EVOLUTION OF PATIENT ESTIMATES

The healthcare industry has experienced a great deal of change over the past decade, as stakeholders have called for increased transparency into medical costs in an effort to reduce costs or create efficiencies in care. This advent of transparency and the further expansion of legislation through the No Surprises Act, aimed at reducing surprise medical bills, has required a tremendous response from healthcare executives responsible for generating and providing patient estimates. Across the Nation, hospitals and health systems were in varying states of preparedness; from those that had already been providing detailed estimates for self-pay and out-of-network patients who were well prepared, to those that had not been providing estimates and were thus less prepared.

In October 2022, eight months following the initial implementation of the No Surprises Act, the healthXchange Patient Financial Services online meeting featured an interactive group discussion on patient estimates and the No Surprises Act. Led by Heidi Peris, the Director of Patient Access at Akron Children's Hospital and Dedra Bouchard, the Patient Estimates Manager at UC Davis Health, the discussion focused on the evolution of patient estimates and the impact on healthcare, delivery of estimates with speed and accuracy, identifying opportunities for improvement through work queues and analysis, as well as the ongoing implementation of the No Surprises Act.

Read on for a full summary of this enlightening discussion, featuring comments and feedback from the panelists and audience members.

Session Summary: Patient Estimates & the No Surprises Act

Session Leaders:

Heidi Peris
Director of Patient Access
Akron Children's Hospital

Dedra Bouchard
Patient Estimates Manager
UC Davis Health

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A Shifting Conversation about Patient Financial Responsibilities

For many organizations that were not providing patient estimates as standard, the transition to a higher level of transparency surrounding costs, and the provision of patient estimates has created an environment where difficult conversations are now happening. Clinicians and hospitals together have traditionally fostered cultures of providing care, at any cost, and worrying about payment at a later time. Legislation including the No Surprises Act has forced hospitals and clinicians to come together to develop and implement collaborative and compassionate ways of conveying estimates to patients, and to create an environment where hospitals and patients work together to ensure payment; whether through providing additional opportunities for support, identifying coverage gaps, or creating payment plans.

One concern posed by clinicians across the industry has been that after receiving an estimate, a patient would then be reluctant to continue their care journey. While this has been the case for some patients, the majority of the audience agreed that what has transpired instead has been an opening of a dialogue between patients and systems regarding the cost of care, and the ways that patients and hospitals can work together to identify support, ensure an equitable payment plan, and ultimately care for the patients' financial well-being in addition to their physical health.

Increasing Speed & Accuracy of Patient Estimates

Providing patient estimates at the right time – ideally at the time of scheduling, as well as delivering an estimate that is as close to accurate as possible, requires the alignment of multiple work flows and stakeholders. In order to deliver at time of scheduling, a variety of supporting factors must be addressed:

- Insurance verification
- In / Out-of-network status
- Identified self-pay patient
- Detail of services to be provided
- Accurate CPT code capture
- Confirmation of orders

Aligning multiple factors and work flows requires the collaboration between estimate and counseling teams as well as clinicians and front-desk staff, who all need to be working towards the same goal of providing estimates as quickly and as accurately as possible.

Benchmarking & Measuring Estimate Accuracy

Attendees surveyed indicated that the majority are working towards the $400 discrepancy threshold, with the following breakdown reported:

10% Estimates are within $400 close to 100% of the time
75% Estimates are within $400 around 75% of the time
15% Unsure of the accuracy or unable to measure

Digging into the estimates that were not within the $400 discrepancy target, the majority of the audience noted that the discrepancies were equally weighted between estimates that were too high, or estimates that were too low, indicating a need to further segment and analyze inaccurate estimates. All participants agreed that they are looking at discrepancy data, but not all participants were currently in a position to tackle resolving the discrepancies. For those using Epic, many are working to leverage the estimates dashboard to help analyze finalized estimates vs. final claims to identify variations.

In many cases, discrepancies appear to be arising from situations where surgical issues, for example, a time discrepancy, has resulted in a larger charge. Another example shared was the identification of workflow breakdowns, where orders are not entered; for example, a patient arrives to cardiology with an estimate, but an echo or EKG was not ordered and added to the estimate, but were then required. Several in the audience agreed that there are frequently workflow gaps more so than CPT gaps, reinforcing the need for strong relations with clinical teams.

In addition to identifying inaccurate estimates, many organizations are segmenting the cases to better identify the root causes, with one organization breaking the discrepancies into segments of $0 to $400, between $401 and $1,000, and $1,000 or more, to then prioritize the higher value cases.

When asked whether organizations were measuring the accuracy of all estimates, or whether they were measuring accuracy on those that would only fall under NSA regulations, there was an even split, with some organizations only monitoring for compliance, while others monitor any estimate provided.

Conveying Estimates to Patients

A number of methods of conveying estimates to patients were noted during the discussion, from some organizations using paper mail for all estimates, others distributing estimates via MyChart or email, as an alternative, some organizations using both mail + electronic, and yet others also presenting the estimates at the time of service.

Pre-service calls are also being made, but many organizations noted that staff are often unable to connect over the phone with patients to discuss the estimates. Work queues are being utilized to help support the delivery of estimates, and where a conversation has not been conducted, patients are being presented with estimates at check-in by front-desk staff.

In situations where out-of-network patients refuse to sign an estimate, where financial consent is required, staff are working to communicate why the acknowledgement is required, and to also consider contacting their insurance provider and switching to an in-network provider.

The No Surprises Act

During this discussion, held in October 2022, 8-months into the implementation of the No Surprises Act, many participants noted the complexity of the implementation and the ongoing uncertainty related to interpreting and implementing the regulation accurately.

Some of the issues raised included:

- How to identify out-of-network components
- Denial of OON vs. payment of the "reasonable rate"
- Cost / benefit analysis of initiating & conducting appeals
- Effectively responding to complaints & concerns
- Level of understanding at the State government level
- Experiences in successfully handling arbitration

In order to meet the challenge of providing estimates to OON patients and those that fall under the scope of the NSA regulation, many systems are looking to harness automation to auto-generate estimates, rather than relying on financial counselors and further staff members manually creating and delivering the estimates. Epic users mentioned using recent estimate builds to begin automating estimates, but noted that in order to leverage the build, there was a need for foundational pieces that weren't always already in place, creating additional complexity.

At UC Davis, it was noted that they have 40,000 scheduled encounters a month, and at this time they estimate that only 10% of those could be automated. At Akron Children's Hospital, they are considering where automation can be leveraged, and initiating auto-generated estimates where they can be rolled out in the most straightforward manner, for example, with office visits, and then working service-by-service, prioritizing highest volume for greatest impact.

Ultimately, teams are looking to use the technology they have in order to automate as many estimates as possible, and are considering the future expansion of the No Surprises Act, and how their teams will handle the additional pressure this will no doubt create.