Consumer Financial Liabilities in the Health Care Setting: Three Comparative Case Studies

by

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Abstract

A recent Kaiser Family Foundation study found that consumer out-of-pocket health care expense increased 77% from 2004 to 2014 while wages only increased 32% over the same time period.[1] This supports the prediction that the consumer cost of health care will only continue to increase over time. The larger question is who will be responsible for paying those rising costs, consumers, employers, payers or the government? An important question providers are asking is "Will I be able to collect payments that should be the consumer's responsibility? Recently the cost shift has been directed at the consumer through increased co-insurance and deductibles.[1] In 2012, consumer out-of-pocket (OOP) expenses were estimated at $320.2 billion dollars or just over 10% of total health care expenditures.[2] It is unknown if this number will continue to grow or decline with the dynamic changes in health care.

Historically collecting out-of-pocket consumer expenses (co-payments, co-insurance and deductibles) was not a top priority for providers, although payers required them to make a "good faith" effort. For providers the primary focus was on collecting third-party (payer) payments which represented the primary source of expected reimbursement. Providers, however, are recognizing that the financial landscape has shifted as their margins shrink and consumers become responsible for a significant portion of their expected reimbursement. This dissertation will review and compare three case studies with very similar interventions to test a proposed model for improving front-end collections (FEC) of out-of-pocket expenses. It will provide empirical results that can be disseminated throughout the field. It will also attempt to identify other factors that impact the success of front-end collection efforts. Many hospitals, health

systems and physician practices have already started to prioritize front-end collections to enhance customer service and improve financial viability because of the market changes. Through the implementation of five primary performance improvement interventions, these case studies will provide insight into the following questions:

- Did these interventions have a positive impact on front-end collections?
- How much of an impact on front-end collections did all the interventions have collectively?
- Did one intervention have more of an impact than another on front-end collections?
- What factors were associated with successful interventions?

The five interventions are focused on improving front-end collections (out-of-pocket consumer expenses) while educating consumers on their financial responsibility for health care. Results from all three case studies demonstrate that front-end collections were enhanced as a percent of net patient revenue as evaluated by reviewing the 12-month average for the baseline period compared to the intervention period. All three case studies experienced an increase in FEC when comparing the baseline to intervention periods. Net collections from baseline to intervention periods increased for all three case study organizations. Gloria Medical Center realized an increase of 43%, Fitzgerald Community Hospital realized the largest increase at 196% and Byrne Hospital achieved a 129% increase. All three organizations studied have experienced a growing consumer population covered by high-deductible health plans; these types of plans are rapidly becoming more of the norm for health insurance products selected by consumers. The major component of high-deductible health plans is as the name implies, higher

deductibles which equates to additional out-of-pocket expenses for consumers and greater financial responsibility for their care.

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Abbreviations

SP – Self-pay, or patients who do not have insurance
OPP – Out-of-pocket cost
ACA – Patient Protection and Affordable Care Act
SPAI – Self-pay after insurance, patient balances after insurance has paid
HDHP – High-deductible health plans
POS – Point-of-service collections
FEC – Front-end collections
HFMA – Healthcare Financial Management Association
NPR – Net Patient Revenue
PLE – Patient Liability Estimator

Chapter 1: Introduction

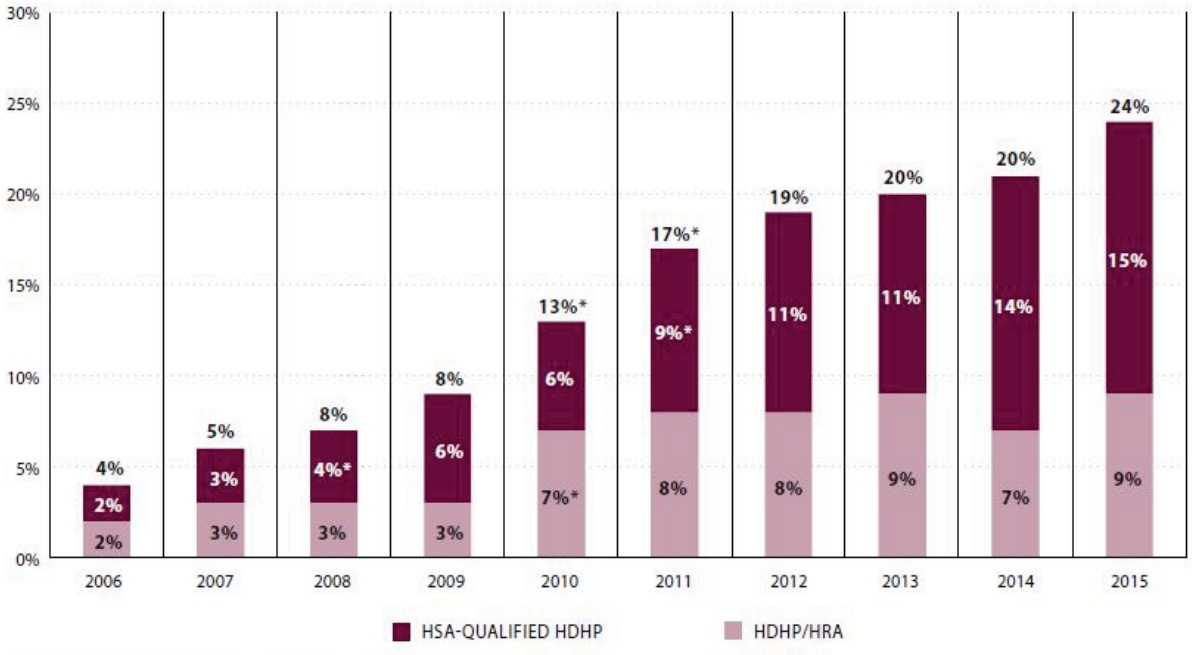
Uncompensated care, charity care and bad debt, have been on an upward trend over the last 30 years reaching $45.9 billion dollars in 2012 or 6.1% of total registered community hospitals' expenses as reported by the American Hospital Association.[3] In 2014, the total for uncompensated care, at $42.8 billion, declined for the first time in three decades.[4] The question remains if the downward trend will continue. The increase in the insured population resulting from the Affordable Care Act was one of the primary factors; 501(r) regulations released by the Internal Revenue Service which set charity care standards, and provider efforts to collect patient liabilities also contributed to the reduction of uncompensated care.

As more of the cost of health care is transferred to the patient in the form of out-of-pocket liabilities, it is expected that the amount of uncompensated care will return to its upward trend. Self-pay (SP) patients, otherwise known as the uninsured, make up the largest portion of uncompensated care for providers historically. The implementation of the Affordable Care Act (ACA) has begun to decrease the total uninsured in large part due to the Marketplace Exchange and the expansion of Medicaid in a number of states. Another less visible group, known in the industry as self-pay after insurance (SPAI) contributes to providers' bad debt. This group represents consumers who have insurance but do not pay their out-of-pocket financial obligations after receiving care. This presents a significant challenge and opportunity for organizations to collect their financial liabilities up-front depending on the source of their health insurance coverage.

The growing cost of health care services has pushed payers to develop more affordable coverage options for purchasers of group health coverage that reduce the

premium expense by reducing the risk associated with payments for medical expenses. For example, payers created the high-deductible health plan or HDHP's. High-deductible plans overtime will decrease provider revenue and increase bad debt if the out-of-pocket balance, which is the consumer responsibility, is left uncollected. Figure 1 below highlights the growth trajectory of HDHP's over a ten-year period with continued growth projected as additional health care expense is shifted to the consumer and employers are unable or unwilling to absorb the additional health insurance premium expense. Although HDHP's are on the rise and have lower premiums than traditional plans, it was still reported that premiums paid by employees for both single and family insurance plans increased by 4% when comparing 2014 to 2015.

Figure 1 - Trend in High-deductible Health Plans 2006 to 2015[5]



*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

One effective strategy that providers have engaged to curb growing bad debt is the implementation of a robust front-end collection process. Part of this approach

includes appropriately educating and informing consumers about the cost of health care. To further expand on what the education of consumers entails, providers need to enhance their ability to identify what portion of the cost will be the consumer's total share for the services provided and explain basic insurance terminology. Insurance is complex and before consumers can make thoughtful decisions about where and what type of care to receive they first need to understand what portion of the total cost they will be responsible to cover for the care they receive.

Front-end collections or, as often referred to in the literature, Point-of-Service (POS) collections, is a well-established indicator used by health care organizations to measure their ability to collect a consumers out-of-pocket liability prior to or at the time of service.

The Healthcare Financial Management Association (HFMA), the leading association for health care finance and revenue cycle managers, has published an industry formula for point-of-service collections (see Appendix I). The formula is:

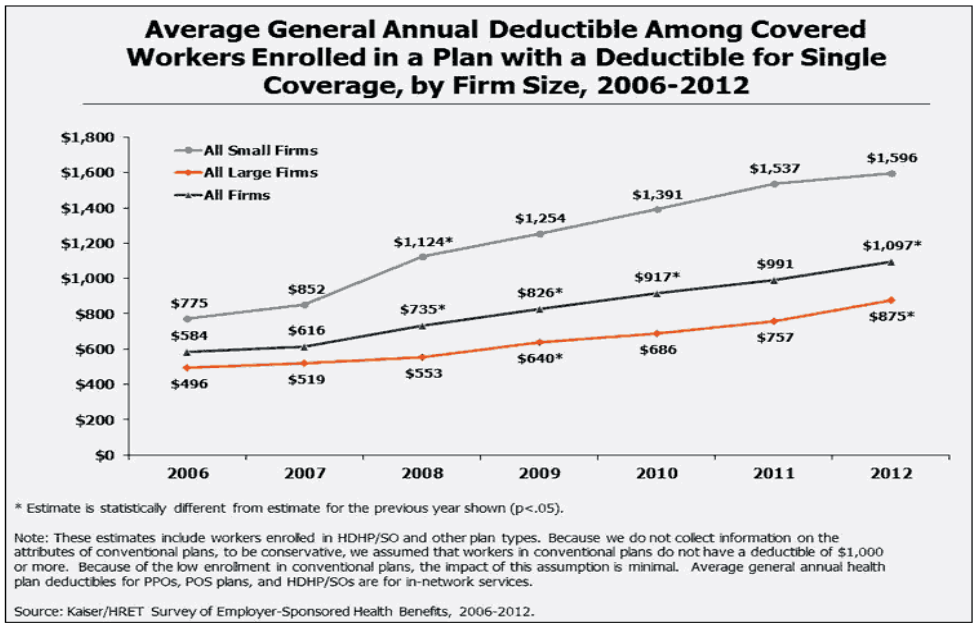
Numerator: POS payments
Denominator: Total patient cash collected

This measure provides insight into multiple indicators and primarily identifies how well the provider performs on collecting from patients up-front. Another industry measure commonly used is point-of-service collections as a percent of net patient revenue, which consists of POS payments divided by net patient revenue for the same period. Consumer communication and education, bad debt management, and financial advocacy are other operational influencers of front-end collections within the organization. Although a well-established measure in the industry, a considerable amount of health care providers' front end collections are minimal in relation to the total opportunity. This lack of collecting

consumer's financial responsibility may create a negative impact on providers overall financial performance as more is owed directly by consumers. The level of structure, process and technology in place to support the collection of out-of-pocket liabilities varies by provider and each of these can contribute to the overall success or failure of front-end collections.[6,7]

As high-deductible plans become more prevalent and employers shift more of the health care financial responsibility to consumers, providers will need to direct more resources to the collection of consumer liabilities. Figure 2 below shows the two-fold growth in consumer deductibles over a 7-year time period and the additional expense consumers have to pay out-of-pocket for health care services. This trend should prompt providers to focus on front-end collection efforts. However, deductibles only account for a portion of the overall total out-of-pocket expenditures for which consumers are responsible. In addition, they are also responsible for co-payments and co-insurance in addition to monthly insurance premiums.

Figure 2 - Average Deductible Change in Large, Small and All Firms from 2006 to 2012



Three organizational case studies were reviewed in this paper, each one being evaluated using a multi-case study format with evaluation criteria based on the Malcolm Baldrige Quality Award and the implementation of five key interventions.

These are the five primary interventions that were introduced at each of the case study locations:

1. Educate and provide scripting and training for front-end staff members.
2. Develop front-end collection goals by department (individually if possible) and a monitoring tool to track progress daily, weekly and monthly.
3. Create or enhance the organization's consumer educational material (consumer liability brochures, website enhancements, multimedia material, etc.) to better inform consumers about their out-of-pocket financial responsibility and the payment options that are available.
4. Propose a comprehensive front-end collection staff members incentive program that rewards staff members for achieving collection goals.
5. Develop and implement a patient financial liability estimation tool to enhance the ability of the organization to provide a price estimate of cost and collection target.

Additional detail on how each intervention was implemented will be provided in each case study.

Chapter 2: Literature Review

These key terms will be utilized throughout this thesis.

a. Key Terms

1. **Patient Protection and Affordable Care Act (ACA)** – Federal legislation that was passed in March 2010 to expand health insurance coverage to more of the U.S. population, reduce health care expenditures, and to improve health care quality in the United States. Several federal laws were enacted as part of the ACA, including capping consumer maximum out-of-pocket costs for health care plans on the insurance exchange and websites where individual insurance plans can be purchased. For example, maximum out-of-pocket costs are capped at $6,850 for a single individual and $13,700 for a family.[8]
2. **Charges –** The amount that is charged by a provider for services provided. Charges are loaded in the providers Charge Description Master and are the same for all payers. Providers use a cost plus a margin formula to develop initial charges and are increased yearly or on another frequency based on payer agreements.
3. **Payments –** The amount that is paid to providers by either payers or consumers. Typically an amount less than charges due to discounting or payer negotiated rates.
4. **Out-of-pocket maximum** – The maximum amount a consumer is expected to pay out of pocket through co-insurance and deductibles for health care services in a year as determined by his or her insurance. The Patient Protection and Affordable

Care Act and the Internal Revenue Service (IRS) release limits each year on what the maximum out-of-pocket can be. The two published limits do not align.

5. **Total consumer liability (or total liability) –** This includes the total consumer financial responsibility that a provider should collect for services provided: co-payments, co-insurance and deductible amounts combined. It could also be referred to as out-of-pocket expense.
6. **Front-end Collection (FEC) –** Front-end collection is the collection of co-payments, deductibles and/or co-insurance prior to (pre-service) or at the time services are provided to a consumer.
7. **Co-payment** – The cost-sharing portion of a consumer's bill for health care services, a fixed dollar amount designated by the payer (i.e., insurance company, health plan) that is the consumer's responsibility to pay at each visit or service (also known as "co-pay"). Common co-payment rates are $10 or $20 for an office visit but can escalate up to several hundred dollars for urgent care and emergency department visits. Some payers use a percentage of the bill as a co-pay which makes it difficult for providers to determine at the time of service. Co-payments are typically not applied toward deductibles.
8. **Co-insurance** – The part of the consumer's financial responsibility that is separate from the co-pay. Co-insurance is typically a percentage of the total medical bill that is the consumer's responsibility while the remaining percentage is covered by the insurance carrier. For example, an individual may have 90/10 in-network insurance coverage, meaning the consumer is responsible for 10% of the bill and the insurance carrier will pay 90% after the deductible is met.

9. **Deductible** – The amount the consumer must pay for medical services before the insurance company starts to pay. The insurance company will set a yearly deductible amount that ranges from zero dollars to several thousand. In 2015, the average deducible for an individual coverage plan was $1,318.[9]
10. **HDHP (High-deductible health plan) –** A type of consumer driven health plan (CDHP) that often has higher deductibles and increased cost-sharing with the consumer than a traditional, Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) plan. This type of plan has higher out-of-pocket costs for the consumer in an attempt to influence frequency, level and choice of health care services. In 2016, the IRS defines a HDHP as one that has a maximum out-of-pocket cost of no more than $6,550 for single individuals and $13,100 for families.[10] The minimum deductible can also be no lower than $1,300 for a single individual and $2,600 for a family.[10] Each year these maximums and minimums are increased slightly from the prior year and are released as part of the ACA regulations.

b. What are Front-end Collections (FEC)?

The term front-end collections is not widely recognized or used in the literature. Terms more commonly used in the literature are point-of-service collections (POS), time-of-service collections (TOS), patient liability, co-payment or out-of-pocket liability. Broadly defined, the process of front-end collections is the collection of a consumer's out-of-pocket liability prior to insurance adjudication (processing and payment) of the claim. This includes the collection of co-payments, deductibles and/or co-insurance depending on the consumer's insurance plan.

Published literature on the collection of a patient's out-of-pocket liability is limited, with the majority being PowerPoint presentations, brief case study write-ups and short articles identifying how organizations improved collections. A multi-case study to determine what interventions actually impact collection efforts has not been identified during a review of the literature. A goal of this research is to contribute to the limited literature by providing a model that assesses the effectiveness of specific interventions and their respective impact on front-end-collections and attempts to answer the question: "What interventions have a positive impact on FEC?"

Three case studies in a multi-case design have been conducted to determine the generalizability of the interventions. One common theme identified in the literature is the education of patients on their costs of health care, usually in the form of an estimate for services provided, and at a minimum attempting to increase price transparency.[6,11-13] In an effort to enhance price transparency to support consumers as they shop for care, the ACA included language that requires hospitals to disclose charges and many states have gone one step further by requiring hospitals to publish the most common charges for services provided and be able to provide consumer price estimates for care.[14,15] Provider "charges" are arbitrary when considering the "price" or the "payment" consumers pay. Price refers to the out-of-pocket expense or cost consumers pay for a specific service and is equal to payment. Providing patients with accurate estimates of their out-of-pocket costs historically has been a complex task for hospitals.[6] Providing estimates for consumers in other industries is common practice; take for example the auto repair industry. Estimates are provided and expected by consumers when seeking automotive repairs.

Price transparency in health care is still in the infancy stage, which has limited consumer's ability to shop around or know ahead of time what the cost of care is going to be. In the most recent publication from The Institute of Medicine, *Best Care at Lower Costs,* it was estimated that $105 billion dollars a year in health care waste is related to non-competitive pricing.[16] The lack of transparency contributes to that waste and if consumers are unaware of costs; it makes it difficult to shop for the best value.

c. Impact of FEC

To highlight the impact of front-end collections, three different perspectives will be examined: provider, consumer and payer. These are also the three primary constituents in the health care industry. The numerous positive and negative effects of FECs will also be discussed from each perspective. A fourth perspective, societal, is also apparent in all three and can have far reaching effects for consumers and their overall health. The increase in consumer financial responsibility puts an additional burden on Americans who are already live pay check to pay check. One major medical procedure or on-going prescription medications can create thousands of dollars in medical expense for consumers. Americans are finding it more challenging to pay for medical bills as they are required to cover more of the cost of their medical care. In 2012, one in four American reported paying for medical bill was a burden.[17] Research tells us that providers who are able to provide consumers with estimates of out-of-pocket liabilities, provide education to consumers on their financial responsibility and ask for those liabilities in a timely fashion have an increased collections and enhanced the patient experience.[6,13]

Consumer out-of-pocket liabilities owed to providers were expected to increase by 68% over a 5-year span from $250 billion (2009) to $420 billion (2015).[18] In contrast, payers are expected to decrease their payments to providers once adjusted for inflation. Providers will need to augment current collection practices and develop processes that are more consumer friendly and transparent. There are numerous financial implications of front-end collections on providers. Positive impacts that affect the bottom line are cash acceleration and reductions in bad debt to name a few but there are also soft benefits, for example, improved customer service. Done successfully, FECs can have a positive impact both for the patient and the provider. Table 1 below identifies several examples of the outcomes that can be related to front-end collections.

Table 1 - Impact of Front-end Collections on Providers and Consumers

Impact on the Provider	Impact on the Consumer
Increase in cash flow	Education of cost and financial responsibility
Reduction in bad debt write-offs	Improved price transparency
Improved customer service	Shorter wait time (pre-service collection)
Better identification of consumers who need financial assistance	Better informed about cost of care
Lower cost to collect	Financial assistance determined prior to services
Reduced billing and collection activities/cost	Financial payment options discussed, reducing anxiety on paying for medical bills

In 2010, the uninsured rate of non-elderly individuals reached its peak at 18.2 percent in the United States. Since that time and the passing of the Patient Protection and Affordable Care Act (ACA) the uninsured rate has steadily been decreasing with the early 2016 estimate at 11.9%.[19,20] The influx of newly insured patients have obtained coverage though the expansion of Medicaid in select states and through the Marketplace

Insurance Exchanges that were set up as part of the ACA. Some states, like New York, have developed additional coverage options for low income individuals that cover the gap between Medicaid and the Exchange plans offered.

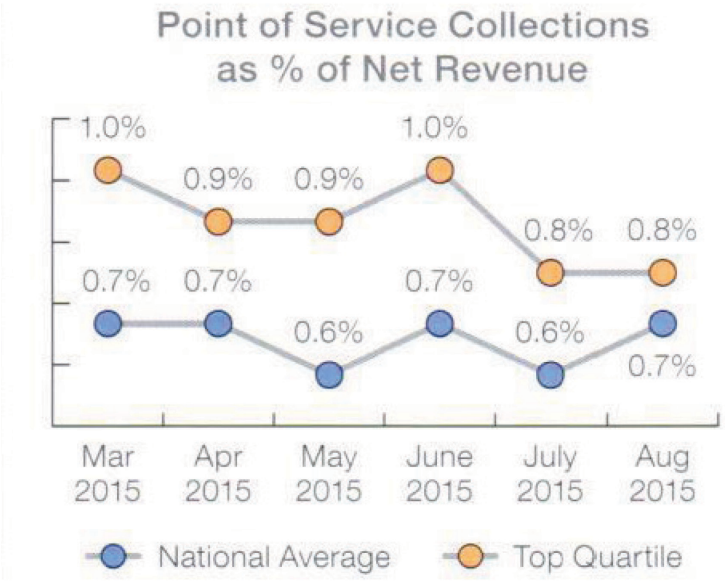
These newly insured consumers financially support the U.S health care system by adding reimbursement that was previously bad debt or charity for hospitals. This flood of insured consumers, with a high proportion of them being covered by HDHP's, also introduces some challenges for providers when trying to collect. It was estimated in early 2016 that 40% of consumers who are covered by a private insurance plan, exchange plan, employer plan or other were enrolled in a HDHP.[20] Medicaid has relatively low or non-existent out-of-pocket costs for consumers. This is not the case for consumers who purchase a high-deductible health plan. As noted earlier, in 2015, the average out-of-pocket cost for a family with a HDHP was a little over $4,300, all of which must be collected by the provider unless the consumer qualifies for financial assistance.[5]

Providers

Payers often require in the contract terms with providers that co-payments are collected at the time of service and that the provider collect any remaining consumer liability after insurance coverage is applied. Some advocate that the collection of co-pays, deductibles and co-insurance prior to or at the time of service should be an industry-wide adopted concept.[21] The reality is that it is not as routine as one would think and in large part because prior to the advent of the consumer-driven health plans (HDPD's and others) providers received the majority of their reimbursement from payers.[22]

Figure 3 below highlights the national average and best practice for collections as a percent of net patient revenue as reported by Healthcare Business Insights.[23] The y-axis represented front-end collections as a percent of net patient revenue (NPR). To put these percentages in perspective, if a 300-bed hospital collects $320 million in net revenue, a high performer in the top quartile would expect to have collected $2.6 million or 0.8% of net revenue in front-end collections yearly.

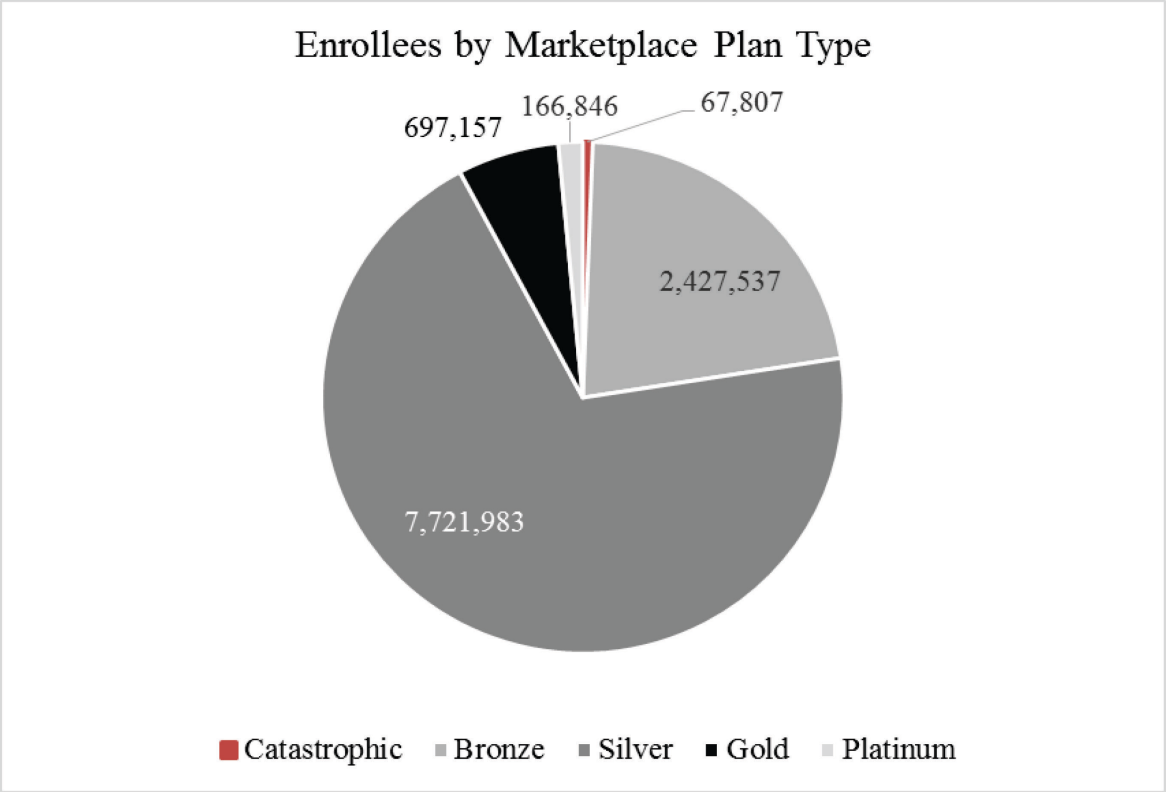
Figure 3 - Point of Service Collections as a % of Net Revenue[23]



Each year the Healthcare Financial Management Association presents MAP Awards, name of the award, to organizations that have participated and achieved a high level of industry Revenue Cycle performance. Of the 14 winners for 2015 the median point-of-services collections was 20.5% using the formula of total point-of-service payments divided by total consumer payments (Appendix I.). This differs from the calculation used in Figure 3, which uses net patient revenue as the denominator. Total consumer payments is a portion of net patient revenue.

The growing cost-sharing to consumers is even more evident in the 2016 maximum out-of-pocket medical expenses for Marketplace Exchange plans, which are $6,550 for a single person and $13,100 for a family.[10] Providers are realizing that HDHP's and additional cost-sharing with the consumer are the "new reality." With nearly one-third of all provider payments being generated from consumer out-of-pocket liabilities, providers will need to evaluate technologies and process improvements to be successful. It is anticipated that a large proportion of the 30 million uninsured individuals who are eligible for insurance coverage under the ACA will select a health plan with a high-deductible or a large portion of cost-sharing risk.[24] The Bronze plan typically has the highest deductible followed by the Silver plan. The Bronze and Silver plans in Figure 4 below constitute over 90% of the total enrollments as of March 2016 with Silver being almost 70% of the total at 10,149,520.[25]

Figure 4 - United States Enrollees Distribution by Marketplace Exchange Plan Type, March 2016 [25]



An inflow of insured consumers should be a win-win-win-win for providers, consumers, health plans and policy makers but it has led to a spike in unpaid medical bills as the newly insured struggle to cover premium costs and large out-of-pocket expenses for care received. Self-pay after insurance is the fastest growing segment of bad debt for providers with one provider organization experiencing 30% growth a year.[11] This is a sign for providers that the time is now to take action and develop a plan to address the self-pay after insurance population.

Negative impacts associated with consumer-driven health plans, or HDHP's, will drive additional pressure on providers to collect from consumers at the beginning of the revenue cycle, which traditionally has been focused on collecting post-care from payers. The growth in these plans has provider organizations scrambling to enhance revenue

cycle processes while at the same time trying to maintain a balance with their loyal consumer base that could be alienated by overly aggressive collections tactics. A new market is being created in the technology sector to assist providers in reinforcing efforts to the front-end of the revenue cycle that will allow them to address the issue of consumer liabilities and the necessity to collect when the consumer presents for care.

Consumers

As previously mentioned, the high-deductible health plan adoption has increased over 100 fold when comparing 2009 HDHP participants to 2014 participants.[26] HDHP's have lower premiums for the same set of services compared to a traditional plan. The lower premium results from the fact that a greater share of the financial risk is borne by the beneficiary, consumer. The lower premium is attractive to individuals from all socioeconomic groups, although there is a misperception that the majority of HDHP plan participants are from low socioeconomic backgrounds.[27] Economic theory suggests shifting more of the cost of health care services to the consumer will increase consumer awareness of the costs of care they receive and will incentivize them to make more informed decisions about the care they seek (location, unnecessary utilization, type of service, and quality).[28] In theory, this approach may reduce health care costs. In reality, consumers do not have access to the necessary information about the price of services, nor do they have access to information to effectively judge quality. The effect then, is that the consumer is simply left with a larger portion of the financial responsibility or, if prices are known (often in the form of "charges"), avoid treatment (necessary and unnecessary alike) altogether.

In addition to the HDHP's, the Exchange plans (Bronze, Silver, Gold and Platinum) also include a cost-sharing component. The lowest level plan, Bronze, typically has a higher total consumer cost-sharing once income level has been established and any governmental subsidies have been applied. Consumers are caught in the middle between the federal requirement to have health coverage and the costs associated with purchasing a plan, which must take into account both premium and out-of-pocket costs.

Many consumers want providers to offer payment options such as on-line bill payment, payment plans, mobile payment technologies (on-line bill pay and pay by mobile phone) and additional price transparancy.[11,29,30] The technology improvements and options for consumers to pay their health care responsibilities have greatly expanded in the last five years. The opportunities for providers to enhance their multiple interactions with consumers are substantial given the technology expansion, and many have just begun to uncover the full potential.[30]

The challenge for consumers will be paying the premium costs in addition to the potential higher out-of-pocket costs typically associated with HDHP's and the Bronze and Silver Exchange plans. On average consumers with private insurance pay approximately 30% of their health care costs (excluding premiums). In 2014, the average deductible for single coverage in a commercial plan was $1,217 compared to $1,318 in 2015.[5,31] The average deductible for HDHP single coverage was $2,215 in 2014 and $2,099 in 2015 and for the newly created Bronze and Silver plans offered on the Exchange, deductibles averaged $5,200 and $3,000 respectively for 2015.[5,31,32] The Bronze plans typically offer lower premium costs and appear more financially attractive to consumers who price shop. Many consumers, however, fail to read the "fine print"

and consider the out-of-pocket responsibility for each plan which could have the potential to increase their overall health care expenses.

As noted earlier, the deductible is just one component of the total cost-share associated with health plans. Cost-shifting to the consumer not only makes them more aware of the total cost of receiving care but also highlights the decision on how much and what type of care to receive. In several studies on health costs and outcomes, cost was a primary factor in consumers' decisions regarding receiving care and obtaining care.[33,34]

The consumer-driven plans (with more cost-sharing) ultimately have the opposite of the intended effect if consumers elect not to receive care, necessary or unnecessary, due to the growing out-of-pocket burden.[35] Although the Bronze plans are the most affordable, they also have higher out-of-pocket expenses when compared to the Silver or more expensive plans offered. As individuals make decisions about costs, this path to Bronze plans could lead to adverse outcomes as consumers delay needed care and providers struggle in collecting the out-of-pocket liabilities.[36]

The growing trend in cost-sharing will also put the consumer on the front lines of covering their out-of-pocket expenses with the provider, whereas before the provider often acted on behalf of the consumer as an advocate to receive payment from the payer.[37] As the Federal government continues to drive down their cost and reimbursement to providers, the private sector will be responsible for absorbing the unpaid expense experience by providers. This shifting impacts consumers through higher premiums and out-of-pocket expense. It is inevitable that providers will become more astute in identifying opportunities to secure payment for services provided, because they will perceive that they are left with no other choice if they are to maintain financial

viability. Unless "solutions" are carefully designed, these trends could lead to more adversarial relationships between providers and consumers.

Payers

The impact of FEC on payers frequently positions them between the consumer and provider. Often, consumers do not understand what portion of the medical bill is their responsibility and what is covered by their insurance company, leading to frustrated and confused consumers who may pay the portion that is their responsibility twice or not at all. High deductible plans have provided insurance companies another product that is more affordable than a traditional health plan. One health plan executive said, "The No. 1 thing is affordability for consumers."[38] For payers, however, it will be important to share in the responsibility of both increasing price transparency and the education of consumers. Aetna, Blue Cross and others have started offering consumers the ability to estimate the cost of needed services through their websites.

Chapter 3: Interventions and Methods

Interventions

The development of the five interventions was based on a review of the professional literature and known implementation strategies used by several health care consulting firms to improve front-end collections across the U.S. Empirical data and research providing support for the interventions was found to be non-existent during a literature review; providing this empirical support is one objective of these three case studies and data analysis. Several of the interventions are however widely publicized in industry journals and trade presentations as approaches that can be used to strengthen front-end

collections. Each intervention will be described with the existing supporting rationale and data gathered through the case studies. The case studies utilized performance improvement techniques to implement these interventions. The comparative case study approach will allow a more rigorous examination of the impact of the interventions on front-end collections than has been possible previously.

Intervention #1 – FEC Education

The first and primary intervention was the development and implementation of a robust front-end collection education and scripting guide for all front-office staff members. Providing training and scripting guidance to front-office staff members to improve collections and educate consumers are widely documented tactics. The process and phrasing of collection efforts can be just as important as making the request. A phrase that is often used in scripting training is, "How would you like to pay for that today? We accept cash, credit or check."[6,39,40] The "How" makes the assumption that the consumer is going to pay instead of asking "would you like to pay today" (requiring a yes/no response).

The education goes beyond simply providing a script; emphasis should also be placed on the interaction and education of the consumers as well.[29] When face-to-face with a consumer, asking for payment can be overwhelming and intimidating for staff that may not be comfortable or trained in handling the variety of responses received. The FEC education that was implemented at each of the three case study organizations followed the same general set-up with time at the end of each session for staff members to ask questions.

Having the right staff member ask for payment is another area of importance and should not be overlooked.[41] One of the most common responses heard from consumers is, "Can't you just bill me?" Providing scripting and one-on-one role-playing during the education session allows staff members to become more comfortable with asking for payment and overcoming the consumer pushback. This also helps identify those staff members who have the needed skill set to ask for payment and those who do not.

The FEC education program typically lasts between one-and-a-half to two hour. The first hour covers basic insurance principles, benefits to point-of-service collections, and current market trends. The second hour is spent reviewing the scripting guide and role-playing with the staff members. Prior to scheduling the education session a list of all registration, patient financial advocates and other front-line staff that may interact with the consumers regarding their out-of-pocket liabilities were identified. Multiple education sessions were scheduled at varying times of the day and week to accommodate staff members' schedules.

The scripting focuses on how to ask for payment from consumers and how to educate the consumers on what their out-of-pocket expenses will be. How to ask for payment was also covered in the scripting role-playing. Here is an example for how one should ask for payment from a consumer, "I see you have a $20 dollar co-pay today. How would you like to pay for that? We accept cash, credit or check." As mentioned previously the use of how makes the assumption that the consumer is going to pay in one of the three forms offered.

Intervention #2 – Goals and Collection Tracker

Whether an organization is seeking top ratings (all 5's) on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) ratings or improving front-end collections, setting goals and sharing results has a long history of driving organizational change. Without goals and sharing of results there is a high likelihood that the stated objective will not be achieved. It was important for each of the three case study organizations to set and agree upon FEC goals, progress reporting format and frequency, and a distribution plan for the progress reports. A good FEC initiative includes goals and measurement to hold staff members accountable, monitor results and share in the success once those goals are achieved.[39]

One organization described in the literature set an, "Aggressive Goal of Collecting 2 to 3 Percent of Revenue at Point of Service."[40] This intervention focused on developing front-end collection goals for the organization at the most granular level possible and then distributing the resulting revenues on a regular basis. Each of the three case study organizations started by developing goals at the organizational level and then attempted to identify department or location specific goals followed by goals at the individual employee level. Organizational, system and data limitations at each of the three case study organizations determined how granular the establishment of goals could be. The goals were reviewed and approved by organizational leadership and then shared with the work groups that were developed. A monitoring tool was developed to track and share progress. Results from the collections tracker were distributed weekly to executives and the management team who in turn were strongly persuaded to share with

their employees, either in a blinded manner or identifiable by employee. This intervention was used as a supporting element in the staff member incentive intervention.

Intervention #3 – Consumer Educational Material

Intervention three is a redesign or initial development of consumer educational material focused on explaining out-of-pocket financial responsibility, options for payment and additional resources available to provide financial assistance. It includes updating brochures, developing new communication techniques, policy revisions and posting signs that inform consumers that co-pays are due at the time of service and disseminating this information to consumers.[21] This set of related intervention also included a review of available information on the organization's website to ensure it aligned with the printed material. Most consumers want to be informed and having print and digital media readily available in addition to the newly educated front-line staff members further enhances interaction with consumers. This is the primary reason this intervention was included. Literature reviewed in trade organization journals, Healthcare Financial Management Association, supporting this intervention was non-existent and focused more on overall communication and educating consumers about their out-of-pocket estimated costs.

Intervention #4 – Collection Staff Members Incentive Program

In one case study reported in the literature it was said, "The key for us was the CFO's buy-in to start a bonus program and the recognition that front-end collections really make a difference."[42] Bonus and incentive programs in health care have historically been reserved for the providers and executive team. Some organizations are starting to see the value in offering incentive programs to front-line staff members who

perform at a specified level. Intervention four is the implementation of a staff member incentive program to increase FEC collections.

The incentive program was an important element of the FEC initiative because it rewarded staff members for going above and beyond what they historically were asked to do. Staff members in the areas where POS collections occur are often some of the lowest paid staff members in the organization even though they play a very important role both as the first person with whom the consumer interacts and the primary information collector. Morale can often be low in these areas and the implementation of an incentive program along with recognition can go a long way to enhance both performance and morale. FEC goals for these staff members were revised if they existed, POS collections was incorporated into their job descriptions, and they were assessed on their ability to collect on a regular basis. Achievable goals in conjunction with an incentive program have been highlighted in the literature as a method to boost collections.[43]

The incentive program that was developed started with a basic framework and then was tailored to each of the three case study organizations according to the size of their goals, available budget to support the program and potential influence or impact on any existing incentive program. The framework developed uses a multi-tier bonus structure that provided an incentive at the department level and at an individual level with the basic premise that as staff members collected more their incentive payout would also grow larger. For this intervention, each of the three case study organizations' programs were structured differently but they had the same outcome measured. The incentive program should not become an expectation of the position. More detail about the programs developed will be discussed in each of the three case study organization's

analyses. Fitzgerald was the only one of the three case study organizations that did not implement an incentive program for staff members.

Intervention #5 – Consumer Financial Liability Estimation Tool

Providing consumers with estimates of their out-of-pocket costs is not a new practice for providers. However, the continued cost-shifting of health care expenditures owed by consumers by way of deductibles, co-insurance and co-payments in general and related to the growth in HDHP's in particular has accelerated provider organizations' developing solutions to address these needs and requirements. Several state-specific laws requiring provider price transparency and out-of-pocket estimates provided to consumers are also impacting provider's acceptance of this practice. A 2009 survey by McKinsey reported consumers would be willing to pay more by credit card 52 percent of the time if an estimate was provided prior to service.[11] Intervention five was the implementation of a comprehensive patient estimation tool that would calculate a consumer's total financial out-of-pocket expense for scheduled services.

The literature suggests that providing consumers with information about their out-of-pocket costs and methods to pay them can increase satisfaction and engagement.[13] The estimation tool was targeted in service areas that have high out-of-pocket consumer financial responsibility--for example, surgical procedures, radiology exams, interventional radiology and cardiac lab procedures. Education in the use of the tool was also provided to staff member at each organization. Gloria Medical Center had a Pre-registration department that ran the estimates and provided them over the phone. At Fitzgerald, a Pre-registration department was created during the study with two staff members who ran estimates; but these individuals were often pulled to cover the

registration desk. Byrne Hospital ran a lean staffing operation so the registration staff members ran estimates when patient flow was slow.

McKinsey also found that only seven percent of households rank medical expenses, including co-pays, co-insurance and deductibles, as the number one priority when budgeting expenses.[11] Providers need to find new and more accessible methods to communicate consumers' financial responsibilities to help them prioritize medical expenses. The estimation tool allowed the organizations to attempt collections on larger consumer balances while also enabling staff members to educate the consumer prior to the day of service avoiding the inevitable "sticker shock" associated with a large financial requests. As mentioned earlier, several states either have enacted, or are in the process of enacting, laws outlining the requirement of hospitals to provider consumer estimates in a timely fashion.

Two of the large credit reporting agencies, TransUnion and Experian, have purchased and integrated consumer financial liability solutions into their software suites. TransUnion has experienced a significant growth in sales of their financial services to hospitals in 2014 and continues to experience growth in this market.[37] Vendors are responding to the market as consumers an estimate is quickly becoming a multi-million dollar industry.

Additional Interventions

Other interventions that may have had an impact on overall front-end collections were implemented but specific data on them were not available or collected at each of the three case study organizations.

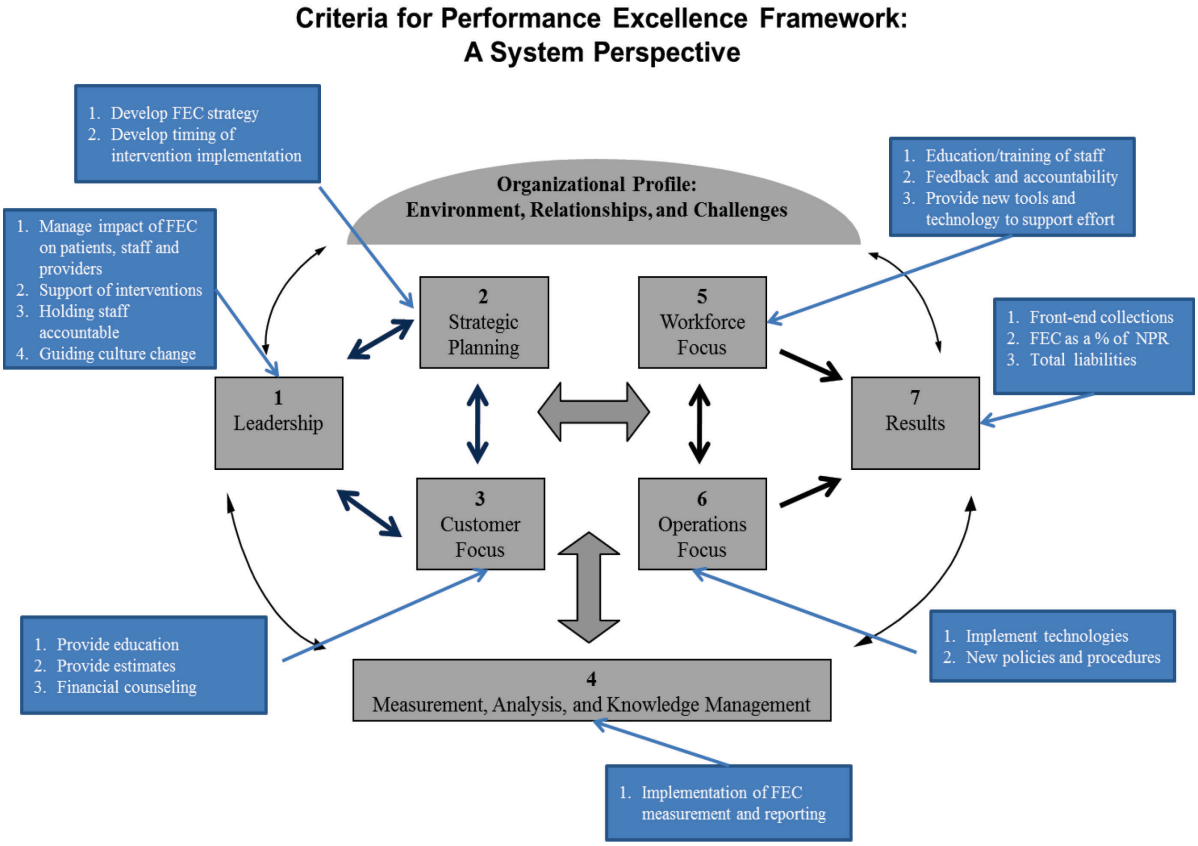
1. Elimination or modification of discounts (prompt-pay, self-pay)
2. Inclusion of collection expectations in all registration job descriptions

3. Revision of payment and other financially related policies
4. Development of a Financial Clearance Policy, Financial Assistance Policy and modification of Charity Care determinations

Conceptual Framework

The conceptual framework, Figure 5, utilized for the case studies is based on the Baldrige Performance Excellence Framework and Criteria. There are seven organizational components included in the framework that support performance improvement efforts. Each of the organizational components will be reviewed for each of the three case study organizations in addition to a description of the five interventions that were accessed.

Figure 5 - Baldrige Performance Excellence Framework from a Front-end Collections Perspective



Source: http://nist.gov/baldridge/publications/hc_criteria.cfm

Case Study Design

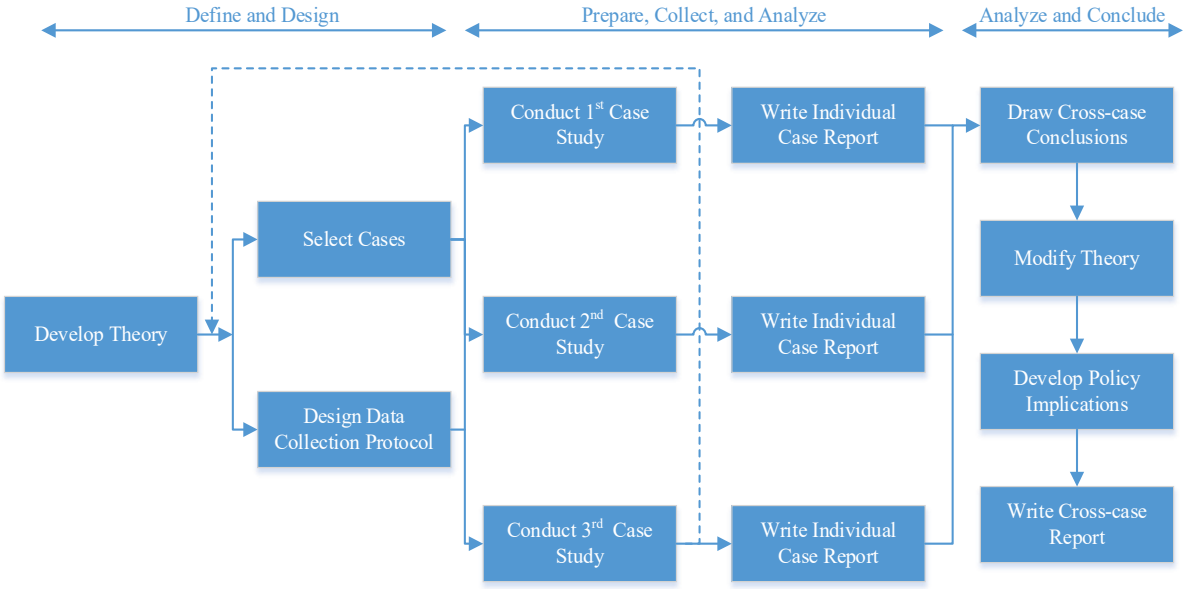
The construct for assessing the intervention strategies in the three case study organizations are based on a literal replication from one case study organization to the next with slight modifications as needed to apply lessons learned from the previous case study organization. The case studies included three separate non-affiliated health care provider organizations that consist of two acute care hospitals and one critical access hospital (~25 beds). Each of the three case study organizations was selected due to their financial need to adopt new collection practices to enhance revenue as well as being geographically dispersed across the U.S., serving different populations. The geographic

locations are representative of where health care is provided in the Unites States. Of note, there are 1,332 Critical Access Hospitals in the United States (as of April 2016) and one of the three case study organization was a Critical Access Hospital.[44] The other two hospitals are more closely representative of standalone community hospitals across the United States.

The three case study organizations will be compared to each other. The timeframe for analysis included data from the 12-months prior (baseline period) to the start of the first intervention and continued through an additional 12-month period after the first intervention (intervention period). This allows time to measure impact on the dependent variables with all the interventions implemented.

The design of the case study model is shown in Figure 6 below and was adopted from Yin and his work at COSMOS.[45]

Figure 6 - Three-Case Model Framework adopted from COMOS



The primary research question for the three case studies was: How would the implemented interventions impact the organization's front-end collection performance?

The primary measures or dependent variables for the case studies are front-end collections as a percent of net patient revenue (patient revenue – bad debt) and front-end collection dollars. The goal is to determine what effect, if any, the selected interventions or independent variables have on front-end collections. The intervention consists of activating all five of the previously described process improvement activities, with the hypothesis being the effects of each are additive, meaning that all are necessary and have overlapping effects on front-end collections.

Case Study Protocol & Implementation Plan

The protocol for each of the three case studies began with a comprehensive assessment, data gathering, work plan and the development of a work team to implement the interventions. Prior to the implementation of interventions, the assessment included background work to gain a clear understanding of each organization's current performance and need to implement a front-end collections initiative.

Data Sources and Data Handling

No patient level data will have been utilized for the analysis or the presentation of the results. Summary financial statements provided by the organizations were utilized to determine net patient revenue (NPR) and other needed financial metrics. The cash collections tracking tool that was implemented as part of an intervention will be used to analyze performance related to front-end collections and collections as a percent of net patient revenue. Historical organizational front-end collection reports were obtained to populate the baseline information in the collections tracker. The three case study organizations are identified using a pseudonym to conceal their identity and maintain confidentiality.

Measures

Table 2 below represents organizational and performance variables identified for inclusion in the analysis and if these were or were not available (Yes/No). The five variables shaded blue in table 2 were used for comparative analysis due to their uniform availability from each of the 3 case study organizations. These variable were also used to determine overall performance improvement in relation to the timing of the interventions.

Table 2 – Collection Variables and Outcome Measures for Each of the Three-Case Studies

Independent Variables	Gloria	Fitzgerald	Byrne
Total number of consumers registered	Yes	Yes	No
Number of collection staff members (FTE's)	No	No	No
Service provided by location	Yes	Yes	Yes
Type of location (clinic or hospital)	Yes	Yes	Yes
Net patient revenue	Yes	Yes	Yes
Payer mix	No	No	No
Bad Debt	Yes	No	Yes
Charity	Yes	No	Yes
Dependent Variables			
Total front-end collections in dollars	Yes	Yes	Yes
Total front-end collections as a percent of net patient revenue (NPR)	Yes	Yes	Yes

Yes = Variable or outcome measure data point was collected for both the baseline and intervention period
No = Variable or outcome measure data point was **not** collected for either baseline or intervention period

Two variables, number of collection staff members and payer mix, were not available or obtained for all three case study organizations. These would have been analyzed separately to determine if either they impacted one of the organizations ability to increase collections. Number of registration staff was going to be used to analyze the significance of having the appropriate number of staff on the front-end to collect. It can

be hypothesized that if a Pre-registration Department is under staffed their overall collections would be lower compared to if they were appropriately staffed. One organization (Fitzgerald) experienced this in their Pre-registration unit when staff members were also asked to cover the registration desk which could explain why they had the smallest increase in FEC when compared to the other three case study organizations. The payer mix variable was going to be used to determine if changes in payer mix had an impact on front-end collections. It would he hypothesized that organizations with a higher proportion of private payers would also have greater potential for out-of-pocket collections and or related bad debt than those organizations with a higher proportion of federal payers. However data for these variables were not consistently available across all three case study organizations.

Descriptive Statistics

A review of key descriptive statistics was completed to provide an initial review of each of the three case study organizations from baseline to intervention period. Table 3 outlines these statistics and highlights initial improvements from baseline to intervention period.

Table 3 - Descriptive Statistics for all Three Case Study Organizations

	Gloria Medical Center	**Fitzgerald Community Hospital**	**Byrne Hospital**
Baseline Period			
Annual Net Patient Revenue (NPR)	$255,000,000	$140,000,000	$30,000,000
Annual Front-end Collections	$1,893,160	$154,191	$274,155
Monthly Average Front-end Collections	$157,763	$12,849	$22,846
Monthly Average FEC % of NPR	0.74%	0.11%	0.93%
Intervention Period			
Annual Net Patient Revenue (NPR)	276,000,000	147,000,000	30,000,000
Annual Front-end Collections	$2,708,252	$456,842	$627,011
Monthly Average Front-end Collections	$225,688	$38,070	$52,251
Monthly Average FEC % of NPR	0.98%	0.31%	2.09%

Chapter 4: Case Study #1 - Gloria Medical Center[1]

Setting

Gloria Medical Center (GMC) is a faith based, not-for-profit hospital that is part of a larger, regional health system with a total of four hospitals and large physician practice. It is located in the mid-west and has been serving the local community and surrounding counties for over a century. The system has additional health care facilities located in the mid-west and south-Atlantic. Gloria Medical Center has approximately 475-beds and ran a daily census of 210 in 2013. Additional hospital statistics are provided in Table 4. They provide the full range of services that a typical acute care facility would offer. With more than 600 medical staff members and 2,000 employees, GMC is able to offer a full range of multi-specialty physician services, urgent care, dental and pharmacy residency programs and multiple centers (Cancer, Vascular and Orthopedic) of excellence in patient care.

Table 4 - GMC 2012 Statistics

Gloria Medical Center CY 2012 Statistics	
	Visits
Emergency Room	65,645
Surgical Procedures	14,416
Discharges	16,625

*estimated

The city had a population of over 70,000 as reported by the 2010 census and a median household income of under $30,000.[46] The economy is mainly comprised of industrial, natural gas, health care and agricultural industries. It is part of a Metropolitan Statistical Area (MSA) that has a population of just over 400,000 people and is within an hour of a large metropolitan city.[46] GMC has one main competitor in the city but there are more than 25 other hospitals within a 30 mile radius that provide competing services.

[1] Pseudonym

Case Overview

The analysis of Gloria Medical Center, the first of three case study organizations assessed using the case replication approach described, was started in June 2013. The objective of the case study was to implement the bundle of five interventions, monitor front-end collections prospectively, evaluate the organization based on the seven Baldrige criteria, and assess performance related to the dependent variables. Did Gloria Medical Center increase their front-end collections over baseline? There were adjustments made to the implementation bundle for the following two case study organizations based on findings and outcomes from the GMC case study. More details will be provided about the adjustments in case design, approach and interventions in the discussion of the two subsequent case reviews.

During 2011-2013, GMC experienced declining patient volumes and reimbursement, motivating the leadership team to take action to mitigate future declines. One of the many initiatives identified to assist in the financial improvement was enhanced front-end collections. Historically, Gloria Medical Center monitored their overall up-front collection efforts monthly as part of their revenue cycle dashboard. Each measure on the dashboard was assigned a goal that was re-evaluated each year. The Revenue Cycle Director was responsible for updating and distributing the dashboard monthly. The goal for 2013 was set at $180,000 a month; January, November and December were the only months the goal was achieved. In 2012, the largest collection month was December where they collected $171,662.

The formula used at GMC to calculate the amount collected attributed to front-end collection efforts was Point of Service (POS) collections within four days of service

and using as the denominator, net patient revenue; a slight variation from the HFMA formula. This approach defined POS collections as a percent of total net patient revenue (less bad debt) as reflected in the formula below.

N: Total POS collections (within 4 days of Service Date)
D: Total Net Patient Revenue (less bad debt)

The case study started with an initial comprehensive assessment of the current front-end- collection processes, data and technology. The assessment consisted of the activities listed below with, the information collected during the assessment providing the framework to develop the work plan.

- Shadowing and observation of key front-end processes (scheduling, pre-registration, registration)
- Review of current technologies in-place (insurance eligibility, estimation capabilities)
- Data collection for current front-end collections or other metrics utilized
- Identification of all collection locations
- Analysis of financial liabilities owed by location compared to what was collected
- Collection of all current marketing/information brochures and information
- Collection of all policies and procedures in-place
- Interviews of management and leadership
- Organization structure overview

During the assessment an executive sponsor, the Chief Financial Officer, was identified. The Revenue Cycle Director was the primary revenue cycle contact.

Case Protocol

In late August 2013, implementation of the intervention bundle began at Gloria Medical Center. Work was guided by a comprehensive work plan, which was shared with, and approved by, the Chief Financial Officer (CFO) and the Revenue Cycle Director. A Patient Access (PA) work group Team Lead and members. The Manager of Central Scheduling was named the leader of the work group. The team members, Table 5 below, were a diverse group of managers and directors throughout the organization with

representation primarily from areas that experience high consumer visit volumes. Meetings were scheduled on a weekly basis for five months starting in mid-September. During the kick-off meeting the work group charter and the draft work plan were reviewed.

Table 5 - GMC Patient Access Work Group Membership	
Patient Access Work Group	
Manager Central Scheduling	Chair
Revenue Cycle Director	Member
Administrative Director Off-Site and Rehabilitation	Member
Laboratory Manager	Member
Laboratory Director & Compliance	Member
Process Analyst (Quality Improvement)	Member

The initial implementation of the five key interventions was to begin in November with the start of the front-end collection education and scripting. The FEC initiative that included all five interventions was included as part of a larger strategy at Gloria Medical Center called Clinical and Operational Redesign (CORE). The FEC initiative reported progress to several higher level committees as shown in the organizational structure at the right. The Patient Access Work Group provided monthly updates to the Revenue Cycle and Executive Steering Committees, which also had oversight of other revenue cycle activities.

Data

Patient level data were not used; financial data collected were aggregated at the employee, department, and location or organization levels. Key financial data were obtained from GMC's monthly income statements. These data included, net patient revenue, bad debt, and charity care adjustments for the baseline and intervention periods, each consisting of 12-months of data. Formulas were used to calculate bad debt as a percent of net patient revenue, charity as a percent of net patient revenue and front-end

collections as a percent of net patient revenue. Four data files were provided during the assessment:

1. Net revenue by department/service line
2. Total consumer financial liability by department/service line (total that was owed)
3. Total consumer payments (total that was collected)
4. Baseline collections by department

The net revenue file was utilized to set initial collection goals by location and employee. The consumer financial liability file was used to confirm that the goals were not set beyond what could actually be collected. In July of 2013 GMC implemented a front-end collections tracker by location that supported an employee incentive program. The revenue cycle dashboard was used monthly while a new front-end collections dashboard was created that tracked collection efforts at the employee level. GMC's current FEC dashboard was also utilized to populate historical data into the new tracker. The baseline was set at September 2012 to August 2013. Financial statements were obtained monthly during the baseline and intervention periods to record net patient revenue, bad debt and charity care. The cash tracker was used to capture monthly collections during the intervention period.

Methods & Interventions

The timing of each of the five elements of the bundled interventions is depicted in Table 6. It also highlights the baseline data collection and intervention periods. The interventions were not implemented in a step-wise process due to the timing and efforts needed for each. FEC education was implemented first followed by the other four interventions as shown. Measurement started after the first intervention was implemented.

Table 6 – Gloria Medical Centers' Initiative Implementation Timeline

Gloria Medical Center	2012				2013												2014									
	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT
Baseline Period	Baseline																									
FEC Education																										
Goals and Collection Tracker																										
Consumer Education Material																										
Staff Incentive Program																										
Liability Estimation Tool																										
Measurement Period															Measurement											

A comprehensive work plan, Table 7, was developed and used to maintain momentum, assign responsibilities and ensure all the interventions were implemented in a timely fashion. The work plan provided detailed steps by intervention. A brief sample of the work plan can been seen in Table 7.

Table 7 - GMC's Front-end Collections Work Plan Sample

Line No.	Type of Work	Description	Gloria Resources	Starting Date	End Date	Status
1	**Initiative**	**Front End Collections**				
1.1	**Intervention**	**Establish FEC Meeting or subsection within Patient Access Meeting**				
1.1.1	Action Step	Evaluate Collections Points: Pre-Service, Point of Service, In-house, ED, and Discharge		9/2/2013	9/12/2013	Complete
1.1.2	Action Step	Review available tools: Payment Processing Applications, Estimation Tools, etc.		9/2/2013	9/12/2013	Complete
1.1.3	Action Step	Review available reporting: Cash Tracker, Individual Reporting, etc.		9/2/2013	9/12/2013	Complete
1.2	**Intervention**	**Shadow**				
1.2.1	Action Step	Confirm whether estimation tool is automatic or manual		9/2/2013	9/12/2013	Complete
1.2.2	Action Step	What HIS fields or codes are used to track collections		9/2/2013	9/12/2013	Complete
1.2.3	Action Step	Determine how patients flow through this process for both self-pay and insured patients		9/2/2013	9/26/2013	Complete
1.2.4	Action Step	Determine what areas are collecting and what areas are not		9/2/2013	9/12/2013	Complete
1.3	**Intervention**	**Baseline our current collections efforts**				
1.3.1	Action Step	Determine how much is being collected by the areas that are collecting in principle with currently set policies		9/2/2013	9/26/2013	Complete
1.3.2	Action Step	Determine how much is being collected by the areas that are collecting in actuality with currently set policies		9/2/2013	9/26/2013	Complete

Intervention #1 – FEC Education

The first intervention implemented was the front-end collections scripting and education. The scripting guide (Appendix III) was approved by the Patient Access workgroup and CFO in September 2013. Sixty-seven total staff members were identified

to participate in the FEC education because they could potentially have an interaction with consumers about their out-of-pocket financial liabilities. The identified staff members were from a variety of departments across the organization: Pre-registration, Scheduling, Admitting, Emergency Department Registration, Financial Counseling, Customer Service, Surgery, and Registration staff from the Urgent Care Centers.

The education/scripting sessions were scheduled at various times of the morning, afternoon and evening to ensure attendance at one of the 16 sessions (Appendix V). Times, dates and locations of the scripting sessions were decided in the Patient Access meeting. Scheduling the sessions was completed in October 2013 with the first education session on October 30, 2013.

Prior to the first session a memo from the CFO, similar to the sample in Appendix IV, was sent to key departments asking for their support of the front-end collection effort. The last education session was held on November 20, 2013 and included several additional sessions to accommodate staff members who were unable to attend a prior one. Trainers who had previously provided over 50 or more similar education session conducted the staff member education. The trainers also instructed staff members on the role-playing portion of the education sessions. A train-the-trainer model was not utilized to make certain that each education session was delivered consistently. Sessions were initially scheduled for 90 minutes; the first 30 minutes reviewed the importance of front-end collections using a PowerPoint presentation and the remaining 60-minutes focused on scripting role play. The scripting guide contains 11 scenarios in a patient and response (staff) format as highlighted in the example below.

PATIENT: "I can't pay that much now!"

RESPONSE: "I understand this may be an unexpected payment for you. If you do not have the full amount right now, we will accept what you are able to pay today and bill you for the remainder. We accept (e.g. cash, check, and credit or debit card)."

Each staff member rotated being the consumer and the hospital employee through each of the scenarios to work on building confidence responding to the consumers' various reasons for not paying their out-of-pocket expense or understanding their financial responsibility. Staff members were not expected to follow the scripting guide responses verbatim. Rather it was instructed that it should be used as a guide to assist them in developing their personalized message to the consumer. The focus was on educating the consumer in an "educate and then ask for payment, educate and then ask for payment" model. If the consumer was insistent on not paying, staff members were instructed to educate the patient about the billing process and proceed with registering the patient

There are four to five general responses that can be used in most situations with the consumer to overcome pushback and the goal is to become comfortable asking for payment. During each session, staff members were asked for other common scenarios they have experienced and the trainer role-played with staff members to provide them a possible response. Trainers were able to identify staff members who struggle or were not comfortable asking patients for payment.

To ensure that staff members were utilizing the scripting and asking for payment from consumers, the trainers went back and shadowed a sample of staff; this included the staff members who were observed in the training as having a difficult time or who were negative about the requirement to ask for payment.

If staff members were not following the scripting guide or asking for consumer payments, feedback was provided to their manager or supervisor to follow-up. As part of this initiative all front-end staff job descriptions were reviewed to confirm that collecting from consumers was part of their job requirements. If it was not included, language was provided that could be included in their job descriptions covering the collection expectation. There was a small amount of turnover during and after the implementation so all new hires attended a make-up FEC education session or were trained by a Medical Center staff member utilizing the same material. The education material and scripting guide were provided both in hard copy and soft copy to Gloria Medical Center so that any new hires could be provided the information.

Intervention #2 – Goals and Collections Tracker

Intervention two was the development of new collection goals by location and the implementation of a weekly FEC tracking dashboard that could be used by leadership and department management to monitor the success of the initiative. Gloria had started monitoring cash collections by individual staff member and location in July of 2013 for an incentive program that was developed; however goals were not set at the location or employee level, only at the organizational level. While the Patient Access work group was working on the FEC education and scripting an analysis was used from the assessment to develop more realistic collection goals for each location. Each location participating in the intervention was identified using two factors that had to be met: did the location interact with the consumer either via phone or face-to-face and could the staff member ask the consumer for payment.

Central Pre-Registration was the first department for which goals were developed and a sample is shown Table 8.

Central Pre-Registration is the department that calls the patient to obtain or verify insurance information, confirm demographics, appointment day/time reminder, provide the consumer an out-of-pocket estimate, and attempt to collect over the phone. This department is the first step in the process at Gloria that provides education to consumers about the cost of services they are scheduled for.

Table 8 – Gloria Medical Center's Central Pre-Registration Departmental Goal Calculation

Central Pre-Registration Collections Goals					
Service Line	**6 Month Average Monthly Net Revenue[1]**	**Relevant Financial Classes Percentage[2]**	**Collection Effort[3]**	**Front End Collections (FEC) Percentage of Net Revenue Goal[4]**	**$ of Revenue Obtained Via FEC Goal[5]**
Calculation	**A**	**B**	**C**	**D**	**E**
Central Pre-Reg. Service lines	$6,192,681	48%	50%	2.5%	$37,156

The calculation to develop the goal for Central Pre-Registration was the following:

See the calculation row in Table 8 above: **A x B x C x D = E**

A is equal to the average of six-months of net patient revenue for the service lines that Pre-Registration covers (sleep lab, radiology, oncology and others). Relevant financial classes under column B took the average across six-months of net revenue by payer and excluded payers that often do not have substantial out-of-pocket expenses for their members. These exclusions included Medicare, Medicaid, Governmental based HMO plans and Worker's Compensation; 48% of the total net revenue remained.

The collection effort, C, was set at 50% because some consumers will choose not to pay at Pre-Registration or prior to being treated. The remaining 50% is expected to be collected by the department as the consumer checks-in. The result of A, B and C multiplied together was then multiplied by a collection goal (D) of 2.5% to develop the monthly collection goal in column E. Appendix VI. has a complete listing of all the

locations and associated goals. The goals for the other locations were not adjusted using the collection effort (50%) unless the Pre-Registration Department pre-registered their patients. The urgent care centers' goals were set by taking a flat increase of 5% or 10% of current collections.

Pre-Registration was the first department to go through scripting training and the impact of that training was immediate. Pre-Registration was the only goal upwardly adjusted for the 2014 fiscal year. The new goals were populated into a new front-end collections tracker that was more automated and able to monitor collections to goals at the location level and employee level. Employee level collections were captured because each front-desk staff member was set up with his or her own cash drawer in MEDITECH. A cash drawer allows the collector to enter payments into the system directly and it records the name of the person posting the payment.

The tracker was built in Excel and allowed monthly, weekly and daily tracking of collection efforts (Appendix VII.), in addition to executive level graphs to highlight progress. It was finalized and the distribution started late March 2014. Managers were now able to view collections at the individual level compared to the goal. Historical location collection data were also loaded into the tracker for trending purposes. Initially managers shared the data and graphs at the employee level and after two months of distribution the information was un-blinded. The new monthly organizational goal for front-end collections was set at $235,727, a significant increase from the prior goal of $180,000.

Table 9 is a snapshot of the tracker from 8/8/2014; this view is the daily collections by location and includes projected month-end, collection month-to-date and the daily goals.

Table 9 - Sample of Gloria Medical Center's Collections Tracker

	EMERGENCY DEPARTMENT	CENTRAL SCHEDULING	RADIOLOGY	RADIATION THERAPY	NEURO/MOPS/GASTRO	SAME DAY SURGERY
Daily Goal by Department[2]	**$ 1,700**	**$ 3,571**	**$ 204**	**$ 119**	**$ 51**	**$ 835**
8/1/2014	$ 1,145	$ 2,915	$ -	$ -	$ -	$ 200
8/2/2014	$ 385	$ -	$ -	$ -	$ -	$ -
8/3/2014	$ 265	$ -	$ -	$ -	$ -	$ -
8/4/2014	$ 1,165	$ 2,414	$ 240	$ -	$ 206	$ -
8/5/2014	$ 825	$ 1,723	$ 145	$ -	$ -	$ 300
8/6/2014	$ 260	$ 3,443	$ -	$ -	$ 535	$ -
8/7/2014	$ 712	$ 2,813	$ -	$ -	$ -	$ -
8/8/2014	$ 140	$ 721	$ 250	$ -	$ 445	$ -
8/9/2014	$ -	$ -	$ -	$ -	$ -	$ -
8/10/2014	$ -	$ -	$ -	$ -	$ -	$ -
8/11/2014	$ -	$ -	$ -	$ -	$ -	$ -
8/12/2014	$ -	$ -	$ -	$ -	$ -	$ -

Goals were set to be re-evaluated every six months, at a minimum, to facilitate continuous improvement. If a department was continuously exceeding their goal, that goal could be increased to reflect the improvement.

Intervention #3 – Consumer Educational Material

At the on-set of the study Gloria Medical Center's revenue cycle team had begun the process of updating their consumer educational brochures. The Patient Financial Services brochure was one of the first interventions worked on by the Patient Access work group. It took several months and multiple drafts between the work group and GMC's Marketing Department to develop a finalized draft of the brochure. The final draft was approved by the work group and Revenue Cycle Director in December 2013 and sent to an outside printing company. In January 2014, the brochures were distributed

to all registration areas across the hospital and urgent care centers to display for consumers. It was also included in the admissions packet of information that was provided to consumers who were admitted to the hospital.

A physician practice education brochure was also developed and distributed to the employed and non-employed providers, physicians not employed by GMC, in the area. The purpose of this brochure was to educate the physician practice office staff members on the requirements to schedule a patient at GMC and what information should be shared with the patient regarding their financial responsibility. Collections signage was developed and distributed to all registration locations to support staff members asking consumers for payment. The signage was standardized across the organization and placed on a placard so that it was visible to consumers at each location. It read, "Payment is due at the time of service". This reiterated to consumers that payment was going to be requested and that it was expected at the time of service. There were minor modifications to the Patient section of GMC's webpage to align with the brochures and consumer financial liability policy changes.

Intervention #4 – Collections Staff Members Incentive Program

A basic staff member's incentive plan existed prior to the start of the case study. For each $50 that the employee collected they would receive one ticket that was placed in a raffle at the end of the month. For example, if Nikki Cash collected $784 dollars in the month, she would receive 15 raffle tickets to be placed in the drawing. The more tickets an employee received the more likely to win the drawing. There were multiple drawing winners at the end of the month and each would win a $25 gift card. When the collection goals were re-calibrated a new incentive structure was also proposed to the Patient Access work group.

A formal policy was constructed and the Revenue Cycle Director shared it with the CFO for approval. It was approved in February 2014 but was retroactively paid out effective January 2014. The new incentive structure consisted of a two tier program; the first tier was a goal for the unit and the second tier was employee based. The objective was to reward staff members for their collection efforts without losing sight that it takes a team to achieve overall goals.

Tier one had two criteria that had to be met prior to the $50 pay-out per unit employee.

1. The department/unit had to meet the monthly collection goal
2. Each team member of that unit would then be evaluated to determine if they met their individual collection goal. This was calculated by (Unit collection goal/Unit hours worked) multiplied by the hours the employee worked

If both the unit and the employee met their collection goals, the employee would be paid a $50 bonus at the end of the month. The second criteria was developed so that the worked hours reflected the employee's effort in relation to the unit goal. Tier two allowed for 5% of the amount above the unit goal to be placed into a pool that was then distributed to staff members based on their work effort.

There were six exclusion/exception criteria as part of the policy that placed boundaries on who would be eligible to receive the bonus payout.

1. An employee who does not contribute at least 50% of the average individual productivity of his or her team is not eligible to participate that month.
2. Employees in training may not participate. Generally, the training period is the first 90 days of employment in the department. The period may be extended at the discretion of management.
3. Credit is given for time worked on a temp-to-perm basis. Employees begin participating in the first full calendar month after the training period is concluded.
4. Employees must be employed for the entire month measured and on the last day of the month measured in order to participate in the incentive for that month.

5. On days on which the Representative does not close his or her Cash Drawer, those collections will not count towards the tier 2 incentive, however will be included in the tier one incentive.
6. Nothing in this program description is a contract of employment. Employment remains at-will and may be terminated by the employer or the hospital with or without notice or reason. This incentive plan is subject to change or elimination at any time upon written notice to participating employees.

Number five was especially important and was added after it was evident that staff members were not appropriately closing their cash drawers daily. At the close of each employee's day they were responsible to close their drawers, verify payments received and posted and turn in their cash bags to the cashier. When the cash drawers were not closed it created additional work for the manager and slowed the posting of cash for the day.

When the incentive policy was presented to staff members they were enthusiastic about the opportunity to earn more money by collecting from consumers. Initially staff members had some concern about the goals being set too high but after a month they became more comfortable. The incentive did not have a dollar cap for staff members or by month. This opened the organization up to the possibility of a very expensive incentive program depending on monthly collections. The CFO felt the additional gains were worth the added expense and did not want to have a cap.

Intervention #5 – Consumer Financial Liability Estimation Tool

Gloria Medical Center already had a patient financial liability estimation tool in place at the start of the case study. Although the technology was available, management and staff members did not feel comfortable that the estimates provided to consumers were accurate. The accuracy concerns were based on consumer complaints and GMC's own internal validation audit comparing the estimates with the insurance company

information on several accounts. A new patient liability estimation tool was not implemented, instead the decision was made to revitalize the existing tool and build staff members' confidence in utilizing it. Historical collections reflected the minimal use of the system.

The system used was called Patient Payment Estimator (PPE) from Passport Health. GMC used another one of Passport's applications to run insurance eligibility and verify insurance benefits. Passport Health has since been purchased by Experian. To remediate the estimate validation issues the Passport representative was contacted and a formal plan was developed to work on correcting the estimation issues one department at a time. Calls were scheduled weekly with GMC staff members providing examples to the Passport team to identify root causes and correct the system. Passport required GMC to submit tickets to their customer support team outlining what the issue was so they could be tracked and worked on. GMC upgraded the Passport system in May 2014 to the most recent version, eCareNext. This new platform provided enhancements to insurance eligibility and verification and the estimation module.

Baldrige Criteria Assessment

Leadership

Gloria Medical Center is a faith-based organization that is rooted in over 100 years of caring for the sick and disabled. The mission of the organization is, "As a Catholic health care organization, our mission at Gloria Medical Center is to continue Christ's healing ministry by providing quality, compassionate, accessible and affordable care for the whole person." To ensure the mission is carried out on a daily basis they have appointed a Sister as the Vice President of Mission and Ministry Services.

The Sister was involved at all levels of the organization and participated in the Executive Steering Committee where the FEC initiative and interventions were discussed. The Chief Executive Officer has been leading GMC for the last 13 years and prior to that served as the Chief Operating Officer. The Chief Financial Officer (CFO) has been at GMC since 2013 and prior to that he was a CFO at another one of the system hospitals where he excelled at making financial improvements that impacted the bottom line. At the start of the case the organization was identifying other operational, financial and cost reduction/savings strategies to ensure a positive financial future.

The senior leadership team developed a brand for these initiatives so they could be communicated across the organization. It was called Clinical and Operational Redesign (CORE). Regular updates were provided to staff members through town hall meetings, newsletters and email memos. The front-end collections initiative was an initiative within the CORE project and monthly status updates were provided to the Executive Steering Committee (ESC) at its monthly meetings. The ESC was composed of the executive leadership team and was a venue for each initiative team to provide progress updates, discuss major barriers and sensitive topics. The Revenue Cycle Steering Committee was chaired by the Chief Financial Officer and in addition to the FEC initiative had to report other revenue cycle initiatives status and barriers. The Revenue Cycle Steering Committee reported to the ESC and the CFO was responsible for providing updates.

After only being in a management role for three months prior to the start of the study, the Scheduling Manager was able to lead the Patient Access workgroup through the interventions successfully in addition to learning her new role and managing the day-

to-day operations of the department. In her prior role she was in the information technology department and was able to apply her technical skills to getting the issues with Passport resolved.

Strategic Planning

The Chief Financial Officer knew that collecting more consumer liabilities would assist the organization's financial status and was essential to include in their long-range revenue cycle strategic plan. It would accelerate cash, reduce bad debts and begin to educate the community on the cost of health services. The FEC initiative work plan that was developed post-assessment was shared with the Revenue Cycle Director and CFO for approval. It outlined the various interventions, owner(s) and timeline for each component of the FEC initiative. The initiative was integrated into GMC's CORE project from a strategic perspective so that it would also have senior leadership visibility and support. A few of the interventions were implemented in tandem or overlapped with others to accelerate the implementation timeline.

Customer Focus

Front-end collections are consumer sensitive and have gained additional national media exposure since the implementation of the Patient Protection and Affordable Care Act (ACA). Asking for payment up-front was not a new concept to the community surrounding Gloria Medical Center. Both GMC and the competing health system in town requested payment up-front from consumers; this was something the local community was fairly accustomed to. The Executive Steering Members were informed prior to implementing the scripting as this was going to be a more assertive approach to consumer collections than GMC had taken historically.

Consumer complaints were monitored post-implementation and there was a slight increase in complaints but this was expected given the increased push to collecting up-front or during pre-service. GMC had a dedicated Customer Service team that handled consumer complaints and provided out-of-pocket estimates. This group also went through the FEC education so they could explain to the consumer what his or her responsibility was and the reason for requesting payment. During an ESC meeting the VP of Mission and Ministry questioned the approach but once it was explained was fully supportive. Additional marketing and educational material was also developed and revised to provide additional clarity for consumers about what was expected prior to services being performed.

Measurement, Analysis and Knowledge Management

GMC had a front-end collection tracking tool at the employee level, and an aggregate collections number and goal were reported on the monthly Revenue Cycle Dashboard. At the on-set of the study, the CFO voiced his concern that the collections goal was set low and that additional money could be collected on the front-end. The development of goals by unit and employee was a further refinement in the improvement process. The FEC tracker provided multiple tabs of information that could be shared at the executive, management and employee levels. It was also utilized as part of the calculation for the employee incentive payout.

Workforce Focus

The FEC initiative was focused on providing employees with the correct tools, education, support, and feedback mechanism to be successful at improving collections and educating the community. This was accomplished with the education sessions that

reviewed the latest trends in consumer financial responsibility along with the scripting training. Enhancements to the estimation tool increased the staff members' confidence in providing estimates to consumers. With the additional consumer marketing and educational material it further supported staff members in assisting the community in understanding why they were being asked for payment. An employee incentive structure did exist for staff members who collected payments but was enhanced to include an individual incentive and a team incentive. This further boosted staff members' morale and an immediate improvement in collections was observed.

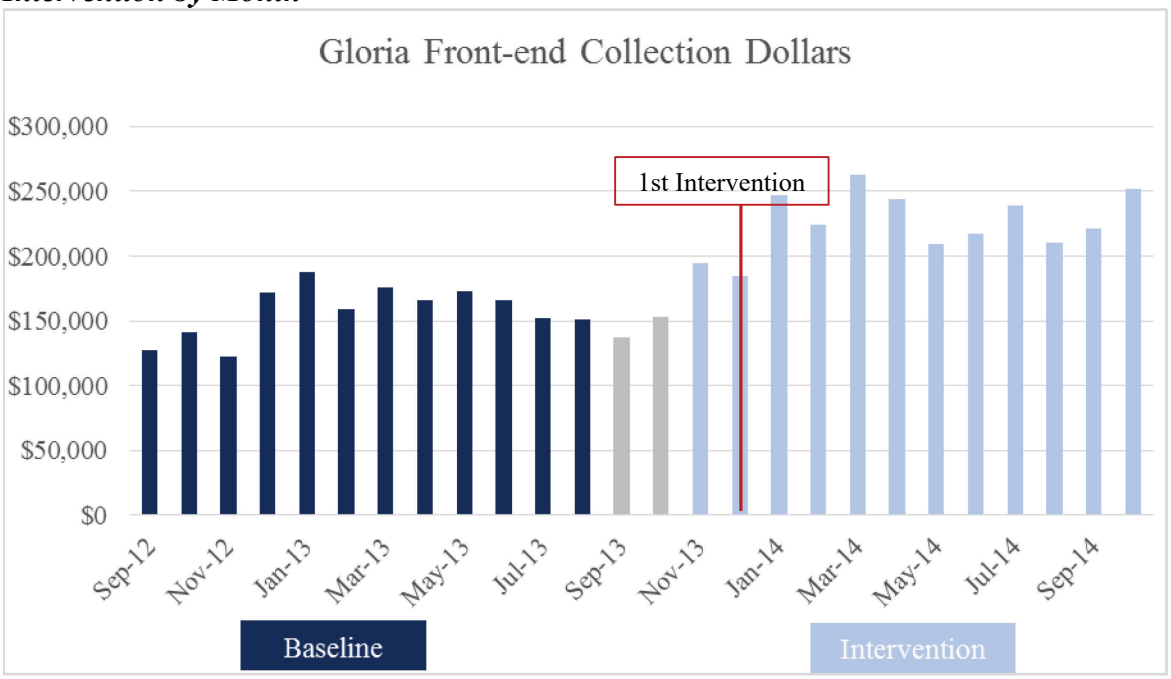
Operational Focus

To operationalize the FEC initiative all five interventions took a significant effort by the Gloria Medical Center staff members in addition to their daily work. Outlining a work plan and dividing assignments among the team and having the full support of the CFO and entire executive team allowed the initiative to overcome barriers and ensure appropriate resources were allocated. Policies and processes were developed to support process changes and ensure accountability. Frequent communication with staff members on the changes and expectations were shared in staff meetings and email communications.

Results

Each initiative under the CORE project was required to show progress and expected to have results. The FEC initiative applied multiple measures to demonstrate improvement. Measuring collections at the employee level also allowed management to monitor performance and identify those that needed additional education. The baseline and intervention period collections are highlighted in Figure 7 below.

Figure 7 - Gloria Medical Center's Front-end Collection Dollars, Baseline vs. Intervention by Month

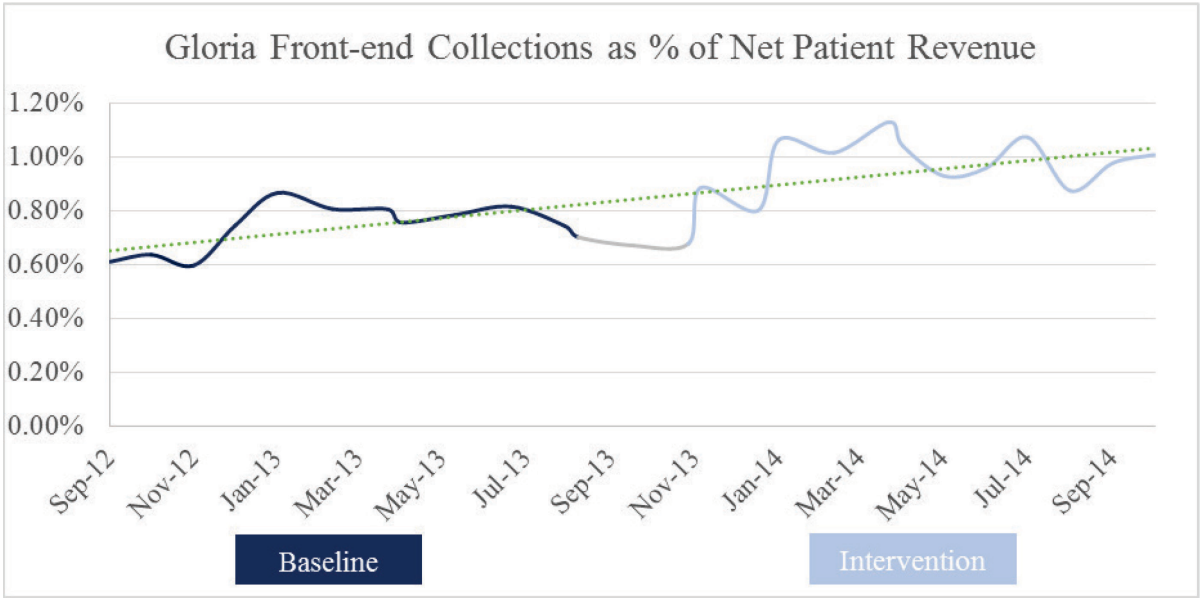


Gloria Medical Center's average monthly front-end collections were $157,763 during the baseline period; they experienced on average a $67,924 per month increase during the intervention period as compared to the baseline and set a new monthly average of $225,688. This resulted in a 43% percent average net increase in collections baseline to intervention, respectively. In the first few months of the intervention period staff members were still gaining confidence in their ability to ask for payment through the use of the scripting guide. The FEC education was completed in November 2013. Issues with Passport, the consumer estimation tool, were resolved in January and early February 2014 where GMC experienced another uptick in their collections efforts as staff members now had renewed confidence in the system and the estimates they were providing to consumers.

Early in 2014, staff members had been made aware of the upcoming revised incentive program and it was implemented in February with March being the first full

month of implementation. This was also GMC's largest collection, $263,119, month in their history of collecting from consumers. Although not part of this case study time period, their December 2014 collections reached $315,648. In October 2013 the Pre-Registration department collected $36,560 and by the end of November they had collected $60,506. The goal for this department was revised for 2014 to 5% of net revenue or $75,000. This was due to their early performance and the realization that the goal was initially set too low. In January 2014, this department experienced their highest collection amount of $93,955 and exceeded the goal by $18,955. In total the organization collected $815,092 more in the intervention period then what was collected in the baseline, an increase of 43%. As shown in Figure 8, GMC was collecting 0.74% of net patient revenue on average during the baseline and increased to 0.98% on average during the intervention period, a 33% increase.

Figure 8 - GMC's Front-end Collections as a % of NPR, Baseline vs. Intervention by Month



Front-end collections as a percent of net patient revenue measures the percent of collections in relation to net revenue. High-performing organizations can reach between

one and three percent of net patient revenue (NPR).[39,40] This measure includes all payer and consumer payments in the denominator of net revenue. At GMC the initial goal was set at 2.5% of collectable net patient revenue. Collectable net patient revenue excluded specific payers that historically do not have up-front collection opportunities or very little consumer responsibility. The front-end collections education intervention was completed in November 2013.

Although the organization did not meet the goal of 2.5% of net patient revenue during the intervention period they did have a substantial increase and were on their way to reaching 1% of NPR which the Advisory Board says is best practice.[39] Net patient revenue increased 7.8% in the intervention period compared to baseline. An increase in net patient revenue increases the denominator diluting the effects of front-end collections. If net revenue had stayed constant the average FEC for the intervention period would have reached 1.06% of net patient revenue.

Figure 9 - GMC's Front-end Collection Dollars by month, Baseline vs. Intervention Comparison

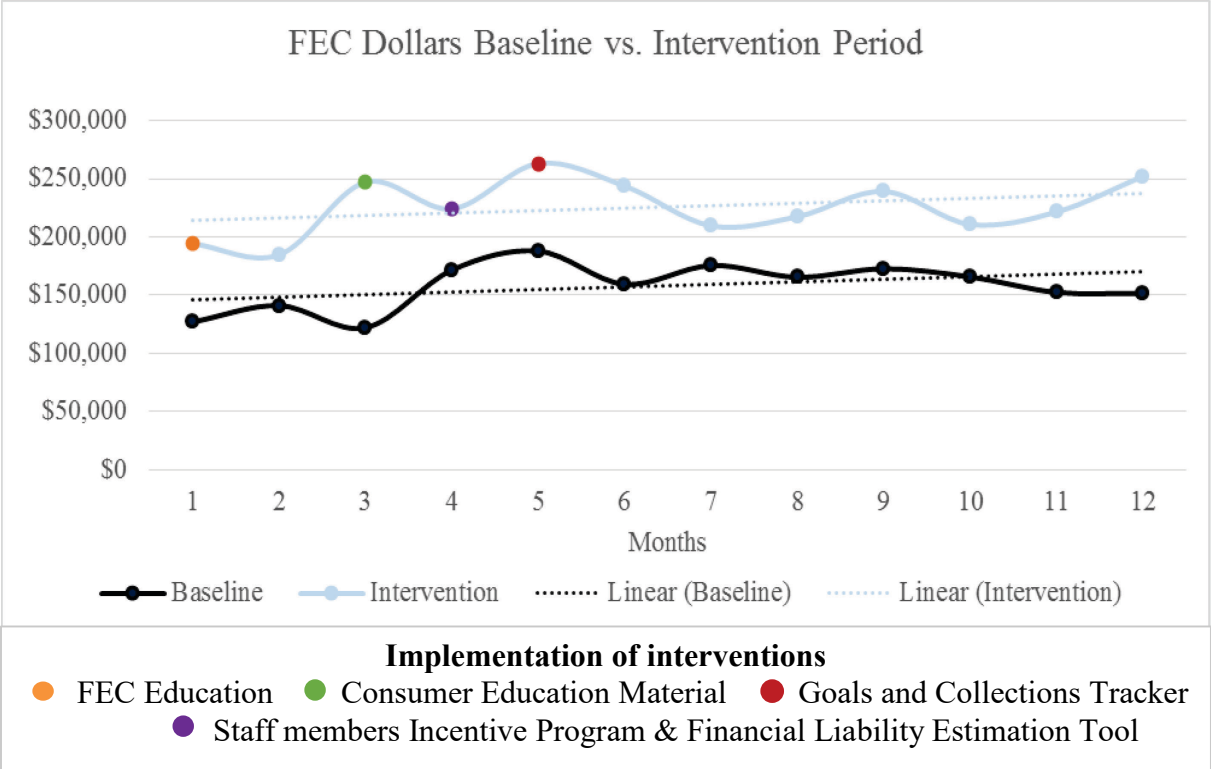


Figure 9 displays the baseline (dark blue) and the intervention period (light blue), FEC dollars, in relation to one another on a linear scale using time in months. The months in the graph do not correspond to calendar months where one would be equivalent to January. They correspond to the start of the baseline and intervention periods. Month one in the baseline and intervention period are not the same calendar month. In the case study these two periods were separated by two months due to organizational timing of when they wanted to start the interventions. When comparing month twelve in the baseline to month one of the intervention, collections increased by $42,767. Providing scripting education to staff members has been highlighted by the literature as one of the key drivers of increased collections.[22,40,47] The second intervention, consumer marketing material, appears to have had less of an impact on

collections at GMC but is considered a supporting instrument for consumers and the front-end staff members as they provide education. The staff members' incentive program and the liability estimation tool appears to have had the largest impact as in month five GMC hit an all-time high of $263,119. Their collections steadily declined in the months following for unknown reasons. These two interventions were finalized in the same month so it is unclear which one had more of an effect but together they did have a measurable impact.

Alternative Explanations

It is possible that all five interventions that were implemented had little or no effect on GMC's increased collections during the intervention period. Some possible alternative explanations will be discussed in the following paragraphs and subsequent case studies. It is evident that collections were increasing during the intervention period. Would that trend have continued organically absent the five FEC interventions?

1. The increase in HDHPs, resulting in more out-of-pocket payments by consumers, suggests more dollars are available to be collected. Having a larger pool of money to collect could increase collections if the organization continued collecting using the same status quo collection practices. The significant change in collections from the baseline to the intervention period in addition to the fact that consumers have been covered by high deductible health plans for over a decade does not support this argument.
2. The state in which GMC resides had decided to expand Medicaid coverage but this fact would have decreased the overall opportunity for GMC as Medicaid consumers have very small if any out-of-pocket expenses.

3. GMC had a staff member incentive program prior to the start of the case and it had been in place during the entire baseline period. Did this incentive program create the increased collections in the baseline and would that trend have continued without the five interventions implemented during the implementation period? Although GMC did have an upward collections trend during the baseline as shown in the previous graph, average collections when comparing the first six months to the last six months only increased by $12,396 or 8%. When looking at quarterly collection averages the last 3 months of the baseline was only higher than the first three months. Post implementation of the revised staff member incentive plan (month five of intervention) collections were 66% higher than the baseline average. The first incentive program appeared to make an impact but not as substantial as the revised program.

Chapter 5: Case Study #2 – Fitzgerald Community Hospital[2]

Setting

Fitzgerald Community Hospital (FCH) is a not-for-profit 100 bed community-based hospital and nursing facility located on the east coast of the U.S. The hospital had a daily census of 78 in 2014. Additional FCH statistics for 2014 are listed in Table 10. Fitzgerald provides a wide range of services to the surrounding community. Oncology treatment is one of FCH's main service lines but they also provide acute and ambulatory care services (Surgery, Dermatology, OB/GYN, Neurology and Cardiology, etc.) that are typically found at a community hospital. The hospital first opened in the early 1900s and has since grown to over 100 providers on the medical staff and 1,000 employees. The hospital has a small residency program to train the next generation of providers.

Table 10 - FCH FY2014 Statistics

Fitzgerald Community Hospital FY 2014 Statistics	
	Visits
Emergency Room	23,303
Surgical Procedures	3,308
Outpatient Visits	130,811
Discharges	3,976

The population of the city is under 25,000 according to the 2010 census with an estimated household income of approximately $27,000.[46] The nearest city with a population over 50,000 is less than an hour away and has multiple competing hospitals. In the city and surrounding area there are four primary industries: agriculture, forestry, healthcare and fishing with Fitzgerald Community Hospital being the largest employer in the area. The city is part of a Micropolitan Statistical Area (MSA) as defined by the U.S. Office of Management and Budget.[46] Fitzgerald holds the designation of being a Nursing Magnet facility, further highlighting their excellence and dedication to providing the best

[2] Pseudonym

nursing care. There are no direct competitors in the city but there are over 10 hospitals within a 30 mile radius including a Level 1 trauma center.

Case Overview

During fiscal years 2012, 2013 and 2014 FCH experienced volume declines in total discharges, surgical cases and Emergency Room visits resulting in declining reimbursement. All of these factors were impacting the organization's overall profitability. Expenses for the same time period decreased as the hospital implemented several cost-savings initiatives; still reimbursement suffered. The primary area of growth was in outpatient visit volumes which is consistent with the national trend as more care is being shifted to outpatient settings. Reimbursement associated with outpatient services is significantly lower than inpatient or Emergency Room services. Flat margins for three years, declining reimbursement and further shifts to outpatient services prompted FCH's leadership team to develop a plan to ensure the organization had a strong financial footing for decades to come. They branded the initiatives in the plan as Fitzgerald Community Hospital Vision 2020.

The hospital's physician practice recently agreed to an affiliation agreement with a larger health system and there are talks of expanding the relationship in the coming years. One of the many initiatives identified to assist in the financial improvement was enhanced front-end collections. The FCH case study started in March 2014 with an assessment of their Patient Access department taking place in October, November and December of 2014. During this time a comprehensive assessment of the current front-end collection processes, data, reporting and technology was conducted.

The assessment included several different aspects that are listed below. The information collected during the assessment provided the insight about the organization that supported the development of the work plan. It also assisted in the prioritization of intervention implementation.

- Shadowed and observed key front-end processes (scheduling, pre-registration and registration)
- Reviewed current technologies (insurance eligibility, consumer liability estimation capabilities)
- Requested current front-end collections or other metrics utilized and tracked
- Identification of all collection locations
- Analyzed liabilities owed by location compared to what was collected
- Collected all current marketing/information brochures and information
- Gathered all policies and procedures
- Interviewed management and leadership about front end collections and overall revenue cycle processes

During the assessment the Chief Financial Officer was identified as the executive sponsor. The Revenue Cycle Director was the primary revenue cycle contact for that area. The objective of the case study was to implement five interventions, monitor front-end collections, evaluate the organization based on the seven Baldrige criteria and attempt to answer the study question: How did FCH increase their front-end collections? FCH's electronic health record, MEDITECH, had the capability to monitor collections at the location and employee level but it was rarely reported and distributed across the organization. The system was also able to report on several patient collections based on specific transaction codes: prior balance collections and point of service collections. Unfortunately leadership did not place an emphasis on front-end collection improvements and goals were non-existent.

Case Protocol

In late March 2014, the Fitzgerald Community Hospital case study began. The first step, as in the GMC case study, was to implement an organizational structure to support the various interventions that would be implemented. Three groups were identified; Financial Outreach, Revenue Cycle Steering Committee and Executive Steering Committee. The purpose of the Executive Steering Committee was to approve initiatives, remove barriers and ensure the work group stays on-task. A sub-group of the Revenue Cycle Steering Committee was formed to complete the tasks identified in the Patient Access work plan. A meeting was held with the Chief Financial Officer (CFO) and the Revenue Cycle Director to review the work plan, identify members of both the Revenue Cycle Steering Committee and Financial Outreach Committee as well as name a Team Lead and members. The Financial Outreach Committee Members can be found in Table 11.

Table 11 - FCH Financial Outreach Committee Members

Financial Outreach Committee	
Patient Access Manager	Chair
Physician Practice Ops Manager	Member
Surgery Lead	Member
Financial Counselor Lead	Member
Imaging Director	Member
Emergency Department Registration Lead	Member
Outpatient Registrar	Member
Manager, Outpatient Therapy	Member

The Patient Access Manager was named the lead of the committee. Unfortunately, the Patient Access Manager resigned in April 2014 and was never completely engaged in the Financial Outreach Committee. The position was not replaced during the case study. In the absence of a Patient Access Manager, the Billing Manager assumed the Chair responsibility of the committee. Unfortunately, she was occupied with her daily responsibilities and unable to dedicate the appropriate amount of time needed to facilitate

implementation of the interventions. Her background was not in Patient Access so it was a learning opportunity for her.

The team members were a diverse group of managers, directors and department leads throughout the organization with representation primarily from areas that experience high consumer visit volumes. Meetings were scheduled on a re-occurring weekly basis for five months. During the kick-off meeting, in late March, the committee approved the charter (Appendix IX.) and a draft of the work plan was reviewed. The initial implementation of the five key interventions begin in March 2015 with developing patient education material and the front-end collection education and scripting guide. The FEC initiative that included all five interventions was part of the FCH organizational strategy called FCH Vision 2020.

The Executive Steering Committee (ESC) oversaw and managed all FCH Vision 2020 initiatives. The FEC initiative reported progress to the Revenue Cycle Steering Committee that in turn reported progress for all the revenue cycle initiative to the ESC as shown in the organizational structure to the right. There were also other initiatives that reported to the Revenue Cycle Steering Committee. The Financial Outreach Committee provided monthly updates to the Revenue Cycle Steering Committee and the Executive Steering Committee.

Data

Patient level data were not used. All financial data collected was aggregated at the employee, department, and location or organization level. Key financial data elements were obtained from Fitzgerald's monthly income statements. These elements included net patient revenue, bad debt adjustment, and charity care adjustments for the

baseline and intervention period, each being 12 months. Formulas were used to calculate bad debt as a percent of net patient revenue, charity as a percent of net patient revenue, and front-end collections as a percent of net patient revenue. Four data files were provided during the assessment:

1. Net revenue by department/service line
2. Total consumer liability by department/service line (total that was owed)
3. Total consumer payments (total that was collected)
4. Baseline collections by department

Each of these files contained 12-months of data and were used to develop the front-end collection goals. In June of 2015, the front-end collections tracker with goals was implemented. Historical collections data were also gathered during the assessment and was used to populate data into the tracker. The cash tracker was used to capture monthly collections during the intervention period.

Methods & Interventions

The methods used to implement each of the initiatives at Fitzgerald Community Hospital were very similar to the methods used in the GMC case. The timing of each of the five interventions is depicted in the Table 12 which highlights the baseline data collection and intervention period. The interventions were not implemented in a step-wise process due to the timing and efforts of each. First implemented was the consumer education material followed by FEC education and then the other three interventions. Measurement started during the implementation of the first intervention to capture any initial impacts related to FEC improvement and the potential of the Hawthorn Effect, the impact of behavioral change from being observed. Intervention four, front-end employee incentive program, was not implemented.

Table 12 - Fitzgerald Community Hospitals' Initiative Implementation Timeline

Fitzgerald Community Hospital	2014								2015												2016			
	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR
Baseline Period	Baseline																							
FEC Education																								
Goals and Collection Tracker																								
Consumer Education Material																								
Staff Incentive Program																								
Liability Estimation Tool																								
Measurement Period													Measurement											

Intervention #1 – FEC Education

Front-end staff members' education was implemented during the same time the consumer educational material was being created and implemented. The scripting guide (Appendix III) that was used at GMC was also used at Fitzgerald Community Hospital with a few slight modifications and a name change. The education sessions were also re-branded to the Patient Financial Responsibility Education from Front-end Collections Education in an attempt to identify with consumers and make it less of a "collect more money" initiative to an enhanced consumer initiative. This re-branding had a positive impact on staff members' acceptance of the program and it made it an easier sell to consumers. It was presented and approved by the Financial Outreach Committee, Revenue Cycle Director and Chief Financial Officer in April 2015. The committee was responsible for identifying a roster of individuals within the organization that should participate in the FEC education. If staff members had the potential of interacting with a consumer about their out-of-pocket expense they were placed on the roster.

Thirty hospital staff members and sixty-four physician practice staff members were identified to participate. These identified staff members were from a variety of departments across the organization: Pre-registration, Scheduling, Admitting, Emergency Department Registration, Financial Counseling, Customer Service, Surgery and

Registration staff members from all of the physician practices. The education/scripting sessions were scheduled at various times of the morning, afternoon and evening to ensure attendance at one of the seven hospital sessions or one of the 13 physician practice sessions. The Patient Financial Responsibility (PFR) hospital training schedule in Table 13 outlines the sessions scheduled. A similar schedule was developed for the physician practice locations. The first education session was scheduled for May 11, 2015 with the remaining sessions continuing through the end of the month. To accommodate any remaining staff members that had not attended one of the sessions three additional sessions were added.

Table 13 - Fitzgerald Community Hospital's FEC Education Schedule

PFR Hospital Education Sessions Schedule (May 11-May 20)			
Date	**Location**	**Time**	**Room**
Monday, 5/11	Main Hospital	1:30-3:30p	Seminar Room
Monday, 5/11	Main Hospital	3:30-5:30p	Seminar Room
Wednesday, 5/13	Main Hospital	11:00-1:00p	Conference Dining Room
Wednesday, 5/13	Main Hospital	3:00-5:00p	Conference Room E
Thursday, 5/14	Main Hospital	9:00-11:00a	Conference Dining Room
Tuesday, 5/19	Main Hospital	3:30-5:30p	Conference Room C
Wednesday, 5/20	Main Hospital	2:00-4:00p	Conference Dining Room

A memo from the CFO, similar to the sample in Appendix IV from Gloria Medical Center, was sent to all hospital staff members prior to the start of the first session asking for their support of the front-end collections initiative. A general front-end collections education sessions was given to a group of physicians as well as to several clinical departments during their monthly meetings to gain clinical staff members' support of the initiative. Experienced trainers delivered the education and instructed staff members on the role-playing portion. A train-the-trainer model was not utilized to make

certain that each session was delivered consistently. Sessions were initially scheduled for 90 minutes.

The first 30 to 45 minutes reviewed a PowerPoint presentation that highlighted the changes in health care related to consumer responsibility, growth of high-deductible health plans and the overall opportunity the organization had to educate and request out-of-pocket expense from consumers. The remaining 60 minutes were dedicated to a group exercise for staff members to practice scripting with different potential consumer scenarios. One staff member would play the role of the consumer while the other staff member would practice attempting to educate and collect. The scripting guide contained eleven scenarios in a patient and response format as highlighted in the example below.

PATIENT: **"Someone else is responsible for my child's medical bills"**
RESPONSE: "I understand that you may have an agreement with that person. I would be glad to give you a receipt so that you can be reimbursed. Will you be paying by (e.g. cash, check, credit or debit card) today?"

All staff members took turns being the consumer and the employee through each of the scenarios. This exercise served two purposes. First, it assisted staff members in building confidence responding to various reasons consumers would provide for not paying their out-of-pocket expense or understanding their financial responsibility. Second, it allowed the trainer to evaluate each staff members' attitude on attempting to collect. The scripting guide was introduced as a guide to assist them in developing their personalized message to the consumer. Staff members were not expected to follow it word for word. The focus was on educating the consumer in an "educate and then ask for payment, educate and then ask for payment" model. If the consumer persisted on having a reason for not paying, the employees were instructed to proceed with registering the consumer without payment. They were also instructed to provide one last education

moment by letting the consumer know they would be receiving a bill for the services and remind them to bring their co-payment at the next visit. If at any point the consumer got irate, loud or out of control the employee was instructed to ask their supervisor or manager for assistance.

There are four to five general responses that can be used in most situations with the consumer to overcome pushback to making a payment of their out-of-pocket responsibility, these were practiced during the scripting training. During each session, staff members were asked for other common scenarios they have experienced and the trainer would role-play with a staff member to provide a possible response to the scenario. Trainers were able to identify staff members who struggled or are were not comfortable asking for payment and during the sessions those staff members received additional attention. At the end of each education session, staff members were required to complete and sign a Patient Financial Responsibility Education confirmation form (Appendix X.). The form confirmed attendance at an education session and receipt of the PFR scripting guide. The completed form was placed in the employee's employment record.

Post-training, to ensure staff members utilized the scripting and asked for payment, the trainers shadowed a sample of staff members. This included those staff members who were observed during the sessions as having a difficult time or who were negative about the requirement to ask for payment. If staff members were observed not following the scripting guide, providing education to consumers, and asking for payment, feedback was given to their manager or supervisor for follow-up. As part of this initiative, all front-end staff members job descriptions were reviewed to confirm that

collecting from consumers was an expectation. If it was not included, language was suggested that could be added covering the responsibility to collect from consumers. There was a small amount of turnover in the physician practices during implementation. All new hires attended an FEC education session or were trained by a hospital staff member utilizing the same material. The education material and scripting guide were provided both in hard copy and soft copy to Fitzgerald Community so that new hires were given the same information.

Intervention #2 – Goals and Collection Tracker

Fitzgerald had the system capability to produce a front-end collections report, but it was not run consistently or shared across the organization. Goals also did not exist for the hospital or physician practices. The aim of intervention two was to develop and implement collection goals by location or department and institute a tracker to monitor collections progress. Thirty-one hospital based departments and physician practices were identified as having potential to collect from consumers. Some of these areas shared consumer check-in desks allowing consolidation to 11 locations for which collection goals were set. During the assessment four key data files were requested that contained data elements needed by department to calculate goals and review historical performance over 12 months. Goal development for Fitzgerald Community Hospital was modeled differently than what was used at GMC.

No insurance companies were excluded from the net patient revenue at Fitzgerald as they were at GMC. Five percent was used at the net patient revenue goals whereas at GMC two-and one-half was used. This was an aggressive goal by any standard but was even more significant given Fitzgerald was only collecting 0.11% of net patient revenue at the start of the case.

To develop the goals by department, as mentioned previously, several data files were utilized.

1. Net revenue by department/service line
2. Total consumer liability by department/service line (total that was owed)
3. Total consumer payments (total that was collected)
4. Baseline collections by department

Data from these files were then used to calculate two percentages. The first was baseline collection as a percent of net patient revenue and the second was baseline collections as a percent of total patient liabilities. These percentages were used to determine the organization's historically consumer liability collections.

There were two limits for developing the collection goals. These limits ensured the organizations goals were not set aggressively high or low. They could not exceed 5% of net patient revenue and total more than 35% patient liabilities. Both limits were used to calculate a consumer liability goal and a net patient revenue goal by multiplying the percentage limit by the respective baseline column in the Table 14. A final front-end collections goal was developed by taking the lesser of the patient liability focused goal or the 5% of net patient revenue (NPR) focused goal. For example, if the net patient revenue focused goal (5%) was more than 35% of the total patient liability as seen in the first line in Table 14 below (Inpatient) the goal was set at the patient liability goal. The first five data columns in Table 14 are baseline data; POS Collection = FCH's POS collections, NPR = net patient review by service line/department, Total Patient Payments = payments made by patients, Total Patient Liability = Total out-of-pocket costs patients owed, POS as % of NPR = collections as a % of NPR. The next two columns are calculations based on the two percentages listed under limits to determine the goal.

Table 14 - FCH's Goal Calculation Worksheet

Limits	
NPR	5%
Patient Liability	35%

Service Line/Department	Baseline Point-of-Service Collections (POS)	Baseline NPR	Baseline Total Patient Liability	Baseline POS as % of NPR	Patient Liability Focused Goal	NPR Focused Goal	POS Goal	Goal Type
Inpatient	$8,472	$39,396,689	$2,157,173	0.0%	$755,010	$1,969,834	$755,010	Patient Liability
Cat Scan	$3,000	$2,431,721	$285,044	0.1%	$99,765	$121,586	$99,765	Patient Liability
EKG/Cardiology	$3	$335,920	$18,745	0.0%	$6,561	$16,796	$6,561	Patient Liability
Emergency Department	$89,932	$15,683,284	$3,685,874	0.6%	$1,290,056	$784,164	$784,164	NPR
Endoscopy	$1,742	$3,930,509	$183,864	0.0%	$64,352	$196,525	$64,352	Patient Liability

There were 51 Service Line/Department goals developed with 65% of them being based on patient liability and 35% based on net patient revenue. Management made the decision to exclude several departments due to the collection amount being significantly low or not having adequate staff members to collect. The departments whose goals were based on net patient revenue (5%) historically had higher collections, some were already reaching 2.5% of net patient revenue, and these were also the department's that had higher consumer financial responsibilities due, for example, surgery, imaging services, and Emergency Room. The total collections goal when compared to net patient revenue during the baseline was less than 2.5 percent.

Goals were not developed at the individual level per the direction of the Revenue Cycle Director. The system did have the capability of reporting at the employee level and the report that was pulled from MEDITECH was employee collections. The collections tracker that was implemented at GMC was used as a model for Fitzgerald but at the department level instead of the employee level. Each employee was mapped to a department and collections were aggregated at the department level. The tracker was built in Excel and allowed daily, weekly and monthly tracking of collection efforts in addition to executive level graphs to highlight progress. It was finalized and distribution started June 2015.

The Billing Supervisor received training on how to run reports out of MEDITECH so that data could be populated daily into the tracker. This individual was also responsible for distributing the report daily. The distribution list was determined by the Revenue Cycle Director. Each location had a designated individual who received the tracker and was responsible for sharing it with staff members. Historical locations collection data were also loaded into the tracker for trending purposes. The organizational monthly goal for front-end collections was set at $255,642, a large, almost unattainable increase from their fiscal year 2014 average monthly hospital collections of $18,699. This should have been the first red flag and the goals should have been re-calibrated to something more obtainable. Everyone wanted to believe that reaching those goals was possible. Goals were to be re-evaluated every six months to facilitate continuous improvement or downward adjustments as needed. If a department was continuously exceeding their goal, it could be increased to reflect the improvement.

Intervention #3 – Consumer Educational Material

Fitzgerald Community Hospital's educational material on patient financial responsibility was sparse prior to the start of the case study. Depending on the consumer population, websites are often places where people go first in search of information. Fitzgerald had a section on their website for visitors and consumers with a subsection called Billing and Insurance. With the intervention, this section was modified to include educational information for consumers about their bill from Fitzgerald, information on how to make a payment, insurances accepted and a link to two newly created brochures with enhanced information on insurance and billing for consumers. This supported the community's increasing use of the internet. The two printed brochures, similar to what

was included on the website, were created to support the front-end collections initiative and were placed in the consumer check-in areas across the organization. The brochures were:

1. **Understanding Your Insurance**

Did you know?

- Just like other goods and services, such as groceries and car repairs, patients are required to pay for a portion, if not all, of their healthcare expenses
- When applicable, insurance requires patients to pay co-payments at the time they check-in for their service or appointment
- As a courtesy to patients, Fitzgerald Community Hospital (FCH) is able to accept cash, check, credit or debit
- For patients without health insurance, a minimum down-payment is required to be paid at the time of check-in
- Some services may require Pre-Authorization from your insurance company prior to scheduling to ensure your insurance will cover the service or procedure
- Depending on your physician's decision on what is best to address your medical needs, service(s) may be added during your appointment which may change the amount you must pay for your medical expenses.

Defining your insurance benefits

- Deductible:
  - A set amount of eligible expenses a patient must pay during each policy year before benefits are payable by the insurance company
  - There are typically individual deductibles and family deductibles
- Co-payment:
  - A flat amount that a patient must pay for each service
  - Typically, these are paid by patients each time a medical expense is incurred during a visit to a Doctor's office, Emergency Department or Pharmacy
  - Amounts may vary by service and insurance, but they are usually between $10 to $200
- Co-insurance:
  - Once patients have met their deductible, insurance will then require patients to pay a co-insurance
  - Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service

- For example, if you've met your deductible and your co-insurance is 20%, then you are responsible for 20% of your medical bill

Contact Us:

- Billing (Phone number)
- Financial Counseling (Phone number)

2. **Patient Financial Assistance and Resources** – This was a bi-fold brochure with all the locations within Fitzgerald Community Hospital and physician practices. The primary purpose of the brochure was to provide information about financial assistance and where those resources could be obtained, this was the primary purpose of the brochure. As an example, one question was, "Can I coordinate a payment plan if I am not eligible for financial assistance?"

Providing consumers with information in many different formats throughout the organization and on the website with a consistent message across all mediums (print, web and one-on-one) allows the consumer learn in the format that is best for them.

Intervention #4 – Collections Staff Members Incentive Program

Fitzgerald Community Hospital did not have an incentive program for front-end staff members prior to the case study. The incentive plan that was developed at GMC with a two-tiered incentive was proposed to the Revenue Cycle Director at Fitzgerald Community Hospital. After continued modification and discussion about the incentive program it was decided that the organization did not concur with the value an incentive program could contribute to their front-end collections initiative and therefor did not want to make it a priority. To implement the proposed incentive program the organization would have to track front-end collection by individual staff member. This was implemented as part of intervention two, front-end collections tracker.

The second data element needed was hours worked by employee, this could have been captured from the hospital's time and attendance system. An incentive would have been paid out to employee's monthly as part of their paycheck. Gathering the necessary data to calculate the incentive was considered extremely time intensive and given the Patient Access Manager resigned in April this would have been the Revenue Cycle Director's responsibility. Thus, it was decided that a staff member incentive program would not be implemented as part of the FEC initiative.

Intervention #5 – Consumer Financial Liability Estimation Tool

Consumer liability estimation software is gaining in adoption with providers given the increased financial responsibility placed on the consumer in additional to federal and state requirements to provide consumers with estimates of their care. Prior to the start of the case, Fitzgerald had started exploring estimation software through their insurance eligibility and verification software vendor, Passport Healthcare. While Fitzgerald Community Hospital was reviewing options for a software-based estimation tool, which can take 3-5 months to make a decision and implement, it was decided to move forward with intervention five and implement an Excel tool in the interim. Established consumer liability estimation vendors have been prevalent in the market for multiple years and until recently few have entered into the market.

As consumers own a larger percentage of their health care costs and providers have a need to collect those liabilities, many new entrants into the consumer liability estimation and other related services have grown. There are benefits associated with providers using the same vendor for insurance eligibility and liability estimation. First, it is one system so multiple logins for staff members should not be required. Second,

interfaces usually exists that allow data elements to pass between the applications and the providers scheduling system. Fitzgerald's electronic health record is MEDITECH and they use Passport for insurance eligibility which is the same structure and software configuration utilized at Gloria Medical Center.

The Patient Liability Estimator (PLE) was built and tested in May 2015 and was implemented for staff members to use in June 2015. Ten staff members were trained on how to use the PLE with the primary users being the three pre-registration staff members. Fitzgerald Community Hospital choose not to provide Patient Liability Estimator (PLE) training to all staff members identified as part of the Patient Financial Responsibility education. To build the PLE, FCH's top 16 insurance contracts were reviewed to determine the reimbursement structure. Six of the plans were fee-for-service while the remaining plans were percent of charge contracts ranging from 52% to 97%, with Medicaid being the lowest at 52%.

Hospitals located in rural areas typically have a higher number of payer contracts based on a percent of charge reimbursement model compared to large urban and city hospitals. The PLE utilized Fitzgerald's charge master, a list of all Current Procedural Terminology (CPT) codes with associated charges developed by Fitzgerald, to identify the base charge by CPT. There were six main inputs in the estimation tool to create an estimate for the consumer:

1. Consumer insurance plan (Aetna, United Health Care, Cigna, etc.)
2. Out-of-pocket max remaining
3. Deductible remaining
4. Co-payment
5. Co-insurance
6. Current Procedural Terminology (CPT)

The numbers highlighted above in yellow are generated from Passport's eligibility application and were run on every consumer that had not been treated by the hospital in the last 30 days. The consumer's insurance plan information is either received with the order for services, over the phone when a pre-registration staff member called the consumer, or at the time of service when the consumer presented their insurance card. The CPT or group of CPT's are found on the order for services submitted by the requesting physician. For example, an order for an MRI may have CPT 70551 (MRI of brain without contrast) on the order.

A screenshot of the PLE is shown below and required cells to complete are highlighted in yellow. This is also an alert to staff members so they know what cells they need to fill-in for an estimation to be generated. The format of the PLE is such that it can also be printed for consumers. To develop an estimation the PLE matches up the insurance plan with the percent of charge for that payer by CPT; this creates the hospital fee. If there are multiple CPT's it will add them together to create a total allowable amount.

Figure 10 - FCH's Patient Financial Liability Estimation Tool

Purpose:
The following document is intended to provide the patient an estimate (NOT QUOTE) of what their out-of-pocket expense would be and provide education on insurance benefits so that the patient may make informed decisions about their healthcare. If there are additional questions or assistance is needed please contact Financial Counseling at 888-447-4502.

Instructions:
To complete the patient estimate, all fields in yellow should be filled out. Items in the "Payer Information" box should be obtained from Passport. Items in the "Procedures" box should be obtained from the order or pages _____ in Meditech. The information in the "Appointment Information" and "Patient Liability" boxes should then be explained to the patient.

Appointment Information:		**Payer Information:**	
Patient Name:	Rusty Schlessman	Insurance Plan	MVP
Appointment Date:	9/4/2015		
Area:	MRI	Out-of-Pocket Max Remaining	$ 2,000.00
Date of Estimate:	9/1/2015	Deductible Remaining	$ 1,200.00
Estimate Run By:	Mary Jones	Co-Pay	$ 150.00
Signature:		Co-Insurance	10%

Procedures:		
CPT Code 1	CPT Code 2	CPT Code 3
73723	73610	
Description 1	Description 2	Description 3
ANKLE LEFT MRI W&W/O CONTRAST	ANKLE LEFT MIN 3 VIEWS	
Hospital Fee 1	Hospital Fee 2	Hospital Fee 3
$1,980.00	$330.00	
Total Estimated Hospital Fees	**$**	**2,310.00**

Patient Liability:		
Allowable Fee Schedule:	$	2,310.00
Deductible Due:	$	1,200.00
Co-Pay Due:	$	150.00
Co-Insurance Due:	$	96.00
Total Estimated Patient Responsibility:	**$**	**1,445.00**

Disclosure:
As a reminder, this is an estimate and is not a guarantee of coverage for care. Depending on the individual case, the patient may be liable for additional services which are medically necessary as a part of the patient's care and not included on the estimate. In addition, other fees may be billed separately based on the care provider. In addition, the estimate is only for the hospital portion of the bill. Additional bills may be received from the doctor. The estimate provided will be a range of possible prices or an average price, which may not be linked to the patient's insurance plan, depending upon their situation and the information provided. Please note an estimate may not be available for the procedure requested.

The three person Pre-registration Unit would call consumers that were scheduled for high-dollar procedures (surgeries, imaging) to inform them of their out-of-pocket estimation and attempt to collect over the phone. If they were unsuccessful at collecting from the consumer over the phone a note was entered into MEDITECH documenting the conversation for the registration staff member to read when the consumer presented the day of the service. Often, the Pre-registration staff members were called to fill-in for registration personnel did not report to work; when this occurred providing estimates to patients was a secondary priority.

In October 2015, FCH implemented Passport Health's Patient Payment Estimates (PPE) software. This replaced PLE as the consumer estimator tool. Passport provided on-site training to staff members on the new application. The Pre-registration team

tested PPE over the next month to monitor the accuracy of estimates and ensure it was capturing the correct consumer information into MEDITECH through the interface.

Baldrige Criteria Assessment

Leadership

Fitzgerald Community Hospital (FCH) has been a primary community resource for nearly 100 years, this has been made possible by the vision and leadership of the community board. The mission of the organization is "FCH exists to provide exceptional health care and comfort to the people we serve." The Executive Steering Committee was chaired by the Chief Executive Officer (CEO). The CEO has been leading FCH for the last decade and prior to that served in various other health care senior executive roles. The Chief Financial Officer (CFO) has been with the organization for six years and prior to that was the CFO at another health system.

Fitzgerald Community Hospital was in the process of working on operational, clinical and other financial initiatives at the start of the case study due to declining reimbursement and inpatient volumes. The senior leadership team developed a brand for these initiatives so it could be communicated across the organization. It was called FCH Vision 2020 and referred to the organizational goals to solidify their financial future through 2020. As part of FCH Vision 2020 regular updates were provided to staff members through newsletters and emails. Due to the small size of Fitzgerald, the CFO was able to be involved in the approval and decision making processes regarding the FEC initiative and interventions. The front-end collections initiative was a part of the larger FCH Vision 2020 project and monthly status updates were provided to the Executive Steering Committee (ESC) meeting by the Revenue Cycle Director.

The ESC was composed of the executive leadership team and was a venue for each initiative team to provide progress updates, discuss major barriers and sensitive topics. The Revenue Cycle Steering Committee was chaired by the CFO and reported up to the Executive Steering Committee. Although the CFO was the chair on paper, he rarely attended the Revenue Cycle Steering Committee and trusted the Revenue Cycle Director to lead the group and provide him updates. Prior to the ESC meeting, the Revenue Cycle Director would meet one-on-one with the CFO to provide an update on the revenue cycle initiatives.

Overall hospital leadership was lukewarm when barriers were presented that needed their intervention, especially if it impacted the community or providers. Leadership supported the FEC goals but did not necessarily support all the interventions, incentive program and organizational accountability, needed to reach them or even get close. The absence of a Patient Access Manager serving as chair of Financial Outreach Committee impacted the work group's ability to accomplish all of the interventions timely and successfully. As mentioned earlier, the Billing Manager took over when the Patient Access Manager left the organization but she did not lead the meetings or independently facilitate the implementation of the FEC interventions. The Patient Access Manager has not been replaced since and the duties were shifted to the Billing Manager.

Strategic Planning

The Chief Financial Officer knew that collecting more consumer liabilities would assist the organization financially. It would accelerate cash, reduce bad debts and begin to educate the community on the cost of health services. The FEC initiative work plan that was developed was shared with the Revenue Cycle Director and CFO for approval. It outlined the various interventions, owner(s) and timeline for each component of the

FEC initiative. The initiative was integrated into FCH Vision 2020 project from a strategic perspective so that it would also have senior leadership visibility and support. Goals were developed for the FEC initiative to support organizational transparency and more closely align their expectations with industry norms. These goals were shared with the departments and the expectation was set that they work towards achieving them.

The organization did not reach the goal, 5% of net patient revenue, set in the 12-month intervention period. It was an aggressive goal to achieve and was beyond the organization's reach even if they had decided to implement an incentive program and fully supported all the interventions. Fitzgerald was collecting 0.11% of net patient revenue during the baseline period; 5% would have required a relentless pursuit with the support of the entire organization and community.

Customer Focus

Front-end collections are consumer sensitive and have gained additional national media exposure since the implementation of the Patient Protection and Affordable Care Act (ACA). Asking for payment up-front was not an initiative that FCH had consistently pursued with the community at large. Nor had they done a good job of educating the community and consumers of the hospital about their financial responsibility when services were provided. Two brochures were created that aimed to improve consumer education about co-pays, co-insurance and deductibles, as well as the consumer's out-of-pocket financial responsibility and how they could get support. Fitzgerald's consumer section on their website was also enhanced to provide another avenue of communication and education to consumers.

All customer related interventions, FEC scripting guide, financial brochures and the consumer estimate process were vetted with the CFO prior to implementation. He understood that the scripting education was going to provide staff members a more assertive approach to consumer collections than Fitzgerald had taken historically. One tactic Fitzgerald implemented when the lines for registering consumers got too long was to shift some pre-registration personnel to the registration desk. This tactic had both positive and negative impacts. It addressed consumer wait times in the imaging department and the clinical team was satisfied with the throughput. However, it also reduced the number of consumer estimates completed daily and negatively impacted collection efforts. Revenue Cycle leadership had received negative feedback from the clinical team about the slow registration process and did not want consumer collections to create more dissention between the front desk and the clinical personnel.

Measurement, Analysis and Knowledge Management

Fitzgerald did not have a front-end collections tracking tool at the employee level or at the department level. Collection reporting capabilities did exist from MEDITECH but consistent and regular reporting did not occur. This was in large part due to the organization not making front-end collections a priority. Part of the FEC education included a summary on the changing health care landscape and why consumer education is important for both Fitzgerald Community Hospital and the consumer.

Additional internal communications would have been beneficial in gaining the clinical personnel buy-in and support of the initiative. At the on-set of the case, the Revenue Cycle Director knew that the organization's collections were low compared to industry high performers and that an apparent opportunity existed to improve collection

efforts; unfortunately, she did not have the full organizational support. As part of intervention two, goals and collections tracker, collection goals were established based on the identified opportunity using Fitzgerald's net revenue and total liability data. The FEC tracker provided multiple tabs of information that could be shared at the executive, management and employee level to set expectations, measure success and identify areas for additional education.

Workforce Focus

The FEC initiative was focused on providing employees with the correct tools, education, support, and feedback mechanism to be successful at improving collections and educating the community. This was accomplished with the educational sessions that reviewed the latest trends in consumer financial responsibility along with the scripting training. The development, implementation and education of the Patient Liability Estimator further supported collection interactions with consumers. A Pre-registration department was developed and staffed with three individuals to provide consumer estimates for surgical and imaging consumers.

To support staff member communications between Pre-registration and Registration, a MEDITECH screen was modified so that Pre-registration could add notes into the system after they spoke to the consumer. These notes would then be utilized by the registration personnel when the consumer presented for their scheduled services, allowing the Registration staff members to continue the consumer liability conversation. The additional consumer marketing and educational material further assisted the community in understanding why they were being asked for payment. Had it been accepted, the staff member incentive proposal would have been an additional workforce

support mechanism to improve front-end collections and reward collection efforts. Registration personnel are some of the lowest paid employees within a hospital; consideration of an additional compensation plan could have helped retain and recruit new staff members, as well.

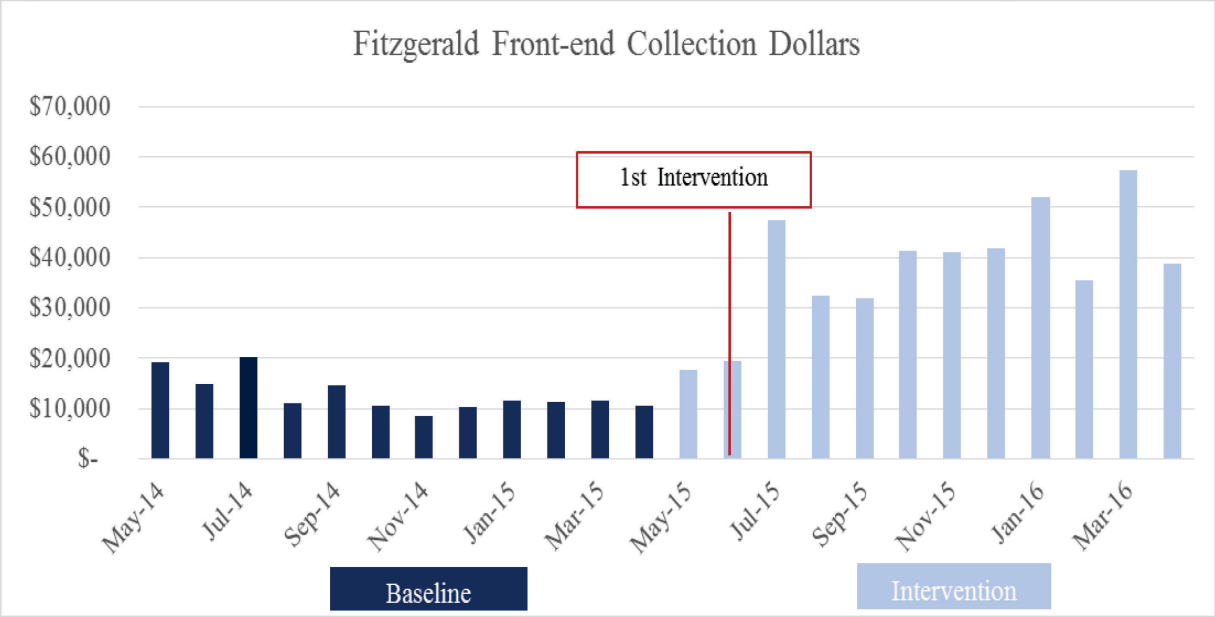
Operational Focus

To operationalize the FEC initiative, all four implemented interventions took a significant effort by the FCH staff members in addition to their daily work. This is especially true given the lack of leadership chairing the Financial Outreach work group. The work plan start and stop dates were followed with only minor delays and all but one of the interventions was implemented. To support the process and technology changes that were implemented, policies and processes were also updated to match the changes. Front-end staff member huddles by department were implemented as part of the FEC education to allow these personnel to provide feedback to management about barriers they faced during collection attempts.

Results

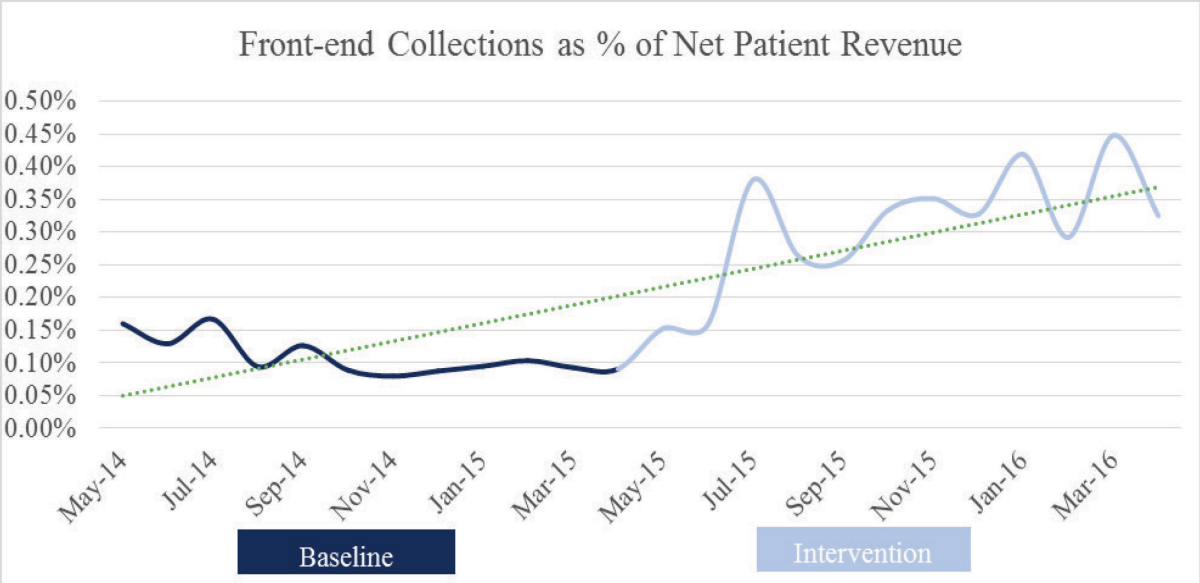
Post-intervention front-end collections as a percent of net patient revenue increased gradually immediately after the FEC education and scripting training, as shown in Figure 11. The Revenue Cycle Steering Committee's responsibility was also to monitor results and report those to the ESC. The FEC initiative applied multiple measures to demonstrate improvement. Baseline and intervention period dollars collected per month are highlighted and show a slight improvement at the point of the first intervention's implementation.

Figure 11 - FCH's Front-end Collection Dollars, Baseline vs. Intervention by Month



FCH's average monthly collections during the baseline period and intervention period were $12,849 and $37,999, respectively. This reflected a total monthly average increase of $25,150 per month and almost a 300% increase in the monthly average comparing baseline to intervention period. The first intervention, FEC education and scripting training, was implemented in mid-May and the organization experienced an immediate improvement in collections by the end of the month. As staff members gained confidence in their ability to ask for payment from consumers, front-end collections continued to increase. The Patient Liability Estimator tool was implemented in June 2015 and in July Fitzgerald had their largest front-end collections month of $47,538, since starting to collect from consumers as shown in Figure 11. In total, the organization collected $302,650 more in the intervention period than what was collected in the baseline.

Figure 12 - FCH's Front-end Collections as a % of NPR, Baseline vs. Intervention by Month



Front-end collections as a percent of net patient revenue measures the percent of collections in relation to net patient revenue. Net patient revenue is calculated by starting with all gross patient revenue, both in-patient and out-patient, associated with providing consumers' care. Then, contractual allowances, difference between what the insurance companies allow and what is charged, is subtracted. Bad debt and charity care are also subtracted to determine net patient revenue. High-performing organizations can reach total consumer collections of between two and three percent of net patient revenue.[39,40] This measure includes all payers in the denominator of net revenue. Fitzgerald was collecting 0.11% of net patient revenue on average during the baseline and increased to 0.31% on average during the intervention period, a 281% increase in collections.

Net patient revenue increased by $6 million or 4.8% in the intervention period over the baseline. Increases in net patient revenue (denominator) decrease the percent. If net revenue had stayed constant the average FEC for the intervention period would have

reached 1.06% of net patient revenue, setting Fitzgerald on their way to reaching their goal.

Figure 13 - FCH's Front-end Collection Dollars by month, Baseline vs. Intervention Comparison

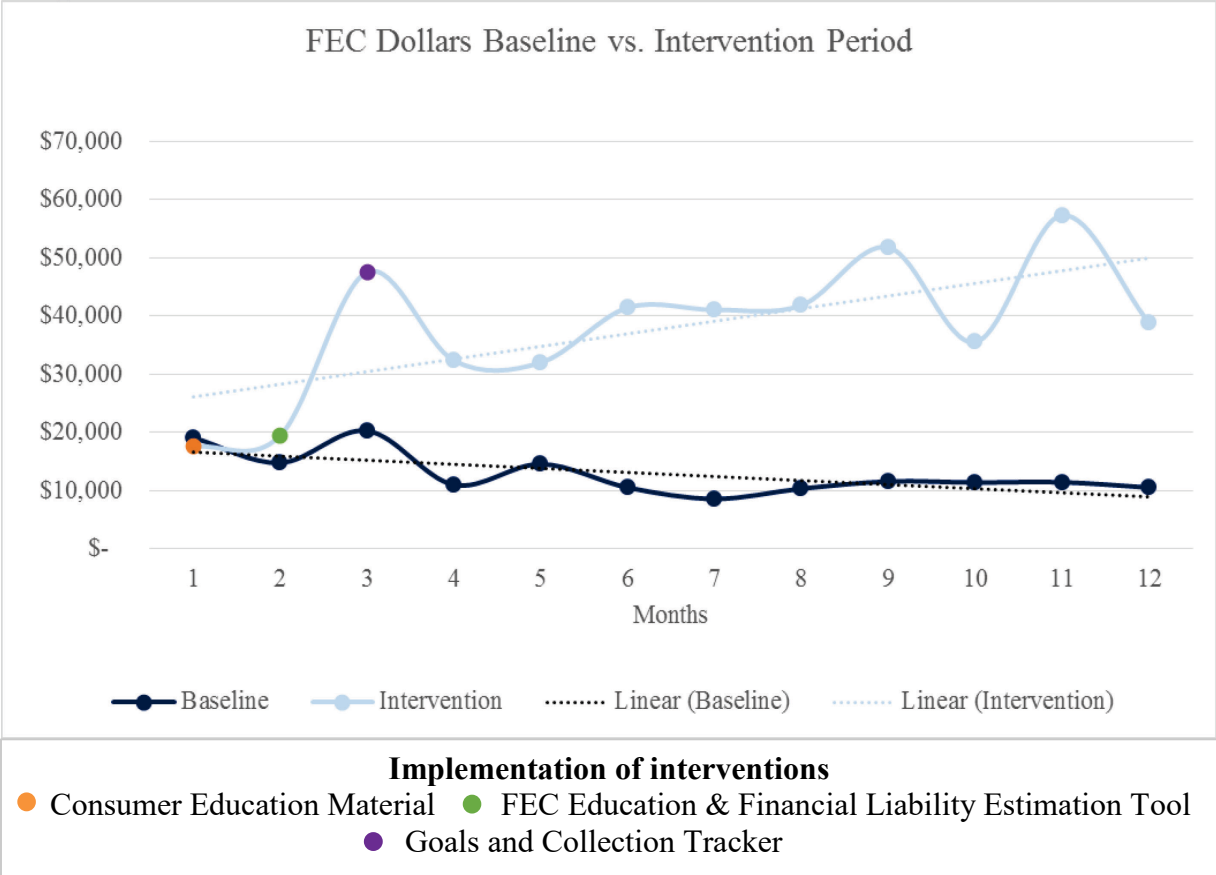


Figure 13, displays the baseline (dark blue) and the intervention period (light blue) in relation to one another on a linear scale using time in months. Month one for both the baseline and intervention period are the same, May. This is the only case out of the three that did not have a lapse of time between the baseline and intervention periods. Consumer education materials were the first intervention to be implemented and it does not appear that this had much of an impact on collections when looking at the difference between month one and two; $1,894 was the collection difference between these two months.

FEC education and the Liability Estimation Tool were finalized in month two. Collections in month three reached an all-time high of $47,538; this was a 244% increase in collections from the previous month of $19,457. The average collections from month three to month twelve in the intervention period were $41,982 or a 215% increase from the collections in month 2 of $19,457. In this case it is evident that Front-end collections education and a liability estimation tool can increase overall organizational collections.

The impact of these two interventions is difficult to dichotomize due to the timing of their implementation. In month three the goals and collection tracker was implemented and although the impact this intervention had on overall collections is unclear, the literature suggests this supports improved collections.[39,40,48,49] It is possible that the goals and collections tracker allowed FCH to maintain the focus on collections.

Alternative Explanations

FCH's collections were on a downward trend in the baseline according to the data. There are several possible explanations as to why this may be--staff members' morale, organizational focus and available technologies just to name a few. This organization could have reversed the baseline trend on their own but it is unlikely given the absence of an estimation tool and a robust front-end collections education program. They did not implement an incentive program and did not have one in place.

Chapter 6: Case Study #3 - Byrne Hospital[3]

Setting

Byrne Hospital (BH) has been serving the surrounding upper mid-west community as a not-for-profit hospital for over 50 years. Byrne Hospital has been designated a Critical Access Hospital (CAH) by the federal government. To be designated a CAH there are several requirements that must be met: operate 25 or fewer in-patient beds, be more than 35 miles from another hospital, offer 24/7 Emergency care services and have an average length of stay less than 96 hours for acute patients.[50] Byrne Hospital has 20 licensed beds and operates a daily census of between 10-15 patients. Additional BH statistics can be found in Table 15. The hospital also has a long-term care facility. The nearest metropolitan city (50,000+ population) is over three and a half hours away and a Level 2 trauma center is approximately two hours away.

Table 15 - BH CY2015 Statistics

Byrne Hospital CY 2015 Statistics	
	Visits
Emergency Room	4,936
Surgical Procedures	1,146
Out Patient	40,000*
Discharges	611

*estimated

The community is comprised of working class individuals primarily from the lumber industry, local prison and area hospitals. Byrne Hospital is one of the area's largest employers with over 250 employees and physicians. Approximately 60% of Byrne's employees are represented by a union. The hospital offers acute care services, general surgery, general cardiac, diagnostic imaging, diabetes, care management, and primary care clinics. The city is not part of a Metropolitan or Micropolitan Statistical Area as defined by the U.S. Office of Management and Budget.[46] In 2013, the

[3] Pseudonym

population of the village was recorded at just under 2,000 with an estimate median household income of roughly $20,000.[46]

Case Overview

The objective of the case study was to implement five interventions, monitor front-end collections, evaluate the organization based on the seven Baldrige criteria and attempt to answer the study question: "Did the interventions result in an increase of front-end collections?" Byrne Hospital was selected due to the population it serves, geographic location and the organizational need to improve its financial health. As a Critical Access Hospital, BH receives reimbursement from Medicare on a cost plus one percent or 101% of Medicare.[50] The hospital operates on a calendar year budget running from January 1st to December 31st and over the last several years the operating margins have been relatively flat. Critical access hospitals represent nearly one-fourth (1,332) of all hospitals in the United States and in 2014, 14 rural hospitals closed their doors.[50,51] Rural hospitals, including CAH's, close for a variety of reasons.

The primary factors have been shrinking profitability and external market factors such as declining populations, consumers seeking care in larger cities, poverty in rural areas and overall competition.[51] Leadership observed some of these factors occurring at other hospitals and decided to take the necessary steps to secure their financial future and prevent an acquisition, merger or being forced to close their doors. They wanted to remain a local independent hospital serving the surrounding community. Unlike FCH and GMC, leadership at BH did not create a brand or slogan for the improvement effort. As with most critical access and rural hospitals, Byrne was a pillar in the community. An assessment of their Patient Access department took place in November and December

2014 and January 2015. During this time a comprehensive assessment of the current front-end collection processes, data, reporting and technology was conducted. The assessment included several different aspects that are listed below.

The information collected during the assessment provided the framework to develop the work plan and determine which interventions were to be implemented first.

- Shadowed and observed key front-end processes (scheduling, pre-registration and registration)
- Reviewed current technologies (insurance eligibility, consumer liability estimation capabilities)
- Requested current front-end collections or other metrics utilized and tracked
- Identification of all collection locations
- Analyzed liabilities owed by location compared to what was collected
- Collected all current marketing/information brochures and information
- Gathered all policies and procedures
- Interviewed management and leadership about front end collections and overall revenue cycle processes

During the assessment an executive sponsor, Chief Financial Officer, was identified. Shortly after the case study began in April 2015 the CFO took a medical leave of absence and the Chief Executive Officer assumed those responsibilities. The Patient Access and Revenue Cycle Managers were the primary contacts while the CFO was out on leave. Byrne had tracked their front-end collections for many years prior to the start of the case but did not have goals. Front-end collections have gained national attention since the passage of the Patient Protection and ACA in 2010 in addition to the explosion of high-deductible health plans. Byrne knew this was an area of additional opportunity for them and in early 2015, had started placing more emphasis on collecting from consumers through the revision of their consumer education materials and a front-end staff member incentive program. Byrne used an outside vendor, HealthPay24, to collect and track consumer collections. Each employee of the Registration staff was set-up as a

user in HealthPay24 and was able to collect cash, credit or check from a consumer. Since late 2014, HealthPay24 reports were distributed weekly.

Case Protocol

In April 2015, the Byrne Hospital case study implementation work started. The first step was to develop a Patient Access Work Group. Membership of the Patient Access work group can be found in Table 16. The purpose of the work group was to lead the implementation of each of the five FEC interventions. An Executive Steering Committee was also developed to oversee all of the initiatives, including front-end collections. The ESC was tasked with approving initiatives, removing barriers and ensuring progress of each of the work group that were developed as part of the organization's improvement initiative. A meeting was held with the Chief Executive Officer (CEO) to review the Patient Access work plan and identify members for the Patient Access Work Group. The Patient Access Manager was named to lead the work group. Team members were a diverse group of managers and front-line staff members from throughout the organization representing areas that experienced high consumer visit volumes. Meetings were scheduled on a re-occurring weekly basis for five months.

Table 16 - BH Patient Access Work Group

Patient Access Work Group	
Patient Access Manager	Chair
Revenue Cycle Manager	Member
Clinic Admissions Representative	Member
Hospital Admissions Representative	Member
Hospital Admissions Representative	Member

During the Patient Access kick-off meeting in April the group reviewed the draft work plan. The initial implementation of the five key interventions began in May with the patient liability estimation (PLE) tool and the initial deployment of additional patient education materials. Unlike GMC and FHC, BH did not implement a Revenue Cycle Steering Committee due to the small complement of personnel and the multiple roles

each had throughout the organization. The Executive Steering Committee (ESC) wanted to maintain their purpose of keeping BH an independent hospital. Updates from the ESC were also reported to the Board of Directors.

Data

Patient level data were not used. All financial data that were collected were either employee or department. Key financial data elements were obtained from the Byrne Hospital's Income Statements and other monthly financial statements. These elements included, net patient revenue, bad debt adjustments, and charity care adjustments for the 12 month baseline and intervention period. Formulae were used to calculate bad debt as a percent of net patient revenue, charity as a percent of net patient revenue and front-end collections as a percent of net patient revenue. Four data files were provided during the assessment:

1. Net revenue by department/service line
2. Total consumer liability by department/service line (total that was owed)
3. Total consumer payments (total that was collected)
4. Baseline collections by department

Each of these files contained 12 months of data and were used to develop the front-end collection goals at either the department, location or employee level. In July of 2015, the front-end collections tracker with goals was implemented and distributed within the organization weekly. Historical collections data were also gathered during the assessment and was used to populate data into the collections tracker. Each week the organization provided a collections file to be used for updating the tracker.

Methods & Interventions

The timing of each of the five interventions is depicted in the Table 17. It also highlights the baseline data collection and intervention period. The interventions were not implemented sequentially due to the timing, efforts and desire of the organization as to when it wanted to implement the interventions. A consumer liability estimator tool was developed first followed by the remaining four interventions. Measurement started during the implementation of the first intervention to capture any initial impacts related to FEC's improvement and the potential of the Hawthorn Effect.

Table 17 - Byrne Hospitals' Initiative Implementation Timeline

Byrne Hospital	2014									2015												2016			
	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR
Baseline Period	Baseline																								
FEC Education																									
Goals and Collection Tracker																									
Consumer Education Material																									
Staff Incentive Program																									
Liability Estimation Tool																									
Measurement Period														Measurement											

Intervention #1 – FEC Education

Front-end education and scripting was implemented in June 2015. The scripting guide used at Byrne Hospital was identical to the one used at both GMC and FCH case studies. A sample can be found in Appendix I. All staff members identified to participate in the FEC education and scripting training were part of a union. To move forward with additional education for these union members the education and scripting guide had to be reviewed and approved by the union. The union and CEO approved the material in May 2015. It was then presented and approved by the Patient Access workgroup. Twenty-three staff members were identified for the FEC education and were from a variety of departments across the organization: Pre-registration, Scheduling, Hospital Admitting, Emergency Department Registration and Clinic Admitting.

The education/scripting sessions were scheduled at various times of the morning, afternoon and evening to ensure attendance at one of the 11 that were scheduled. Times, dates and location of the scripting sessions were determined in the Patient Access work group. Scheduling the sessions was completed in May 2015 and the first education session was on May 28, 2015 and they concluded June 18, 2015. Due to the size and limited staff size at BH, each session only had one to three staff members present.

Prior to the first sessions the CEO held a team meeting with the front-end staff members asking for their support of the front-end collections effort. Experienced trainers delivered the education and instructed staff members on the role-playing portion. The trainers lead all the sessions, a train-the-trainer model was not utilized, to make certain that each education session was delivered consistently and with the same approach. At BH the education sessions were reduced in length to 60 minutes compared with 90 minutes for both GMC and FCH. Sessions were initially scheduled for 60 minutes, the first 20-30 minutes reviewed the importance of front-end collections using a PowerPoint presentation and the remaining 30-40 minutes focused on scripting role play. The scripting guide contained 11 scenarios in a patient and response format as highlighted in the example below.

PATIENT: **"I've never been asked to pay before"**
RESPONSE: "As a courtesy to our patients, we collect patient obligations upfront. We perform insurance verification prior to your service and to reduce some of the financial worry associated with a hospital visit, we advise our patients of the amount due and request payment on the balance to reduce your wait time at the /time of service. We will accept your full payment by (e.g. cash, check, credit or debit card).

Because the education groups were much smaller at Byrne the trainers rotated being the consumer and the hospital employee through each of the scenarios. This

allowed all participants to take part in being the consumers and hospital employee and allowed them to build confidence responding to the consumers various reasons for not paying their out-of-pocket expense or understanding their financial responsibility. Staff members were not expected to follow the scripting guide responses verbatim. Rather, it was instructed to be used as a guide to assist them in developing their personalized message to the consumer.

The focus was on educating the consumer in an "educate and then ask for payment, educate and then ask for payment" model. If the consumer persisted on having a reason for not paying, the employees were instructed to proceed with registering the consumer without payment and education them on the bill they will receive. There are four to five general responses that can be used in most situations with the consumer to overcome pushback with the goal of educating them and becoming comfortable asking for payment. During each session, staff members were asked for other common scenarios they have experienced and the trainer would role-play with a staff member to provide possible responses. Trainers were able to identify staff members who struggled or were not comfortable asking patients for payment.

To ensure that staff members were utilizing the scripting and asking for payment from consumers the trainers shadowed a sample of participants, including those staff members who were observed in training as having a difficult time or who were negative about the requirement to ask for payment. If staff members did not follow the scripting guide or ask for consumer payments, feedback was provided to their manager or supervisor for follow-up. As part of this intervention front-end staff member job descriptions were reviewed to confirm that collecting from consumers was included. If

it was not, language was provided that could be added covering the expectation to collect from consumers. The educational materials and scripting guide were provided in hard copy and soft copy to BH so new hires could be educated on the collection process.

Intervention #2 – Goals and Collections Tracker

Byrne frequently distributed front-end collection reports at the individual level prior to the start of the case study but goals that were set to industry high-performers were not included. The staff member incentive plan in place prior to the start of the case study included tiered goals for the organization to reach in order for collections personnel to earn an incentive payment as shown in Table 18.

Table 18 - BH FEC Goal Tiers

Tier	Goal
1st Tier	$25,000
2nd Tier	$30,000
3rd Tier	$40,000
4th Tier	$50,000
5th Tier	$60,000
6th Tier	$70,000

Byrne developed these goals at the end of 2014 to incentivize staff members and increase collections but they were not calculated on net patient revenue or other leading collections indicators. As the organization achieved the respective tier, a monetary incentive was paid to each collections staff member. The purpose of intervention #2 was to develop and implement collection goals at the staff member level and institute a tracker to monitor and report progress. Five departments, a mix of hospital and physician practices, were identified as collection locations within the organization.

During the assessment, four key data files were requested that contained data elements at the department level to calculate goals and review historical performance. The data are:

1. Net revenue by department/service line
2. Total consumer liability by department/service line (total that was owed)
3. Total consumer payments (total that was collected)

4. Baseline collections by department and individual

Goal development for Byrne Hospital was modeled differently than what was used at GMC or FCH. No insurance companies were excluded from net patient revenue at Byrne as they were at GMC. At Byrne, 2.5% was used as the net patient revenue goal whereas at GMC and FCH, two-and-half and five percent were used, respectively. A review of the total consumer liability file was completed to ensure 2.5% of net patient revenue would be achievable.

Table 19 - Byrne Hospital's FEC Goal Collection Worksheet

Target: Collections at 2.5% of 2014 Annualized Net Revenue					
2014 Annualized Net Revenue	$23,546,265				
Annual Collection Target	$588,657				
Monthly Collection Goal	$49,055				
Team Members (FTE's)	17.00				
Average monthly/person	$2,886				
Average monthly/team	$16,352				
	Rampup Period				
	August 15'	*September 15'*	**October 15'**	**November 15'**	**December 15'**
Minimum Collection Incentive Threshold: Live in October	*$638*	*$736*	**$981**	**$1,104**	**$1,226**
Percent of Total Monthly Collection Goal	*1.30%*	*1.50%*	**2.00%**	**2.25%**	**2.50%**

Table 19 highlights the annual organizational target of $588,657, monthly goal of $49,055 and the employee level goal of $2,886. BH was the only hospital out of all three case studies where goals were developed at the employee level. GMC developed an incentive at the employee level that was based on department collections in addition to the employee's percentage of effort from worked hours and dollars collected. FCH implemented departmental level goals only. Each employee at BH was set at the same goal amount, simplifying the process of monitoring and awarding incentives. Individual goals were set to an escalation period to get individual staff members progressively

collecting more each month until they reached the month goal of $2,886. A team goal was also set. All 17 staff members were assigned to one of three teams, with each team selecting their team name. The team goals were determined by the number of staff members on the team.

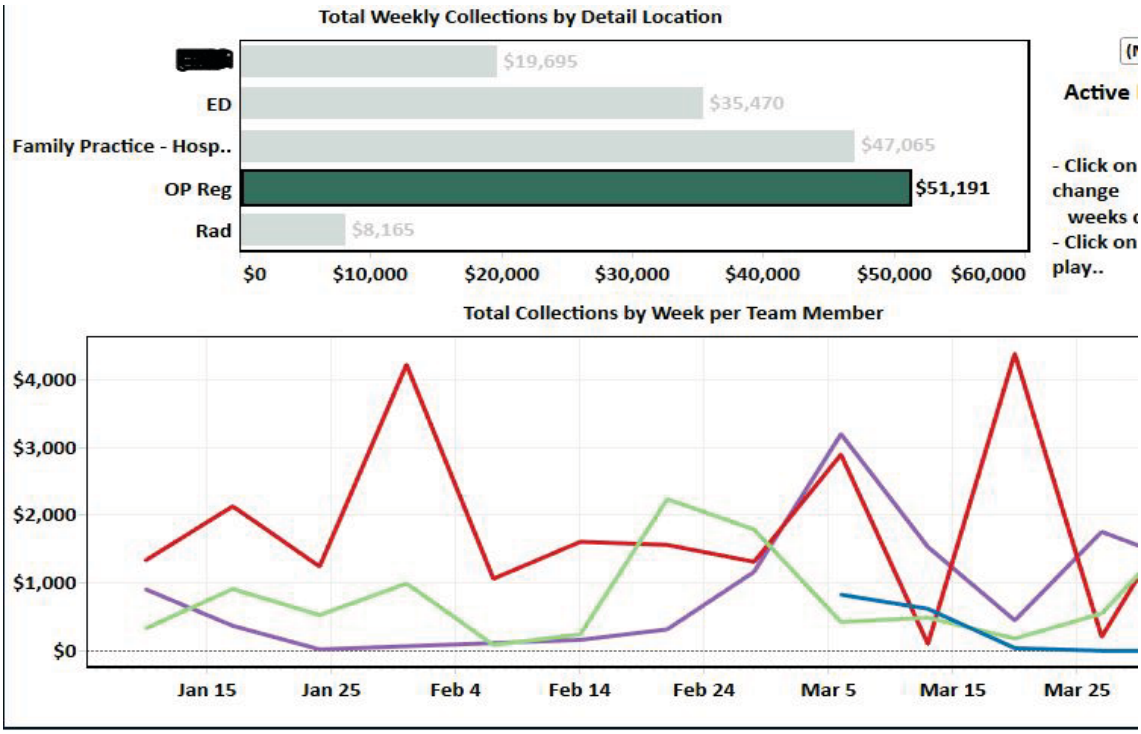
All goals (organization, team and individual) were shared with the CEO for approval. They also were presented to the Union for review and approval as it was an additional job requirement. A two-page description of how the goals were developed, overview of up-front collections and the impact additional collections could have on the overall financial success of the organization was presented by the CEO to the Board of Directors. In the small community, it was a strategic decision to include as many people in the communication as possible. The Union and the Board understood the necessity to collect from consumers up-front and the importance of setting goals to monitor progress.

The FEC tracker that was implemented at BH was built in a software program called Tableau. Each week the Patient Access Manager ran a collections report out of a system called HealthPay24 and uploaded it to a secure site so the collections tracker and graphics of current performance could be updated. Tableau contained the same data elements and reporting capabilities as the Excel Collections tool except it had advanced graphics and the ability for real-time data manipulation for different displays of the data. Byrne was already reporting and distributing collections at the staff member level without blinding the data and this process continued with the Tableau version.

For example, in the tracker a location such as, Out Patient Registration (OP Reg.), could be selected and it would display the collections by each individual mapped to OP Reg. The top bar graph in Figure 14 is the total weekly collections by department while

the bottom line graph displays weekly collections by employee with the y-axis representing dollars collected. There were four people assigned to OP Reg. as highlighted by the four colored lines in Figure 14 below. You can also see one employee, blue line, started in early March.

Figure 14 - Sample of Byrne Hospital's Front-end Collections Tracker



HealthPay24 reports were able to be run by current collections and prior balance collections, this was another display category in the collections tracker. In speaking to staff members, they enjoyed the healthy competition across the three collections teams and between each other. Each of the 17 employees were mapped to a department and collections were aggregated to the department level for weekly and monthly reporting. The Collections Tracker was finalized and distribution started July 2015. Each location posted the collections tracker weekly for all staff members to see. Historical location collection data were also loaded into the tracker for trending purposes. The

organizational monthly goal for front-end collections was set at $255,642, a substantial increase from their fiscal year 2014 average hospital collections of $224,338. Goals were to be re-evaluated every six months to facilitate continuous improvement and to eventually reach the collection goal of 3-5% of net patient revenue.

Intervention #3 – Consumer Educational Material

Byrne Hospital had recently reviewed and updated the majority of their consumer education and marketing materials to enhance their consumer's knowledge of insurance and provide information about financial assistance. They had a printed financial assistance brochure that outlined the different types of support offered and who to contact if needed. On the hospital website under the patient section, BH included educational information for consumers about co-pays, co-insurance and deductibles. Although this information was available on their website it was not available in a printed format for consumers.

When the Patient Liability Estimator was implemented, a document was created that included an insurance overview describing co-pays, co-insurance and deductibles. The educational half-page document was attached to the consumer's estimate and was provided for the first six months. The following information was included in the document provided with consumer estimates.

> ***Co-payment (co-pay):*** *A flat amount that a patient must pay for each service. Amounts may vary by service and insurance, but they are typically between $10 and $150. A co-pay is paid by the patient each time a medical expense is incurred (doctor's office, ED, pharmacy).*
>
> ***Deductible:*** *A set amount of eligible expenses a patient must pay during each policy year before benefits are payable to the hospital by the insurance company. There are typically individual deductibles and family deductibles that have to be met each year.*

> ***Co-insurance:*** *The portion of the bill the patient must pay (usually a percentage). If the coinsurance is 20% then the patient is obligated to pay 20% of the bill and the insurance company pays 80%. There are caps on out-of-pocket fees, so the patient may not pay their full percentage if the cap has been met.*

Internal communication about the FEC interventions was also important. A memo was provided to the CEO, at his request, to the Board of Directors explaining the importance of collecting consumer liabilities, what the organizational opportunity was, and to outlining how the organization's new collection goal were established.

Intervention #4 – Collections Staff Member Incentive Program

The hospital implemented a collections staff member incentive program December 2014/January 2015 in an effort to increase point-of-service collections. When reviewing the data the program had an immediate impact on organizational collections. It was a basic incentive program that was in existence prior to the start of the case study. There were several differences between the original incentive program and the program that was implemented as part of the case study.

A side-by-side comparison of the two programs in the Table 20 on the following page highlights the main differences. The new program tiers started at the collection goal needed to reach 2.5% of net patient revenue. To encourage support for higher collections, leadership supported keeping the incentive that existed in the old tiers the same. A ramp-up period was identified to gradually allow staff members to reach the target. Staff members had a minimum amount they had to collect each month to participate in the incentive. Some collections personnel were hesitant about the new goals as they were now more aggressive. A policy was also developed to outline the circumstances an employee would and would not qualify for the incentive program. Both

the policy with the new tier structure and payout were shared with the Union for approval.

Table 20 - BH's Staff Member Incentive Program Comparison

Measurement	Prior Incentive Program	Ramp-Up Period (August & September)	Proposed State (October & beyond)
Monthly Collections Goal	N/A	N/A	Beginning October 2015, monthly goal: $49,055[1]
Incentive Tiers & Associated Bonuses (based on TOTAL Upfront Collections)	1st Tier: $25,000 w/ $50 bonus for FT staff		1st Tier: $49,055 w/ $200 bonus for FT staff
	2nd Tier: $30,000 w/ $100 bonus for FT staff		2nd Tier: $60,000 w/ $250 bonus for FT staff
	3rd Tier: $40,000 w/ $150 bonus for FT staff		3rd Tier: $70,000 w/ $300 bonus for FT staff
	4th Tier: $50,000 w/ $200 bonus for FT staff		
	5th Tier: $60,000 w/ $250 bonus for FT staff		
	6th Tier: $70,000 w/ $300 bonus for FT staff		
Individual Minimum Collections Threshold (to qualify for incentive) [4]	N/A	N/A	$1,226/month for FT, $613/month for PT and $306 for Midnight ED Staff[2,3]
Additional Incentive Opportunity within Incentive Tier [5]	N/A	- 1 Ticket per staff who collect $638 in August or $736 in September [6]	- Based on campaign, 1 ticket per staff who win a weekly campaign award with no limit in the number of tickets available per staff member
		- Based on campaign, 1 ticket per staff who win a weekly campaign award with no limit in the number of tickets available per staff member[7]	

In addition to the tiered bonus program, an additional bonus opportunity was created that was based on a monthly campaign. Each month the campaign would change and targets were developed by the two managers with staff members' input. The campaign would include three shout-outs each week. Shout-out awards were presented to staff members for achieving a specific goal, for example, "who had the highest

collections per account," "who collected the most up-front collections from one consumer," and "who collected on the most accounts." At the end of the month there would be two raffles. If all staff members reached the minimum collection amount, one staff member would be pulled from a raffle and awarded an additional bonus equal to the tier met that month. The second raffle was for the individual staff members who received shout-outs in the month. The more shout-outs collected in the month the higher the odds of winning the raffle at the end of the month. Four names would be drawn and those staff members would receive the same bonus as the first raffle.

The incentive program had one criteria that had to be met prior to the bonus payout.

1. If a full time staff members member is on PTO/Vacation/FMLA, etc. for more than 5 work days, their minimum collections threshold will be prorated according to the time worked BUT the bonus will not be prorated. If the minimum threshold is met, the staff member receives the corresponding bonus.

As an example on how the incentive program worked: Mary Cash collected $2,399 in April and the organization collected $61,034 in total resulting in tier 2 ($60,000) being met with a $250 bonus payout for staff members. Mary was also awarded six shout-outs during the month. She won one of the shout-out raffles with a bonus value of $250. Her total bonus pay for the month would have been $500. The various bonus options present a significant opportunity given their hourly wage is less than $15 an hour. The Chief Financial Officer was a supporter of the original bonus plan and approved the revised bonus structure.

When the incentive policy was presented to staff members they were enthusiastic about the opportunity to earn more money by collecting from consumers. Initially staff

members had some concern about the new goals being set much higher than before but they also had a more reliable estimation tool and enhanced scripting training to better prepare them for tough consumer conversations. During the process the CEO made sure that customer satisfaction and education were the primary objectives. Asking consumers for their liability was to be done with a smile on the staff members' face.

The Manager of Patient Access was responsible for running the cash collections reports out of HealthPay24 on a monthly basis to determine how much each staff member collected and determining what bonus they were eligible for. She would then share that information with Human Resources so the bonus payout could be included in the employee's paycheck.

Intervention #5 – Consumer Financial Liability Estimation Tool

Byrne Hospital had a patient liability estimation tool, PayNav, in-place at start of the case study but collections personnel and management did not feel confident that the tool provided valid consumer estimates and therefore it was infrequently used. It was decided early on that a significant cost savings existed by cancelling the PayNav contract, a product from the Advisory Board Company, and replace it with an in-house consumer estimation tool built in Excel. The new Excel version was based on the same structure as the one implemented at Fitzgerald Community Hospital.

All payer contracts were reviewed included terms based on a percent of charge reimbursement model which is common for critical access hospitals. This was essential to build the Patient Liability Estimator (PLE). Medicare reimburses CAH's on a cost plus 1% structure and the other plans covered between 90% and 100% of charges. The special reimbursement for CAH's from Medicare is the federal government's attempt at

keeping them financially viable as an important safety net for the providers in the communities served.

The PLE utilized BH's charge master, a list of all Current Procedural Terminology (CPT) codes with associated charges developed by the hospital, to identify the base charge by CPT. There are six main inputs in the estimation tool to create an estimate for the consumer:

1. Consumer insurance plan (Blue Cross Blue Shield, Cigna, Humana Medical Advantage, etc.)
2. Out-of-pocket max remaining
3. Deductible remaining
4. Co-payment
5. Co-insurance
6. Current Procedural Terminology (CPT)

The variables highlighted above in yellow were generated from payor websites as BH did not have a tool similar to what FCH and GMC had to identify consumer eligibility. Registration personnel ran eligibility on every consumer that had not been treated by the hospital or practice in the last thirty days. The consumer's insurance plan information is either received with the order for services, over the phone when pre-registration called the consumer, or at the time of service when the consumer presented their insurance card. The CPT or group of CPT's should be included on the providers order for services. For example, a computed tomography (CT) would have CPT 74176 (CT of the Abdomen and Pelvis without contrast).

The difference between the PLE at BH compared to the one used by FCH was that BH required the estimate to be printed, signed, and returned by the consumer if the consumer was not paying for their services up-front. Byrne also attached a half-page document, Figure 15 that outlined the different types of patient liability, co-pay, co-

insurance and deductible. The consumer signature portion of the hospital PLE is seen in Figure 16 below.

Figure 15 - BH's Patient Financial Liability Estimation Consumer Signature Page

Disclosure:
As a reminder, this is an estimate of your financial responsibility to Byrne Hospital and is not a guarantee of coverage for care. Depending on the individual case, the patient may be liable for additional services which are medically necessary as a part of the patient's care and not included in this estimate. In addition, other fees may be billed separately based on the care provider. The estimate provided will be a range of possible prices or an average price, which may not be linked to the patient's insurance plan, depending upon their situation and the information provided. Please note an estimate may not be available for the procedure requested. Acceptable payment methods include" cash, check, money order, credit card or debit card. Financial Assistance and/or payment arrangements may be available for those unable to pay in full. Financial Counselors is available Monday - Friday from 8AM to 4:30PM by calling

I would like to be referred to a financial counselor for: _____ Financial Assistance _____ Payment Arrangement

This is an ESTIMATE - Patient Initials

Patient Paid $ Patient Unable/Refused to Pay. Patient Initials:

Patient Signature Date

Received by Rect. # Date

The remaining part of the PLE was the same as the one implemented at Fitzgerald. The hospital did not have a pre-registration team whereas GMC and FCH did. The pre-registration teams at GMC and FCH ran consumer estimates and called the consumer to verify demographic and insurance information. Registration staff members would run consumer estimates during times when they were not busy checking consumers in.

To develop an estimation, the PLE matches up the insurance plan entered with the percent of charge for that payer by CPT, creating the hospital fee. If there are multiple CPT's it will add all the hospital fees together to create a total allowable amount for that payer. Four other components, highlighted above, were needed to determine a consumer total liability. An example is if the consumer had Blue Cross insurance and the negotiated agreement with Byrne Hospital was 90% of charges for all services. Blue Cross would reimburse Byrne Hospital 90% of charges for services provided. As

mentioned earlier, Byrne Hospital's charges are in a master list called a charge description master.

Baldrige Criteria Assessment

Leadership

Byrne Hospital (BH) is a not-for-profit critical access hospital that has been serving the surrounding community for over 50 years. The mission of the organization paraphrased is to put the patient at the center of the care continuum and within the organization. The size of BH allows the executive team to be more involved in the day-to-day operations than what is found at larger hospitals. It was also their size that allowed them to forgo the implementation of a Revenue Cycle Steering Committee. All the interventions reported progress to the Executive Steering Committee that was chaired by the Chief Executive Officer (CEO). The CEO has been leading BH for the last six years and prior to that served as the CFO of the hospital. The Chief Financial Officer (CFO) has been at the organization since 2010.

Byrne did not create a strategic brand for all the revenue cycle improvement initiatives; instead they held multiple town hall meetings that were led by either the CEO or CFO to keep staff members informed. Staff members had direct access to all leadership and frequently would see them rounding through the hospital. The absence of the CFO during the case study did not negatively impact the implementation of the five interventions as the CEO was in regular contact with the Patient Access Department, work group and assisted in the implementation of the initiatives. He supported the overall initiative and presented the new incentive program and goals to the union as well as presenting the overall FEC initiative and goals to the Board of Directors.

Strategic Planning

At the onset of the case study the Chief Financial Officer recognized that the increase in consumer collections they had experienced since January was only a part of the total opportunity. Both the CFO and CEO knew that collecting more consumer liabilities would assist the organization financially and support the organization's strategy to maintain their independence as a stand-alone health care provider. The FEC initiative was one of many that were identified to achieve this decree, all of which were reported to the Executive Steering Committee and communicated to the Board of Directors. The organization historically had experienced a positive working relationship with the various unions representing BH employees and this continued during the implementation of the FEC interventions.

A work plan was developed during the assessment and shared with the CFO prior to her departure for approval. It was also approved by the CEO and outlined the various interventions, owner(s) and timeline for each component of the FEC initiative. The CFO and CEO wanted to ensure the new collection goals were achievable, measurable and that staff members had the correct tools to reach them. An escalation period was implemented to slowly require additional collections each month.

Byrne was collecting 0.87% of net patient revenue during baseline and the goal was set at 2.5% of net patient revenue. This was an achievable goal and staff members were motivated both financially and in spirit to achieve it. The competition between the three teams added camaraderie to the organizational collection effort. The individual collection goals were shared with the staff members openly to garner their feedback, both positive and negative.

Customer Focus

The consumer was the focus for BH throughout the initiative. The CFO and CEO wanted collections to be aggressively pursued with a smile and education provided to the consumer. Due to the size of BH, the CFO, CEO and Patient Access Manager were able to round through the hospital and observe staff members interactions with consumers. There has been a trend occurring in rural settings where consumers are selecting to drive further for comprehensive and what they perceive as higher quality care at larger hospitals. Rural hospitals like BH have taken notice of this migration and are attempting to keep the consumers local when they can by providing excellent customer service and access to telemedicine services they have not been able to offer in the past. Front-end collections are consumer sensitive and have gained additional national media exposure since the implementation of the Patient Protection and Affordable Care Act (ACA).

Asking for payment up-front was not a new concept to the community surrounding Byrne Hospital. To monitor the impact on consumers of more assertive collection practices, BH also reviewed consumer complaints. The negative findings were minimal. The Executive Steering Members were informed prior to implementing the scripting as this was going to be a more assertive approach to consumer collections than BH had taken historically. Additional marketing and educational materials were also developed or revised to provide more clarity to consumers about what was expected prior to services.

Measurement, Analysis and Knowledge Management

Byrne Hospital had revised their collection strategy in late 2014 and as part of that early initiative to improve collections they implemented a tiered collection goal and

provided basic education for staff members. Byrne had the fundamental building blocks to develop a robust collections program. The implementation of the FEC initiative provided more education, knowledge and accountability to the program to continue the growth. When the case study started it was determined by the CFO that the FEC education and scripting would be beneficial to staff members and provide them additional knowledge on collection tactics. The Tableau collections dashboard was a further enhancement to their current cash tracker as it allowed them to display the data several different ways. The Tableau dashboard was also used to determine individual staff member collections for the incentive bonus. Lessons learned from the prior two case study organizations, a ramp-up period to meet the final collections goal was implemented at BH. This alleviated staff member's anxiety about the goal and allowed them to gain confidence in their collection capabilities to reach the organizational goal.

Workforce Focus

Providing education and the necessary tools to the staff members was an imperative of the FEC initiative. All twenty-five staff members attended the up-front collections training and scripting to become better prepared to collect from consumers. The education was well received and when paired with the bonus opportunity, staff members wanted all the tools and training possible to be successful. In the front-end collections training the latest trends in consumer financial responsibility were reviewed along with a significant portion of time spent on the scripting guide.

Staff members also received training on the Patient Liability Estimator and how to communicate estimates to consumers. The new tool and additional education gave collections personnel faith in the accuracy of the estimates, unlike with the prior

estimation tool. BH was in a small rural community, so it was not uncommon that the consumer coming to the hospital was an employee's family member, friend, or neighbor. Asking for payment from your neighbor or family member could have been difficult; instead staff members rose to the challenge and decided to use this to their advantage to educate and even engaged them in the collections competition.

Staff members were and continue to be part of the development process and open communication existed throughout the initiative. This solidified their buy-in and their acceptance of the escalating goals. An employee incentive structure did exist for staff members who collected payments but was enhanced to mirror the new goals that were developed. The new incentive plan provided a more lucrative bonus for staff members and proved to be a significant motivator. Turnover among this group of employees was minimal, with only one relocating to another state.

Operational Focus

In critical access hospitals the same person may be responsible for several different jobs. At BH, registration personnel also verified insurance and handled pre-registration. The execution of the FEC interventions required a significant effort by BH staff members as it was common for them to hold multiple roles. A robust work plan was developed to identify tasks, assign responsibilities and monitor progress of the FEC initiatives. The executive team monitored the progress of the work plan and resolved any identified barriers or assigned resources that were needed.

Policies and processes were developed to support needed changes and ensure accountability. One example of this was the Upfront Collections Accountability Guidelines, a policy that addressed the collection expectations and the incentive bonus.

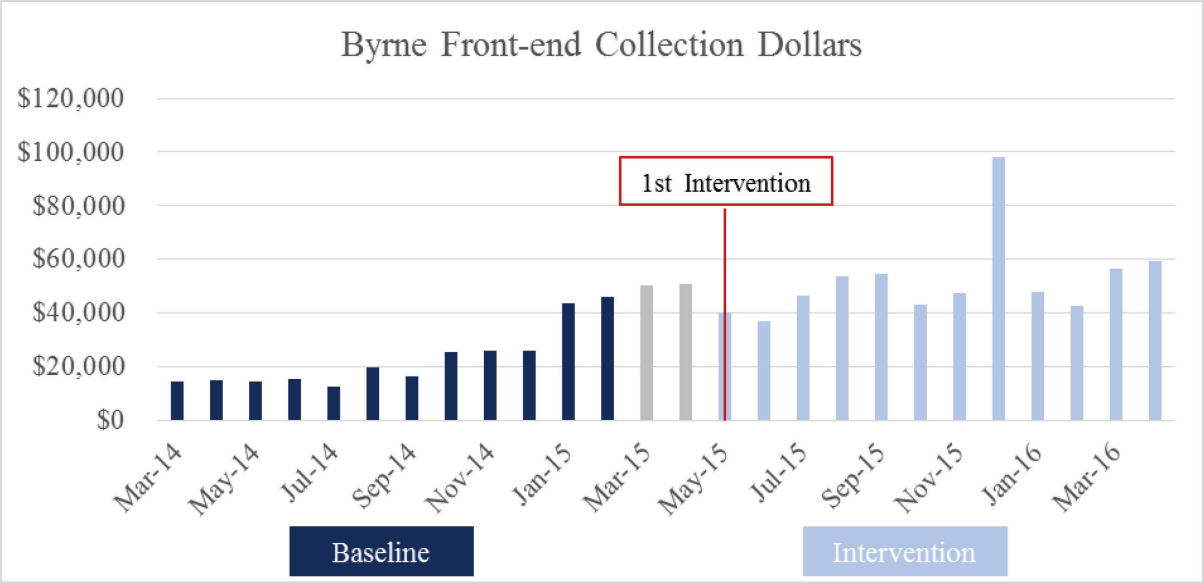
This policy was reviewed and approved by the union. Individual staff member collection results are shared weekly with all collections personnel. If performance fails to meet the stated goal, the two managers have to provide an explanation to the CFO. Frequent communication with staff members on the changes and expectations were shared in employee and town hall meetings.

Results

Byrne's consumer collections increased immediately post-implementation of the staff member incentive program in December 2014. January 2015 collections as a percent of net revenue were up 0.74% compared to December 2014. As the case study started and implementation began of the five interventions the collection of consumer liabilities continued to experience growth from the baseline. The Patient Liability Estimator was the first intervention to be implemented followed shortly thereafter by the FEC education and scripting training. The Patient Access work group was responsible to monitor results and report those to the ESC on a monthly basis.

The FEC initiative applied multiple measures to demonstrate improvement. Baseline and intervention period dollars collected per month are highlighted in Figure 16 below and show a decline during the implementation of the first few interventions. The beginning of the year is open enrollment for many health plans, which means that consumers' deductibles are reset to zero and providers have the opportunity to collect a significant amount of consumer liabilities. Conversations about new goals and changes to the employee incentive structure started at this time. The staff members were actively involved and there was open communication about the possible changes.

Figure 16 - BH's Front-end Collection Dollars, Baseline vs. Intervention by Month



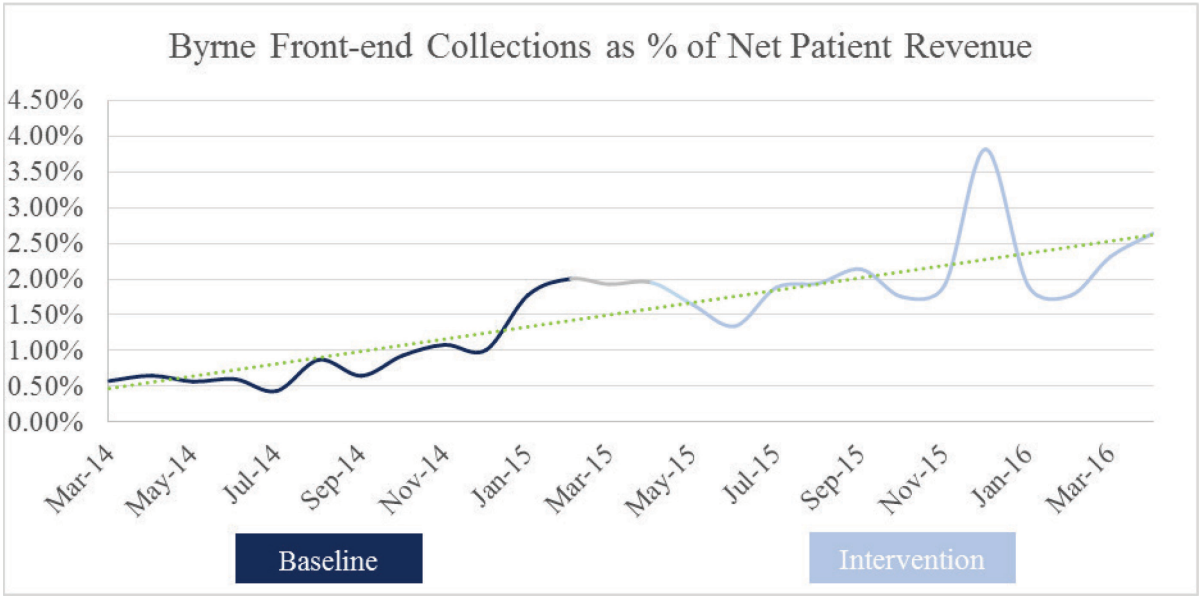
At the end of July both the goals and new incentive program had been implemented and staff members started to become comfortable with the new expectations. Byrne's average monthly collections during the baseline period and intervention period were $22,846 and $52,251, respectively. This represented a total monthly average increase of $29,405 per month and over a 200% increase in the monthly average comparing baseline to intervention period. Prior to the implementation of the first intervention in May 2015 Byrne experienced an increase in collections as seen in the Figure 17 above.

Upon further investigation, collections for January through April 2015 averaged $47,650 compared to $52,251 during the intervention period. This was a two-fold increase from the baseline and just under what was achieved during the intervention period. It was identified during the assessment that Byrne had implemented a staff member incentive program in December 2014. This program was described in intervention #4 and was likely the driving force behind BH's upward trend at the end of the baseline. Byrne decided to offer a discount to consumers who had prior balances on

their account from services provided that occurred before September 15, 2015. The offer was a 50% discount on prior balances if paid in-full; the program ran from December to early April.

These programs are often called debt amnesty programs and are implemented during the holidays or tax time when consumers are expected to have more available cash to pay medical bills. Collections reached $97,983 in December 2015; this was the largest collection month for Byrne during the intervention period and predicted to be a result of the debt amnesty program in addition to the early staff incentive program. This is atypical given consumers historically have met their deductibles by late in the calendar year and there is less opportunity to collect. In total the organization collected $352,856 more in the intervention period than what was collected in the baseline period. This increase in collections is a combination of both prior balances collected and front-end collections.

Figure 17 - BH's Front-end Collections as a % of NPR, Baseline vs. Intervention by Month



The measure utilized in the Figure 17 above is front-end collections as a percent of net patient revenue (NPR). The y-axis represents FEC as a percent of NPR. This metric measures the percent of collections in relation to net patient revenue. High-performing organizations can reach total consumer collections of between two and three percent of net patient revenue.[39,40]. Net patient revenue is calculated by taking all gross patient revenue, in-patient and out-patient, associated with providing consumer's care. From gross patient revenue contractual allowances are subtracted, which is the difference between what the insurance companies allow and what is charged, as well as bad debt and charity care to determine net patient revenue. This measure includes all payers in the denominator of net revenue.

At Byrne the initial goal was set at 2.5% of net patient revenue. The 12-month collections average during the baseline was 0.93% of net patient revenue compared to 2.09% during the intervention period, an overall increase of just over 220% when comparing the two timeframes. Byrne experienced a 1% reduction in net patient revenue in the 12 month intervention period compared to the baseline. This decrease had a nominal effect on the collections percentage.

Figure 18 - BH's Front-end Collection Dollars, Baseline vs. Intervention

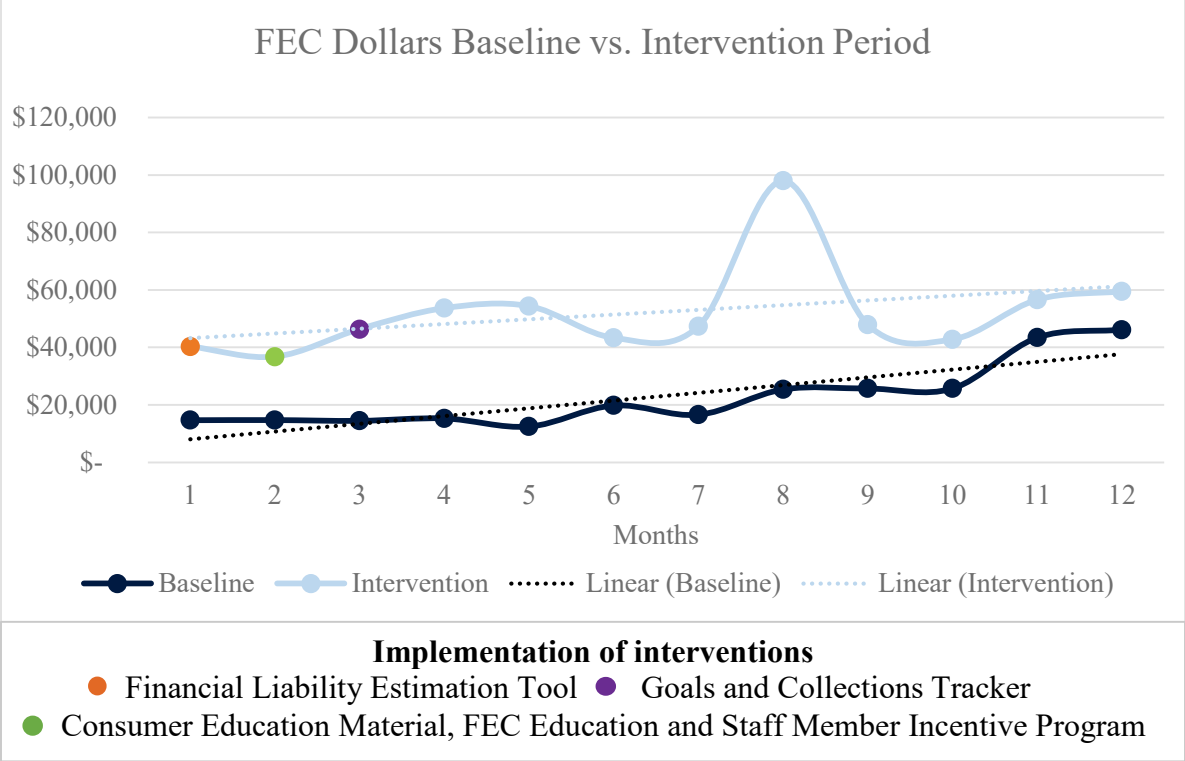


Figure 18, displays the baseline (dark blue) and the intervention period (light blue) in relation to one another on a linear scale using time in months. The y-axis represents FEC dollars collected while the x-axis represents months. Month one for the baseline is April and month one for the intervention period is May. As mentioned previously BH had implemented a staff member incentive program that went live at the end of the baseline period. The average of the first three months of the baseline was $14,600 compared to the average of the last three months at $38,411. This was a 263% increase in the average collections in the baseline alone and it could be hypothesized that this is in relation to the initial incentive program Byrne instituted.

To determine if the five interventions implemented during the intervention period had an impact, the last three months average was compared to the entire average of the intervention period and Byrne realized an additional 36% increase in collections. The

Liability Estimate Tool was the first intervention implemented but collections did not increase for two months. The next three interventions were implemented next and collections started to increase again. With all three being implemented at the same time it is difficult to determine the cause and effect of each.

The spike in December, month 8 of the intervention period, was discussed previously. The revised incentive program did not substantially change the bonus incentive for staff members but did adjust the goals that had to be met. A new Liability Estimator Tool could have impacted the collections as it did promote staff members' confidence in providing accurate estimates.

Alternative Explanations

Byrne had such a dramatic increase in the last three months of the baseline it is difficult to determine the impact of each of the five interventions. An incentive program was the only intervention that was implemented prior to the intervention period but there could have been external factors that support their upward trend in collections. It was evident that collections were increasing during the intervention period at a steady pace. Would that trend have continued organically absent the five FEC interventions?

1. Byrne's staff member incentive program was implemented at the end of the baseline period. Did this incentive program create the increased collections in the baseline and would that trend have continued without the five interventions implemented during the baseline? Given the trajectory that Byrne was pacing towards it can be estimated they would have continued the upward trend. This is the strongest alternative in any of the three cases in support of a staff member incentive program. However, it could be argued that without proper education,

scripting and an estimation tool collections personnel would have eventually reached a point where dissatisfied consumers would start complaining. This did not occur at BH.

2. The increase in HDHP's resulting in more out-of-pocket costs for consumer's suggests that more dollars are available to be collected and is the same alternative argument listed in the GMC case study. Due to the increase in consumers' selecting HDHP's, the total financial liabilities that providers have to collect have also increased. This does not mean the provider organization will necessarily collect more, especially if continue collecting using the same status quo collection practices. The significant change in collections from the baseline to the intervention period does not support this argument given increase in HDHP's has been occurring over that last several years according to Figure 1.

Chapter 7: Cross-case Analysis

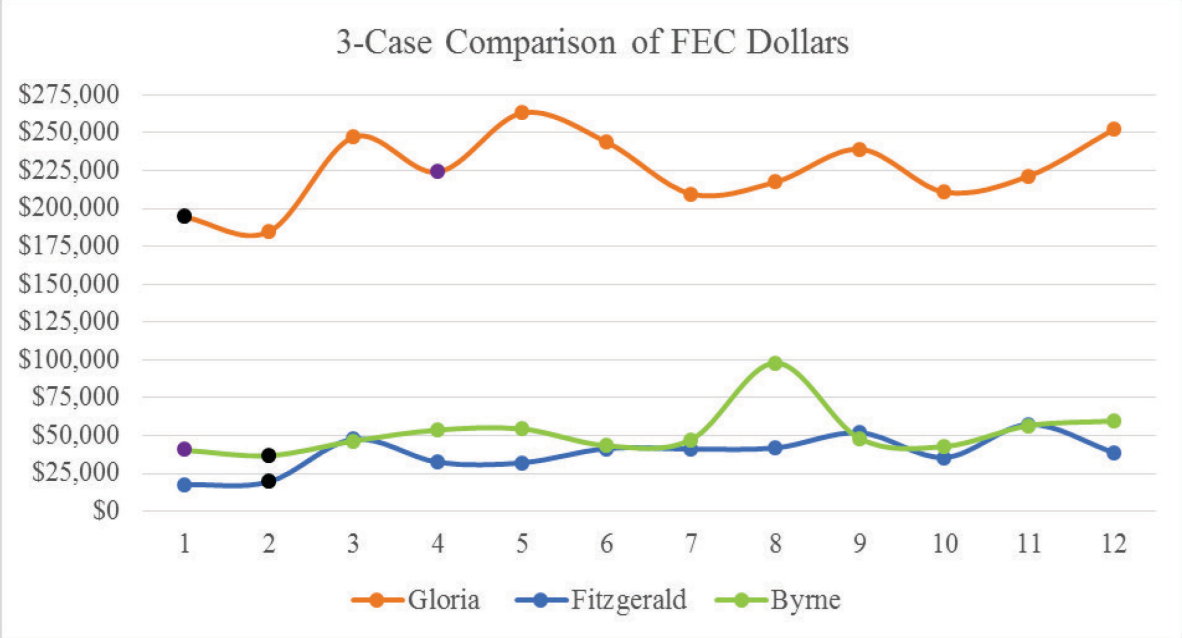
Each of the three case studies presented different challenges to implementation. The data reviewed in the Results section of each of the case studies provides support for three conclusions. A staff member incentive program can help organizations increase collections and although the goals and cash tracker were not found to directly impact collections they do support the measurement of an incentive program and allow for continued accountability. The incentive program's bonus payout needs to be adequate enough to garner the employee's interest yet not be so lucrative that it diminishes the additional collections.

GMC had an incentive program that started during the baseline but it was a raffle based incentive and the maximum payout to a single individual each month was no more than $50 regardless of how much or how little he or she collected. The dollar amount and lottery aspect of the incentive did not motivate staff substantially. As a result their collections only slightly increased during the baseline under this incentive program. Byrne implemented an incentive with a larger bonus pool during the baseline and their collections immediately increased. The GMC incentive program was revised and collections started going up.

The order of the interventions was not consistently applied across all three case studies. The initial goal was to implement them in the same order at each entity but organizational and external factors impacted when the interventions went live. The results by intervention may have been different if consistency was maintained. Figure 19 represents all three case studies front-end collection dollars during the intervention period. The legend indicates when each of the three primary interventions, FEC

education, liability estimation tool and staff members incentive program, were implemented. The remaining two interventions, consumer education materials and goals tracker were not plotted as they are supportive interventions of the primary interventions.

Figure 19 - Three-Case Comparison of FEC Dollars Collected, Intervention Period

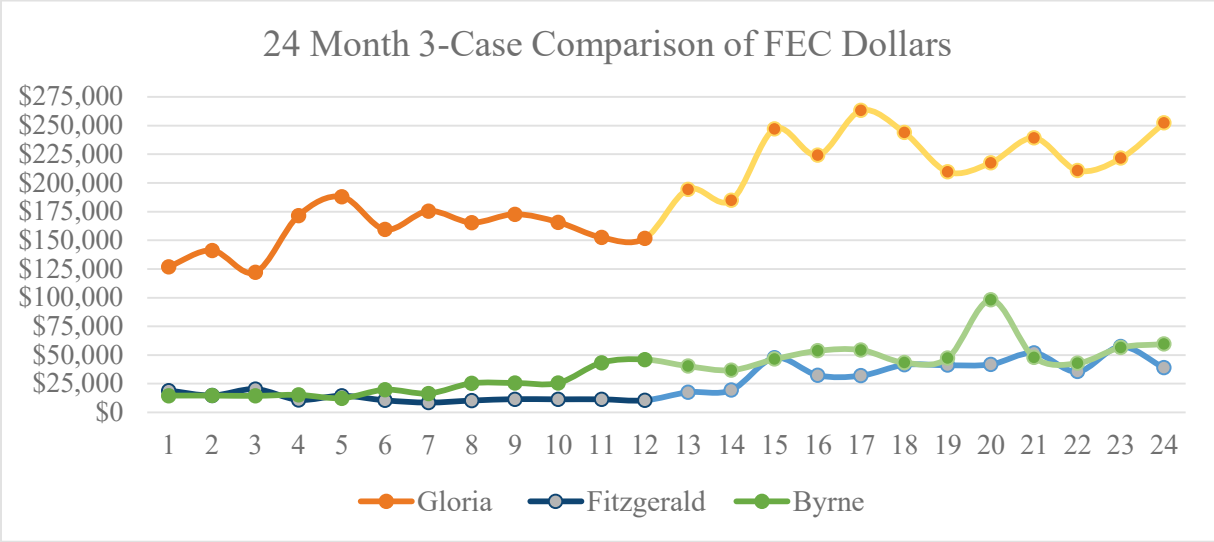


Case	Key	Intervention
GMC	●	FEC Education
GMC	●	Liability Estimation Tool & Incentive Program
FCH	●	FEC Education & Liability Estimation Tool
BH	●	Liability Estimation Tool
BH	●	FEC Education & Incentive Program

The two interventions not plotted in Figure 19, consumer education material and cash tracker and goals, appeared to have less of an impact on overall collections than the other three listed in the figure key above. Sustainability of the interventions is an area each case study organization will need to focus on if they want to continue to increase collections. An incentive program should be adjusted over time or eliminated as it becomes a job expectation. The FEC education program material was left with the

organizations and should be used as a refresher course and for any new hires. By the end of the case studies only one organization--Byrne-- was using the Patient Liability Estimation tool. However, it was created in excel and it will eventually become obsolete as the organization replaces it with more advanced technology as the budget allows. FH purchased the liability estimation tool from Passport Health and the issues GMC had with Passport were resolved. Both the consumer education materials and the goals and collection tracker will be updated as the health care landscape continues to change.

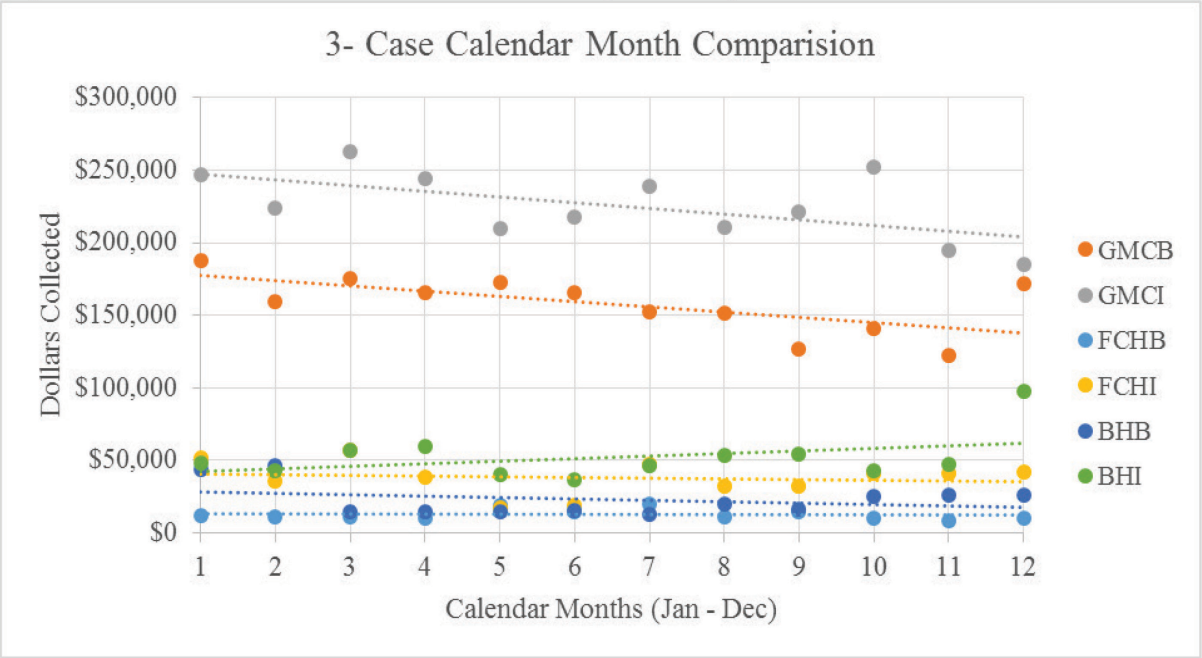
Figure 20 - Twenty-four Month Comparison of FEC Dollars Collected by Case Study



GMC is significantly larger in total bed size and net patient revenue than both FCH and BH combined. They also have a much larger opportunity to collect out-of-pocket liabilities from consumers. When the cases were each trended continuously in Figure 20 on a 24 month timeline, not accounting for any time lapse between baseline and intervention, the data highlights that GMC collected more FEC dollars than BH or FCH. In contrast, Byrne collected more than Fitzgerald in both the baseline and intervention periods. This would lead one to believe that organizationally Fitzgerald

focused less on front-end collections historically than the other two. Other factors that could impact front-end collections and are beyond the control of the organization include: payer mix, insurance plan make-up, percent of HDHP's, health plans available on the exchange, health plans provided by local employers, consumer education, socio-economic status of surrounding population, competing providers and federal and state regulations.

Figure 21 - Three-Case Calendar Month Comparison of FEC Dollars



In Figure 21 we explored the relationship between the collection calendar month, January (1) through December (12), and the front-end dollars collected to determine if there is a correlation between the calendar month and amount of money collected. To provide some description about the key, GMCB is GMC baseline and GMCI is GMC intervention for the respective 12 month timeframes. Each data set from the cases was put into a 12 month format regardless of when the case started or ended. Figure 21 highlights that of the 6 trend lines, 4 are trending downward during the 12 months, x-axis.

The y-axis is FEC dollars by month and indicates less FEC's are collected at the end of the calendar year compared to the beginning. BHI or Byrne during the intervention period, had an outlier month in December which created an upward trend. The possible cause of the dramatic increase was the implementation of a staff member incentive program in addition to the debt amnesty program that was offered to consumers. When this month is normalized to the monthly average the trend line is similar to the FCHB trend, i.e., flat. As more consumers have growing out-of-pocket expenses and a large portion of health plans rolling over coverage on January 1 each year, a possible conclusion could be drawn that there are more available dollars to collect at the beginning of the year as deductibles are reset. The case study data support this argument with more dollars being collected in the baseline and intervention periods during the first part of the year and less being collected at the end of the year.

Measurement and Goals

Gloria Medical Center and BH had established goals at some level--organizational, departmental or individual--prior to the start of the case. Fitzgerald did not have goals but had the reporting capability to identify collections by individual while both GMC and BH were measuring collections at the individual level. GMC had an organization goal for front-end collections that was included on their monthly Revenue Cycle dashboard but it was not set to an industry practice. The same was true at Byrne. Measuring and setting collection goals has been widely publicized as a leading practice to increase front-end collections and hold staff members

Figure 22 - Three-Case Comparison of Goals, Baseline and Achieved Results of FEC as a Percent of NPR

Case Study	Goals	Baseline	Achieved
GMC	2.50%	0.74%	0.98%
FCH	2.18%	0.11%	0.31%
BH	2.50%	0.93%	2.09%

accountable.[6,40,48,49] The goals that were set at each of the organizations were structured differently, but when looking at the expected increase in dollars compared as a percentage of the baseline net patient revenue, they were similar as depicted in Figure 22. As described in the Fitzgerald case study they had the highest percent of net patient revenue goal set at 5 percent but when reviewing the data across all departments' collection goal, the total percent of net patient revenue goals equaled 2.18%. Byrne achieved the greatest percentage increase from the baseline followed by GMC and then FCH.

Strength and Weaknesses

Case study research has the same exposure to strengths and weaknesses as a quasi-experimental study design. The additional challenge with case study research and specifically these three case study organizations was that several uncontrollable factors can occur within the daily operation of a hospital that cannot be controlled by the researcher. The strengths of the case study design were the following:

1. Standardized front-end collections scripting training and education provided by trainers with over 50 education sessions utilizing the same format.
2. 12-months of baseline data and 12-months of intervention data to provide equal comparison periods.
3. Industry accepted performance improvement metrics as identified in the outcome or dependent measures.
4. Representative case study organizations of hospitals across the United States.

Weaknesses of the case study design were primarily the data available to be collected and the ability to systematically time each intervention implementation so that each could be measured by itself and in combination with other interventions. The implementation of the interventions was based on the organizations' willingness to implement change and leadership support. Other weaknesses of the case study design are as follows:

1. The case study research was limited to three organizations
2. Unknown generalizability of each of the case study organization's results
3. Limited data collection of other possible confounding factors

Future Case Studies

Future case studies should take one of two approaches in the design of the study to better control for the listed weaknesses above. Approach one is to select those interventions, such as FEC Collections Education and the Patient Financial Liability Estimation Tool, that were shown to have the greatest impact on FEC and focus on the implementation of those two only. In addition to selecting the two interventions, the implementation of each of the interventions should be spaced sufficiently apart to measure the impact of each separately.

The second approach would be to use all five interventions at a new case study organization but systematically time each of the interventions so that there are multiple months between each implementation, thus providing the ability to measure the impact of each. This will require more than 12-months of post-intervention measurement but will allow the researcher to better determine the impact of each separately.

Either approach selected should also include additional data elements to control for confounders and identify any unintended consequences as the result of the interventions. Data on payer mix and number of collection staff should be collected as both could impact the organization's ability to improve front-end collection dollars and FEC as a percent of NPR. Other additional measures to identify unintended consequences to the consumer could be: consumer complaints related to front-end collections, HCAPS scores and comments and refunds provided to consumers. Case study organization selection could also be modified to select two similar organizations by size and community composition so that there would be a replica comparison study to better address generalizability of results.

Chapter 8: Recommendations for Health Care Leaders

There is not a shortage of changes happening in health care today; the shift of financial responsibility and cost containment are also not foreign to the industry with previous programs dating back 40 plus years. The solutions are much slower to emerge and should be referred to as incremental approaches to solving large complex issues. The Affordable Care Act is attempting to institute drastic changes within health care but the jury is still out on its overall effectiveness. The following section will identify recommendations and possible solutions to the ever increasing cost that consumers must absorb as their out-of-pocket responsibility, and providers must collect to remain financially viable.

Providers

Providers are faced with one of the largest challenges and subsequent rewards. As the financial responsibility continues to shift to consumers, the opportunity for providers to develop solutions on how to collect these responsibilities becomes magnified. It is a necessity for providers to be working on programs that support front-end collections. They will need to balance the amount of resources and technology allocated to collecting more from consumers while at the same time providing education and transparency around cost. Providers should monitor consumer complaints specifically related to financial liabilities and be aware of when consumers elect to forgo treatment due to cost or the request of payment. Organizations should have clear policies and procedures to assure those individuals are routed to a Financial Advocacy unit to assist in obtaining the needed financial resources and that necessary and appropriate treatment is not unduly delayed. Another measure that providers should monitor is the amount of refunds provided to consumers as they increase their efforts to collect. Consumer financial hardships will increase as more of the U.S. population selects HDHP's as their health insurance and providers need to be proactive in developing sustainable solutions.

Technology is advancing and consumers want simple easy methods for paying bills, whether it be on-line or through their smartphones. Providers must deliver the same price transparency available from a local mechanic replacing tires. This is no small undertaking and some dynamic changes should be made to accomplish this. Providers also must take a retail approach to providing payment options for consumers to pay their medical expenses. Growth in mobile payments was expected to increase by $22.6 billion from 2009 to 2015; this is becoming the "new normal".[30] Providing consumers

additional financing options, including interest-free lines of credit, and educating them on financial arrangements will also be paramount.

Payers

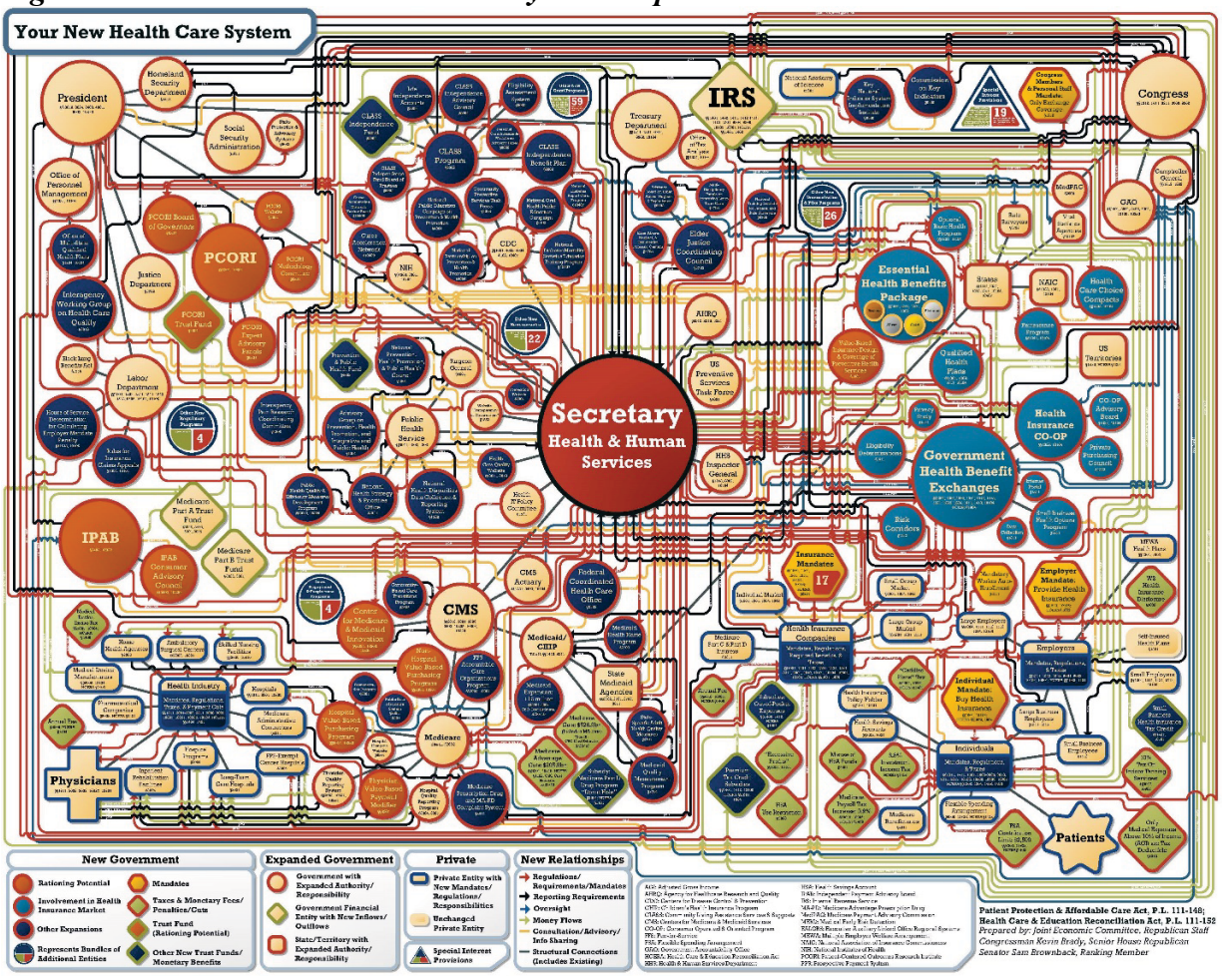
What part in the story of increasing consumer financial responsibility do insurance companies play? Most insurance companies are for-profit organizations, whereas the majority of hospitals in the United States are not-for-profit. Nearly 3 out of every 4 hospitals in the U.S. hold not-for-profit status. To be clear this does not mean they do not make a profit; not-for-profit hospitals focus on treating consumers and historically payers have focused on driving bottom line growth for their shareholders. Insurance companies have been creating products like the high-deductible health plans to attract more businesses and consumers and to address the spiraling cost of health insurance coverage.

The Affordable Care Act has a provision that requires United States citizens to have "minimum" health insurance coverage.[14] The minimum requirement must cover 10 essential health care services according to the law. The law also set forth an amendment to the Internal Revenue Code of 1986 with several new requirements, one being a yearly penalty if the "minimum" level of health insurance coverage was not obtained by consumers. With the goal to secure health coverage for approximately 26 million consumers, it had the potential to add millions of dollars to the payers' bottom lines. The explosion of HDHP's in recent years is to further address the "affordable" portion of the ACA. The result has been more consumers covered with a health plan but often times with out-of-pocket costs they are unable to pay.

Consumers

Health care is complex, this has been highlighted by numerous organizations and agencies both federal, state and private. Figure 23, created by the Joint Economic Committee, depicts how complex our new health care system is and the number of stakeholders involved.

Figure 23 - United States Health Care System Map[52]



If our health care system is as complex as the picture above, how and who can explain it so that the general population is able to understand and navigate it. This is the unknown. The case studies described in this dissertation only focus on a small portion of the overall health care system. However, it is an area that is gaining national attention

and becoming a focus for consumers, providers and payers alike as they try and determine what health care services will cost and how much transparency is needed. Consumers will need to become more involved than they ever have with aspects of their health care, including selecting an insurance plan, selecting a provider, selecting between the expensive treatment option or the less expensive with the same outcomes, as well as selecting a location to receive services and what level of services (physician office visit, urgent care, emergency department) are needed for the medical condition. Our system has not done an adequate job of directing consumers to the appropriate level of care; as a consequence, often the consumer receives the bill and is shocked at the cost.

Waiting to get the hospital bill in order to find out about the costs of treatment should no longer be an option. Consumers need to be accepting of providers discussing financial responsibility as this has become part of receiving medical care. Providers have slowly adopted new processes and technology to support the financial needs of consumers, but more progress can still be made. For instance, some providers have started offering lines of credit to consumers, where they pay the accrued interest in exchange for payment of medical bills. Medical expenses for consumers rank 7th in the payment hierarchy behind non-necessity items like internet and cell phone bills.[11] Consumers need to seek out education about their insurance plans and the costs of their care when they see a provider in different care settings (emergency room, urgent care, clinic). Each of these levels of care has a different expense to the consumer and often this is not understood.

Policy Makers

The significance of these case studies and their results for policy makers are indirect. This is because the hypothesis of each of the case studies is to determine if the

interventions that were implemented had a positive effect on front-end collections. You may ask why policy makers would be interested in the interventions' effect on front-end collections; the answer is they probably would not. They should be interested in the impact of front-end collections on providers and the shift that is occurring where more and more of that responsibility is on the provider to collect and the consumer to pay. In 2013, approximately 56 million Americans had difficulty paying for their medical care and now with the added requirement of the ACA that all consumers have health insurance coverage, this number will likely increase. The core goals of the Patient Protection and Affordable Care Act were to lower cost, improve quality and provide health coverage to millions of under or un-insured individuals. Shifting more cost to the consumer through higher deductibles, or less coverage at the same cost, were not mentioned in the Act and yet all of these have occurred. The Act also did not take into consideration how all three constituents involved, including consumers, providers, and payers, should have an equal stake in profits and losses of the health care settings they operate in. Representatives of all three parties invested in this complex non-system have to be at the table with policy makers to develop a solution.

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Appendices

Appendix I. Healthcare Financial Management Association Point-of-Service and Bad Debt Metric

Point-of-Service (POS) Cash Collections

Purpose: Trending indicator of point-of-service collection efforts

Value: Indicates potential exposure to bad debt, accelerates cash collections, and can reduce collection costs

Equation:

N:POS payments
D: Total patient cash collected

Bad Debt

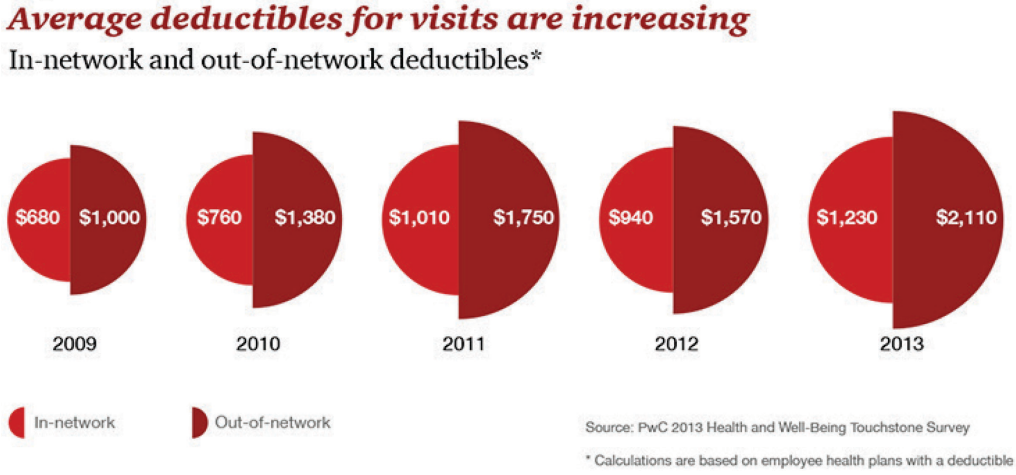
Purpose: Trending indicator of the effectiveness of self-pay collection efforts and financial counseling

Value: Indicates organization's ability to collect self-pay accounts and identify payer sources for those who can't meet financial obligations

Equations:

N: Bad Debt
D: Gross patient service revenue

Appendix II. Deductible Growth 2009-2013



Appendix III. Gloria Medical Center Front-end Collection Scripting Guidelines

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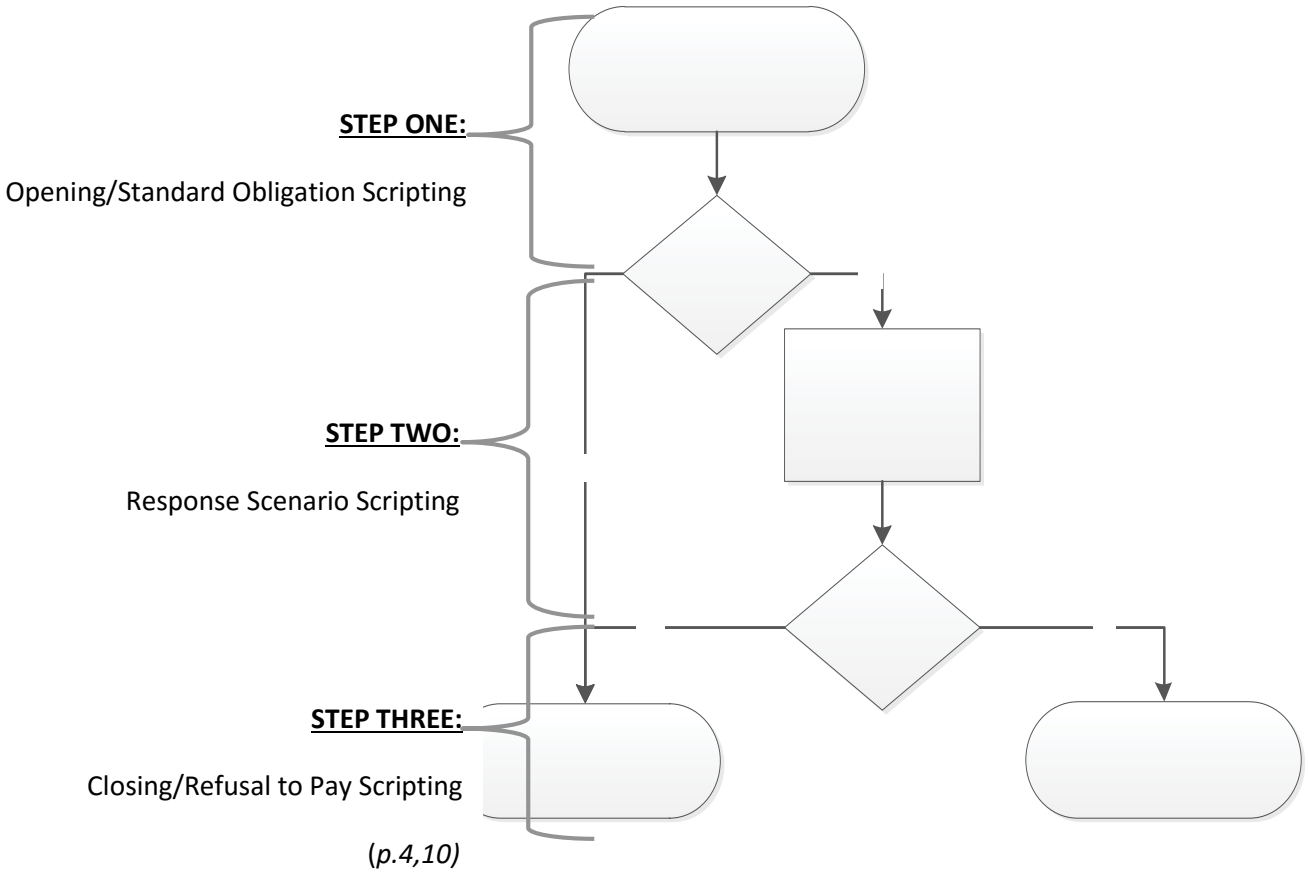
Scripting Process Flow



(*p.4,10)*

Expectations

Objective

The objective of front end collections is to collect the portion of the bill that is likely the responsibility of the patient prior to services being rendered or the patient being discharged. Successful collections today will result in improved cash flow, reduced bad debt, and enhanced patient experience. It will allow the hospital to continue its mission of providing compassionate, high quality healthcare to the communities served.

In order to accomplish this task, proper communication with patients and a clear description of policies must take place. Experience shows that people who pay part of the bill at the time of service are 50% more likely to pay their remaining balance.

Efforts to appropriately resolve payment barriers permit Gloria Medical Center to conserve its financial resources in order to offer services to the greatest number of patients and financial assistance to those in the community who truly need it.

Preparation

To prepare for successful front end collection efforts the following questions should be answered:

- Do you have all the necessary tools and applications open before you speak with the patient?
    - MEDITECH
    - Skip Jack
    - Passport
    - Phone Extension List
- Have you checked the volume on your headset?
- Do you have the calculator tool open on your computer? If not, do you have a calculator?

Conversation Openings and Closings

The following are sample openings and closings used when speaking to patients. These demonstrate how you can be effective and assertive while obtaining specific, detailed information and payments.

Opening Statement:

Example 1:

"Good morning, this is (name) with Gloria Medical Center Pre-Registration. May I speak with (name of patient) about an upcoming scheduled appointment?"

Example 2:

"Welcome to Gloria Medical Center. My name is (name). How can I help you today?"

Standard Patient Obligation Explanation Scripting:

Example 1 – **Insured in Passport:**

"Based upon the information provided today and according to your insurance benefits, your out of pocket amount for your services is ($), which represents ($) for your deductible, ($) for your copay and ($) for coinsurance. For your convenience, we accept all major credit cards. How would you like to take care of your out of pocket responsibility today?

Example 2 – **Insured, NOT in Passport:**

"Based upon the information provided, we are unable to verify your benefits. Our hospital policy therefore requires a deposit of ($). For your convenience, we accept all major credit cards. How would you like to take care of your out-of-pocket responsibility today?

Example 3 – **Uninsured:**

"Based upon the information provided, your out of pocket amount for your services is ($).

ELECTIVE: Gloria does extend a (%) discount for our patients who do not have insurance coverage so your reduced out of pocket expense is ($). For your convenience, we accept all major credit cards. How would you like to take care of your out of pocket responsibility today?

URGENT: Our hospital policy requires a deposit of ($). For your convenience, we accept all major credit cards. How would you like to take care of your out of pocket responsibility today?"

Closing:

Example 1:

"Thank you and have a very good day. Please feel free to call Patient Accounts Customer Service at (330) 489-1145 if you have any additional questions."

Patient Response Situations & Expectations

The following are common situations representatives will encounter in the process of pre-registering and registering patients.

SITUATION #1 – PATIENT QUESTIONS INSURANCE COVERAGE

PATIENT: **"My insurance will pay"**
RESPONSE: "We verified your insurance coverage, and your insurance company told us that you have a deductible/co-payment obligation that is your responsibility. Your insurance will cover a portion of your total payment, but you are responsible for the remainder according to your contract with them. We offer several payment options that include (e.g. cash, check, credit or debit card). How would you like to pay today?"

PATIENT: **"This amount seems very high. I'm sure my insurance company used to cover more of this."**
RESPONSE: "You're probably right. Most employers did pay a higher percentage of health care costs in the past. However, almost all of them are now selecting insurance plans that require the employee to pay a higher percentage of the costs, including copays, deductibles and coinsurance amounts."

PATIENT: **"I don't even have a deductible/co-pay – my insurance is wrong"**
RESPONSE: "As a service to you, we've contacted your insurance company regarding your insurance guidelines. We verified that your annual deductible is $ and you've already met $. The great news is that we have a contract with your insurance company, which means they receive a substantial discount on your services. I'll be glad to issue you a receipt today and your payment will be reflected on your itemized statement – which you should receive in about _____ working days from your date of service. We have several options for payment including (e.g. cash, check, credit or debit card). How do you want to take care of that today?"

PATIENT: **"I buy insurance to cover my healthcare costs. Why don't you just bill them?"**
RESPONSE: "We will be billing your insurance company, but we have already verified that this is what you owe for your copay/deductible/coinsurance. Please keep in mind that the majority of healthcare insurance plans pay only a portion of a patient's healthcare costs."

PATIENT: **"What is the difference between co-pays, co-insurance and deductibles?"**
RESPONSE: "I understand that can be confusing. With a lot of insurance plans changing, many patients aren't sure of the difference. Your insurance plan mandates that you pay these three obligations before your insurance benefits for medical services are provided. All three represent cost sharing arrangements that you have agreed to with your insurer.

1. A copay is a flat amount that you have to pay for each visit. Amounts may vary by service and insurance, but they are usually between $10 and $150. A co- pay is paid each time you visit a medical facility (doctor's office, ED, pharmacy).

2. A deductible is typically a set amount a patient must pay during each policy year before benefits are payable by the insurance company. Depending on the plan you have, there can be either individual deductibles or family deductibles that need to be met annually.
3. Coinsurance is the portion of the bill that you pay (usually a percentage). If the coinsurance is 20% you are obligated to pay 20% of the negotiated rate and the insurer the other 80%."

PATIENT: **"My insurance company told me that I don't have to pay until they pay their portion."**

OR

"My insurance pays first and then I pay when I receive the bill"

RESPONSE: "I'm sorry to say that you have been misinformed. The amount I've quoted is an estimate that represents your balance that the insurance company will not pay. In the case that your payment surpasses your final patient liability, we will refund this difference. For your convenience, we accept (e.g. cash, check, credit or debit card). How would you like to pay today?"

SITUATION #2 – PATIENT WANTS TO BE BILLED LATER

PATIENT: **"Bill me later"**

RESPONSE: "We can no longer delay collecting owed payments for services. Per your agreement with your insurance carrier and as a hospital policy, a payment/deposit is due before or at the time of service. Would you like to pay by (e.g. cash, check, credit or debit card) today?"

PATIENT: **"I'd like to wait until my insurance pays, then I'll pay"**

RESPONSE: "We have verified your insurance and there is a deductible/co-payment associated with your treatment that you owe at this time. This means that your insurance covers a percentage of your total bill and you are responsible for the remainder according to your insurance contract. How would you like to take care of that today? We have several options for payment including (e.g. cash, check, credit or debit card)."

SITUATION #3 – PATIENT WANTS TO PAY AT TIME OF SERVICE

PATIENT: **"I will pay at the time of service" (CHECK-IN COLLECTIONS AVAILABLE)**

RESPONSE: "I understand your desire to pay at your date of service, but please be aware that paying prior to service will allow less worry when you present for your appointment and shorten your time at registration."

PATIENT: **"I will pay at the time of service" (CHECK-IN COLLECTIONS NOT AVAILABLE)**

RESPONSE: "I understand your desire to pay at your date of service, but unfortunately we do not have staff to collect your payment at the time of service."

SITUATION #4 – PATIENT QUESTIONS FRONT END COLLECTION POLICY

PATIENT: **"You seem more worried about the bill and your money than my health."**
RESPONSE: "I assure you we are concerned about your care first. Even though your health and welfare do come first, we need to make sure that we can pay for your care, and offer the highest quality of care to you as possible. So, you do have our apology for placing what appears to be a high emphasis on payment, but this too is a critical aspect of your care."

PATIENT: **"I've never been asked to pay before"**
RESPONSE: "As a courtesy to our patients, we collect patient obligations upfront. We perform insurance verification prior to your service and to reduce some of the financial worry associated with a hospital visit, we advise our patients of the amount due and request payment on the balance to reduce your wait time at the time of service. We will accept your full payment by (e.g. cash, check, credit or debit card).

RESPONSE B: "I understand your concern, but changes in healthcare are requiring patients to accept more financial responsibility for their care. Paying prior to service helps speed up your registration process and reduces your wait time resulting in savings to you. Plus, it lets you take care of your payment now and reduces your worry about receiving a bill later. Would you like to pay by (e.g. cash, check, credit or debit card) today?"

RESPONSE C: "In order to better serve you, we have begun collecting payments up front. It allows you to take care of your payment now, rather than worry about a bill later or paying at the time of service. Would you like to pay by (e.g. cash, check, credit or debit card) today?"

SITUATION #5 – PATIENT SAYS HE/SHE CANNOT PAY RIGHT NOW

PATIENT: **"I can't afford it right now"**
OR
"I don't have any money"
OR
"I am not working. How can I pay if I don't work?"
RESPONSE: "I understand. We do offer options for our patients that are concerned about paying. Let me introduce you to one of our Financial Counselors to discuss the available options."

PATIENT: **"I can't pay that much now!"**

RESPONSE: "I understand this may be an unexpected payment for you. If you do not have the full amount right now, we will accept what you are able to pay today and bill you for the remainder. We accept (e.g. cash, check, credit or debit card)."

PATIENT: **"Can I pay this off over time?"**
RESPONSE: "We offer many financial options to help you including payment plans. You will receive a bill _____ (based on payor) days after your service. At that time you will need to contact customer service at the number listed on your bill to discuss available options."

SITUATION #6: PATIENT CLAIMS HE/SHE WAS MISLED BY THEIR DOCTOR

PATIENT: **"I can't afford to pay for these tests and the doctor knew that. I don't understand why the doctor sent me in for tests/ this procedure knowing I couldn't pay."**
RESPONSE: "I'm sure the doctor considers the tests as a necessary part of your treatment. If they had been elective procedures, we would have waited to schedule the tests when you were in a better financial situation. However, since the tests were required immediately, let me introduce you to a Financial Counselor who can assist you."

PATIENT: **"This is terrible. My doctor told me not to worry about the bill!"**
RESPONSE: "I'm sorry this is a surprise to you. Your doctor didn't mean that you wouldn't have to pay, but that you shouldn't worry about the bill because payment policies allow us some flexibility. We do offer many financial options to help you including payment plans. You will receive a bill _____ (based on payor) days after your service. At that time you will need to contact customer service at the number listed on your bill to discuss available options."

SITUATION #7: PATIENT DISAGREES WITH AMOUNT OF PAYMENT

PATIENT: **"Why is the bill so high?"**
RESPONSE: "Our pricing is competitive with other facilities in the area. Healthcare costs are constantly increasing because the advances in technology and extensive services offered to provide our patients with the best health care possible."

PATIENT: **"I don't agree with the amount you have quoted me"**
RESPONSE: "The amount quoted is an estimate based on the information we received from your insurance company. As a service to our patients, we contact the insurance company on your behalf, however, if you feel there is a discrepancy you will need to call your insurance company regarding information about your deductible/copay/coinsurance. Would you prefer that I call you back tomorrow after you've had the opportunity to do this?"

PATIENT: **"Why is there a deposit?" (CHECK-IN COLLECTIONS AVAILABLE)**

RESPONSE: "In order to make sure you are cleared financially, we ask for payment prior to your appointment. As a benefit to you, this will allow less worry when you present for your appointment and shorten your time at registration. We have several options for payment including (e.g. cash, check, credit or debit card). How would you like to pay today?"

PATIENT: **"Why is there a deposit?" (CHECK-IN COLLECTIONS NOT AVAILABLE)**

RESPONSE: "Every insurance plan has a set co-pay/deductible or co-insurance. Therefore, we take a minimum deposit of (X). Since we do not have staff to collect at the point of service, we need to take this payment now to cover your patient liability. We have several options for payment including (e.g. cash, check, credit or debit card). How would you like to pay today?"

SITUATION #8: PATIENT DISAGREES WITH TIMING OR METHOD OF PAYMENT

PATIENT: **"Why are you charging my credit card now? I'm not having the procedure until next week."**

RESPONSE: "Your card will be charged today and the payment will post to your account. If you should decide to cancel your visit to Gloria Medical Center, we will refund you. However, to ensure your registration process is quick on the day of your service we do request payment now. Would you like to pay by (e.g. cash, check, credit or debit card) today?"

PATIENT: **"I'll pay after I'm treated/seen by the physician/after my procedure" (CHECK-IN COLLECTIONS AVAILABLE)**

RESPONSE: "While I would like to accommodate that, unfortunately we are not set up to collect payment after your treatment. However, you do have the option to pay at point of service."

PATIENT: **"I'll pay after I'm treated/seen by the physician/after my procedure" (CHECK-IN COLLECTIONS NOT AVAILABLE)**

RESPONSE: "While I would like to accommodate that, unfortunately we do not have staff to collect payment after your treatment."

PATIENT: **"I don't feel comfortable giving my credit card information over the phone" (CHECK-IN COLLECTIONS AVAILABLE)**

RESPONSE: "I understand your concern of giving your credit card information over the phone. I assure you Gloria takes all precautions in protecting this information and there is no risk in making payment today. You also have the option of coming to the hospital to make a payment in advance. You can also pay at point of service when you come in on the day of your service, but I was hoping we could resolve it today so that you don't have to worry about that extra step on the day of your service. You can pay by check, cash, or credit card when you come in for your procedure."

PATIENT: **"I don't feel comfortable giving my credit card information over the phone" (CHECK-IN COLLECTIONS NOT AVAILABLE)**

RESPONSE: "I understand your concern of giving your credit card information over the phone. I assure you Gloria takes all precautions in protecting this information and there is no risk in making payment today. You also have the option of coming to the hospital to make a payment in advance."

SITUATION #9: PATIENT CLAIMS HE/SHE IS NOT RESPONSIBLE FOR CHILD'S MEDICAL BILLS

PATIENT: **"Someone else is responsible for my child's medical bills"**

RESPONSE: "I understand that you may have an agreement with that person. I would be glad to give you a receipt so that you can be reimbursed. Will you be paying by (e.g. cash, check, credit or debit card) today?"

SITUATION #10: PATIENT DOES NOT HAVE ANY METHOD OF PAYMENT

PATIENT: **"I did not bring a credit card/cash/check book."**

RESPONSE: "We have a phone available if you would like to call someone to bring that over to you."

SITUATION #11: PATIENT WANTS TO BE SELF-PAY

PATIENT: **"I don't want to use my insurance."**

OR

"I want to be Self-Pay so I can have the discount."

OR

"Can I be Self-Pay because I don't want this to go to my insurance company?"

RESPONSE: "It is your option to not use your insurance, but please be aware of the following:

- In order to receive the Self-Pay/Prompt Pay Discount, you must pay your balance in full within 30 days
- Many insurance companies have contracted discounts with Gloria Medical Center that you will no longer be eligible for. I would be happy to look up your insurance to see how much of a discount your insurance plan offers.
- Due to precertification penalties and timely filing rules, we will not bill your insurance at a later time if you do decide not to use your insurance
- Your payment will not be credited toward your deductible

Lastly, if you do not want your insurance to receive a bill, you are obligated to pay in full before the time of service. If you do not do so, the hospital has the right to send a bill to your insurance company. Would you still prefer to be Self-Pay?"

Refer to Standard Opening Scripting to collect on insured or self-pay obligations

Patient Refusal to Pay Situation & Expectations

SITUATION #12: PATIENT REFUSES TO PAY

PATIENT: **"Then just forget it, I want to cancel."**
RESPONSE: "I understand, but please be aware that our payment policies do offer some flexibility. If you do not pay by the time of service, our hospital can send you a bill after you receive your service. Please also know that we offer many financial options to help you including payment plans. You will receive a bill ____ days (based on payor) after your service. At that time you will need to contact customer service at the number listed on your bill to discuss available options."

PATIENT: **"The law says care in the ER is free." (ADMITTING)**

(INSURED)
RESPONSE A: "Per the EMTALA law, hospitals must give each patient an appropriate medical screening exam to determine if they have an emergency medical condition, and must provide any necessary care to stabilize the medical condition before any discussions of payment take place. After the patient receives necessary care, per our hospital policy, the patient must meet his or her financial obligation or they will be referred to a Financial Counselor."

(UNINSURED)
RESPONSE B: "Per the EMTALA law, hospitals must give each patient an appropriate medical screening exam to determine if they have an emergency medical condition, and must provide any necessary care to stabilize the medical condition before any discussions of payment take place. After the patient receives necessary care, per our hospital policy, the patient is obligated to pay an initial deposit and will be referred to a Financial Counselor."

PATIENT: **"I'm not paying." (PRE-REG)**

(INSURED)
RESPONSE A: "Please understand that if you do not pay by the time of service, you will be receiving a bill within approximately 45 days after your service with your liability."

(UNINSURED)
RESPONSE B: (If more than two days out) "I understand this is a surprise to you. Per hospital policy, a payment/deposit is due before or at the time of service. We offer many financial options to help you including payment plans; let me introduce

you to one of our Financial Counselors, who can discuss with you all of the available options."

IF THE PATIENT SAYS NO:

"As per hospital policy, we are required to reschedule your appointment unless you agree to speak with a Financial Counselor."

(If two days or less out) "Please understand that you will receive a bill 5-7 days after your service with your full balance."

PATIENT: **"I'm not paying." (AT CHECK-IN)**

(INSURED)

RESPONSE A: "Please understand that if you do not pay by the time of service, you will be receiving a bill within approximately 45 days after your service with your liability."

(UNINSURED)

RESPONSE B: "Please understand that Gloria extends a 40% Self-Pay Prompt Pay Discount if you pay today. If you do not meet your financial obligation, you will receive a bill 5-7 days after your service with your full balance."

Appendix IV. Sample CFO Memo to Management/Staff Supporting the FEC Initiative

Directors, Managers, Supervisors and Staff:

The U.S. healthcare system has become more rigorous than ever to navigate, particularly when it comes to being reimbursed for the high quality services we aim to provide here at Gloria Medical Center. While we are working extremely hard to ensure reimbursement from various commercial and government payers is successful, similar efforts also need to be put into ensuring our patients meet their financial obligations.

In order to continue to provide quality holistic care, expand our service offerings, and meet our community's needs we must make every effort to assist patients in meeting their financial obligation for the care received.

For those that are unaware, these efforts have already begun in several areas:

- Pre-Registration thoroughly explaining to the patient their liability prior to their time of service
- Admissions explaining to the patient their liability and allowing them to meet their part of the balance at the time of service
- Improving our Urgent Care Centers collection of patient liabilities at the time of service
- Fully staffed Financial Counseling unit to educate patients on various assistance programs or payment options available to them

To further provide a high quality service to our patients we are working on expanding our patient collection locations to the following:

The proposed initiative will occur in two phases:

Phase 1 (Radiology, Radiation Therapy, Oncology, Cardiac Diagnostics, Pain Management, Sleep Lab)

  - XX/XX: MEDITECH access will be updated
  - XX/XX: Physical equipment to begin collecting will be distributed (lock box, credit card swipe, etc.)
  - XX/XX: Training will be provided on technology, process and scripting
  - XX/XX: Point-of-Service Collections will commence
  - XX/XX to XX/XX: Ongoing at desk training will continue

- Phase 2 (Gastroenterology, Vascular Lab, Minor Outpatient Surgery, Neurodiagnostic, Cardiac Pulmonary Rehab, Pulmonary Function)
  - XX/XX: MEDITECH access will be updated
  - XX/XX: Physical equipment to begin collecting will be distributed (lock box, credit card swipe, etc.)
  - XX/XX: Training will be provided on technology, process and scripting
  - XX/XX: Point-of-Service Collections will commence
  - XX/XX to XX/XX: Ongoing at desk training will continue

As always, we want to be the leading healthcare provider for our County and the surrounding communities, and this initiative is just one of the many steps we are taking to enhance our patient experience and allow our hospital the ability to provide the care we all deserve for years to come.

We welcome your feedback and thoughts to this new initiative. More information will be shared in the coming weeks.

Regards,
CFO

Appendix V. FEC Training Schedule – Gloria Medical Center

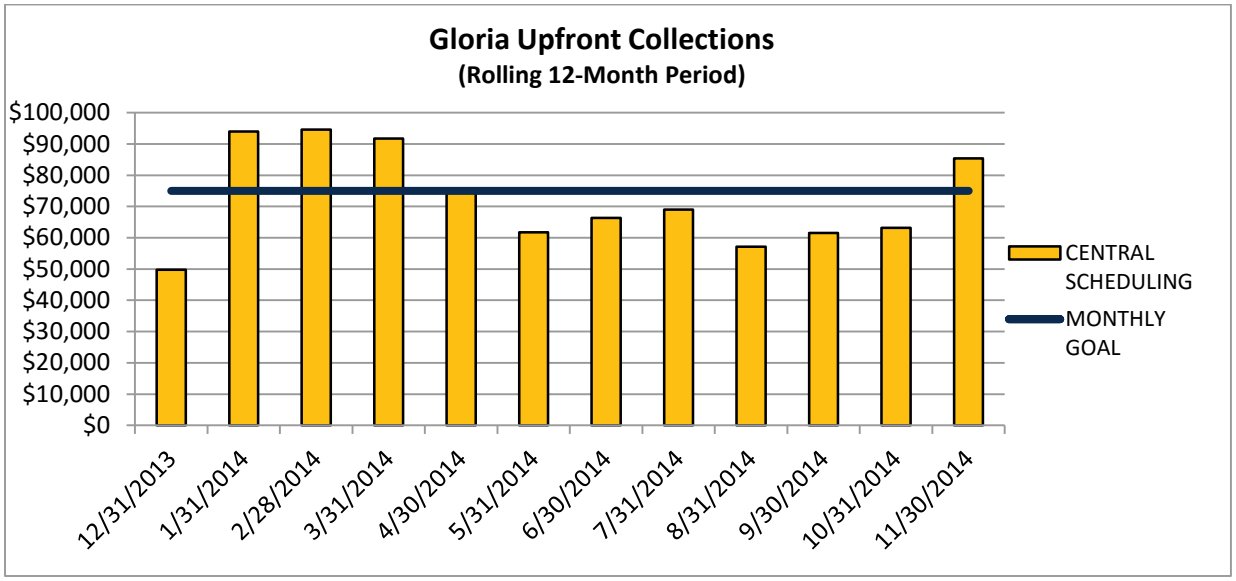
Date	Time	Length of Time (mins)	Trainers	Employee	Area	Position/Title	Topics Covered
FRONT END COLLECTION TRAINING SESSION							
					Central Scheduling	Manager	
					Surgery Reg	Representative	
					ED Reg	Representative	
					Admitting	Representative	- Front End Collections Education Guide
10/28/2013	4:00 PM	90	Jaime		Admitting	Representative	- Situation Response Guidelines
					Central Scheduling	Representative	
					Central Scheduling	Representative	
					ED Reg	Representative	- Front End Collections Education Guide
10/29/2013	7:00AM	90	Jaime		Breast Imaging	Representative	- Situation Response Guidelines
					Central Scheduling	Representative	
					Surgery Reg	Representative	
					Admitting	Representative	
					Admitting	Representative	
					ED Reg	Representative	- Front End Collections Education Guide
10/29/2013	9:00AM	90	Kimberly		Breast Imaging	Representative	- Situation Response Guidelines
						Representative	
					Central Scheduling	Representative	
					Central Scheduling	Representative	
					Central Scheduling	Representative	
					Admitting	Representative	- Front End Collections Education Guide
10/29/2013	11:00AM	90	Kimberly		ED Reg	Representative	- Situation Response Guidelines
						Representative	
					Admitting	Representative	
					Central Scheduling	Representative	
					Central Scheduling	Representative	
					Central Scheduling	Representative	- Front End Collections Education Guide
10/29/2013	2:00PM	90	Kimberly		ED Reg	Representative	- Situation Response Guidelines
						Manager	
						Manager	
						Manager	
						Manager	- Front End Collections Education Guide
10/30/2013	8:30AM	90	Kimberly			Manager	- Situation Response Guidelines
					ED/Admitting/Surgery	Manager	
					Patient Accounts	Manager	
					Financial Counesling	Representative	
					Admitting	Representative	
					Admitting	Representative	
					Admitting	Representative	- Front End Collections Education Guide
10/30/2013	1:30PM	90	Kimberly		ED Reg	Representative	- Situation Response Guidelines

Date	Time	Length of Time (mins)	Trainers	Employee	Area	Position/Title	Topics Covered
FRONT END COLLECTION TRAINING SESSION							
10/30/2013	4:00PM	90	Kimberly		Financial Counseling Admitting Admitting	Representative Representative Representative	- Front End Collections Education Guide - Situation Response Guidelines
10/31/2013	7:00AM	90	Kimberly		ED Reg ED Reg ED Reg Financial Counseling	Representative Representative Representative Representative	- Front End Collections Education Guide - Situation Response Guidelines
11/5/2013	7:00AM	120	Kimberly		ED Reg Central Scheduling	Representative Representative	- Front End Collections Education Guide - Situation Response Guidelines
11/6/2013	2:00PM	60	Kimberly		Customer Service	Representatives	-Situation Response Guidelines
11/6/2013	3:00PM	60	Kimberly		Customer Service	Representatives	-Situation Response Guidelines
11/6/2013	2:00PM	60	Kimberly		Customer Service	Representatives	-Situation Response Guidelines
11/6/2013	3:00PM	60	Kimberly		Customer Service	Representatives	-Situation Response Guidelines
11/12/2013	7:00AM	80	Kimberly		ED Reg	Representative	- Front End Collections Education Guide - Situation Response Guidelines
11/14/2013	11:00AM	90	Kimberly		Surgery		- Front End Collections Education Guide - Situation Response Guidelines

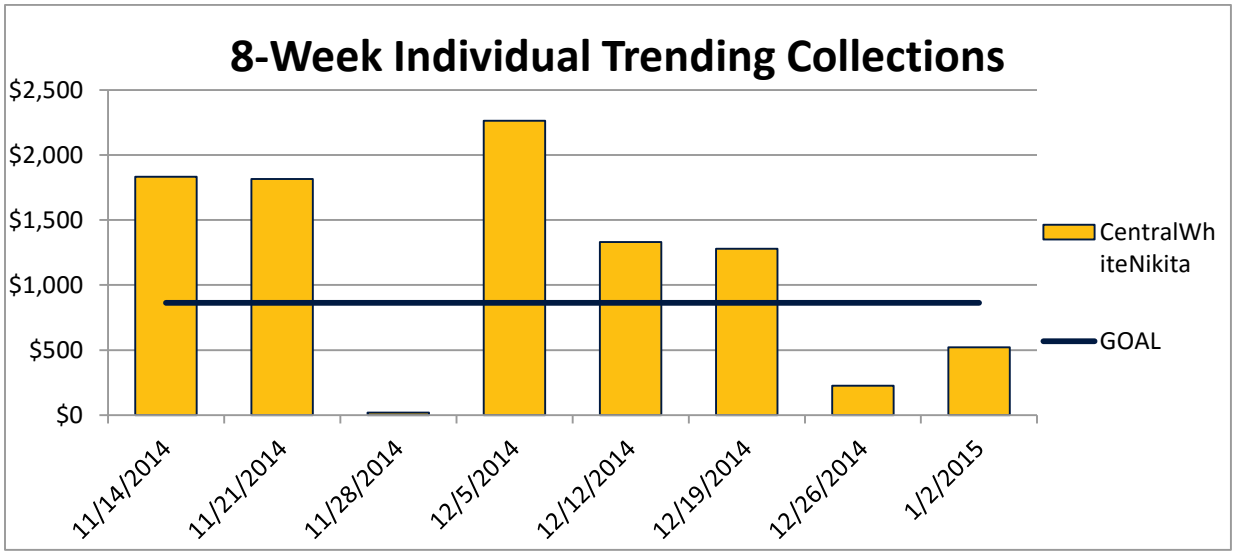
Appendix VI. Gloria Medical Center Sample Location Collection Goals

Front End Collections (FEC) Benefit Dashboard						
Collecting Group	Location	6 Month Average Monthly Net Revenue[1]	6 Month. Average Collections[2]	Monthly Goal[3]	Monthly Variance[4]	Annual Benefit[5]
Central Pre-Reg		$ 6,192,681	$ 33,699	$ 37,156	$ 3,457	$ 41,485
Admissions	Emergency Department	$ 1,463,852	$ 32,455	$ 35,701	$ 3,246	$ 38,952
	Laboratory and Radiology	$ 167,835	$ 1,076	$ 1,184	$ 108	$ 1,291
	Same Day Surgery	$ 2,920,938	$ 2,506	$ 17,526	$ 15,020	$ 180,236
Central Service Lines Check-In Excluding Stat Care	BDMUPT	$ 312,948	$ 5,855	$ 6,441	$ 586	$ 7,032
	Cardiac Diagnostics	$ 188,132	$ -	$ 1,129	$ 1,129	$ 13,546
	Gastroenterology	$ 100,501	$ -	$ 603	$ 603	$ 7,236
	Minor Outpatient Surgery	$ 40,819	$ -	$ 245	$ 245	$ 2,939
	Neurodiagnostic	$ 37,746	$ -	$ 226	$ 226	$ 2,718
	Oncology	$ 404,158	$ -	$ 2,425	$ 2,425	$ 29,099
	Pain Management	$ 126,145	$ -	$ 757	$ 757	$ 9,082
	Radiation Therapy	$ 415,279	$ -	$ 2,492	$ 2,492	$ 29,900
	Radiology	$ 712,752	$ -	$ 4,277	$ 4,277	$ 51,318
	Sleep Lab	$ 121,860	$ -	$ 731	$ 731	$ 8,774
	Therapies	$ 121,606	$ 4,470	$ 4,917	$ 447	$ 5,364
	Vascular Lab	$ 56,553	$ -	$ 339	$ 339	$ 4,072
Urgent Care	A	$ 199,554	$ 13,103	$ 14,413	$ 1,310	$ 15,724
	B	$ 424,189	$ 21,550	$ 23,705	$ 2,155	$ 25,860
	C	$ 66,538	$ 767	$ 844	$ 77	$ 920
	D	$ 49,544	$ 2,341	$ 2,575	$ 234	$ 2,809
	E	$ 495,085	$ 22,848	$ 25,133	$ 2,285	$ 27,418
	F	$ 56,188	$ 5,577	$ 6,135	$ 558	$ 6,692
	G	$ 178,430	$ 8,805	$ 9,686	$ 881	$ 10,566
Discharge		$ 10,069,767	$ -	$ 42,293	$ 42,293	$ 507,516
Totals			$ 155,052	$ 240,931	$ 85,879	$ 1,030,549
Percent of Total Net Revenue[6]		0.97%				

Appendix VII. Gloria Medical Center's Collection Dashboard (Central Scheduling view)



Appendix VIII. Gloria Medical Center's Collection Dashboard (Collector view)



Appendix IX. Fitzgerald Community Hospital Financial Outreach Committee Charter Sample

Purpose of Team

As part of the **Comprehensive Performance Improvement** implementation efforts and in response to increasing patient financial obligations and the financial risk this poses on Fitzgerald Community Hospital if unaddressed, the Financial Outreach Committee (FOC) is charged with assessing the proper work flows, accountability structure, education planning, job functions, policies, and communication structure to ensure patient obligation collections are maximized and unnecessary financial risk to Fitzgerald Community Hospital is avoided.

Key Objectives of the Financial Outreach Committee

- Work with Executives, Patient Access management, and individual department leadership to implement necessary policies and work flows to increase collections
- Outline solutions for any process breakdowns/barriers to collect and discuss implementation requirements for each department
- Schedule and complete all patient financial responsibility education and scripting training, to instill the confidence in staff that will allow them to succeed in meeting collection targets and educating the patient community
- Establish all reports required to support the department with daily tracking of front-end collections by department and individual
- Establish a monthly meeting with hospital executive leadership to report front-end collections progress and request assistance with non-complying departments

Expectations of Team Members

Each team member is asked to commit to the following:

- Attend and be on time for all scheduled team meetings
- Complete assignments in designated timeframes and openly communicate key issues/concerns
- Restrict discussion of sensitive issues to members of the Implementation Team; determine as a team what communications should go forth from the meetings
- Approach decision-making crossroads with an open mind, being receptive to new ways of doing business
- Consider the interests and concerns of various health system constituencies without compromising the ultimate objective of successful implementation
- Champion the initiative within the larger health system community

Team Members

Mary Millions Gary Collector Namoi Nopay

Appendix X. FEC Training Schedule – Fitzgerald Community Hospital Physician Practice

FR Physician Practice Education Sessions Schedule (May 18-June 1)			
Date	Location	Time	Room
Monday, 5/18	North	11:30-1:00p	North
Tuesday, 5/19	Main Hospital	7:30-9:00a	Conference Dining Room
Tuesday, 5/19	Main Hospital	11:30-1:00p	Conference Room E
Wednesday, 5/20	Main Hospital	7:30-9:00a	Conference Dining Room
Wednesday, 5/20	Main Hospital	11:30-1:00p	Conference Dining Room
Thursday, 5/21	Main Hospital	7:30-9:00a	Conference Dining Room
Thursday, 5/21	Deer	11:30-1:00p	Deer
Tuesday, 5/26	Main Hospital	7:30-9:00a	Conference Dining Room
Wednesday, 5/27	Main Hospital	7:30-9:00a	Conference Dining Room
Wednesday, 5/27	Main Hospital	11:30-1:00p	Seminar Room
Thursday, 5/28	Main Hospital	7:30-9:00a	Conference Dining Room
Thursday, 5/28	Deer	11:30-1:00p	Deer
Monday, 6/1	North	11:30-1:00p	North

Appendix XI. Fitzgerald Community Hospital Patient Financial Responsibility Education Confirmation Form Sample

Patient Financial Responsibility Education Confirmation Form

Program Name: _____
Participant Name: _____
Participant Signature: _____
Date: _____

The objective of the Patient Financial Responsibility Initiative is to collect the portion of the bill (to the best of our knowledge by the time of check-in) that is likely the responsibility of the patient prior to services being rendered or the patient being discharged. Successful collections today will result in improved cash flow, reduced bad debt, and enhanced patient experience. It will allow the organization to continue its mission of providing compassionate, high quality healthcare to the communities served.

Efforts to appropriately resolve payment barriers permit Fitzgerald Community Hospital to conserve its financial resources in order to offer services to the greatest number of patients and financial assistance to those in the community who truly need it.

In order to accomplish this task, proper communication with patients and a clear description of policies must take place. Furthermore, a standardized and consistent approach to patient education and collections is paramount to ensuring success for this initiative. The above will be addressed during the Patient Financial Responsibility Trainings led by trained educators.

The above signature confirms that the employee attended the Patient Financial Responsibility Education seminar and received the Patient Financial Responsibility Education Scripting Guide.

Signature of Authorized Signatory
Name: _____
Title: _____
Date: _____

Personal Biography

Rusty Schlessman is a student in the DrPH Health Policy and Management program at Johns Hopkins University Bloomberg School of Public Health. In December 2016, he will graduate from the program. In addition to being a part-time student he works full-time as a health care management consultant for a national consulting firm. He has over 13 years of health care experience with areas of concentration in hospital operations, management, clinical services, revenue cycle and international hospital management.

Prior to joining his current firm, Rusty was employed at another national consulting firm in their Revenue Cycle & Management Consulting Practice. In this role he focused on implementing revenue cycle best practices to improve organization performance, preparing organizations for regulatory changes related to ICD-10 and providing guidance to financial executives.

In his health care career, Rusty has held management and leadership positions at several hospitals/health systems focusing on performance improvement, operations and finance. He started his career at Johns Hopkins Health System in Baltimore, MD where he spent 5 years in various capacities including several years as an Operations Officer at a hospital operated by Johns Hopkins International in the Middle East.