redesigning patient responsibility for a new era

As patients assume responsibility for a growing proportion of their healthcare costs, providers face a financial burden from having to write off costs for patients who cannot afford to pay their share. Providers can benefit from developing programs to alleviate this burden.

According to an annual survey conducted by Kaiser Family Foundation and Health Research & Educational Trust, the percentage of workers enrolled in a plan with a general annual deductible of $1,000 or more has risen dramatically in the past decade, from 10 percent in 2006 to 41 percent in 2014. The average deductible for single coverage is $1,217, up from $826 in 2009. More people are getting health coverage under the Affordable Care Act (ACA), but as of April 2014, 85 percent of individuals who had signed up through exchanges selected Bronze or Silver plans, which offer lower coverage.

This situation creates a complex set of trends that translates into a rising tide of financial responsibility for providers. In the second quarter of 2014, U.S. hospitals wrote off 5.93 percent of their total gross revenue under their financial assistance programs, compared with 5.09 percent in the first quarter of 2014. Of the 5.93 percent written off as uncollectible, 3.03 percent was for bad debt.

Ochsner Health System, the largest health system in the Gulf South, followed the same market trends. In 2013, more than 60 percent of the financial burden at Ochsner came from residual balances, with more than 70 percent of the residual bad debt coming from commercial accounts. The same year, the Ochsner patient portion of total expected liability for insured accounts was 8.4 percent. The average collection rate for such patient balances is only 46 percent, which increases pressure on the overall margin for insured revenues as more of the burden shifts to the patient. With rising patient responsibility, Ochsner’s leaders realized that previous approaches would no longer be sufficient.

Notes:

Like other high-performing healthcare groups, Ochsner had implemented many of the common approaches for improving patient payment processes and financial stability, as shown in the exhibit below. Through these initiatives, Ochsner achieved Healthcare Business Insights (HBI) top-quartile performance for preservice and point-of-service cash collections as a percentage of net revenue, with bad debt as a percentage of gross revenue decreasing from 2.2 to 1.7 percent from 2011 to 2013.

Despite a solid foundation and above-average performance, Ochsner’s leaders recognized the need to take steps to position the organization for success in the face of increasing market pressures. Accordingly, their 2014 strategic plan was aimed at further reducing financial risk as a percentage of revenue.

**A Comprehensive Framework for a New Era**

In July 2014, Ochsner launched an initiative to enhance preservice financial clearance processes, increase the culture of responsibility, improve patient engagement and satisfaction with the patient financial services process, and support the organization’s financial viability as it fulfills its mission.

Ochsner’s leaders recognized that they needed a systemwide approach to success and would need to engage in a process of developing support around the initiative. To this end, they launched a core work group of 10 revenue cycle leaders responsible for designing and implementing the process enhancements and measuring success. The selected leaders brought expertise from across the revenue cycle including scheduling, preregistration, insurance verification, financial counseling, eligibility counseling, registration, post-service collections, and denials. Ochsner’s leaders also engaged an advisory team comprising 12 financial, operational, and physician leaders across the system to provide input on the design and communication needs for ensuring adoption across the system. This diverse group of hospital CEOs and CFOs, clinical department administrators, and physician leaders not only provided valuable insights to the policy and processes, but also served as champions for rolling out the new approach across the system.

Collectively, the work group and advisory team established four key goals for the initiative.

- **Foster loyalty by improving patient experience.** Ochsner needed to ensure all patients would receive clear, consistent, and timely communication that would enable them to make fully informed decisions about their care.

- **Deliver essential financial assistance to the community.** The focus here would be to design Ochsner’s financial assistance program to proactively and consistently offer assistance to those who truly cannot pay.

- **Achieve financial stability.** Ochsner would need to establish appropriate patient payment processes to achieve stability in financial risk.

- **Improve physician satisfaction by enhancing quality.** Ochsner would focus on better meeting physicians’ needs through more timely financial service delivery (e.g., increasing lead days).

### OCHSNER’S APPROACHES FOR IMPROVING PATIENT PAYMENT PROCESSES/FINANCIAL STABILITY

<table>
<thead>
<tr>
<th>Improvement Initiatives</th>
<th>Year Implemented</th>
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<tbody>
<tr>
<td>• Re-emphasized point-of-service collection of copayments and deductibles</td>
<td>2010</td>
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<tr>
<td>• Preservice clearance unit collection on balances prior to service</td>
<td>2011</td>
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<tr>
<td>• Presumptive financial assistance prior to bad-debt write-off</td>
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<tr>
<td>• Interest-free payment plans</td>
<td>2012</td>
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<tr>
<td>• Single patient statements for hospital and physician services</td>
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<tr>
<td>• Enhanced and insourced medical cost assistance/eligibility program, including assisting patients with Affordable Care Act health insurance enrollment</td>
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<tr>
<td>• Emergency department discharge desks</td>
<td>2013</td>
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<tr>
<td>• Patient estimator upgraded to include professional balances and coinsurance</td>
<td></td>
</tr>
<tr>
<td>• Point-of-service financial counselors placed in high-cost areas</td>
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Designing a New Approach to Patient Responsibility

Ochsner designed a new approach to patient-responsibility revenue focused on tailoring liability requirements and patient interactions to align with financial risk. To make patient counseling about financial options more effective, the revenue cycle team created a more finely tuned financial clearance process with an expanded culture of responsibility. To address the critical concern of ensuring that the process would not hinder or delay urgent clinical care, the work group incorporated exceptions for medically urgent services into the approach.

Ochsner’s new financial clearance process involves an evaluation of the financial risk associated with each upcoming visit. To provide a basis for such evaluations, the work group defined five financial risk categories for scheduled services that would trigger the financial clearance process, based on an in-depth analysis of the sources of bad debt by patient type, payer source, balance threshold, and propensity to pay. The risk categories include considerations such as no insurance coverage, high expected out-of-pocket cost, high outstanding balance for previous services, and missing authorization. As a risk threshold, the clearance process targets the top 30 percent of accounts driving about 70 percent of the outpatient financial risk. Both professional and hospital balances are considered under the policy.

All scheduled accounts with an expected liability flow to the financial call center to inform patients of their upcoming liability and to request payment. But for those flagged as involving risk, the Ochsner team member is prompted to have a different conversation with the patient regarding his or her options and requirements. Full payment is requested, but minimum deposits are required for expected and outstanding liabilities, with tiered thresholds based on the amount due. For those who cannot pay, interest-free loans and financial assistance are offered. Application and qualification for financial assistance are confirmed prior to service. Patients who may qualify for Medicaid or other coverage are connected to an eligibility counselor to complete the appropriate applications.

If a patient cannot comply with any of the above options, the service may be rescheduled to allow the patient additional time to do so. Prior to a potential reschedule, the referring physician is consulted to determine the urgency status of the service. If the physician deems the service urgent, the appointment proceeds as planned even if financial requirements are not met. For nonurgent services, the scheduling team works with the patient to reschedule the service for a future date that will allow time to complete the financial obligations.

To support the new process, the work group created scripting and training for patient and physician office staff interactions. The group increased the insurance verification lead time to more than seven days so preservice collections teams would have sufficient time to engage with patients. The group also implemented new flags in the health information system (HIS) to identify the at-risk accounts and track outcomes, created new reports in the HIS and a financial clearance scorecard to measure daily and weekly volumes and outcomes, and defined escalation procedures and scripting should any physician or patient complaints arise.

Overcoming Resistance and Encouraging Buy-In

The work group was responsible for implementing the new approach but needed to engage clinical and operational stakeholders to ensure success and sustainability. Historically, many clinicians and operations staff were not attuned to the financial aspects of providing care and sometimes created mixed messages for patients and misunderstandings among revenue cycle, clinicians, and clinical operations staff. With assistance from the advisory team, the work group designed and launched a communication plan to obtain sponsorship from key stakeholders. The group began by identifying key cascading messages that explained the initiative’s rationale and objectives, what would be changing, and where the work group needed support.
CASE STUDY

Four Critical Success Factors for Implementing Effective Financial Clearance

Ochsner Health System in New Orleans attributes its success in developing an effective financial clearance process for its patients to the following four factors.

Executive support. Ochsner leadership championed the new policy so it could be developed and implemented systemwide. Project leaders engaged a cross-functional group of influential stakeholders to advise on new policy development and help sponsor the initiative.

A solid foundational process. The existing culture of up-front collections processes and tools helped set the stage for enhancing patient payment. In particular, strong insurance verification performance and lead days were needed to support new processes and allow enough time to engage with patients.

A well-executed communication plan. The work group successfully identified stakeholders, key messages, and best forums for delivery of those messages, and partnered with executives and physician leaders to deliver the messages through appropriate channels. The work group leveraged successes during the pilot to gain buy-in for broader implementation.

Measurement and accountability. Implementation included four weeks of staff shadowing after initial training to reinforce collections scripting. The work group measured and distributed key metrics (e.g., service deferral rate) to drive performance improvement, dispel rumors, and ensure broad support from physicians. The group also developed service-level agreements between revenue cycle and operations regarding expectations for communication, minimizing add-ons, and other factors.

The work group partnered with executives and advisory team members to deliver key messages to stakeholders through existing physician and operational leadership forums, and then reinforced the messages through email reminders and internal newsletters. The group also provided answers to frequently asked questions and resources for more information.

Given the large culture shift and sensitivity around potential deferral of service, the work group chose to pilot the new approach in two service areas (surgery and radiology) at the Ochsner flagship facility. The four-week pilot included shadowing preservice and point-of-service staff to reinforce new scripting and processes; conducting daily huddles with key work group members to address staff questions and unanticipated scenarios; and refining processes, scripts, training, system flags, and key metrics. The work group leveraged the successes of the pilot to build sponsorship as the process was rolled out systemwide over a three-month period.

Tracking Results

As with any new process, measuring the results was critical for driving performance improvement. The work group developed and distributed a weekly scorecard of key metrics including preservice lead days for scheduled accounts, financial clearance rate, referrals and patient self-cancellations, urgency exceptions, and collection totals. The group was able to show early successes with a clearance rate of more than 95 percent, few deferrals and patient self-cancellations, and improvement in preservice and point-of-service collections.

Although early results were strong, analysis of the data disclosed that add-on accounts (services scheduled less than 48 hours in advance) were the largest barrier for financial clearance. The group used the data to reach out to the referring physicians’ offices with the highest volumes and educate them about the new processes for financial clearance.

The work group also used reporting to track the volume of urgency exceptions that were not cleared by physicians, to verify that this exception was being used correctly. At the advice of the advisory team, the work group shared these trends on a monthly basis with system and facility executives as well as physician leaders to address compliance issues with individual physicians. This approach helped to maintain physician involvement, dispel rumors and unfavorable anecdotes related to deferrals, and ensure sustainability of the new processes.

For example, one outpatient department experienced a dip in its patient volumes exactly when the new process went live. This department
believed the new process could be a contributing factor, but a closer look at the data showed the timing was simply a coincidence and another, unrelated issue needed to be addressed. The work group heavily publicized that the deferral rate was less than 1 percent to prevent any misperception that patients were frequently being deferred. Without this kind of data tracking and communication, misunderstandings could have undermined buy-in and put the entire initiative at risk.

Positioned for the Future
With a highly positive response from patients, physicians, and staff, Ochsner’s initiative has been on pace to achieve or exceed all of the defined objectives. Specific successes after more than nine months of run time with the new process include:

- A financial clearance success rate over 95 percent
- Less than 1 percent of services deferred or self-cancelled
- A 36 percent increase in preservice and point-of-service collections over the same period in the previous year, well exceeding the HBI top-quartile benchmark for preservice and point-of-service collections as a percentage of net revenue
- A 6.5-percentage-point increase in patient cash as a percentage of total patient liability
- An increase in scheduled-account lead days to more than seven

The comprehensive framework for the policy, scripting, and training, as well as systemwide support, has enabled the preservice and point-of-service collections teams to have more effective conversations with patients about their liabilities and their options. Patients are better educated about their financial responsibilities and better able to make informed decisions about their care, resulting in stronger collections and a strong avoidance of the need to defer or cancel a patient’s service. Meanwhile, patients who truly do not have the funds are provided interest-free loans or full financial assistance. Physicians and operational leaders have created a partnership with the revenue cycle leadership. As a side benefit, the improvement in insurance verification lead days has helped improve the physician and patient experience.

Ochsner is now better positioned to address the rise in patient financial responsibility, remain financially strong, and continue its mission of delivering premier health services for the communities it serves.

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