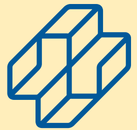
hfma executive roundtable



hfma™

Issues in Up-Front Collections

About the HFMA Executive Roundtable Series

The HFMA Executive Roundtables are a series of discussions among healthcare leaders who have come together to share their experiences with and solutions to pressing healthcare finance issues. This roundtable, addressing hospital leaders' experiences with up-front collections, is sponsored by McKesson.

Self-pay accounts are surging as more and more Americans are uninsured or underinsured, or face increased cost-sharing under their health plans. To make sure of receiving full payment for services, many providers are working to establish patients' financial obligations and collect appropriate payments before rather than after the services have been rendered. But this seemingly simple proposition is rife with challenges.

HFMA recently brought together a group of healthcare finance executives to learn how their organizations are working to collect patients' payments up front. The following are highlights of their discussion.

THE PARTICIPANTS IN THIS HFMA ROUNDTABLE WERE:

David R. Allen, CPA, vice president of finance for City of Hope National Medical Center, a biomedical research, treatment, and educational institution and comprehensive cancer center in Duarte, Calif.

Terry W. Blackwood, FHFMA, CPA, chief financial officer and treasurer for City of Hope National Medical Center.

Terre Churchill, director of patient accounting for Corona Regional Medical Center, a 228-bed facility on two campuses in Corona, Calif.

David M. Cohn, vice president of patient financial services for Scripps Health, a not-for-profit, community-based healthcare delivery network in San Diego, Calif.

Roger E. Parsons, chief financial officer of San Antonio Community Hospital, a 283-bed, full-service, acute care facility in Upland, Calif.

Richard K. Rothberger, senior vice president and chief financial officer of Scripps Health.

Alan H. Smith, Jr., chief financial officer for Corona Regional Medical Center.

Karen Stephenson, director of business services and managed care at San Antonio Community Hospital.

The moderator for the discussion was **Daniel Yunker, MBA,** director of business development for the Healthcare Financial Management Association.

Representing the roundtable sponsor was **David Hammer, FHFMA,** vice president, revenue cycle management services, for McKesson Corporation.

ROUNDTABLE DISCUSSION

▶ **Yunker: To what extent do you collect copayments or deductibles up front from your insured patients during the admission process?**

▶ **Stephenson:** We've always had some type of a deposit program that's built off of copays and coinsurance. It's geared toward those people who are coming in electively, because you can verify benefits and eligibility ahead of time. We then call the patient and tell them what we're going to expect to be paid and what we're going to expect them to pay, so that when they're lying in a hospital bed, they're not worried about how much money is going to come out of their pocket. No elective patient who comes in has 100 percent coverage, so we're talking to them before they come in and asking for the coinsurance or the copayment, or at least a deposit on it, so if necessary we can then work out payment returns on the balance. We do the same thing with elective outpatients who are coming in for the procedures like CTs, MRIs, and outpatient surgeries.

▶ **Churchill:** Along the same line, when our patients come through the ER and they're admitted, we have an insurance verifier who contacts family members to let them know up front there is a deductible or a copay. Few inpatient admits anymore are elective. They're usually emergencies to some degree, so you're on the run to determine deductibles and copays. That's why it's key to have a good insurance verifier department and to have financial counselors who can go to the floor to talk to patients and their family members.

▶ **Cohn:** There's a tremendous shift going on now from inpatient services to outpatient services, with outpatient showing exponential growth. An example would be the huge growth in the CT scans and other imaging services.

What we've set up in the last few years on the outpatient side is what Scripps Health calls RAVE: registration, authorization, verification, eligibility. It is a centralized preregistration team for our hospitals, because what was happening was that on the high-volume outpatient services, we were not able to verify eligibility, get the authorizations, and contact the patients as well as we should have. We were doing a good job on the inpatients, but our challenge really was the high-volume outpatient services and how we could get to all of those.

It's still a challenge, though, even if you call the patient to let them know what their balance or copay amount is going to be. Few patients are actually willing to give you their credit card payment over the phone. More often, we'll let them know up front what their payment is going to be, and when they come in, their entire packet is set up for them.

▶ **Allen:** Our facility is a little bit unusual. Historically, we didn't collect from patients. The care that we provided to patients, at least their portion of the responsibility, was entirely free, because City of Hope's historical mission was to provide care to those in need, regardless of ability to pay. Unfortunately, due to economic realities, we've no longer been able to do that. So it's been a transition for us. We're really just starting to be more proactive in terms of collecting the patients' coinsurance at the time of service. We've been billing for a while, but we're new at collecting at the time of service.

We collect the inpatient Medicare deductibles and copays upfront for our physicians, and recently we've begun to collect coinsurance for some of our more predictable surgeries. We have very expensive surgeries, but since they have a pretty predictable length of stay, we know what our third-party payers will pay and what the coinsurance expectations are. We're also going to transition that process to the more expensive procedures, like PET scans and MRIs.

▶ **Churchill:** It's really important that your insurance verifiers and your financial counselors have access to your contracts. So if the patient's responsibility is a percentage—and we see that going up now—those verifiers need know what the per diems are so that they can go in and figure out what the patient's copay is.

▶ **Allen:** Our managed care people have built a table for our front-end people that includes all of the major contracts and all the major third-party payers, and lays out what the per diems and coinsurance amounts are. It's been very, very helpful. I think we're starting to make good progress, at least on the more expensive inpatient procedures. But since we're a very heavily utilized outpatient facility, our real challenges are on the outpatient side.

Our managed care people have built a table for our front-end people that includes all of the major contracts and all the major third-party payers, and lays out what the per diems and coinsurance amounts are.

▶ **Yunker: What type of staff education do you currently use? What additional education do you think you need?**

▶ **Cohn:** We have set up three different levels of access representatives—billers, follow-up personnel, and front-end staff—in our centralized business office and in our facilities. Each of those positions requires training in our nine-business-day "boot camp." When we first began, the big issue was how much training would be required of the employees who had been with Scripps for a long time. We decided that everyone must attend the classes so that we would have clear and measurable performance standards throughout our facilities.

What we've found is that our level of education really has been brought up since we required it for all of these job functions. We've found it to be a very positive, clear way of laying out expectations and requirements. It has led to better customer service, too, because now there's more consistency between all of our facilities.

▶ **Allen:** We've been focusing on the revenue piece. We have a very long-tenured, dedicated staff at City of Hope. They are very sensitive to the patients and care deeply about them, so we had to gradually try to emphasize the revenue side of the equation. We've taken some stabs at providing some scripts for our staffs. It's not entirely consistent—it's not boot camp. Maybe we do need to have something as formal as boot camp to really drive home some of the things that we want to achieve, but right now, it's an incremental process. But I do see us making progress.

We decided that everyone must attend the classes so that we would have clear and measurable performance standards throughout our facilities.

▶ **Churchill:** We have a program that all of our staff go through called "Service Excellence." During a special training, each staff member writes goals based on six criteria that we have set for service excellence. Then they go back and meet with their manager to go over their goals and discuss whether they are good goals—achievable, measurable, and something the employee is accountable for—and then the manager signs off. The goals are put in their human resources files, and part of their yearly review is based on meeting those goals, so everyone is very clear about what they need to achieve and where they are.

▶ **Smith:** Those goals that they establish are centered around the patient. The patient is our customer, and we want to treat the patient in such a way that they would remain loyal to the hospital.

Corona is in an especially interesting position right now. We were not-for-profit up until the end of 2003, and now we are a for-profit hospital owned by Universal. What's interesting to us, looking at the transition, is that Universal is no more aggressive towards collecting copays than we were prior to the acquisition. We do want to collect all fees that we possible can—any hospital would—but we also have to be sensitive. These patients are in a difficult situation: They don't want to be there, they're not comfortable, they're in pain. So we have to extract money from them in the most pleasant way possible. We do that by providing them with information through a coordinating effort with the physician's office—we consider this a service to them, because they know that at some point in time they're going to be faced with a bill. This way, they know what they're going to owe rather than having to worry about it while they're worrying about their health.

Our scheduling department is integral in this whole process, because we have centralized scheduling, and that's the hub that starts the preauthorization and the determination of what the copay requirement is. We have a very tight relationship with the surgery department. The surgeons often call directly into the surgery to make appointments, but we are immediately informed of what is pending so we can contact the patient. Also, the staff in the surgery suites tell the patient, "You can expect a call from patient financial services, and they'll be going over all the financial information and helping you through that process." It is all intended to make the painful situation of the bill as painless as possible.

▶ **Smith:** Have you noticed a particular trend in how your HMO copays are increasing? And if you have, are you treating them any differently than you are your standard copays and coinsurance?

▶ **Stephenson:** We don't treat them any differently. It's a copayment just like one in any other insurance plan. Unfortunately, though, sometimes I think that we're the first ones to really explain to patients what they owe.

▶ **Allen:** We have no capitation agreements. In terms of inpatient services, these are all negotiated rates, so we don't have that issue. On the outpatient side, we collect copays for our physicians, and I'm sure there's been some creep-up in copays there. We also provide retail pharmacy services, where we've seen copays ramp up considerably, and I think that has put some stress on our patient population.

▶ **Yunker: How are you dealing with some of those copays that you can identify in advance? Are you collecting those up front?**

▶ **Churchill:** Following the insurance verification and notification call process, staff are going up to the hospital room and educating the patient on the fact that they do have those copays. We actually give them a letter. Hopefully, a loved one is there so that it can be resolved, because in many cases we've taken the patient's valuables before they are admitted—and then we're asking them for money. It's sensitive.

▶ **Smith:** That gets back to the earlier question about education. There are a lot of systems available to hospitals to gain information about their patients and their benefits. The three things that we think are especially critical in training our staff are: first, understanding our managed care contracts and all the nuances associated with them, including the senior HMO contracts; second, understanding basic benefits concepts and being able to use the benefit information they receive from a patient with the managed care contract to do some calculation on what that patient is going to owe; and third, navigating the Internet to get information on behalf of the patient from the insurance companies that have Internet-based authorization and inquiry capabilities.

▶ **Hammer:** How much of your training is split between process questions, like understanding benefits, and system training? Is it shifting with the increasing emphasis on Internet?

▶ **Cohn:** Out of the nine days in our boot camp, we probably spend four days on a basic knowledge of our contracts, how patient accounting works, how our revenue cycle works, and what it means to us in terms of Scripps. Even those people who come to us from other healthcare facilities have to undergo this training. We're not going to assume that they understand all of those basics. Only then do we start to look at our systems training, which would include our patient accounting systems and creating a standard of performance for how they deal with patients.

▶ **Hammer:** What percentage of your third-party payers are available on-line? What do you think about the accuracy of the eligibility information you're obtaining on-line?

▶ **Churchill:** You can purchase a service from an outside vendor who would give you that data, but I've found that their data is a little old. When I go onto the carriers' web sites, I find much better data than I'm finding through the vendor, because the carriers' is updated in real time, whereas the vendor's is updated once a day. Plus, I get a little more information on the carriers' web sites than I do through the vendor; the web sites give me percentages and copays, while the vendor pretty much just tells me if the patient is eligible or not and who their medical group is. Probably about 60 percent of our carriers have web sites for which we have passwords to be able to get information.

> We have a very tight relationship with the surgery department. The surgeons often call directly into the surgery to make appointments, but we are immediately informed of what is pending so we can contact the patient.

▶ **Allen:** We do some very esoteric things at City of Hope. For us, to go on a web site and find that, "Okay, they have insurance,"—that's not good enough. We have very thorough staff training on how to determine coverage, because we do bone marrow transplants, we have very complex chemotherapy regimens, we have many different treatments that are very expensive. We also have a retail pharmacy, and most of our patients are not going for an aspirin or some Lipitor; they need very expensive immunosuppressant drugs and chemotherapy agents and those sorts of things. So we have to do a very thorough eligibility verification and benefit verification that is above and beyond what most hospitals really need to do.

▶ **Churchill:** On the inpatient side, we still call the insurance provider. Because of case management, we want to check what home care provider or SNF we need to discharge to for any follow-up care and that sort of thing. The on-line information doesn't tell us that.

But we do use the web sites frequently. To collect from the patient, we're looking for what their deductible is, how much of their deductible has been met, what their percentage is. That is the part that those vendors don't give us and that the web sites do.

▶ Yunker: What are some of the challenges that you're facing in terms of the up-front collection processes for the uninsured patient population? What are some of the areas in which you feel you're having some success?

▶ **Stephenson:** I think the biggest challenge is that to a large extent, you don't know if an uninsured patient is coming until the patient arrives, because they're the ones who are generally coming to the emergency room. Of course, you've got to treat them in the ER and make sure they're clinically stable before you talk to them, so our biggest challenge is getting them early enough in their treatment to start discussing the options available to them, to find out whether they meet Medi-Cal criteria.

We are not a contracted Medi-Cal facility, but we still see quite a few Medi-Cal patients. We have a company that works on site to help us with those applications. But it's a process initially of just trying to find out if they have insurance, and if they don't have insurance, what are their financial resources. In San Bernardino County, if the patient is eligible for the Medically Indigent Adult (MIA) program, then there is some reimbursement we can get from the county. If they're not eligible for any financial assistance, then we'll take a financial application and consider them for charity care.

▶ **Churchill:** For our ER clerks, we have sheets that ask the basic questions for uninsured patients to see what kind of program they may be eligible for. Then we can start routing the patient from that point on. When that patient hits that door on Friday night and is discharged by Sunday, that's probably the biggest self-pay issue that we can't do anything about. Once they're gone, they don't have a lot of incentive to get us the payment we're due.

▶ **Stephenson:** I would say that collections for self-pays in the emergency room are pretty dismal unless you happen to get lucky and find somebody who's got a credit card or a family member who can take care of it. If patients are scheduled ahead of time and we know about it, we can talk with them and work with them to find out what options are available. We also give them the realities of what the numbers are for the procedures they need.

Again, it goes back to customer service and not waiting until the end to surprise them with a $50,000 bill. So they have an option of asking themselves, "Do I really need to come in or not? And if I do, maybe I need to go to County Hospital."

▶ **Allen:** We have a fairly unusual situation with uninsured patients at City of Hope, because a lot of our patients are with us for 60, 80, 90 days, and that'll exhaust their benefits. We'll go through a financial screening to see if we can find some resources, but typically a lot of that ends up being charity care.

▶ Yunker: A few of you have mentioned that it's challenging to collect from people who show up first in the ER. What do you do mechanically to address that?

▶ **Stephenson:** All of the ER clerks who do registration can do the initial financial screening process. Then typically, we have a financial counselor down in the emergency room about 16 to 20 hours a day. That person becomes the primary contact to those uninsured patients, and focuses on the patients who are going to need additional care, not just your basic ER patients who come in, get treated, and leave. That counselor works in conjunction with the case management department, which also has somebody down in the ER 24/7. So between the case manager, the financial counselor, and the clinical staff, they can start talking about what this patient needs, what kind of aftercare he or she will need, and how much it is going to cost, so hopefully they can then have that conversation with the patient.

We, too, have the MIA screening, which is a series of about five questions, such as, "Are you pregnant? Are you over 21?" But it is just a tool. It's not until after the medical screening exam has been done that we can even truly talk to the patient about the financial side. Our biggest issue is trying to get the coordination down with the clinical staff so they remember to tell us, "Okay, you can talk to the patient now."

▶ **Parsons:** Just to clarify: one of the reasons we have case management in the ER 24/7 is because our ER was built in the mid-'70s to handle about 30,000 patients, but last year we saw 62,000. Our case managers are in

the ER not so much to manage costs, but to make sure that we get patients identified and properly placed in the hospital, or to home health, or to an extended care facility, or wherever they're going.

▶ **Cohn:** How long have you have had financial counselors in your emergency room? What's your return—in other words, have you found this to be worth the benefit of investing?

▶ **Stephenson:** I actually have. We've only had our financial counselor down in the ER for probably the last two to three years, and we target that person to come in the evenings, so that if we're short anybody, we at least have the evenings covered. During the day, the 8:00-to-4:30 folks can cover. The person we hired to be there actually started keeping his own numbers to track what he was collecting, and he had set some goals for himself. He collected more than his salary a couple times over again, so he definitely paid for himself.

▶ **Cohn:** Does anyone here have incentives on your point-of-service collections, or any other kind of systems in place to improve your up-front POS collections?

▶ **Stephenson:** We do not have an incentive system. We've talked about it, but we haven't done it yet. People have done things for themselves. But this is interesting: Last year, the assistant director in the ER decided to start posting, by initial, how many copays each person collected. At first, people thought it was very unfair, but it was surprising how they started trying to up each other every single month. The reward was a couple of movie tickets or something very incidental from a cost perspective. Then we stopped doing that at the end of the year because we wanted to focus on something else, and it's been kind of interesting to watch the number of copays drop. So even small incentives work.

▶ **Churchill:** We put a goal in place for ER registration staff. We take the number of ER visits and multiply it by $35, the basic copay rate for an ER, and that's their cash goal. We also have a quality assurance process in our registration area, and that cash goal is one of the QA pieces. Then we go back and educate: If one or two people are falling lower in that QA process and you see their percentages getting out of whack, then you talk to them and start the education process over for them.

▶ **Allen:** We have a little bit different approach, but we have an incentive plan as well. It's a very informal one, but we try to look at it as a whole team effort—so instead of singling out any one group, we set a goal for the entire revenue cycle team. We're a union environment, so that kind of ties our hands in terms of some of the things we can do. But if we hit those goals we try to have celebrations—barbecues, little gift packs and goody bags, things where we really go out of our way—and bring in our CEO and CFO to tell the staff how much their efforts are appreciated. The staff really does appreciate it. They look forward to those events and that recognition.

▶ Yunker: How are you establishing incentive goals, and how are you making decisions about units versus dollars versus percentage?

▶ **Churchill:** We look for a 95 percent accuracy level where we've requested money from the patient. It all kind of rolls up to the business office, also. If the business office doesn't make their cash goal for the month, which is based on 60 days of revenue plus a little bad debt factored in there, nobody gets money. So if the business office doesn't make its goal, then registration doesn't achieve its goal either, so it really pulls everybody together as a team and makes everybody understand where the money's coming from and that we all need to work together. The only problem is that right now it's a very manual system. If there were any way to automate more, that would be wonderful.

▶ **Hammer:** That is really the next step: workflow automation tools for all of the major systems. That's what the marketplace is asking for. The approach that people are trying to take now is to build rules that say, "This is what the standard performance ought to be," and then let the system count—to the greatest extent that it possibly can, based on all of those rules—how much of the goal was achieved.

I've had some discussions with representatives of other systems—we're all marching down that road, and we're getting there at a variable rate. But I think workflow automation is clearly one of the key development efforts that are underway with all the major system vendors, because that's what matters. Sampling manu-

ally is very time-consuming—it's a huge job to sample even 10 percent of your registrations, because you need to do the work on 100 percent.

▶ Yunker: What approaches for improving self-payment rates have you found to be particularly effective and patient-friendly?

▶ **Allen:** In terms of self-pay patients, the majority of the responsibility falls into the laps of the financial counselors. They sit down with the patients and say, "This is what we see in terms of a course of treatment, and this is what we would expect in terms of cost," and take it from there. I know that's not the experience that most of you have, except with your scheduled admissions.

▶ **Churchill:** Our scheduling and preregistration are one and the same. Those staff have been trained on how to give patients clinical information, but they also know how to give patients relevant financial information. Since they do both functions, they really understand what is needed on both sides.

▶ Yunker: Are there areas that you are currently outsourcing or considering outsourcing?

▶ **Stephenson:** We don't do any outsourcing, but we do use a company to do long-term payment arrangements. All that really does is allow us to get some money up front. Obviously, the account's still on our books, but then the vendor does their letter cycle. We make patients aware of it, and it just gives them an option of another way to pay their bill.

▶ **Churchill:** We outsource to an early-out agency, which takes our self-pays at day four. We also have a county worker who handles Medicaid applications, but unfortunately we don't have a space to put this worker in. We have run out of space completely, so we do outsource all of our out-of-state Medicaid, and as a bonus to us they will pick up our ERs that are over a thousand dollars.

▶ **Cohn:** We outsource our insurance small dollar accounts. We have a dollar threshold on third-party, nongovernment accounts, and that also could include self-pay after insurance. But we only outsource after a certain period of time, typically 90 days, on unresolved accounts for selected financial low-dollar classes.

▶ **Hammer:** It's interesting: the basics never change. Healthcare is still an "ABC" environment—admitting, billing, and collecting—and the challenge is in doing that well. What's different now, though, is that we really have a much more patient-centered focus. HFMA's own research shows that organizations that embrace patient-friendly billing do achieve better results.

About the Sponsor:

McKesson transforms the delivery of healthcare through advanced administrative, financial and clinical systems that reduce or eliminate paperwork, facilitate access to data at the point of care, and reduce the variability of healthcare. Our comprehensive portfolio of revenue cycle and healthcare performance management solutions helps organizations address their most critical financial and operational issues. For more information, visit the McKesson web site at http://infosolutions.mckesson.com. Contact David Hammer by e-mail at david.hammer@mckesson.com or by phone at (954) 537-9540.

Copyright 2004 Healthcare Financial Management Association. All rights reserved.