Curbing Bad Debt by Improving the Patient Financial Experience

It's no secret that the rise in high deductible health plans and the increasing amount of self-pay have impacted healthcare organizations' bottom lines. But, is it fair to say that enhancing patients' financial experiences can drive payment and improve an organization's financial health? In this roundtable, sponsored by Change Healthcare, several revenue cycle leaders discuss how their organizations are tackling the issue of escalating patient responsibility, exploring how they are putting individuals on pathways toward payment that boost satisfaction as well as revenue.

What are some of your biggest challenges related to improving the patient payment experience?

Jim Porter: At Edward-Elmhurst Health, we are constantly striving to engage our patients more effectively, so when they receive a bill from us, they understand it and are amenable to paying it. One of the hurdles we face relates to a lack of patient understanding surrounding insurance coverage. While patients may know they have insurance, sometimes they don't realize it comes with deductibles, copays and co-insurance. Moreover, they may not know whether they have an HMO or a PPO and what is required for each. Things can get even more confusing when they go to access the health system. Maybe they must go to hospital A for services but not hospital B. If for whatever reason they choose hospital B, they now have a higher financial responsibility, which is frustrating to them. To the extent that we can demystify their benefits and give them what we believe is a realistic estimate of what they're out of pocket costs are going to be, we can help them more effectively navigate the system — sometimes having to tell the patient that they may be better off going to our competitor because it will be less costly. Although that might seem self-defeating, if we are going to be collecting a lot of money from the patient, and it's going to be a difficult experience for us and them, then it's to everyone's advantage to point them to the appropriate facility. In the end, education is a huge priority. Many employers are doing their employees a disservice by not helping them understand the different plans and how they're covered. It's becoming the health system's role to unpack the details, especially if we want to provide a good experience and maintain a strong relationship with the patient.

HFMA Roundtable Participants

Rhea Heath is executive director of finance and revenue cycle for Beacon Medical Group in South Bend, Indiana

Chris Johnson is vice president of revenue cycle management at Atrium Health in Charlotte, North Carolina

Kelly Black is vice president of revenue cycle for the ambulatory division of Novant Health in Winston-Salem, North Carolina

Jim Porter is vice president of revenue cycle at Edward-Elmhurst Health in Naperville, Illinois.

Shaun Ronan is vice president of revenue operations for Health First in Rockledge, Florida.

Michelle Fox is director of revenue operations and patient access at Health First.

Kelley Blair is senior vice president for Change Healthcare in Chicago.

Shaun Ronan: The changes in patient responsibility are leading to a large growth in self-pay after insurance, which is extremely hard to collect up front. At Health First, we've put several resources in place, including a price estimation tool, to give patients an idea of what they will owe, so we can start to collect upfront. Even so, reliably capturing this money can be difficult. Part of the problem is that people don't truly understand what it means to have a high deductible. During enrollment, they opt for the cheapest plan to save money. While they may be covered in the event of a catastrophic health issue, they are going to have to pay for more routine care – and that's a hard concept to grasp until you experience it. Unfortunately, healthcare organizations are sometimes left to explain how insurance coverages work in light of these high-deductible plans and the potential high costs that patients must bear in these plans, and deal with the choices patients make.

Rhea Heath: Part of the struggle we're having at Beacon Medical Group is getting consistent patient access and payment processes and messages across all our practices. We are just now building a centralized pre-registration department for the entire medical group, because we are comprised of many different independent practices that came together. Those inconsistencies have caused patient dissatisfaction. For example, we had one practice that required patients to leave a 20 percent deposit for a procedure while other practices didn't. We are trying to build some standardization, so the patient experience is the same no matter what practice they visit.

Another point of patient frustration is that we may send them a bill six months after their date of service because it can take that much time to work through the claim adjudication process. By that point, patients don't remember the service and how much they paid already, and they think we're incompetent or trying to pull a fast one.

Porter: It is important to set expectations upfront as to when the bill will be coming. We aim to talk with patients on the front end and collect a deposit at the time of service, telling them that they won't receive a final bill for about 60 days due to insurance company adjudication. By taking this approach, we help patients better understand what's coming and what their responsibilities will be. For us, this is a work in progress, but we are making some headway in accelerating cash. We are also hoping this becomes a patient pleaser because they have greater insight into the process.

Chris Johnson: It's interesting to hear the different perspectives. Currently, Atrium Health doesn't bill our patients until they have a self-pay balance, and that is an intentional choice. We made a judgment call a number of years ago that started us on this path. When we send patients statements that say they owe us X, we want to be sure that's truly what they owe us and all that they owe us. Because the big complaint we got from patients was, 'you bill me and I pay that, and then you send me another bill, and it's a different amount, and I pay that, and then you send me a refund – it's irritating.' Since we don't tell them what the refund is for, they end up calling us to sort out what the amount owed truly is. It's time consuming for us and them, and for patients, it's annoying.

Heath: Another obstacle that can slow down patient payment is the lack of staff training to handle patient financial conversations. As an industry, we don't train our customer service and patient access people to engage in complex patient interactions. Patient access and customer service are entry level positions who directly impact the patient experience, determine whether we have accurate information for billing and affect whether a claim is going to be clean. We have to shift the thought process nationally around these job types, so that they are not always entry level positions, but ones that require more advanced skills, require more training and are above entry level.

Ronan: From what we see, the labor trends are not going to change, and we have to consider other options, such as automation, to streamline repetitive processes and make things more efficient and ultimately easier for our patients.

Heath: Yes, that's true, but you need to find the right balance with automation, because when you're dealing with people who are scared and who have just received a catastrophic diagnosis, they don't want to look at the computer to figure out how much they're going to pay. They want to hear a compassionate human voice on the phone. We need to figure out how we can best utilize technology while still offering a compassionate and caring experience. One of the things we're budgeting for is virtual financial counseling. We don't have enough people to put financial counselors in all our practices, but we need to make them available. Using secure digital connectivity and other online communication tools may be a solution.

How do you segment patients for collections, payment plans, charity care and so on?

Heath: Primarily, we look at dollar thresholds. If a patient's account reaches a certain dollar amount – whether through outstanding bills or new charges – then a financial counselor will speak to the patient and advise the customer of all the ways the bill can be paid. Based on this

initial conversation, we determine if the patient is potentially eligible for financial assistance. We look at that from a Medicaid perspective and from a charity care perspective, and we route them to the correct path based on a phone conversation.

Johnson: We also consider the patient's payment history. One of the complaints that we received several years ago was that we treated everybody the same regardless of whether they were good about paying in the past. We heard comments from the patient community saying, 'You treat me like I don't pay my bill, or that I'm not going to pay my bill. However, if you look at my record, I do pay my bill.' We started doing some analyses and realized that the patient feedback was valid. Now we consider a patient's payment history with us before we ever do a formal segmentation.

What are some best practices you're seeing to maximize self-pay collections?

Johnson: It's about starting a conversation with a patient in which we identify some of the obstacles to payment and try to remove them. I believe this boosts patient satisfaction and also helps payments go up. Ultimately, we're trying to send a message that if you have a balance and you truly have an interest in paying it, then we have a method to assist you with that. And we start that at the front door with education.

Michelle Fox: Health First has seen positive results from our automated price estimation tool. After we implemented it, we saw a 27 percent increase in our cash collections and a decrease in our bad debt. This solution loads our contracts and chargemaster, figures out an estimate, and provides a written copy. This has helped us establish credibility with patients and build relationships. Not only do we have something to walk through with patients based on solid information, but the estimate also gives our staff more confidence in talking with individuals. We provide an estimate to every patient, even when they don't ask for one or they don't owe anything. We have found that this has been a huge patient satisfier, especially in the emergency department.

Johnson: Providing a consolidated hospital and professional statement is also a patient satisfier. We made that move about three plus years ago based on patient feedback. I don't have a quantitative measure of satisfaction, but we receive a lot less complaints. Patients get one statement about their professional and hospitals charges, and they can call one customer service team with questions and concerns, which has been a big win for us.

Heath: We also offer payment plans. We facilitate up to a six month payment plan in house, and then we work with an outside vendor that provides a 36-month, interest-free payment plan to patients who are deemed in need and have a high propensity to pay.

Ronan: It's also beneficial to provide opportunities for patients to set up plans for themselves. Some of the technology out there is consumer friendly, and if we can take the burden off our staff, whether it be the front-end or the backend, all the better. Let's say the individual has three or four bills with us, he or she can use the technology to combine these into a two-year payment plan that allows a $150 per month bill. The hospital won't need to follow up with the individual about paying; it's between the patient and payment plan vendor.

Kelly Black: A credit card on file is also an option. That way we don't even have to ask for the payment. We set the card up in a secure app, and it gets charged once everything has been adjudicated. We never see it or touch it.

Porter: Putting technology in the hands of the patient lets them manage things on their own with minimal staff input, which is not that different than booking airline tickets.

Ronan: That said, people still sometimes want to talk to someone to make sure they're doing it right or they haven't missed something.

Johnson: There is also a motivation difference between paying a healthcare bill and booking a trip. If I'm a patient and I've tried to pay a bill and something goes wrong with that process, I easily can get discouraged and give up. With an airline ticket, the person is going to hang in there and figure out the problem because he or she wants to go somewhere. Patients may not want to pay the hospital or doctor bills. As such, it is critically important that payment technology reliably works and is not overly complicated because there can be a significant drop off in payment if paying the bill becomes onerous.

What are some key lessons learned you would share with others looking to improve the patient experience and reduce bad debt?

Porter: We've covered a lot of different approaches, but one area we haven't talked about relates to incentivizing staff to collect payments. While educating them about the importance of the work is crucial, it can also be helpful to tie specific financial encouragements to the effort.

We are rolling out a four-pronged plan this summer for our patient access and patient accounting department with an overall goal of increasing cash collections. The program also includes other metrics around denial reduction and limiting accounts receivable aging. With this plan, we're hoping to incentivize staff. It's not much, but the goal is to elevate performance and increase their compensation.

Johnson: Another lesson learned is making sure you've got a path for every patient to get to payment. We clearly recognize from the outset that there are some patients that it doesn't matter how much education we provide; they're not going to pay. We aim to figure out who those people are quickly and move them out, so we can focus on the people who are going to pay. It won't fix everything, but in our world, there's a difference between a patient who can't pay but wants to and a patient who can't pay and won't no matter what.

Black: Staff education is also important, and you have to continually update an education program. This is not a one-and-done project. People leave and go elsewhere, and you constantly have new people coming on board that need the information to be successful. There's no school for studying how to handle insurance and register patients, and so we've got to create a program in house. At Novant Health, we have a revenue cycle university within our organization, but it's in the early stages and we've only had it for a few years. It's challenging to get everybody moved through the education process and offer relevant and up-to-the-minute material. Once staff finish the course and get up to speed in applying their knowledge, they often need to come back because it's changed. Even amidst the challenges though, it's critical to provide the education, otherwise the service you deliver to patients may not be that good.

Fox: One way Health First has approached staff education is by hiring an observer whose sole job is to watch staff-patient interactions. She makes sure our employees know how to speak to a patient, be respectful, engage in a conversation, handle difficult topics and so on. She observes each associate at least once a month – all 180 on my team. We found the money for the position through staff attrition, and thought it was a necessary resource, especially as we strive for a level of customer service we haven't had before. Health First created the observer position three years ago, and the staff have found it to be quite beneficial. In part, because the individual is a neutral party. Instead of being unsettled by the fact that their manager is watching them, staff can learn from the neutral observer whose primary directive is to improve customer interactions.

Kelley Blair: Addressing patient collections is a complex process that requires multifaceted solutions. Collecting data to segment patients is critical so you can appropriately focus your efforts upfront. Education for staff is also essential. You need to prepare your employees to enable a positive patient experience and monitor those interactions to make sure relationships are being formed. There are numerous methods for increasing patient payment, and the most successful ones will put patient needs first. By leveraging technology, data and expertise, organizations can make progress in this area, increasing patient satisfaction and driving revenue at the same time. ■