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Respond to these ACA problems — Access must revamp processes

Patients presenting with incorrect information

Even if the patient standing in front of you obtained coverage on the Health Insurance Exchange Marketplace, the claim still could end up being denied.

"There are several reasons for this," says **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access at St. Joseph's Wayne Hospital and St. Joseph's Regional Medical Center in Paterson, NJ.

Staff members might be unfamiliar with authorization requirements of the new "exchange" plans. In other cases, payer plan system upgrades aren't working correctly. "We submit the information via the payer portal as required, but do not get a response back via the portal," Rivera explains. "In those cases, we end up calling the payer to follow up." This process causes delays, due to lengthy hold times.

Some "exchange" plans now require referrals in addition to authorizations. **Jill Eichele**, CHAA, manager of patient access services at Littleton (CO) Adventist Hospital, says, "This has caused our pre-auth process to take longer in some cases. This could potentially create a delay in getting the patient in for their test."

Many newly insured patients have little or no understanding of what

HAM focuses on healthcare reform

This month's issue of *Hospital Access Management* is a special issue on how patient access process have changed as a result of the Affordable Care Act. Inside, we report on strategies to: avoid claims denials, help patients concerned about the cost of care, provide financial counseling earlier in the process, decrease bad debt, identify the correct plan, and comply with new requirements for financial counseling. We hope you enjoy our special coverage of this timely topic.

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their plan covers or what their responsibility is, says **Betty Bopst,** director of patient access at Mercy Medical Center in Baltimore, MD. "Patients often do not have their insurance cards with them and have difficulty telling the staff which plan they have," Bopst reports. "Lengthy discussions with patients can cause quite a backup in the high-volume areas."

Some claims are denied simply because staff members don't read the entire eligibility response. "This occurs when a plan has been terminated or changed, but the information hasn't caught up with the eligibility system, and the patient hasn't provided the correct information," Bopst says.

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In some cases, patients already have switched to a different plan than their insurance card indicates. "If the member has gone in and out of one of the plans and we fail to obtain authorization, we appeal the denial," says Bopst. "But it is most often upheld."

Registrars at St. Joseph's Wayne Hospital and St. Joseph's Regional Medical Center work scheduled cases ahead of time, so payer issues can be resolved before the patient comes in.

"Our goal is to do it correctly the first time," says Rivera. These steps are taken:

- notifying the physician offices if authorization wasn't obtained;
- verifying with the payer that the authorization is for the correct site, procedure, and date;
- documenting the verification of information and when the physician and patient were notified.

Rivera has worked with the hospital's director of contract management to resolve ongoing problems with payers' system upgrades. "The approval logs stopped coming," she explains. "We were following up three or four times on the notification of admission."

Rivera set up quarterly in-person meetings with payer representatives, and she ensured she sent information on problems with specific claims ahead of time. "This way, they can research it and bring the outcome to the meeting," she says.

Most patients are unaware that a hospital isn't necessarily contracted with their particular plan.

"We are trying to do our best to catch them before the patient comes in," says Eichele.

Quality reports were built into the department's system to catch non-contracted plans ahead of time, for accounts that are pre-registered. "One thing it checks for is certain alpha prefixes in the subscriber policy number," says Eichele. "If that alpha prefix is identified with a certain payer code that we are not contracted with, it hits the report."

Staff members then are able to notify the patient prior to arrival. "This has been especially challeng-

EXECUTIVE SUMMARY

Due to changes resulting from the Affordable Care Act, patient access departments need revamped processes to prevent the following: claims denials, increased wait times, and patient dissatisfaction.

- Many patients lack understanding of their coverage.
- Some payer system upgrades are not working correctly.
- Patients need to be informed if the hospital is not contracted with their plan.

ing if patients came to us before, when they had a different insurance," notes Eichele. Patient access staff members must explain why the patient needs to go to a different facility.

Another challenge involves the grace period that patients are given when paying premiums for "exchange" plans. "Their insurance shows as active, even if they are not current with their premiums," explains Eichele. "If they don't get current, we could see take-backs from the payers down the road."

Access staff now have to ask payers, "Is the member current with their premiums?" when they are inquiring about benefits and authorization. If the answer is "no," staff members discuss this issue with the patients before they come in. If the patients are not current with premiums, patient access staff ask them to sign a waiver stating that they understand that if they do not become current, they would be changed to self-pay status.

"We have also worked directly with payers in addressing some of the issues we had early on," says Eichele. "We have been able to come up with some good solutions."

One payer required the patient's primary care physician to be called for a referral for a diagnostic test, even though a specialist was ordering the test and the primary care physician already had referred the patient to the specialist. After discussing the problem, the payer agreed that a second referral from the primary care physician was not needed.

"We are able to generate the referral ourselves online," says Eichele. "This saves us a lot of time and a lot of extra phone calls." ■

'Doctor, how much will that cost me?'

Patient access employees at Virginia Mason Medical Center in Seattle moved "from a reactive to a proactive process" for having financial conversations with patients, according to **Amber Reeff,** director of patient access systems.

"This is a major initiative for our revenue cycle," Reeff reports. "Our patients are becoming much more savvy, and their out-of-pocket expenses are much higher due to the Affordable Care Act."

Increasingly, providers are fielding questions about cost from their patients, many of whom purchased high-deductible plans on the Health Insurance Exchange Marketplace. **Monique Gatterson,** supervisor of patient financial services, says, "Patients want that concrete information. They want to know, 'If I go and have this procedure, I am not going to go into debt.'"

It typically isn't possible for providers to tell patients what their out-of-pocket cost will be, says Reeff. This cost depends on many factors, including the hospital's contracted rate, the patient's benefit structure, and discounts given to self-pay patients.

Patient access put together a "cheat sheet" for providers, listing out-of-pocket costs of a colonoscopy for various insurance plans. "The feedback that we got from providers was that they were worried that by disclosing this information, that the patient may put it off or refuse to have the test," says Gatterson. "This puts the provider in a bind."

Financial counselors and providers formed a partnership. "Our providers do need to feel comfortable with having a basic financial conversation with the patient," says Gatterson. "But they reach out to the financial counselors to have a more extensive financial conversation."

The financial counselors give patients options to pay their out-of-pocket responsibility. "This helps ease the fear of 'Can I afford to move forward?'" says Gatterson.

The clinical care team contacts financial counselors for assistance when patients have concerns over cost.

"We are in the process of embedding the financial counselors into the clinic flow," reports Reeff.

When questioned about payer requirements and high deductibles, "providers feel a little helpless," Reeff says. Once the financial counselor becomes involved, the provider might be able to come up with a less costly treatment plan that does not compromise quality of care, such as prescribing a generic drug instead of a name-brand.

"We are moving those conversations to the very

EXECUTIVE SUMMARY

Patient access departments are moving the financial counseling process to the point of scheduling and helping providers to address patients' concerns about the cost of care.

- Financial counselors can inform patients of out-of-pocket costs in providers' offices.
- Providers might be able to offer a less costly alternative.
- Patients obtain assistance in a single phone call prior to the scheduled service.

beginning," says Reeff. "When the doctor comes up with a treatment plan, it includes the financial piece." *(See related story, below, on other changes the department made to its financial counseling processes.)* ■

Revamp process for financial counseling

Previously, all financial counseling at Virginia Mason Medical Center in Seattle was done on the hospital's main campus. It wasn't offered at the organization's seven outpatient medical clinics.

"If anybody needed a price estimate, help paying a bill, or even help with a Medicaid application, they would have to do that by phone, which patients weren't always happy with," says **Amber Reeff,** director of patient access systems.

Financial counselors now are available at every location. "Standardized processes are used, so all patients get the same information," says Reeff. Here are other changes the department made to its financial counseling processes:

• A new price estimate tool is being implemented.

"We had a previous estimate tool, but it did not pull in the patient's deductible, coinsurance, or what they paid to date," says Reeff. "With this tool, we believe we can get to 99% accuracy."

Previously, most patients scheduled for surgery didn't give much thought to out-of-pocket expenses, reports **Monique Gatterson,** supervisor of patient financial services, "but patients are now coming in with detailed questions," she says. "We notice that our patients are really trying to plan now. We will be able to give real-time costs for their out-of-pocket."

The new tool is TransUnion Healthcare ClearQuote, manufactured by Chicago-based TransUnion.

• All financial counselors obtained certification as in-person assisters for the Health Insurance Exchange Marketplace.

"Whether patients are in our hospital or they are just calling and shopping around, we can assist them with obtaining insurance," says Reeff. "This has been a great benefit to our patients."

• The financial counseling team was expanded to include outreach.

The outreach team contacts all patients with scheduled procedures or surgeries. "Previously, we would only do the registration component," says Reeff. "Now we are also having the financial conversation with the patient."

This "pre-admit" registration includes a discussion about the patient's out-of-pocket costs. "We are setting expectations, so that patients are not getting the bill after the fact," says Reeff. "The worst thing is to have that conversation when the patient is onsite."

In some cases, patients can obtain assistance right away. "Maybe the patients just lost their jobs and they qualify for charity," says Reeff. "If so, the person on the phone will assist them right there, instead of another handoff."

This system gives patients enough time to make payment arrangements or obtain assistance. "We refrain from using the word 'can't." We say, 'Here's what we can help you with,'" says Reeff. "It may not be exactly what they want, but we can always offer some help."

Some patients report that they already called the payer and were told that no authorization was required for a certain procedure. Financial counselors might discover that in fact, the procedure is not a covered benefit, which is something even savvy patients would be unlikely to ask.

"One thing we forget is that we have a different language," says Gatterson. "We can't talk in our lingo. We have to talk in patient's terms."

Patients need help determining what a quoted "cost" or "price" of a procedure means to them specifically. "Patients don't just want a raw number. They want to know what it means for their out-of-pocket cost," says Gatterson. ■

Payers are shifting liability to patient

Changes under the ACA are `call to action'

Many hospital leaders expect that the Affordable Care Act (ACA) will increase bad debt, but "it is early in the game to know the extent of bad debt increases," says **Katherine H. Murphy,** CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Passport, part of Experian, a provider of technology for hospitals and healthcare providers. Murphy is seeing these trends in patient access areas:

• High-deductible plans and patients' increased out-of-pocket costs are increasing the potential for bad debt.

"As patient balances rise, so does bad debt,"

says Murphy. "As bad debt grows, so does the cost to collect."

• Payers aren't consistently providing Health Insurance Exchange Marketplace information in their electronic eligibility transactions.

"This makes identification of these patients more difficult at the onset," says Murphy.

• Payers often are slow to divulge information on whether patients have their premium paid up to an end date or whether a patient is in the "grace period" with coverage pending the patient's payment of premiums.

"Hospitals have received conflicting information as to whether premium payments can be made by providers on behalf of the patient," says Murphy.

Some patients receiving services during the "grace period" will never pay another premium. "Therefore, the hospital will ultimately have to refund the payer and try to collect from a patient who is not likely to pay them either," says Murphy.

Hospitals are giving patients deep discounts for self-pay portions, she adds. However, these might not be enough to deter the account balance from getting classified as bad debt.

Create "collections culture"

Once service is provided to a patient, "the cost to collect goes up, and the likelihood of collecting it goes down," says **Paul Shorrosh**, CHAM, founder and CEO of AccuReg Front-End Revenue Cycle Solutions in Mobile, AL.

Patient access must be "empowered with systems, processes, and people to create a 'collections culture,'" he urges. "This does not mean sacrificing the patient experience."

In fact, patients appreciate knowing what their liability will be and having a plan for how they are going to pay for it, says Shorrosh. "We must consider the ACA's impact on our patient population," he adds. "Liability is shifting to the patient."

More uninsured patients have insurance, he explains, but most patients are now underinsured and face higher deductibles, coinsurance, and co-pays. Whereas in the past, hospitals collected 80% of expected reimbursement from payers and the remaining 20% from patients, "now they collect 60% from payers and 40% from patients," says Shorrosh. "And that ratio may turn out to be 50/50 in the near future." *(See related story, below, on how patient access can decrease bad debt.)* ■

EXECUTIVE SUMMARY

Hospitals' bad debt is expected to increase due to such factors as higher out-of-pocket costs and failure of patients to pay plan premiums. Patient access can minimize bad debt by doing the following:

- Clear patients financially prior to scheduled services.
- Automate eligibility verification and financial screening.
- Offer online options for bill payment and financial assistance applications.

Take these steps to reduce bad debt

Dramatic changes in healthcare are a "call to action" for patient access, warns **Katherine H. Murphy,** CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Passport, part of Experian, a provider of technology for hospitals and healthcare providers.

"You cannot expect to operate the same way and hope for different outcomes," Murphy says.

Patient access departments can take these steps to prevent bad debt:

• Have a comprehensive process to clear patients financially prior to scheduled services.

If patient access doesn't have this in place, says Murphy, "they need to develop one immediately or move to outsourcing the management of this process."

• Implement automated solutions to streamline eligibility verification, patient identity verification, financial screening, and charity application processes.

"Optimize financial stratification of accounts at the earliest point in the process," advises Murphy. "Don't let the account become a bad debt in the first place."

• Prioritize which accounts should receive the most attention and what kind of attention (letter, bill, or phone call) they should receive and at what intervals.

"Minimize the bad debt opportunity, and work with the patient for best payment outcomes," says Murphy. "Doing this at the pre-service point or point of service — or prior to discharge, if an inpatient — is most effective."

• Offer user-friendly solutions such as web-

based patient portals.

"Meet consumer expectations with online bill payment, communication, and financial assistance application processes," says Murphy. "This will add another protective layer for the bad debt potential."

Empower registrars

As much as 30% to 50% of bad debt likely could have been prevented through front-end denials prevention prior to service, estimates **Paul Shorrosh**, CHAM, founder and CEO of AccuReg Front-End Revenue Cycle Solutions in Mobile, AL.

According to Shorrosh, another 20% to 30% could have been diverted to charity, Medicaid, exchanges, disability, third-party coverage, prompt-pay discounts, self-pay discounts, or extended payment arrangements or charged to available credit balances, paid through nonrecourse loans, or handled through other financial options.

"For both patient experience and the revenue cycle, patient access teams at every hospital in the country must change from 'collection reluctance' to a 'collections culture,'" says Shorrosh.

This change requires top-down support, training, and scripting, he says, as well as automated systems for estimation, collections, and financial assistance.

"Systems have to be simple enough so that every registrar —and more importantly, pre-registrar — can divert bad debt before service is provided," Shorrosh says. She says patient access systems should have these capabilities:

• Systems that automatically check all self-pay patients for undisclosed coverage from top payers.

"This alerts your registration or pre-registration employee to flip the plan code from self-pay to a payer code when coverage has been found," says Shorrosh. "We find that 5% to 15% of self-pays already have insurance."

• Systems that alert registrars of the amount patients can pay on a payment plan.

If an uninsured or under-insured patient scheduled for outpatient surgery cannot afford to pay the estimated $5,000 liability, but can afford to pay $1,000 in 10 monthly payments based on their credit and income scores, says Shorrosh, "the likelihood of payment versus nonpayment is much greater."

"There is a 'tipping point' where patients are likely to pay nothing when faced with a sum that is completely out of their reach, as opposed to paying what they can afford," says Shorrosh.

Hospitals would much prefer to receive $1,000 over time than nothing, with the added cost to collect ending in a bad debt write-off, he says. "This bad debt diversion and increased point-of-service collection can both be accomplished during registration or pre-registration," he says.

• Systems that automatically alert registrars that prior authorization is required for a procedure, prior to the patient's arrival, or that the patient's eligibility, identity, or address is in question.

Some alerts tell pre-registrars that there is no eligibility with the insurance carrier for the date of service, that there is hidden coverage with a different payer, or that the patient's benefits are limited or exhausted. The system tells the registrar what options to offer the patient, based on their financial status.

"Now you're empowering a registrar to reduce bad debt prior to service, and at no additional back-end cost to the health system," says Shorrosh. "It's happening already, and new innovations are coming to market." ■

Face denials if you don't ID right `exchange' plan

Patients risk large out-of-pocket costs

Patient access leaders at Wheaton Franciscan Healthcare in Glendale, WI, worked hard to educate staff on the new plans available on the Health Insurance Exchange Marketplace.

Carriers typically provide many different "exchange" plans, each with different levels of benefit offerings, explains patient access manager **Terri Miles**. "If the plan a patient participates in is not clearly identified upfront, it could result in a huge out-of-pocket for the patient," she says.

This situation could end up as bad debt if the patient doesn't have the means for payment. "This ultimately affects the facility's financial viability," says Miles. Reduced patient satisfaction is another concern. "Patients expect us to be the experts. They expect us to be able to provide this information to them," says Miles.

Patient access staff lose credibility with the patient if the patient's out-of-pocket cost is higher than the original estimate because an incorrect plan was selected, she adds.

Tami Cheatham, patient access services repre-

EXECUTIVE SUMMARY

Claims denials will result if patient access staff incorrectly identify the correct payer when patients present with coverage obtained on the Health Insurance Exchange Marketplace.
- Post sample cards on the hospital's intranet for patient access employees to refer to.
- Make carrier phone numbers available to staff.
- Flag plans as "out of network" so patients can be informed upfront.

sentative III at OSF Healthcare in Peoria, IL, says, "As insurance cards are constantly changing, this makes it difficult to choose the appropriate plan codes." When contacting patients to pre-register them for scheduled services, OSF Healthcare's registrars sometimes ask if there any identifying icons on the card. This question sometimes helps them pinpoint the correct plan.

Patient access managers at OSF Healthcare also display actual cards of new "exchange" plans so staff can easily identify those plans, says Cheatham. (*See related stories, p. 80, on giving staff "visuals" to identify plans and identifying which plans are out of network, right.)*

Selecting a plan code is one of the major steps that patient access staff members are responsible for, emphasizes **Connie Longuet**, MBA, MHA, CHAM, director of patient access services at The University of Texas M.D. Anderson Cancer Center in Houston. "If we don't get it right, everything is wrong from that point forward," Longuet says. Problems include wrong claim routing, missed filing deadlines, and manual rework for the billing department. "Patients may be dissatisfied if their claims aren't resolved correctly and quickly the first time," adds Longuet.

Denials are avoided

OSF Healthcare's patient access managers did a focused audit recently specifically to identify incorrect plan codes.

Jessica Atkinson, project specialist in engineering administration, said, "We looked at every single account that came into our outpatient center in a certain timeframe. Just by doing that, we have caught a lot of errors."

Any incorrect plan code that was verified gets sent back to the employee who made the error, so that he or she can go back into the system to correct it, says Atkinson.

At Wheaton Franciscan, patient access managers made carrier phone numbers available to staff. "We verify eligibility and provide cost estimates to our patients upfront," explains Miles. "If a payer is not automated through our computerized eligibility tool, we do have to make verbal outreach."

During these calls, staff members verify that a patient is eligible for coverage and that the policy and/or group number is accurate.

"We review the benefits available for the service to be provided, so we can complete the patient estimate," says Miles. ■

Out-of-network plans must be identified

Patient access informs patients upfront

Wheaton Franciscan Healthcare in Glendale, WI, is participating in only two of the plans available on the Health Insurance Exchange Marketplace.

This participation in two plans means that patient access employees must explain to some patients that the hospital is not "in network" with their plan.

"This has increased the amount of communication we are needing to do with our patients, whether they are new to our organization or have come to us previously," says patient access manager **Terri Miles**.

The new "exchange" plans were added to the Wheaton Franciscan's computer insurance dictionary. "These reflect 'out of network' when we do not participate in that carrier network," says Miles. "A simple 'OON' was added to the end of the carrier name."

When "OON" is seen, anyone in patient access, whether a scheduler, registrar, or financial counselor, informs the patient that they are out of network. They explain that if the patient chooses to have services at Wheaton Franciscan, they will have a higher out-of-pocket cost. "As we are not always sure of what the insurance will pay — an out-of-network benefit level or no payment at all — we provide the patient with estimated charges for the total service," says Miles. "We make no promises around payment or discounts."

Staff members tell patients, "We have identified that Wheaton Franciscan Healthcare is not an in-network provider for your services. While you can receive your services here, you need to be aware you will have a higher out-of-pocket responsibility

than if you were to use an in-network provider. To verify in-network providers, you will want to follow up with your insurance agent or carrier directly."

Registrars at The University of Texas M.D. Anderson Cancer Center in Houston document whether the patient's plan is in or out of network on the benefits screen. "We provide patients with a written insurance summary that has the benefit levels listed on it," says **Connie Longuet**, MBA, MHA, CHAM, director of patient access services. The hospital is contracted with several "exchange" plans.

"At first, it was slow confirming eligibility," says Longuet. "Some payers were backed up on loading benefits, but it is pretty much back to normal times now."

Patient access leaders are at Wheaton Franciscan are reaching out to insurance plans for special consideration of extending in-network coverage for those patients who were in a course of treatment at Wheaton prior to choosing their new plan, reports Miles. Patients often are unaware of the limitations that "exchange" plans impose on where they obtain care, she says, especially those who are newly insured.

"We all know healthcare is a complicated business," says Miles. "We now have a lot of people selecting healthcare plans for maybe the first time." ■

Give access staff a `visual' for plans

Patient access leaders at The University of Texas M.D. Anderson Cancer Center in Houston created a visual tool in 2013 to help staff to determine the correct payer.

"It looks like a Jeopardy board. It was designed by a group of front line staff as a 'fun' way to get to the correct answer in as few clicks as possible," says **Connie Longuet**, MBA, MHA, CHAM, director of patient access services. *[The screen shots used by the department are included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

The tool is accessible to all patient access staff. "It is updated frequently," says Longuet. "Staff open it in the morning and keep it open all day as they load new insurance plans."

The tool gives patient access staff an easy way to select the correct plan code among the hundreds of insurance plans they see each month. "Our patients come from all over the world," explains Longuet. "Our staff see not only local market plans, but unique plans from all over."

Feedback from patient access employees has been very positive. "As staff make further suggestions to enhance the tool, we update it regularly," says Longuet.

Payers' phone numbers and websites recently were added to the tool, as a result of staff feedback. "It takes one to three clicks to determine the payer, depending on the insurance plan," adds Longuet.

Quick answers to questions

An email "hotline" was set up so that staff can get a quick answer to any question about a particular plan.

"Our educators answer them usually within minutes," says Longuet. "We are ensuring the data is as accurate as possible from the start."

At Wheaton Franciscan Healthcare in Glendale, WI, patient access leaders post sample insurance cards on the hospital's intranet. **Terri Miles**, patient access manager, says, "Many of the cards have a similar look or logo. The sample cards can be referenced by any associate."

Having the sample cards helps employees to identify the plan level the patient selected: Gold, Bronze, or Silver.

"This has been especially helpful when working on the phone with our preadmit processes," says Miles. "It allows them to prompt the patient for the complete information." ■

Access departments might be non-compliant

Rule's focus is on financial counseling

A proposed rule from the Internal Revenue Service (IRS) requires nonprofit hospitals to inform patients about available financial assistance, and it bars "abusive" collection practices prior to doing so. *(The proposed rule can be*

viewed at http://www.irs.gov/pub/irs-drop/reg-130266-11.pdf.)

"There were numerous examples of hospitals trying to collect from patients who were indigent," says **Mark Rukavina**, principal of Chestnut Hill, MA-based Community Health Advisors, which assists non-profit hospitals in complying with regulatory requirements. "The question arose from some in Congress, 'Why are we giving a tax break to institutions that are suing poor people, or in some cases sending them to jail, for not paying medical bills. Is that a charitable act?'" says Rukavina.

The new regulations, required by the Affordable Care Act (ACA), affect patient access processes significantly. **Rachel Bienemann**, senior director of Huron Healthcare, a Chicago-based consulting firm specializing in revenue cycle improvement, says, "Patient access teams are on the frontline to kick off the financial assistance process. Organizations failing to comply can be charged excise taxes and/or be removed from tax-exempt status."

Although a final rule has not yet been issued, the IRS issued a notice in December 2013 stating that hospitals could follow the proposed rule and assume to be in compliance. "It appears that these new provisions are formalizing an important part of the safety net in the healthcare delivery system: non-profit hospitals," says Rukavina.

The new regulations ensure that all hospitals that get the benefit of the federal tax exemption are operating under the same rules, he says. Currently, there is a lot of variation across states.

For some hospitals, this situation isn't much different from what they had in place prior to the ACA. "For others, it's dramatically different," says Rukavina. "In some parts of the country, it seemed to patients that hospitals determined who got charity care by making arbitrary decisions."

EXECUTIVE SUMMARY

Patient access departments need revamped processes to be sure patients are informed of available financial assistance, to comply with a proposed rule from the Internal Revenue Service.

- Staff should be able to direct patients to the financial counselors and other resources.
- Staff should document when an application has been provided to a patient, when an application is returned, and when a collection is attempted.
- Hospitals should review their Emergency Medical Treatment and Labor Act (EMTALA) policies and the proposed requirements.

High level of transparency

Because for-profit hospitals often follow the lead of the nonprofits, says Rukavina, "if you are operating in a market, and there is a high level of transparency around financial assistance policies, there will be spillover. The for-profits will be more forthcoming too."

The overall goal is transparency: for hospitals to be able to explain their financial assistance policy to the community, says Rukavina. That goal includes patient access staff, he emphasizes.

"Anybody working with patients around financial issues should know what the policies are," he says. "These should not be just in writing. The policies should actually be put into practice."

The need to put policies into practice makes the role of patient access employees more challenging. "You are not only verifying insurance coverage. You are also seeing if there might be some relief under the financial assistance policy," says Rukavina. "It can get complicated."

Bienemann says patient access leaders should take these steps to ensure compliance with the new regulations:

• Ensure all patient access staff are well-versed in the financial assistance policy and its requirements for eligibility.

Staff members should be able to inform patients where they can obtain an application, and direct patients to the hospital website, financial counselors, and other resources available to assist with the application.

"This is particularly important in the emergency department, given the additional requirements for financial collection activities [in that setting]," says Bienemann. *(See related story, p. 82, on what constitutes "abusive" collection practices under the new regulations.)*

• Review patient consent packets, signage, billing statements, and policies posted on the hospital's website.

"Dual language signs and documentation is required where any language other than English makes up more than 10% of the residents in the community," notes Bienemann.

• Review the financial assistance application process.

"Ensure that there is a clear process flow and handoff of information, where needed, to com-

plete the application and determine eligibility," says Bienemann.

• Document when an application has been provided to a patient, when an application is returned, and when a collection is attempted, along with the proposed estimated amount.

It will be critical, if an audit were to occur, to have supporting documentation notating all steps taken for financial activity with the patient," says Bienemann. ■

Are collection efforts by your staff abusive?

Definition of 'financially needy' changing

Are uninsured patients billed at a higher rate than insured patients?

Did patient access staff fail to make reasonable efforts to determine if a patient is eligible for financial assistance?

Were patients billed for charges that would have been covered under the hospital's financial assistance policy?

All of these practices are considered "abusive" under proposed new regulations from the Internal Revenue Service (IRS), warns **Rachel Bienemann,** senior director of Huron Healthcare, a Chicago-based consulting firm specializing in revenue cycle improvement.

"Collecting copays, deductibles, and out-of-pocket premiums for insured patients would not be considered abusive, under the new regulations," assuming the patient's responsibility does not exceed insured rates and that the hospital provides notification of the financial assistance policy, adds Bienemann.

Many hospitals provide financial assistance not only to uninsured patients, but also to underinsured patients. "While the regulations do not spell out all of the inclusions and exclusions, it is widely believed that the standards are focused on patients considered in need of financial aid," Bienemann says.

However, with more patients obtaining high-deductible plans on the Health Insurance Exchange Marketplace, the definition of a "financially needy patient" is changing, says Bienemann. "It cannot simply be presumed as the uninsured population only."

The new requirements are "supportive of and similar to" the Emergency Medical Treatment and Labor Act (EMTALA), says **Mark Rukavina,** principal of Chestnut Hill, MA-based Community Health Advisors, but with emphasis that care will be provided for emergency conditions regardless of whether a patient is eligible for financial assistance.

The proposed rule states that "any hospital policy or procedure that discourages individuals from seeking emergency medical care, such as demanding that emergency department patients pay before receiving treatment or permitting debt collection activities in the emergency department, may jeopardize a hospital facility's compliance with EMTALA and with the requirement under 501(r)(4)(B) to establish a nondiscriminatory emergency medical care policy."

The proposed rule clearly discourages any practices that would interfere with someone trying to access emergency care, says Rukavina. "Exactly what that looks like isn't really clear," he adds. "You could point to an egregious example and say that it crosses the line. But these are delicate conversations."

Hospitals should be particularly careful when pursuing collections in the emergency department (ED) setting, cautions Rukavina. "There's a lot of effort going into collections right now. Whether the patient is self-pay or underinsured, no doubt it's best to collect at the time of service, because you eliminate any kind of collection cost," he says. "For non-emergent care, that's within bounds and makes sense."

Hospitals should review their EMTALA policies and the new requirements, and "marry those two, especially for the ED setting," advises Rukavina. "Anything that could be seen as discouraging someone from seeking care is going to be frowned upon." ■

Beef up your processes for discharge planning

CMS surveyors will check for compliance

As the Centers for Medicare & Medicaid Services (CMS) continues its emphasis on discharge planning, it's more important than ever to create a comprehensive discharge plan that provides everything patients need to manage in the

next level of care, some experts say.

Beginning this year, surveyors will use a discharge planning worksheet to review how hospitals comply with the discharge planning portions of the Medicare Conditions of Participation (CoPs). As part of its Patient Safety Initiative, CMS has also developed worksheets to help surveyors assess compliance with the CoPs for performance improvement and infection control. The worksheets are designed to assist the surveyors and the hospital staff to identify when they are in compliance.

CMS has been pilot-testing the worksheets since 2011, according to **Sue Dill Calloway,** RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH. CMS tested the third revised surveyor worksheet in 2013 and came out with the final revised worksheet for discharge planning in March 2014. Surveyors will use the worksheet whenever a CMS survey is done. The updated infection control and quality improvement worksheets are expected to be finished this year.

"The worksheets are very important, and all hospitals that accept Medicare or Medicaid reimbursement should be intimately familiar with them," Dill Calloway says. "It doesn't matter who accredits hospitals; they have to be in compliance with the CMS standards. Hospitals have to comply with the Medicare Conditions of Participation or they could be fined or lose their ability to bill for Medicare and Medicaid."

The discharge planning survey worksheet gives hospitals a step-by-step guide to what CMS expects hospitals to be doing to comply with the CoPs, but it also is a blueprint for what hospitals should be doing anyway, says **Laura Jacquin**, RN, MBA, managing director for Huron Healthcare, a Chicago-based consulting firm. "The Conditions of Participation are patient-focused, patient-centric rules that spell out the right thing to do for patients. They are very much focused on providing an effective, comprehensive discharge plan with patient safety and preventing readmissions in mind," Jacquin says.

Hospitals must have discharge planning policies and procedures in writing, but it's not enough to just have them in place; you have to be able to follow them and show that you have done so, adds **John Laursen**, managing director for Huron Healthcare.

"The challenges we see as we work with clients is operationalizing the policies on a day-to-day basis," he says. "Case managers and the entire care team need to work together."

The surveyors will be reviewing hospitals' discharge policies and procedures to determine if they meet all the requirements of the CoPs and if they are in effect for all inpatients, not just Medicare patients, Jacquin says. They will look for evidence of discharge planning activities on every unit and will determine if the staff are following the discharge planning policies and procedures.

Dill Calloway suggests that hospitals put together a team to review all three worksheets and complete them as a self-assessment to make sure they are doing everything that CMS requires. The discharge planning worksheet reflects the changes made in the CMS standards on discharge planning that went into effect on July 19, 2013. "CMS completely rewrote all of the discharge standards in a 39-page memo that decreased the number of standards from 24 to 13," she adds.

CMS now publishes quarterly deficiency reports that show that many hospitals are receiving deficiencies in the discharge planning standards, Dill Calloway says. "In fact, in the January 2014 report, there were 364 deficiencies," she adds. *(The deficiency reports are available at http://go.cms.gov/Rako0H. Look in the "Downloads" section.)*

"The worksheet is a good communication tool to ensure that everybody in the organization is knowledgeable about the discharge planning standards. Sometimes the questions in the worksheet are not apparent from a reading of the CMS hospital interpretive guidelines. It is very important for every nurse, social worker, and discharge planner to be familiar with the discharge planning standards and incorporate them into their staff education and their hospital's policies and practices," she says.

The worksheet spells out what case managers should be assessing, says **Michele Kala**, RN, MS, a

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surveyor for the Chicago-based Healthcare Facilities Accreditation Program (HFAP), which has deeming authority from CMS.

The key issue in compliance is identifying patients who are at high risk for readmission and developing a discharge plan to make sure that wherever they go after discharge, they will be able to manage in a safe manner and stay healthy and out of the hospital, she says.

Those with limited resources might not have the staff to conduct a discharge planning evaluation on every patient. They should develop a mechanism to identify high-risk patients by diagnoses, severity of illness, and psychosocial needs, Kala says.

"If facilities don't have the resources to invest, it's acceptable to Medicare to create a discharge plan only for patients who are at risk," she says.

Very sick patients, discharged earlier

Patients who are admitted to the hospital tend to be very sick and are being discharged earlier than ever, says **Jackie Birmingham,** RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Group, a Newton, MA-based transition management software company.

"If the inpatient admission criteria set says the acute care hospital is the only place for patients to be, they should be assessed to determine where they should go next," Birmingham says.

The best practice for hospitals is to conduct a discharge planning evaluation on every patient, Dill Calloway adds. However, if you don't evaluate every patient, your policies and procedures must include a process to notify patients, family members, and attending physicians that they can request one, even if the patient doesn't meet high-risk criteria, she says.

The surveyors will look for a process to notify patients that they can request a discharge planning evaluation. Dill Calloway suggests that the information be included in the patient rights and responsibilities document and that the patients be asked to sign that document. The nurse also can inform the patient of his or her right to request an evaluation during the admission assessment and document it.

"Don't just hand the patients a sheet listing the patient rights," Dill Calloway says. "The best practice is for the registrar to give the patient the rights and responsibilities document at registration and go over the specific items." ■

PRM CODE SELECTION TOOL

Managed Care Liaisons DNA List

Medicare & Medicare Supplements	Medicaid & CHIP	Commercial	Access Networks	Other
Managed Medicare	CHIP	Aetna	Access Networks	Stem Cell Transplant
Medicare and Medicaid	Managed Medicaid	Blue Cross Blue Shield		Self Pay
Traditional A&B	Traditional Medicaid	Cigna		International or Embassy
Traditional A only	Out-of-State Medicaid	Coventry Health Care		County Referred (including HCHD)
Traditional B only		Memorial Hermann Health Plan		Charity Care
Medicare Supplement		Humana		Tricare or Other Governmental
		UnitedHealthcare		Other

NOTE: Effective 1/1/14: **Credit Rating C** applies only to approved grandfathered 50% PFAs through 2014.

HUMANA

Is the product a Medicare Advantage product? If yes, Click Here
Examples: Humana Gold Choice (Medicare PFFS), Humana Gold Plus (Medicare HMO)

Is the product National Open Access or National Open Access Plus, including an out of state exchange (Marketplace) plan? If yes, Click Here

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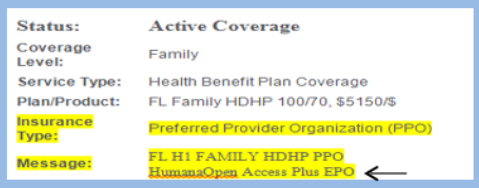
MDACC is not contracted with the Humana HMO X health insurance exchange (Marketplace) plan.

If you use Availity, look at the **Message** to obtain the specific plan name, then review the list of plan names in the Humana slides to determine whether MDACC is contracted:



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- Humana HMO
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- National HMO
- Humana Preferred POS-Open Access
- Humana Smartnet
- Humana Preferred
- Humana Open Access Plus EPO

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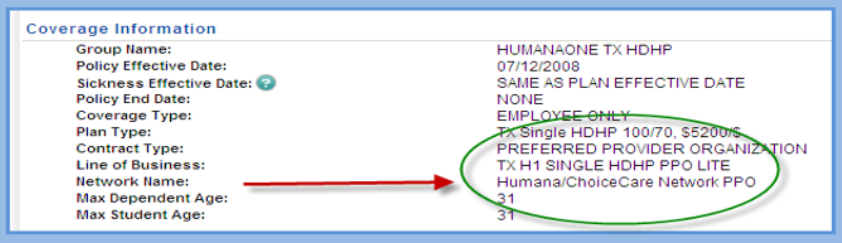
Use the Humana website or Availity to assist you with insurance eligibility or contact Humana at their Customer Service phone: 800-4-HUMANA (800-448-6262). The Radiology /DI Vendor is Health Help.



Verify and obtain referral and/or health plan authorizations as required by the patient's plan.

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SOURCE: The University of Texas M.D. Anderson Cancer Center, Houston.