Credible, Defensible Estimates
More Accurate Upfront Financial Calculations Bring Increased Revenue, Satisfaction With Entire Care Experience

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Executive Summary

In healthcare, every interaction with the patient matters. Especially in today’s environment of continuous improvement, efforts have been concentrated on coordination among providers, the patient care experience and quality outcomes – all laudable goals.

Often overlooked in these improvement efforts are the front-office and back-office functions that intersect with the care experience from beginning to end. A patient’s perception of the care experience begins when the phone rings for the initial appointment or appearance in the ED, and doesn’t end until the final bill is paid and the account balance is zero. The billing portion is often the place where patient satisfaction falls short.

A survey of 500 consumers showed a direct correlation between patient perceptions of the billing experience and their overall satisfaction level with the provider. The higher the satisfaction with the billing process, the higher the overall satisfaction with the hospital and the clinical treatment received. Recognition of this direct correlation and adaptation of service delivery is essential to adapt to the “new-normal” model of high-deductible coverage and overall increased patient out-of-pocket responsibility.1

Helping patients gain a realistic expectation about their financial responsibility for visits, tests and procedures can help move toward the goal of increasing patient satisfaction scores while also driving toward lower A/R days and ultimately heightening the positive perception of a health system within a community.

There are many variables involved in creating a patient-specific estimate of responsibility, but the technology, tools and staff development models exist to accomplish this with a high degree of accuracy and compassion.

This white paper will explain why hospitals and health systems should concentrate efforts on determining a patient’s financial responsibility up front and will outline the gains that can be made by setting clear expectations for payment while preserving the positive perceptions of the care experience.

High-deductible plans bring more upfront patient costs

As costs shift to the patient due to the increased popularity of high-deductible health plans and ever-higher healthcare costs, the onus is squarely on providers to collect full or partial payments up front for office visits, procedures, therapy and other care services.

The move toward high-deductible plans shows no indications of slowing. More than 13.5 million Americans are now covered by health savings account (HSA)-eligible insurance plans, a figure that has tripled overall since 2007. While employer type and geographic location variances exist, the fastest-growing markets are large-group coverage, which grew by 26 percent, and small-group coverage, up 9 percent.2

These high-deductible plans also can be called consumer-directed health plans or account-based plans. Each combines a high deductible with a savings vehicle such as an HSA or a health reimbursement arrangement (HRA) to help offset the additional financial outlay before co-insurance kicks in. About one in every eight employers offers an account-based plan as their only plan option. By 2014, that percentage could climb from 12 percent to 46 percent.3

Employees and employers are both being saddled with increasingly high costs. Healthcare costs are expected to rise by 5.3 percent in 2013, following a 5.9 percent increase in 2012.4 The average annual premium for family coverage has risen to $15,745, with the employee picking up more than 27 percent of the cost.5

Correspondingly, the general annual deductibles for singles and families also are on the rise. Deductibles for coverage in a high-deductible, HRA plan are $1,923 for singles and $3,666 for families. Deductibles in HSA-linked plans are even higher, with a $2,190 general annual deductible for singles and $4,068 for families.6 IRS rules state that high-deductible plans must have a minimum deductible of $1,250 for individuals and $2,500 for families in 2013, with maximum out-of-pocket limits reaching $6,250 for individuals and $12,500 for families.7
More patients are responsible for first-dollar coverage, not as a $10 or $20 co-pay but for every penny of the negotiated rate up to their defined deductible, which leaves hospitals and health systems scrambling to find ways to collect this money without damaging the relationship with patient-customers. Health systems must remember the “consumer” part of these high-deductible plans to compete effectively in today’s more transparent environments. Patients have choices, and now more of their own money is at stake. Having access to accurate and up-to-date insurance information – specifically plan year-to-date deductible, co-insurance percentage and out-of-pocket maximum amounts – is critical to the patient responsibility calculation.

In the indemnity insurance world, patients didn’t make much distinction between in-network or out-of-network providers, merely plunking down their co-pays and expecting service. But the increased popularity of high-deductible plans and the shifting of costs in general from employers to their workers are forcing savvy patients to price shop — everything from physician visits to heart valve replacements.

As a result, health systems must become more transparent in their pricing, which, coupled with efficient and courteous collection efforts, actually can help a hospital compete in its market.

Collection experience linked to patient satisfaction

A fine line exists between collecting sufficient funds at the point of service and creating animosity through strong-arm tactics that go well beyond accepted business practices. A positive billing experience can reinforce the feeling of receiving quality care. A bad billing experience can leave a foul taste that can plague the provider forever with the patient and everyone the patient speaks with. Recent examples such as Fairview Health Services in Minnesota and its former collection agency Accretive Health highlight the fine line providers must walk when discussing financial obligations at the point of care.8 While the Emergency Medical Treatment and Active Labor Act (EMTALA) provides guidance on acceptable timing and processes in emergent situations, providers should take a community-driven approach that includes education and outreach on collection policies. A good example can be found at Newman Regional Medical Center, Emporia, Kan., which outlined its ED collection and charity policies in an open letter in the local newspaper.9

An industry study shows a direct link between billing satisfaction and overall satisfaction among those who owed money after insurance had been settled. Only one in four respondents rated the hospital billing experience a five on a five-point scale, but 85 percent of those people were very satisfied with the hospital overall, and very satisfied with the clinical treatment they received. Among those who rated billing a one or two, just 11 percent were very satisfied with the hospital and 63 percent with the clinical treatment.10

Higher overall patient satisfaction also has been linked to increases in future volume. A Press Ganey study of patient satisfaction in 1999 and patient volume over the next five years showed that hospitals with patient satisfaction in the 90th percentile increased their patient volume by one-third, or nearly 1,400 extra patients per year. Conversely, hospitals in the bottom 10th percentile saw a 17 percent decrease in patients, or 2,600 fewer per year.11

So, the links between patient satisfaction, hospital volume and billing satisfaction, and overall hospital satisfaction are well-documented. Organizations that can effectively communicate with patients about financial matters throughout the care delivery process will have more success at eliminating the sources of confusion and misunderstanding within their patient populations, and simultaneously set appropriate expectations. Setting, adjusting and delivering on expectations may well prove to be the linchpin for achieving high billing satisfaction rates, and it is an easier task than you might imagine.
Medicine not as individualized as one might think

All healthcare is local and personal, but there are more commonalities among patient conditions, physician and facility preferences and health plans than is commonly acknowledged. In nearly every instance, a physician performs a certain procedure the same way every time. Of course, some variability may exist in each case, but what appears to be chaotic at a glance can be quite predictable.

Health plans, agnostic third parties and forward-thinking health systems already have developed tools to estimate costs for certain visits, tests and procedures based on historic data. For example, 30 Blue Cross and Blue Shield plans are using a cost-estimator tool for nearly 60 procedures, with plans to add dozens more by mid-2013. Members can find a provider, compare quality results and determine estimated costs -- all based on their health plan information and usage for the current plan year.¹²

Some are more accurate than others, but these so-called decision support tools are gaining prominence as patients take more control of their healthcare dollars.

Even health systems that don’t currently publish prices for common tests and procedures have access to that information in their billing databases. With today’s robust information interchanges, a provider can look up a patient’s health plan information and receive a near real-time picture of where the patient stands in relation to deductible and co-pays, as well as the negotiated rate for the visit, test or procedure. But it’s not enough to know what a patient owes in advance. You must ask for the money you are owed and be prepared to defend the accuracy of your estimate.

What goes into a good estimate? It’s a combination of data on:

- The patient’s benefit plan
- Whether the deductible has been met
- The co-pay and co-insurance amounts
- Details of the particular visit, test or procedure
- The negotiated amount for each procedure, based on the benefit plan
- The physician-specific variations for the procedure or test

So how many of these calculations can your health system currently perform? RelayHealth has developed an Estimation Maturity Model (EMM) to help hospitals and health systems determine their strengths and challenges in this area.

The EMM includes 14 characteristics germane to estimates, divided into five levels based on a facility’s ability to perform against each characteristic. As a facility moves farther to the right (or matures), the better job the facility does in producing and disseminating good estimates and performing the appropriate collection activities. The five levels from least to most mature are:

1. Initial
2. Repeatable
3. Defined
4. Managed
5. Optimizing

Briefly, organizations in each respective level could be generally described as follows:

Level 1

Initial Estimates

- Have not yet adopted or implemented a strategic approach to estimation and pre-service collections across the enterprise
- May be piloting estimation and pre-service collection processes and tools for discrete service lines or locations
- May be performing some estimations, but they are performed exclusively by a small group of “domain experts”
Level 2: Repeatable Estimates

- Have adopted and implemented a strategic approach to estimation and pre-service collections and have a documented model for select cases at select locations
- Estimation models and collection calculators are used to manually create estimates for select service lines or locations
- Estimations are performed exclusively by senior registration leaders
- Calculations are derived from fee schedules and ad-hoc calculation of historical services

Level 3: Defined Estimates

- Have adopted and implemented strategic approach to estimation and pre-service collections and have a documented model for scheduled encounters at most locations
- Estimation models and collection calculators incorporate both acute and professional charges
- Estimations and collection tools support the registration workflow and are available to senior staff members
- Calculations are derived from fee schedules, as well as pre-calculated and charge detail history

Level 4: Managed Estimates

- Have adopted and implemented a strategic approach to estimation and pre-service collections and have a documented and integrated model for ED visits and scheduled encounters at all locations
- Uses estimation models and collection calculators for all services and all payers that are personalized, whenever possible, to a patient based on their year-to-date benefits
- Estimations and collection tools are integrated into registration workflow and most registration staff members are accountable for their use
- Calculations are derived from fee schedules, as well as pre-calculated and charge detail history that recognizes such variations as service location, physician preferences and the effect that these variables have on out-of-pocket costs

Level 5: Optimizing Estimates

- Are providing estimates and performing pre-service collection activities consistently, with few exceptions
- A continuous improvement focus is applied to estimation models and collection calculators, which are used for all services and all payers and personalized to a patient, whenever possible, based on their year-to-date benefits
- Estimations and collection tools are integrated into registration workflow, and all registration staff members are accountable for their use
- Collections activities incorporate into the workflow a patient's propensity (ability + likelihood) to pay
As with all maturity models, the designation of a specific EMM level for an organization is not an exact science. Variations in process definition and process adherence within an organization make the selection of a single level a daunting task. Adding the multiple points of service, disparate facilities and elements as subtle as shift differentials add further complexities to narrowing to a specific level. Rather than designating a single level for your organization, consider measuring the specific attributes (rows) of the EMM to create a blended view of the organization’s adoption, both in principle and in practice. In short, don’t fixate on quantitative terms such as “all” or “most” or inclusive concepts such as “or” and “and” as a litmus test for a level.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Initial</th>
<th>Repeatable</th>
<th>Defined</th>
<th>Managed</th>
<th>Optimizing</th>
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<tbody>
<tr>
<td>Process</td>
<td>Undocumented</td>
<td>Documented</td>
<td>Documented and Semi-Automated</td>
<td>Documented and Integrated Workflow</td>
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<td>Financial Counselor</td>
<td>Lead / Sr. Registrar</td>
<td>Sr. Registrar</td>
<td>Registrar</td>
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<td>Special Case</td>
<td>On Request or Select Services</td>
<td>Most Scheduled Encounters</td>
<td>All Scheduled and Select ED</td>
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<td>Historical Claims Fee Schedule</td>
<td>Charge History + Payer Contracts</td>
<td>Charge History + Contracts + Patient Benefits</td>
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<td>Standardized Estimate Form</td>
<td>Personalized Estimate</td>
<td>Personalized Physician + Hospital</td>
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<td>Scheduled OP/IP &amp; ED</td>
<td>All Service Lines</td>
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<td>Full Encounter</td>
<td>Full Encounter</td>
<td>Plan of Care</td>
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</table>
Conclusion

A strong correlation exists between a positive billing experience and overall patient satisfaction with the hospital and the treatment received. It’s also true that hospitals with higher satisfaction scores bring in more patients.

The key to a positive billing experience begins with mining the information your system already has in its databases to create a credible and defensible billing estimate. Accurate billing is robust, changing over time as new information is received, costs change, new procedures are developed, or new physicians bring their own approaches to the procedures they perform.

RelayHealth’s Estimation Maturity Model can help you determine where your facility is along the maturity continuum and provide guidance to move toward more accurate and defensible estimates that patients will understand and accept.
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