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recalibrating payment in the era of consumerism

Engage patients as consumers and finding ways to make it easier for them to pay for their health care are two critically important objectives in today's increasingly consumer-focused U.S. healthcare system.

In theory, healthcare consumerism is a straight-forward idea: Shifting costs to consumers, typically in the form of high-deductible health plans (HDHPs), will give them an incentive to make informed, judicious decisions about the healthcare services they purchase.

In practice, consumers have been slow to shop for health care based on price, despite high enrollment levels in HDHPs, with the National Center for Health Statistics reporting that nearly 40 percent of consumers purchased private HDHPs in 2016, up from 26 percent in 2011.[a]

A 2017 report by the consumer credit reporting agency TransUnion found that 57 percent of Millennials, 50 percent of Gen X-ers, and 42 percent of baby boomers have "little to no understanding of their health insurance benefits."[b] Such poor understanding has made it difficult for consumers to anticipate and plan for medical expenses. A 2016 survey by the Kaiser Family Foundation (KFF) and the *New York Times* found that primary reasons patients cited for being unable to pay for healthcare services were unknowing visits to out-of-network providers (32 percent), unexpected claims denials (26 percent), and high deductibles (26 percent).[c]

a. Cohen, R.A., and Zammitti, E.P., *High-Deductible Health Plans and Financial Barriers to Medical Care: Early Release of Estimates from the National Health Interview Survey, 2016*, National Center for Health Statistics, June 2017.
b. TransUnion, *Decoding Millennial Financial Health: Generation Revealed*, 2017.
c. Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G., Brodie M., *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey, Henry J. Kaiser Family Foundation*, Jan. 5, 2016.

AT A GLANCE

Essential functions of an effective patient access program include the following:

- Conducting pre-appointment checks
- Ensuring billing is clear and concise
- Making it easy for patients to pay
- Providing support for patient access staff

Moreover, high costs are causing many patients to delay care. According to a 2017 Gallup survey, 29 percent of patients have put off medical care because of costs; and 63 percent of that group say their conditions are serious.[d]

None of these trends is good news for providers in terms of clinical outcomes, financial health, and patient satisfaction. Indeed, healthcare consumerism represents the biggest challenge to the bottom lines of providers.

The Patient as Payer: The New Reality

Fallout from rising and stubbornly opaque healthcare costs aside, consumerism represents a significant new cultural challenge. Providers may complain about health insurers' complex and often convoluted payment requirements, but at least insurers' processes are defined by rules. The patient as payer leans more heavily on behavior and individual circumstances.

The reality is that if patient payments are not captured up front, they probably won't be captured at all. Once a patient leaves a provider's office, the provider's chances of collecting payment drop by 62 percent, on average.[e] This shortfall might not have posed a huge revenue hit when patients were paying a $20 copay on a $4,000 bill, but now that they may be responsible for 10 percent or 20 percent of that bill, the impact takes on real significance, making it crucial for providers to capture as much revenue as possible from consumers at or before the point of service. Simply put, patient access has become a critical concern for providers' finance leaders.

Although most providers have made considerable investments in propensity-to-pay infrastructure, including software and human resources, inefficiencies and poor workflow can exacerbate the very problems that improvements in patient access were intended to solve.[f] It's important to get patient access functions right early.

Defining Patient Access

Patient access is a mix of technology, process efficiencies, and strategies to engender patient accountability, and it is based on the three foundational pillars of the complete end-to-end revenue cycle program: enhancing the patient experience, increasing yield, and containing cost.

Properly implemented, patient access processes allow providers to drive measurable and meaningful business improvements with tools that improve accuracy and increase overall revenue. Equally important, a good patient access program will uncover unique opportunities to lead patients through a new learning curve to understand the real cost of care and how to pay for it.

Patient access is the first part of the revenue cycle, where front office staff initially engage with patients. This staff has three essential goals:

> Help patients understand what they owe
> Make it easy to pay
> Set patient expectations

One of the defining pillars of consumerism is that the patient is empowered by choice. Providers therefore should evaluate the extent to which they are offering patients the range of options that truly make patients feel empowered. Questions that providers should address include the following:

> How many choices do our patients have for scheduling or canceling an appointment?

d. McCarthy, J., "U.S. Women More Likely Than Men to Put Off Medical Treatment, Gallup News, Dec. 6, 2017.
e. Availity, *Method to the Madness: 10 Patient Collection Strategies That Work*, May 2016.
f. Availity, *The Impact of Consumerism on Provider Revenues*, February 2015..

> Are the patients able to choose their preferred communication channel?
> Are they offered payment options that work within our cash-flow demands?

When it comes to billing, patients have various expectations, practices, and preferences in how they pay. By using technology and building more flexibility into its collections, a provider organization can reduce its reliance on paper statements and bill collectors, get paid more quickly, and reduce its administrative costs.

To achieve these goals, a provider must invest in its patient access department, including in technology that can provide the following:

> Fast and accurate estimates of each patient's financial responsibility, based on a broad-spectrum evaluation that includes eligibility and authorization status
> Forecasts of each patient's capacity to pay
> Capacity for multiple payment options and patient-assistance plans
> A basis for proactive and consistent denial management policies

However, a high-performing patient access program also seamlessly integrates human interaction. Healthcare providers are deeply experienced in helping lead patients through difficult discussions about their health. The same cannot be said for how experienced they are in communicating complex financial issues.

Yet it is critical that they become more adept at having such conversations. The ability to speak with patients—clearly and accurately—about their financial obligations can help build patients' confidence in their ability to pay for care, thereby improving the provider's likelihood of being paid. Just as important, engaging in such conversations offers a unique and important opportunity to lead patients through a new and daunting learning curve regarding the real cost of care and how they can pay for it.

Functions of a Patient Access Program

Patients who know in advance how much they will pay for their care are likely to be better satisfied. It is just common sense to avoid surprising patients with markedly higher bills than they were expecting. Correct estimates also give patient access staff an indispensable basis for collecting more prior to the time of service.

Pre-appointment checks should be part of every provider's standard workflow, coupled with estimates of liability conducted to ensure the provider is fully informed about how much to collect from the patient.

To translate these concepts into reality, providers require an patient access program that effectively performs the following steps.

Conducts pre-appointment checks. Before they begin to access a provider's services, patients should know about the provider's payment options and financial assistance. They should be educated about which services are covered by their insurance, what their total financial obligation will be, and what the organization expects to be paid for the appointment. Pre-appointment checks should be part of every provider's standard workflow, coupled with estimates of liability conducted to ensure the provider is fully informed about how much to collect from the patient.

Furnishing patients with the most accurate estimates possible requires automatic access to the most comprehensive information available, including authorization and medical necessity information.

Providers also should use automated tools to perform these price estimates. The time is past for patient access departments to be expected to make estimates by poring over spreadsheets and books of payer rules that are all too likely to be outdated. Organizations that do not keep pace with technology will be at a competitive disadvantage because they will have a reduced ability to secure payment from patients. It is therefore imperative that providers keep pace with technology by adopting automated patient pricing tools. Such tools, which are available through a "software-as-a-service" model, can generate all the needed information to present patients with accurate estimates are based on their most current levels of coverage and benefits used year-to-date.

Furnishing patients with the most accurate estimates possible also requires automatic access to the most comprehensive information available, including authorization and medical necessity information. Obviously, an estimate that omits the fact that a particular procedure won't be authorized is setting both the patient and the provider up for uncomfortable news down the road. Simply put, such automated tools will be a major success factor in health care's consumer-focused world of the future.

If, for example, authorization issues are a common reason for denials, the root cause may well be found in manual processes. In such a circumstance, the provider should evaluate the extent to which its patient access employees are spending time working the phones, fax machines, and payer portals for authorization status and the return on that staff effort. Automation of preauthorization provides a means for retrieving information about a limitless number of claims at once, from multiple payers, thereby ensuring the provider is paid and patients are not presented with surprises.

There's a burgeoning market for data analytics in health care, and the industry is evolving to the point where such technology also is imperative. When applied to billing operations, analytics can provide greater transparency into the payment cycle, and pinpoint areas on which to focus improvement efforts and maximize performance.

Comparative analysis is one such approach that enables an organization to assess its own productivity and performance relative to that of its peers (even by specialty), locally and nationally. Peer-to-peer benchmarks on key metrics such as payer processing times, staff productivity, and denial rates provide an unparalleled means to obtain actionable insights within an organization's revenue cycle.

Ensure billing is clear and concise. The expanded role patients have assumed as payers for their own health care due to the proliferation of HDHPs also has increased the extent to which providers must deal with bad debt. Patients often struggle with even understanding what they owe as they contend with a medical billing system that can be confounding to even the most experienced healthcare professional. It's not unusual for patients to receive bills from multiple hospitals, physicians, labs, and specialists for the same episode of care that differ in content, presentation, and use of health industry jargon.

Providers should not wait for medical billing to become standardized, because it may be a long time coming, if ever. Instead, providers should look for ways now to improve their own billing statements. For example, they should assess whether the bill's language is clear and concise, and ensure it is free from excess industry jargon. For older populations, font sizes large should be enough for easy reading. Costs should be itemized, and a section should be included that details the insurance company's obligation.

Patients who don't understand their bills are less likely to pay than are those who understand clearly their responsibility and payment expectations. In sum, to keep from confusing patients, statements should be designed so every patient can easily understand the language and format. By proactively addressing financial information and solutions regarding payment options, a provider can boost transparency and help patients feel more engaged in their care.

Patients also want healthcare price transparency because they are contributing a larger share of the cost of care each year. Although it is a laudable concept, and one that providers should fully embrace, the stumbling block for providers is that accurate pricing of healthcare services is nearly nonexistent. Provider organizations negotiate prices with payers, but one side often has a disproportionate influence, and what individual patients pay depends on their insurance, while providers lack the means to easily account for the differences.

By using technology and building more flexibility into collections, provider organizations can reduce their reliance on paper statements and bill collectors, speed payments, and reduce administrative costs. To interact effectively with patients, real-time adjudication and point-of-service collections with tangible and effective follow-up strategies are imperative.

Make it easy to pay. Patients have different expectations, practices, and preferences regarding how they pay their healthcare bills. A small technology investment can bring more flexibility to a provider's collections processes. For example, most practices, hospitals, and billing services already include the option to pay by credit card, but relatively few organizations offer an online payment option at this point.

Many vendors and services—including clearinghouses or practice management systems that are in widespread use—offer online payment portals. An important consideration is whether the portal allows automated monthly debits for payment plans because, with such a feature, organizations need not rely so much on patients remembering to make their payments each month.

Organizations also should consider offering deeper discounts for early payments. Such discounts motivate bargain shoppers and avoid payment procrastination. Moreover, discounted rates for self-pay patients in the range of 25 percent, or even sliding-scale pricing based on a patient's income, can mean the difference between getting paid a portion of usual and customary charges for services and not getting paid at all.

The biggest opportunity to collect from patients comes when they are at the point of service, so providers should make it standard practice to ask for payment and collect while the patients are on site within the organization. Top-performing practices don't just ask *if* a customer would like to pay today; they ask *how*.

Provide support for patient access staff. Collecting payments is a challenging task. It can be quite

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difficult for patient access staff to ask patients they know personally, and who may be very sick and struggling financially, for payment. Organizations therefore should take time to train the patient access team on the best ways to approach a variety of payment scenarios. The scenarios also should be documented, and scripts should be developed that staff can reference. A well-designed script not only ensures consistency for front office and patient access staff, but also can be both helpful and empowering to them.

Investing in training also is important, particularly for patient-facing roles. Provider organizations should evaluate whether their staff-onboarding function is effective or whether accessing external resources, such as on-demand training modules, is warranted. For example, an onboarding best practice is to train patient access staff to work patient assistance programs into the conversation with patients as soon as possible, to provide consistent communication to encourage patients to keep current with payments, and to engage patients from the beginning with reliably accurate information.

Professional associations often are good resources for training, and free or low-cost online training may be offered by one of the organization's vendors.

Engaging Patients as Consumers

Encouraging patients to keep current with payments will be an increasingly important task for providers as patients increasingly take on a consumer mentality while becoming a primary payment source for these organizations. For providers, accomplishing that task will require consistent communication with patients—delivered using text messaging and emails, where possible. Many organizations also underestimate how important engaging patients from the beginning with reliably accurate information is to establishing and maintaining positive relationships with patients. By proactively addressing financial information and solutions regarding payment options, provider organizations can boost transparency and help patients feel more engaged in their care.

A healthy revenue cycle in the age of consumerism begins with patient access management. Flaws and inefficiencies in this critical first step only exacerbate poor cash flow and collections and negatively impact patient satisfaction. With the right technology and human resources, hospitals, health systems, and other provider organizations can side-step avoidable financial disasters and leverage innovative strategies to grow their bottom line. ■

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