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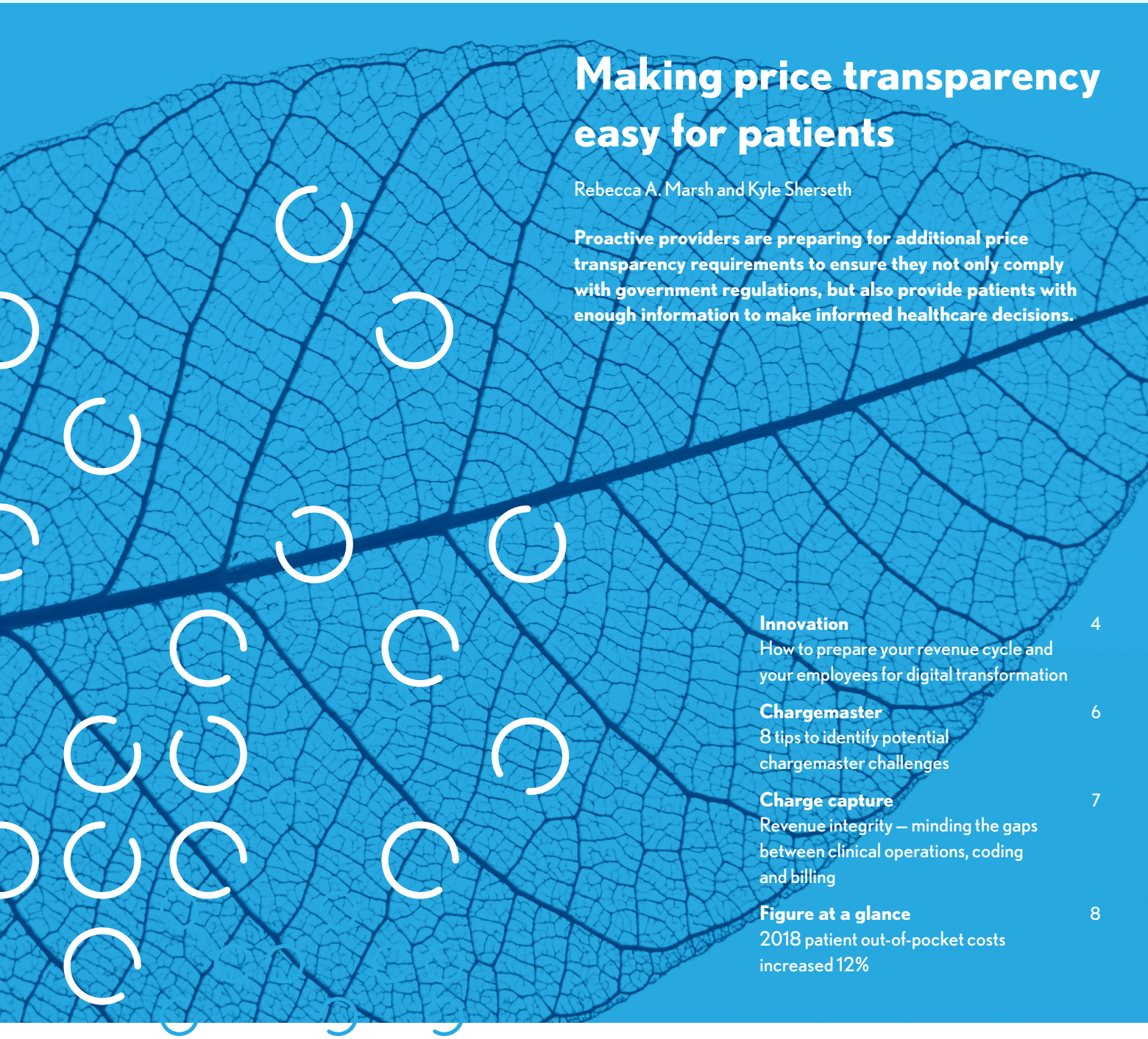
REVENUE CYCLE STRATEGIST

September 2019
hfma.org/rcs



Making price transparency easy for patients

Rebecca A. Marsh and Kyle Sherseth

Proactive providers are preparing for additional price transparency requirements to ensure they not only comply with government regulations, but also provide patients with enough information to make informed healthcare decisions.

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Revenue Cycle Strategist is published 10 times a year by the Healthcare Financial Management Association, Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732.

Presorted nonprofit postage paid in Chicago, IL 60607.

Volume 16, Number 7

To order reprints, email reprints@hfma.org.

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ISSN 1549-0858

Making price transparency easy for patients

Rebecca A. Marsh and Kyle Sherseth

To ensure compliance, hospitals must develop chargemaster structures that reflect industry standards and establish defensible pricing strategies.

Although the goal of the Centers for Medicare & Medicaid Services (CMS) Jan. 1 price transparency regulation is to increase visibility into hospital prices so patients can make informed decisions, the result has been less than satisfactory.

A review of CMS price transparency goals is in order, as well as certain steps hospitals can take to make price transparency easy for patients.

As with any other goods or service, patient consumers have a right to know how much they will pay. Right now, healthcare consumers still have questions about the prices of healthcare services. For example, what is the total charge amount for a knee replacement and how does that relate to the patient's actual out-of-pocket cost? The price could potentially vary by thousands of dollars across different hospitals.

Price transparency as a strategic priority

CMS has made price transparency a strategic priority. As CMS Administrator, Seema Verma, stated, "We must do something about the rising cost [of healthcare], and a key pillar is to empower patients with the information they need to drive cost and quality by making our healthcare system evolve to one that competes for patients."

Verma made it clear that the requirement is an "important first step" to increased price transparency. "While many hospitals have said chargemaster information can be confusing for consumers, let me be clear, hospitals don't have to wait for us to go further in helping their patients understand what care will cost," Verma said.

The regulation is designed to provide patients more information, but the confusion it may cause will likely outweigh the benefits created. For the average person, or even someone with a strong healthcare background, it is impossible to use the chargemaster alone to accurately calculate the total price for a service, let alone determine the estimated out-of-pocket cost.

Forward-thinking healthcare providers are meeting the goals of this CMS regulation and proactively providing the right tools for patients to make informed decisions. For example, hospitals are re-evaluating their pricing strategy to ensure it is reasonable and reflects accurate cost information. Also, hospitals are deploying technology to assist with providing accurate estimates using claim level detail.

As the requirement for price transparency grows, so does the need for compliance and accuracy.

What price transparency means for healthcare providers

Publishing list prices is a strong first step, so healthcare providers must ensure that their charges are defensible, related to the cost of the service provided and uniformly applied to all patients, whether inpatient or outpatient.

To ensure compliance, hospitals must develop chargemaster structures that reflect industry standards and establish defensible pricing strategies. Risk areas requiring defined protocols include, but are not limited to:

- Clinic and emergency department evaluation and management services

> Surgical services
> Routine nursing
> Screening tests
> Equipment
> Non-billable supplies

3 steps to providing accurate healthcare pricing

A defensible price strategy must be transparent and relative to cost. As the requirement for price transparency grows, so does the need for compliance and accuracy. High deductible plans have made patients more savvy consumers because they are paying a larger portion of the cost.

Access to simplified and accurate healthcare pricing is critical because healthcare consumers may use this information to make informed decisions on where they receive care. Hospitals can provide transparent and easy-to-use pricing by following these three steps:

Adopt patient bill estimation technology. Providers should adopt processes, education and technology to create a positive financial experience that will improve patient satisfaction and accelerate cash flow associated with patient liabilities. How?

Make the process easier for patients to translate information from the chargemaster into a meaningful and accurate estimate. Implement patient bill-estimation technology that references historical account-level detail, empowering patients with the ability to create a customized estimate that incorporates insurance coverage on a user-friendly platform.

Develop a workflow. Develop an operational workflow with a formalized education and training program. This begins with effective communication between all parties. Patient access must partner with managed care on the back end to make sure they are using the most current payer contracts to provide patients with accurate estimates. Closing this loop will help ensure precise contract updates and timely negotiations.

Even when utilizing technology, it is important for patients to understand that the calculated price is just an estimate. A disclaimer is necessary to explain the variables that may impact their out-of-pocket cost, such as pending claims for other services provided.

To ease the burden of hospital employees having to deliver pricing information to consumers, provide online resources that are credible, accurate and readily available for consumers. Having good resources available also makes the most efficient use of employee time for responses to patient inquiries on pricing. It is also imperative for the hospital to deliver a consistent message in laymen's terms and effectively communicate that the estimation is based upon previously processed claims.

To ease the burden of hospital staff having to deliver pricing information to consumers, provide online resources that are credible, accurate and readily available.

Price transparency is designed to improve satisfaction by helping patients better understand what their care will cost and allowing them to make educated decisions based on their ability to pay. Based upon our experience working with multiple hospitals to optimize their revenue cycle and establish best practice workflows, when patients have access to out-of-pocket cost information ahead of time, they are better equipped to make these decisions well in advance of the scheduled service date. Without this information, providers miss the opportunity to have patients reschedule and book another patient who is prepared to proactively pay for their planned visit.

Analyze resource costs. Ultimately, price transparency will result in more competition between hospitals for consumer-driven and/or shoppable services. According to CMS regulations, the price of a service should be based on the cost of the resources utilized. Historically, providers have either applied a blanket percent increase across the board or have modeled pricing based on payer payment. Over time, providers have lost sight of what the cost of care truly means, especially when they do not have a cost accounting system directly linked to the chargemaster. Hospitals must develop a chargemaster structure that reflects the industry standard and establish a defensible pricing strategy that is current.

Do not assume that healthcare costs always increase. With advances in technology, it is not uncommon for service costs and pharmacy and supply items to decrease, and that should be reflected in the current pricing established. Hospitals with inflated prices are at risk of losing patients when calculating patient estimates for shoppable services.

Recent executive order on price transparency

The recent executive order signed by President Trump on June 24 outlines preliminary plans for additional transparency measures, including expanded price disclosure requirements, rules requiring hospitals to release negotiated contract rates, expanded access to quality data and changes to flexible spending account rollover rules. The administration made its intent clear that price transparency is a priority, and broad, sweeping mandates are potentially on the way in *very* short order, calling for draft price transparency policies by the Department of Health and Human Services within 60-180 days.

The proactive provider is preparing for these additional requirements to ensure they not only comply with government regulations, but also achieve the goal, which is to provide patients with enough information to make informed decisions. •

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How to prepare your revenue cycle and your employees for digital transformation

Prashant Karamchandani, Steve Wood and Travis Ish

A participative, multi-disciplinary governance committee helps prioritize, organize and drive ideation to implementation.

As healthcare organizations are tasked with lowering costs and improving performance, it's no surprise many are considering automating the repetitive, error-prone functions of revenue cycle operations with robotic process automation (RPA) technology.

An RPA server-based software solution implementation includes a well-organized governance structure, integrated plan and a workforce management strategy that will accomplish the following:

1. Maximize the effectiveness of the new "digital employees," software "robots" or "bots."
2. Decrease the stress of the human workforce with an information campaign about redeployment to higher-value tasks and other opportunities within the health system.
3. Prepare the organization to reskill and upskill legacy employees on new non-robotic responsibilities. Much of the RPA solutions value comes from the ability to redeploy an organization's most valuable resource — it's people.
4. Avoid negative publicity sometimes associated with replacing human workers with digital employees by developing a strategy to transition, reskill and upskill impacted resources as an initial focus, not an afterthought.
5. The most prevalent digital employee in the market is derived by RPA technology, a server-based software solution (i.e., a software robot, bot or digital employee) that uses existing system interfaces to automate repetitive, mundane and error-prone work previously performed by humans.

Unfortunately, with the low barriers to RPA implementation, there can be a tendency to implement with haste and without structure and planning, resulting in confusion with terms of policies, change management and execution. Furthermore, utilizing this type of technology can be deemed as a threat to the purpose or literal roles of the current human workforce, causing anxiety and apprehension. Because redeployment of the human workforce to higher value tasks is a major element of the RPA ROI, executives should manage this area carefully. Therefore, creating the right governance with an integrated plan, for both digital and human employees, is crucial to maximizing your new digital workforce without alienating your best resources.

Governing a new digital workforce

Although successful deployment of digital employees requires speed and scale of adoption as well as nimble decision-making leadership engagement, the key is a well-organized governance structure aligned with organizational strategic priorities.

For example, if patient experience is an organization-wide initiative, it is logical to prioritize a series of bots to rapidly process appointment requests and financially clear and/or complete pre-registration activities to allow for quicker and more accurate patient-intake processes.

Organizations will need a participative, multi-disciplinary governance committee to help prioritize, organize and quickly drive bot ideation to implementation. Ensuring a smooth transition requires healthcare organizations to carefully consider the following questions:

When do you launch? Standing up the RPA governance structure at the right time is critical to ensuring team members stay engaged and willingly support the initiative. Organizations don't want a group of talented, busy leaders attending meetings with no meaningful actions.

The most successful programs have developed a vision and a solid business case for an RPA program before formally activating a full governance structure. The best time to begin activating elements of the governance structure is soon after funds are allocated and the greenlight is given to proceed with RPA deployment. Identifying executive sponsors, steering committee members and team leaders should happen early on as their input is needed to develop program guiding principles, success factors and a charter.

What type of governing body is needed? The intended level of RPA deployment will likely drive the answer. Those seeking to pilot RPA in select areas might initially leverage an appropriate committee that already exists, preferably a strategic or innovations group. Conversely, organizations choosing to implement significant RPA solutions that overhaul entire business units may consider establishing a more robust Center of Excellence (COE) model to help initiate, prioritize and execute RPA initiatives with an enterprise-level vantage point.

Regardless of the chosen model, organizations seeking to deploy RPA governance need to be capable of making quick and collaborative decisions to enable both speed and breadth of adoption (*Enterprise RPA Adoption Pinnacle Model Assessment*, Everest Research Group, March 2018).

Who is needed to create a digital workforce? RPA governance should be comprised of well-respected and progressive leaders from a variety of departments. The chair/sponsor of the committee should be a senior financial and/or operational leader. Other contributors include:

- Human resources leaders who can help navigate and process potential changes to position descriptions, paygrades and employee movement.
- Training, communication and change management representatives to help support the changes to human employee activities.
- Although RPA initiatives are frequently led by business teams, it is IT that owns and manages the tools, security access and infrastructure knowledge necessary to safely implement RPA (*How to scale RPA: in six slides*, by UiPath's Guy Kirkwood). Therefore, RPA governance should include IT stakeholders from end-to-end to establish good communication and to confirm cultural alignment between IT and the business units (*Enterprise RPA Adoption Pinnacle Model*).

Integrate both digital and human workforce plans

There is significant media scrutiny over bots replacing humans in the workplace; however, this position appears to be overstated. There are widely circulated articles that state 38% of jobs are at risk of being automated (Suarez, D., "Will AI and Robotics Replace People in Healthcare?" Pwc, August 2018). In addition, 45% of human activities could be replaced today, yet, research groups that surveyed companies with RPA currently deployed are not reporting large lay-off numbers (Chui, M., et al., "Where machines could replace humans — and where they can't (yet)," *McKinsey Quarterly*, July 2016).

Instead, there appears to be efforts to move their freed-up human workers to higher-valued tasks. For example, a recent study showed that only 11% of RPA-impacted employees were indeed laid off. The other 89% were redeployed, reskilled and upskilled to other jobs within their company (*Enterprise RPA Adoption Pinnacle Model*).

How to best integrate a strategic human workforce plan with a digital workforce plan while also managing employee anxiety and apprehension is the challenge.

To determine the amount of capacity created by the new digital employees and serve as the foundation for a transitioning human workforce plan, consider the following:

What is left of an FTE job after automation? What cannot be automated? What is the new number of FTEs needed for that position group? Have you automated parts of a job that were complex or high risk, thus lowering the skill level needed to perform the non-automated parts of the job?

Decide where you need smiling faces. If you had more human resources where would you deploy them? Think about the "gaps," "nice-to-haves," or the "how have we survived without people" areas. Every healthcare institution has these areas.

For example, with patients now representing the third largest payer group, behind Medicare and Medicaid, hospitals need more professionals to help patients in need of financial advice to navigate their options for assistance (Sanborn, B.J., "Hospital bad debt rises in tandem with growing share of patient financial responsibility," *Healthcare Finance*, June 2018, and Kneller, S., "Innovators Wanted: Mounting Patient Financial Responsibility Driving Provider Demand for Positive Disruption and Change (Part 1 in a 3 Part Series)," TripleTree Holdings, December 2015).

Having reassuring staff trained in patient financial options, with the ability to compassionately and professionally counsel, benefits healthcare institutions.

Develop a plan to reskill and upskill human employees. As you take the automated processes out of your talent's job descriptions and redeploy them to non-robotic jobs, where their talent is better showcased, you will need infrastructure in place to train legacy employees on their new responsibilities. Most institutions have training infrastructures already in place and should leverage those resources. However, a well-structured training plan is needed with training resources ready to take on potential mass reskilling and upskilling.

Have a transition/cutover plan ready. The go-live day for your new digital worker is most likely not the same day you should transition many employees to their new responsibilities. How much overlap is needed? Should this be a scaled transition? The answers are dependent on the size of the automation and the level of patient-experience risk or provider-experience risk. Most prudent automation installers will err on the side of caution and plan for a slow but deliberate transition plan that allows for continuity through any potential issues early in the digital worker's life.

Communicate well or suffer consequences. As mentioned earlier, the media hype around robots replacing human workers is prevalent, and an RPA initiative can produce anxiety and concern. This may lead to low morale, untimely attrition, slow implementation and generally put the initiative at risk. To combat this outcome, a complete communication plan is needed that does the following:

- Informs stakeholders of RPA's purpose.
- Answers the "what's in it for me" question.
- Illustrates the transition plan for robot and human.
- Provides an avenue to ask questions and get answers.

Healthcare organizations interested in implementing RPA solutions are likely to realize much more value from that journey if they establish governance structures and develop workforce management strategies. A well thought out governance structure ensures the right stakeholders are involved and empowers them to make decisions in an efficient manner so that RPA can be adopted quickly and broadly. •

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8 tips to identify potential chargemaster challenges

Caroline DeLaCruz

Identifying chargemaster problems and challenges is critical to chargemaster integrity. It is also a key component of denials management strategies. Carefully evaluating department codes related to the chargemaster to ensure that designated codes are being used properly ensures accurate CPT/HCPCS codes. Because these codes are hard coded in the chargemaster for most ancillary departments, an annual review for new, revised and deleted codes is critical to ensure proper payment.

Use these eight tips to identify potential issues:

1. Review billing edits and claim denials for missing or invalid codes. Track the data.
2. Determine when the last full chargemaster review was performed. Quarterly review is recommended but updating more often is required if new materials or services are added.
3. Check to be sure all codes are compliant for use in the current year.
4. Determine if an internal process exists for staff who may discover an issue or edit when entering charges.
5. Examine the item descriptions to ensure accuracy. Look for incorrect abbreviations and match the CPT/HCPCS code.
6. Ensure there is a charge amount or fee for each line.
7. Capture all goods and services by involving each clinical department to make sure all items are reflected in the chargemaster code selection.
8. Involve materials management (purchasing) and pharmacy to ensure accuracy of all pricing and unit information.

Failure to regularly update codes increases the likelihood of using outdated codes and increased denials.

For example, during a recent chargemaster review at a hospital, it was determined several outdated codes were still being used, and there was no chargemaster coordinator or other individual solely responsible for monitoring the chargemaster additions or deletions. Using outdated codes resulted in billing edit/claim denials and shifted responsibility for addressing the issue to another department.

To prevent similar issues, which negatively affect both revenue capture and the patient experience, it's important to have well thought out strategies in place. •

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Revenue integrity — minding the gaps between clinical operations, coding and billing

An HFMA survey found that 22% of healthcare finance executives identified revenue integrity as the leading priority for their organizations, but fewer than half have established programs.

Forward-looking health systems are beginning to create newly defined roles and entire departments dedicated to revenue integrity. The goal is to bridge the gaps that naturally form between clinical operations, coding teams and the business office.

Revenue integrity focuses on better coding and charge capture, in particular, to reduce the risk of noncompliance, optimize payment and minimize the expense of fixing problems downstream with claim edits.

In an industry where "no margin means no mission," revenue integrity is emerging as a tool and initiative to enhance margin and preserve the mission of health systems.

What is revenue integrity?

In 2004, revenue integrity began to evolve as health systems moved toward value-based and risk-adjusted payment models. When Medicare added hierarchical condition categories (HCCs) to assess patient risk as part of the consideration for payment, the need to be precise with coding and charge capture increased.

Correct coding and charge capture require coordination between clinicians, revenue generating departments, compliance staff and billers, which can tax traditional revenue cycle management processes and technologies.

While organizations may pursue a variety of goals via revenue integrity — improved revenue capture, reduction of accounts receivable days, improvement of documentation and charge redundancy, charge process efficiency, responses to third-party charge audit requests, billing system edit resolution, workflow optimization — a central goal of any program will be the development of congruous clinical and operational workflows that produce correct charge capture the first time, without the need for repeated edits.

Why do you need a revenue integrity department or director?

Even as revenue cycle issues continue to be an area of intense focus for many healthcare organizations, revenue integrity remains a new area to embed into revenue cycle operations.

According to a recent HFMA survey of 125 healthcare finance executives, 22% identified revenue integrity as the leading priority for their organizations, but fewer than half (44%) have established revenue integrity programs. Not surprisingly, many are still tinkering with how revenue integrity fits into their organizations.

Revenue integrity departments have a definite ROI in terms of revenue capture and risk avoidance. Furthermore, a revenue integrity department or director can help lead enterprise-wide efforts to coordinate elements of claims processing and charge capture, acting as the connective tissue between clinical operations and billing by optimizing the workflows between these often-divided areas. The knowledge needed to accomplish this includes:

> Regulatory changes that impact charging practices
> Quality assurance statistics
> Tracking, trending and analysis of unbilled reports and charge review results
> Clinical operations and billing office workflows
> Understanding clinical charging technology and how it impacts revenue
> Internal audit activities related to the revenue cycle

The processes and tools used to support revenue integrity include workflow optimization, compliance, clinical documentation improvement, data analytics and business intelligence.

Even though its constituent concepts are relatively familiar, and there is no well-established industry standard for program design, the National Association of Healthcare Revenue Integrity (NAHRI), offers certification credentials in the subject and provides resources for launching revenue integrity. NAHRI resources include business proposals for making the case for revenue integrity to leadership and developing action plans, project spreadsheets and organizational charts.

Organizations have myriad options when it comes to designing their revenue integrity strategies. Whether the creation can be spearheaded by a single director or necessitates adding a new department will vary from one organization to the next.

What are next steps?

Today's healthcare organizations — feeling the pinch of shrinking top and bottom lines, increasing documentation scrutiny from payers and regulators, along with dozens of other pressures — understand that there is an inherent evolutionary danger in waiting too long to act.

As they assess how to fit revenue integrity within their organizations, providers would be wise to start with the familiar and work upstream from there. Most either have revenue cycle departments of their own or partner organizations. For hospitals and healthcare systems, these partners and/or team members will be invaluable in identifying initial steps.

One vital advantage of revenue integrity is that it is an entirely evolutionary step, meaning that the need for a complete operational overhaul is unlikely. Consequently, organizations can push forward at their own pace while also keeping an eye on remaining current with best practices as they continue to emerge. •

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• figure at a glance •

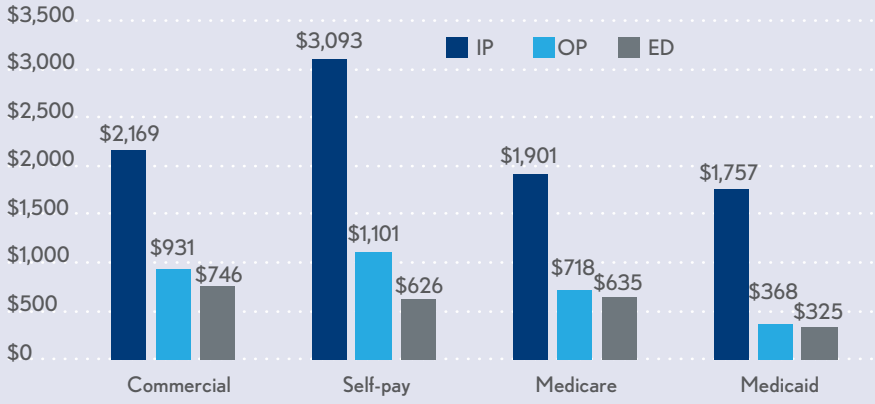
2018 patient out-of-pocket costs increased 12%

Patients experienced annual increases of up to 12% in their out-of-pocket responsibilities for inpatient, outpatient and emergency department care in 2018, according to a TransUnion Healthcare analysis.

"For several years patients have faced a greater cost burden as healthcare expenses shifted from payers to patients," says Dave Wojczynski, president of TransUnion Healthcare. "As a result, patients are now making decisions about where they receive care based on costs – not just the quality of care they may receive. This means price transparency is critical for healthcare providers who are not only competing for patients but also want to secure timely payments from them."

The analysis also found that about 59% of patients in 2018 had an average out-of-pocket expense between $501 and $1,000 during a healthcare visit. This was a dramatic increase from 39% in 2017. Conversely, the number of patients who had an average out-of-pocket expense of $500 or below *decreased* from 49% in 2017 to 36% in 2018. •

2018 patient average out-of-pocket payment by payer



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