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LACK OF STEWARDSHIP IN THE US HEALTH SYSTEM **LEAVES PATIENTS AT RISK.**

The recent controversy over surprise billing highlights the challenges associated with the U.S. healthcare delivery system, where for all intents and purposes nobody seems to be at the helm.

The impact of this rudderless ship is highlighted in the story of a Colorado mother Sonji Wilkes.

On June 12th, 2019, Ms. Wilkes testified before the Committee on Energy and Commerce Subcommittee on Health of the U.S. House of Representatives "No More Surprises: Protecting Patients from Surprise Medical Bills" regarding the delivery of her second child at a local Colorado hospital. Ms. Wilkes had commercial insurance and proactively checked to ensure her obstetrician and hospital were in her health plan's provider network.

Shortly after delivering her son, Ms. Wilkes was informed that her baby boy had severe hemophilia A, a genetic disorder that prevents his blood from clotting. Based on the recommendation of the providers, her son was transferred to the NICU. After discharge and returning home, Ms. Wilkes was shocked when she received a bill for more than $50,000. She later learned that her hospital sub-contracted out their NICU—which was not a participating provider of her health plan.

Years later Ms. Wilkes is still recovering from the financial impact of this unexpected financial catastrophe. Unfortunately, she is not alone as one out of every seven patients that are admitted to a hospital in the US receive a surprise bill, according to a study of 620,000 claims from 37 states conducted by the Health Care Cost Institute's (HCCI).[1]

1 Kennedy, K., Johnson, B., Fuglesten Biniek, J. (March 2019). Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016. Hospital Care Cost Institute. Retrieved July 2019 from https://www.healthcostinstitute.org/blog/entry/oon-physician-bills-at-in-network-hospitals

It is easy to ask who is to blame for surprise healthcare bills in cases like Ms. Wilkes'. However, when we look at the various roles in a typical hospital-based encounter, it is extremely challenging to identify a single culprit.

Let's explore the list of players in Ms. Wilkes' scenario:

- Various Physicians – the obstetrician, pediatrician, and hematologist each had portions of care for Ms. Wilkes and her newborn. Did anyone have the role of coordinating and centralizing the care for her and her son's delivery and stay?;
- Hospital System – had a participating provider network relationship with the health plan, but sub-contracted out their NICU;
- NICU – as a separate contractor they were perceived as part of the larger hospital system and could be argued to have moral responsibilities to inform the patients of potential financial risks;
- Employer – selected the health plan and benefit package for employees and their families, to provide healthcare services
- Health Plan – could have informed the patients of potential financial risks if certain situations occur in the hospitalization. Many health plans have their own Utilization Management services that could have alerted the NICU and the patient that they were in an out-of-network situation;
- Patient – Ms. Wilkes checked that the hospital and her obstetrician were in network, but erroneously assumed the NICU was part of the hospital system;
- Regulators – could have passed laws that limited the ability for a healthcare organization to unbundle their services to contracts, set better transparency laws, create arbitration boards for such cases, or have price controls on services so that charges are limited.

All the above parties, with the exception of Ms. Wilkes, have financial incentives to keep things status quo. Even the legislators who receive financial contributions from multiple healthcare lobbying groups have little incentive to change the laws. In this vacuum it is only natural, probably unfairly, that the hospital takes a leadership role in helping the patient to navigate the healthcare financial landscape.

However, it is focus from media and executive office on surprise billing that is leading to legislative activity. Current legislation on surprise billing is looking at pricing caps for out of network services, arbitration boards as ways to control the impact of surprise bills, and better provider directory transparency by health plans as options to address the surprise billing issue.

HOWEVER, WHAT DOES THE PATIENT TRULY WANT IN THE END?

Healthcare patients have high expectations

In an era in which patients can instantly access information on any topic at any time, they expect to understand the implications of healthcare procedures before proceeding:

1. How much will my anticipated services cost?
2. What are the payment expectations?
3. Who will be sending me a bill?
4. What are my financial risks of uncovered services or medical complications?
5. What if the procedure is not urgent and I have limited financial resources, do I have less expensive options that may be just as effective long-term?

With a plethora of billing data available today, modern Artificial Intelligence (AI) analytic capabilities, and the access to evidence-based medicine, there is no reason healthcare organizations cannot answer those basic questions. The first four are the financial responsibility of the healthcare organization and the fifth is a clinical discussion with a patient's clinical team and addition to the financial impact of potential clinical options.

One can only imagine that in the near future patients will look to digital assistants such as Siri and Alexa to help personalize and guide their delivery decisions. Integrating location data, social and clinical data reviews, AI-driven risk analysis, and personalization can help patients make their decisions and outline their risks.

In the meantime, healthcare organizations have an ethical obligation to shield their patients from the complexity of the healthcare system and provide basic financial guidance, while warning of potential risks.

As a start, here are five steps that healthcare organizations should do now:

Create a Transparency Advisory Board

Create a working group that includes c-suite representation and community representatives to clarify the organization's mission and how financial transparency fits into that mission. An offsite design thinking workshop could help ensure that consensus is developed around what type of 'financial' stewardship or transparency role the organization wants to have in their market.

Perform a self-pay risk assessment

As self-pay collections become a bigger part of the health organizations' revenue sources, it is also a bigger risk for 'surprise billing' and other negative market risks associated with billing and collection operations. Challenges around price transparency, expected charges, complex contractual relationships, personalized propensity to pay insights, risk analysis, and customized payment plans are all part of a self-pay strategy that will impact your risk for surprise billing or bad press.

Create a payor collaboration team

A group that identifies major payors in the local market and focuses on improved network directory transparency, sharing of data to identify surprise billing high risk areas, and improved eligibility and prior authorization collaboration opportunities.

Build a patient transparency task force

This team develops various patient journeys, e.g., ED use cases, elective surgery use cases, chronic care coordination, and outpatient services to map the patient experience as they travel through the health institution, asking the following:

- How informed is the patient about their financial responsibility?
- How easy is it for a patient to find the cost of services?
- If the organization shows expected patient costs, what risks and patient education are needed to protect the facility?

Outcomes and financial analysis

In the end, the best protection an organization can have for both transparency and a future of value-based reimbursement is about outcomes and comparative data. Does the organization have the analytics and AI capabilities to measure the value that is provided in the local market?

At Sutherland Healthcare , we have spent the last thirty years in developing the technologies and expertise healthcare organizations need to engage their patients and address the issues of financial transparency and surprise billing risks. From state-of-the-art Design Thinking labs, advanced analytics, and as a market leader in dealing with patients' healthcare financial responsibilities, we can help healthcare organizations design, build, and deliver patient engagement solutions.

For more information on how we can help you transform your processes, visit us at **www.sutherlandglobal.com**, email us at **sales@sutherlandglobal.com**, or call **1.585.498.2042.**

As a process transformation company, Sutherland rethinks and rebuilds processes for the digital age by combining the speed and insight of design thinking with the scale and accuracy of data analytics. We have been helping customers across industries from financial services to healthcare, achieve greater agility through transformed and automated customer experiences for over 30 years. Headquartered in Rochester, N.Y., Sutherland employs thousands of professionals around the world.

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