HEALTHLEADERS MEDIA

REVENUE CYCLE EXCHANGE

Insights Report

JUNE 2016

DAVID HARTIG

PATIENTS: NEW PARTNERS IN CONSUMERISM

Analysis and in-depth discussion from healthcare leaders at the HealthLeaders Media Revenue Cycle Exchange in March 2016

An independent HealthLeaders Media report

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Analysis

Engaging With Patients Fosters Financial Health

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Gone are the days when a person's out-of-pocket healthcare expense was a drop in the bucket. Today's high-deductible health plans—thrusted on consumers, promoted by employers, and accompanied by changes in what insurance companies will and won't cover—have shifted more responsibility for payment onto individuals. But the pressure is not borne by consumers alone. Hospitals are also feeling the sting as patients, unprepared for meeting their financial obligation, are coming up short of cash.

At the March 23–25, 2016 HealthLeaders Media Revenue Cycle Exchange at the Fairmont Grand Del Mar in San Diego, 33 financial executives from astute organizations across the U.S. shared how they are transforming patient interactions into collaborative relationships that involve education, loan programs, prompt pay discounts, and financial counseling. Realizing the complexity of the payment process, many revenue cycle teams are redesigning billing statements for greater clarity and transparency, and instituting easier modes of payment via mobile and online platforms. Revenue cycle leaders are also restructuring their staffs with highly trained employees who can interpret and untangle a patient's coverage, provide better customer service, and possess the panache to straightforwardly ask for payment.

Overhauling the provider-patient relationship is harvesting rich rewards, with organizations recovering money they're owed earlier and more effectively. Yet, executives agree they have just begun to tackle the numerous obstacles lying in the path of payment and face many more innovations and changes to come.

Discussion

Forging Fiscal Relationships

JULIE AUTON

In today's provider-patient relationship, consumers are not only price-shopping healthcare services and comparing clinical outcomes, but also taking more responsibility for payment. Healthcare organizations are simplifying the financial process for patients by revising billing statements, creating easier payment methods, and delivering a better customer service experience.

Thirty-three revenue cycle executives from leading hospitals and healthcare systems across the United States discussed ways to better involve patients in meeting their financial obligations of care during the HealthLeaders Media Revenue Cycle Exchange, held March 23–25 in San Diego.

Education fosters compensation

Central to engaging patients in financial responsibility is education. Healthcare organizations are taking great measures to explain costs, provide estimates, and employ counselors as means of helping patients navigate their financial liabilities. However, education starts by equipping revenue cycle personnel with the necessary knowledge and tools to communicate healthcare costs to consumers.

TAKEAWAYS

- **Education fosters compensation**
- **Removing impediments to payment**
- **Asking for payment**
- **New direction necessitates new roles**

Columbus-based OhioHealth, a not-for-profit, 11-hospital, 3,050-bed system, utilizes educators to train everyone along the revenue cycle as part of its patient financial engagement strategy—training topics include explaining coverage to patients and answering questions; understanding clinical terms and regulatory and billing information; and providing superior customer service.

"We also provide scripting, focusing on standardizing messaging to the patient," says Jane Berkebile, system vice president of revenue cycle at OhioHealth. "A better-educated patient who understands their coverage is going to respond more positively to our interaction, as opposed to us just calling and asking for money."

According to Rick Scherich, corporate controller at Ohio Valley Health Services & Education, which includes two acute hospitals and 289 beds, educating consumers up front is critical since many patients are unaware of the cost of services. "In the past, patients would get their services done and, a month later, they'd receive an extraordinary bill and weren't able to pay ... and it's a shock," he says.

Establishing a financial admissions policy changed the conversation for Scott Ulrich's team at Houston Methodist Hospital, part of a seven-hospital system with 1,119 beds and $5.4 billion in revenue. "Who's admissible to the facility, from a financial standpoint? What's the minimum collection policy? What

PEER INSIGHTS: Members of the Revenue Cycle Exchange listen to and offer insights at the discussion table. From left, John Peters, vice president and chief financial officer at Banner Health, Arizona East Division in Phoenix; Rick Scherich, CPA, corporate controller for Ohio Valley Health Services & Education in Martins Ferry, Ohio; and Tammy Thomlison, chief revenue cycle officer at University of Mississippi Medical Center in Jackson, Mississippi.

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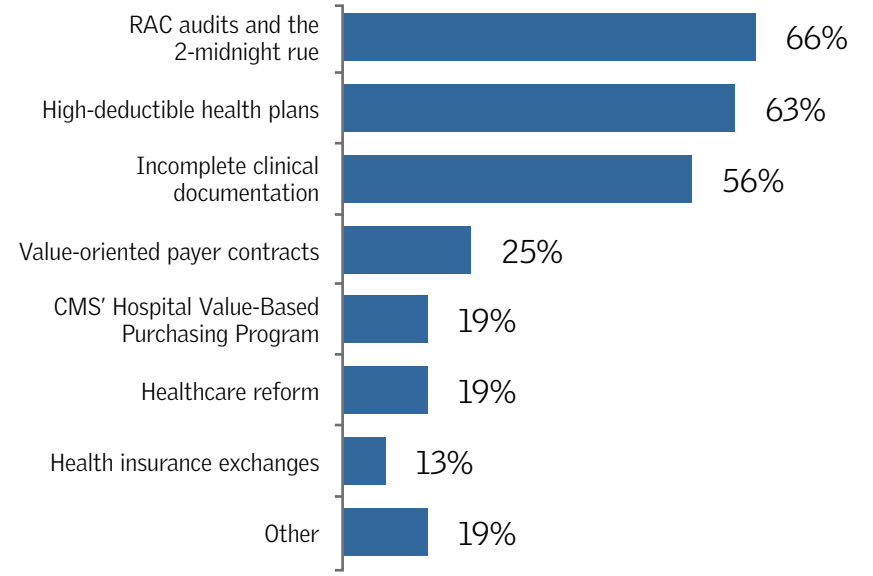
do we expect, in terms of collection? Do we expect 100% of the liability? We had no idea how to adjudicate the claim before it was generated, to figure out what the liability was going to be, so we had to get to a place to be able to pre-adjudicate as best we could," says Ulrich, Houston Methodist's director of revenue cycle operations.

"Then we had to make sure out-of-pocket liabilities were communicated to the patient, so they could weigh the value of the care they received versus their cost," he says. "If we don't tell them in advance, then they have no ability to make an informed decision about whether to proceed with care."

Baton Rouge General Medical Center, a not-for-profit, community-owned hospital in Louisiana with 466 beds and almost $960 million in revenue, abates consumers' surprise about medical costs through a chat platform. "Our hospital website has an online chat feature, so a patient can start a chat with us to get a price for a procedure," says Don Shaw, vice

What are the three biggest threats to your organization's revenue cycle?



Multi-response
SOURCE: HealthLeaders Media Revenue Cycle Exchange Pre-Event Survey. Base=32

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president of revenue cycle. "We use a price estimator and have gotten pretty good with the quotes."

"We also try to get them on the phone to verify that it's a legitimate patient, rather than someone price shopping or a competitor. Then we find out which doctor is going to do the procedure and will call the doctor's office to learn what the procedure is. We get [the patient's] benefits and run the quote. And we try to handle the questions people would normally ask their insurance company, but we try to make it easier and engage them with the facility to link them to us," says Shaw.

Along with providing realistic estimates so that patients can make informed decisions, organizations are also working on publicizing their fees and exploring areas to reduce costs.

"Transparency has become a strategic goal for this year," says Hayley Studer, vice president of revenue cycle at ProMedica, a mission-driven, locally owned not-for-profit system based in Toledo, Ohio, with nearly 2,400 licensed inpatient beds and $3.1 billion in revenue. "It's defining the strategy of what we want to focus on: Are there specific areas that are either more shoppable services, or in which we get the most patient complaints, or are the most transparent from the patient standpoint?"

Removing impediments to payment

Communicating a patient's payment obligations encompasses more than explaining the cost of care. It also means issuing simple-to-understand statements and establishing easier payment methods.

The University of Chicago Medicine, comprising a 617-bed medical center with $1.7 billion in revenue, is instilling a culture of improved consumer financial experience. Among its initiatives is implementing Epic's price estimator to give patients an accurate idea of cost, revising patient statements to make them more understandable, and developing MyChart to post patient statements and accept payments online, according to Charlie Brown, vice president of revenue cycle.

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Cone Health, a not-for-profit, six-hospital health system based in Greensboro, North Carolina, with 1,262 beds and more than $3 billion in revenue, created a patient-friendly statement that's colorful, clear, and concise. This approach increased patient payments by 20%, according to Mike Simms, system vice president of revenue cycle.

Instituting a loan plan has also facilitated payment. "For patients who couldn't pay within six months, we offer a loan program," says Simms. "It's a recourse program through another partner, and based off scoring, we can obtain advance funding so we don't have to wait two to three years for payment plans to pay out. Since implementation of the loan program in 2014, Cone has received $7.1 million in funded payments. The recourse rate is only 2%, so patients are paying and appreciate the long-term payment option."

New York–based Northwell Health, a 21-hospital system with 6,000-plus beds and more than $10 billion in revenue, established a business office focused on self-pay and bad debt. "That's been a real business driver for us and a patient satisfier because it's one-stop shopping for that patient—when they have a balance across any of our [21] hospitals, as well as in our medical group, and the 450-plus locations," explains Laura Semlies, vice president of finance, revenue cycle transformation.

Asking for payment

Another revenue cycle shift is simply asking patients for the money they owe. Historically, healthcare systems that have shied away from directly asking for payment have fallen short in collecting. Those taking a proactive approach, meanwhile, are generating positive results.


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"Our hospital website has an online chat feature, so a patient can start a chat with us to get a price for a procedure."

DON SHAW
VICE PRESIDENT OF REVENUE CYCLE,
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BATON ROUGE, LOUISIANA

Which of the following are the top three areas that will have the greatest positive influence on your efforts to reach your organization's financial targets over the next three years?

Cost control	46%
Physician-hospital alignment	38%
Strategic partnerships with providers	33%
Care models (e.g., population health, medical home)	31%
Strategic partnerships with payers	28%
Revenue cycle	24%
Expansion of ambulatory/outpatient care	23%
Care standardization	22%
Healthcare IT and analytics	22%
Care redesign	19%

Multi-response

SOURCE: HealthLeaders Media Intelligence Report, *Industry Survey: Ready, Set, When? The Drawn-Out Shift to Value,* January 2016; *hlm.tc/10UbCKK.*

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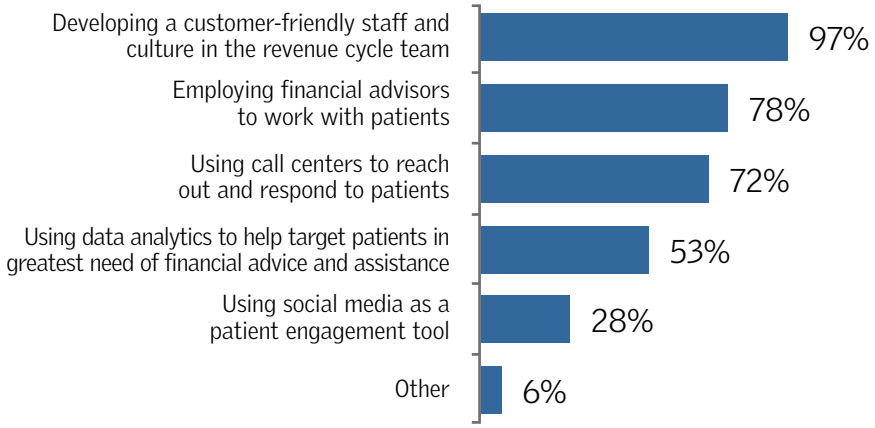
"When I started at OhioHealth, I was [tasked with] improving patient collections and reducing bad debt," says Berkebile. "I talked to my team about collecting money from patients and one person said, 'Excuse me, but we don't ask patients for money at OhioHealth.' And I replied, 'Guess what? We do now. So this is what I want you to do. We're going to work on technology. We're going to work on education and training. We're going to set new policies and procedures in place. And if you take a call from a patient about anything, and they owe a balance, then ask them for the money.'

"That week, they collected $45,000 by just asking for the money. Now we collect about $9 million from patients every month. It was a process that included training and education and setting expectations. Having conversations with the people doing the work is important, so they understand they're not doing something bad by asking for money. Also, patients need to understand they have a responsibility to healthcare, and they have to pay for it now. There are no free rides anymore," she says.

High-deductible plans were causing Phoenix-based Banner Health, a 29-hospital system with more than $5 billion in revenue, to write off a significant amount of the balance after insurance payments. "We looked at the amount of balances that were bad debt and made a concerted effort to push the front-end collection process for elective cases—to get [payment] five days out in scheduling," says John Peters, vice president and chief financial officer of the health system's Arizona East Division. "[We conveyed] to the physicians to either keep the case on the books when the up-front piece was collected, or reschedule, or make payment arrangements. We've seen nearly a 15% increase in our cash collections on the front end as a direct result of improved performance, and we're seeing double-digit, year-over-every-year increases in cash collections."

What strategies are you utilizing to engage patients as financial partners?



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New direction necessitates new roles

Another way organizations are partnering with consumers is by leveraging financial counselors, which not only increases collections but also leads to patient satisfaction. With people viewing financial counselors as supportive partners, healthcare providers are reassessing the job title.

"We've changed the name of financial counselors to benefits advocates," says Michael Grant, regional director of patient financial services at Trinity Health, a not-for-profit Catholic health system with 90 owned or managed hospitals in 21 states. "It's taking an advocate approach in which we can sit down with an individual and counsel them on a pre-service basis.

"For benefits advocates, you need someone who almost has a social work, accounting, or MBA background on the front end because they're making critical decisions and have become the gatekeepers to the organization."

MetroHealth System, an integrated health system with more than 1 million patients within Cuyahoga County, realized that "financial counseling" carried a negative connotation.

"Counseling typically means you're not managing something correctly, whether it's within your life, at work, or in your finances. The face of an uninsured or underinsured patient is different today. Financial counseling does not provide the meaning of us navigating a patient through the complexities of insurance and removing financial barriers so patients may receive preventive and continuity of care," says Donna Graham, senior director of revenue cycle at MetroHealth System. "MHS' financial eligibility specialists are advocates because we match the community and our patients to financial programs that are tailored to their specific needs, such as Medicare, Medicaid, healthcare exchange, and other governmental and financial programs."

Effectively transforming revenue cycle operations requires a staff with a high-performance skill set—people capable of speaking with patients over the phone and serving as financial advisors. The revenue cycle staff carries tremendous responsibilities, such as knowing how to enroll people with Medicaid and securing other financial services and resources. To implement changes, organizations are

revamping their revenue cycle teams by training, upgrading job titles and descriptions, and increasing pay.

"When I started [changing the revenue cycle process], I talked in my staff meetings about them being loan officers and what that meant," says Ulrich. "Once I got that concept ingrained [in the staff members' minds], we started talking about service and the quality of the job they do. What we ask of them is much more complex than what we ask a collector to do. They need to know medical terminology; they need to be able to read the order."

ProMedica upgraded its patient-access and customer service positions. "We have tiers within the revenue cycle and took the customer service reps to the highest-level tier. We want people to aspire to be in those positions and have a career path," says Studer. "It's not easy to be on the phones, talking to patients and trying to explain bills or explain the healthcare system, and sometimes taking the brunt for everything that may have gone wrong in a patient's journey through the healthcare system. We have the first and last touchpoint with patients, and it's very important that we do both of those well. In order to do that, we have to have our best people on both ends and make sure we're compensating them appropriately for the expectations we now have."

MetroHealth System revised its job descriptions to include more professional and technical expertise, reflecting the complexity of the health system's evolving revenue cycle roles. "We have career ladders that require certifications such as CAC, CHA, CRCR for Access, Claims Adjudication, and Patient Advocacy. Over 95% of our team has formal credentials," says Graham. "This facilitated incorporating professional growth and career ladders, while improving the overall patient experience. Through strategic planning and positioning our professionals proactively, we were able to remain budget neutral and reduce phone calls to our patient advocacy department regarding statements by 45%, with an increase in self-pay collections by 6%, reducing bad debt."

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