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Access has dramatically expanded role, but salaries aren't keeping up

Higher skill level is required

If you find yourself struggling to hold on to your best employees, compensation is probably an issue. "Employees tend to transfer to other positions in the facility for more money, such as the business office," says **Antionette Anderson**, CHAA, CHAM, director of patient access and centralized scheduling at Skaggs Regional Medical Center in Branson, MO.

In fact, **Charlene B. Cathcart**, CHAM, director of admissions and registration at Palmetto Health Richland in Columbia, SC, names "finding creative ways to staff without increase staffing levels" as the No. 1 current challenge for her patient access department.

"In many areas of patient access, such as the emergency department, the patient volumes are growing much quicker than expected," she explains.

Pay impacts turnover

Many still consider patient access an entry-level position, with entry-level pay, despite the fact that responsibilities have grown sharply, says Anderson. "In fact, patient access is the front-end business office," she says. "Patient access has to input all information correctly, ensure the medical necessity, ensure the pre-certification is done, and ensure that all out-of-pocket expenses are paid at the time of service."

Still, Anderson points out that good employees can advance in patient access, moving from registrar positions to roles in pre-registration, centralized scheduling, and financial counseling.

As more back-end revenue processes migrate to the front end, the skill sets are "evolving to a higher level," says **Carol Triggs**, MS, director of patient access at St. Joseph's Hospital Health Center in Syracuse, NY. "We are recruiting more experienced and qualified candidates."

Over the past 10 years, many processes have shifted from the back end to the front end, notes Triggs. These include verifying insurance,

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interpreting benefits, ensuring and validating medical necessity, providing pre-service estimates, and communicating with physician offices and insurers to ensure authorizations are obtained, she says.

"Much of the success of the revenue cycle depends upon patient access," says Triggs. "Many of us have implemented career ladders to create a higher level of compensation based on functions and skill sets. This in turn reduces staff turnover."

Patient access is contending with the impact of health care reform and numerous other requirements, says **Jessica Murphy**, CPAM, corporate director for patient access services at Methodist Le Bonheur Healthcare in Memphis, TN. "There are constant regulatory and other changes at the front doors," she adds. "It takes the ability to multi-task and embrace change to be successful in this field."

In order to meet the requirements of health care reform, Murphy says that access "will certainly have to be ready and tuned in to changes in coverage for our patients. We will need to perform at optimal productivity and quality, in order to operate in new budgetary territory."

Angela Cabarteja, admitting supervisor in the patient financial services department at Virginia Mason Medical Center in Seattle, says that the responsibilities of her staff have expanded a great deal recently.

"We empower and coach our staff members to come up with and test ideas that eliminate waste and improve quality and consistency in our work flows and processes," says Cabarteja. When patients can't afford to pay for medical care, staff members screen and complete charity applications with them, using on-line screening tools or paper applications, she adds.

Cross-training and flexible scheduling help spread the work of obtaining authorizations more evenly across the team, says Cabarteja. "This gives staff members more visibility for the correct copay amounts we should be collecting," she explains. "It enables them to better answer patients' questions."

When patients know authorization for the surgery they are about to undergo has been approved, it helps put them at ease, says Cabarteja.

During a pre-admission process, staff verify insurance eligibility and obtain benefits information including deductibles, co-insurances, and out-of-pocket responsibilities, says Carbarteja. When there is no secondary insurance, staff submit the authorization and call the patient at home to complete the "admission" process, she explains.

"This helps identify patients who may qualify for financial assistance upfront. It reduces the time they spend in admitting on the date of service," says Carbarteja. "It also allows us to provide needed 'concierge' services, such as providing driving directions and information on area hotels."

Some increases

Murphy says that the biggest current challenge for patient access, and all areas of health care, is "doing more with less." "The trend for reimbursement reductions and pay-for-performance measures has squeezed budgets everywhere," she says.

Patient access plays a critical role in ensuring that information is complete and accurate for

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every patient encounter, says Murphy, so that claims are filed in a timely and "clean" manner. "This allows for maximum reimbursement, with short turnaround from the payer," she says.

Murphy says that patient access salaries have remained stable at her facility. "These are compared each year to similar jobs throughout our community, to ensure they stay competitive," she reports. "Last year, I was able to secure a one-grade increase and raise for our ED staff. That has had a very positive effect on our turnover in the ED."

Cabarteja says that patient access salaries have risen commensurately with the increased responsibilities in her department. A program called "tiering" is used for new employees who have passed their probationary period and are competent in their primary area of responsibility, she says.

Staff can be cross-trained in another patient financial services area for a 5% increase in pay for each tier, explains Cabarteja. "This is staff-driven," she says. "We have found that while staff members like the pay increases, they find the process of learning new skills most rewarding," she says. "It helps them understand the work flow better, prevents defects, and improves processes."

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Some surprising new roles in store for access staff

Major shift is occurring

The patient access world is seeing nothing less than a sea change in its roles and responsibilities, according to **Pam Carlisle**, CHAM, corporate director of patient access services at OhioHealth in Dublin.

"The patient access areas are seeing a shift in the functionality and roles they hold," says Carlisle. "The access world has changed to support both regulatory requirements and financial success within each entity."

Patient access areas now are expanding roles to promote career growth, reward high-performing staff, and streamline processes to gain efficiencies, says Carlisle. Here are some new positions Carlisle sees being created in the access area:

• Senior access specialists.

This role includes providing onsite training, educating staff on new processes, and auditing of current processes to ensure compliance, says Carlisle.

• Data analyst roles.

These individuals specialize in collecting and trending information to assist patient access leaders on the training programs needed for their teams, says Carlisle, as well as areas where processes need to be re-designed or improved.

"They also demonstrate success of newly implemented processes," adds Carlisle. "This position has become more solid than ever, to really help the front end focus in on accuracy, data integrity, and compliance information."

• Training and education coordinators.

"Previously on the down trend due to budget cuts, development of online training programs and system training programs with competency tests are once again emerging," says Carlisle.

Carlisle adds that tracking and trending compliance education and staff competency is "a must, to ensure we have well-trained staff on the front lines to enhance the revenue for our hospitals."

• Handling medical necessity and precertification needs in the pre-services area.

"We have not experienced this yet, but many hospitals across the country are adding a nurse in this role. The more insurance companies add on administrative requirements, the more this addition may grow to other entities," says Carlisle.

The role includes validating medical diagnosis codes and communicating with physicians, notes Carlisle. "Peer-to-peer reviews for authorizations are helping many hospitals secure payment for their services," she adds.

• Cashiers/collectors.

The cashier/collector position reviews all open accounts with patients, establishes payment plans, and secures information needed for a charity application at the time the patient is present. "There is a movement toward re-engineering the cashier office functions to more than just taking one payment from a patient into more of a collector," says Carlisle.

Patient access staff have just a few minutes to engage in a dialogue to confirm who patients are, why they are here, how much they owe, and

educate them on all regulatory information, says Carlisle. "This must all be done within three to five minutes, so as not to delay care," she adds. Here are four newly expanded responsibilities for access that she sees:

1. Patient identity.

"The information the staff on the front line collect is all subject to what is presented by the patient," says Carlisle. "Confirming those red rules is a necessity, not only for patient safety, but to protect the identity of your patient."

Some patients become frustrated with the amount of data that staff must verify, notes Carlisle. "We have to explain that our process is for their benefit," she says. "We collect very personal and financial information that, if compromised, would be damaging to our patients."

2. Privacy.

"Space allocation in all hospitals is a challenge," says Carlisle. "We have to maximize our clinical space to be able to provide great care to our patients. At the same time, we cannot jeopardize or minimize the space design for the administrative functions."

Carlisle says that, too often, patient access areas are the last to be included in the design phase. "However, with the growing acceptance and understanding of this profession, we have seen a trend of putting them at the table during initial design discussions," she says.

3. Point-of-service collections.

Despite a trend of rising deductibles and higher out-of-pocket responsibility, Carlisle says that increasing numbers of unemployed and underinsured patients is complicating the collection efforts for many hospitals. "We all know point-of-service collections are critical to the revenue cycle in reducing A/R and bad debt," she says.

Patient access staff are "struggling today to balance collection and customer service efforts with the patients they serve," says Carlisle. Staff can identify the amount owed, and ask for that amount at the point of service, but cannot delay care, she explains.

You should look at point-of-service collections as part of your service to the patient, says Carlisle. This includes educating them on their out-of-pocket responsibility, giving them options if they can't pay, and working with them to satisfy their financial obligation, she says.

"We would like patients to focus on getting better quicker. We want to relieve that financial stress by taking care of all administrative details prior to their service," says Carlisle. "A changing economy has made this balance difficult to manage."

4. Staff development.

Carlisle says that in order to meet all of these challenges, patient access departments must give staff the tools they need. This includes education programs "as often as staff need them," she says, and process designs that are efficient for their work flow.

"They have to service all of their patients quickly and accurately. We have to build an environment for their success," says Carlisle. "This will result in better satisfied employees, which leads to greater customer service for our patients."

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Give best registrars chances to advance

Reward excellent work

Every patient access department has registrars who can be counted on to rise to every occasion, but better pay may lure these valuable employees to other hospital departments or industries. Instead, why not give these employees "an offer they can't refuse"— that is, a clear path to career advancement.

"We have created a career ladder for our patient access staff," says **Antionette Anderson**, CHAA, CHAM, director of patient access and centralized scheduling at Skaggs Regional Medical Center in Branson, MO. The career ladder has five rungs, enabling staff to increase their wages by $1.75 per hour, says Anderson, and the last rung requires that staff pass the Certified Healthcare Access Associate (CHAA) examination.

"Each rung has several line items of criteria, such as 98% accuracy, or training new employees," says Anderson. "Each rung [involves] a different level of competency exams that they must pass. After they have achieved them, competency testing is done on a yearly basis."

Jessica Murphy, CPAM, corporate director for patient access services at Methodist Le Bonheur Healthcare in Memphis, TN, says there is a four-tier management team at each facility's access department, consisting of lead, supervisor, manager, and director.

"We work with staff to encourage their acceptance of cross-training in other departmental positions," says Murphy. Staff also are encouraged to attend locally offered training classes and exhibit leadership skills by working with new associates and becoming the "go-to" resource in their area, she adds.

"These traits are noted and rewarded through the annual performance evaluation, and by encouraging these associates to apply for management jobs when available," says Murphy. Here are some other approaches to retain patient access staff:

• Improve the way you communicate with staff.

"Updating standard work processes, and reviewing these with each staff member one-on-one, really helps ensure we are all on the same page," says **Angela Cabarteja**, admitting supervisor in the patient financial services department at Virginia Mason Medical Center in Seattle.

Cabarteja also provides monthly reviews to identify any necessary training staff may need and eliminate any barriers that might be keeping them from doing their best work.

• Thank staff members for all they do.

"This isn't just with the big things. It is also recognizing the little things they do when they think no one is looking," says Cabarteja. "We purchased a fleece jacket with our logo and gave it to them 'just because.'"

An internal recognition system gives staff members "applause" points with specific details about something they did very well, says Cabarteja. "We also bought the team bubble tea and pizza when they collected $1 more in copays than the previous month," she reports. "We randomly send them cards at home to say what we appreciate about them."

• Provide staff development.

Carol Triggs, MS, director of patient access at St. Joseph's Hospital Health Center in Syracuse, NY, says that staff development is critical to retain competent and dedicated staff.

"Much of the former back-end processes have now shifted upfront," says Triggs. "In addition to accurate registrations, access staff must be well-educated in payer requirements, medical necessity, and estimating patient copays, deductibles, and balances. Staff must be trained in multiple software applications to perform many of these functions."

Equally important, says Triggs, is that staff understand the importance of their own role in the revenue cycle. "They are the 'key' in preventing costly rework and reduced reimbursement," says Triggs. "Customer service training is an equally important component of education. Every patient's first encounter begins with patient access, which sets the tone for the patient's stay."

The department has tried to ensure that staff in multiple service locations are familiar with the roles and functions of their patient access colleagues throughout the network, says Triggs. To accomplish this, managers developed a "Walk in My Shoes" program last year, she says.

"This has been well-received by staff," reports Triggs, adding that a career ladder has been vital in helping the access team become multi-functional and obtain their CHAA certification.

"We have a formal orientation and training program for all access new hires," says Triggs. "A weekly communication of important updates occurs through our 'Access Communique,' which is e-mailed to all access staff throughout the network."

In 2011, the department will be looking at ways to formalize open communication and share ideas and knowledge through unit-based councils. "We will model this after our clinical unit-based councils," says Triggs.

• Pick top performers to act as preceptors.

Charlene B. Cathcart, CHAM, director of admissions and registration at Palmetto Health Richland in Columbia, SC, says that her department has implemented a successful preceptor program. "We started out by identifying our top performers in each of our entry points including the ED, the Children's Hospital, and the Heart Hospital," says Cathcart.

Each employee's supervisor wrote a short letter of recommendation, and each candidate was interviewed by Cathcart to make certain that they were interested in and committed to the program.

The preceptor team went through a series of educational sessions, says Cathcart. Managers expected each competency test to be passed with a score of no less than 95%, she adds. Upon completion of the 12-hour training sessions, each participant received a small pay adjustment.

Now, every new employee is assigned to a preceptor. "This program has helped quickly establish a relationship between the new employee and the department," says Cathcart. "It also allows the preceptor to be recognized and rewarded for their efforts."

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Avoid costly mistakes with Medicare registrations

Prevent penalties for noncompliance

Years ago, when patients came in with Medicare coverage, registration staff were "ecstatic," recalls **Robin Teneyck**, director of patient access for Sound Shore Health System in New Rochelle, NY.

"All they needed to worry about was whether the effective date of coverage preceded the date of service under Part A for inpatient and Part B for outpatient," she says. Teneyck says that today, her patient access staff must do the following things:

- Verify if the patient has Medicare or Medicare HMO coverage, by checking the eligibility response.
- Cross-reference another table if the eligibility comes up as Medicare HMO, to determine which Medicare HMO.
- Call the Medicare HMO to determine if pre-certification is required.
- Verify recent care with the patient or family, to try to establish the extent of available coverage, such as the available number of inpatient days and whether any deductible under Part A or B is due.
- Verify with the patient or family that there is no other coverage, through the patient's or spouse's possible employment.
- Explain coverage limitations to patients, such as inpatient deductible being due again if the patient has not been hospitalized in more than 60 days, if physical therapy is due to a car accident in which no-fault insurance is primary, or how group coverage is primary to Medicare.
- When a Medicare patient is under age 65, and has been found eligible for Medicare due to a permanent disability, determine whether the patient may still be within a 30-month period of eligibility for group coverage through him- or herself or spouse since the condition was diagnosed. "This would be primary to Medicare for end-stage renal disease," says Teneyck.
- Complete the Medicare Secondary Payer Questionnaire for every visit by a patient with Medicare coverage.

Heavy toll on staff

Teneyck says that compliance with federal regulations takes a "heavy toll" on patient access staff. "Registration takes so long today because of all the documentation that has to be secured from patients, acknowledging their rights are being protected," says Teneyck.

Teneyck says that this documentation includes consent of treatment, patients' rights, patient privacy, the Important Message from Medicare, medical necessity, Medicare Secondary Payer Questionnaire, release of information, assignment of benefits, and guarantor responsibility.

"Another form ascertains the transaction took place in a language understood by the patient," adds Teneyck.

Penalties for noncompliance could include take-backs on future reimbursements, or ultimately, forfeiture of approved provider status, warns Teneyck.

"It is best to look upon regulations as a road-map to quality care," she says. "Using the example of the Medicare Secondary Payer Questionnaire, it is in everyone's best interest to bill the proper payer from the start. This includes complying with eligibility, referral, and authorization rules."

Immediate input

To ensure timely payment by Medicare, registrars need to immediately input physician information, the diagnosis and the tests ordered, says **Joy Wright**, a patient registration supervisor at Lodi (OH) Community Hospital.

However, staff must sometimes call or fax the order to the physician's office for an additional diagnosis, says Wright. "If the physician's office is closed, the patient is required to sign the ABN [Advance Beneficiary Notice]," says Wright. "The patient may not understand the choices, or they don't have the testing completed."

Teneyck ensures that staff immediately input physician information, diagnosis, and tests ordered to safeguard proper and timely payment by Medicare, spot-checking the registrars' work throughout the day. She also updates and monitors a daily report of the next day's scheduled services, listing accounts missing the physician's name, diagnosis, tests, and/or payer information.

"There is computer software to automate monitoring of quality improvement processes by not allowing progress to the next screen unless selected parameters are met," notes Teneyck.

An ABN must be collected from patients, adds Teneyck, detailing their awareness that a service to be provided is not medically necessary. "Staff need to explain to the patient that under the circumstances, the patient is expected to pre-pay for the

service or postpone the care," she says.

Teneyck says that she has found that the best approach is to address this at the time of service. "If the doctor's office calls for the appointment, you can complete the medical necessary check and ask any additional question you need to complete the check," she says.

If the patient calls for the appointment, Teneyck says that staff usually have enough time prior to the appointment to call the physician to make sure the diagnosis is correct. "If the services are not covered, we call the patient at home to alert them before they come in and give them the option of paying or cancelling," she adds.

If the patient shows up without an appointment and without the medical necessity check being completed, staff call the physician while the patient is present, says Teneyck. If the physician is not there, staff speak with the physician on duty to ensure it is not an emergency and the test can wait, she explains.

"If it's not an emergency, we give the patient the option of paying for the test, cancelling or rescheduling," says Teneyck. "We notify the physician's office of any canceled appointments."

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Revamp collection process for admitted ED patients

Results can be dramatic

It's hard to imagine a tougher point-of-service collection challenge than collecting from emergency department patients. Patients may expect to pay a small copay, and when they change to inpatient status, may suddenly owe thousands of dollars toward their deductible.

"It seems that this is still quite a shock to many," says **Maria Wence**, corporate director for patient access at Lourdes Health System in Riverside, NJ.

ED is bigger challenge

At Children's National Medical Center in Washington, DC, patient access staff are trained to determine the patient's out-of-pocket responsibility during verification of insurance benefits, says **Carole Helmandollar**, executive director of ambulatory services.

If there is going to be a large out-of-pocket cost, staff refer the family to the hospital's financial information center to either apply for secondary Medicaid coverage if eligible, or apply for the hospital's charity care program under the financially indigent coverage offered, says Helmandollar.

"To qualify, their out-of-pocket expense for all medical services would have to exceed a certain percentage of their net income," notes Helmandollar. A third option is for staff to negotiate a payment plan, she says.

"Ironically, we sometimes also experience the reverse of this problem," says Helmandollar. "A parent has paid their ER copay, but when they're admitted, this is waived and they have no out-of-pocket expense. The family obviously wants their money back, but we aren't always able to resolve that request the same day. That can lead to customer service issues."

Lourdes Health System implemented a new upfront collections policy in May 2010 for most registration areas, focusing mainly on elective procedures, scheduled outpatients, and ED copays.

"As a result, we have seen a dramatic improvement in payments received from patients," reports **Kim Barnes**, the organization's vice president of corporate development. "The new processes implemented have had the most significant impact on payments received from scheduled patients." The collection of out-of-pocket payments for emergency department patients remains a bigger challenge, however, says Barnes.

"Year to date, our collections for one facility increased by 1,870%. Yes. 1,870%!" says Wence. "At our other facility, the increase was approximately 86%."

Major challenges

Wence says that the No. 1 challenge in collecting payments from emergency department patients is simply determining how much to collect.

While the patient's copayment is usually clear, other out-of-pocket costs and co-insurance payments can be quite complicated, Wence explains. "Just one insurance company may have dozens of products with different rates, and we work with a number of different insurers," she says. "Thus, estimating the correct payment to collect is the most difficult problem."

This is particularly challenging for patients being admitted to the hospital from the ED, says Wence. One reason is that the status of patients

is often not known upon admission, and patients may move from observation status to inpatient status and vice versa, she says.

"This makes it almost impossible to determine the proper payment at the beginning of their stay," says Wence. "We are only focusing on the ED copay at this time. We have a set estimated average price that we ask from our self-pay patients."

The medical condition of patients being cared for in the emergency department is also "a huge challenge," says Wence. "Since the patients are very ill and in need of emergency care, they may not be capable of discussing payment for services," she says. "Patients and their families often are not prepared to go to an emergency department. They may not have their wallets or proper information."

Process changes

Patient access leaders instituted a process change in the emergency departments at Lourdes in 2010. "We now have a dedicated team of financial counselors within the emergency department," says Barnes. "They are available to work with the patients immediately, to assist in facilitating the payment process."

Patients who cannot make payments at the time of care are now given a letter stating the amount of the payment required, and a self-addressed paid envelope to send in their payment at a later date, says Barnes. "Our team also works with patients to develop extended payment options as needed," she says.

The financial counseling team deals with many challenges, says Wence, including compliance with the Emergency Medical Treatment and Labor Act, patient cooperation, clinical staff time with the patient, bed turnover, and identification of the patients they should see.

"However, the patient reactions are positive," says Wence. "Once the financial counselor explains to them that it's a free service, and that they are trying to help them with the expense of their medical visits, approximately 90% of patients are happy and cooperative."

Wence estimates that about 10% are "uncooperative from the start." Out of the 90% that are cooperative, she says that about 60% continue to be cooperative after they leave the ED and bring all the documentation needed to be approved for assistance.

"The good thing about the financial counselor seeing the patient in the ED and beginning the application process is that we will at least have a signed application," says Wence. This means that the hospital can collect some money from its charity care pool for uncooperative patients, she explains.

"They must have the initial signed application though for us to be eligible for that," notes Wence. "We instituted this process in October 2010 at our facilities. We have increased 'reimbursement' from the charity care program by $32,000 in one month for one hospital."

The hours of the financial counselor shift were determined by running statistics of the ED visits by insurance type and by time of day, says Wence. "Then, we determined the times of the day and days of the week with the most need," she explains.

Barnes notes that the best practice in the industry is to have a "discharge desk" in the emergency department and dedicated staff to collect out-of-pocket charges. "At this time, Lourdes does not have the space and staff to accommodate that practice," she says.

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Patients demanding out-of-pocket info

Need to know is greater

Patient estimation software implemented in late 2009 at Tallahassee (FL) Memorial Hospital has "helped tremendously" with collections, says **Joan S. Braveman**, director of patient access and financial services. "In this past fiscal year, we increased our front-end cash collection by 40%," she says.

Staff can give patients an accurate estimate of what they'll owe for any payers whose contracts are built into the system, says Braveman. Some patients have insurance, but the contracts are not built into the system, she adds.

For this scenario, Braveman says that staff are given specific individuals to contact at the insurers, so staff can call to find out what the allowed amount will be.

Multiple copays

Inaccurate estimates may occur, though, when a physician schedules a procedure or surgery and ends up doing something different or doing additional

work, says Braveman. "One area where this really is a big problem is radiology," says Braveman. "One of our major HMOs is now stacking copays."

If patients are scheduled for a CT scan of the abdomen, staff will inform them that they have a $100 copay for the procedure. This amount can suddenly change, however, if additional views are needed, says Braveman, because the HMO charges another copay for each view.

"The radiologist may look at it, and say that they really need two more views. The patient could end up having a $300 copay," says Braveman. "That is problematic."

For this reason, staff are very careful to explain that additional copays may apply if any additional work is done, says Braveman. "People may hear what they want to hear, though," she says. "To the patient, they had a CT scan. They don't see that something different was done. That has been one place we have had a lot of issues and patient dissatisfaction."

Braveman recalls that in previous years, some HMOs stacked copays for a period of time, but many eventually settled on obtaining a single copay per 24-hour period. A few years ago, though, one local HMO started this practice again, she says.

"If someone goes to the ED and has a CT while they are there, for example, two copays apply. Patients are often unhappy about this," says Braveman.

Avoid surprises

Due to larger out-of pocket-responsibilities, and "with consumer-driven health care, the need to address patient financial responsibility 'upfront,' is greater than ever," says **Carol Triggs**, MS, director of patient access at St. Joseph's Hospital Health Center in Syracuse, NY.

Out-of-pocket costs have risen for patients in both consumer-driven and traditional plans, notes Triggs. "Verification of the patient's insurance and accurate identification of a patient's out-of-pocket costs during the pre-registration process is critical," says Triggs. "We need to ensure that the patient encounters no surprises on the date of their visit, or at the time of their discharge."

Providing a link through patient access to financial assistance programs, for both the uninsured and the underinsured, is "more important than ever," adds Triggs.

Accurate estimates

Braveman says that her staff were reluctant to give estimates to patients, fearing these would be inaccurate. "They were kind of pulling numbers out of the air. Now, we have some real numbers to deal with," she says.

Braveman said that initially, scripting was used for point-of-service collections, but unpredictable patient responses made this difficult. "It's pretty hard to script something if you don't know what's going to come from the other end," she says.

Braveman says while the patient estimation software had a big impact, she credits most of the department's success to a better-educated staff. "We have done a lot of education, not just about the importance of cash collection at the time of service, but also about the revenue cycle in general," she says.

Braveman asked staff this question: "What happens to the $100 copay that you didn't collect when the patient walked in the door?"

"If we are only collecting 50 cents on the dollar, that $100 becomes $50," says Braveman. "The likelihood of the patient paying goes down, the further away from the service you get."

Positive reinforcement

Braveman sends an e-mail out to all of her staff every month, showing them how they did with collections. "We've kind of made this into a celebration. That has made a big difference," she says.

If someone does an exceptional job with collections, Braveman gives that person free movie tickets. When staff had an exceptional month with ED collections, she bought pizza for everybody.

"I'm not into incentivizing the program, because it's in their job description," says Braveman. "But doing that extra bit of recognition says that somebody's paying attention to what you're doing."

Not all staff have access to the payment estimation system, Braveman notes. "The reason we opted not to give it to all of them is to because you need the exact CPT code for what is going to be done in order to get an exact price," she explains. "If someone comes in and says, 'I'm here for a CT,' that doesn't tell them enough to be able to figure out what the copay is."

Different types of CTs have different reimbursements associated with them, Braveman explains.

Braveman notes that state regulations require that staff must provide a written good-faith estimate to any patient requesting this. "When that regulation first came out about two years ago, we got calls from patients all the time," she recalls. "There were so many that it got

to the point that we had to set up a separate phone number for those calls. Patients would leave their information for someone to call them back."

Braveman recalls that back then, "people were absolutely out shopping. And for someone who is either uninsured, or has a coinsurance rather than a copay, it made a lot of sense. But we're not seeing that as much today."

One reason may be that staff now call patients in advance to give them an estimate of what they will owe. "This is an opportunity for people to ask questions," says Braveman. "I only have a couple of people that I allow to call patients. They are very talented and they don't need every word they say scripted."

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Take proactive approach to prevent claims denials

Patients may be dissatisfied

When a claim denial occurs, the underlying cause is not necessarily the payer's requirements, says **Silva Gramlich**, director of registration services in the finance department at Nationwide Children's Hospital in Columbus, OH. Gramlich reports that in order to save costs, employers are modifying the type of coverage that they are offering their employees.

"In some cases, they are limiting the number of visits or treatments," says Gramlich. "Or, the denial can come back because that particular employer has chosen not to cover a specific service any longer."

Visits for certain types of therapies may have been unlimited in the past, but now the employer is covering only a limited number, says Gramlich. "That means more work for the billing team. We have been paid in the past, but now you have to rework the claim," she says. "That adds to the days in accounts receivable."

It also can lead to patient dissatisfaction, notes Gramlich. "The majority of people have a tendency not to read the material about their benefits," she explains. "They may think they can go for unlimited services because the hospital is a provider, which is not the case. The consumer is sometimes surprised that coverage is reduced, or that a service is not covered at all."

Fixable denials

Judith Toth, the hospital's director of patient accounts, says that many denials are "fixable rejections. There are rejections that can be corrected. Then there are denials that the payers are not going to pay us for, such as when we find out retrospectively that the patient doesn't have coverage."

Patient access staff analyze denials to see if any improvements are needed, says Toth. "For those that are contractual issues, we get payer relations involved," she says. "There are denials where they are asking for additional information, which I call technical denials. Those are sometimes a little harder to understand."

The patient accounts department implemented software to address some of those, says Toth. "Sometimes you have what we call 'local review policies,' which the payers use to determine medical necessity. So you have to work those," says Toth.

Denials may involve a difference of opinion on what the payer and the hospital consider to be non-covered services. "Those can sometimes be a grey area. We think that we should be paid for certain things, and payers will disagree with that," says Toth. "Then, we have to go to payer relations and talk about how we are going to resolve it."

Another type of denial that is difficult, says Toth, involves technical difficulties on the part of the payer. "We have had some payers recently who have installed new software. They are denying things they should not deny, because the software is not set up appropriately," says Toth. "That is kind of challenging, because it backs up your A/R."

Toth notes that certain Medicaid HMOs have begun to install Correct Coding Initiatives (CCI) edits, which they did not have previously. These CCI edits are used widely by Medicare and other payers for reimbursement, as a result of a Centers for Medicare & Medicaid Services (CMS) mandate, says Toth.

Because of this, she says, "things are getting denied for inappropriate reasons, or they are not recognizing things that should be paid. That's been our major challenge. And it is going to be ongoing, because that mandate is out there. Our payer mix is pretty heavily Medicaid."

Medicaid was mandated by CMS to install these

specific edits in order to limit services from being billed into one procedure, says Toth. "They limited things from being unbundled, because they feel there is a tendency for overpaying for certain things," she says. "More of the payers are adopting those CCI edits. It makes billing a lot tighter and more complex."

Brett Taylor, director of payer relations for Nationwide Children's, says that more stringent requirements, and resulting claims denials, are partly a product of the increase in Medicaid managed care plans. "More states are going to that, and they are playing catch up to where the commercial plans were a few years ago," he says.

Payer-specific requirements

There are many payer-specific requirements that staff need to watch out for, says Toth, giving the example of a claim denied for an invalid CPT code. "It may be a valid CPT code, but one that that particular payer does not recognize," says Toth. "So you have to research it, and supplement it with one that fits appropriately for the situation, if at all possible."

Another claim might be denied as "medically not necessary" because it was billed in the physician field as inpatient, and the insurance company feels it should be have been observation, says Toth.

Other claims denials involve Medicaid patients who are admitted to the facility from another hospital, says Gramlich. "That information is now always passed to the patient access staff member who is doing that admission," she explains. "Potentially, you are going to get a denial. Medicaid wants you to code that as a transfer, yet the personnel didn't know the patient came from another hospital."

The good thing about those particular denials is that they are very easy to fix and resubmit, says Gramlich. "There isn't a lot of utilization of resources going into those, but we do re-educate staff that they need to work collaboratively with the transport team," she says.

The transport team now indicates that the patient was picked up from another hospital, not from a doctor's office, home or the scene of an accident, says Gramlich.

"We are doing much better with that. But as a large organization, we have turnaround and people that come and go," says Gramlich. "We are always educating staff, as soon as we see those type of errors." ■

Patients, employers both fiscally stressed

Additional training needed

Patient access staff are encountering patients under financial stress, and the same is true for employers, notes **Brett Taylor**, director of payer relations for Nationwide Children's in Columbus, OH. "Unfortunately, it's just the environment that we are in," he says. "The patient's responsibility is increasing. At the same time, employers are trying to educate members on their health plan so that they can make an informed decision."

Silva Gramlich, director of registration services in the hospital's finance department, says that staff are often put in the position of letting patients know that their out-of-pocket obligation is higher than the previous year.

"It does put staff in a bad position to be the bearer of bad news," she says. "It's not a pleasant situation, and the consumer may be upset with the hospital."

Taylor says that he finds this to be more pronounced in a children's hospital. "There is a difference between the pediatric world versus the adult world," he says. "There is a little bit more emotion that comes to a day-to-day visit here, versus what you might see in the adult setting."

Staff were given customer service training to help them discuss a patient's financial status and make payment arrangements, says **Judith Toth**, the hospital's director of patient accounts. "We make it as easy as possible for people who do qualify to be able to get any kind of assistance they may need," she adds. "We also direct them to an outside group to get approval for any governmental programs that are out there."

COMING IN FUTURE MONTHS

- Use 'secret shopping' to gauge customer service
- Motivate staff without any extra salary
- Improve the satisfaction of uninsured patients
- What to do with your uncollectible accounts

Many times, patients are unaware that there may be programs to help them, especially those with language barriers, says Toth.

Competency required

A patient may have a $5,000 deductible before services are covered at 80%, says Toth. "People can have bills that are hundreds of thousands of dollars, so 20% responsibility is a lot," she says. "We see what we can do to help them with the difficult financial challenges that they are experiencing."

Gramlich says that a new model of training was created in 2010. Staff now are expected to pass a competency test. "We are now seeing this start to pay off with accuracy," says Gramlich. "In the past, they might not have selected the right insurance plan. They now take an extra second to make sure that the right ID number is typed in."

This prevents the billing team from getting a "member not covered" denial, says Gramlich.

While new staff members always took a competency test, now anyone in a patient access role is being asked to pass it, says Gramlich."If you do not pass, you have to go through new employee training. If you do not pass a third time, your log-on is revoked."

By increasing accuracy, the work that all of the various billing divisions have to do is lessened, says Toth. "If you complete a good record here, it will decrease the workload for the team that is responsible for billing or paying posting," she says. "Plus, it is a negative impact to the family when we get those mistakes. We then have to reach out to the family again and say they are not covered. That is a cost to the organization." ■

HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Importance of security risk assessments rise with advent of electronic health records

Millions available for hospitals that meet meaningful use requirements

A landmark study conducted by the Poneman Institute Reference shows that 70% of hospitals say that protecting patient data is not a top priority and 67% have less than two staff members dedicated to protection management.[1] *(See page 3 for more study results.)*

Hospitals and other covered entities have a new incentive to step up efforts to protect patient data and conduct annual security risk assessments now that meaningful use and incentive payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act are available. The meaningful use regulations require organizations to conduct or review a security risk analysis and implement security updates as needed, along with correcting identified security deficiencies as part of their risk management process.

"People have ignored the need for a decent risk assessment and have chosen to accept the risk of a breach as less costly than the investment needed for thorough risk assessment," says **Feisal Nanji**, executive director of Techumen, a consulting firm focused on securing health care information. Incentive payments for meaningful use of electronic health records (EHRs) are significant and will make the risk assessment more important for organizations, he says.

"The incentive payments are a significant source of funds to offset the implementation of electronic health records, but to be eligible, your risk assessment must be based upon National Institute of Standards and Technology's [NIST] guidelines," says Nanji. *(See resources, page 2 for guidelines.)* The financial incentives for hospitals are based upon an initial base payment of $2 million, plus an amount per Medicare patient discharge for the year, with a four-year cap of $11 million. Physicians and other eligible professionals can receive incentive payments up to $18,000 per year with a maximum payout of $44,000.

The last day that hospitals can register and attest to receive an incentive payment for the federal fiscal year 2011 is Nov. 30, 2011, so there are a number of steps hospitals can take to be sure they are able to participate in the program, says **Sandra E. Quilty**, JD, attorney, Baudino Law Group, Des Moines, IA. *(See page 3 for all deadlines.)* "Larger hospital systems have the technical, legal, and op-

Executive Summary

Information security has moved up the priority list for hospitals that want to participate in the Center for Medicaid & Medicare Services' meaningful use incentive program. Security risk assessments that meet specific standards are required to qualify for payments of up to $11 million over four years to offset the cost of implementing electronic health records.

- Risk assessments must be based upon National Institute of Standards and Technology's guidelines.
- A need to improve data protection is evident, according to a Poneman Institute study that shows 70% of hospitals say that patient data protection is not a top priority.
- Hospitals should evaluate who is in charge of monitoring information security, and ensure that operations and compliance are separate functions in separate departments to improve integrity of monitoring function.

erational support needed to comply with meaningful use requirements, but small or rural hospitals may find the regulations burdensome," she says.

The Department of Health and Human Services' Regional Extension Centers are designed to provide some of the technical assistance that critical access and rural hospitals need to convert from paper-based medical records to certified EHR technology, she says. *(See resources, this page.)*

The security risk assessment should include all of the key players in implementing and ensuring the security of an EHR system, says Quilty. Information technology, compliance officers, clinical leaders, legal counsel, and key managers of departments that will use or support the system should be involved in identifying and evaluating potential security risks, she says.

An EHR system poses different security challenges than many information systems, says Nanji. While you can control the number of individuals who access different types of information throughout a hospital, electronic medical records must be easily accessed by a wide range of providers to ensure quality care, he explains. "This increases the opportunity for unauthorized access or use of information so the assessment must be thorough to identify and minimize risks," he adds.

Another issue that many hospitals need to address to ensure security on an ongoing basis is the identification of the right person to monitor the integrity of information systems, says Nanji. "In most hospitals, the chief information officer or someone who reports to the chief information officer is often the person designated to monitor the security of the system, even if he or she reports to a person who serves as the overall compliance officer," he says. This means that hospitals are asking an operations person, the CIO, to also monitor and ensure security — two tasks that may be at odds with each other, he says.

"As an operations manager, the CIO must meet budget restrictions and keep the information systems up and running efficiently," he points out. "As a security officer, the CIO may identify upgrades or enhancements to the system that may not be within budget parameters or will not be as convenient for system users," he says. In most cases, the CIO will make decisions that favor operations if the security risk is not deemed as important as the need for cost-efficiency, he adds.

"I always ask compliance officers if they are sure they are getting the information they need from their CIO," says Nanji. Enhanced criminal, civil, and monetary penalties that are in place with the passage of HITECH increase the importance of compliance officers getting the right information at the right time, he says. "A hospital governance structure that places responsibility for information security separately from information operations is the best approach," he says. "I also recommend that compliance officers be able to understand the information they need and to obtain advice from outside consultants if necessary," he adds.

The security risk assessment is only one part of the requirements for Phase I of the meaningful use of electronic health records, points out Quilty. The other requirements include the use of technology certified by the Centers for Medicare & Medicaid Services *(see resource box on page 2 for information about certification agencies)*, core clinical measures

Resources

- National Institute of Standards and Technology's free Special Publication 800-30, Risk Management Guide for Information Technology, can be accessed at *csrc.nist.gov/publications/nistpubs/800-30/sp800-30.pdf*.
- A list of Department of Health and Human Services' Regional Extension Centers can be found at *http://healthit.hhs.gov*, selecting "HITECH Programs" on the left navigation bar and choosing "Health Information Technology Extension Program."
- A list of certification rules and programs for electronic health records can be found at *http://healthit.hhs.gov*. Select "Regulations and Guidance," then "Standards and Certification," and "Certification Programs."
- The health information technology association, Healthcare Information Management and Systems Society (HIMSS) offers the Meaningful Use OneSource, a compilation of documents, tools, and links to other resources related to Meaningful Use and Certification Criteria and Standards. Go to *http://www.himss.org/ASP/topics_meaningfuluse.asp*, and choose from the left navigation bar.
- Free tools to help health care organizations track the requirements for EHR incentive payments can be found at *www.hitechanswers.net*. Select "Free EHR Tools" at the bottom of the page.

that must be reported, basic requirements of the system including computerized physician order entry and e-prescribing, and patient communication capabilities. "Other phases of the meaningful use rule will expand upon these requirements and will be published in 2013 and 2015," she says.

Throughout all phases of electronic medical record implementation, security will continue to be important, says Nanji. "The security risk assessment is critical, but a hospital's responsibility doesn't end with the assessment. You must be prepared to identify your risk and explain how you will address the risks on an ongoing basis."

REFERENCE

1. Poneman Institute, Benchmark Study on Patient Privacy and Data Security 2010. Traverse City, MI.

[For more information about security risk assessment for meaningful use, contact:

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Meaningful use incentive program dates

- Oct. 1, 2010 — Reporting year began for eligible hospitals and critical access hospitals (CAHs).
- Jan. 1, 2011 — Reporting year began for eligible professionals.
- Jan. 3, 2011 — Registration for the Medicare EHR incentive program began.
- Jan. 3, 2011 — For Medicaid providers, states may launch their programs if they so choose.
- April 2011 — Attestation for the Medicare EHR incentive program begins.
- May 2011 — EHR incentive payments expected to begin.
- July 3, 2011 — Last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR incentive program.
- Sept. 30, 2011 — Last day of the federal fiscal year. Reporting year ends for eligible hospitals and CAHs.
- Oct. 1, 2011 — Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 for the Medicare EHR incentive program.
- Nov. 30, 2011 — Last day for eligible hospitals and critical access hospitals to register and attest to receive an incentive payment for federal fiscal year (FY) 2011.
- Dec. 31, 2011 — Reporting year ends for eligible professionals.
- Feb. 29, 2012 — Last day for eligible professionals to register and attest to receive an incentive payment for calendar year (CY) 2011.

Patient data protection not a top priority

Hospitals report too few resources to be effective

Data breaches cost health care organizations more than $6 billion annually, and 71% of the respondents to a study released by the Ponemon Institute say they do not have enough resources to prevent or to quickly detect a loss of patient data.[1]

The study surveyed 65 hospitals in the 100- to 600-bed range, with researchers interviewing an average of 3.25 senior-level personnel in each organization.

Study findings include the following:

• The majority of responding organizations have less than two staff dedicated to data protection management (67%).

• Hospitals say that protecting patient data is not a top priority (70%).

• Most at risk is patient billing information and medical records.

• Patients are typically first to detect a significant number of breaches at health care organizations (41%).

• 60% of organizations had more than two data breaches in the past two years. The average number for each participating organization was 2.4 data breach incidents.

• The average number of lost or stolen records per breach was 1,769. A significant percentage of organizations either did not notify any patients (38% or notified everyone [34%]) that their information was lost or stolen.

• The top three causes of a data breach are: unintentional employee action, lost or stolen computing devices, and third-party mistake.

• 41% discovered the data breach as a result of a patient complaint.

• More than half (58%) of organizations have little or no confidence that their organization has the ability to detect all patient data loss or theft.

• 63% of organizations say it took them between one to six months to resolve the incident.

• 56% of respondents have either fully implemented or are in the process of implementing an EHR system. The majority (74%) of those who have an EHR system say it has made patient data more secure.

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1. Poneman Institute, Benchmark Study on Patient Privacy and Data Security 2010. Traverse City, MI. ■

Pay attention to content of phone messages

Honor patient requests for phone privacy

Calling to remind patients of their appointments, instructions on how to prepare the night before a procedure, or to see if patients have questions prior to surgery are important ways to keep your outpatient surgery or diagnostic testing departments' schedules on track. With the renewed focus on privacy and security of patient information, how much information can you leave on a voice mail service that may be accessed by people other than the patient?

According to a FAQ on the Office of Civil Rights website, you can leave information for patients on answering machines or voice mail systems, but to safeguard their privacy, you should limit information to only what is needed to confirm an appointment. If more information is needed, ask the patient to return the call.

Although you can leave a message, pay attention to some diagnoses that are covered by more stringent privacy laws, says **Vicki Hohner**, MBA, senior HIPAA consultant, Fox Systems, a Scottsdale, AZ-based consulting firm specializing in health information technology implementation in health care. "Some diagnoses, conditions and services, such as HIV/AIDS, reproductive health, and mental health or drug and alcohol diagnoses and treatment are covered under more stringent state and federal privacy laws and may restrict what, if anything, can be communicated by phone," she says. "Other considerations such as domestic violence and protective orders may also restrict what communications can be made via phone," she adds.

It is not a bad idea to ask your patients how they want you to handle messages, either on voice mail or with another family member who answers the phone. Although the privacy rule allows providers to disclose limited information to family or friends not involved in the patient's care, it is up to the provider to use professional judgment to determine what is best for the patient.

"If other persons living in the household are involved in the patient's care and treatment, the provider may provide additional details subject to professional judgment," says Hohner. "The patient can also specifically authorize access to other persons who would potentially answer the calls," she says. Of course, if the person who would potentially receive the calls is a personal representative of the patient, through power of health care attorney or power of attorney, that person has the legal authority to access any of the patient's information as if he or she were the patient for as long as they hold that legal power, she adds.

Permissions to give information or messages to other people are not normally needed for each individual visit, but are not necessarily permanent either, says Hohner. "Time limits on each approach can be set independently and as determined by the physician and/or patient," she explains. "However, the patient has the right to revoke any of these permissions for any reason at any time," she says.

"Verification of the individual who answers the telephone is not necessarily required under HIPAA, but many providers have instituted verification practices, at least in the office setting, to avoid medical identity theft and other potential inappropriate disclosures such as those related to domestic violence or child abuse," says Hohner. "It is at the discretion of the provider to obtain further verification if desired or required by other law or professional practice," she says. Some providers only leave messages when the patient is identified by name on the voice mail or answering machine.

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RESOURCE

To see answers to frequently asked questions related to HIPAA privacy and security, go to *http://www.hhs.gov/ocr/privacy/hipaa/faq/index.html*, and enter keywords to search for answers. ■