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# Hurting financially? Save the day with front-end revenue increases

*New business paradigm needed*

Today's hospitals are facing an unprecedented revenue challenge, due to surges in uninsured patients and skyrocketing out-of-pocket responsibilities for the insured. In this challenging new fiscal environment, patient access will play a starring role.

"The current economic environment has played a major role in increasing bad debt and shrinking net patient revenues," says **John E. Kivimaki**, director of patient accounts at Mary Rutan Hospital in Bellefontaine, OH.

"Sixty percent of bad debt is generated from insured patients," notes Kivimaki. "This is a problem that will increase as patient responsibility continues to rise, and as 30 million U.S. citizens become insured under health care reform."

Kivimaki says that both Mary Rutan Hospital and the health care industry as a whole must shift the revenue cycle from the back end to the front end. "Making this shift provides more funding for medical research, recruiting efforts, and improves overall quality of care," he says.

In the past, the primary payers in the health care industry were either private or public insurance organizations. Health care providers' systems were built specifically to bill and accept payments from these payers.

"Any patient responsibility not captured was either written off as bad debt, or pushed to 'early out' and other collection efforts," says Kivimaki. "Every dollar pushed to the back end of the revenue cycle is reduced to 16 cents on average, if collected at all. The value of our 'health care dollar' gets reduced as the patient's account ages through the revenue cycle."

To improve revenue by reducing claims denials, schedulers and registrars at Pennsylvania Hospital, part of the University of Pennsylvania Health System, perform a great deal of preparation before the day of service.

For instance, if a radiology study needs to be scheduled, the schedulers check the various systems depending on the patient's insurance. They confirm that the patient is eligible and learn whether a referral or autho-

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rization is required.

"This is very important, since some radiology studies are high-ticket items," says **Debra A. Artwell**, manager of outpatient access. "At this point, the scheduler is able to advise the patient, and/or physician office, what is needed in order for the patient to have the study."

Mary Rutan's patient access department found itself ill-equipped to adapt to the changing environment, with rising patient responsibilities including higher copays, deductibles, and co-insurance, says Kivimaki. Its systems and processes were geared toward billing the insurance provider or government programs, not collecting from individual patients.

"It is predicted that 30% of hospital revenues will come directly from patients by 2012," says Kivimaki. "Health care has gone retail, and we must adapt to this new business paradigm."

Patient access leaders at William Beaumont Hospital in Royal Oak, MI, have been asked to look for ways to improve quality and point-of-service collections to support the hospital's revenue cycle objectives.

"And, of course, we need to do it with as little cost possible!" says **Cheryl Webster**, director of patient registration services. The department increased cash collections by 25% over the previous year. Here are the steps they took to increase front-end collections:

**1. The department added a link to the patient's self-pay amount to its registration screens.**

"Staff can quickly identify the amount owed," says Webster.

Investments in patient estimation software for the front end may not be possible in a tough economy, though, despite the fact that it's the very time it's needed most. Instead, patient access departments like Webster's are being asked to make do with what they already have.

Fortunately, it is sometimes possible to unearth savings by tweaking existing systems and processes. "We worked with our IT department to determine what we could do to improve the system we have already," says Webster. "We pulled information from the billing section to the registration screens. After a trial-and-error period, we have something that is not perfect. But we are getting there."

**2. Registrars now ask about outstanding balances at every registration encounter.**

"We are working on a report to list all of the patients with an outstanding balance who are on the schedule for the next business day, to help us better prepare," says Webster.

**3. Managers are implementing a process to allow registrars to work with patients to establish payment plans.**

"In the past, this task was handled by the billing staff, but we want to help get our patients on their way to making payments and settling their out-of-pocket responsibilities," says Webster. Registrars will initiate the process whenever patients say they cannot pay off their balance.

"We are continuing to develop the payment plan process," says Webster. "We are rolling it out with a paper system. Then, hopefully, we will move to something a little more streamlined."

**4. Staff received extra training to help them feel**

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**more comfortable asking patients to pay for their outstanding balances at the time of registration.**

When talking with staff about their concerns, Webster often heard that their own personal financial situation was worrisome. Thus, staff didn't feel comfortable asking a patient to make a payment that they could not make themselves. "The Michigan economy has suffered. Many of us have family members who are out of work," says Webster. "It is easy to empathize with our patients, especially those with large balances."

**5. Two staff members were chosen to help with training on collections.**

The management team talked to staff and reviewed collection results. They identified two registrars who were very successful in collecting payments, while being very kind and service-oriented. "We looked for staff with high collection success and no patient complaints," says Webster.

The two registrars worked with supervisors to prepare a training guide. "Then we asked the staff to sit with their peers throughout the department to help role-play and share their tips for service-oriented cash collection," says Webster. "We are still working on training, and tools and processes. But we are very pleased with the results so far."

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# Triple POS collections using this approach

**Carmen Arroyo**, clinic operations manager of cardiology, nephrology, and pulmonary medicine at Children's National Medical Center in Washington, DC, set a goal to increase her area's time-of-service collections by 9% over the previous fiscal year. She wound up tripling the amount collected. Here is how she did it:

First, Arroyo contacted the manager of the hospital's customer service department in the business office to discuss how to best accomplish the 9% goal. The manager agreed to meet with Arroyo and her staff to review patient accounts, insurance cards, and co-insurance.

"She showed the front-desk staff how to review past balances owed on both hospital and professional accounts," says Arroyo.

The group discussed setting up payment plans for parents who could not afford to pay these balances in full. "After just one training, we were on our way," says Arroyo. "We have always prepped clinic ahead of time, but now we actually review each scheduled patient's account."

When a registrar finds that a patient has a past balance, a copayment of more than $20, or a co-insurance payment, he or she contacts the family before their visit. "We inform families of their copays and co-insurance payments," says Arroyo. "If there is a past balance, we also let them know that we will be collecting it at their upcoming appointment."

If the patient's balance is high, staff take the opportunity to discuss what they are able to pay at their appointment. Also, staff instruct the patient to see a counselor in the financial information center to set up a payment plan for the remaining balance.

"We document our discussion in our patient account notes, in case we have a 'forgetful' parent," says Arroyo.

Managers created a time-of-service collection sheet, which is completed during clinic prep. It indicates the amount of copay or co-insurance due for the visit, any past balance owed, and the amount the parents said they would pay during the prior phone conversation.

Staff already know how much to collect, because this sheet is posted at the front desk every day. If a credit is found on an account, staff contact families and let them know that a copayment will not be due because the credit will be applied toward any balance owed.

"We generally find that families appreciate the advance notice," says Arroyo. "It allows them to come prepared and know ahead of time what their financial responsibility will be."

In the beginning, the staff said they found the process to be very time-consuming. "They have now embraced the new procedure," says Arroyo. "I believe it actually has produced a greater awareness of the hospital's financial situation."

The efforts have paid off. Time-of-service collections, which were $52,389 in fiscal year 2009, increased to $96,545 in fiscal year 2010.

"They see this change as their contribution to improving the hospital's financial strength, which is one of our pillars," says Arroyo. "The staff was completely surprised when, as a result of their hard work, they were treated to lunch at their favorite restaurant."

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# Cut hospital losses with upfront injection of cash

*Front end is the focus*

**John E. Kivimaki**, director of patient accounts at Mary Rutan Hospital in Bellefontaine, OH, was asked by his CFO to identify areas in the revenue cycle where losses could be reduced by focusing on upfront efforts.

His proposal identified several best practice processes and technologies to increase front-end account settlements, improve cash collections, reduce bad debt, and improve quality of care. *(See Kivimaki's proposal on page 5.)*

"By implementing these process changes and by providing our registrars with current technology, we can increase our current $2 per front-end registration effort to a conservative $10 per registration," says Kivimaki.

A $10 increase would add more than $40,000 in monthly revenue, or more than $500,000 in annual revenue. "This injection of cash would increase our cash on hand, improve our bond rating, and improve our bottom line," says Kivimaki.

First, Kivimaki researched multiple technologies and processes. He used resources such as the Healthcare Financial Management Association, a Westchester, IL-based organization that provides education on maintaining fiscally healthy health care organizations.

The result of this effort pointed to one partner, says Kivimaki, whose clients are averaging $100 per registration in upfront account settlements. "They provide a turnkey solution and best practice processes that fit our goals like a glove," he says.

Kivimaki says that based on this research, he concluded that his patient access department can reach its goal of reducing losses by providing registrars with the following tools:

**• identity and address validation/verification**

This ensures the name and address provided by the patient is an accurate U.S. postal address, and also that the guarantor is associated with that address. "This step will reduce returned mail and reduce denied claims," says Kivimaki. "It will also reduce fraud, and ensure we are compliant with the FTC Red Flag Rules."

**• capacity to pay determination**

"Thanks to the Internet, there is loads of non-credit-scoring information available today," says Kivimaki. "By identifying the patient's true capacity to pay at the point of registration, we can design our discounting policies around the guarantor's capacity to pay." Also, registrars can identify those patients who qualify for charity.

**• interactive scripts**

"Once we have the patient's capacity to pay, it is important to provide our registrars with a script to follow, so they can engage in a conversation with the patient about their financial responsibility," says Kivimaki.

The script integrates the hospital's business rules and discounting policies. It provides the registrar with the exact words to say to every patient, in order to settle his or her account at the point of service.

**• charity screening**

"By having the guarantor's capacity to pay, we can automatically identify who qualifies for charity," says Kivimaki. "And, we can prompt our registrars to complete necessary charity application forms on the spot."

Those forms can be electronic, with the patient information entered into the system auto-populated. This saves time and ensures the forms get completed and filed.

**• price transparency & payment plan negotiation**

"In order to settle patient accounts on the front end, we must provide an estimated cost of services," says Kivimaki. "The estimated cost of services provides our registrar and the guarantor an estimated price to start with."

Since registrars know the cost of most common procedures, this information can be provided to the patient upfront. This estimated cost can then be used as a basis to negotiate a settlement with the patient, and set up a down-payment and payment plan.

"The interactive script then provides the registrar with the parameters to settle the account with the guarantor," says Kivimaki.

**• simplified insurance verification**

In order to verify insurance, registrars need to be

(Continued on page 6)

# This proposal could reduce significant losses in revenue cycle

The below proposal was submitted by **John E. Kivimaki**, director of patient accounts at Mary Rutan Hospital in Bellefontaine, OH, to identify areas in the revenue cycle where losses could be reduced by focusing on upfront efforts. It was accepted by the hospital's administration, and implementation is underway.

REVENUE IMPACT ANALYSIS

The following ROI is based on increasing our per patient upfront settlement average to $10. This is a very conservative estimate. Once implemented across our facility, our minimum monthly return on investment is $42,500 monthly or $510,000 annually.

CURRENT STATE: Baseline for Analysis

| FRONT END BEST PRACTICE | CURRENT SITUATION |
|---|---|
| Healthcare management system | Automated |
| Insurance Verification | Automated |
| Address Validation | No automated address validation technology in place: exposure to returned mail costs and denied claims, which slows revenue recognition |
| Capacity to Pay | No capacity to pay technology in place: hard to apply discounting policies according to patient's ability to pay and hard to apply charity policies consistently leading to compliance exposure |
| Business Rules and Policies | Business rules and policies in place today: no technology to automate the application of those business rules and policies across all patient accounts |
| Charity Policies & Guidelines | Charity policy in place today |
| Red Flag Rule Compliancy | Red Flag process in place today: no automated Red Flag compliancy technology in place to ensure process is followed and to provide reports if audited by the FTC |
| Price Transparency | No automated price transparency technology in place today |
| Payment Plan Development | No payment plan negotiation technology in place today leading to longer revenue cycle and reduced net patient revenues |
| Promissory Notes | No automated promissory note development technology in place |
| Front End Collections | Limited front-end collections capability: averaging $2 per registration today |

FUTURE STATE OPPORTUNITY: Front End Impact

| FRONT END BEST PRACTICE | CURRENT SITUATION |
|---|---|
| Healthcare management system | Automated, but searching for a new one.<br>One proposed system can interface with current and future system. Will only charge for first interface, second one is on the house once system chosen |
| Insurance Verification | Next-generation and simplified insurance verification tool included with proposed system. |

| | |
|---|---|
| Address Validation | Real-time address validation, which verifies address provided is actual U.S. address and validating the patient is associated with the address via web resources available<br>Reduces returned mail, reduces denied claims and identifies potential fraud (FTC Red Flag compliancy) |
| Capacity to Pay | Real-time capacity to pay determination based on non-credit scoring, web-based data utilizing over 57 resources<br>Rates patient based on the market and provides insight into the patient's capacity to pay via both income and net worth criteria |
| Business Rules and Policies | Automated business rules and discounting policies, provides a script to the registrar telling them exactly how to process every patient based on their capacity to pay and based on if they are insured, uninsured or charity<br>Reduces registration time, provides process consistency across all patient accounts and limits exposure to lawsuits |
| Charity Policies & Guidelines | Automated charity policy process, determines if patient qualifies based on household income and federal poverty guidelines, and provides appropriate forms in a web format for completion on the spot |
| Red Flag Rule Compliancy | Automated Red Flag rule compliancy ensuring hospital is compliant with FTC Red Flag rules |
| Price Transparency | Automated price transparency built into the system based on your most common procedures<br>Provides a balance to negotiate and settle on with patients before they leave the hospital, accelerates the revenue cycle |
| Payment Plan Development | Payment plan calculator built in, providing a tool to negotiate payment plan with patient based on associated discounts and balance<br>Provides ability to settle patient balance before patient leaves the hospital |
| Promissory Notes | Automated promissory note developed, which includes balance, payments and negotiated terms |
| Front-End Collections | Clients average $35 in cash collected and $100 in terms negotiated per registration leading to incredible front-end collections.<br>Improves cash on hand (improving bond rating and ensuring compliancy with bond covenants), improves net patient revenues and reduces bad debt |

**Summary**

Based on a detail examination of a number of areas, a conservative estimate of between $250,000 to $500,000 a year would be saved by using the software. ■

Source: John E. Kivimaki

(Continued from page 4)

able to identify the guarantor's copay and deductible information. "By providing these two data points to the registrar, we can speed up the settlement process and improve collections," says Kivimaki.

Insurance verification also should provide primary and secondary insurance information, and also identify pre-authorization requirements. "This prompts our registrars to contact the insurance provider before we complete a procedure requiring pre-authorization," says Kivimaki.

**• payment processing**

"We should equip our registrars with a real-time, easy-to-use payment processing tool," says Kivimaki. "This ensures the money we collect from the patient goes directly to our merchant bank."

Ideally, the tool should allow the registrar to set up recurring payments based on a negotiated payment plan. This way, the patient does not have to be billed, and instead, can pay via a credit card or

monthly automatic check handling transfer.

• **Red Flag compliance**

"The FTC has determined that hospitals are required to follow Red Flag rules," says Kivimaki. "If audited, our facility is at great financial risk if we are not in compliance. Our front-end system should identify potential fraud. Registrars should be prompted to take the appropriate steps to ensure the patient is who they say they are."

Address validation is an important first step, and another is the ability to provide reports to the FTC auditor. "Even if the FTC does not enforce Red Flag rules, identifying fraud is simply good business practice," says Kivimaki.

• **reporting**

"We cannot manage what we cannot measure," says Kivimaki. "It is critical that the management team has real-time insight into each registration and each patient account negation that occurs."

Management needs to know what payment arrangements and settlements registrars are completing, and more importantly, what they should be completing. This way, they can address training issues as they occur.

"We can also budget more effectively by knowing the revenue streams that will be coming into the hospital, based on payment plans that have been set up," says Kivimaki. ■

# Accuracy may be key to revenue increases

If registrars are more accurate when completing registrations, fewer claims denials will result. This clearly improves your hospital's fiscal situation, but remains a daunting challenge for many patient access departments. Here are some steps taken by the patient access department at St. Joseph's Hospital Health Center in Syracuse, NY:

• **Every person responsible for registration in the network is audited monthly for face sheet and Medicare Secondary Payor accuracy.**

"The audit also includes a review of the account to ensure the claim was passed 'clean' on the initial billing," says **Carol Triggs**, MS, director of patient access.

• **A monthly incentive program is used.**

The face sheet and Medicare Secondary Payer audit is one-third of the program. The second component of the program is the attainment of a monthly copays collection goal.

"This is team-based, unlike the face sheet/Medicare Secondary Payer accuracy audit, which is based on individual performance," notes Triggs.

The remainder of the program is based on patient accounting attaining their monthly collection goals. "This third component reflects the importance of front-end accuracy on the back-end collections," says Triggs. "Our staff incentive program has been very successful over the past eight years."

• **Each area has goals specific to its service.**

For example, pre-registration tracks the percentage of scheduled patient visits that are pre-registered. Centralized scheduling tracks the average call wait time to their call center.

"Our departmental goals also reflect our customer satisfaction scores, our percentage of clean claims passed, and the monthly percentage of claims denied for no authorization," says Triggs.

• **A career ladder ties into obtaining personal goals.**

"Staff are invigorated to give their best efforts in attaining goals, when they understand the basis and importance of the goals set before them," says Triggs. "Education for both customer service and overall revenue cycle education is very important."

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# Now is the time to improve your financial counseling

*New processes are necessary*

More than ever, patient access staff are being challenged to step into a new role — that of financial counselor. Patients have more complex questions and needs, and are turning to front-line staff for answers.

At University of Kentucky (UK) HealthCare in Lexington, the patient access department recently combined the professional and hospital counselors into one unit. "The benefits we hope to achieve are providing one statement covering the entire out-of-pocket expenses," says **Ed Erway**, chief revenue officer. "Decreasing costs, while improving information, should ultimately improve patient satisfaction."

The department also is planning to implement two new programs. These will focus on pricing transparency and determining guarantors' ability

to pay for their health care financial obligations.

"These programs will be integrated with our patient access pre-registration functions, to provide improved services to our patients before their service," says Erway.

**Antionette Anderson**, CHAA, CHAM, director of patient access and centralized scheduling at Skaggs Regional Medical Center in Branson, MO, says that financial counseling is a new role for patient access staff. "In my facility, I have three financial counselors under patient access," she reports. Here are their roles and responsibilities:

The emergency department's financial counselor screens patients for Medicaid and/or charity assistance when registrars are unable to collect from the patient during in-room registration. If the patient does not qualify for either, a payment plan is set up.

An inpatient financial counselor goes up to the patients' rooms, lets them know what their out-of-pocket expense is, and collects this amount. If the patient is unable to pay, the counselor screens for Medicaid or charity eligibility. If the patient does not qualify, a payment plan is set up.

"We also have a financial counselor for out-patients," says Anderson. "Any scheduled test or procedure needs to have financial clearance if the patient is self-pay or charity, before the test is scheduled."

The hospital has a monthly budget for charity care. "Anything that is not an emergency goes before a committee that meets bi-weekly," says Anderson. The committee is made up of the director of patient access, a financial counselor, the hospital's CFO, clinic administration and four physicians.

"They OK the procedure, or suggest alternative testing," says Anderson. "Sometimes, we have the ordering physician come to the committee to help the committee better understand the procedure that they are wanting to do." All elective procedures are denied.

Self-pay patients are required to talk with a financial counselor prior to scheduling. The counselor informs the patient of the cost of the procedure, and asks how they will pay for it.

"We attempt to collect 100% upfront," says Anderson. "If the patient is unable to do this, we ask for a down payment. The patient is set up on a payment plan." *(See the department's matrix, which is used to set up payment plans, this page.)*

## Set self-pay patients up on a payment plan

Here is a payment plan matrix for self-pay patients used by patient access staff at Skaggs Regional Medical Center in Branson, MO.

| If Bill is | payment options | Enter estimated amount | patient monthly payment due | First Payment Due |
|---|---|---|---|---|
| $100.00-$500.00 | in full | $400.00 | $400.00 | on or before date of service |
| $501.00-$1,000.00 | 2 payments | $800.00 | $400.00 | on or before date of service |
| $1,001.00-$2,000.00 | 3 payments | $1,200.00 | $300.00 | on or before date of service |
| $2,001.00-$4,000.00 | 4 payments | $3,000.00 | $600.00 | on or before date of service |
| $4,001.00-$6,000.00 | 5 payments | $5,500.00 | $916.67 | on or before date of service |
| $6,001.00-$10,000.00 | 6 payments | $8,000.00 | $1,333.33 | on or before date of service |
| $10,001.00-$15,000.00 | 12 payments | $12,000.00 | $2,000.00 | on or before date of service |
| $15,001.00-$20,000.00 | 12 payments | $15,000.00 | $2,500.00 | on or before date of service |
| $20,001.00-$50,000.00 | 18 payments | $18,000.00 | $3,000.00 | on or before date of service |

Source: Skaggs Regional Medical Center.

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# Quality assurance audits may be too subjective

*Staff must view them as impartial*

Registration accuracy is always a foremost concern for patient access leaders, as problems in this area can lead to needless claims denials; ineffective quality assurance audits, however, won't get results, says **Diane E. Mastalski**, CHAA, CHAM, Virtua's corporate director of patient access.

In October 2008, Virtua Healthcare System in Marlton, NJ, decided to revamp its patient access internal audit/education program. A seven-member audit/education team was dispersed through Virtua's five hospitals.

The three largest campuses each had a team of two auditor/educators. The remaining auditor/educator's time was split between Virtua's two smallest campuses and serving as the team lead for the manager of those divisions.

The program had been successful, Mastalski says. The department's registration accuracy rating had increased from 92% when the program started in 2000 to 97% in 2008. But despite the success, the program was in need of some fine-tuning, she says.

"Our registrars felt that the auditing process was too subjective," says Mastalski. "There was a perception that the auditors would let their personal feelings determine who would receive an edit and who they would let slide."

This may not have been the truth, but it was difficult to change this perception, she says. In addition, what may have been considered an edit on one campus might not be at another location.

"We realized we needed a more uniform process to keep the audit as objective as possible," says Mastalski.

The decision was made to pull the auditors from campus-specific positions. They were moved to a central location where they would audit the three largest hospitals. The two smallest campuses would continue to be audited by their auditor/team lead.

"By removing the auditors from the campuses and rotating on a daily basis, not only which registrar but also which campus they audited, we felt that the audit process was as fair and impartial as it had ever been," says patient access supervisor **Alice Wood**.

Pooling the auditors also had another benefit. "We have five different auditors with five different skill sets and five different approaches to education," says Wood. This meant that the education process could be catered to the individual registrar's needs.

"If one auditor/educator is having difficulty creating that moment when the light bulb goes on for the registrar, we have four more auditor/educators ready to step up to take on the challenge," says Wood.

The new process did create some challenges, however. The three campuses totaled more than a hundred registrars, with experience levels ranging from new hires to staff members with more than 30 years of experience.

"We have registrars working twenty-four hours a day, seven days a week," says **Nate Wolf**, auditor/educator. "And our staff's experience and computer competency levels vary widely."

Being able to provide them all with education catered to their needs proved to be difficult. However, the team found that its flexibility, both with schedules and education methods, turned into one of its greatest strengths.

"Some staff needed face-to-face education, while some were fine receiving e-mails," says Wolf. "Some preferred to receive group education, while others wanted one-on-one meetings. Discovering each individual's needs was difficult at first."

The auditor and educators had to first overcome the registrars' misconception that they were "out to get them." "Many people felt that the only time they heard from us was when they had made a mistake," says **Amanda Whitman**, auditor/educator. "In order for the program to be successful, we needed the registrars buy-in. We needed them to understand we are a resource, to help them do their jobs to the best of their abilities."

The educators make sure to reach out not just when a mistake has been made, but also when someone does a good job. Congratulatory e-mails are sent out at the end of the month to registrars who achieved a 100% accuracy rating for the month, and also those who make a marked improvement.

"Something as simple as an e-mail saying 'Hey, that was a tricky insurance, great job!' or going to a campus for no other reason than to be available to answer

some questions, goes a long way," says Whitman.

Virtua converted to electronic medical records in November 2009, doing away with paper charts. This allows the auditors instant access to any scanned documents and eliminated the need for paper charts to be transported from the campus to the auditor/educators, Mastalski says. It also allows the audit to be done within the important five-day bill drop period, she says.

"When the charts went electronic, it was a great help to us," says **Gabrielle DiCristo**, auditor/educator. "Now if the registrars have a question about an insurance card, all they need to do is give us the billing number and we can see what they're seeing. It's a great learning opportunity."

The registrar is told what the correct insurance is on the spot. "Hopefully, they will remember that for the next time it comes across their desk," says DiChristo. "It's especially helpful for registrars who work second or third shift." If these registrars have a question, they can send an e-mail with the billing number to anyone on the team. The following morning, the question is answered, and the chart is corrected if necessary.

The instant access to scanned documents had a positive impact on the department's administrative denials. "We went from a denial percentage of 11.53% in 2005 to 2.25% in 2010," says auditor/educator **Dana DeLuca**. "A big part of that is how quickly we can perform the audit and notice any trends that are giving the registrars issues."

Since the team corrects any deficiencies before they are billed out, incorrect billing is prevented, along with the denial that would potentially follow. "In addition, we're able to identify areas that need education immediately. We nip those problem spots in the bud," says DeLuca.

The creation of a uniform audit process for the health system, the ability to correct any potential insurance issues before the billing process is completed, and nearly instant feedback provided to the registration staff have helped Virtua to achieve its best-ever registration accuracy ratio in 2010, at 97.9% year to date, says Mastalski. But having actual registration experience may be the team's greatest asset.

"Each member of the team has been, at one point or another, a registrar," says auditor/educator **Cynthia Loveless**. "We all know how difficult it can be to enter the information in a timely manner, keep track of ever-changing insurances, and most importantly, provide each patient who sits across the registration desk from them with excellent customer service."

Loveless says that the team "absolutely takes that into consideration when performing the audit. We do our best to ensure that the registrars know we're working with them to accomplish their goals."

With technological advances continuing to shape the registration process, Virtua has found that the key to a successful quality assurance program is to be constantly adapting to meet the needs of the registrars.

"Patient access is the front line for creating an outstanding patient experience," says Mastalski. "Our registration staff know they can rely on the support of the audit/education team as they continue to strive for excellence."

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# Tackle the toughest POS collection areas

Point-of-service collections are becoming increasingly important for patient access areas for many reasons, but this revenue doesn't come easily.

"Collections are a big topic in registration now," says **Vicki Lyons**, patient access manager at Baptist Hospital East in Louisville, KY. "Everything now is moving to the front end. Trying to be innovative to have the patients pay before services is a real challenge."

Getting patients to pay their copays and deductibles upfront is one of the biggest challenges that Baptist Hospital's registration areas are dealing with.

"It is a known fact that the hospital bill is one of the last bills that patients will pay, so any amount upfront we can collect is well worth it," says Lyons. "I don't think there is any great way to get patients wanting to pay what they will owe upfront. We do give a percentage off if they are self-pay and are willing to pay upfront."

**Ed Erway**, chief revenue officer at University of Kentucky HealthCare in Lexington, reports, 'We are revitalizing our efforts to improve the upfront collections."

First, managers gave scripts and extra training to front-line emergency department registration staff. Due to high turnover in those positions, managers incorporated training into their orientation, as well as ongoing evaluations.

The ED registration supervisor also provides incentives for higher collections with gift cards and pizza parties. "Leadership has also established metrics for time-of-service collection, and then regularly tracks the

monthly collections by area and hospital sites," says Erway. "Eligibility verifying programs enable the registration staff to identify any copay responsibilities of the patients and assist in the collection process."

**Barbara Thies**, UK HealthCare's manager of patient accounts, says, "We focus on the patient's entire care coverage by utilizing pharmacy programs, state and federal programs, not just covering hospital bills, so that we have a healthier patient." Here are some ways Thies says the department does this:

**• Staff monitor the pediatric patient population to make sure patients with long-term illness are in the appropriate state assistance programs.**

If a pediatric patient is considered disabled, he or she would be more appropriately processed under adult Medicaid. The program allows a higher family income because only the patient's income is considered.

"This allows the patient's parents to be unafraid of accepting a job with a higher income, because the fear of losing medical care for their child has been eliminated," says Thies.

**• Staff work with organizations throughout the state to inform Medicare patients of the best health care options.**

Staff may assist individuals in applying for the Qualified Medicare Beneficiary program, a state program designed for individuals who are dually eligible for Medicare and Medicaid, or obtaining supplemental health and prescription coverage.

"These organizations will assist our Medicare population in obtaining prescription drug assistance throughout the year, not just during open enrollment," adds Thies.

**• A team informs patients of their financial responsibility for physicians and hospital copays, prior to service.**

"They make a telephone call, plus mail a letter to each patient, prior to service," says Thies. Staff ask that all financial responsibility be paid in advance. If the patient is unable to do this, staff ask for a good-faith deposit and a commitment to a payment plan.

"We don't pursue at this time co-insurance responsibility on hospital stays," says Thies. "But, we are looking into programs that would assist us in determining patient financial responsibility so that we can start collecting those based on our contract."

The department is working on a program to introduce to the obstetrics population, so staff can collect their financial responsibility for delivery in advance of services being provided.

"We are considering a 'Welcome to UK HealthCare' packet in which the patient has information to review, prior to being scheduled for a financial consultation," says Thies. "During the consultation, we would be establishing a payment plan with the patient to ensure all anticipated services are paid prior to delivery for the physician and hospital."

The No. 1 challenge, according to Thies, is "changing the culture of our patients." Traditionally, she explains, hospitals have allowed patients to be billed their co-insurance responsibility due to the inability to determine exactly what would be owed.

"Hospitals have not been aggressive as physician offices or free-standing diagnostic clinics on collecting copays. So patients resist, even when they have a set copay," says Thies. "Patients are typically informed by the medical team to not bring anything of value. They show up with only their insurance card, if that."

**Debra A. Artwell**, manager of outpatient access at Pennsylvania Hospital/University of Pennsylvania Health System in Philadelphia, says, "We have had some challenges in collecting upfront. However, not many. Most patients are well aware of their responsibility."

Each month, most registrars are at 100% in their collection rate. This means that the registrar was able to collect from every patient that he or she registered and was identified as having a copayment.

Sometimes, an authorization is required and the physician office has not yet gotten this information. This puts the registrar in a somewhat difficult position when the patient arrives. He or she is then told that an authorization from the insurance company is required.

"This is not good customer service, because the patient has to wait until that information is received before they are seen," says Artwell. "Insurance companies will not give an authorization after the fact."

The department's strategy is for the registration staff to inform the patient of any out-of-pocket responsibility before the date of service, Artwell says. In addition, schedulers advise the patients of their copayment responsibility at the time of scheduling.

"This way, there are no surprises when the

## COMING IN FUTURE MONTHS

- Get the right technology in place for health care reform
- Revamp the way you handle ED collections
- Turn staff into first-rate financial counselors
- Improve the way you screen self-pay patients

patient arrives for their tests," says Artwell.

There is a monetary incentive for employees if a certain percentage is reached for that quarter. "The incentive is an organizational effort. It's based on a projected monies collected, versus actual," says Artwell. "Organizationally, we have to meet or exceed the amount expected."

When collection goals are met by registration staff at Hendrick Health System in Abilene, TX, a monetary incentive is received. "When the goals are achieved, supervisors and co-workers should extend praise individually and commend the team as a whole," says admissions supervisor **Cindy Gardner**. "When team members are committed to doing quality work, there is less negative feedback."

The department sets monthly goals for quality, productivity, and collections. "We have one common department goal for collections," says Gardner. "I think that the department goal, versus individual or small team goals, has been the key to our success."

If that goal is not met, there is no incentive payout; if the goal is met, then the admission's staff share 3% of the total collections, divided between all full-time employees, Gardner says. Temporary employees get 3% of their individual collections. For instance, if total collections are $250,000, $7,500 is divided between 35 FTEs, totaling $214 per employee, she says.

"This has really been an inspiration to the entire department to work as a team to reach the goal. Everyone encourages everyone else," says Gardner.

The goal is reevaluated annually. "The leadership team decides whether or not to raise it," says Gardner. "We have met the goal 10 out of the last 12 months. When we first started upfront collections, our goal was $50,000 a month. We have now graduated to $190,000 per month as our goal." In 2009, the department collected $2.65 million dollars.

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2010 SALARY SURVEY RESULTS

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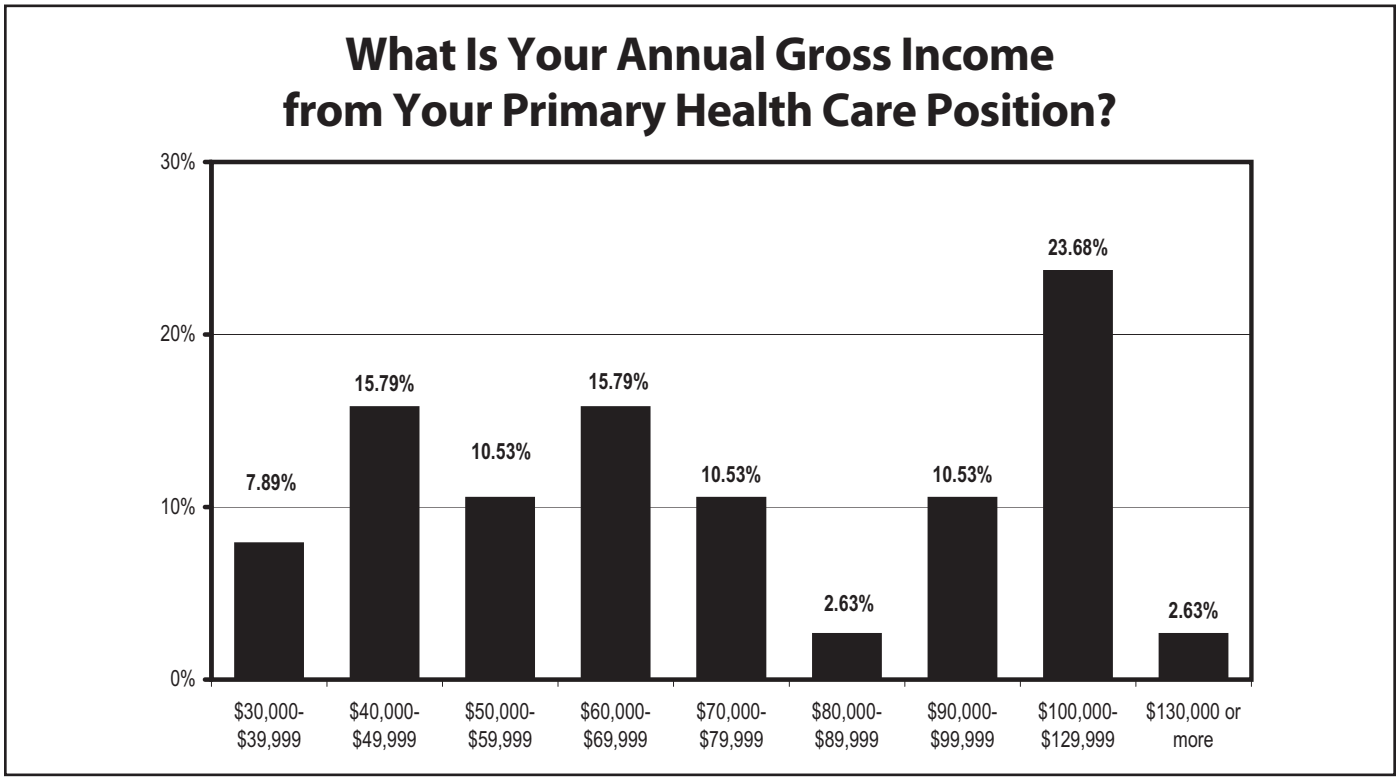
# What's in store for access? Higher skill set, constant changes

*Top three challenges: regulations, market, technologies*

Things are changing faster than ever before in the patient access world, and leaders must stay one step ahead. **John Woerly**, RHIA, CHAM, a senior manager at Accenture in Indianapolis, IN, says that the top three challenges faced by patient access are keeping up with changing health care regulations, a changing employment market, and changing technologies.

According to the 2010 *Hospital Access Management* Salary Survey, 16% of respondents received salaries in the range of the $40,000 to $49,000 range, with 8% earning less than that amount. Another 11% earned between $50,000 and $59,000, and 26% make more than $100,000. Notably, about a third (32%) of respondents reported no change in salary in the last year, while



47% reported a 1% to 3% increase, and 11% received a 4% to 6% increase.

The survey, which was administered in July and tallied, analyzed, and reported by AHC Media, publisher of *Hospital Access Management*, identifies some of the factors impacting salaries and benefits in patient access.

Other key findings of the survey:

• Twenty-nine percent of respondents worked between 41 and 45 hours, and 29% worked between 46 and 50 hours. About a third (37%) put in more than 50 hours.

• Eleven percent of respondents have worked in patient access for only one to three years, and 8% between four and six years. Thirty-two percent have worked in patient access for 25 or more years.

• Forty-two percent of respondents were over age 50.

## Higher skill set

A higher skill set is expected for today's access staff. Registrars will be having complex financial discussions and complying with more regulatory requirements at the time of registration. "It will be incumbent on the leadership team to ensure that initial training and ongoing skill enhancement programs are focused on these changing needs," says **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center.

**Charlene B. Cathcart**, CHAM, director of admissions and registration at Palmetto Health Richland in Columbia, SC, foresees a movement into a patient care-centered model.

"This model would include the patient access reps in the clinical work — taking the patient's weight or reminding them of their last physical," she says.

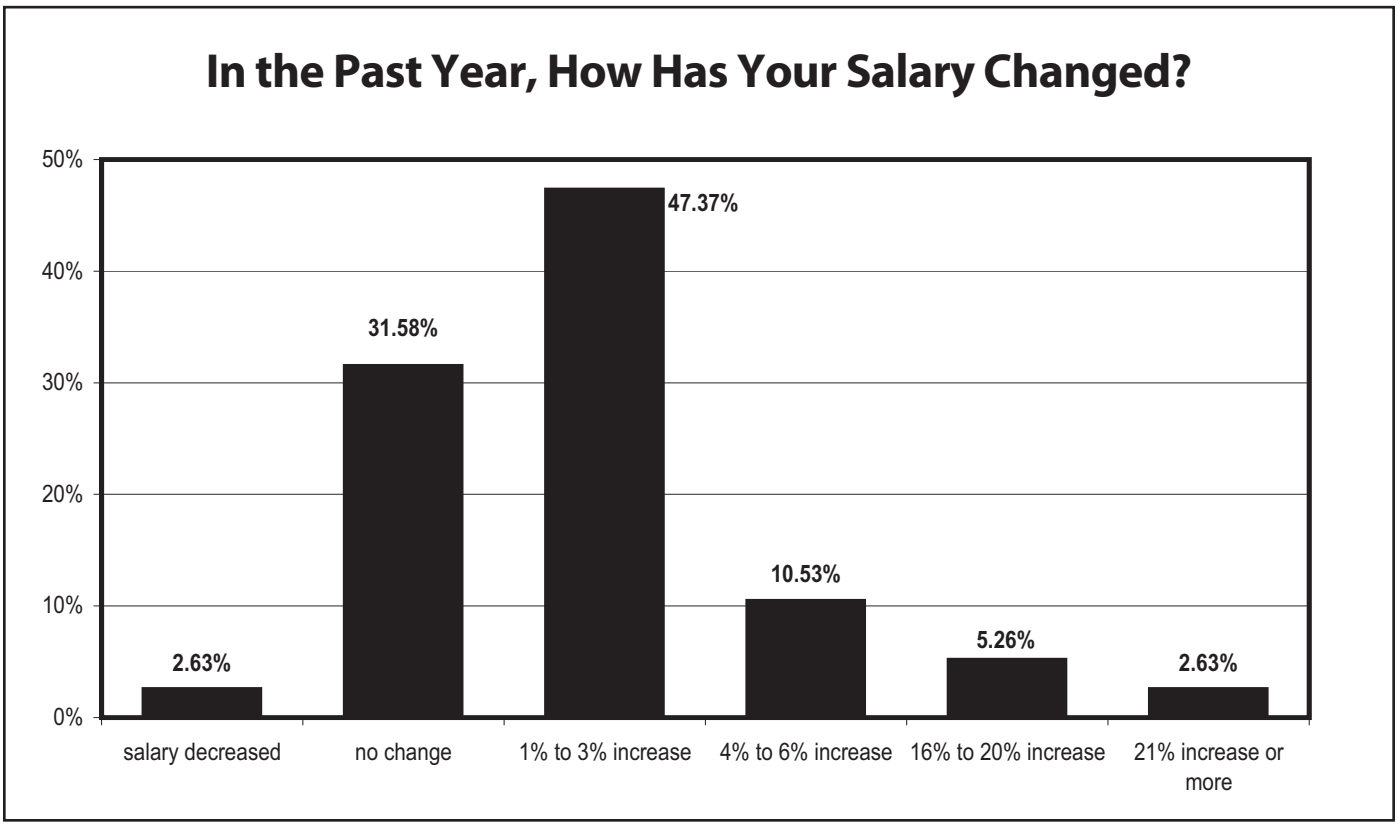
Although patient access professionals have traditionally worked in the hospital and ambulatory settings, other employment venues have opened in the past few years. These include management and operational consulting and technology design/deployment within the revenue cycle.

Woerly says, "Knowledge of front-end operations, together with the know-how to fully engage and optimize people, process, and technology," makes the patient access professional a great candidate to move to non-traditional roles.

"Although such a change may be seen as a role stretch, for the right person it can be exhilarating, both from a professional and a personal level," says Woerly.

Within the hospital setting, multi-hospital entities are beginning to embrace the concept of shared services operations, notes Woerly, which has been successfully implemented within other industries.

**Antionette Anderson**, CHAA, CHAM, director of patient access and centralized scheduling at Skaggs Regional Medical Center in Branson, MO, notes that patient access is now responsible for medical neces-



sity screening. Preventing identity theft also is playing a growing role in their responsibilities. "We are now taking pictures of all our patients at point of entry and asking for a picture ID," says Anderson.

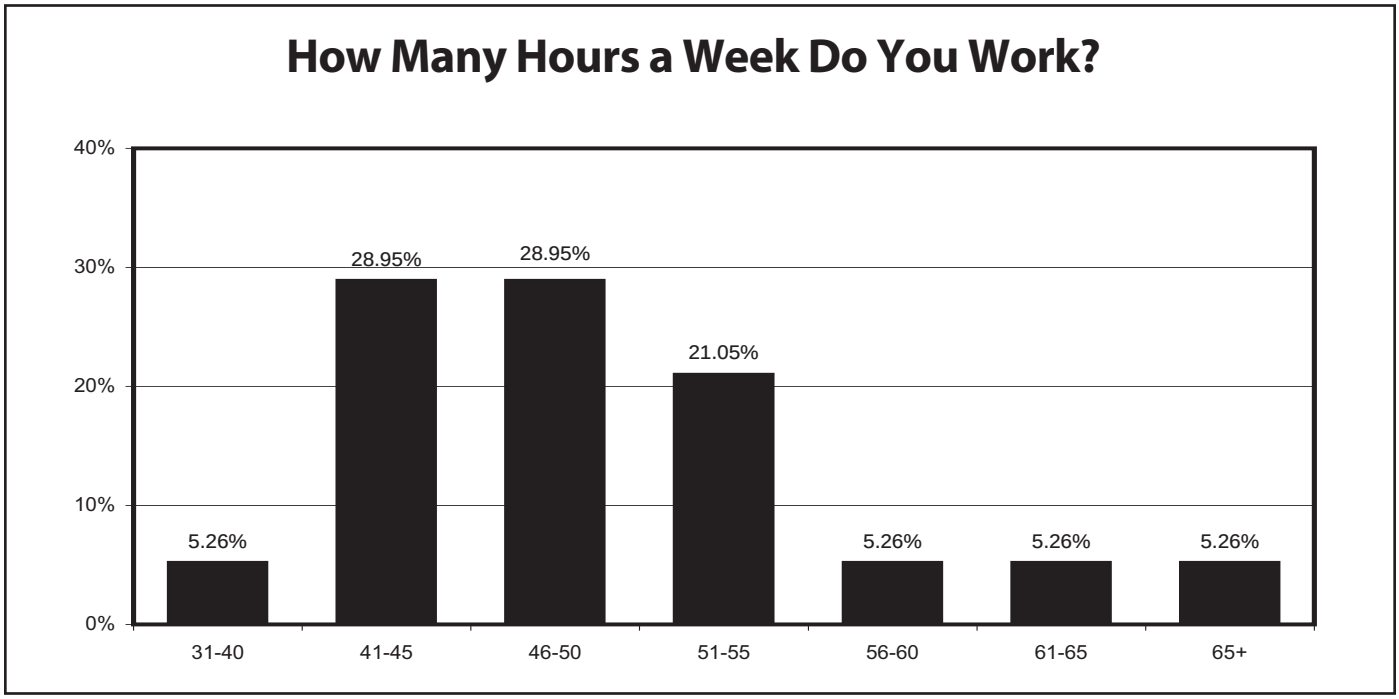
Anderson's staff also collect previous balances when the patient comes in for testing. "Our preadmission staff preregister 98% of the scheduled procedures," she notes. "They call the patient prior to their appointment and advise them of their out-of-pocket responsibility."

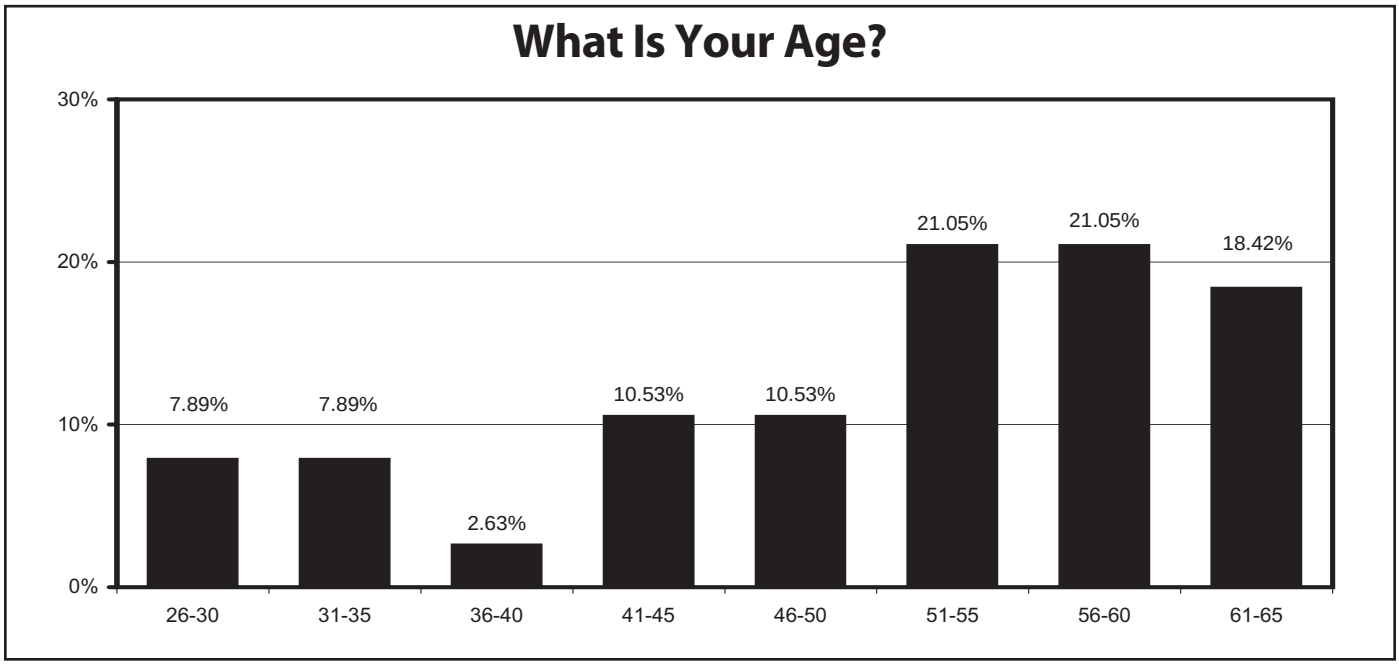
Staff either collect this amount over the phone, or prepare an estimation sheet for the registrars to let them know that the patient will pay at the time of service. "Our collections have increased considerably," reports Anderson. "For a 165-bed hospital, we are able to collect over $1 million a year upfront."

## Reform on horizon

**Vicki Lyons**, patient access manager at Baptist Hospital East in Louisville, KY, says that her department struggles to comply with all of the various government requirements. "The newest thing is making sure the patients are made aware that we do provide charity," she says.

As for health reform, patient access leaders are still unsure what this will mean for their



departments. "I don't think anyone really knows at this time what changes the health reform is going to mean for patient access," Lyons says. "Registration is an ever-changing area, so we will be ready for any change we need to make."

Clearly, though, there is a growing need to help patients understand changes in their benefits. "We need to make certain that we have the programs in place to screen uninsured patients and help link them to the correct programs," says Cathcart.

Patient access will have to be knowledgeable on all of the coming changes that impact a patient's coverage, and when they become effective. "They will have to dig deeper and ask more questions," says Anderson.

For instance, if an adult under age 26 presents, he or she may be insured under his parents even if he is married. "More people will qualify for Medicaid under different levels, so there will be more screening by the front-end staff for self-pay patients," says Anderson.

## Salaries are obstacle

At Albany Medical Center, the salary of the front-line staff member has not changed, as it is aligned with the billing staff. "That said, there is a growing need for the front-line staff to know and understand payer contractual obligations, with the ability to interpret and impact this information to our patients," says Pallozzi. "This may necessitate the need to evaluate the front-line patient access staff salary structure."

Lyons reports that "even though it seems more job requirements are being placed on registration to keep expenses down, the pay increases are being reduced.

Since registration has only so many management positions, there is not a lot of room for advancement. "But with the ever-changing job duties of registration and more expectations, we may see a change in this," says Lyons.

Woerly has a similar expectation. "Although last year's economic situation may have negatively impacted many, I believe that we'll see increased salaries as patient access professionals move to non-traditional roles," he predicts. "In addition, they are moving to a more corporate level within their organizations."

For better or worse, front-end operations clearly influence back-end operations. "If the right thing was done at the right time in the right way in patient access, other health care personnel would see an enormous improvement in their output," says Woerly.

Health information management, patient financial services, case management, utilization review staff, and others would see a marked reduction of "rework." "Health care leaders are beginning to understand this, and so will properly invest in the right professionals to improve their operations," predicts Woerly.

How do you position yourself as the "right professional?" Woerly says, "Advancement comes with doing the right thing for the right reason." In order to demonstrate your leadership skills, show that you are someone who is truly enthusiastic in your work. Collaborate with diverse personalities to successfully design and implement new solutions.

"This will aid the individual in advancing," says Woerly. "Who better to work with but someone who creates a positive, energized environment? Being seen as the 'go- to person' and the authority, will be rewarded by your leadership. If not today, then perhaps tomorrow." ■