Systemic Problems in Financial Assistance, Billing and Collections Processes at UNM Hospital
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1. Across the organization, staff and providers at UNM Hospital do not know about or promote financial assistance programs when serving patients.
   - Missed opportunities to identify and refer patients at point of service are common. Reasons include staff/provider lack of awareness about financial assistance programs, and their personal judgment of patient’s likelihood of qualifying for or rights to such benefits;
   - Patient and family are expected to figure it out with minimal information. It is very difficult to self-advocate. No friendly, welcoming, easy-to-find place to go to fill out applications, ask questions, obtain information. Most staff and providers can’t answer simple questions about financial assistance programs.
   - Business office/financial assistance operations are completely independent of other areas in the hospital and do not communicate to improve customer service or address systemic problems.
   - Data collection systems don’t talk to each other; no programmed way to flag patients that could potentially qualify for financial assistance early in their interactions with system.

Patient Story: A Native American patient needed to renew her UNM Care coverage. She presented to the pre-arranged financial assistance appointment, was directed to go to another floor in the hospital, was redirected by that office to go to yet another office, and finally after 30 minutes of going around in circles was back to the first office who told her she missed her appointment and needed to reschedule. Six weeks later she is in need of medical care but is delaying it because she has not been able to renew her UNM Care coverage.

2. Application process for financial assistance programs is not comprehensive or patient-centered.
   - A simple application form is not provided for patients and families to work from or to complete at their convenience. In the case of SCI applications, UNM Hospital is unique in this regard, by not offering a mail-in option for applying to the program.
   - Communication between the patient and the office is not easy to establish beyond the initial eligibility process. The patient must be persistent in getting answers to questions about benefits over the course of using services.
   - Particularly for immigrants, there is not a consistent approach to identifying multiple, potential options for assistance in paying for medical services. The eligibility worker makes the decision which programs to apply for and options are not discussed with the patient.
   - For the self-pay discount program and for the limited financial assistance program, there is no formal, objective appeals process when eligibility is denied. This primarily impacts immigrants.

Patient Story: A 9-yr old cancer patient, covered by Children’s Medical Services (CMS), presented for a PET-scan that was ordered by his doctor as a preventative measure for his aggressive cancer. He was denied services because the “insurance company denied procedure.” The family has been qualified for the self-pay discount program, so could have been charged a co-pay so their son could receive the procedure. Instead, frontline staff only considered primary payer source and denied services without looking at other payment options.
3. The process for making payment arrangements or for discussing billing concerns is inconsistent and unclear, and the service atmosphere is not patient-centered or friendly.
   - The decisions about setting up a payment plan and payment amounts reside with the eligibility worker, who has numerous tasks to perform, many of which have conflicting purposes, i.e., collecting payment on outstanding bills while facilitating a process that will delay or reduce the amount paid when setting up a payment plan with a patient.
   - Communication between the patient and the business office is not routine or easy to establish. The approach to common customer service-type interaction, from asking simple clarifying questions about a bill to negotiating a payment plan, is not available. But this is common and expected in most other service industries such as utility companies and banks, for example.
   - When a payment arrangement is made, it is very difficult to adjust the payment if economic circumstances change for the patient. An attitude of “no excuses” is encountered.

Patient Story: A 56-yr old breast cancer patient presented to a financial assistance appointment to set up a payment plan. She was told by the eligibility worker that the minimum monthly amount would be $100 for hospital and doctor bills, combined. The worker added that, if the amounts were less $100, it would take the patient too long to pay her accounts and that would cause her to be sent to collections. The eligibility worker did not review the patient’s ability to pay $100 per month without causing financial burden. The patient felt she needed to agree to this contract despite her inability to pay that amount.

4. Billing & collections practices are rigidly implemented regardless of whether a patient has been determined to be low-income and uninsured, and in spite of demonstrated coverage through state Medicaid or Medicare for most of their billed services.
   - The billing system allows for a large margin of human error in which accounts may be sent to collections regardless of payment plan arrangements. The burden of proof is on the patient.
   - The three-tiered billing system: business office, extended business office, and collections agency, is a burdensome, complicated and confusing process for patients to navigate. Communication between the three billing tiers is limited and it takes a long time to receive resolution on an account.
   - An effective way of flagging “Medicaid/EMSA pending” accounts has not been implemented to prevent these accounts from going to collections pending eligibility determination for these programs or alternate payer sources, despite the knowledge that these are low-income patients.

Patient Story: The family of a 6-month-old baby boy began receiving collection notices and daily phone calls several months after the baby had been in the hospital. The baby's stay had already been covered by Emergency Medical Services for Aliens (EMSA), and the family was surprised by the notices and calls. Although the baby's mother tried to explain this to the collection agency worker, she was told that they would not stop collection attempts until they have proof of payment from UNM Hospital. A year later, this family continues to be harassed by the collection agency on this account.