

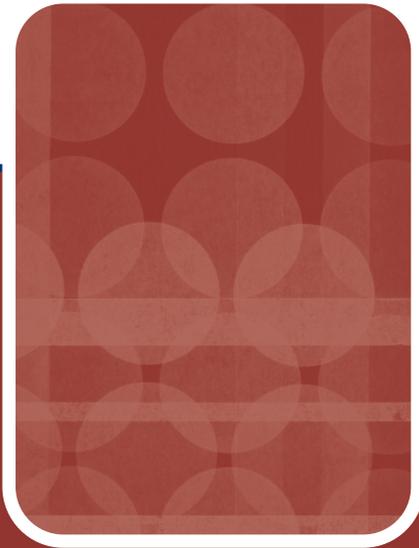
A REPORT FROM THE

PATIENT FRIENDLY BILLING[®]

PROJECT

Hospitals Share Insights to Improve
Financial Policies for Uninsured
and Underinsured Patients

February 2005 Report

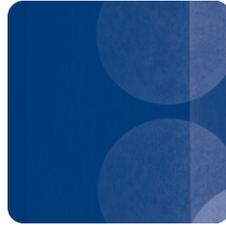


hfma[™]
healthcare financial management association



American Hospital
Association

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Dear Colleagues,

We are pleased to present this report on the *PATIENT FRIENDLY BILLING*[®] Project's examination of the issues surrounding discounting and collection practices for patients with limited ability to pay. As increasing numbers of hospitals are updating their financial policies, they find that there are many factors to consider and numerous alternative approaches. Hospital leaders need practical ideas as they revise policies. This project and report were designed to address some of these issues.

The *PATIENT FRIENDLY BILLING*[®] Project worked with hospital system leaders across a broad cross-section of the field to produce this report. We conducted interviews, solicited advice from systems that had recently updated their financial policies for uninsured and underinsured patients, and analyzed alternative approaches to updating policies and procedures.

Each hospital and community has unique considerations. There is no single approach or set of solutions that apply to all hospitals. By addressing the following seven questions, each hospital can develop responsible, balanced policies and practices for their community:

1. Who qualifies for discounted or free care?
2. What services are discounted?
3. What discount levels are offered?
4. How are policies communicated?
5. How are unpaid patient accounts resolved?
6. What structures and systems are in place to implement and administer policies effectively?
7. What is the relevant legal and regulatory context?

Hospitals that have recently revised their policies shared with us lessons learned about characteristics of useful policies; the need to involve others; procedures for training, implementation and monitoring; methods to help patients; and the importance of early action. We hope discussion of these questions and lessons learned encourages hospitals to continually improve their financial policies.

Many of the ideas and approaches in this report address symptoms of the bigger issue—45 million Americans without health insurance. These Americans also have difficulty paying for prescription drugs, physician services and other healthcare services. Hospitals need to continue to work with policy makers and others to develop solutions to the underlying issues of increasing numbers of uninsured and underinsured patients. In the meantime, please join our efforts to make an immediate difference in your community by considering ways to improve your financial policies.

We hope the tools and approaches in this report give you specific, practical ideas that work!

Sincerely,



Richard L. Clarke, FHFMA
President & CEO
Healthcare Financial Management Association

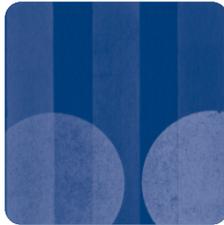


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PATIENT FRIENDLY BILLING[®] Project

Introduction

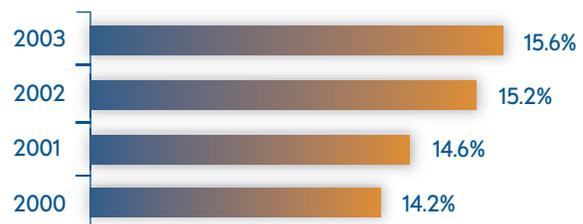


Hospitals are faced with a dilemma. An estimated 45 million Americans have no health insurance, and millions more have inadequate coverage that leads to difficulties in paying for health services. The burden of providing access to health services for uninsured and underinsured patients has fallen substantially on hospitals, public health departments and community health centers. Hospitals are committed to their communities and carry out missions that include significant charity services. And all hospitals with emergency departments are required by law to provide certain emergency services to anyone, regardless of their ability to pay.

But at the same time, hospitals are expected to operate in a financially responsible manner and manage limited resources effectively. Balancing patient needs and stakeholder expectations while operating in a dynamic regulatory and market environment creates major challenges for hospitals. Given these conflicting demands, a fundamental challenge for hospitals is how to best identify those patients who are unable to pay and establish payment expectations for those who are able to pay.

To better serve patients, many hospitals are evaluating their discounting and collections policies and practices for services to the uninsured and underinsured. In

National Percentage of the Uninsured Through Time



Source: U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the United States: 2003."

2003, the *PATIENT FRIENDLY BILLING*[®] Project began to develop tools and share knowledge and practical ideas to help hospitals and health systems revise their policies and procedures and implement those revisions quickly and effectively.

This work was developed through discussions, interviews and surveys with hospitals and health systems and state hospital associations. The hospitals and health systems represent various geographical locations, market types and hospital sizes. The Lewin Group, Inc., www.lewin.com, was engaged to conduct interviews and other research, to collect and analyze data, and to provide drafts of this report.

This report outlines seven key questions that hospital leaders may ask when reviewing their financial policies for uninsured and underinsured patients and summarizes important aspects of each question to consider when

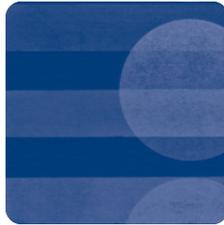
Reference Materials: Studies on the Uninsured and the Patient Friendly Billing Project

<http://www.patientfriendlybilling.org/2005report/tools.htm#1>

effectively revising these policies. Additional tools and resources are available on the *PATIENT FRIENDLY BILLING*[®] website, www.patientfriendlybilling.org.

The information provided in this report is anecdotal and based on the experiences of the hospitals interviewed for this project. It should not be viewed as representative of every hospital or system. Individual hospitals should use the report and subsequent tools within the context of their own institutional and community circumstances.

Section One: Guiding Principles



The following principles set forth by the AHA have guided this Project:

- Treat all patients equitably, with dignity, with respect and with compassion;
- Serve the emergency healthcare needs of everyone, regardless of a patient's ability to pay for care;
- Assist patients who cannot pay for part or all of the care they receive; and
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals' doors open for all who may need care in a community.¹

The following additional principles were also used to guide the discussion of discounting and collections policies and practices for uninsured and underinsured patients:

- Patients and their families have a responsibility to help hospitals qualify them for the appropriate level or type of financial assistance given their circumstances;

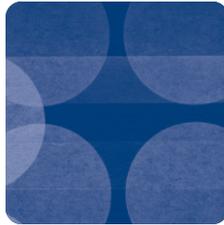
- To ensure the continued ability of hospitals to serve all patients, hospitals have a responsibility to develop and administer financial assistance policies fairly. Hospitals also have a responsibility to all patients to seek payment from those patients who have the ability to pay; and
- When developing more patient-friendly policies and procedures, hospitals may want to seek input from their communities.

1. AHA Hospital Billing and Collection Practices: A Statement of Principles and Guidelines, December 17, 2003. See http://www.hospitalconnect.com/aha/key_issues/bcp/index.html

Reference Materials: AHA's Guiding Principles

<http://www.patientfriendlybilling.org/2005report/tools.htm#2>

Section Two: Challenges to Overcome When Revising Uninsured Policies and Practices



Hospitals, patients and policy makers have struggled with a range of multi-faceted and complex issues as a result of the framework of state and federal regulations and third-party contracting in which hospital charges were traditionally set. Discounting and collections policies for uninsured and underinsured patients vary significantly across hospitals in the United States. When revising them, hospitals should take into consideration the unique needs of their organizations and communities. Complicating the issue further are factors such as the following:

Environmental Factors

- The nation currently has no solutions to the problem of the growing number of uninsured and underinsured patients. Many health insurance plans, including Medicare, leave patients with growing out-of-pocket costs. While some believe that higher patient obligations will help keep costs down, this situation makes it increasingly difficult for some to pay their hospital bills.
- Many patients simply lack the financial means to purchase insurance. Additionally, some health savings plans can create disincentives for patients to be forthcoming with their insurance and income information. Some uninsured patients (or their employers) can afford

National Uncompensated Care Costs 2000–2003 (in Billions)



Source: Health Forum, AHA Annual Survey Data, 1980–2003.

- health insurance but choose not to obtain coverage.
- Litigation could impose excessive costs on hospitals for shortcomings of the overall healthcare system.
- Hospitals that discount or write-off a patient's balance without documenting the patient's inability to pay may cause other payers to reduce the amounts they pay for services rendered, thereby creating a vicious cycle of payment shortfalls. In addition, changes to hospital discounting and collections policies for uninsured and underinsured patients have the potential to distort or change insurance markets overall; for example,

Reference Materials: Employer Cost Shifting and Affordable Insurance

<http://www.patientfriendlybilling.org/2005report/tools.htm#3>

employers might reduce coverage for services if hospital care in the area will be written off or discounted.

- Hospitals alone cannot address the problems of the uninsured. Instead, hospitals should work with others in the healthcare system, such as payers, legislators and their communities, to explore the adoption of new policies and procedures.

Regulatory Factors

- Clarifications regarding how the federal government will interpret relevant regulations and laws communicated in February through late December 2004, have been constructive and make hospital policy changes more possible. However, some issues arising under federal healthcare programs remain unresolved.
- As regulations and laws evolve, care needs to be taken to ensure that they do not become even more complex and have the unintended consequence of making it more difficult to discount or provide charity care.
- In many locales, state and local regulations can create additional considerations. For example, such regulations may specify when discounts are permitted or required or how they are to be calculated or communicated.

Hospital Factors

- Given the increasing number of uninsured and underinsured patients, many hospitals may want to review their policies and practices to determine if they continue to meet the needs of their organizations and the people they serve.
- Hospitals struggle to sort out which patients are unable to pay bills and which are unwilling to pay. In order to protect the financial viability of the facility and continue their service to the community, hospitals have a responsibility to bill and collect from patients to the

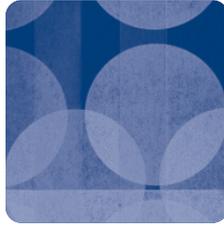
extent they have the ability to pay even a modest amount toward their care.

- Hospitals face a difficult task in setting the appropriate discount levels. If a hospital's discount levels are too high, the ability to survive financially can be threatened. If discount levels are too low, important community and patient needs may not be met.
- Many hospital Charge Description Masters were designed to meet requirements of state and federal regulations and third-party health insurance contracts.
- It can be difficult for patients to learn about the financial assistance that is available to them. Front-line staff at many hospitals may need additional training and better tools to communicate with patients and their families.
- Billing and collections policies affect many departments throughout the hospital; therefore, changing those policies creates practical and complex issues that need to be resolved so that policies can be implemented successfully.

Reference Materials: Medicare Issues, Cost Shifting to Other Payers, and Gross Charges and Uninsured Patients

<http://www.patientfriendlybilling.org/2005report/tools.htm#4>

Section Three: Key Questions to Address When Evaluating Policies



These challenges require hospital leaders to address numerous significant issues when reviewing or changing current policies and practices related to discounting and collections for care provided to uninsured and underinsured patients.

Following are some questions hospitals can use as tools to guide this process. By addressing these questions, hospitals can develop responsible, balanced policies and practices that assist uninsured and underinsured patients:

1. Who qualifies for discounted or free care?
2. What services are discounted?
3. What discount levels are offered?
4. How are policies communicated?
5. How are unpaid patient accounts resolved?
6. What structures and systems are in place to implement and administer policies effectively?
7. What is the relevant legal and regulatory context?

The discussion of these questions highlights issues for hospitals to consider and helps put these issues in context. *THE PATIENT FRIENDLY BILLING*[®] website contains a convenient checklist that hospitals can use to make sure they have considered the different aspects of each question, evaluate their current status, and help identify appropriate changes.

1. Who qualifies for discounted or free care?

Most policies of hospitals interviewed by the Project specify that certain patients (e.g., those who do not qualify for Medicare or other coverage and with household incomes up to a specified percentage of the Federal Poverty Level or “FPL”) qualify for 100 percent discounts (or “free care”) and that other patients (e.g., those with incomes up to some higher specified percentage of the FPL) qualify for discounts on their hospital bills. The exact discounts and qualifying income or asset levels vary from hospital to hospital. Hospitals take into account a broad range of factors in determining patient eligibility for discounted care, including:

Patients’ Potential Eligibility for Third-Party Coverage (e.g., Medicaid).

Many hospitals interviewed for the Project have refocused their efforts to help patients apply for government-sponsored health insurance programs or other third-party coverage, such as COBRA, prior to resolving patient accounts. Hospitals use a variety of approaches to assist patients. For example, they pay salaries for Medicaid eligibility workers or outsource eligibility activities to vendors. Often patients can be in limbo waiting for decisions about their pending Medicaid applications. Hospital financial

Reference Materials: Worksheet for Reviewing Financial Assistance Policies and Uncompensated Care Policy Guidelines

<http://www.patientfriendlybilling.org/2005report/tools.htm#5>

assistance policies are becoming more specific about when discounts are offered for these patients.

State Regulations. Some states specify which patients qualify for free or discounted hospital care. For example, Massachusetts has a free care program with detailed requirements surrounding eligibility and financing of the program. Hospitals must be aware of their state's requirements before writing or revising current policies.

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Many state hospital associations have compiled guides to relevant laws and regulations for their hospital members.

Federal Regulations. Federal regulations also must be considered when examining discounting and collections policies. For example, if discounts on copayments and deductibles are considered too generous for low-income Medicare patients, hospitals could be at risk for inducing federal health program business. These and other regulations are discussed later in this report.

Local Economic Conditions and Cost of Living. Local economic conditions are an important factor in establishing fair policies for discounting care as well as ensuring that hospitals set eligibility thresholds that they can sustain. Some hospitals serve communities with many low income patients, small employers and service industries, while others provide care to communities with wealthier populations. Offering free care to all patients with incomes below a certain percentage of the FPL would have very different consequences for hospitals in these different circumstances.

While many hospitals and health systems use the FPL alone as the metric for determining discounts, others select different income levels in different communities or apply a statistic that adjusts for local income variations. The state Medicaid income eligibility level should also be considered. The metrics used by the U.S. Department of Housing and Urban Development (HUD) vary by location and are examples of alternatives to the FPL.

Hospital Mission. Each organization defines its mission to meet the needs of its constituencies. These needs may include ensuring the availability of services, charity care, education of health professionals, research, repayment of debt to lenders, honoring the desires of donors, and providing a return on capital. Individual organizations make different choices in determining their missions and carrying them out. Many healthcare systems and hospitals believe that waiving or discounting hospital bills for uninsured and underinsured patients is an important expression of their missions.

Patient Insurance Status. Most hospitals interviewed for the Project offer discounts to low-income insured patients who have a liability remaining after insurance has paid. Qualified underinsured patients are those who have some level of insurance, but still have out-of-pocket balances that exceed their financial abilities. Out-of-pocket balances could result from deductibles, coinsurance, noncovered services or other policy limitations. As hospitals revise their policies, they frequently become more explicit about whether and how their policies apply to underinsured patients in addition to the uninsured. For example, they might consider whether discounts will be offered to insured patients receiving services not covered by insurance, patients with large deductibles and coinsurance, or all patients

Reference Materials: State Uninsured Laws and Regulations, Federal Poverty Guidelines, and Example Policies for Underinsured Patients

<http://www.patientfriendlybilling.org/2005report/tools.htm#6>

with self-pay obligations. This can help hospital staff better explain policies and assist underinsured patients.

Payer Contract Requirements. Some payer contracts and state regulations require hospitals to attempt to collect deductibles and coinsurance amounts from patients without discounting or to disclose any waivers of deductibles or coinsurance. Deductibles and coinsurance requirements for patients with noncontract insurance companies may result in patient liabilities that exceed amounts that would be billed under hospital financial assistance policies. Hospitals may want to review existing payer contracts with this in mind. Hospitals may want to ask payers to change contract provisions and policy makers to remove regulatory barriers that complicate offering discounts to patients. In the interim, hospitals may want to consider including guidance on these circumstances in their policies and practices.

Establishing Patient Ability to Pay. Hospitals interviewed for the Project have different approaches to establishing a patient's ability to pay. Most require patients to document their household incomes. All interviewed hospital executives said they struggle with how to define a family for purposes of establishing household means; they are also challenged with how to work with patients whose incomes are just over established guidelines. Most allow patient account representatives to be flexible in dealing with these circumstances.

Many hospitals consider certain patient assets in evaluating ability to pay. The use of assets in means-testing is required for Medicare patients if the hospital intends to seek reimbursement for Medicare indigent bad debts; the Centers for Medicare & Medicaid Services (CMS) recently stated verbally that no assets test is required for non-Medicare patients as a condition for

allowing Medicare indigent bad debt reimbursement. A few hospitals examine assets for patients only if their incomes exceed a certain level or based on the services provided or the amount of the patient bill. Some organizations use credit reports to help validate patient assets.

Application Processes and Documentation Requirements. Hospitals and health systems may be moving in different directions regarding documentation requirements for patients to qualify for financial assistance; some organizations interviewed for the Project are reducing the required amount of documentation in order to make it easier for patients, while others are considering additional requirements. Additionally, hospitals with more generous discount policies face administrative burdens caused by the higher numbers of applications that their policies generate.

But whether they are reducing or increasing the amount of documentation, most hospitals struggle with how to get patients to complete or provide all documents required to qualify for financial assistance. Some hospitals have documentation compliance rates that hover at only about 50 percent, meaning that many people who may qualify for discounts aren't getting them simply because they can't or won't fill out the paperwork. It is particularly challenging for hospitals to verify income and obtain paperwork for high-volume outpatient services. Patients also have a responsibility to cooperate with their insurer and complete documentation, such as coordination of benefit forms. Overall, this is an area that continues to be problematic, and no single solution is apparent.

The hospitals interviewed work hard to establish eligibility for financial aid and believe it is sound practice to seek payment unless they know that the patient is unable to pay. In the absence of reasonable documenta-

Reference Materials: Examples of Percentage of Charges Waived, Sliding Scales, Policies on Establishing Patient Ability to Pay, and Steps to Check Eligibility for Financial Assistance

<http://www.patientfriendlybilling.org/2005report/tools.htm#7>

tion, hospitals will pursue payment from patients who refuse or fail to complete financial assistance forms.

Some hospitals attempt to improve compliance rates by simplifying the forms and making them more patient-friendly, having patients complete documentation before leaving the hospital, and providing staff support to assist patients in completing documentation. Others align their financial assistance application forms with Medicaid's so that patients experiencing Medicaid denials may then apply for hospital discounts without providing additional documentation.

The consumer finance industry has easy-to-use tools to help in determining an individual's ability to pay. Hospitals may want to consider how to use these and other tools.

Discounts for the Medically Indigent. Some hospitals interviewed for the Project extend free care or discounts to patients who are deemed to be medically indigent. These are patients whose incomes may be relatively high, but their hospital bills exceed a certain proportion of their annual household income or assets. Some states require hospitals to offer discounts to uninsured or underinsured patients in this situation.

2. What services are discounted?

In deciding what healthcare services to discount, hospitals can consider the following factors:

State Requirements. Some states have specific rules regarding whether hospital policies must apply equally to elective, urgent, emergency or medically necessary care or to specific hospital services. Hospitals must be aware of these requirements before writing or revising policies.

Qualifying Services. Many hospitals interviewed for

the Project discount only medically necessary or non-elective services. Some specify that discounts are only for emergency and urgent care. Others have clinical approval processes to make these determinations. Still others rely on charity care committees to review individual cases.

Hospital definitions of medical necessity vary. Some are explicit and rely, for example, on definitions that govern the Medicare or Medicaid programs. Other hospitals leave more discretion to their medical staffs to determine necessity. For some, cosmetic surgery and non-medical services such as social, educational and vocational services are not covered. One hospital defines medically necessary to include "essential clinical services provided to the patient to clinically maintain or improve the patient's health." Another defines medically necessary services as the physician-ordered standard-of-practice care that is required to treat an illness or condition and is not cosmetic or experimental in nature.

Alignment with Medical Staff. No hospitals interviewed for the Project require medical staff members to grant similar discounts to uninsured and underinsured patients unless the physicians are employed by the hospital. Some hospitals communicate charity care decisions and eligibility information such as Medicaid determinations to physician offices, particularly to hospital-based and faculty physicians. Hospitals may also consider communicating to other providers when a patient qualifies for discounts. Hospitals would need to appropriately consider the need for patient permission in accordance with HIPAA requirements before communicating with others. Such communications might be helpful to the patient if all providers knew that he or she will need assistance. In addition, hospitals might consider encouraging other providers (medical staff,

Reference Materials: Example Policies for Patient Responsibilities and Determining Medical Indigency, Outline of Patient Responsibilities, and Example Definitions of "Medically Necessary" and "Eligible Services"

<http://www.patientfriendlybilling.org/2005report/tools.htm#8>

pharmacies, equipment suppliers, etc.) to offer discounts.

Application of Policies to Non-Hospital Services.

Many hospitals are members of health systems that include home health agencies, nursing homes, rehabilitation programs and other freestanding health services. System policies might specify whether financial assistance policies that apply to hospital services also are relevant to these other settings.

3. What discount levels are offered?

Many hospitals offer a variety of discount levels, which often depend on their organization’s and community’s particular circumstances. They also may depend on issues such as:

Hospital Charge Description Master. A key factor to consider when revising financial assistance policies and discounting is how the hospital Charge Description Master compares to levels prevailing in the local area, to cost, and to rates paid by other payers. The hospital’s mix of services and distribution of patient care by payer also are important considerations. Discount rates should be revisited as services and gross charge levels change.

Implications for Payer Contracts. Some hospitals expressed concern that managed care payers may try to renegotiate or otherwise reduce their payments if hospitals adopt more generous discounts for uninsured and underinsured patients. Employers may respond by

dropping insurance coverage for hospital services or for health care altogether, thus shifting an even greater burden to hospitals.

Impact Analysis. Most hospitals interviewed have attempted to predict the potential impact of revised discounting and collections policies. Many anticipated a shift in uncompensated care from bad debt to charity care. In assessing actual experience with the new policies, hospitals find it difficult to isolate the impact of policy changes from the effects of growing numbers of uninsured and underinsured patients. Most systems indicate that it is simply too early to estimate the full impact of changes.

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In determining the overall impact of proposed policy changes on the organization, hospitals should consider the organization’s mission, mix of services and payers, and financial condition. Estimating the effect of changes is more difficult than merely applying a pure mathematical model to historical measures. Hospitals may also want to monitor and trend the impact of the changes over time; to do this, hospitals might track shifts in payments from insured and uninsured patients in addition to tracking absolute dollars.

Example Discount Matrix Based on Income and Amount of the Patient’s Bill

Charges (\$)	<\$1,000	\$1,001- \$2,500	\$2,501- \$5,000	\$5,001- \$10,000	\$10,001- \$25,000	\$25,001- \$50,000	>\$50,000
Income Level	Charity Discount Matrix						
>0 - 100% FPL	100%	100%	100%	100%	100%	100%	100%
>100-200% FPL							
>200-300% FPL							
>300-400% FPL							

Administrative and Systems Matters. Hospitals interviewed for the Project indicate that applying a percentage discount to charges is administratively straightforward, while calibrating discount levels to alternative price points (such as Medicare rates, Medicaid payments, or managed care contract levels) is more complex. Hospitals can assess their system's ability to support various pricing structures.

Varying Discounts Based on Patient Means and Level of Medical Indigency. Virtually all interviewed hospitals have developed a sliding-fee scale that specifies different percentage discounts from gross charges depending on patients' household incomes; for example, policies may call for free care for patients at a specified percentage of the FPL, with lesser discounts for patients with progressively greater means. Discount levels can also vary between medically indigent patients and others. This approach results in a discount-level matrix, as shown on page 12.

Medicare Rates or Other Price Points. Most hospitals interviewed for the Project apply discounts to gross charges although some peg their discount levels to alternative price points, such as Medicare rates, Medicaid payments or managed care contract levels.

4. How are policies communicated?

Interviewed hospitals and systems have made substantial efforts to increase patient awareness about the availability of discounts and payment plans using a wide variety of communication methods. The goal of these efforts is to broadly publicize the availability of financial assistance and make more specific information available in written form, such as brochures. In developing a communications plan, organizations might take into account the following:

State and Federal Regulations. Some states require not-for-profit hospitals to post information regarding charges and charity care policies in public places. Federal Medicare regulations create some questions about how best to communicate the availability of financial assistance without advertising or inducing business (although posting notices in registration and admission areas is permissible as is asking each patient when they arrive if they require financial assistance).

Importance of Patient Friendly Billing. Financial communications with patients should be concise and easy to read. For some organizations, it might be necessary to make a communications piece available in multiple languages. The goal is for written and spoken terminology to be easily understood by most consumers. Ideally, a communications piece should describe its purpose and any actions the patient needs to take and provide contact information for questions or additional information.

Communication Approaches. Most interviewed hospitals use signage to communicate the availability of financial assistance, particularly in states where this is required of not-for-profit hospitals. Others communicate the availability of charity care on patient bills or publish their policies in local newspapers. The availability of prompt-pay discounts typically is communicated upon request. Alternative sources of financial aid, such as Medicaid and Crime Victim Funds, also can be publicized. Hospitals should continue to seek new and innovative ways to make the availability of financial assistance widely known.

Members of the medical staff and hospital employees who have contact with patients should have an overall understanding of the hospital's discounting and collections practices and how patients can obtain assistance. Employees also need to recognize that language and cul-

Reference Materials: Examples of How Hospitals Determine Charges to the Uninsured/Underinsured and Communicating Charity Policies

<http://www.patientfriendlybilling.org/2005report/tools.htm#9>

ture can present challenges for patients who may qualify for financial assistance. Hospitals have adopted various strategies to communicate with non-English speaking patients, such as posting signs, printing bill statements and having patient information brochures available in multiple languages; making translation services available; and having automated phone answering systems that communicate in languages common in the hospital's service area.

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Some hospitals work with local advocacy groups, local media and members of the community to improve their communication approaches.

5. How are unpaid patient accounts resolved?

For patients with the ability to pay, a number of issues need to be considered when reviewing or developing policies and practices for obtaining payment, including:

State or Federal Regulations. Some states have laws addressing various practices such as wage garnishment or the placement of liens on property or primary residences. Federal Medicare regulations specify that collections policies for Medicare patients must be comparable to, and no less rigorous than, for non-Medicare patients if the hospital wants to be reimbursed for Medicare bad debts. Other federal considerations are highlighted later in this document.

Early Collections Activities. Financial expectations should be set and communicated as early in the process

as possible. For emergency patients, financial matters should only be discussed at an appropriate time after the patient's condition is stabilized. For other patients, hospital personnel can ask the patient at preadmission how he or she will pay the amount to be owed. If the patient cannot pay, the hospital can ask the patient to complete financial assistance/Medicaid application documentation.

If the patient has a previous bad debt or outstanding balance, the hospital can try to collect or make payment arrangements for prior and new amounts owed or help the patient apply for Medicaid or other financial assistance.

Payment Plans and Prompt-Payment Discounts.

Many interviewed hospitals are implementing additional options to help patients with their bills, including prompt-pay discounts, payment plans and interest-free loans. Ideally, these options are presented during (or in advance of) scheduled appointments, at patient registration or prior to discharge. Most hospitals' billing and collections staffs also make many of these options available throughout the billing process. Most hospitals try to set up payment plans for a maximum of six months, but many are flexible and work with patients to set up plans that extend over a one- to three-year period or longer. Most hospitals interviewed do not charge interest on patient account balances, including those under a payment plan. In cases where an account is financed by an outside lender, that lender typically charges the patient interest.

Role of Extended Business Offices. Some interviewed hospital systems have established an extended business office, a department within the hospital that focuses exclusively on self-pay accounts. These departments can improve communication with patients and attempt to

Reference Materials: Communicating Community Benefits and Examples of Communication Methods and Cultural Competency

<http://www.patientfriendlybilling.org/2005report/tools.htm#10>

prevent referrals to outside collection agencies. These are centralized functions that support all system hospitals to ensure consistent and uniform application of policies.

Role of Collection Agencies. Accounts for those patients that have an ability to pay but cannot be resolved within a prescribed time period usually are sent to collection agencies. These collection agencies may be owned by the hospital or may be outside vendors. Increasingly, hospitals have become more explicit about the process agencies are to follow and the manner in which agencies work with patients by taking steps such as establishing contracts with clear terms and ensuring collection agencies' interactions with patients are appropriate and effectively supervised.

The timing for interviewed hospitals to send accounts to collections ranges from about 120 to 220 days. If the patient accounts department is actively working with a patient to apply for public programs, financial assistance or payment plans, the account is not referred to a collection agency.

Legal Actions and Other Options. State or local regulations often control the extent to which hospitals interviewed for the Project (and their collection agencies) resort to liens, other legal actions or other options to address unpaid accounts. The range of actions might include:

- Reporting unpaid accounts to a credit reporting agency;
- Wage garnishments;
- Liens against judgments, such as a lien against an amount awarded for an auto accident;
- Bank levies; and
- Property liens, foreclosures and other bank liens.

Most hospitals that have recently revised their policies have made them much more specific regarding the

circumstances under which these actions can be pursued. For example, some prohibit foreclosures on primary residences, while others forbid liens on retirement accounts of certain value. Others allow liens on assets (including homes) but do not permit foreclosures. For example, a hospital might file a lien against and foreclose on a vacation home. In some cases, a hospital may file a lien against an expensive home but not foreclose. This protects the hospital's interests in the event the home is sold but does not impact the patient while living in the home. Hospitals might also file a lien against an estate so that the hospital account is settled before the inheritance is distributed.

Some organizations require hospital staff or the board of trustees to sign off before initiating any legal action. One interviewed hospital limits the percentage of cases for which the collection agencies may initiate legal action.

Changing Patient Circumstances. Many hospitals interviewed for the Project allow discounts or free care to be granted at any stage of the patient experience (during pre-registration, during treatment or after treatment). Some encourage or require collection agencies to return accounts that qualify for charity back to the hospital for all subsequent account management. This allows for changing patient circumstances and additional opportunities throughout the revenue cycle for a patient to apply for financial assistance or to develop payment plans.

6. What structures and systems are in place to implement and administer policies effectively?

No matter how much effort goes into the planning and development of new policies, the policies will be ineffective and won't help patients if the organization's structures and systems do not support them. When

Reference Materials: Examples of Debt Collection Laws, Collection Procedures, Allowable Legal Actions, and Hospital System Oversight of Collection Activities

<http://www.patientfriendlybilling.org/2005report/tools.htm#11>

adopting new discounting and collections policies, hospitals might consider the following:

Staff Training. Training front-line staff on current and new policies is essential for effective and consistent administration. These activities should include training on customer service so that employees can better help patients facing difficult financial situations. Many hospitals have developed extensive training materials and programs to ensure that staff members are both knowledgeable and helpful.

Charity Care Committees. Some hospitals have charity care committees to make decisions about difficult cases and/or to handle patients' appeals. Some committees



Hospitals interviewed for this Project note that training is time- and resource-intensive, so staff training activities should be accounted for in scheduling implementation plans for new policies.

include community or patient-advocate representatives, which can be an effective way to achieve dialogue and involvement with the community on these issues.

Specifying Decision Making Authorities. The question of who decides about the granting of discounts is answered differently among interviewed hospitals. Some allow front-line patient accounts representatives some discretion within specified parameters in granting discounts. Many hospitals have different decision-makers depend-

ing on the amount of the bill; authority ranges from patient accounts representatives to revenue cycle managers to the hospital's chief financial officer. Some hospital systems require local administrators to sign off on accounts before they are sent to collection agencies.

Information Systems Solutions. Hospitals indicate that automated solutions to help implement policies and procedures for discounting bills and collections payments for uninsured and underinsured patients need further development. Systems to check insurance coverage and help document patient income or assets, solutions that help implement charge-based discounts or alternative price points, and interfaces with collections agencies could streamline and standardize the hospital processes and improve the patient's experience.

Monitoring and Measuring Performance. Some hospitals interviewed for the Project have established specific metrics to monitor the effectiveness of their policies. Measures such as the proportion of self-pay accounts referred to collection agencies, proportion of accounts with payment activity, age of accounts receivable, and other performance measures help monitor results. Hospitals might also consider monitoring the effectiveness of internal processes, such as effectiveness of staff training and procedures through patient satisfaction and other measures.

Involving Partners and Outside Vendors. Interviewed hospitals have found it valuable to involve partners (such as eligibility vendors, collection agencies and extended business office staff) in updating policies and procedures. Involvement of these parties on the front end can help to avoid later problems with implementation and unintended consequences of policy changes.

Reference Materials: Examples of Staff Training

<http://www.patientfriendlybilling.org/2005report/tools.htm#12>

7. What is the relevant legal and regulatory context?²

Historically, hospitals have had a number of valid concerns that discounting charges or having less aggressive collection efforts for uninsured or underinsured patients would create issues with federal healthcare programs, fiscal intermediaries, or the Office of the Inspector General (OIG).

CMS and OIG issued written interpretations of applicable law and regulations in February 2004. CMS and OIG also answered questions orally in an Open Door Forum in June 2004. CMS' most recent guidance on this issue was posted to its website on December 29, 2004. Taking all of OIG's and CMS' guidance together as of December 29, 2004, it is reasonably clear that hospitals can now waive charges and offer discounts to uninsured and underinsured patients without affecting Medicare payments for inpatient or outpatient outlier cases or additional payments for new technology cases.

Offering discounts to uninsured or underinsured patients may, however, have implications under state law, or may affect payments under contracts with non-governmental payers. Each hospital should research the applicable law in its state and review its third-party payer contracts to assess whether its proposed policies will pose problems and whether it can resolve or mitigate such problems.

Some Federal Issues Remain. Some of CMS' answers in the Open Door Forum relating to Medicare allowable bad debts have not been confirmed in writing at the time of this report. Areas where hospitals may desire additional written guidance from CMS or their intermediaries that payments for Medicare bad debts will be unaffected are:

- Making determinations of indigence for non-Medicare patients without applying an asset test; and

- Making determinations of indigence for non-Medicare patients based on a self-attestation.

There also is still uncertainty under the patient inducement statute and the illegal remuneration statute (often referred to as the "anti-kickback" statute) in some circumstances. Some areas where hospitals may desire written guidance from OIG are:

- Prompt-payment discounts for Medicare deductible or coinsurance amounts;
- Discounts furnished after a Medicare patient has exhausted covered days; and
- Advertising availability of financial assistance for federal healthcare programs.

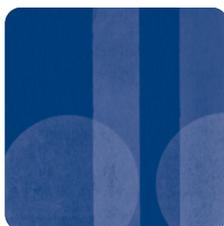
In addition to federal legal and regulatory issues, hospitals will want to consider issues that may arise under state law including: state laws barring discounting or waiving copayment amounts; the effect of discounts on Medicaid payments under the state plan; and any state laws on hospital charging practices. Nongovernmental third party payers who have negotiated contracts based in whole or in part on charges, e.g., percentage of charge contracts, may also contend that discounts offered to the uninsured or underinsured affect their contractual obligations to the hospital.

2. These comments are relevant to the legal and regulatory environment as of December 30, 2004. Some finer points have been omitted. These comments do not constitute legal advice. Individual hospitals should consult with their own legal counsel about their specific policies and situations.

Reference Materials: Legal References

<http://www.patientfriendlybilling.org/2005report/tools.htm#13>

Section Four: Lessons Learned by Hospitals That Have Revised Their Policies



Interviewed hospitals that recently made changes to their policies offer the following advice for other hospitals contemplating policy changes:

Policy Characteristics

- The most effective policies are simple, clear and written with the patient in mind.
- It is helpful if the policies allow some flexibility. For example, recent pay stubs may indicate income slightly over the discount policy guidelines, but the patient says his work hours have recently been reduced.

Involvement of Others

- Including the community in the process can lead to success.
- Hospitals that involve eligibility vendors, collection agencies and others with a role in the process of designing policies and procedures have fewer implementation problems.

Training, Implementation and Monitoring

- Implementation plans need to allow sufficient time to develop and test patient education materials (brochures) and to conduct necessary staff training.
- Hospitals that train front-line staff to discuss payment before the patient leaves the hospital (particularly for pre-scheduled services) can minimize the need for collection activities.

- An extended business office can focus on self-pay accounts, be responsive to uninsured patients' needs, and can promote effective policy implementation.
- Hospitals may find it helpful to track and analyze the impact of policy changes; automated solutions can support this process.

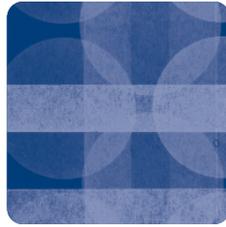
Effects on Patients

- Hospitals can increase the insurance coverage available to patients by helping them apply for third-party coverage.
- Hospitals can help patients not eligible for governmental health insurance programs to obtain COBRA coverage or may consider paying COBRA premiums for patients, although hospitals should check with their counsel first to ensure that such action would not violate state laws.
- Hospitals can better help patients through the process if patients believe that bills and payment arrangements are reasonable.

Importance of Action

- All hospitals should recognize that this is an important issue; if hospitals do not act responsibly, lawmakers may act for them.

Section Five: Actions for Hospitals



To respond to these growing challenges, there are a number of actions that hospitals can consider:

- **Adopt guiding principles.** Hospitals can use the principles issued by AHA and used in this report, those issued by state hospital associations, or develop individualized principles based on their individual missions and values. Guiding principles help in the development of policies and in the communication of the organization's goals and priorities.
- **Update policies and practices** for discounting and collections for uninsured and underinsured patients.
- **Communicate to patients available financial assistance.** This includes assistance from governmental programs and the hospital's charity care programs. Effective communications are clear, concise, easy to understand and designed from the patient's perspective. The objective is for patients to understand the steps they need to take and the steps the hospital will take to help them resolve their account balances.
- **Develop improved methods to communicate with the patients** the amounts they owe for services and the basis for billed amounts. This includes communicating financial expectations as early in the process as possible and communicating in a way that treats patients with dignity, respect and compassion.

Helping Patients Get Insurance Coverage or Financial Assistance



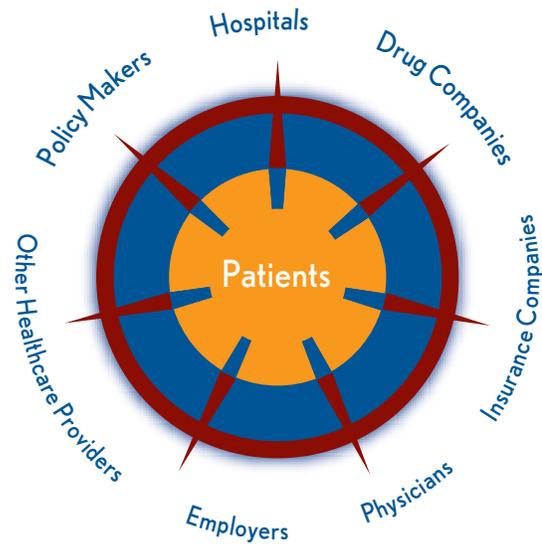
- **Engage the community and other stakeholders in these processes.** The community can provide valuable input to the hospital. Members of the community also can help inform the public about the ways that the hospital serves the community.
- **Work with information technology vendors** to identify technology features that would improve the hospital's ability to offer discounts, improve collection processes and communicate with patients.
- **Advocate for reductions in regulatory complexity** and volumes.

- **Consider how the hospital can move from a charge structure that is set in a regulatory and insurance environment to one that considers the patient as a retail customer.** This may be a longer-term effort as many aspects of the healthcare billing and payment systems are based on the existing, complex hospital charge structure.

Many of the ideas and approaches in this report are incomplete solutions. Hospitals might consider working with policy makers and others to develop solutions to the underlying issue of increasing numbers of uninsured and underinsured patients. These patients also have difficulties paying for prescription drugs, physician services and other healthcare services provided outside of the hospital setting. Therefore, drug companies, physicians, other healthcare providers, insurance companies and employers all have responsibilities, and hospitals would benefit from including them in developing solutions to these multi-faceted problems. Hospitals can request that policy makers provide immunity from class action lawsuits and provide additional government payments to hospitals that follow

certain practices to help uninsured and underinsured patients. In the meantime, hospitals can make a difference in their communities by considering ways to improve their discounting and collections policies and practices for uninsured and underinsured patients.

Working With Others



About the *PATIENT FRIENDLY BILLING*[®] Project



The *PATIENT FRIENDLY BILLING*[®] Project helps healthcare industry leaders create a friendlier, patient-focused healthcare billing and collections process. The Healthcare Financial Management Association (HFMA) leads the Project in partnership with the American Hospital Association (AHA), other associations, leading healthcare providers who have participated in task forces, and professional service and technology firms. The Project has issued four primary reports:

- November 2001 report, which summarized findings based on patient focus group research and recommendations by the first task force;
- June 2002 report, which focused on approaches to improving patient financial communications by medical group practices;
- June 2003 report, which emphasized the use of technology in improving patient financial communications; and,
- This February 2005 report, which provides insights from hospitals that have studied and revised discounting and collections policies and practices for uninsured and underinsured patients.

Origin of this Report

From August 2003 through early 2004, hospital system leaders supported the concept of a national industry coalition to develop ideas and tools for hospitals to use in improving discounting and collections practices for

uninsured and underinsured patients. This report is the outcome of those discussions.

In April 2004, HFMA, AHA and the *PATIENT FRIENDLY BILLING*[®] Project leader selected Project advisors, including antitrust counsel, Medicare counsel, and a Project consultant. From April to August, hospitals and hospital systems were engaged through interviews and surveys. The hospital systems represent various geographical locations, market types and hospital sizes. Most of the hospital systems interviewed for the project have recently studied and revised their discounting and collections practices for uninsured and underinsured patients.

Project Process

The Project consultant collected and analyzed data and qualitative findings from hospitals and systems. The Project consultant also interviewed state hospital associations. The research was summarized into five categories:

- Forces driving changes in policies and procedures;
- Barriers to change;
- Approaches to updating policies and procedures;
- Advice from the field; and
- Future challenges.

The research was used to prepare this analysis and examine the alternative ways that hospitals are approaching discounting and collections for services provided to their uninsured and underinsured patients.

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American Hospital Association

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