Improving the Healthcare Patient Payment Experience

HIMSS Revenue Cycle Improvement Task Force

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Abstract

Healthcare is being re-imagined. Central to this re-imagination are the elements of technology, automation, business processes and the need to comply with an ever-increasing landslide of legislation and reform.

Yet, in this great re-imagining a fundamental element is often overlooked and under-studied: the impact that the patient has upon the entire healthcare delivery process. In a world where patient payments represent an increasingly large portion of a provider’s revenue, and as the healthcare community begins shifting away from a fee-for-service model toward pay-for-performance (and eventually to pay-for-outcomes), the patient has become even more important in this process.

The Healthcare Information and Management Systems Society (HIMSS) has dedicated resources to bringing attention to this important area, placing specific emphasis on how patients impact and are impacted by revenue management processes associated with healthcare delivery. The HIMSS Revenue Cycle Improvement Task Force (RCITF) has been in existence for nearly ten years, and in 2011 delivered an initial white paper on this topic: The Future of Revenue Cycle: Preparing for Near-Term Change; and a follow-up paper in 2012: Next Generation Patient Access. In 2013, the task force released HIMSS G7 Advisory Report: The Healthcare Payment Experience and The Patient Financial Experience: Problem Overview, Clinical Scenarios, and Questionnaire.

This paper summarizes these previous works and aims to bring greater understanding of the importance of the patient’s impact on revenue cycle operations and success. This paper brings to the surface the significance of the role that the patient plays and how important it is to measure patient satisfaction, identify problems early, and improve the bottom-line by improving the patient’s experience.

The HIMSS RCITF members include a cross-section of providers, payers, vendors, consultants, associations and governmental contributors whose goal is to improve insight and foster industry-wide collaboration with respect to the patient payment issues.
Introduction

Since 2011, the HIMSS Revenue Cycle Improvement Task Force (RCITF) has been on a quest to bring clarity to an emerging dynamic in healthcare: the importance of the patient experience and the impact of patient financial satisfaction on a healthcare provider's bottom line. The RCITF’s paper, Next Generation of Patient Access (2012) brought attention to the fact that patient satisfaction is playing an increasingly more important role as a front-line agent of change to improve patient payment and reduce physicians’ and other providers’ bad debt.

The 2012 paper highlighted the discovery that patient financial touch points are often more numerous than clinical touch points. In addition, patients are often at a disadvantage because the tools and resources available to help them understand these touch points may be inadequate. Given that patient satisfaction is a critical path to patient payment, the paper detailed and recommended several “Patient Access Process Maps” for providers and vendors to consider in creating the next-generation architecture to address patient payment issues brought about by legislative changes in programs such as the Patient Protection and Affordable Care Act (ACA), the rise of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), emerging reimbursement models and the impact of adding millions of insured patients through the ACA’s health insurance exchanges.

In response to the findings in the 2011 paper, HIMSS convened the HIMSS G7, a thought-leader stakeholder group of healthcare providers, health plans, banks, information technology firms, government, employers and consumers, to help envision the healthcare financial network of the future. The output from the this group was a proposal to create a “Value Proposition Index,” which would assign agreed-upon weights for common outpatient medical services and measurements for assessing the cost/quality value represented by the amount paid for those services. In essence, the Index would serve as a scorecard that institutions and patients could use to evaluate options when choosing healthcare plans and providers.

RCITF considered the G7’s recommendation, and issued a report: The Patient Financial Experience: Problem Overview, Clinical Scenarios, and Questionnaire (2013). The report advised that specific changes be made to the existing revenue cycle management (RCM) process, including greater integration between verification of insurance and benefit eligibility and the collection of more complete patient demographics; capturing charges, coding, and claims submissions; collecting payments from an ever-changing patient financial means mix; denial management; reporting; and data analysis. The report stopped short of creating the Value Proposition Index suggested by the HIMSS G7. It called on the industry to begin measuring patient satisfaction in three areas—pre-visit, visit, and post-visit—to uncover patient perceptions, identify payment risks earlier in the revenue cycle process and help providers engage patients “intentionally, early and often” to encourage prompt payment from them.

The purpose of this paper is to build on these previous works to better understand the value of the patient financial indicators and help an organization improve overall patient financial satisfaction while mitigating financial risks and improving reimbursements associated with patient payment.
Cause and Effect of Patient Dissatisfaction

Patients receiving healthcare services today are facing more difficult choices than ever before. As the rollout of ACA and the Health Insurance Marketplaces (Marketplaces) proceeds, the Centers for Medicare and Medicaid Services’ (CMS) healthcare cost data demonstrates that the percentage of uncollected healthcare delivery revenues continues to climb. The reasons for this vary, but there are several studies available\(^1\) that indicate patient payment issues will become more vital as the patient’s percentage of financial responsibility for the total bill continues to increase.

Delivery of healthcare services in the United States is fragmented among numerous institutions and individual practitioners. There are also inconsistencies in the way payments are made for these services. The resulting complicated system is difficult to navigate for both providers and recipients of healthcare services. With all of the complexity in the U.S. healthcare delivery system, there are a number of things that can “go wrong” relative to the patient’s financial experience.

Confusion is one of the primary challenges. It is often difficult for the patient (or the patient’s family or guardian) to understand what to pay, what constitutes a final bill, and the clarity of understanding what services. Such confusion has the potential to delay the patient in paying their portion of expenses. Furthermore, the absence of price transparency makes it difficult for the patient to predict what the total cost of care will be or what their personal financial responsibility will be when they are considering a plan of care, resulting in “unpleasant surprises” when the bills begin arriving.

In addition, doctors usually do not explain the costs and benefits of alternative forms of treatment. Instead, they frequently recommend what they believe is best for the patient in terms of convenience or the latest treatment options being offered without regard to cost or individual circumstances or wishes of the patient.

One reason physicians may not approach plan of care discussions with costs in mind is that over the years they have been conditioned to focus on the management of the patient’s physical well-being without regard to the patient’s financial well-being. As a result, few physicians can tell anyone how much a particular procedure will cost because they simply do not know – and often they don’t consider it their job to know. The changing dynamics of healthcare reimbursement demand that physicians reconsider this position. This patient collaboration needs to extend across the enterprise, to include discussions of how the patient will manage their portion of financial responsibility for the care received before it is received.

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Processes for submitting and adjudicating insurance claims are frequently convoluted and fraught with inefficiency and opportunities for mistakes. Mistakes in coding claims, or in claims processing can result in incorrect charges being submitted to the insurance company. Providers and payers often disagree on interpretations of eligibility and coverage. Delays in communication between the payer and provider can cause duplicate or erroneous and confusing documentation being sent to the patient. Especially in situations involving multiple providers, patients may receive so many “interim” billing statements and Explanations of Benefits (EOBs) that they become confused about what they should pay to whom and when. This confusion may create a situation where the patient simply ignores the billing statements until they are notified that they are being sent to collections.

Inadequate knowledge or training of hospital or physician staff can result in unintended poor financial customer service interactions for the patient. Examples of patient challenges related to this lack of knowledge or training may include:

- Difficulty finding out about financial assistance resources that may be available to the patient.
- Difficulty finding or reaching the right person(s) with whom to discuss payment arrangements.
- Perception of rude treatment by representative(s) when the patient or their representatives try to find out about payment options.
- Fragmented billing with limited information about how the services provided are connected to the overall care received.
- Payer-provider “finger-pointing” regarding mistakes or inconsistencies in billing and payment.

If problems with the patient financial experience are not resolved quickly and accurately, both patients and providers can be adversely affected. Examples for the patient include:

- Patient confusion and frustration arising from a bad experience may lead to a poor, or misconstrued understanding of the plan of care and could lead to a failure to follow medical advice.
- Unresolved billing issues and overall unhappiness with how they are being treated regarding their questions about billing can create resistant behaviors or ambivalence.
- Difficulty accessing care because of an inability or perceived inability to pay.
- Doctor/clinic/hospital “shopping” to find a better experience, potentially resulting in delayed care.

There are several ways in which poor patient financial experiences can adversely affect provider organizations:

- Loss of business when patients go to other providers.
• Loss of referrals (patients who are unhappy with their experience are not going to recommend that same physician to their friends and family).

• Delays in getting financial issues resolved lead to delay in receiving payment for services.

• Patient frustration with financial experience may cause them to give the provider a low satisfaction score, affecting the provider's reimbursement from the insurance company.

• Impact on accounts receivable/increase in bad debt.

• Added administrative costs to resolve issues.

Care needs to be taken to treat all encounters, clinical or financial, with the same level of clarity and compassion. Patients are becoming much savvier. In addition to their own experiences and those of their family and friends, they now have tools at their disposal, such as the CMS Hospital Compare website, where they can look up specific hospitals, see various performance factors and make a decision based on scores. If a patient feels the provider is shifting their behaviors to one of impatience during various encounters, the provider can expect some push-back and may experience stretched-out accounts receivable days and a growth in uncollected revenues.

**Regulatory and Industry Efforts to Affect Change**

In professional circles, the subject of patient payment frequently evokes an uplifted eyebrow and often generates head scratching. Over the past 10 years, organizations such as HIMSS, the Healthcare Financial Management Association (HFMA), Press Ganey, Connance, CMS, McKinsey, the American Health Information Management Association (AHIMA), the American Medical Association (AMA), the American Hospital Association (AHA), and a host of large healthcare systems and vendors have been working together to develop and test indicators to suggest new models to create better patient pay. Governmental regulations are often a driver. As part of Medicare’s move to value-based payment, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) penalty related to patient dissatisfaction was increased from 1% to 1.25% in 2014, and will grow again in 2015. Providers must gain a deeper appreciation of what is involved in the myriad issues surrounding patient satisfaction, including the correlation between patient satisfaction and their financial experience. By making the connection between a patient’s financial experience and their overall satisfaction, providers subject to HCAHPS may experience better scores and improved financial outcomes.

The CMS Hospital Compare site is a resource available to the public to see HCAHPS scores and overall satisfaction. Keeping HCAHPS scores high and stable is a great way to keep in touch with a patient’s perception of a particular hospital. When the physician version of the CAHPS program becomes active in 2015-16, the program will also reach the physician level.

In the third quarter of 2012, CMS shared HCAHPS scores based on surveys of hospital patients discharged between October 2011 and September 2012. The scores reflect patient satisfaction information gathered from 4,047 participating hospitals that administered surveys via mail (60%), telephone (40%), mixed mode (0.1%) and IVR (0.3%). While the data is being used to incite the
improvement of “quality of care” the results are also being used for hospital Value-Based Purchasing (VBP), and pay-for-performance for Inpatient Prospective Payment System (IPPS) hospitals, and now other CAHPS programs are moving beyond information gathering to placing more Medicare reimbursements at risk. From 2013 to 2014 the percentage of Medicare reimbursement that was at risk under the CAHPS program increased from 1% to 1.25% (a 25% increase in one year). To appreciate the volume of revenue affected by this risk model, one should consider that in December 2012 alone, more than 2.9 million completed surveys from patients at 3,892 hospitals were tallied, and every day more than 7,900 patients completed the HCAHPS survey; in short, the CAHPS program never rests. Over the past 10 years many advances have been made in the areas of patient financial services. From trade associations, to government entities, to providers themselves patient finance touch points have been analyzed, rethought and re-engineered in many provider settings.

One of the foremost efforts to affect change occurred in early 2000 when HFMA created the Patient Friendly Billing Project, which used information gathered from focus groups involving patients and healthcare workers around the country to develop a process for creating patient bills that are clear, correct, concise and patient-friendly. Despite the progress represented by these efforts, a decade and a half later the healthcare industry is still trying to create bills that are clear, correct, concise and patient-friendly. This is a clear demonstration of just how complicated this issue is.

Among the latest in a series of government actions aimed at creating greater cost transparency within the healthcare delivery system is Regulation 501(r), an Internal Revenue Service (IRS) requirement enacted through the ACA. Regulation 501(r) is complex and will impact nearly 3,400 non-profit and government hospitals across the nation. This section is being provided only as an overview with focus on impact on patient financial experience.

Regulation 501(r) requires that any organization operating one or more hospitals that have been granted 501(c)(3), or tax-exempt status meet the following requirements in each of its facilities:

1. Establish written financial assistance and emergency medical care policies;
2. limit the amount charged for emergency or other medically necessary care to individuals eligible for financial assistance under the hospital’s Financial Assistance Policy (FAP); and
3. make a reasonable effort to determine if an individual does meet the hospital’s requirements to be eligible for financial assistance before engaging in what are referred to as “extraordinary” collection actions against the individual.

The hospital’s written FAP must include the following elements:

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2 PPACA Section 3001(a)

3 While the rules discussed here, and the related suggestions, are consistent with the current state of 501r legislation, it is critical to note that this has yet to be enacted and the landscape may continue to shift before the final rules are established. It is a virtual certainty that much of the legislation will be enacted in its current form, but certain items (such as the definition of specific terms and timelines) may very well be refined.

4 http://web.law.columbia.edu/sites/default/files/microsites/attorneys-general/501(r)%20Article-2.pdf
• Eligibility criteria;
• indicate whether the available financial assistance includes free or discounted care, and, if so, what the criteria for that level of assistance is;
• basis for calculating amounts charged to patients;
• method of applying for financial assistance;
• action that may be taken by the hospital in the case of non-payment, including collection actions and reporting to credit agencies; and
• must explicitly state that an individual eligible for financial assistance will not be charged more for care than the amounts generally billed to individuals who have insurance coverage for that same care, and include an explanation of the method the hospital uses to determine the amounts generally billed.

These requirements apply to inpatient, outpatient, and free-standing facilities operated under the hospital’s license, even if the facility is located in a geographically different location than the hospital itself. Organizations that fail to meet the new requirement for all of their applicable areas of operation risk losing their tax-exempt status and could incur fines of up to $50,000 (for each qualifying “hospital organization”) and other financial penalties (reclassification of non-profit activities that could result in additional tax obligations, etc.).

One of the challenges with legislation of this nature is how it might impact the patient’s financial experience with the healthcare delivery system. Some may say that it creates an onerous burden and risks putting the patient in “information overload.” For example, the requirement that a hospital make a reasonable effort to determine if an individual meets financial assistance criteria before it turns a bill over to a collection agency or file a negative report with a credit agency could mean that the hospital require all patients to complete a Financial Assistance Program (“FAP”) application, even if the individual is not interested in doing so. In instances where the individual refuses to complete an application, the hospital may be forced to employ other means of assessing an individual’s ability to pay – a costly investment.

Similarly, the requirement that the FAP include information regarding how charged amounts are calculated sounds simple enough, but a closer look at the language of the law demonstrates how complex this requirement can be and how it might impact a patient’s financial experience. This is because the law appears to restrict affected hospitals to two options for calculating charges: the “look-back method” and the “prospective Medicare method.”

The “look back method” allows a hospital facility to determine the amount generally billed by multiplying the hospital facility’s gross charges for the care provided to the individual by one or more percentages of gross charges calculated at least annually. Those percentages would be calculated by dividing the sum of all claims for emergency and other medically necessary care that have been paid in full to the hospital during a prior 12-month period by the sum of the associated

5 Ibid
gross charges for those claims. Importantly, the regulation requires that the hospital explain this methodology, or the methodology being used, in the FAP in a manner that a patient will understand.

Alternatively the hospital could use the "prospective Medicare method" to calculate charges. Under this approach the hospital facility would use the same billing and coding processes it would use if the individual were a Medicare fee-for-service beneficiary. The amount charged would be the equivalent of what the hospital facility would expect the sum total of the amount Medicare and the Medicare beneficiary would pay for the same care. Once again, explaining this to the patient can become cumbersome so some thought needs to be given around how to do this in a "user friendly" way.

Clearly, implementation of 501(r) is an issue that could impact the patient financial experience by creating new communication requirements with patients. In some states, similar legislation is being introduced at the state level. In an age of medical consumerism, if the hospital is being required to provide information around how they are calculating charges, as is the case with 501(r), the next step is simply creating an estimate of charges so that the patient knows both how the bill is being created and what they should be preparing to pay. Technologies that assist the provider to do this are evolving and could provide the next logical platform for improving the patient’s healthcare financial experience.

The Influence of ACOs

An Accountable Care Organization (ACO) is a group of healthcare providers coordinating care and payment, specifically connecting provider reimbursements to quality metrics. Quality metrics allow a user to quantify the quality of a selected aspect of care by comparing it to a criterion. Examples of quality metrics include:

- **Access measure** assesses the patient’s ability to obtain timely and appropriate healthcare.
- **Outcome measure** is the patient’s health status after receiving healthcare services. It can be used to evaluate the quality of care to the extent that healthcare services influence the likelihood of desired health outcomes.
- **Patient experience measure** aggregates reports of patients about their observations of and participation in healthcare.
- **Process measure** assesses the actual healthcare service provided to, or on behalf of, a patient.
- **Structure measure** describes a feature of a healthcare organization or clinician relevant to its capacity to provide healthcare (e.g., nurse to patient ratio, number of beds).

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6 Proposed Regulation 1.501(r)-4(c)(4), Example 2.
7 CMS [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/)
The goal is to provide care accountability (quality care) and to reduce cost of care for a group of patients. The ACO is a growing collaboration model between providers, vendors, payers, states and the federal government. It is a model that is expected to dramatically change and improve the patient's overall experience with the healthcare delivery system, and, as such, bears mention in a paper focused on patient engagement.

ACOs can choose from several payment models to adopt. According to a news brief from the American Academy of Actuaries the five payment models are:

1. One-sided shared savings: If quality metrics are met and care is provided at a “lower-than-projected cost” providers may receive bonus payments.
2. Two-sided share savings: Similar to one-sided payments except that ACOs take some risk because they are now responsible for a portion of money spent over a targeted budget.
3. Bundled/episode payments: Providers and organizations are paid in full for an episode of care and all the appointments associated with that care.
4. Partial capitation/global payments: ACOs are only responsible for physician care, not hospital/non-physician services.
5. Global payments: A budget is determined and payments are made to the ACO monthly or annually regardless of the services provided.

As the industry pushes toward these payment models, the need for customer satisfaction must not be forgotten. The payment models focus on outcomes (quality) and efficiency. It would be easy to put patient satisfaction on the back burner as payers pay not per patient, per service; but in bundles not necessarily defined by patients (defined above per model). Payer revenue isn't the only revenue playing a role in practice cash flows. With these models the opportunity for increased patient revenue is high and customer engagement has the potential to greatly increase patient revenue. Quality and efficiency can increase patient revenue, as long as the patient understands what quality healthcare and efficiency means to them. Quality and efficiency can also greatly reduce patient revenue if, for example, a patient sees efficiency as not getting enough attention from the provider or if a provider suggests less patient visits. Open communication with customers and understanding patient needs and wants, will mitigate risks of losing patient revenue as a result of these new payment models.

**A New Approach for Affecting Change – Recommended Next Steps**

So what can a healthcare organization do to indemnify, ameliorate, mitigate, or reduce the risks associated with patient pay, and keep patients loyal and financially engaged? Get educated, understand the changing landscape and have a solid patient satisfaction strategy. Below is a short list of suggested agenda items for enterprise-wide strategic discussions to help organizations get there.

- Create an internal task force comprised of team members from across the organization’s revenue cycle. Include any group with financial connections to the patient (patient access team, billing team, financial counselors, denials team, case managers, etc.) Use this group to determine the consistency of messaging regarding the patients’ financial situation throughout the organization and throughout the patient’s experience. Make sure to have
this group weigh in as the organization implements the survey tool and tailor it to the organization’s unique situation. Most of the suggestions below could be executed or at least over-sighted by this group.

- Review the integrity of the organization’s internal process for submitting and adjudicating insurance claims. Use the newly required electronic eligibility inquiry process, as well as electronic remittance advices to get better information prior to claim submission and after claim submission.

- Review the organization’s revenue cycle tools and infrastructure using the maps suggested in the 2012 RCITF paper Next Generation Patient Access to create a matrix to use in developing requirements for tools from vendors and service providers to give the organization integrated end-to-end solutions that can optimize its infrastructure and deliver greater patient experiences across the enterprise. Be sure to consider the potential impact of new reimbursement models, such as an ACO.

- Review the industry and governmental efforts, advances and impact upon the organization and the provider, and weigh in on the impact to the patient tool.

- Evaluate the financial impact, the shift from fee-for-service to pay-for-performance and the eventual move towards pay-for-outcomes will have on the organization.

- Become familiar with industry efforts, such as the HFMA patient friendly billing project.

- Implement a survey tool and process, such as referenced and recommended in: The Patient Financial Experience: Problem Overview, Clinical Scenarios, and Questionnaire
  - Establish a survey method.
  - Determine who conducts the survey.
  - Identify where in the various workflows (pre-admission, claims-process, during treatment, access-services interactions, discharge and throughout the ongoing financial interactions, etc.) the organization can test for and identify patient sentiment.
  - Create risk mitigation strategies to improve collaboration and compassion across all patient encounters – clinical or financial.

- Develop a process to monitor and act on patient-interaction outcomes. Establish a benchmark for quality interactions and team performance to positively affect change and identify risks associated with patient perception before they become problematic (risk mitigation).

- Consider integrating patient tools into patient portals required as part of EHR Meaningful Use standards.

- Get engaged with governmental, vendor, association (like HIMSS) and patient-advocacy efforts so the organization’s voice can be heard; create a positive impact upon the organization’s daily operations while keeping its bottom-line healthy.

This list is not all-inclusive. It is intended to provide a list of considerations and create a coordination of efforts to bring focus to the evolving importance of patient financial interactions.

**Conclusion**

The HIMSS RCITF has discovered the breadth and depth of patient payment issues and the evolution and impact of patient financial satisfaction to the bottom-line of providers.
The re-imagining of healthcare unavoidably focuses on the financial systems of healthcare. The need to prepare for the rapid shift from fee-for-service to pay-for-performance and pave the way for landing safely in pay-for-outcomes is critical to financial risk mitigation. This preparation involves more than a cursory review of revenue cycle management procedures. Gone are the days when organizations can see more patients and raise prices to ensure financial security. A healthcare organization’s financial security depends greatly on how they choose to manage their patients’ satisfaction with their financial experience related to care received. As outlined in this paper and our previous papers, the value of patient satisfaction will improve reimbursements associated with patient pay and the mitigation of financial risks.

Now is the time to take the necessary steps to reduce financial risks and keep patients loyal and financially engaged. Healthcare organizations should not wait until patient satisfaction becomes a problem; they should mitigate the risk now by defining and addressing issues early in the revenue cycle process. They can use the resources and next steps provided in this paper as the foundation to create a plan of action to meet the organization’s needs. Organizations should create a dedicated team to develop measureable goals, understand regulations, survey patients, monitor processes and get involved. Each organization’s financial future depends on it.
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