healthleaders

THE GREAT PAYOFF

TRANSFORMING PATIENT SATISFACTION ROI IN THE REVENUE CYCLE

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A unique discussion on transforming the patient financial experience to uphold ROI in the revenue cycle.

Nashville was more than just history, music, and food as revenue cycle leaders converged to discuss their organizations' patient financial experience strategies with HealthLeaders.

As a result of new regulations, workforce considerations, and technology needs, revenue cycle leaders have turned an eye to creating a more positive patient financial experience—but are they seeing their hard work pay off?

An emerging theme from the conversation was the emphasis on patient education and how that plays into the patient experience. Patients don't always understand the complexities of the billing process, such as payer contractuals, and do they really need to? Patient education takes an organization time, effort, and money to do a good job of informing patients about their financial responsibilities, yet it is essential to creating a patient-centric experience.

Read on to learn more about our recent Nashville roundtable discussion and discover the strategies the participants are using at their organizations to drive the patient financial satisfaction ROI needed to survive and thrive.

The Experts

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Reviewing billing processes.

How patients are billed plays a large role in the overall patient financial experience and satisfaction. Because of this, these revenue cycle leaders said that helping patients navigate the billing process is essential in creating a positive patient financial experience. While adding bill-pay technology is essential, patient education has been key for these leaders in ensuring a ROI.

KEY TAKEAWAYS

> Create billing statements that patients can understand.

> A digital front door is a necessity for a retail-like experience.

> Determining patient preferences for how they receive bills is essential.

WHAT ARE THE PROS AND CONS OF THE CURRENT BILLING PROCESSES YOU ARE SEEING IN THE HEALTHCARE INDUSTRY?

"I think it's making it more like the Amazon experience. People want to go online and pay or have e-statements or get text messages, and we're just starting to move into that space. But to also do that and not make it confusing for the patient, because no matter how hard you work on your statement, patients don't always understand. We're trying to put a lot of thought and work into that, having focus groups look at statements, because when we look at it, it makes sense, but when the patient gets it, they still have questions.

And I think that whole digital front door is huge, especially with the change in the market. The baby boomers coming out and more millennials coming in. They want that experience. They want to pay from their phone. They don't want to have to always get a paper statement in the mail or write a check. Those things are changing in the industry.

What keeps me up at night is, are the bills always accurate with the electronic posting that you have in place? And then if you are manually posting, people make mistakes, which lends into the whole surprise billing. We've had mistakes made where we're billing a patient for something that should have been written off or appealed because these codes that are coming across from payers aren't used standardly, even though they're supposed to."

— Mary Wickersham, Avera Health

"Just the number of different products out there that patients or employers can choose has most certainly seemed to add to the levels of complexity that cause downstream issues. In our EHR, so much of the accuracy of the billing process further downstream relies upon making sure we've properly identified the exact product that the patient has so we can pull in the proper benefits and proper out-of-pocket amounts." **— Mary Neal, Ochsner Health**

Bettering the patient billing experience.

Paper statements work, but the digital age has pushed organizations into not only wanting to add in that digital billing experience, but they are needing to. Patients are now expecting both digital and automated options when it comes time to pay their bill. The panelists said that when first taking that step toward a digital billing experience, patient education is vital to success. Organizations can offer the most sophisticated bill-pay technology, but what use is technology if a patient doesn't know how to use it?

KEY TAKEAWAYS

- The last touchpoint of the revenue cycle is the billing experience. If it's not great, even the best clinical experience won't matter to the patients.
- As much as revenue cycle leaders try to automate, the automation is only as good as the people who build, check, and audit it.
- Patient education about their bills is crucial for a successful financial experience. Yet it takes time, effort, and money to do it well.

WHY IS IT IMPERATIVE TO IMPROVE THE PATIENT BILLING EXPERIENCE? WHAT FEEDBACK ARE YOU GETTING FROM PATIENTS, AND WHY DO YOU NEED TO IMPROVE THE BILLING EXPERIENCE?

"In terms of the legislation that's being implemented with pricing transparency and surprise billing, it's important to get the patients involved in their patient financial journey. Ensuring that they understand what they're seeing when they get a bill and knowing what questions to ask is important. And even helping them anticipate what that bill might look like before they get it allows them to understand their benefits ahead of time. At Ochsner we proactively provide estimates to our patients prior to being seen and this helps them understand the differences between the charges, contractual allowances, and their patient responsibility."

— Savanah Arceneaux, Ochsner Health

"From a market share standpoint, patients—depending on their insurance— they can choose to go to a competitor and if they have a bad financial experience, they may go across town to the competitor, because they feel like there's more focus on the billing experience than there used to be. There's a lot more scrutiny because of price transparency and people want to challenge everything, which is good, but I think there's just been that shift and the light is shining more on the financial side.

We have outside providers that come in and treat patients. The anesthesia group that we have, it's not Avera. But they're putting people to sleep in our hospital and they don't understand that they're not Avera, so they get a separate bill from them and that doesn't make sense.

But with the No Surprises Act, we're going to have to put their charges on our estimate so the patient has that full picture—how are we going to figure all that out?"

— Wickersham

"We're talking about this being a buying and billing experience like Amazon—that patients want and you want that digital or engaged experience. I guess what I'm hearing is it starts with the patient not being educated.

They're not educated about their billing experience and it's complicated. There are all these inputs that go into it—you have your insurance, you've got your provider, you've got your hospital fees, and you potentially have your physician fees, and you have your anesthesiology. You have all these complex things and then you are supposed to explain this to the patient and you're explaining something that's very expensive. Never do you get a bill and say, 'That's cheaper than I thought it was going to be.' It's always higher. Where do you start?

In theory, you have to educate the patient about it, but that takes a lot of time and it takes a lot of money and things change rapidly."

— Brian Brown, CarePayment

"As much as we try to automate to lower the cost, the automation is only as good as the people who build it and validate it regularly."

"Not every patient has the financial literacy or literacy in general to grasp even the most simple concepts sometimes, so that can make it harder on us to educate.

I think when you're speaking about the consumer experience in general, even taking healthcare out of it, we don't dissect the different pieces and parts and say, 'Well, the care was great, but the billing part was just okay.' You're evaluating that product or service as a whole.

If the financial piece is not where it needs to be, one could only assume this is representative of the level of quality of everything else that you're going to get."

— Neal

"I think that's where you're being judged more in revenue cycle. The last touchpoint is the billing experience. If it's not great, it doesn't matter your clinical experience."

— Brown

"There's an overarching misunderstanding in every community, they look at our charges and they're like, 'Why are they so high? How can the hospital not be making money?' There's this thing called contractuals. It's like there needs to be some big news special explaining healthcare, charges, contractuals, payer contracts, because people don't get that, and I wouldn't understand it either unless I worked in it."

— Wickersham

"As much as we try to automate to lower the cost, the automation is only as good as the people who build it and validate it regularly.

It's difficult when you're trying to explain to a patient that maybe there was an error on their bill because not every single claim gets a human looking at it for accuracy before it goes out the door.

There's good, legitimate reasoning behind that, but patients don't want to hear, 'Oh, this is wrong because it just ran through the machine, and this is what bill we sent you.'"

— Neal

HOW DOES YOUR EHR WORK TO STREAMLINE THE PATIENT FINANCIAL EXPERIENCE? HOW DO THOSE TWO WORK TOGETHER?

Utilizing EHRs to streamline the patient financial experience

EHRs create mass amounts of data on patients. So how can revenue cycle leaders use this data to help streamline and better the patient financial experience? The panelists say that utilizing the EHR to create a digital front door has been a game changer for the patient experience.

"We've been focused on opening that digital front door to our patients. Ochsner's EHR Epic utilizes MyChart, a patient portal, that pulls everything from the Epic EHR into the MyChart patient portal. We've been able to utilize this for our estimates. As soon as an estimate is finalized, it goes to the patient's MyChart. They can pay on their own or if it's over $250, our FCC department will contact the patient.

MyChart not only allows patients to see estimates for scheduled services, but patients can also create their own estimates in MyChart. We have over 300 shoppable services for patients to create estimates.

Aside from that, we've used MyChart for our registration processes like e-pre-check. Location services also allow the patient to use MyChart to let us know they have arrived and check in for their appointment from their phone. Patients can also pay their bill through MyChart. It's important for us to get the patient involved in every touchpoint of their health care experience." **— Arceneaux**

"Ochsner is very, very into the portal. We have a lot of self-service. We're one of the highest utilizers of self-scheduling of all the Epic clients and especially during COVID.

A lot of patients went online and signed up for MyChart trying to get an entry point to book a vaccine appointment. We had a lot of patients who maybe had seen the marketing and didn't really take an interest, but when they had that need that went unfulfilled, then all of a sudden, it's how can I get in? I'll try the portal.

I personally think there's usually one or two functions that as a patient that's what pushes you to the portal. Maybe you just hate calling to pay your bill or you hate waiting on hold to get an appointment. Whatever it is, you may opt to try the portal and then when you get in, you see there's a lot of great functionality that makes it easy to use.

We were doing some analysis of patients who call in to our customer service department to pay their bill who happen to be active on the portal. We wanted to know, why are they active on the portal, but not choosing to utilize that as their payment method? Is there something we can do from an education standpoint or to understand better how to move those transactions to the portal?" **— Neal**

"Part of your clinical experience should be when you go through a procedure, this is what's going to happen. This is what your recovery is going to look like. This is how long you're going to be out of work. This is what you need to financially expect.

You have care coordinators, but you don't have that financial aspect and I think part of it is we're so focused on managing to cost to collect that you don't have that time to say, "We need to invest in the patient education." **— Brown**

KEY TAKEAWAYS

> The plethora of data can help patients self-serve, such as creating their own cost estimates.

> Utilizing data can help customer service teams customize payment options and migrate patients to self-service.

Working with, not against, cumbersome regulations.

Regulations like the No Surprises Act has put a burden on revenue cycles. Staff now spend more time creating good faith estimates and updating files for price transparency. Although regulations like these are created with good intentions, is it translating to a better patient experience? The panelists say that streamlining workflows and educating patients on new and updated regulations drive their ROI.

LET'S TALK ABOUT REGULATIONS AND THE NO SURPRISES ACT. WHAT ARE YOUR GENERAL THOUGHTS AND WHAT REQUIREMENTS HAVE BEEN THE EASIEST TO IMPLEMENT?

KEY TAKEAWAYS

> While regulations tend to have good intentions, they are not always easy to implement and operationalize effectively

> Regulation-related duties are putting the squeeze on the revenue cycle workforce, so revenue cycle leaders need to work to avoid administrative burdens.

"I think it has good intent. Bad process. I think for us, we were lucky, because obviously it applies to emergency room services and CareFlight and all that, but if we don't have any providers that aren't enrolled where the facility is enrolled, the providers are always in and the facility is always in or they're both out. We don't have a lot of patients where we have to disclose that. It's more about the estimate, the additional estimate requirements and then the ambulatory. We had to hire three or four additional FTEs just to comply with the ambulatory estimates." **— Wickersham**

"We have some external providers, but we don't balance bill, so that wasn't something we had to put a lot of time into. Regarding estimates, we've always had a robust financial clearance policy. We were already providing estimates to all our self-pay and insured patients for radiology, surgical, and high-dollar clinic services. What was challenging for us was adding office visits and labs and ultimately, we utilized a third-party vendor to assist with the additional 3,000 patients needing self-pay office visits a week. Additionally, we have a big outpatient rehab therapy group throughout the system, so creating PT/OT estimates has been challenging as Epic doesn't have functionality to create one estimate for reoccurring services making it a manual process.

Most recently, we had to pull compliance in to help us gain a better understanding of what is being asked in terms of the convening provider charges. Who is responsible for having information regarding all possible billed charges and giving that estimate to the patient? The way that we've interpreted it is whoever is scheduling the appointment needs to provide the estimate to the patient.

Compliancy of the details on the estimate letter was easy for us [to implement] because of the Epic functionality. For example - NPI, TIN, provider name, and where the patient is being seen was easy to pull in. A variety of things that we didn't have on our estimate prior to the legislation.

We also saw success with implementation due to the input from teams all over the system like patient access, billing, IS, and legal. It took multiple teams and support from leadership to ensure compliancy with the No Surprises Act."

— Arceneaux

"Whenever new regulations roll out, I feel like it goes back to the education piece. I think the lawmakers are listening to the patients and they see that there's a problem and they have good intentions to try and fix it, but I would guess the majority of them don't understand the complexities of what we're dealing with. What we end up with is a vague regulation where we understand what we think is the intent, but there are so many boxes to check in actually implementing something." **— Neal**

"What I've heard from providers is the intent isn't a bad intent. How it was created and how it was forced down to providers with very little time to prepare for it— thinking that we could all snap our fingers and things get done is very out of touch for people that are making these laws or putting these into place." **— Brown**

"The future expectation is for the healthcare systems to digitally provide the estimate to the individual's plan for insured patients, but there's no legislation requiring the payers to increase their digital front door. Although Ochsner is already providing this information to our insured patients as part of our financial clearance policy, we need these requirements put in place to allow us to deliver the information to the payer the way that they're asking us to." **— Arceneaux**

"On the regulation, I think it's interesting what we're seeing from our side. We're seeing states regulate the maximum amount you can collect from a patient on a monthly basis. There are about five states that have mandated in the patient financing space that providers have to offer payment plans but the payment plans cannot exceed 5% of AGI, the patient's monthly adjusted gross income.

Providers are saying how do we get the patient's AGI? You now have to solicit from the patient what is your adjusted gross income, monthly gross income, which is an education thing. Patients don't know that.

It's a trend we're watching because they're really saying, 'Hey, you can charge for healthcare but it's going to be limited to 5% of your gross income,' which is—you think of how that changes your collection agency?

There's a ton of regulation and compliance that is holistically getting at what the patient owes which changes how we approach or look at that patient financial experience. " **— Brown**

"The future expectation is for the healthcare systems to digitally provide the estimate to the individual's plan for insured patients, but there's no legislation requiring the payers to increase their digital front door."

Navigating the state and payer compliance pressures

The focus on regulatory and compliance pressures continued as the roundtable took a deeper dive into workforce, staffing, and other ways of creating a positive patient financial experience. One common thread was that state and payer regulations tend to be the most complex.

WHAT OTHER COMPLIANCE PRESSURES HAVE IMPACTED YOUR ORGANIZATION'S PATIENT FINANCIAL EXPERIENCE?

> "We don't have the expertise on the regulations for every state. We're looking at different ways to help stay on top of this."

"We have been in multi-states for a while, and we have started our own managed Medicare product.

We don't have the expertise on the regulations for every state. We're looking at different ways to help stay on top of this as we continue to partner outside of Louisiana. We have a team member who will go through and scrub all of our managed care communications and compile an executive summary of pertinent updates. It's much more efficient than having all of our leaders scouring multiple newsletters and updates for things they need to know." **— Neal**

"There's hundreds of other providers that are going through the exact same research that need the content summarized, that need to distribute it and digest it. We always look at it from a clinical perspective. We don't look at it from financial operations and it's there where there is a lot that's coming: No Surprises, good faith estimates, all this stuff that's coming down the pike." **— Brown**

"We have managed facilities that are part of the Avera network, but they're not owned by Avera. They basically pay a management fee and then they can reach out for help. So they lean on us to say, 'Explain this regulation to me and what do I need to do to operationalize it?'" **— Wickersham**

KEY TAKEAWAYS

- Each state may have different billing regulations, which can make it that much more complicated for a large health system.
- Payer regulations can be the most burdensome to keep up with. Revenue cycle leaders need to have regulation changes curated and summarized in a digestible way to stay compliant.

Utilizing technology to fill labor gaps

One of the biggest drivers for adding new technology has been workforce shortages. The roundtable took a look into how new technology has affected both the onboarding and recruitment of new staff. The common thread of education was once again touched upon, as panelists said organizations need to create an educational pathway for new staff into healthcare revenue cycle.

HOW HAS TECHNOLOGY BEEN IMPROVING OR COMPLICATING RECRUITMENT AND ONBOARDING OF NEW BILLERS, AND HOW HAS THIS AFFECTED THE PATIENT FINANCIAL EXPERIENCE?

KEY TAKEAWAYS

- It's a necessity for new revenue cycle staff to be comfortable with technology.
- Revenue cycle leaders need to be ahead of the game and offer new employees incentives as hourly rates have gone up for most industries.
- Creating an educational pathway for new talent is essential.

"I don't know that we can always reliably say we have to find someone who has billing experience. You might be looking for somebody who has some financial, some banking, the competency to deal with this type of technical information but maybe haven't had that direct billing experience who are comfortable doing remote and Zoom." **—Neal**

"I've always thought for the longest period of time healthcare revenue cycle and financial operations is something that isn't more broadly talked about enough at the collegial level or community college level. There's not a pathway of having to go into revenue cycle or go into financial operations. And so then we don't have people we can get directly from those sources. You have to create a pipeline and that's one thing that we don't have. How do you get into healthcare revenue cycle?

Then you have companies that they're in the same talent vortex as well and so they're coming and stealing people and making it hard for providers. They're going and getting people that have been in for 10 or 15 years. They're self-educated through the process. And then it's like we just lost 15 years of knowledge to a big vendor and there's not a pipeline of folks. There's not an educational pathway." **— Brown**

"That's the problem. You don't stay at a job very long like the workforce today. The average tenure is not what it was so you're not learning as much.

How do we make more structure around a career ladder to where we set some clear expectations about, if you stay in this department when you're here two years, then here are three options [in which] you could step forward into and here's what you need from a performance review standpoint or from a knowledge or education standpoint. That's probably something that we're lacking in that the activities of the pandemic haven't allowed us much extra time for.

But something that we want to focus in on is being a little bit more prescriptive because sometimes I think when we lose staff, it's because they just don't know what's next. There are more questions than answers." **— Neal**

Food for thought

The roundtable closed out the discussion with final thoughts from each participant. Takeaways included the emphasis on patient education and communication, as well as striking a good balance between technology and your human resources.

WHAT'S ONE TAKEAWAY THAT YOU WOULD WANT YOUR PEERS TO UNDERSTAND ABOUT THE PATIENT FINANCIAL EXPERIENCE AND THE STRATEGIES TO MAKE THE REVENUE CYCLE PATIENT-CENTRIC?

"Ensuring the resources we have are meaningful to the patient to allow them to own their patient financial journey. As leaders, we talk about adjusting our communication styles to our teams, but how can we do that for our patients as well?

We should explore different opportunities for those who are less financially literate to understand available resources and give them the chance to be part of that journey." **— Arceneaux**

"We serve a very important part, all of us, in care delivery that is seen through the lens of many people as nontraditional. They don't think of financial operations—revenue cycle."

"How can you do things to educate your patients without taking a ton of time that people don't have? Can you leverage different departments? Or where are those touchpoints where we have the patients that are maybe more clinical that you could start to turn? Or at least get some sort of word in about the financial experience because it's not just us that are touching the patient." **— Wickersham**

"It's obviously no secret that you have to embrace the technology and the innovation, but it's important to strike that good balance between the tools and the human resources because obviously you cannot just 'set it and forget it' on your workflows, everything touches the patient." **— Neal**

"We serve a very important part, all of us, in care delivery that is seen through the lens of many people as nontraditional. They don't think of financial operations—revenue cycle. And I think from my perspective, we can't let that hold us back from bringing the technology that we need to the patients and understanding that there's many different preferences in how they engage.

There's a technology desire to make it more efficient, both the consumer and the staff, the provider staff that's working in it. And there are some good technologies out there and good approaches that I think can be used to enhance healthcare." **— Brown**

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