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Revamp MSPQ processes: Over half of hospital revenue is possibly at risk

Training cut MSPQ 25% in three months

If the Medicare as Secondary Payer Questionnaire (MSPQ) is not complete, your patient access department faces denied claims, lost revenue, and potential loss of Medicare funds.

"If we are not compliant with completing the MSPQ, Novant Health is at risk of losing approximately 55% of its revenue," says **Tate Batson,** assistant director of onsite access for Novant Health's Charlotte and coastal markets in North Carolina.

By implementing a fail-safe MSPQ process, you are likely to see fewer RTPs (Returned to Providers), says Batson. "This results in fewer accounts receivable days, and less rework in the business office," she says. Here is Novant Health's MSPQ process:

• Batson works with the hospital's Information Technology Services team to identify MSPQs that were not answered completely.

These claims are now held until they're corrected, which avoids costly denials. "Holds are identified with reports or work queues," Batson says. "Discrepancies are resolved before the claims are released."

• Patient access leaders implemented a quality assurance tool that allows

EXECUTIVE SUMMARY

Patient access leaders say the Medicare as Secondary Payer Questionnaire (MSPQ) remains a major educational challenge in their departments, despite more than half of hospital revenue potentially at stake. One hospital decreased its decreased MSPQ errors by 25% in a three-month period by emphasizing education.

• Have peers give one-on-one training.
• Validate the completion of MSPQ for every patient that is a Medicare beneficiary.
• Correct problems in real-time, before claims are sent.

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registrars to link the MSPQ and the Common Working File response.

"This ensures that we are complaint with CMS [Centers for Medicare & Medicaid Services] regulations and reduces denials," says Batson.

• The department's MSPQ process is integrated into registration pathways, so that the questionnaire is asked at each visit.

"If a discrepancy does exist, we resolve it by contacting the Coordination of Benefits office," says Batson.

Patient access leaders at Central DuPage Hospital, Winfield, IL decreased MSPQ errors by 25% in a three-month period. "A critical step is how we circle back to the user's errors," says Barbara Novak, revenue cycle manager.

Errors are grouped by the type of error, the department, and the user. This information is shared openly with employees.

"No one likes being on the top of this list," says Novak. "Access leaders then ask for more information. What did the front-end user initially enter? What corrections did billing make?"

Audits reveal inconsistencies

At UK HealthCare in Lexington, KY, patient access leaders have been through several audits of the department's MSPQ process and billing compliance, conducted by internal and external auditors.

"Establishing the proper reason for eligibility was one area that was highlighted," says **Courtney M. Higdon,** MBA, director of Enterprise Patient Access Services. Although no payments were made in error, there were inconsistent answers with the Coordination of Benefits assigned to accounts.

"The audits helped us to further develop two specific strategies within patient access, to support best practice and optimal performance in this area," says Higdon. These two changes were made in the past year:

• Patient access leaders developed a more robust auditing program for the completion and accuracy of the MSPQ.

"We established automated methods through real-time system reports, to validate the completion of an MSPQ for every patient that is a Medicare beneficiary," says Higdon.

Previously, staff identified problems through batch review and rectified them later in the revenue cycle. This made errors more difficult and costly to correct.

Staff now catch the problems in real-time so they can be corrected right away, before claims are sent out. "This reduces the amount of staff rework that previously took place later in the revenue cycle," says Higdon.

For example, if staff members discover that the MSPQ was not completed at all for a Medicare beneficiary, this can be corrected while the patient is still in the hospital or clinic. "Currently, we are creating mechanisms to do some editing of the MSPQ answers, in order to reduce conflicting answers and missing information," says Higdon.

• Patient access leaders worked hard to train all patient access staff about MSPQ.

"The problem with this issue is that it is complex. It can sometimes be confusing, for staff and

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Editor: **Stacey Kusterbeck**, (631) 425-9760.
Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Interim Editorial Director: **Lee Landenberger**

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

for patients," says Higdon. "The retirement date is always an area that is easy for staff to be confused about, as well as the guidance around ESRD [End-Stage Renal Disease] eligibility."

Managers developed online training on this topic, and they added training on MSPQ to initial classroom training for new hires and annual refresher training. However, they soon realized that constant focus on MSPQ is necessary.

"We have strengthened performance expectations of our staff in this area as part of our patient access job promotion process," Higdon reports.

Staff members are reminded that billing correctly the first time minimizes delays in payments, which creates a positive impact on cash flow. "Additionally, maintaining compliance with federal guidelines on this issue minimizes our risk of having payments recouped," says Higdon. *(See related story, below, on training on MSPQ processes.)*

SOURCES

For more information on Medicare as Secondary Payer Questionnaire processes, contact:

• **Tate Batson**, Assistant Director, Onsite Patient Access, Charlotte and Coastal Markets, Novant Health, Winston-Salem, NC. Phone: (704) 384-4069. Fax: (704) 316-9667. Email: tebatson@novanthealth.org.
• **Courtney M. Higdon**, Director, Enterprise Patient Access Services, UK HealthCare, Lexington, KY. Phone: (859) 257-6780. Email: Courtney.Higdon@uky.edu.
• **Barbara Novak**, Revenue Cycle Manager, Central DuPage Hospital, Winfield, IL. Phone: (630) 933-6514. E-mail: Barbara.Novak@CadenceHealth.org.
• **Nikki Taylor**, CPAR, Assistant Director, Patient Access Services/Patient Accounts, Georgia Regents Health System, Augusta. Phone: (706) 721-8001. Fax: (706) 721-1818. Email: ntaylor@gru.edu. ■

MSPQ is `tricky' despite education

Ongoing, one-on-one training needed

Despite the large amount of revenue at stake, completion of the Medicare as Secondary Payer Questionnaire (MSPQ) remains a tough educational challenge, according to patient access leaders interviewed by Hospital Access Management.

"The MSPQ is so important to complete accurately, but at times it can be tricky," acknowledges **Nikki Taylor**, CPAR, assistant director of patient access services and patient accounts at Georgia Regents Health System in Augusta.

Incorrect completion of MSPQ is one of the most common root causes of inaccurate registrations reviewed by Taylor.

A recent month's report identified this problem in two accounts for day surgery patients. These were used as training tools for patient access staff. "Using these accounts to follow up with employees and provide training is very helpful," says Taylor.

Peers provide training

Registrars at Novant Health in Winston-Salem, NC, are educated on MSPQ by attending classroom training during orientation, completing interactive online modules, and during staff meetings.

"It's important to provide ongoing training to reiterate the importance of completing the MSPQ," says **Tate Batson**, assistant director of onsite access.

Patient access leaders at Winfield, IL-based Central DuPage were disappointed with the results they were getting from electronic and group training to address MSPQ problems, so they came up with a different approach.

"We have added another type of communication: the one-on-one staff update," says Barbara Novak, revenue cycle manager. These sessions are informal, take 10 or 15 minutes per staff member, and involve a review of the error and what should have been entered.

About 10% of the patient access employees are designated as "super users" who assist with the one-on-one MSPQ training.

"Staff appreciates this training from a peer. It is the only way we have been able to keep up with this," says Novak. "Otherwise, the resource and time issue becomes an obstacle." ■

Combat the top reasons staffers leave access

Don't accept status as a 'jumping off' point

More pay, better hours, and the chance of advancement. These are the most common reasons patient access employees leave the department, says **Betty Bopst**, CHAM, CPAM, director of patient access at Mercy Medical Center in Baltimore.

"We have been working very hard to come up with non-financial incentives for employees, because pay increases are just not in the budget," Bopst says. Here are some changes made by patient access departments

to improve retention:

• Patient access leaders at Northwestern Lake Forest (IL) Hospital, recently paid for all the department supervisors to take the Certified Healthcare Access Associate (CHAA) exam.

"All of them passed, and all were thrilled to add those four letters to their email signatures," says **Elizabeth Burnstine**, CHAM, manager of patient intake and access. *(For more information on this topic, see "12 registrars in this system CHAA-certified each year!"* Hospital Access Management, *June 2013, p. 65.)*

• Registrars and schedulers at Northwestern Lake Forest have the opportunity to become an "ambassador."

One representative from the main registration area, offsite registration, the emergency department, and scheduling is selected to become an ambassador for a three-month period, during which they meet monthly to address a specific topic.

"The initial group is selected by their supervisors. From there, they select their own successors," says Burnstine.

Bringing in someone from scheduling allowed staff in each area to get a sense of what the other area did. "Before, the schedulers would always say, 'Why don't the registrars get this information?' The registrars would say the same thing," she says. "They have done a little bit of sitting in each other's shoes."

A recent group put together a computerized presentation about how the patient access teams work together to promote customer service. At the monthly staff meeting, one of the ambassadors gave the presentation to her colleagues. "Being able to stand up in front of a group of peers is hard. Having that skill can help anybody move forward," says Burnstine.

At first, the ambassadors were less than thrilled about their new role, since they assumed it would just mean extra work. "They thought it was just one more thing for them to do, but then they saw they were getting special treatment," she says.

Once a month, the ambassadors take a break from their work and sit for an hour and a half talking with their peers about important challenges the department is facing. "I have already seen the demeanor of previous members change, as they grow in their commitment," says Burnstine.

For their three-month term, the ambassadors also get the privilege of going outside the department's standard dress code of a white top with a black, navy, or tan pants and are allowed to wear a colored shirt.

In the central scheduling department, where the dress code is more relaxed since employees don't have face-to-face contact with patients, the ambassadors are permitted to wear jeans.

"It sounds like such a little thing, but they really appreciate us giving them that freedom," she says. "They know we can't give them money." *(See related story on creating a lead patient access role, below.)*

• Employees at Mercy Medical Center are allowed to switch to another area of patient access.

Because the patient access area is mostly decentralized, there are many areas that might be more appealing to staff members who are unhappy in their current jobs.

"If we want to retain someone who is looking to leave, I talk with them to discuss possibly moving to another area of patient access," says Bopst.

Some of the other areas don't require weekends or holiday hours, and offer higher pay. These jobs require more knowledge and a different skill set, such as more insurance experience.

"It is our standard practice to move staff into these more desirable areas when openings occur, before we offer them to the public," says Bopst. *(See related stories on making access positions more appealing, p. 113, and offering more flexible hours, p. 114.)*

SOURCES

For more information on improving retention in patient access areas, contact:

• **Betty Bopst**, CHAM, CPAM, Director, Patient Access, Mercy Medical Center, Baltimore. Phone: (410) 332-9390. Fax: (410) 545-4044. Email: bbopst@mdmercy.com.

• **Elizabeth Burnstine**, CHAM, Manager, Patient Intake and Access, Northwestern Lake Forest (IL) Hospital. Phone: (847) 535-6380. Fax: (847) 283-6909. Email: eburnstine@lfh.org.

• **Tonia Metoyer**, Supervisor, Emergency Department Registration and Admitting, Patient Access Services, Edward Hospital & Health Services, Naperville, IL. Phone: (630) 527-3889. Fax: (630) 548-8164. Email: TMetoyer@edward.org. ■

Retain staff: Create a `lead' position

At Mercy Medical Center in Baltimore, MD, **Betty Bopst**, CHAM, CPAM, director of patient access, created a variety of "lead" positions for various areas of the department. "These jobs include different tasks and responsibilities that are not typical of their routine registration functions," she says.

Some of the lead positions require employees to review and correct accounts sent back from patient accounts. Other jobs involve re-running eligibility systems, reviewing Medicare members' registrations to ensure the Medicare as Secondary Payer Question-

naire is accurate and complete, or attending revenue cycle meetings.

"This has been well-received by all," says Bopst. "They now come to me or their managers asking for things to do," she says. Staff members complete these levels in the department's career ladder, to qualify for one of the lead positions:

• Intern.

"This slot is for nursing and college students, with a flat pay rate," says Bopst.

• Patient access representative I.

"This is an entry-level position in the emergency department or lab outreach, where someone with little or no experience could begin," says Bopst.

• Patient access representative II.

"This requires some experience and proven ability," says Bopst. At this level, staff members are able to move into the other areas of patient access, such as women's imaging, admitting, outpatient, or chemotherapy.

• Patient access representative III.

"These are high-performing staff who are ready to move into lead or supervisory positions," says Bopst. Managers require Certified Patient Account Technician (CPAT) or Certified Healthcare Access Associate (CHAA) certifications for these jobs.

"Each level is a promotion with a pay increase," says Bopst. "The next step will be looking at our centralized scheduling center. This area would be a promotion from patient access representative."

At Edward Hospital & Health Services in Naperville, IL, a lead patient service representative role was created to allow aspiring employees an opportunity to advance. The job gives them some experience in managing the daily activities of the department.

"It allows the patient service representatives an available 'go to' person to ask questions," says **Tonia Metoyer**, supervisor of emergency department registration and admitting. "They can get assistance and training on the spot." ■

Make access jobs more appealing

To reduce turnover, **Tonia Metoyer**, supervisor of emergency department registration and admitting for patient access services at Edward Hospital & Health Services in Naperville, IL, took a close look at the open positions in her department.

"We reviewed them to ensure they would be appealing to a large number of candidates," she says.

After reviewing the open positions, Metoyer made some changes to make the jobs more appealing to applicants. For some of the jobs, she removed the requirement to work every Saturday and Sunday, or every Friday and Saturday night. Instead of offering applicants only a Friday/Saturday/Sunday position, Metoyer offered Monday/Wednesday/Friday or Tuesday/Thursday/Saturday positions. She also offered applicants the chance to work Monday/Friday/Saturday shifts one week, and only Monday/Friday the following week.

"We also tried to ensure that the overnight full-time positions had two days off in a row, versus being split up by working a day, then off a day, then working a day," she says.

Turnover is challenge

Metoyer says turnover is a challenge primarily because the Patient Service Representative (PSR) role is typically considered an entry-level position, because it doesn't require a degree.

"However, what we ask our PSRs to do in their daily activities is substantial!" she says. "The challenge of hiring and retaining PSRs has been one we've faced continually."

By making these changes, the department improved its turnover rates significantly, says Metoyer:

• Patient access managers plan for balance in staffing by hiring only a certain number of students at one time.

Many of the PSR candidates are in school and pursuing a career in healthcare, and they leave the department after they obtain their degrees, explains Metoyer.

"Depending on what stage they are at in their career path, they stay varying lengths in the PSR position," she says. "We are always happy for them to stay."

• Patient access partnered with recruiting.

"We came up with a plan to aid in the selection process, that lends itself to hiring for longevity," says Metoyer. The hospital's primary recruiter came to the patient access areas to shadow employees, to gain a better understanding of the position and the type of applicant that would be the best fit.

• Metoyer asks candidates about their career growth goals.

"I ask where the candidate sees themselves in one year and also in five years," she says.

Metoyer says there is no right or wrong answer to this question, but the goal is to get an idea of the candidates' goals. For example, the interviewer might learn that the candidate is pursuing certain educational or career goals in the short or long term.

"The hope is that the candidates' response provides an indicator on where they are headed in their career and how the PSR role fits within their plan," she says.

• Metoyer provides explains the job's responsibilities in depth during interviews.

An 80-hour shadowing training program is offered to all new hires, so they can learn their new job in the midst of everyday activities. "We also offer candidates a tour of the work area," she says. "They are introduced to employees and see daily activities." ■

What do your staffers want most? Flex hours

It can be more important than pay

When a registrar who had been in the department more than 30 years was thinking about leaving because of a problem with her hours, a solution was found quickly, says **Elizabeth Burnstine**, CHAM, manager of patient intake and access at Northwestern Lake Forest (IL) Hospital.

The registrar recently had been made a full-time employee, but she wanted to go back to part-time status. "We went to the VP and made it work," says Burnstine. "We got through it fairly easily, but I was prepared to substantiate exactly how it would benefit the organization if necessary."

Burnstine and the hospital vice president decided to do something they had never tried before, by splitting the registrar's full-time position into two 0.6 part-time positions. "We had never done any job sharing in our department before. But we sat down and found a way to make it work for her, in a way that the department would not be shorthanded," she says.

Together, the two employees work more than 40 hours, equivalent to a 1.2 FTE, but because the other part-time person's salary is much less due to her entry-level status, it comes out budget neutral, Burnstine says. As a result of the change and being able to keep her benefits, the employee not only decided to stay in the department until retirement, but thanks Burnstine profusely whenever she sees her.

Previously, other employees have requested a similar arrangement, and the department wasn't able to accommodate it. However, because it has worked out so well in this case, Burnstine would consider doing a split position again. "It made such a difference in the employee's life," she says.

Patient access leaders don't have much control over salaries in their departments, but flexible hours are often even more important to employees struggling to balance work and family obligations, says Burnstein. In Northwestern Lake Forest Hospital's central scheduling office, one employee works different hours during the summer because she has school-age children.

"Somebody in the department switches their hours with her over the summer, so the department still has the right coverage," says Burnstine. ■

Updated job descriptions needed for patient access!

Be prepared for staff members' responses

"That's not in the job description I was given." When a patient access employee made this statement during an annual review, it was difficult to respond because it was true, says **Steven K. Cochran**, CHAM, patient access supervisor over admissions and emergency room (ER) registration at Och Regional Medical Center in Starkville, MS.

Cochran realized that the job descriptions he was using to evaluate employees didn't reflect what they actually did on a daily basis. As a result, he is updating these.

Cochran says the new job descriptions will be a much better tool during the hiring process because they will allow him to make a good decision on which candidate is the best fit for the available position. "It sets the tone from the very beginning of what your expectations are in your employee/supervisor relationship," he adds.

Reviewing updated job descriptions with existing employees is an opportunity to emphasize to staff members, who sometimes feel underappreciated, how vital their role is to the hospital, says Cochran.

"When dealing with long-time employees, it gives you goals to set and achieve," he says. "It prevents them from feeling they are in a position that is becoming stagnant and routine."

Take these steps

Patient access leaders at Riverside Regional Medical Center in Newport News, VA, recently updated all of the job descriptions for their department.

"The registrar's role has expanded greatly over the past few years," explains **Robin Woodward**, CHAM, director of patient access. "That needed to be acknowledged and reflected in the job description." Woodward took these steps:

• She obtained input from the administrative direc-

tor, who sent the revised job descriptions to compensation for re-pricing consideration. Pay increases were approved, based on the new job descriptions.

• She notified team members that their job descriptions were being revised.

"Team members may have input on an item that we in management may have overlooked while making revisions," says Woodward. For example, staff reminded Woodward that they needed time to escort patients to their next location, which is a big patient satisfier. Two minutes were added to the wait time expectation listed in the job description, which is currently 15.5 minutes or less.

• Lastly, Woodward reviewed the new job descriptions with each employee.

Ask staff what they do

As part of the process of updating job descriptions, Cochran is talking with employees about what they do in their jobs.

"I am making a point of involving the staff in researching this information," says Cochran. "I am finding that they are mentioning responsibilities and duties that I had actually let slip my mind."

Once Cochran has received all the input from his employees, he will compare their lists with the responsibilities that he thinks should be added. "Then I will make the edits and additions to our existing job descriptions," he says.

The biggest new responsibility in the job descriptions is going to be upfront collections, says Cochran, adding that this will help him find people able to confidently collect from patients in a courteous manner.

"This is something that people tend to be too 'soft' on in our rural area," he explains. "This is a primary focus in my interviews."

Have responses ready

When Cochran announced his intention to update patient access job descriptions, employees mostly were pleased that their expanded role was being acknowledged. However, he also encountered these two responses:

• "This is the way we've always done it."

Some employees resented the updated descriptions because they thought they were being asked to do additional work. Cochran responded by saying, "You expect your salary to increase and change with each passing year. So your responsibilities should, too."

"I also reminded them of the importance of everything that we do," he says. "They impact the entire revenue cycle and operations of the facility. They are much more than just data entry clerks."

• "Since you are adding more duties and responsibilities, shouldn't I get more pay?"

When staff members asked Cochran this tough question, he reminded them that pay raises are earned, not something they are automatically entitled to.

"Actively including your staff in decisions and changes regarding policies and procedures helps to eliminate, or at least lessen, this type of attitude," says Cochran.

SOURCES

For more information on steps to take when updating job descriptions, contact:

• **Thomas P. Buckley**, Vice-President Revenue Cycle, Patient Business Services, Virtua, Marlton, NJ. Phone: (856) 355-2020 Ext. 52020. Fax: (856) 355-2171. Email: tbuckley@virtua.org.

• **Steven K. Cochran**, CHAM, Patient Access Supervisor, Och Regional Medical Center, Starkville, MS. Phone: (662) 615-2581. Fax: (662) 615-2619. Email: scochran@och.org.

• **Robin Woodward**, CHAM, Director, Patient Access, Riverside Regional Medical Center, Newport News, VA. Phone: (757) 594-4211. Fax: (757) 594-4495. Email: Robin.Woodward@rivhs.com. ■

EXECUTIVE SUMMARY

When updating outdated job descriptions, patient access leaders are finding it helpful to get input from employees on their responsibilities and to prepare for questions about salary increases.

• Talk to staff about what they do in their jobs.
• Set goals with long-term employees.
• Be clear with new hires about current responsibilities.

Put excellent service into job description

Virtua, Marlton, NJ, recently made changes to its patient access positions, with an emphasis on providing excellent customer service, reports **Thomas P. Buckley**, vice president of the revenue cycle and patient business services.

Previously, patient access job descriptions primarily were focused on the amount of time it took to complete various functions. For example, it took about 60% of a registrar's time to enter a patient's demographic, financial, and insurance information into their system, and another 20% of time to obtain signatures on all required documents.

The updated job descriptions take into account the

expectation that patient access staff create an outstanding patient experience, says Buckley. "The Virtua patient access staff is helping our community be well, get well, and stay well, one person at a time, by alleviating suffering and delivering acts of kindness," he says.

"Seemingly small" behaviors

Patient access relationship-based care can be achieved in ways that don't involve a large percentage of time, Buckley explains. For example, acknowledging a patient's arrival with "Good Morning, Mr. Smith," or asking friendly questions such as "How was your drive in today?" don't take much time, but are very important to the patient access role.

Other patient-friendly behaviors that take little time are making eye contact or knocking on patient's door before entering. "Although these seemingly small behaviors have a huge impact, they generally are not identified on patient access job descriptions," says Buckley. He made sure these behaviors were included in the department's updated job descriptions by specifying expectations for "communication," "courtesy," "respect," and "professionalism."

This information is helpful during the hiring process, he says, because managers can ask candidates to respond to requests such as, "Give me an example of how you used courtesy during a registration."

"Examples can range from holding a door for a patient, to listening as patients tell their story, to calling physician practices to help the patient navigate the healthcare continuum," says Buckley. ■

Staff keenly aware of their bigger role

They're ready for a challenge

Patient access employees at Riverside Regional Medical Center in Newport News, VA, were happy about their job descriptions being updated, because they already were very aware their role has broadened, says **Robin Woodward**, CHAM, director of patient access.

"There are a lot of things registrars must remember to do," says Woodward. "Patient access team members do want to be challenged and move beyond a registration desk."

Below is the updated job summary for a registration representative:

- Effectively utilizes all department-specific computer and telephone systems.
- Responsible for registration of all patient types and statuses, having full understanding of the requirements for the charity program and self-pay processes, network/out of network, authorizations versus no authorizations, medical necessity, providing quotes, calculating patient payments, electronically posting patient payments, identifying issues, and reporting trends.
- Acts as a liaison between the patient access office and all other departments and insurance companies, providing consistent and relevant detail on issues and trends.
- Demonstrates strong problem-solving skills, high attention to detail, and an aptitude for learning.
- Promotes teamwork and customer service by demonstrating positive interpersonal relations.

Riverside Regional's patient access team members are encouraged to complete cross training in other departments. They move up the department's career path, as follows:

- Registration representatives must be cross-trained to cover one area within the department, such as surgery check-in, emergency department registration, or the information desk.
- A registration associate must be cross-trained to cover all areas of their assigned department, which could include obstetrics, emergency department, admitting, and cashier.
- A revenue cycle associate must be able to cover another area outside their department, such as the call center, patient accounting, or scheduling.

"You must be in each role a year to advance. Each advancement level is a new grade in pay," says Woodward. Three to five employees participate each year, and employees are encouraged to do so at their annual evaluations. Here are the requirements:

- Individuals must be in each level at least one year/
- Each level requires the individual to complete required responsibilities, classes, and competencies.
- The employee must meet a certain score on the annual evaluation and maintain a required accuracy rate.

"The goal of our career path is to recognize and advance revenue cycle team members who demonstrate excellent customer service, positive interpersonal communication skills, and relationships with patients, families, and interdisciplinary healthcare teams," says Woodward. ■

Incorrect info equals incorrect estimates!

Get correct codes for diagnosis, procedure

Patients want to know the dollar amount they're responsible for, but how can members of the patient access staff possibly give them that information without the correct patient status, procedure, and diagnosis codes?

"Procedure codes are not always easily accessed, and verbal communication can sometimes be miscommunicated or misunderstood," says **Pamela Konowall**, manager of health care access at Cooper University Health System in Camden, NJ.

In addition, patients are not always sure exactly what procedure is planned. "In order to calculate an accurate estimate, having complete information is of the utmost importance," says Konowall.

To ensure accurate price estimates are given, the hospital's pre-encounter team compares patient status and scheduled procedure to the OR schedule. "Should any discrepancy be identified, the team supervisor reaches out to the physician's office for further clarification," says Konowall.

Discrepancies in patient status are sometimes identified. A patient might have been processed as an outpatient when the correct status is inpatient, which means an authorization will be required for managed care. Other patients are processed as an inpatient but should be an outpatient, which means a precertification or referral could be required by the patient's insurance carrier. "Failure to provide either the referral or the authorization would create a denial or have a negative impact on revenue for the hospital," says Konowall.

Coding discrepancies are sometimes flagged, which require clarification. "Inaccurate coding could have a negative impact on providing a patient with an accurate estimate," says Konowall.

Patients will want refunds

At Mercy Hospital — Springfield (MO), registrars use an automated price estimation tool to complete estimates prior to the visit, if scheduled, or at the visit for walk-in appointments.

"The most important thing we have learned is to get the estimates to patients early if at all possible," says **Michael Spence**, MBA, financial analyst for patient access.

Any substantial inaccuracy in an estimate is bound to be a patient dissatisfier. "The expectation of a patient coming in for healthcare is accuracy at its finest," says Spence. "That does not mean just clinical accuracy, but administrative accuracy as well."

If the estimate turns out to be too high, this situation results not only in refunds, but also some distrust. "If patients see these, they begin to want to delay payment until after billing because they don't trust the estimate," says Spence.

In this situation, registrars explain to the patient that estimates are based on what the typical procedure will be, but in healthcare the final outcome is based upon the individual circumstance. "Also, certain amounts may change as charges flow through their insurance provider," says Spence.

If the estimate turns out to be low, on the other hand, some patients won't pay the additional amount that is due. "We have had patients refuse to pay the difference, even though we make it clear that our estimates are just that — an estimate," says Spence. "As a result, we have seen some instances of lost revenue."

Registrars review the medical record and itemized bill, and they identify what charges were above the norm or not originally expected. "Generally, this will satisfy the patient," says Spence. "But at times, they stand strong by the original estimate."

Designate employees

After noticing a trend of patients beginning to "price shop" by calling several hospitals in the area to compare out-of-pocket costs, patient access leaders at Cooper University Health System gave certain employees the job of giving estimates to patients.

The hospital's "pre-encounter team" gives estimates to insured patients several days before their scheduled appointment, and the patient accounting team gives estimates to uninsured and underinsured patients.

"Many more patients are asking for estimates for a variety of services, including infusion treatments, lab work, radiology, and surgeries," says Konowall.

EXECUTIVE SUMMARY

If patient access employees give incorrect information on a patient's out-of-pocket responsibility, the result will be dissatisfaction, refunds, and lost revenue.

- Compare patient status and scheduled procedures to the OR schedule.
- Flag coding discrepancies.
- Designate certain employees to give price estimates.

"This reflects a major shift in how patients are choosing their healthcare provider."

Patients are choosing hospitals not only where they have confidence in the clinical reputation of the provider, but also where they believe costs are reasonable and customary, says Konowall.

"Patients are making informed decisions as to where they choose to receive services," says Konowall. "Clearly, revenue is at stake if patients choose another provider for any reason." *(See related stories on obtaining current coverage information, below, and using an automated price estimator, below right.)*

SOURCES

For more information on giving accurate estimates to patients, contact:
- **Pamela Konowall**, Manager, HealthCare Access, Cooper University Health System, Camden, NJ. Phone: (856) 342-2437. Email: konowall-pamela@CooperHealth.edu.
- **Terri Miles**, Manager, Patient Access, Wheaton Franciscan Healthcare, Glendale, WI. Email: Terri.Miles@wfhc.org.
- **Michael Spence**, MBA, Financial Analyst, Patient Access, Mercy Hospital — Springfield (MO). Phone: (417) 820-9897. Fax: (417) 820-4880. Email: Michael.Spence@Mercy.Net. ■

Outdated information is one reason for denials

Registrars need current information

When giving price estimates to patients, do staff members have accurate information about the patient's current coverage?

"If we are working with a patient on eligibility or benefits and are not using the latest information available, this could directly affect the patient's out-of-pocket responsibilities," says **Terri Miles**, manager of patient access at Wheaton Franciscan Healthcare in Glendale, WI. Here are problems that can occur:

• Registrars could miss identifying an HMO or PPO affiliation during the preregistration process.

"This could mean that we miss timely notification of that service, which creates penalties for the patient and/or the organization," says Miles. The key to avoiding this situation is making sure that the registrar is paying close attention to the detail provided by the payer related to plan participation, she advises.

• The hospital is not a participating provider for the carrier, which results in a reduced payment from the carrier.

"For the organization, it could mean an increase in the payer allowance. For the patient, it could result in a higher out-of-pocket responsibility, due to out-of-network benefits," says Miles.

• Registrars might receive outdated information about a patient's coverage, depending on the timing of the inquiry and the database being accessed.

"This could include termination of coverage or changes that have not yet been updated by the carrier, such as a benefit change the group may have had, which would alter the patient responsibility for that service," she says.

For example, coverage termination or benefit changes could occur at the start of a new month. "Employment could have terminated during the previous month," says Miles. "Or a benefit change could have been implemented, directly affecting the patient's out-of-pocket responsibilities."

Miles says this situation probably can't be avoided fully, unless a call is made directly to the employer to verify their eligibility information for the upcoming date of service.

To be sure you have the most current information on the patient's coverage, Miles says to do the following:

- Gather detailed information from the patient.
- Use an eligibility application to verify information.
- When in doubt, assist the patient in contacting the payer.

"That is actually who they have the contract with and who can also provide them the latest, most accurate information," says Miles. "When it is a group health plan, we advise patients to check with their human resource department for policy details." ■

Staff identified problems with estimation tool

Problems were resolved

Patient access employees at Cooper University Health System in Camden, NJ, now use an automated price estimator (CarePricer, manufactured by Alpharetta, GA-based MedAssets) to determine the patient's liability in advance of the visit. This estimator benefits the patient and the hospital, says **Pamela Konowall**, manager of health care access.

"Patients are made aware in advance of their expected financial responsibility," Konowall says. "This eliminates unexpected bills to the patient and allows the hospital to collect money upfront."

When the tool was first implemented, however, the preparation of the estimate took quite some time for the user to complete. "There were some discrepancies identified, requiring the vendor to make some changes," says Konowall. "This was based on input from patient access employees who were involved with the pilot testing."

Patient access employees compared results and reported discrepancies to pilot team representatives. "Outcomes evaluated were obtained from Cooper University Hospital's integrated eligibility application, eligibility websites, and phone calls made directly to carriers," says Konowall.

Staff members determined that they weren't able to create estimates without an admit date. Also, the patient's deductible data was not auto-populating.

Inconsistencies were reported to the vendor on a daily conference call. The vendor resolved these problems by adding additional fields to the HL7 feed, which allowed staff members to create accurate estimates. There are now very few discrepancies in quoted estimates, reports Konowall, and patients are very satisfied with the results.

"There has been a noticeable improvement over this past year. Estimates are prepared in a timely and accurate manner," says Konowall. ■

Video: The YouToons get ready for Obamacare

The Kaiser Family Foundation released a new animated video to help people understand the changes taking place under the Affordable Care Act (ACA) once major parts of the law go into effect in 2014.

"The YouToons Get Ready for Obamacare" (http://bit.ly/14ZBUro) explains the basic changes in the way Americans will get health coverage and what it will cost starting in 2014, whether it's through their employer, Medicaid, Medicare, or buying insurance on their own with the help of federal tax credits. The new animation is available on kff.org, the foundation's website, and on YouTube. It can be embedded on other websites.

Written and produced by the foundation, the animated video features narration by Charlie Gibson, former anchor of ABC's "World News with Charlie Gibson" and a member of the foundation's Board of Trustees. The video serves as a how-to guide to help viewers understand what benefits they qualify for and what they can do to prepare for open enrollment starting Oct. 1, 2013. At press time, a Spanish-language version of the video also was planned for release.

The animation was developed to inform and educate Americans about what will and will not change under the ACA. The April 2013 Kaiser Health Tracking Poll (http://bit.ly/Zr7rxD) found that many Americans (42%) were unaware that the ACA is still the law of the land, and even more (about half) said they did not have enough information about the health reform law to understand how it would impact their families.

"The reality is that nearly every American will be touched by the Affordable Care Act in ways small and large, and many will face important decisions this fall," said **Drew Altman**, president of the Kaiser Family Foundation. "This cartoon is meant to demystify a complex law and explain what it means for you, whether you support or oppose Obamacare."

The video is meant to be shared with family and friends and can be linked to numerous social networks via the share buttons on the YouTube video. It can also be featured on other websites, using embeddable code available at kff.org/youtoons-obamacare-video. The YouToons first appeared in "Health Reform Hits Main Street," a 2010 animated video written and produced by the foundation that explained how the health reform law would work, narrated by Cokie Roberts, ABC News and NPR news commentator and a former member of the foundation's Board of Trustees. A Spanish-language version of the 2010 video is also available online.

"The YouToons Get Ready For Obamacare" is just one of many resources on the foundation's website to help the American public better understand healthcare reform. Other foundation health reform resources include a health insurance subsidy calculator (http://kff.org/interactive/subsidy-calculator), an interactive ACA implementation timeline (http://kff.org/interactive/implementation-timeline), frequently asked questions (http://kff.org/health-reform/faq/health-reform-frequently-asked-questions), and a 10-question quiz (http://kff.org/quiz/health-reform-quiz) about the law. The foundation will be producing new consumer-friendly informational materials to explain the ACA as implementation of the law proceeds. ■

COMING IN FUTURE MONTHS

- Offer help to patients with misleading health coverage
- Update your department's patient ID technology
- Get near-perfect scores for customer service
- Dramatically boost collections with electronic payments

Help for navitgating insurance marketplaces

Health and Human Services (HHS) Secretary **Kathleen Sebelius** has announced $67 million in grant awards to 105 navigator grant applicants in federally facilitated and state partnership marketplaces.

These navigator grantees and their staff will serve as an in-person resource for consumers who want additional assistance in shopping for and enrolling in plans in the health insurance marketplace beginning this fall. Also, HHS has recognized more than 100 national organizations and businesses who have volunteered to help Americans learn about the healthcare coverage available in the marketplace.

"Navigators will be among the many resources available to help consumers understand their coverage options in the marketplace," said Sebelius. "A network of volunteers on the ground in every state — healthcare providers, business leaders, faith leaders, community groups, advocates, and local elected officials — can help spread the word and encourage their neighbors to get enrolled."

The announcement builds upon the significant progress in outreach and education made this summer. Consumers can learn about and enroll in coverage later this fall through HealthCare.gov. HHS launched a 24-hours-a-day consumer call center ready to answer questions in 150 languages. The phone number is (800) 318-2596. The text telephone (TTY) number is (855) 889-4325

More than 1,200 community health centers across the country are preparing to help enroll uninsured Americans in coverage, and a partnership with the Institute of Museum and Library Services will help trusted local libraries be a resource for consumers. ■

Did you receive bulletin on out-of-pocket expenses?

On Aug. 13, we sent an email bulletin to *Hospital Access Management* subscribers on a new development that will result in continued high out-of-pocket expenses for patients. If you didn't receive it, it means we don't have your email address. You can receive future ebulletins by contacting customer service at customerservice@ahcmedia.com or (800) 688-2421. ■