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Physicians, Patients Rarely Discuss Cost: Registrars Can Help

Physicians order tests, prescribe drugs, give referrals to specialists, and recommend surgery — almost always without ever addressing how much all of it costs.

"Even though patients and physicians alike express positive attitudes about having cost conversations, the rates are still quite low," says **Nancy Grant Harrington**, PhD, director of the University of Kentucky Health Communication Research Collaborative.

Cost conversations occurred in only about 28% of visits, according to a recent review of 54 studies.[1] It is not because patients do not want to discuss it. "Among the studies that included data on both desire for cost conversations and incidence of cost conversations, desire exceeded incidence each and every time," Harrington reports.

Clearly, money conversations are not part of most healthcare visits. "We think one of the main reasons is because people just don't know how to talk about cost," Harrington offers. Some other key findings:

• **Patients preferred a physician who discussed cost over one who did not.** This flies in the face of a common misconception — that patients do not want to talk about money with their doctors.

• **Conversation timing is important.** Ideally, it happens before a treatment plan is finalized. "If a treatment decision is made, then later it's determined that the patient simply cannot afford it, then it's like starting from scratch. That's a waste of time that no one wants," Harrington explains.

• **Conversations that included discussion of cost were somewhat longer than those that did not.** Physicians already are stressed about patient flow. They worry if they bring up money, it is going to wreak havoc on their schedule — and there is some truth to that. "Still, considering the negative impact that cost can have on patient financial and psychological well-being, a slightly longer office visit may be worth the investment," Harrington suggests.

Physicians can address costs without it taking over the entire visit. "It is the quality of the conversation, not the quantity, that matters," Harrington notes.

Try a simple statement: "We want to make sure to consider the treatment options that are right for you. We'll want to consider cost to make sure that we find a treatment option that works for you financially."

• **Patients may assume if they do not fill a costly prescription, their physician will realize it is too expensive.** "One of

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the unsettling findings was that some patients hope that nonadherence to treatment will be a clue to their physicians that cost is an issue," Harrington says.

Telling physicians the true reason is a much better idea. That gives everyone a chance to come up with an alternate plan (e.g., finding a lower-cost medication, or giving patients free samples).

To learn more about cost-of-care conversations between physicians and patients, the same group of researchers interviewed 36 primary care physicians.[2] Some physicians directly addressed cost, some avoided any discussion of costs, and some falsely reassured patients about cost concerns.

"Physicians need to develop communication skills to discuss what is perceived to be a difficult topic. This is an important gap that needs to be addressed," Harrington says. What keeps physicians from talking about money?

• Neither patients nor physicians are comfortable bringing up money. It is no wonder physicians avoid it. After all, they do not know what portion of the bill the health plan is going to cover. "No one expects physicians to have all sorts of cost information at hand," Harrington observes.

Physicians should acknowledge that part of their role is coming up with a plan that will not financially devastate the patient. "When there are treatment options, including cost as a factor in decision-making should be a matter of course," Harrington suggests.

• Physicians already are pressed for time. It is not realistic or desirable for physicians to spend loads of time navigating the complexities of health coverage. "Physicians should not be having deep financial conversations. It is not their area of expertise," says **Jonathan Wiik**, principal of healthcare strategy at TransUnion Healthcare.

Physicians are trained to diagnose and treat patients, not deal with health plans. "In my experience, it has proved very difficult to engage physicians in cost. They want what is best for their patient, regardless of cost," Wiik reports.

Investigators surveyed 45 oncologists to assess their knowledge of treatment costs, insurance coverage, and copays.[3] Generally, respondents said they did not know much about out-of-pocket costs. One-third said they were confident about their insurance knowledge, but only 16% expressed confidence about their out-of-pocket costs knowledge and 8% expressed confidence about their copay knowledge.

Still, 58% of respondents had changed a patient's treatment plan in the previous year specifically because it cost too much. Overall, 36% of respondents talked about costs with patients.

A primary care physician would not try to manage someone's myocardial infarction; they would call a cardiologist. Likewise, physicians need someone with insurance expertise with whom they can discuss cost issues. That is where revenue cycle staff come in. "The physicians need to direct all patients to the financial navigators. Dentist offices have been doing this for decades, that little desk you stop at on your way out," Wiik says.

Patients stop to pay and ask financial questions. Ideally, says Wiik, hospitals could use the same approach, with financial counselors stationed right next to the registration area. "Financial discussions should occur as close to treatment as possible," Wiik offers.

• Physicians do not want costs to stand in the way of patients' medical needs. "However, not discussing payment with patients prior to service could actually increase risk," says **Ronald Hirsch**, MD, FACP, CHCQM-PHYADV, CHRI, FABQAURP, a Medicare regulatory specialist with Chicago-based R1 RCM Physician Advisory Solutions.

That is because patients agree on a treatment plan during the office visit. At that time, they may not know what their insurance will cover. The trouble starts later, when patients find out the bad news on their coverage. Some decide to forgo the ordered tests or expensive drugs.

That is a bad model, according to Hirsch. Telling patients the cost earlier buys time to come up with a better plan. "For example, many of the new medications for diabetes have costs that exceed $500 a month," he notes.

If cost is going to be a barrier to filling a prescription or undergoing a test, physicians should ask patients to contact the office so everyone can work together on an alternate treatment plan.

• Physicians usually do not know what health plans are going to cover. "Physicians need easily accessible information to ensure every prescribed medication is on the insurer's formulary," Hirsch says.

A patient visits the pharmacy — and learns about an astronomical copay because that particular drug is not on the health plan's formulary. "No condition has ever been successfully treated by a medication that the patient wasn't able to purchase," Hirsch says.

Physicians need this information in real time as part of their normal workflow. For example, when a physician orders a diagnostic test, automated tools can perform checks: Is prior authorization needed? Is the test a covered service? Are medical necessity criteria met? Is the plan even in network?

Likewise, if a non-formulary medication is ordered, other options should appear automatically. "This can reduce denials, improve the patient and physician experience, and help patient access teams work more efficiently," Hirsch says. ■

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Observation Status Is Issue in Claims Denials

If an ED patient cannot be discharged safely, does the patient need to be admitted, or is observation the better choice?

"This is very fact-oriented, highly clinical, and individual to every patient. Insurers might, in hindsight, dispute the judgment of the physician who is actually treating the patient," says **Kurt Hopfensperger**, MD, JD, vice president of medical solutions at Optum.

Health plans are going to review the medical record days or weeks after the visit. Sometimes, it looks like admission was not needed; instead, the patient should have been observed for a period. "In general, the reimbursement for an inpatient stay is about three to four times [that of] an observation visit," Hopfensperger notes.

The health plan's decision on whether to pay the claim is based on what the ED chart shows. Specifically, the focus is on the severity of illness and the intensity of services provided. "However, there are other considerations that treating physicians weigh when making the decision to admit an inpatient," says Hopfensperger, including comorbid conditions (heart or lung disease, cancer, or use of certain medications) that put patients at high risk for poor outcomes. "A high-risk patient often requires more intensive diagnostic testing, monitoring, or treatment. That justifies inpatient, rather than observation, level of care."

But even if a patient should be in an observation setting, "just as often, the physician documentation does not capture information that would meet the payor's inpatient criteria," says **Kathy White**, assistant vice president of virtual utilization review/bedded insurance authorization processing at Ensemble Health Partners. It all hinges on the clinicals that are submitted. Timing may be the real problem. Payors usually require hospitals to notify them of admission within 24 hours. "Often, that is not enough time for doctors and providers to capture the true nature of the patient's illness and a reliable diagnosis code," White says.

A patient may be admitted for a vague complaint like "chest pain." After two days of testing, the patient is diagnosed with severe coronary artery disease, necessitating coronary artery bypass graft surgery. The health plan denies the admission for "chest pain" since that is all that was known at the time the patient was admitted.

To stop these unfair denials, White says patient access should be documenting the true severity of a patient's illness on day two or three of hospitalization. By that time, there is an

actual diagnosis to support the need for admission. "Payors only want to pay for services that are medically necessary and reasonable," White says.

Payors need data, such as daily progress notes, that support the need for treatment in a particular setting (whether observation or inpatient).

"The agreed-upon criteria are the rules of the game," White says. "Anytime the rules are not met, there will be a denial." ■

Stop Surprise Bills by Identifying Out-of-Network Status Much Earlier

Everything is scheduled, the procedure is complete, and it was a success. Suddenly, someone discovers the insurance is out of network. The patient receives an unexpected bill, which leads to complaints, lost revenue, and bad debt.

"Patients often remain unaware of the complex system of contracts, regulations, and policies that determine how their medical services are paid by insurance," says **Sondra Cari**, managing director in Huron's performance improvement business focusing on revenue.

Tucked into the COVID-19 relief package Congress passed at the end of 2020 was a provision that essentially ends surprise billing.[1] When the terms of this provision take effect in January 2022, some out-of-network providers will not be able to balance bill patients unless the provider sends the patient an estimate 72 hours before he or she receives services and consents to undergoing out-of-network care.[1] *(Editor's Note: Be sure to read future issues of* Hospital Access Management *to learn much more about the terms of this deal.)*

For now, though, every out-of-network claim is at risk of going unpaid. The hospital is in a tough spot, forced to either write off the bill or try to collect from an angry patient. "Collection efforts often risk patient satisfaction, and even the hospital's reputation in the community," Cari notes.

The dreaded out-of-network bill might happen because it was an emergency, and the patient had no choice in where he or she went for care. But surprise bills can occur even when details are scheduled in advance. "Often, these bills don't come from the hospital but from a group, such as ER doctors or anesthesiologists," Cari explains.

Many elective surgeries at in-network facilities, with in-network surgeons, still resulted in an out-of-network bill, according to an analysis of commercially insured patients.[2] Of 347,356 patients, 20.5% received an out-of-network bill, with a mean balance of $2,011. Most bills came from surgical assistants and anesthesiologists. Patients with health insurance exchange plans and those who experienced surgical complications received more out-of-network bills.

To prevent canceled procedures, Cari says the key is to identify any out-of-network providers as early as possible while there is time to do something about it. Hospitals should be sure payor networks are aligned, and that nobody who is out of network with the coverage is going to end up caring for the patient. "Something as simple as missing one contract expiration can create a cascade of surprise bills," Cari says.

If the claim is denied on out-of-network grounds, Cari says to turn the patient into an advocate. Warn the patient the dispute might take weeks or months to resolve. "This is also an opportunity to inform the patient of potential community programs and charity options to assist in paying their bills," Cari suggests.

At Cleveland Clinic, the patient access department instituted processes to address out-of-network coverage specifically. Right when care is scheduled, the registration system alerts staff if a patient has out-of-network insurance. "At that time, scheduling is stopped until the patient is financially cleared," says **Annmarie Kish**, assistant finance director in the revenue cycle management team's financial counseling department.

First, the authorization team obtains permission for the service. Next, the patient financial advocate team contacts the patient to notify him or her of the network status and their financial responsibility. If the patient wants to proceed regardless of the out-of-network status, the process moves forward. The patient gives a deposit and agrees to pay anything the health plan does not cover.

"If there is an urgent clinical need for the patient to proceed, the scheduler is able to override the warnings and create an appointment," Kish notes.

Staff are clear on what to expect with out-of-network coverage and what options exist. Some patients presented with coverage that was in network, but then circumstances changed suddenly. "Many patients don't know they are out of network, or even what that means," Kish says. "We don't want patients to be surprised by large bills because of this."

For unscheduled care (e.g., ED visits or urgent care), Cleveland Clinic staff follow the health plan's guidance on the patient's financial liability. "Depending on the amount, a charity adjustment is evaluated," Kish reports.

All accounts with out-of-network coverage are flagged for the insurance

follow-up team to handle. "We are able to track and trend the out-of-network bad debt and controllable loss," Kish says.

If staff do figure out after the service that a patient's insurance is out of network, "we do not bill the patient," according to Kish. In some cases, the health plan agrees to pay the claim as if it were in network. "We can, on rare occasions, overturn the denial due to medical necessity," Kish adds. ■

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Despite Many Challenges, Patient Access Manages to Retain Staff

Low pay, high stress, working holidays and weekends — these are good reasons for poor retention rates in the revenue cycle. Still, some departments have found ways to combat the problem.

"We've made some really great headway with morale and turnover," says **Whitney Benedict**, MHA, CRCR, senior director of contact centers, authorizations, referral management, and scheduling at Spectrum Health in Grand Rapids, MI.

• Front-end staff received the chance for advancement and higher-paid positions. In late 2020, the patient access service center implemented a career ladder that designates positions as follows: associate positions handle inbound calls, outbound work queues, and scheduling referrals; intermediate positions handle daily management of providers' schedules and reschedules; senior positions handle complex specialty tasks for service lines and provide support to other staff; and lead positions handle training and are responsible for daily metrics for process improvement efforts.

• Staff are cross-trained, but only to work in similar areas. "It was cross-training burnout. Staff said they felt like a jack of all trades and master of none," Benedict reports.

Cross-trained staff working in areas totally unfamiliar to them resulted in high error rates in 2019. For instance, the workflows of primary care and radiology or endoscopy and primary care are entirely different. As a result, some patients were not prepped for tests correctly. Others were sent to the wrong provider, wrong location, or scheduled for the incorrect test.

Staff were upset about the mistakes and asked for more expertise in their registration areas. "We re-engineered the access center to be more clinical service line-specific," Benedict explains.

Patient access completely revamped the way they performed cross-training. Staff still cover other registration areas, but only if they are clinically similar to the employee's regular area. "It's a delicate balance," Benedict notes.

For instance, a radiology scheduler can schedule "low-tech modalities," such as mammography, ultrasounds, or bone density scans. Once those skills are mastered, the scheduler can move up and train in "high-tech" radiology. "These are areas of high complexity with safety protocols," Benedict says. "For instance, staff need to coordinate with anesthesia for tests requiring sedation."

• Leaders gave registration teams a sense of purpose. The COVID-19 pandemic provided some unexpected lessons in boosting retention. One newly formed team has reported high morale — the 103 employees who are charged with scheduling COVID-19 screening appointments with physicians, COVID-19 testing, and COVID-19 vaccination appointments for employees.

Radiology schedulers received a similar morale boost when they had to redouble their efforts to reschedule thousands of patients waiting for diagnostic tests that had been canceled when the pandemic started. "Our schedulers were very concerned about patients who had high-risk symptoms and were going undiagnosed," Benedict says.

Morale is high, even though the schedulers had to work much harder. Both of these high-morale teams had something in common: a sense of purpose. "They see their role is connected with the health and wellness of the community," Benedict observes.

• Staff can work from home. Previously, patient access lost some staff to billing positions. Pay was a little higher, and there was a chance to work at home. That kind of turnover is not happening any longer since the front end now is fully remote.

Of 550 staff, all but a handful work from home full time. Previously, only about 40% of staff at 12 locations worked remotely. "We are having conversations now on keeping people working at home going forward," Benedict says. Patient access staff complete satisfaction surveys quarterly. The most

recent survey included a new question: What are you grateful for at Spectrum Health?

Surprisingly, most named working at home. Staff described all sorts of reasons, ranging from child care to health concerns. "That's our biggest recruitment and retention strategy right now," Benedict says.

Potential new hires ask specifically if they can work from home. Some even call to ask if they can work from other cities or states, something leaders are exploring. Meanwhile, remote staff are kept connected, busy, and able to advance. Turnover has plummeted from a high of over 30% to less than 10%.

At Hartford-based Connecticut Children's, leaders developed a patient access career ladder to improve retention. "We try our best to keep our employees within our teams — or at least within our organization," says **Jessica Budri**, RN, MSN, APRN, director of patient access.

The ladder includes Associate I, II, II and team lead, and assistant manager positions. Staff have to meet various criteria to advance, such as earning a CHAA certification or joining a hospital finance committee. Once staff pass their CHAA (or CHAM), the department reimburses for the cost of the exam.

In terms of advancement, staff are not left to figure it all out themselves. "We invite team members in their quarterly one-on-ones to share with us their career goals or education they are working to obtain," Budri says.

Some employees who are in nursing school ask to be connected with HR when the time is right to move on to a nursing position. Other times, patient access leaders connect the employee to HR to see if there are any open positions that would be a good fit.

Some team members are working on their bachelor's or master's degrees and want to explore other jobs in healthcare. "We allow them to shadow or talk to other team members in those positions," Budri says. Even if an employee leaves patient access, he or she might stay within the organization. For those who stay in patient access, they can expect more personalized attention from managers.

Before the COVID-19 pandemic, the department planned to do this in person, but shifted to virtual acknowledgement. A staff-led engagement committee was formed, which votes on the top three employees of the month. Their pictures are published in the newsletter, they earn a gift card, and they receive a handwritten note from their direct leaders.

To give staff even more of a personal connection, Budri started director "open office" hours in an informal group setting. Staff receive an invite to click on the link if they want to join. "I do not have an agenda or presentation, but rather invite them to share their concerns, ideas, or anything they want with me," Budri says. ■

Patients Want Good Answers on Cost of Care

Several years ago, patient access leaders at Aurora, CO-based UCHealth kept hearing the same complaint. Patients were calling to ask about the cost of their care, but staff were unprepared to offer answers.

"That was a source of frustration not only in my department, but also ambulatory departments and clinics," says **Candice Hoshi**, vice president of revenue cycle.

At that time, there was not a good price estimate tool available. Staff worked off a list of the most common charges, which was not much help to anyone. Price-shopping patients were not interested in gross charges that did not take their individual insurance into account. "What people wanted to know is how is it going to hit their pocketbook," Hoshi says.

The department began a year-long project to fully implement a better price estimate tool. At the same time, a group of staff were designated to solely work on price estimates. "A lot of work went into training the patient estimate team," says **Matthew Kelly**, senior director for patient access.

These highly skilled staff members can give good estimates to any patient who asks for one, whether at the hospital, for a scheduled procedure, or the ambulatory clinic. The hospital's website also includes an estimate tool for price-shopping patients. In the last available six-month period, 4,189 estimates were completed.

To receive an accurate quote, patients must select the correct service, location, provider, and verify the insurance that is on file. If patients need any kind of help with estimates, they can call the patient estimate line. "We also added the ability for price-shoppers who are non-UCHealth patients to access the tool," Hoshi says.

The estimates include both hospital and professional charges. It factors in outstanding deductibles, copays and coinsurance, and contracted prices with health plans.

To promote it to the public, the marketing team created a video introducing the price estimate tool and posted it on the UCHealth website. Patient access leaders alerted providers that there was a group of designated experts ready to provide price estimates. This is great news for providers, but also for patient access staff. "We were able to take that burden off their shoulders," Hoshi adds. ■

How to Ease Financial Anxiety

Revenue cycle staff have more to worry about than collecting copays and sending "clean" claims. They also have to worry about how it is going to affect the patient.

"Today, more than ever, financial toxicity is a major contributing factor in both the mental and physical health of patients," says **Michelle Vasquez**, MHA, CHAM, patient access services director at Banner Casa Grande (AZ) Medical Center.

Over the past two years, Banner's revenue cycle modernization team has focused on giving staff every possible tool to ease patients' financial anxiety by making the following changes:

• Staff offer comprehensive financial assistance programs based on federal poverty guidelines. "It is vital that these programs provide support for both uninsured and underinsured patients," Vasquez stresses.

• Staff go out of their way to explain insurance coverage. Patients misunderstand their benefits. Many still believe their insurance will cover all costs. "Patients are confident because they have insurance. But they are not entirely aware of their coverage plan details," Vasquez explains.

Staff explain confusing terms, such as deductibles, out-of-pocket maximums, copays, and coinsurance. Recently, the problem was a "limited benefit" plan. The patient was admitted to the hospital with insurance that covered the first $500 of the admission. The remaining balance was the patient's responsibility, a big problem with no obvious solution.

"Situations like this can be upsetting. An important part of our role is to translate insurance benefits for our customers. We speak a language they may not always understand," says **Paula Huggard**, CHAM, patient access services manager at Banner Ogallala (NE) Community Hospital.

• Staff verify coverage in real time. The news is not always bad. "Sometimes, we find coverage that patients are unaware of," Huggard reports.

Either way, staff can engage in better conversations with patients because they know the actual dollar amounts, using a price estimate tool based on the person's individual plan.

• Staff offer upfront payment plans at preservice and at point of service, including previous balances. "We recently partnered with a healthcare financing vendor to provide our patients with flexible, low- or no-interest financing options," Huggard says.

These can be used at hospitals, clinics, and urgent care centers. "This equips patients with peace of mind for future circumstances," Huggard observes.

One patient was worried about borrowing money from her mother to pay for her surgery. Staff explained the payment plan program to her, she applied, and was relieved to be approved for interest-free payments.

• The department collaborates with Medicaid eligibility vendors. The vendors help uninsured and underinsured patients apply for Medicaid, but also many other programs (unemployment, nutrition assistance, cash assistance, school meal options, childcare assistance, and tax credits, among others).

A patient recently came in to Banner Ogallala specifically to thank registrars. "Because of a visit to our facility that resulted in a screening by our vendor for services, she was approved for food assistance," Huggard says. ■

Rural Hospitals Face Uphill Battle with Financial Viability

Many hospitals are struggling financially, especially rural facilities, even before the COVID-19 pandemic started. These problems can be attributed to low income, high unemployment rates, and a variety of other factors.[1]

Researchers analyzed the financial viability of 1,004 U.S. rural hospitals during the period between 2011 and 2017. Here is what they found:

- The median overall profit margin declined (from 3% to 2.6% for nonprofit, non-critical access hospitals; from 3.2% to 0.4% for for-profit, critical access hospitals; and from 5.7% to 1.6% for for-profit, non-critical access hospitals).
- In states that did not expand eligibility for Medicaid under the terms of the Affordable Care Act, rural hospital financial viability deteriorated.

"Improving occupancy rate is a necessary condition for rural hospitals to remain financially viable," concludes **Ge Bai**, PhD, CPA, the study's lead author and an associate professor of health policy and management at Johns Hopkins Bloomberg School of Public Health.

About one-third of all acute, general care hospitals in the United States are considered rural.[2] Although each facility is small (about 25 beds per hospital, on average), these places collectively serve 60 million Americans. In addition to expanding Medicaid, Bai and colleagues suggested finding ways to provide more emergency care in these areas so that patients who live in remote areas do not have to travel so far for these essential services.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law in March 2020, included $10 billion targeted to rural facilities, which may provide short-term help.[2]

In the latest federal relief package Congress approved in December, lawmakers included a provision that may help in the long term: eliminating the cap on the number of Medicare-funded residency slots, which could lead to more training opportunities and help address staff shortages.[3] ■

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- Red flags indicating registrars are experiencing burnout
- The best possible scripting to bring up money with patients
- Price-shopping patients need a reason to pick your hospital
- Limited-benefit plans wreaking havoc with hospital revenue

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