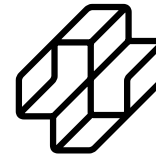


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Change or Be Changed: Assessing Your Options as Patient Payments Rise

As patients bear ever more financial responsibility for healthcare services, the long-term implications for hospitals are difficult to forecast. But one thing is crystal clear: “You can’t say, ‘I won’t change my business model. You have to conform to me.’ That isn’t going to work in an increasingly consumer-empowered, out-of-pocket payment world,” says James Bentley, PhD, senior vice president for strategic policy planning for the American Hospital Association (AHA).

On the contrary, C-level executives need to be nimble and prepare to adjust to the changing market as needed, advises Bentley.

Brace Yourself

After studying the concepts and trends associated with high-deductible health plans (HDHPs), the AHA Long-Range Policy Committee forecasted what everyone already expects but nobody wants to hear: The increase in patients’ out-of-pocket payments will weaken hospital finances.

AHA Chairman Kevin E. Lofton summarized the committee’s findings in a recent

issue of *Hospitals & Health Networks*. The committee identified four likely impacts:

- > Bad debt will increase.
- > It will be unclear which physicians or hospitals health plans will pay when patients with HDHPs receive services from multiple providers.
- > As they learn to shop for healthcare services on price and quality, consumers may be unwilling to continue the cross-subsidies—or overpaying for one service to help hospitals maintain unprofitable services—that have long been an essential component of most hospital business models.

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> Hospitals will see accounts receivable and working capital requirements increase.

What to Do Now

Big changes in health coverage are inevitable, but exactly how they will play out is not yet clear. “Compared to what the strongest advocates expected, this [HDHP phenomenon] has started more slowly,” says Bentley. “It may continue to develop very, very slowly and it may not ultimately catch on. Or it may take a long time to get started and have a huge impact going forward.”

Regardless of the future of HDHPs, patient out-of-pocket responsibility is expected to increase. The AHA committee recommended that hospitals begin preparing now.

Document the impact of new forms of insurance.

Hospitals should gather data so they can see trends related to HDHPs. “Do you see this impacting peoples’ access to and use of health care?” says Bentley. “And, if so, for what kinds of services are affected?”

In particular, you should watch for the following:

> Decreasing use of ambulatory services as patients forego preventive and early diagnostic services

> Increasing use of emergency departments (EDs) and inpatient services by patients who have serious medical problems related to a lack of preventive or early care

“Are you beginning to see more people coming to the ED with asthma or congestive heart failure at a more severe state of illness?” says Bentley.

If you see this trend, find out if your patients’ health benefit designs discourage early and preventive care. Use this information to identify the advantages and unintended consequences of increasing patient payment responsibility. Analyze how HDHPs affect community health, share those findings with policy makers, and help the community find ways to address problems that arise from HDHPs.

Prepare for more complex deductibles and copayments. Low deductibles have already gone the way of the dinosaurs, and the one-size-fits-all copayment, much maligned for misleading consumers to think health care is inexpensive, may be on its way out as well.

Some researchers advocate tiered copayments to encourage consumers to make

wise healthcare purchases. The AHA committee expects that tiered copayments will evolve in the following manner:

- > Effective care (that is, treatments for which evidence of efficacy is most clear cut, and misuse of the treatment is uncommon) will have the lowest copayments. Bentley offers hip replacements as an example.
- > Preference-sensitive care, for which patients can choose among alternative treatments, will come with medium-priced copayments. A prostate cancer patient, for example, might receive a flat sum from his health plan that would cover the cost of the least-expensive and reasonable treatment option. If he chooses another option—such as radioactive seeds or surgery—the patient would pay the differential.
- > Supply-sensitive care—in which easy availability is associated with higher use of services—will have the highest copayments, or networks of providers who agree to provide the service under specific circumstances.

continued on page 11 →

Moderate Growth in CDHPs* for 2008

CDHPs are most common among the largest employers, where they are typically offered as an option alongside other medical plan choices. The lion’s share of the plans added in 2007 were based on HSAs, which don’t require an employer contribution. “Employer adoption of CDHPs slowed in 2007 and will be moderate in 2008 as well,” said Blaine Bos, Mercer worldwide partner and spokesperson for the survey. “The next big wave of adopters is still waiting to be convinced that the plans work before they commit.”

	10-499 employees	500+ employees	20,000+ employees
Offer HSA or HRA in 2006	5%	11%	37%
Offer HSA or HRA in 2007	7%	14%	41%
Very likely to offer either HSA or HRA in 2008	11%	18%	43%

Source: Mercer’s National Survey of Employer-Sponsored Health Plans. Reprinted with permission

* In this survey, CDHPs were defined as a medical benefit design in which employees use spending accounts—health reimbursement accounts (HRAs) or health savings accounts (HSAs)—to purchase routine healthcare services directly. Non-routine expenses are covered by traditional insurance after members meet a generally high deductible.

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Online Business Office Marketing Puts Patients First

Hospitals nationwide are devising strategies to use their web sites to maximize the patient care experience. The goal is to engage patients more fully in their health care and connect them with online tools to manage their health and their hospital bills. From personal health records to online price estimators, hospital web sites are being redesigned to drive traffic, provide access and convenience, improve service and satisfaction, and enhance provider efficiencies.

Not to be outdone in this new online marketing era is the hospital's business office. Business offices are following the aggressive roadmap of their hospital clinical marketing counterparts in using the Internet to reach out to patients.

Given the Internet's "anytime, anywhere" convenience factor, many patients expect their hospital of choice to be "connected." Smart hospitals, realizing the necessity of fostering closer patient relations while boosting their own operational efficiencies, are embracing online business offices. In fact, 23 percent of health providers now offer an online business office. (Source: Trends in Healthcare Financial Systems, *Healthcare Informatics*, 2007).

The Time Is Ripe

A virtual hospital business office offers tremendous benefits. Because it gives patients round-the-clock access to their accounts, it sharply reduces the volume of telephone calls commonly received by a bricks-and-mortar business office. Moreover, trend-setting hospitals report that their online offices have boosted collections from self-pay patients and reduced the cost of mailing paper statements, as patients converted to online statements.

The successful launch of an online business office is dependent upon a hospital's ability to communicate clearly, concisely, and continuously with patients, making them aware that online opportunities exist and that there are benefits to be gained from using web-based tools. It is also important that employees who work in the business office learn how to communicate the value of their online business office to their patients.

Maximizing Online Business Office Usage

The following suggestions can help ensure a successful experience and adoption for all participants:

- > Place the online business office link prominently on the hospital's home page.
- > Collaborate with the marketing department to develop promotional materials or use quick-start marketing tool kits offered by vendors. (See the example of a promotional advertisement, above right.)
- > Develop a marketing plan to communicate advantages to patients, with activities to include:
 - Distributing wallet cards and brochures touting the online business office URL at all patient registration locations.
 - Displaying posters in high-traffic areas, such as the main lobby.
 - Inserting a wallet card or program information in paper statements.
 - Mailing postcards advertising the URL.
- > Encourage employees to use the online business office through posters, notices in the employee newsletter, and paycheck enclosures.
- > Promote the virtual office to registrars and ensure that they mention it at every new patient encounter.
- > Maintain ongoing promotions past the official launch date.


Good Marketing Is Essential

The investment in marketing materials promoting

Source: RelayHealth. Reprinted with permission.

Sample Advertisement.

the hospital's online business office is guaranteed to deliver ROI in terms of increased patient knowledge and satisfaction with web-based services, improved collections, reduced mailing costs, and better use of staff.

Health care has always been a business, and today, marketing is needed more than ever to help with insurance and reimbursement challenges. Its evolution into online communications is a valid alternative to more traditional advertising approaches for hospitals focused on ensuring continued visibility and viability of quality services. 

RelayHealth operates as a neutral partner in an open intelligent network to support quality care improvements and reduce administrative costs for providers, payers, pharmacies, financial institutions, and patients. RelayHealth's proven financial clearance and settlement solutions enable you to confirm patient payment pre-service, to collect self-pay dollars faster through online billing and customized patient statements, to ensure registration data quality, and to effectively manage your claims from inception through resolution. RelayHealth securely processes over 10 billion financial and clinical transactions each year. Learn more at www.relayhealth.com, or call 800-778-6711.

Managing Consumer-Driven Healthcare Payments

The challenge that consumer-driven healthcare poses is simple: While high-deductible health plans are less expensive for employers, these plans increase risk for providers. Providers faced with the task of collecting large deductible amounts from patients correctly fear an increase in uncollected patient receivables and pressure on their back-office operations.

At a Glance

Providers need to establish new methods to handle large deductible payments in order to avoid increased operating costs and increased collection losses. Two such methods are:

- > **Set up point-of-care payment systems. Some health systems are moving patient payments to the front office from the back office. Centura Health of Englewood, Colo., worked with its technology vendor to develop a web-based system and new internal processes. Combined with focused training for staff members, the system helped Centura increase collections by 124 percent between 2005 and 2006.**
- > **Have payers settle patient finances, reducing the risk of bad debt. This arrangement is sometimes referred to as integrated financial settlement. The health plan moves money from a patient's HSA to a funding account at the plan. The carrier then pays the provider for both the patient portion and the health plan portion.**

Providers need to establish new methods to handle payments from patients and health plans to avoid increased operating costs and increased collection losses.

Payment at Time of Service

Point-of-care payment can be a challenge, but some health systems, such as Centura Health of Englewood, Colo., are moving patient payments to the front office from the back office. Centura worked with its technology vendor to develop a web-based system and new internal processes. Combined with focused training for staff members, the system helped Centura increase

collections by 124 percent between 2005 and 2006.

Centura Health is a faith-based, not-for-profit healthcare organization formed in 1996 by Catholic Health Initiatives and Adventist Health System. Centura Health encompasses 12 hospitals with more than 1,800 beds, seven senior living facilities, and Centura Health at Home, which includes home care, hospice, infusion, home medical equipment, and oxygen services.

Centura's problem collecting self-pay payments is one that many hospital executives can relate to. Centura historically had not been efficient at collecting up-front copayments and deductibles and had not aggressively solicited debit or credit cards as a payment option. This was partly because of Centura's reliance on an outdated, stand-alone merchant terminal system for accepting payment cards. The old system

Prepare Now for Consumer-Driven Care

Providers can take some steps now to prepare for and influence the future of consumer-driven healthcare:

- > Providers should focus on patient payments and design their infrastructure to support patient payments across the organization.
- > Negotiations with health plans must put the issue of payment assurance on the table. Consumer-driven health care translates into reduced assurance of payment and health plans should not expect comparable contractual rates unless they are partnering with providers to eliminate their increased financial risk.
- > Providers should incorporate solutions to allow for a sharp increase in electronic data interchange payment volume. This should align with a strategy to increase electronic remittance and payment. Integrated financial settlement may be one option presented by payers to address CDH, but providers may want to consider solutions that give them control over the patient payment stream rather than relying on the health plan to pull funds from their members' accounts.

used terminals that were inconveniently located and required patient admitting personnel to get up from their work stations to make imprints of patient's payment cards. Credit card slips were collected at days end and keyed into Centura's enterprise software. This process interrupted the work flow at the front desk, and duplicate keying was error-prone.

When the hospital set out to find a better way, Tina Eller, Centura's former director of consumer operations, identified two goals. "We wanted to increase the collection of copays at the time of service and have a system that had recurring payment capability for patients with large self-pay balances after Explanation of Benefits receipt," she says. "Another goal was to integrate the payment initiation with posting so that data-entry into the patient accounting system was eliminated."

The solution implemented by Centura delivers features that providers should look for in a payments solution to address the challenges of consumer-driven health care.

- > Staff members at each point of care within the healthcare system can collect funds by cash, checks, credit cards, and debit cards. Because the system is web-based, it is available to authorized users throughout the organization.
- > Dedicated terminals are not necessary and work flow is uninterrupted.
- > The user screens are simple, so collecting payment actually enhances the registration process rather than slowing it down.
- > Payment processing at the point of service is integrated with the patient accounting system, eliminating data-entry and discrepancies between the funds collected and the credits to the patient accounting system.
- > Sophisticated dashboard reporting by department and by user allows managers to monitor patient payment activity and target opportunities for improvement.

For some departments, collecting money may be an entirely new process, and for others, measuring performance will identify opportunities for process improvement.

Until recently providers were not well equipped to handle patient payments with the robust cashiering capability of retail stores, yet in a consumer-driven market, these capabilities will be essential to preserving cash flow without disrupting the patient experience. Based on the experience of Centura Health and other health systems using effective patient payment solutions, dramatic results can be achieved from shifting patient payments from a back office process to the front office whenever possible.

Best practices for self-pay payment processing are essential because of the shift to CDH and knowledgeable healthcare financial managers should look to their banking partners to provide solutions.

What Are Health Plans Doing About CDH?

Health plans are working to reduce the patient collection risks related to health savings accounts. One solution is known as "integrated financial settlement" and its adoption by payers may lower collection costs for providers, while reducing the risk of bad debt and improving cash flow. Indeed, health plans that offer integrated financial settlement may find providers willing to accept lower reimbursement rates than they otherwise would.

In simple terms, integrated financial settlement uses contractual and operational procedures that automate provider payments and eliminate the task of collecting from the consumer. Here is how it works:

- > After a patient is discharged, the provider sends the claim to the carrier.
- > The carrier adjudicates the claim and determines the patient liability amount.
- > Based on an authorization from the plan

Until recently providers were not well equipped to handle patient payments with the robust cashiering capability of retail stores, yet in a consumer-driven market, these capabilities will be essential to preserving cash flow without disrupting the patient experience.

member, the plan moves the money from the consumer's health savings account (HSA) to a funding account at the plan.

- > The carrier then pays the provider for both the patient portion and the health plan portion. Collection efforts are reduced, as is bad debt risk, to the extent that the HSA balance is adequate to cover the deductible. Operational costs for provider payment processing could be reduced if the health plan and the provider support electronic funds transfers and electronic remittance advices.

The devil is always in the details, and different carriers may implement this process in slightly different ways. The biggest barrier to integrated financial settlement is that members must agree to allow the health plan to deduct directly from their HSAs. To date, that has not been widely accepted.

The Bottom Line

In summary, healthcare providers should look to solutions that enable accurate and secure patient payments up front. They should also examine their overall collections process and accelerate efforts to receive remittances and payment electronically. ☎

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Cost of Uncompensated Care on the Rise

The cost of uncompensated hospital care in the United States totaled \$31.2 billion in 2006, up from \$28.8 billion in 2005 and \$21.6 billion in 2000, according to the latest data from the American Hospital Association's (AHA's) Annual Survey of Hospitals.

Underpayment by Medicare and Medicaid reached nearly \$30 billion in 2006, up from \$25.3 billion in 2005 and \$4 billion in 2000. Medicare reimbursed 91 cents and Medicaid reimbursed 86 cents for every dollar hospitals spent caring for these patients.

AHA President and CEO Rich Umbdenstock said the data "show what we've been hearing from the field—that hospitals are seeing more and more patients while future financing is uncertain, emergency departments continue to be overcrowded, and fewer workers are available to provide care." For more information, visit www.hospitalconnect.com.

Hospitals Post Quality Data on Web Site

Mountain States Health Alliance (MSHA), which includes 13 hospitals serving 28 counties in Tennessee and surrounding states, has joined a growing number of U.S. hospitals that post quality scores in public view.

"By making our quality scores available to our communities, we are committing not only to transparency but also to being accountable to deliver quality patient care," says Dennis Vonderfecht, MSHA's president and CEO. "We want everyone to know that we take the safety and quality care of our patients very seriously, and we're not bashful about talking about it."

MSHA officials believe that public web sites, such as Medicare's www.hospitalcompare.com, are difficult for patients to find and navigate. Thus, the independent hospital alliance posts its scores on a "Performance and Safety" link prominently displayed on its home page. The information is presented in a way that allows patients to quickly

compare one hospital's performance against another's, as well as against state and national averages.

"This is about more than just saying we are doing a good job," says Ken Marshall, MD, senior vice president of medical affairs for MSHA. "We see great value for the communities around us in posting our outcomes on our site. Now residents can see exactly how we perform." For more information, visit www.msha.com.

Rising Costs Cause More Shifts in Access

Rising healthcare costs are increasingly changing the way Americans use the healthcare system.

Many of these changes are positive, but others, such as delaying seeing a physician and skipping or not filling doses of prescribed medications, could hurt patients' health, according to the 2007 Health Confidence Survey. The survey, conducted by the Employee Benefit Research Institute, is the group's 10th annual assessment of the American public's experience with the U.S. healthcare system. Below are some key findings from the survey:

- > More than six in 10 Americans with health insurance coverage reported an increase in the costs they are responsible for paying under their plan in the past year. Of these, more than 80 percent said the increase caused them to try to take better care of themselves, and 66 percent said they talk to their physician more carefully about treatment options and costs.
- > About three-quarters of those with employer-provided health coverage said they would prefer \$7,500 in employer-based health benefits to an additional \$7,500 in taxable income. For more information, visit www.ebri.org.

States Grapple with Rising Number of Uninsured

States are facing increased pressure to address healthcare issues arising from the estimated 47 million uninsured people nationally, according to initial 2007 findings from the Center for Studying Health System Change (HSC).

Since 1996, HSC researchers have been visiting 12 metropolitan communities every two years to interview local healthcare leaders, including those at hospitals, health plans, and physician practices, as well as policy makers, employers, and consumer advocates. In 2007, the 12 communities were Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y.

The 2007 interviews revealed that, in most areas, the fiscal health of states had improved dramatically since 2005, which allowed states to expand public healthcare programs and restore previous cuts. In a few states, however, the fiscal climate had not improved and, in fact, appears to be worsening.

Other findings from the survey:

- > Safety-net providers across local communities report increasing demand for their services. Adding to their burden is a declining capacity and willingness of some hospitals and physicians to provide charity care, particularly specialty care.
- > Hospitals are seeking closer alignment with some physicians, particularly in cardiology, neurology, and orthopedics, as a way of providing emergency on-call coverage and care for uninsured patients. Hospital employment of physicians is becoming more prevalent. For more information, visit www.hschange.com.

National Uncompensated Care at Registered Community Hospitals*

Year	Hospitals	Uncompensated Care Costs	% of Total Expenses
1986	5,676	\$8.9 billion	6.4%
1996	5,134	\$18 billion	6.1%
2006	4,927	\$31.2 billion	5.7%

Source: American Hospital Association, October 2007, Health Forum, AHA Annual Survey Data, 1980-2006

*Uncompensated care figures represent the estimated cost of bad debt and charity care to the hospital.

Disease Management May Not Save Money

Disease management programs that help guide the care of patients with chronic health problems appear to improve the quality of health care, but there is little evidence that such efforts actually save money, according to a study issued Dec. 10 by the RAND Corporation.

The RAND Health study reviewed all past research on disease management programs, which seek to help patients with conditions such as diabetes, by offering a system of coordinated health-care interventions. These interventions can range from prerecorded telephone reminders to home visits by medical professionals.

Researchers selected 29 evaluations, systemic reviews, and meta-analyses to focus on, covering 317 unique studies. That review found consistent evidence that these programs can improve healthcare quality, improve disease control, and, in the case of patients with congestive heart failure, reduce hospital admission rates. But patients with depression who were enrolled in disease management programs were more likely to use outpatient care and prescription drugs, increasing costs. There also is little evidence about whether these programs improve health outcomes over the long term.

The study report, "Evidence for the Effect of Disease Management: Is \$1 Billion a Year a Good Investment?" will appear in the December issue of *The American Journal of Managed Care*, which is available at www.ajmc.com.

Health Groups to Collaborate on PHR Portability Standards

Health Level Seven, Inc. (HL7), America's Health Insurance Plans (AHIP), and the Blue Cross and Blue Shield Association (BCBSA) announced on Dec. 4 that they have signed a memorandum of understanding to create a collaborative process for the maintenance of portability standards for personal health records (PHR).

The memorandum expands the number of stakeholders involved in the standards development

process to help facilitate data portability between health insurance plans to give plan members the ability to move their personal health data when their health coverage changes.

HL7 formed a PHR working group in early 2005 to develop a set of functions present in a PHR system and guidelines that facilitate health information exchange among different PHR systems and between PHR and EHR systems. In early 2008, HL7 intends to publish a PHR-S functional model draft standard for trial use version to allow the industry to work with a stable standard for up to two years while it is being refined into an ANSI-accredited version.

RHIOs Are Slow to Get Going

The widely held vision of achieving electronic clinical data exchange across the United States is far from a reality with few organizations facilitating such exchange and many failing in the process, says a new web exclusive study by Harvard researchers published today by *Health Affairs*.

The study, based on a 2007 survey of 145 regional health information organizations (RHIOs), is a comprehensive assessment of the state of electronic health data exchange—hailed at one time as the key to improving the quality, efficiency, and coordination of care. However, at the time the survey was conducted, nearly one-quarter of the 145 RHIOs were defunct. Only 20 initiatives were deemed to be of at least modest size and exchanging some clinical data. Five of those RHIOs exchanged data for a specific population; only 15 RHIOs exchanged clinical data across a range of patient populations.

"If we want RHIOs to attain the vision of comprehensive health information exchange, we need to increase our investments in them," said lead study author Julia Adler-Milstein, a doctoral candidate in health policy at Harvard University. "Otherwise, many of these RHIOs will be unable to sustain themselves under the current market-oriented approach." For more information, visit content.healthaffairs.org.

"I posed the following statement to the audience of some 550 physicians: 'Pay-for-performance is really just a CMS scheme to save money, wrapped in the flag of quality.' And 79 percent of the audience agreed with this statement. Medicare clearly has some work to do if it cares about getting the buy-in from docs."

—Robert M. Wachter, MD, chief of the division of hospital medicine and chief of the medical service at University of California-San Francisco Medical Center, writing in Wachter's World Blog

"Hospitals are increasingly reporting patient safety data on their web sites. While this is long overdue, the data is only helpful if it's accurate.

The absence of proper oversight in measuring and reporting patient safety not only could mean some problems aren't being fixed but also that the public is potentially being misled."

—Peter Pronovost, MD, PhD, medical director of the Johns Hopkins Center for Innovation in Quality Patient Care

"The Healthcare Visa Gift Card is yet another innovation that will help a broad range of consumers."

—Kenneth R. Melani, MD, president and CEO, Highmark Blue Cross Blue Shield

"The emphasis on prevention and wellness activities, along with growing availability of provider cost and quality information, arguably was the most striking development observed across the 12 communities (in an longitudinal study) in 2007. But whether the so-called healthcare consumerism movement can produce results—improved health and cost savings—remains to be seen."

—Debra A. Draper, PhD, associate director, Center for Studying Health System Change

"As we debate in earnest, at national and state levels, how to provide insurance for millions of people without protection, consumer-driven plans have to be at the top of the list of reasonable solutions."

—Helen Darling, president, National Business Group on Health

How Consumerism Influences Payer-Provider Dynamics

As patients assume more financial responsibility for their healthcare services, the traditional relationships between health plans and hospitals are in flux. Curtis Terry, president of healthcare delivery for Aetna's West Region, gives a health plan's perspective on the changing dynamics.

Patient out-of-pocket responsibility has been steadily increasing for some time now. What will be a typical deductible or copayment five years from now?

Terry: My bet is that the deductibles will be higher than they are today, although they may not trend at the same rate we have seen over the past five years. The leading indicators will be the rate of healthcare cost inflation, regulatory actions to control deductibles, competition for skilled workers, and the impact of consumerism on utilization, unit cost, and distribution of healthcare services.

We probably will see a continuing spread in copayments among physicians, urgent care services, and emergency department services to motivate patients to access care at the appropriate site. This trend may also extend to copayment differentials based upon place of service for services such as diagnostic imaging or certain procedures.

As healthcare consumerism evolves, what should hospitals expect from health plans in the foreseeable future?

Terry: There will be a continuing need to demonstrate value to the purchaser and

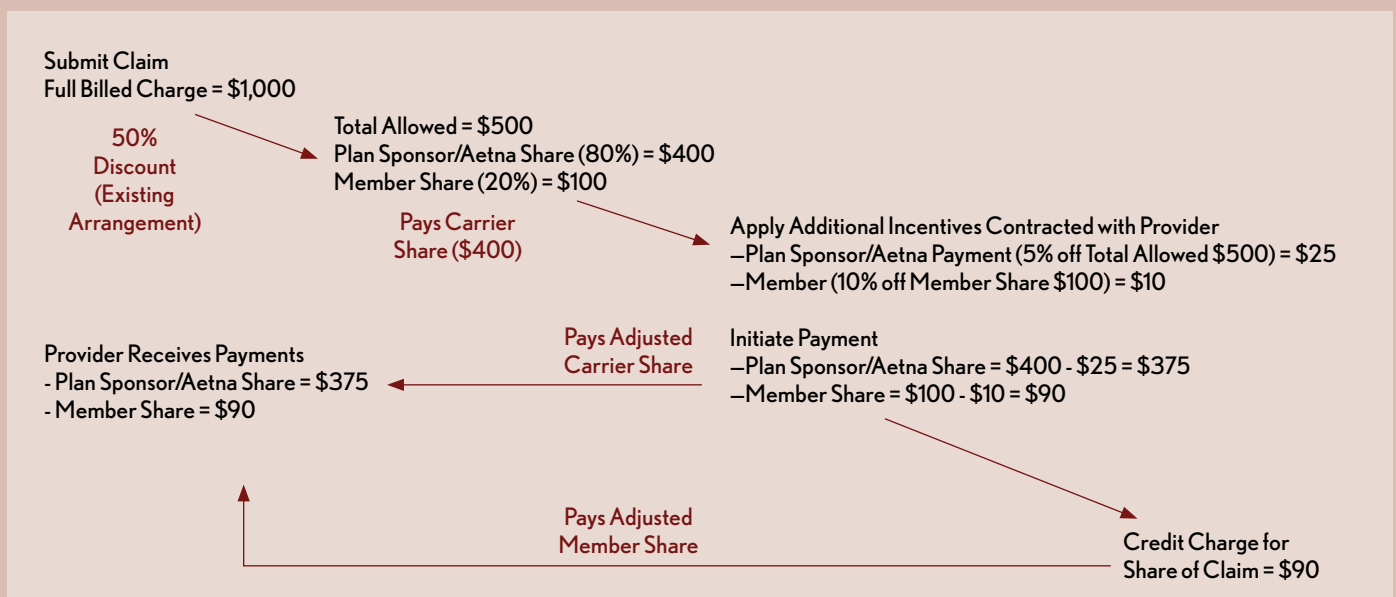
consumer as it is measured by the cost and quality of healthcare services. More sophisticated buyers are looking to health plans and their networks to clearly demonstrate this value.

Health plans will push for administrative simplification that makes payer-provider transactions more efficient and we will be looking for more standardization of business processes. Also, as hospital costs become more transparent, there will be a need to ensure the accuracy and timeliness of rate changes, so that consumers can trust the upfront cost information they receive.

What hospital business processes are health plans focusing on?

Terry: Top priorities include moving claims payment into real-time adjudication, simplifying contracts to align with administrative

Aetna Payment Assurance Plan: How It Will Work



Source: Aetna. Reprinted with permission.

Hospitals that participate in Aetna's Easy Pay program will accept discounted rates from payers and patients in exchange for collecting patient payments via payer-facilitated credit cards.

capabilities, and displaying cost and quality information on a more real-time basis. All of these initiatives will require close collaboration among providers and payers.

Aetna is rolling out a “payment assurance” program for hospitals that are willing to accept a discounted rate. (See the exhibit on page 8.)

Why would hospitals accept discounted payments?

Terry: We understand that with a greater share of costs shifting to the consumer, there will be bad debt issues. Aetna is offering, in conjunction with Medical Funding Services Inc., the Easy Pay program as one plausible solution to mitigate that problem. Each hospital will have to determine whether timely payment at a discounted rate is better than its current rate of collection on patient receivables. If more cost shifts to the healthcare consumer and the

rate of hospital debt rises, that cost-benefit equation may change over time.

What is the status of this program?

Terry: Our members who participate in the Easy Pay program can assign any credit or debit card to pay their portion of health-care bills, and they will receive a 10 percent discount on their charges. We started marketing this program to our members January 1, and we intend to roll the program out, on a region-by-region basis, over the next four years. So far, about 250 hospitals and physicians in our first region—Pennsylvania, Ohio, Maryland, Virginia, West Virginia, and District of Columbia—have contracted with us to offer the Easy Pay service.

Do you see healthcare consumerism requiring incremental adjustments to current business models—or is it a transformative development?

Terry: Consumerism is introducing new market forces that will shape the health-care industry of the future. Although these forces are having varying degrees of impact on a given market, it is important not to underestimate the short and longer term effects of these forces on the financing and delivery of health care.

Although the times we are in may appear somewhat threatening to our established ways of doing business, these are also times of great opportunity. I am encouraged by the more forward-thinking provider organizations that recognize this and are innovating to provide greater value to all stakeholders. ☞

Who's Who in Consumerism

Who: The Access Project, based in Boston, works in conjunction with local organizations to improve access to healthcare services. In operation since 1998, the not-for-profit project is funded by grants from the Annie E. Casey Foundation, the W.K. Kellogg Foundation, the California Endowment, the Quantum Foundation, the Blue Cross Blue Shield of Massachusetts Foundation, the Missouri Foundation for Health, and others.

Among other activities, The Access Project is documenting the increasing level of medical debt in American, and the problems associated with it.

Significance to Consumerism: The Access Project is a leading advocate for people who are strapped with medical debt. In 2007, the Project published three noteworthy reports:

- > *The Illusion of Coverage*, which describes how private insurance plans do not always protect people from financial hardship or guarantee access to healthcare services.
- > *Borrowing to Stay Healthy*, which documents the widespread use of credit cards to pay for medical care.
- > *Living in the Red*, a series of personal accounts of how medical debt affects patients' access to care and causes other problems in their lives.

Also in 2007, Mark Rukavina, executive director of The Access Project, testified before the U.S. House Committee on the Judiciary about the relationship between medical debt and personal bankruptcy.

- Recommended Strategies:** In its *Borrowing to Stay Healthy* report, written in collaboration with Demos, The Access Project proposes reforms to alleviate the medical debt burden, including:
- > National guidelines to identify and differentiate medical debt from consumer debt
 - > Policies that discourage medical providers from sponsoring credit cards or credit lines to patients
 - > Increased oversight of lines of credit attached to health savings accounts
 - > Improved screening for patient eligibility for financial assistance programs
 - > Enactment of a Borrower's Security Act that regulates the fees and interest that credit card issuers can charge

For More Information: Visit www.accessproject.org.

Get Patient Input When Developing a Self-Pay Discount Policy

Developing a discount policy for uninsured and underinsured patients requires a wide range of perspectives—from the access management staff to the board of directors to the patients responsible for their own medical bills. Sandra Johnson, senior vice president of revenue cycle management for Jackson Health System in Miami, says careful policy development may pay off in two ways: avoiding public relations problems and decreasing the no-pay problem.

Who needs to be involved in creating a self-pay discount policy?

Johnson: Because this policy is so complicated, our team includes representatives from contract management, billing, compliance, fiscal IT, legal, and access management.

For any policies that involve financial assistance, we want the board to be aware of all the things that have been taken into consideration, and how decisions have been made. And we want to make sure our board has approved those policies because they are the most sensitive policies you can have.

Some people say that when the bill is so large and overwhelming they feel like there is no hope at all so they don't pay anything. With the new policy, we think there will be a positive impact because patients will see an opportunity to participate in their healthcare expenses.

How did you get started on this task?

Johnson: First, we had to come up with a good definition of what self-pay truly is. There are so many possible categories to consider: charity, indigent, insured people responsible for deductibles and copayments, uninsured, and underinsured. Coming to consensus on our own definition took quite a bit of time.

How did you involve patients in developing the policy?

Johnson: We took a sample of 25 patients who were in our categories of uninsured or underinsured. We asked their opinions on self-pay discounting, but we also wanted to find out about the mechanism for discounting. Would you rather pay upfront and get a large discount versus pay 30 days later and get a smaller discount? We wanted to see what would work best for them.

We invited the patients to a meeting and we contacted some by telephone. Most were very forthcoming. They wanted to tell their story and we talked through that with them. Then we asked, "How can we help you to satisfy this bill? What works better for you?"

Do you have any insights from these patient interviews to share?

Johnson: There are huge public relations issues around self-pay discounting. To hear the patients' opinions has helped as we are building this policy, and now we already know how it will be received from the public.

We did notice that when we talked with patients one on one they were much more open than when they were in a group. Many self-pay patients are proud working people, and they would love to have insurance but they can't afford it. In a group setting, they did not seem to feel free to talk about their own situation.

How will the discount policy affect your hospital finances?

Johnson: We really think it's going to have a positive effect. Some people say that when the bill is so large and overwhelming they feel like there is no hope at all so they don't pay anything. With the new policy, we think there will be a positive impact because patients will see an opportunity to participate in their healthcare expenses. ☺

Worksheet for Reviewing Financial Assistance Policies

The following is excerpted from a worksheet that was developed as part of HFMA's **PATIENT FRIENDLY BILLING**'s® project. The full worksheet, which identifies nearly 50 decision points in six topic areas, is available for downloading at www.hfma.org/library/revenue/PatientFriendlyBilling/worksheet05.htm

Consideration	Relevant?	Actions needed	From whom do you need buy-in?	Who needs training?
<p>Who qualifies for discounted or free care? Does the policy support the hospital's mission statement while protecting its fiscal viability?</p> <p>Does the policy specify the income guidelines (Federal Poverty, HUD level, or other) to be used for free or discounted care?</p>				
<p>What services are discounted? Does the policy comply with state rules regarding whether policies must apply equally to all for specified hospital services?</p>				
<p>What discount levels are offered? Has the policy team assessed possible implications for private payer contracts or Medicaid payments?</p>				
<p>How are policies communicated? Do the policy's communication provisions comply with federal regulations prohibiting business inducements?</p>				

Change or Be Changed: Assessing Your Options as Patient Payments Rise *continued from page 2*

From the insurer's viewpoint, a tiered approach will offer a more sophisticated copayment system, says Bentley. "The hospital point-of-view is more complicated," he says.

Identify new options for subsidizing services that are not self-supporting. Competition from lower-cost providers means hospitals will lose out on some profitable procedures. New ways to support money-losing services will have to be found. "There are likely to be some services that hospitals have been able to offer in the past that they may not be able to in the

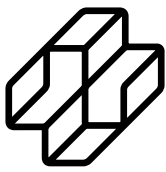
future," says Bentley. "If those services cannot be financially viable, they're going to have to close."

Before that happens, of course, most hospitals will try to find new revenue sources. Bentley says options to consider include additional support from a hospital foundation and appropriations from local government entities. In either case, the hospital will be expected to discuss its financial situation publicly and present the case that new money from the community is essential.

Consider developing a new business model.

If consumers show a preference for new locations or formats for receiving health-care services, hospitals need to adapt, says Bentley says. And be prepared for some failures. You need to create a way to evaluate the success of a new venture, and close that new program/service if it is not economically viable.

"Hospitals are more experienced in starting new services than in stopping a service," says Bentley. "If it doesn't work, you're going to have to close it down." ☞



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