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INSIDE

RELIAS MEDIA

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Many Skeptical Patients Do Meet Financial Assistance Criteria

Millions of people are uninsured, unemployed, and unable to pay their hospital bills. Patient access is stepping in to offer all kinds of help.

"We are seeing a larger increase in patients wanting financial assistance," reports **Linaka Kain**, DE, regional manager of patient financial coordinators and the marketplace exchange for UnityPoint Health.

UnityPoint's financial assistance programs are primarily for uninsured patients facing catastrophic medical bills. They are not necessarily for those who present with insurance but still face paying high out-of-pocket costs. "Also, even if someone does qualify for financial assistance, it only helps them at the hospital they incur their medical bills at, as an option of last resort," Kain explains. If the person goes to a different hospital, he or she would need to re-apply to see if they meet that hospital's criteria.

Financial coordinators first check to see if those with private commercial insurance can qualify for Medicaid as secondary insurance coverage. "That's going to help them with every medical bill they incur, at any hospital," Kain notes.

If the patient is well above the federal poverty level and has commercial insurance, "there's not much you can do for those people," Kain says. Payment plans or low-interest loans are offered. For some, the biggest worry is they will not qualify for a loan. "When they find out no credit check is run, they breathe a sigh of relief because they know their credit is not very good," Kain observes.

Sometimes, the patient can afford the payments at first, but things change for the worse. If someone cannot make the payments later, "then we have to go to financial assistance," Kain reports.

Financial coordinators routinely screen inpatients to see if they might qualify for Medicaid. Many skeptical people say, "There's no way I'll qualify. I make too much money."

"Those are the people who actually end up qualifying," Kain says. "They just don't know how to figure their income out the way that DHS or the marketplace is looking at it."

There may be an instance when the patient's diagnosis makes him or her eligible for disability because the patient cannot work through treatment. "We can get them signed up for Medicaid. There are assistance programs that can get them free medication for two or three months, which really helps," Kain says.

Financial coordinators ask six screening questions to identify if someone is eligible for Medicaid. If the person is eligible, he or she completes a Medicaid application

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immediately. "The name of the game is doing everything you can all at one time," Kain stresses.

Staff apply for the hospital's in-house program for medication assistance. They also apply for any community benefits that might be available, and examine whether financial assistance is an option. "We apply for anything we determine the patient may be eligible for. It's a one-stop shop we are trying to do so the patient doesn't have to come back and be inconvenienced," Kain says.

Many do not expect to meet criteria for any help. "They are surprised because they have not been educated in what's available to them," Kain says.

Perhaps someone applied for Medicaid previously and was rejected because his or her income was too high. When things change (e.g., job loss or hours reduction), those people assume they cannot apply again until the following year. "Not working overtime any more, or losing their job, could put them within different criteria," Kain explains.

That is because while other programs consider yearly income, Medicaid is concerned with monthly income. Financial coordinators ask these questions:

- What is your total household income?
- Have you applied for insurance in the last three months?
- When is the last time you had insurance?
- Are you currently employed?
- What is your rate of pay?
- Have you lost a job recently, have your hours been reduced, or have you been laid off?

These days, many people answer "yes" to this last question. Most are quite surprised to learn they still have coverage through their former employer. "They think that if they quit or got fired that their coverage ends that day. That's not the case," Kain underlines.

The coverage still may be good through the end of the month, or may be good for an additional month. Some people have a 60-day window after leaving or losing a job to qualify for a special enrollment period through the Health Insurance Marketplace. "The majority of people just don't know," Kain says. "It's all about asking the right questions."

At Novant Health in Winston-Salem, NC, patient access made two changes:

- **Staff are placing temporary holds on accounts if patients express concerns about their ability to pay while out of work.** This buys patients time to figure out a solution, as opposed to allowing accounts to go to collection. "Those holds will be revisited periodically to determine if they should be released or extended," says **Elkin Pinamonti**, MHA, CHAM, assistant director of patient access.
- **A new process uncovers cases for which insurance has denied a claim.** Staff proactively contact the patient to offer assistance. "We refer any visits within the retroactive eligibility period to be screened for Medicaid," Pinamonti says.

Certain patients do not qualify for Medicaid. Others qualify, but the visit date falls outside the retroactive eligibility window. Those problematic accounts are routed to a financial counselor who contacts the patient. Together, they create a plan. "Patients are surprised that even if they do not qualify for a full charity adjustment, they can sometimes qualify for a significant discount," Pinamonti reports.

These pleasant surprises are becoming more common. Almost half of uninsured adults may have been eligible for subsidized insurance (either through the Health Insurance Marketplace or their state's expanded Medicaid program).[1] "Either they are eligible for Medicaid, the kids are eligible for CHIP [Children's Health Insurance Program], or they are eligible for the marketplace with premium subsidies or cost-sharing

reductions," says **Jack A. Meyer**, PhD, an independent healthcare consultant.

For the patient access role, it means a shift away from upfront collections. Instead, staff are focused on assessing people for eligibility for various programs. "We are not just talking about poor people here. We are talking about a lot of middle-income people, too," Meyer says.

For eligible patients, Medicaid pays virtually all of the hospital bill. For the hospital, it means much-needed revenue. "They'll get Medicaid payments, which are lower than commercial insurers, but it's about 70 cents on the dollar. If I had a choice between getting 70 cents on the dollar and zero, that's not a hard choice," Meyer offers.

Many hospitals have fine-tuned processes to tell people their out-of-pocket costs. But this transparency about costs is not enough at this point. "You can be transparent, but if being transparent is telling the person it's going to cost thousands of dollars, and they can't afford it, what good is it?" Meyer asks.

For instance, many cannot afford to pay their deductible. "Some hospitals may work with health plans to waive or cover the deductible in some cases," Meyer says.

The hospital might pay the deductible. Patients receive needed medical care, and the hospital receives some reimbursement from the health plan. "This prevents the hospital from billing the account for five years and getting stuck with bad debt," Meyer adds. ■

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Insurance Coverage Data Show Stalled Progress on Racial Disparities

An analysis of the Affordable Care Act (ACA) revealed racial disparities in health insurance remain persistent.[1]

"The study aimed to highlight the impact of the ACA on communities of color, specifically with regard to insurance coverage and access to care," says **Jesse Baumgartner**, a research associate at The Commonwealth Fund.

Researchers wanted to know how disparities between people of color and white adults may have narrowed since the ACA's main provisions went into effect. They also were interested in what role Medicaid expansion played in that progress.

"We also wanted to report out any racial and ethnic disparities that still remain today," Baumgartner adds.

One significant finding was insurance coverage for Black adults living in Medicaid expansion states increased dramatically. "It has improved by such a large amount that they are now more likely to be insured than white adults living in non-expansion states," Baumgartner reports.

However, overall progress regarding racial disparities has largely stalled, and even eroded, since 2016. "Structural racism is built into our current health system. It's important to detail remaining racial inequities," Baumgartner says.

This includes health insurance coverage disparities. Also, communities of color can be treated differently by providers even when they do access the system.

"This type of data can be used by policymakers and other decision-makers to make the U.S. health system more equitable," Baumgartner says. ■

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Registrars See More 'Junk' Plans, Which Offer Little or No Coverage

Registrars are seeing many more patients presenting with insurance cards that look valid but turn out to offer little or no coverage.

"The Trump administration has allowed the sales of plans that might not cover much of the care people need," says **Allison K. Hoffman**, JD, professor of law at the University of Pennsylvania.[1,2]

The most common of these, typically called "junk" plans, are short-term offerings. "These plans were intended as temporary stop-gap measures, not longer-term coverage," Hoffman reports.

Initially, the plans were limited to three months. The Trump administration redefined "short-term" to allow these plans to last for 364 days, with renewal for up to 36 months. "The problem with these plans is that they don't have to cover the same benefits as

required for other plans under the ACA [Affordable Care Act], known as essential health benefits," Hoffman explains.

Certain plans exclude pre-existing conditions and cap coverage levels at tiny amounts. Many are stuck with significant out-of-pocket costs for benefits that are not covered, or costs above the allowable limit. "If a patient cannot pay, the hospital will have to manage the debt," Hoffman observes.

Three million people were enrolled in short-term limited duration insurance in 2019, a 27% increase from the previous year.[3] After the ACA, says Hoffman, "most hospitals saw a higher number of patients with decent insurance coverage. If a large number of people opt for short-term plans, which are considerably cheaper than ACA-compliant plans, the tide might turn."

This makes life difficult for patient access. Registrars are the bearers of bad news to patients who do not realize their health plan is "junk."

"We definitely are seeing an increase in plans with very limited or no coverage," says **Sarah Clark**, senior director of registration and financial counseling at Spectrum Health West Michigan. Clark details certain plans her department is handling:

• Narrow network plans. "Individuals are trying to do the right thing in balancing the cost of premiums with what they can afford. They don't realize it will limit which providers they have coverage for," Clark says.

It is only when people schedule needed care that they learn the coverage does not include the hospital. "Their options at that point are rather limited," Clark adds.

Patients who paid their monthly premiums in good faith are understandably frustrated and angry. Some insist the registrar is wrong about their coverage, or demand to know why the hospital will not accept the coverage. "Many ask, 'Why didn't somebody tell me this?'" Clark reports. Staff redirect the conversation toward finding options for the patient. "Most of the time, at the conclusion of the interaction, the patient is actually very grateful for the education they received," Clark notes.

If patients really cannot wait for care and do not want to go to a different hospital, they are classified as self-pay. "Most of the time, they seek care at a facility that's in-network, which maybe isn't what the patient wants at all," Clark says.

Sometimes, people can delay scheduled care, with the intent of obtaining better coverage. Usually, they have to wait for the next open enrollment period to do so — but not always. "We may be able to identify a qualifying circumstance to allow them to select a new plan right away," Clark offers. To prevent future problems, every time staff identify a narrow network plan, it is added to the registration system. "A pop-up alerts the registrar," Clark says.

• Faith-based membership plans or ministry-type funds. "These are being marketed as an alternative to insurance during open enrollment periods," Clark explains.

The plans are attractive to consumers because of low premiums and what seems like good coverage. In reality, this is not insurance at all. "The hospital has no contracted agreement with them," Clark says. "Individuals see it as an option that would provide them with coverage, and it just does not."

The plans are notoriously hard to detect, even for experienced registrars. The membership cards look exactly like valid insurance, even down to the terminology used. "The registration specialist enters it in as a health plan without identifying it," Clark says.

Unfortunately, for most who present with these plans, their income is well above federal poverty levels. Even if a patient is low income, he or she still may own too many assets to qualify for charity care. There really is nothing the hospital can do to secure reimbursement on behalf of the patient. "The patient is left to negotiate with the members or the board of directors in the fund on what sort of payment will be available," Clark says.

(Editor's Note: We first reported on these so-called "sharing ministries" plans in the August 2019 issue. Read more about these plans at: https://bit.ly/3eIkIj7.)

• Indemnity plans with only outpatient coverage or limited inpatient benefits. Certain health plans cap inpatient benefits at a paltry $500. "People select a plan with limited coverage because it's all they can afford. They are essentially uninsured," Clark laments. Patients pay a monthly premium, only to find out they are responsible for virtually all of their bill. Whatever the situation, the earlier registrars handle it, the better for everyone. Clark highlighted these processes her department put in place:

For scheduled services: The hospital bill is sorted out in advance. No one has to deal with health insurance coverage issues on the day of surgery or when they are home recovering. "We are really active on doing a review of coverage as early as possible," Clark says.

For unplanned services: Staff have an in-person conversation about the financial situation. "This gives the patient options on whether to proceed or delay care," Clark explains.

The department goes even further by trying to avoid the problem of people choosing bad health plans in the first place. A team of Certified Application Counselors help patients during the annual open enrollment period. "We are out in the community hosting events, and helping patients to find a solution that provides good coverage," Clark says.

It helps that financial counselors are trained in de-escalation and empathy, and put themselves in the patient's shoes. "These are individuals who went through a process with all the right intention to

do the right things [and] have been left with coverage gaps," Clark says.

Spectrum created some scripted guides that are somewhat helpful when staff are searching for the right words. "But given the uniqueness of every circumstance, it's not a robotic approach," Clark notes.

Staff are trained to listen to the patient's entire story without interrupting. "We can sometimes identify some paths to coverage that they didn't see before," Clark suggests.

One patient needed emergency surgery for an eye injury sustained while working on his car. The patient discovered his health plan included minimum coverage. "The financial counselor was able to help the patient realize that there was some coverage available through his auto insurance plan," Clark says. ■

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Self-Serve Registration Options Continue to Evolve

Until recently, many hospitals were looking for ways to increase self-serve registration kiosks use. Priorities have changed, or at least expanded.

"I've heard some hospitals have recently removed kiosks. Many have moved to more touchless technologies," says **John Woerly**, RHIA, CHAM, FHAM, an Indianapolis-based revenue cycle consultant.

There is an overall move away from face-to-face registration. "Kiosks are still a very viable option — better, at this point, than human interaction," Woerly offers.

A few hospitals have found creative ways for patients to check in using their own phones or facility-owned tablets. This allows people to update registration and clinical information, sign consents, make payments, and schedule future appointments.

"We now have more state-of-the-art technologies that patients would be more comfortable in using in these times," Woerly says. The bottom line is that patients want "easy, convenient, and safe" registration, Woerly adds.

Today, fewer than 20% of hospitals operate kiosks, according to an estimate from **Jonathan Wiik**, principal of healthcare strategy at TransUnion Healthcare. "It is still in early adoption due to patients wanting face-to-face interaction," Wiik says.

This varies somewhat by generation. Older patients may prefer personal interaction. "Millennials would prefer touchless, but the industry is not there yet," Wiik observes. During the COVID-19 pandemic, hospitals have used patient portals as much as possible for preregistration. "Social distancing from COVID-19 has certainly changed the admissions, registration, and intake process," Wiik notes.

Patients texted their arrival, and staff escorted them inside. Paperwork and insurance verification were handled in advance. However, this labor-intensive process works best when patient volumes are unusually low.

"As the industry brings back the elective procedures that were deferred, volumes will demand a more streamlined approach to patient intake," Wiik explains.

Installation and deployment of a kiosk system take months. Enough time is needed to install the kiosk, to change workflows, and to educate staff. "There will be more adoption going forward, as they are an efficient and operational way to manage patient flow in a socially distanced manner," Wiik predicts. For hospitals that already operated kiosks, workers are placing dots or tape on the floor six feet apart. Also, staff clean kiosks between each use. "Most people, however, want to bypass the waiting room altogether," Wiik says.

Remote registration and an "express care" concept is becoming an expectation. "As consumers, we all want to get in and out of whatever errand we have quickly, especially healthcare," Wiik notes.

There are some formidable challenges. "Regardless of what a patient may expect, hospitals have budgets. They cannot staff to infinity," Wiik says. Clinical positions are prioritized over clerical roles. "It is [too expensive] for a hospital to staff a concierge or escort for every patient," Wiik explains.

Many patients would love to set up a profile for their healthcare, just as they do when shopping online. "This would streamline intake considerably. However, there is not a lot of momentum with providers as care is still episodic in nature," Wiik cautions.

Hospitals see a patient perhaps once a year, at most, unless there is a significant diagnosis or major trauma. "Engaging patients more frequently can help ensure

the demographics, health behaviors, and health history is up to date and electronic," Wiik suggests.

At Tampa, FL-based Moffitt Cancer Center, the patient and families advisory council expressed eagerness for more self-service options. "We are in the middle of building online registration and self-arrival kiosks, with a planned roll out by the end of the year," reports **Marion Knott**, manager of clinic access.

Through online registration, patients can complete registration in advance, either on home computers or smartphones. "The kiosks, when implemented, will be for the arrival aspect only," Knott says. Staff will properly identify the patient, armband them, assist them (if needed), and clean the kiosks.

"We plan on having wipes located at each one for the patient to wipe them again if that makes them feel more comfortable," Knott adds. ■

Tiny Differences in Health Plans Cause Huge Problems

Registrars contend with dozens of health plans, some of which are almost exactly alike. Those details mean entire claims are denied.

"There are so many logos on insurance cards today, it is difficult to determine who is the core payer. The largest logo does not always win," says **Pamela Carlisle**, MHA, FHAM, director of revenue cycle management at Genesis HealthCare System in Zanesville, OH.

The department created an education class specifically for insurance. Trainers use actual physical cards to teach registrars to tell them apart. They also review the details of the coverages and subtle differences between government and commercial plans.

"Pulling staff away from the team, and taking time just to talk about insurance cards, truly improved the quality of their work," Carlisle reports.

Patient access trainers give frequent updates — again, using visuals of problematic insurance cards. "This allows the selection of the correct insurance," Carlisle notes.

For years, registrars at Hackensack (NJ) Meridian Health struggled to keep track of all the look-alike plans. No matter how careful they were, mistakes were made because processes were mostly manual.

"Each payer has multiple product lines, and employers all have different benefits," explains **Anne Goodwill Pritchett**, MPA, FHFMA, senior vice president of revenue cycle operations. Registrars might enter the correct plan, but the wrong product line. They selected HMO instead of PPO, or vice versa. Staff were not careless or unprepared. "Everyone knows what the terms HMO and PPO mean. But on the card it may have used some other language that is not as familiar," Goodwill Pritchett suggests.

The mistakes caused major problems for the revenue cycle. "There were discrepancies between what we had anticipated as the expected reimbursement and what the payer actually paid," Goodwill Pritchett reports. Health plans negotiate different rates depending on whether the plan is an HMO, PPO, or indemnity. If the wrong option is selected when the claim is submitted for payment, the contract management tool calculates the expected reimbursement for the chosen product line. If staff select an HMO with expected reimbursement of $5,000, but the patient really presented with an indemnity plan that offered reimbursement of $6,000, the payer would pay the $6,000.

The payer was meeting contractual obligations for the selected plan. Yet the hospital's system only expected to receive $5,000 from the payer, since HMO was selected incorrectly. In that kind of confusing situation, it seemed like the payer overpaid by $1,000. "That would create a credit balance in the system," Goodwill Pritchett notes.

It also worked the opposite way. If staff chose PPO, but the patient actually presented with an HMO, the payer situation would pay $5,000. It looked like the payer still owed $1,000. "That's why choosing the correct product line in the first place is so important," Goodwill Pritchett stresses.

Denials also happened because it turned out the patient's coverage was not active on the date of service. "We were relying on individuals to make phone calls to verify coverage. Maybe the registrar didn't always update the coverage correctly," Goodwill Pritchett suggests.

Most of these hassles were resolved with an insurance verification tool. Registrars no longer have to keep track of scores of plans and product lines. "Due to the complexity of coverage, we use technology extensively to confirm benefits and eligibility," Goodwill Pritchett says.

The department lowered claims denials to an absolute minimum. "We find out, in seconds, whether the patient is covered, the benefits, and the patient's responsibilities," Goodwill Pritchett says.

Registrars see how much of the deductible was met already. Guesswork on whether the plan is an HMO, PPO, or something else is eliminated. If the patient carries an out-of-network benefit, it is displayed, too. "Our goal is to make sure we have the correct information to minimize denials," Goodwill Pritchett says. Not all health plans can be retrieved

through the online application. For smaller plans (such as workers' compensation and some no-fault payers), staff turn to payer portals to verify coverage.

"As a last resort, we call. But our calls are really at a minimum," Goodwill Pritchett says. The department's biggest challenge has become the constant coverage changes health plans make. Whenever something changes, training is needed. "The training depends on the type of change it is," Goodwill Pritchett says.

If it is a simple change, such as adding a new payer plan or a payer identifier for a new product line, the trainer sends an email to all the appropriate team members. If it is something more complex, a "learning dashboard" is created for staff to refer to at any time. Formal training is conducted only for major changes, such as a system upgrade (previously handled in-classroom; now handled through WebEx).

Eligibility-related denials are rare, but medical necessity denials are cropping up. "With certain types of services, payers want a letter of medical determination," Goodwill Pritchett says. If patients are coming in for an elective service, payers want all the clinical documentation in advance, or they will not approve the service. If a patient is admitted through the emergency department, an electronic notification is sent to the payer. If clinical data are needed, then case management is notified electronically — and it is sent quickly and documented in the system.

"Even there, we are using technology to improve processes that were very manual," Goodwill Pritchett adds. ■

Uncertainty on Auths Means Anxiety for Patients, Registrars

Many health plans waived some authorization requirements during the COVID-19 pandemic, but the actual effect on revenue is unclear.

"Despite these good intentions, there is concern that the payers didn't waive authorization requirements consistently," says **Jonathan Lo**, principal and global revenue cycle leader at Deloitte Consulting.

Not all authorizations were waived for the same dates of service, or for all services. Payers acted independently and did not follow a set standard, making it impossible for patient access to track what was waived.

"In a rapidly changing environment, with provider and payer staffs both working remotely, this was sometimes challenging to understand and potentially confusing for patients," Lo notes.

Hospitals are fully expecting to receive erroneous denials that will need to be appealed. "There is also concern that payers will 'trade off' denials," Lo adds.

For instance, payers might have waived authorization requirements, but are going to deny those same claims for medical necessity instead. Many patient access departments tried to obtain straight answers, but found it was next to impossible.

"We received different messages from the various payers. Because of this, we did not change our authorization process during this time," says **Jackie Weber**, MHA, senior manager of practice operations for patient access at Orlando Health UF Health Cancer Center.

The patient access department at Mount Laurel, NJ-based Virtua Health made the same decision.

"We elected to continue business as normal as opposed to navigating the varying insurance waivers," says Patient Access Director **Traci Mulvenna**.

Staff review every observation/inpatient encounter twice within 24 hours to ensure authorizations are submitted.

"Patient accounting maintains a grid that summarizes the insurance communication," Mulvenna reports.

Denials are reviewed against the grid to identify opportunities to seek appeals for unfairly denied claims.

"That said, our denial rate has gone down, and we were not adversely impacted," Mulvenna says. Some health plans did not employ enough staff to manage all the calls about authorization waivers.

"Comprehensive denials reporting and analysis will be beneficial as we collectively work to understand the impact of this crisis on reimbursement," says **Kevin Thilborger**, managing director in Huron's healthcare business.

Some payers waived fully insured members, but not self-funded plan members. "There are also differences in Medicare, Medicaid, and commercial insurance, depending on the plan type," Thilborger observes.

Not all health plans updated claims payment systems to remove the waived authorization requirements. "We expect to see denials, most likely by mistakes due to timing," Thilborger says.

Health plans might have waived authorization in some cases, yet still deny for "no auth" in place.

"Additionally, true denial types are being masked by use of other classifications. We have reports of 'non-covered services' being used as a catch-all," Thilborger says.

At Norfolk, VA-based Sentara Healthcare's hospitals, registrars are trained to check health plan portals consistently. If it indicates "no auth

required" for a service, no authorization is obtained.

"We are given a reference number to attest to this. But the payer still denies for no authorization, and it is appealed," says **Paul G. Hudgins**, director of Sentara Healthcare scheduling and concierge services.

To prevent "no auth" denials during the pandemic, "we follow 'business as usual' practices. We follow a series of steps, consistently," Weber says. Staff have continued to submit requests in a timely manner, based on health plan guidelines, use worklist tools to capture authorizations in real time, and identify if certain documents are missing.

"We provide continuous training in understanding the EMR [electronic medical record], and how to extract the information needed to submit and expedite the authorization process," Weber explains.

Waivers have not changed the fact authorizations continue to demand way too much time and effort. "The processing time required for prior authorizations sets up a continual race against the clock," says **Christina Harney**, vice president of access management at Indiana University Health.

Patient access staff are scrambling to keep up with demand, rescheduling all the postponed surgeries and diagnostic tests. "While authorization timeframes were extended, our team still must ensure they are updated with the payer," Harney says.

Each case requires, at minimum, confirmation the waiver is in place and approved for the new service date. Fortunately, this does not require the authorization to be filed a second time. "But there is still work to be done to ensure that everything is financially clear for the new date of service and new set of parameters," Harney notes.

Since each payer's waiver rules differ somewhat, the team has to check on every case. "The different parameters across all payers force us to reconfirm every authorization," Harney says.

Delayed patient care is a constant worry. "As we wait for payer determinations, we do what we can to avoid an administrative denial for services," Harney reports.

Concurrently, staff do all they can to keep the hassles from interfering with patient care. "Prior authorization timeframes are unpredictable," Harney says. The department has made two important changes:

- **Patient access created a clinical review process for patients whose care is about to be delayed because of a pending authorization.** A cross-functional team, including physician advisors, works together to ensure all payer requirements are met. "This achieves authorization and supports medical necessity," Harney says.

Many claims denials have been prevented with this approach. "This, combined with an educated prior authorization team, avoids delays in care," Harney adds.

- **Staff obtain authorizations at the point of scheduling.** The authorization process for surgery starts up to one month before the service date, or as soon as services are scheduled. For radiology or imaging procedures, authorizations start about five days before service. "We try to work within these timeframes to minimize reschedules," Harney explains.

Even with all these processes, there is no getting around the fact that for many patients, authorizations equate to anxiety. Staff reassure patients by stating, "It is our job to watch over this process, and ensure that your insurance company has the information necessary to cover your care."

Registrars also give many updates to worried, waiting patients. "We make sure to communicate regularly so they know where we are in the authorization process," Harney says. ■

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