HealthLeaders Virtual Roundtable

USING PRICE TRANSPARENCY AND SURPRISE BILLING RULES TO YOUR ADVANTAGE

The healthcare industry is barreling toward increased consumerism with its price transparency and surprise billing rules. But it's not enough to simply comply with these rules. Instead, forward-thinking revenue cycles should seize the opportunity to fundamentally reimagine the way they engage with patients and to differentiate themselves from the competition. In this roundtable discussion, revenue cycle leaders will talk about the ways they can manage this shift into a more cohesive and satisfying front-end patient experience.

Katherine Cardwell
Vice President,
Revenue Cycle
Ochsner Health
New Orleans, Louisiana

Jana Danielson
Vice President
Revenue Cycle
Nebraska Medicine
Omaha, Nebraska

Mike Morris
President & CEO
Xtend Healthcare
Hendersonville,
Tennessee

Mike Simms
Vice President
Revenue Cycle
Cone Health
Greensboro,
North Carolina

Alexandra Pecci (Moderator)
Revenue Cycle Editor
HealthLeaders

IPOPBA/GETTY.COM

SPONSORED BY:

Xtend Healthcare

HIGHLIGHTS

HealthLeaders: *How have you used online and digital resources to increase transparency, provide estimates, and give patients financial education?*

Jana Danielson: We have really attempted to leverage the functionality within Epic itself and utilize our website to direct patients to a pricing tool accessed via MyChart. We're also educating our front-end folks using the Epic technology. We are currently looking at open scheduling for financial counselors and allowing the telehealth methodology. If a patient wants to discuss balances, get an estimate, and things along those lines, they can get to somebody really quickly face to face. We're also assessing chatbots right now.

Mike Simms: We were able to do it through Epic. We had the online estimator and basically all the surgical data that we needed to comply with the compliance. A firm by the name of Turquoise Health has reviewed our price transparency and we've been given a five-star rating. In the self-service aspect in our industry, it's kind of like the airlines—everybody wants that digital experience. We're focusing in on the digital experience so patients can preregister on their phones. We have a vendor that we've contracted with that will allow for that and will flow into Epic and all the consent forms and everything can be signed on their phone.

Katherine Cardwell: We're an Epic shop and we have our 300-plus services available both on the ochsner.org site and through our MyChart tool. We encourage our patients to use the MyChart tool because it contains their existing information such as insurance and demographics already. We feel like that's how they can get the most accurate self-service estimate. We've had a chatbot for some time now, and we recently deployed live chat.

Mike Morris: We see a lot of health systems that are not yet offering a compliant price transparency tool—anywhere from 30% to 60% of health systems. Even when a health system is compliant, they don't have the linkage yet to a positive patient experience. I can go online and get a quote, I can input my insurance information, but it's hard for me to understand how to interpret that quote, especially when there is typically an appreciable difference between the lowest and highest reimbursement rates from payers (de-identified minimum and maximum charge requirements). I think a lot of patients will struggle to understand that. As an industry, we've got to figure out how to make this easier. Consumerism is only good when it helps educate the consumer and makes their life easier, not more difficult.

Simms: Let's face it, it's not like going to Jiffy Lube where you obtain a precise estimate. Patients do not understand about CPT codes. They don't understand about the complex surgical procedures. That's why it's very important to have disclaimers indicating that it is only an estimate. The public does not have a general knowledge of patient out-of-pockets. We need to do a better job in educating the public about their healthcare benefits that they have selected.

> **"The public does not have a general knowledge of patient out-of-pockets. We need to do a better job in educating the public about their healthcare benefits that they have selected. "**
>
> —Mike Simms, Vice President, Revenue Cycle, Cone Health, Greensboro, North Carolina

Danielson: We're going to have some very clear, concise scripting and ways for people to answer questions, especially if something needs to go to arbitration. We do have our plans marked whether they're in network or out of network, so that information can be shared with the patients real time or up front. And I think those things, just as time goes on, are going to become even more important than they are today.

HealthLeaders: *How have you been able to use the COVID-19 pandemic as a launch point for digital engagement, pre-access services, and low-touch tools for patients?*

Danielson: We've been thinking through the ability for live chats, chatbots, and looking at the opportunity for direct scheduling with counselors. For an oncology patient, for example, we always make sure we do a meet and greet in advance, explain to the patients what their benefit plan looks like, what we're anticipating based on what we know today. Some of that can be scheduled and done remotely, which makes it more convenient for the patient. It makes it more convenient for the counselor. We also made sure that we can get our signatures through remote methodologies and allowing patients to upload financial service–related documents into the portal.

Cardwell: From a COVID perspective, we moved forward quickly with our mobile check-in adoption. Historically, we had a low adoption rate of mobile check-in mainly due to things like the location services having to be turned on within the app. When COVID hit, we turned off most of our kiosks, and that really drove a lot of patients to the e-precheck and mobile processes. We also have our contactless or a low-contact arrival process where patients call us when they arrive. We can register them via the phone and shoot them a text or a call when it's time for them to come in. We give patients the options to either wait in their car or come in and wait in the lobby.

Simms: From a remote perspective, I'm glad to say that we thought ahead. All of our staff was remote in July of 2019, so before the pandemic. As far as digital engagement, telehealth has zoomed. Recently we have seen a decrease in telehealth visits as patients do prefer when they can to visit their physician in their office.

Morris: I think it's interesting because two years ago most people would have viewed interactions with their health provider as being face to face only. Now with the pandemic and with people somewhat hesitant to go to a hospital, they're much more willing to interact with providers via online tools. So, I think the adoption of telehealth and even the adoption of price transparency has likely been accelerated because patients have had to figure out how to interact with a provider without necessarily being face to face. Additionally, many offices have digitized questionnaires, registration forms, consents, and other paperwork to reduce physical contact.

HealthLeaders: *How have you moved price transparency from an IT exercise to a way to market your services and drive more patients into your health system?*

Simms: It's probably too early for that. What it can do though, quite frankly, is shift volume away from you if you're [higher priced] than the competition. From that perspective, we need to compare our pricing with other hospitals in our area to make sure that our pricing is in line.

Danielson: I think marketing for price transparency is really in its infancy stage. There are certainly some things that we do market, and we make sure that we're priced within the market, such as plastic procedures, elective procedures where we have individual agreements, and offering cash prices for radiology.

Morris: I think there's an opportunity for microtargeting. And that is when you can identify and market to individuals that went to your website and utilized your price transparency tools, other tools on the website, or other medical reference material. Additionally, there is outreach, brand awareness, and brand loyalty opportunities to help patients better understand and interpret the price that they saw online. Patients, for the most part, don't want to switch from provider to provider, as long as they feel like they're getting a reasonably good price for the service that they're seeking. Moving from price transparency to proactive marketing and helping people understand the price that they saw online is the next big wave that, as providers, we have to figure out.

HealthLeaders: *Let's talk about compliance: Are you fully compliant, and if not, do you plan to be?*

Danielson: For all of the estimates and that 300-plus [shoppable services], we're definitely compliant. We didn't hide anything or use any technology in order to do so.

Simms: We're fully compliant.

HealthLeaders: *How do you ensure that the data that you're using to deliver patient estimates is always accurate, up to date, and robust?*

Cardwell: We built templates and made sure our contracts were loaded and up to date. We also do analysis on the estimates that are incorrect to determine the root cause. We measure our accuracy percentage as a main KPI. If an estimate is within $50 or 5%, we consider the estimate to be accurate.

Simms: Cone Health has a revenue integrity department that makes sure that everything is updated. Since everything is in Epic, it updates it automatically. Some things we have to update as far as our estimate templates are concerned, but for the most part, I think we're going to be able to stay current.

Danielson: One of the updates that's coming is that estimates will auto-update with different benefit changes and things that are coming in. I think that's going to be extremely beneficial. There are things that you may not even think about necessarily being automated—like concurrent coding, so we can drive a working DRG into the system to help with estimated length of stays and the expected discharge date and eventually create inpatient estimates before the patient's discharged.

HealthLeaders: *Has delivering estimates made the revenue cycle run more smoothly?*

Cardwell: One of our main consumerism/pricing transparency metrics is the percentage of all patient cash that comes in before or at the point of service. That's a number we track year over year to ensure that that number is growing, that we're collecting more and more up front. A couple of years ago we came up with different ways to increase this metric, such as placing phone calls or sending a MyChart message to our high-deductible health plan patients in the clinic for them to pay online ahead of time. We call it a deposit versus an estimate.

Morris: With price transparency in particular, a patient's understanding of their financial responsibility and confidence in the estimate's accuracy drives their willingness to pay pre-service. I expect an increase in point-of-service collections as consumers get more familiar with price transparency and as they gain confidence in the numbers they see when they look online.

Danielson: I kind of smiled, Katherine, when you said the word deposit. We started implementing the deposit against the deductible three or four years ago but called it something different. Later, we actually changed the words to "deposit against the deductible" so that people had a better understanding.

"One of our main consumerism/pricing transparency metrics is the percentage of all patient cash that comes in before or at the point of service. That's a number we track year over year to ensure that that number is growing, that we're collecting more and more up front. "

—Katherine Cardwell, Vice President, Revenue Cycle, Ochsner Health, New Orleans, Louisiana

HealthLeaders: *Let's switch gears to surprise billing. How are you all preparing for that rule? Have you done anything yet? If so, what, and what do you think still needs to happen?*

Simms: We're going to need more staff and we're going to need some legal resources for appeal and arbitration. We're educating our staff. We're going to look at what we're receiving now as far as some balanced billing issues and estimate what that volume might be going forward to determine possible resources needed. We'll also use as needed our vendor relationships that we already have in place that do some denial work for us. I would assume vendors like Xtend will see an increase in denial work.

Cardwell: Our goal is to let the patient know as early as possible in the scheduling process that we are out of network. We've set our payers up in Epic with an out-of-network flag to alert the schedulers and registrars. We flag the employer groups that we know about, the larger ones that we know are out of network. And I think we have a more consistent process when the patient is scheduled for a higher-dollar service that routes through our pre-service department and financial clearance process. Our patients scheduled for a clinic visit are more challenging to find ahead of time. But our financial counselors do proactively reach out to the out-of-network clinic patients ahead of time, and also the patients sign a facility disclosure form which indicates if we are in or out of network with their payer.

HealthLeaders: *It sounds like you're already letting people know that they're out of network, but is it going to be a huge logistical task to stop balance billing?*

Cardwell: Yes, we will need to evaluate various safety nets to put in place, whether it be manual or automated.

Simms: That's going to be a challenge. Of course, if you have the plan set up, but again, things can fall through the cracks, and so we're just going to have to monitor it. There may be situations where the patient does get a statement, and that's another thing that's going to cause confusion. And if we can't bill a patient, the patient might think, "Oh gee, everything is fine. I'm not getting any statements." If we win the appeal, the patient might get a statement for their out-of-pocket a year later. So, we have to consider patient satisfaction in this process.

HealthLeaders: *When it comes to doing that financial education outreach counseling, what are some things that you've put in place in terms of surprise billing and price transparency to get ahead of this legislation?*

Cardwell: We have pamphlets, videos, and a financial resources webpage on our website. We have been very focused on the patient financial education piece. Our patients can also schedule an appointment with a financial counselor. We try to communicate as much as we can electronically and through digital means. We've recently gone live with a text message reminder that says, "Hey, just a reminder your bill's due" for our patients if they haven't paid their bill and it's past 60 days. We're trying to really learn about our patients and how they want to be communicated with—is it text, is it email—and really trying to provide as much information and education as possible that's convenient for them.

Simms: From our pre-service center that we have for all scheduled services, we're making the calls before the date of service and we're going through the registration and giving them the estimate and advising them of their plan benefits. We also talk to them when they come in for the service if they decide not to pay over the telephone in the pre-service center. We haven't done any videos, but that's a great idea.

Morris: That's really smart. The more you can invest in patient education and patient advocacy pre-service, the smoother the revenue cycle function through full bill adjudication will be, especially with all the changes that are occurring from a legislative and regulatory perspective.

HealthLeaders: *Katherine, have you found that with resources like educational videos, the revenue cycle is working more smoothly or the patient experience is better?*

Cardwell: I agree with Mike Morris that the patients who we communicate with up front with an estimate and an option to pay through MyChart/electronic means or a phone call have a better experience and have a less likelihood of going to bad debt. It's much easier to collect the money up front prior to service or at the point of service, and I think it's a better patient experience. Patients don't like to get a large bill after they've had surgery without any kind of warning or communication. I do think patient financial education is important to the patient experience.

HealthLeaders: *A bad billing experience can make or break what a patient thinks about a facility.*

Cardwell: Exactly. We always remind our team members that the patient could have the best clinical experience and then the billing can just ruin their whole patient experience.

Morris: Oftentimes that underlying frustration with the provider is really a function of the insurance plan they have.

Cardwell: Right. Patients have several questions about their benefits, and they do not always have a good understanding of their plan and benefits. Even though the patient selected the plan, they don't always understand why they owe a balance if they have insurance. Instead of telling the patients to call their insurance company, a financial counselor will call the insurance company while the patient's there (or do a conference call) to help them navigate through their question. We've taken a more active role in helping the patients sort out their insurance piece.

"We started implementing the deposit against the deductible three or four years ago but called it something different. Later, we actually changed the words to "deposit against the deductible" so that people had a better understanding."

—Jana Danielson, Vice President, Revenue Cycle, Nebraska Medicine, Omaha, Nebraska

Simplify the revenue cycle for your staff and patients.

Our expertise and technology improve cash flow and experiences for health systems, hospitals, and physician practices.

Xtend Healthcare

Discover what's possible at:
xtendhealthcare.net