

Calculating and Communicating Patient Financial Responsibility



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How can point-of-service collection be considered a success if you don't collect? Just ask Lorraine Schnelle, executive vice president, Bridgefront, whose organization provides online training in revenue cycle management, among other training topics for healthcare providers.

To Schnelle, a POS collection encounter can be successful even if you don't get a dollar, "as long as the patient walks away from the registration desk understanding why he or she owes that \$200 and thinking about how to pay it. You can still feel that you've done your job simply by educating customers about their financial responsibility."

It's not that the money isn't important. It's that, at this particular historical juncture, as consumerism takes hold in health care and individuals are being asked to shoulder a greater portion of the financial burden—including rising deductibles and copayments—the conversation about the money is almost equally so.

These days, hospitals must be prepared not just to deliver accurate and timely information about a consumer's benefits on the spot (itself no easy trick), but also to explain that information in terms that make sense to the consumer, to listen to the consumer's response and react appropriately, and then to bring the conversation to a close that satisfies both parties.

■ Multiple Challenges

Providing real-time estimates of out-of-pocket expenses—and experts agree that's what patients really want, that hospital charges are not as important—is a highly complex business. It requires hospitals to pull together into one figure information from distinct databases on patients, payers, and providers, including the interaction of insurance contracts, individual benefits, specific medical conditions, expected treatments, physician preferences, and discount policies.

Copayments are pretty cut-and-dried by now, notes Schnelle. "Generally the information is either right on the insurance card or you can access it with an online tool." Co-insurance and deductibles pose more of a challenge because the information is more fluid, and this is where many hospitals

are struggling right now. Then there's the balance due from past visits, which some hospitals throw into the mix and others don't.

Technology can go a long way to help find and fit the different pieces together. Automated tools can enable hospitals to track and match benefit information—including coverage, rules, exclusions, limitations, copays, and employment status—identify eligibility for financial assistance, and calculate charges. But technology is not a panacea.

"There's no one-stop shopping yet—no tool that can access every third-party payer database without the need for workarounds," observes Schnelle. "Even with HIPAA [Health Insurance Portability and Accountability Act of 1996], the consistency and uniformity of transactions haven't spread to all payers. Depending on the market, finding a workable solution can be very resource intensive. And some smaller hospitals may not be in a position to invest in the tools that are available."

The complexity of information exchanged external to the hospital also presents its difficulties, as Schnelle notes. "Is communication between the employer and the third-party payer timely, so that you know who actually is eligible for benefits at a given moment? How fast are other providers submitting claims on that patient's coverage? What is the effect of the adjudication process? These will all affect the quality of information the hospital is working with," she says.

On the people side of the equation, the challenges are almost as daunting. Typically, hospital employees in positions of direct contact with patients about financial expectations are considered entry-level, have only a high school education, and are paid relatively low wages (for example, making between \$9 and \$12 an hour in the Phoenix area). As a result, turnover is often high and communication skills low among scheduling and preregistration staff. Turning this situation around—attracting, training, and keeping better qualified people—is a costly undertaking.

It's natural to wonder: Is it worth all of the expense and effort required to provide cost estimates, to ask consumers to pay what they owe up front, and to educate them about health-care finance?

Consider that simply collecting a \$75 copay during 35,000 emergency department visits would bring in an immediate \$625,000; collecting a \$20 copay during 75,000 clinic visits would amount to \$1,500,000. What's more, the longer a hospital waits to collect, the more money it must spend on follow-up correspondence and collection activities and the less likely the patient is to pay the bill.

With this in mind, the following discussion highlights how three healthcare providers with different interests and financial means are responding to the need to calculate and communicate patient financial responsibility.

Maricopa Integrated Health System

Maricopa Integrated Health System, a public health system in Phoenix, has made headway despite limited resources. For patients who have commercial insurance, Maricopa uses the HIPAA EDI transaction sets (270/271) to query the payer to confirm the person's deductible and coinsurance amount, says Mary Lee DeCoster, vice president, revenue cycle. "If Cigna comes back and says 'Yes, this person is still a member and they have a \$50 copay for outpatient services and \$250 for inpatient care,' then that information is scripted into our patient accounting system using a notes function, so that we always have a record," she says.

Maricopa does this at preregistration and with nonemergency walk-ins. "As the registration clerk is interviewing the patient and entering data into the fields, our electronic tool is extracting the information needed for the query," explains DeCoster. "We can set it up so the query goes out in real time during the interview or batch them to send at the end of the day, which is cheaper. We batch everything that goes to Medicaid, and we run each uninsured account against the state database looking for a match."

Most queries are batched, for only 8 percent of the hospitals patients are commercially insured. Medicare covers 9 percent of patients and Medicaid is available to more than half of patients. The uninsured make up 20 percent of the hospital's patients. "Our patients aren't price shopping," DeCoster says. "They're here because we're the only ones who will take them."

The Well-Written Price Quote

Following up a verbal estimate with a written letter is important for at least three reasons: It makes it very difficult for patients to claim later that they were misled about their financial obligation. It helps to educate patients, so that they can understand the vital link between receiving and paying for needed services. And it is an excellent opportunity for hospitals to do a little PR.

To take full advantage of each of these benefits, consider the following recommendations of elements to include in your letter.

- An expression of appreciation for choosing or considering the hospital/system as a partner in the person's health care
- Mention of any recognition the hospital/system has received for its work in the area of concern
- Congratulations on the person's proactive approach to his or her health care.
- A statement that the fees shown are only estimates and are in effect only until [date]
- An explanation of the individual factors that may cause the final bill to vary from the estimate, including:
 - How long recovery takes
 - What kinds of medications are required
 - Whether additional treatment is needed
 - Whether the procedure is more or less difficult than expected
 - Ancillary services that may be needed
- Notice that the person may receive separate bills from nonhospital physicians for services such as radiation therapy and anesthesiology
- The name and number of a staff member to contact if the person has any questions

Ideally, you will write all of this very succinctly and get it all on one page!

Even when patients don't have insurance, the hospital needs to be able to tell them how much they will owe the organization. "We are currently working to develop a pricing estimator that uses historical claim and payment data and also interacts with our chargemaster and applies our charity fee schedule, which will give us a much more robust and accurate estimate," DeCoster says. But until that tool is up and running later this year, Maricopa's financial counselors must rely on a manual reference tool, a grid that hangs on the organization's intranet.

"The tool pulls together the cost of the ordered service, the person's credit score (based on information provided by a national search service that the hospital uses if someone has a social security number), and any discounts the patient may qualify for under our financial assistance program," explains DeCoster.

The figure that emerges is provided to the patient verbally and in a letter to be taken home. The message: A deposit is needed today of at least half this amount. Of course, even if the person can't pay anything, Maricopa, as a safety net hospital, is unlikely to delay or deny treatment.

■ Saint Luke's Health System

Saint Luke's Health System, an 11-hospital not-for-profit system with headquarters in Kansas City, Mo., also is working to enhance advance estimates of patient financial responsibility.

For scheduled patients who do not have insurance, Saint Luke's requires a deposit on the estimated total. If the patient is unable to pay at that time, the hospital offers to reschedule the service. If a patient does have insurance, then the system policy is to ask for payment during scheduling or preregistration, but not to insist. Some people would just as soon get it over with and not have to deal with a bill while they're recuperating, notes Diane Watkins, vice president of revenue cycle.

"We're going to open a centralized pre-service area later this year, which will allow us to reach out and talk to more of our patients in advance and provide them with information that will help them plan for their financial responsibility," she says.

Saint Luke's already operates a centralized price line to provide customized quotes to people who request one, using an automated tool that generates a plan-specific price. Requests most frequently are for radiology, surgery, and maternity services. In 2007, over 1,200 patients used the price line service, and half of them were self-pay patients.

An account service specialist gathers information over the phone, including insurance plan information, physician, and procedure/service requested. Often, the specialist is able to provide the quote during the initial call; other times, when all the information is not available, it may take an additional day. In either case, he or she discusses the quote and its components with the patient and mails out a written confirmation.

The quote relies on whatever information about the deductible and coinsurance the caller provides, although in the future Saint Luke's plans to verify this information to the extent possible. "Most people have a pretty good understanding of these things. The ones who don't even realize they have a deductible aren't calling the price line in the first place," says Watkins.

■ Orlando Regional Health System

In addition to a pricing phone line, Orlando Regional Health-care, a 1,780-bed Florida system with seven hospitals, aids pricing efforts with a central diagnostic scheduling center, a central preregistration area, and an aggressive up-front collecting policy, according to Keith Eggert, the system's vice president of revenue management.

ORH staff call patients at home prior to service and advise them what they owe. They then collect the amount due over the phone from 80 percent of the scheduled patients they reach. (Contrast this with many other hospitals that still struggle to achieve 80 percent preregistration).

Such timing is smart. The longer a hospital waits to ask for the money, the less likelihood there is of collecting it.

While ORH collects both copays and deductibles up front, Eggert says, it prefers to collect coinsurance after the

Take Action!

In its recent report on “Consumerism in Health Care,” the Patient Friendly Billing project, a national initiative led by HFMA, with support from the American Hospital Association, the Medical Group Management Association, and many providers, suggested that healthcare providers would do well to adopt the goals of price transparency, agreement on payment expectations and terms, simplified charge and payment structures, easy patient access and scheduling, and appropriately trained staff.

Toward that end, the report lists dozens of proven strategies that can help get today’s hospitals and other healthcare organizations from here to there, ranging from the simple to the more sophisticated. Here are just a few of them:

- Develop formal policies and procedures for providing written out-of-pocket estimates to patients (guaranteed when possible) and for requesting that patients either pay or agree to payment arrangements by the time of service. Make one department responsible for these transactions.
- Strongly encourage insurers to make benefit information available on a real-time, electronic basis.
- Consider imposing a minimum monthly payment and a maximum length of time to pay as part of payment arrangements.
- Improve opportunities for patients to make payments by offering payroll deduction programs and making referrals to external financing sources as appropriate.
- Tailor pre-service collection and financial counseling practices to the patient’s specific type of benefit plan. (For example, arrange to accept automatic payments from a health savings account or support use of debit cards for such accounts.)
- At the time services are scheduled for patients with the ability to pay, obtain their permission to hold an appropriate amount on a credit card, and charge the card when service is delivered, as done by hotels.
- Provide education to patients about billing processes in a variety of formats, such as in brochures, on web sites, by phone, and in person.
- Include outstanding balances from previous services during financial counseling and in discussions about payment arrangements.
- Use a centralized scheduling function.
- Offer 24-7 access for self-scheduling through multiple venues such as self-service internet portals, integrated voice response systems, and check-in kiosks.
- Have the scheduling function report through the revenue cycle or otherwise ensure the departments are closely linked.
- Seek frontline employees from other service-savvy industries such as hospitality, credit card, banking, insurance, and funeral home collections.

To access the full report as well as other resources—such as a decision tree for delivering a price quote, a spread sheet tool for developing charge estimates, or examples of letters that providers are using to communicate patient responsibility—go to www.patientfriendlybilling.org.

insurance company has paid its portion, simply because it involves so many variables. And staff provide estimates of the total out-of-pocket cost only to inpatients who ask, which fewer than 5 percent of them do.

“Typically, it’s the self-pay population that’s price shopping,” he says. “We work closely with the ordering physician practices to find out what services are going to be provided, and then we use an automated tool that allows us to capture the average charge range.” It is important to note that, like many other hospitals and systems, ORH provides an estimated range for patient financial responsibility, rather than a precise figure, reflecting the uncertainties that are intrinsic to health care.

The individual hospitals in the ORH system use a traffic light approach to admit patients, who are coded red, yellow, or green based on those prior interactions. Eggert explains:

Green = “You’ve been here before, we have your signed consent-to-treat form on file (ORH uses a 365-day form), and we’ve collected what you owe over the phone. So the only thing to do is to ‘arrive’ you in the computer system and escort you to the point of service.”

Yellow = “We have all the information on your benefits but we couldn’t reach you to collect your copay and/or deductible, so we need to meet with you to take care of that and to collect any signatures that we haven’t already obtained.”



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Red = “There are significant issues to deal with.” Most of the Medicare population (30 percent of the system’s total patient population) is red light, because there is so much regulatory detail that needs to be handled in person.

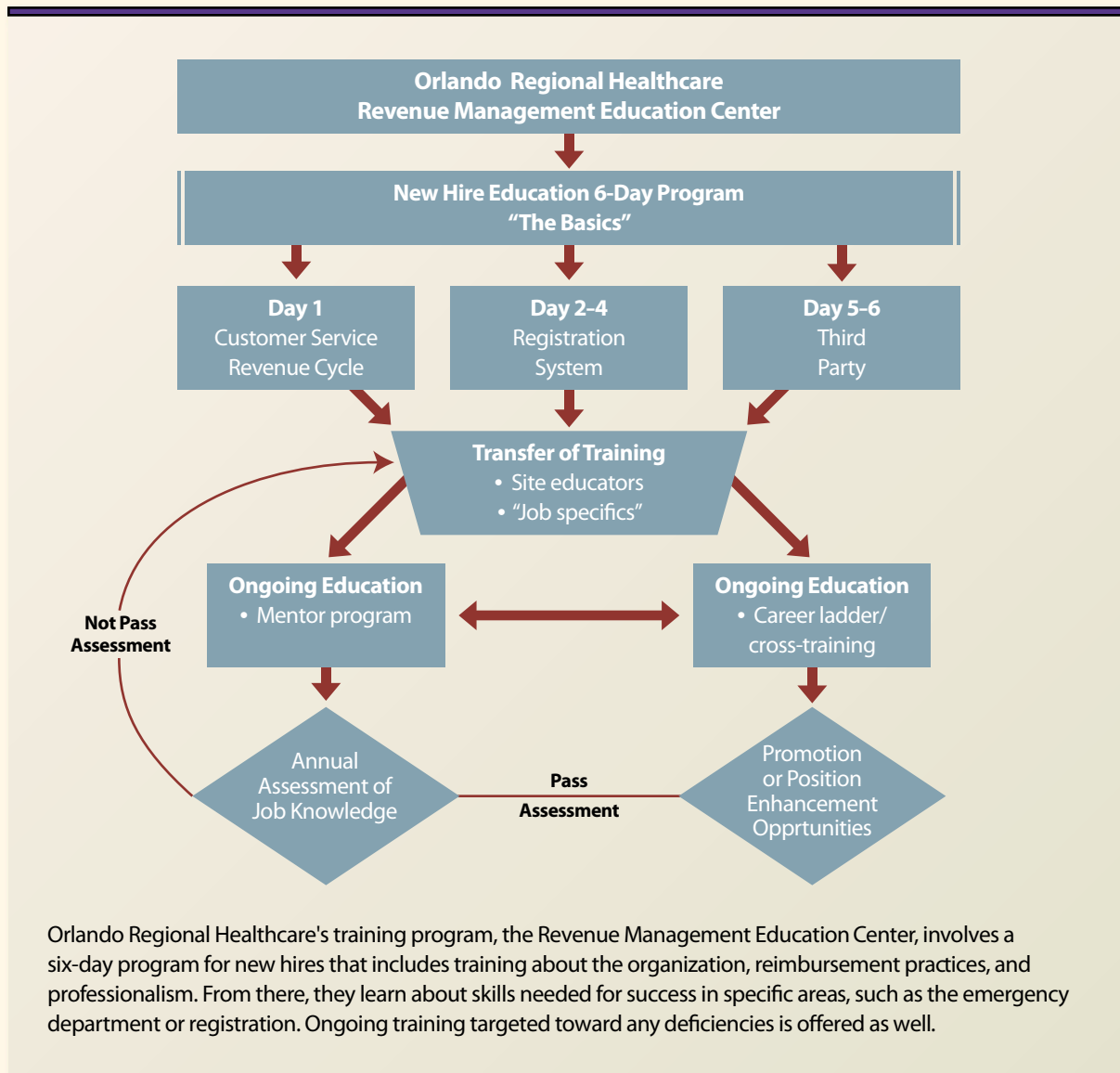
■ Training Solutions

ORH credits most of its success in communicating patient financial responsibility to its commitment of time and resources toward training. The system does system training, reimbursement training, and professionalism training, starting with six days of classes for all new hires at what it calls the Revenue Management Center for Excellence—and that’s just Phase 1.

Phase 2 involves department-specific, one-on-one training by mentors in the individual work areas such as registration, emergency department, business office, etc. New hires also have additional educational resources available to them on a request basis. In addition, all revenue cycle employees are recertified annually, using a comprehensive assessment tool available through ORH’s e-learning network. Additional courses and targeted training is developed based on the results of these assessments.

Maricopa Integrated Health System would like to offer the same kind of training to its frontline employees and may be able to move in this direction next year, says DeCoster, depending on budget. Improved customer service skills and greater confidence, she believes, could help lower a staff attrition rate of between 30 percent and 32 percent and help employees deal with challenges such as members of the patient population who may not speak English or be literate in any language, or who may be disorderly because they are under the influence of drugs or alcohol.

Currently, however, the hospital has focused its limited resources on technical training in the use of the 14 screens in the patient accounting system that capture registration information. This training is delivered by the hiring supervisor and/or a trainer from Maricopa’s education department. In addition, some peer training goes on, matching up new hires with an experienced registration clerk.



Source: Orlando Regional Healthcare. Used with permission.

“And then on a periodic basis, usually weekly,” says DeCoster, “the supervisor provides feedback based on quality audits of the registrations each person has completed.”

As the paradigm has shifted over the past five to eight years to one where previously unskilled frontline staff are taking on greater responsibility for talking with patients about money, Schnelle would like to see community colleges take the training burden off the hospitals “and raise the quality of candidates available to take on these additional responsibilities on the front end of the revenue cycle.”

■ Keys to Success

In addition to comprehensive training, Eggert credits most of ORH’s success with calculating and communicating patient financial responsibility to technology that has made it easier to obtain the necessary information and to the organization’s culture.

“We’ve built our corporate culture over the past 15 years on a high degree of professionalism in the registration areas,” he explains. “We don’t have ‘clerks,’ we have ‘financial counselors’ or ‘patient business representatives.’ Everyone dresses

in business suits. We offer a highly competitive base wage and pay incentives on top of that, based on the employee's ability to collect dollars at the front door."

Even with all of these things in place, keeping staff current with ever-changing rules and regulations is an ongoing challenge, Eggert admits. Key to keeping ahead of the curve, he says, is quick communication.

"We post new information on our online mentor program, which allows us to provide consistent, accountable education in between the major assessment we do annually. If you're a patient business or accounting team member, you sign into the web site once a month and read all of the updates that pertain to your job, and then acknowledge that you've read it."

At Saint Luke's Health System, Diane Watkins cites two factors that are helping the organization embrace the financial aspects of consumerism. When Saint Luke's was developing its program of estimating and, in some cases, collecting what patients will owe up front, she says "we did it in partnership with our nurse line services and our marketing division."

Such perspectives can be very useful. "It's really helpful when you're getting started, or just want to review your current program, to go outside the finance area and tap into the expertise available elsewhere in the organization about how to relate to customers," she says.

The other factor, says Watkins, is a consistent system for documenting communications. "You have to follow up that verbal price quote with a written letter, so there's something



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to refer back to in case there's a misunderstanding. When someone comes back later and asks why they owe more than what was estimated, it's almost always because they had X, Y, and Z done in addition to the A, B, and C that was anticipated. You have to make this possibility clear and document that you've done so."

Of course, human nature being what it is, even the most painstaking efforts to help patients come to terms with their financial obligation in advance can occasionally fall short. To wit, the man who asked for and was given a price quote for the birth of his child at Saint Luke's—but neglected to mention that he and his wife were having twins. "We just could not make this gentleman understand that they had to pay for both babies," says Watkins with a laugh.

Having learned the hard way, she says, "we now very clearly ask prospective obstetric customers 'How many babies are you planning on having?'"



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