PATIENT FRIENDLY BILLING UPDATE:
IMPLEMENTING THE PATIENT CENTRIC REVENUE CYCLE

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Director, Healthcare Finance Policy, Revenue Cycle MAP
HFMA
Overview: Patient Friendly Billing℠

Patient Friendly Billing Project Research Report

Key Revenue Cycle Competencies

- People
- Processes
- Technology
- Metrics
- Communication
- Culture
Overview: Patient Friendly Billing℠

Patient Friendly Billing Project
Research Report

Key Revenue Cycle Strategies: high regard for revenue cycle customer service that resulted in increased patient satisfaction and improved revenue
The Model Must Change

**Historical Model**

- Gather basic info before & at the time of service.
- Most billing processes are post-service, amounts due based on data gathered after service, calculated retrospectively.
- Patients notified of financial obligations after insurance is billed & paid.

**The Now & Future**

- Gather info before & at time of service. Prospectively calculate expected out-of-pocket costs.
- Providers bill at or right after time of service. Many times, patients know in advance what they owe & agree on terms.
- Insurance bill verifies what the patient already expects.

**Pre-Service:**
- Prospective Data Gathering and Processing

**At Service**

**Post-service:**
- Retrospective Data Gathering and Processing

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**hfma**

healthcare financial management association
The Patient-Centric Revenue Cycle Roadmap

Engaged Patient
- Coordinated Care
- Coordinated Financial & Clinical Care
- Compliant Clinical Documentation

Engaged Consumer
- Ease of Access
- Improved Consumer Service
- Improved Quality

Satisfied Customer
- Appropriate Payment
- Effective & Efficient Account Resolution
- Decreased Cost to Collect
Patient As Consumer Themes

• What has changed in financing healthcare?
• How do I buy without a price tag?
• Is this about politics or policy?
What Has Changed?

• Personal financial accountability

• Higher deductibles and cost sharing

• Consumers in unfamiliar territory
Where Do I Find the Price Tag?

- Patients choosing among providers and insurers
- Shopping in a store with no price tags
- Consumer making cost vs. quality buying decisions
Politics or Policy?

• The new reality is still unfolding

• Patient-consumers are reshaping the marketplace

• There will be a new way of paying for healthcare

• All have to make adjustments, including providers
Time Of Service Segment
The Patient’s Perspective

I say the glass is half full;
You say the glass is half empty

Who decides who is right and who is wrong?

The Moral: the patient’s perspective is the patient’s reality!
The Changing Demographics

Baby Boomers and Seniors are active, computer literate, demand service, transparency and value for their money, have free time.

Parents with children, single middle-aged adults are high tech oriented, demand mobile access and favor social media over traditional media; cost sharing issues.

Teens and young adults are totally into social media and text messaging, lack experience with healthcare systems and may not see value in traditional insurance products.
Consumers Want Better Price Information

“Participants repeatedly said they wanted to see a resource, or ask their doctor, to better understand what a particular test or procedure would cost before they agreed to it, and wanted to comparison shop among providers when possible. They said that they also wanted the ability to know what a treatment should cost before they agreed to it, and needed more transparent information on price in order to do this....They were very interested in efforts to share information on price and quality.”

“Somebody has to do something, and it’s going to be—and it has to be—you.”

Former Senator and Senate Majority Leader
Bill Frist, MD
Speaking at ANI 2010
Transparency Drivers Today

- Rising deductibles and out-of-pocket payments
  - Continued growth in employer-sponsored high-deductible health plans (HDHPs)
  - High exposure to HDHPs in ACA plans
- Narrow networks
- Employer pressure on private payers & providers
- Growth of third-party transparency tools
Cost and Price Are Not the Same

Cost, charge, and price should not be used as interchangeable terms.

- **Cost** varies by the party incurring the expense.
- **Charge** is the dollar amount a provider sets for services rendered before negotiating any discounts.
- **Price** is the total amount a provider expects to be paid by payers and patients for healthcare services.
An Actionable Definition of Price Transparency

Readily available information on the price of healthcare services, that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.
Price Transparency in Healthcare

- Clarifies basic definitions that are often misused
- Sets forth guiding principles
- Establishes roles for payers, providers, others
- Reflects consensus of key stakeholders

http://www.hfma.org/dollars
Transparency goals for consumers

• Consumers will:
  • Know how to get a price estimate
  • Understand what the estimate includes (and excludes)
  • Be able to comparison-shop among providers
  • Improve their ability to make healthcare decisions based on value
  • Have more interest and be more engaged
Educate Consumers

- Describes how to request price estimates, step by step
- Clarifies what estimates may or may not include
- Explains in-network and out-of-network care
- Defines key terms
- Available for posting on your website at no charge
- Hardcopies available for purchase in bulk at a nominal price through AHA’s online store

http://www.hfma.org/consumer guide
Or at www.ahaonlinestore.org
Provide Simple, Clear Estimates for Self-Pay Patients
Blue Consumer Transparency Solutions: Meaningful Cost Comparisons

- The Blues’ data assets are the foundation for a user-friendly customer experience

**BLUE COST INITIATIVES**

Blue national data includes cost information for **402 of the most commonly billed procedures:**

- 34 Inpatient Treatments (knee replacement)
- 96 Outpatient Treatments (ACL repair by arthroscopy)
- 149 Diagnostic Treatments (CT scan, MRI)
- 123 Office Visits (annual exams, immunizations)

Expansion to more than 1,600 treatment categories will include allergy, physical therapy, immunizations and dialysis
Blue Consumer Transparency Solutions: Robust Quality Measurement

- Blue provider quality initiatives ensure member access to meaningful quality information

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<th>Provider Facility A</th>
<th>Blue Distinction</th>
<th>Knee Replacement Total Cost</th>
<th>Compare</th>
<th>Mileage</th>
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<td>8 patient reviews</td>
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<td>You Pay $3,000</td>
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**Blue Physician Recognition (BPR)** provides physician quality improvement and recognition information

- **Patient Review of Physicians (PRP)** allows Blue members to read and write reviews of their doctor and other professional providers

- **Blue Distinction Centers/Centers+** are facilities recognized by Blue Cross Blue Shield for their expertise and efficiency in delivering specialty care

- **Hospital Quality Measurement (HQM)** displays third-party hospital quality information
myCigna Mobile App
Your Health Has Met Its App.®
The myCigna Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere.

Download it today from the App Store℠ or Google Play™.
Find a doctor, dentist or health care facility
View ID card information for the entire family
Review deductibles, account balances and claims
And, much more!

Source: https://my.cigna.com/web/public/guest

But when it comes to costs for tests or procedures:
“Not enough Cigna customers treated with your plan type to calculate costs”
Direct Contracting with Centers of Excellence

Sources:
1) http://thehealthcareblog.com/blog/2013/10/18/walmart‐moves‐health‐care‐forward‐again/
2) http://my.clevelandclinic.org/about/cleveland-clinic/newsroom/releases-newsletters/lowe's expands heart healthcare benefits
Every day, healthcare professionals conduct sensitive financial discussions with patients. But there have been no accepted, consistent best practices to guide them in these discussions - until now.
A Message from Joe Fifer, HFMA’s CEO
Patients Don’t Speak the Language of Health Insurance…

Consumers Needing Help Understanding Basic Insurance Concepts, 2015

Among your Program’s clients who considered or purchased QHPs, how many needed help understanding basic insurance terms, such as “deductible” or “in-network service”?

- Most (44%)
- All or Nearly All (30%)
- Some, but Less than Half (18%)
- Few or None (5%)
- Don’t Know (3%)

NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers, August 2015.
Insured Still Challenged to Pay Bills

Figure 8
Problems Paying Medical Bills Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014

- Any problem paying medical bills: 36% (Uninsured), 17% (Newly Insured), 18% (Previously Insured)
- Problem with medical bills led to using up savings: 21% (Uninsured), 10% (Newly Insured), 9% (Previously Insured)
- Problem with medical bills led to difficulty paying for basic necessities: 18% (Uninsured), 8% (Newly Insured), 8% (Previously Insured)
- Problem with medical bills led to borrowing money: 15% (Uninsured), 6% (Newly Insured), 6% (Previously Insured)
- Problem with medical bills led to being sent to collection: 24% (Uninsured), 10% (Newly Insured), 10% (Previously Insured)

NOTE: Includes adults ages 19-64. “Previously Insured” includes people who were insured as of interview date and have been insured since before January 2014. “Newly Insured” include people who were insured as of interview date and gained coverage since January 2014. “Uninsured” includes people who lacked coverage as of the interview date.

* Significantly different from Newly Insured at the p<0.05 level.

Patient Financial Communications

• Best practices for healthcare providers:
  • Emergency Department
  • Time of Service (Outside the ED)
  • In Advance of Service
  • Patient Financial Communications – All Settings
  • Measurement Criteria Framework
    • Training
    • Process compliance evaluation
    • Technology evaluation
    • Feedback and response evaluation
    • Executive level metrics reporting
Topics Addressed in Patient Financial Discussions

- Patient Share
- Prior balances (if applicable)
- Balance resolution

Value = Quality

Payment
Parameters for Patient Financial Discussions

- Compassion
- Patient advocacy
- Education
Ensure That Conversations with Patients Are Done Right

• Discuss specifics about each patient’s financial responsibility
• Provide information on financial assistance & application process
• Offer help applying for Medicaid or coverage through the ACA public exchanges
• Discuss payment plans & options
• Give information on how a prior balance does (or does not) affect current care
# Be Transparent About Network Status

<table>
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<tr>
<th>Situation</th>
<th>Steps to Mitigate</th>
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<tbody>
<tr>
<td><strong>Intentional</strong></td>
<td>Health plan should</td>
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</table>
| Patient seeks care from an out-of-network provider | • Clearly explain impact on out-of-pocket expenses.  
• Inform patients that it is their responsibility to seek price information from out-of-network providers.                       |
| **Inadvertent**            | In-network provider should                                                                                                                                                                                       |
| Patient schedules a procedure at an in-network provider but also receives services from an out-of-network provider. | • Disclose that individual physician services will be billed separately  
• Advise patient to confirm network status of physicians  
• Provide names of medical groups engaged to provide services (radiology, pathology, etc.) so patient can confirm their network status with health plan |
| **Emergency**              |                                                                                                                                                                                                             |
| No advance opportunity to identify providers’ network status. | • Work with patients on an individualized basis  
• May need a policy solution |
Narrow Networks

- Lack of access to certain specialties
- Limited availability for new patients or timely appointments with in-network providers
- Uncertainty about which providers are in-network

Surprise Bills

...bills sent to patients who received either elective or emergency services at an in-network facility that included services provided by an out-of-network provider, typically without the patient’s prior knowledge.

- To what extent do you consider surprise billing to be a problem in your state or market?
- What do you see as the main barriers to solving the problem?
- Is your organization making any attempts to protect patients from surprise bills?

https://consumersunion.org/surprise-medical-bills/
Three Steps to Take Now

1. Check out the billing and payment section of your organization’s web site to familiarize yourself with the information available to your patients and community members online.


3. Schedule a cross-departmental meeting
   - Look at your patient financial communications from a patient’s perspective.
   - Start a dialogue about opportunities for improvement.
   - Explore HFMA’s free resources.
HFMA’s Programs

• Education Products – comprehensive program available now from HFMA

• Adopter Recognition – Available now;

• Adopter profiles – www.hfma.org/communications

• Compliance Recognition – Available now

• Vendor “Peer Review” program for consulting assistance on Patient Financial Communications Best Practices implementation – Available now
Patient Financial Communications Adopter Checklist

• Take Home Exercise: Think about the pre-service and time of service policies and processes in place in your organization. Complete the Adopter Status Checklist. Discuss within your team & identify opportunities for improvement.

• Go to this website to apply: http://www.hfma.org/Communications
Signify Your Commitment to Excellence in Financial Communications

- Adopter recognition demonstrates commitment to excellence
- Based on HFMA review of an application and supporting documentation
- All provider organizations may apply
- No cost for this self-attestation process
- Recognition valid for two years
- Adopters may use the phrase “Supporter of the Patient Financial Communications Best Practices” in their marketing materials
“Profiles in Excellence”

• “In our patient registration area, we say ‘the party starts with us.’ Patient registration is just as important as are the clinical services and everything else. Success is really about getting it right at the very beginning.”

• “I feel empowered with the tools that are available to help our patients.”

• “We may be revenue cycle, but we are focusing on the human side of healthcare.”

• From Proven Experience™ to a guaranteed price estimate – it’s the right thing to do
As a patient access leader, what opportunities must you create to apply patient-focused initiatives, improve patient satisfaction and increase revenue?
New and Elevated Roles Facilitate Patient Engagement and Improve Revenue Cycle Performance

Patient Access Significantly Impacts Satisfaction and Payment

“Organizations are using clinical navigators to work collaboratively with patients and assist them with their care plans. Similarly, organizations should empower patient access staff to guide patients through the financial experience.”

Lorraine Schnelle, CPA, Healthcare Financial Management Association

Questions ???? and Contact Information

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Ms Wolfskill is responsible for revenue cycle and MAP initiatives at HFMA. Her extensive experience in revenue cycle management includes leading engagements with clients engaged in process mapping and analysis, project management, staffing analyses, using contemporary metrics to identify improvement opportunities, staff education, interim management and system implementation testing and training. Prior to joining HFMA, she worked closely with HFMA in supporting the task force work which lead to the CRCR study guide and certification process.

Background and Affiliations
Ms. Wolfskill received a BA cum laude from Wittenberg University and a Master of Arts degree from The University of Delaware. Prior to founding her consulting firm, Sandra not only had extensive revenue cycle experience, but also provider management experience in a variety of positions, including serving as the chief financial officer for a small community hospital.

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