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Millions in revenue go uncollected in ED: Revamp your processes now

Collections more than doubled at one hospital

Many emergency department (ED) registrars don't make any attempt to collect patients' out-of-pocket responsibilities, even if patient access does so successfully in other hospital settings, according to revenue cycle experts interviewed by *Hospital Access Management*.

"Many hospital systems, especially those with lagging collection practices who do not want to risk being out of compliance or on the evening news, avoid collecting in the ED," says **Ketan Patel**, a senior manager in the healthcare provider segment of strategy and operations for New York City-based Deloitte Consulting.

However, hospitals that don't collect in the ED "potentially leave millions of dollars on the table and at risk," says Patel. In the ED, however, "often the directive from leadership is to not ask — to only accept payment if the patient offers, or simply inform them of their liability without an attempt to collect," he explains.

ED collections, therefore, are "one of the largest drivers of patient liability write-offs," says Patel. Due to requirements in the Emergency

EXECUTIVE SUMMARY

Emergency department (ED) collections more than doubled with a quality assurance tool at Greater Baltimore Medical Center, and a check-out process allowed ED registrars at University of Utah Hospital to collect $295,000 in FY 2014. They now increase ED collection goals between 5% and 10% each year. Some successful strategies include the following:

- Require patients to "check out" at discharge windows.
- Provide financial counseling in the ED.
- Use realistic scenarios to practice collecting from "difficult" patients.

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Medical Treatment and Labor Act (EMTALA), registrars are restricted as to when they can approach patients to collect liabilities. *(See related story, p. 99, on training patient access staff in ED collections.)* "As budgets continue to get squeezed, staff shortages and appropriate coverage in the ED is a challenge," adds Patel. "This often leaves collections as a low-priority function." Additional out-of-pocket costs, such as deductibles, are typically unknown to ED registrars. These amounts go uncollected, says Patel.

Cherie Patterson, CHAA, CHAM, patient access operations manager at Greater Baltimore (MD) Medical Center, says, "In the ED, we have no idea what the patient's total visit cost will be." The department doesn't collect deductibles or coinsurance from ED patients, and it has no plans to do so.

Patel says, "Aside from copays on insurance ID cards, many EDs have limited tools to determine other out-of-pocket costs."

ED almost 40% of collections

ED collections accounted for almost 40% of total point-of-service collections at Greater Baltimore Medical Center in 2013, reports Patterson.

"We started collecting in the ED back in 2008 and have made a few tweaks to our process over the years," she says.

The department implemented a quality assurance tool (AuditLogix, manufactured by Plano, TX-based DCS Global) to determine eligibility and identify copay amounts due. "Before we started using the tool, we collected 3,754 co-pays — around $250,000 in total collections," Patterson says. "Now we're collecting more than double that amount." In fiscal year 2014, patient access employees collected 8,071 copays from ED patients, which totaled more than $680,000.

The department integrated its credit card processing system with the tool, so staff don't have to log onto two websites for each patient registration. "Our ultimate goal with ED collections is to make the process as seamless and convenient as possible," says Patterson.

Get timing just right

The timing of financial conversations in the ED, in relation to assessment and treatment of the patient, "is especially important," says **Julie Ingraham**, senior director at Huron Healthcare, a Chicago-based company specializing in revenue cycle improvement. "It needs to be coordinated carefully with the clinical team."

Patient access staff need to know if the patient has been properly assessed, if the patient has been treated, and whether there are any special circumstances that would prevent a conversation about the patient's financial situation.

"Create communication channels between the clinicians and the financial counseling and registration staff, and mechanisms for the clinicians to pass on information about the patient to the collections staff," advises Ingraham.

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$295,000 collected in ED

Requiring patients to "check out" at discharge windows gives ED registrars another opportunity to collect liabilities, says Patel.

It's important to connect with the patient after they have been treated but before he or she leaves, emphasizes Ingraham. "Often, the best mechanism is a handoff from the clinician to the financial counselor and/or registrar," she says. "This can be done either virtually through a system or through incorporating the collections staff into the discharge process."

Before patients can exit the ED at University of Utah Hospital in Salt Lake City, they must pass the financial counseling desk. Nurses bring patients to the discharge desk and introduce them to a financial counselor. **Ischa Jensen**, MHA, CHAA, supervisor of financial counseling and inpatient access services, says, "This allows for a one-on-one interaction with the patient to discuss ED plan coverages."

The process is convenient for clinical staff and the financial counselor, and ED collection goals have increased between 5% and 10% each year. "It has led to much success," says Jensen. "We collected $295,722 in the ED for fiscal year 2014."

SOURCES

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Learn to collect from difficult `patients'

Role-playing helps staff to collect compassionately

At Greater Baltimore (MD) Medical Center, patient access managers use extensive training, scripting, and role-playing to increase point-of-service collections in the emergency department (ED).

"There is a fine balance between being compassionate toward a patient that is in pain or someone worried about their loved one, and still making an attempt to collect without seeming pushy or uncaring," says **Cherie Patterson**, CHAA, CHAM, patient access operations manager,

In contrast to other hospital settings, many ED patients don't expect to be asked to pay upfront. "Educating the patient in a customer service-oriented way can be challenging," acknowledges Patterson. Some staff members might feel uncomfortable asking for money.

"As much as we all dread role-playing, that tactic, as well as practice with scripting, really does help," says Patterson.

Here are examples of ED scripting used by patient access employees:

• "Mr. Smith, according to your insurance, you have a $50 copay due. How would you like to pay? We accept personal check and all major credit cards."

• "Mrs. Johnson, we have verified your insurance benefits and see that a $75 copay is due for your son's visit. How would you like to pay? We accept personal checks and all major credit cards."

"The general script conveys that we're honoring the patient's insurance copay requirement," says Patterson. "The main point is not to ask *if* the patient would like to pay, but *how*."

Opportunity to help

When role playing, patient access employees take turns being "difficult" patients and collecting from one another. "I always approach the subject of copay collection as an opportunity to help the patient," says Patterson.

She explains to staff that the patient won't have to worry about a bill later. "This results in less stress for the patient and less cost for the hospital. It's a win-win situation," says Patterson. Here are two scenarios used during role-playing:

• A registrar pretends to be a busy, worried mother bringing her child into the ED.

Staff explain to the "mother" that paying the copay upfront means she doesn't need to worry about getting a bill later, which allows her to focus on her family. "This exercise shows how to be compassionate, but also conveys that we need to collect," says Patterson.

• A registrar pretends to be a self-pay patient who is very worried about how he or she will pay for the hospital bill.

"This exercise gives us the opportunity to let the patient know about our financial assistance program," says Patterson. "We also ask the patient to pay whatever they can toward today's visit."

Staff offer information about financial assistance and point out to the patient that there are several options for payment. If the patient asks the amount staff want to collect, staff members ask for $50. "However, if the patient can only pay a few dollars, we will collect whatever they offer," says Patterson.

Goals are set

At University of Utah Hospital in Salt Lake City, financial counselors and ED registrars are trained to collect payments.

"This ensures there is someone always available to collect, even after scheduled financial counseling hours," says **Ischa Jensen**, MHA, CHAA, supervisor of financial counseling and inpatient access services.

Each collector in the ED receives an individual cash collection goal for the year. "Progress toward these goals are sent to the teams weekly," says Jensen. "They are able to see how their collections are contributing to their own goals, as well as our department goals."

An important change was made to the scripting used by staff when collecting. "Instead of saying, 'Can you pay your copay today?' we now present with, 'How would you like to pay your copay today?'" says Jensen. ■

Get a true picture of access' productivity

Data `critically important' for patient access

Capturing productivity data on patient access staff is "critically important" in establishing cost-effective staffing benchmarks, says M**ark S. Rodi**, MHA, CHAM, associate vice president of revenue management at Geisinger Health System in Danville, PA.

"Successfully staffing a patient access area directly contributes to increased patient satisfaction scores, effective patient flow, and reduction of staff turnover levels," says Rodi.

Productivity is hard to measure in patient access areas, however, says Rodi. The primary reason is that multiple members of the team contribute to the successful financial clearance of the patient encounter. "Often, IT systems capture the last team member involved in the patient account and attribute the completion of the registration solely to this staff member," says Rodi. Data doesn't always reflect the contributions made by all the other employees in scheduling, pre-registration, financial counseling, and registration.

"Turnover rates tend to be significant in patient access," notes Rodi. "A proven method of reducing staff turnover is the establishment of staffing benchmarks which can be flexed according to demand."

Data tied to successful staffing

Patient access leaders need productivity data to make effective decisions in scheduling and registration areas on a daily basis, emphasizes Rodi.

"Without this information, managers cannot adequately staff their respective areas," says Rodi. "They cannot forecast patient demand and will not be able to flex staff to other patient access areas." *(See related story, p. 101, on must-have metrics for patient access areas.)*

Patient access leaders must determine which metrics are the most representative of the job duties staff performs, says **Jeff Markin**s, a financial analyst at Nationwide Children's Hospital in Columbus, OH. They also must consider varying patient volumes or job duties in the same areas on different shifts.

"Midnight shift in the ED may have significantly less patient volumes than day shift. So the staff may perform electronic insurance verification for scheduled patients during lulls," says Markins.

Poor performers are difficult to identify without productivity data, he adds. This problem could cause a decline in department performance and

EXECUTIVE SUMMARY

Accurate productivity data is critically important to adequately staff registration areas, but patient access leaders often lack technology to capture this information.

- Use scorecards to give employees immediate feedback.
- Look for steady improvement.
- Take accuracy into consideration if employees aren't meeting productivity goals.

morale. "Serious issues may not be addressed in a timely manner," says Markins. "This, in turn, could negatively affect the hospital's bottom line."

Multiple functions performed

Given the multiple functions now performed by a registrar, productivity data is essential to ensuring that key revenue cycle needs are met, according to **Frank Danza**, senior vice president and chief revenue officer at North Shore — LIJ Health System in Manhasset, NY.

Productivity data ensures that staffing is adequate and that staff members are able to acquire complete demographic information, obtain insurance information, determine patient responsibility, collect copays, and provide financial counseling, says Danza.

If patient access leaders lack this information, he says, "revenue cycle activities can fall to a lower priority in admitting and registration areas that support a large volume of patients or are constrained for space."

Many patient access areas lack technology that allows them to monitor productivity easily, says **Joseph Ianelli**, associate director of admitting at Massachusetts General Hospital in Boston.

"It does take some investment," Ianelli acknowledges. "But all of this is tied to finance and revenue."

Speed isn't everything

The fastest registrars might be the same ones creating the most duplicate medical record numbers, or they might make the most mistakes resulting in denied claims.

"It's not just about the productivity, but also accuracy and quality," warns Ianelli. "Productivity is the first piece, but beyond that, are they also accurate?"

Productivity data sometimes reveals that appearances are somewhat deceiving. "Sometimes, the ones running around looking the busiest aren't necessarily the most productive employees," Ianelli says. Likewise, some staff members appear very unproductive according to the data, but the quality of their work makes up for it. "I always recommend taking a broader view than just the numbers," says Ianelli. "Data has its limitations."

One registrar works more slowly than her colleagues, but hardly ever has a claims denial because her work is so accurate. "I try to look at people really comprehensively," says Ianelli. "You need to consider what you get in terms of reliability and commitment to an organization."

If a registrar isn't meeting productivity goals because he or she is very detail-oriented, Ianelli tries to find another role for that employee.

"If somebody is a great employee who is contributing to the overall mission but is just not meeting productivity goals, it's never a good idea to just wash your hands of them," he says.

SOURCES

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Must-have metrics for patient access

When monitoring productivity of patient access staff, managers should use subjective and objective methods, recommends **Mark S. Rodi**, MHA, CHAM, associate vice president of revenue management at Geisinger Health System in Danville, PA.

"Data on the number of completed patient access transactions, the number of claims denials, and cash collection percentages is important," Rodi says. "But it's not the only way to measure productivity."

Rodi uses satisfaction scores, third-party observations, and patient interviews. "A combination of productivity data and satisfaction data allows the patient access manager to gauge the overall effectiveness of patient access employees," he says.

If a patient access manager solely focuses on production and pays little attention to patient satisfaction scores, warns Rodi, "demand for services will decrease, as will overall patient satisfaction scores. These can be directly related to heathcare reimbursement."

Frank Danza, senior vice president and chief revenue officer at North Shore — LIJ Health System in Manhasset, NY, expects to see these scores for these metrics:

- 95% or better accuracy of demographic data collected;
- 70% of copays and deductibles collected at the point of service;
- 95% of insurance verified and authorized prior to service.

Metrics are also collected on patient throughput per registrar, and the number of financial assistance applications taken and approved, with expected percentages varying by area.

"Key metrics include both productivity and quality of actions performed," says Danza.

He sees having and applying the right technology as the biggest challenge in measuring productivity in patient access areas. The reason is that each person involved in the process often has multiple functions he or she performs throughout the day.

"We have installed tools specifically designed to measure work performed by our registrars," he says. These tools also give managers the information they need to assess and track the quality and completeness of the work performed by each registrar throughout the organization.

"These metrics are tracked and shared back with each department on a routine basis," says Danza. "Staff can get timely counseling, and staffing levels can be assessed continuously."

Use scorecards positively

At Geisinger Health System, scorecards are emailed to patient access staff and are posted on a secured shared drive. "This gives employees immediate feedback related to the critical work they do on a daily basis," says Rodi.

The scorecards list the total calls answered, the calls answered percentage, appointment slot utilization, copay collection percentages, outstanding balance collection percentage, and percentage of successful new medical record numbers created. "However, it's extremely important to use this information in a positive manner to ultimately achieve the results we all look for: satisfied patient access staff, patients, and providers," says Rodi.

Rodi suggests highlighting the positive aspect of the measure instead of the negative. He gives the example of two popular access measures: the percentage of duplicate medical records created, and the abandonment rate of phone calls.

"Both of these measures can be reflected in a positive manner by focusing on the successful completion of new medical record numbers and the percentage of patient calls answered by agents," says Rodi.

Link productivity to KPIs

Florence Davis, director of patient access at Children's Healthcare of Atlanta, recommends tying productivity to key performance indicators (KPIs) for patient access, such as point-of-service collections as a percentage of net revenue, length of registration, and turnaround time.

"Another effective way to assess productivity in patient access is by establishing productivity by core job function," such as scheduling, registration, insurance verification, obtaining authorizations, or financial counseling, Davis says. "Once the productivity metric is identified, a goal should be set for the team or department and, where feasible, per employee," she says. "Communicate the expectation."

Patient access leaders can use the data to make operational decisions and to recognize top performers. "Partner with your analytics team to help create productivity reports to track," Davis advises. "Timely feedback should be given to employees." ■

Include access in survey preparation

Patient tracers often leave out registration areas

During a recent survey by The Joint Commission at OSF St. Joseph Medical Center in Bloomington, IL, surveyors asked emergency department (ED) registrars how they communicate with patients who don't speak English.

"Staff responded very appropriately about using the InDemand video remote interpreting services," reports **Gail Scoates**, BSN, MSN, RN, regulations and standards coordinator.

Next, surveyors asked ED registrars to demonstrate how they routinely conducted their patient interviews in treatment rooms. "The surveyors then discussed safety issues and provided safety pointers," says Scoates. Here are some things surveyors told ED registrars:

• Always put yourself and the computer between the patient or family and the door, so you always have an escape route.

• Do not go into a room and close the door behind you.

• Never go into a room if you fear for your safety.

• It is OK to ask for help or to ask persons to leave.

Often left out of process

Patient access areas are often not included in survey preparation to the extent they should be, according to Scoates.

For example, organizations don't always include registration areas in "patient tracers" done as part of survey preparation. "I am afraid we have not involved these areas as much as we should," she acknowledges. "There are times when they are included in tracers just because 'they are there.' We only think about these departments as we are touring the medical center."

Since surveyors are likely to visit registration areas, patient access employees certainly should be included in survey preparation, says Scoates. "It truly is very simple. It is just a matter of being mindful," she says.

While patient access areas obtain general education provided by the organization on The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) surveys," they're likely not included as much as they should be," says Scoates.

She recommends patient access leaders take these steps to prepare employees for surveys:

• Know which CMS and Joint Commission standards apply to registration areas.

"Requirements involving physician orders, staff competency, and confidentiality all involve patient access areas," says Scoates.

• Review department and institutional policies with patient access staff.

"Validate that they know where to locate them," says Scoates.

Do focused preparation

As chair of the National Association of Healthcare Access Management's (NAHAM's) Government Relations Committee, **Michael Sciarabba**, MPH, CHAM, heard from many patient access professionals that they felt unprepared for surveys and audits.

"Patient access is often overwhelmed with how to prepare for what can be a complicated and stressful event," he says.

Sciarabba, director of patient access at University of California, San Francisco, oversaw NAHAM's development of toolkits for patient access to use to prepare for the Joint Commission and CMS surveys. *(See resource at end of this story for more information.)*

Patient access managers and front-end staff can use the toolkit's checklists and question sets to prepare. "Often, patient access staff are prepared. But they don't have the confidence to respond to surveyor questions," Sciarabba explains. "The goal is to achieve a state of constant readiness, instead of just reacting."

Hospitals often focus on patient safety with survey preparation, and patient access is "kind of an afterthought," says Sciarabba. "But it's critical, because every patient encounter starts out with patient access."

Patient ID is focus

Patient access areas are directly involved in compliance with patient identification standards, emphasizes **Angela Click**, patient access services manager at OSF St. Joseph Medical Center. *(See related stories on patient privacy questions surveyors might ask, p. 104, and other questions surveyors might ask in patient access areas, p. 104.)*

When asked about this area during a survey, Click says her patient access employees can inform surveyors that they take these steps:

• All outpatients presenting to registration are assigned armbands with their names and dates of birth.

EXECUTIVE SUMMARY

Patient access leaders should expect surveyors from The Joint Commission or the Centers for Medicare and Medicaid Services (CMS) to interact directly with front-line staff in registration areas.

• Patient access areas aren't always included in patient tracers conducted by organizations.

• Registrars might be asked what they do to protect patients' privacy.

• Requirements for physician orders, staff competency, and patient identification all involve patient access areas.

• Once the patients present to their testing departments, then the departments verify the patients from their armbands.

"However, the correct armband information must start in registration," says Click. "We use key identifiers to make sure we are registering the correct patient."

• Patient access staff members ask for government-issued photo identification, ask patients to spell their names and provide their dates of birth, and verify the last four digits of their social security numbers.

"This helps to ensure we are registering the correct patient every time," says Click. "Other departments rely on registration getting the identification correct, so they can perform the correct tests."

SOURCES/RESOURCE

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* Toolkits to help access leaders and frontline staff prepare for Centers for Medicare & Medicaid Services and The Joint Commission surveys are available at no charge to members of the National Association of Healthcare Access Management. To access the tool, go to www.naham.org and click on "Government Relations" and "Joint Commission Survey Toolkit" or "CMS Survey Toolkit." ■

Here are answers for privacy questions

"How do you protect a patient's privacy?" Some patient access employees get a "deer-in-the-headlights" look when surveyors ask this simple question, says **Michael Sciarabba**, MPH, CHAM, director of patient access at University of California, San Francisco.

"It appears that they don't know the answer," he says. "But they just haven't stopped to consider all the things they do in their day-to-day job."

Staff members can tell surveyors that they only ask for last four digits of the patient's social security number, that they always talk in low voices, that they shred all confidential patient information, and that they give out privacy notices, for example.

When preparing registration areas for surveys by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission, "one area we wanted to make sure we were prepared for was privacy policies," says **Angela Click**, patient access services manager at OSF St Joseph Medical Center in Bloomington, IL. The reason is that patient access areas gather a lot of protected health information (PHI) during the check-in process, and the staff members need to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

"We put a process in place to make sure all patients were getting registered at a private booth and not having to provide their PHI while in the registration line," says Click.

During busy times, registrars often get up to check the fax machine for an order or to ask a question. "Once they leave their desk, if they do not secure their computer screen, then they could possibly be open to a HIPAA violation, as the patient's information would be left open on an unsecure computer screen," says Click.

Patient access managers placed small signs on each monitor reminding registrars to "Secure your computer screen" before they walk away. "These processes help to ensure patient safety," says Click. "It also ensures we are prepared for our CMS and Joint Commission surveys." ■

Your surveyors might ask these questions

Patient access employees are responsible for knowing the general policies and procedures of the hospital, emphasizes **Angela Click**, patient access services manager at OSF St Joseph Medical Center in Bloomington, IL.

"Surveyors have every right to ask the front-end staff questions in regard to these polices," Click says. Surveyors could ask about fire evacuation plans, hand hygiene, handling of protected health information, for example, or they could ask department-specific questions about ongoing competencies and how education on patient privacy regulations is provided.

Click makes sure members of her patient access

staff are familiar with the basics of all these policies. "I also make sure if they are not sure of the exact wording of the policies, they know how to easily access the information through our portal," she says. "This way, they are prepared for any questions that come their way."

Patient access leaders should regularly review questions surveyors might ask of patient access employees during surveys, advises **Gail Scoates**, BSN, MSN, RN, regulations and standards coordinator at OSF St. Joseph Medical Center. Scoates gives these examples of questions surveyors are likely to ask and appropriate responses from patient access staff:

• How does your organization deal with angry or verbally abusive patients or visitors?

"We have policies to direct staff actions. Part of those policies are to provide education and training, and processes for staff to call for help if this should occur. Our registration staff is involved in this."

• What does the organization do for training and responding to disasters?

"This is part of orientation education for all employees and yearly education updates, including registration staff."

• How does your staff communicate with patients and visitors who do not speak English?

"We primarily use InDemand video remote interpreting services. We have three computers. If those are all busy, we have a backup process using interpreters via phone. Registration staff is part of this education."

• What training has your staff received for infection control purposes?

"We have orientation, annual education, and many reminders throughout the year. The registration staff is very involved in this during flu season. We place hand gel, masks, and tissues at our desks." ■

Did price estimate turn out to be wrong?

Exact quotes aren't always possible

Despite the best efforts of patient access staff, price estimates sometimes turn out to be incorrect. This situation happens because of inaccurate benefits information, unexpected add-on procedures, or incorrect procedure selections.

EXECUTIVE SUMMARY

Patients rely on patient access employees to inform them of out-of-pocket costs, but accurate estimates are challenging to give. This challenge is due to changes in what is done clinically, provider contracts, patient co-morbidities, and the complexity of coverage. Patient access can do the following:

- Contact physician offices to obtain medical coding information.
- Implement software to integrate professional and hospital services.
- Set up a price estimation line for patients to call.

"An estimate is not just plug-and-play. It is sometimes like nailing [gelatin] to a wall," says **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Experian/Passport Health, a provider of technology for hospitals and healthcare providers.

If the estimator displays the actual step-by-step calculations, it's easier for staff and patients to understand how the patient liability amount was arrived at, says Murphy, "allowing for a highly transparent and positive interaction."

Estimates are just that, however, and are not as accurate as preliminary billing statements unless there is a direct one-to-one match with the charge-master or a flat rate is being used, says Murphy.

At Strong Memorial Hospital in Rochester, NY, if a patient was given an estimate and the cost isn't within the quoted range, he or she is referred back to the price estimation specialist for review.

"If the quote was incorrect, the patient would be responsible only for the amount quoted, unless the procedure or services provided to the patient were different than what the original quote was based upon," says **Karen Stein**, manager of patient services in the hospital's finance department. Stein adds that there is a less than 2% error rate on estimates given to patients.

If the discrepancy is not related to a complication or a different service being provided, the patient is held harmless for the difference between what they were quoted and the actual costs. If additional services were provided, however, staff members tell the patients that these services weren't part of the initial estimate.

"If necessary, we reach out to the physician to get an explanation of why the original procedure

was changed, so we can give further details to our patient," says Stein. *(See related story, below right, on involving providers in price estimates.)*

Patients need help

Most patients are not familiar with deductibles, coinsurance, or co-payments, nor do they understand what charges they are responsible for.

"Patients may need help understanding what it means to have to meet a deductible before services are paid by their insurance, as well as how coinsurance works," says Stein.

Many patients chose insurance coverage based solely on the cost of the premium. "They then unexpectedly incur exorbitant expenses if something catastrophic happens," says Stein.

When patients ask what their true, out-of-pocket costs will be for a requested service, therefore, patient access employees have to do considerable education. "Many patients don't understand the terminology, costs, and benefits with their insurance plan," says Stein.

She says the primary challenge is explaining to patients that the estimates they're given are based on a specified procedure. There could be complications or other factors that necessitate additional procedures.

"It's not always possible to provide an estimate to an exact dollar, as those clinical variables can greatly affect cost," says Stein.

Patients given info

Strong Memorial's patient access department implemented a price estimation line so that patients can call to obtain estimates for the hospital and for physician services.

"If a patient has insurance, we will reach out to the insurance carrier to discover each patient's specific benefit information to learn their potential out-of-pocket expense," says Stein.

Staff members then give the patients estimates based on the true, expected reimbursement for the services. "At that time, we also explain our financial assistance programs, as well as any questions they may have in regard to their benefits," says Stein.

Information was added to the hospital's website to alert patients about the price estimation line. "At the point of care, postcards are available that can be given to patients to let them know about this service," says Stein.

Delay in estimates

Patients calling for a price estimate want a quick, simple answer. "They are not aware of the technical information needed in order to obtain the cost," says Stein.

In fact, estimating is a highly complex process, says Murphy, and automation is the only way to do it well. "It is not an exact science, but often, this is not clear at the executive level," she adds.

Writing off the differences if an estimate turns out to be incorrect is a hospital's prerogative, notes Murphy.

"But if a clearly stated disclaimer is on the estimate, and the facts show why the estimated verses actual amounts differ, then discrepancies could be well-articulated," she says.

SOURCE

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Involve providers in price estimates

Patients often given misinformation

If providers fail to keep automated price estimators up-to-date on contract terms and historical claims, incorrect estimates will occur.

"Also, users do not always have the level of sophisticated training necessary to produce the highest integrity on an estimate. These are huge gaps I've seen," reports **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Experian/Passport Health, a provider of technology for hospitals and healthcare providers.

In cardiology and radiology, for example, some procedures have associated charges that always go with a procedure, such as a hysterosalpingogram and persantine stress test.

"The estimator must be built to always accommodate these associated charges, because your users will not know to do so," says Murphy. "This leads to misinformation for the healthcare consumer."

Reach out to physicians

To obtain a precise estimate, members of the patient access staff at Strong Memorial Hospital in Rochester, NY, contact the various physician offices to obtain the medical coding information needed.

"This causes a delay in how quickly we can provide the patient with the estimated costs," says **Karen Stein**, manager of patient services in the hospital's finance department.

Stein says that software integrating professional and hospital services would be very helpful to the department. When they previously looked at starting this program, no vendor could do physician and hospital pricing in one system.

"That was one of our main requirements. I am not sure if there are any vendors who can now do this at an enterprise level," says Stein. "We are hoping to have this capability directly within our billing systems."

At times, patient access employees give an accurate estimate to a patient, but by the time the service is performed, the pricing has changed.

Murphy says, "Providers must keep in step with all the nuances that affect estimates."

Look for tools that factor in the patient's deductible or copay, and calculate combination estimates that include professional charges and application of multiple discounts, she says.

"It is even possible for an estimator tool to flag for registration errors which would specifically affect the quality of the estimate calculation," says Murphy.

Estimates that take into consideration the place of service within the health system and the individual physician performing the procedure become even more precise.

"Research all of this thoroughly when automating, to make the best choice to meet your specific goals for transparency, collection, and estimates of the highest integrity," advises Murphy. ■

10.3 million gain coverage during open enrollment

A new study, published in *The New England Journal of Medicine*, estimates that 10.3 million uninsured adults gained healthcare coverage following the first open enrollment period in the Health Insurance Marketplace. The report examines trends in insurance before and after the open enrollment period and finds greater gains among those states that expanded their Medicaid programs under the Affordable Care Act.

"We are committed to providing every American with access to quality, affordable health services, and this study reaffirms that the Affordable Care Act has set us on a path toward achieving that goal," said Health and Human Services (HHS) Secretary **Sylvia M. Burwell**. "This study also reaffirms that expanding Medicaid under the Affordable Care Act is important for coverage, as well as a good deal for states. To date, 26 states plus D.C. have moved forward with Medicaid expansion. We're hopeful remaining states will come on board, and we look forward to working closely with them."

According to the authors' findings, the uninsured rate for adults ages 18 to 64 fell from 21% in September 2013 to 16.3% in April 2014. After taking into account economic factors and pre-existing trends, these numbers correspond to a 5.2 percentage-point change, or 10.3 million adults gaining coverage. The decline in the uninsured was significant for all age, race/ethnicity, and gender groups, with the largest changes occurring among Latinos, blacks, and adults ages 18-34, which are groups the Obama administration targeted for outreach during open enrollment.

Coverage gains were concentrated among low-income adults in states expanding Medicaid and among individuals in the income range eligible for Marketplace subsidies. The study finds a 5.1-percentage-point reduction in the uninsured rate associated with Medicaid expansion, while in states that have not expanded their Medicaid programs, the change in the uninsured rate among low-income adult populations was not statistically significant.

The study also looked at access to care. It found that within the first six months of gaining cover-

COMING IN FUTURE MONTHS

- Revamp processes to meet new payer requirements
- No-cost ways to reward patient access employees
- What to tell patients if coverage is out of network
- Dramatically improve accuracy by setting clear goals

age, more adults (about 4.4 million) reported having a personal doctor and fewer (about 5.3 million) experienced difficulties paying for medical care.

The study does not include data from before 2012, as coverage was changing rapidly during this period. Thus, the results do not include the more than 3 million young adults who gained health insurance coverage through their parents' plans.

The analysis builds on previous studies by reviewing a larger sample size and taking into account changes in the economy and pre-existing trends in insurance coverage. Using survey data from the Gallup-Healthways Well-Being Index for Jan. 1, 2012, through June 30, 2014, the authors analyzed changes in the uninsured rate. This study is also the first one to associate reductions in the uninsured rate with state-level statistics on enrollment in the Marketplaces and Medicaid under the Affordable Care Act and to assess the impact of the improved coverage on access to care. To access the study, go to http://bit.ly/1r9cwZV. ■

App targets assistance for cancer patients

The National Comprehensive Cancer Network (NCCN) has launched its Reimbursement Resource App, which offers providers, case managers, patients, and payers access to payment assistance and reimbursement programs for multiple cancer types.

The NCCN Reimbursement Resource App is a free resource to search for available reimbursement resources and patient assistance programs for multiple cancer types and supportive care indications. The app is available via the Apple Store and Google Play Store.

The app includes interfaces tailored for each of three audiences: patient or caregiver, payer or case manager, and physician or provider. Users can search for payment programs by three categories: cancer type or supportive care indication, drug name, or reimbursement or assistance program. The app is available for Apple and Android mobile devices. For more information about the app and how to access it, go to http://bit.ly/1nL9tnv.

Content contained within the NCCN Reimbursement Resource App is updated simultaneously with the NCCN Virtual Reimbursement Resource Room at nccn.org/reimbursement_resource_room. ■