

PATIENT FRIENDLY BILLINGSM Project Summary

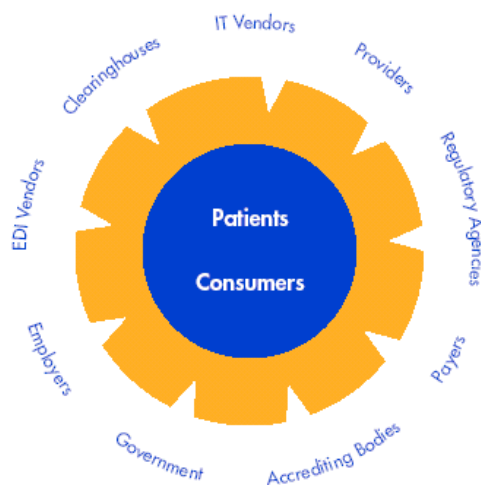
Prepared by

PATIENT FRIENDLY BILLINGSM Task Force

Purpose: PATIENT FRIENDLY BILLINGSM is the healthcare field's approach to making patient bills more clear, concise, correct and patient friendly. This project is a catalyst for change. HFMA and AHA have examined the issues surrounding collecting and communicating billing and financial information to patients and others. This report, written for hospitals, summarizes the complexity of the current hospital billing and financial communication processes, illuminates the patient's perspective on the process, identifies barriers to billing simplification, offers current better PATIENT FRIENDLY BILLINGSM practices, and proposes solutions.

I. The Issue

Listen to almost any patient or family member talk about medical care and the conversation will likely include a discussion about problems related to the bill. Patients and their families identified the patient bill as a "...symbol of the confusion, mystery and there is a perception of high costs and overcharging." (*Reality ✓ II*, American Hospital Association) Healthcare financial professionals confirm that the billing process is confusing and frustrating. These billing problems have eroded the trust between patients and their families and those who represent the healthcare system. Because providers, government, insurers (payers), employers, and to some extent patients are partly responsible for the complexity of the billing system, fixing this system involves everyone.



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The healthcare billing process is a multi-party, interdependent relationship not within the control of any one entity. Billing is comprised of complex processes that are standardized and non-standardized, manual and automated. Billing is complex and confusing. A single bill can be as simple as a one item charge or as complex as a multi-procedure, multi-facility episode of care that results in many bills from a variety of providers and coordinated among several payers. But the patient is often left alone to understand, coordinate and navigate through a maze of bills, claims, referrals, authorizations, regulations and explanation of benefits.

During the 36 years since the creation of the Medicare and Medicaid programs, more than 130,000 pages of rules related to these programs have been promulgated, most of which relate to claims payment and reporting financial information for an episode of care. Many of these rules govern the providers and insurers (payers) and are transparent to the patient. Unfortunately, these voluminous rules add complexity to the system and result in multiple compliance interpretations. Additionally, the pluralistic nature of both public and private funding of health services in the United States yields a variety of approaches to coverage and payment. The current patchwork of benefit plans, payment systems, and billing formats creates a system that is expensive to operate, and results in financial communication that is confusing, complex, and, too often, incorrect. Unfortunately, the patient's needs and perspective are easily overlooked.

Many state and national organizations are examining the causes and potential solutions to the problems of the current patient billing system. Currently, major health plans, the American Association of Health Plans, and the Health Insurance Association of America have formed the Coalition for Affordable Quality Healthcare. One of the goals of this coalition is to simplify administration to "...reduce hassles for physicians and consumers, and make consumer information easier to access, understand and compare." (*CAQH, Progress Report, July 2000*) Another is the American Hospital Association's Task Force on Regulatory Reform and Relief. This task force is charged with recommending methods "...to reduce the regulatory burden on hospitals (with an emphasis on the Medicare program) by identifying: 1) process reforms; 2) specific regulations that need reform; and 3) a new model for the future of regulatory oversight." (*The Regulatory Burden Facing America's Hospitals, AHA, May 2001*) The United States government also recognized the burden placed on the healthcare system and has identified savings through simplification and standardization. Such efforts to reduce the complexity of the underlying rules and processes that drive patient billing increase the potential for improvement in the patient-billing process. Most of these efforts are focusing on one or more of the major players in the process, the Patient Friendly Billing focuses on the needs of the patient and consumer first.

The consumer's perspective relates four key messages to healthcare leaders:

1. Consumer satisfaction increasingly is driving long-term success of healthcare organizations.
2. The healthcare organization's non-clinical interactions with patients and consumers have as much impact on their satisfaction as clinical interactions.
3. The patient billing process (including insurance interactions) is a major cause of dissatisfaction for both patients and consumers.
4. A patient friendly billing process will increase satisfaction and thereby increase long term success of healthcare organizations.

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The billing process is a tangible and lasting reminder of the healthcare encounter.

II. This Project

Patients and families want a bill, or more precisely, a flow of financial and other information flows, that is clear, correct, concise, and patient-friendly. The bill should be:

- **Clear:** The bill is easy to understand and is written in clear language. The general type of services provided to the patient is documented. Patient and payer responsibilities are clearly stated, necessary actions are described, and a source of additional help and information is provided.
- **Correct:** Bill items reflect the episode of care. Information on how patients can get more information or question their bill are referenced and available from the hospital's patient representative or from various written and Internet sources.
- **Concise:** The bill contains the appropriate amount of detail necessary for the message communicated. Information on how to request a more detailed bill should be included.
- **Patient Friendly:** In addition to being easy to read and understand, the bill should be easily matched with the payer's explanation of benefits (EOB); the patient's, the hospital's and the payer/employer/government's understanding of the insurance benefits; and the episode of care.

Components of a Patient Friendly Bill

The bill contains appropriate language, a large typeface, and an easy-to-read layout.

The bill elements have been simplified to a concise outline of packaged and bundled services, without internal codes and medical jargon.

Clear directions are provided about what actions need to be taken by the patient to assure payment.

This bill is part of a suite of consistent financial communications to the patient including letters and statements.

Basic billing system demographic and insurance information is presented to ensure data integrity, completeness, and accuracy.

Details of customer support services is indicated.

The back of the bill contains definitions and explanations to help the patient understand the billing process.

Friendly Hospital 123 Patient Friendly Way Anytown, ST 12345		Bill For Services	
Mr. John Doe 2005 Hill Street Anytown, ST 12345		Account Number: 123-234 Billing Date: 10/31/2001 Primary Insurance: Medicare Secondary Insurance: None	
Bill For Hospital Services for your 10/15/2001 Visit			
Service Date	Service Description	Amount	
10/15/2001	X-rays	\$ 200.00	
10/15/2001	Lab Services	\$ 254.00	
		\$ 454.00 Total	
		\$ 354.00 Insurance Pending	
		\$ 100.00 Due From Patient	
Please Pay This Amount			
Thank you for using Friendly Hospital. Your satisfaction is our primary concern. We have billed your insurance company, however there is a remaining amount as shown. Please remit this to the address above. Again, thank you for visiting us.		Billing Questions: Weekdays 9am - 8 pm Saturday 9am-3pm Phone: 555-555-5555 Fax: 555-555-5555 To Request an Itemized Bill: 555-555-1212	

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No single participant in the billing process can solve the systemic and complex problems described. An effort will be required by payers, providers, employers, and the government, together with patient education and feedback, to attain the goals of Patient Friendly Billing. HFMA and AHA's *PATIENT FRIENDLY BILLINGSM* project is the start. The Healthcare Financial Management Association (HFMA) and the American Hospital Association (AHA) have set out to examine what hospitals and health systems could do now to address consumers' concerns related to the billing process and provide a forum and framework from which the rest of the industry could work.

To examine the issues, HFMA and AHA assembled a task force of hospital and health system experts in the areas of provider registration, billing, contracting, follow-up, and collections to identify steps that can be taken immediately to respond to issues raised by patients and their families. The task force also identified future actions that can be taken to remove barriers to, or that facilitate, the clear, correct, and concise flow of financial and other information to consumers.

To gain the patient and family member's perspective, the task force commissioned six focus groups comprising certain demographic and other characteristics of hospital and health system patients, including recent patients, patient guardians, and individuals with varying types of insurance coverage. Two additional focus groups were made up of hospital and physician office employees. The focus groups were conducted in four locations throughout the United States.

The task force also collected examples of "better practices" being used by leaders in the hospital field today for creating a more patient friendly billing process.

Based on the feedback from the focus groups and these accepted better practices, the task force developed this report as a guide for hospitals and health systems to address the concerns raised by patients and their families.

III. Consumer's Views of the Hospital Bill

Focus groups were commissioned to obtain structured feedback from consumers (patients, guardians, and family members) and hospital and physician business office employees on how the billing process and information related to hospital and physician episodes of care could be improved. Seventy-five people participated in these focus groups, which were conducted in January 2001. All participants had health insurance coverage, and all patients or family members had had an encounter with a hospital within the prior 12 months.

A trained moderator, using a written facilitation guide approved by the task force, led the focus groups. Questions related to financial and other information flows including pre-registration, registration, and activities during care, post-care communications, and follow-up. Participants also were asked what, if anything, would improve this communication process.

Summarized below are the major points and recurring themes from the focus groups:

- Public frustration with "the system" begins before care actually is delivered. The billing system is perceived as fragmented with minimal communication among entities that participate in the health care delivery system. Most participants report that regardless of previous admissions to the hospital, personal and financial information had to be

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provided with each new encounter. For some, it was the physician's office that provided the information to the hospital; others received calls from the hospital prior to admission. As stated by one woman whose child has had multiple hospitalizations "...you still have to go through all the hoops..."

- Consumers did not want to discuss coverage and billing issues during their medical episode, nor did they view this as an appropriate time to discuss such issues. Coverage is not top of mind for them... *"it's...am I going to be okay?"*
- Both consumers and healthcare employees understand that billing problems are only a reflection of larger problems within the healthcare system.
- It is extremely difficult for consumers to clearly distinguish what information was received from what sources and in what order. Some said they received "something" from the insurance company within a few weeks after hospitalization; others said their first communication was from the hospital. While some said they could tell what a particular document was – "Not A Bill", but an "Explanation of Benefits" – few thought the document clearly stated either what occurred in the hospital or what, if anything, the patient was to do.
- For many consumers, multiple bills and statements are a source of frustration and confusion. They described documents that were filled with codes and abbreviations difficult for a layperson to understand. Further, these communications hampered their ability to ensure the bills were accurate in terms of the services they actually received. Their frustration was compounded by the fact that they or their family were not fully informed about all of the tests, physician consults, and other services performed on their behalf.
- Few focus group participants felt they were informed about or prepared to receive the numerous bills and documents they did receive from multiple sources. Few identified any source of assistance. Most began with the physician's office or hospital billing department, but the quality and availability of the assistance varied widely.
- Focus group participants viewed the payment process as a struggle that positions providers and insurance companies against each other. They see insurance companies constantly "gaming the system" by delaying or denying payments to providers for any number of "excuses" such as coding errors, and consumers often feel trapped in the middle.

When asked what they would suggest to improve the system, focus group participants said the following:

- A statement should be issued that simply explains what was done, by whom, when, the "real cost" (to the consumer), and what is (and is not) covered by insurance.

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- The bill should be easy to read and understand, and should omit codes and acronyms. (One participant, a hospital employee stated that her hospital started using fewer abbreviations and changed some of the language on the hospital bills, resulting in a decrease of 37 percent inpatient calls with billing questions.)
- Every procedure, activity, and provider involved in an episode of care should be under the umbrella of the hospital bill, thus preventing the patient from receiving multiple bills.
- Statements or bills should be sent to the patient only after claims have been submitted to the insurance company.
- There should be more uniform billing cycles among providers.
- There should be greater oversight of insurance companies to ensure more timely payment to providers and to deter “the games” carriers play with providers.
- “Explanation of Benefits” and other forms should be standardized across all providers and payers.

Finally, the moderators made the following observations:

- The views of senior citizens differ sharply from other consumers. Older Americans have more faith in the system. Additionally, in many ways, Medicare works better in terms of billing for both providers and recipients than billing from other components of the healthcare system.
- The attitudes of consumers are changing by generation. Babyboomers and younger consumers do not have the faith in the system their parents had and will be more aggressive in demanding information and accountability for both billing and clinical services.
- A persistent wish among consumers and families was to receive more information about their care. Much of the public’s irritation with the medical billing system is rooted in a lack of trust and confidence. Having more knowledge of, and voice in, the care process would likely influence perceptions about billing.
- Some people see a need for an independent point of contact for consumers to help them sort out questions about coverage, services, and billing.

IV. Creating a Patient Friendly Billing Philosophy

The comments of consumers are not surprising and likely confirm many of our own personal experiences. Addressing these frustrations however is an extremely complex problem.

For simplification purposes this summary outlines a universal philosophy that the entire industry can adopt and proposes two implementation strategies. The first is a series of steps and changes that an individual provider can implement and the other is change that the industry can adopt.

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Listed below are a series of “patient friendly billing” statements that can help guide implementation of changes to make the communications process more effective and friendly. These statements should be a starting point for hospitals to develop their own philosophy and focus efforts throughout their organization.

- The needs of patients and family members should be paramount when designing administrative processes and communications.
- Information gathering should be coordinated with other providers and payers, and this collection process should be done efficiently, privately, and with as little duplication as possible.
- When possible, communication of financial information should not occur during the medical encounter.
- Financial communications should contain language, and in a format, that can be understood by the average consumer.
- Continuous improvement of the billing process through implementations of better practices and incorporating feedback from patients and consumers.

Many of these issues are systemic and require broad-based solutions. These solutions must be developed with other players, including the government, payers, and employers. Some issues, however, relate to how hospitals and health systems organize and communicate financial and other information. The task force considered both types of issues and crafted potential responses.

V. Steps to Create a Clear, Correct, Concise and Patient Friendly Bill

Based on the consumer research and expert analysis, the following responses should be considered by hospitals and health systems in changing their operations while implementing patient friendly billing:

Consumer Issue – Pre-Encounter (Registration/Pre-Registration Processes):

Public frustration with “the system” begins before care actually is delivered. The billing process is perceived as fragmented with minimal communication among the entities that participate in the health care delivery system. Most participants report that regardless of previous admissions to the hospital, personal and financial information had to be provided with each new encounter.

Potential Responses:

While hospitals and health systems continually make improvements in pre-registration, data collection, and data retrieval, patients continue to experience frustration with the system. Hospitals and health systems strive to pre-register non-emergent, scheduled admissions or visits. Activities that may respond to consumer concerns include:

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- Informing patients in advance about what they should expect from the episode of care, both medically and financially.
- Informing patients about the timing of the billing cycle, their insurance coverage and potential insurance benefits, payment expectations, payment options, and names and phone numbers of individuals they can contact if questions arise.
- Maintaining local health plan insurance coverage and benefit information that is as current as possible.
- Implementing internal and external data retrieval capabilities within your organization to reduce redundant questions asked to patients. Validating data within the system to insure completeness and accuracy.
- Simplifying contractual relationships with managed care and other health insurers. Complex payment arrangements often lead to confusion regarding the identity of the services that are covered, and the amounts that are due from the payer and the patient, and potentially delays payment.
- Improving communications between the hospital's business office and payer organizations, and working collaboratively to simplify the administration of their contractual relationship with mutual awareness of the downstream impact on patient billing.
- Employing well-trained and motivated staff who are able to communicate effectively with patients. Training staff to become patient advocates.

Consumer Issue – During Encounter (Correct Bills):

Focus group participants described documents that were filled with codes and abbreviations difficult for a lay person to understand. The documents do not provide a meaningful summary of their episode of care, which further hampers the efforts to be certain that the bills are accurate in terms of services they actually received. Focus group participants' frustration was compounded because they and their family were ill informed about all of the tests, physician consults, and other services received.

Patient billing is complex, costly, and often wrong. A three-to four-day stay can result in 10 to 15 pages of detailed charges. The process of accumulating these charges is a nightmare of automatic and manual input, and electronic and paper hand-offs. Hospital Charge Masters often contain more than 15,000 chargeable items, all of which must be coded and maintained on a routine basis. It is estimated that the complexity of the billing system adds billions of dollars in costs to provider organizations each year.

The complexities of the charging and billing process increase the potential for errors at any of the steps between service delivery and final payment. In her March 9, 2000, testimony to Congress, Health and Human Services Inspector General June Gibbs Brown estimated that net billing errors paid by the Center for Medicare and Medicaid (formerly HCFA) to providers totaled about \$13.5 billion,

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or about 8 percent of total Medicare fee-for-service benefit payments. These errors result in increased cost in terms of rework, audit, and fines. Concerns about the extent to which these errors cause overpayments by federal, state, and private payers have resulted in investigations of possible fraud and abuse, increased cost to providers and government, and negative public perceptions of healthcare.

Potential Responses:

Patients have lost trust in the billing process. Patients generally have little understanding of all the components of an episode of care and have received repeated messages from the government, press, and payers to scrutinize their bills with little information or education on how to make an informed inquiry.

- Patients should be given a clear bill with an easy-to-understand summary of the services
- Resources should be available upon request to assist and educate patients with detailed bills.

The bill should reflect the way in which the provider is reimbursed for the episode of care. For example, if a provider is paid a fixed price based on a Diagnostic Related Group (DRG), then the detail of the bill needs to support the established DRG, not every single item in a provider's cost accounting system associated with that episode of care. For example, a bill might indicate the proverbial \$100 aspirin as a detailed description of costs that has nothing to do with the reimbursed case rate based on the DRG

Consumer Issue – Billing Formats:

For many consumers, multiple bills and statements are a source of frustration and confusion. Focus group participants described documents that were filled with codes and abbreviations difficult for a layperson to understand. Further, these communications hampered their ability to ensure the bills were accurate in terms of the services they actually received. Their frustration was compounded because they and their family were ill informed about all of the tests, physician consults, and other services performed on their behalf.

Potential Responses:

Billing forms often follow the Medicare UB-92 or Medicare 1500 formats. These formats are adequate for billing payers, but are confusing to patients. Some hospitals have modified their billing formats or have outsourced their billing to a firm that specializes in simplified communication. Solutions to consider include:

- Immediately after the episode of care, send an informational letter explaining what the patient should expect (such as billing of a certain insurance company, identification of what payments, if any, are due from the patient, and if payment is due, when it is due).
- Use a format that is similar to other bills the patient receives, such as a credit-card billing format.
- Identify the location of services provided in addition to the name of the hospital or clinic.

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- Use terms that are easily understood by laypersons and avoiding abbreviations, medical jargon, disease and procedure codes, and other specialized terminology.
- Use a standard billing cycle that is consistent regardless of how often the patient visits inpatient or outpatient hospital units.
- Study the unique needs of the marketplace and enlist suggestions from patients, family members, and the caregiver community to develop a simple patient bill.

Consumers want to see a statement of “...what was done, by whom, when, what the ‘real cost’ is, and what is covered.” The type of billing information displayed and the amount of detail provided is an issue of great debate. There is some confusion about how much detail should be contained in a detailed bill. Most hospitals, however, will send only a summary bill (usually by revenue code) unless more detail is requested by the consumer or required by contract or state law. In addition to the issues noted above, hospitals could consider the following:

- Communicate only information that is useful to the patient. Consumers wish to see the “real cost” (to the insurance company and to them), and therefore a display of full charges and contractual allowances generally are not meaningful to consumers and typically result in an increase in confusion and suspicion.
- Display what was due from (paid by) the payer and what remains due from the consumer.
- Where possible, reduce the number of chargeable items by combining items and developing package prices to reduce complexity, provide the patient more useful information, and reduce questions about individual services that are impossible for the patient to track.

There was mixed reaction among consumers about the use of the Internet to inquire about patient billing. Some thought using the Internet would make it easier to track billing activities and facilitate communication among all parties. However, many participants in the focus groups had serious concerns about security and privacy, and some felt that due to the complexity of many billing issues, they needed to speak to someone. The use of the Internet, therefore, may best serve to augment other forms of communication until privacy and security issues can be resolved to patients’ satisfaction.

Consumer Issue – Multiple Bills and Follow-Up:

Few focus group participants felt they were informed about or prepared to receive the numerous bills and documents they received from multiple sources. Few identified any source of assistance. Most began with the physician’s office or hospital billing department, but the quality and availability of the help varied widely.

Potential Responses:

Except in rare instances, provider-based physicians and admitting and attending physicians bill separately from the hospital. Medical transport, independent labs, medical device companies, and other entities generate additional bills. Often the patient does not realize these individuals or

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companies provided services, and the number, timing, and format of these multiple bills frustrate the patient. Although some type of combined billing may be desirable in the future, currently there are steps hospitals can consider related to this issue:

- Providing the patient with the names of any provider-based physicians who also may bill the patient either on the bill or as a separate letter. Helpful information would include the group or practice name as it appears on billing forms, the names of the physicians providing services, the types of services the group provides, and phone numbers to use to contact the appropriate person(s) if questions or problems arise with these bills.

Consumers want access to competent, well-trained staff who can answer their questions. They are often unable to work on billing issues during normal business hours. Hospitals and health systems could:

- Maintain office hours that match the needs of consumers (evenings and weekends may be necessary);
- Hire and train a well-motivated, customer-service-oriented staff who can communicate effectively with various consumer groups and who have access to information necessary to answer questions and solve problems quickly without sending consumers to multiple contacts.

VI. Regulatory Barriers to Meeting Consumer Expectations

The consumer issues and responses identified above can be considered and addressed by hospitals and health systems. There are, however, regulatory barriers that increase complexity or inefficiency. All of these issues impact the organization's ability to provide a clear, correct, concise, and patient-friendly bill. Solutions to these issues require working together with government to evaluate or change current policies and regulations. AHA, in conjunction with other interested hospital advocates, will seek changes in the following areas:

Consistent Patient Information Across Payers, Providers, and Employers:

A better informed patient and consumer is the goal of consistent patient education resources that explain the billing process and help the patient make choices.

- Hospitals and health systems can begin or enhance existing volunteer efforts to have resources available to help patients understand, navigate, and adjudicate bills and other financial correspondence.
- Collaborate with others in the community or state to create a uniform set of educational resources available via printed, Internet and other pathways. These materials need to cover the end-to-end process from the patient's view and include a standard glossary of terms.

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Detailed Bill Definition/Combined Billing Approaches:

As noted above, the definition of what constitutes a detailed or itemized bill needs to be clarified, so providers can respond effectively and legally to requests for detailed bills.

- Develop a clearer, flexible definition of an itemized bill for purposes of satisfying Medicare requirements.
- Ensure a regulatory environment that allows “package pricing” and billing for hospital services that recognize the different needs of various consumers and potential responses by hospitals and health systems.

Medicare Cost Report:

The Medicare cost report was developed in the late 1960s to determine the cost of treating a Medicare patient and formed the basis of the payment due to a healthcare provider. Over time, however, the methods of payment to most hospitals for inpatient and outpatient services have become independent of the calculations of the cost report. Currently, the main use of the cost report is to analyze and trend hospital costs. Since many hospitals use detailed charges to accumulate the necessary volumes and revenue calculations for this report, the process of charge master development and maintenance is much more complicated than necessary. A by-product of this complication is a patient bill that often is overly complex and error-prone. Since the cost report is no longer used as the basis for payment, and since it creates a barrier to clear, correct, and concise patient billing, its value as a data collection device needs to be examined.

- Require the Centers for Medicare and Medicaid (formerly Health Care Financing Administration) to meet with provider representatives to explore ways to revise and, in the future, replace the Medicare cost report.

Small Balances:

The complexities of the current system increase the cost of administration. In an effort to reduce complexity and cost, healthcare providers seek to balance the amount of money due from or to a patient and subsequent insurance and other payments with the cost of collecting those balances. Offering, paying, soliciting, or receiving anything of value as an inducement to generate business covered by Medicare or Medicaid is illegal. The write-off of a small balance that is too costly to collect may be construed as an illegal inducement. Therefore, many hospitals and health systems must bill or refund small balances even when the cost of doing so is more than the value of what is due or owed and when doing so increases the “hassle factor” for patients.

- Allow hospitals to write-off small debit balances below a specified level to simplify billing. Issues related to credit balances due to patients or others may also require state approvals.

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Regulatory Simplification:

The complexity of the current healthcare financing system is driven by a variety of factors. One area of complexity that has a negative effect on the communication between providers of care and patients is changes in payment policy, especially related to the Medicare program. For example, the adoption of the prospective payment system for hospital outpatient services significantly complicated the process of billing Medicare, caused multiple changes to the method of charge capture, and, most importantly, caused significant communication problems with Medicare patients. Providing clear, correct, concise, and patient-friendly bills is extremely difficult, if the amount due from the patient cannot be accurately calculated as a result of regulatory changes. These changes are expensive to implement and shift needed resources away from direct patient care.

- Evaluate, and if necessary, modify the regulatory implementation of the Health Insurance Portability and Accountability Act (HIPAA) to ensure that it does not present new barriers to meeting consumer expectations in the area of hospital billing.
- Create a process that will review new regulations to ensure that they help streamline the billing process.

Claims Payment Issues:

A time restriction for the resubmission of a claim causes problems for the consumer, provider, and payer. Many managed care and other health insurance companies restrict the timeframe during which a provider or patient can resubmit a claim for payment. In many instances, there is not enough time to follow-up on the causes of a rejected claim and the gathering of the information necessary to resubmit it. Additionally, consumers and providers of care are frustrated with the long time taken to pay claims fueling negative perceptions of insurers and health plans.

- Work with representatives of major health insurers to determine if standards can be developed to address this claim resubmission issue.
- Create a national standardized “Clean Claim” definition, which then could simplify billing communications with patients by avoiding duplication and overlap of claims statements and bills.

Consumer Cost Sharing:

Another issue that creates confusion and an inability to effectively communicate what the patient owes from an episode of care relates to deductibles, co-payments, and co-insurance which are difficult to verify and often difficult to calculate.

- As part of a broader-based reform effort for Medicare, Congress should review ways in which beneficiaries contribute their share of program costs with an eye toward simplification and cost reduction.

Return On Investment:

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In the case studies and subsequent conversations with providers who have adopted Patient Friendly Billing in their settings, post implementation effects were examined and measured. Clearly in each instance participants felt that they understood their patient's needs and frustration with the hospital's billing practices. This understandably actually had a ripple effect into many other aspects of operations such as parking, dietary, way finding, volunteer services and signage. Successful implementation showed decreases in calls to billing departments, increases in patient satisfaction surveys, increases in collections and decreases in days outstanding. One CFO even expressed how this project completely changed his approach to patients and his understanding how healthcare works.

VII. Making Billing More Clear, Concise, Correct and Patient Friendly in the Long Term

If the responses and recommendations noted above are implemented, consumers will see an improvement in the patient billing process. However, certain issues will continue unless more systemic changes are made. Consider the following focus group comments:

Additional Consumer Issues:

Focus group participants viewed the payment process as a struggle that positions providers and insurance companies against each other. They see insurance companies constantly "gaming the system" by delaying or denying payments to providers for many "excuses," such as coding errors, and consumers often feel trapped in the middle. This is repetitive of the first bullet point on page 5...do you intend for it to be so repetitive?

Some people see a need for an independent point of contact for consumers to help them sort through questions about coverage, services, and billing.

Consumer Friendly System:

While short-term fixes can be made to improve patient financial communications, how do we change the system to pry the consumer out of the middle?

There is no simple solution to this problem, since it involves a fundamental tenet of the American healthcare system – pluralism and choice. Health care in this country is pluralistic in that there is both public and private coverage and responsibility. Additionally, employers and consumers want choice in their health plans, providers, and benefits. This fundamental tenet makes simplification difficult. Changing the system will require the interaction, cooperation, and agreement of providers, payers, government, and employers – a daunting task. The **PATIENT FRIENDLY BILLINGSM** Project identifies the need for this to occur and recommends a multi-faceted approach to seek a solution.

Given our system, a solution will require the multiple players to cooperate and standardize for the benefit of the consumer. Although it is difficult to imagine how this will occur, from the consumer's perspective, the desired outcome is obvious, clear, correct, concise, and patient friendly financial communications.

From the consumer's perspective, what is needed is a process that would capture and summarize bills from all providers (hospitals, physicians, pharmacies, etc.), and automatically match those

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with all payments from health or other insurance. This process will result in a consolidated communication that clearly identifies all the services that were provided for an episode or episodes of care, the coverage of that care by health or other insurance companies, the expected insurance payment, and the amount that is owed by the consumer. The consumer would have a single point of contact (either by phone or web site) which is designed to answer inquiries, complaints, or issues about benefits, coverage, payments, and so on. An appeals process would be established to handle disputes that consumers may have about eligibility, coverage, charges, and payments. Eligibility, coverage, and payment issues between providers and payers also will be resolved through this system, handled in a way that is transparent to the consumer. Payments by consumers would be made to a single source, and automatically distributed to those providers and suppliers involved in the episode of care. And, of course, all of this would be handled in a way that ensures the appropriate privacy and confidentiality of individually identifiable patient health information.

A pipe dream? Given the administrative simplification provisions of HIPAA, the explosive growth and effective use of the Internet, actions by various health plans and “dotcom” companies to automate and make Web-enabled certain critical eligibility and benefits information, the solution may not be that far fetched. The savings among all trading partners by simplifying the process will more than pay for the development of this centralized approach.

Removing the confusion and patients' frustration from the billing and payment process is a key long-term goal of the Patient Friendly Billing project. If that goal is achieved, the industry will gain from both improved consumer relations and cost efficient outcomes that benefit everyone involved.

The *PATIENT FRIENDLY BILLINGSM* project should seek industry and grant funding to gather various providers including provider associations, payers (including payer associations), government (including state and federal agencies), and representatives of the public to define an approach to “getting the consumer out of the middle” of health services financial transactions.

VIII. Conclusion

This report, and its detailed appendices were developed to provide general guidance to hospitals and health systems on how to respond to consumer concerns about the patient-billing process. This document also suggests courses of action to address current barriers and long-term systemic problems with the patient billing function. This is but one of multiple efforts underway to reduce administrative complexity and improve communication with consumers.

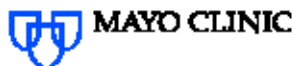
PATIENT FRIENDLY BILLINGSM Project

Project Summary

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Contact Information:

Web site: <[Http://www.patientfriendlybilling.org](http://www.patientfriendlybilling.org)>

Email: info@patientfriendlybilling.org

Phone Number: 708-492-3367