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How Patient Access Can Save Money and Improve Satisfaction

Revamped processes are necessary to prevent major problems when handling out-of-network coverage issues

Many more patients are receiving an unpleasant surprise: Their coverage is out of network. This coverage means high deductibles, out-of-pocket maximums, co-insurance amounts, or no coverage at all.

"The decision to go out of network is either very costly or not an option at all," says **Angie Bustamante**, CHAA, team lead for financial clearance for the Patient Access Center at Sutter Shared Services.

For example, it's not uncommon for out-of-network patients to face a $6,000 deductible or higher before co-insurance of 50% begins.

"The high deductible for out-of-network benefits is so financially taxing, the patient has very little choice," Bustamante says, noting some patients end up going to another hospital for surgery, even though the ordering physician is in-network. "The question that we should be asking is, 'Why even have out-of-network benefits if the patient can't afford to use them for elective procedures?'"

"WE WANT EVERYONE FULLY CAPABLE OF ANSWERING QUESTIONS FROM FAMILIES."
— STACY HUTCHISON-NEALE, CRCR, NEMOURS ALFRED I. DUPONT HOSPITAL FOR CHILDREN

Sutter Health's financial clearance team members determine if the insurance is out of network as early as possible.

Usually, this coverage is determined shortly after the service is scheduled. Financial clearance team lead **Raye Deleurme**, MBA, CHAA, says, "That could be anywhere from 24 hours to four weeks in advance of the date of service, depending on when it populates in our work queue."

Registrars also look for limited benefit plans, or benefit limitations that exclude certain procedures, such as total hip or total knee replacements.

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Any of these things could result in a denied claim.

"This allows for timely notification to the provider and the patient, giving the opportunity for the service to be scheduled in a participating facility," Deleurme says, adding that it's also an opportunity for patient access to educate the physician's office. "Just because the physician is contracted does not mean the facility they book the patient service at will also be part of the patient's in-network benefits."

Registrars reach out directly to the surgery scheduler at the physician's office and as if they're aware the patient is out of network at the hospital. If not, the registrar explains why the patient's coverage is not contracted.

"In addition, we explain the potential negative financial impact to the patient, compared to using the patient's in-network benefits," Deleurme says.

Usually, the surgery schedulers are not aware that they have scheduled the patient at an out-of-network facility.

"The unintentional error occurs because the physician is in network, so the patient is scheduled at the hospital the physician has privileges at," Deleurme says.

'Full-On' Approach

Patient access leaders at Nemours Alfred I. duPont Hospital for Children created a new process to address patients with out-of-network coverage. **Stacy Hutchison-Neale**, CRCR, supervisor of the hospital pre-authorization department, says, "This new process will be a totally transparent approach."

With the new process, all four Nemours sites now handle non-participating patients the same way. Previously, each area had limited knowledge of insurance coverage.

"This only upset the family and associates more," Hutchison-Neale explains. "Not everyone knew how to answer the questions that families asked."

Ultimately, it's the patients' responsibility to know and understand their insurance coverage.

"But most are unaware of their benefits and out-of-pocket responsibilities," Hutchison-Neale adds.

Registrars don't wait for something to be scheduled before finding out the hospital is out of network.

"Previously, we would schedule follow-up patients with no lead time," Hutchison-Neale says.

This system resulted in very frustrated families if procedures had to be rescheduled. Also, out-of-network families were scheduled without knowing how much they'd owe.

"Services would be rendered, and they received a large bill, which they were not expecting," Hutchison-Neale notes.

Now, registrars inform families of their benefit amounts before giving them the option to make an appointment, using this process:

• New patients are directed back to their physician's office so an authorization can be obtained for the services by the primary care provider.

"If the patient has out-of-network benefits, they ask for a prior authorization for services to take place at a non-participating provider," Hutchison-Neale says.

If they have no out-of-network benefits and the primary care provider is unable to obtain an authorization, the registrar refers the family to a participating provider.

Once the authorization is in

place, and the insurance company provides a single case agreement, patient access contacts the family to schedule the appointment.

"If for any reason there is a denial, the family is notified," Hutchison-Neale adds.

• Existing patients are allowed to make an appointment, but it's scheduled far enough in advance to obtain authorization and a single case agreement.

The discussion about out-of-network coverage starts at the first contact with the family.

"This prevents false expectations and disappointment," Hutchison-Neale says, explaining that previously, scheduled appointments had to be cancelled.

Patient access staff are given classroom training on out-of-network coverage.

"We provide the family with their exact out-of-network benefits, including deductible, coinsurance, and copays," Hutchison-Neale says.

Registrars also make them aware of in-network benefits. The family members can make an informed decision if they still want to proceed with a non-participating provider.

"This is a full-on approach to training," Hutchison-Neale explains. "We want everyone fully capable of answering questions from families."

Exceptions Are Possible

In some situations, payers sometimes allow services to be paid as though they were in-network.

"If a maternity patient is in the second or third trimester, the insurance reimburses at the old contracted rate," Bustamante says.

Exceptions are sometimes made if patients have to travel significantly farther to the nearest in-network hospital.

"If the out-of-network location is in the best interest of patient care, a letter of agreement is secured," Bustamante says.

The determination can be quick for some of the larger insurance plans.

Deleurme says, "However, an independent insurance plan or a less common insurance plan can become very time-consuming, because we have to call the insurance to verify if we are contracted."

In the first eight months of 2016, 1,049 single case agreement requests were submitted to Nemours' managed care department.

"There are certain insurance companies that will not negotiate single case agreements, since we are non-participating," Hutchison-Neale notes. "But we still try by requesting them."

Sometimes "continuity of care" exceptions are made for patients that have seen the provider for a prolonged time.

"However, they may only provide a limited amount of approval for the appointment, so that the patient can be transitioned to a participating provider," Hutchison-Neale says.

Some payers make "gap exceptions" if patients are travelling long distances to the in-network provider.

Timing is another obstacle. "Some insurance companies take 51 days from the request date to close a single case agreement request," Hutchison-Neale warns.

Families can consult with one of Nemours' authorization specialists about their out-of-network status.

"But we are limited with what we can do, since the insurance company has decided to not participate with the facility," Hutchison-Neale adds.

If the family still wants to be seen by the non-participating provider, patient financial advocates assist with payment options.

"If they do decide to move forward, there won't be any surprises," Hutchison-Neale says. ■

EXECUTIVE SUMMARY

An increasing number of patients are out of network, risking surprise medical bills for patients and lost revenue for hospitals. Registrars can do the following:

- inform patients of their coverage status before scheduling;
- remember that the physician's contracted status doesn't mean the facility is in network.
- determine if the payer is willing to make an exception.

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- **Angie Bustamante**, CHAA, Team Lead, Financial Clearance, Patient Access Center, Sutter Shared Services, Roseville, CA. Phone: (916) 297-9202. Email: bustama@sutterhealth.org.
- **Raye Deleurme**, MBA, CHAA, Financial Clearance Team Lead, Sutter Shared Services, Roseville, CA. Phone: (916) 297-9104. Email: DeleurR@sutterhealth.org.
- **Stacy Hutchison-Neale**, CRCR, Supervisor, Hospital Pre-Authorization Department, Nemours Alfred I. duPont Hospital for Children, Wilmington, DE. Phone: (302) 651-5184. Fax: (302) 651-4224. Email: Stacy.HutchisonNeale@nemours.org.

Surprise Medical Bills Add Up Fast

Patients often unfairly blame hospitals

About one-third of insured patients with problematic medical bills received care from an out-of-network provider that their insurance wouldn't cover, according to a recent report from the Kaiser Family Foundation (KFF).[1] Sixty-nine percent were unaware of this problem when they received the care.

"That's an indication that surprise medical bills arise frequently and result in bills that patients can't afford to pay," says **Karen Pollitz**, a senior fellow at KFF.

Pollitz and colleagues conducted some case studies on people with medical debt.

"Numerous times, people expressed surprise that one hospital stay could generate so many bills," she reports.

Physicians and other healthcare providers aren't always hospital employees; thus, they don't always have contracts with the same insurers as the hospital.

"Surprise bills can turn into big numbers pretty quickly," Pollitz says. "We talked to one woman who, sadly, lost her house after her husband was hospitalized and had severe complications."

Where Bills Originate

Patients might receive bills from the laboratory, attending physicians, imaging, surgical assistants, the ED, ICU doctors, the pathologist, and the hospitalist.

"A lot of patients don't even realize that it's possible that every person who touches them while they're in the hospital could send them a separate bill," Pollitz says.

Patients usually believe they've done their "due diligence" by confirming that their physicians and hospitals are in network.

Mark Rukavina, principal of Community Health Advisors, which assists non-profit hospitals in complying with regulatory requirements, says, "Later, they get walloped by a bill because some specialist isn't in the network."

The Blame Game Begins

Not surprisingly, patients typically blame the hospital for surprise bills.

"The patient is oftentimes miffed and sees the hospital as being responsible," Rukavina says, noting this blame can negatively affect the hospital's revenue. "I have no empirical data on this — it's purely anecdotal — but after talking with patients and many revenue cycle people, it's clear that surprise bills from specialists make it harder for hospitals to collect the bills that patients owe them."

Patients are in a tough spot, because information on who is in network for their particular plan isn't always easy to find.

"Hospitals are trying to do a better job of informing patients. But, frankly, they don't know all the time, either," Rukavina adds.

Hospitals might explain to patients, "Yes, we accept your insurance, but some lines of service might not. You need to talk to those providers directly to find out whether they're in network."

"Anesthesia, radiology, and ED are the three big specialty areas that create problems," Rukavina explains.

Legislative Solutions Not Foolproof

The problem of surprise medical bills is nothing new.

"It's certainly been a concern for quite some time, but there is growing frustration with it," Rukavina says. "There is a lot of tumult at this point in time."

In 2015, New York's Emergency Medical Services and Surprise Bills law was enacted, which requires greater transparency on out-of-network charges.

"States have tried to attack it in various ways, holding consumers harmless in some ways through various approaches," Rukavina says.

Several states, including Florida and California, have introduced similar legislation.

Some laws limit what a patient is obligated to pay if the hospital is in network, but providers aren't. In Rukavina's eyes, this limit isn't a solution.

"The consumer may be held harmless, leaving the provider and the insurer to duke it out," he explains.

Some hospitals agree to apply a discounted rate or exercise some forbearance on collection, if patients end up with out-of-network bills.

Some plans indemnify patients from the costs of unexpected out-of-network care, if the patient received care at an in-network facility.

"If someone inside that facility ends up treating you, and they are out of network, the plan will pay the charges," Pollitz explains.

Patients who buy insurance typically aren't informed about the possibility of surprise medical bills.

"If we're requiring people to buy insurance, we should require those selling it to explain how it works. Patients shouldn't have to be detectives to figure it out," Rukavina says. ■

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Do Registrars Gossip About One Another?

Put an end to it quickly to protect morale

When **Kim Rice**, director of patient access at Shasta Regional Medical Center in Redding, CA, hears employees making negative remarks about colleagues, she wants both sides of the story.

"We then come up with an agreement and understanding of what is expected during working hours," she says. Rice takes these steps.

1. She asks the employees being complained about for their feedback during a one-one-one meeting.

2. She reviews relevant hospital policies, such as dress code, attendance, or meal breaks, with the employee.

"Reflecting back on the policy is critical, so the employee doesn't think it is a personal attack," she says.

Rice brings up the fact that HR probably went over the topic during the employee's orientation.

"I make it clear that I do not want to revisit the discussion moving forward," she adds.

3. Rice conveys how gossiping hurts others on the team.

"I let them know as well if anyone tries to engage in bad conversation, that they should say to that person that they are not going to engage in gossiping," Rice notes.

Rice instructs employees to encourage colleagues to come speak with management if they have concerns so issues can be resolved properly.

Using these proactive approaches, Rice has never had to let an employee go due to gossiping.

"One person's negative behavior has a huge impact on the team. Employees will leave if they believe the issue is not getting resolved," Rice says.

Negativity Spreads

Brenda Pascarella, CHAM, associate director for patient access at Albany (NY) Medical Center, says gossiping "needs to be stopped immediately, or it can spread quickly within the entire department."

One of the department's tenets is "What We Permit, We Promote," which leaders take to heart.

"Gossiping and negativity within a department can bring employee morale way down," Pascarella says.

A supervisor or manager occasionally must intervene to hold staff accountable for their behavior.

"If staff is feeling a hostile work environment due to gossiping, then this would need to escalate to a manager," Pascarella recommends.

Typically, though, Pascarella encourages staff to communicate directly with one another.

"When staff is able to directly convey to their coworkers how they are feeling, staff is able to fully realize the impact their actions can have on others," she explains.

Sometimes, two co-workers and a manager come together for a mediated meeting.

"But the outcome is well worth the investment in time," Pascarella notes. ■

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- **Brenda Pascarella**, CHAM, Associate Director, Patient Access, Albany (NY) Medical Center. Phone: (518) 262-4559. Fax: (518) 262-8206. Email: PascarB@mail.amc.edu.
- **Kim Rice**, MHA, Director of Patient Access, Shasta Regional Medical Center, Redding, CA. Phone: (530) 229-2944. Fax: (530) 244-5185. Email: krice@primehealthcare.com.

EXECUTIVE SUMMARY

Engaging in negative gossip can harm morale in patient access areas. Some strategies:

- Ask the employee for feedback during a one-on-one meeting.
- Review hospital policies on related topics.
- Ask registrars to tell complaining co-workers to go directly to management.

Online Training Helps Staff Members Keep Up with Fast-paced, Changing Industry

One of the toughest challenges for patient access at Springfield, MO-based CoxHealth is "keeping everyone updated and on the same page with the fast-paced changes we see in healthcare," says revenue cycle educator **Jill Pfeifer**. "E-learning is a key player in that solution."

In 2016, the revenue cycle department started providing online training to patient access, health information management, revenue integrity, and patient financial services.

"This supplements the education we create internally," Pfeifer says.

Once a pattern of mistakes involving a certain topic is identified, managers create an online module. The department uses PowerPoint to create the modules internally, then publishes them through the hospital's learning management system (Nashville, TN-based HealthStream).

"To identify trends, we look at auditing and denial reporting," Pfeifer adds. "We also listen to those diligent employees who notice trends through daily workflow." Patient access staff then take a follow-up quiz with a mandatory passing score. Here are two recent examples:

• Registrars were incorrectly completing the Medicare Secondary Payer Questionnaire.

• Registrars were failing to verify the patient's identity prior to the start of the registration process.

"The content of the module and quiz reinforces the correct process steps that need to be followed," Pfeifer says. "This allows reeducation for the masses without requiring a live classroom setting."

Record High Collections

Online training gave a big boost to upfront collections at Cooper University Health Care in Camden, NJ. The point-of-service collection training module consists of eight 20-minute courses, costing $30 for each registrar, provided by Litmos, a provider of learning technology.

The online training covers:

• copays, coinsurance, and deductibles;

• communication styles used during collections;

• understanding the stages of patient collections;

• collection strategies;

• quality assurance methods.

Randall Smailer, manager of healthcare access, says, "As a result of the online point-of-service collection training and two-day classroom training, our ED collections have reached record highs." By the middle of 2016, the ED's copay collections equaled total copay collections for the previous year.

"An added benefit of this online training platform is that it allows us to develop our own courses, reports, surveys, and assessments," Smailer explains, noting the department can do this by uploading electronic graphic presentations and video files from the online training library. "This allows us to create quizzes — multiple choice, keyword, or essay questions — to assess staff retention of learning material."

'Jam-packed' with Info

Pfeifer names staff engagement as the top challenge with online training. "The last thing they want to do is another module," she says.

There always is a risk of registrars just clicking through screens to get to the end, without really retaining the information.

"We need to become experts at how to make the education entertaining, to keep the attention of the student long enough to accomplish the main goal: to educate," Pfeifer says.

Pfeifer expects online education to be a "bigger and bigger" piece of how the department provides revenue cycle training.

"The online modules need to creative, interactive, and jam-packed with small bites of information that can be delivered and digested quickly," she says.

These types of modules allow the department to roll out more education at quicker intervals.

EXECUTIVE SUMMARY

Patient access professionals are turning to online training to keep staff up to date with constant changes. CoxHealth saved $12,500 by reducing 300 hours of classroom training. Departments have successfully used online training to improve the following:

• compliance with Medicare secondary payer questionnaire;
• use of correct patient identification processes;
• point-of-service collection.

"That's how we hold the interest of our audience," Pfeifer says. "If we can follow that formula, our online education can be successful." ■

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- **Jill Pfeifer**, Revenue Cycle Educator, Revenue Integrity, CoxHealth, Springfield, MO. Phone: (417) 269-0021. Fax: (417) 269-8109. Email: Jill.Pfeifer@coxhealth.com.
- **Randall Smailer**, Manager, Health Care Access, Cooper University Health Care, Camden, NJ. Phone: (856) 361-1642. Fax: (856) 968-8461. Email: smailer-randall@cooperhealth.edu.

Reap Big Savings Through Online Education

In the past year, online training of patient access employees at Springfield, MO-based CoxHealth resulted in $12,500 in savings, estimates revenue cycle educator **Jill Pfeifer**.

"Several modules are grouped together and titled as 'Pass to Class' in our learning management system," Pfeifer says. Before attending a live class, patient access employees review the online modules. Topics include system terminology, basic system, navigation, introduction to Medicare and Medicaid, and revenue cycle basics. "Each individual module is followed by a short quiz to ensure comprehension. There is also a shadowing packet included," Pfeifer explains. The packet allows the registrar to shadow in their specific area and document the specific tasks that they will be doing. "The packet is brought to class, so the educator knows the specific workflow of each of their students," Pfeifer adds.

About 300 hours of classroom training is no longer needed because staff members were able to cover a large amount of the material on their own by reviewing the online modules. "This has reduced the live classroom time that takes away hours of productivity," Pfeifer says.

Online education also means the health system, which has multiple campuses spread across southwest Missouri, doesn't have to pay for employees' travel time and mileage. "The time for travel is given back to patient access areas, increasing productivity," Pfeifer adds.

Productivity also is higher for the educator team. "We aren't having to push through 200-plus employees through the same live class," Pfeifer explains. ■

State Laws on Price Transparency Aren't Enough

Due to high out-of-pocket costs, patients are 'becoming the new payer'

(Editor's Note: This story is the second of a two-part series on price transparency and patient access. Last month, we covered how to give accurate and timely cost estimates. This month, we explore how recent state laws are changing patient access.)

Frustration with the difficulty of telling patients how much something will cost is driving big changes in patient access.

"It's not just consumerism that's driving this; it's regulations. If it's not already on your radar, it needs to be," says **David Kelly**, MHSA, CHFP, director of revenue cycle at Mary Rutan Hospital in Bellefontaine, OH.

A growing number of states have instituted price transparency laws. In part, these laws are driven by consumer complaints about high-deductible plans.

Sandra J. Wolfskill, FHFMA, director of healthcare finance policy at the Healthcare Financial Management Association, says, "If providers are not being transparent about prices up front, the surprised patient is dissatisfied and registers that dissatisfaction with their local state representatives."

Mary Lee DeCoster, a Phoenix-based revenue cycle consultant, sees lack of standardization as a serious problem with the laws.

"My own state has a poorly written law," she says.

Arizona's law mandates hospitals post the "direct pay price" for the 50 most commonly reported DRGs on their websites. Most hospitals simply posted their chargemaster rates.

"That is not very helpful information to patients who want to know what a specific service is going to cost them," DeCoster argues.

Patients aren't able to accurately compare costs of care at various hospitals.

"Very few patients are shopping for the cost of 'sepsis' or 'pneumonia' care," DeCoster adds.

Not Specific Enough

Forty-three states received an

"F" grade on the 2016 Report Card on State Price Transparency laws, developed by the Health Care Cost Institute and Center for Payment Reform.[1] Of the seven other states, New Hampshire, Colorado, and Maine received an "A," Oregon received a "B," Vermont and Virginia a "C," and Arkansas a "D."

Jonathan Wiik, principal for revenue cycle management at TransUnion Healthcare, says that states with an "A" rating enacted laws that focus on collecting information on patient responsibility and average insurance reimbursement.

In Wiik's view, most of the state price transparency laws have "missed the mark." The laws typically require providers to share prices upfront, either upon request or via their websites. Wiik says there are two problems with this approach:

- The posted prices don't factor in hospitals' contractual discounts with payers.
- An individual patient's benefits aren't factored in.

DeCoster says commitments for providing a timely response to a request for a price estimate is "well-intentioned, but lacks specificity." Hospitals easily can post the gross charges for a service, but this information doesn't tell patients what they'll actually pay.

Wolfskill says, "The reality is, patients do not care about our 'charges.' Posting charges is no longer sufficient." Instead, patient access needs tools and training to be able to give an accurate price estimate to a particular patient.

DeCoster says, "If the hospital lacks the technology to provide a specific estimate based on the patient's insurance coverage, plan type, and deductible status, more time will be lost in trying to retrieve this information from the health plan."

No More Excuses

Some payers offer interactive web-based tools so consumers can query the cost of a procedure performed by a specific provider.

However, DeCoster says that "most consumers do not think to contact the plan. They want the answer from the provider, during the visit when the provider is ordering the procedure."

Wolfskill says that this desire is where the role of patient access is crucial.

"Through technology advancements, there is no room for the excuses of the past, where providers complained that creating an estimate was just too difficult," she adds.

Wolfskill views the patient's "financial healthcare" as an essential component of the patient's overall experience, along with clinical healthcare.

Lee Patillo, patient access director at UAB Hospital in Birmingham, AL, says patient access needs better tools and continuous training to answer increasingly complex questions related to cost.

"We have put together a group of employees that are tasked with calling patients prior to their scheduled date of surgery," Patillo says, explaining that during the call, patients are pre-registered and informed of out-of-pocket costs. "Patients would much rather know upfront about their out-of-pocket responsibilities than to receive a bill in the mail that they weren't expecting."

Clearer Choices Needed

Hospitals often lack technology to provide a "retail" consumer experience for patients.

"It frankly is difficult to pay a hospital bill, before, after, or during, your care," Wiik says. "It has evolved into a very complex process."

Patients are left confused over costs and little ability to compare costs at various hospitals.

"Patients are becoming the new payer," says Wiik. "Establishing funding mechanisms for patients in advance, and providing payment options early, are critical to fixing this issue."

Some insurance carriers offer patient pricing portals.

"However, the adoption is shockingly low, and it has had little impact on patient behavior," Wiik says.

Fewer than one in 10 consumers used the portal, and it didn't result in lower spending, according to a recent study.[2]

Wiik says the key is for patient

EXECUTIVE SUMMARY

Many states have enacted price transparency laws in response to demand from patients who want to know the cost of care. Some challenges include the following:

- Posting hospital charges on websites doesn't give useful information.
- Patient access professionals need continual education to answer questions on cost.
- Some insurance carriers offer patient pricing portals, but these are underused.

access to engage patients early in the process, with an individualized discussion on costs and coverage. "Then, and only then, can consumers drive their care and control their costs," Wiik says.

The Healthcare Financial Management Association's Patient Financial Communications Best Practices address communication in advance of service and at the time of service, with a framework of measurement to determine compliance. To download a PDF of all the best practices, please visit: http://bit.ly/1s2u63E. ■

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- **David Kelly**, MHSA, CHFP, Director, Revenue Cycle, Mary Rutan Hospital, Bellefontaine, OH. Phone: (937) 651-6338. Email: David.Kelly@maryrutan.org.
- **Lee Patillo**, Patient Access Director, UAB Hospital, Birmingham, AL. Email: lpatillo@uabmc.edu.
- **Sandra J. Wolfskill**, FHFMA, Director, Healthcare Finance Policy/Revenue Cycle MAP, Healthcare Finance Management Association, Westchester, IL. Phone: (708) 531-9600. Fax: (708) 531-0032. Email: swolfskill@hfma.org.

To Build Trust, Tell Patients Why You Need Race and Ethnicity Data

It's easy for patients to understand why they must submit addresses or dates of birth, but the same is not true for race and ethnicity data.

"Patients aren't clear how this information is affiliated with their medical treatment," says **Michelle Reno**, patient access manager in the ED at The University of Tennessee Medical Center.

Patients often ask, "Why is my race important?" or "What is the information used for?" They react negatively to the question for various reasons, Reno says. Sometimes, patients view the question as intrusive or offensive.

"The most common example we encounter involves undocumented patients who are concerned that we are asking for the purpose of reporting to authorities," Reno explains.

To ease concerns, registrars respond this way: "We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can make sure that everyone gets the highest quality of care. The only people who see this information are registration staff, administrators for the hospital, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law."

Polite Explanation Given

Tammy Mendenhall, patient access manager in central registration at The University of Tennessee Medical Center, says a non-confrontational approach is always best.

"We take care not to push the issue, if it is clear the patient does not want to respond to the questions," she adds.

In Mendenhall's experience, asking about race and ethnicity is "the most sensitive question asked during a registration. It's uncomfortable, and registrars tend to brace themselves for a negative response."

Usually, patients provide the information after registrars explain why it's needed.

"When you do so in a nonthreatening and polite manner, resistance to

EXECUTIVE SUMMARY

Patients sometimes react negatively when asked for race and ethnicity data due to a lack of understanding on why hospitals ask the question at all. To prevent dissatisfaction:

- Explain why the information is necessary.
- Assure patients their responses are confidential.
- If someone doesn't want to answer, don't push the issue.

providing this information is minimized," Mendenhall says.

About 20% of people still refuse to give the information. Typically, they tell the registrar, "You don't need this information to treat me," or "It really shouldn't matter to you — it's irrelevant to my care."

"If someone does not want to answer these questions, we simply record 'declined,' and move on with the registration process," Mendenhall says.

SOURCES

- **Tammy Mendenhall**, Patient Access Manager, Central Registration, The University of Tennessee Medical Center, Knoxville. Phone: (865) 305-6554. Email: TMendenh@mc.utmck.edu.
- **Michelle Reno**, Patient Access Manager, Emergency Department, The University of Tennessee Medical Center, Knoxville. Phone: (865) 305-6971. Email: mreno@utmck.edu.

Does Your Collections Scripting Come Off as Friendly or Robotic?

Conversational approach gets best results

Depending on the registrar's delivery, telling patients how much money they owe for services delivered and asking how patients would like to pay can come across as easygoing or robotic.

"I have found that requiring team members to follow scripting verbatim makes them sound robotic. Patients can sense this," says **Will Brown III**, MBA-HCM, manager of patient access services at Baptist Medical Center South in Jacksonville, FL.

He says two things happen in this situation: Patients are less likely to pay what they owe, and they'll think poorly of the organization for trying to collect from them in their time of need.

"Scripting should be tailored so team members can speak confidently with patients on their financial responsibility for services rendered and still create an opportunity for their personality to show," Brown says.

Listen More Than Talk

When coaching on collections, Brown tells employees to "be patient, be confident, and listen more than you talk."

Sometimes registrars are so nervous that they don't wait for the patient's response.

"I've seen team members talk themselves out of a copay by assuming the amount is too high for a patient," Brown says.

First, the registrar tells the patient the amount that is due. Next, he or she states that the patient can take care of the payment via cash, check, or credit card.

"This is where we use what I call the 'awkward silent' approach," Brown explains.

The discussion pauses until the patients respond with how they will pay or if they cannot pay. This technique is especially helpful if registrars are hesitant to ask for money.

"They do not get engaged in the uncomfortable back and forth that occurs with some patients," Brown notes.

Most patients are receptive to this approach. Successful collections boost the registrar's confidence for future conversations.

"It also helps with team members that may collect too aggressively, as it limits their opportunity to say things to patients that may be questionable," says Brown, who recommends these two approaches:

- Find a script that works for your patient population. "Then stick with it, and hardwire it through consistent training and role playing."
- Shadow team members from time to time. "Help them tweak their approach after a failed collection attempt."

EXECUTIVE SUMMARY

Scripting is especially helpful for reluctant collectors, but it can come across as rehearsed and robotic. To be successful, registrars should do the following:

- Listen carefully to what the patient says.
- Don't assume the amount is too high for the patient.
- Pause after telling the patients what they owe.

Train Thoroughly

Tara Farrington, registration supervisor at Genesis Medical Center-Davenport (IA) and Genesis Medical Center-DeWitt (IA), has seen a $30,000 increase in ED collections from fiscal year 2015 to fiscal year 2016. She credits the success to the following:

• Engaging in face-to-face financial discussions instead of over the phone.

"We want to have these conversations with the patients while they are in front of us," Farrington says.

This system allows patients to ask questions and share concerns in person with the registration team, instead of trying to understand their statements at home by themselves.

• Ensuring registrars fully understand terms such as deductible, coinsurance, copay, and out of pocket.

"This can help our team better explain the breakdown of benefits to the patient," says Farrington.

• Tweaking the scripting so it encourages patients to pay their bills.

Registrars use scripting such as, "How would you like to pay for that today?" or "How will you be paying today?" instead of, "Are you able to pay today?" Or "Would you be able to pay for that today?" ■

SOURCES

- **Will Brown III**, MBA-HCM, Manager, Patient Access Services, Baptist Medical Center South, Jacksonville, FL. Phone: (904) 271-6134. Fax: (904) 391-5913. Email: willie.brown@bmcjax.com.
- **Tara Farrington**, Registration Supervisor, Genesis Medical Center-Davenport (IA)/Genesis Medical Center-DeWitt (IA). Phone: (563) 421-2211. Email: FarringtonT@genesishealth.com.

Pair Best Collectors with Struggling Ones

At Ann & Robert H. Lurie Children's Hospital of Chicago, some registrars feared confrontation or being put on the spot if they asked for money. Others correctly stated what the patient owed, but their statements appeared to be scripted.

"Representatives must engage the consumer in conversation, versus simply stating, 'This what I see, and this is what you owe,'" says **Robin Speaks**, MSHSA, CHAM, director of admitting.

To address this, the department pairs one or two reluctant collectors with an experienced collector to "show them the ropes."

Here are some tips that the high-performers shared:

• Practice the art of conversation.

"Rattling off a bunch of scripted words that do not fit the scenario is time wasted, non-valued, and a dissatisfier to the consumer," says **Zander Davis-Washington**, director of ambulatory support at Lurie Children's outpatient clinics.

Instead, registrars carefully listen to what the patients are saying, so they can engage in a true conversation.

"The registrar may refer the patient to appropriate resources such as financial counselors, social workers, or patient relations," Davis-Washington adds.

• Always make eye contact with the patient.

Eye contact allows the registrar to "read" the patient's facial expression. "If there is high anxiety or worry from the consumer, deflect the conversation for a moment, but come right back to it," Davis-Washington advises.

• Wait for a response.

"Do not give consumers a choice not to pay before you have heard their response, just to keep the line moving," Davis-Washington says.

• Say different things, depending on the division.

Depending on the area the registrar works, he or she must be able to engage in financial discussions on facility, physician, surgical, and anesthesiology fees.

"All of the right tools and resources must be in place so representatives can have an informed and intelligent conversation with the consumer," Speaks says.

Since "one-size fits all" scripting doesn't work, patient access leaders came up with a list of situations and effective responses.

"What applies to one division does not necessarily apply to another," Speaks explains. ■

SOURCES

- **Zander Davis-Washington**, Director, Ambulatory Support, Ann & Robert H. Lurie Children's Hospital of Chicago. Phone: (312) 227-3145. Fax: (312) 227-9801. Email: ZDavis@luriechildrens.org.
- **Robin Speaks**, MSHSA, CHAM, Director, Admitting, Ann & Robert H. Lurie Children's Hospital of Chicago. Phone: (312) 227-1231. Fax: (312) 227-9710. Email: rspeaks@luriechildrens.org.

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