

Performance Strategies



Help Address the Economic Downturn with Financial Clearance Tools

Vol. 3, Issue 1, 2009

St. Elizabeth Optimizes Pre-Service Financial Clearance



By Joe Ruark
Assistant Vice President of Patient Financial Services
St. Elizabeth Medical Center



Optimizing Our Financial Clearance Processes

At [St. Elizabeth Medical Center](#), we've always had a successful revenue cycle management program, including efficient insurance verification. Our 1,169-bed healthcare system in Northern Kentucky had a well-organized process and competent staff in place, but we knew there was room for improvement. To take our pre-service financial clearance processes to the next level, we introduced automation to optimize and streamline the process.

The Right Technology

Unfortunately, we learned the hard way just how important it is to get the right technology in place. With our initial insurance verification system, transaction fees made the process expensive. It also artificially limited the number of transactions we could send on a monthly basis. The lack of payor connectivity limited the technology's value. In addition, the system was difficult to use because of a cumbersome user interface and non-standard data formats, which made it even less effective. In short, the system did little to help us go from good to great.

When we replaced this technology with an integrated suite of revenue management technology tools, we saw quick results. For example, with [RelayHealth RevRunner](#), we quickly identified valid insurance coverage for 3% of our self-pay accounts that previously had been written off as bad debt. This provided an immediate \$375,000 boost to our bottom line.

Being able to identify appropriate coverage is becoming increasingly important. About one in four non-elderly uninsured people in 2006, or about 12 million, were eligible for public health insurance programs but were not enrolled, according to a study conducted by the National Institute for Health Care Management, a Washington, D.C.-based non-profit group.

The Right Results

Now with automated eligibility processing in place, we can:

- Quickly verify insurance during pre-registration and/or registration.
- Verify eligibility when patients submit new insurance information.
- Identify patients who have been awarded Medicaid insurance.
- Search for Medicaid or Medicare insurance on self-pay accounts prior to sending the accounts to bad debt.
- Estimate patient liability in the emergency department and outpatient clinics.

Because now we are paying a fixed fee, instead of a fee based on the number of transactions, we can send unlimited insurance verifications. St. Elizabeth is saving \$20,000 per month as compared to our previous transaction-based model.

The system, which features an inviting color-coded user interface, also has helped us streamline registration, insurance verification and point-of-service collection — processes that previously took significant staff time. As a result, staff members can now redirect their energies to tasks that further enhance our revenue management success. For example, registration auditors use the tool to work registration exceptions the day after a patient is admitted, a task that formerly occurred several days after admission.

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St. Elizabeth Optimizes Pre-Service Financial Clearance (Cont.)

An Important Tool for these Economic Times

To further improve our processes, we plan to implement the automated financial advocacy functions of the technology. When these features are up and running, we will be able to qualify patients for coverage and financial assistance pre-service, enabling staff to automate the process for enrolling patients in financial assistance programs.

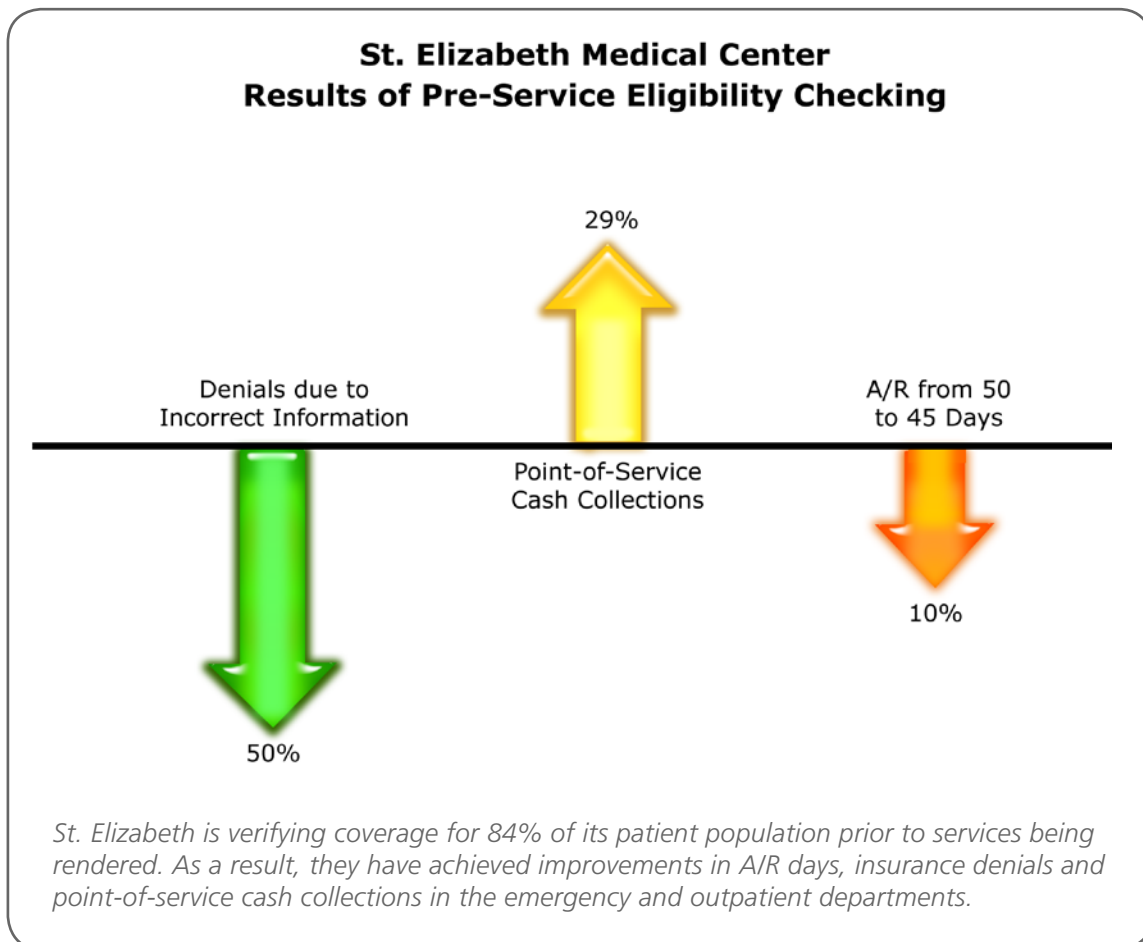
In addition, a propensity-to-pay function will enable registrars to determine both a patient's ability to pay and their probability to pay.

Using this tool to automate insurance verification during pre-registration and registration, St. Elizabeth has been able to:

- Verify insurance coverage for 84% of the patient population prior to services being rendered.
- Reduce by 50% insurance denials due to incorrect information collected during pre-service.
- Increase by 29% point-of-service cash collections for outpatients and in the emergency department.
- Decrease days in A/R from about 50 to just 45.

These results are especially important in these uncertain economic times for both providers and patients. Financial clearance automation helps us focus and streamline our efforts to identify financial responsibility, and it helps patients find alternate financial resources before delivery of care.

Joseph Ruark, CPA, has 29 years of financial and accounting experience. He currently is the Assistant Vice President of Patient Finance at St. Elizabeth Medical Center in Northern Kentucky. The St. Elizabeth Medical Center, founded by the Sisters of the Poor in 1861, is a five-hospital system located in Northern Kentucky. St. Elizabeth recently merged with St. Luke Hospitals to form one health system. Mr. Ruark also is a part-time instructor at Northern Kentucky University. He is a CPA and a member of the Kentucky Chapter of the Healthcare Financial Management Association (HFMA).



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[HIStech Report — RelayHealth Adds Services to Manage Uncompensated Care](#)

[Mission: Revenue — Enabling Technologies](#)

[Group Practice Journal: Managing Prompt Insurance Payments](#)

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Health Alliance Nets Financial and Patient Satisfaction Benefits with Real-Time Eligibility Verification



*By Doug Gardner
Director of Patient Financial Services
Health Alliance*



Shedding Light on Eligibility

At [Health Alliance of Greater Cincinnati](#), we've found that the more we know about a patient's eligibility upfront the better. That's why we started to review the pre-service financial clearance process used by our healthcare system, which comprises four hospitals and one long-term care facility. Our health system uses a central business office that processes about \$440 million in accounts receivable each year.

Because we sent our requests to verify eligibility in a batch once a day, it took 24 hours or more to learn whether patients were qualified for Medicaid coverage. So, we would treat them first and later figure out exactly how payment would be made — a process that was not optimal for us or our patients.

In addition, our previous revenue cycle system did not connect to all of Medicaid's payors, which made it difficult to ascertain whether patients had coverage through the state program. And because eligibility checking was such a laborious, paper-intensive process, we typically would check self-pay patients for Medicaid eligibility once. We did not have the time to perform rechecks to ascertain if their status changed.

Verifying Eligibility in Real Time

We realized that our processes were not financially healthy for us or the patients. As a result, we decided to overhaul our pre-service financial clearance operations to move eligibility checking upfront and in real time. Automating it meant eligibility was checked each time a patient presented for care so that we were able to stay up-to-date with Medicare status changes.

Two years ago, we implemented the [RelayHealth RevRunner](#) solution for financial clearance. The solution electronically accesses patient demographic files from the hospital's accounting systems. After formatting the data, it sends an eligibility request in real time to the correct payor. Once the payor response is received, the patient's eligibility status is displayed in a format that enables our staff to quickly identify the patient's eligibility coverage before service is provided.

With this technology update, we are able to stay on top of eligibility status from the second that a patient walks through the door until reimbursement is received. For example, when patients arrive for care, we receive real-time verification of Medicaid eligibility. As a result, we are able to work closely with ineligible patients to identify alternate sources of reimbursement before delivering care.

Realizing Results Today, Making Improvements for Tomorrow

Health Alliance carries self-pay accounts for 90 to 120 days. During this period, we run a batch eligibility check at 6 days and again at 75 days. Rerunning the check identifies patients who were deemed ineligible for Medicaid coverage when they received services, but whose status has changed since then.

Recovery of \$500K per month: By automatically running these eligibility verification checks, we typically recoup \$500,000 worth of additional Medicaid eligibility each month. This money previously would have been lost, or the account would have been forwarded to a collection agency. In some cases, the agency would discover that the patient had, in fact, become eligible for Medicaid, but we still would have to pay the collection agency fee.

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Health Alliance Nets Financial and Patient Satisfaction Benefits with Real-Time Eligibility Verification (Cont.)

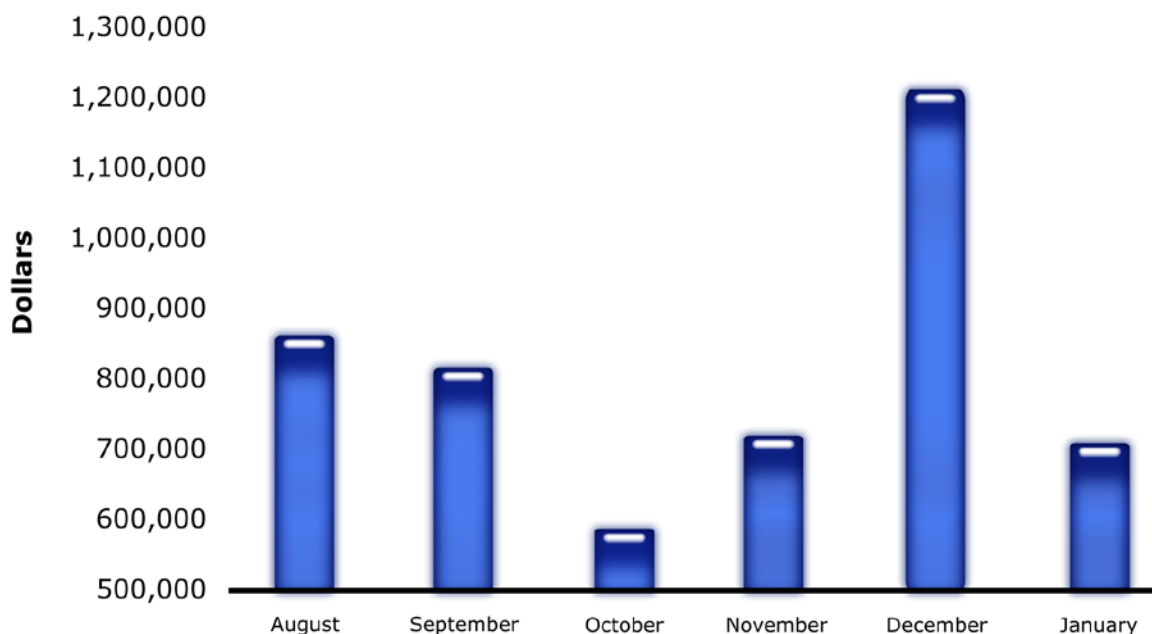
Reduced agency fees: Because we no longer forward these status-changed accounts for collection, we have been able to reduce our agency fees substantially. In addition, the agencies that we work with have found that it is much more difficult to collect on our accounts because our technology uncovers reimbursement sources early in the process.

Improved patient satisfaction: Real-time eligibility verification also improves patient satisfaction. By providing us with current information, we can explain payment options to patients at the time they present for care. Also, previously collectors might call patients seeking reimbursement after care and find their Medicaid status had changed. Some of these patients would become upset because they assumed that we would be aware of their new eligibility.

Our success has reinforced the need for a proactive approach to improve our revenue management processes. For example, we currently have staff members manually checking the status of claims for those that need follow-up. However, we are looking at automating the entire process with RevRunner technology, which would automatically flag such accounts. We expect that automating the process will enable us to further improve workflow and reduce labor costs significantly.

Doug Gardner is the Director of Patient Financial Services for the Health Alliance of Greater Cincinnati. Prior to working for Health Alliance, Doug spent eight years as an Operations Manager at Citibank, managing various stages of retail collections. After joining the Health Alliance as the Self-Pay Manager, Doug transformed the once dormant collections operation into a progressive, technology-focused, high-performing revenue generator. By installing processes commonly used in retail collections, and incorporating state-of-the-art equipment, Doug was able to increase self-pay collections from \$19M a year to \$34M a year in less than 3 years. He continues to emphasize technology and progressive performance management strategies in his role as Patient Financial Services Director.

Health Alliance Recoups Monies by Identifying Medicaid Status Changes



First Six Months of Review for Status Changes in 2006-2007

During the first six months of automatically reviewing self-pay accounts at 6 days and 75 days, Health Alliance was able to identify status changes in Medicaid eligibility prior to sending for collection. The reviews enabled the organization to recoup these charges, reduce bad debt, and save fees that would have been paid to a collection agency. Now the status change reviews recoup approximately \$500,000 per month.

Learn More

[Eligibility Verification: Once is Not Enough](#)

[AHA Report on the Economic Crisis](#)

[Moving to the Front End of the Revenue Cycle](#)

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Mary Rutan Hospital: Experiencing Bottom-line Benefits via Online Eligibility Verification



*By John Kivimaki
Director of Patient Accounts
Mary Rutan Hospital*



Getting Ready for the RAC Audit

Before we started working with RelayHealth, we didn't do much eligibility checking at [Mary Rutan Hospital](#), a 105-bed facility in Bellefontaine, Ohio.

If we didn't get a card from Medicaid patients, we would call a voice response line to see if the patient was covered. Patients with commercial insurance would usually present us with a card, but that did not guarantee coverage.

Unfortunately, we could not verify eligibility in a timely manner. With Medicare patients, we just took the information from a previous account or the patient's card. When patients had commercial coverage, we accepted the information on their cards, because we simply did not have the time to consult payor web sites and make phone calls to verify eligibility before the bills were generated from our hospital information (HIS) system.

When our revenue world started to change, we felt an even greater need for quick eligibility verification. More uninsured patients, an increase in the number of high-deductible health plans and the growth of Medicare Advantage Plans (which enable beneficiaries to receive healthcare through a variety of commercial health plans) made it even more crucial for us — and for our patients — to address coverage issues.

Why? Many of these Medicare Advantage patients arrived without their cards, and we erroneously processed their bills through Medicare instead of the specific Medicare Advantage plan. In addition, we didn't address their payment responsibilities at the point of service, and frequently co-pays and deductibles would not be paid.

Automating Eligibility Checking to Realize Results

In 2004, we addressed this problem by serving as a beta site to develop the HIPAA 270/271 eligibility process with RelayHealth.

Together, we developed a batch eligibility process where Medicaid account files from the previous day's registrations are accessed by [RelayHealth's RevRunner](#) and downloaded into the state's eligibility data base. Results are returned within the day to the HIS where reports are generated to correct any outdated information. We now use the batch eligibility process for approximately 25 payors. The eligible and ineligible responses received back from the payors are entered into our HIS.

Identifying self-pay patients for Medicaid: Electronic eligibility verification has created a windfall of sorts for us. When we used the technology to automatically identify whether self-pay patients were eligible for Ohio Medicaid, we found that many patients were qualified for assistance, but didn't realize it or had not applied for Medicaid.

Because Medicaid allows you to go back for a full year for eligibility, we went through all self-pay accounts and identified more than \$300K worth of revenue from Medicaid-eligible patients. From 2004 to 2007, we uncovered more than \$1 million in Medicaid-eligible revenue — all monies that never would have made it into our ledger book had we not started checking eligibility electronically.

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Mary Rutan Hospital: Experiencing Bottom-line Benefits via Online Eligibility Verification (Cont.)

Expanded connectivity to commercial payors: By adding electronic connections to 25 major commercial payors, we now can quickly receive eligibility reports that tell us if a patient is eligible for coverage according to the individual plan's benefits.

And results continue to materialize. For example, from September through December of 2008, we verified eligibility on 161 patient accounts from these payors, worth \$85,494 in revenue. If we continue to realize such results, we could net more than \$250K in additional revenue annually.

Prior to using the electronic system, this money would have been written off to bad debt. In addition, identifying eligibility early in the process helps us cut costs by reducing the time our staff must spend to produce statements, verify eligibility or chase bad debt.

Taking it to the Next Level: Real-Time Eligibility Verification

Our next step is to implement real-time eligibility verification via an electronic dashboard. Once implemented, our staff will be able to review eligibility at a glance and verify the right insurance, identification numbers and address at the point of service.

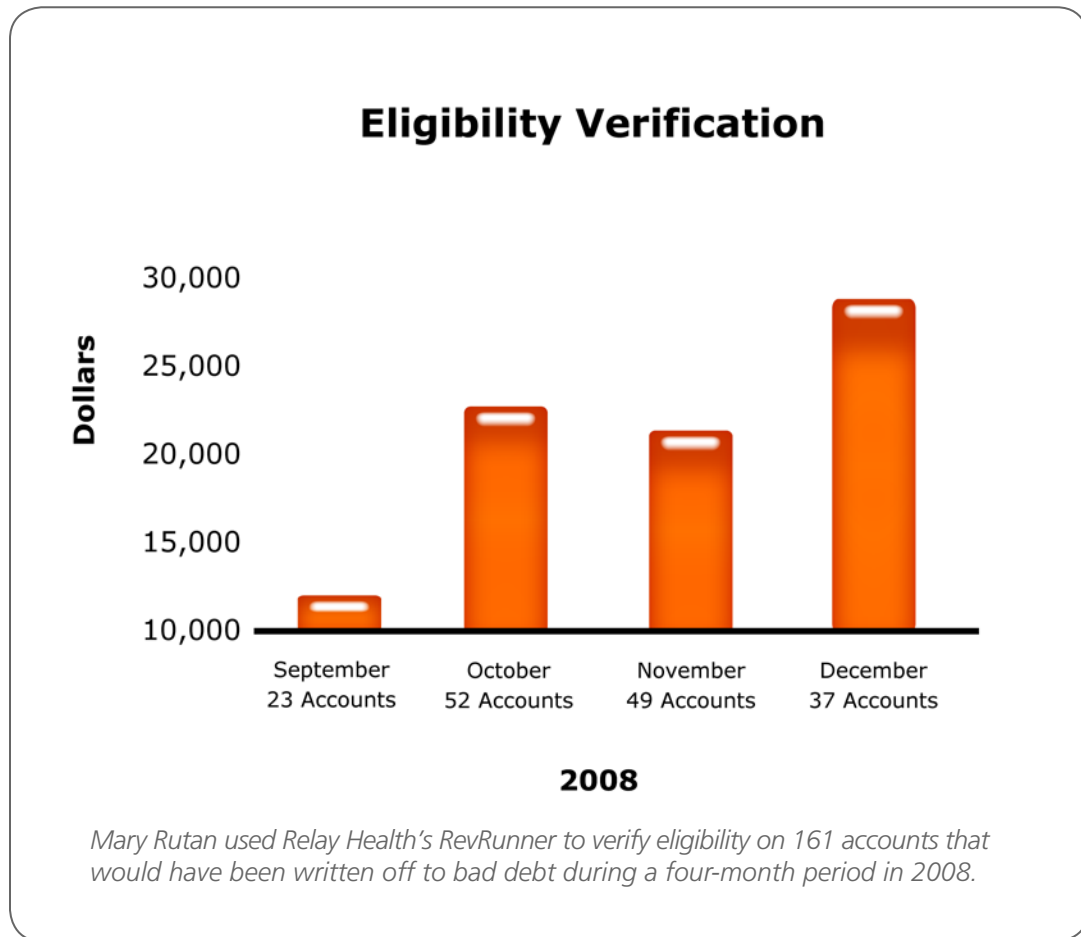
- With verification of insurance prior to service, we will be able to address co-payment and deductible issues with patients immediately. This will greatly enhance our point-of-service cash collections as well reimbursement potential down the line.
- With accurate insurance information, we will immediately bill the correct payor for the correct amount, eliminating delays in the reimbursement cycle.
- With correct patient addresses, we can confidently send statements and not have to spend time investigating potentially forged addresses. Patients will receive their statements, and we can expect more timely payments for their deductibles and co-payments.

Realizing Verification Improves Revenue Cycle Performance

The significant results we've achieved to date have convinced us that addressing eligibility is one of the most effective ways to improve revenue cycle performance. Just the impact to the bottom line from our eligibility verification of bad debt accounts illustrates its value. We look forward to the increased benefits of making the process real time.

John Kivimaki is Director of Patient Accounts at Mary Rutan Hospital in Bellefontaine, Ohio. In 1993, he was selected as "Receivables Manager of the Year" by Zimmerman and Associates. This award recognized the most innovative financial managers in the healthcare industry. He served on the Ohio Hospital Associations' ABC (Admitting, Billing, and Collections) Committee for four years, and is on the editorial boards for HARA (Hospital Accounts Receivable Analysis); "The Receivables Report" newsletter; and "Health Care Billing and Collections Manual." In addition to his membership in the Healthcare Financial Management Association (HFMA) Central Ohio Chapter for 20 years, he is also a member of the Central Ohio Patient Account Managers (COPAM), having served as treasurer and past President.

Mary Rutan Hospital: Experiencing Bottom-line Benefits via Online Eligibility Verification (Cont.)



Learn More

[HFMA: How the Financial Downturn Will Change Healthcare](#)

[AHA: Calculating Uncompensated Care Costs](#)

[Meet the Self-Pay Challenge in Economic Tough Times](#)

Performance Strategies



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Vol. 3, Issue 1, 2009

Making Do with Less in the Current Economy



*Richard L. Clarke, DHA, FHFMA
President and CEO
Healthcare Financial Management Association (HFMA)*

Taking the Pulse of the Healthcare Economy

Turmoil in the financial markets and a deepening recession have affected all sectors of the U.S. economy. Although healthcare has been described as a “recession proof” industry, the events of recent months have refuted that notion. Based on HFMA survey findings, there are several reasons this recession is different from those of the past when it comes to healthcare.

Turmoil in the financial markets. This turmoil has resulted in tightly constrained credit markets, which makes it difficult for hospitals and health systems of all sizes to access capital. In addition, declining investment portfolios are pulling down non-operational revenue from both investment income and philanthropic donations.

Lower patient volumes. Fifty-five percent of hospitals responding to our survey noted lower inpatient volumes, with 27% of these hospitals reporting declines of 2% or more.

Increasing bad debt and charity care expenses. More than 60% of our survey respondents noted that changes in bad debt and charity care expenses have had a negative impact on financial performance, with almost one in six indicating that this negative impact has been extreme.

HFMA will continue to provide information about the scope and nature of healthcare’s economic health, along with specific steps healthcare organizations can take to support their missions and their competitive positions. More information on the survey is available on the HFMA Web site at www.hfma.org.

Strategies to Survive the Current Environment

Hospitals can take several steps to meet these challenges to their economic health.

1. Hospital leaders must communicate the seriousness of this downturn and its actual and potential impact on the services provided by the hospital. This message should be shared with hospital staff, board members and the surrounding community.
2. Hospitals must focus on being low-cost providers. They should focus on rooting out and eliminating inefficiencies and waste while improving the quality of patient care. This will require an organization-wide commitment to redesign care and service processes to achieve sustainable improvements that reduce cost and improve quality.
3. Hospitals must preserve cash to get them through difficult economic times. They should redouble their efforts to reduce denied claims, reassess their risk tolerance, and scrutinize capital investment plans in terms of return on investment and impact on patient care.

Front-line staff also must be educated and equipped to discuss financial obligations with patients as early as possible in the process. Ideally, hospitals should manage expectations about the patient’s financial responsibility for nonemergency services before the patient arrives at the hospital.

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Making Do with Less in the Current Economy (Cont.)

Everyone's in the Same Boat — Patient and Provider

As hospitals are called upon to make do with less, they must remember that many of their patients are in the same position. Factors that contribute to rising bad debt and charity care expenses include:

- Increasing co-payments and deductibles for many patients fortunate enough to have employer-provided health insurance.
- Increasing numbers of the uninsured and unemployed. Not-for-profit hospitals must be especially sensitive to the needs of these patients.

Making do with less requires careful strategic planning and clear communication. It also requires a consistent focus on mission. Healthcare has gone through difficult times before and has proved to be a resilient industry. By acting wisely today, hospitals can ensure that they will survive and be able to provide even greater value and service to their communities in the future.

Dr. Richard Clarke has served as President and CEO of HFMA since June 1986. He has held executive positions at major healthcare systems in Colorado and Florida. Dr. Clarke has also served as the former chairman of the Accrediting Commission on Education in Health Administration (ACEHSA), and AHA Financial Solutions, Inc. (a wholly owned subsidiary of the American Hospital Association). He holds an adjunct faculty position in the Department of Health Systems Management at Rush University in Chicago. Dr. Clarke has been named to Modern Healthcare magazine's list of the 100 Most Powerful People each year since the list's inception.

County Finds that Uninsured Didn't Realize They Were Eligible for Coverage

A November 28, 2008, article in the *Washington Post* reported that an initiative in Virginia's Howard County, which was established to help secure care for the needy, uncovered a surprising fact. Once the county started to enroll the residents, they discovered the residents were already eligible for assistance from federal, state or nonprofit programs.

The article reports that a study by the National Institute for Health Care Management found that nationally about 12 million of the non-elderly uninsured (1 in 4) were eligible for programs, but were not enrolled. The study by the non-profit group, which is partly underwritten by insurers, found there are several reasons the eligible may not be taking advantage of coverage. In addition to not being aware they are eligible (often not realizing they are at or below the poverty line), they are discouraged by the complexity of the paperwork or are embarrassed to apply for assistance.

Read [the article](#) on the *Washington Post* Web site.

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Phoenix, Arizona
Booth # 121

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Weather the Economic Storm with Financial Clearance Tools



*By Dave Mason
Vice President and General Manager
RelayHealth*

Coping with Economic Upheaval

Recent economic conditions have forced many industries — and individuals — to focus on one thing: financial survival. Contrary to the popular belief that healthcare is immune to recession, hospitals are feeling the pinch of the economy. Many are struggling to avoid bankruptcy and others are just trying to stay the course.

The harsh economic times are wreaking havoc with hospital revenue cycles. About 15% of Americans currently do not have health insurance. And for every 1% increase in unemployment, 1.1 million people lose their health insurance, according to the Kaiser Family Foundation, Menlo Park, Calif. Those with health insurance also are struggling. The Commonwealth Fund estimates that about 25 million people have some insurance but still can't afford to pay their medical bills.

As a result, hospitals must find ways not only to collect every dollar they earn, but also collect it efficiently. The Advisory Board Company, a Washington, D.C.-based research firm, recommends accelerating revenue capture as part of a four-pronged approach to surviving the economic storm (including securing patient volumes, containing operating expenses, and reprioritizing capital allocations). The Advisory Board encourages hospitals to improve revenue capture by:

- Developing a comprehensive self-pay strategy.
- Reforming accounts receivable days management as payors delay reimbursement.
- Refining coding and denials management.

Zeroing in on Pre-Service Financial Clearance Services

Hospital leaders must focus on the growing need for effective pre-service financial clearance services. With pre-service financial planning, patients do not feel surprised or shocked when they get their bill and therefore can make informed and better payment choices. The hospital can work with patients to determine the optimal payment method prior to service instead of relegating financial matters to the back end of the patient encounter.

To achieve optimal performance, three financial clearance services — eligibility verification, bill estimation and financial advocacy — must work in concert.

Eligibility verification: Through eligibility verification, the hospital verifies coverage and limitations before rendering services. Having that knowledge upfront is essential for revenue cycle success in the current environment.

Bill estimation: Bill estimation determines the patient's estimated out-of-pocket liability. This enables administrative staff to notify patients upfront about their portion of the cost of service and help them determine an optimal payment plan. Providing patients with such information early in the process is key to getting paid. Once patients leave the hospital, the chance of the bill being paid drops dramatically. The value the hospital can expect from the receivable drops to 90% of the bill at 60 days, 80% at 90 days, 73% at 120 days, 67% at six months and just 45% at one year.

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Weather the Economic Storm with Financial Clearance Tools (Cont.)

Financial advocacy: The financial advocacy function determines patients' ability and likelihood to pay, and enables the hospital to identify alternative sources of assistance, such as a state or hospital charity program or Medicaid. By identifying these alternate reimbursement sources upfront, hospitals avoid engaging in lengthy and costly collection efforts that often prove futile for patients that do not have the ability to pay.

Leveraging Technology Upfront

Using financial clearance tools before services are delivered, hospitals can verify eligibility in real time and pre-service. These tools can automate financial clearance tasks, helping hospitals:

- More accurately estimate patient balances for insured, underinsured and self-pay patients. For the insured, the system uses the insurance contract terms and the service codes for that visit. The system calculates the patient's deductible copayment, coinsurance, out-of-pocket maximum, and how much of the deductible and out-of-pocket amounts have been met to determine the payment.
- Determine the most appropriate payment methods, including alternate sources for uninsured and underinsured patients. To maximize collections, hospitals should provide flexible payment options, both at the point of service and over the duration of the payment plan. Staff should be able to accept credit and debit cards and e-checks.
- Screen for the patient's propensity to pay their healthcare bills. The system can calculate a payment plan that is based on the hospital's policy and each patient's ability to pay, which is determined from family situation questionnaires and credit scores. This credit check does not impact the patient's credit rating or score.
- Validate demographic and plan information critical to eligibility verification and accurate billing.

By automating clearance tasks, hospitals shift the focus from collecting payment after the patient visit to the point of service.

The keys to success are establishing community-sensitive financial assistance policies, investing in the necessary enabling technologies and adjusting workflow to support new operational best practices. McKesson's [next-generation enterprise revenue management system](#) includes financial clearance tools as part of a comprehensive, integrated solution for managing an organization's revenue cycle. Hospitals that do these things properly will find the right balance between margin and mission in this challenging new world of patient financial responsibility.

NOTE: You can learn more about how to help your organization survive the economy by reading the *Performance Strategies* issue on "[Reducing Bad Debt](#)."

Dave Mason is vice president and general manager of provider solutions for RelayHealth, a business unit of McKesson. He has responsibility for the operational management of services and systems related to financial clearance, settlement solutions and connectivity services through RelayHealth's intelligent network for providers, healthcare institutions and consumers. Mason has 30 years of healthcare management experience. He joined RelayHealth in 2007 with McKesson's acquisition of Per-Se Technologies, where he was president of the company's Hospital Solutions division. Prior to that, Mason was CEO and executive director of Quantum Radiology. He has served in various practice management and administration positions, including at Georgetown University Hospital in Washington, D.C., and Northside Hospital in Atlanta, Ga.

Weather the Economic Storm with Financial Clearance Tools (Cont.)

HIMSS White Paper Recommends Strategies to Address Pre-Service Challenges

A Healthcare Information and Management Systems Society (HIMSS) white paper released in 2008 reviews how to re-engineer the revenue cycle for the new consumer-directed healthcare environment. A section of the white paper reviews pre-service challenges and recommends:

- Collecting all medical and financial data at the point of scheduling the appointment.
- Verifying insurance information before the first contact and then re-validating it at every contact after that.
- Asking referring physicians to provide all relevant information to the provider so that the services comply with medical necessity requirements.
- Validating coverage using eligibility systems, with work-listing to review errors so corrections can be made prior to service or claim generation.
- Checking self-pay patients for Medicaid eligibility.
- Estimating out-of-pocket expenses and providing pricing transparency tools to assist the patient with understanding the cost of care and to set payment expectations.
- Managing self-pay receivables according to HFMA Statement 15, designating care cost as “collectible, charity care or bad debt no later than the time of service.”

The white paper notes that information technology and online tools can automate these pre-service checks to validate demographic information, medical necessity, insurance eligibility, and propensity to pay. Review the [white paper](#) on the [HIMSS Web site](#). A table for technology that enables front office best practices in revenue cycle management starts on page 18.

Related Solutions

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