



# The Patient Financial Experience: Problem Overview, Clinical Scenarios, and Questionnaire

*A number of participants from the nation's largest associations, healthcare providers, health plans and others met on September 25, 2012 at the HIMSS G7 Roundtable to discuss and progress its initiative, "The Healthcare Financial Network of the Future." The results of this strategic discussion along with several subsequent discussions among the members of the HIMSS Revenue Cycle Improvement Task Force are documented in this Report.*

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## Introduction

The HIMSS G7, a think tank group that meets three times per year to tackle specific issues in healthcare, has targeted the issue of consumer-driven healthcare, particularly the administrative experience and options for patients. One challenge raised by those discussions is how to adequately assess the experience for a given body of patients to determine a particular provider's success in delivering a positive financial experience for each of its consumers.

Patient financial touch points—defined in this paper as all of the points in the process where the patient has an administrative experience that influences their financial experience with the provider—may exceed the number of clinical touch points. This observation closely follows another: [The Patient Protection and Affordable Care Act](#) (PPACA) underscores the need to keep patient satisfaction high and has a financial incentive for providers who do so. Since 30 percent of the Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) value-based purchasing algorithm is based on patient-experience surveys, it has become an important tool to measure patient satisfaction beyond the clinical experience. Failure to keep HCAHPS scores competitive will result in lower reimbursements.

Providers need a means to measure and improve patient financial satisfaction. In addition to new regulations, the environment also is underscoring this need. Consumers are creating demand for more detailed information regarding their care and how it is billed. They also want the same administrative conveniences that are available to them in other industries.

This paper highlights the concept of the patient financial experience and offers a Patient Financial Experience Scorecard. It examines current patient financial touch points, methods used to judge the success of those interactions, how those touch points can be measured, and offers the assessment tool, designed to create a meaningful and actionable feedback loops for improving this process.

### Key Concepts:

- During the patient care encounter, the patient financial experience often includes more touch points than the clinical experience, yet is rarely measured in a meaningful way.
- Patient touch points are generally more numerous in the administrative process than in care delivery—and more patient complaints are found in this portion of the process. Many of the billing-related complaints that are generated around business office functions can be traced to mistakes made during the “access process”—the initial patient encounter with the healthcare provider and the series of practices this involves, from filling out paperwork to determining amount and form of payment.
- To evaluate a patient's financial experience with an institution, it is necessary to examine their interactions across the entire revenue cycle, not just in one area.
- Once a determination is made as to where improvements are needed, technology and process tools can be utilized to enhance the patient financial experience.

## Defining the Issue

### What is Revenue Cycle Management (RCM)?

Revenue Cycle Management (RCM) extends beyond patient billing and collections; it incorporates checking eligibility, collecting complete patient demographics, benefits verification, capturing charges, coding, claim submission, collecting and posting payments from patients, denial management, reporting and data analysis (see Figure 1). The main objective is maximizing revenue while optimizing patient satisfaction.

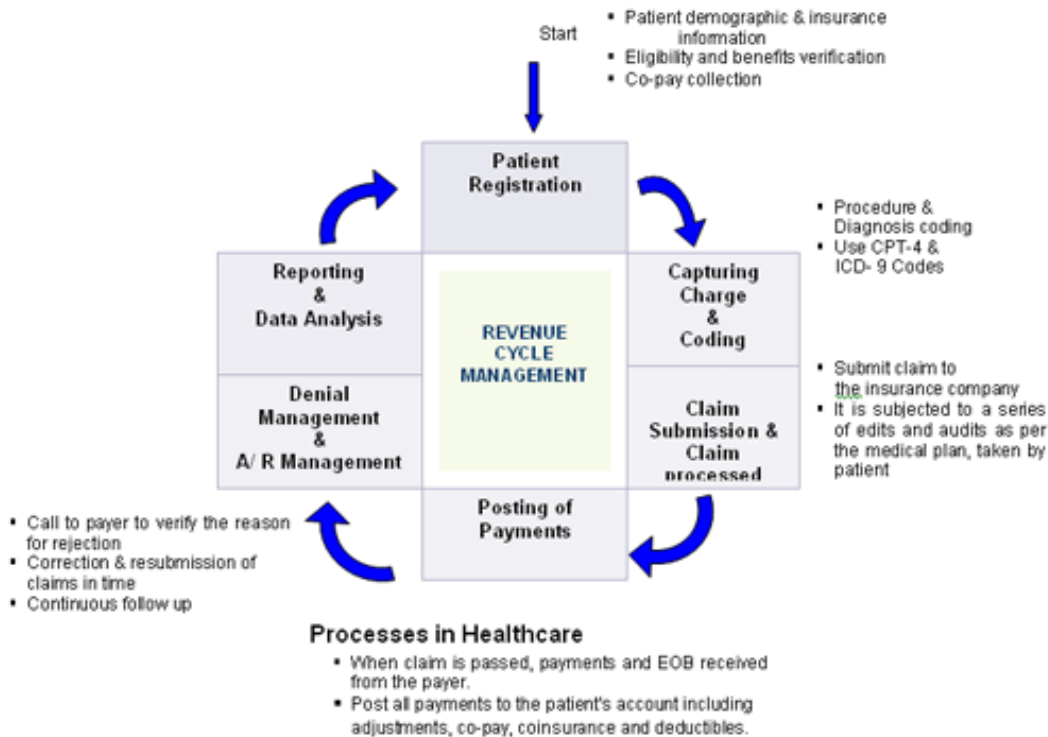


Figure 1. Basic Revenue Cycle Management Model<sup>1</sup>

Much of the process in Figure 1 occurs in the back office (the area where much of the claims processing work occurs at a provider location) and out of the view of the patient, but it plays a significant role in the patient's financial experience.

### Financial Touch Points

This section gives a complete overview of all of the points in the process where the patient has an administrative experience that influences their financial experience with the provider.

We will look at the patient financial experience in three phases: Before, during, and after the patient's encounter with the healthcare provider.

<sup>1</sup> HIMSS. *Financial Edge*. [eNewsletter] October 20, 2009. [http://www.himss.org/files/FinancialEdge/FinancialEdge\\_20091020.htm](http://www.himss.org/files/FinancialEdge/FinancialEdge_20091020.htm)

Some sample points include:

- Before (Did the patient understand what to expect and what options are available?)
  - Initial scheduling: What is asked here determines how pre-registration or registration is handled.
  - The Pre-registration call/registration onsite.
  - Initial financial discussion: This includes the initial discussion around insurance, co-pay collection, financial counseling if appropriate.
  - Financial counselor discussion.
  - Patient liability presentation and discussion.
  - Payment options presentation.
  - Ease of making payment.
- During (The purpose is to test clarity—did patient understand options?)
  - Additional financial discussions during treatment process (financial counseling visit, additional charges presented, etc.)
  - Discharge financial discussion for inpatients.
  - Bill presentment at discharge.
- After (Validate that patient understood obligations, service pleasant, a bill is forthcoming)
  - Follow-up bill presentment.
  - Outbound calls for payment follow up.
  - Customer service calls for payment follow up.
  - Post-service financial counseling discussion.

### Measurement

A challenge in designing any measurement instrument is determining what *not* to measure. There are many different aspects to the patient financial experience. The goal is to determine which of those aspects can be affected by a change in process or systems, and to gather actionable data which can be used to determine the quality of current methods. Since each aspect of the patient financial experience is best analyzed through the subjective impressions of patients, data gathering can best be accomplished by creating an instrument which converts subjective information into something quantifiable. In this instance, the G7 team agreed that a patient survey would be the proper instrument to collect the needed data. However, asking all of the key questions would require a very large survey. For an instrument to be successful, comprehensiveness must be balanced with ease of use. The questions offered in this particular instrument are laser-focused on those measurable—and changeable—aspects of the patient financial experience. Scoring methodologies are based on input from both patients and providers about the relevance of the variables.

### Scoring and Evaluating Results

The scoring for the questionnaire must be established. The authors of the survey have selected a scoring range of one to seven. This is the same used by [HIMSS Analytics](#) in many of its survey instruments. Survey participants are given clear information about scores' criteria at each end of the range.

Since there is no baseline to work from, early scoring will be used to create one. But some results should be obvious enough to foster a clear need for action. For instance, if the financial counseling portion of the tool yields a score of 3 out of 7, action(s) need to be taken to improve the score. Understanding what makes that score a 3 is a critical success factor for the process to yield improvements. Each area receives a score and is evaluated on its own merits. The scores must have enough detailed explanation to assist the user in determining next steps.

### **EXAMPLE: Financial Counseling Grading (from “At-Risk” to “Functional”)**

0-1: Financial counseling process virtually non-existent (“At-Risk”). Root causes and steps need to be identified and taken to improve the score. Patients have low confidence or trust.

2-3: Financial counseling process in place, but weak. Suggests a detailed review of process and technology is needed to determine shortcomings. Patients have low confidence.

4-5: Financial counseling meeting minimum standards, per the provider’s internal business requirements, but has room for additional training and improvement. Patients feel heard and needs are being addressed, but are not very confident in provider’s ability to satisfy needs.

9-6-7: Financial counseling is running well and patients feel properly cared for in this regard. No change necessary except to keep a continuous improvement program in place to maintain high scores.

Scoring metrics for each area will be released once the survey tool has passed through the initial beta phase and the survey process has been validated with users.

## **Using the Results to Change Behavior**

This section includes both the process and technologies available and currently in use by those entities that would likely score 6s or 7s in a particular section. To continue with the financial counseling example, we include a discussion of how the patient is referred to the financial counselor, how the interview process is conducted, the tools used to conduct that process, the tools used to evaluate those results and recommend programs or options, and the tools used to evaluate the success of those recommendations. We suggest the “ideal world” scenario for reaching a ‘7’ in that specific area, so readers and users of the tool can create their own gap analysis between where they are today and where they need to be.

Key objectives include:

- Encouraging processes that are readily understood and easily adhered to by the patient.
- Encouraging the adoption of practices that result in a mature process that is consistent, predictable, and continuously improving.

## **Conclusion**

The main theme of this paper is to offer healthcare organizations a useful framework to create tools and methodologies to address needed changes in the revenue cycle, and assist the RCM team to address patient-facing challenges that may lead to lower revenue intake and patient dissatisfaction. A

patient-centric revenue cycle will create new practices intended to engage patients intentionally, early and often, and to implement patient-convenient processes that may result in timely and prompt payment from patients.

The appendix at the end of this paper provides patient scenarios that demonstrate how the healthcare industry might better understand and improve the patient financial experience. The questionnaire is a useful tool that could be customized for use in various organizations to measure your patient financial experience and satisfaction.

## Appendix 1: Understanding and Evaluating the Patient Financial Experience

The following patient financial scenarios are designed to illustrate challenges and opportunities to improve the patient financial experience. Each scenario includes different variables that may impact the patient experience, a patient story and key consideration in developing a tool to assess and improve the patient financial experience.

### *SCENARIO 1 – PATIENT WITH COMMERCIAL INSURANCE*

<b>Insurance Type</b>	<b>Individual Plan – High Deductible</b>
<b>Sex</b>	<b>Male</b>
<b>Age Group</b>	<b>50-65</b>
<b>Race/Ethnicity</b>	<b>Caucasian</b>
<b>Educational level</b>	<b>College Degree</b>
<b>Primary Language</b>	<b>English</b>
<b>Patient Type</b>	<b>Outpatient</b>

#### *PATIENT STORY:*

John Smith is a 62-year-old independent consultant who purchased an individual healthcare plan with a high-deductible. He develops a minor obstruction in his left nasal passage that has persisted for a few weeks. He calls his primary care physician who refers him directly to an ear, nose, and throat specialty clinic.

At the time of the appointment the receptionist states their process and suggests John have a routine CT scan, which is done for all new patients. John requests the cost of the CT scan; the receptionist does not have the information so he decides to decline the study.

On arriving at the clinic, John is seen by a physician assistant (PA) who uses a small hand-held scope to look into his nasal passages. The PA determines that John has a small, benign polyp and recommends nasal saline flushes and no further treatment unless symptoms worsen or persist. The PA suggests an MRI for completeness. John again attempts to get the reasoning for the MRI, since there was considerable certainty that this was just a benign condition. John is again told that the MRI is suggested to be thorough.

After considerable effort, John determines that the cost of the MRI is \$950 with no discounts for direct patient payment. John declines this procedure as well.

Subsequently, John is unpleasantly surprised by several items on his bill:

- Though seen by a PA, a charge of more than \$400 for a “high-level consultation.”
- A \$450 facility charge for a simple patient exam room because the clinic was connected to the hospital by a sky bridge. An affiliated clinic elsewhere in the city would not have that facility charge.
- A \$520 dollars for an “endoscopic procedure,” which is a normal part of any ENT exam.

After asking about the bill, John was simply told that all charges were normal and appropriate. There was no consideration of a discount on the bill and specifically no willingness to accept normal insurance levels.

Considering this encounter was for one of the least complex types of ENT conditions, requiring nothing more than a saline nasal rinse treatment, John was not pleased that he was charged nearly \$1,500 with little visibility into the process.

### *PATIENT FINANCIAL EXPERIENCE QUESTIONS*

1. Does the facility provide upfront estimates of the patient encounter?
2. Are there routine studies ordered before the patient is evaluated?
3. Is the price of any ordered study readily available?
4. Are alternatives and alternative costs regularly discussed with the patient?
5. Are facility charges disclosed and an offer made to offer lower cost options (other charges different) for the same services that may be provided in other affiliated clinics that are in other locations?
6. Is the patient who is paying out-of-pocket offered a discount that approaches what would normally be accepted from a commercial payer?
7. Is bundling of services, per the Accountable Care business model, consistent with what would be expected for commercial payers?
8. Is there a web site available that allows patients to view cost estimates for various services?

### *SCENARIO 2 – MEDICARE PATIENT*

<b>Insurance Type</b>	<b>Medicare</b>
<b>Sex</b>	<b>Female</b>
<b>Age Group</b>	<b>65+</b>
<b>Race/Ethnicity</b>	<b>Caucasian</b>
<b>Educational level</b>	<b>High School</b>
<b>Primary Language</b>	<b>English</b>
<b>Patient Type</b>	<b>Inpatient</b>

### *PATIENT STORY:*

Mary, a 71-year-old retired administrative assistant and recent widow, has some independent financial means left by her husband, as well as a small pension. Mary’s hip has been deteriorating for some time and finally reached a point where it needs replacement. She had been told that this day



was approaching, but her last visit to the orthopedist confirmed that it cannot wait any longer if she wants to be able to walk pain-free. Mary is afraid of the surgery, but not overwhelmingly so. She is more concerned about her portion of the cost, as she has no Medigap plan.

Mary receives a call from the registrar at the referral hospital. The individual she speaks with is very polite, but when Mary inquires as to her likely portion of the bill, she is informed that they will generate an estimate when she comes in for her surgery. Mary informs her that she is concerned she will not have enough money to pay, and the registrar suggests that Mary speak to one of their financial counselors to explore options. Mary does so, and the counselor works to generate an estimate that shows the whole surgery will cost approximately \$33,000 and Mary's likely portion, after discounts, will be roughly \$3,000. Mary is relieved that the amount isn't higher, but she is still not sure she can pay it one lump sum. The counselor discusses payment plan options.

Mary has a successful surgery with no complications. However, she is experiencing some persistent post-operative dizziness. Since she has no family members to assist, she is forced to hire temporary help at home. She had not considered this possibility, nor was it discussed with her prior to the operation.

Mary receives a series of bills related to her visit, and she is at a loss to understand the purpose of each bill. She contacts the hospital, as several items appear to be services not covered by Medicare, which have now been moved to her liability. No one explained or offered her an Advanced Beneficiary Notification (ABN) form to explain which services may not be paid for by Medicare. The hospital informs her that she should just wait, as some things have been resubmitted and the next bill will look different. Mary is confused and anxious about her total financial exposure.

### *PATIENT FINANCIAL EXPERIENCE QUESTIONS*

1. Does the facility provide upfront estimates of the patient encounter?
2. Is there a standard price list for common procedures which can be shared with the patient?
3. Are alternatives and alternative costs regularly discussed with the patient?
4. Do you have a signed ABN, from the patient, where you explained which services Medicare may not provide to make it clear what parts they are financially responsible?
5. Does the facility routinely refer cases to financial counseling before services are performed, when the situation changes (e.g., when complications occur or the diagnosis changes), or only after discharge/service?
6. Is the patient who is paying out of pocket offered a discount that approaches what would normally be accepted from a payer?
7. Are post-service considerations and the costs associated with those, discussed with the patient?
8. Is assistance available to walk the patient through the bills received after discharge/service?

## Appendix 2: The Patient Financial Experience Scorecard

The questions posed in the scenarios are not always simple to ask in a practical context. Since one of the main aims of this document/survey is to create a useful instrument for providers to generate an authentic assessment, the points highlighted by these questions and critical satisfaction issues are posed in the questionnaire.

### Administering the Patient Financial Experience Survey

Administering the survey that drives the patient financial experience scorecard can be accomplished by internal or external resources over the phone, or through a web portal provided for consumers. Some consideration should be made as to offer parts of the survey during different phases of the patient experience. Early qualifying and testing questions can head-off issues and lead to higher patient satisfaction and payments earlier in the process. One could develop a portal that patients can use for which the hospital provides a link, and from which results are returned to the identified provider (while allowing the patient anonymity) to drive more candid responses.

One must be aware of the fact that the medium in which the response is received may skew results. Those who decide to take the time to respond over the web may be doing so for a specific reason and may not represent a random sample. Responses received via telephone are more personal and may result in more complete answers. This methodology, however, is typically more expensive and time-consuming, thus the provider will need to determine the best medium to deliver the survey.

If organizations decide to administer the process themselves, it will require an enormous data set to develop a baseline for the results to have statistical significance. Sample sizes as small as fifty may produce a margin of error under 15%. As the population is segmented, however, more data would be needed to make each segment statistically significant.

Still, given the five to eight minutes required to administer the questionnaire attached to this document, and assuming that same amount of time to find a willing participant, a resource assigned to this task should be able to review 25 to 30 participants in a day. In other words, in two days, a provider could have a healthy insight into their patients' financial experiences.

### Scoring

Some baseline questions will be the same regardless of patient type, whereas others will vary due to that patient's likely financial path through the organization. The goal is to understand while it is critical to generate scores for the patient financial experience, that experience will vary based on what payer is involved, if any, and other factors. Ultimately the scoring rubric will consist of the following:

- Patient financial experience overall score.
- PFE pre-visit score.
- PFE during visit score.
- PFE post-visit score.
- PFE inpatient score.
- PFE outpatient score.

Segmentation by payer, at minimum, will include: Commercial, Medicare, Medicaid, and self-pay.

Once the sample size being processed through the instrument is large enough, segmentation will mature to include population factors such as age group, education level, income level, race, local economies of scale, or case-mix. These categories could reveal trends in the process to which a facility can respond and ultimately keep the patient satisfaction scores high and cash flowing.

### Appendix 3 - Questionnaire

	<b>COLLECT PER PATIENT SURVEY (Can be preloaded)</b>	
	Balance Range – In increments which mirror facility’s typical range	
	Gender	
	Age	
	ZIP Code	

<b>PRE-VISIT</b>					
	<b>FORMAT</b>	<b>SUBJECT</b>	<b>QUESTION</b>	<b>SCORING</b>	<b>WEIGHT</b>
A	1-7 Scale	Financial Obligation	When you scheduled your visit, was your financial obligation clearly explained to you?	1 = not clear 7 = very clear	8
B	1-7 Scale	Estimate of Charges	Did the estimate of charges you were provided make sense?	0=not provided, 1=could not understand, 7 = made perfect sense	12
C	1-7 Scale	Payer vs. Liability	Were you clear on what charges were covered by you and which were covered by your insurance?	1 = not clear 7 = very clear	10
D	1-7 Scale	Payment Plan Options	Did you feel you were provided a useful range of payment options for your portion of the bill (pay up front, over 6 months, loan plan, etc.)	1 = No good options 7 = Many good options	10
E	Choice	Method Selected	Which payment method did you choose to pay your bill? (Check at facility, check by mail, check by phone, Credit card at facility, by mail, by phone, mobile payment, online check, online credit card, other)		No Weight – tracking only
F	1-7 Scale	Satisfaction with Hospital Financial Team	Overall, how satisfied were you with the financial aspects of your visit BEFORE you entered our facility?	1 = Not satisfied 7 = Very satisfied	20
G	1-7 Scale	Financial Counseling	(If referred) – Did you understand the reason for the questions being asked of you in the financial counseling process?	1 = Reasoning not made clear 7 = Reasons clearly explained	
H	1-7 Scale	Financial Counseling	Did you feel the financial counselor understood your situation and tried to help?	1 = Did not understand 7 = Understood and helped	
I	Choice	Choose the words that you think best describe the process	Professional Caring Businesslike Courteous Positive Rude Confusing Abrupt Disinterested		+2 for each positive -2 for each negative
J	Comment	Suggestions	What could we have done differently?		

<b>DURING VISIT</b>					
K	1-7 Scale	Additional Tests or Procedure Costs	Were you made aware of additional tests or procedures that would add costs and were fully apprised of those costs?	0 = No Costs Incurred 1 = No costs were explained 7 = Addl. costs fully explained	
L	1-7 Scale	Changes to Costs	Were you satisfied with the amount of information you were provided regarding any potential cost changes during your clinic visit or hospital stay?	1 = Not satisfied 7 = Very satisfied	
M	1-7 Scale	Getting more information	What could we have done differently to help you understand changes to your financial situation during your stay?		

<b>POST VISIT</b>					
N	Response	Promptness	How soon did you receive a copy of your bill?		
O	1-7 Scale	Bill Clarity	How understandable was your bill?	1 = could not understand at all 7 = very easy to understand	
P	1-7 Scale	Getting more information	Was it clear how to get additional information?	1 = not clear 7 = very clear	
Q	1 to 10 Scale	Payment Methods	Did you feel you were provided useful methods to pay your bill (or the plan to which you agreed)?	1= Not useful at all 7 = Very useful	
R	Choice	Method Selected	Which method did you choose? (Check at facility, check by mail, Credit card at facility, by mail, by phone, mobile payment, online check, online credit card, other)		
S	1 to 10 Scale	Satisfaction	Overall, how satisfied were you with the financial aspects of the billing for your visit and subsequent follow up?	1 = Not satisfied 7 = Very satisfied	
T	Comment	Suggestions	What could we have done differently?		

## HIMSS Revenue Cycle Improvement Task Force Contributors

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The Revenue Cycle Improvement Task Force was established to provide resources and best practices to healthcare providers for leveraging technology with revenue cycle management and the lifecycle of the patient encounter, and identify and promote emerging best practices for hospital provider CFOs and CEOs. Topics for inclusion are best practices, impact of real-time processing, metric performance measures, identification of emerging business practices, and identification of new cross-domain synergies that can improve revenue cycle, such as medical banking. More information is available at the HIMSS [Health Business Solutions Committee](#) web site. If you are interested in working with the Revenue Cycle Improvement Task Force, contact BCS Manager, [Joanne Bartley](#).

### About HIMSS

HIMSS is a global, cause-based, not-for-profit organization focused on better health through information technology (IT). HIMSS leads efforts to optimize health engagements and care outcomes using information technology.

HIMSS is a part of HIMSS WorldWide, a cause-based, global enterprise producing health IT thought leadership, education, events, market research and media services around the world. Founded in 1961, HIMSS WorldWide encompasses more than 52,000 individuals, of which more than two-thirds work in healthcare provider, governmental and not-for-profit organizations across the globe, plus over 600 corporations and 250 not-for-profit partner organizations, that share this cause. HIMSS WorldWide, headquartered in Chicago, serves the global health IT community with additional offices in the United States, Europe, and Asia.