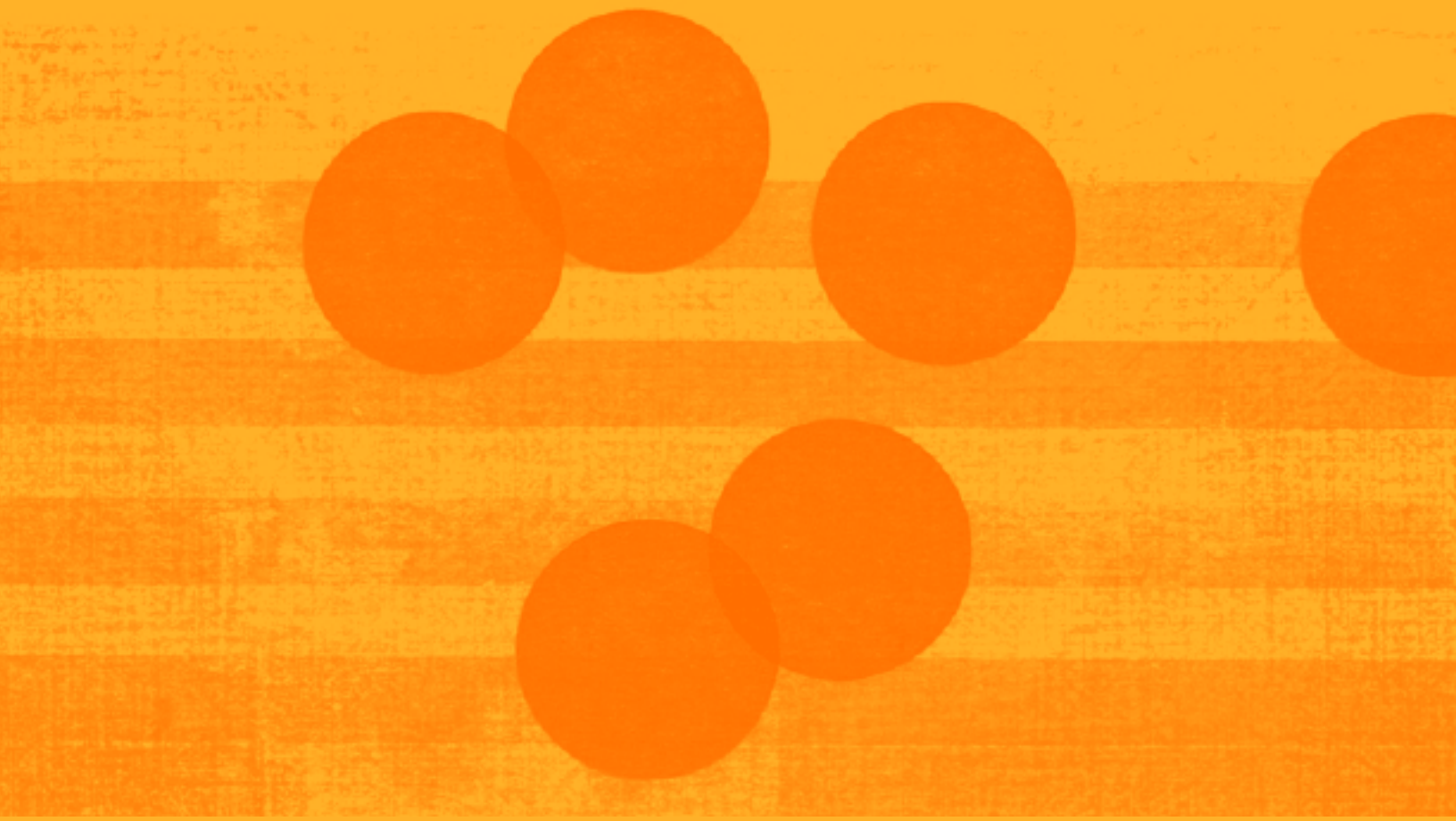
CONSUMERISM IN HEALTH CARE

An Initiative of the PATIENT FRIENDLY BILLING® Project

SUMMER 2006



Achieve a consumer-oriented revenue cycle.

hfma
healthcare financial management association

American Hospital Association

Medical Group Management Association
MGMA®

Dear Colleagues:

We are pleased to present the latest report in the ***PATIENT FRIENDLY BILLING***® project, Consumerism in Health Care.

The message of this report is simple: embrace consumerism. Consumerism that is engaging consumers in their health and medical decisions may encourage improved health status of the people we serve while potentially controlling rising costs.

Putting consumerism into effect, however, is a vastly complex endeavor requiring collaboration among government, providers, payers, employers, and consumers themselves. For providers specifically, a clear challenge is managing the impact of increasing patient financial obligations including use of high-deductible health plans. Equally challenging is designing and implementing the specific methods to enhance the consumer's experience and achieve quality and price transparency, retail pricing approaches, needed collaborations, and training and development of staff.

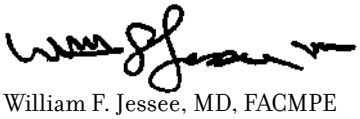
This report is designed to help all of the stakeholders understand the goals, roles, and responsibilities inherent with consumerism, with an emphasis on the effect on revenue cycle activities of providers. The report lays out the strategies that must be considered, adapted, and implemented for the healthcare industry to take advantage of the opportunities and challenges consumerism offers.

Some of the strategies presented can be enacted in the short term. Others will take a longer time and include significant changes in structures and processes from multiple parties. Despite the ambitiousness of the endeavor, the necessary actions are clear, and it is up to all of us to start now to embrace consumerism.

Sincerely,

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

Richard J. Davidson
President & CEO
American Hospital Association



William F. Jessee, MD, FACMPE
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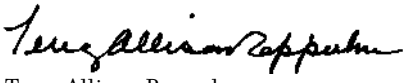

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INTRODUCTION: TOWARD RADICAL CHANGE

June 2011: Healthcare Consumerism in Action

Morning. This is the morning Jack will visit his internal medicine doctor to follow up on a sinus infection. (Jack has previously chosen his primary care physician and hospital based on price and quality information accessed on the Internet.) At the time Jack made the appointment, which he did on the physician's secure website, he updated his medical file with a description of the symptoms from his persistent sinus problems. He also updated his insurance and address information, and received an electronic message that he will owe a $25 copayment for the visit.

After Jack's exam, his doctor determines that he does have a sinus infection and needs an antibiotic. She checks Jack's medication history through the electronic health record (EHR), which alerts her to a potential adverse medication interaction, recommends generic alternatives, and details pharmacy costs for the drug. The physician sends an e-prescription for the generic antibiotic to the pharmacy. Before leaving the doctor's office, Jack uses a kiosk to schedule a sinus CT scan that evening at the hospital, and receives driving instructions, information about what to expect during the CT scan, and an estimate of the amount he is expected to pay at the time of the CT scan.

Afternoon. Jack calls his wife to tell her that he will be late because he is getting a CT scan on his way home from work. When he arrives that evening at the hospital to register, the receptionist greets Jack by name. She recognizes him from her screen, which shows photographs of all patients registered for procedures that evening. The hospital's information system automatically re-verifies his eligibility, benefits, deductible status, and copayment requirements. After Jack's CT scan, the radiologist checks his notes, which were entered via voice dictation as he reviewed Jack's scan. He e-mails a follow-up note to Jack's internal medicine physician and electronically signs the EHR; this action automatically posts real-time transactions to the physician and hospital billing systems and sends electronic insurance claims to Jack's health plan with diagnosis and procedure coding validated as consistent with EHR documentation. The claims are adjudicated, and within seconds the physician and hospital receive electronic payments. Jack pays his obligation with a debit card from his health reimbursement account, which immediately adjusts his balance. Jack picks up his prescription at the pharmacy on his way home.

June 2006: Getting from Here to There

We may be off by a few years or a few details, but there is no doubt that this scenario represents what health care will become. And while consumers may be setting the course, it is clear that providers have much to gain at journey's end. Jack is spared the confusion and concern that often marks patient encounters with the financial side of health care. But you will notice that days in accounts receivable are not just reduced, they are eliminated.

There are many important questions about the future that we cannot answer yet.

Will consumerism in health care bring about a decline in healthcare consumption, as patients become more discerning about purchasing healthcare services?

Will consumerism facilitate necessary preventive care?

Will providers and payers be able to provide meaningful price and quality information to allow consumers to make decisions about healthcare value?

Will consumers be willing and able to assume the administrative complexities and financial burdens of consumer-directed health plans?

Will providers find ways to compete with convenient care centers offering pricing advantages?

Will the widespread use of health savings accounts generate sustainable savings?

But there are three things we know for sure as we head down the road toward a retail model of pricing and payment.

First, healthcare financial services will need to become more patient-centric in focus. This means coming up with new ways to identify and address patient needs, learning how to communicate with patients as partners, and incorporating such patient-friendly concepts as pricing transparency, point-of-service payment, and simplified charge structures. Providers will also need to provide meaningful information about quality of care.

Second, in order to be successful in the future, providers must be willing to make radical changes. Consumerism in health care poses a truly different way of doing business. Incremental change—nibbling around the edges—will not be enough to get us where we need to go.

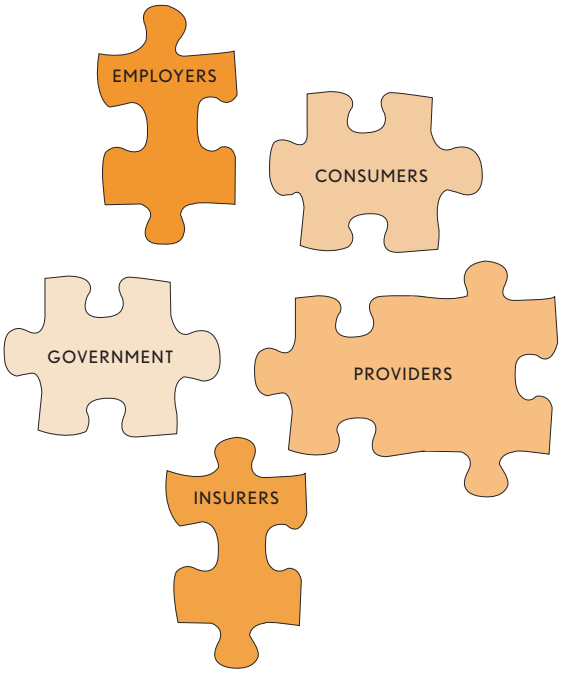
Third, we cannot go it alone. The only way to make the system truly work for the consumer is to collaborate creatively with other providers, commercial and government insurers, employers, regulators, and—first and foremost—consumers themselves.

The sponsors of and participants in the ***PATIENT FRIENDLY BILLING®*** project's initiative on consumerism in health care (see page 17 for a list) have dedicated a lot of time exploring how to do this—thinking, talking, brain-storming, debating, problem-solving. This report showcases their best ideas on how to get from here to there.

GUIDING PRINCIPLES

If consumers could better understand and more effectively use health services, community health status could improve, the value of health care to the consumer could be enhanced, and the rate of increase in healthcare costs could be reduced. Pursuing this goal entails responsibilities for providers, payers, employers, government and consumers. In working to help prepare hospitals and physicians for consumerism in health care, including increased consumer cost sharing at point of service, the Patient Friendly Billing project has been guided by the following principles—principles the project participants encourage all stakeholders to consider:

RESPONSIBLE PARTIES



Safeguards. Providers, employers, payers, and government have the responsibility to implement safeguards to ensure that:

- Access to and use of needed services are not denied based on the consumer's ability to pay
- Consumers who have the ability to pay for health services do pay
- Healthcare providers receive reliable, fair, and timely payment for services provided
- Consumer-sensitive information is protected
- High-deductible health plan cost sharing processes do not add to the complexity and cost of healthcare administration

Communication about health insurance options. Private payers and employers have the responsibility to effectively communicate to their enrollees/employees the benefits, alternatives, trade-offs, and financial responsibilities related to any health plan/insurance they offer. In addition, they should:

- Encourage members to adopt healthy life styles
- Require or facilitate the funding of health savings vehicles for high-deductible health plans
- Provide real-time, electronic verification of eligibility, benefits, and status of deductibles, coinsurances, and out-of-pocket maximums
- Work toward adjudicating and paying claims on a real-time basis

Consumer engagement. Consumers must take responsibility for their health. Those with the ability to pay should expect to do so and seek appropriate health insurance for that purpose. They must also:

- Understand the coverage and benefits afforded by their health insurance
- Adhere to the requirements of their plan
- Meet their financial obligations to providers in a timely manner

Standards and funding mechanisms. Government has the responsibility to facilitate improvements in health care by doing the following:

- Work with the private sector to develop and implement consistent standards for quality, pay-for-performance systems, safety reporting, and exchange of funds and information (including EHRs) among employers, payers, and providers
- Ensure appropriate funding mechanisms for charity care and governmental programs, including ending the cost shift to other payers that occurs when government programs pay providers less than their total cost of providing care

Accessibility of information about price and quality. Providers must provide transparent and easily accessible information to consumers, payers, and employers by doing the following:

- Make available estimates of the patient's financial responsibilities before most services are provided but only after emergency patients are medically stable; a few services cannot be estimated in advance because they entail too many potential variations
- Be able to bill payers and patients at the time that services are provided
- Provide relevant, meaningful information about quality so consumers can make a valid determination about the overall value of care

Enacting these principles will require significant system-wide changes. Some of these changes can be enacted in the near term. Those include changes to ensure that consumers are provided incentives to actively participate in decisions regarding their health care, including adopting healthy life styles and funding health savings vehicles. Other changes that can be made in the short term include providing consumers with clear and transparent disclosure of key quality indicators, safety measures, and discounting and payment policies for uninsured or indigent patients. Relatively soon, payers and employers should provide real-time verification of insurance and benefit level status. Over the longer term, providers should develop comprehensive charging structures and payment methodologies that are more simple, easier to administer, and easily explainable to the public. Providers, payers, and government must cooperate and collaborate for the good of consumers by working together to remove barriers to these changes.

WHAT WE MEAN WHEN WE SAY…

Patient financial obligation. The amount the patient owes for healthcare services, after payments from other sources and after any discounts have been considered. This includes copayments, deductibles, coinsurance, and amounts due for services not covered by insurance.

Total payments. The total amount owed to the healthcare provider by the patient and other payers. This amount is after discounts have been considered.

Charges. Gross prices charged for healthcare services before considering any discounts to insurers, government payers, uninsured patients, patients who qualify for financial assistance, or discounts for any other reason.

CDM. Charge description master, or chargemaster, or a file that contains a list of chargeable services.

ACHIEVING KEY OBJECTIVES

This report of the Patient Friendly Billing project presents providers with a variety of innovations and alternative approaches to achieving the major objectives that will make consumerism in health care a positive force for all stakeholders.

These objectives include:

- Price transparency
- Agreement on payment expectations and terms between providers and patients
- Simplified charge and payment structures
- Easy patient access and scheduling
- Appropriate staff with the requisite training and tools

What follows in this section are practical strategies for achieving these objectives recommended by some of the best minds in health care. Not every strategy will fit with every provider organization; hospitals and physicians must consider what will best meet the unique needs of their respective communities. However, all of the strategies are well worth considering as you put together your own plan for the future.

In some cases, a strategy may be picked up as is, or with minor alterations, and implemented immediately. More often, preparing to adopt a particular strategy will require a long-term commitment to wide-reaching organizational change.

First, take a moment to review the factors standing between most providers and a successful transition to a consumer-oriented revenue cycle.

The Barriers to Change

The most significant impediments within provider organizations to reaching the objectives listed are a host of standard operating procedures that have evolved over time to make the revenue cycle a confusing, inefficient, and often irrational system.

Charge structures and discounting policies, for example, are driven by a complex set of dynamics that are, in some cases, outside of the provider's control and that create complications and complexity. A few examples of the complex dynamics are regulatory requirements, payer mix, and service mix.

Clinical information essential for realistically estimating payment amounts—e.g., orders for specific services, patient acuity, individual physician practice patterns—is frequently unknown before the service is provided. This is particularly problematic in cases involving highly variable payment, out-of-network services, and emergencies.

Technological capabilities often trail far behind expectations. For example, most insurers cannot provide real-time electronic confirmation of individual patients' insurance coverage, benefits, noncovered services, or copayments and the status of their deductible, coinsurance and maximum out-of-pocket limitations.

Providers typically do not use information technology well to support consumer-oriented financial processes—processes that help ensure patient financial information is integrated and is communicated with patients in a clear, concise, and correct manner.

Legal and contractual restrictions often get in the way, too. Some payer contracts and some states restrict the ability of providers to discuss payments with patients; some prohibit discounting for the insured patient's financial obligation or require that providers disclose discounts to the insurers.

Another set of problems stems from the fact that *scheduling and registration* functions are usually not designed with patient convenience in mind. New technologies such as electronic physician scheduling can facilitate the scheduling process, but not all providers can afford the technology. The complexity in specific health plans makes it hard to know which providers are in-network and what services are covered.

Sometimes delays in transmitting updated eligibility data result in insurers and employers denying claims for benefits they had previously verified to providers.

Consumer expectations are on the rise. Sometimes the information to enrollees from employers and insurers is a bit sparse or legalistic. Many patients simply don't understand their benefit package and how the provider networks operate. Of course, their ability to figure out what they owe on their own is complicated by multiple incomprehensible bills from different providers. For that matter, many providers do not have a single point of contact for pricing information, resulting in inconsistent responses to patient inquiries.

As consumers come to expect higher service levels, they will need to interact with *better trained employees with higher skill levels and better tools* than are currently available. Front-end staff have not been expected to discuss financial expectations with patients and may need to upgrade their customer service, financial, and technical skills to do so. The inconsistency of payer practices makes such training more difficult.

Historically, the healthcare field has not emphasized the need for strong service excellence in financial services and current salary surveys generally do not reflect these higher skill levels; as a result, executive leadership may resist increasing staff salaries to appropriate levels.

Sometimes *difficulties between providers and payers* causes problems requiring changes on both sides. Insurers, government, and providers will have to work together to enable providers to simplify charges while managing the impact on net payments.

Issues related to *governmental funding shortfalls, uncompensated care, and medical education* create their own barriers, including the need on the part of providers to cost shift, or increase payment by others to compensate for government under-funding. Ironically, the more governmental and uninsured patients that a provider serves, the greater is that provider's need to cost-shift onto other patients. A provider's service mix affects its need to cost-shift, too, as providers with more unprofitable services have a greater need for higher payments to cover those services. Providers that offer unprofitable but needed community services and/or physician training require some form of subsidization.

Finally, the sheer *volume of contracts* that would have to be renegotiated gives many providers pause. Indeed, some industry leaders anticipate that any moves toward simplification will involve a highly disruptive transition period.

What Providers Can Do To Achieve Price Transparency

Participants in this phase of the Patient Friendly Billing project believe that price information provided to consumers *must be meaningful* to them. For that information to be meaningful, it must focus on the patient's financial obligation—what the patient is expected to pay—and not merely charges. It must be tailored to the patient's specific condition, treatment, and insurance coverage. Therefore, meaningful price transparency ideally involves a patient having the ability to get an estimate—prior to service—of the amount the patient will actually owe for the treatment, and that the estimate incorporates the patient's specific condition and insurance coverage. Such estimates from several providers, coupled with information about each provider's quality of care, would allow patients to make meaningful decisions about the value of care from each provider. Publishing average charges or payments in the absence of some meaningful context, may not be particularly useful to all consumers, except for a very few treatments that have little variability from patient to patient.

Ultimately, the objective is to provide patients with easy and timely access to information that clearly explains their financial obligation to pay for health services—in most cases, in advance of receiving those services.

Some organizations already provide average charges or payments for their most common healthcare services. Some go a step farther and calculate average expected payments after discounts for uninsured or financially limited patients. Very few, however, are able at this point to reliably address individual patient variations en masse due to such factors as the specific benefit plan, the patient's ability to pay, or the nature and intensity of services needed.

Possible practical strategies…

Organizational strategies:

- Develop formal policies and procedures for providing patients with written estimates of their expected financial obligations and for requesting that patients either pay or agree to payment terms at the time of this service; make one department responsible for these transactions.
- Develop procedures to obtain certain clinical and charge information, such as admitting diagnosis or procedure codes, earlier, so that patients can be provided with estimates of their expected financial obligations either in advance of or at the time of service. Start small, with scheduled patients in one location, or with patients requesting quotes; then expand this capability.
- For services that are predictable, establish and publish a rate that is available to any patient who pays the entire amount in advance. Consider offering this rate to uninsured patients, as well as insured patients if they will pay in advance with no risk to the provider for denials, bad debts, etc. Start with a narrow list of services for which resource use is predictable and, over time, expand the number of services with guaranteed rates.

Human resources strategies:

- Enhance awareness and understanding of reimbursement concepts and procedures among employees; ensure that staff members know what questions to ask and how patients can get answers about their financial obligations.
- Include success drivers such as patient satisfaction and estimation accuracy in employee incentive programs.

- Educate contracting personnel about the importance of providers giving consumers estimates of their expected financial obligations. Currently, some payer contracts prohibit such communications.
- Use scripts and role playing tailored to the needs of patients in different settings such as emergency and outpatient departments to train employees about how to communicate financial information.

Patient communication strategies:

- Give information about financial obligations to patients in writing with appropriate caveats. If appropriate, include language that pre-service information about financial obligations is only an estimate.
- Clearly communicate to patients what the information about financial obligations does and does not include. For example, it might include the financial obligations for hospital and anesthesiologist services but not for the surgeon.
- Encourage patients to become fully educated on their benefits, and what they themselves can expect to pay for healthcare services.

Collaboration strategies:

- Price transparency is something that can best be achieved through collaboration with other stakeholders. You can start by establishing payer contracts that allow you to communicate to patients in advance of treatment what their expected financial obligations will be.
- Encourage insurers and employers to fully educate enrollees on their coverage choices, the benefits they will receive, and what they should expect to pay personally for healthcare services.
- Encourage insurers to make available on a real-time, electronic basis information about coverage, benefits, noncovered services, copayments, and patients' deductible, coinsurance, and maximum out-of-pocket limitation status by implementing the committee on Operating Rules for Information Exchange (CORE) rules[1] on eligibility and benefits.
- Encourage payers to actively educate enrollees regarding providers not in their networks (e.g., pathologists, anesthesiologists, radiologists, and hospitalists) and to alert enrollees in advance about those providers who are not in-network when enrollees would reasonably expect to be receiving in-network services. As a backup for times when this first step fails, providers can try to alert patients to these situations.
- Consider referring patients to their insurer for information about their financial obligations. Some insurers are already giving enrollees information about their financial obligations for specific healthcare services from specific providers, and the rest should be encouraged to follow suit.
- Work with provider associations, payers, payer associations, and others toward the goal of having financial information for commonly performed services available to patients throughout your community in a format that allows meaningful comparisons to be made.
- Support a national database for the purpose of coordinating benefits.
- Encourage hospital information system and practice management system vendors to become CORE-certified to achieve interoperable, all-payer access to eligibility and benefits information.

[1] CORE, spearheaded by CAQH, is a multistakeholder body that develops operating rules for administrative transactions. CORE's Phase I Rules build on the HIPAA 270/271 transactions for eligibility and benefits verification and aim to improve access to accurate, timely healthcare administrative information.

What Providers Can Do To Achieve Agreement on Payment Expectations and Payment Terms

The objective is to have patients and providers work together to agree on appropriate payment expectations and terms of payment.

Possible practical strategies…

Organizational strategies:

- For patients with the ability to pay, collect their estimated financial obligation in advance or at the time of nonemergency services.
- In addition to establishing payment terms early in the patient encounter, also offer payment arrangements or financial assistance if you become aware that the patient needs assistance.
- Approaches to payment arrangements may include requiring a minimum monthly payment and a maximum length of time to pay, establishing payroll deduction programs, and referring patients to external financing sources, among other arrangements.
- Tailor pre-service collection and financial counseling practices to the patient's specific type of benefit plan. For example, design processes to accept automatic payments from health savings account or health reimbursement arrangement debit cards.
- Develop specific and fair discount policies for uninsured patients.

Human resources strategies:

- Ensure that staff who interact with patients have the ability to interact with compassion, respect and effectiveness.
- Hire staff with customer service skills and the ability to communicate financial expectations. Cross-train staff in these areas.
- Provide staff with tools necessary to assist patients in meeting their financial obligations.

MOVING THE FINANCIAL ADMINISTRATIVE PROCESS TO THE PRE-SERVICE POINT

"Here's what happened when we accelerated to a pre-service basis, many revenue cycle functions that had historically been performed at point-of-service or after the clinical encounter…"

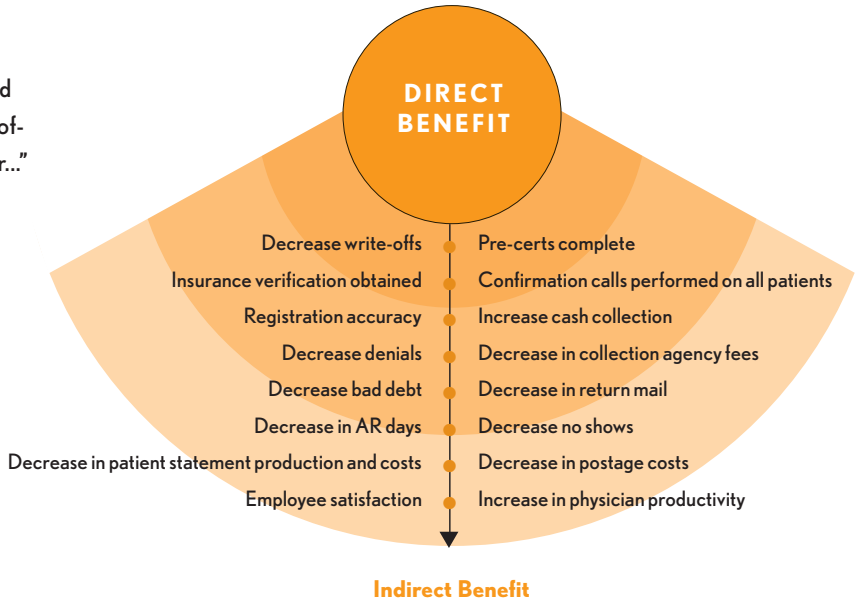
Greg Snow, Vice President Revenue Cycle, Geisinger Health System

Benefit
↑ $6.7 million*

Cost
↑ $2.8 million*

ROI
> 200%

Patient Satisfaction
↑ 3%



*This represents 60% of the program implemented after 9 months. A full year of implementation will be higher.

Patient communication strategies:

- Provide patient education about billing processes, including what to expect, being prepared to pay for services or make arrangements to pay over time, and how to obtain assistance. The patient can be provided with information in a variety of methods, such as in brochures, on web sites, by phone, and in person. Facilitate the patient's understanding of their insurance coverage for services expected to be provided.
- Use consumer-finance tools to identify patients who cannot pay and to provide estimates of the amounts that other patients have the ability to pay. Use this information to offer financial assistance (where permitted) to those patients who need it, and to make payment arrangements for other patients.
- For uninsured, scheduled patients, provide a written estimate of their expected financial obligations. This payment estimate may or may not be guaranteed and any guarantee might have exceptions for outlier services.
- Include outstanding balances from previous services during financial counseling and in discussions about payment arrangements.

Technology strategies:

- Develop online billing and payment capabilities.
- Offer patients multiple ways to make payments, such as cash, credit cards, payments from health saving vehicles, payment arrangements, outside financing sources, or other approaches that are acceptable in your community.
- At the time services are scheduled for patients with the ability to pay, obtain permission to hold an appropriate amount on their credit card, charging the card when service is delivered, as in the approach used by hotels and other businesses.

Collaboration strategies:

- Develop programs to have employers or insurers collect amounts due to providers from their employees/enrollees. Support efforts to provide seamless payment to providers for amounts due from both the insurer and the patient.

What Providers Can Do To Achieve Simplified Charge and Payment Structures

The objective is to simplify providers' charging structures and the methods used to determine payments for healthcare services.

A major impediment to pricing transparency is the fact that healthcare list charges in many cases are higher than expected payments. It will be more difficult to simplify the charge structure for inpatient than for outpatient services, because the latter typically are paid on the basis of individual procedures. In both cases, however, it will be easier for providers, especially hospitals to make a change if government ends their need to cost shift by adequately funding governmental health programs. The government could also simplify initiatives by changing certain payment methodologies that rely on charges, such as outlier payments and some workers' compensation and Medicaid programs, and by vastly simplifying the Medicare cost report, which is based on statistics that are usually derived from the existing hospital charge structure.

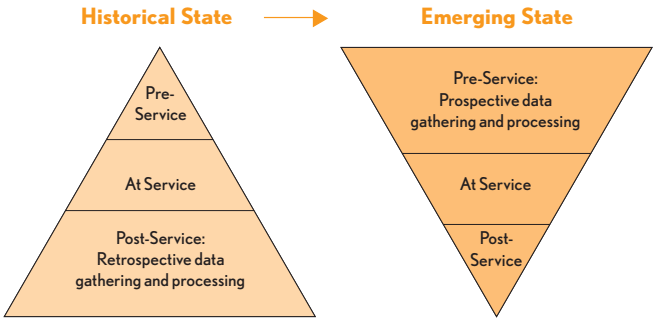
On the payment side, a multitude of payment methodologies adds complexity and cost to healthcare administration. In order for providers to streamline the processes used to determine payments, they will first need to work together with payers to manage the effect of change on payments.

Possible practical strategies…

Organizational strategies:

- Take into account questions and complaints from patients and insurers about specific charges when updating the CDM.
- Simplify and reduce the number of items in the CDM. For example, supply items routinely given to patients can be included in the overall room or procedure charge, and individual charges for some services can be bundled into a single package.
- Over the long-term, develop a comprehensive charging policy that is more rational and can be more easily explained to the public; this may require significant revisions to the CDM.

EVOLUTION OF PATIENT FINANCIAL EXPERIENCE



Providers gathered basic admission information before and at the time of service.

Much of the billing and collection process occurred post-service, as total amounts due were based on data gathered after services were rendered, and calculated retrospectively.

Patients first received information on their financial obligations after insurance was billed and had paid.

Providers gather detailed information before and at the time of service and prospectively calculate patients' expected out-of-pocket costs.

Providers will give patients bills at or immediately after the time of service, so that for many healthcare services, patients will know in advance what they will owe and will agree on payment terms.

In most cases, the insurance billing and collection process will be a verification of what the patient already expects.

Collaboration strategies:

- Work with employers and insurers to rationalize the CDM and to manage the impact on revenue.
- Consider implementing a reference pricing methodology, in which the payment methodology is standard but the amount of the payment is negotiated. For example, if the reference payment were to be a base amount, some payers would negotiate their payment at a percentage over the base and some payers would negotiate their payment at a percentage under the base. The effect is to reduce administrative costs and make payments simpler and more easily understood by consumers.

What Providers Can Do To Achieve Easy Patient Access and Scheduling

The objective is to make scheduling and registration services convenient for the consumer and cost-effective for providers.

This is an important aspect of the patient experience. It is where first and often lasting impressions are formed and it is also the consumers' entry point into the revenue cycle process. Make things work right here and you are on your way to a satisfactory experience for patients and employees alike.

Possible practical strategies…

Organizational strategies:

- Use a centralized scheduling function.
- Offer flexible scheduling, such as providing services in the evenings and on weekends.
- Obtain all financial and demographic information prior to the visit and coordinate this information among physicians, hospitals, and other providers throughout the system. This allows the patient to focus on clinical care on the day of the visit and eliminates the need to ask the patient for the same information multiple times.

- Schedule by CPT code, procedure, DRGs, etc., instead of simply filling time slots. This will help ensure that the needed clinical information is available to facilitate pre-service communications with the insurer, and that the appropriate amount of time is reserved.
- Offer 24-7 patient access for self-scheduling through multiple venues (e.g., self-service Internet portals, integrated voice response systems, check-in kiosks).
- Have the scheduling function report through the revenue cycle organization or otherwise ensure that they are closely linked.

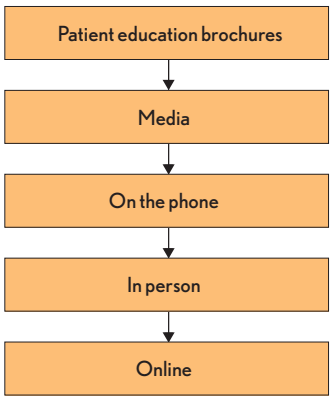
Human resources strategies:

- Dedicate a trainer/coach to building integrated processes and education programs.
- Reach out to clinical staff to gain their support for a patient-centric, streamlined scheduling and registration function; explain protocols, benefits, internal resources, and expectations.

Patient communication strategies:

- Provide patients with estimates of their expected financial obligations and make payment arrangements at time of scheduling or registration. Then, at the time of service, provide patients with the actual amount they owe, and update financial arrangements if the amount changed.

OFFER MULTIPLE WAYS FOR PATIENTS TO OBTAIN BILLING AND PAYMENT INFORMATION



- Use technology to remind patients of appointments and financial obligations. For example, automated systems can call or e-mail patients the day before their appointments. This can reduce the no-show rate and improve collections and patient satisfaction.

Technology strategies:

- Use and expand seamless technology with the ability to link to insurer online tools, store patient demographic and insurance information, generate patient estimate letters, automatically send patient information throughout the system, and interface information into the provider financial system.
- To update patient demographic and insurance information, consider utilizing existing databases or clearing houses. Examples include comparing data to the U.S. Postal Service change of address database, skip tracing services, and credit reporting or scoring databases. Some providers have used eligibility software to compare uninsured patient data to insurer databases, successfully verifying previously unidentified insurance coverage. Over the longer term, support a national database with enrollee demographic information that enables patients to make changes and to specify which providers and insurers could have access to information.

Collaboration strategies:

- Encourage insurers to make available real-time and electronic information about coverage, benefits, noncovered services, copayments, and patient status regarding deductibles, coinsurance, and maximum out-of-pocket levels by implementing the CORE rules on eligibility and benefits.
- Improve connectivity and coordination between physician offices and hospital departments; assign responsibility for this function to a specific person or department. Consider hosting meetings with physician office schedulers in the evenings, or bring lunch to their office.

What Providers Can Do To Achieve Appropriate Staff Support

The objective is to identify employees with new skill sets, and provide them with tools and training in order to enhance patient communications and the patient's overall experience.

Possible practical strategies…

Organizational strategies:

- Establish a separate function to move the patient experience with the revenue cycle from post-service to pre-service and point-of-service. Personnel in this function could be specifically trained in service excellence and the requisite technical and financial skills. In setting salary ranges for these positions, consider the financial impact each employee can have.

EMPLOYEE SKILLS FOR DETERMINING ESTIMATED PATIENT FINANCIAL OBLIGATIONS

- Experience with benefit plan designs
- Comprehensive knowledge of third-party payer protocols, medical terminology, and healthcare reimbursement methodologies
- The ability to perform complicated calculations
- The ability to use charges and historical information related to similar episodes of care
- Understanding of clinical/financial process relationships
- Strong written and oral communication skills
- The ability to function independently and to use independent judgment to bring financial counseling activities to a conclusion satisfactory to patient and provider alike

Human resources strategies:

- Seek service-savvy employees from other industries such as hospitality, credit card companies, banking, insurers, and funeral home collectors.
- Make sure employees responsible for determining estimated patient financial obligations have the requisite skills.
- Share revenue cycle metrics with all staff to increase awareness and support for improvements; consider group incentive programs for overall exceptional performance.
- Incrementally upgrade the skills of current staff to include patient-centric processes, starting with registration and scheduling areas.
- Provide additional training for staff in scheduling/registration, financial counseling, customer service, physician offices, and other departments that may intercede on behalf of a patient.
- Use e-learning and train-the-trainer techniques to accelerate cost-effective training, automate competency assessments, and track participation in educational activities.
- Develop and implement metrics to measure performance in areas that are important to the patient.

Patient communication strategies:

- Provide access to highly trained financial staff for patients 24-7.

CALL TO ACTION

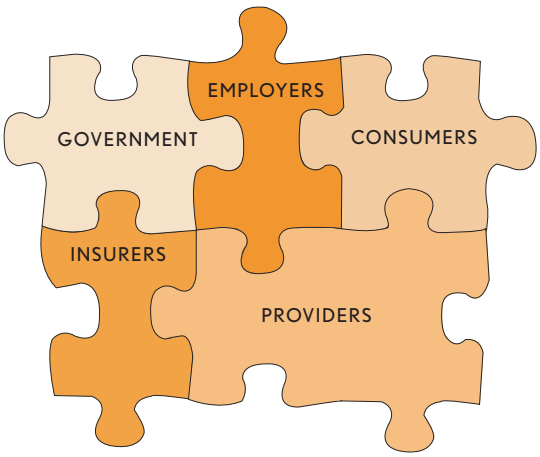
Consumerism in health care is growing. Consumers are becoming more involved in decisions about their health care, and employers are limiting what they will pay for health care. Providers, employers, private payers, government, and consumers all need to work together to effect the necessary changes. Providers need to take the lead. It is up to hospitals and physicians to seize this opportunity to elevate fairness and rationality in patient financial services to the level of authority that high-quality care and safety now experience.

We encourage all providers to:

- Review the guiding principles of the Patient Friendly Billing project consumerism initiative (see page 4) and use them as a basis for discussion within your organization
- Embrace the possibilities consumerism presents to help patients better understand and more effectively use health services
- Work toward transparency in pricing
- Simplify charge and payment systems
- Make your access and scheduling functions seamless, respectful, and convenient
- Upgrade consumer service skills among financial services employees
- Improve communication with patients concerning quality, prices, and payment responsibilities
- Work with payers to promote healthy lifestyles and during the normal renewal periods, reformulate contracts based on updated pricing that is more easily understood by consumers
- Collaborate with payers on systems to facilitate real-time, electronic exchange of key information, including patients' benefits, coverage, and status
- Engage with government to develop national standards for comparability of quality
- Advocate for regulatory revisions in line with the key objectives of consumerism in health care

These actions may seem a tall order for healthcare providers already pressured to fulfill a multitude of obligations. However, these actions are critical for providers to remain viable forces and to fulfill their mission of patient care in the future.

RESPONSIBLE PARTIES



ABOUT THE *PATIENT FRIENDLY BILLING*® PROJECT

Patient Friendly Billing is a national project to make financial communications to patients clear, concise, and correct.

Patient Friendly Billing project has issued five primary reports:

- Findings of patient focus group research and recommendations by the first task force (November 2001)
- Approaches to improving patient financial communications by medical group practices (June 2002)
- The use of technology in improving patient financial communications (June 2003)
- Discounting and collections policies and practices for uninsured and underinsured patients (February 2005)
- How to prepare for consumerism in health care through improvements to the revenue cycle (June 2006)

Previous research and findings from the Patient Friendly Billing project can be found at *patientfriendlybilling.org*.

This Initiative on Consumerism in Health Care

The Patient Friendly Billing project has examined how retail concepts in consumerism affect hospitals, physicians, and patients, especially during the revenue cycle from the point of preregistration through patient account settlement. This includes the growing trends toward high-deductible health plans, health reimbursement arrangements, and health savings accounts. The project leaders sought to fill the gap in practical, in-depth, operational guidance available to providers trying to prepare for these developments.

INITIATIVE SPONSORS

Initiative Sponsors

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- Lee Memorial Health System
- Mayo Clinic
- Partners HealthCare System, Inc.
- Rush University Medical Center
- Spectrum Health

PricewaterhouseCoopers served as project consultant and conducted the research, Clearwater Cardiovascular and Interventional Consultants was a technical advisor, Sidley Austin LLP was antitrust counsel, and Terry Allison Rappuhn was project leader.

Technical Advisor

Antitrust Counsel

Project Consultant

hfma℠

healthcare financial management association

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