



## Siemens Healthcare Podcast Transcript

### **“Breaking old paradigms of point-of-service collections”**

*The following is a transcript from a Siemens Healthcare podcast interview entitled “**Breaking old paradigms of point-of-service collections**”*

**Steven Wright:**

My name is Steven Wright and I’m a marketing manager at Siemens Healthcare. Welcome to today’s discussion regarding breaking old paradigms of point-of-service collections.

Today I’m joined by Travis Gentry, Founder and President of Financial Healthcare Systems and creator of FHS ClearQuote. FHS is a business partner of Siemens HDX. FHS ClearQuote, offers providers a secure, web-based solution that calculates a patient's out of pocket financial responsibility.

Travis, welcome.

**Travis Gentry:**

Thank you Steve.

**Steven Wright:**

Your company works with hundreds of health care facilities to provide estimates on the patient portion owed for services. And as such what are your customers expressing as their greatest challenge today in the area of point-of-service collections?

**Travis Gentry:**

Historically, the majority of the provider’s revenue was coming from the insurance company. Providers were not accustomed to collecting large dollars from patients up front. Managed care has trained patients and providers not to care about out of pocket expense because small co-pays and deductibles were not considered significant. This situation has lead to financial apathy. If healthcare providers want to collect upfront from patients, they need to make a credible and defensible case to them.



**Steven Wright:**

So how do providers address this issue?

**Travis Gentry:**

By crafting a more proactive approach to patient collections. We find that most patients really are very receptive to conversations about payment responsibility if you present it in a clear and credible manner. Most patients don't really understand how the final cost of their healthcare is calculated. By educating the patient at the time of registration about all the provider and payer cost inputs that make up their final out-of-pocket responsibility, you can achieve better financial results and enhance patient satisfaction. So the question is, how do you come up with an accurate estimate of the patients' responsibility?

Patient out-of-pocket estimates could be created manually, but the results of this approach have not been very promising. However, there are solutions in the market, such as ClearQuote, that can automate the estimation process.

Let's look a little closer at the data you really must have to come up with a credible estimate. There are three components to calculating a patient's out of pocket estimate. First, the patient's healthcare benefits. Second, the provider's historical information, such as charges or length of stay. And lastly, the provider's contractual relationship with the patient's insurance company.

**Steven Wright:**

Why not just provide the patient with the charge for the procedure?

**Travis Gentry:**

Patients will call the provider and ask for the charge for a procedure – it happens often. However, charges are meaningless. The charge is always different than the allowable that has been negotiated between the payer and provider, but most patients don't know that.

**Steven Wright:**

My guess is that each component of the out of pocket estimate calculation has its own set of challenges.

**Travis Gentry:**



That is correct. Contracts are a sensitive issue as they have been historically considered taboo for individuals outside the managed care department to have access to this information. Very few of the provider's staff really understand the contracts. They are also complex. Contracts contain many different kinds of reimbursement methodologies such as DRGs,MS-DRGs, per diem, case rates, percentages of charges, percentage of Medicare, fee schedules, ,on and on. With Historical Data, which means charges and Length of Stay, the information is not always relevant to the actual reimbursement. Most contract reimbursement methodologies don't need historical information. The calculation of historic charges is overemphasized in the need to calculate the estimate. Length of Stay is important for per diem cases, and charges are important for percentage of charges. There is also a natural variation in the data. 100 patients can have the same procedure performed, yet the natural range and dispersion of the historic data is significant. As for patient benefits you have the issue of incomplete data. Insurance companies commonly have a backlog of days or several weeks of unprocessed claims which can impact the year-to-date numbers for deductible met and out-of-pocket met benefits. The result is the benefit information presented on the day of admission could significantly change by the time the backlogged information is entered and the claim is actually processed. Benefit information is sometimes difficult to access. Providers either pay third party eligibility vendors for electronic access or they spend critical personnel time on the phone or manually looking up benefits on insurance company websites.

**Steven Wright:**

So how can a hospital provide a credible estimate to the patient?

**Travis Gentry:**

You have to use a combination of several credible sources of data. A credible and defensible estimate comes from using several key datapoints, the first being the patient benefits information, which is most effectively obtained with an eligibility verification transaction through a clearinghouse provider. The second key data point is the provider's charge description master. When you explain to a patient that the provider and payer relationship is a contractually negotiated, you can provide the hospital's charges as the baseline from which the final allowable paid by the payer is negotiated. Third is the physician's historical preferences, which includes examining the types of procedure codes the patient's doctor typically performs for a certain type of diagnosis. This will help insure that the patient estimate follows what is the normal process for their physician. Lastly, and probably most importantly, the contractual relationship between the healthcare provider and the insurance company. In the payer and provider



contract, the estimate is created leveraging the most current reimbursement methodologies. The estimate is created using the same document the provider would use to challenge payment remitted by the insurance company. It is defensible.

**Steven Wright:**

Is there a challenge to this contracts-based approach?

**Travis Gentry:**

The challenge with this approach is access to the contracts and the maintenance required. Many estimation solutions do not consider contracts because of their complexities and the difficulty of modeling their terms. Solutions that do not model contracts solely leverage historical information implying that yesterday's claim is tomorrow's estimate. This approach is not credible. Try explaining to a patient that their estimate is based on what other similar patients paid and their first response is, "Well, that is not my case, my insurance is better, and that cannot be my cost." It is not defensible.

**Steven Wright:**

Why not just use claims data to create an estimate?

**Travis Gentry:**

Aggregate historical data has been used to predict the future in many industries in the absence of hard forecasting data. In order to be statistically significant, a claims-based system would require hundreds of CLAIMS from every payer for every procedure every year. However, when using the payer and provider contract to define reimbursement, the need to assume the future patient population will respond exactly as the historical population to the medical procedure is not applicable.

**Steven Wright:**

So a claims-based approach to estimates would have to have a significant amount of claim volume for each payer.

**Travis Gentry:**



Exactly. A provider will build the volume more quickly for their larger payers just because they see more patients. But for their lower volume payers, the provider may only see a handful of patients for a limited set of procedures. To compensate for needing extensive data, these systems will attempt to average the reimbursement across multiple payers.

**Steven Wright:**

Will the volume of claims need to be from the same payer and provider contract year?

**Travis Gentry:**

Yes. A claims-based approach to estimates has trouble gaining the specific data required to provide a credible estimation. Most payer and provider contracts are negotiated on an annual basis and are termed on a calendar year. This means that if the average time needed to adjudicate a claim is 6-10 weeks, the estimate would have to be “artificially” manipulated for the first quarter of the year to reflect any contract changes while vying to get the volume needed per the point I just discussed.

**Steven Wright:**

How many claims are correctly adjudicated the first time?

**Travis Gentry:**

How many times must providers re-submit claims to receive correct payment? How much do providers trust that payers pay correctly? The answers are typically...several, rarely, and never. It is rare that payers pay a claim correctly the first time. This is why many providers distrust payers and have to verify payment. Typically, providers must defend the claim, repeatedly submit the claim, and monitor payment to get paid what they are due. Each time this happens, incorrect claims data is introduced into the estimation system creating further “noise”, instability and inaccuracy of the estimates.

**Steven Wright:**

How do averages play into creating an estimate?

**Travis Gentry:**



One critical differentiation is the use of median verses average calculations. An approach that uses median charges improves the reliability of the estimate because average charges are skewed by the extreme high and low values. Median calculations evaluate the charges by what is most common.

**Steven Wright:**

So now I understand the best approach to creating a credible patient estimate, but how do I implement a process or solution to create and communicate the estimates to patients so that I can increase my point-of-service collections?

**Travis Gentry:**

I have seen several hospitals try to create patient out-of-pocket estimates just manually. They use spreadsheets and look at copies of payer contracts. But I have not seen any instance yet where this has been effective long term. The problem is that, if you are going to provide a really good estimate, there are too many data points to synthesize in a brief amount of time. A typical patient access representative does not have time, and often doesn't possess the skill set to pull all of this data together quickly in a clear, concise manner.

It's best to investigate automated patient bill estimation solutions. A good software solution will do the work of pulling all the datapoints you need into a clear, concise estimate that you can actually hand to a patient at registration time.

**Steven Wright:**

So if a provider wants to deploy a patient out-of-pocket estimation solution, how do they best roll it out to their organization?

**Travis Gentry:**

It's best to walk before you run. You could just start with high dollar procedures so that your staff gets used to not just the new software, but the new business processes. We always say, "don't let the tail wag the dog" meaning don't let technology drive the process, rather the process should drive the technology. Before implementing any technology, providers need to understand how they plan on using it. Specifically for estimation, providers need to decide where employees are going to give estimates. In pre-registration, registration, or financial counseling. What information do they have about "why" the patient is coming in such as which doctor, what procedure or what insurance benefits. How do they plan on presenting it to the patient and are all users trained how to educate and collect from patients.



**Steven Wright:**

What types of benefits will hospitals see by using a contracts-based estimation tool?

**Travis Gentry:**

The obvious benefit is an increase in point-of-service collections. It allows the provider to go beyond just collecting deductibles and co-pays based on some random price list taped to the desk of the registrar. Now they can create an estimate that looks at contractual information in relation to charges, historical data to determine what other procedures may occur with the primary procedure code, and view eligibility data returned to determine co-pay, deductible, deductible met, out-of-pocket and out-of-pocket met and co-insurance. Once our users understand that our methodology works, they feel confident in asking for money up front and can explain to the patient how the system came up with this estimate. If you ask with confidence, a patient is more likely to pay if they are able.

And, you are providing the patient with a service by informing them on their amount owed to the facility. No other industry allows you to obtain a good or service without knowing how much it is going to cost. Patients really do want to know how much this is going to cost them. By educating the patient upfront, you eliminate financial surprises after the procedure. This gives the patient the power to make the appropriate financial decisions, such as working with the hospital's financial counseling department to set up payment plans or see if they qualify for charity care. In some cases, they can even arrange for a loan through the hospital. Many doors open to patients in how to handle paying for a procedure when they know up front.

**Steven Wright:**

You have provided a lot of useful information on patient bill estimates. Thanks for sharing, Travis

**Travis Gentry:**

Thank you Steve