

**CarePayment Program Hospital Outcomes:
Results from Semi-Structured Interviews with Hospital Staff**

Julie Solomon, PhD

Principal and Member, J. Solomon Consulting, LLC
Mountain View, California, USA

Laura Lessard, PhD, MPH

Assistant Professor, University of Delaware
Newark, Delaware, USA

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Abstract

Introduction: Although the Affordable Care Act (ACA) has resulted in lower medical debt rates among Americans, bad debt remains a significant problem for U.S. hospitals. A number of companies offer patient financing programs that may help ameliorate hospitals' bad debt-related challenges, including CarePayment (CP), which offers a zero interest line of credit to patients at participating hospitals. We undertook an exploratory study of CP outcomes that is, to our knowledge, the first independent outcome evaluation of a patient financing mechanism in the U.S. One purpose of the study was to investigate hospital-level outcomes through qualitative interviews with hospital staff.

Methods: We conducted semi-structured, in-person interviews with staff who worked directly with the CP program at a purposive sample of hospitals. Priority was given to hospitals serving low-income populations, and to creating a sample of hospitals of different sizes and offering CP for different time-periods. The interview questions addressed hospital context, interviewees' experience with CP, and CP outcomes. Interviews were audio-recorded and transcribed. The online platform Dedoose was used to facilitate coding and qualitative analysis. Analytic memos on outcomes of focus were developed and discussed among the study team.

Results: Five hospitals participated in interviews, with 23 staff interviewed in total. Across the hospitals, bad debt was reported to have either gone down or leveled off due to CP. All five hospitals reported that having CP manage a bill payment plan was beneficial. Four reported not having the staff, skills, and/or systems to efficiently manage the internal payment plans they had prior to CP. Contrary to our expectation, no interviewee felt that changes in bad debt rates or other savings associated with CP have had a direct impact on hospital provision of charity care or other community programming. Finally, at least one interviewee at each hospital expressed the view that CP helps to give the hospital a competitive advantage because of patient satisfaction with the program. Interviewees offered stories exemplifying patient satisfaction, and cited few complaints and repeated use of CP as further evidence.

Discussion: The findings provide preliminary qualitative evidence of positive outcomes for most indicators that were examined. Two hospitals' experiences of observing higher-than-expected rates of returned accounts due to non-payment by CP patients underscore the need for ongoing analysis of collections performance in light of revenue cycle objectives, in order to ensure the best possible revenue outcomes through the program. Limitations that should be taken into consideration in interpreting the study findings include CP's involvement in selection of and outreach to potential participant sites, and the possibility of social desirability bias influencing the interviewees' responses. Steps were taken to reduce both potential sources of bias.

Conclusion: Bad debt and payment collection challenges are likely to remain important problems for U.S. hospitals. External patient financing options, such as CP, have the potential to reduce bad debt and improve payment collection efficiency and patient satisfaction. Hospital administrators might consider the promise of such programs for benefitting both the bottom line and patient care.

1. Background

Although implementation of the Affordable Care Act (ACA) has resulted in a higher percentage of Americans with health insurance and a lower percentage with medical debt or medical bill problems¹, bad debt remains a significant problem for U.S. hospitals. Under the traditional payment system, when the patient cannot pay the medical bill, the balance goes to collections or is written off immediately as bad debt (see Figure 1). The high out-of-pocket expenses that many Americans are paying under ACA-compliant insurance plans are currently a major driver of hospitals' bad debt.^{2,3} Some estimate that healthcare providers collect only \$0.18 to \$0.34 on the dollar from individuals with high deductible plans⁴, and an industry brief suggests that the source of unpaid hospital debt will shift from majority self-pay (primarily uninsured individuals) to majority balance after insurance (insured individuals) in the next several years.⁵ Additionally, many medical providers incur considerable expense collecting payments from patients because the providers lack streamlined practices and appropriate resources for such collection efforts; the cost involved in contacting patients to pay off a small balance can exceed the amount to be re-paid.⁶ Hospitals are also limited in the range of internal payment plans they can offer to patients, given current banking laws.⁷ To address the persistent issues of bad debt and inefficient payment collection practices, experts have called for medical debt repayment plans that are matched to the patient's financial situation^{8,9}; use of external parties to handle patient payment processes^{10,11}; and use of the latest technologies to facilitate patients' bill payment.^{12,13}

¹ Collins SR, Rasmussen PW, Doty MM, Beutel S. (2015). *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014*. New York: The Commonwealth Fund. Accessed February 7, 2015 at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf.

² Kutscher B. (2013a). ACA-compliant plans may not help hospitals cut bad debt. *Modern Healthcare*, 43(44):10.

³ Kutscher B. (2013b). Targeting bad debt. Hospitals getting proactive on billing. *Modern Healthcare*, 43(33):32-3.

⁴ Kutscher B. (2015). High-deductible plans change how hospitals interact with patients. Accessed August 29, 2015 at <http://www.modernhealthcare.com/article/20150624/NEWS/150629941/high-deductible-plans-change-how-hospitals-interact-with-patients>.

⁵ Bayley M, Calkins S, Levine E, Machado-Pereira M. (2013). Hospital revenue cycle operations: opportunities created by the ACA. Accessed August 29, 2015 at http://healthcare.mckinsey.com/sites/default/files/793544_Hospital_Revenue_Cycle_Operations.pdf.

⁶ Koenig S. (2010). A prescription for turning self-pay accounts into revenue. *Journal of Health Care Finance*, 37(1):30-34.

⁷ Brasch W. (2014; May 9). Navigating the compliance minefield of patient financing. *Becker's Hospital Review*. Accessed October 13, 2015 at <http://www.beckershospitalreview.com/finance/navigating-the-compliance-minefield-of-patient-financing.html>.

⁸ Unland JJ. (2005). Two years into the storm over pricing to and collecting from the uninsured--a hospital valuation expert examines the risk/return dynamics and asks: would fair pricing and fair medical debt repayment plans increase yields to hospitals and simultaneously mitigate these controversies? *Journal of Health Care Finance*, 32(1):54-66.

⁹ Levitt JC. (2004). Transfer of financial risk and alternative financing solutions. *Journal of Health Care Finance*, 30(4):21-32.

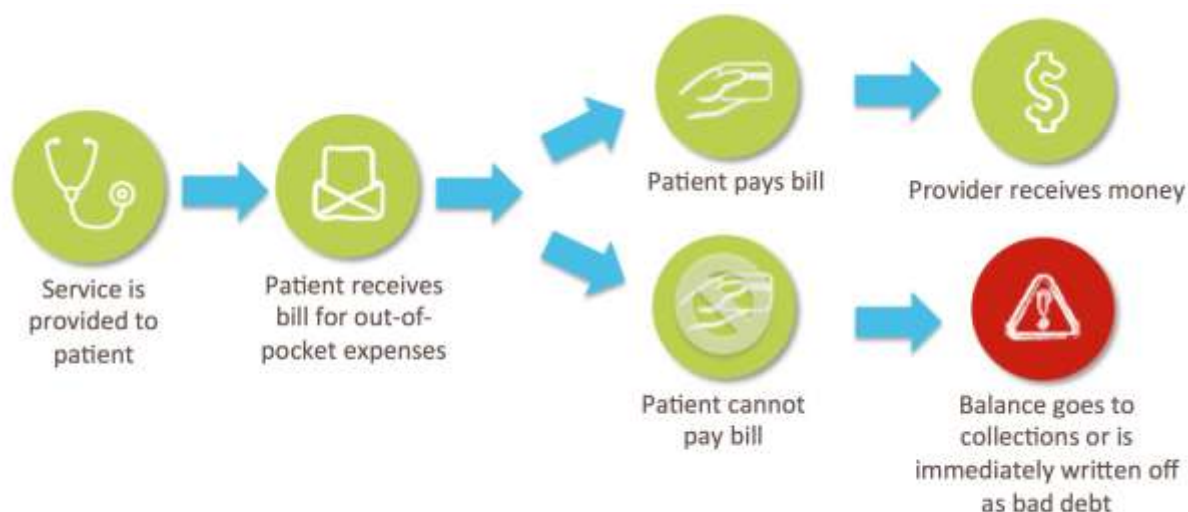
¹⁰ Bayley et al. (2013).

¹¹ Koenig (2010).

¹² Evans M. (2013). Across the board: Affordable Care Act prompting hospital trustees to pay closer attention to policies on patient billing, collection and bad debt. *Modern Healthcare*, 43(27):30-31.

¹³ Phelps R. (2011). New technologies reduce bad-debt risk and collection costs. *Revenue Cycle Strategist*, 8(5):6-7.

Figure 1. The Traditional Model of Medical Bill Payment



A number of companies offer patient financing programs to hospitals and their patients that may help ameliorate hospitals' billing and bad debt challenges. One such company is CarePayment (<https://www.carepayment.com>; hereafter CP), which offers a 0.00% APR (no interest for the life of the account) revolving line of credit to patients (or their guarantors¹⁴) at participating hospitals. This plan involves debts up to \$25,000 and typically a 25-month re-payment period, with monthly payments starting at 4% of the debt amount or \$25, whichever is higher. With the increase in high-deductible health plans and provider requests for extended terms, CP now offers term lengths from 3-72 months configurable by the provider client. Patients have the option to add new charges from the hospital to the plan, and they receive one bill for all services within the hospital network that are being financed through CP.

CP conducts a Patient Cycle Analysis with new client hospitals to assess collections performance, discuss revenue cycle objectives, and make recommendations on the CP program configuration that would best meets the provider's needs. For example, hospitals can offer the CP program to patients both up front, before they have had their medical service (see Figure 2), and on the back end, once they have incurred a self-pay debt that they are unable to pay off right away (see Figure 3).¹⁵ Some hospitals transfer aged accounts of all eligible patients to CP, while others use an opt-in process. In either case, once the patient is offered the program, participation is voluntary.

Once the CP program is configured for a hospital, accounts to be sent to CP are flagged within the hospital billing system. These accounts are transmitted to CP once final service charges are determined. The hospital receives immediate funding on all qualified accounts (see Figures 2-3). CP handles patient engagement, collections, compliance, and customer service. CP's technology is integrated with hospital billing systems, and materials about CP that are made available to patients and their families (e.g., on-site posters, brochures, and bills) are co-branded by CP and the hospital. CP also provides on-site hospital staff training. Hospitals pay

¹⁴ Usually the patient is also the guarantor. However, in some instances, due to minor age or mental incapacity, another person, commonly an immediate family member, serves as the guarantor for the patient's bill.

¹⁵ Note that Figures 2-3 display common elements across the diverse CP program configurations that are available.

fees to CP, and are responsible for reimbursing CP for accounts that are returned to the hospital for patient non-payment. CP services are also available to physician groups and other medical providers; in March 2015, CP was available at over 700 hospital facilities and physician clinics nationwide.

Figure 2. The CarePayment Model: Point-of-Service Offer



* Some configurations include immediate funding to provider for high-propensity-to-pay accounts prior to initial patient payments.

** If patient does not pay or stops paying, account is returned to provider; if account has already funded, funding is returned to CarePayment.

Figure 3: The CarePayment Model: Post-Service Offer



* Some configurations include immediate funding to provider for high-propensity-to-pay accounts prior to initial patient payments.

** If patient does not pay or stops paying, account is returned to provider; if account has already funded, funding is returned to CarePayment.

Since its founding in 2004, CP has conducted a satisfaction survey of patients, collected patient “stories of impact”, and developed case examples of hospital client success stories (see <https://www.carepayment.com/for-providers/client-case-studies/>). However, there had been no independent assessment of patient or hospital outcomes. In fact, we are unaware of any independent evaluation study to date on the outcomes of a patient financing mechanism, for hospitals or their patients.

With a grant from the W.K. Kellogg Foundation, we undertook an exploratory study to document such outcomes. One of the purposes of the study was to investigate hospital-level CP outcomes through interviews with staff involved with CP at a small sample of hospitals.

2. Methods

The evaluation of hospital outcomes involved semi-structured, in-person interviews with staff who worked directly with the CP program at a purposive sample of hospitals around the U.S. The Arcadia University Institutional Review Board reviewed the study procedures and granted an exemption to this study component.

2.1. Sample and recruitment

The study team worked with CP to make a purposive selection of CP client hospitals across the country. Priority was given to hospitals serving low-income populations, and to creating a sample composed of hospitals of different sizes and offering CP for different periods of time. At least one hospital in Michigan was included, per Kellogg Foundation priorities. CP provided a sample of 12 hospitals for recruitment efforts. Recruitment email content was developed by the independent study team and sent to these hospitals by the respective CP Account Managers.

The independent study team (i.e., Principal Investigator [PI] and Co-Investigator [Co-PI]) followed up with the CP points of contact at the hospitals that responded positively to the recruitment email, in an effort to schedule interviews. This procedure served to maintain confidentiality, such that CP would not know which hospitals ultimately participated. The study team requested to interview one or more individuals at each hospital that were involved in the revenue cycle, including explaining CP to patients (e.g., registration, billing); marketing; and community benefit or community programs.

2.2. Data collection

The study team developed a flexible semi-structured interview protocol that included largely open-ended questions addressing the context of the site, interviewees' experience with CP, and CP outcomes. Based on the literature on hospital revenue cycles and patient financing, we hypothesized that use of CP would lead to reductions in hospitals' bad debt and accounts receivable, as well as improvements in the efficiency and quality of hospital billing procedures, resulting in reduced billing costs.^{16,17,18} We also expected that the resultant increases in hospital revenue might lead to increased provision of charity care and other services to patients and community members. In addition, we hypothesized that use of CP would contribute to increased hospital market share, due to patient satisfaction with billing procedures and the lower stress associated with being able to pay off medical bills over time and avoid the many potential negative financial and access to care consequences of medical debt (e.g., accruing credit card debt; medical debt going to collections and damaging credit scores; and deferring or avoiding needed health care, including preventive care, specialized treatment, and prescription medication^{19,20,21,22,23}). We designed interview questions that addressed the hypothesized hospital-level outcomes of CP, and also included questions that encouraged interviewees to describe any other outcomes that they had observed.

Examples of questions posed only to staff who interacted directly with patients and their families about CP are: "How do you explain CP to patients? What questions to they ask about it?" Examples of questions posted only to other staff (i.e., administrators and those in community benefit and marketing) are: "Why did your hospital originally decided to implement CP?"; "How, if at all, has CP impacted the following aspects of your hospital: bad debt; cash flow; patient satisfaction; competitive advantage; and ability to provide charity care or other community programming?"; and "What has been the most significant change that you have seen as a result of CP?" A question posed to all interviewees was: "If we were talking to someone in your position at another hospital that does not use CP, what should we tell them about the effects they could expect on their hospital from CP?"

¹⁶ Bayley et al. (2013).

¹⁷ Garnier A. (2015). Using IRS Code 501(r) to Improve Patient Financial Engagement. [White Paper.] Lake Oswego, OR: CarePayment.

¹⁸ Koenig (2010).

¹⁹ Collins et al. (2015).

²⁰ Herman PM, Rissi JJ, Walsh ME. (2011). Health insurance status, medical debt, and their impact on access to care in Arizona. *American Journal of Public Health*, 101(8):1437-1443.

²¹ Kalousova L, Burgard SJ. Debt and foregone medical care. (2013). *Journal of Health and Social Behavior*, 54(2):204-220.

²² Sommers A, Cunningham PJ. (2011). Medical bill problems steady for U.S. families, 2007-2010. *Tracking Reports*, 28:1-5.

²³ Traub A, Ruetschlin C. (2012). The plastic safety net: 2012. Accessed October 15, 2012 at <http://www.demos.org/publication/plastic-safety-net>.

The PI or Co-PI conducted each interview in person, in a private space (i.e., office or conference room) at the respective hospital site. While most interviews were conducted one-on-one, some were conducted with small groups (2-3 staff members) due to scheduling constraints. Each interviewee was asked to read and sign an informed consent form prior to the start of the interview and was given a copy to keep. Interviews lasted between 15 and 45 minutes. All were audio-recorded, with interviewee permission. Interviewers also took notes during the interviews; these were marked with a code number to protect participant confidentiality. At the end of each interview, the interviewee was offered a \$10 gift card to a locally accessible retail establishment as a thank you for participation.

Basic descriptor information was also collected about the participating hospitals, including the length of time that the hospital had been offering CP, hospital size, and geographic setting. Two categories of length of time offering CP were established by the research team: newer (i.e., offering CP for less than two years) and older (i.e., offering CP for more than two years). Information about hospital size and geographic setting were obtained from the American Hospital Association (AHA; see <http://www.ahadataviewer.com/quickreport/>). With respect to hospital size, per AHA definitions, a small hospital has less than 100 staffed beds; a medium hospital has 100-399 staffed beds; and a large hospital has 400 or more staffed beds. With respect to geographic setting, per AHA definitions, an urban hospital is inside a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget (OMB); and a rural hospital is outside an MSA, as defined by OMB.

2.3. Data analysis

The audio recordings of the interviews were transcribed by a professional transcription company and reviewed for accuracy. Dedoose (<http://www.dedoose.com>), an online platform for qualitative and mixed-method data analysis, was used to facilitate analysis. The study team developed an initial coding scheme that reflected the interview questions as well as a review of all interview transcripts. Using the initial coding scheme, the PI and Co-PI each separately coded one randomly selected interview transcript. Discrepancies between coding were identified and discussed until 100% agreement was achieved, along with agreement on associated revisions to the coding scheme. The Co-PI then updated the coding scheme and re-coded the interview using that scheme. This entire procedure was repeated with a second randomly selected interview transcript. After the Co-PI made final updates to the coding scheme and re-coded the second interview accordingly, she coded the rest of the interviews. The Co-PI prepared analytic memos on each of the key outcomes of focus, as well as other outcomes that emerged from the data. These memos were reviewed and discussed with the PI.

3. Results

3.1. Characteristics of participating hospitals

A total of five hospitals (of the 12 originally identified for recruitment) participated in interviews. Most of the other seven hospitals reported not having time to participate in the study. The characteristics of the five hospitals that were coded for are shown in Table 1. As the analysis found no compelling associations between particular characteristics and the outcomes that were examined, these characteristics are not referenced in the discussion of the findings, below.

Across the hospitals, a total of 23 staff members were interviewed, three to eight interviewees per hospital. At every hospital, the interviewees included a mix of persons with regular contact

with CP patients (n=14 across the hospitals) and persons with other CP-related responsibilities (n=9 across the hospitals).

Table 1. Characteristics of Participating Hospitals

Characteristic	n
Time offering CP	
Newer	1
Older	4
Hospital size	
Small	3
Medium	2
Large	0
Geographic setting	
Rural	3
Urban	2

3.2. *Bad debt and accounts receivable*

In accordance with our hypothesis, across the five hospitals, bad debt was reported to have either gone down or leveled off due to CP—although no interviewee cited specific statistics to support their claim. Statements about the effects of CP on bad debt rates fell into the three categories described below.

Bad debt has gone down. This outcome was reported by staff at two hospitals. One interviewee explained, “Our bad debt went down. We, you know, we saved money, and we had happier customers and happier customers definitely increases your bottom line because they come back.”

Bad debt initially went down but has now leveled off. One hospital reported an initial decrease in bad debt, but then a leveling off, due to the patient debt profiles that the hospital was seeing, including high deductibles for hospital services. A representative explained the situation this way:

“I feel that in the very beginning we got a big benefit, bad debt decreased. That has leveled off some. Some of it is to do with high deductible plans. Some have to do with just balances being totally out of range.... As far as bad debt, in the beginning I saw a huge, huge decrease but now with dollars being so much higher, your accounts higher, charges higher, I don’t – not now.”

Bad debt has stabilized and is no longer going up. Two hospitals reported that bad debt has stabilized. A representative from one of them explained the situation as follows—also with reference to the increase in high-deductible insurance plans:

“I would say in that the bad debt hasn’t gone down, but it has stabilized, which I think is a direct consequence of the program, because I think with all this growth in high deductible plans we would have continued to see the bad debt threshold increase and increase and increase. And I think instead of that balance increasing, as far as bad debt, I think we’ve

been able to keep it sort of at this plateau or this plain and really augment it with the CarePayment program so that it doesn't continue to climb."

In addition to talking about the bad debt rate, several staff across multiple hospitals reported that accounts receivable (AR) are down because the hospital receives payments quickly from CP. For example, one interviewee expressed the view that the most significant change for the hospital resulting from CP was the decrease in AR, because "the funding is there quickly".

However, across hospitals, multiple interviewees pointed out that some patients with CP do not pay their bills and thus their accounts are returned to the hospital. When this occurs, the money that CP had paid for them must be returned to CP, and fees to CP must still be paid for those patients, which impacts the hospital's bottom line. Two hospitals reported adjusting their CP program configuration to address this challenge. An interviewee described the situation this way:

"I think what we've learned over time, one, because we're now opting in people versus sending everybody, the pool of patients that we're sending over is not as large as we anticipated. So the cash flow impact isn't on the scale of what it was originally thought to be when we started. And... because you do still have a certain population that does fall into that recourse category where they never—even though they agree to the program, they never follow through... I wouldn't say we're collecting more money than we would have without it; I would say that we're probably, you know, collecting relatively the same...."

A second hospital also reported making changes to who is eligible for CP, due to the realization that including patients who are unlikely to pay can hurt the hospital financially. An interviewee from this hospital explained:

"...[W]e probably tried to give too many people the opportunity to avail themselves of CarePayment, which in and of itself is fine. But, if a big piece of that population is probably not going to do it, all you've done is increase the cost of the program, because the way the fee structure works...."

3.3. Billing processes and associated cost reductions

Also in accordance with expectations, all five hospitals reported that having CP manage a bill payment plan was beneficial to the hospital. Four hospitals reported that they did not have the staff, skills, and/or systems to manage the internal payment plans that they had prior to CP efficiently and in accordance with all legal requirements. CP gave them the opportunity to offer a payment option that was favorable to the patient and that was managed by a highly capable outside party, making it more efficient and legally adherent. One interviewee explained:

"We are not a financial institution. We didn't like doing monthly payments with patients. They weren't anything that we could... really track very well. So this gave us the ability to offer more flexible payment arrangements and all the things that you know CarePayment's going to sell.... [I]t truly was not something that we could offer our patients before."

While interviewees at one hospital did not report limited capacity to manage a payment plan, staff did report that having CP do this work had resulted in a reduction in the staff time needed to deal with billing and payments. One staff member explained:

“And now that CarePayment is in the mix,... it cuts down on... [our] follow-up done on a guarantor. So, I mean, I definitely think it’s very beneficial as far as production-wise for you as the person working in the accounts, because before, you were following up all these payment plans that are behind [and] are hitting your work pile, whereas now, they’re someone else’s problem.”

In addition, an interviewee from a different hospital reported that due to CP’s role in billing and payments, the hospital was able to reduce the number of staff in the hospital’s soft pay area. It was also able to reduce costs by no longer sending out monthly statements. The interviewee explained:

“...[W]e have people that will come right in and [say]... ‘Don’t send me statements.... Please send me right to CarePayment.’... That’s what I do and so put it right there which saves us costs, too. We don’t have to, you know, send other statements....”

3.4. Charity care and programming for the community

Contrary to our expectation, none of the interviewees felt that changes in bad debt rates, accounts receivables, or other savings associated with CP have had a direct impact on hospital provision of charity care or other community programming. Several interviewees made clear that with respect to charity care, there are independent guidelines for who is entitled to full, partial, or no charity care. One interviewee explained:

“We have our charity guidelines that we have to follow. If the patient doesn’t qualify for assistance—we go by a federal poverty guideline... a percentage of that... then we have a sliding scale. If they do not fall within there, they don’t qualify. So even with CarePayment, I don’t believe we’re seeing more charity help at all.”

Just one interviewee noted that improving the hospital’s bottom line indirectly impacts patients: “...]f you’re improving your bottom line, you’re improving your technology, your, you know, your clinical services or your IT. I mean there’s more money to go places..... [I]ncreasing your bottom line increases your, you know, everything else and [CP] did increase our bottom line, definitely.”

3.5. Competitive advantage

In alignment with expected outcomes, at least one interviewee at each hospital expressed the viewpoint that CP gives—or helps to give—the hospital a competitive advantage over others, because of the satisfaction that patients and their families have with CP. Indeed, interviewees at all hospitals reported that many or most patients who used CP seemed to be satisfied with it. Interviewees offered stories exemplifying patient and guarantor satisfaction, and cited lack of—or few—patient or family member complaints about CP, as well as repeat use of CP by patients, as evidence of satisfaction. Having no interest charge and being able to pay bills over an extended time period were widely cited by interviewees as features that particularly appealed to patients.

For the majority of hospitals, at least one interviewee reported that overall patient satisfaction with the hospital appears to have risen because of CP, although none cited quantitative data in support of this point. One interviewee, for example, noted: “It’s not a question that I think you could directly tie to our patients on a satisfaction survey. We’ve heard stories.” Another interviewee explained the linkage between CP and increased patient satisfaction with the hospital as follows:

“...[Patients are] pleased that we have been able to offer this to them. To have a medical bill loom over them and not be able to make our [internal hospital payment plan’s] three monthly payments, even if it’s a \$1,216 Medicare deductible for our elderly, it is... very hard for them to make that on their Social Security. I think the increased satisfaction of our customers has been a very, very, very, very positive [thing], for CarePayment to be with us.”

Several interviewees made the point that patients are now “shopping around” for their medical services, and that CP helps to make their hospital stand out. One interviewee described the situation as follows:

“More and more places are going to estimates, quotes, so people are shopping. People are looking around to see where they want to go, where the best price is, where the options are. We get people call for quotes honestly and then when we say ‘We have CarePayment to help with your portion’—OK. That’s a nice perk.... That helps because they may have insurance but there’s a lot of high deductibles.... So CarePayment helps.”

4. Discussion

The findings from the semi-structured interviews with hospital staff provide preliminary qualitative evidence for most of the hypothesized hospital-level CP outcomes. Across hospitals, interviewees reported positive outcomes in the areas of bad debt and accounts receivable, billing processes, and competitive advantage. Charity care and other community programming, however, were not reported to have been directly impacted by CP. Two hospitals’ experiences of observing higher-than-expected rates of returned accounts among CP patients, due to non-payment, and responding by changing their CP program configuration, underscore the need (also discussed in recent literature²⁴) for ongoing analysis of collections performance in light of revenue cycle objectives, in order to ensure the best possible revenue outcomes. In response to this challenge, CP has recently made several changes in their service offerings, such as extending term lengths and adding hardship features.

This exploratory study has limitations that should be taken into consideration in interpreting the findings. CP was involved in the selection of the initial pool of hospitals from which sites were recruited and made the initial contact with the sites in the pool. It is possible that this introduced sampling biases that affected the outcomes that were documented. However, CP involvement in the study was necessary to access information about the hospitals, and CP’s participation in recruitment and data collection was minimized to improve data quality and decrease potential bias. Additionally, the findings reflect the perceptions of hospital staff who were selected by a point of contact at each site and who were available and willing to speak with the researchers. As in the case of any study involving self-reported outcomes, social desirability biases may have affected their responses. To reduce potential social desirability biases, the interviewers informed interviewees up front, both orally and in a written consent form, that their responses would not be shared with CP and that confidentiality would be stringently protected.

²⁴ Bayley et al. (2014).

5. Conclusion

Bad debt and payment collection challenges are likely to remain important problem for U.S. hospitals in the foreseeable future. External patient financing options, such as CP, have the potential to reduce hospitals' bad debt and improve payment collection efficiency, particularly when patient repayment patterns are taken into account in the configuration of financing arrangements. Moreover, despite the lack of explicit connection between CP and charity care, it is clear that reduced bad debt and increased cash flow within hospitals can indirectly impact patients in a positive way. Hospital administrators might consider the promise of patient-friendly external patient financing programs such as CP for benefitting both the bottom line and patient care.

About the Authors

Julie Solomon, PhD

Principal and Member
J. Solomon Consulting, LLC
Mountain View, California, USA
julie@jsolomonconsulting.com
+1-408-315-4695

Julie Solomon, PhD is Principal of J. Solomon Consulting, LLC, a program evaluation consultation company based in Mountain View, California. She directs and consults on mixed-method (quantitative/qualitative) evaluation studies, particularly those that involve behavioral and social approaches to health prevention and promotion. She also provides evaluation infrastructure-related consultation and training to non-profit organizations, grantmakers, universities, governmental organizations, and coalitions. Prior to founding her own firm, she worked as a Senior Research Associate and the Director of Training Support for Sociometrics Corporation, an applied social science research company. She has AM and PhD degrees in linguistics from Stanford University.

Laura Lessard, PhD, MPH

Assistant Professor
University of Delaware
Newark, Delaware, USA
LLessard@udel.edu
+1-302-831-6587

Laura Lessard, PhD, MPH is an Assistant Professor in the Department of Behavioral Health and Nutrition at the University of Delaware where she conducts research on policy and environmental change interventions across a range of topics. She is also an experienced evaluator, having conducted or collaborated on evaluations focused on educational, training and health programs. She previously served as Assistant Professor of Community and Global Health at Arcadia University and as Social Scientist within the Nemours child health system. Her training includes a Master's of Public Health degree from Tufts University and a Doctorate in behavioral sciences and health education from Emory University.

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