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AHC Media

Patient access capturing $12M more in revenue: Convert self-pays to Medicaid

Patients are surprised and grateful

About 15% to 20% of self-pay patients qualify for Medicaid, which represents more than $12 million in gross revenue, at Riverside Regional Medical Center in Newport News, VA.

"We currently have a vendor onsite to review our self-pay population for Medicaid and disability," reports **Robin Woodward**, CHAM, director of patient access. "We also request that all self-pay patients apply for Medicaid prior to applying for our charity care program."

Scheduled self-pay patients are pre-registered, given an estimate of their out-of-pocket responsibility, and asked to pay upfront or establish a payment plan. If unable to pay, patients are asked to apply for Medicaid and bring a denial letter if they aren't eligible.

Many patients assume they won't qualify but comply with the requirement, and many are surprised to learn that they are, in fact, eligible. "Patients are appreciative when they find they have coverage for current services and in some cases, retroactive coverage," says Woodward. "Some patients would never have applied if not for our process." Patient access staff members take these steps:

• Staff members use an automated price estimator for the non-scheduled self-pay population.

• If patients are unable to pay estimated amounts in full or by setting up a payment plan, the patient access financial specialist discusses charity and

EXECUTIVE SUMMARY

Self-pay patients qualifying for Medicaid represent more than $12 million in gross revenue at Riverside Regional Medical Center in Newport News, VA. To increase revenue:

• Request that all self-pay patients apply for Medicaid before applying for charity care.

• Ask patients to bring a denial letter if they aren't eligible for Medicaid.

• Help patients complete applications onsite or with an outside vendor.

Medicaid application requirements with the patient.

• Staff members collect demographic information from patients and find out the urgency of the tests or procedure the patient is having.

"If a patient has a previous balance, the patient is referred to an onsite vendor to discuss the Medicaid application at that time," says Woodward.

Hospital/patient partnership

Patient access leaders developed a financial assistance program two years ago at Nash Healthcare Associates in Rocky Mount, NC.

"Our community had quite an adjustment to getting on board with their financial responsibilities," says **Kathy Watson**, CAM, supervisor of outpatient services. "We found that we needed to help our patients understand what they could do and where there was help."

Patients are referred through the pre-arrival department or care management. "We want to make sure that our patients understand that we offer services to help assist them with their financial obligations," says Watson.

One counselor helps outpatients set up payments or obtain other financial assistance, another counselor assists Emergency Care Center patients, and a third counselor visits admitted patients to discuss financial services. "We have developed a fair and clearly understood program to help our patients who need financial assistance," says Watson. "The program emphasizes a hospital-patient partnership." These steps occur:

• When the patient is referred, an email is sent to the financial counselor in that department.

• The patients are contacted by the counselors and a financial application is completed, covering employment status, dependents, and assets.

• The application determines if the patient falls within established Federal Poverty Level guidelines and meets criteria for Medicaid referral.

• If the patient is Medicaid-eligible, the counselor might complete the application or the patient might be referred to an outside vendor specializing in assisting patients with the completion of Medicaid applications.

Follow-up is key

Linking uninsured patients to Medicaid/Supplemental Security Income (SSI) coverage or to hospital-funded charity care will remain a major focus for today's patient access departments, says **Lindsay Rubin**, director of Huron Healthcare, a Chicago-based consulting organization specializing in performance improvement.

"Even for those hospitals and systems that are high-performing in their revenue cycle, the current landscape of healthcare necessitates that hospitals stay focused on these financial counseling efforts," she says.

Discussing financial coverage options with uninsured patients before their services or prior to discharge for urgent or emergent hospital stays increases the likelihood that patients will follow up and get coverage or obtain charity care, says Rubin. Patient access managers need to monitor that follow-up is occurring as needed, both with state offices and by patients themselves, she emphasizes.

Without diligent follow-up, patients often are

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confused by the arduous process of qualifying for coverage. "This holds true regardless if financial counseling functions are managed through a vendor or through hospital employees," says Rubin.

Woodward says that if patients choose not to follow up, they are billed as normal, and they might miss the opportunity for Medicaid and/or charity consideration. "We put this process on the patient," she says. "If it's still within the time period for possible Medicaid or charity, we will ask our onsite vendor to meet with them. Otherwise, they will go through normal billing processes."

In-house or outsource?

Patient access staff can do a lot to ensure that the patient does not "slip through the cracks" when attempting to qualify, says Rubin. Each department needs to evaluate the most cost-effective way of doing this step, she says.

"We have assisted clients in moving from an outsourced financial counseling model to in-house and vice versa," she says. "Many variables should be analyzed in making this determination."

These variables include cost of labor, vendor performance, and the hospital's overall ability to effectively manage vendor inventories and qualitative performance, says Rubin. "While there is no one-size-fits-all model, providers that are in high labor cost markets may outsource to reduce labor costs," she advises. "Also, some providers may not have the in-house expertise."

In these cases, relying on a vendor with local market expertise might be a better solution. However, some patient access departments already possess much of this knowledge in-house due to assisting patients with the hospital's charity application process. "Staff can easily be repurposed to expand their skill set, allowing them to assist patients with qualifying for a variety of sponsorship options," says Rubin.

SOURCES

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Misunderstandings hurt staff retention

Jobs are constantly changing

Do some of your employees still think that getting correct information is enough to fulfill their role in patient access, with no regard for excellent service, financial counseling, or knowledge of eligibility systems?

"The patient access role is constantly changing," says **Irma Becker**, manager of patient access at Phoenix Children's Hospital.

Jean Valenta, an admitting manager at St. Anthony's Medical Center in St. Louis, says patient access leaders "must do a phenomenal job of explaining the 'why' behind a change." For registrars to "buy in" to constant changes in their jobs, Valenta says they need to understand the revenue cycle and the importance of first impressions in providing excellent customer service. "If a new employee is provided quality education and training on processes and applications, the employee has the knowledge and tools to be successful," she says.

Patient access leaders at Phoenix Children's Hospital have made communicating changes in the access role a major focus, says Becker. *(See related story, p. 136, on recent changes in the department.)* "We have gone so far as to hire two full-time trainers who provide focused training to patient access staff," she says. "New employees missing certain expertise can be brought up to speed before they begin their new roles." Some of Valenta's new hires lacked expertise in collecting patient responsibility and understanding eligibility/benefit responses. "Ongoing training must focus on providing education in these areas," she says.

When emergency department registrars first began to collect copays,

Valenta contacted the collection agency contracted with the organization to provide training on how to

EXECUTIVE SUMMARY

Patient access leaders must ensure employees are able to keep up with their quickly changing roles, and they provide resources so employees can succeed.

- Give focused training to new hires.
- Answer staff questions in a newsletter format.
- Meet one-on-one with employees to correct misunderstandings.

collect patient responsibility in a patient-friendly manner. "I continue to use their suggestions in current training," she says.

Becker says providing staff with the tools and training they need is the way to ensure their success. "We take great care to ensure existing staff are meeting expectations," she says."We have found that 99% of errors can be avoided with great training." Becker takes these steps to help registrars cope with changes in their jobs:

• She meets personally with the employee. "This is much more effective than sending emails or communicating by phone," says Becker.

• She encourages staff to approach her with questions, concerns, or ideas.

• She has an open-door policy. "Misunderstandings are a normal part of life," says Becker. "Keep an open channel of communication with the employee. This allows you to quickly resolve the misunderstanding in a positive, supportive manner." *(See related stories on new hires, below, morale of emergency department registrars, p. 137, and a patient access newsletter, p. 137.)*

SOURCES

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Hospital sees many changes for access in short time

Patient access staff at Phoenix Children's Hospital have experienced all of these changes in the department in the past few years, reports **Irma Becker**, manager of patient access:

• A self sign-in system is used, which allows patients to update their own demographics.

"This system enhances wait times and customer satisfaction at the time of arrival," says Becker.

• Account creation and registration are automated.

"Due to our being a hospital-based facility, dual registration was needed on the physician side," says Becker. "The clinic facility account is now auto-created, so the registrar is dealing with only one account."

• Staff pre-register 100% of patients.

"We have a pre-access team in place that verifies eligibility, benefits, demographic information, and liability prior to patients arriving," says Becker.

• Staff members are responsible for giving patient estimates using a newly implemented electronic tool and collecting copays upfront.

On the first visit, registrars discuss deposit amounts. If the patients say they're unable to pay, staff members provide them with applications for the state's Medicaid program and information on commercial insurances.

"We operate on the premise that people want to pay their bills," says Becker. "Individuals who are hesitant about providing financial data usually end up in bad debt because they were non-compliant with our financial assistance policy."

If the patient is uninsured, registrars review the admitting diagnosis, determine a treatment plan with case management, and then schedule an appointment with the parent. If the patient has commercial insurance, the counselor reviews the parent's benefits and determines what the parent's estimated financial liability will be for the admission.

"An appointment is then scheduled to explain the parent's benefits to them, and a request for payment is made," says Becker. "With this approach, we have been able to decrease bad debt and increase up-front collections considerably."

• New locations were added, including satellite clinics.

"The satellites provide specialty services during the day and revert to urgent care status in the evening," says Becker. ■

Identify problems with role before hiring

Verify applicant understands access

"I can't work on Saturdays." "I can't stay late on Wednesdays." "I could never do bedside registration because I can't deal with blood or vomit."

Hopeful applicants aren't likely to tell you these things, but they might do so when talking with someone they view as a peer.

Jean Valenta, an admitting manager at St. Anthony's Medical Center in St. Louis, uses peer interviews to make sure that new hires truly understand the patient access role. *(For more information on this topic, see "Ask staff to flag problem applicants" in* Hospital Access Management, *July 2012, p. 78.)*

"Candidates feel they can share more with peers. They may reveal scheduling restrictions or the inabil-

ity to deal with situations," she says.

Human resources have trained five experienced patient access employees in giving interviews and provided them with a Peer Interview Summary Report. *[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.]*

After completing the interview, the manager invites the potential candidate to meet with one or two patient access employees. The peer interviewers ask behavior-based questions that encourage a conversational answer. "After the peer interview, I meet with staff to review the Summary Report," says Valenta. "Staff know I take their insights seriously and trust in their judgment."

Valenta also teams new hires with an experienced patient access employee. "The goal is for the new hire to have not only a preceptor, who teaches job functions of the position, but also a 'first friend,'" she says. "He or she is responsible for teaching the 'ropes' in our department."

The preceptors make new team members feel welcome by showing them the nearest restroom and vending machine, the cafeteria, and the best places to park. "Program participants feel greater job satisfaction and value in their department. New team members feel welcome," adds Valenta.

Stop high turnover with ED registration

Turnover in a fast-paced emergency department environment often is higher than in other registration areas, acknowledges **Jean Valenta**, an admitting manager at St. Anthony's Medical Center in St. Louis.

"This is due to the increased responsibility of frontline staff to obtain not only demographics and signatures at the bedside, but to verify insurance eligibility and benefits, check for Medicaid or Medicare coverage, and collect copays while not impeding clinical care," she says.

Here are ways that Valenta decreases turnover of emergency department registrars:

• She says "thank you" to staff at the end of a shift.

"I write thank-you notes every day. It's a great way to end your day," says Valenta. "I thank the highest copay collector for the previous day."

• She gives soda or snack vending coupons to staff who work a shift to cover an unscheduled illness for a co-worker, or come in early or stay late to meet staffing needs.

• She involves high-performing employees in the decision-making that impacts their workflow.

"This keeps your high performers well-informed of the organization's goals and financial position," says Valenta. "You may be surprised what your staff is willing to do to keep the organization moving in the right direction, if they believe their input is valued."

Patient access staff came up a new process to use when placing calls to consultants requested by ED physicians. "To reduce overhead paging, ED physicians began utilizing cell phones," says Valenta. A patient access staff member suggested asking the consultant to hold and then transferring the call to the ED physician, to be sure the consultant was connected to the right person.

• She allows staff to self-schedule.

"Flexible hours allow for continuing education for employees," says Valenta.

• She created a quick and easy way for staff to access important information for low-volume, high-risk registrations.

"Patient access staff complete an annual competency for Level 1 trauma patients, but the process is posted at the staff work area for a quick refresher if needed," says Valenta.

Answer questions in your own newsletter

Emergency department registrars at St. Anthony's Medical Center (SAMC) in St. Louis have a new way to get answers to their most pressing questions: a newsletter created just for emergency department patient access staff called Inquiring Minds Want to Know.

"I solicit questions and publish the answers," says **Jean Valenta**, an admitting manager. Here are some recent questions asked by ED registrars and Valenta's answers:

Question: How do I transfer an outside caller to a patient's hospital room?

Answer: If you receive a call and would like to transfer the caller to a patient's hospital room, dial 8, then the room number. If you would like to provide the caller the knowledge to call the patient directly, inform the caller to call (314) 525-4000, and instructions will be provided. The caller will need to know the patient's hospital room number, so be sure to provide! (This is for calling a hospital room, not an ED treatment room.)

Question: I think I remember something about entering the Medicare number on Medicare HMO patients. Would you remind me again, please?

Answer: Sure, thanks for asking. Patient Accounts requires the patient's Medicare number to bill Medicare HMOs. The term "Medicare Advantage" is a more accurate way to describe Medicare replacement plans. SAMC's list of Medicare HMOs in Star (the hospital's information system, from San Francisco-based McKesson Corp.) is not true HMOs, but includes PPO, FFS, HMO, etc.

Collecting the Medicare Number applies to ALL Medicare Advantage/HMO plans: Advantra, Blue Cross Medicare, Care Improvement, Essence, Gold Advantage, Humana Medicare HMO, Humana Medicare PPO/FFS, Medicare Misc HMO, UHC Dual Complete/Evercare, UHC Medicare Complete/ Secure Horizons, and Wellcare Medicare HMO. Enter the Medicare Number in the Comment field in Star on the Ins Page.

Question: I tried to run Blue Cross eligibility without the BC ID number. The response returned FAIL. Any suggestions?

Answer: I do have a suggestion. For BC Anthem plans, try running the Blue Cross eligibility transaction with JWC followed by the SSN. For out-of-state plans, try XOS followed by the SSN. Be sure to update the ID number in Star!

Question: I received a phone call from the floor that a patient arrived from the OR [operating room], and the nurse could not "find" the patient in Epic. What should I do?

Answer: Check the service field in Star. The Star service field is very important in identifying a phase of care in Epic. When an ER patient (or patient in a bed) goes to the OR, the OR contacts Bed Control. Bed Control updates the Star service field to POR (Patient in OR). This makes the patient appear on the correct Patient List in the OR and helps with medication distribution. When the patient arrives on the floor, the floor calls to have the patient appear on the nursing divisions Patient List. The Star service field is updated to the appropriate service (based on Patient Type and MD service). For example, if the patient has a Patient Type of EOV (which refers to an observation visit in the emergency department), the service field is ER. Hint: The same is true for PCL (Patient in Cath Lab) and PGI (Patient in GI Lab).

Question: I tried to run Medicare on a patient with an entitlement: Jr. The response returned Invalid Missing Subscriber Name and/or DOB.

Answer: This is tricky. When a patient has an entitlement, try Smith JR, John. ■

Immediately report these clinical concerns

Registrars are part of team

Your registrars might not have a medical background, but that doesn't mean they can't potentially save a patient's life.

Patients have fainted, developed chest pain, and had seizures in registration areas at University of Utah Health Care in Salt Lake City, reports **Karen Duncan**, nurse manager in the admitting department. In each case, registrars immediately called the hospital's Rapid Response Team.

"Registrars should always believe that they are part of the patient's team, because the patient sees the registrar that way," says Duncan. "The patient has shared the reason for the visit or diagnosis with the registrar, which is very personal information."

Registrars have shared concerns about suspected abuse and patient statements concerning suicide with clinical staff, adds Duncan. "The registrar and manager decide how to share that information with the provider caring for the patient," she says. "The specific words and context are very important for the provider to understand."

During the day shift, registrars report concerns to their admitting supervisor or manager, and off hour and weekends, the registrars page the nursing house supervisor.

"We have had a patient and tell a registrar that he was feeling suicidal. The registrar excused himself from the desk and walked the patient to the Emergency Department," says Duncan. "We have also had a patient tell a registrar that her portable oxygen was empty. The registrar called our Respiratory Therapy department to bring portable oxygen."

Positive outcomes

It is crucial that registrars pay close attention to comments made by the patient and parents, says

EXECUTIVE SUMMARY

Patient access staff might observe a patient in need of immediate care or hear comments regarding abuse or suicide that must be reported to clinical staff. Registrars should:

- Pay close attention to comments.
- Alert clinical staff if symptoms worsen.
- Share suspicions about identity theft.

Pamela Konowall, manager of health care access at Cooper University Healthcare in Camden, NJ. "The clinical staff has complimented the registration staff on numerous occasions because they have communicated their concerns regarding patient's conditions," says Konowall. "In doing so, potential critical situations have been avoided."

Cooper University's registrars have alerted clinicians to a lethargic infant, a child who was having difficulty breathing. "Both were Level one emergency situations, both were admitted, and both had good outcomes due to the quick thinking of the registrar and the fast action of nursing," says Konowall. "Clinicians immediately assessed the children. Care was rendered without delay, which had a positive impact on the outcome."

Registrars have also alerted clinicians to adults with chest pain, adults with difficulty breathing, gunshot wounds that presented through the main entrance of the ED rather than an ambulance entrance, patients who say they have been sexually abused, patients who are extremely anxious, and patients who have threatened to hurt themselves or others. To elaborate on the examples of the two children referenced; Cooper University Hospital ED clinical staff is easily accessible to the registration staff. The preferred and quickest method of communication is to verbally alert the clinicians immediately of any concerns a registrar might have.

"If a patient's condition or symptoms worsen while they are in the waiting area, registrars alert clinical staff," says Konowall. "The bottom line is, if the registrar has any concerns, the clinical staff prefer that they be notified." *(See related story, below, on reporting concerns about identify theft.)*

SOURCES

For more information on registrars reporting clinical concerns, contact:

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- **Pamela Konowall**, Manager, Health Care Access, Cooper University Healthcare, Camden, NJ. Phone: (856) 342-2437. Email: konowall-pamela@CooperHealth.edu.
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Registrars help to prevent ID theft

Were suspicious documents provided for identification? Were credit monitoring reports received? Did others report suspicions about the validity of a patient's identify? Registration staff should not hesitate to report any of these concerns, says **Ronald Marcum**, MD, director of the integrity office at Oregon Health & Science University Hospital in Portland.

"Front-line and registration staff are trained to look for activities or behaviors that would alert us to potential medical identify theft, which is a significant risk to the integrity of the medical record," says Marcum.

Registrars report concerns to their manager or supervisor, the hospital's integrity office, public safety, or to the hospital's hotline. "Prevention strategies include education of staff, having a policy in place, having processes in place to identify patients, and more recently, capturing a photo of each patient during initial clinical visits," he says.

Members of the registration staff enter the initial demographics and establish patient identity, depending on whether the registration is by phone or in person, says Marcum. Patient access staff take the patient's photo at the clinical visit. "The challenges are to achieve some standardization for the photo, for example, distance from the camera, a common background and trying to achieve standard head size in the photo" so that patients can be identified from the photo when they check in for their appointment, he says.

When identify theft is confirmed, appropriate authorities are notified, and medical records are corrected or merged through an established process by health information management staff to preserve the integrity of the record. "A flag is placed on the electronic health record of the patient involved, to alert staff to request additional photo identification and make them aware of previous identity theft issues," says Marcum. ■

Patients expecting steeper discounts

Be diplomatic in your response

Patients with large deductibles often feel patient access staff members are unreasonable to ask for the amount upfront, but what about the other side of the coin?

"If patients were denied coverage or services, we charge them the lesser of our contracted rate or the self-pay discount of 45%" says **Stephen Hovan**, vice president of revenue cycle at The University of Tennessee Medical Center in Knoxville. "We offer

EXECUTIVE SUMMARY

Self-pay and underinsured patients are increasingly asking for larger discounts, and registrars need to communicate policies while providing good customer service.
- Offer discounts if patients pay upfront.
- Inform patients of what the discount will be before their arrival.
- Allow patients to make a deposit if the deductible is less than the total cost of the procedure.

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patients who pay their out-of-pocket amounts upfront a 10% discount."

Some underinsured patients are asking for additional discounts from the contracted rate, reports Hovan. If a patient has a $10,000 deductible for example, and is charged $5,000 for a positron emission tomography (PET) scan, and the contracted amount is $1,000, the $1,000 is normally directly billed to the patient. "But the patient wants a deal. So in some cases, we are further discounting the amount from what the payer would have paid us," Hovan says.

Robb Wilburn, director of patient registration at Sarasota (FL) Memorial Health Care System, says, "Patients are asking for larger and larger discounts. We stick to our current policy. The largest discount we can offer is a 60% prompt pay discount."

For patient with large deductibles, if their deductible is greater than the procedure, registrars ask for full charges. If the deductible is less than the total cost of the procedure, registrars allow patients to make a deposit. "In some cases, we have allowed patients to make payment arrangements on the deductible, but we do not discount their deductible," Wilburn says.

Registrars inform the patient of the discount they're getting before their arrival. "This seems to help ease the blow. Our staff is trained to be as compassionate as possible on this matter," Wilburn says. "We explain to the patient that this is a contractual agreement between them and their insurance company."

Linaka Kain, DE, a Medicaid specialist at Trinity Regional Health System, Rock Island, IL, is seeing more patients who are employed and have insurance that ask about charity care and are over income to qualify. Kain tells these patients that unfortunately, they do not meet the criteria for assistance as they are not indigent, homeless or living below the poverty guidelines.

"When they hear some of these words, it reminds them of what other people do not have and how fortunate they are," she says. "They are then not upset that they do not qualify."

Patients are offered a 20% discount if they pay their bill in full. "That seems to satisfy a lot of the population that have the money to do so," says Kain.

SOURCES

For more information on discounts offered to self-pay patients, contact:
- **Stephen Hovan**, Vice President, Revenue Cycle, at The University of Tennessee Medical Center, Knoxville. Phone: (865) 251-4534. Email: SHovan@mc.utmck.edu.
- **Linaka Kain**, DE, Medicaid Specialist, Trinity Regional Health System, Rock Island, IL, Campus. Phone: (309) 779-2648. Email: Kainll@ihs.org.
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Do registrars inform patients about options?

Access processes under scrutiny

"Nobody ever told me financial assistance was available." This is a typical comment from patients who are struggling to pay hospital bills, reports **Jessica Curtis**, JD, director of Boston-based Community Catalyst's Hospital Accountability Project, a national consumer advocacy organization focusing on healthcare issues.

In some cases, patients really weren't given the information, and other times, patients just don't remember being told. Either way, patients' account balances have typically already gone to collection by the time they seek help, Curtis says.

"Patients are delaying care because they are afraid of acquiring medical debt," says Curtis. "Patients with chronic illness are putting off preventative care and instead, coming to the emergency department when there is some type of emergency."

EXECUTIVE SUMMARY

Patient access staff members face increasing scrutiny over how patients are informed of financial assistance, due to recent media coverage, research, and guidelines.
- Use a consistent approach to notify patients.
- Be aware of state and federal requirements.
- Work with community partners to get out the information.

No consistent approach

Patient access leaders can expect much more scrutiny about what and when patients know about financial assistance, says Curtis.

"The problem has gotten a great deal of media attention in the past year," she notes.[1,2,3] A 2012 study found poor compliance in New York hospitals.[4]

"This isn't just a one-off incident where patients are falling through the cracks in one hospital," says Curtis. "There isn't a consistent approach for how patients should be notified."

Twenty-two states require hospital to notify patients about financial assistance in some way, notes Curtis, and the Patient Protection and Affordable Care Act requires hospitals to widely publicize their financial assistance policies. *(For information on free healthcare laws and regulations in each of the 50 states, go to http://bit.ly/TqTaAO.)*

In addition, the IRS has proposed more detailed, prescriptive proposed rules on notifying patients, including requiring hospitals to work with community partners to get out the information, and the American Hospital Association has its own guidelines for informing patients. *(To access the AHA Policies & Guidelines on Billing, Collections, Tax-Exempt Status, and Community Health, go to http://bit.ly/QQEAAo.)*

"Right now, federal rules affect only nonprofit hospitals. But this is a practice all hospitals should be looking at," advises Curtis. "The burden is shifting from the patient to the hospital staff to tell patients upfront about financial assistance, so patients can take steps early to apply. It's kind of like informed consent, but on the financial side."

Patients uninformed

Many non-profit hospitals are not adequately informing patients about charity care policies, despite federal requirements. In Community Catalyst's survey of 99 hospitals, 15 did not mention the availability of charity care, and less than half provided written materials.[5] **John A. Gale**, MS, research associate at the Muskie School of Public Service at the University of Southern Maine in Portland, says, "Hospitals still have a long way to go in terms of making this information available. There is a lot of room for improvement."

Gale did a study in 2007 of critical access hospitals. He found that the vast majority had a formal charity care policy in place, but they made the information available only if patients specifically requested it. Less than half made the materials available in multiple languages.[6]

"If patients aren't adequately informed about charity care, it can not only cause public relations problems for the hospital, it can also jeopardize the hospital's nonprofit tax status," says Gale.

Gale points to Provena Health in Mokena, IL, where portions of the property tax exemptions were stripped away because of its debt collection practices and level of charity care provided. "They had a lot of complaints about very aggressive collection practices," he says. "It has worked its way through the courts and was eventually upheld."

Illinois state officials are looking at the way hospitals provide charity care and trying to set minimum levels of charity care performance, notes Gale. IRS officials are looking at charity care practices, how decisions are made, under what circumstances hospitals can deviate from their policies, and how well the information is made available to the public. "Hospitals are being looked at by a variety of policyholders and stakeholders," Gale says. "Patient access staff need to understand that this is a very, very big issue."

Access is key

Curtis recommends that registrars simply tell patients, "We have programs available to help if you think you might have difficulty paying." *(For more information on this topic, see "Do you tell patients about charity care?" in* Hospital Access Management, *September 2012, p. 104.)*

Patient access employees are "the first and best line of defense to avoiding problems, by informing patients upfront," says Curtis. "It also makes good business sense for hospitals. It is always better to get reimbursed than not to."

Patient access staff are the best ones to let patients know about charity care options, adds Gale. "They are the front line. The time to let people know about this and begin to collect this information is when the patient is right in front of you, instead of waiting until there is a 90-day receivable for that account," he says.

Underinsured patients might not realize they will end up with a large out-of-pocket responsibility down the road, he adds, so it's important for them to get the information early in the process.

More patients will presumably have coverage as a result of healthcare reform being implemented in 2014, says Gale, but the same processes still will be needed. "Every single uninsured person won't be covered, and illegal immigrants will still be seeking services," he notes. "Also, there is a greater cost shift to patients, so deductibles and copays may still be subject to charity care or discounted care." *(See related*

stories on how patient access inform patients, below, and what patients report about financial assistance information, right.)

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Go the extra mile to inform patients

Access management services staff at Robert Wood Johnson University Hospital in New Brunswick, NJ, provide each patient with the hospital's charity care and reduced charge charity care notices, but they go even further to be sure patients are informed of their options, says **Kathy MacGillivray**, MHA, access management services director.

Following a trauma injury, a 30-year-old uninsured female came in to register at the hospital's Orthopaedics Clinic for care after surgery. The patient asked a registrar about the cost for services and expressed concern that she might not be able to afford it. When she overheard the conversation between the patient and the registrar, a patient access supervisor offered the patient phone numbers and addresses for financial counselors and provided preliminary information on eligibility requirements.

"This patient could have been responsible for a portion, if not all, of her follow-up care if she had not been made aware of the resources available to her," says MacGillivray. Grateful for the information, the patient submitted an application for charity care.

MacGillivray says that if patients disclose that they are uninsured or have limited means to cover their medical expenses, it's common practice for registrars to facilitate interviews with financial counselors to help these patients learn about the resources available to them.

"Our teams work hand in hand," says MacGillivray. "Financial counselors always take the time to either sit down immediately with the patient or schedule a follow-up conversation." ■

Here's what patients are telling helpline

They're often uninformed

While state and federal law require that non-profit hospitals provide individuals with notice of the availability of free care, patients are often unaware, and not all hospitals are compliant or consistent, says **Mia Poliquin Pross**, Esq., associate director of Consumers for Affordable Health Care (CAHC) in Augusta, ME.

As Maine's Consumer Assistance Program, CAHC operates a statewide toll-free HelpLine that answers 2,000 to 3,000 calls per year from consumers needing assistance with healthcare coverage or costs.

"We often provide consumers with information about hospital free care," says Pross. "It is clear to us that many hospitals go above and beyond the law, to provide financial assistance to individuals with income higher than the law requires, and provide services beyond the emergency department."

However, Pross says these are areas of concern, based on what patients say during the phone calls:

• Hospitals don't always inform patients about free care availability.

It is quite common for HelpLine callers who have received services at a hospital to be unaware of the availability of free care, says Pross. In such cases, CAHC coaches them on how to contact the hospital and start the application process.

• Patients might be denied free care incorrectly.

Patients sometimes aren't offered a fair hearing and aren't informed of the process. "CAHC provides consent forms to callers who have been incorrectly denied free care and intervenes on their behalf," she says.

• There is no clear, consistent way for patients to access information about free care.

To provide accurate and targeted assistance to HelpLine callers, CAHC annually updates information on each hospital's income guidelines for free and sliding scale care in Maine. *(To view the information on 2012 Income Guidelines for Hospitals, go to http://bit.ly/T1yRHL.)*

In phoning each hospital, CAHC followed the procedure that a consumer would most likely undertake. "The general phone number was called, and we requested to speak with either the billing office, a patient advocate, or someone who could speak to us about hospital free care," says Pross. Some hospital staff members indicated that there was no such program.

"In addition, when CAHC was able to speak with hospital staff whose job it was to screen for such programs, it was clear that some were unaware of the regulations, what the federal poverty level [FPL] is, and/or that they were utilizing out-of-date FPL numbers," Pross reports.

Patient access staff must be aware that the FPL changes almost every year, she advises. *[To view the 2012 U.S. Department of Health and Human Services (HHS) Poverty Guidelines, go to http://1.usa.gov/wBQemo. To sign up for email updates from HHS, go to http://1.usa.gov/TTZCCx and click on "HHS Office of the Secretary."]* "Free care policies need to be updated as soon as possible, so patients aren't incorrectly denied free care," Pross says. ■

Underinsured patients will need cost-effective options

Less expensive alternatives should be considered

It's a "tremendous victory to have something approaching universal access" as a result of the Patient Protection and Affordable Care Act, but the resulting increase in underinsured patients will pose ethical challenges for providers, according to **Joseph J. Fins**, MD, MACP, chief of the Division of Medical Ethics at Weill Cornell Medical College and director of medical ethics at New York Presbyterian Hospital-Weill Cornell Center in New York City.

The fact that patients are insured should not be taken as a guarantee that they are adequately insured, he explains. "There are people who, by virtue of the mandate to buy health insurance, will buy the cheapest insurance they can afford, which comes with higher deductibles," says Fins. "The fact that they are insured doesn't mean they are protected against under-treatment. So the next policy challenge is not just access to care, it's access to sufficient care."

Practicing evidence-based care and trying to avoid waste saves the patient money and provides better care, he argues. "This is a clarion call for patients and doctors to talk about the various ways of working up medical problems," he says. "Patients may be able to avoid dire choices promoted by underinsurance."

On the other hand, Fins underscores the importance of not breaching professional standards to save patients money, such as ordering an X-ray instead of a magnetic resonance imaging or CT scan for the evaluation of back pain in a cancer patient. "Care of patients comes first, and finances come second," he says. "Just as cost containment is never a malpractice defense, underinsurance is not an excuse for bad medical care."

There might be legitimate alternatives in which evaluation can be performed in a less costly way, but it is unacceptable to deviate from the standard of care if this puts the patient at risk, warns Fins. "I think we have to appreciate now that families unfortunately have to sometimes make choices," says Fins. "Physicians need to be aware of that, because if they don't speak about the cost of care, they may prescribe things that are not followed-up on. There may be a problem with non-compliance."

Fins observes that the scope of this problem is larger than it appears. He notes that health service investigators have described under-insurance as "a moral hazard."[1] Research has shown that the metric of out-of-pocket costs, by which under-insurance is tracked, underestimates the scope of the problem because the under-insured delay, defer, or avoid care when a more

fully insured patient would seek it.

"So by the time an underinsured patient gets to the point of seeking care, a diagnostic or therapeutic inadequacy has already occurred," he explains. "The opposite is true with patients who are very well insured, say without a deductible, who will over-utilize services."

Inability to pay

Patients should never be denied emergency care and treatment due to their inability to pay or inadequate insurance coverage, says **Marianne L. Burda**, MD, PhD, a Pittsburgh, PA-based ethics consultant and educator. Physicians have an ethical obligation to do the following, says Burda:

- ensure that the tests, treatments, or procedures they recommend to their patients are medically indicated and not unnecessary or a result of practicing defensive medicine;
- consider whether there is a less expensive alternative that is comparable to a higher-priced test, medication, or treatment and will obtain the same result, such as an older generic medication or a different diagnostic test;
- fully inform patients of all care and treatment options including doing nothing, risks and benefits associated with each option, and the costs of all options;
- advocate for underinsured patients to get needed medical treatment covered;
- provide some free or discounted care to patients.

"If they are unable to do so for a particular patient, they should help the patient locate financial assistance, or free or reduced sources of the needed medications, tests, and treatments," says Burda. For example, physicians can refer patients to social workers or agencies in their community that can work to locate and secure these resources.

- work with patients to design affordable payment plans that do not delay patients receiving needed care.

"Insurance discounts to costs of care should apply. Underinsured or uninsured patients should not be charged full costs for care, as they are the least able to pay these prices," says Burda.

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• **Joseph J. Fins**, MD, MACP, Chief, Division of Medical Ethics, Weill Cornell Medical College, New York City. Phone: (212) 746-4246. Email: jjfins@med.cornell.edu. ■

Peer Interview Summary Report

Applicant Name:		Position:	
Interviewer Name:		Date:	

Score the section as "0" - Unable to Express, "1" - Partial Answer, "2" - Appropriate Response

Mission	**Score**	
☐ Please give me an example of a time you gave compassionate care.		
☐ Tell me about a situation with a difficult co-worker/customer and how you handled it.	**2 1 0**	
☐ Our mission is: "St. Anthony's, a Catholic medical center, has the duty and privilege to provide the best care to every patient, everyday." What does this mean to you?		
Market	**Score**	
☐ Why would you be proud to work at St. Anthony's Medical Center?		
☐ How have you directly influenced a customer to return for services?	**2 1 0**	
☐ What previous job was the most satisfying and why?		
Quality	**Score**	
☐ What does providing "excellent service" mean to you? Tell me about a time that you provided this level of service to a customer.		
☐ What did you do in your last job to contribute toward a team environment?	**2 1 0**	
☐ How do you make the customer feel they are the center of your attention?		
Financial	**Score**	
☐ Tell us how you used department resources wisely in your current/most recent position.		
☐ How do you organize your work to ensure you are effective and efficient?	**2 1 0**	
☐ Give me an example of a time you offered a process improvement suggestion in your department.		
Physician Partnership	**Score**	
☐ Give me an example of a time you have partnered with a physician to treat a patient.	**2 1 0**	
☐ Tell me about a time you disagreed with a physician regarding a patient's care. What did you do to resolve the issue?		
☐ How can you impact our physician satisfaction scores?		

Source: St. Anthony's Medical Center, St. Louis, MO.

Total Score (transfer to next page)	

Job Specific Behavioral Section	**Score**	
☐		
☐	**2 1 0**	
☐		
☐		
Patient and Employee Satisfaction Results	**Score**	
☐		
☐	**2 1 0**	
☐		
☐		
Job Specific Scenarios (Unique to Dept or Team)	**Score**	
☐		
☐	**2 1 0**	
☐		
☐		

Total Score:	

Notes:

Recommendation:

Recommend for Hire ☐	Average Candidate ☐	Would Not Recommend ☐

Source: St. Anthony's Medical Center, St. Louis, MO.
December 2012 / Online Supplement to HOSPITAL ACCESS MANAGEMENT®

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