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New eligibles will turn to access for help: Don't be caught unprepared

Financial counseling role is in the forefront

(Editor's Note: This is a special issue of Hospital Access Management *on how the Patient Protection and Affordable Care Act [PPACA] will change patient access processes. Inside, we cover how patient access staff will help newly eligible patients to obtain coverage, what steps to take to handle increased patient volumes, how to change processes for self-pay patients, why healthcare reform makes customer service a top priority, and new requirements for informing patients on charity care programs.)*

"Your deductible is $2,000. How would you like to pay that?" This information simply won't be enough for registrars to offer patients when the Patient Protection and Affordable Care Act (PPACA) takes effect in 2014, according to **Luis Guerrero**, director of patient access services at Ochsner Baptist Medical Center in New Orleans.

Patient access departments will be in a position to offer far more help to patients than they do currently, including detailed, accurate information on various coverage options, he says.

"It is not enough to say, 'You will owe this amount of money. I can refer you to financial counseling,'" Guerrero says. "Registrars have to become more analytical, based on the information they have in front of them."

Jack Smarr, MHA, associate director of revenue management for UK HealthCare in Lexington, KY, says, "Brush up on your financial assistance

EXECUTIVE SUMMARY

Patient access staff will offer much more assistance to patients, including detailed information on coverage options, after healthcare reform is implemented. Make these changes:

- Move financial counseling to the beginning of the process.
- Include patients with high out-of-pocket responsibility.
- Assist patients in determining eligibility for state Medicaid or disability programs.

and charity care policies. Be prepared to accommodate an influx of newly insured people into your system."

At UK HealthCare's Patient Access Center, where all clinic visits are scheduled, patient access staff will need to know which patients are qualified for coverage and how to begin the process of enrollment, says Smarr.

Even if the number of self-pay patients reduces over time as healthcare reform takes hold, providers and patients alike will continue to struggle with confirming eligibility, communicating benefit coverage, and defining patient responsibility/liability, says **Laura A. Semlies**, vice president of finance at North Shore — Long Island Jewish Health System in Manhasset, NY.

"At North Shore — Long Island Jewish, the customer experience related to patient access and other related administrative functions has recently taken the spotlight," she reports.

The organization launched a multi-year initiative to completely transform their revenue cycle to meet demand for self-service capabilities such as online scheduling and kiosk-based check-in, and more sophisticated financial coordination including comprehensive eligibility checking, liability estimators, and financial counseling for those requiring support with coverage applications and/or payment plans, says Semlies. She recommends taking these steps to prepare for healthcare reform:

- Implement comprehensive eligibility checking to perform real-time confirmation of coverage.
- Implement tools and processes to estimate and communicate patient liability in advance of care.
- Establish financial counseling role to provide options for patients with significant liability as well as to provide support for self-pay patients seeking coverage.
- Enhance patient access analytics, including routinely monitoring payer mix adjustments, financial coordination performance, and patient liability estimate accuracy.

"Lines will blur"

"Patient access departments who already have a good working relationship with their state Medicaid offices will definitely have an advantage," says Smarr. "Contact your state Medicaid office and get in on the ground floor of their planning."

Ochsner Baptist Hospital's registrars and preservice specialists now direct patients to financial counselors to file applications for Medicaid, Medicare, social security, and charity care in the moment the need is identified. "In the past, financial counseling was taking place at the end of the cycle. Now it is taking place at the very beginning of the cycle," says Guerrero.

Previously, financial counseling occurred at the end of the cycle or when the patient received the bill, but it is now part of the registration and scheduling process. Under healthcare reform, registrars will perform even more financial counseling earlier in the process — not just for uninsured patients, but also patients with high deductibles and coinsurance, says Guerrero.

Registrars will use the online portals of the health insurance exchanges to be set up by the state, to guide patients through the process of obtaining coverage, he explains. "Registrars, and access, and financial coun-

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Editor: **Stacey Kusterbeck**, (631) 425-9760.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Senior Vice President/Group Publisher: **Donald R. Johnston**

Editorial Questions
For questions or comments, call Joy Dickinson at (229) 551-9195.

seling will be more closely related, to the point where the lines will blur," Guerrero says.

Expanded role

The intent of healthcare reform isn't to have patients struggle to figure out how to obtain coverage on their own, says Guerrero. In fact, this responsibility soon will be part of the job of patient access employees.

"Our financial counselors will have all the tools to help patients obtain the proper insurance, whether state-funded or not," he says. "It's not just Medicare or Medicaid or traditional options any more. We are operating on the assumption that everybody is going to have some kind of coverage."

Smarr expects to see a decline in self-pay patients in 2014, but he says that he expects that point-of-service collections will remain an important aspect of the revenue cycle. UK HealthCare's financial counselors assist patients in understanding their eligible coverage through state Medicaid or disability, he says, and this assistance will continue under healthcare reform.

"People will initially present to the hospital and clinics as uninsured," he says. "They will need assistance in signing up for the government health insurance, much like they do today, when someone presents as self-pay." *(See related story on preparing for increased volumes, below.)*

SOURCES

For more information on financial counseling done by patient access employees, contact:

- **Luis Guerrero**, Director of Patient Access Services, Ochsner Baptist Medical Center, New Orleans, LA. Phone: (504) 842-2912. Email: Lguerrero@ochsner.org.
- **Laura A. Semlies**, Vice President of Finance, North Shore - Long Island Jewish Health System, Manhasset, NY. Phone: (631) 414-1463. Email: lsemlies@nshs.edu.
- **Jack Smarr**, MHA, Associate Director, Revenue Management, UK HealthCare, Lexington, KY. Phone: (859) 227-4921. Email: fsmar2@email.uky.edu. ■

You must get ready now for many more eligibles

'Great increase' in volume expected

Patient access departments need to prepare for a "great increase" in the volume of patients who are eligible not only for Medicaid, but also private insurance policies, as a result of the Patient Protection and Affordable Care Act (PPACA) according to **Luis Guerrero**, director of patient access services at Ochsner Baptist Medical Center in New Orleans.

"This will require more attention to detail and collection of data in order to process the bill properly," he says. "One part that will become critical is providing the patient with clear information about their benefits and responsibilities."

Presumptive eligibility determination requires a high level of accuracy, adds Guerrero. "It won't be enough to ask the patient, 'How much did you make last week?' or 'Can you provide us with your last eight paystubs?'" he says. "We will have to critically analyze the different components of eligibility."

This step is necessary to reduce errors when directing patients toward the right type of coverage and to reduce reimbursement delays arising from the patient having to refile when presumptive eligibility has been incorrectly determined, says Guerrero.

"In addition to that, the price estimation and patient responsibility estimation will need to be carefully presented on two fronts: under the presumptive eligibility, and under the self-pay standards," he says. "We will be required to provide information that is clear and concise."

More data to collect

Ochsner Baptist recently created a preservice center to improve patient flow and prevent delays. "We have already started to put actions in place, so that come 2014 we will be fully prepared to take on all the additional cases that will go through that center," Guerrero explains.

The pre-service area is designed to perform a comprehensive access process for patients. During the pre-service phase, the team validates patient information and insurance data, obtains authorizations, details benefits, and calculates patient responsibilities. "If financial counseling is needed, our preservice center facilitates the access so patients don't have to take additional time from their busy days," he adds.

Guerrero expects to see increased wait times in the emergency department and for same-day walk-in services as a result of the PPACA, due in part to the increased amount of data staff will need to collect. "We will have to be sure to collect any shred of data regarding the individual policies that will allow us to create clean claims," he says. "For the insured patients, we will not have to collect 'new' data — instead, the volume of cases where we will have to create a payer in the system may increase dramatically."

For patients who are not insured, data collection might include demographic data to adequately determine presumptive eligibility, he adds.

Flexibility is needed

"Because of Epic and other tools, we won't have to stay on the phone an hour waiting for an authorization or verification. Most of that is done electronically now," says Guerrero. "It's still going to be a challenge at the very beginning when we go from having 600 payers to 6,000 payers, but with the right tools, we will minimize the impact."

Jack Smarr, MHA, associate director of revenue management for UK HealthCare in Lexington, KY, says that financial counselors within his patient access department are used to working with self-pay patients, and an external vendor is used to process applications for Medicaid and disability.

"This model has worked well for us in the past. But with the shift away from self-pay, we may be able to make that an internal function again," says Smarr. "If the volume of 'newly eligible' spikes, we have the flexibility with our vendor to accommodate that increase." ■

Self-pays: Soon a thing of the past?

Many, but not all, will be covered

How many fewer self-pay patients do you expect to see after the Patient Protection and Affordable Care Act (PPACA) is implemented in 2014? The answer might depend in large part on patient access employees themselves, according to **Rachel Klein**, executive director of Enroll America, a Washington, DC-based organization that works to ensure that all Americans are enrolled in and retain health coverage.

When a patient is standing in front of a registration desk, "it's clearly a time when people are thinking about healthcare," says Klein. "That is a critical point for people to learn about new affordable coverage options and even to apply for coverage."

Patients might be able to get coverage not only for themselves, but also the rest of their family before they are in a situation requiring hospitalization, which means hospitals will be reimbursed for future visits, she adds. "There are 40 million uninsured people today who will be eligible for new coverage and help with the cost of that coverage. In order to reach them, we need all hands on deck," says Klein.

Open enrollment for health coverage under the PPACA begins Oct. 1, 2013, which gives patient access staff six months to help as many uninsured patients as possible get coverage before the end of the first open enrollment period in March 2014, she says. Patient access staff will need training to understand how the new coverage works, who will be eligible for new coverage, and how to help people apply, says Klein.

"By ensuring that patient access staff have access to the Internet on a laptop or tablet computer, and training about how to navigate the enrollment process, hospitals can help self-pay patients get affordable health care coverage," she says.

Many are unaware

According to a 2012 survey by CVS Caremark, 78% of consumers who would be eligible for new healthcare coverage under the PPACA have never heard of the state-based healthcare exchanges where they will have to shop for coverage beginning in 2014.

"People often don't understand that a new program is going to help them. We really do have a public information hurdle to cross," says Klein. "Patient access staff are in a good position to help."

Only Wisconsin and Oklahoma allow applications to be completed online for state-funded insurance currently, says Klein, but this online access soon will become commonplace.

"This is a real sea change in how people will be able to get health insurance coverage," she says. "Some people may be able to fill applications out while they are waiting, and in some cases get very close to a real-time determination." *(See related story, p. 101, on determining if self-pay patients have coverage.)* ■

EXECUTIVE SUMMARY

Patient access staff can decrease the number of uninsured individuals by helping patients completing online applications when open enrollment for health coverage begins in October 2013 under the Patient Protection and Affordable Care Act. To reduce the number of self-pay patients currently:

- Use an automated verification system to determine if patients have active Medicaid coverage.
- Work closely with care managers to provide assistance.
- Have a counselor meet with each new self-pay admission.

Patient may not be 'true' self-pay

Patient access staff at Methodist Charlton Medical Center in Dallas now run all self-pay patients through an automated verification system to identify those that are unaware that they are still active with the Medicaid program.

"For those true self-pay patients admitted to our facility, we work very closely with the care management department to provide patients with any assistance available to them," says **Jeanette Foulk**, director of patient access.

A financial counselor visits with each new self-pay admission to explain the estimated financial obligation, provide options that might be available, and assist in completion of a Medicaid or charity application. For eligible patients, counselors also complete an application for Project Access Dallas, a community service program that was created by the Dallas County Medical Society along with several community partners.

"This program was formed to assist Dallas county residents who struggle daily with the hardships of poverty and are unable to afford medical insurance," says Foulk. "Our goal is to expand this program to our emergency and outpatient areas in the near future." ■

What's even more critical for access? Service

It's how you ask for payment

There is a growing emphasis on "sensitivity in hospital collections" that patient access staff should be aware of, advises **Richard L. Gundling**, FHFMA, CMA, vice president of healthcare financial practices for the Healthcare Financial Management Association (HFMA).

"We are going to be dealing with this issue for a long time," he says. "Patient access are the people the patient sees first. They are often the ones who ask for the first copay or deductible."

Patient access staff must communicate financial expectations in "a professional, kind way," says Gundling. "We often hear about 'shared accountability,' but what that really means is the patient pays more," he says. "The brunt of that is also on the revenue cycle staff, because they are the ones collecting that from the patient."

Collecting upfront doesn't have to mean dissatisfied patients, even if a large out-of-pocket responsibility is due, emphasizes Gundling. In focus groups conducted by the HFMA's Patient-Friendly Billing project, patients preferred knowing payment obligations before they have the service. "This offers the opportunity to comparison shop for services and learn about payment alternatives including financial assistance," Gundling says. "We find patients are much more angry on the back end, when they are surprised by the bill."

Telling patients their out-of-pocket responsibility gives them time to discuss it with their physician if necessary. "They can have a discussion about their care and explore other alternatives. They may find out that can do something differently and avoid a high deductible," Gundling says.

Patient access managers should make the ability to show compassion and respect a top priority with new hires, he advises. *(See related story on assessing customer service skills of applicants, p. 102.)* "I have seen many examples of hospitals with high revenue cycle metrics and high patient satisfaction scores," says Gundling. "We know it can be done." He recommends:

• Give customer service training to all patient access staff.

"The healthcare environment is filled with medical and billing jargon and acronyms," he says. "Tell staff to put themselves in the patient's shoes."

Pay close attention to messaging and communication practices around collections, such as having staff use carefully crafted scripts, providing clearly worded billing and collection materials, and making resources available in the most prevalent languages, Gundling recommends.

• Make prices more transparent.

"Technology is aiding these efforts," says Gundling. "Some hospitals are able to apply a payer's negotiated

EXECUTIVE SUMMARY

Patient access staff will continue collecting patients' out-of-pocket responsibilities under healthcare reform and should be mindful of a growing focus on sensitivity in hospital collections. To improve service:

- Inform patients of out-of-pocket costs upfront so they can discuss these with their physicians if necessary.
- Make the ability to show compassion and respect a top priority with new hires.
- Focus on a specific area you want to change, such as registrars saying the patient's name during every encounter.

contract rate, deductible, copayment, and co-insurance percentage to get an accurate estimate of the patient's out-of-pocket payment."

• Ask access staff for ideas.

"Involve them in improvement processes," says Gundling. "They are talking to the patients directly. They know what works and what doesn't."

Some hospitals provide journals to their staff members so they can write their interactions with patients, peers, and other departments, and these are then shared regularly to engage in better customer service, he adds.

• Consider the unique needs of your community.

Gundling did a site visit at one hospital that served primarily low-income patients and yet had very good revenue cycle metrics because they had excellent processes for helping patients qualify for Medicaid.

"It's not always going to be one size fits all," he says. "If you are an inner city hospital, patients' needs are going to be very different than in the suburbs." *(See related story on obtaining feedback on access processes from the community, below.)*

RESOURCE

• A report on strategies to promote patient-friendly financial communications from the HFMA'S Patient Friendly Billing project can be accessed at no charge at www.hfma.org. Click on "HFMA Initiatives," "Patient Friendly Billing," "Case Studies in Customer Service," and "View." ■

Ask community for feedback

Have community advisory groups give feedback not only on clinical processes, but also the revenue cycle, advises **Richard L. Gundling**, FHFMA, CMA, vice president of healthcare financial practices for the Healthcare Financial Management Association (HFMA).

"These advisory groups can provide insights to support a positive scheduling and registration experience," he says.

Organizations that score high in being "patient-friendly" within their registration/admitting area also are inclined to have better revenue cycle financial and operational metrics, adds Gundling.

Advisory groups might tell patient access, for example, that they can better support patients by not requiring redundant information to be shared repeatedly. Gundling recommends asking advisory groups these questions about patient access:

• How would you describe an ideal scheduling/registration experience?

• How did you find the experience with our hospital?

• Was the communication from the access staff easy to understand?

• Was the registration process efficient and respectful of your time?

• Were you greeted in a friendly and professional manner?

• Was the information accurate that was on file?

Many times, advisory groups focus on clinical or other service areas and fail to address the revenue cycle, says Gundling.

"It's a good way to stay customer focused and increase the patient experience," he says.

Does applicant have service skills, or not?

Jamie Kennedy, a patient access supervisor at Ohio State University East Hospital's ambulatory clinic, says that her clinic is hiring additional staff, and customer service is her number one priority.

"How the person presents themselves to us will give an indication of how they will present themselves with patients," she says.

During an interview, Kennedy asks questions in an interview that are related directly to customer service, such as, "Give an example of a time when you had to handle a difficult situation with a patient. How was it resolved?" Next, she asks the applicant to name one thing they might do differently.

"The way a person answers this question tells you a lot about their customer service skills," she says. "If they speak negatively about the patient and the issue that occurred, it might be a red flag."

In addition, Kennedy looks for the applicant to make eye contact and face her directly as a sign of confidence and leadership.

"Someone who is facing the door might be perceived as having a lack of confidence or standoffish," she says. "We want someone friendly and outgoing, not someone closed off and passive aggressive." ■

Don't wait to revamp insurance verification

Healthcare reform makes processes for insurance verification a top priority for patient access areas, says **Sebrena Johnson**, manager of insurance

verification and precertification in the Admission Services Department at Cone Health System in Greensboro, NC.

"It will be more important to get all verification and authorizations prior to patients getting admitted, because of financial responsibility," she says. "If this is not obtained, there could be penalties or complete denial of claims for very critical and expensive visits."

Cone Health System recently made very significant changes to its insurance verification processes, reports Johnson. "We have just begun implementing the Epic system where all parties — the hospital, medical records, and doctor's offices — are working together with one patient and one medical record," she says. "It has required a new way or thinking for all parties involved."

The new system gives patient access staff a fuller picture of the patient's care, but extensive training was needed. "Some people were nervous and fearful of the unknown. It required everyone pulling together and filling in for others while they were training," Johnson says.

Patient access staff members need a thorough understanding of the different types of insurance plans, knowledge of the requirements for each plan, and the ability to maintain good relationships with insurance providers, advises Johnson. "There is an easier notification process when all information is properly obtained on the front end," says Johnson. "The new process has also required that we have more coverage to make the notifications in a timely manner."

Continual checking

At Geisinger Health System in Danville, PA, members of the patient access staff do insurance eligibility checking during all phases of the process, says **Angela Long**, associate vice president of administrative services in revenue management. These steps are taken:

• Staff check the patient's insurance during the scheduling/registration process.

"We do this in real-time for close-in/same day services or in batch mode a few days in advance of the service being rendered," Long says.

• Insurance verification is sometimes performed during the visit with a referring provider or specialist, to determine if a test or service being ordered will be covered by a patient's insurance plan.

"This upfront verification of insurance helps not only the organization, but also the patient. They will know upfront if there are any issues with coverage," says Long.

• For patients classified as self-pay at the time of service, staff run batch insurance eligibility transactions against Medicaid's database to determine if the patient has since qualified for insurance through that plan.

• Staff verify insurance when following up on an outstanding insurance balance to determine if the correct payer was on file when the claim originally was submitted.

• Staff run batch eligibility processing in between the appointment or service being scheduled and the actual date of service.

"We create worklists for instances where the insurance that is listed is not valid and/or the patient is not covered by that particular plan," says Long. This information is trended to determine if a particular employee is struggling with data capture of insurance.

"We then reach out to the user and provide an overview of how to process insurance correctly," says Long. "If the issue continues in that particular area, we work with their manager and suggest the user go through re-training."

• Insurance eligibility verification is integrated within technology systems throughout the revenue cycle process.

"We not only run files through automated batch insurance eligibility processes; we have also built work-lists and rules to be sure that exceptions are routed to the most appropriate resource at the most appropriate time," says Long. *(See related stories on identifying trends, below, and offering price estimates online, 104.)* ■

EXECUTIVE SUMMARY

Patient access departments are updating insurance verification processes to avoid costly claims denials. Make these changes:

• Inform the patient early in the process if specific procedures won't be covered.
• Determine root causes of trends in claim denials.
• Use insurance eligibility verification results from batch processes to educate staff.

Self-pay A/R cut by $15 million

Drill down to ID verification flaws

Self-pay accounts receivable (A/R) was reduced by about $15 million annually after the patient access department at Geisinger Health System in Danville,

PA, implemented daily eligibility checking of self-pay accounts against Medicare and Medicaid to find instances in which patients had coverage for that particular date of service.

"Doing this daily, versus waiting until after the patient collection process, helped us reduce self-pay A/R," says **Angela Long**, associate vice president of administrative services in revenue management.

In some instances, patient access staff had verified that a patient had Medicare coverage, but claims were being denied because some of these patients only had Part A coverage. This problem was discovered as part of the department's process to examine trends or spikes in claim denials to determine root causes, says Long.

To prevent these mistakes from happening, staff were educated to "drill further down into the eligibility response to determine level of coverage," she says.

Long works with the IT department to further refine the worklists by comparing the eligibility response with the service that is being scheduled. "In instances where we find a flaw in insurance verification — human or otherwise — we look to further enhance our automated rules/processes to help prevent the issue from occurring," she says.

Another example involved the department's rising self-pay A/R. Only after patients were sent multiple statements, and after numerous collection attempts, would registrars learn that they actually had coverage.

"We found pockets of the organization where appointments or services were being scheduled and no insurance was being obtained from the patient — either at all, or it was being entered into the account a few days post-service," says Long. ■

Offer price estimates for 'self-service'

Patients want online options

Patients are asking patient access staff for "various self-service options" for registration processes, including price estimates, reports **Angela Long**, associate vice president of administrative services in revenue management at Geisinger Health System in Danville, PA.

To meet this need, the organization's online patient portal now allows individuals to obtain a price estimate for a service they are interested in receiving.

"Patients enter their insurance and the type of service they are interested in receiving," says Long. The portal then performs a real-time insurance eligibility transaction to verify that the patient has a valid insurance plan and coverage for the service they are interested in receiving. If they do, they will then receive a price estimate of the out-of-pocket expense they can expect for that particular service at one of our locations," says Long.

Geisinger has offered online patient portals for eight years, beginning with giving patients the ability to review their lab results and expanding to allow patients to pay balances. A patient service call center fields all calls from patients about how much it would cost to receive services, but patients now can choose to do this step online.

At times, something unexpected occurs that adjusts the out-of-pocket expense, so patients are clearly informed they're receiving an estimate and not a guaranteed price. "We have some challenges maintaining the set-up behind this tool, given the ever-changing coverage terms of a particular insurance and/or contract," says Long. "Also, the tool we use is all in-house and not a vendor offering, so the support of this is all internal."

When the system was first implemented three years, the patient had two options to obtain the estimate: filling out a form that is routed to an agent who contacts the patient with the estimate, or calling to obtain the estimate.

"We expanded on the functionality to provide a price estimate for over 200 services here at Geisinger online, self-serve by the patient," says Long. "We have integrated the insurance eligibility to ensure we are providing the patient with an estimate applicable to their particular insurance." ■

Do you tell patients about charity care?

Many unaware of programs

Your patient access department already might have a discount policy in place, but this policy doesn't do anything to help a patient unless he or she is aware of it.

Patients often have no idea about the charity care programs available to them, says **Jessica Curtis**, director of Boston-based Community Catalyst's Hospital Accountability Project, a national consumer advocacy organization focusing on healthcare issues.

"Even in cases when patients do ask about it, there is often no follow-through to help the patients go

through the process, especially for non-English speaking patients," she says.

While some patient access departments go above and beyond to help patients to apply for financial assistance or public programs such as Medicaid, says Curtis, "what is troubling is that it is not commonplace."

Patients uninformed about existing discount or charity care options might delay care or put the balance on a credit card and fall behind on their mortgage or rent, says Curtis. "The problem is well-documented," she says. "The question is: What are some of the things that a hospital can do that allows them to collect what they need to, but also treat the patient fairly?"

In many cases, patients have no idea of their out-of-pocket responsibility until they receive bills in the mail and start to hear from collection agencies, says Curtis. "At that point, they are definitely in the back end of the cycle," she says. "In many cases, they contact legal services because they just don't know where to go. They might find they are eligible for public assistance, or that they could have asked about the hospital's financial assistance policy."

More changes for access

There are other recent developments that could change the job of patient access employees, says Curtis. *(See related story on legislation involving hospital collections, below right.)*

"There are some things in the works that would limit or at least prescribe what front-end staff should be saying and doing and in what order," says Curtis.

The Patient Protection and Affordable Care Act (PPACA) requires all nonprofit hospitals to notify patients about financial counseling policies, she notes. "Their policy can be pretty bare bones, or it can be comprehensive," Curtis says. "Right now, it is up to hospitals to decide whether they want to offer any help to uninsured or underinsured patients."

In addition, the U. S. Department of the Treasury released proposed regulations related to these new requirements for non-profit hospitals. Both the PPACA and the Treasury Department rules require non-profit hospitals to make a "reasonable effort" to qualify patients for financial help prior to engaging in certain collections activities. "These would require that patients need to be notified about financial help during any conversations about their bills," Curtis says. "That is something that patient access should be thinking about right now."

Examine policies

The Supreme Court's recent ruling giving states the option whether to expand Medicaid also has implications for patient access, says Curtis.

"In a state that chooses not to pursue the expansion being offered by the feds, hospitals will still see the lowest income patients coming through their doors, and those patients will still be uninsured," says Curtis.

The intent of the Medicaid expansion included in the PPACA was that even if hospitals weren't receiving as much revenue as with commercial insurance, they still would be receiving some revenue, says Curtis.

Curtis points to Massachusetts' experience with healthcare reform. "We haven't gotten rid of uncompensated care entirely. Hospitals still have some bad debt," she says. "But we can expect that with the PPACA, both of those amounts will go down."

Curtis says patient access should take a look at their financial collection policies and "do it yesterday. Hospitals should be re-evaluating this at the board level." She says patient access leaders should ask the questions: Where do we do a really good job of connecting patients with information? Where do we need to improve?

"They have crucial information that should be shared with hospital leadership," Curtis says. "It could be they have great policies, but the tools to implement them aren't good enough." ■

EXECUTIVE SUMMARY

Patients might be unaware of discount policies or charity care options, which can lead to financial burdens or delayed care. Patient access leaders should:

- Examine financial collection policies to identify areas in need of improvement.
- Be sure that staff members follow through to help patients with the process.
- Keep a close watch on regulations that affect upfront collection processes.

ED collections are under scrutiny

Processes may need to change

The public's awareness of the U.S. Senate investigation of Accretive Health, a debt collection company hired by a Minnesota hospital to do reg-

istration and upfront collections, has important implications for patient access departments, says **Jessica Curtis**, director of Boston-based Community Catalyst's Hospital Accountability Project.

"They had a strategy that allowed them to collect a certain percentage more than their competitors. You can see from the hospital's perspective lots of reasons why that would be attractive, but they got into trouble," Curtis says.

Some of the allegations involve patients being asked for payment in the emergency department, including a patient who was asked for payment before she received a medical screening examination, and another patient who was asked to pay an outstanding bill when he came in for a scheduled appointment for an unrelated condition.

EMTALA is issue

As a result of the Accretive case, questions have been raised as to whether asking patients for upfront payment in EDs is a violation of federal Emergency Medical Treatment and Labor Act (EMTALA) regulations because of its potential to adversely affect access to care, adds Curtis.

"The fact that there has been such a focus on upfront collection brought this issue to the attention of other policymakers," she explains.

Sen. Al Franken (D-MN) introduced the End Debt Collector Abuse Act of 2012, which would amend the federal Fair Debt Collection Practices Act to include medical debt. This act would apply to all hospitals and prohibit asking for payment upfront in EDs or in labor and delivery, says Curtis.

"The conversation is not over. It's a hot potato of an issue," she says. "This is an area where the law will continue to change over the next one or two years." ■

Medicare patient being observed?

He or she may face unexpected bills

Hospitals are left in an "untenable position" due to changes in policy by the Centers for Medicare and Medicaid Services (CMS) that are causing hospitals to place patients in observation status for more than 48 hours instead of admitting them, according to an April 27, 2012, amicus brief filed by the American Hospital Association (AHA).

According to the brief, hospitals face loss of reimbursement and penalties from auditors and prosecutors for admitting patients for short medically necessary inpatient stays, while at the same time hospitals also face criticism from CMS and patients for substituting observation for admission.

"Professionals who manage hospital patient access or registration are often put in a difficult position," says **Don May**, the AHA's vice president of policy. "They must educate and work with physicians, ensuring they have all of the information needed to make the correct admissions decisions within the rules."

Patient access leaders need to educate physicians on complete and timely documentation and help them be up to date on current Medicare admission policies, advises May. In addition, he adds, patient access staff should clearly communicate to patients about their care status. "When patients are being admitted to the hospital, they must understand the difference between a regular hospital admission and being admitted in an observational status, which is really outpatient care," says May.

For patients who are being observed, May advises making sure registrars use language such as, "We continue to observe your clinical condition to determine whether you should be admitted for full inpatient care."

"If the patient is in observation, don't use the term 'admit', because then the patient thinks they are inpatient," he says.

122% increase in five years

Over the last five years, observation cases for Medicare patients have increased 122% at Sarasota (FL) Memorial Health Care System, reports **Diane C. Settle**, CPA, CHFP, executive director of the revenue cycle.

Medicare outpatients must pay the outpatient deductible, coinsurance, and self-administered drugs, says Settle. "Self-administered drugs can be

EXECUTIVE SUMMARY

Hospitals face loss of revenue admitting Medicare patients for short, medically necessary stays or dissatisfaction due to placing these patients in observation status. Patient access areas should:

- Educate physicians on current Medicare admission policies.
- Be sure patients understand their care status.
- Avoid using the term "admit" if the patient is in observation status.

several hundreds of dollars if the patient is in observation for several days," she says. "These drugs are covered by Medicare if you are an inpatient, but not covered under observation status."

The Medicare beneficiary will experience increased out-of-pocket costs due to observation status being classified as outpatient, says **Bernadette Lodge-Lemon**, director of revenue cycle at University of California — Los Angeles Health System. Outpatient services are subject to a 20% coinsurance of the Medicare Allowable, she notes, so if the patient does not have supplemental or secondary health insurance coverage, they are required to pay the coinsurance themselves.

"This may present a financial hardship to some Medicare beneficiaries," Lodge-Lemon says. "We have seen an increase in patients applying for financial assistance in an effort to cover these costs." *(See related story, below, on maintaining patient satisfaction despite this scenario.)* ■

Early education is key with Medicare status

Do what you can to stop dissatisfaction

Medicare patients often are shocked to learn that they have a significant out-of-pocket responsibility due to being in observation status instead of inpatient, reports **Diane C. Settle**, CPA, CHFP, executive director of the revenue cycle at Sarasota (FL) Memorial Health Care System.

"Most questions come into the hospital's customer service line after they have received their bill," says Settle.

Patients often are upset that the drugs are more expensive than at a retail pharmacy and that their Medicare supplement does not cover these self-administered drugs under Medicare Part B, says Settle.

Patients don't understand the additional cost to administer drugs in a hospital, due to pharmacists reviewing all medication orders for patient safety reasons and nursing administering and charting the drugs given to each patient, explains Settle. "For example, the charge for esomeprazole is $26.20 per dose. The patient is upset because they know what they pay a dose for the same drug at a retail pharmacy," she says.

Members of the hospital's case management department distribute the "Medicare Inpatient versus Outpatient Letter" to the patients as early in their stay as possible and answer any questions they may have. "We do miss a few patients because of their short length of stay," she says. *(To view the letter, go to http://1.usa.gov/QOo31I).*

Patient access is required to notify the patients before their departures from the facility if their statuses change from inpatient to observation as they will be subject to a different and generally higher coinsurance than their initial inpatient status, says **Bernadette Lodge-Lemon**, director of revenue cycle at University of California — Los Angeles Health System. "It is critical for our clinical documentation to support the level of service being provided to the patient," adds Lodge-Lemon. "This requires ongoing in-servicing, education, monitoring, tracking, and reporting to all participants in the scope of the patient's care." These include physicians, utilization review, registrars, billers, collectors, and medical coders.

Most patients do not understand how they can be classified as an outpatient when they are being treated in an inpatient facility and occupying an inpatient bed, adds Lodge-Lemon.

"It is essential for the registrars to inform and explain to our patients that their observation status is considered to be outpatient and that they will be responsible for the Medicare outpatient coinsurance," she says. ■

20% increase in ED copay collection

Emergency department (ED) copay collections increased 20% after a process was implemented at Washington Adventist Hospital in Takoma Park, MD, that required patient access reps to perform a benefit check on patients presenting with insurance.

"This process not only helps with receiving insurance payments; it also allows the patient access rep to know how much they are to collect for the ED copay," says **Carole L. Sraver**, director of patient

COMING IN FUTURE MONTHS

- Identify many more patients eligible for Medicaid
- Give unforgettable customer service to patients
- Use cutting-edge processes for price estimates
- Stop denials caused by inaccurate information

access.

Once the patient has been seen by the physician, the patient access rep completes a full registration, at which point insurance information is gathered and the benefit verification is completed. Checking a patient's benefits allows access staff to know if the patient has insurance coverage, and if not, staff members can discuss payment and qualifying for medical assistance or charity, explains Sraver.

At first, many clinical staff thought it was inappropriate to collect money, and some made comments to staff. "They would notify me so that I could have a one-on-one conversation with the department director and/or the clinician in question, to address any concerns they had about the process," says Sraver.

Resistance from clinical staff "was an obstacle in the beginning," she acknowledges, but patient access leaders explained to staff the importance of being paid for care provided. These steps are taken for ED patients at Washington Adventist Hospital:

- During the full registration that occurs after the patient has been seen by a qualified medical professional, members of the patient access staff ask the patients about their insurance coverage.
- If insurance information is provided, the rep does a benefit verification, and if there is coverage and a copay, the patients are asked to pay at that time.
- If the patients don't have insurance, another rep screens the patients for medical assistance eligibility.

"Should the patient qualify, that process is then set in motion," says Sraver. "If the patient will not qualify, the patient access rep begins the conversation of making a payment and/or paying in full."

- If it is determined through conversation that the patient is not able to pay, he or she is provided with a charity application that must be completed in full before a determination can be made.

ED collections are a focus of the patient access department at University Health System in San Antonio, TX, says **Juliet De Leon**, director of patient access. "Our department is restructuring workflow in coordination with the clinical department, to ensure all patients are processed through our dismissal area upon discharge," De Leon says.

The clinical staff has agreed to include registration as part of their dismissal workflow. "Communication between our groups is vital in the ED," De Leon says. "We have also initiated use of electronic notification flags, within a shared application viewable to both registration and clinical staff, to notify clinical staff when dismissal is required."

This process helps when trying to complete information for trauma patients, says De Leon, adding that patient access leaders and the ED regularly meet to discuss ways to improve teamwork. "We have also purchased wireless phones for staff to ensure communication is uninterrupted while processing registration in various areas within the ED," says De Leon.

Electronic alert flags were set up to advise clinicians when more information is required from patients. "Even though many emergency patients are unable to pay at the time of service, we want to ensure meeting with all patients prior to discharge to discuss funding," says De Leon. ■

Hospital Access Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. access manager
- O B. director, access management
- O C. manager, patient accounts
- O D. supervisor
- O E. patient accounts representative
- O F. other _____

2. What is your highest degree?

- O A. ADN
- O B. diploma (3-year)
- O C. BSN
- O D. MSA
- O E. other _____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary health care position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to $89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. Where is your facility located?

- O A. urban area
- O B. suburban area
- O C. medium-sized city
- O D. rural area

7. In the last year, how has your salary changed?

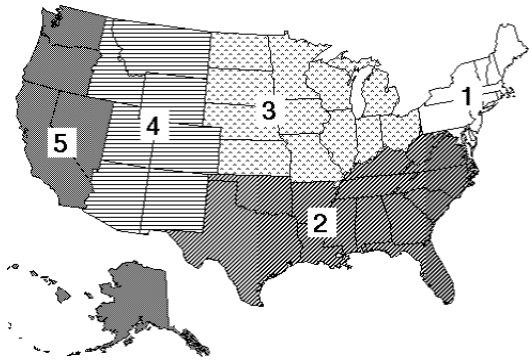
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for profit

11. How long have you worked in your present field?

- ○ A. less than 1 year
- ○ B. 1-3 years
- ○ C. 4-6 years
- ○ D. 7-9 years
- ○ E. 10-12 years
- ○ F. 13-15 years
- ○ G. 16-18 years
- ○ H. 19-21 years
- ○ I. 22-24 years
- ○ J. 25+ years

12. How long have you worked in health care?

- ○ A. less than 1 year
- ○ B. 1-3 years
- ○ C. 4-6 years
- ○ D. 7-9 years
- ○ E. 10-12 years
- ○ F. 13-15 years
- ○ G. 16-18 years
- ○ H. 19-21 years
- ○ I. 22-24 years
- ○ J. 25+ years

13. Which certification best represents your position?

- ○ A. FMFMA
- ○ B. CHAM
- ○ C. RRA
- ○ D. MSA
- ○ E. other_____

14. How many hours a week do you work?

- ○ A. less than 20
- ○ B. 20-30
- ○ C. 31-40
- ○ D. 41-45
- ○ E. 46-50
- ○ F. 51-55
- ○ G. 56-60
- ○ H. 61-65
- ○ I. 65+

15. If you work in a hospital, what is its size?

- ○ A. <100 beds
- ○ B. 100 to 200 beds
- ○ C. 201 to 300 beds
- ○ D. 301 to 400 beds
- ○ E. 401 to 500 beds
- ○ F. 501 to 600 beds
- ○ G. 601 to 800 beds
- ○ H. 801 to 1,000 beds
- ○ I. >1,000 beds
- ○ J. I don't work in a hospital

Deadline for Responses: Oct. 15, 2012

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media, P.O. Box 105109, Atlanta, GA 30348.