A Reality Check:
Moderator's Guide for Patient Friendly Billing Focus Groups

Purpose

Why is the ***PATIENT FRIENDLY BILLING***[SM] project holding focus groups? The objective is to obtain structured feedback from consumers (patients, guardians, and family members) about how to improve the collection and communication of financial information related to hospital care. The focus groups are not intended to compile bad experiences, but to explore opportunities for improvement. The discussion should uncover how *process* improvements can make patient billing consistently clear, concise, and correct to minimize disruption in the lives of patients, guardians, and family members.

The PATIENT FRIENDLY BILLING[SM] Project

The PATIENT FRIENDLY BILLING[SM] project was established to help hospital and health system leaders create a more patient-focused and patient-friendly healthcare billing and collection process. This project is led by the Healthcare Financial Management Association (HFMA) in partnership with the American Hospital Association (AHA) and several leading provider and consulting organizations.

Patient billing affects many dimensions of inpatient healthcare delivery, including scheduling, registration, insurance eligibility and verification, patient management, order management, and nursing, among many others. However, the PATIENT FRIENDLY BILLING[SM] project's focus is limited to financial communications.

The first phase of this project addresses three key attributes of financial communication: clear, correct, and concise.

Clear: The bill should be easy to understand and written in clear language. The general type of service provided to the patient should be documented. Patient and payer responsibilities should be clearly stated, necessary actions described, and a source of additional help and information provided. Instructions on how patients can get more information about or question their bill should be specific and accurate.

Correct: Bill items should correctly reflect the financial aspects of the episode of care.

Concise: The bill should contain just the right amount of detail necessary to communicate the message.

Directed discussions in each focus group must cover these attributes

Special Considerations

The focus group moderator should be sensitive to the disruptions in consumers' lives associated with recent hospital visits and focus on improvements rather than negative impressions of the experience.

Research suggests that the tone of the discussion must be carefully monitored to avoid creating a negative reaction to the healthcare provider. Patients, guardians, and family members are selected to participate in a focus group because of inpatient or outpatient episodes of care within the past 12 months. While the outcomes of the encounters may have been extremely positive, these hospital visits may still be emotionally challenging events for many consumers. Frustration over these disruptions in their lives can easily result in consumers expressing criticisms of some healthcare professionals and providers. Even though the consumers have volunteered to participate in the focus group, selected words about hospital encounters may bring unpleasant images into the minds of some consumers resulting in an antagonistic view toward a few aspects of the episode of care.

A professional focus group moderator is aware that many consumers may still be anxious about health and require guidance to positively direct attention to the collection and communication of billing information. The focus group moderator has a challenging task of obtaining a balanced reflection by patients, guardians, and family members about this unwelcome intrusion into their lives from the perspective of how the billing and financial communication *process* can be improved.

When the feedback highlights legal barriers that prevent hospitals and health systems from producing clear, concise, and correct bills for consumers, the Focus Group moderator will acknowledge the suggestions, make a brief statement about legal constraints, and then direct the consumer discussion to other areas for improvement.

Discussion Topics

The focus group moderator should direct the discussion toward the following issues.

1. In the scheduling and registration process, how much personal and financial information did the consumer have to provide?

    a. If the consumer had a previous episode of care at the hospital or medical center, how much of the information requested for the current episode of care repeated information requested previously (besides the confirmation of address, current employer, and healthcare coverage associated with our mobile society)?

    b. Where was the consumer when he or she provided this information (home, physician's office, registration desk at hospital/medical center, inpatient room, etc.)?

2. Did a patient care coordinator (or other hospital/medical center representative) visit or meet with the patient (or guardian or family members) during the stay and explain the financial aspects of the episode of care?

    a. Was the visit during the first two days of a hospital stay or during the beginning of a hospital outpatient visit?

    b. Did the patient care coordinator also answer questions about the medical/surgical activities likely to occur during the episode of care?

    c. Was there a second visit before discharge?

    d. Were most of the consumer's questions fully answered by the patient care coordinator?

    e. Was the consumer given any written communication about financial matters prior the patient's scheduled discharge?

    f. Was the first explanation of the financial obligations presented to the consumer at the point of discharge?

3. *(Addresses communication from the insurance carrier to the consumer.)* Did the consumer receive a report or document such as an Explanation of Benefits (EOB) from a third-party payer?

    a. How soon after the episode of care was this received?

    b. How did the consumer view this document? (Was it positive and informative or a distraction or unwelcome intrusion during a difficult period?) Did the EOB clearly explain how much the patient owes?

    c. Was the level of disclosure about the episode of care appropriate and understandable (general medical/surgical condition or specific Current Procedures Terminology codes or International Classification of Diseases, 9h Revision, Clinical Modification codes)?

    d. Did the EOB provide more or less detailed information than desired?

    e. Did the EOB clearly indicate what might be the next step for the consumer (a bill from the hospital/medical center or a bill from another third-party payer)?

4. *(Addresses the first communication from the hospital/medical center to the consumer—often a letter).* Did the consumer receive any written communication from the hospital/medical center prior to receiving a bill?

    a. How soon after the episode of care was this received?

    b. How informative was the written communication in preparing the consumer for subsequent bills and patient statements?

    c. Did the written communication inform the consumer about separate patient bills from physicians, reference laboratories, and related providers?

9. *(Seeks the consumer's perspective of what information is needed in a bill from the hospital/medical center and how the consumer uses that information.)* Did the consumer receive a bill from a hospital/medical center?

    a. How much detail was included on the statement?

    b. Was the level of disclosure about the episode of care appropriate and understandable (general medical/surgical condition or specific Current Procedures Terminology codes or International Classification of Diseases, 9th Revision, Clinical Modification codes)?

    c. Was the information presented on the bill in a logical order?

    d. Did the bill clearly state the amount owed by the consumer? Did the bill clearly state the amount that had been paid by the insurance company, governmental agency, and other third-party payers?

    e. Was the information concise? Would summarizing information in broad categories have been adequate disclosure?

    f. Was the information correct (were there errors on the statement)?

    g. Did the bill contain telephone numbers, e-mail addresses, and contact persons for additional information?

    h. Was the bill clear as to any special action that may be required of the consumer?

6. *(Addresses the consumer's perspective on billing disputes—e.g., because of coding errors and missing documentation—between the hospital/medical center and the insurance carrier/managed care plan.)* Were there problems regarding coverage and claims process issues between the hospital/medical center and the insurance carrier/managed care plan?

a. Did the consumer have to make telephone calls to settle any problems?

b. What other actions were required by the consumer to resolve the problem?

c. How could these issues have been avoided?

7. *(Addresses ongoing communication from the hospital/medical center to the consumer after the patient bill was sent.)* When the consumer does not immediately submit a payment in full as indicated on the patient bill from the hospital/medical center, a follow-up statement is submitted to the patient. Was this statement clear?

   a. Did the consumer receive multiple patient bills and statements from what appeared to be the same source? (Medical or physician group may be owned by the hospital/medical center and the bills from the same general entity may be confusing to the consumer.)

   b. Did the consumer fully understand which hospital/medical center services were associated with a given statement?

   c. Did consumers experience any confusion with patient statements (as distinct from the initial patient bills)?

8. *(Pertains to secondary insurance coverage, which is not applicable to all consumers.)* How long after the point of discharge were all billing issues among all third-party payers and the hospital/medical center resolved?

   a. What was the primary reason for the delay?

   b. How could this delay have been avoided?

   c. Are there any recommendations for improvement in the process?

9. *(Further examines multiple patient bills and statements from the same or similar mailing address to the consumer for a given episode of care.)* Did the consumer receive a number of separate bills submitted for the same episode of inpatient stay? How did the consumer react to these bills?

   a. Did the consumer receive separate bills for physicians, laboratory interpretations, radiology interpretations, and other services?

   b. Did the hospital encounter require the use of a reference laboratory resulting in a separate bill?

c. Did the patient care coordinator explain to the consumer that different care providers (e.g., hospital/medical center, physicians, reference laboratory) would send separate bills?

d. Did the hospital/medical center provide the consumer the names of the care providers that would be sending separate bills?

e. Did the consumer experience special coverage problems with primary third-party payer for certain claims (such as those from a reference laboratory)?

10. *(The remaining questions seek the consumer's perspective on the ideal communications about episodes of care in a "perfect world" where there were no legal constraints and regulatory restrictions.)* What information would a consumer prefer to have on a patient bill? How would the consumer use this information?

11. What information would a consumer prefer to have on a patient statement? How would the consumer use this information?

12. What role should the hospital/medical center have in communicating with the consumer about all the parties providing medical and healthcare services to the patient during an episode of care?

13. Based on the consumer's experience, what are the specific recommendations for improving the process of collecting and communicating billing information to consumers?

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