Optimizing the Patient Financial Experience

The Academy — The Health Management Academy

Cedar

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Introduction

Over the past decade, expectations around the consumer experience have changed drastically. More and more, consumers expect to receive goods and services where, when, and how they want it and expect a personalized experience. While other industries (e.g., retail, banking) have weathered this evolution, healthcare is just beginning to experience this pressure.

Beyond evolving consumer expectations, legislative and regulatory requirements around price transparency and surprise billing have forced health systems to implement strategies to better manage the patient financial journey. Additionally, as the number of patients covered by high deductible health plans (HDHP) has increased, so has patients' out of pocket financial obligation. Ultimately, patients are taking on more financial responsibility and a higher proportion of health system revenue is coming from patients as payers. Thus, it is essential for health systems to cater to consumers to facilitate the financial process in order to capture this revenue.

However, historically the patient financial experience has been fraught with challenges. Industry disruptors are looking to cater to this demand and provide services to patients in a way that is accessible, convenient, and affordable. Recognizing the threat, health systems are working to disrupt their own processes to facilitate a more consumer-friendly experience.

Reflective of the growing need to optimize the patient financial journey, The Health Management Academy (The Academy) and Cedar - a patient payment and engagement platform - aimed to identify health systems' current priorities, strategies, and challenges regarding the patient financial experience and provide a framework for a consumer-centered approach to this issue.

Legislative & Regulatory Requirements

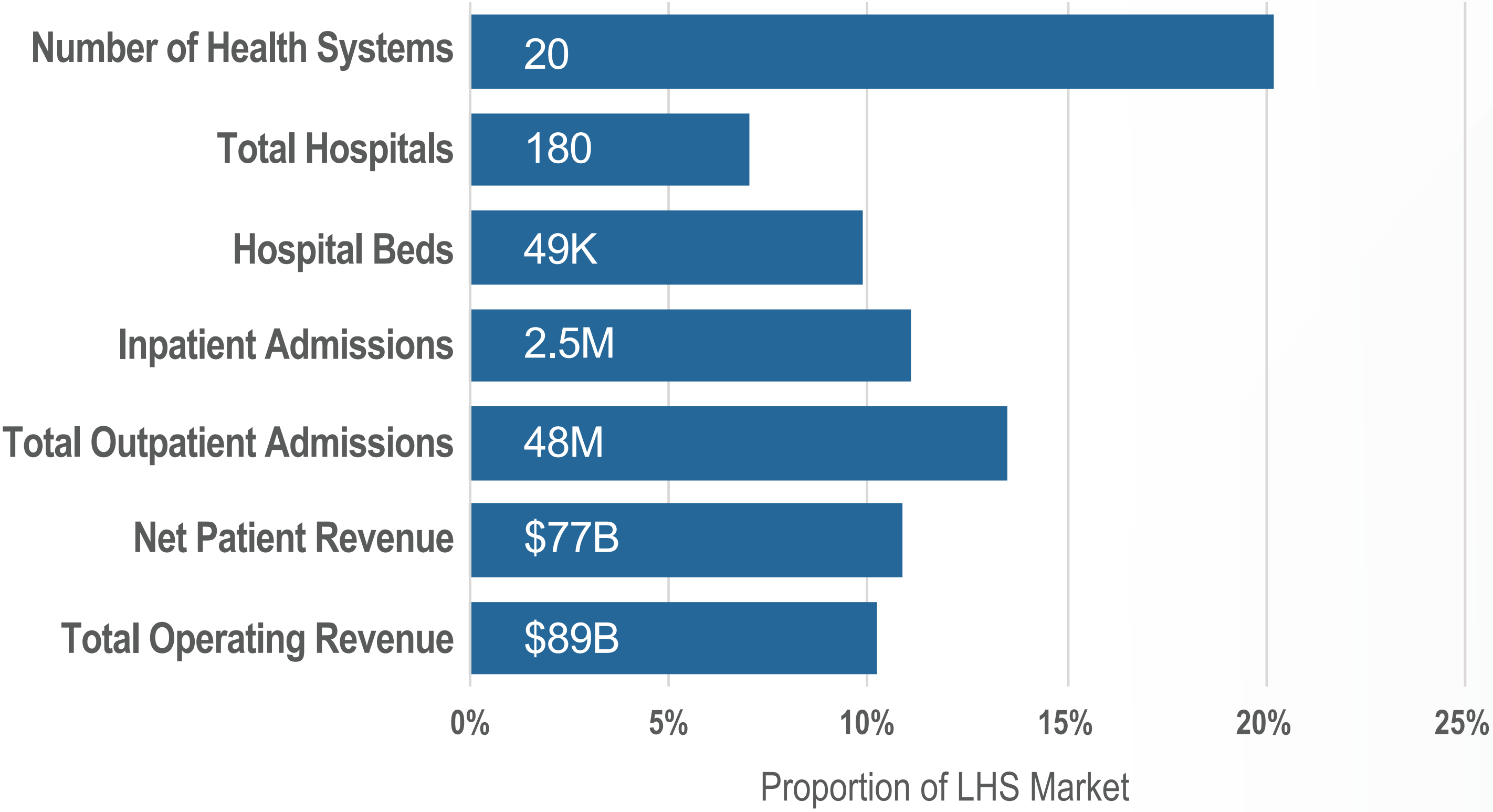Changing Consumer Expectations

Patients Becoming Payers
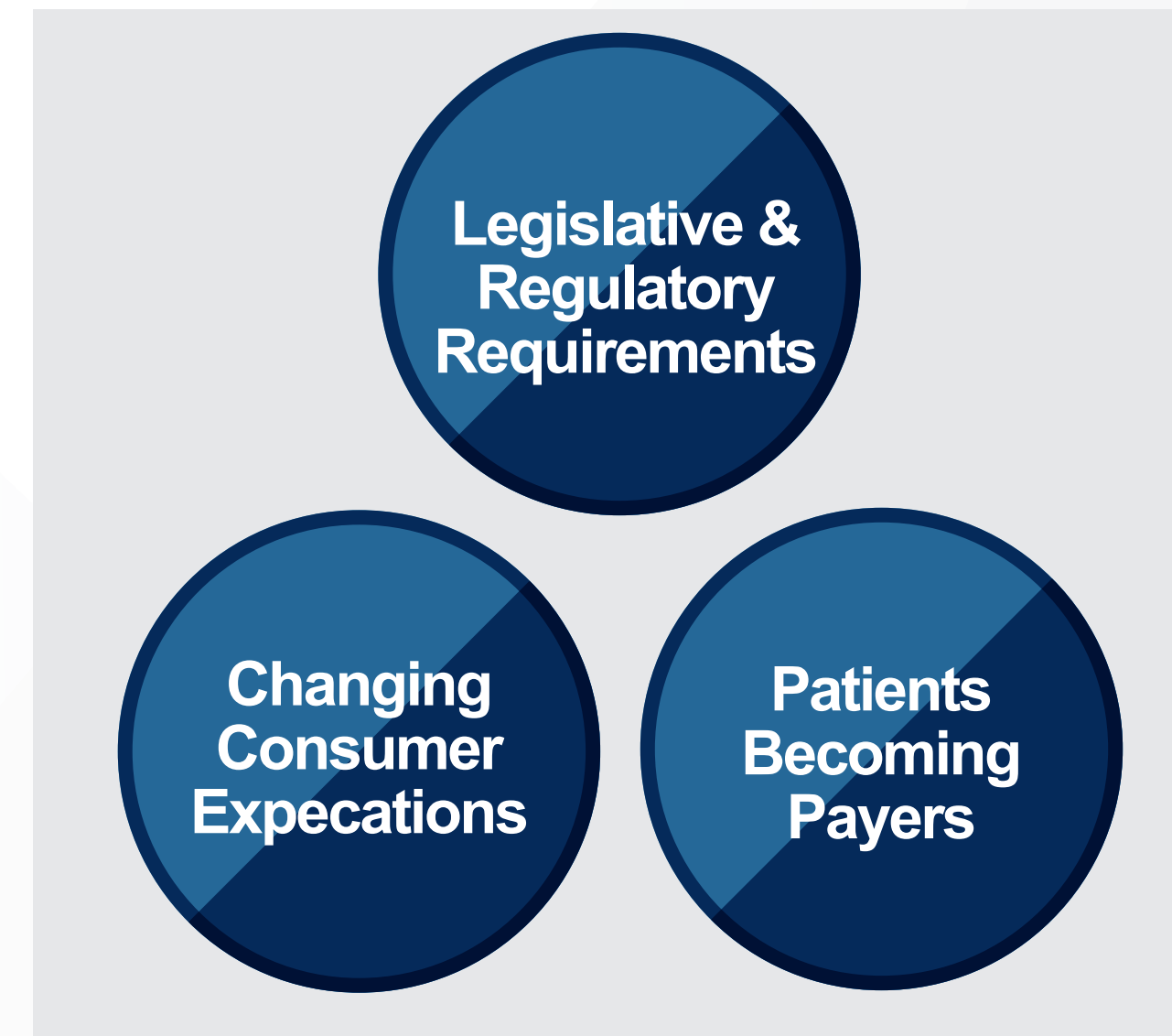
Growing Pressures to Improve Financial Experience
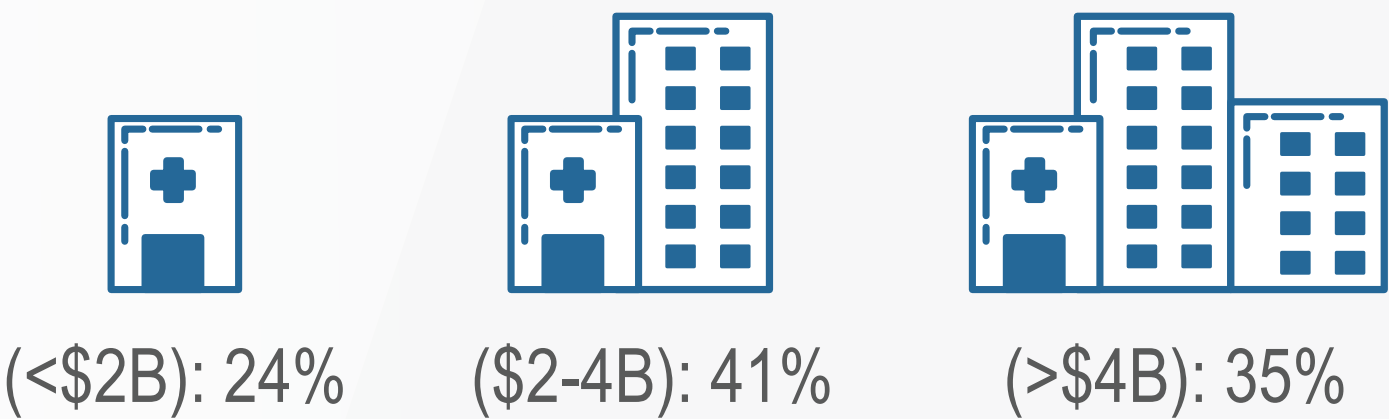
Key Consumer Challenges

- Accessing pricing information, pricing variation
- Accurately estimating OOP costs
- Scheduling services
- Time between service and billing
- Understanding billing language and personal obligation
- Understanding Payment Options

Study Participants are Representative of the Leading Health System Market

Health System Size (NPR)

(<$2B): 24%   ($2-4B): 41%   (>$4B): 35%

Category	Value
Number of Health Systems	20
Total Hospitals	180
Hospital Beds	49K
Inpatient Admissions	2.5M
Total Outpatient Admissions	48M
Net Patient Revenue	$77B
Total Operating Revenue	$89B

Proportion of LHS Market (x-axis: 0% 5% 10% 15% 20% 25%)

Respondent Roles
Chief Financial Officer (CFO)
VP, Revenue and Treasury
System Director, Budgeting
VP of Revenue Cycle
VP of Financial Services
Chief Officer of Strategic Communication
SVP, Finance
Chief Patient Experience Officer
SVP, Revenue Management
VP, Finance
VP, Marketing
Director, Strategy

Note: Leading Health Systems are defined as The Academy's membership, which includes the 100 largest and most innovative health systems across the U.S.

Source: The Academy Database, 2019

Key Findings

1

Prioritization

Improving the financial experience for patients is a **high priority across health systems;** however, **greater alignment is needed across functional areas** to effectively operationalize a system-wide strategy.

2

Initiatives

Health systems have a **number of strategies in place** to optimize the patient financial experience, however initiatives are commonly implemented in a **piecemeal rather than systemic fashion.**

3

Challenges

Despite a variety of external pressures, health systems note **barriers to improving the financial experience are primarily internal** – notably competing priorities and patient engagement.

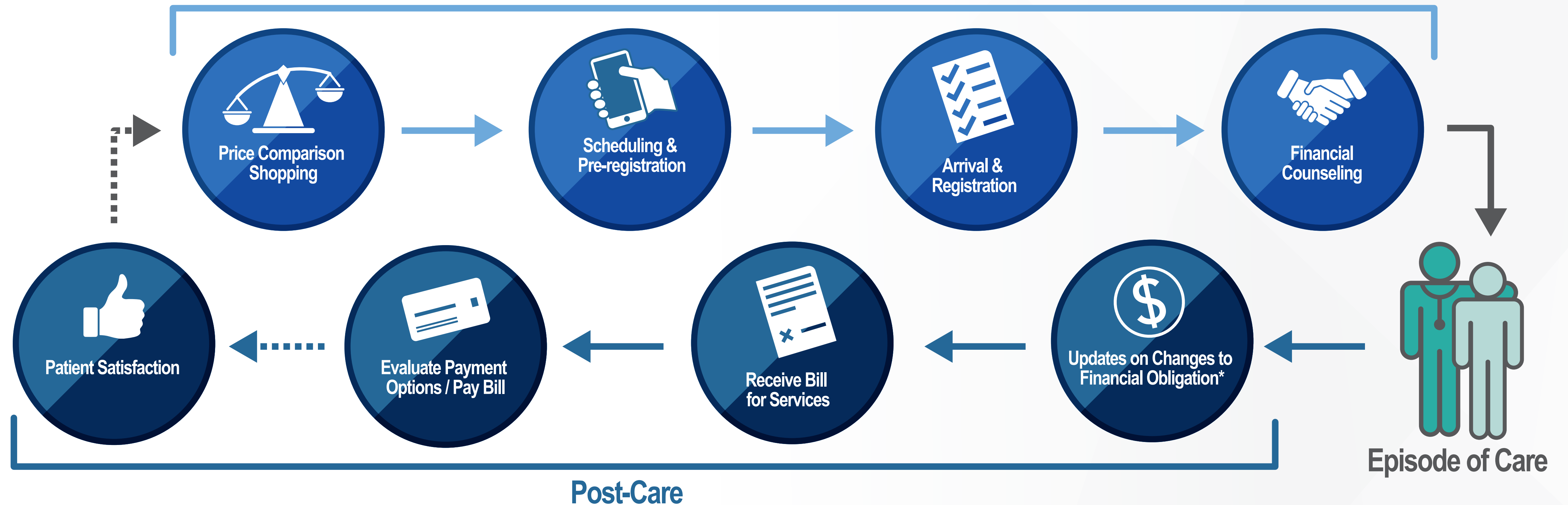# Defining & Prioritizing the Patient Journey

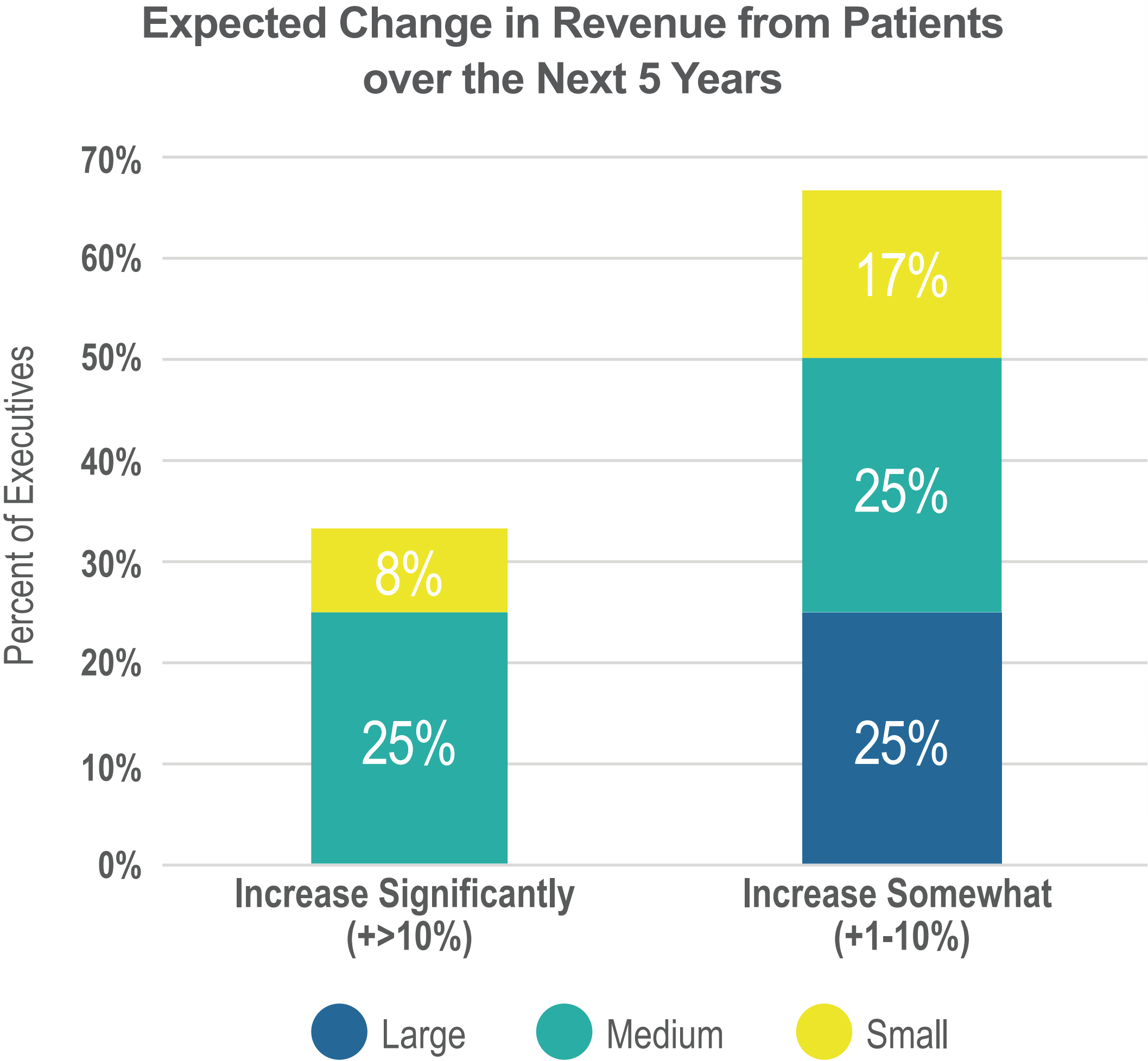# The Patient Journey Extends Beyond Care Delivery

Health systems are increasingly prioritizing the patient experience as a key measure of success; however, these efforts have historically been limited to satisfaction with care delivery. As consumers continue to demand more convenient and affordable healthcare, health systems are recognizing the patient journey extends far beyond satisfaction with care delivery. As financial interactions are the first and last touch-points a health system has with a patient, organizations are working to improve commonly confusing and challenging processes to promote a positive patient experience and build patient loyalty.

Pre-Care

- Price Comparison Shopping
- Scheduling & Pre-registration
- Arrival & Registration
- Financial Counseling

Episode of Care

- Patient Satisfaction
- Evaluate Payment Options / Pay Bill
- Receive Bill for Services
- Updates on Changes to Financial Obligation*

Post-Care

63% of health systems have implemented strategies aligning with 4 or more components of the financial journey

Percentage of LHS Revenue from Patients is Increasing

Expected Change in Revenue from Patients over the Next 5 Years

Percent of Executives

- **Increase Significantly (+>10%)**: Small 8%, Medium 25%
- **Increase Somewhat (+1-10%)**: Small 17%, Medium 25%, Large 25%

Legend: Large (blue), Medium (teal), Small (yellow)

While increasing consumerism underlies health systems' prioritization of the financial experience, there is also a financial incentive for health systems to optimize this process.

All health systems expect the share of revenue coming from patient obligation to increase over the next 5 years. Two-thirds (67%) of finance executives expect the proportion of revenue coming from patients to increase between 1-10% over the next 5 years, and one-third (33%) expect the proportion of revenue to increase by over 10%.

With more revenue tied to patient obligation, this income is at risk if the billing and payment processes are not improved. If patients cannot understand their obligation or how to pay their bill, health systems risk not collecting a greater portion of their revenue.
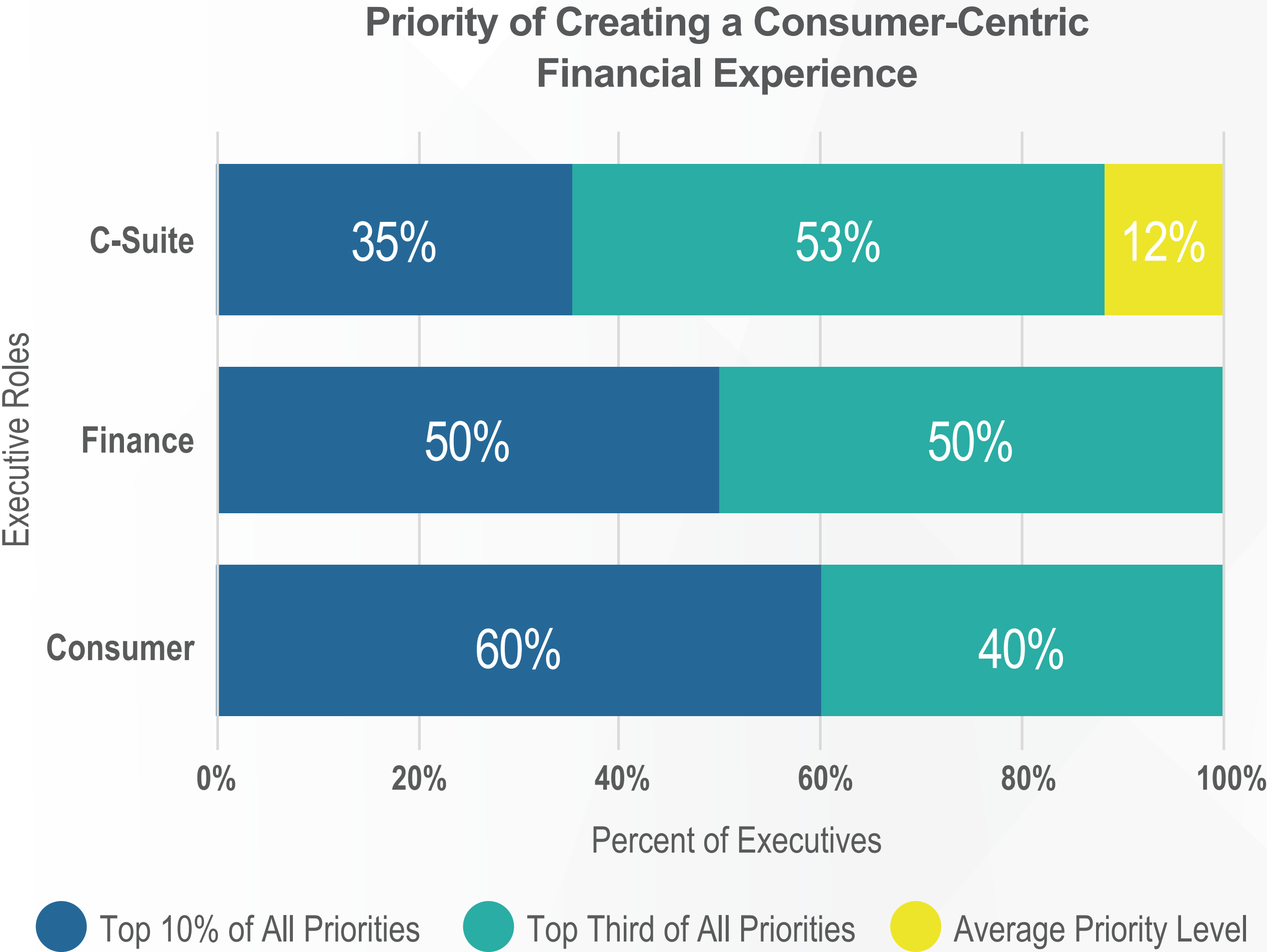
> *We have absolutely seen the patient percentage of revenue increase. As more patients get high deductible health plans they have to pay more when they do need care."*
> **– System Director, Budgeting**

High Priority Across Roles, Highest within Finance and Consumer Functions

Creating a consumer-centric financial experience is a top priority across all functional areas at responding health systems. However, senior Finance executives (e.g., SVP, Finance, VP of Revenue Cycle) and Consumer executives (e.g., VP of Marketing, Director of Strategy) more commonly rate this issue in the top 10% of all priorities compared to C-suite executives. Fewer C-suite executives rank creating a consumer-centric financial experience in the top 10% of their priorities.

Given this issue hasn't risen to the top 10% of all priorities for the C-suite – which sets the priorities of the organization at large – it is difficult for systems to align the consumer and finance functions and create a comprehensive strategy focused on the consumer perspective.

Priority of Creating a Consumer-Centric Financial Experience

Chart: Percent of Executives by Executive Roles

- **C-Suite:** Top 10% of All Priorities 35%, Top Third of All Priorities 53%, Average Priority Level 12%
- **Finance:** Top 10% of All Priorities 50%, Top Third of All Priorities 50%
- **Consumer:** Top 10% of All Priorities 60%, Top Third of All Priorities 40%

Legend:
- Top 10% of All Priorities
- Top Third of All Priorities
- Average Priority Level

The Patient Financial Journey: Pre-Care Delivery

Pre-Care   During Care   Post-Care →

There Is Work to Do on Price Accessibility

For many services, the first interactions a patient will have with the health system come well before care delivery or communication with a clinician. These interactions are commonly the financial and administrative components of the patient journey (e.g., price shopping, scheduling). As societal expectations evolve, consumers are demanding easier access to information and increased convenience in this process.

Reflective of this demand and broader issues of access and affordability, lawmakers are also requiring increased transparency in the pricing of services (i.e. chargemaster publication). However, these requirements are commonly viewed as ineffective in providing useful information to patients.

Health system executives are cognizant of the need for greater price transparency, however many still struggle to provide accurate estimations to their patients. Executives recognize health systems have a lot of work to do in this space, however many are optimistic about their current abilities. Senior executives rate the accessibility of pricing information at their organization currently as a 6.6 on a scale from 1 (Difficult to find) to 10 (Very accessible) on average.

6.6 | Average accessibility of pricing information as perceived by LHS executives

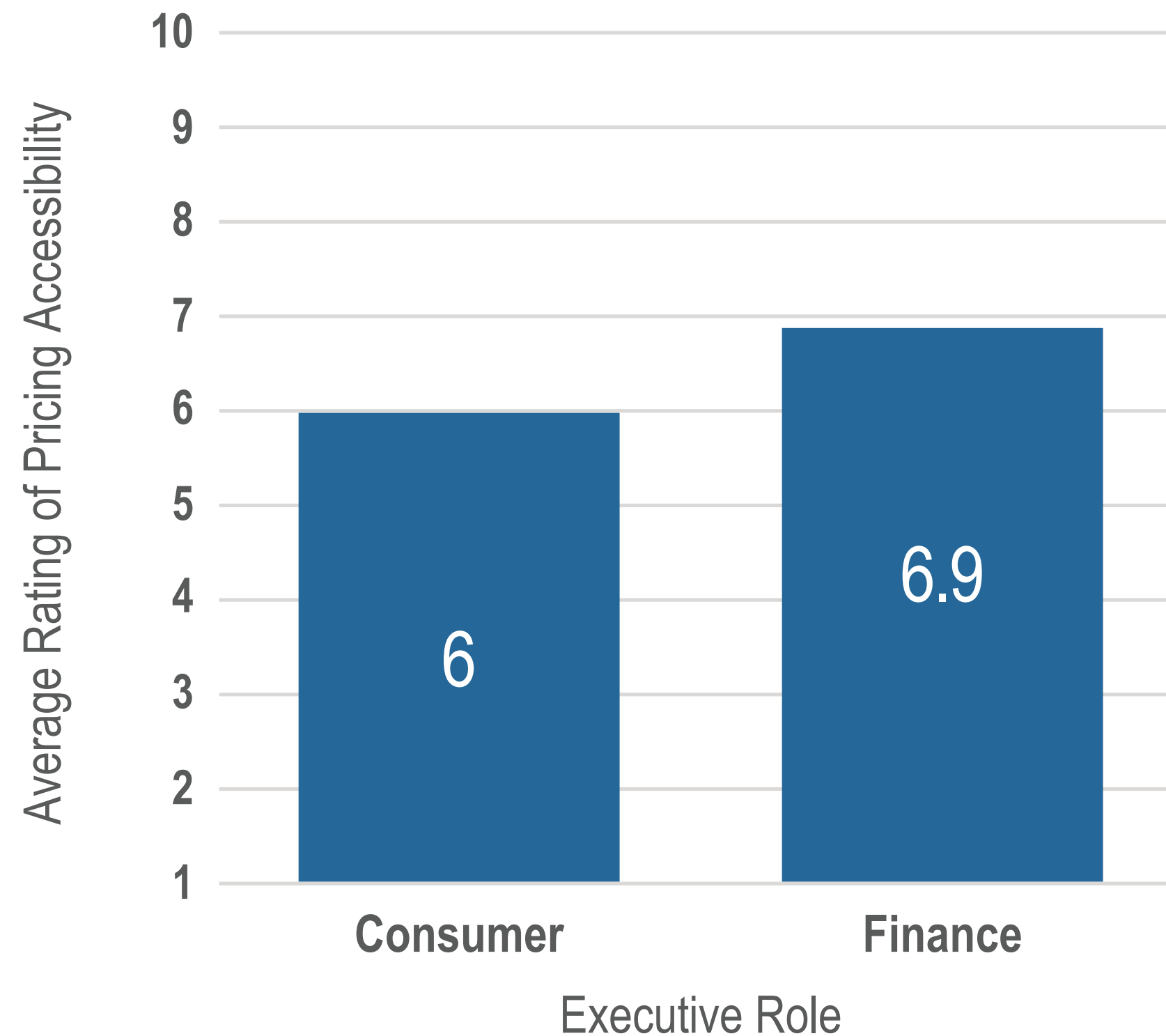*On a scale from 1 (Difficult to find) to 10 (Very accessible)*

" *The chargemaster means zero. Obviously we are trying to follow the rules, but anything about posting charges has no value to the average consumer."*
– VP, Finance

Some Disconnect Between Finance and Consumer Executives

Average Accessibility of Consumer Pricing Information by Role

While health systems have worked to improve pricing accessibility, most executives recognize there is significant work to do to make the information available and comprehensible for consumers.

Across health systems, Finance executives are on average more optimistic about their health systems' consumer pricing information accessibility compared to Consumer executives.

This may be indicative of a greater disconnect between Consumer and Finance executives when it comes to consumer strategy and the approach to optimizing the patient financial experience. As responsibility for improving pricing transparency and the broader financial experience commonly exist within the Finance function, it is important to develop an overarching system strategy that aligns the Consumer and Finance perspectives.

"
For the most part, the strategic initiatives are owned by Finance and the Revenue Cycle Management team and there is little interaction between the Patient Experience team and Finance."
– VP, Finance

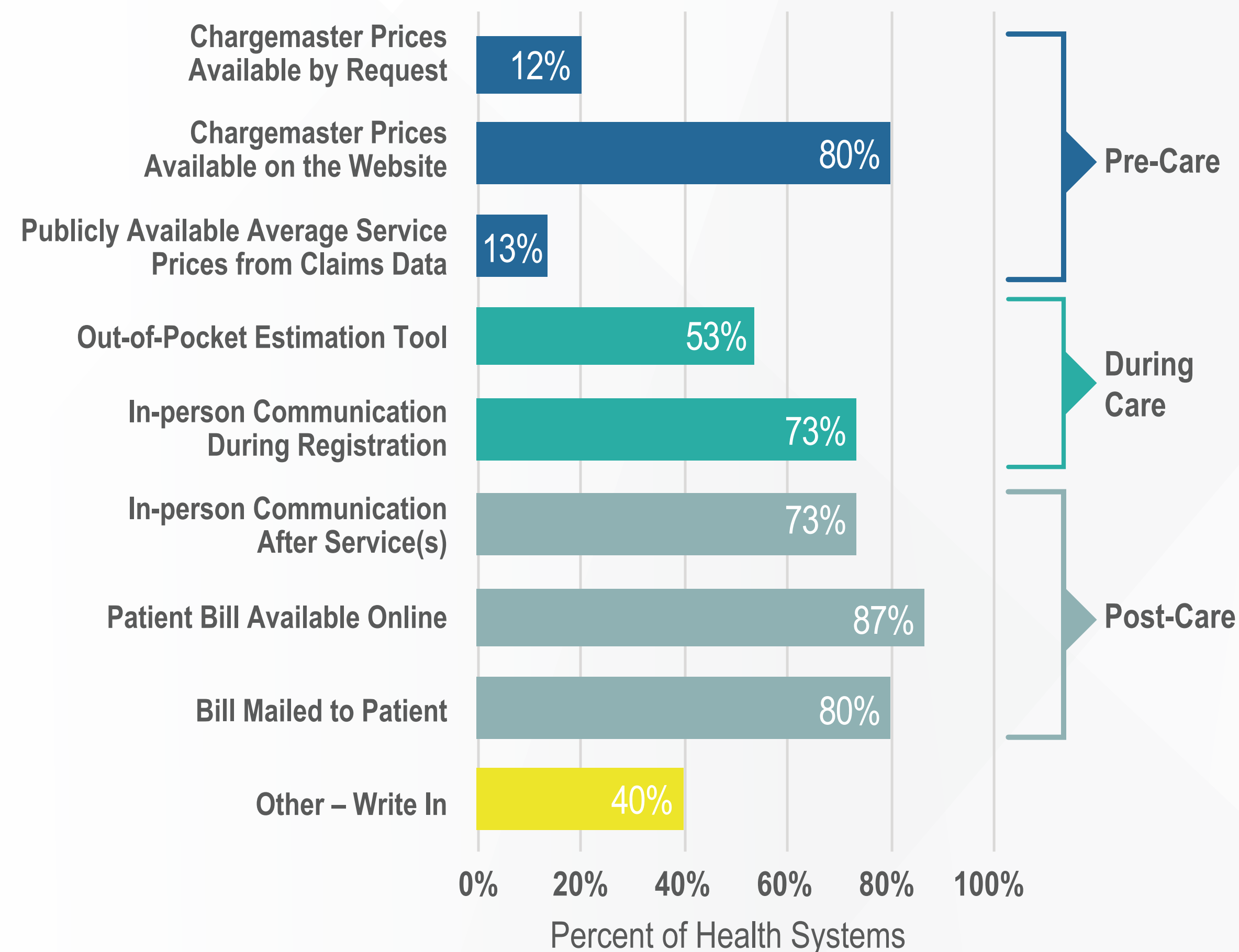# Most have Multiple Touchpoints to Communicate Pricing Information

Chargemaster Publication is Common, but Less Impactful

In response to increased demand for price transparency, health systems have worked to improve accessibility to pricing information prior to care, most commonly through publication of the chargemaster on the health system's website (80%). However, as the chargemaster prices are not the prices charged to the patient, these resources are commonly confusing and hard to interpret for consumers and ultimately cannot provide accurate estimations of patient obligation. Additionally, patients usually receive a combination of many chargemaster services making it difficult to calculate the total price for care with the chargemaster list alone. Due to these challenges, many health systems (53%) have also developed out-of-pocket estimation tools that provide customized and more accurate estimations of a patient's obligation.

Health Systems Have Multiple Methods of Communicating Pricing Information

Additionally, health systems are working to communicate pricing and cost information throughout the patient journey to ensure patients are informed before, during, and after care delivery. Most health systems (80%) have implemented multiple communication methods (4+), and almost half (47%) have 6 or more points at which they communicate pricing information with patients.

Methods for Communicating Pricing Information

Method	Percent
Chargemaster Prices Available by Request	12%
Chargemaster Prices Available on the Website	80%
Publicly Available Average Service Prices from Claims Data	13%
Out-of-Pocket Estimation Tool	53%
In-person Communication During Registration	73%
In-person Communication After Service(s)	73%
Patient Bill Available Online	87%
Bill Mailed to Patient	80%
Other – Write In	40%

Pre-Care · During Care · Post-Care
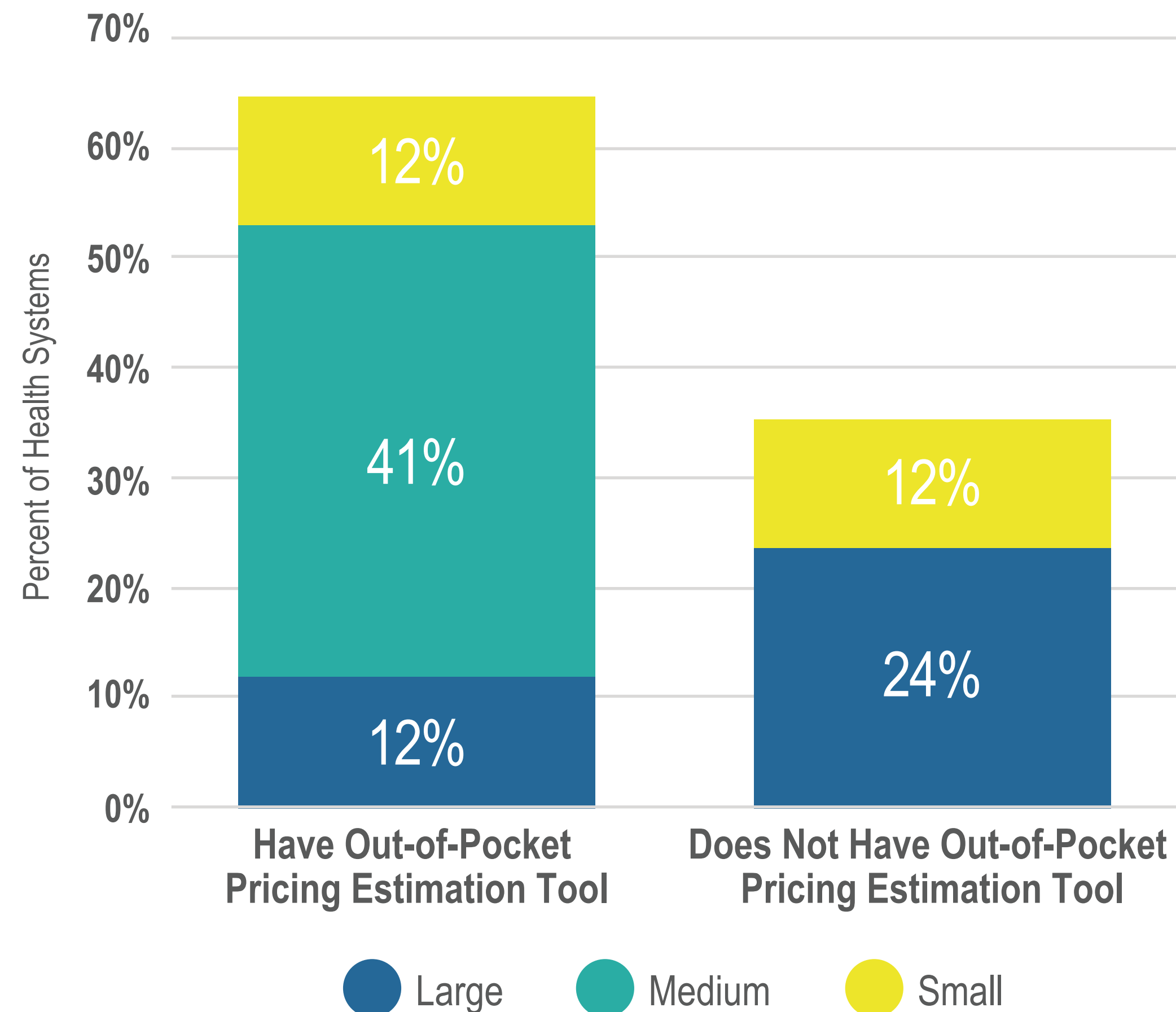
Percent of Health Systems

Note: Other communication methods include email statements, written estimation of out-of-pocket costs, and calls with customer service

Out-of-Pocket Price Estimators are Critical

Availability of Out-of-Pocket Price Estimation Tool

Many executives believe providing cost estimations is one of the most important touch points in the financial experience, yet not all have meaningful pricing estimation tools available for patients. With general agreement that chargemaster prices are not practical for understanding patient obligation, many health systems are implementing out-of-pocket pricing estimation tools to provide this information to patients. Furthermore, as of June 2019, the Trump administration has signed an executive order that could mandate that health systems provide out-of-pocket cost estimations to patients upfront.

Approximately two-thirds (65%) of health systems have out-of-pocket price estimators for patients pre-care delivery. Providing an accurate cost estimation prior to care delivery is essential for setting patient expectations. Health systems commonly use estimator tools through Epic, existing revenue cycle management (RCM) vendors, or develop custom tools leveraging payer data and analyzing claims data.

Challenges in implementing an out-of-pocket estimation tool commonly include obtaining consumers' insurance information, changing insurance coverage, and knowing if a patient has met their deductible. Additionally, variation in clinical practice can result in price variation, which is a challenge in providing an accurate out-of-pocket estimation for patients.

We are pretty weak in understanding what the patient's cost is going to be. We often don't know what the patient charge is going to be at the admitting point." **– SVP, Finance**

Significant Focus on Optimizing Patient Scheduling

Priorities for Improving Patient Scheduling

- Mobile Capabilities
- Online Scheduling
- Tracking Abandonment Rate
- Utilize Consumer Data
- Automatic Cost Estimations
- Wait Time Targets
- Pre-fill Patient Info

Improving scheduling is a key priority for LHS as part of the patient journey. Ensuring patients are able to easily schedule appointments in a fashion convenient to them is important to ensure the health system is not losing patients before they walk in the door.

Reflective of this prioritization, LHS are implementing strategies and solutions to streamline the scheduling process. Health systems are aiming to provide scheduling options that are easy and convenient, as well accessible through a variety of avenues to allow for patient choice.

Additionally, some health systems are leveraging consumer research and data to design solutions that meet the needs of their patient populations. By understanding consumer behavior, health systems can implement solutions that are informed by these habits and seamlessly integrate into consumers' lifestyles. A few health systems have utilized focus groups to understand consumer needs when it comes to scheduling appointments and identify critical areas for improvement. Additionally, others have leveraged existing consumer data to pre-fill scheduling and registration forms or provide automatic out-of-pocket cost-estimations, streamlining the process for patients.

LHS that have implemented these strategies commonly use non-traditional metrics to measure success, such as average call wait time and abandonment rate.

"
We are looking at non-traditional metrics like the third date a patient could get an appointment to assess how many days out we are in scheduling."
– VP, Finance

The Patient Financial Journey:
During Care Delivery

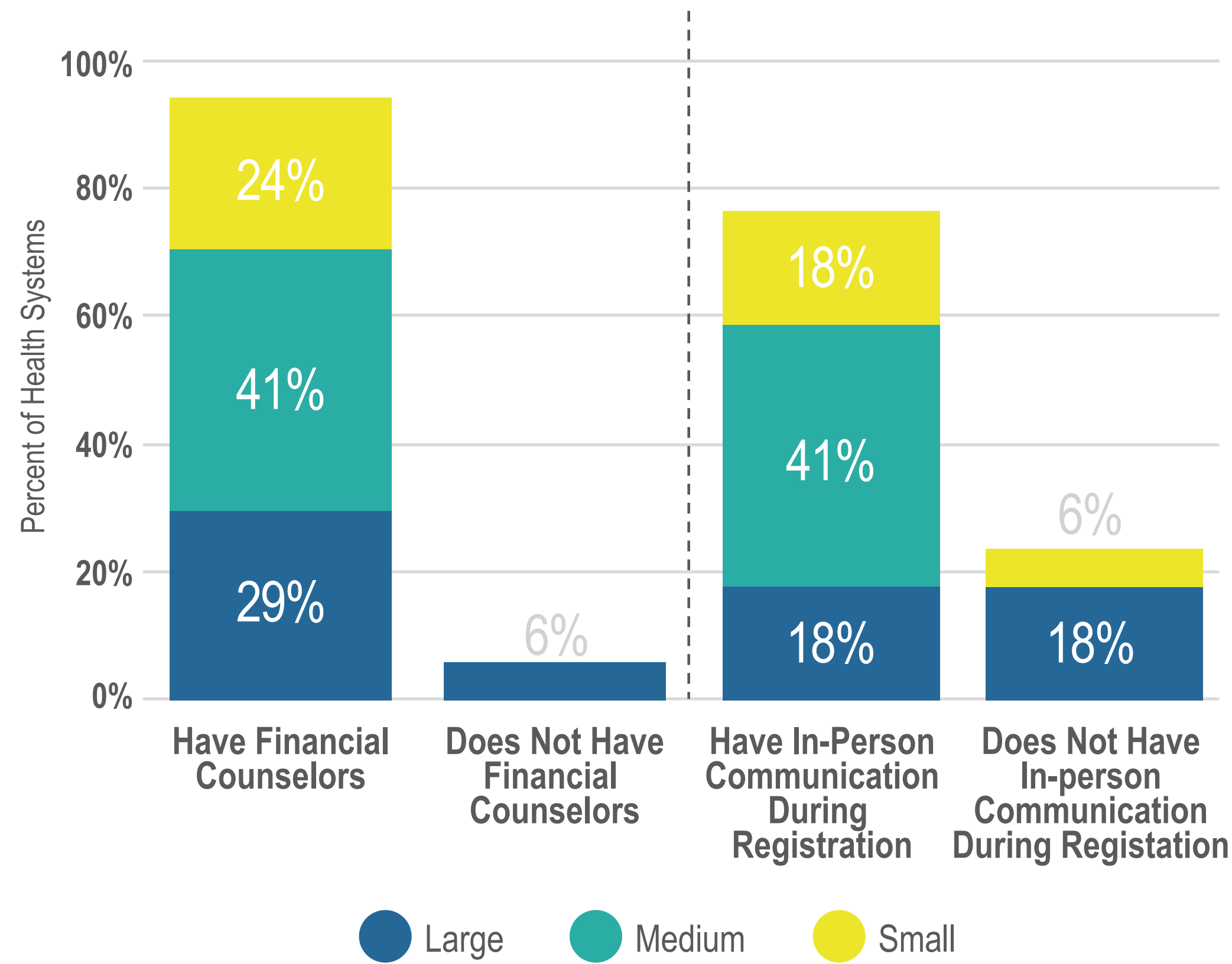Pre-Care   **During Care**   Post-Care →

Most Have Resources Available to Patients Upon Arrival

Availability of Financial Counselors and In-person Communication

Large • Medium • Small

Availability of Financial Counselors

The vast majority of executives (94%) responded that their health systems have financial counselors available upon arrival. The counselors are responsible for educating patients and families about their financial obligation and guide patients through the financial experience. Executives agree that financial counselors are critical for patients to help them make informed financial decisions based on their unique circumstances. Although most health systems have financial counselors available, the accessibility may vary. While many health systems have counselors on-site, some organizations have counselors available remote or by request which may make it more difficult for patients to access these services.

Providing In-Person Communication during Registration

Executives commonly stress the importance of early communication of financial obligation prior to service. Reflective of this, the majority of executives (77%) responded that their heath systems have in-person communication during registration. This communication is often completed by the financial counselor. While most health systems leverage this communication channel to provide patients information about their financial obligation, some will also utilize this process to begin a patient's payment plan. Beyond communication during registration, many executives stress the importance of continuing those communication channels throughout and after care delivery.

We have a team of financial counselors who work with patients in the hospital and afterwards. They do their best to help the patient maneuver."
– VP, Finance

Up Front Screening Associated with Lower Denials Rates

Average Medicare Denial Rate vs. Eligibility Screening During Registration

Medicare Denial Rate

- 7.0%
- 6.0% — **6.10%**
- *5.5% Average*
- 5.0% — **5%**
- 4.0%
- 3.0%

🟢 Communication / Eligibility Screening During Registration

🟡 No Communication / Eligibility Screening During Registration
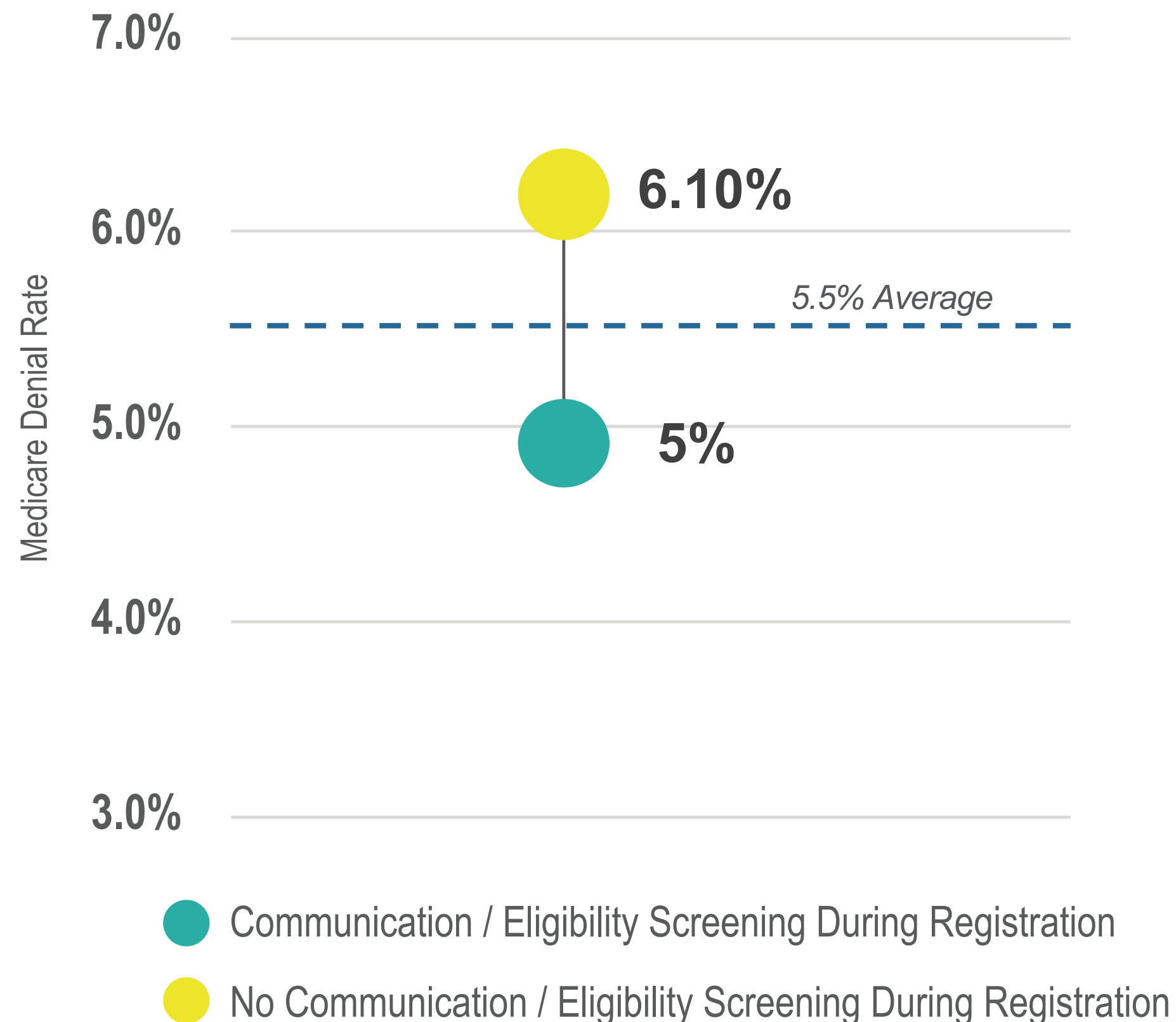
Some health systems have integrated eligibility screening into the registration process to ensure patients are receiving as much assistance in meeting their financial obligation as possible. These health systems will screen patients for eligibility for assistance through Medicare, Medicaid, or charity care.

Although responding health systems have Medicare denials rates below the national average, there was a marginal difference in the denials rate for health systems that screen for eligibility versus those who do not. Health systems who screen for eligibility during in-person registration have an average Medicare denial rate of 5%, 1.1% less than those who do not screen for eligibility. Verifying insurance eligibility is also the first step in mitigating surprise billing, detrimental to a successful consumer experience. Additionally, screening for eligibility and insurance coverage allows the health system to obtain preauthorization for services where needed. Checking whether a patient is eligible for charity care or will need a payment plan are effective methods for improving collections long term.

> *When we know there will be a large patient responsibility, we will see if the patient is eligible for charity or will need a payment plan."*
> *– VP, Finance*

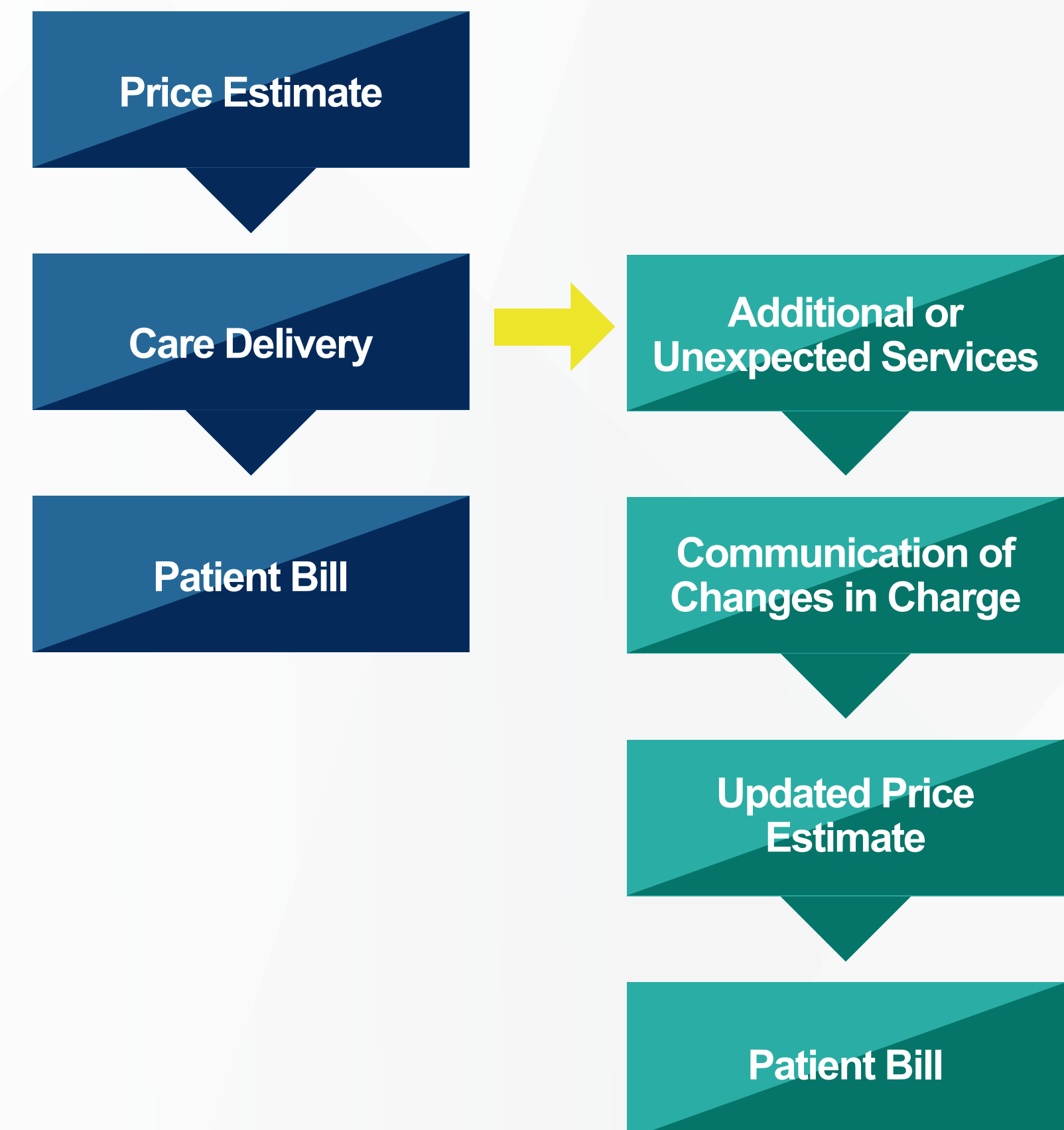# Touchpoints During Care Processes are Critical

Communication of services throughout the care process, particularly when there is a change in service is highly important in ensuring the patient is aware and engaged in their experience. While health systems strive to provide accurate cost estimations to patients, the unpredictable nature of clinical care delivery may result in a change in service or additional services due to medical complications.

When this occurs, health system executives note it is crucial to keep the patient informed of these changes and the impact on their financial obligation. Timely and clear communication helps prevent surprises for the patient and ultimately improves patients experience, however many health systems struggle with this component.

These conversations are typically handled by the financial counselor, however health systems rely on physicians to alert counselors of a change in service. Due to the manual nature of this process, this step is often overlooked.

*What makes price estimates more difficult is when what the physician ordered isn't actually what ends up being performed. **If there is an additional or different service, that changes the original estimate.** Explaining that difference is time consuming for providers and frustrating for the patients."*
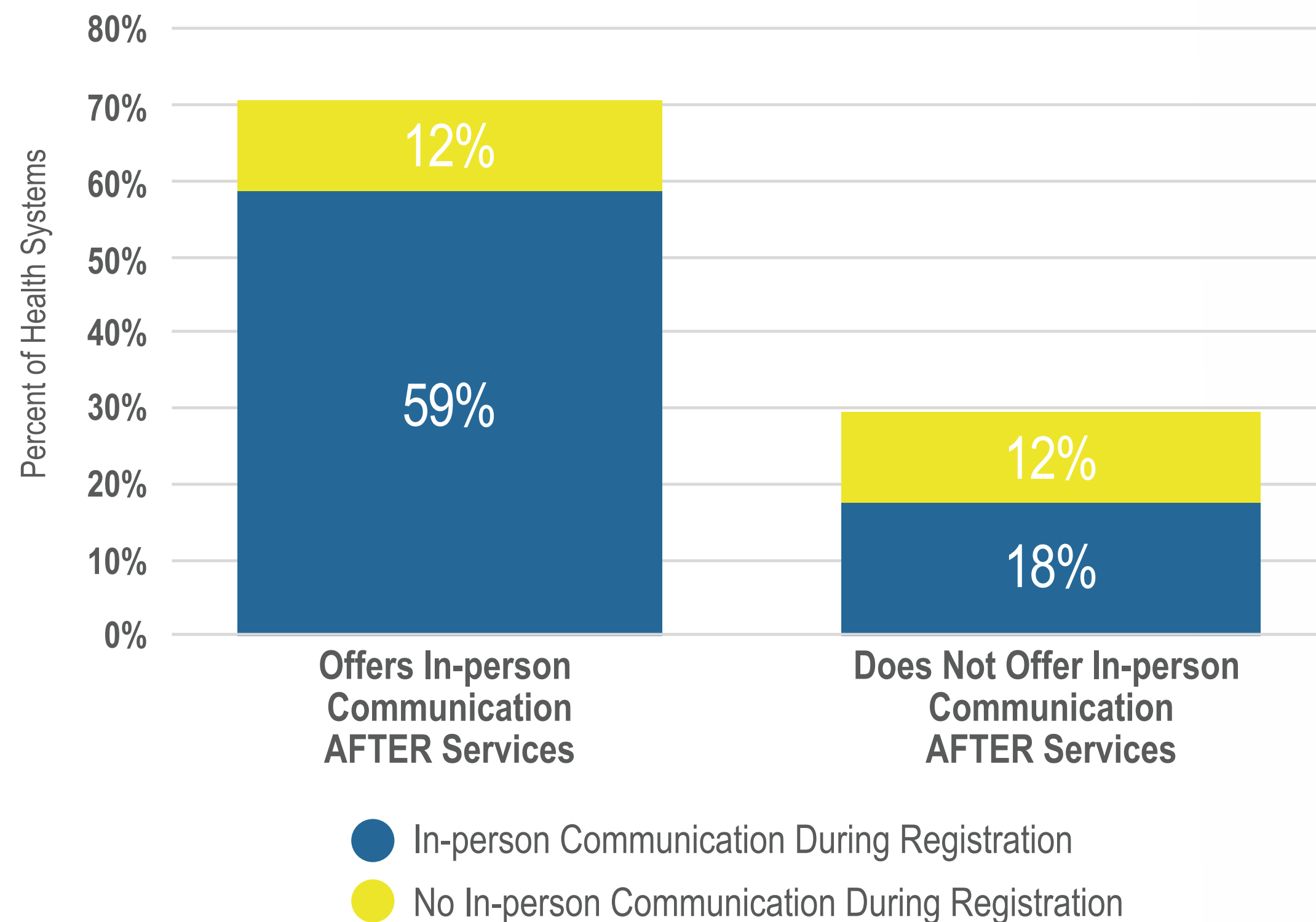**– VP, Patient Financial Services**

Cost Estimates Evolve when Services Change During Care Delivery

Price Estimate

↓

Care Delivery → Additional or Unexpected Services

↓ ↓

Patient Bill Communication of Changes in Charge

↓

Updated Price Estimate

↓

Patient Bill

Majority Continue Pricing Communications After Service Delivery

Availability of In-person Communication after Delivery of Services

The majority (71%) of health systems offer in-person communication of patient financial obligation after services have been delivered. Most commonly, health systems that offer in-person communication during registration also offer in-person communication after services are rendered. It is unusual (18%) for health systems to offer in-person communication after services, but not during registration.

Health system executives emphasize the need for regular communication of patient obligation throughout the patient journey. The most effective strategy for many health systems involves communication touchpoints before, during, and after care delivery to ensure the patient is well informed about their responsibility as well as how to access and pay their bills. However, while communication before and after service is common among LHS, many executives note their organization still struggles with the post discharge experience overall.

The Patient Financial Journey:
After Care Delivery
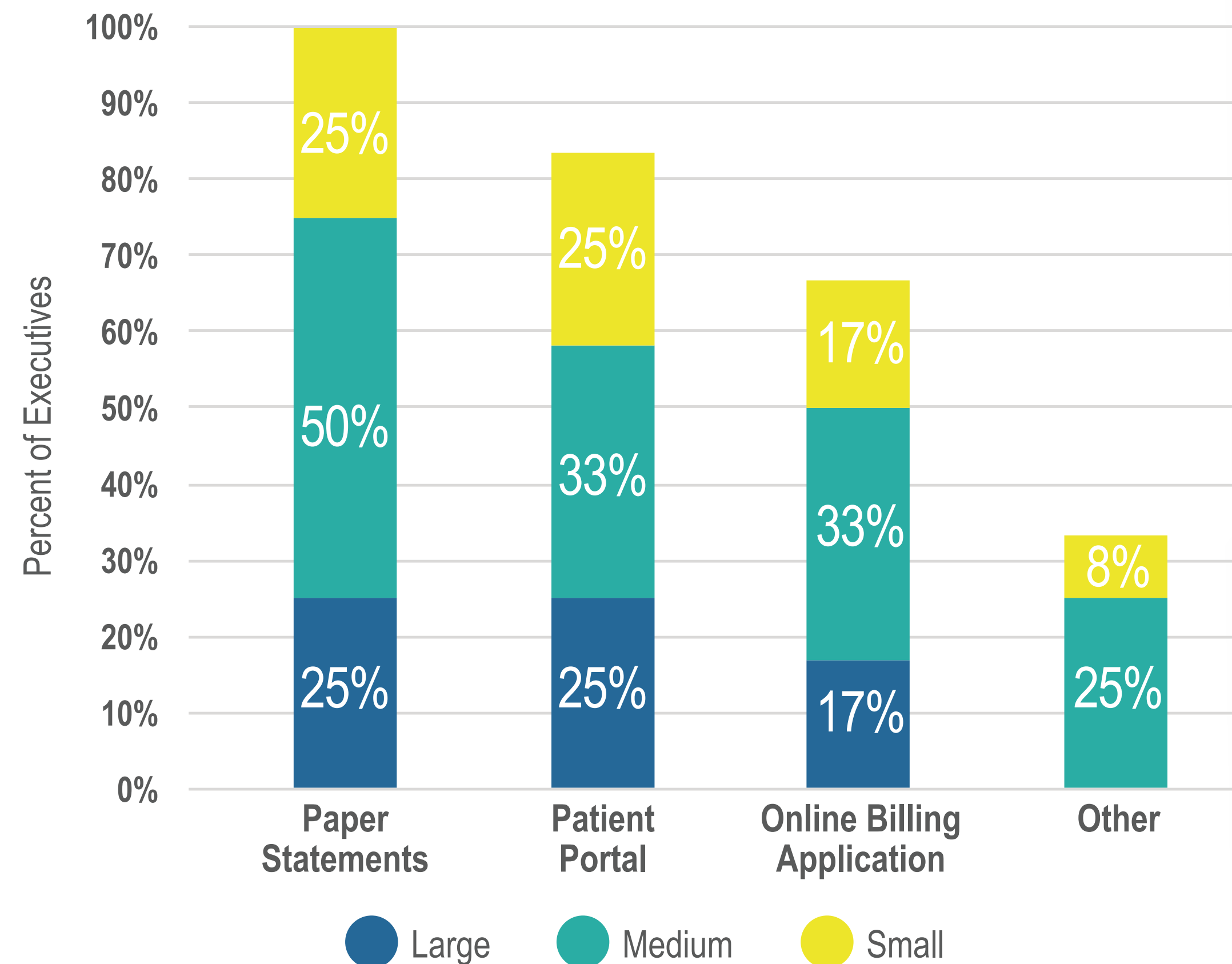
Pre-Care   During Care   **Post-Care** →

Most LHS Rely on Traditional Methods for Billing

Methods for Sending Bills to Patients

Paper billing, the traditional and most common method, is still used among 100% of finance executives. The second most prevalent method is patient portals with 83% of finance executives responding that they have a patient portal where patients can access their bill. Other methods include email statements, text messages, and vendor technology solutions. Overall, there was no notable variation in billing methods by health system size.
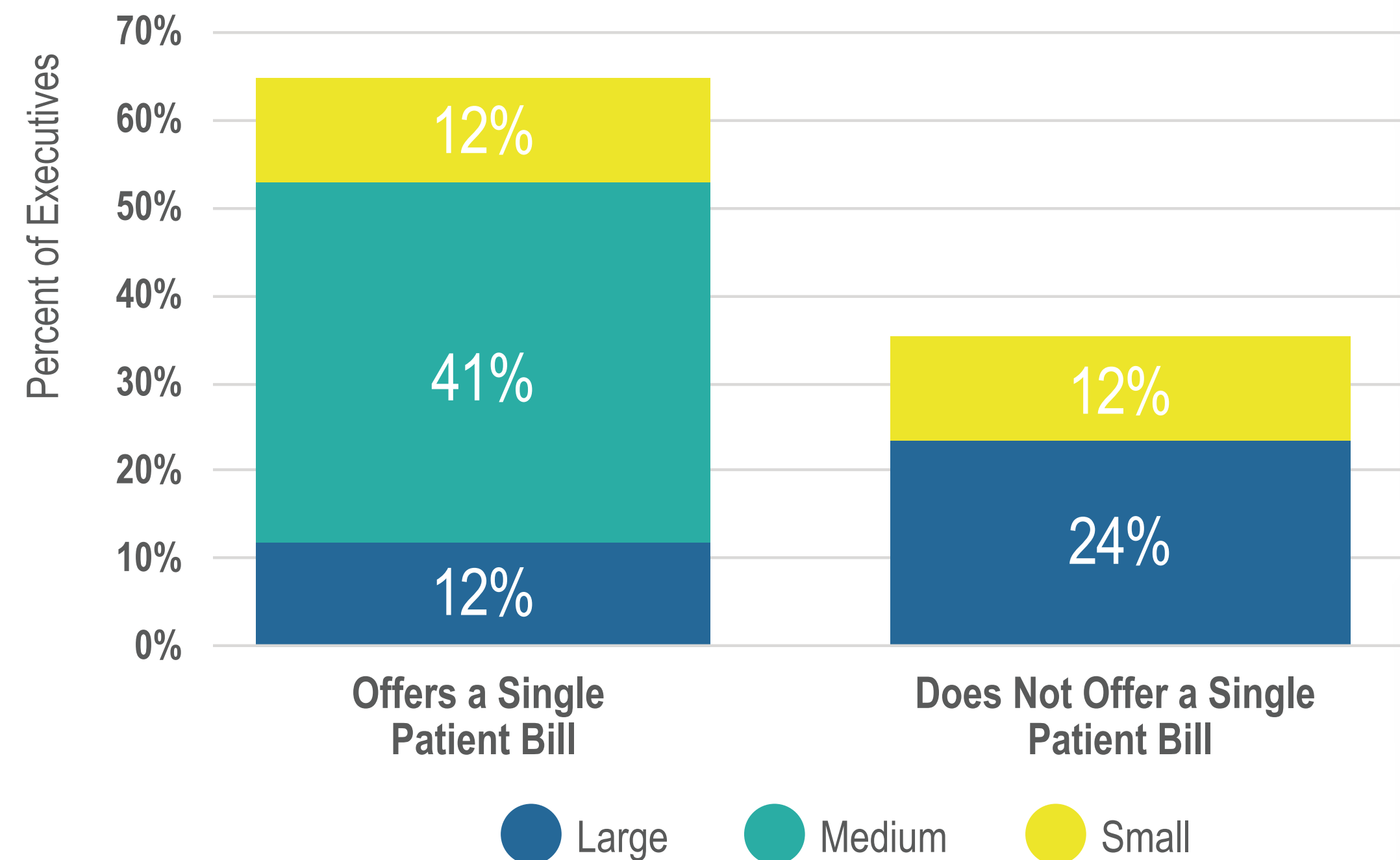
All finance executives reported using two or more of the billing methods above with 75% of health systems utilizing three or more of these billing methods.

" *We integrated the statement and an online portal where patients can research and pay their bill. We have a vendor for that."*
– **VP, Finance**

Most Aim to Send Patients One Comprehensive, Consolidated Bill

Availability of a Single Patient Bill

Percent of Executives

Offers a Single Patient Bill: Large 12%, Medium 41%, Small 12%

Does Not Offer a Single Patient Bill: Large 24%, Small 12%

Legend: ● Large ● Medium ● Small

Most health systems executives (65%) responded that they do provide a single bill to patients. Many health systems note that getting to a single bill is challenging, and involves centralizing the RCM processes of physician groups and hospitals. Without centralization of these two groups, patients receive different bills from each one which often leads to confusion and frustration from the consumer.

One health system has partially transitioned to a single patient bill by developing enterprise-wide master patient index numbers, a unique access code for each patient that connects a patient's data across the various components of the health system. This structure allows patient's to see all of their bills in one location and consolidates the information into a master bill. However, this structure is limited to entities within the health system (e.g., hospitals, medical group, post-acute care, home care). Physician groups or entities that are independent but affiliated with the system are not yet included. Combining this data will be an additional challenge.
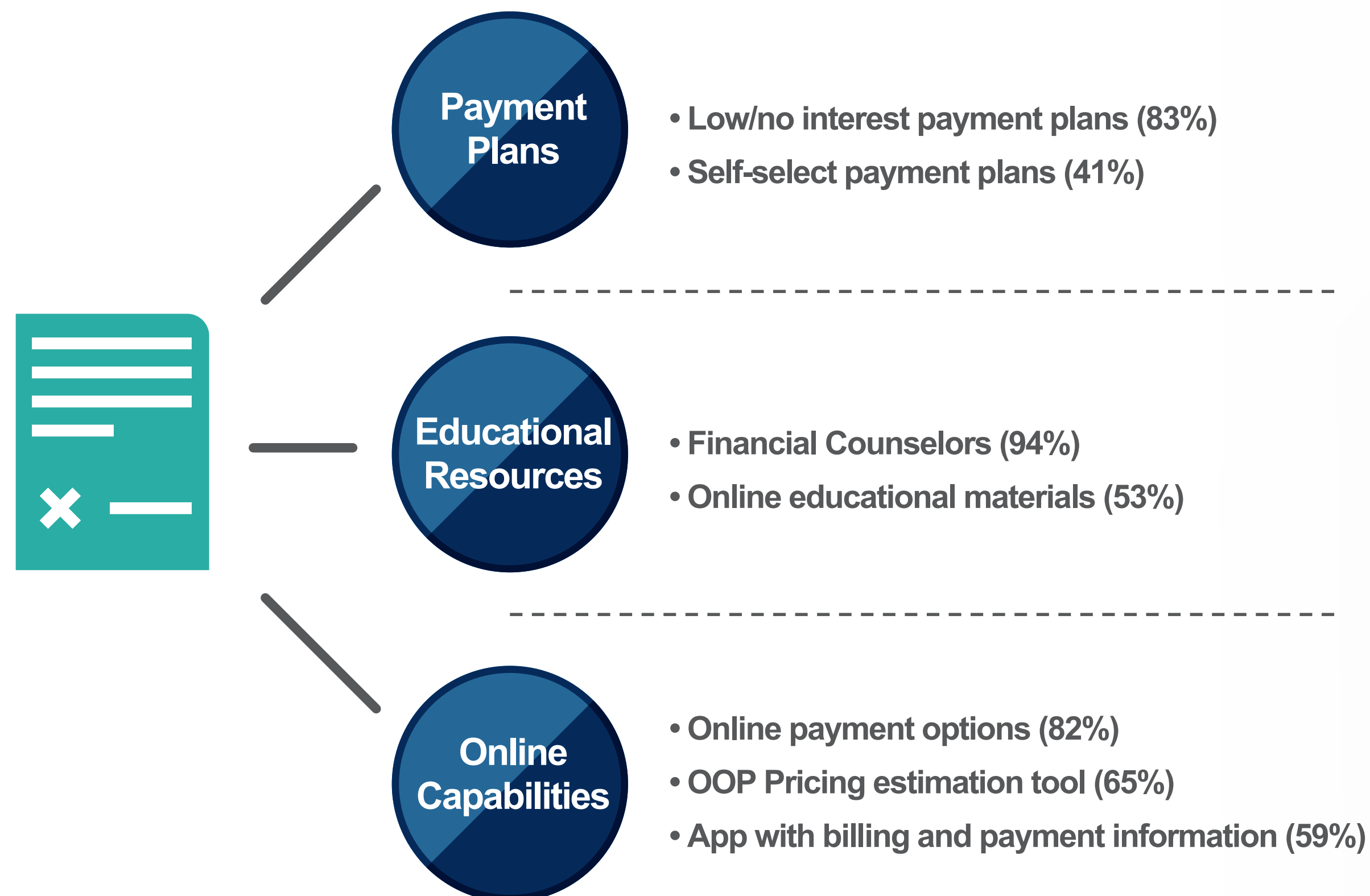
While health systems are working to consolidate to a single bill, restructuring the format and language of the bill to be easily understood by patients is still a challenge.

> *Patients who are frustrated because they can't understand what is on their bill, they are calling around but once they have the information they want to do the right thing. We have to make it easy for them to do the right thing."*
> **– System Director, Budgeting**

Health Systems Have a Variety of Resources Available for Patients, However Little Coordination

Patient Resources to Facilitate the Billing Process

Payment Plans
- Low/no interest payment plans (83%)
- Self-select payment plans (41%)

Educational Resources
- Financial Counselors (94%)
- Online educational materials (53%)

Online Capabilities
- Online payment options (82%)
- OOP Pricing estimation tool (65%)
- App with billing and payment information (59%)

Financial Counselors are Most Common

Most commonly, health systems leverage financial counselors (94%) to facilitate the billing process for patients. Other common patient resources include low- or no-interest payment plans (83%), online payment options (82%), and out-of-pocket pricing estimation tools (65%).

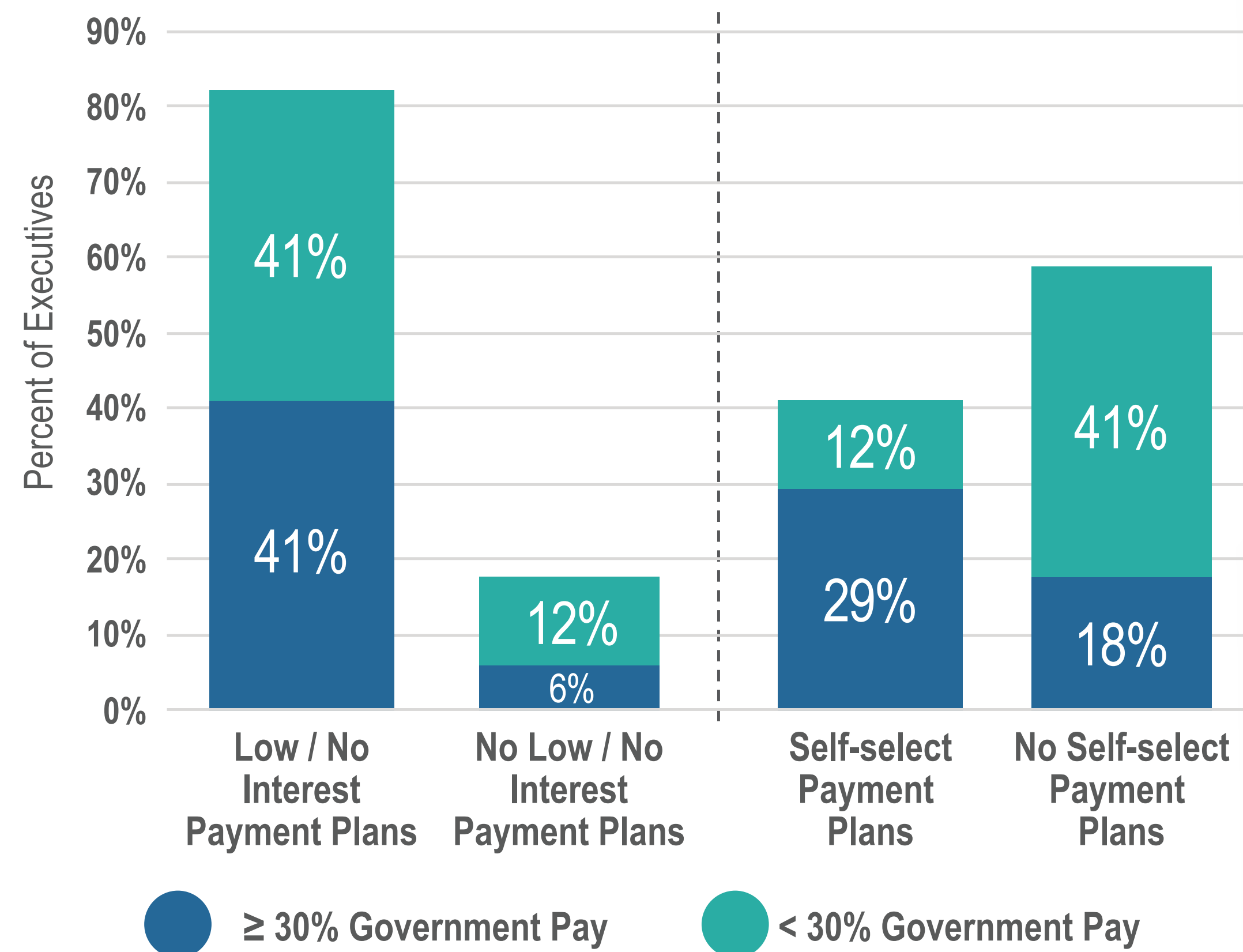## Utilizing a Combination of Resources

Typically health systems leverage a combination of resources to optimize the patient billing process, with the majority of health systems (59%) having six or more patient resources available. Only one health system has two or fewer resources available to patients to facilitate the billing process. Health systems most commonly combine financial counselors with low- or no-interest payment plans as their core resources available to patients.

Although health systems commonly have numerous resources available, many note there is still work to be done to coordinate and align these resources across the organization. Working toward a single entry point for all of a patient's financial needs is a priority for health systems to facilitate a simple, streamlined process for patients.

Provide Payment Plans to Assist Patients in Bill Payment

Relationship between Payer Mix and Payment Plan Availability

Percent of Executives

- Low / No Interest Payment Plans: 41% (≥ 30% Government Pay), 41% (< 30% Government Pay)
- No Low / No Interest Payment Plans: 6% (≥ 30% Government Pay), 12% (< 30% Government Pay)
- Self-select Payment Plans: 29% (≥ 30% Government Pay), 12% (< 30% Government Pay)
- No Self-select Payment Plans: 18% (≥ 30% Government Pay), 41% (< 30% Government Pay)

● ≥ 30% Government Pay   ● < 30% Government Pay

Low- and No-Interest Payment Plans

Most health systems (82%) offer low or no interest payment plans to patients, allowing patients to pay their bills in a manner that works for them. One might think there would be a difference in payment plan availability in health systems that serve a higher proportion of Medicare and Medicaid patients. However, there is no difference in availability of low or no interest payment plans between health systems who receive over 30% of their NPR from Medicaid and Medicare versus those who receive less then 30%.

Self-Select Payment Plans

Only 41% of health systems stated that they provide self-select payment plans to their patients. Of those that offer such plans, the majority (29%) receive greater than 30% of their NPR from Medicaid and Medicare. The opposite is true for health systems who do not offer self-select payment plans, with 41% receiving less than 30% of their NPR from Medicaid and Medicare.

Some health systems will also leverage propensity-to-pay scores to segment patients and identify the most appropriate payment plan. While health systems typically do this during the billing phase, some are working to shift this segmentation to the front-end to determine the most appropriate resources for each patient.

"*We have a payment plan already based on how much they owe and their credit history. We have a pretty robust financial assistance team.*"
– Chief Financial Officer

Managing Surprise & Balance Billing

Along with affordability, surprise billing and balance billing have risen to a top issue in the national conversation around healthcare. Due to the fragmented nature of healthcare systems, patients may receive balance bills from out-of-network providers even if they receive care at an in-network facility. These unexpected charges are commonly extremely expensive and result in a poor patient experience and damage to the health system reputation.

Surprise Billing: A Focus on Education

Health system executives are keen to differentiate between balance billing and surprise billing, in which a patient may receive a charge or have a payment that is unexpected. Although health systems are working to alleviate both issues, executives note strategies around surprise billing are more focused around patient and family education.

Health systems are leveraging clear and concise bills and regular communication and education with patients to ensure patients are not surprised by their obligation. A key pain point for health systems is a requirement to include the health systems charges on the patient bill. Executives note since the charge is not what the patient ultimately has to pay, including it on a bill is confusing for patients and can result in sticker shock. By streamlining the billing process health system executives hope to manage the frequency of surprise bills.

Balance Billing: Case-by-Case Evaluation

Health system executives were generally neutral regarding issues around balance billing, with many citing organizational strategies to handle to issue. Health system strategies involve systematic review of the charges for each individual and assessing whether the patient qualifies for charity care. Most executives note balance billing is infrequent at their organization, however when it does occur it can be damaging to the health system brand.
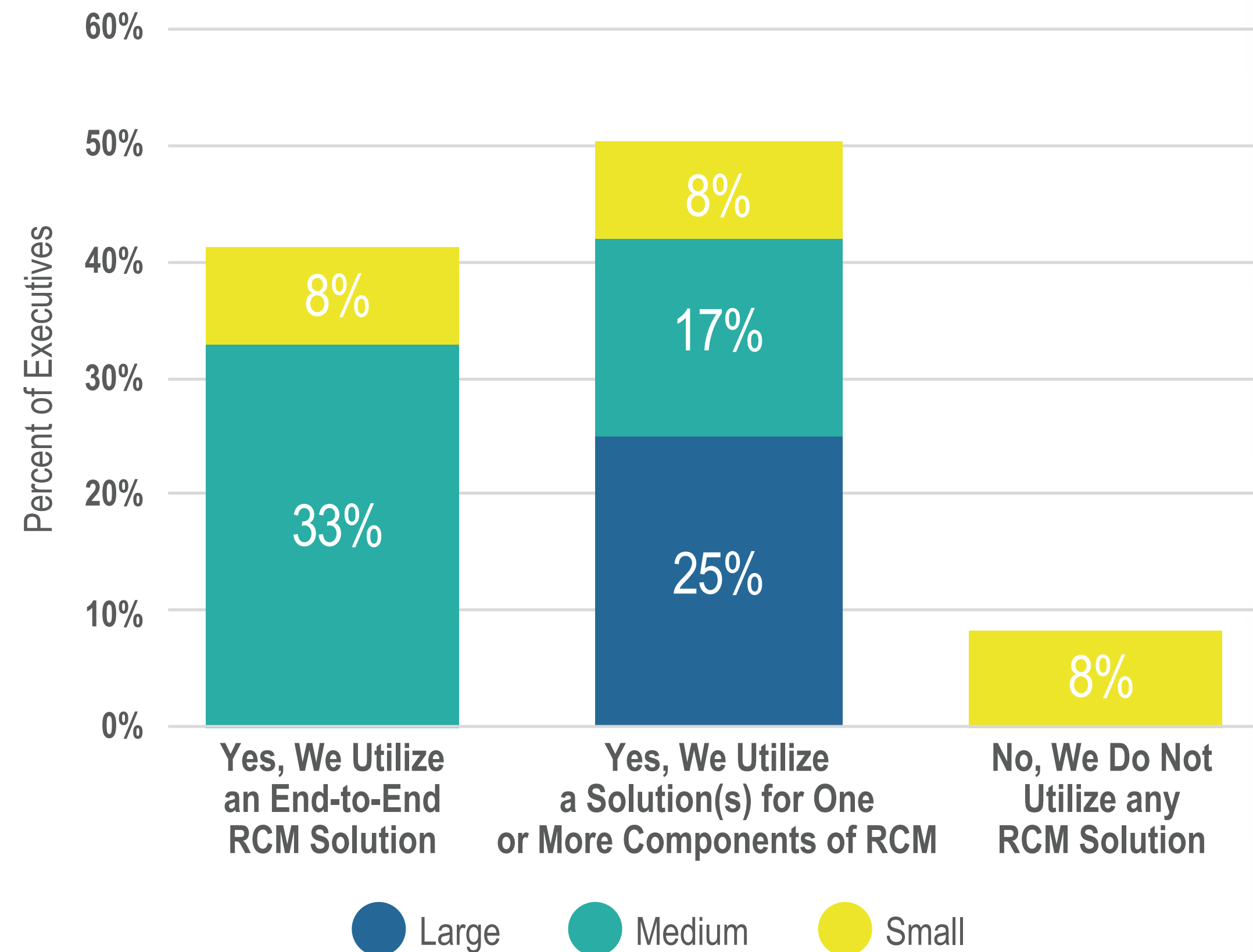
Typically, health systems handle balance billing on a case-by-case basis. Bills are reviewed at the system level to determine if the organization will move forward with the bill and if there is any assistance that can be offered to the patient. Additionally, some health systems have implemented a policy not to send balance bills to patients and instead include the balance as part of bad debt.

"*For the most part we do not balance bill. If we do, it is a determination at the top level that we will drop the bill to the patient.*" – **VP, Finance**

Optimizing RCM for an Improved Patient Experience

RCM Outsourcing Preferences

Percent of Executives

- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

Yes, We Utilize an End-to-End RCM Solution: 8% / 33%

Yes, We Utilize a Solution(s) for One or More Components of RCM: 8% / 17% / 25%

No, We Do Not Utilize any RCM Solution: 8%

Legend: ● Large ● Medium ● Small

To facilitate key components of the patient experience, including development of a single patient bill or timeliness of the bill, health systems must optimize their internal revenue cycle management processes that support these functions.

Most health systems (92%) utilize a RCM solution in some capacity to optimize the revenue cycle process. The greatest proportion of health systems (50%) reported utilizing a solution for one or more components of their RCM operation. Particularly, reflective of the scope of large health systems, none reported utilizing an end-to-end RCM solution. Instead, all large health systems leverage RCM solutions for varying components of the revenue cycle.

Health systems that outsource components of the revenue cycle vary on which capabilities they leverage vendors. To improve the patient experience, health systems commonly outsource tools including:

- Price estimators;
- Mobile device software that translates bills to plain English;
- Tools to increase accuracy in data collection;
- Automatic reminders for appointments; and,
- Technology that interfaces with payer for bill estimation.

It might not make sense to outsource everything to a vendor, but it might make sense to offload some of the larger things to them so we can focus on other key areas." – **Chief Financial Officer**

Key Criteria for Consumer Engagement Technologies

Most Important Capabilities for Consumer Engagement Tools

Scheduling — 80%
Patient Payments — 60%
Other — 20%

Percent of Consumer Executives
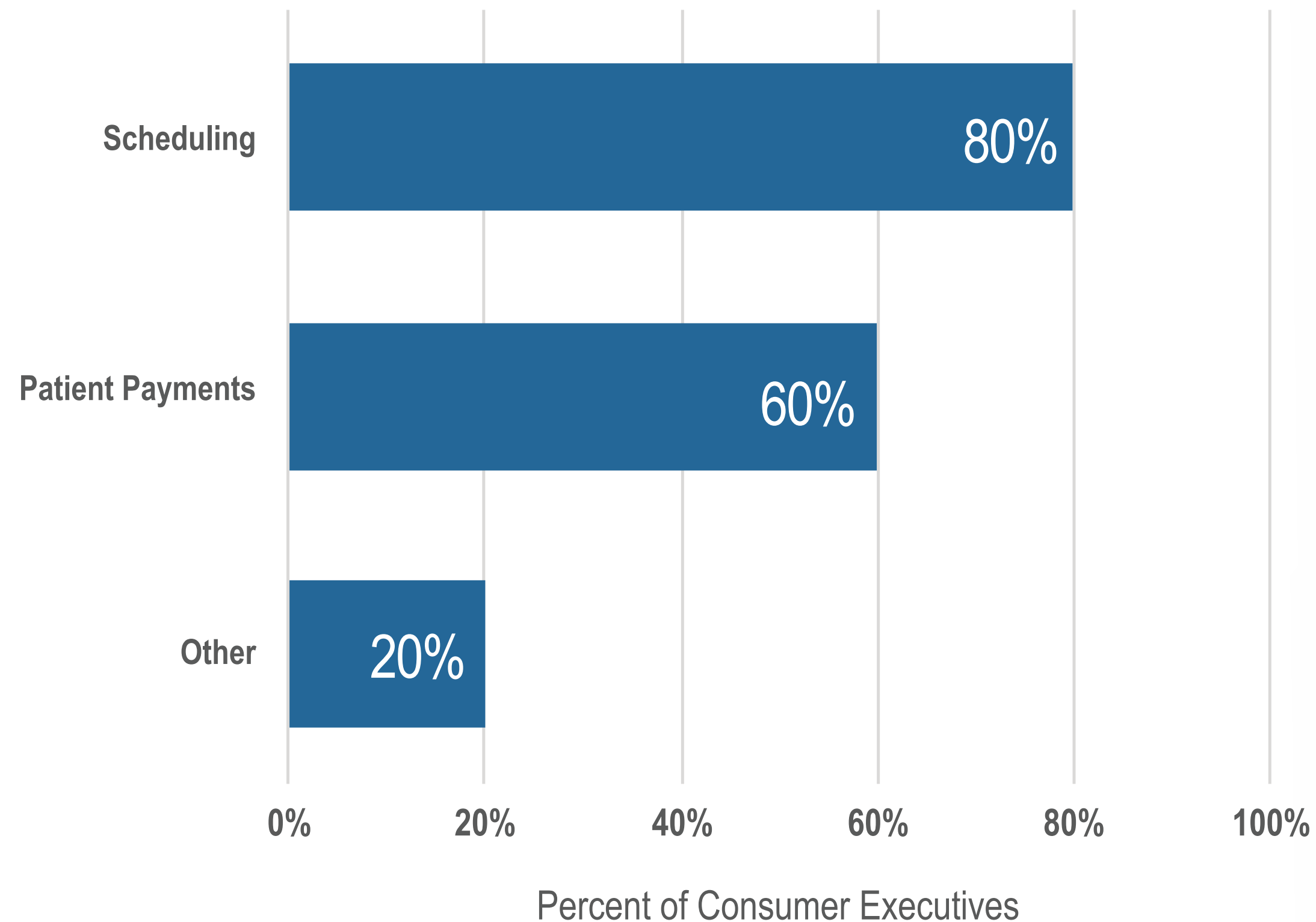
As health systems implement a variety of initiatives around the patient experience, many will leverage technology solutions to optimize this process. As health systems consider which solutions to implement and vendors to partner with, the most important capabilities for consumer-facing engagement tools are scheduling (80%) and patient payments (60%). Other capabilities emphasized include financial counseling for patients.

Health systems also utilize these solutions to track key measures of success in priority areas of the financial experience. As health systems look to implement new solutions to improve the patient experience, solutions that optimize key patient touchpoints are highly valuable.

We do have the ability to see how patients are grading us on various aspects and we are looking to improve. We track abandonment rate on calls as well as average wait time." **– VP, Finance**

Integrating the Consumer Perspective

Majority of LHS Conduct Consumer Research

A majority of LHS conduct consumer research around the patient financial experience, either regularly (20%) or occasionally (40%). This research may comprise consumer surveys, focus groups, public opinion research, or other consumer outreach. Some systems are leveraging these insights to develop a consumer strategy that aligns with the needs and desires of their consumers.
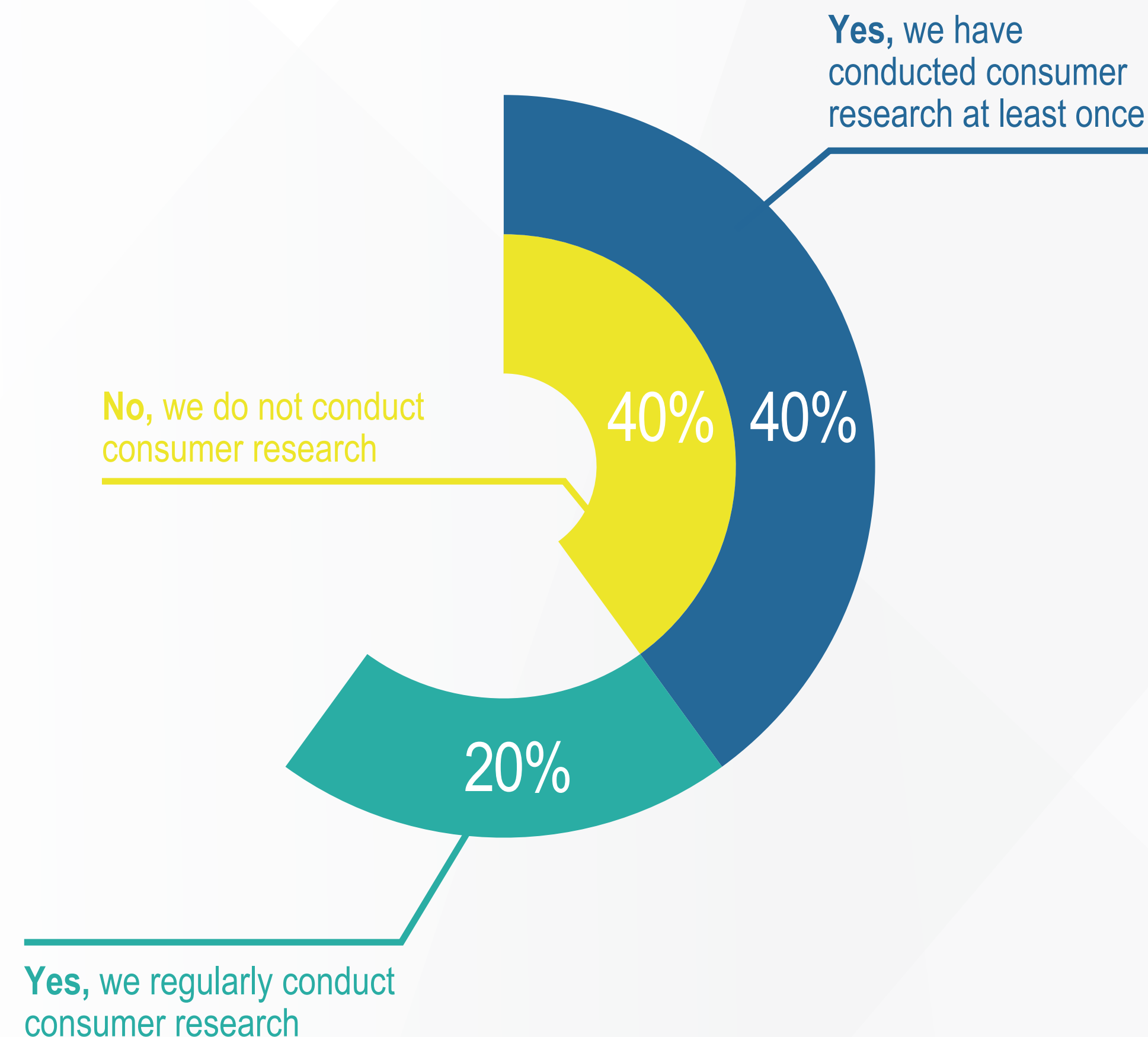
For example, health systems utilize consumer research to:

- Segment the needs of various patient populations (e.g., uninsured, underinsured) and ensure patients are receiving the appropriate support and counseling
- Identify pain points and improvement areas through secret shopping
- Obtain feedback on the usability of scheduling tools or patient bill design changes

While some health systems segment their patient populations based on insurance status - primarily uninsured versus insured - these efforts are typically to facilitate the collections process. To develop a strong patient financial experience, health systems should look to design solutions and resources that are tailored to the needs and preferences to particular patient segments rather than a one-size-fits-all approach.

> *We are looking at consumer data and keeping track of consumer habits to develop a shoppable strategy. We identified the most popular services and then worked with insurance companies to lower the patient out of pocket for those services"*
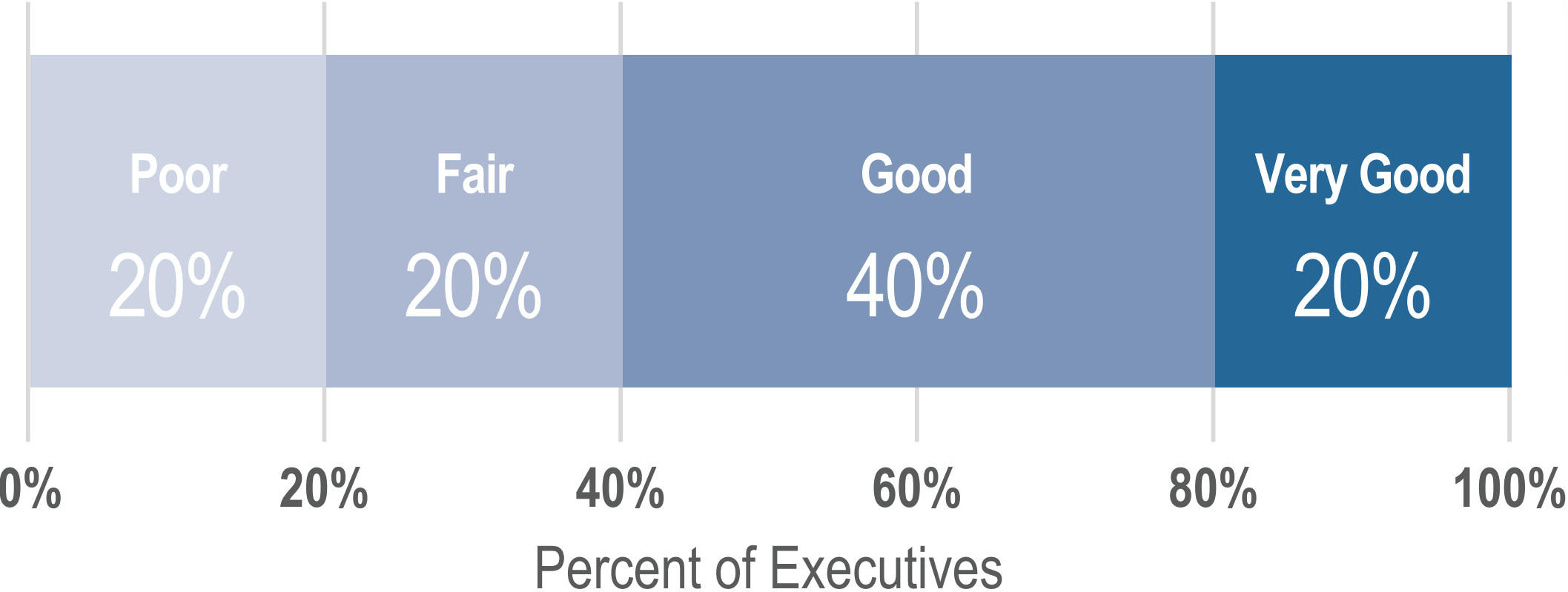> *— VP, Finance*

Regularity of Conducting Consumer Research

Yes, we have conducted consumer research at least once

No, we do not conduct consumer research

40%

40%

20%

Yes, we regularly conduct consumer research

Health Systems are Focused on Patient Education

Perceived Strength of Patient Billing Education

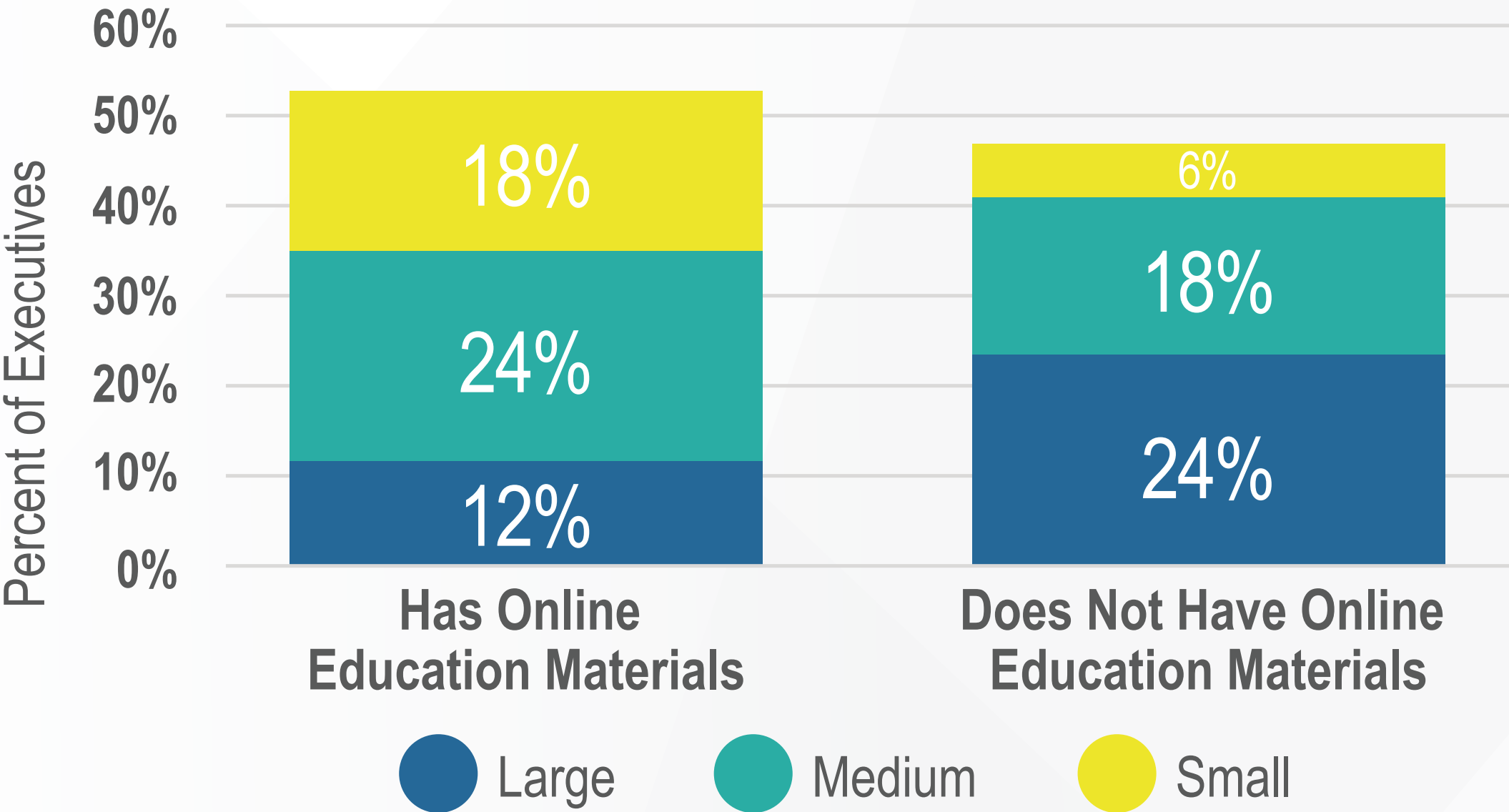| Poor 20% | Fair 20% | Good 40% | Very Good 20% |

Percent of Executives

Most consumer executives are optimistic in the strength of their health systems' patient billing education, with 60% of executives rating their patient billing education as "Good" or better and only 20% of executives rating their education as "Poor".

Most commonly, health systems leverage in-house financial counselors for patient and family education on financial obligations. Executives note that early and frequent education of patients is recommended for ensuring patients are fully aware of their share of the cost.

Availability of Online Educational Materials

Percent of Executives

Has Online Education Materials: Large 12%, Medium 24%, Small 18%

Does Not Have Online Education Materials: Large 24%, Medium 18%, Small 6%

● Large   ● Medium   ● Small

Just over half (54%) of health systems have online educational materials for consumers about the patient financial experience. The greatest proportion of that group are medium sized health systems at 24%. A relatively large proportion (24%) of large health systems do not offer online educational materials.

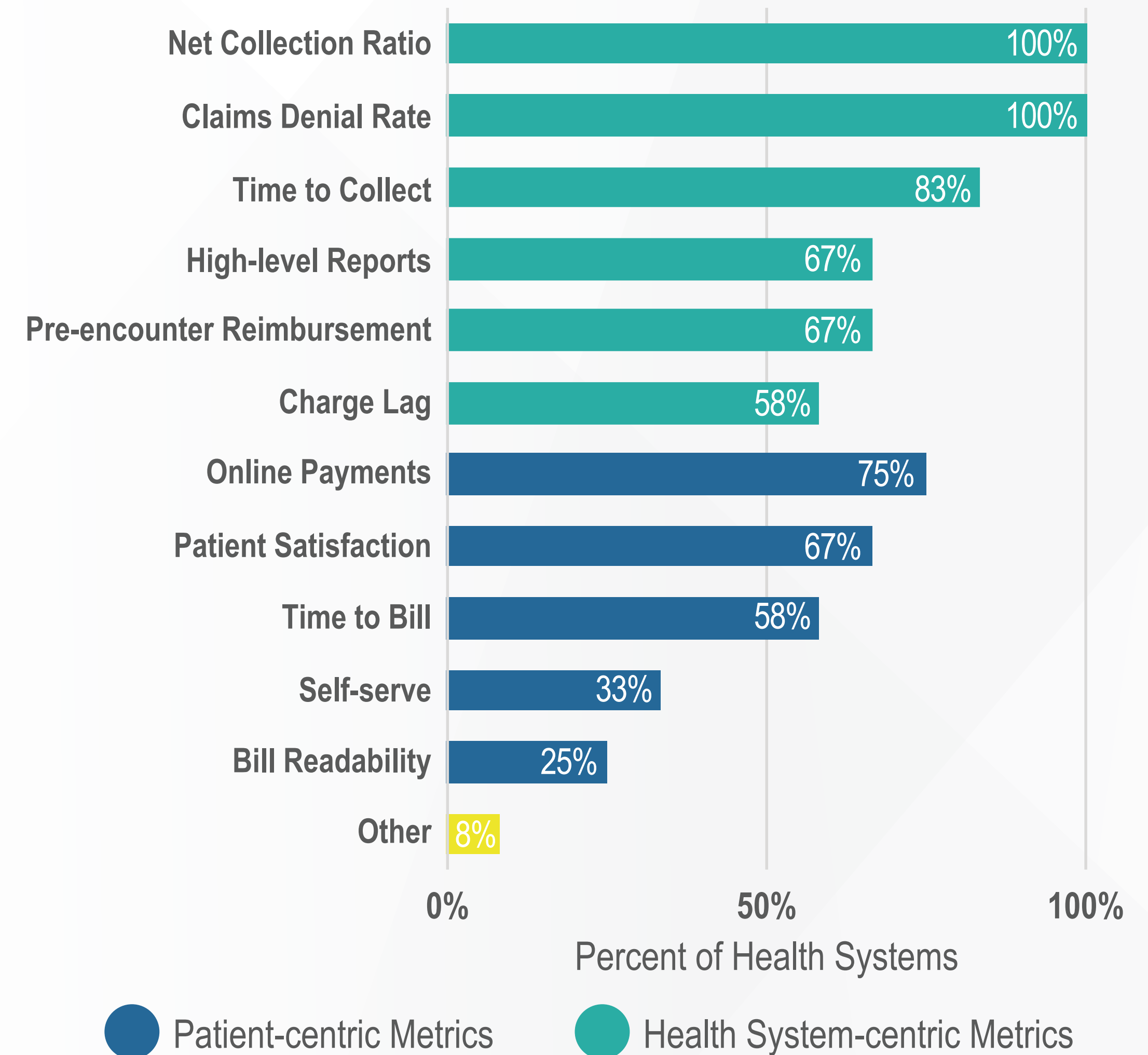# Most Leverage Traditional RCM Metrics Over Patient-Centered Metrics

Patient billing is a key component of the revenue cycle, and health systems leverage their RCM teams to optimize this process. Net collection ratio and claims denials rate are the most popular revenue cycle metrics with all health systems utilizing both metrics to evaluate performance. Overall, the top metrics utilized are traditional revenue cycle metrics that focus on the financial wellbeing of the health system. Health systems are beginning to integrate more patient-focused measures, including online payment rates and patient satisfaction, however these measures are not as prevalent.

All health systems track multiple RCM metrics (average of 7), with 58% tracking 7 or more. However, fewer health systems track multiple patient-centered metrics. While a majority will track online payments or patient satisfaction, less than half (41%) track more than two patient-centered metrics. On the whole, health systems are more focused on traditional financial metrics for RCM, with some health systems using a consumer-lens toward this function.
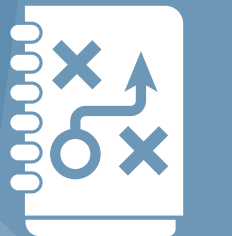
While health systems are beginning to integrate patient-centric metrics for measuring RCM success, some organizations have also established additional patient metrics beyond the revenue cycle. These metrics include:

- Net promoter score
- Call abandonment rate
- Call wait times
- Total number of phone calls received
- Number of days for appointment scheduling
- The third date a patient can schedule an appointment

Key RCM Metrics Tracked

Metric	Percent of Health Systems
Net Collection Ratio	100%
Claims Denial Rate	100%
Time to Collect	83%
High-level Reports	67%
Pre-encounter Reimbursement	67%
Charge Lag	58%
Online Payments	75%
Patient Satisfaction	67%
Time to Bill	58%
Self-serve	33%
Bill Readability	25%
Other	8%

Percent of Health Systems

● Patient-centric Metrics   ● Health System-centric Metrics

Key Challenges & Future State

Primary Focus on Improving Billing & Payment

As health systems work to improve the patient financial experience, the greatest area of focus is around improving the post-care delivery components including billing and payment. Executives recognize the frustrating nature of patients' current experience and are working to enhance these processes. A key priority for most health systems is to improve patient awareness and understanding of their financial obligation. Health systems are looking to achieve this goal through streamlining their billing process and development of a single, understandable bill for patients. Additionally, many health systems are emphasizing early communication and education for patients to ensure they are engaged and aware of their obligation before receiving their bill.

Brand Impact

*Post discharge experience tends to deviate greatly from the clinical experience. **It has been a considerable sore spot for us and has been a point of poor reputation** for our health system in the community."*
– VP, Finance

Consumer Perspective

*We just did some **focus groups** last year to look at billing. One thing we heard is our statements are pretty hard to read, so **we just finished a complete statement revamp.**"*
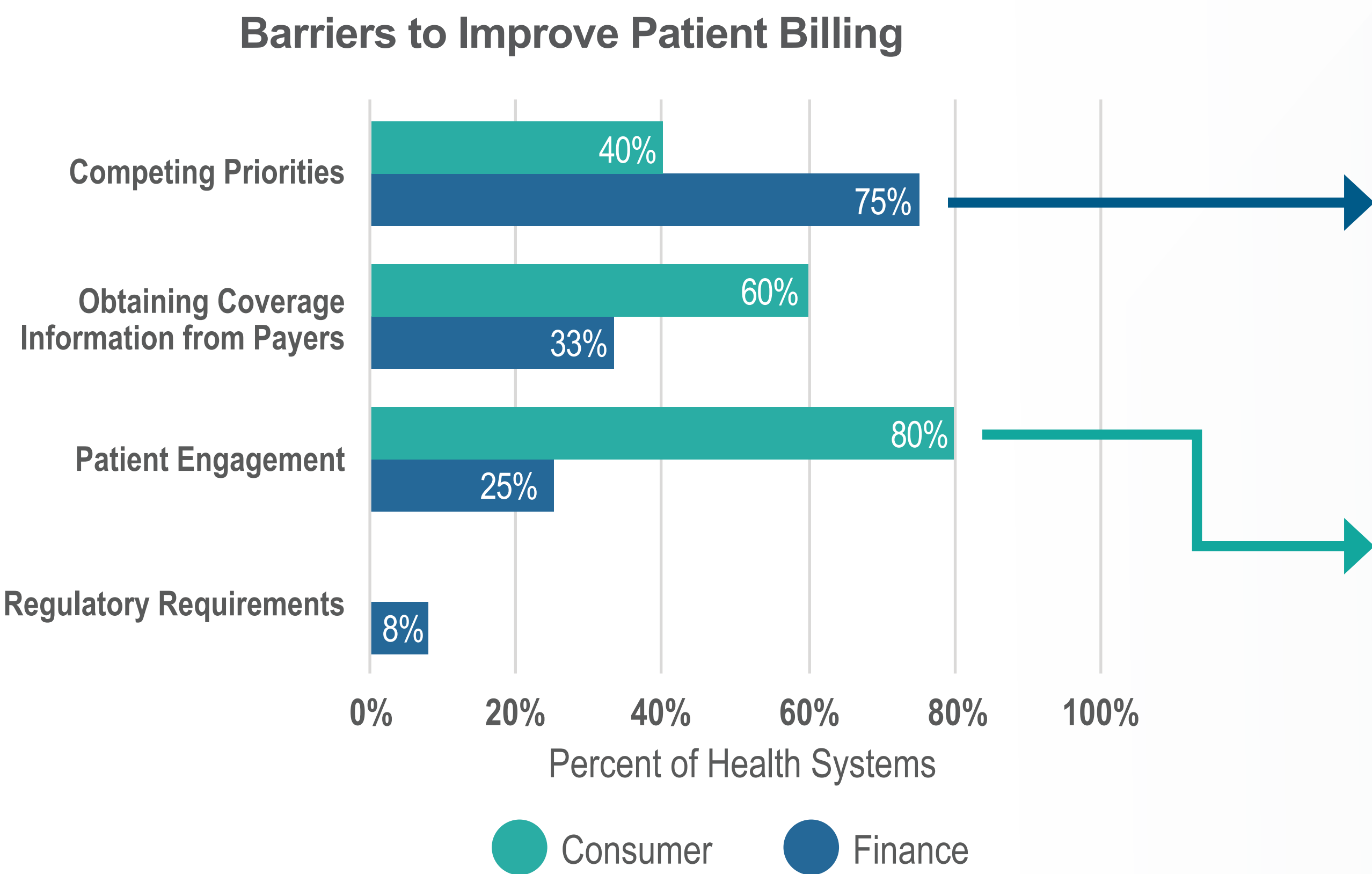*– VP, Finance*

Streamlined Solution

*We want to send **a single bill and provide cost estimation**, making the consumer aware of the responsibility that they are going to have"*
– SVP, Revenue Management

Executives Disagree on Top Barriers

While there are a number of external pressures impacting health systems around the financial experience (e.g., regulation and policy changes, consumer expectations), health systems' key challenges are primarily internal and operational. Overall, competing priorities, patient engagement, and obtaining coverage information from payers are the top barriers for health systems.

However, there is a notable disconnect in the perspectives of Finance and Consumer executives when it comes to the top barriers. Finance executives believe that competing priorities are the most common barrier to improving patient billing (75%), while Consumer executives believe that patient engagement is the most common barrier (80%). Interestingly, the barrier that one group chose the most, was the barrier the other group chose the least in both cases.

Barriers to Improve Patient Billing

Barrier	Consumer	Finance
Competing Priorities	40%	75%
Obtaining Coverage Information from Payers	60%	33%
Patient Engagement	80%	25%
Regulatory Requirements		8%

Percent of Health Systems

● Consumer   ● Finance

*We would like to be further along but it's been hard to prioritize what is going to have the greatest impact. We want to do so many consumer-focused things, but we can barely get bills out the door." – **VP, Finance**

*The piece that's hard is getting people to engage with and use the tools. We've made progress, but I still think there could be more." – **VP, Finance**

A Focus on a Seamless Consumer Experience

Health system executives are cognizant of consumer demands for increased transparency, convenience, and access to information. Historically, health systems have not prioritized the patient experience beyond clinical care delivery; however, as industry disruptors give consumers more choice, health systems will have to learn to compete for business.

Health systems are beginning this process by focusing on aspects of the patient experience that are most frustrating for consumers (e.g., scheduling, billing). While health systems have a long way to go, many are taking cues from other industries on how to meet consumer expectations.

"

Look how easy it is to get things from Amazon, but in our industry, you are lucky to get a bill within 6 months. **If your credit card bill came in 6 months, it would be ridiculous."** *– VP, Finance*

"

Patients will be given more options of where they can go for healthcare and will be able to make more educated financial choices regarding their healthcare. Patients will likely go places where they feel more educated about their cost and care and continue their future services in that direction. **It will become mandatory that healthcare be as efficient as 'Amazon' when it comes to online services."** *– Chief Financial Officer*

"

The challenge is **providing options, being transparent and making it easy for them to pay.** *There is no way you will meet 100%, but if we can demonstrate we are trying to make it easier that will go a little bit further than continuing on in the traditional way."* *– Chief Financial Officer*

Health systems display varied levels of maturity in optimizing the patient financial experience. Maturity scores were determined by calculating the organization's consumer-centeredness and number of consumer-centric resources.

▪ A health system's **consumer-centeredness score** was calculated based on the utilization of consumer metrics and consumer research, and overall organizational priority level of improving the patient financial experience.

▪ Organizations' **resources score** was determined by the number of initiatives health systems have in place across the various components of the patient financial journey.

Just over half (55%) of health systems exhibit above-average maturity in their consumer-centeredness or number of resources or both. Commonly, there is a correlation between a health system's consumer-centeredness and the resources that have been implemented. Organizations with a more consumer-centric perspective tend to have more resources in place throughout the different phases of the patient journey.

Patient Financial Experience Maturity Matrix

Consumer Centeredness Rating (1-5)

Number of Consumer-Centric Resources (0-8)
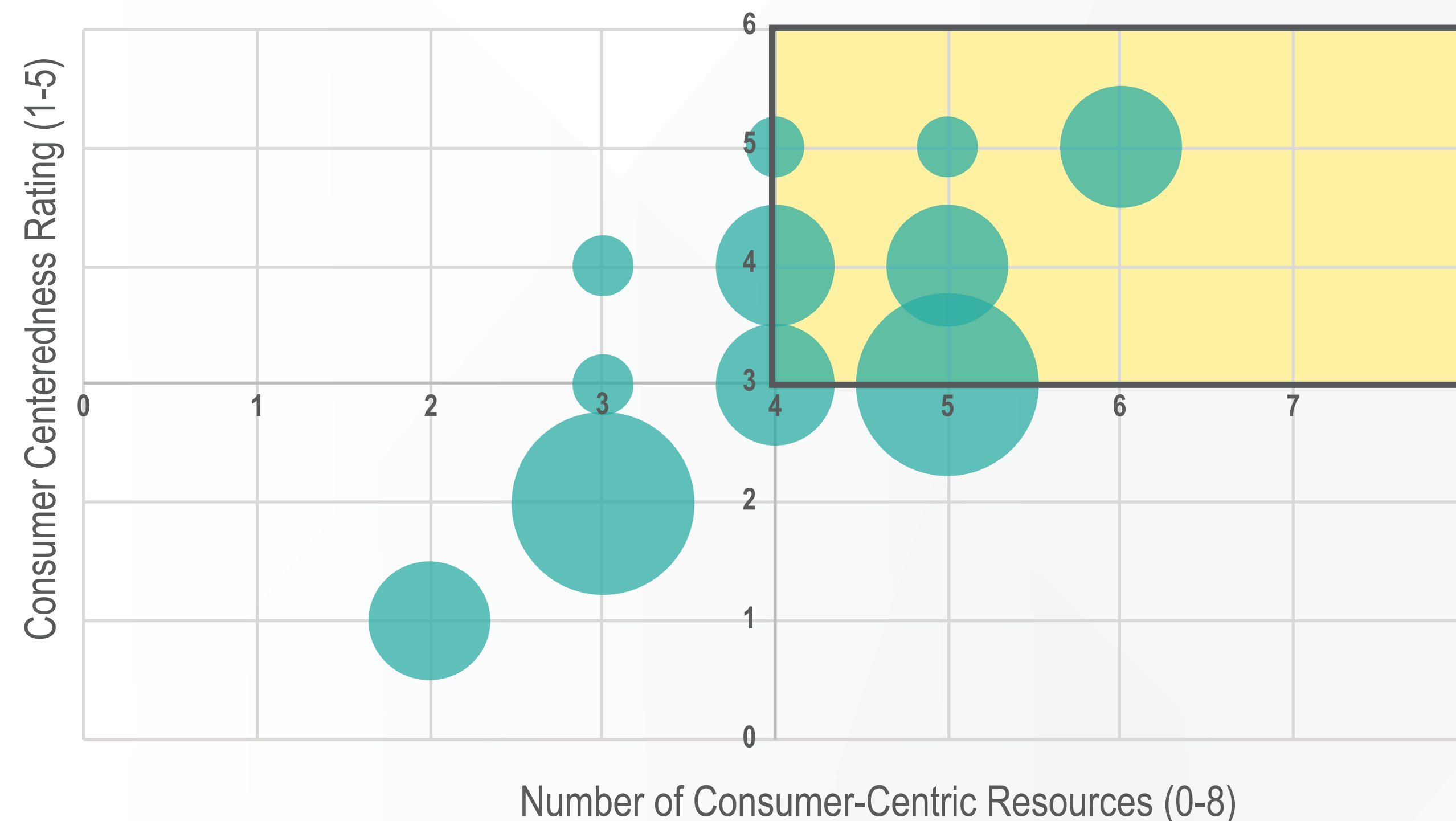
Mature health systems tend to include:

1. Buy-in from the executive team underpinning the view that optimization of the patient financial experience is **more than just a finance issue.**

2. Strategies that address the **entire patient journey**, including pre-, during, and post-care delivery.

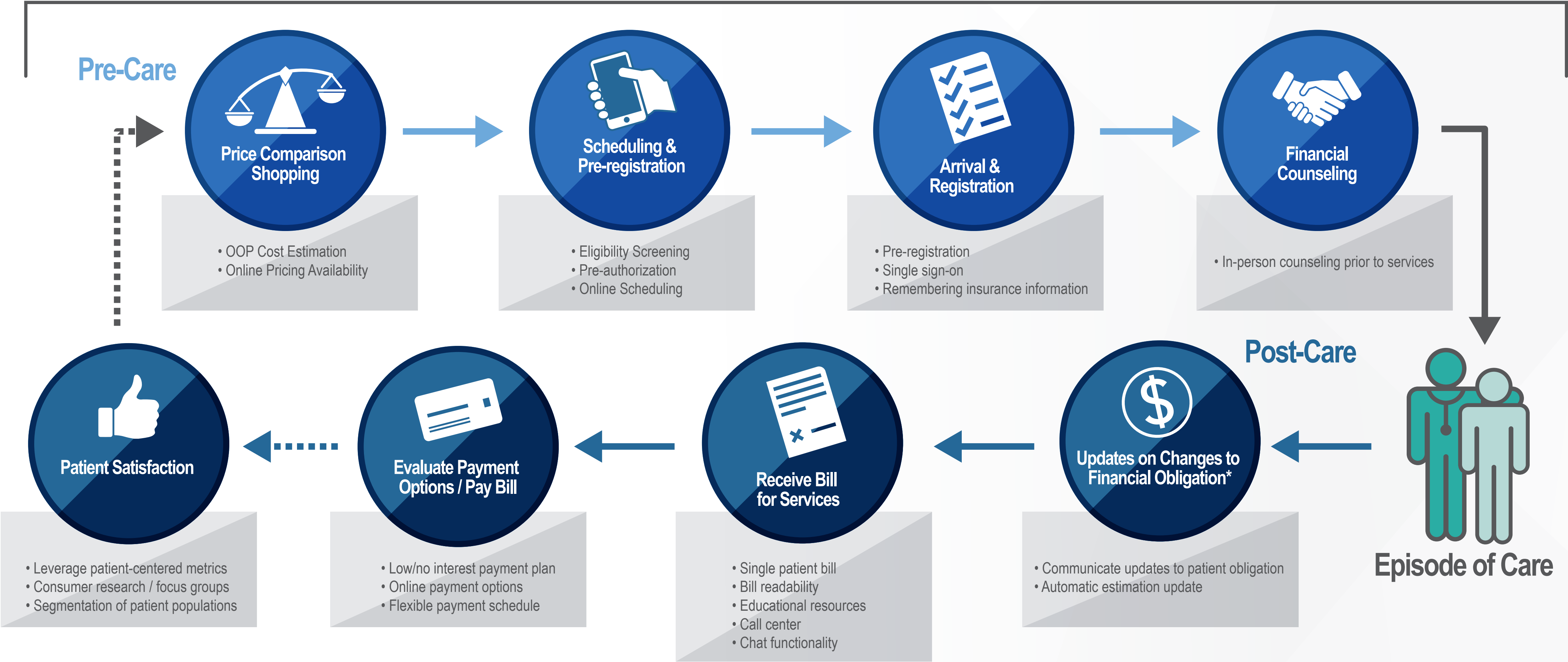3. A **segmented approach** based on identified consumer preferences.

Consumer-centeredness rating is calculated based on utilization of consumer metrics, consumer research, and organizational priority level. Health systems' Resources rating is determined by the number of strategies and capabilities in place to optimize the patient experience. The size of the bubbles corresponds to the number of LHS at each discrete rating (small = 1, medium = 2, large =3).

Optimal Patient Financial Journey Roadmap
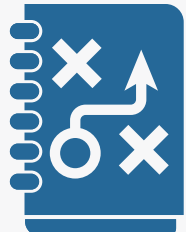
To optimize the experience, health systems can integrate a combination of solutions – such as the examples noted in the diagram – across each component of the patient journey as part of an overarching system-level strategy.

Comprehensive Health System Strategy & Leadership Alignment

Pre-Care

Price Comparison Shopping
- OOP Cost Estimation
- Online Pricing Availability

Scheduling & Pre-registration
- Eligibility Screening
- Pre-authorization
- Online Scheduling

Arrival & Registration
- Pre-registration
- Single sign-on
- Remembering insurance information

Financial Counseling
- In-person counseling prior to services

Post-Care

Updates on Changes to Financial Obligation*
- Communicate updates to patient obligation
- Automatic estimation update

Episode of Care

Receive Bill for Services
- Single patient bill
- Bill readability
- Educational resources
- Call center
- Chat functionality

Evaluate Payment Options / Pay Bill
- Low/no interest payment plan
- Online payment options
- Flexible payment schedule

Patient Satisfaction
- Leverage patient-centered metrics
- Consumer research / focus groups
- Segmentation of patient populations

Methodology

In May and June of 2019, The Health Management Academy conducted a series of quantitative and qualitative assessments with senior Leading Health System executives regarding the patient financial experience. The 23 total respondents represent 20 unique health systems. Respondent roles included Chief Financial Officers, VP of Revenue and Treasury, System Director – Patient Financial Services, VP of Revenue Cycle, VP of Patient Financial Services, Chief of Staff, Chief Officer of Strategic Communication, and Senior Vice President .

The responding health systems have a median Total Operating Revenue of $3.8 billion and own or operate a total of 180 hospitals.

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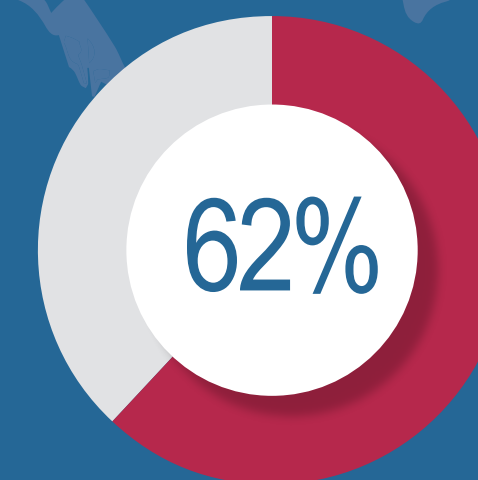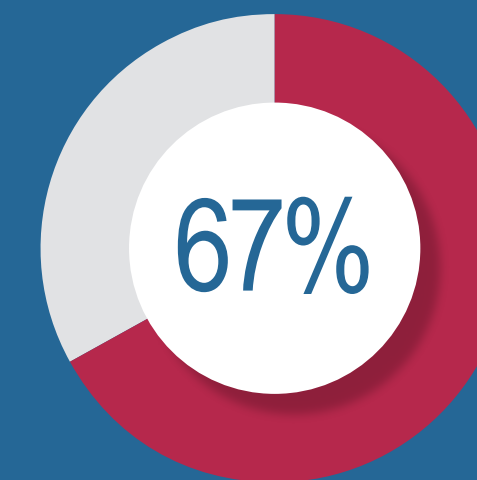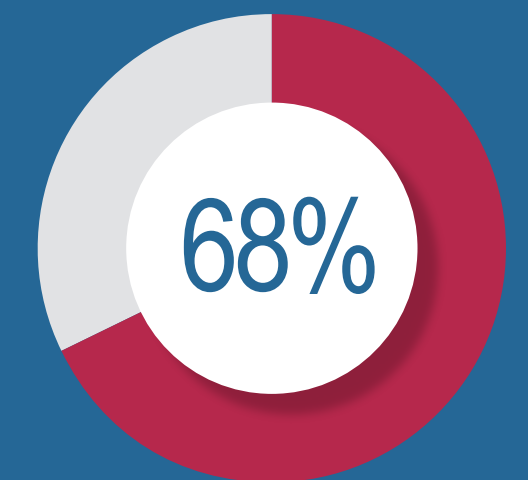
About Cedar

Cedar is a patient payment and engagement platform for hospitals, health systems and medical groups that drives improved financial results and patient satisfaction. At Cedar, we are focused on improving the overall healthcare experience and personalizing patient engagement. Our solutions leverage advanced data science to customize, simplify and modernize the way that patients interact with the administrative side of healthcare -- from pre-visit to bill resolution. Cedar is PCI and HIPAA compliant as well as HITRUST certified. Learn more at www.cedar.com

The Academy extends its appreciation to Cedar for the financial support for this project.