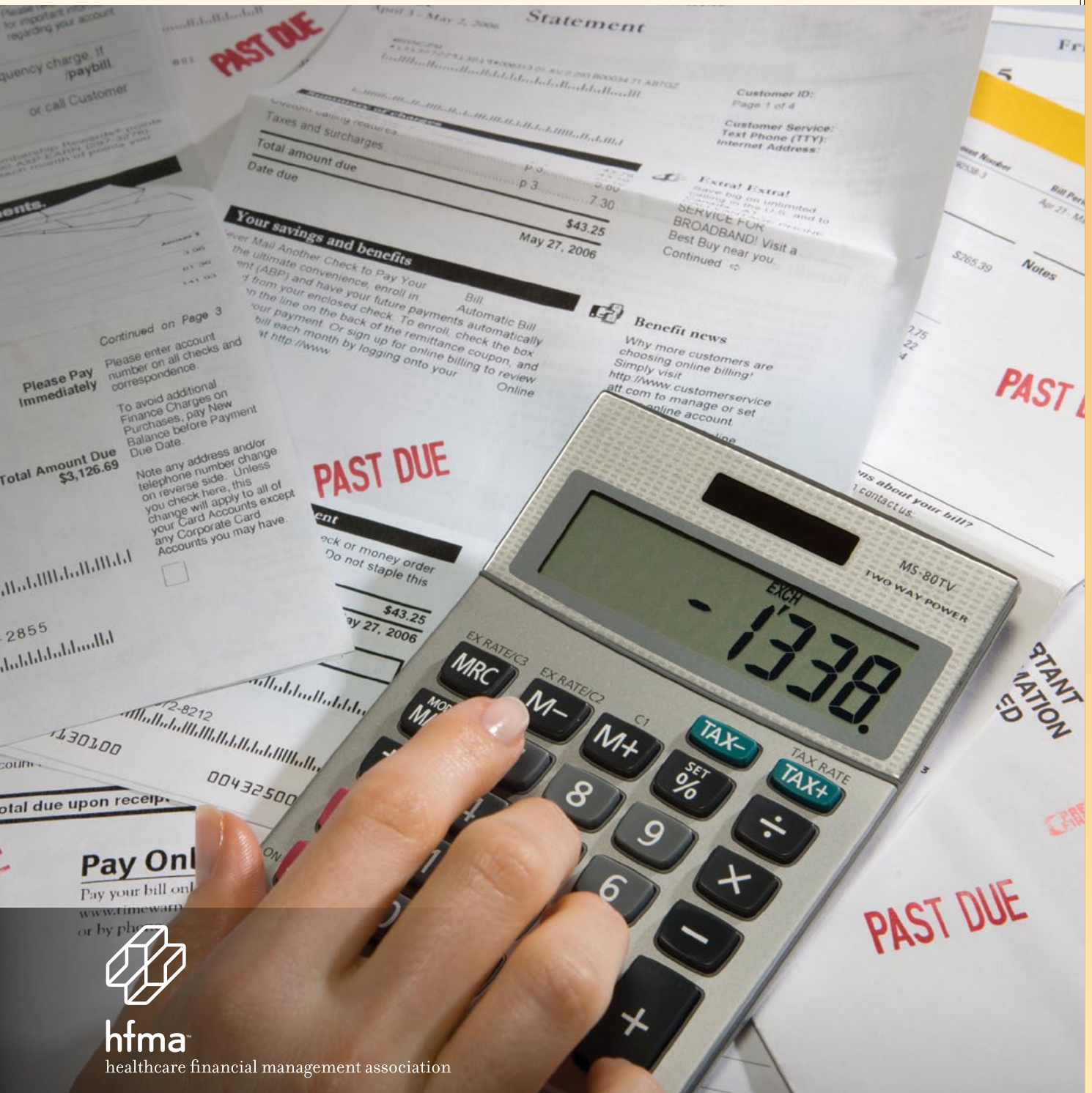


Strategies for Reducing Bad Debt



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If the state of affairs in health care is bleak now, then the future does not appear to be any brighter. In 2007, an estimated 25 million people between ages 19 and 64 lacked adequate insurance—a 60 percent increase since 2003.¹ At the same time, census figures show 45.7 million people lacked health insurance altogether. Into this mix throw in rising unemployment, lower earnings, and a worsening economy. The result: As more patients are becoming responsible for their healthcare costs, it's becoming increasingly difficult for them to afford care and, in turn, for hospitals to collect from them when they do seek care.

For many hospitals, this perfect storm of eroding health benefits, increasing patient financial responsibility, and economic woes has led to a rise in bad debt. According to the American Hospital Association, the cost of uncompensated care (including bad debt and charity) for the country's 4,897 registered community hospitals grew to \$34 billion in 2007.²

■ Stemming the Flow

Given this worsening environment and the related mounting bad debt, hospital executives may feel there is little that can be done. Fortunately, this isn't the truth. By leveraging innovative technologies and rethinking or evolving processes, many healthcare providers are discovering opportunities for keeping bad debt in check.

One key strategy hospitals can employ is to improve efforts to differentiate between patients who are able but unwilling to pay and those who truly are unable to pay. Stronger efforts should then be undertaken for those patients without payment ability not only to assist in determining eligibility for financial assistance or charity care but also to aid in the enrollment process. Individuals with an ability to pay can be best served with efforts that help them understand the obligation and processes that help facilitate payment.

Of course, pursuing such an approach can be challenging. Providers may find themselves reengineering processes, retooling with new technology, and retraining employees. Also, underlying any self-pay strategy should be the realization that a delicate balance must be maintained between a high-tech tool that increases efficiency and a personal touch that recognizes the importance of treating all patients with respect.

■ Shifts in Revenue Cycle Focus

Not so very long ago, discussion of payment and payment options took place in some cases long after the hospital service was rendered. For example, a patient had surgery and a bill was then sent followed perhaps by a collections letter or two. If payment wasn't received promptly, only then did discussion about payment options begin.

In today's environment of patients' increased financial responsibility, the discussion of payment and payment options after the delivery of nonemergency care is not well-suited. Instead of focusing on payment after healthcare services are rendered by the hospital, the discussion of financial responsibility often must shift to the front of the revenue cycle.

Like many providers, Martin Memorial Health Systems, a 344-bed, two-hospital organization based in Stuart, Fla., has changed its payment processes to promote earlier discussion about financial responsibility and up-front collections practices. Rather than the day before the patient is admitted to the hospital for elective procedures, the eligibility process at MMHS begins several days before the patient is admitted, says Carol Plato Nicosia, administrative director of corporate business services for MMHS. If registration staff determines that an uninsured patient scheduling services does have the means to pay, then the hospital requests an up-front payment before the patient is admitted. Uninsured patients pay a steeply discounted rate, which helps patients' ability to pay in many cases, she adds.

Starting eligibility verification early in the process allows the patient time to come up with the down payment, if needed. Patients appreciate the up-front communication, Plato Nicosia says. "They are not faced with an unexpected responsibility for a large dollar amount the day before the procedure."

The process change not only has been welcomed by patients, but also has been a welcome relief to the bottom line. Since implementing the change three years ago, MMHS has been able to slow the rate of increase of its bad debt by about 1 percent, says Plato Nicosia.

Many hospitals are beginning to use similar strategies, recognizing that financial gate-keeping has to start earlier than previously was done. Lyman Sornberger, executive director of Patient Financial Services for Cleveland Clinic, says it's a best practice to begin discussion about payment right at the beginning—when the patient calls to schedule an appointment.

At Cleveland Clinic, which manages 3,391 beds at its 11 hospitals, self-pay patients are expected to pay a portion of costs up front, before the scheduled service is performed, while the balance is due at a later date. “And it’s a softer discussion when it occurs in the beginning, rather than after the patient has had surgery. When a patient is still trying to recover, it’s not the best time to be talking about paying bills,” Sornberger says.

To speed up the process of determining payment responsibility and whether financial assistance is appropriate, information about eligibility for charity care is gathered at the same time the patient is screened for Medicaid eligibility—before the service has been given, Sornberger says.

Early communication is key, too, at Morgantown-based West Virginia University Hospital, a 531-bed system that includes a teaching facility. Financial counselors at the organization contact patients prior to the date of service and discuss payment expectations, says Alex McFadden, WVUH’s director of patient services and patient access.

Counselors call to determine insurance benefits and ask patients if they have any unmet deductibles or coinsurance, and then conduct an estimate on the cost of the surgery or service being performed. That estimate is then applied to any deductibles and coinsurance owed and an estimate of the patient’s financial responsibility for the visit is derived, McFadden explains.

“For scheduled services, we ask for payment in full prior to service,” he says. If the counselors are unable to resolve financial issues, they will then contact the patient’s physician to determine whether the surgery can be moved until the patient is able to pay, McFadden says.

The hospital moves only about 200 surgeries, or 2 percent, of its total monthly surgeries, “But it’s a start,” he says.

About two years ago, WVUH also began asking self-pay patients in the emergency department for an up-front payment of \$75 as a form of down payment, McFadden says. “Three years ago, we did about zero dollars in up-front collections, and our goal for 2008 was to do \$1 million in up-front collections,” he says. “We got pretty close to that.”

McFadden says that when the new financial resolution process was implemented, one of the concerns was that patient satisfaction scores would drop because the hospital was asking for payment up front. However, the opposite happened.

“We actually saw our scores improve, and patients were thanking us for the outreach of letting them know what their responsibilities were going to be before the service,” he says.

■ Adding Appropriate Tools

Generally, changes in processes are supported by technology that, when used effectively, can create efficiencies and correct human errors—often with results that go straight to the bottom line.

Plato Nicosia credits much of the improvements in bad debt at MMHS to automatic eligibility and pricing estimator technology. Registration representatives use an online tool to automatically verify coverage for insurance patients. The tool also is useful for verifying demographic information, such as name, address, and social security number, she says.

Although insurance coverage has always been verified at MMHS, the technology has strengthened these efforts. “It allows us to be more efficient,” she says. “We’re able to get more accounts verified and addresses checked during the same period of time.”

At MMHS’s two outpatient radiology centers, technology has taken the automatic verification function one step further by allowing registration staff to give patients an estimate of the patient’s financial responsibility for the test. Using tools similar to the eligibility technology, the center’s staff enters the CPT (current procedural terminology) code of the test the patient will be undergoing, and the computer provides an estimate of the patient’s financial responsibility for the cost of the test, Plato Nicosia says. The staff then collects that payment before the test is administered. During a one-month period after the technology was implemented, up-front cash payments increased by more than 50 percent— from \$24,000 to \$38,000, she says.

MMHS also has decided to implement the technology in radiology departments at its two hospitals and is considering the technology for other hospital departments, as well. A possible third phase would involve enabling patients to use an online system so they can determine their financial responsibility themselves, Plato Nicosia says.

Changes to processes brought about by technology have also stemmed the increase in bad debt for Dallas-based Tenet Healthcare Corporation. Despite seeing increases in patients without insurance, in addition to those with higher

deductibles and copays, the Tenet system saw nearly flat debt from 2007 through the second quarter of 2008, according to Jeffrey Nieman, vice president of patient financial services operations for Dallas-based Conifer Revenue Cycle Solutions, a wholly owned subsidiary of Tenet that oversees patient financial services for Tenet. The health system operates 56 acute care hospitals in 12 states, encompassing 14,580 licensed beds.

"What we think has been driving some of our flat bad debt is improvements in our processes that have offset some of those volume change issues," Nieman says, citing the example of an investment the past year in new auto dialer technology that makes the organization more efficient and effective at contacting patients.

Previously, the health system used older, homegrown technology that wasn't very effective at connecting with patients, he says. So the hospital invested in an off-the-shelf dialer solution that Nieman says is similar to what other collections agencies and large call centers use. Although investment in the technology was considerable, it offers several features that the old technology didn't. "For example, it can distinguish between a digital voice and human voice that answers," Nieman says.

When a human voice is on the line, the system routes the call to an agent; when a digital voice answers, the system leaves a prerecorded message on the patient's answering machine. Such functionality increases productivity by allowing financial services collectors to spend greater time talking with people who haven't paid their hospital bill instead of devoting 30 to 40 seconds to leave a message, Nieman says. "We've actually increased the total number of outbound telephone attempts that we're making by about 300 percent over what was seen prior to implementing the technology," he says, adding that the system is about 99 percent accurate in distinguishing between a human and digital voice.

The organization also is using innovative approaches in other areas. About five years ago, Tenet began using self-pay segmentation modeling to more accurately identify those patients with the means to pay. Such capability helps the organization appropriately direct its collections efforts, Nieman says.

Using modeling, the organization attempts to predict the probability that a patient will pay by reviewing any preexisting historical data on the patient, plus U.S. Census Bureau data, such as household size, income, and home value, and credit

data, such as a credit score, available lines of credit, and on-time payments. All of these data go through a proprietary algorithm, which then outputs a score on a scale of 0 to 100 based on the probability of receiving payment, Nieman says.

Based on the score, patients are then categorized into one of 12 different workflows. The hospital expends little collection effort toward those at either end of the spectrum. Those patients who are most likely to pay require little collection follow up, and those who are least likely to pay are steered toward government assistance or charity care programs. It's those in the middle that the hospital focuses on through additional phone calls and letters to collect payment.

"The approach benefits both hospital and patient," Nieman says. "It allows us to devote our resources more efficiently while providing the most appropriate service. We're able to focus solely on the patients who need the focus to get them to pay."

Another area where technology is proving useful for many hospitals is in providing patients with more accurate cost information in advance. Cleveland Clinic uses an estimator tool to verify coverage and out-of-pocket expenses within 72 hours before a service is performed. "So we're telling patients what we believe they're going to owe," Sornberger says.

The challenge with such estimates, he says, is that hospitals generally are at the mercy of payers in terms of what kinds of benefits data they'll provide, with some payers providing only limited information. Hospitals, he says, need to become more assertive with requiring that information from the payers (via contracting or other venues).

To help with the cumbersome process of gathering patient data to identify whether financial assistance is appropriate, Cleveland Clinic developed an automated financial clearance tool. The tool allows a patient's application for financial assistance to be viewed anywhere in the hospital system, so patients don't have to fill out multiple applications. Hospital staff can use the tool to check where patients are in the application process. "It's a sharing of information and kind of monitoring tool so that you can expedite this process for the patient as soon as possible," Sornberger says.

Technology also can take over when processes become too technical or complicated. After conducting an audit that turned up a 30 percent error rate during manual charity care processing, WVUH developed an online tool about

four years ago for determining charity eligibility. Financial staff input patient information, such as income, assets, and expenses, into a system that includes the hospital's charity care rules. Based on these rules, the tool will determine at what level the patient qualifies for a charity care program.

The system includes a repository of various financial assistance programs, from Medicaid to catastrophic care programs, so each account gets a list of programs for which the patient may qualify. Until the patient is found to be ineligible for each of these programs, the system won't approve that account for charity care, WVUH's McFadden explains.

The system also generates reports that allow the organization to monitor the top reasons why patients are denied, the level of processing completed for charity programs, and the number of applications that are pending. "So we're really able to manage backlogs and keep processes current," McFadden says.

McFadden attributes use of the tool, in combination with payment process changes, as a key reason why in a toughening economic era, bad debt at WVUH has been decreasing steadily, from 3.21 percent in 2004 to 2.79 percent in 2008. "We've seen a definite shift in bad debt," he says.

■ Focusing on Staff Development

Rounding out where hospitals are targeting their efforts is staffing—a particularly important area as a growing portion of the financial discussion shifts from the institutional payer to the private individual. Dealing with revenue cycle issues with the staff at a health plan is one thing, but dealing directly with the recipient of the hospital's care is quite another. To handle this change, hospitals are adding financial services staff and giving them special training in customer service.

The delicate discussion regarding how payment will occur is where hospitals typically meet with some of the greatest challenges. A fundamental issue for some hospitals is getting patients to understand that they are responsible for all or a portion of their healthcare costs.

As an example, Plato Nicosia points to part of MMHS's patient population that includes early retirees who are opting not to get private health insurance with the idea of waiting until they are eligible for Medicare. Many of these retirees don't understand that they're not eligible for charity assistance if they have available assets that can be used to cover health-care costs, she says.

Are You Making Bad Debt a Top Revenue Cycle Priority?

The majority of hospitals surveyed in a recent report by the American Hospital Association reported an increase in the proportion of patients unable to pay for care. The report also found that uncompensated care rose 8 percent from July to September 2008 over the same period in 2007.³

Managing patient expectations is a key goal of communications. At MMHS, training for those in registration typically involves role playing and practicing scripts so that staff can respond appropriately to questions or concerns of patients.

One of the most important expectations staff must set is emphasizing to patients that requests for up-front payment are based on estimates of their financial liability, says Plato Nicosia. Technology is only as accurate as the data in the system so additional bills and deductibles not yet input at the time a cost estimate is derived may affect the amount a patient will owe the hospital.

Despite such challenges, Plato Nicosia says dealing with financial issues with patients is not as sensitive an area as it used to be. Patients are beginning to realize that they are responsible for the cost of their care. "Now, the shock is over," she says.

Of course, communication strategies also will need to take into consideration a patient's ability to pay. When a patient has few resources, many hospitals are going that extra mile to help. About one and a half years ago, Tenet Health piloted an in-house program called the Medical Credit Counseling Service, which is like a concierge service for helping patients figure out how to pay their bills, Nieman says.

The MCCS program, which has been rolled out at 11 of the system's hospitals, focuses on providing patients with financial assistance services through a single point of contact. Instead of a separate medical eligibility specialist and a financial counselor, a single counselor visits the patient and takes a more holistic approach in assessing the patient's financial needs, attempting to help the patient with both medical and nonmedical bills, Nieman says.

Patients are asked a series of eight to 10 questions that determine eligibility for some type of government aid program or charity assistance, Nieman says. Counselors are trained in ways to gather this information in a respectful manner. As an example, initiation of what might be perceived as a difficult discussion begins with the counselor asking: "Could you answer a few questions here that might help us determine the best way to help you?"

One of the greatest challenges hospitals face when trying to help patients with financial assistance is getting them to fill out forms and provide the necessary paperwork. Many patients struggle with providing necessary proof of income and other forms that verify eligibility. At Tenet, counselors respond by increasing their follow-up: sending additional letters or making phone calls urging submission of the required paperwork. Still, such efforts don't always work.

"We educate about options to the extent that we can," Nieman says. "At the same time, you don't want to be intrusive. If somebody clearly doesn't seem to be interested in meeting program requirements, then you have to respect that choice as well."

At WVUH, McFadden says the hospital has tried to address the challenge by simplifying financial assistance forms as much as possible. Also, hospital staff will even help patients with filling out their forms.

Four years ago, WVUH stepped up its financial counseling program. Back then, the system had four financial counselors; today, there are 10. The hospital also has extended the times the counselors are available to include evening and weekend hours.

In addition, WVUH has developed financial counseling brochures that explain the hospital's financial assistance

programs. "We try not to call it charity service because a lot of patients don't like the connotation of charity," he says.

In 2006, WVUH initiated a full-scale Medicaid eligibility program. Counselors were successful in confirming Medicaid eligibility for many uninsured patients, with \$13.6 million of self-pay debt reclassified to Medicaid. "In 2007, we reclassified \$19 million," says McFadden. "And we're on target for 2008 to increase that amount."

Along with training staff on how to broach financial issues with sensitivity, increasing staff authority has yielded success. For example, financial services staff at WVUH can make adjustments of up to \$1,000 on patient bills over the phone without seeking prior approval, McFadden says. Employees don't use this authority very often, but when they do, it's appropriate to the situation, he says. "They know that we trust them, and they can meet that patient's need right then, without going through a complicated process," he says.

Simplifying the Payment Process

Another strategy for addressing the rise in bad debt is exploration of retail-like strategies to assist patients in the bill payment process. Such strategies include special discounts, payment plans, and online payment options.

Three years ago, during tax season, WVUH offered a tax sale. Patients received coupons in their hospital statements for discounts off their bill. "That was successful," McFadden says, adding that it was the foundation for the hospital's current policy of offering 20 percent discounts to patients who pay their balance within 30 days after the first day of the statement. In the same way, prompt payment at Cleveland Clinic is supported with a 35 percent discount.

Payment plans also can assist patients with payment. WVUH offers this option. When marketing the program, the organization is clear that there are no interest charges or late fees and a simple phone call to the hospital will suffice if a payment is going to be late. "We make it very customer friendly, so patients know that we're trying to help them," McFadden says.

For the past four years, Tenet has discounted bills for uninsured patients such that costs are in line with the payment level of its managed care payers, Nieman says. In addition, patients can also take advantage of payment plans and have numerous ways to pay, such as in person, by mail, with a credit card



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Your Financial Assistance Policy

Many hospitals are introducing prompt payment discounts and other innovative financial assistance programs to encourage resolution of self-pay accounts. Before setting up such a program, however, it's important to consider a variety of factors, including regulatory and legal constraints.

The checklist below, based on HFMA's **PATIENT FRIENDLY BILLING**® *Worksheet for Reviewing Financial Assistance Policies*, lists just a few considerations when determining **who qualifies for discounted or free care**.

- Does the financial assistance policy comply with federal, state, and county/municipal regulations regarding who qualifies for free or discounted care? Also, does the policy comply with state regulations regarding bans on discounts or waivers of copay amounts?
- Does the policy appropriately reflect local conditions? (How many patients in the community are uninsured or underinsured and therefore qualify for discounted care? Can the hospital maintain financial stability at the level of discounted or free care included in the policy? How does the hospital policy compare with state Medicaid income eligibility level?)
- Does the policy provide for input from community stakeholders?
- Does the policy clearly address underinsured patients' eligibility for discounts? (What types of out-of-pocket balances qualify for discounts? What income levels, relationships between income or assets and account balance, or other metrics are used to determine eligibility for discounts? Do any health plans require disclosure of waivers or copays?)
- Does the policy clearly specify income guidelines and other criteria to be used for determining eligibility? (Are assets considered for Medicare and/or non-Medicare patients? Is there flexibility for families with income or assets just over the limits?)
- Does the policy take into consideration reimbursements for Medicare bad debts?
- Are documentation requirements appropriate? (What is the compliance rate for completing documentation, and is the amount of documentation required increasing or decreasing? Have forms been reviewed to assess whether patients understand and complete them? Can the forms be aligned with Medicaid applications to reduce paperwork burden?)

Similar detailed examinations should be made regarding the **types of services discounted**, the **discount levels offered**, **ways financial assistance policies are communicated**, and **ways patient accounts are resolved**.

For the full worksheet addressing these areas, see www.hfma.org/library/revenue/PatientFriendlyBilling/worksheet05.htm.

through an automated telephone system, and more recently online, where patients can set up a one-time payment or recurring payment plan, he says.

■ What's Next?

Despite such seemingly comprehensive options, hospital efforts to curtail increasing bad debt and enhance financial assistance programs will continue to be a primary focus for improvement as more consumers find themselves uninsured or underinsured in the years ahead.

When managing accounts of those patients with an ability to pay, McFadden recommends hospitals determine the main source of their bad debt and focus their efforts in that

department. For WVUH, that would be the emergency department (ED), where administrators are considering setting up a packaged pricing system for self-pay patients. Currently, the hospital offers packaged pricing for elective procedures. The package combines the cost for the physician, anesthesiologist, and hospital services, he says. If insured patients pay their share of the costs up front under this packaged program, the hospital will adjust charges if it turns out the costs were higher than the packaged price, McFadden explains. Self-pay ED patients would receive some kind of discounting, as well, he says.

"We're looking at innovative ways to discount those ED visits for self-pay patients more steeply, if they'll pay within the first 30 days," he says.

In addition, partially in response to patient requests, WVUH is rolling out an online feature that will allow patients to make appointments, view their statements, and pay their bills. "Patients can basically manage their account activity from home," McFadden says.

Lyman Sornberger says Cleveland Clinic has done a great job in the past few years of responding to the challenges of patients' increased payment responsibility and assisting patients with financial matters. Still, bad debt comprises 2.3 percent of gross revenue. "That may not sound like a high percentage—but we're a \$5 billion plus organization, so 1 percent is a lot of money," notes Sornberger.

Cleveland Clinic offers online registration and is in the pilot phase of using real-time eligibility verification. "Our intent is that patients can receive benefits information at the time an appointment is scheduled," Sornberger says. "Phase two of the initiative is to offer the public a way to access their eligibility information through a portal."

Still, Sornberger says, hospitals need to be even more responsive to patient requests for their healthcare costs. He says the ultimate would be allowing patients to verify their benefits online in real time, in addition to scheduling appointments and registering.

Ultimately, he says, patients should be offered various a la carte options of using online features or completing registration/payment processes the "traditional" way with hospital patient financial services staff. "I believe we will be heading toward a cafeteria plan of what patients need," he says.



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Nieman acknowledges that improving collections and reducing bad debt is an uphill battle. "Despite all the things we're doing, the collection rate on the uninsured for us runs about 12 percent," he says.

Tenet has tried hospital financing, wherein patients set up credit through a finance company partnered with the hospital, but found patient interest lacking. Nevertheless, Nieman says he's always willing to try new options for reducing bad debt. "We are constantly looking at opportunities and innovations and ways to continue to improve on our performance and collection rates, but we also want to be patient friendly and patient focused," he says. "It's a matter of constantly looking for ways to do more."

Endnotes

- 1 Schoen et al., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs*, 2008; 27: w298-w309.
- 2 *Uncompensated Hospital Care Cost Fact Sheet*, American Hospital Association, November 2008.
- 3 *Report on the Economic Crisis: Initial Impact on Hospitals*, American Hospital Association, November 2008.



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