The Changing Self-Pay Environment

hfma healthcare financial management association

As high-deductible health plans (HDHPs) proliferate, the size and scope of patient payments are increasing. Without effective processes for engaging patients around their financial responsibilities, healthcare organizations can experience mounting levels of bad debt. As hospitals and health systems strive to make improvements in this area, some key strategies to keep in mind include enabling robust patient financial communications, implementing pre-service automation, offering up-front pricing, engaging in presumptive charity care, and segmenting patient accounts. In this Executive Roundtable, sponsored by Parallon, senior revenue cycle leaders discuss their organizations' efforts to capture patient payment, sharing lessons learned and strategies for success.

To what degree is your organization focused on boosting patient collections?

Kim Roelfson: The shift in healthcare payment has brought patient collections to the forefront. When the Affordable Care Act (ACA) changes began, our county qualified well over 150,000 people for Medicaid. As a result, we saw a huge shift in our mix. Today, we see a lot of people with low-cost health plans and large deductibles, and they have no more ability to pay their bills than they did before they got insurance. This has caused us to quickly adapt our collection strategies.

Ron Wachsman: Today, new HDHPs, health exchange memberships, and reduced cost-sharing from employers all add up to a greater liability for consumers. We have responded to this by focusing on both front- and back-end changes. Because the point of service is the best time and place for patient collections, we calculate individuals' projected liabilities using estimation software and try to settle their accounts during pre-registration. We collect past balances and set up payment plans at that point as well.

When we still need to collect after discharge, we engage patients as much as possible via email. They are able to follow an embedded link, log into their accounts, understand their balances, drill down to find case details, make or arrange payments, or settle their accounts. This Web-based approach reduces the cost-to-collect and increases patient satisfaction.

Scott Hawig: Our interest, curiosity, and passion lie in making a better experience for our patients, and that includes the financial process. We gauge our success by closely reviewing patient satisfaction and loyalty metrics, using them to drive many of our decisions. Because we do not score as high on billing, check-in, and registration as we do on clinical care, we want to raise those numbers by improving the revenue cycle experience.

PARTICIPANTS IN THE HFMA EXECUTIVE ROUNDTABLE

Scott Hawig is senior vice president of finance, CFO, and treasurer at Froedtert & Medical College of Wisconsin Health Network in Milwaukee.

Jessica McKinney is vice president of patient access operations at Parallon in Nashville, Tenn.

Kim Roelfson is director of revenue management and customer service at Centura Health in Denver.

Ron Wachsman is chief revenue officer with Memorial Hermann Health System in Houston.

Sandra J. Wolfskill is director of healthcare finance policy and revenue cycle MAP for HFMA in Westchester, Ill.

What role do strong patient financial communications play in increasing collections while maintaining patient satisfaction?

Jessica McKinney: Educating patients about financial responsibility is part of our obligation; however, it is challenging. Healthcare organizations typically have to educate patients about insurance at the worst possible time, when they are sick and not in the best frame of mind to learn. Complicating matters, we see a number of people who are new to health insurance and do not understand the concepts behind how the system works. Our staff spends a lot of time talking to these individuals about their benefits.

It is important for our registration staff to take the right educational approach. Although they follow a prescribed, formally documented process for discussing patient financial responsibility, they also have to evaluate each case critically and tailor the conversation to the coverage. The interaction is quite different for a patient with a $50 copay and $1,500 reimbursement than for a patient who has a $1,500 deductible.

Roelfson: The shift to consumer liability has given us savvier patients who are more conscious of costs. Our strategy for helping them revolves around price transparency, and we find that up-front communication yields enormous benefits. Our website also offers information about charity, financial assistance, and pricing, which we have standardized across all our facilities for common tests and procedures.

Our software tools allow us to work through a phone conversation, screening for insurance coverage, Medicaid eligibility, and charity qualification, and delivering a price estimate so people know what to expect. Patients get to talk to and ask questions of an actual person who understands and explains things, which is what most patients want. Being a nonprofit, faith-based entity, a patient-centric environment is what we want to create.

Hawig: I have heard the argument that a more engaged patient leads to better collections, but we're not aiming for that specifically. Our No. 1 goal is to create a good patient experience, which we achieve, in part, through communication. We surveyed 1,000 people in our community about their expectations, their sensitivity to pricing, and how much healthcare shopping they do. The No. 1 desire for half the patients was to get early price estimates for their care; the other half gave their top rating to flexible financing. To some degree, these values relate to communication, and they represent the minimum that we must achieve for our patients.

We use HFMA standards to help with patient financial communications. For example, we submit our data to HFMA annually as part of their recognition program, and we are applying to HFMA's recently launched Patient Financial Communications Best Practices Adopter program as well.

Sandra Wolfskill: There are myriad influences affecting the need for strong patient financial communications. For example, Medicaid expansion, high-deductible health plans, advancing consumerism, and value-based reimbursement all make these conversations critically important. Having a defined approach based on best practice is essential for not only improving the patient experience but also effectively capturing revenue. Pursuing best practices like those offered through HFMA can bring consistency, clarity, and transparency to patient financial communications. These practices address key questions, such as: Where should you talk with patients about their financial responsibilities? Who should be responsible for working with patients? How should interactions differ depending on the care setting? How should you verify insurance? Offer cost estimates? Make payments easier? In addition to the best practices, HFMA offers metrics to measure whether your financial communications are up to par and where there are opportunities for improvement.

How can automating pre-service processes help increase patient payments? Why is this a beneficial strategy?

Hawig: Automating key processes, such as cost estimation, allows a large organization like ours to be more efficient, which means we can reach out to more folks than we could if we did everything manually. We also can enable a fuller, more informed conversation from the start, rather than spending time with patients making calculations, which can be less accurate.

McKinney: A combination of automation and outsourcing lets us handle financial arrangements efficiently while offering patients a range of convenient ways to pay. At the point of scheduling, the information goes to an insurance eligibility vendor that processes the transaction and posts it back to our information system. Any problems with patient coverage go into a work queue for exceptions-based processing, handled by in-house staff.

Wolfskill: Automating solutions on the front end of the revenue cycle is extremely valuable. Registration tools that reliably collect and communicate patient demographics, automated insurance verification solutions that check on patients' insurance, and cost estimator tools that give patients a sense of what they will owe can set the stage for a positive patient experience. Implementing automated payment solutions can drive patient payment

as well. People are used to being able to electronically handle their financial responsibilities. You can pay credit card bills, book hotel rooms, and even pay college tuition online, and you should be able to pay your healthcare bill that way as well. When organizations allow recurring online payments, it furthers patient convenience because people can set up an automated payment plan and not be worried about missing payments.

Roelfson: Auto pay has been widely successful for us—patients love setting up automated payment plans with credit cards. Even if patients have the money to pay as a lump sum, they sometimes choose this option until the services are complete and the final charges are calculated.

Does your organization provide cost estimates to patients before care? How have patients responded to the information?

McKinney: With many providers now engaged in point-of-service collections, an up-front estimate has become much more common than it was just five years ago. Estimates make it possible to discuss patients' liability pre-service, rather than sending a surprise bill after the fact. People tend to be more responsive to an early conversation about costs. Even though people may be anxious before elective surgery, for example, in many cases they are in a better frame of mind before a procedure than they are immediately afterward.

The reality is that patients now expect to be told about their out-of-pocket costs. We have used an internally developed patient estimation solution for our facility and our full-circle revenue cycle clients since 2007.

Wachsman: Patients certainly do appreciate the transparency. They want to know what their liability is going to be. The challenge is to predict the amount of services, what insurance will pay, and what the individual will owe according to his or her policy's coinsurance and deductible. We make sure our technology is advanced enough to gather information from the insurance company to get an accurate estimate. By using a platform that is customizable to our contracts and workflows, we can be more precise and improve patient satisfaction.

Hawig: Cost estimation software drives our up-front process in a way that is beneficial to patients. The price estimator tool runs in the background while staff schedules an appointment and then inserts its estimate of patient responsibility into a template. For example, if Mr. Jones schedules knee replacement next week, then the order for surgery triggers the system to verify insurance and calculate the copay and remaining deductible. Staff talks to Mr. Jones on the phone and verifies that he has $500 left on his deductible and a $500 copay, so he will owe $1,000. This conversation gives Mr. Jones the opportunity to fully understand his responsibility and iron out any inconsistencies with his insurer.

Wolfskill: Even if an organization is committed to creating accurate estimates, there are times when they may not be as close to the actual costs as the organization would like, especially when it comes to the differences in preferred supplies and devices from one physician to the next. It may be helpful to do periodic audits to gauge the accuracy of your estimates, making adjustments as necessary.

Why is it important to proactively identify charity care accounts? How can this limit bad debt? Does your organization also segment patient accounts, including patients with HDHPs?

Wolfskill: By using a presumptive charity model, organizations can immediately funnel those patients who are completely unable to pay out of the traditional collections pipeline and into charity care. This way hospitals can avoid spending multiple cycles trying to follow up with a patient and seek payment when there is no chance the patient will be able to afford the care. Presumptive charity care also prevents the account from going into bad debt.

Even if you don't employ a presumptive charity care solution, keeping an eye on bad debt versus charity care is a good idea. Organizations should regularly trend these metrics because a high percentage of bad debt may indicate an improvement opportunity. Plus, an increase in this metric may reflect a change in process or patient demographics.

Organizations may also want to think about using a limited plan code for HDHPs to pinpoint patients with these plans. Once you identify them, your staff can reach out to inform them about self-pay options. This will allow you to get patients on payment plans sooner, increasing the chance of receiving payment and also boosting patient satisfaction.

Roelfson: HDHPs are hard for patients and health systems alike. By identifying these accounts, we can be proactive and reduce the risk of bad debt. Late last year, we changed to a presumptive charity system. Previously, we only scrubbed uninsured accounts for charity eligibility, but HDHPs have led us to scrub accounts that have an out-of-pocket balance after insurance. Based on the information we have, including demographics and Social Security numbers, our vendor can determine eligibility and adjust for charity care before the account goes to bad debt.

Hawig: We do not identify charity care accounts up front because we do not have the necessary financial information at that point. We have a live discussion, and if a patient has no insurance or a high deductible that he or she cannot afford, then the call is routed to financial counseling. A financial counselor figures out the patient's exposure and determines if Medicaid, charity, or our financial assistance program fits the patient's eligibility and needs.

Wachsman: We approach collections by first dividing patient liability into two categories: with or without insurance. When patients have no insurance, we enroll them in Medicaid or help them find a plan, if possible. When patients do have insurance, we employ a number of strategies to increase our collection rate for their liability, including front-end processes and a Web-based approach on the back end. We engage in as much outreach as we can to qualify patients for our internal charity policy. Because our charity is internal, we are not paid for those cases, but we can classify the write-off appropriately instead of adding it to bad debt.

What lessons learned would you share with other organizations looking to drive patient collections?

Wachsman: In tracking data and looking for efficiencies, we began offering more online, self-service payment options. After about 18 months, these kinds of payments have gone up 60 percent—an encouraging result that motivates us to keep moving in that direction. As debt liability grows, organizations must find better ways to collect more efficiently. Also, you need to keep advancing patient interactions, not just sending more statements that will probably get thrown in the trash.

We network with other large systems to share notes and success rates because we all face the same challenges. In general, we try to follow best practices. By collecting up front with patient estimation tools—what amounts to about 3 percent of our net revenue—and focusing on digital engagement on the back end, we are taking steps in the right direction.

Hawig: Fundamentally, organizations need to closely review what they are doing to engage patients. What is your financial counseling process? Do you explain collection practices on your website and in the clinic? Do you offer estimates? How comprehensive are they? Can a patient call and ask about costs and pay on the phone? Does the community know how they can talk to you?

Organizations may want to go through the HFMA Patient Financial Communications Best Practices Adopter survey to see what gaps exist in their services, and then consider how to close some of those gaps.

Wolfskill: When patients understand what is going on and satisfy their accounts early, the results are better for both patients and the hospital. Organizations should monitor their teams to ensure they have the right tools and know all of the plans available to patients. You also want to make sure you educate patients thoroughly in an approachable style, answering every question. This will not only yield more informed patients, but it will also help you achieve your goals.

McKinney: The biggest barrier to point-of-sale collections is education, and the team you employ to educate patients has an enormous impact. Not only do they need to know the tools inside and out, but they also have to understand the important reasons behind what they do. If staff fail to collect up front, then in many instances the organization will take on bad debt. You have to tie all of these pieces together for the staff, so they can work with patients as effectively as possible.

Roelfson: Our presumptive charity approach, used in combination with up-front payments and pricing estimates, has helped increase collections and reduce debt in our facility. Anything you can automate and standardize is a win all the way around; it saves you money and proves to be a strong patient satisfier.

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