christi Health System, Wichita, Kan.

**Mitch Icenhower** is revenue cycle strategy executive, Siemens Medical Solutions, Malvern, Pa.

**Christine Sarrico** is CFO, Enloe Medical Center, Chico, Calif.

**Charles Shetler** is CFO, Bedford Regional Medical Center, Bedford, Ind.

**Mike Winiarski** is CFO, East Liverpool City Hospital, East Liverpool, Ohio.

In self-pay cases, we expect parents or guardians to apply for Medicaid or for coverage through SCHIP (State Children's Health Insurance Program) if they are eligible.

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#### Collecting on self-pay accounts is a challenge. Given increases in the uninsured and associated growth in bad debt, what strategies are you finding most useful?

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**Sabbir Dadabhai:** We emphasize that payment is a priority from the outset. For elective surgeries, we start assessing patients' ability to pay during preadmission. When necessary, we will provide an estimate of what the patient will owe. If the patient isn't sure of ability to pay the amount, then a decision needs to be made on whether to enter a payment plan with us or postpone the elective surgery.

However, I think it is important to recognize it isn't just an issue of the uninsured. We've started an in-depth analysis of our bad debt and found that approximately 68 percent of our emergency department bad debt is from self-pay. We were surprised to discover the second largest component of our total bad debt is PPO patients who are not paying their copayments and deductibles. Some are having financial difficulty and others are trying to save money just in case they lose their jobs. To meet these needs, we are offering installment plans over a six-month period as long as the payment amount is reasonable. If the patient is in greater need, proposing to pay \$25 a month on a \$1,000 account, then we start looking into whether the patient may qualify for charity care or a county program called the Medically Indigent Service Program. Also, we have in-house assistance available for Medi-Cal applications.

We also offer a financing program through a bank. Some patients are automatically referred to the program. Others we refer after we've been unsuccessful in attempts to collect. Some patients will contact us after making a couple of payments and tell us they would prefer to work out arrangements with us directly, and we will try to work with them. We're definitely trying to make the financing options easy on the patient.

**Mike Dewerff:** We have two sliding-fee scales, or discount policies: one for insured patients and the other for uninsured. Our uninsured discount is equal to or greater than the insured discount, and in fact goes up to 1,000 percent [of federal poverty income levels]. But in order for the individual to be eligible for the discount, we require that a financial assistance form be filled out. Many people are unwilling to complete the form.

**Michael Calder:** Getting patients to complete Medicaid applications correctly and on a timely basis is a significant challenge to hospitals. When I was at Saint Vincent Catholic Medical Centers (New York), we partnered with a firm to engage patients during their hospital stay and, if necessary,

later sent representatives to patients' homes or shelters to assist them in the step-by-step process of completing the application. That approach was very financially successful.

In terms of dealing with bad debt, one strategy that I found particularly useful during the bankruptcy at St. Vincent's was the sale of some of its aged receivables. While this is a new approach for health care, I believe it will be an invaluable tool to help us meet our financial obligations and goals—but only if it is done correctly. We were sure to structure the transaction in such a way that our patients were protected. For example, we reserved the right to recall an account at any time, and we included provisions that made it necessary for us to review all correspondence sent to patients and to approve the initiation of legal action.

In addition to the contractual protections, you have to select the right purchaser. The company has to be knowledgeable of healthcare regulatory requirements and rules. In many ways, our purchaser was better equipped to manage the accounts we sold. I have seen the technology such companies use to analyze these debts. They take the files and break them down by zip code, credit score, marital status, and gender, among other things. They can then price the accounts on the basis of estimated ability to pay, and the hospital receives immediate cash flow. They also use this type of information to develop a collection strategy that is targeted to each account profile.

**Dadabhai:** On the front end, one approach that has helped us improve up-front collections for copays was changing our discharge process in the emergency department. Nursing and registration staff worked together to come up with a process whereby the nurse accompanies the patient to the business office or registration area right after discharge instructions are given but before receipt of prescriptions. The patient is not discharged until after we've discussed insurance status and verified that information. Every attempt to get that \$10, \$20, \$30—whatever we can get up front—is important.

**Burns:** We've implemented a process to assess collectability when the patient comes through the door. Doing so requires our registration folks to electronically verify eligibility. We also start the process to assess individuals for Medicaid insurance or charity care. In the physician's office, there are metrics we track and report to them every month, including collectability ratios. We've put a financial counselor in the emergency department too.

**Christine Sarrico:** Self-pay accounts are only about 2 percent of our inpatient business, while they make up about 7 percent of outpatient business. The change we've seen is that insured patients won't pay their copayments, similar to Sabbir Dadabhai's experience. In California, our community benefit charity policy covers people earning up to

400 percent of federal poverty levels, which could include many of our employees. So that's an interesting dynamic.

**Dadabhai:** There is also the issue of patients with high-deductible health plans. Even those who should easily have the ability to pay are asking for discounts.

**Calder:** For many patients—including those who are employed—the healthcare bill is the last bill they pay. They pay their cable TV and cell phone bills before they pay us. We need a culture shift so people understand that survival for a lot of hospitals depends on prompt payment.

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**Given some of the trends discussed, what do you see needed in the future?**

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**Dadabhai:** When we go back to the table to negotiate with health plans, we're going to tell them we need better reimbursement from them up front instead of relying on patients to pay their copayments and deductibles, because patients are not paying as they should.

**Calder:** I think we also need to educate our boards about why it's essential to pursue patients' payment more aggressively. As we told our board at St. Vincent's when we were in bankruptcy, "No margin, no mission!"

**Sarrico:** Consumers, too, need education. They should feel like there is some sort of financial consequence for their healthcare spending. The consumer has to stop and think, "Do I really need to go to the emergency department for the flu?" Also, the healthcare bill itself needs to be respected. Consumers need to understand their responsibility to pay, and we need to hold them accountable. Perhaps one way we could do that is by charging interest, developing some sort of system of charging patients a fee after a debt goes unpaid for a certain period, such as six months. It seems like there needs to be some sort of dynamic so that paying cable and cell phone bills isn't more important to consumers than paying for their health care.



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**Bernick:** I'm not sure that interest charges would make a difference. If the consumer can't pay his bill, he won't care what the interest rate is. That's the reality of today's economy.

**Dewerff:** Perhaps, but there still is something to the overall spirit of engaging consumers more frequently in payment discussions. We started educating the community three or four years ago about the difference between charity care and bad debt. Since then, our overall write-offs have remained flat, but our bad debt as a percentage of revenue has actually *decreased* and our financial assistance/charity care has increased. Granted, I'm from a small community, but patients have a better understanding of the difference between bad debt and financial assistance.

**Calder:** None of us—health plans, employers, and providers—have educated consumers enough about benefits and payment obligations. I think this lack of education is especially apparent when it comes to high deductibles and copays for health insurance coverage. Employees sign up for those plans because they're the cheapest healthcare option, but they don't read and understand their benefit and payment responsibilities until the first time they're sick.

**Shetler:** Some of what is most needed is a shift in our culture regarding the value of health care itself. We have a large employer in our area that recently changed its health plan design so employees now have a copayment. Well, those employees are absolutely incensed. They've never had to pay for health care before.

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**How is the current shift toward self-pay affecting your needs for staff training? In particular, how can you prepare your staff to ask for money in this changing environment?**

**Sarrico:** I don't think it's about training; it's about changing your hiring practices. As part of the interview process,

we need to engage in role playing the collections experience so that candidates understand their job is collections—not just gathering insurance information. You can train all you want, but if your employees don't understand from the start that collections is their job, you may wind up hiring people who just aren't comfortable asking for money.

**Calder:** The front-end staff needs to know so much due to increasingly complex regulatory and managed care rules and regulations, yet they're the lowest paid employees in our organization. I was part of a task force that recommended elevating the front-end staff to a higher graded position and adding an associate degree or professional certification requirement. If you get it right on the front end, then the back end is a true collection department. If you get it wrong on the front end, then the back end is a *correction* department. So it's important to recruit front-end people with some professional training and education because the front end is your lifeline.

**David Hadley:** I agree. The front-end staff are not just information gatherers—they're collectors. And let's face it, how do collectors get paid? They are usually paid a percentage of what they collect. We have an incentive plan for all front-end staff, not just emergency department staff. We divide the incentive into three different buckets: one if the whole team hits the target levels, another tied to how much each individual collects in relationship to the entire pool, and a third bucket for information quality. For that last bucket, we do a retrospective review of the information employees have collected and if we find that someone just populated fields with any kind of data so the fields wouldn't be empty, then they can lose their bonus. It took us a while to get these tracking processes automated; we had to do it manually for a while, but the effort has paid off. We've seen the collection rate go up almost 200 percent.

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