



The Self-Pay AcceleRator

Strategies to *Accelerate* Your Self-Pay Recoveries

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Start With Point-of-Service Collections

Out-of-pocket healthcare expenses, as a percentage of disposable income, continue to rise. Today, the average patient spends over \$1,000.00 per year on healthcare services that are not covered by insurance. In 1960, this expenditure was only \$141.00.

What impact do out-of-pocket healthcare expenditures have on the self-pay recovery process? How can healthcare providers maximize their cash flow? A starting point is a comprehensive plan to collect co-payments and deductibles at the time of initial service.

Registration and admitting staff generally think that "finance" is not in their job description. The first step is to make sure they believe it is. Think about it! Why is there not a protocol to collect at point of initial service? Is the issue one of training, job description, integrated accounting systems, or policy?

A well-trained point-of-service staff, trained in collection procedures, will save time and money on the back-end for the hospital. The role the staff plays and how they perform is important to the care of the patient as well as the viability of the organization. They are an integral part of the hospital's services to patients and their

families. It is management's responsibility to ensure that the staff knows that their job is important and valuable.

Taking the time to hire and employ the right people for point-of-service collections is imperative. The job tasks can be learned; a positive mindset cannot. When looking for candidates consider that the best performers have the following characteristics: positive attitude, self-motivation, empathy, and good listening skills.

A positive attitude is the most important characteristic. Attitudes affect everyone around you, both other employees and patients. A positive attitude reduces stress, increases patient satisfaction and creates a productive working environment.

Self-motivation is another characteristic of good front-end representatives. To be proactive, they must be prepared to manage the patient registration process. They must know their job functions and how to get answers.

Employees in this role must also possess empathy. Healthcare is expensive, yet patients want the best healthcare available at an affordable cost.

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The Real World

Recently, I sat down with Patricia Hennessey, Director of Patient Accounts for the North Shore Medical Center, which is part of the Partners Healthcare Network.

I asked Patty to describe how HBCS helps her with point-of-service collections.

Brian: "Patty, describe the type of information provided to you by HBCS that assists with point-of-service collections."

Patty: "From the 'back-end' of unpaid claims and self-pay bills, we can determine both missed insurance information and invalid insurance information. We use the found insurance to define the number of patients that have been seen and where (what entry point or service area) insurance information is not gathered. Corrected insurance information

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Did You Know?

In 2004 healthcare spending rose to \$1.9 Trillion. Projections for 2009 are \$2.9 Trillion.

(Borger, C. "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* 25:1, 2006: 186-196)

Nearly 46M Americans are uninsured, yet the US spends more on healthcare than any other industrialized nation.

(California Healthcare Foundation. *Healthcare Costs 101 -2005. 02, March 2005*)

In 2005, healthcare premiums rose by 9.2% - the fifth consecutive year of over 9%.

(Henry J Kaiser Foundation, *Employee Health Benefits: 2005 Survey. 14 September 2005.*)

Retiring elderly couples will need \$200K in savings to pay for basic medical coverage.

(Fidelity Investments, *Press Release, 06 March 2006.*)

Coming in September...

- Hiring, training & maintaining customer service staff
- How IT can help with your customer service issues
- Evaluating your staff: the 80/10/10 rule
- Industry Q&A's regarding finding good patient account reps

The HR Corner

Hiring the right individuals as customer-service representatives is an extremely important process for your hospital. With the right people in place, the customer-service experience can be a friendly, consultative process for both parties. This, in turn, creates happier patients and ultimately a smoother recovery process for your hospital.

Like any professional, a customer-service candidate must first possess certain basic talents and character traits that are fundamental for success. Characteristics such as a pleasant speaking voice, a cheerful disposition, and a compassionate manner should be detected in an initial interview.

However there are other characteristics that are often overlooked and yet are critical for the customer-service position. Traits like dependability, decision-making ability, critical thinking skills, persuasiveness, and ability to think on one's feet separate an average customer-service rep from a true healthcare receivables professional. These characteristics must be uncovered in the interviewing and evaluation process with a series of probing questions designed to discover if the candidate has these traits.

A well thought out behavioral interview process will successfully reveal whether or not a candidate is the right person for your hospital. The importance of the interview process cannot be emphasized enough as it lays the foundation for the success of your customer-service team. It's a vital factor in ensuring that you have an individual who is ready and capable to represent the patient accounting function in a manner that will support your team's business goals in addition to delivering optimum customer service.

To download our free tip sheet, "7 Smart Questions to Ask When Hiring a Customer-Service Professional" please visit <http://www.hbcs.org/hiringtips.pdf>

Maureen DiEleuterio is Vice President - Human Resources & Training HBCS. She can be reached at dieleume@hbcs.org.

Start With Point-of-Service Collections (cont.)

Empathize with your patients. Understand the angst associated with a hospital visit. Understand that patients would rather spend their money elsewhere, keeping in mind that positive cash flow affords everyone access to quality healthcare.

A good listener makes for an excellent collector. Good listeners gain trust with patients. They must listen for clues as the patients tell their stories. For example, if patients discuss losing a job, there may be charity care available. If they are saving for a house or car purchase, they may have available credit.

In the end, it starts at the beginning. It all comes down to asking for the payment at time of registration. Payment solutions require empathy, not sympathy and explanations. Recognize those that cannot pay. Make sure they are the exception, not the rule.

A positive caring attitude on the part of the employee will open dialogues to improve the collection process. The health-

care community is so concerned with this issue that they are offering guidelines for healthcare professionals. Here are some examples:

- Greet the patient & identify yourself
- Identify the patient and the guarantor
- Validate the information
- Explain the payment policies and processes
- Ask for payment
- If there is a negative response, determine the problem
- Solve the problem
- Re-enforce the payment policies and processes

Every hospital has a Mission Statement which includes an expression of the need to bring quality healthcare to the community. Financial freedom in the form of positive cash flow supports this mission. Positive cash flow begins with the registration process.

Kathleen Maher is Director of Marketing at HBCS. She can be contacted at maherkj@hbcs.org.

The Real World (cont.)

is shown through updated information that caused a claim to reject and end up in self-pay. From the reports we receive, we can determine where the issues are coming from (department, entry point, employee, etc.) and use this as a tool for training purposes."

Brian: "Is the information helpful to the hospital?"

Patty: "Absolutely! Each month we take the reports and give the information to access management, and other areas as needed. We can segregate repeat errors and correct them. We can also isolate people within departments that need more training."

Brian: "What impact has the monthly reporting had on your point-of-service process and accounts receivables?"

Patty: "Employees know the importance of correct information when they see the

rejections and mail returns on the back end. It also helps with patient complaints.

In addition to the HBCS reports, we use internal reports and compare the two, to analyze data for better front-end processing. When we get the correct information the patient is much less likely to "blame" the hospital when they receive a bill.

I haven't calculated the exact impact on the A/R, but can tell you that claims are being processed correctly the first time since we have looked at and addressed front-end errors. This obviously reduces our days in A/R and increases cash flow."

Brian Wasilewski is Vice President of Operations at HBCS. He can be contacted at wasilebj@hbcs.org.

Deficit Reduction Act Puts Renewed Focus on Citizenship Paperwork

Congress passed the Deficit Reduction Act, which was signed into law in February 2006 by President Bush, to impose some fiscal discipline on budget-busting entitlement programs like Medicaid. The Act aims to ensure that illegal aliens will not have access to government programs. As a result of the DRA, a more stringent documentation requirement has been established for benefit applications. The new system could result in millions of people across the country losing eligibility for Medicaid because of a lack of proper documentation.

The consequences would be devastating to those losing coverage and those providing them with care. The result could very likely be a significant increase in self-pay and free-care patients. Providers, particularly hospitals, should take steps now to educate Medicaid recipients on the new eligibility requirements and, where possible, help in the collection of the necessary documentation.

Who is Affected and What Paperwork is Needed?

Anyone who is eligible for Medicaid but not Medicare or SSI – in other words, not dually-eligible – must provide proof of citizenship, which can be a passport or birth certificate, or a lesser form of documentation from a CMS-approved list. The documentation is required for individuals now going through either the application process or an eligibility re-determination. Once the documentation is provided, the requirement will be satisfied and it will not need to be produced in the future.

The Washington, D.C.-based Center on

Budget and Policy Priorities states that if as few as two percent of Medicaid beneficiaries nationwide cannot readily come up with a birth certificate or passport, one million low-income Americans could lose Medicaid coverage and become uninsured or be delayed in obtaining coverage.

What Can I Do as a Provider?

To minimize the impact of this new regulation on receivables, providers should:

1. Anticipate and forecast a decrease in Medicaid-eligible patients and revenue, at least for the first year of the new requirement.
2. Offer counseling and guidance to Medicaid-eligible patients to assist them in complying with this requirement, such as distributing a flyer with the documentation they will need to obtain benefits or maintain their eligibility.
3. Retain a consulting firm that has expertise in Medicaid enrollment to assist patients during the transition and case manage the eligibility process.
4. Ensure self-pay systems are in place to obtain payment from those no longer eligible for Medicaid.

As is often the case with federal policy changes, healthcare providers have as much to lose as Medicaid-eligible individuals as a result of the DRA. By taking the above proactive steps, providers can ensure greater continuity in Medicaid reimbursement and a higher payment percentage from self-pay patients while providing valuable assistance to affected individuals.

Gerard A. Vitti is the President of Healthcare Financial, Inc., a privately owned for-profit company specializing in connecting low income and disabled individuals, families, children and elderly with public health insurance benefits. The company specializes in advocating for the socially and/or medically complex applicant. Mr. Vitti can be reached at (617) 482-2200 x222 or gvitti@hfi-mass.com.

**Comments or suggestions?
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The Tech Corner

The accounts receivable recovery process is tested the moment the patient enters the hospital. The challenge for registration and admitting personnel is to accurately capture and then verify the patient's identification, including demographics, and the patient's insurance information, including self-pay obligations.

The first principle in collecting patient information is to always ask for updated insurance and demographic information for every date of service no matter how recent data appears in the current system.

Information systems that manage demographic and insurance verification can be deployed to provide employees with the means to assure the accuracy and correctness of information collected.

Real time desk-top Internet based patient accounting applications, such as Siemens HDX's system, have established verification modules which aid in the collection of accurate information at time of patient registration.

Using direct credit bureau data to complement these systems and to facilitate accurate demographic identity of your patients and guarantors is a helpful step in the process. The advantages of using a Credit Bureau's data is that this data is heavily regulated by law (The FACT Act) and is often supplemented by additional data sources.

Another challenge of the registration process is confirming the accuracy and correctness of the insurance information. To assist with this process, healthcare providers on a regional basis have set up local networks. For example, New England has established the EDI Network (NEHEN) which provides the means for batch and real time insurance verification.

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A Message from Jack

Customer Service, Customer Complaints, and Cash Flow

In general, the source of most patient complaints is billing errors or the behavior of representatives in the collection process. An occasional complaint is not bad, nor is it unexpected. Occasional complaints generally mean that the Revenue Cycle process is functioning at a sufficiently aggressive level to maximize cash flow. However, a high level of customer complaints indicates that something is "broken" in the Revenue Cycle process.

The CEO and the CFO have a much broader perspective on customer service than perhaps patient account department staff members. They recognize the tremendous value of the hospital's patients and medical staff. Nothing is more upsetting to the CEO than a complaint from any patient, especially one from a friend or family member of the hospital's professional staff.

The goal is to have patients informed upfront, lessening the chances for misunderstandings down the road. The higher the level of customer service, e.g., managing inquiries and correcting errors, the more satisfied the hospital's patients will be. Cash flow improves, the professional staff is happier, and the opportunity for repeat and referral business is more certain.

The self-pay collection staff should be thoroughly trained in customer service skills, as well as the hospital's collection protocols. Agent training, monitoring, and the effective use of information systems will accelerate the recovery process and generate patient goodwill.

Look for articles to improve customer service in this issue and future issues of The Self-Pay AcceleRator. As always, I welcome your comments and suggestions.

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Ask Joanne

Informative questions and answers from our clients. Please e-mail selfpay-accelerator@hbcs.org to submit your questions.



Joanne Courtney

Q: *Joanne, what information captured on the back-end of the revenue cycle process would be useful in improving my hospital's front-end performance?*

A: Two specific pieces of information come to mind immediately. The amount of returned mail and corrected address or phone number information given when your self-pay representatives speak with the guarantor/patient should be captured. Generate monthly reports that capture this flawed demographic information, i.e., bad address or bad phone number.

Another useful report would identify all accounts in the self-pay process, where guarantor/patient contact yielded insurance information that was not captured at the point-of-service. In both instances, the information should be reported by registration area, allowing the hospital to focus resources and training on areas that require improvement in capturing correct demographic and insurance information.

Q: *Our hospital is interested in implementing a pay-for-performance program for employees that impact the front-end of the revenue cycle. Any suggestions?*

A: I recommend a comprehensive incentive plan for individual performance that focuses on two or three performance metrics. For instance, a **collections/cash metric** for an Amb Surgery registration representative could be calculated by taking 90% of monthly Amb Surgery visits processed by the representative and multiplying the visits by the basic co-pay rate for an Amb Surgery visit. A **quality metric** could be that 95 % of all demographic and/or insurance information captured by the Amb Surgery representative must be accurate. Utilization of the information provided in the reports outlined in the question above would validate this performance metric.

I also suggest a **productivity metric** based on the number of historic, monthly, Amb Surgery visits. Each representative should process an average number of monthly visits. A monetary incentive would be tied to each performance metric.

Hospitals can create their own plans with an emphasis on areas that they believe significantly impact the revenue cycle. In addition to individual performance metrics, another component of a monthly incentive could be team based. If the business office achieves the overall monthly collection goal, an added team incentive would be awarded to each representative. Team-based incentives foster relationships and accountability among work units.

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