

healthcare registration

ASPEN PUBLISHERS

September 2009 • VOLUME 18, NO. 12
EDITOR: LAURA J. MERISALO

Patient Access Is Key to Effective— and Friendly—Patient Billing

Demystify health care bills for patients (and providers)

As health care has moved to a retail-like model, with individuals taking on more financial responsibility for their own care, providers must have effective systems and procedures on the front end to make the payment process as transparent and “patient friendly”¹ as possible. Just a few of the activities that should occur during pre-registration or point of service include:

- Correctly verifying patient identity and getting adequate, accurate demographics;
- Determining capacity to pay and discounting options;
- Determining patient financial responsibility and collecting proper payment (or working with the patient to set up a payment plan);
- Identifying and starting the enrollment process for charity care and government/social services assistance; and
- Verifying insurance to reduce the number of denied claims.

A health care provider organization’s point-of-service system should address all patients—from the uninsured to the fully insured—so that all questions about patient accounting are settled up front and are not re-routed to a back office operation. If done properly, this approach is certainly the “friendliest” for patients and providers alike.

Changing Times: From Patient to Consumer

It’s confusing and time-consuming. It’s frustrating and often wasteful. It’s the subject of countless reports, blog posts, and articles. It’s the cause of much hand-wringing and angry phone calls. “It” is (drum roll) the health care payment system.

Entire industry segments have sprung up to help providers navigate the health care payment landscape, not to mention the lobbying efforts continually taking place on the state and federal levels. Ever-shrouded in mystery, the costs of health care—along with who pays for what and how and why—remain a mystery that continues to plague both patients and providers.

Back in the day, the complex tasks related to health care payments could, for the most part, be left to providers’ back office staff and third-party payers, such as Medicare, Medicaid, and private insurance. Patients generally were left in the dark about what their health care actually cost, as well as how it got paid for. Just a flash of an insurance card, a promise to pay, or a quick agreement to apply for indigent care, and off the patient went through the double doors.

This is, of course, no longer the case. A number of changes have occurred to steer health care into a retail-like revenue cycle, such as consumer-driven health care; higher copayments, coinsurance, and deductibles for traditional insurance plans; and the growing uninsured/underinsured populations. The result? Patients should be more appropriately viewed as health care consumers, as they take on greater financial responsibility for their care.

As health care consumers, patients are seeking more insight into the costs of their care, and are

asking the appropriate questions that accompany their increasing responsibilities in paying for it:

- How much is my care going to cost?
- How much will come out of my pocket?
- Do I have any payment options?
- Can someone please explain my bill to me?

Patients are demanding clearer, more accurate information during preregistration and at the point of service so they can budget for medical bill payments, as well as decide when (or whether) to schedule a procedure or appointment.

A Healthcare Information and Management Systems Society (HIMSS) white paper² entitled “Re-engineering the Revenue Cycle for the Emerging Medical Consumer” sums up the new role of the health care consumer:

Consumers need tools to support more informed decision-making and manage their health care finances. With declining employer-based health care and the increasing focus on the patient as consumer of health care products and services (retail model) versus the payer as consumer (wholesale model), patients are directly responsible for an increasing share of health expenditures. As the consumer takes on more responsibility for directing their health care expenditures, they will require timelier, relevant information in order to make informed health care decisions.

On the flip side, hospitals and other health care service providers no longer can solely rely on back-end, post-service payments from third-party payers. To remain financially viable, and to continue providing exceptional service, they must adjust everything about their revenue cycle process to focus on the front end—to engage the patient in a dialogue about expected payment arrangements from the get-go. From collecting out-of-pocket costs like copays and deductibles, to screening for charity care, to applying discounts for up-front cash payments, to insurance verification, to offering price transparency for common services, health care providers now must focus on giving their consumers—the patients—accurate, real-time information.

Unfortunately, many providers have yet to implement a point-of-service solution to consistently accomplish such tasks related to patient financial communications—and they and their patients are

suffering. Just pick up a newspaper to read about hospitals’ lack of cash on hand, recent staff layoffs and service cuts, emergency departments shutting down, bad debt numbers, and the like.

Enter Patient Friendly Billing®

One nationally recognized and applauded effort to help things along, to “promote clear, concise and correct patient friendly financial communication,” is the Patient Friendly Billing® project. This initiative, a collaborative endeavor spearheaded by the Healthcare Financial Management Association (HFMA), with support from the American Hospital Association, the Medical Group Management Association, providers, and other parties, is focused on giving patients and their families the information “they need and deserve about paying for healthcare.” Two critical expected outcomes of the project’s work are that “[e]ach patient’s personal payments will be related to what they can afford to pay, and providers are more likely to receive sufficient payment from all appropriate payment sources so that they can continue to provide quality healthcare services.”³

According to its summer 2003 report,⁴ the Patient Friendly Billing project began work in 2001, with a series of focus groups around the country. The origins of the project were personal; according to the same report:

After the death of his father, HFMA President and CEO Richard Clarke received a pile of medical bills from his mother. The stack contained separate bills and statements from about 20 different providers involved in his father’s treatment. Clarke’s 86-year-old mother could not understand the bills. Neither could Clarke, who formerly was a hospital CFO.

The findings of those early focus groups reflected Clarke’s—and many others’—struggles and frustrations with health care billing. Simply, patient billing continues to be a big problem not only for patients, but also for providers.

The initiative’s call to provide clear, concise, correct, and patient-friendly information is further explained⁵ in the project’s purpose statement:

Clear

All financial communications should be easy to understand and written in clear language. Patients should be able to quickly determine what they need to do with the communication.

Concise

The bills should contain just the right amount of detail necessary to communicate the message.

Correct

The bills or statements should not include estimates of liabilities, incomplete information, or errors.

Patient-Friendly

The needs of patients and family members should be paramount when designing administrative processes and communications.

In May 2009, HFMA released new guidelines on patient financial communications. The HFMA newsletter⁶ summarized these, noting:

The recommended practices stress that, except in emergency situations, patients want to know what they will be expected to pay for health care services before they incur the costs, especially as patients become responsible for a larger portion of their hospital bills. Early, transparent financial communication allows patients the opportunity to comparison shop for services, learn about payment alternatives (including financial assistance), and explore other alternatives with their own physicians.

The project's recommendations stress three points⁷ to ensure "patients' optimal financial experience for non-emergency services." The recommendations are as follows:

1. Providers gather detailed information before and at the time of service to prospectively estimate patients' expected out-of-pocket costs.
2. Providers use tools to help estimate the amounts and terms of payment that patients can afford. The resulting information allows providers to:
 - Identify and aid patients who need financial assistance, either through in-house programs, Medicaid, or other assistance programs; and
 - Efficiently reach an agreement on payment amounts and terms for patients who are able to pay all or a portion of their bills.
3. Providers communicate earlier, so that patients understand their financial obligation before they undergo treatment.

The report further recommends and underscores that, should a patient's urgent care needs prevent these steps from being taken prior to service, health care providers should complete these steps as soon as appropriate after medical services are provided.

The efforts of the Patient Friendly Billing project are commendable; they go a long way in helping to demystify the health care payment system for both patients and providers. The "letdown" comes, however, when one looks at the reality of what actually happens within the walls of many health care delivery facilities.

All too often, health care provider organizations are content to maintain the status quo, perhaps adjusting a few things here and there, but, for the most part, provider organizations still focus on the back-end business office segment of the revenue cycle. For instance, a provider might implement a system so that patient access staff members can accept credit cards and cash for up-front payments of patient-pay balances, such as copays and deductibles. Creating an ability to collect patient-pay balances on the front end, however, is insufficient if the provider fails to ensure that patient access employees have the capability to accurately identify and then communicate to patients what the cost of their care will be. Absent such information, collecting patient-pay balances are prone to fail if the cost of care is an unknown until after care is provided.

Further, even the name of the initiative—Patient Friendly *Billing*—connotes an "after-service" activity. **The reason:** Bills come in the mail, or are delivered electronically, after a service has been provided.

Point-of-Service Considerations

To be truly effective, and to deliver the clearest, most accurate billing information to the patient, health care providers need to turn the status quo on its head and implement a point-of-service solution that automatically handles and processes every aspect of patient financial communications prior to or at the time of service. A bill sent to the patient after care can be as clear and pretty as can be, but if nothing related to medical costs was discussed on the front end, and if no up-front agreements were made about payment expectations, that bill may not result in the hospital receiving anything (except perhaps an angry phone call from a patient who is mystified by the bill, its amount, and so on).

When considering point-of-service solutions, providers should strive to implement a system that is easy to use, that is able to be quickly installed, and

that provides a “one-stop-shop” product. Such a solution prevents potential headaches in getting different systems to talk to each other; ensures all information related to patient financial communications is housed in one secure location; allows for comprehensive, easily generated reports; and streamlines the employee training process.

A point-of-service solution should address all aspects of necessary front-end tasks, as well as document every facet of a patient encounter. Specific to the recent Patient Friendly Billing guidelines, providers should be sure to consider a system that directly addresses the recommendations for “early, transparent” communications for an optimal patient experience.

Best Practices

In addition to effective point-of-service processes, a front-end solution should incorporate technology that will allow patient access professionals to streamline and address the activities to improve front-end operations and, in turn, patient satisfaction and the bottom line. Following are some best practices for front-end activities that center on patient financial communications.

- Begin the dialogue as early in the process as possible, either at pre-registration or point-of-service; offer the patient clear, easy-to-understand information, similar to what happens in a retail environment;
- Provide patient access staff with real-time, customized scripts, walking them through the exact steps of how to deal with each individual patient based on his or her capacity to pay, and according to the policies/procedures of the facility;
- Determine patient capacity to pay using non-credit score information;
- Ensure adequate, accurate patient information is collected pre-service in order to verify patient identity/address, reduce the risk of fraud, and decrease the number of returned statements/bills and denied insurance claims;
- Automatically screen patients for charity care or government/social services assistance; begin the process of enrollment pre-service;
- Offer price transparency for a facility’s most common services;
- Determine if a patient is eligible for discounts due to prompt payment, capacity to pay, and other initiatives;
- Determine and collect any out-of-pocket costs, such as copays, coinsurance and deductibles, giving the patient options for payment (*e.g.*, cash, credit/debit card, e-check);
- Verify a patient’s insurance eligibility, with automatic pre-population of deductibles and/or copays;
- Offer and set up patient payment plans as appropriate, print out promissory notes pre-service that automatically calculate a patient’s monthly payment, and have the patient agree to and sign before leaving the facility; and
- Ensure that patient financial accounting—for both insured and uninsured patients—is handled appropriately and consistently.

In Summary

For health care delivery organizations, recognizing and investing in patient access as the critical start of an effective revenue cycle management process will reap significant benefits. Among them are the following:

- Increased patient satisfaction;
- An increase in up-front collections (*i.e.*, more cash in hand);
- A decrease in returned mail;
- Fewer outsourcing costs;
- Reduced employee turnover due to an improved workplace environment;
- Reduced number of days accounts receivable are outstanding;
- Decreased bad debt; and
- More timely identified charity care.

Improved patient satisfaction occurs as patients become better-informed health care consumers, as they receive clear and accurate information to help them navigate the health care system. **The reason:** A front-end focus sets the stage for patients to receive outstanding service from patient access employees, who have the tools to accurately and consistently assist patients and the guarantors for patients’ accounts in resolving all payment issues. Patients also can rest assured that if they are eligible for any type of financial assistance or discounts, they will be notified of them.

Simply, patient friendly billing begins at the point of service, and having the necessary tools and technology on the front end is the key to success. In providing patient access employees with the necessary training and tools to communicate and collect patient-pay balances prior to or at the time of service, patients and providers are better poised to effectively manage what historically has been viewed as a complex payment system. Further, with a front-end focus, the often scary and surprising bills mailed to patients months after service may indeed become things of the past. ■

Notes

1. PATIENT FRIENDLY BILLING® is a proprietary trademark of Healthcare Financial Management Association.
2. "Re-engineering the Revenue Cycle for the Emerging Medical Consumer White Paper," A Work Product of the HIMSS Financial Systems Revenue Cycle Task Force, http://www.himss.org/content/files/FinancialSystems/FY08-FS-Revenue_Cycle_White_Paper.pdf.

3. Healthcare Financial Management Association, <http://www.hfma.org/library/revenue/PatientFriendlyBilling/ETFCRec.htm>.
4. Patient Friendly Billing, 2003 Summer Report, http://www.aha.org/aha/content/2003/pdf/hfma_pt_friendly_billing_030519.pdf.
5. See HFMA Web site, <http://www.hfma.org/library/revenue/PatientFriendlyBilling/purpose.htm>.
6. See HFMA Web site, <http://www.hfma.org/hfmanews/default,month,2009-05.aspx>.
7. See HFMA Web site, <http://www.hfma.org/library/revenue/PatientFriendlyBilling/ETFCRec.htm>.

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