Leading hospitals and health systems recognize that enhancing their patient financial communications can boost consumer satisfaction, loyalty and even the bottom line.

By Laura Ramos Hegwer
As patients face greater out-of-pocket costs because of high deductibles or inadequate healthcare coverage in certain markets, leading providers are developing new strategies to share more meaningful price information with consumers. These healthcare organizations recognize that the way in which they communicate with patients about financial obligations has the potential to reinforce or undermine consumers’ clinical experience.

Making price transparency and stronger patient financial communications an organizational priority requires careful planning as well as investments in staff training and technology. Leaders for the three organizations featured here are embracing a consumer-centric approach—and the lessons learned could provide other organizations the needed base with which to implement their own price transparency strategies.

ESTABLISHING A PRESERVICE CENTER
Some organizations are revamping their revenue cycle processes to help patients understand their potential liability upfront, which can help minimize sticker shock.

The MetroHealth System, Cleveland. Akram Boutros, MD, FACHE, president/CEO, has welcomed the industry’s move toward greater price transparency not just because it is the right thing to do, but also because it is a smart business strategy. “For MetroHealth, we have seen multiple data that indicate our prices may be 20 to 30 percent below the market, so we are in favor of making prices more transparent,” Boutros says.

In 2012, the public health system, which serves Cuyahoga County, implemented a new operating model referred to as the preservice center, which shifts some back-end revenue cycle functions to the front end. “We knew that if we could help patients feel better informed and engaged as it relates to their cost-sharing portion prior to the clinical encounter, we had the opportunity to reduce our cost to collect and, ultimately, reduce our bad debt exposure,” says Craig Richmond, senior vice president and CFO.

In designing the preservice center, Richmond and his team aimed to separate the administrative processes from the clinical encounter. “When patients arrive for their care, we want them focused on their care, not on how they are going to pay for their care. We also want them to be seen right away, which improves the patient experience as well as the physician experience because physicians can treat the patient on time,” Richmond says.

How it works: Once an appointment is made, a representative within the preservice center automatically receives the information from the scheduling transaction, and the process of verifying insurance and eligibility information, obtaining preauthorization approvals and determining the patient’s cost-sharing portion begins. Most of this process is automated. If the patient has a significant out-of-pocket responsibility on his or her insurance and benefit plan, then preservice center staff will call the patient to begin the financial education process. “The more you can engage patients upfront in the process, the more they are willing to work with you in addressing their financial obligations,” Richmond says. “Currently, our professionals collect approximately 10 percent of identified patient balances before the clinical encounter. The goal is to provide a

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STEVE A. PURVES, FACHE
MARICOPA INTEGRATED HEALTH SYSTEM
positive patient experience and to promote early and open communication with our patients about their financial situation. Collecting the financial obligation prior to the clinical encounter is just a bonus.”

Prior to the clinical encounter, preservice center representatives assist the patients with their financial situation, which includes developing reasonable payment plans or enrolling patients in the appropriate federal, state or local financial assistance programs (approximately half of MetroHealth’s patients are on Medicaid and 5 percent are self-pay). Following the launch of its preservice center, MetroHealth made significant changes to its own financial assistance program. The organization now offers 100 percent coverage to county residents who earn up to 300 percent of the federal poverty level.

The results are impressive: From 2012 to 2014, MetroHealth improved its insurance verification and preauthorization rates by several percentage points. These improvements translated to 22 percent fewer avoidable denials and a 23 percent decrease in their cost to collect, which added approximately $5 million to the bottom line.

MetroHealth also has seen its self-pay collections improve. In 2012, self-pay collections comprised approximately 2.9 percent of the organization’s self-pay gross revenue. That amount rose to 4.2 percent in 2013 and 6.3 percent in 2014. At the same time, revenue cycle professionals now receive fewer calls regarding billing questions or the patient's inability to pay, Richmond says. The team also has seen an uptick in positive letters and comments from patients who are satisfied with how the health system has communicated with them on financial matters.

Leaders at MetroHealth credit the preservice center and the adoption of nationally recognized best practices with their success. The organization was first in the nation to adopt the Healthcare Financial Management Association’s Patient Review your chargemaster regularly. Every other year, Henry County Health Center hires an outside firm to work with its clinical departments to identify any issues and realign prices as needed. “Having an outside firm review the chargemaster ensures HCHC leaders are aware of and understand the basis of their charges,” says Robb M. Gardner, president/CEO, HCHC, and an ACHE Member. “Second, the firm provides an in-depth review so we can understand further how our costs relate to our charges. The more we are aware of how and why the chargemaster is structured, the better we will be able to communicate with our patients about the costs of the services they are to receive.”

Listen to your community. All organizations in this article redesigned their bills or other patient financial communications using consumer feedback. HCHC revamped its financial statements after members of its community advisory groups noted when their bills were difficult to understand.

Certify your staff. HCHC requires all of its revenue cycle specialists to be certified by the American Association of Healthcare Administrative Management and the Healthcare Financial Management Association. This is true for its vendors as well. The organization hired an outside firm to handle all A/R functions for its self-pay population, and all of the vendors’ staff are dual-certified. “We hold our

7 STRATEGIES FOR IMPROVING TRANSPARENCY AND PATIENT FINANCIAL COMMUNICATIONS

CEOs, CFOs and other healthcare executives should consider the following lessons learned about price transparency from these leading organizations.

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Financial Communications Best Practices, which offer general guidance on improving patient financial communications and specific recommendations for discussing financial issues with patients in the ED, at the time of service outside the ED and prior to service.

About a year ago, MetroHealth moved to a consolidated patient financial statement that includes hospital and professional charges. Patients can find a sample of their bill—which was developed using feedback from a patient focus group—on the organization’s website. A price list that contains room and board charges, and services in the ED, operating room, delivery room, radiology and cardiology, labs, physical therapy, occupational therapy and respiratory therapy departments also can be found on the website.

Boutros says he believes the industry needs to prepare for more widespread adoption of online cost calculators and other comparative tools that review price and quality. Currently, MetroHealth’s website includes links to the websites of several payers that offer cost estimation tools for patients. Organization leaders are considering adding comparison tools directly to the website in the near future. For Boutros, this is one way his organization can stay ahead of the consumerism trend, even if this trend has been somewhat slow to transform his market. “So far, we’ve seen very little impact on the Cleveland market from high deductibles and consumer selection based on the Triple Aim or value,” Boutros says. “But if we look out to the next couple of years, this will be a major issue for providers.”

EMBRACING PATIENT-FRIENDLY BILLING

Some organizations are making simple changes to their billing process and embracing consumerism to improve patient financial communications.

Henry County Health Center, Mount Pleasant, Iowa.

This 25-bed critical access hospital with an attached 49-bed long-term care facility is debunking the myth that innovation only happens in the big cities and suburbs.
In 2008, the health center was one of the first adopters of the consumer-centric principles set forth in HFMA’s Patient-Friendly Billing Project. Since then, the organization made its bills easier to read, replacing “diagnostic imaging” with “X-ray” to simplify language. The health center also bundles medical and surgical supply charges with room and procedure rates, so patients do not see individual charges for such things as needles or gauze.

“We’ve done away with all supply charges, even in the OR, except for implants,” says CFO David J. Muhs, FHFMA. “If a patient comes in for a colonoscopy, he or she will receive the same charge as other colonoscopy patients, no matter what supplies were used.”

Like other Iowa hospitals, HCHC posts a link on its website to Iowa Hospital Charges Compare, a site that allows patients to compare hospital charges for inpatient and outpatient services by city and facility. HCHC’s website also links to Medicare Hospital Compare, which provides consumers with the ability to view patient experience and quality data on HCHC and other hospitals in the vicinity.

“Having a jumpstart on improved patient financial communications and transparency has helped HCHC prepare for increased consumerism in its market, says Robb M. Gardner, president/CEO and an ACHE Member. “People with high-deductible plans may have deductibles as high as $5,000 or $6,000, which is higher than even just three or four years ago,” Gardner says. “People are being more selective about their elective procedures and starting to ask about their own cost.”

Currently, 5 percent of HCHC patients are self-pay. For the past six months, staff have provided cost estimates to self-pay patients before they come in for a high-cost elective service such as a sleep study. “We have only had two patients decide to postpone their test until their deductible is met,” says Sara J. McClure, CRCS-I, CRCS-P, patient financial services director. “But all patients really

### Price Transparency Initiative Helps Improve Satisfaction and Cash Flow at Henry County Health Center

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<th>Average HCAHPS Score for “Would You Recommend This Hospital to Friends and Family” Has Increased</th>
<th>Days in Accounts Receivable Decreased</th>
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<td>Jan–April 2013 = 52.8 percent</td>
<td>April 2002: 110 days (start of the patient-friendly initiatives)</td>
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<td>Jan–April 2015 = 71.2 percent</td>
<td>April 2011: 42.3 days</td>
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<td>April 2015: 36.9 days</td>
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Since implementing patient-friendly billing, Henry County Health Center in Iowa has realized improvements in its patient experience scores as well as its cash flow.

**Source:** Henry County Health Center.
appreciate knowing what it will cost.” At the point of service, staff will work with self-pay patients to develop payment plans or enroll them in Iowa’s Medicaid program or patient assistance programs, if they are eligible.

HCHC began stepping up these efforts with self-pay patients in July, thanks to a new patient eligibility and price estimator tool that allows patient financial services staff to provide real-time, out-of-pocket cost information to patients. Currently, staff are focusing on self-pay patients interested in surgery or high-dollar radiology services. Eventually, leaders at HCHC plan to provide estimates on the patient’s out-of-pocket costs for all services provided at the hospital.

So far, the organization is reaping the benefits of its efforts to improve patient financial communications. HCHC has boosted its average HCAHPS score on the “Would you recommend this hospital to your friends and family” question by 18 percent. Better patient financial communication and other revenue cycle changes also have improved cash flow. Back in 2002, the organization’s days in accounts receivable had climbed to 110. Today, A/R days are down to 36.9. “It goes to show that you can be nimble and progressive on these issues, even at a community access hospital,” Gardner says.

HELPING THE MOST VULNERABLE PATIENTS

Despite Medicaid expansion, many safety net providers still have patients who do not meet the qualifications for coverage. Offering estimates, sliding fee scales and package prices can help these patients manage their finances.

Maricopa Integrated Health System, Phoenix

Arizona’s only public safety net health system has been at the forefront of price transparency. “We believe we need to lead the way because our patients are often uninsured or underinsured, and they are looking for services they can afford,” says CEO Steve A. Purves, FACHE.
Sixty percent of MIHS’ population is on Medicaid, while 15 to 20 percent remain uninsured. Although the state expanded the Medicaid program and defaulted to a federally run exchange, many patients still struggle with financial insecurities. “We are still seeing a high level of self-pay patients who are in the cracks because they don’t fit into a program where they can get coverage,” Purves says.

Since March 2013, the organization has published self-pay prices for its most common inpatient and outpatient procedures on its website. Health system leaders began by posting self-pay prices for the 10 most frequent inpatient and outpatient procedures. Today, the list has expanded to include the top 50 inpatient and outpatient procedures, as required by the state since Jan. 1, 2014. This section of MIHS’ website has had healthy traffic: Since Jan. 1, 2015, more than 6,000 unique visitors have visited the site, and they typically spend three to four minutes reviewing the prices.

To develop the self-pay prices, a multidisciplinary task force worked for four months on the project. The task force included physicians from MIHS’ medical group, the CMO and department chairs. “To develop the self-pay prices, we needed to understand what the hospital-based physicians would charge,” Purves says. “We also had to consider how factors like complications and OR time could affect prices.”

MIHS includes 13 federally qualified health centers that must offer a sliding fee schedule to county residents. The task force developed the sliding scale with payment categories based on the federal poverty level. (Patients who live outside the county are eligible to receive an uninsured discount.) It also revamped the health system’s charity care policy, which is published on its website. Consumers on the health system’s governing council vetted both the sliding fee scale and charity care policy.

Leaders at MIHS continue to refine their price transparency initiatives so the information they provide to consumers is more actionable. “Ultimately, price transparency means providing patients with what they need to understand the total cost of care—not just what they are going to pay for the procedure itself, but also the physician fees, medication and follow-up,” Purves says. As an example, MIHS created a single bundled payment for maternity patients who reside in Maricopa County. Residents at any income level can receive complete prenatal maternal care at one price and earn a discount if they pay in full at the time they sign up.

Without such bundles, conveying the total cost of care is difficult. Organizations need to have one-on-one conversations with patients and maintain consistent communications across the organization, Purves says. That is part of the reason why MIHS plans to centralize its registration personnel. “At the end of the day, you need to have an infrastructure so if patients want to understand their total cost of care, they can talk to someone who will spend time discussing their benefits, their deductible and so forth,” Purves says.

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