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INSIDE

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Will Robots Take Over? They May Free Registrars From Tiresome Tasks

Patient access staff spend countless hours on the phone with payer reps, trying to determine if a particular procedure requires authorization. Still more hours are spent going between systems, figuring out why a patient's insurance claim was denied. What if a robot handled these tasks instead?

"Many revenue cycle processes are time-consuming and repetitive," observes **John Woerly**, RHIA, CHAM, FHAM, an Indianapolis-based revenue cycle consultant.

Departments struggle with inefficient, error-prone, manual processes. All this makes patient access an "excellent candidate" for robotic process automation (RPA), according to Woerly. For patient access, using software robots to automate often-mundane tasks could be a real game-changer. For one, it can stop many costly mistakes that are causing denied claims and lost revenue.

"RPA, if used correctly, allows staff to refocus upon customer service and other value-added responsibilities," Woerly says.

RPA is most effective for highly manual, high-volume tasks, that are prone to human error. There is certainly no shortage of those in patient access. Woerly says the list of tasks RPA could take over include, but are not limited to: scheduling patients for appointments online, reverification of insurance data, identification of secondary insurance, predictive screening for Medicaid and charity care, and identifying what causes claims denials.

"RPA should allow patient access departments to be more productive and improve overall quality," Woerly argues.

RPA also could mean some significant financial benefits for patient access. Leaders dream of reducing claims denials, decreasing A/R days, and increasing collections, all with no extra staff. It will not happen overnight.

"Complete automation of the revenue cycle is not likely a near-term reality," Woerly says.

Patient access staff, if they have heard of RPA at all, probably worry it will take their jobs. In the revenue cycle world, this kind of concern probably is unfounded, says **Isaac Sieling**, a managing director in Huron's healthcare business. "When you hear the words 'robots' or 'automation,' there is the immediate perception that it means downsizing of the workforce. However, we are not seeing that to be the case," Sieling notes.

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Doing more with existing resources does not necessarily mean fewer full-time employees (FTEs) on the payroll. It just means those FTEs will be handling different tasks. Essentially, RPA is a digital workforce that "augments the human workforce," Sieling explains.

In the case of patient access, RPA would handle the kind of simple, repetitive tasks that no one particularly enjoys performing anyway. Patient access employees would switch to dealing with tasks that can put them on a path toward advancement because they align with organization-wide goals.

"For instance, what else could your team be doing to make sure patients receive care at the right place and at the right time?" Sieling asks.

While registrars are working on that complicated issue, RPA can take care of simpler, but time-consuming tasks. Two areas in particular are obvious choices for departments, according to Sieling: "We see many organizations start with eligibility and prior authorization."

If talented registrars are not hindered with constant tedious tasks, they will have time to work on some tasks that really matter to patients. "Not only could automation enhance the patient experience, it could also improve staff morale and job satisfaction," Woerly offers.

There are two possibilities that can benefit patients: First, by automating authorization statuses, prior authorizations could be initiated earlier to prevent rescheduling. Second, if the process to submit and confirm Medicaid enrollment is automated, then patient access staff could provide outreach to patients in need instead.

RPA software platforms can collect data from multiple sources; the electronic health record or payer websites are two examples. Right now, registrars gather that data manually. "But it is the blend of people and technology that can truly optimize patients' access to care," Sieling adds.

For instance, deciding to reschedule a patient because prior authorization was denied requires a human to approve it. The same is true for answering questions on the cost of care or resolving scheduling errors.

Even with RPA, the personal touch still matters, possibly more so now than ever. For patient access, this kind of human connection "continues to be a differentiator for organizations," Sieling says. ■

Two Good Reasons to Earn a Certification: Pride and Validation

Revenue cycle employees need complex skill sets, yet few have earned any type of certification in their field. This is no longer the case at Whittier, CA-based PIH Health.

"As patient access leaders, it's important to make these certifications a part of the job requirement," says **Cindy Ovalle**, patient access manager of patient registration.

The department's management, financial counselors, lead representatives, and level II registration representatives are required to earn the Certified Healthcare Access Manager (CHAM) credential, offered by the National Association of Healthcare Access Management (NAHAM). If level I registration representatives earn the credential, they are promoted to level II.

After passing the exam, employees "feel a sense of pride and validation," Ovalle reports. "It also opens up some new opportunities." Ovalle says there are four ways patient access leaders can help eliminate barriers to certification:

• Create study sessions for employees before or after work hours;

• Allow staff to study for the exam during work hours;

• Offer a salary increase or job title change if employees become certified;

• Pay for the cost of the certification exam for certain job positions.

The department covers the cost of the first exam and the renewal costs so staff can remain certified.

"Engage executive leadership to support this additional cost," Ovalle suggests.

Leaders offer handouts, quizzes, and study sessions to help employees prepare for the exam. Outside of work hours, the studying continues.

"Staff study together on their own time, with groups of employees who will be taking the exam," Ovalle says.

One year ago, only 10 revenue cycle employees were certified at Grand Rapids, MI-based Spectrum Health.

"Now, it's up to 111 and growing rapidly," says **Amy Assenmacher**, senior vice president of revenue cycle.

The change came from the top. "The CFO challenged all of us as leaders to get our certifications and set the example," says Assenmacher, who earned her Certified Healthcare Financial Professional (CHFP) and Certified Revenue Cycle Representative (CRCR) credentials, both offered by the Healthcare Financial Management Association (HFMA).

Leaders at Spectrum Health, regardless of their role or level, are encouraged to obtain any one of the six certifications offered by HFMA. These cover healthcare finance, revenue cycle, and analytics. "Regardless of whether you are a front-line registrar or a senior director setting strategy for the access services department, the HFMA certifications are the same," Assenmacher says.

The health system's CFO told leaders if they earned certifications within two months, he would take them to lunch. Newly certified revenue cycle leaders made the same offer to their staff.

Although it is strongly encouraged, certification is not required, at least not yet. Patient access leaders have discussed making it mandatory. They also are looking at tying certification to advancement by making it a requirement in the department's career ladder.

For individual employees, the prestige of listing a credential after their names is important in itself. "I definitely see an increased confidence," Assenmacher observes.

Previously, if employees wanted a credential, they had to pay hundreds of dollars to take the exam. Spectrum Health decided to eliminate this barrier by investing in an agreement with HFMA that includes certification for all the health system's employees. "All 1,500 employees in revenue cycle have been strongly encouraged to consider pursuing these certifications," Assenmacher says.

There remains a time commitment — about eight hours studying time and 90 minutes sitting for the exam. To make this easier, revenue cycle educators offer a lunch-and-learn series on how to study for the exam and why the credential is so important. "Usually, someone who has successfully passed the exam shares a testimonial of sorts," Assenmacher says.

Some employees are worried they will flunk, especially those who have not taken an exam in years. "They want to know the process," she says. "When anyone hears the word 'test,' there is a normal anxiety that arises."

One employee sheepishly admitted she failed the test on the first try. Assenmacher told her, "It's just proof to me that you are committed and that you really want to do this. It's not an easy test, and it may take you several times, and that's OK."

As soon as they are certified, many staff add digital badges to their LinkedIn profiles. "It demonstrates to others, outside your area, that you have a commitment to becoming an expert in your field," Assenmacher notes.

Each revenue cycle department is engaged in a competition to see who can certify the most employees by the end of this year. "They are also helping each other and sharing tips and tricks," Assenmacher adds. "There's an awesome momentum around it." Staff who already obtained the credential usually advise their colleagues to break up the material in bite-size amounts.

For some enthusiastic employees, certification is just the first step. Some have found other ways to make a name for themselves in the revenue cycle field by signing up at a local committee or attending a national conference. "It's a gateway," Assenmacher says. ■

Insurance Companies Steering Patients Away From Hospital Sites

Registrars are canceling procedures on short notice much more often these days, not because anyone needs to reschedule but because insurance companies are contacting patients to tell them the hospital setting will cost more. "We frequently see patients cancel their hospital-based radiology study to pursue cheaper studies at an outpatient free-standing facility," reports **Jessica Budri**, RN, MSN, APRN, senior manager of patient access at Connecticut Children's Medical Center in Hartford.

Usually, the free-standing centers are not pediatric-specialized. Thus, families

are not choosing them for any reason other than cost. "We are seeing this in our outpatient hospital surgery ambulatory center, our radiology department, and our infusion center," Budri reports.

In the infusion center, parents are resistant to switching to an outpatient center. This is due to strong bonds with their child's provider, who may have followed them for many years throughout their childhood. "They prefer the pediatric setting, with nurses who are specially trained in this type of care," Budri says.

Still, parents feel they are left with little choice due to payer policies. "The insurance companies are pushing more and more patients, of younger and younger ages, to outpatient infusion centers that are not hospital-based," Budri says.

Payers are calling patients right before their appointment to tell them that the infusion will be denied if it is performed at the hospital-based facility. "This is the worst-case scenario," Budri laments.

Staff have gone through the authorization process already; everything is in place to proceed with the service. "It's causing undue angst to the patient and disrupting their plan of care," Budri observes.

The last-minute cancellations are interrupting time-sensitive care and wreaking havoc with scheduling. "It has greatly impacted the complexity of the authorization process," Budri says. "This leads to decreased productivity." Registrars, pulled away from the work of obtaining authorizations for other patients, are left with a cancelled procedure and a confused patient. They do what they can to help. "We push all families to contact their employer and insurance plan directly to advocate on behalf of their children," Budri says.

Patient access does its best to appeal the denial. "We often proceed with the care while the appeal is processing," Budri explains.

Previously, physicians engaged in a face-to-face interaction with the patient once every six to eight weeks when the patient came in for his or her infusion. Now, physicians have lost that opportunity. "They only see [patients] if complications arise, putting them at risk for the small complications, which could've been caught earlier during that routine infusion check-in," Budri says.

Following every step of the appeal process to the letter has overturned some denials. At first, the success rate was about 70%. "But we are seeing that decline. We are seeing less success with older patients. Now, less than 25% of patients over 17 get approvals through the appeals process," Budri says.

Peer-to-peer sessions, when the patient's treating physician discusses the case directly with the insurance company's physician, sometimes result in approvals. "We have had to educate physicians on the importance of 'fighting the fight,' if you will," Budri explains.

Physicians are in full support of the patient continuing to receive treatments at the hospital. They simply do not have time to make lengthy phone calls to the insurance companies. "This becomes an administrative burden," Budri says. "They try to find the time during high demands of clinical time."

As a licensed APRN, Budri can handle peer-to-peer sessions herself, which has led to some denial reversals. Her job is to show the insurance company why receiving the service offsite is unsafe for the patient. For instance, some patients have a history of allergic reaction to medications, which can be life-threatening.

"Outpatient centers are not equipped to handle that. It is much safer to be in a hospital setting," Budri says. Even in these cases, says Budri, "I find that if it's not recent documentation or an event in the last year, they don't count it. You have to be very high risk for insurance companies to approve it for this reason."

Another issue payers do not take into account: Most children would rather go to a familiar place for treatment. "What we have found to be disappointing is that the social or mental impact of this recommendation is not considered," Budri says.

Involving families can make or break the outcome of the appeal. When the parent is the one making the call, says Budri, "the conversation is no longer about money, which it may appear to be when the request comes from the hospital. It's now about patient preference — and safety." ■

New Appropriate Use Criteria for Radiology Will Affect Patient Access

Updated Medicare Appropriate Use Criteria (AUC) will go into effect Jan. 1, 2020. On that date, providers must document that AUC was consulted when ordering outpatient advanced imaging (CT scans, MRIs, PET, or nuclear medicine) for Medicare fee-for-service beneficiaries. For patient access, the big question is: Is this Medicare's first step toward requiring authorizations for radiology services? "Though it is being stated as a 'review' and suggestion system to better utilize healthcare, I do believe this is step one of Medicare instituting authorizations for high-end radiology procedures," predicts **Craig Pergrem**, senior director of preservice and onsite access at Winston-Salem, NC-based Novant Health.

Medicare has seen the success that managed care companies have

experienced with similar requirements on Medicare replacement plans. "They are smart to follow suit for cost savings," Pergrem says. "With that being said, Medicare is so large that it needs to be an online product that allows the procedure to be reviewed. The AUC is that first piece."

The testing period in 2020 will provide more clear-cut answers. For now, here are some patient access processes that will be affected:

• **An order is going to be required for completion of the questions.** This is the biggest challenge Pergrem sees for patient access. "The ordering provider will hopefully go through the appropriate channels to answer those questions to select the proper code," he says.

• **Procedure scheduling, including how walk-ins are handled, will change.** "We are hoping that our contractor can assist in getting these areas carved out appropriately and feed us data that will be integral to us getting paid properly," Pergrem says.

The new requirements will affect scheduling, patient access, insurance verification, as well as the revenue cycle in general, says **Tammie Myers**, regional senior manager at Novant Health Imaging. "It seems this will work very similarly to the auth requirements of other carriers," Myers observes.

While Medicare is not calling it an "authorization requirement," it will work mostly the same way. Without the AUC information in place and correctly coded, the hospital will not be paid. "The financial burden lies on us as the rendering hospital," Myers notes.

The mandatory testing period in 2020 is expected to provide useful data for analysis and correction. This should prevent a huge increase in denials. "However, it's still possible that there will be revenue loss from this new program," Myers cautions.

The best course of action for patient access: strategic planning. Leaders should be ready to change the way they handle scheduling and insurance verification. "We should be prepared to make numerous changes to ensure the best patient outcomes are received, and our financial vitality remains intact," Myers offers. ■

Many Continue Asking Age-Old Question: 'Why Do Hospitals Charge So Much?'

A growing number of states, including Oregon, Rhode Island, and Delaware, are enacting laws to control the cost of healthcare, including services rendered at hospitals.[1-3]

"This is the kind of thing we're going to be seeing more of. There is going to be huge attention on this," predicts **Suzanne Delbanco**, PhD, MPH, executive director for Berkeley, CA-based Catalyst for Payment Reform. As it stands now, "hospitals are charging higher prices because they can," according to Delbanco. This could change as public frustration and scrutiny increases.

"Hospitals will need to think very carefully about whether they really want to have a profit margin that comes from having high prices," Delbanco offers.

The widespread perception is that hospitals are raising prices year after year, without addressing the underlying costs.[4,5]

"Everyone argues that Medicare payments are too low. But if hospitals are more efficient, the Medicare payment turns out to be adequate," Delbanco explains.[6]

Earning a reputation as the hospital that charges the most could put that facility in a less competitive position. "It could cause them to lose volume to someone else who's got a more efficient ship," Delbanco notes. There is growing awareness that hospitals in the same area are charging significantly different prices for similar procedures.

"Prices at the highest-price facilities are up to two or three times as high as at the lowest-price facilities," says **Anna D. Sinaiko**, PhD, assistant professor of health economics and policy at the Harvard T.H. Chan School of Public Health in Boston.[7]

As patients learn more about the way things work, they likely will choose hospitals that are able to offer good quality care at lower prices. "The challenge is how to get that message out in a way that meaningfully affects patient choices for hospital care," Sinaiko says. A patient's hospital choice also depends on his or her physician and insurance. Thus, the most effective marketing message should be directed at all of these groups, Sinaiko suggests.[8]

Barak Richman, JD, PhD, says state efforts will focus on two areas:

• **Curbing the worst abuses.** "These are the extraordinarily high prices and price gouging, which usually express themselves either through illegal monopolies or through surprise bills," says Richman, professor of law and business administration at Duke University.

• **Solving the problem of how to provide affordable rural healthcare.** "States are learning they will need to support physician groups and other professional partnerships that are independent from hospitals," Richman says.

The movement toward price transparency began around 2011, Delbanco says. At that time, companies were interested in reference pricing, the idea that health plans and employees agree on what is a reasonable price for a given service. Reference pricing works this way:

• If the provider meets or beats the reference price, the health plan pays the maximum amount allowed;

• If the provider's price is higher than the reference, the plan member has to pay the difference out of his or her own pocket.

"If you want to put a program like that in place, providers need to share price information with the plan members," Delbanco explains. That is the only way for people to know what their out-of-pocket costs will be in advance.

Soon, people figured out that there was no easy way for anyone to obtain that kind of price information. This became an obstacle to reference pricing. "Health insurance companies were then pushed to develop these resources," Delbanco says. It also created an opening for startup companies to create tools to share price information with consumers. "That is how the price transparency movement really started," Delbanco explains. "Since then, we have seen a lot of progress."

Major insurance companies all offer some kind of price information, although not for all providers.

"In some cases, it's even customized in such a way that a patient can see what their personal out-of-pocket costs would be for selecting a given provider," Delbanco says. Some tools even take into account how much of the deductible has been met.

Initially, people looked to health insurance companies to provide information on the cost of care. Recently, the focus has shifted to healthcare providers' responsibility to give out the information.

Recent federal legislation requiring hospitals to post prices reflects this expectation, although the information proved to be of little use for consumers. While some hospitals created web pages listing typical charges, the information is rarely customized to a particular patient. "It's marginally useful," Delbanco argues. On the state level, some legislation has been passed targeting this area. "A lot of states have done nothing. Of the ones that have, it ranges from something that is pretty hard to find to something much more functional," Delbanco reports. A few recent developments:

• Some states have passed laws requiring hospitals or health plans to provide price estimates within a certain period. There is no guarantee people will receive good price quotes in the timeframe. In Massachusetts, a law requires that hospitals give the information in 24 hours.

"A secret shopper survey found that most hospitals were not equipped to answer the question, even after the law was passed," Delbanco explains. An expanded concept of "informed consent" is needed, according to Delbanco.

"When patients sign consent for surgery, why not put in there what's likely to be charged to them?" she asks, adding that there is no reason for the cost of most care to be a surprise. "When you think of the mental stress getting these surprise bills puts on people, it has to affect their health."

• Some states, including New Hampshire, have created an all-payer claims database. This pools information from health insurance companies and is searchable by providers and services. Some databases are customized, at least to some degree, to the patient's health insurance.

"From that, you are able to produce pretty good information on what the patient is likely to pay in a typical hospital after having typical surgery by X provider," Delbanco says.

• Recent consolidation has changed the way hospitals negotiate with payers. "As healthcare systems have gotten more market share and more market power, it has changed the way they negotiate with payers," Delbanco says.

Certain hospitals have put provisions in contracts, protecting them from the health plan revealing what the hospital is paid. "Some even prohibit the health plan from offering network designs that would look unfavorably on that hospital," Delbanco notes. The provisions might prevent health plans from creating a narrow network that does not include that provider or a tiered network that does not list the hospital in a preferred tier. Several antitrust cases were settled recently, prohibiting those practices.[9]

"We know that these kind of contract provisions exist and that they are pretty anti-consumer," Delbanco says. ■

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Financial Navigators Can Solve Complex Cases

Recently, an exasperated parent brought a shoe box full of bills to Ann & Robert H. Lurie Children's Hospital of Chicago. Some hospital bills were in the stack, but there were also paper bills from multiple other providers and facilities. "The financial counselor separated, organized, and reviewed each bill," says **Robin Speaks**, MSHSA, CHAM, quality manager for the revenue cycle.

It turned out some of the bills were duplicates. Others were for various amounts, small and large. The parent left much calmer, with a solid plan in place. "In the end, the patient was eligible to apply for state programs to assist with meeting their financial obligations," Speaks says. For patients facing a stack of hospital bills, there is a new kind of expert ready to help. Highly trained employees now "financially navigate" on behalf of patients.

At Lurie Children's, one financial navigator helps patients, but more are in training. "We are strengthening the department to eventually develop a team of financial navigators," Speaks says. Here are some of the patients who are receiving much-needed help:

• People who have never had commercial insurance. Many in this group have no idea how insurance works, or even what a copay is. Sometimes, an employer provided no information. Other times, there was information, but the employee did not understand it. "We take our time to explain and give examples of how their plan works," Speaks reports. "Patients are able to make better healthcare financial decisions."

• Patients who switched from the traditional Medicaid program to the state-mandated Medicaid Managed Care Organization (MCO) program. After this change, the financial navigator dealt with many people who were "confused or exasperated," Speaks says. First, the navigator explained the reason for the change and the family's responsibility (i.e., selecting the appropriate MCO for the child and family). "We assisted in obtaining referrals and prior authorizations for services, which these patients never had to do before," Speaks notes.

Many people with a Healthcare and Family Services (HFS) medical card suddenly were required to enroll in HealthChoice Illinois, the Medicaid managed care program. HFS mailed letters to families informing them of this change. Some never received the letter; others misplaced it or ignored it. "Countless families were going to be affected by this change," Speaks explains. The hospital took a proactive approach by educating all revenue cycle staff. Not surprisingly, the change did not go smoothly. "There were innumerable complications with the state rolling out the program and recipients trying to reach out to the state-provided vendors," Speaks recalls.

• Families who are overwhelmed by the sheer volume of bills, statements, and Explanation of Benefits they receive. Phone calls and mail comes from the hospital, various physicians, and the insurance company. A surprising number of people simply ignore it all. "Once the financial navigator gets involved, it becomes clear that the patient is actually eligible for a state program," Speaks observes. This can help even when the bills are from other hospitals or providers. "Other facilities acknowledged the need to apply old balances to charity care," Speaks says.

The financial navigator assures the patients they are not alone. Navigators help patients understand their commercial or state coverage and benefits, including workman's compensation or other third-party liabilities. They help patients sort out multiple bills and understand it all. Navigators inform patients if their coverage is in network or out of network and whether there are requirements for prior authorization or referrals. Also, navigators help patients complete financial assistance applications, enroll in state programs, or set up payment plans.

All financial navigators have at least two years' experience in patient registration, and have some accounting or banking experience. They also have solid knowledge of ICD-10 coding, medical terminology, third-party billing and collections, and commercial and managed care industry requirements. Perhaps most importantly, anyone doing this job "must also have a genuine 'heart' for people, to help and advocate when necessary," Speaks adds. Providing financial navigation training to staff at hospitals and cancer centers is more than just the right thing to do. It turns out it can decrease patients' out-of-pocket expenditures significantly. *(http://bit.ly/2VnCdw5.)*

"We have long been interested in the financial toxicity associated with cancer care and the long-term consequences," says **Todd Yezefski**, MD, a senior fellow at the Fred Hutchinson Cancer Research Center in Seattle. Of 11,186 new patients with cancer seen at four hospitals between 2012 and 2016, 32% qualified for financial assistance. "The sheer magnitude of the financial benefits for both patients and hospitals was the most surprising finding," Yezefski says. The four hospitals avoided write-offs and saved on charity care by an average of $2.1 million a year. "There is a huge return on investment for the hospitals," Yezefski adds.

Patients accessed tens of thousands of dollars worth of life-saving care they may not have received otherwise, or for which they would have had to pay high out-of-pocket costs. Hospitals enjoyed significant cost-savings thanks to the fact they did not have to rely so much on charity care, receiving compensation for services provided. "By training and hiring just a handful of staff members as financial navigators, hospitals have the potential to bring in millions of dollars of additional revenue," Yezefski says. ■

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e. Total Free or Nominal Rate Distribution *(Sum of 15d (1), (2), (3) and (4))*			12	19
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* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies, skip to line 17 on page 3.

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