What revenue cycle strategies enhance the patient experience

When facing health challenges and unsure about payment options, patients may resist engaging in financial conversations. To better guide patients through the billing cycle, providers must identify payer sources as well as find ways to facilitate these discussions.

By leveraging partnerships and cultivating relationships within their organizations, healthcare stakeholders are improving management of the reimbursement process and educating patients about available resources. In this roundtable, sponsored by Parallon, revenue cycle leaders discuss strategies they've developed to enhance the patient experience while navigating the payment process.

SHAWN STACK: What out-of-the-box strategies or other coverage opportunities do you pursue to optimize reimbursement at your facilities?

LESLIE PIERCE: Methodist Health System is looking at ways to help the uninsured population that falls through the cracks to the healthcare exchange and the Medicaid eligibility program. Along with our competitors in the Dallas-Fort Worth market, we have joined a foundation where we refer patients for help applying for insurance funding. We share funding with our competitors and have to trust each other. It's definitely been out of my comfort zone.

TOM YOESLE: When they go into this referral process, how do you tag the account?

PIERCE: Everyone stays in a self-pay class, and we have a billing indicator that tags it to a referral to the foundation. We can see how many of these patients are coming back after they get a referral to the foundation, which will be a deciding factor on whether I want to participate long term.

SHERRI LIEBL: Do you wait until they are cleared through the process and have some sort of mechanism of coverage before you provide the service?

PIERCE: If they are [getting] a scheduled service, non-emergent, we hold until they've gone through eligibility clearance. It was difficult to move the physicians in that direction because there is sometimes a delay in getting the patient cleared. But we set that expectation and continued to follow-up, and physicians help us guide patients through the process.

ZUBAIR ANSARI: Luminis Health has focused on our drug rate sheets, ensuring we are getting at cost or better on pharmaceuticals to optimize reimbursement.

CANDICE POWERS: Mon Health has collaborated with competitor WVU Medicine to revamp our Medicaid eligibility program. Patients picked up at any of our facilities are in the system with the singular vendor. We partner with our foundation, which has an oncology fund to assist with Medicaid managed care plans and pharmaceutical navigation. We have also partnered with West Virginia University Cancer Institute and West Virginia Health Right to improve access to colon cancer screening. If you are at risk of colon cancer and test positive in the screening, then we schedule you for a colonoscopy that's grant

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funded through the West Virginia Cancer Institute.

STACK: One of my colleagues and I teach a finance class to chief medical officers. I tell them that since revenue cycle teams are the first and last people who touch the patient because they're the ones who bill them, being engaged with revenue cycle is the best thing for the patients. That really drives it home for them. **How have you streamlined your screening and application processes to make them more patient-centered?**

ANSARI: We used to have different processes for hospital billing and professional billing and have recently put one seamless process in place.

POWERS: Often it's a nurse the patient gets close to and confides in. West Virginians don't like to ask for help, and so it's the responsibility of everyone, not just the financial staff but also the clinical staff, to know what options are available.

LEAH KLINKE: At WVU Medicine, we've seen that some patients or their family members are resistant to engaging in the Medicaid screening process. We do the first screening ourselves. If the patient is not engaged, and the patient's situation gets more dire and the costs go up, we reassess either with our internal team or through our business partner. How that conversation happens changes whether or not the family is willing to engage. For any self-pay patient, we watch the dollars, and as those dollars go up, decide whether we need to reengage the patient and family. This can happen either during the patient's stay or post-discharge.

PIERCE: We're doing the same, screen the first time, then process them through. But we now have a weekly session with our case management team members, including physicians and other clinicians, as well as our Medicaid eligibility vendor and financial counselor. They go through each patient and rank them in order of what their needs are. We used to set up just complex reviews with the family if we had a discharge planning need, but now we're considering financial as a discharge planning need.

POWERS: We have had to modify our financial assistance policies and procedures. You may initially qualify but if at any point in the future you have a qualifying event or diagnosis, we reserve the right to reevaluate you.

KLINKE: It's really changed the patient education piece of it too, and even the system education. A patient will walk in the door and tell you the most intimate details about their health, but you start talking about finances and they shut down completely. And so we really had to educate everybody, saying, 'When they start talking about finances, bring us into the conversation.' It's also educating the patient, for instance, when charity care

HFMA Executive Roundtable

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"From a vendor perspective, when we approach Medicaid eligibility, we look at hiring caseworkers to help our teams in hospitals. Tracking the data is powerful, and we can point to it when having a conversation about performance and productivity." — Tom Yoesle, Parallon

financial assistance is short term, let's look at a long-term plan for you. We've had to change those conversations and do pre-education as early on as we can.

POWERS: We're a four-, soon to be five-hospital system and all had different financial assistance policies, different mechanisms and procedures for getting screened for Medicaid eligibility. So we took a hard look at those policies and procedures to make it easier for our patients. We've had $1.6 million in reimbursement come in, and it's resolved $5 million to $6 million worth of accounts receivable that prior to this program being in place would have gone directly to our bad debt line.

LIEBL: We have Amish and Mennonite populations who are not eligible for government programs. This population does not want free care but cannot pay at a full charge rate. So we have negotiated rates that have made it feasible for them to receive care. We are seeing results. For example, there are fewer Amish babies in our NICU because they're receiving care when they should be, and the parents can afford the care.

STACK: With the No Surprises Act, do you see your charity care and discounts changing?

PIERCE: When Texas implemented their surprise billing regulation, we looked at our charity policy and processes. We put in a presumptive charity program, and leveraged technology to do a financial analysis score for patients to help us determine who would be a candidate for charity. We have a tremendous number of patients who want to pay their bill and don't want to apply for charity. The presumptive program has helped us identify that population and have a conversation with them in a different manner. It has also helped us meet the No Surprise billing act, making sure all of our discounts hit the account before it gets billed out.

STACK: I'm finding there's a lot to learn from states who've already had to implement these pieces. Other providers need to hear things you're still struggling with. **What keeps you up at night when it comes to securing eligibilit y/reimbursement for your patients?**

PIERCE: Arbitration will be a problem for us because just like all the other letters that you get from entities asking for records, the arbitration letters go everywhere. They don't know who to send them to. And I think with the federal regulation, it keeps me up at night because I think we're going to see that expand to a larger group.

ANSARI: We're concerned with ensuring that we are in compliance all the time.

POWERS: COVID has had a detrimental impact on our staffing as well as the [West Virginia] Department of Health and Human Resources. So for these folks that we're finding coverage for, we're finding delays in getting them processed. And so that ramp up time, particularly when you're talking oncology and cardiac diagnoses, people who put off care are already sicker by the time they come to see you. And there are staffing challenges in those departments that are screening applications. It's creating a situation that is devastating for access for patients.

PIERCE: We have a state worker who's located in our organization, and we pay 50% of her salary. We're looking at adding a second [state] worker.

KLINKE: We don't have any [state workers] at our academic medical center, but at some of our other facilities we do. Mainly because it depends on the person, and a few times the worker wasn't helping the process along, and our vendor was doing a better job of getting through the process.

PIERCE: We still complete all of the applications, and the state worker's there to keep the process going. We've evolved over the years and now get to interview [applicants for the position], and it's a 50-50 decision on who gets hired for the position.

YOESLE: From a vendor perspective, when we approach Medicaid eligibility, we look at hiring caseworkers to help our teams in hospitals. Tracking the data is powerful, and we can point to it when having a conversation about performance and productivity.

LIEBL: We are working with a vendor. When the patient schedules an appointment, the software will provide an estimate. At the time of the estimate cre-

ation, it will help the patient determine how the patient will pay for the service, utilizing a Q&A with a decision tree built in the background. The same process will be implemented post service. When the patient statement drops digitally to the patient, the patient will be presented with options to satisfy their liability. Ultimately in the end, the decision tree will assist the patient in identifying if they qualify for Medicaid or Financial assistance.

YOESLE: We put QR codes in the EDs now and just say, 'Before you walk out, scan this with your phone.' [Scanning the QR code] brings up a self-screening app, and you can see where they're at in the app, how long they stay on it, and if they're having trouble, we can text them to offer help.

LIEBL: The other strategic initiative we are working on involves financial counseling at checkout. The plan is to schedule the follow-up appointment and then discuss their options to settle their liability and start the Medicaid and Financial assistance screening process.

PIERCE: We've added a navigator to set up a plan with patients, discussing their goals and how to keep them out of the ED. We've reduced our ED visits by about 30% over a two-year period, moving these patients into a primary care setting. We started with five diagnoses to target: diabetes, COPD, CHF, high blood pressure/hypertension, asthma. The navigator opens the door for our eligibility vendor to help with applications, etc. We're measuring that base of patients and their visits at the time we started with them, following them to the visits that they're having now.

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> — Leslie Pierce, Methodist Health System

POWERS: We've always had a nurse navigator who helps coordinate all the clinical appointments for our oncology patients. Three months ago we hired a financial navigator that not only helps them with access to care, but other things, such as food and housing.

STACK: Are any of you participating in the acute care at home program?

PIERCE: We initiated a home oxygen program during the peak of COVID. So once they hit a certain [oxygen] liter, they could transition home. And then our physicians and our primary care clinics pick them up from a telemedicine perspective and visit with them twice a day. Once we got that kicked off, then it was a no-brainer to start looking at hospital at home.

STACK: Many studies show that the acute care at home program yields a 20% better outcome for the patients, clinicians and family care providers, all of whom give the program high ratings. These are the kinds of creative program successes we are seeing as an industry now. ▮