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AHC Media

Getting aggressive with collection of ED copays? Don't violate EMTALA

Practices might receive more scrutiny

You might assume that registrars giving emergency department (ED) patients the impression that they are required to pay money to receive treatment is a thing of the distant past, as this situation is a likely violation of the Emergency Medical Treatment and Labor Act (EMTALA) which has been in place since 1986.

However, that's situation is what is alleged to have occurred in several Minnesota hospitals, according to a lawsuit filed by the state attorney general's office that included allegations of aggressive collection practices in EDs. The case was settled in July 2012.[1,2]

The widely publicized case could mean that ED point-of-service collections will be more closely scrutinized by patients and the Centers for Medicare & Medicaid Services [CMS], warns **M. Sean Fosmire**, JD, a healthcare attorney with Garan Lucow Miller in Marquette, MI.

"This type of report does tend to attract a lot of attention -- not only from the news media, but also the state survey agencies which do the investigations

EXECUTIVE SUMMARY

Emergency department point-of-service collections might be more closely scrutinized by patients and the Centers for Medicare & Medicaid Services as a result of a highly publicized case involving aggressive collection practices and possible violations of the Emergency Medical Treatment and Labor Act (EMTALA) violations. To ensure compliance:

- Instruct registrars not to talk with patients about any payment issue at all until the patient has been seen, the required medical screening examination (MSE) has been done, and stabilizing medical treatment has been provided.
- Never dissuade a patient from completing their treatment by demanding payment.
- Obtain demographic information, including insurance, only if it does not delay the MSE.

and report back to CMS," says Fosmire, adding that patients might be more likely to complain about similar episodes after hearing about the case.

Most attorneys recommend that no one, including patient access staff, talk with patients about any payment issue at all until the patient has been seen, the required medical screening examination (MSE) has been done, and stabilizing medical treatment has been provided, says Fosmire. "That is not something that is required by the statute," he acknowledges. "Nothing in the statute prohibits staff from discussing payment issues." However, Fosmire says this approach provides the best protection against any possible future claim that treatment decisions, such as whether the patient should be admitted or seen by a specialist, were influenced by the patient's ability to pay.

"After the MSE and stabilizing treatment, there is no problem talking with the patient about payment issues," says Fosmire.

You can't delay MSE

There is nothing in EMTALA that says registrars can't ask for a copay or deposit while the patient is waiting for the MSE to occur, so long as it isn't delayed, according to **Mike Williams**, MPA/HSA, president of the Abaris Group, a Martinez, CA-based consulting firm specializing in hospital and emergency department process improvement.

"But most hospitals want to be squarely on the compliance side, of waiting until the patient is initially screened by the physician provider," he says. Once the MSE occurs, Williams says that registrars can ask for a deposit at any point, even if test results haven't yet returned that could indicate the patient has an emergency medical condition as defined by EMTALA.

Any implication that you are delaying the MSE by taking the deposit, or any indication that you might withhold or delay services, is an EMTALA violation, acknowledges Williams. "If your ED sees 45,000 to 60,000 patients a year and you have 15 to 18 registrars, how do you keep them all in line? The best approach to keep out of trouble is to use scripting," Williams says. Registrars can say, for example, "Now that you have seen the doctor, I can take your copay to speed things up and make your exit faster. Would you like to take care of that now?"

Todd B. Taylor, MD, FACEP, a Phoenix, AZ-based consultant specializing in EMTALA compliance, says, "Everybody knows that if patients are not critically ill, they are going to wait a period of time in the ED." Therefore, there is no reason that registrars can't go ahead with obtaining a full registration before discharge, as long as it doesn't delay the patient's treatment, Taylor says.

While this registration clearly is permissible according to CMS' own directives, in the past, some CMS regions misinterpreted the law and cited hospitals for this practice, reports Taylor. "Some hospitals are very conservative for that reason," he says. "But if you wait until the end to collect that information, very frequently you will not ever get the patient registered."

Don't mistime collections

You cannot dissuade patients from completing their treatment by demanding payment, and merely asking for payment can be construed as a "demand," Taylor

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emphasizes.

"If a patient leaves after being asked for money prior to completing the MSE, with all tests completed and results available, you may run into an EMTALA issue," he explains.

While it is fine to obtain demographic information, including insurance or lack thereof, as long as it does not delay the MSE, violations have occurred when registrars tried to collect copays before the patient was fully evaluated, says Taylor. One such case involved a Florida hospital that failed to medically screen a patient with new onset of diabetes mellitus after the patient indicated he could not make a requested deposit, and instead, referred him to follow up the next day at a clinic. Upon leaving, the patient immediately presented to another hospital where he was admitted.[3]

There is a difference between collecting demographic information and making a request for money, says Taylor. CMS' guidance to surveyors indicate that it is permissible to collect demographic information as long as that does not delay the patient's medical care and evaluation, he says. However, it also states that "reasonable registration processes may not unduly discourage individuals from remaining for further evaluation."[4,5]

"It is possible a demand for payment or copay could do just that," says Taylor. "There is nothing wrong or illegal about point-of-service collections in the ED, as long as it is done at the conclusion of the visit, after discharge."

Patients might leave

While registrars are highly unlikely to tell a patient, "You won't be treated until you pay your bill," it's the perception that is the issue, says Taylor. If an uninsured patient is asked for a $500 deposit while waiting to be seen and decides to leave and go to another hospital, this situation could be considered as "dumping" under EMTALA, he explains.

"It's perfectly legal to ask somebody for a copay, and tell them, 'If you can't pay, we're going to see you anyway.' Some hospitals do that. But the problem is that eventually, somebody is going to leave," says Taylor.

If a patient leaves after being asked for a copay and dies of a heart attack outside the ED, "the way the media is going to portray it is, 'For $30, they let this patient die,' says Taylor.

Anything you do that appears to be a barrier to care could result in being an EMTALA violation, Taylor emphasizes.

"You want everybody to be seen, welcomed and get through the system," he says. "Then, apply the appropriate responsibility at the end of the service, just like a restaurant."

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Revenue captured increases $1.5 million

Costly vendors no longer needed

Annual revenue collected for Medicaid patients has doubled at Trinity Regional Health System in Rock Island, IL, since January 2010, since the screening process is now done internally instead of by a contracted company.

"We have increased our revenue by $1.5 million to date," reports **Linaka Kain,** DE, a Medicaid specialist at the organization.

Previously, an outside contractor screened and applied for Medicaid for self-pay inpatients, and the contractor was paid 18% of all approved and paid Medicaid accounts. "As you can imagine, this was quite expensive," Kain says.

Two years ago, the hospital switched to using two Trinity-employed Medicaid specialists for the health system's Bettendorf, Moline, and Rock Island campuses. "We are now able to screen all of our self-pay

patients, not just the inpatients," she says. "We are saving our hospital system a significant amount of revenue by doing this ourselves." *(See related stories on processes to screen self-pay patients, below right, and handling screening internally, p. 113.)*

Self-pay form used

Patient access managers created a self-pay form, which all registration staff use at the time of service in all inpatient and outpatient departments throughout the hospitals. *[The form is included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

This tool is used to screen every self-pay patient for possible eligibility for Medicaid, and it alleviates duplication of efforts, says **Mary Kay O'Keefe**, the other Medicaid specialist on the team. "The results are documented in the patient's account. Those notes are made available to all appropriate staff, including financial advocates, case managers, and the central billing office," says O'Keefe.

Of the 1.7 million currently uninsured, 540,000 will become eligible for Medicaid in 2014, according to estimates from the Illinois Department of Human Services (DHS). "The measures we have already implemented will put us in good standing to be on the forefront to coordinate and improve care to all of our patients," O'Keefe says.

Here is how the process will work when healthcare reform is implemented for a patient being admitted through the emergency department:

- The patient is screened with the self-pay form.
- If the patient is determined to be possibly eligible for Medicaid, the self-pay form is sent to the Medicaid specialists for follow up, and they determine whether the patient is eligible for benefits.
- A Medicaid specialist meets with the patient, completes the application process, and files the case with DHS.
- The patient then becomes "Medicaid pending" in the hospital system, returns to the emergency department, and then is admitted as an inpatient.

"When the patient is in-house, they become eligible," O'Keefe says. "This enables us to bill DHS for all services and eases the patient's concerns about their bills."

It also allows case management to coordinate discharge planning for skilled nursing facilities and utilize medical equipment, oxygen, and pharmaceutical medications. "Without the approval in place, these would not be available to the patient, which might hinder continuity of care," O'Keefe says.

SOURCES

For more information on processes for identifying Medicaid-eligible patients, contact:

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Which patients are Medicaid-eligible?

Screen self-pays internally

Identifying Medicaid-eligible patients is a top priority for patient access staff at The University of Tennessee Medical Center in Knoxville, reports Stephen Hovan, vice president of the revenue cycle.

"We have worked with vendors that specialize in eligibility to ensure we are capturing all the patients that may be eligible for safety net programs," Hovan says. "We have also increased our financial counseling roles internally."

In FY 2011, staff collected on 69% of the accounts identified as Medicaid-eligible, totaling 1,594 accounts and $73 million, but this amount is expected to increase to $82 million in 2012, reports Hovan.

Questions to screen for eligibility for public programs were embedded into the system so that financial counselors don't have to remember them, he explains.

The same process is going to be used to comply with new regulations for nonprofit hospitals regarding how patients need to be notified about charity care programs, says Hovan. "There will be very strict timeframes for when and how to notify them," he says. "From our standpoint, the increases in the safety net programs are going to drive how the charity applications are done."

If patients don't have coverage, financial counselors do whatever they can to obtain them coverage of some sort, which will put the department in a good position to help newly eligible patients in 2014, says Hovan.

Several FTEs in the business office have been real-

EXECUTIVE SUMMARY

Identifying Medicaid-eligible patients has become a top priority for patient access due to rising numbers of self-pay and underinsured patients and the possibility of many more patients becoming eligible as a result of healthcare reform. Use these approaches:
- Work with vendors that specialize in eligibility.
- Increase financial counseling roles.
- Embed screening questions into eligibility systems.
- Consider doing screening internally instead of contracting with an outside company.

located to the front end to handle the additional financial counseling. "What we are trying not to do is add additional resources," says Hovan. "We are trying to reallocate and work with the resources that we have."

Access is issue

Jennifer Cameron, MBA, director of patient access at Children's National Medical Center in Washington, DC, says, "It is important to communicate the services that we provide upfront, to increase awareness and improve access."

Many patients and families are reluctant to seek care because of their inability to pay, she adds. "We have noticed an increase in our uninsured and underinsured patient population," says Cameron. "Early identification is a primary focus within the patient access department."

Patient access leaders have received positive feedback from families, who say it decreases the amount of stress involved, says Cameron. She gives these recommendations:

- Provide literature in different languages to address the needs of your diverse patient population.
- Identify uninsured and underinsured patients early in the process.
- Utilize resources, such as onsite representatives of the Department of Health and Human Services, to aid with face-to-face interviews and timely processing of applications.
- Have an "open house" to screen people in the community for Medicaid eligibility. ■

Identify internally, and outsource follow-up

At Harris Health System in Houston, patient access staff identify patients who fall into the category of self-pay or under insured, but the completion of the application and follow-up is outsourced, reports **Veronica Rodriguez Patricio**, audit, appeals, quality assurance, and training manager for eligibility and registration services.

"We provide this service at no additional cost," Patricio says.

Here is how the process works:

- Financial counselors screen all self-pay inpatients for third-party coverage.
- The financial counselors assist the patients deemed potentially eligible for third-party coverage with completing the necessary forms, and they tell them what information is needed to complete the application.
- Harris Health System contracts with onsite caseworkers from the Texas Health and Human Services Commission who process all Medicaid applications for inpatients.

"In addition, we have the eligibility department that screens clients for our charity program, Medicaid, Children's Health Insurance Program [CHIP], CHIP Perinatal, and Title V," says Patricio. ■

ED 'checkout' adds $1 million in revenue

Less risk of violations

A third of patients seen at one Arizona emergency department (ED) were uninsured, but this percentage was cut in half after a "checkout" process was implemented, reports **Todd B. Taylor**, MD, FACEP, a Phoenix, AZ-based consultant specializing in Emergency Medical Treatment and Labor Act (EMTALA) compliance.

"We essentially changed our demographic, by helping eligible patients enroll in Medicaid," he says. "It resulted in about $1 million in additional revenue with almost no additional cost, which is virtually unheard of in healthcare."

Almost half of uninsured patients "are not truly indigent; they are just uncooperative," according to Taylor. "This is an opportunity to apply the appropriate incentive, and I believe it's a unique opportunity that doesn't exist in a doctor's office."

Though many ED registrars collect copays after the medical screening examination (MSE) but before the patient is discharged, Taylor recommends doing this step only at the end of the visit, acknowledging that this change might cause problems with patient flow. "The problem is that patients are discharged in waves. So registrars may be sitting with nothing to do when they could be collecting copays," he says.

EXECUTIVE SUMMARY

Patient access staff members have a unique opportunity to collect demographic information and increase revenue with a "checkout" process in the emergency department. Do these things after medical care has been completed:
- Collect copays.
- Provide financial counseling including payment arrangements.
- Verify that the patient's address, phone number, and Social Security number are legitimate.

At the end of the ED visit, patients often walk out without paying copays, adds Taylor. "Most EDs have a quick and easy exodus, with no process in place to be sure the patient goes through checkout once the medical care is completed," he says.

The checkout person should be able to handle registration and financial counseling, says Taylor, with "the ability and the authority" to make arrangements for payment, including completing Medicaid applications if appropriate.

Information verified

In one case, an ED patient's bills kept getting returned due to an inaccurate address: the hospital's.

"Somebody had just typed it in, and it was never updated," says Taylor. "You would be amazed the times people will just give you an address for a vacant lot."

At checkout, the registrar also has the opportunity to verify that a patient's Social Security number, address, and phone number are legitimate. "The ED is a big victim of theft: people who can pay, but simply choose not to. Very little effort goes into preventing that," says Taylor.

Checkout also is a good time to ask the patient, "Do you have any questions that were not answered?" "Did you get your discharge instructions?" and "Do you have any concerns about your care today?"

"Complaints usually come about a month or two later, when the patient gets the bill or it gets turned over to collections," says Taylor. "If you give that person the chance to bring up any issue at that moment in time, it can be addressed before they leave."

Some of the hospital's managed care contracts stated that if the copay wasn't collected at the time of the visit, then the patient couldn't be billed for it, adds Taylor. "This was money that was just being thrown away, because we didn't understand the system," he says. "We went from collecting $1,000 a month to $100,000 a month." *(See related story on how one ED doubled collections, below.)* ■

ED revenue doubles with new process

Eligibility moved upfront

Emergency department (ED) collections jumped from $55,000 to $120,000 annually after eligibility software was implemented at Mary Rutan Hospital in Bellefontaine, OH, reports **John E. Kivimaki,** director of patient accounts.

"The need to acquire an estimation tool is crucial, since patients continue to see greater out-of-pocket responsibility," Kivimaki says. "There are also a greater number of self-pay patients coming to ERs. But collecting is harder because of the economy."

One of the biggest challenges in collecting upfront in the emergency department is simply having the chance to discuss out-of-pocket responsibility with patients, he says. "We have charity programs and other ways to assist the patient in taking care of their unexpected visit," says Kivimaki. "But most of the time, we have very little time to talk to the patient about these programs." These practices are used:

• Registrars identify insurance copays upfront as the patient is being registered.

"We can now identify these patient liabilities in the ED, unlike outpatient registration, where we do not have anything to estimate the patient liability after their insurance makes their payment," says Kivimaki. Registrars in outpatient areas ask for a small deposit, depending on the service, he adds.

• Registrars reference a list of individual copays for all employers in the hospital's service area.

"This is used mostly on insurances for which we cannot access eligibility and patient copays through our eligibility process," says Kivimaki.

• Registrars ask self-pay patients for a minimum amount and try to collect something from every patient.

• Incentives are now based on total collections instead of only self-pay collections and co-pays.

"All registrars now can receive incentives on any patient liability amount, including charge-off accounts," says Kivimaki. "We have also increased the maximum amount of incentive a registrar can earn monthly."

Incentives also were changed to reward employees based on what the total department collects, as opposed to what individual staff members collect. "As

the department total increases, so do the individual incentives," he says.

• **Two financial counselors were added, to consult with patients regarding their out-of-pocket responsibility.**

This addition will allow the department to pursue patient liabilities on higher dollar amounts in inpatient and surgery accounts, which weren't collected previously. "In the ED, the addition of financial counselors means there is potential to collect more co-pays and self-pay liabilities," says Kivimaki.

SOURCE

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Make it a top priority: single service changes

Simple changes impress patients

For one month, patient access leaders at Witham Health Services in Lebanon, IN, targeted one simple but important change to improve the level of customer service given by registrars.

"We focused on registrars saying the patient's name at least twice during the encounter," reports **Tonya Hart**, manager of patient admission services.

All employees were given customer service training using the Acknowledge, Introduce, Duration, Explanation, and Thank You (AIDET) process a year ago, but the patient access services department has "taken it steps further," says Hart. These are other changes that were made:

• Staff thank the patient or family for something during every registration.

Staff might say, "Thank you for your patience," "Thank you for your understanding," "Thank you for your time," or "Thank you for choosing to come to Witham today."

When Hart asked her registrars to do this step, she told them, "I have confidence that each of you can do this. Like Santa, we will be watching and listening. And, if you are sincere when you say it, it won't sound hokey."

• Registrars say something positive about the department the patient is going to.

"Whether it is radiology, lab, or ACS [Ambulatory Care Services], staff let the patients and their families know they are in good hands," says Hart. Registrars might tell a patient, "Kevin will be your technician today. He has over 15 years experience," "The phlebotomists here are great," or "Our nurses in Ambulatory Care Services will take excellent care of you today."

• Staff give patients and families approximate wait times.

Registrars tell the patient that if they have waited more than 10 minutes without being seen by the lab or radiology technician, please let them or someone at the front desk know.

"This is especially important at main registration and radiology," says Hart. "Of course, if the patient is a half hour early for their procedure, we remind them of their appointment time and again, explain the wait time."

This approach has allowed the department to meet its current goal of a minimum score of 95 for two questions in the Registration Section for Outpatients of the organization's Press Ganey survey: Helpfulness of registration person and ease of registration process.

Members of the registration staff hand out customer service cards to all lab and radiology patients, which prompts patients to "talk up" those departments or technicians, says Hart. "The cards explain that the patient could receive a Press Ganey survey and we strive for excellence on the surveys, and if they cannot score us that way to let us know," she says.

Registrars write in their own names and the technician or phlebotomist's name when they hand the patient the card. "We have seen an increase in our staff's names being specifically mentioned in the comment sections of the survey," reports Hart. "The lab and radiology departments' Press Ganey scores have also increased."

SOURCES

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EXECUTIVE SUMMARY

Identify a simple but important change to improve service, such as registrars saying the patient's name at least twice during the encounter. To improve service:

- Thank patients for something.
- Give approximate wait times to patients.
- Hand out customer service cards at the time of registration.

Payers might give you the wrong information

Documentation is best defense

Recently, a large payer denied a claim for a CT scan of the abdomen due to no authorization, even though a registrar previously had been told none was required.

"When we sent our appeal, we included the name of who we spoke to, the number we called, and the specific codes used in the call to determine coverage," says **John T. Porter Jr.**, access denial analyst for patient financial services at Scripps Health in San Diego. "The claim was overturned, and we were paid."

The Appeal Resolution letter from the payer acknowledged that information had been provided indicating precertification was not required for the procedure. "We made it very easy for the payer to locate the error on their part. It resulted in a successful appeal," says Porter.

At UT Medicine San Antonio (TX), the clinical practice of the School of Medicine at The University of Texas Health Science Center San Antonio, patient access staff members sometimes receive authorizations from payers, only to have the claim denied due to lack of authorization, says **Dale Flowers**, MBA, chief administrative officer.

"When the claim is appealed, the payer 'finds' the authorization," says Flowers. "This type of incident is difficult to guard against, and it is difficult to put in processes that prevent it from happening. It ends up delaying payment and requiring staff resources for follow-up."

When you call the payer to obtain an authorization, it's not only what you say; how you ask the questions also is important, says **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access at St. Joseph's Wayne (NJ) Hospital and St. Joseph's Regional Medical Center in Paterson, NJ. "Communication is not a uniform process between the payers and even different representatives who may receive the call at the payer sites," she warns.

Many times, if a patient has a new plan, or recently married and is on the spouse's plan, registrars might call the payer and the payer might state the patient is not on the plan, but the situation might not be so clear-cut, says Rivera. "This is often a matter of timing. It depends on when the payer last updated the database for the employer," she says.

Payers sometimes inform registrars that the service does not require prior authorization when it does, or incorrectly state that a service is covered when it is not, says Porter. "Access staff is just given the standard 'This is not a guarantee of coverage or payment,' disclaimer, and the payer is protected against any wrongful representation of coverage," he says.

If a service required prior authorization and it was not obtained, the claim will be denied and require an appeal or retro authorization to have the denial overturned, says Porter. If a service is excluded or has a limitation, the claim will be denied with the explanation of "non-covered service."

"This is a more challenging denial," says Porter. "There is a specific exclusion, and the standardized disclaimer usually states 'exclusions may apply.'" Here are strategies to avoid denials involving incorrect information:

• Involve others as needed.

In some cases, patient access staff members have had continued problems with particular payers giving inaccurate information on same-day surgical cases, reports Rivera.

"We have had to call the employer to deal directly with the payer rep in charge of the benefit plan," she says. "In other cases, we have had three-way calls between the patient, the physician office, and the facility."

When payers inaccurately state an authorization is required, Flowers says this information is documented and shared with UT Medicine San Antonio's Managed Care Operations department. "They communicate this to their contacts in the health plans, in hopes of curtailing this practice," he says. *(See related stories on how to collaborate with providers to avoid denials, p. 117, and what to document, p. 117.)*

• Always ask if the service requires any kind of prior authorization or precertification.

"I've found the payer will not always volunteer that these benefits hinge on a pre-service action like an authorization or policyholder phone call to the payer," says Porter. "You have to prompt them for the information."

EXECUTIVE SUMMARY

Payers might give conflicting information to registrars and providers, but good documentation results in successful appeals. To avoid denials:
• Specify procedure codes when verifying coverage.
• Identify the specific procedure codes that were discussed.
• Obtain certain pieces of information during all payer calls.

SOURCES

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Stop denials due to inaccurate info

Work closely with providers

When speaking with a payer representative, verify eligibility first, then move on to more specific details such as service category and codes, recommends **John T. Porter Jr.**, access denial analyst for patient financial services at Scripps Health in San Diego.

"Consider what information is on your billing claim, which is required to determine payment," says Porter. "If this information is not available, start requesting it from providers as a standard practice."

When a physician's office contacts patient access staff to order a procedure, Porter advises obtaining the exact Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and International Classification of Diseases (ICD-9) codes that will be on the final order.

"Access staff are not always certified coders and should not be left to interpret or assume what codes will be used by the referring or ordering physician," he says. "The reason is that every CPT/HCPCS code is correlated with a list of medically justified ICD-9 codes."

These medically-justified code combinations are contained within an insurance company's medical coverage policy and vary for every insurance company you contact, says Porter. He recommends these practices to ensure the correct codes are verified for coverage prior to service:

• Request the referring office to include procedure codes, procedure description, diagnosis codes, and diagnosis descriptions.

This step will ensure the codes that are used to verify coverage are the same as the ones used on the claim by certified coders, says Porter.

• Inform providers that the insurance companies require codes to be accurate in order to determine coverage.

"Explaining that you are trying to prevent a claim denial for their patient goes a long way," says Porter.

• Educate providers that medical policies and the codes involved are constantly being updated.

"What was covered yesterday might not be covered today," says Porter. "Constant communication and feedback between providers is essential to stay up to date on the ever-changing state of healthcare coverage."

Document this when speaking with payer

The fact that payers almost never give a guarantee of payment prior to service and require registrars to confirm that there is no guarantee "should set off warning bells when verifying coverage information," says John T. Porter Jr., access denial analyst for patient financial services at Scripps Health in San Diego, CA.

"Our job is to corner them into the closest thing to a guarantee as possible," Porter says.

In addition to documenting the Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and International Classification of Diseases (ICD-9) codes that were provided to obtain coverage determination, Porter says to document these items:

- name of insurance company contacted;
- person contacted;
- date contacted;
- call reference number;
- insurance effective date;
- date of service reported;
- contracted provider (yes/no);
- service type quoted;
- benefit category quoted; • CPT codes checked;
- Utilization review (UR)/pre-cert required (yes/no);
- UR/pre-cert phone number;
- independent practice association (IPA) name (if a health maintenance organization);
- IPA effective date;
- authorization responsibility: IPA or health plan?
- deductible;
- deductible met (yes/no);
- co-pay or coinsurance;
- claim mailing address;
- verified (yes/no);
- maximum allowable for service;
- out-of-pocket maximum;

• lifetime maximum;
• annual maximum.

"Payers tend to dictate what information is given, and a checklist will guarantee all bases are covered," Porter says. "This documented information is important because it can be used to overturn a denial." ■

Asked about costs? Give first-rate service

While many patient access departments can give patients the estimated full cost of a service, to date, very few are able to provide an accurate out-of-pocket estimate, says **Becky Peters**, regional director of patient access services for Sutter Health West Bay in San Francisco.

"Challenges include understanding what specific services the patient is asking about," says Peters. "There are so many new procedures and different variations for given procedures." For surgical cases, the specific surgeon and the type of equipment used could affect the total cost of the procedure.

To help patients understand their out-of-pocket responsibility, four hospitals in the Sutter Health network launched the Patient Care Price Estimation Service. The service is available for patients covered by private insurance, self-pay, government-sponsored programs, or any combination of these payment methods.

"Patients deserve to know their out-of-pocket costs. It helps them make an educated decision about where and when to receive care," says Peters. "No one likes surprises, especially when they are also dealing with an illness." These steps occur:

1. Patients call the financial counseling office, just as they did before.

However, the previous tool could only give the patient the estimated total cost. "Our new tool is much more robust, accurate, and quicker," says Peters. "We can pull the individual patient's insurance information and give them the estimated out-of pocket costs."

2. Registrars give a price estimate in a manner of minutes while on the telephone with the patient.

"It is done 'real time.' Prior to having this enhanced service, it could take several hours of research and multiple calls with patient," says Peters.

3. Staff proactively reach out to patients with scheduled elective procedures to discuss out-of-pocket costs.

"It gives us the opportunity to assess if the patient will have any financial difficulties in covering their costs," she says. "If that is the case, we work with them right away to discuss financial options."

4. Patients and family members are encouraged to ask about the cost of care and make their own choices about what will work best for them.

Registrars automatically provide estimates to scheduled patients, and physician offices and clinical departments inform patients about the service.

"To us, it is all about consumer choice, whether it is about the cost estimate or how quickly they obtained it," says Peters. "Our goal is to make the decision as easy as possible." *(See related story on what to tell patients, below.)*

SOURCES

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Be very clear: It's just an estimate

When patients call and ask what a test costs, the information isn't always straightforward, says **Robin Woodward**, CHAM, patient access director at Riverside Regional Medical Center in Newport News, VA.

"There are many variables to different tests. Patients may not have that information," Woodward says. For example, a patient asking about the cost of a CT scan might not know if this cost is with contract,

EXECUTIVE SUMMARY

Patient access departments might need new processes to inform patients of their out-of-pocket responsibility, due to rising demand for this information. Use these processes:
• Give estimates regardless of whether patients are self-pay or covered by private insurance or government-sponsored programs.
• Offer price estimates when the patient is still on the phone.
• Contact patients with scheduled procedures to discuss costs.

without contrast, or possibly both. "It is important that we explain that this is only an estimate, as additional charges may be added," she emphasizes. For example, a lab study with a positive result might require further testing that wasn't part of the initial quote.

Karen Hughes, CHAM, manager of insurance verification at Riverside Regional, reports, "We have seen an increase this past year of patients asking upfront what services will cost." There is a possibility patients will go elsewhere for services if they can't get this information, Hughes adds. "That is why we work diligently to ensure we are supplying the most accurate information we have available," she says.

To give more accurate estimates, patient estimator software was implemented, which allows registrars to quote prices based on the current chargemaster and insurance contracts.

"The patient estimator software has worked very well," says Woodward. "One call to our call center will get the patient the quickest estimate." ■

Survey: Hospitals name least favorite insurers

From: Kaiser Health News

It is a truth universally acknowledged that health insurance companies can be a pain for patients. What may be a surprise is that hospitals often complain, too, for the same reasons: denied claims, low reimbursement, late reimbursement, and thickets of red tape.

Each year ReviveHealth, a hospital public relations firm in Santa Barbara, CA, asks hospitals to name the most problematic payers. (See list at http://bit.ly/Qm2DUn.) This year's loser: WellPoint, which "managed to have some pretty intense negative opinion" in the regions where it does business, said Revive President Brandon Edwards. "That vaults them above — or I should say below — all the other health plans, even those that operate in all 50" states.

Insurers called the report unscientific and biased, and they point to the agency's interest in cultivating hospital clients. But not all insurers do that. Cigna spokesman **Joe Mondy**, via email, said, "Sorry to see some attacking the survey — Cigna did quite well, so maybe it's easy to say – but we view data from this and other 'report cards' (athenahealth, AMA) as very useful in identifying opportunities to improve and gaug[e] the impact of past improvement initiatives." (Revive's press release is available at http://bit.ly/Qm4f0g.)

Edwards says the research was commissioned by Revive but performed by a third party, Monigle Associates, which contacted every hospital system in the country and received responses from more than 400.

WellPoint ranked last in overall favorability and in the "dealing with hospitals" category. Cigna was No. 1 in overall favorability, while Aetna scored best in the dealing with hospitals category.

WellPoint spokeswoman **Jill Becher** said, "We believe the Revive survey is inherently flawed and without merit. We have a long history of working with providers to improve the accessibility, affordability, and effectiveness of quality health care."

Rising from the basement in previous surveys was UnitedHealthcare, the country's biggest private health insurer. United scored sixth out of seven in the dealing with hospitals category and fifth out of seven in overall favorability. Edwards said, "United certainly hasn't moved to a point where people say, 'It's a great health plan for me to deal with,' but it's only fair to acknowledge that they've made some pretty big strides in improving their reputation in the provider community."

Independent Blue Cross and Blue Shield plans ranked worst in hospital payment rates for the second year in a row.

Allan M. Korn, MD, chief medical officer for the Blue Cross and Blue Shield Association, defended the Blues' relations with hospitals and doctors. "Revive is a PR firm that represents medical providers in payment negotiations with insurers and often creates a contentious public and media atmosphere around these talks," he said through a spokeswoman. "This survey is merely another tactic aimed [at] boosting payments for Revive's clients without regard to the impact this has on millions of Americans who want and deserve affordable healthcare." ■

COMING IN FUTURE MONTHS

- Make registrars happier with no extra costs
- Must-have training on financial counseling
- Pros and cons of "self-service" registration
- Comply with new charity care requirements

State Medicaid expansions show several benefits

In a study recently published in The New England Journal of Medicine,[1] state Medicaid expansions to cover low-income adults were significantly associated with several benefits, including reduced mortality and improved coverage, access to care, and health, as self-reported.

In the past 10 years, several states have expanded Medicaid eligibility for adults. Heatlhcare reform is allowing states to make a dramatic expansion in Medicaid in 2014. "Yet the effect of such changes on adults' health remains unclear," the authors say.

They studied whether Medicaid expansions were associated with changes in mortality and other health-related measures. They compared New York, Maine, and Arizona because those states had substantially expanded their adult Medicaid eligibility in the past 12 years, and their border states had not expanded. Adults between age 20 and age 64 were observed from 1997 through 2007.

The primary outcome was all-cause county-level mortality among 68,012 year- and county-specific observations in the Compressed Mortality File of the Centers for Disease Control and Prevention. Secondary outcomes were rates of insurance coverage, delayed care because of costs, and self-reported health among 169,124 persons in the Current Population Survey and 192,148 persons in the Behavioral Risk Factor Surveillance System.

Medicaid expansions were linked to a significant reduction in adjusted all-cause mortality (by 19.6 deaths per 100,000 adults, for a relative reduction of 6.1%; P=0.001). Mortality reductions were greatest among adults with these characteristics: older, nonwhites, and residents of poorer counties. Expansions increased:

- Medicaid coverage by 2.2 percentage points, for a relative increase of 24.7%; P = 0.01;
- decreased rates of uninsurance by 3.2 percentage points, for a relative reduction of 14.7%; P < 0.001;
- decreased rates of delayed care because of costs by 2.9 percentage points, for a relative reduction of 21.3%; P = 0.002;
- increased rates of self-reported health status of "excellent" or "very good" (by 2.2 percentage points, for a relative increase of 3.4%; P = 0.04).

REFERENCE

1. Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. *NEJM* July 25, 2012. Accessed at http://bit.ly/Oa2iVI. ■

TRINITY
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SELF PAY FORM

Patient name: _____

Account # _____

1. Has patient applied for Medicaid within the past 3 months already? Yes ___ No ___

2. Check the following if applicable.

Medicaid categories:

____ Patient is currently 18 or under and currently lives in Illinois

____ Patient is currently 20 or under and currently lives in Iowa

____ Patient is a pregnant woman

____ Patient is a caretaker of a minor child who lives full time in the household

- **(ex: grandparents raising children in place of parents)**

____ Patient is age 65 or over

____ Patient is disabled

- **(per guidelines of social security)**

____ Parent with underage biological or adopted children living in home full time

____ Step-parent

- **(person legally married to patient's biological parent)**

____ Patient is considered legally blind

SOURCE: Trinity Regional Health System, Rock Island, IL