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January 2014: Vol. 33, No. 1
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95% of revenue collected at time of service: Exceed 'low hanging fruit'

Much untapped revenue is at stake

When patient access staff at Danbury (CT) Hospital first began collecting copays, they focused on scheduled patients only. "In 2006, we collected less than 50% that was due at the time of service," reports **Cindy Thomas Lowe**, CHAM, patient access director.

By centralizing scheduling and financial clearance through the hospital's Contact Center, staff members achieved consistency in verification processes. Registrars now know the amount due at the time of service, from daily reports and notes within each pre-registration.

Lowe says that due to scripting, tracking collections, and "sending statistics to show our success to all, we are now consistently collecting 95% or more that is due at the time of service."

Amber Reeff, director of patient access systems at Virginia Mason Medical Center in Seattle, says, "Healthcare needs to function more like retail: a transparent cost, and paying before you leave."

It costs an organization more to bill for small charges such as copays than to have a robust collection process at pre-arrival and/or arrival,

Special issue on upfront collections

Inside this special issue of *Hospital Access Management*, we report on strategies that have dramatically increased collections, how to deal with unsuccessful collectors, technology needed to successfully collect, and the best ways to train employees. We also offer some personal tips from patient access employees on how they successfully collect from patients.

Next month's issue of *Hospital Access Management* will include a Salary Survey Report covering trends in salaries, must-have skill sets, and advancement opportunities in the field of patient access.

according to Reeff. "By engaging our patients prior to services being provided, we can help identify the cost of care and work with them on payment options," she adds.

Virginia Mason makes 2 changes

Virginia Mason's patient access areas made these changes:

• Employees were given "financial sensitivity" training to help them feel more comfortable asking for payment and collecting balances on accounts.

• Patient access leaders became more transparent with collections by reporting how much was collected by each team member on a daily basis.

"This provides close to real-time collection performance. It allows the leadership team to see who is excelling and learn why," says Reeff.

If hospitals don't do upfront collection well, the lost revenue is "immeasurable," says Reeff. She suggests considering how much it costs to produce statements, staff the customer service department, answer questions about the patient's bill, and do third-party collections.

If the money was simply collected upfront instead, says Reeff, "all of those costs could be used to support the organization's value-added needs."

Educating members of the community on their insurance benefits, as well as providing patients with options to meet their financial responsibility prior to or at time of service, are two top priorities for patient access leaders at Florida Hospital East Orlando, reports **Ramon A. Rivera**, MBA, director of patient access.

Price estimator tools were implemented to meet these goals. "This allows us to get as close as possible to final patient responsibility, based on historical data, CPT codes, and payer information," says Rivera.

Educate clinicians on role

The emergency department (ED) is an especially challenging area in which to collect, due to the patient's condition, length of stay, and layout, says Rivera. He says 39% of the hospital system's current year-to-date upfront cash has come from the ED setting, which equates to roughly more than $14 million.

"Treat-and-release ED patients are a good portion of visits for a majority of hospital campuses, as more and more patients find themselves without a primary care physician or insurance," adds Rivera.

EXECUTIVE SUMMARY

There is still a significant amount of untapped revenue with upfront collections, say patient access leaders. By putting information on the patient's responsibility in the hands of registrars, Danbury Hospital now collects 95% of revenue due at the time of service, up from 50% in 2006. Other successful approaches include the following:

• Report on how much each team member collected.

• Educate emergency department clinicians on the patient access role.

• Assign specific personnel to inpatient units to build relationships.

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Road, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Access Management™, P.O. Box 550669, Atlanta, GA 30355.

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Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $429. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $80 each. (GST registration number R128870672.)

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One challenge with ED collections is simply finding the right time to enter the room to have the conversation at bedside, without interrupting patient care or invading the patient's privacy. Clinical partners lacked understanding of the job function of a registration representative and the bad debt amounts that resulted from patients not being seen by patient access, says Rivera.

"Opening the lines of communication has assisted the clinical leaders to educate [their staff] on the importance of making time for registration to see the patient at the bedside," he says.

Now, clinicians are more willing to convey to the patient that they are "in good hands" with registration, so patients feel comfortable with the collection discussion. For example, an ED clinician might tell a patient, "Our goal is to reduce any anxiety that may come with the financial aspect of a hospital visit. We have a great team of registrars that are here to help go over your insurance benefits and provide payment options that meet your needs. For your convenience, they will be visiting you during your stay."

"This makes the patient experience a priority, while increasing financial stability for the organization," says Rivera. "The collection interaction is not seen as 'strictly business.'"

Build relationships

Collecting from inpatients at the bedside is another challenging setting, says Rivera, as the patient's financial responsibility can change from day to day as charges are accrued.

"Patient condition can be a barrier, as well as knowing the right time for visiting: after a radiology exam, when the doctor is not in room," he adds.

Patient access assigns specific personnel by inpatient unit to build relationships with case management and nursing managers. "When our partners know that a patient needs to be seen prior to discharge, they will call the assigned registrars to come up," says Rivera. "This eliminates the back and forth or guessing game." *(See related stories on unsuccessful collectors, right, and 30-minute training sessions on collections, p. 4.)*

SOURCES

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Find better fit for struggling collectors

Virtually every patient access department has at least one employee who, despite much training and effort, simply isn't able to collect successfully.

"There are team members who, without having had a collections background, struggle to balance the patient experience and collecting financial responsibility upfront," says **Ramon A. Rivera**, MBA, director of patient access at Florida Hospital in Orlando.

Part of the patient access leader's job is to hire team members who are compassionate, yet comfortable with having discussions about money in the healthcare setting, says Rivera. "Once the team member is hired, it is important to shadow and role-play," says Rivera. "Validate that all the tools needed to make the team member successful are in place."

If the team member is identified as not having the skill set to collect, says Rivera, then it might be time to discuss other areas within the department and/or the organization that might be a better fit for that employee. "Everyone contributes something to the big picture," says Rivera. "There are employees who were hired for their positive energy and ability to make a patient feel at home."

If employees are not putting all of their efforts into trying to make their collection goals and are in good standing with all other metrics, it is worth directing them into another role, he says.

Rivera has found that some employees were a better fit outside of the emergency department setting, and these excelled at customer service and accuracy on the outpatient side. "Productivity is measured, and the strongest team members who excel with service, accuracy, and speed are scheduled to follow up at the bedside with patients," says Rivera.

These employees input the data captured, scan documents, greet patients, and make sure they are taken care of throughout their entire stay. Other employees excel at interpreting benefits and catching errors on accounts.

"You cannot have an entire team of non-collectors, but there should be room for a small per-

centage that contribute to the goal of enhancing patient experience," says Rivera. ■

30-minute session sharpens skills

During 30-minute sessions, patient access employees at Florida Hospital in Orlando have dramatically improved their collection skills.

"Frontline staff are placed in collection scenarios with real-time feedback," says **Ramon A. Rivera,** MBA, director of patient access.

Every other month, the team attends a 30-minute scenario-based skills lab that helps sharpen their skill set around the following key performance indicators:

• **The patient experience.**

Staff are expected to acknowledge the patient, introduce themselves, explain the steps that will be taken during registration, and thank the patient for choosing the hospital.

"A volunteer will typically play the patient, to see if the employees do a good job with engaging the patient, getting at eye level, and offering to assist with anything else during the registration process," says Rivera.

• **Collections.**

The employee is presented with insurance benefits and a "patient" to collect from, and then the employee receives feedback on how well he or she interpreted the benefits and presented collections options to the patient.

"The volunteer 'patients' have their responses ahead of time to know if they will be paying or giving reasons they cannot to see how the employee would handle it," says Rivera.

• **Accuracy.**

Test accounts are used to see if the employee goes to the appropriate website to run benefits and to see if they can interpret the benefits correctly.

"Adding the insurance to the system is also graded," says Rivera.

• **Time management/multitasking.**

Emergency department registrars are asked to follow up on multiple patients needing attention to see how they prioritize each one. At the end of the scenarios, the employee receives feedback on what he or she did well, and how to improve.

"Employees have increased their competency with engaging the patient and increased their confidence in offering payment options, as well as tackling any rebuttals," reports Rivera. ■

Price estimate is biggest challenge

Tool must be 'visibly pleasing to the eye'

Point-of-service collections at Ohio Health in Columbus have steadily increased, from about $12.8 million in fiscal year 2011 to more than $19 million for fis¬cal year 2013.

OhioHealth was seeing a steady increase in patient out-of-pocket responsibilities, and a growing number of patient requests for price estimates was coming in to the system's hotline. "We needed to find an automated solution to create real estimates based on the patient's specific insurance coverage," says **Pam Carlisle,** CHAM, senior director of patient access services.

Patient access leaders partnered with a vendor to implement a price estimation tool (PMMC Estimator Pro, manufactured by Charlotte, NC-based PMMC) giving the health system the capability to produce patient-specific price estimates. For pre-service discussions, OhioHealth now generates an average of 9,250 estimates per month. "The estimate combines the payer's expected reimbursement and charge information," says Carlisle. "The estimate also includes any prior balances a patient may have incurred."

Patient liability is the focus

Patient access leaders at Virginia Mason Medical Center in Seattle still are working with the hospital's arrival teams on knowing how much to collect for a co-pay or deposit.

"We are not able to communicate the patient's total liability, and this is something they are requesting from us today," says **Kristi Hoagland,** manager of admitting.

The department is upgrading its patient estimator to include liability. "This will allow us to communicate total out-of-pocket expense prior to arrival," says Hoagland.

Carlisle gives these tips to use when shopping for

EXECUTIVE SUMMARY

After price estimation technology was implemented at Ohio Health, collections increased from $12.8 million in FY 2013 to more than $19 million in FY 2013.

- Patient-specific price estimates are produced.
- Estimates combine the payer's reimbursement and charge information.
- Estimates include the patient's prior balances.

a price estimate tool:

- Be sure the tool is "visibly pleasing to the eye, because some¬times data can get so overwhelming and hard to follow," she says.
- When implementing a solution, pricing updates and technical upgrades need to be carefully synched and thoroughly tested in a dedicated test environment before they go live.
- Continuously evalu¬ate the solution to make sure it is being used to the fullest extent possible.

"You need to continuously monitor enhancements to the solution and new ways that you can maximize benefits from its use," says Carlisle.

As patients become more accustomed to requesting information about out-of-pocket responsibility in advance of services being rendered, hospitals are likely to become increasingly dependent on the ability to provide pricing insight, says Carlisle.

"We need to give accurate estimates to our patients coming in, so that as consumers, they can make educated choices about the healthcare they want to have," she says. "You need automation to do that successfully." *(See related story, below, on how an automated eligibility tool resulted in increased collections.)*

SOURCES

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Collections are now at $540,000 monthly

Manual process is now automated

Before an automated tool for insurance eligibility and benefit identification was implemented at Wheaton Franciscan Healthcare in Glendale, WI, the collections process was "very manual," says **Terri Miles**, patient access manager.

"Previous to having this tool, we had just a single person working on point-of-service collection, using information provided by our precertification department," she reports.

A single person in each of the healthcare system's southeast Wisconsin markets used a grid prepared by finance that included procedures; the average costs, both contractual and total; and a benefit sheet. "This was prepared by our precertification department and sent their way, to manually calculate the patient's responsibility," says Miles.

While this process helped to determine patient responsibility for some high-cost services, employees were limited to using charts and graphs provided by finance to calculate the total charges. "Because we weren't using CPT codes, there were sometimes discrepancies between the estimate and what the patient actually owed," says Miles. "This tended to negatively affect patient satisfaction."

Tool determines estimate

With the technology, insurance eligibility, benefit identification, and the estimate process are now a standard piece of the preadmit/admission process.

"We use this same tool to determine the estimate using the expected CPT code and the facility's charge history," says Miles.

The goal is to talk to every patient who will have an out-of-pocket responsibility, even though services will not be denied if the patient chooses to be billed. "We also use this conversation to determine if a patient may need a payment plan for their portion or may possibly be eligible for any type of assistance," says Miles.

The department has set a goal to collect $648,000 per month. "Over the last six months, we averaged slightly above $540,000 per month, after having about 4,700 patients each month pay upfront," reports Miles.

In terms of associate productivity, the department's prior expectation of talking with four patients per hour has not changed. This expectation is despite the fact that additional responsibilities have been added, such as creating the estimate.

"With the technology the time needed to complete these processes usually hasn't taken that much more time to complete," Miles explains. ■

These collections tips are tried and true

Be 'natural, not mechanical'

When she first started collecting from patients, **Gabriele Thatcher**, CHAA, a patient financial advocate at University of Utah Hospital in Salt

Lake City, always gave a detailed explanation to the patients on what they owed, then asked if they thought they could pay some of that amount.

"But I have come to realize that each case is different. I need to use a personalized approach each time," says Thatcher.

Thatcher tries to make a personal connection with each patient. "I always try my best to be respectful and empathetic. Once I've done that, it's easy to collect," she says.

To overcome her hesitation of asking for money, for fear of offending the patient, Thatcher reminds herself that patients are expected to honor their financial obligations. "There is nothing wrong with asking for a payment from the patient upfront," she says. *(See related story, this page, on the department's biggest current collection challenge.)*

When **Ljupka Fuit**, a pre-service financial advocate at University of Utah Hospital, collects from patients, she is "natural, not mechanical." First, Fuit reviews the patients' insurance benefits and their estimated responsibility. Next, she tells the patients how much the insurance is being billed for.

"This way, they have a picture of how small their portion is compared to what the insurance pays," she says.

Lastly, Fuit tells the patients what their 10% discount is for pre-payment in full. Then she asks: "How would you like to take care of that?"

"If the patient hesitates, I explain that by paying upfront the hospital saves money by not sending multiple bills out to them; and that is how we can afford to give the 10% discount," says Fuit. She adds: "If this bill is coming, you might as well pay upfront and save some money."

Before **Vernesa Kronojelac**, an inpatient financial advocate at University of Utah Hospital, visits patients, she calls their rooms first. "This allows me to make sure that they are in a non-intensive care unit, since they have a phone by their bed," she says. "I never collect from a patient when they are in intensive care."

Kronojelac reviews the patient's insurance benefit, and mainly focuses on the remaining deductible and/or out-of-pocket cost. "I have had much success in collecting the full out-of-pocket remaining, by pointing out that they will get a 10% discount if paid in full today," she says.

Kronojelac says this final statement helps with collecting: "Either way, you will most likely have to pay your out-of-pocket by the end of your calendar year, with any follow-up services once you have been discharged. This way, you will get a discount by taking care of it now."

Upfront collection needs to be done "in a diplomatic way," emphasizes **Glenda Imes**, a registration manager at Ochsner Medical Center — North Shore in Slidell, LA. "If we do not present our request in a respectful way, we will hurt the relationship with the patient," she says. Imes says to follow these steps:

- Identify your top collector and have other employees shadow him or her.
- Send employees to other facilities to learn new collection techniques.
- Ensure your staff members know when to escalate, when they can make a decision themselves, and who the contacts are when a financial decision needs to be made.

"If your staff begins to flounder, the patient will quickly pick up on that," says Imes.

SOURCES

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EXECUTIVE SUMMARY

Successful collectors agree that requests for money should be respectful and matter-of-fact.

- Make a personal connection with each patient.
- Tell the patients how much their insurance is being billed for.
- Offer a 10% discount for pre-payment in full.

Collections to top $8 million in 2013

Difficulty getting pricing info is challenge

Cash collections for admitting, the emergency department and financial counseling at University of Utah Hospital in Salt Lake City totaled $2.7 million in 2010. This increased to $5.2 million in 2012, and topped $8 million for fiscal year 2013.

Patient financial advocate **Gabriele Thatcher**, CHAA, credits this increase to accurate insurance verifications and upfront estimated patient liability amounts. "Allowing for a 10% prompt pay discount has also motivated more and more patients to pre-pay for their services," Thatcher adds.

The biggest collection challenge her department faces is lack of access to "completely updated, accurate, consistent, and reliable" pricing data from which to pull price estimates, she says. For example, radiology costs are not pulled from the hospital's system, but rather, from a separate spreadsheet.

"Community clinics have their own and differing price lists that are used when giving estimates," adds Thatcher. "This can sometimes be confusing for patients." For example, radiology patients might need a procedure that is scheduled from a central location or phone number.

"There are cases where the patient is sent to a community clinic due to availability, but was already given a price estimate for a 'hospital' location," says Thatcher.

Another example is of patients requesting a price estimate for a specialist new patient consultation before deciding whether to schedule an appointment. "Unfortunately, we are giving them a very broad answer with a price range of between $150 and $550, because we just do not know," says Thatcher.

This range is because the CPT code selected is left up to the physician and is selected based on the level of care the patient will require. Thatcher expects the hospital's health information system will help to address these issues.

"More and more people are 'price shopping,'" says Thatcher. "I am excited for the prospect of using Epic to help us with these challenges in the near future." ■

1% of net revenue: Tools needed to do it

Bad debt is increasing

Technology makes the difference between hospitals that excel at upfront collections and those that do "just OK," says **Patrick Teta,** a senior consultant with Revenue Cycle Solutions in Pittsburgh. He says the tools top performers in patient access are using include:

- real-time insurance verification to determine eligibility, coverage limits, coinsurance, deductibles, and co-pay amounts;
- payment estimation tools to determine coinsurance amounts;
- patient risk scoring to determine a patient's ability to pay;
- point-of-service cashiering, to post payments real-time to patient accounts and provide receipts;
- Internet-based credit card services, which turn each registration personal computer into a credit card terminal. "Top performers take advantage of all the functionality including setting up recurring payments," says Teta. *(See related story on one department's quest to offer patients electronic payments, p. 8.)*

If hospitals don't have a good process or tool to determine what the patient's deductible or coinsurance might be, Teta warns, they're limited to collecting only co-payments. "It takes a lot of $25 co-pays to equal some of the large coinsurance and deductible amounts," he says.

Depending on payer mix, a typical hospital with good tools, good processes including a financial clearance policy, and incentivized staff should be able to collect 1% of net revenue, according to Teta. "All three areas are key. However, a lack of technology will make that 1% of net revenue number nearly impossible to meet," says Teta. "This could amount to hundreds of thousands of dollars, even for a smaller community hospital."

More bad debt

Ken Perez, a Menlo Park, CA-based healthcare IT and policy consultant, says that with healthcare reform, patient financial responsibility is increasing sharply, "which will undoubtedly lead to more bad debt."

The Middle Class Tax Relief and Job Creation Act of 2012 reduced Medicare bad debt reimbursement for non-critical access hospitals from 70% of allowable bad debts to 65% for 2013 and beyond, notes Perez.

One revenue cycle expert recently projected that bad debt could swell to $200 billion by 2019.[1] "In 2011, U.S. hospital bad debt totaled $24.2 billion. That works out to about $5 million for the average

EXECUTIVE SUMMARY

To excel at upfront collections, patient access need real-time insurance verification, patient risk scoring, and payment estimation tools, according to revenue cycle experts.

- Hospitals need to determine deductibles or coinsurance amounts.
- Bad debt is expected to increase, due to more patient responsibility.
- Hospitals should be able to collect 1% of net revenue.

hospital," says Perez.[2]

Integrated system ideal

Ideally, hospitals should employ a single system that integrates multiple information sources and guides patient access staff with "an intelligent, logical workflow that ensures efficient financial counseling," says Perez.

For most U.S. hospitals, the front end of the revenue cycle involves numerous disparate systems, most of which are not integrated into a logical workflow, says Perez.

To collect successfully, Perez says patient access areas need to do the following effectively: patient demographic verification, charity eligibility screening, eligibility and benefits verification, and patient payment estimation. "Studies show, and it stands to reason, that patients who make some payment upfront are more likely to respond positively to subsequent invoices," says Perez.

REFERENCES

1. Hanson SM. Best practices for managing consumer payments in the current environment. Presented at the Healthcare Financial Management Association National Institute 2013. Orlando; June 2013.
2. American Hospital Association. Uncompensated Hospital Care Cost Fact Sheet. Chicago; 2013.

SOURCE

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Patients to have Web, bedside pay options

Currently, patient access leaders at Palmetto Health Richland in Columbia, SC, are researching various technologies to assist in taking electronic payments.

"As we grow our market, it becomes increasingly difficult to collect payment on the back end of the revenue cycle," says **April C. Robinson**, MBA, MHA, patient access manager.

Once the insurance is billed and pays, the likelihood of collecting any additional monies decreases significantly, she explains. "As we move into the future of healthcare, however, we are looking at means to make those payments on the front of end of the revenue cycle," Robinson says. "This will increase the chances of collecting."

By having the technology to collect electronically, patients are offered better options and an easier solution, says Robinson. Patient access areas are working hard to expand web payments throughout the facilities, as well as bedside payment options for medications in pharmacy areas.

Some of the obstacles they face are the need to work through multiple computer systems, patients making check payments over the phone, and portable credit card payment devices that are not integrated with registration systems. "Being a large healthcare facility, we are faced with the challenge of having too many computer systems to do one job: register our patients," says Robinson.

This setup poses a challenge for electronic payments, because no one system communicates with another system 100% of the time. "We are often left with using aged devices that prolong our processes," says Robinson. "This takes up our patient's valuable time." ■

Teach staff to fix collection mistakes

Don't focus only on failures

If patient access employees know they're expected to request money upfront, but don't know how to go about doing so, they can become quickly frustrated.

"If their failures to collect are pointed out, but no instruction on how to correct their mistakes is given, the department suffers and morale lowers," says **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City.

Managers should provide opportunities to learn how to avoid errors and missed monies in the future, instead of just focusing on the failure, says Robison. They should also explain why collection is important for the hospital. "If I don't understand why I'm asking for money from a patient, the patient is not going to understand why they should pay anything at the time of service," he says.

Robison uses role playing to put employees in the patient's shoes. "That gives them a better understanding as to why someone might be so disagreeable about paying a bill," he says.

It also gives staff an opportunity to practice various ways of explaining why copays need to be paid upfront or why balances need to be paid off before receiving treatment. "Freely acting out situations where unhappy patients are unreasonable, in a safe environment away from any possible negative patient reactions, helps greatly when dealing with similar events," says Robison.

At a recent staff meeting, the team was split into equal groups. One group represented the patient, and the other represented patient access representatives. Staff members sat across from the "patients" and were given situations in which they would request money owed for services rendered. "What this taught me is that even if the patient has the saddest story to give, the patient access representative is always able to counter with an option," says Robison. Payment plans or other funding methods such as Medicaid might be suggested, for example.

"For me, that was the biggest takeaway," Robinson says. "You don't always need to focus on one way of getting payment from a patient. There are always other options."

More confidence

Heather Bent, a patient access manager in the emergency department at Florida Hospital in Orlando, uses peer shadowing, role playing and skills labs to train her staff in collections.

"Lack of training breeds lack of confidence," she says.

Bent develops an individualized action plan for what the representative needs to work on specifically. Next, a follow-up session is scheduled to see how the individual has progressed.

"Being confident, and knowing how to answer patient questions, is key to making them trust that they are being given the correct information about their benefits and responsibility," she explains.

Training representatives on all of the different payment options is also key. "Otherwise, the patient may leave without a payment arrangement for their balance being set up, and the likelihood of obtaining the full balance decreases," says Bent.

Teaching patient access representatives the basics about insurance and getting them comfortable with the terminology is also essential, says Bent.

"Representatives that connect with the patient on a personal level and provide a top-notch patient experience tend to be the most successful in this role," says Bent. *(See related stories on learning from top collectors, below, and how pre-service center staff members were trained to collect, p. 10.)*

EXECUTIVE SUMMARY

Patient access leaders should explain to employees why collection is important to the hospital and instruct staff on how to correct mistakes.
- Give staff an opportunity to practice responses to negative reactions. Have one group represent patients and the other represent patient access employees.
- Teach staff to offer various payment options to patients.

SOURCES

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Have staff members learn from top collectors

They have 'insider' knowledge

One of the most powerful tools to use when requesting monies from a patient is silence, says **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City.

When asking for a copay, he says, "It looks like you have a $40 copay due today. How would you like to pay it?" He then waits patiently for the patient to respond.

"Waiting for patients to break the silence, instead of doing so myself, usually results in them responding with a form of payment," he says.

Robison says if he were to break the silence first by saying, "Are you able to take care of this today?" "then the patient has been given an easy out of the responsibility, by simply saying that they cannot pay anything at that time."

Robison suggests looking within the department for someone who successfully collects from patients, so others can learn from that person. "Having a fellow coworker give tips or advice on how to better collect from patients could possibly work better than an outsider," he says. "Your coworker knows the intimate workings of the department."

Working alongside a successful collector can also

give a team member phrases or methods that they didn't know about before, at a very low cost to the department, he says.

Robison says that the simpler your approach, the more likely you will collect from a patient. "Both tone of voice and eye contact can make or break your opportunity for getting anything from a patient," he adds.

By maintaining eye contact and voicing your request in a steady and firm manner, Robison says you are communicating to the patient that this request for money is part of their responsibility and participation in their care. He uses these words: "Your insurance has determined that for a certain procedure your responsibility will be XX."

By telling a patient this information, Robison reminds the patient that the insurance company makes the rules as to what amount the patient pays. "The healthcare provider doesn't determine what you will owe. That's up to your coverage plan," he says. ■

Training is key to pre-service center

Employees more comfortable collecting

Greensboro, NC-based Cone Health Systems recently revamped its processes for upfront collections and reduced denials for scheduled surgeries and outpatient appointments by creating a new department named the PreService Center.

"Some benefits of the PreService Center include educating our patients prior to the visit of their benefits, copays, out-of-pocket amounts, and co-insurance responsibility," says **Sebrena Johnson**, team lead specialist. "Due to the training, staff are more confident in their new roles. They have a better understanding of the necessity of upfront collections and reducing denials."

The PreService Center staff receives ongoing training on customer service and effective collection processes, including verification of insurance and using credit card machines. "We are noticing successful results are coming from educating the staff and making sure staff are prepared with accurate information prior to contacting the patients," says Johnson.

The PreService Center is collecting for outpatient and inpatient surgeries and outpatient scheduled appointments for MRIs, CT scans, ultrasound, and vascular studies.

Employees are more comfortable in collecting because they can explain the information to the patient with greater confidence.

"Even though our collections have increased immensely, there is still opportunity to bring in more revenue," says Johnson. "It is an ongoing training and learning process." ■

Offer incentives to top collectors

In 2012, patient access staff at OSF Healthcare in Peoria, IL, collected 69 copays and about $2,900. In 2013, they collected 376 copays and more than $30,000.

"We collect copays for our high-dollar tests: MRI, CT, and cardiology services. We are not currently collecting any payments on low-dollar accounts," says **Jacqueline Doerman**, MBA, patient access services manager in the hospital's Patient Accounts & Access Center.

Incentives are the primary reason for this dramatic increase, according to Doerman. "We have different incentives for staff throughout the month for copay collection," she says. These are as follows:

- Any employee that collects anything at all receives a "care coupon" worth $2 at the gift shops or eateries at the hospital.
- The second through fifth top collectors get a "Wow" coupon that is worth $5, and it can be turned in for a variety of gift cards.
- Doerman treats the top copay collector to lunch.

This lunch allows her to interact with the employee and get to know him or her on a personal basis outside of work. "It is also a time for them to get away from the facility and go eat at their favorite restaurant. I pay for it out of my pocket and have really enjoyed it," she says.

Doerman has taken some employees that have been distant with her to lunch. After sharing stories of their children and family, she has grown closer to them as a result.

EXECUTIVE SUMMARY

After implementing incentives in 2013, OSF Healthcare collected more than $30,000 in copays, up from $2900 in 2012. Some low-cost incentives:
- coupons for hospital gift shops/eateries;
- treating top collectors to lunch;
- gift certificates for winning collection contests.

"I think it helps the morale of the employee, as well as my relationship with them," she says. "They begin to realize that I care about them from a personal perspective, not just work."

Sustained results

Javohir Sahler, a patient access assistant manager in the emergency department at Florida Hospital East Orlando, says, "Incentivizing employees is one way to motivate them to perform at a higher level and therefore sustain their positive results."

At Florida Hospital East Orlando, registrars receive these incentives:

- monetary incentives ranging up to $300 based on monthly performance, including collections, productivity, and accuracy;
- gift certificates ranging from $5 to $25 for winning various announced or unannounced friendly contests such as the most payment plans, the most receipts, or the most dollars secured;
- Florida Emergency Physician incentives. This organization rewards the top four ED representatives for their collections by allocating $200 each month for incentives;
- Gift Shop Program. Based on performance, employees accumulate points that have a value equal to the same number of dollars and use the "dollars" to purchase items from the department "gift shop." Managers keep a small selection of snacks, candy, notepads, and pens on hand for employees to "purchase."

"This one is the most cost-effective method. We are able to keep the items interesting and appealing, and not too expensive," says Sahler.

To get the most out of incentives, Sahler says to set clear targets and follow through when desired results are achieved. Individual and team incentives can be effective, depending on the type of goal or target set by the patient access leader, says Sahler.

"When employees have low team chemistry, they are more likely to work harder toward an individual goal," says Sahler. "It's always better when the team is able to work together, contribute to the bigger picture, and earn their incentives that way."

SOURCES

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Provision of Obamacare fuels sticker shock

When setting premiums for 2014, insurers baked in bigger-than-usual adjustments, driven in large part by a game-changing rule: They can no longer reject people with medical problems.

Popular in consumer polls, the provision in the health law transforms the market for the estimated 14 million Americans who buy their own policies because they don't get coverage through their jobs, according to Kaiser Health News. Barred from denying coverage, insurers also can't demand higher rates from unhealthy people and those deemed high risks because of conditions including obesity, high blood pressure, or a previous cancer diagnosis.

But the provision also adds costs. To a larger degree than other requirements of the law, it is fueling the "sticker shock" now being voiced by some consumers about premiums for new policies, say industry experts.

In setting the 2014 rates, insurers must factor in "assumptions about who will sign up: high users or healthy people," said **David Axene**, a fellow of the Society of Actuaries. "You can imagine who most of the health plans thought would be predominantly signing up."

Regulatory filings and comments from insurers show they expect that accepting the sick as well as the healthy could raise their claims costs 5% to 50% or more this year. That "would be the largest single factor" at Blue Shield of California, accounting for about a 20% increase in expected claims costs, said **Mike Beuoy**, director, actuarial services.

The focus on premiums heightened in November amid news reports about large numbers of individual policyholders nationwide who are learning that their current plans are being discontinued and they must choose a new policy.

To be sure, there are other factors affecting premium cost changes. For one, the law requires insurers include 10 benefits deemed essential by the law, including hospitalization, drugs, maternity care, and

COMING IN FUTURE MONTHS

- ■ Increase productivity with cross-training
- ■ Avoid problems before switch to ICD-10
- ■ Get all registrars CHAA-certified
- ■ Tie staff pay to their evaluations

mental health services, benefits not all plans sold to individuals currently include. Indeed, this change is one of the major reasons insurers cite for discontinuing policies. Another provision caps consumers' annual out-of-pocket costs to no more than $6,350 for individuals or $12,700 for families, which could add to premiums as well.

Insurers must also charge men and women equally, and they are limited to charging older Americans no more than three times what younger policyholders are charged, which is considerably less than they could before in many states.

Altogether, those changes for some consumers might mean a sharp increase in premiums between their soon-to-be discontinued policies and new ones being offered them by insurers, even for similar plans.

Still, despite the factors that can drive up premiums, including medical inflation, not all consumers will see higher prices. The health law rules mean people who are older and sicker might see a drop from what they're paying now. And about half of consumers who currently buy their own policies will be eligible for a subsidy to help offset the premium cost, according to a study released in August.

BlueCross BlueShield of Illinois spokeswoman **Lauren Perlstein** said that the health law will "expand access to health care coverage for millions and may offer additional benefits for many [and] … the impact on premiums may vary widely."

The changes make the so-called individual market more comparable with the way insurers price and offer coverage to employers, where rules have long been in place barring them from rejecting employees with health conditions. Employer coverage also generally covered more benefits with lower deductibles and fewer restrictions than policies purchased by individuals, who sometimes did not realize the limits of their coverage.

Michael Lujan, a health benefits consultant and former director of sales and marketing for Covered California, the state's new online marketplace, said, "We as consumers may not know just how lacking our current policies are because it seemed like a good value and we didn't use it much."

The less their policies covered previously, the more consumers' premiums are likely to rise, experts say. Georgetown University research professor Sabrina Corlette said that while adding some benefits only costs "pennies on the dollar," others are more expensive. A Maryland Health Care Commission report from 2012, for example, said the state's requirement that insurers include maternity coverage added about 4% to the cost of a premium. ■

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