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The Patient Access Equation

Supporting Mission and Margin

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Kelli Jenkins

Research Analyst, Revenue Cycle

Over the course of nearly four years at HBI, Kelli has built her expertise in pre-service operations, having done extensive research on topics such as scheduling, pre-registration, insurance verification, pre-authorization, financial clearance, and more. She answers healthcare providers' questions about about patient access, has presented on front-end strategies at the HFMA MidSouth Institute conference, and recently contributed to a best practice report on price transparency.

Kelli has a bachelor's degree from the University of Wisconsin-Green Bay and enjoys baking, blogging, and hiking in her free time. She currently resides in Wisconsin with her husband and their 10-year-old pointer mix.

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What is HBI?

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Challenges to Address

1. Patient Liabilities Continue to Grow
2. Patients Lack Financial Understanding
3. Price Transparency is Evolving
4. Inconsistent Processes Hinder Progress

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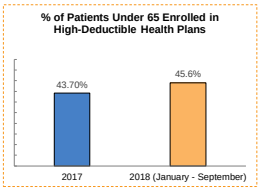
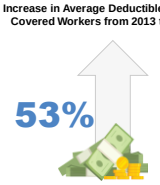
Patient Liabilities Continue to Grow

- Collecting from patients has more of an impact on the bottom line than ever



*CDC



*Kaiser Family Foundation

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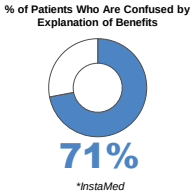
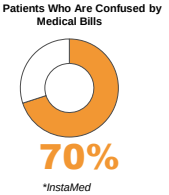
Patients Lack Financial Understanding

- Though patient liabilities have continued to increase, financial literacy remains low



*InstaMed



*InstaMed

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Audience Question

- What percent of U.S. citizens wish their out-of-pocket costs were more predictable?

Source: Consumers for Quality Care (2016)

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Audience Question

- What percent of U.S. citizens wish their out-of-pocket costs were more predictable?

Source: Consumers for Quality Care (2016)

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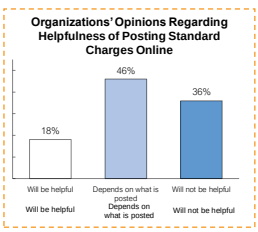
Price Transparency is Evolving



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- As of January 1, 2019, organizations are required by CMS to have their standard charges posted online
- CMS' 2020 Outpatient Prospective Payment System proposal would expand this

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Price Transparency is Evolving

- How will organizations explain what professional charges are and how they affect a final bill?
- Will physicians and other clinical staff be prepared to answer questions patients may have about cost?

*HBI's Revenue Cycle Academy

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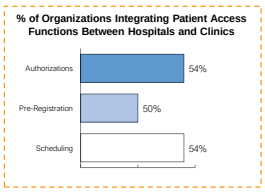
Inconsistent Processes Hinder Progress



*HBI's Revenue Cycle Academy

- Many organizations do not include clinic patient access teams in a systemwide revenue cycle structure
- What can leaders do to meaningfully train and monitor staff who are not under their direct purview?

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Motivate Staff to Collect Upfront

1. Teach Staff to Collect Compassionately
2. Set Realistic Goals
3. Incentivize Staff to Collect

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Teach Staff to Collect Compassionately

Barriers to POS Collections:

- High turnover rates
- Inadequate training
- Inconsistent performance tracking and expectations
- Perceived patient discomfort
- Over emphasizing copays
- Unrealistic goals
- Lack of top-down support

- Front-end staff may perceive asking for payment upfront to be a negative interaction with patients

"We ask registrars to collect 80% of copays at time of service. We had a registrar who works within an oncology clinic and her co-payment collection rate had always hovered between the 40-55% range. Anytime we talked to her about it, she would say, 'My patients are different.'"

-Director of Access Services, UW Health

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Teach Staff to Collect Compassionately

- UW Health offers a Compassionate Collections class to frontline hospital and clinic access staff

Patient Objections	Sample Response
"My ex-spouse / spouse is responsible for all of my / my child's medical bills."	"I understand that you may have an agreement with your spouse / former spouse. I will be glad to give you a receipt so that you can get reimbursed from him/her. Would you like to pay by cash, check or credit card?"
"I'm currently not working, money's tight. I don't have it today."	Calculate impact (e.g., contract modeling)

- ✓ Trainers teach staff how to handle common objections in a patient-centric manner
- ✓ Emphasize collecting upfront as a positive for the patient
- ✓ Scripting provided as on-the-job reference

"All of a sudden, [the oncology clinic registrar] was hitting 80%. She told us the class helped her connect the dots: It was not the patient; it was her. She had felt she did not have the skills to ask in the right way."

-Director of Access Services

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Teach Staff to Collect Compassionately

- As a result of these efforts and more, UW Health's monthly front-end collections have increased

POS Collections Dollars at UW Health

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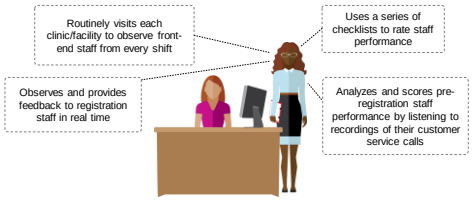
Teach Staff to Collect Compassionately

- An organization in Washington state has a dedicated **patient experience educator** who observes pre-registration and registration staff to ensure they are collecting in a patient-centric manner



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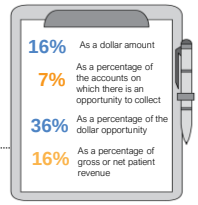
Set Realistic Goals

- Standardization is important, but goals must be achievable
- Setting goals based on the opportunity to collect is optimal
  - It accounts for unique factors that influence staff's ability to collect

24% of organizations reported using another way of setting goals

Organizations' Primary Method for Setting POS Collection Goals



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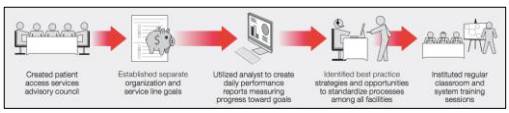
Set Realistic Goals

- A pediatric health system in Texas improved POS collections by basing goals on the opportunity to collect overall and by service line

Implementation Steps Taken by Pediatric Organization to Improve POS Collections



- The organization consistently collects 98-99% of its annual $9 million systemwide goal

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Incentivize Staff to Collect

- A pediatric organization in Georgia ties ED POS collections goals to monetary incentives
  - Each of its three hospitals has a different goal based on payer mix

	POS Collections Goal (31–57% of Accounts)	Denial Rate Goal	Total Possible Incentive
If Team Meets Goal	$100 per staff member	$100 per staff member	$200 per staff member
If Team Exceeds Goal	$125 per staff member	$125 per staff member	$250 per staff member

- If monetary incentives are not feasible, consider alternative incentives like lunches, gift cards, or "wear-your-jeans-to-work" days
  - An Illinois-based organization rewards registrars with vouchers for its onsite gift shops or marketplace

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Strengthen Front-End Accountability

1. Standardize the Registration Process
2. Enhance Quality Tracking
3. Foster Denial Awareness
4. Coordinate Scheduling and Authorizations

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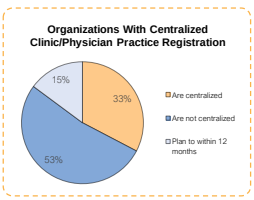
Standardize the Registration Process

- Registration continues to grow in complexity as medical necessity, authorization, and payer requirements increase



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- Clinic registrars may have varied duties, making it difficult to keep up with these changes

62% Of organizations have standardized procedures, training, and quality assurance in place for clinic/physician practice registrars

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Standardize the Registration Process

- An organization in Missouri centralized registration in key outpatient areas (e.g., lab, cardiology, radiology) to improve registration quality

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Enhance Quality Tracking

- The tool creates monthly reports that are shared with registrars

Example Overall Performance Report Card for Registrars at Featured Missouri Organization

		Accounts Registered	Total Kronos Hours	Projects/ Meetings /Misc	Actual Hours(minus Projects/Misc)	Daily Avg Accts Registered	QR Audit %	AHIQA Grade	Copay Collection
Mar-17	Employee 1	443	183.50	95	88.50	40	97%	91%	57%
	Employee 2	516	183.50	30.84	152.66	27	96%	99%	84%
	Employee 3	626	159.75	7	152.75	33	94%	86%	48%
	Employee 4	915	179.00	0	179.00	41	94%	84%	N/A
	Employee 5	606	182.50	64.25	118.25	41	98%	100%	93%
	Employee 6	717	184.25	0.1	184.15	31	93%	85%	0%
	Employee 7	856	183.50	1.15	182.35	38	97%	100%	81%
	Employee 8	842	184.50	0	184.50	37	97%	100%	N/A
	Employee 9	827	157.50	0	157.50	42	97%	99%	N/A
		Average QR Audit March 2017					96%		

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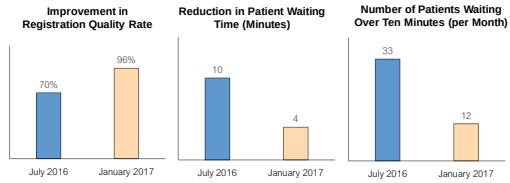
Enhance Quality Tracking

- As a result of its efforts, the Missouri-based organization increased registration quality and reduced wait times



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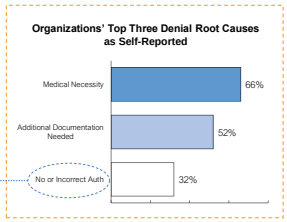
Foster Denial Awareness

- In 2018, HBI's members reported denials as a top area of focus
- Authorization-related issues are the third-most reported cause of denials

Oftentimes, these denials do not make their way back to the originating department



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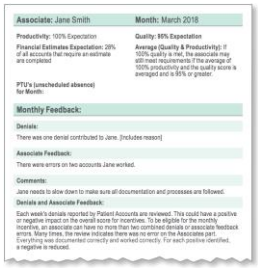
Foster Denial Awareness



Associate: Jane Smith **Month:** March 2018

Productivity: 100% Expectation

Financial Estimates Expectation: 20% of all accounts that require an estimate are completed

Quality: 95% Expectation

Average (Quality & Productivity): If 100% quality is met, the associate may still meet requirements if the average of 100% productivity and the quality score is averaged and is 95% or greater.

PTU's (unscheduled absence) for Month:

Monthly Feedback:

Denials:
There was one denial contributed to Jane. [includes reason]

Associate Feedback:
There were errors on two accounts Jane worked.

Comments:
Jane needs to slow down to make sure all documentation and processes are followed.

Denials and Associate Feedback:
Each week's denials reported by Patient Accounts are reviewed. This could have a positive or negative impact on the overall score for incentives. To be eligible for the monthly incentive, an associate can have no more than two combined denials or associate feedback errors. Many times, the review indicates there was no error on the Associates part. Everything was documented correctly and worked correctly. For each positive identified, a negative is reduced.

- Access and pre-auth staff are included on a denial management committee at one organization in Georgia

A monthly report card is sent to pre-auth staff, which includes denials they were accountable for.

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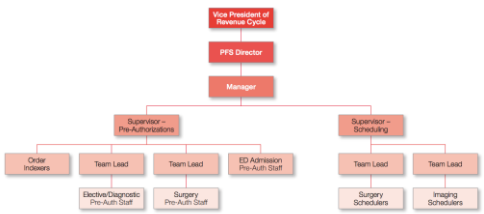
Coordinate Scheduling and Authorizations

- The organization also has segments of its scheduling and pre-auth teams report to the same manager



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Coordinate Scheduling and Authorizations

- A workflow tool automatically sends in-scope services from scheduling to the authorization team
- Pre-auth staff work accounts by appointment date and are held to hourly productivity goals:
  - Diagnostic Pre-Auth Staff: **4 per hour**
  - Surgery Pre-Auth Staff: **5 per hour**
  - ED to IP Admissions Pre-Auth Staff: **6 to 6.5 per hour**

Schedulers use a cheat sheet to identify how far in advance services should be scheduled by payer.

Excerpt of Georgia Organization's Payer Pre-Auth Chart for Schedulers

Payer	Scheduling for Pre-Auth Requirements
Aetna	3 days out
Ambetter	14 days out
Amerigroup	7 days out
Blue Cross	3 days out
Cigna	3 days out
Cigna Health Spring	14 days out
Coventry	3 days out
Humana	3 days out
Medicaid	14 days out
Medicare	0 days out
United Healthcare	7 days out

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Coordinate Scheduling and Authorizations

- As a result of its strategies, the organization is able to secure pre-auths further in advance

Number of Days in Advance Diagnostic Pre-Auths Are Obtained at Georgia Organization

Then	Now
1 Day Before Care	4-5 Days Before Care

Obtained 95% of the time

"Successful pre-auth processes are a team effort. Not every health system has scheduling and pre-auth staff married together and there is a great value in that. In addition to teamwork, it is critical to understand your denials so you can work the root causes to improve and eliminate them."

-Pre-Authorization Manager, Featured Organization in Georgia

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Create a Consumer-Friendly Experience

1. Examining Trends in Self-Service
2. Offer a Customizable Experience
3. Embrace Mobile Technology
4. Enable Patients to Generate Estimates

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Examining Trends in Self-Service

What Self-Service Options are Organizations Currently Offering?

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27%
Offer Mobile Scheduling

15%
Enable Patients to Create Their Own Estimates

39%
Allow Patients to Pre-Register Online

53%
Allow Patients to Schedule Online

33%
Offer a Mobile Billing Option

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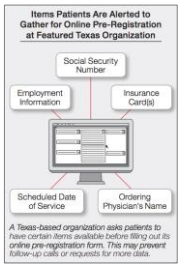
Offer a Customizable Experience



- Online pre-registration offers a positive, private experience
  - But, make sure the portal guides patients through the process
- Consider allowing patients to specify unique needs, such as if they need a translator or have religious beliefs that may affect their care

Average Time to Register Pre-Registered Patients	*Average Time to Register Patients Who Are Not Pre-registered*
3.2 *minutes*	9.5 *minutes*

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Audience Question

- What percent of patients would like to check in for their service using their own mobile device?

Source: InstaMed (2017)

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Audience Question

- What percent of patients would like to check in for their service using their own mobile device?

Source: InstaMed (2017)

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Embrace Mobile Technology

- A cancer center in Florida is phasing out its check-in kiosks for portable tablets and other mobile options

HBI's Pros and Cons of Front-End Kiosks

Kiosk Benefits	Kiosk Drawbacks
• Patients are familiar with them in other industries (e.g., airlines)	• Units are more expensive than other familiar technologies (e.g., iPads)
• Feature-rich kiosks can print documents, accept payment, and integrate with EHRs	• Adding extra features often comes with an associated cost on top of the base price
• In the right service setting, kiosks can right-size registration staffing	• Patients may struggle to use the machine correctly or simply not want to use

Cost Per Unit of Self-Service Technology Determined by Featured Florida Organization

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Embrace Mobile Technology

- The new process accommodates both patients who want to pre-register online and those who prefer to register in person

- Utilization is high: **70% of patients** sign up for an account prior to their first visit

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Enable Patients to Generate Estimates

- Providing estimates is an effective way to spark financial conversations
- New regulations may create confusion and a possible uptick in estimates
- Get ahead of it through proactive education and by leveraging technology

47% Of organizations plan to provide complementary education to charge lists

% of Organizations Have Increased Pre-Service and POS Collections by Providing Estimates

73%

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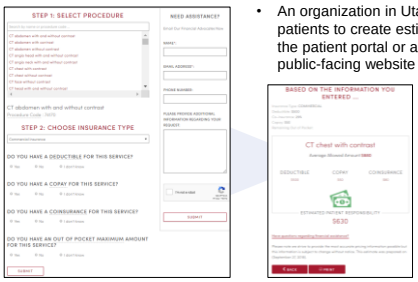
Enable Patients to Generate Estimates



- An organization in Utah allows patients to create estimates using the patient portal or a tool on its public-facing website

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Reinvigorate Financial Assistance

1. Calibrate Your Policy to Protect Mission and Margin
2. Connect With Patients Proactively
3. Build Financial Awareness

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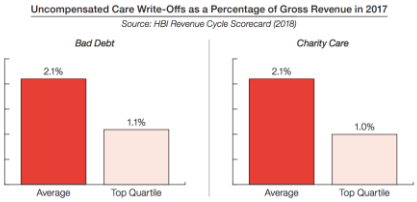
Calibrate Your Policy to Protect Mission and Margin

- Financial assistance is important to both your financial and mission-based goals



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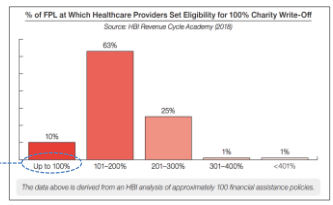
Calibrate Your Policy to Protect Mission and Margin

- Many organizations offer parameters for partial assistance, and some are upping the ceiling for full write-offs

- Factors to consider:
  - Local cost of living
  - Unique patient population characteristics
  - Organizational characteristics

In 2019, the FPL for an individual in the 48 contiguous states and the District of Columbia is **$12,490**, and the amount increases by **$4,420** for each additional family member.



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Calibrate Your Policy to Protect Mission and Margin

- A health system in Utah streamlined its financial assistance models to prevent confusion and encourage patients to apply

- Estimated financial impact: **$22 million in bad debt is expected to move to charity care**

Previously, the organization had four assistance models, as well as assistance for extenuating circumstances.

Financial Assistance Models at Featured Utah Organization

Model	Description
Maximum Assistance Model	• Applies to patients with household incomes <200% of the federal poverty level • Patients are responsible for variable copay ranging from $30–$150 per service, maxing out at $300 • Primary care costs $35 per visit, home care costs $50 per month, behavioral health and wound care costs $10 per month, while eligible patients are asked to pay $150 per inpatient stay, $50 per outpatient visit, and $150 per ED visit
Catastrophic Assistance Model	• Applies to hospital balances and bad debt encounters for patients with a balance >35% of annual gross income • Extended to patients with household incomes >500% of the federal poverty level • Remaining balance is adjusted down to 35% of patient's household income
Estimated Ability to Pay Model	• Applies to hospital balances and bad debt for patients with household income between 201% and 500% of the federal poverty level • For every 10% increase in federal poverty level standing, patients pay an additional 1.1667% of their annual gross income.

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Calibrate Your Policy to Protect Mission and Margin

- A multi-state health system in the Northwest offers full or partial assistance to both patients who are uninsured or have a balance after insurance
- Also has a catastrophic clause that allows decisions to be made based on unique situations (e.g., new illness or death in family)

Financial Assistance at Featured Northwestern Organization

Household Income as a % of FPL	Write-Off Amount
300% or less	100%
301-350%	75%

"It's not an easy job. When you talk to people about their finances in a really critical time, you need the right temperament and the ability to have empathy, but still be able to gather the necessary information."

-Director of Financial Counseling and Assistance

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Connect With Patients Proactively

- The aforementioned cancer center in Florida calls scheduled self-pay patients and those whose previous charity determination is expiring a week before care to screen them for assistance
- Counselors follow a multi-step process:
  1) Screen patient for Medicaid eligibility
  2) Automatically screen patient for financial assistance eligibility using third-party vendor
  3) Manually screen patient with vendor-provided portal
  4) If patient cannot be cleared, advise them to fill out financial assistance application

If either of these screenings show the patient qualifies, counselors can approve them immediately for assistance.

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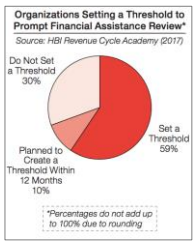
Connect With Patients Proactively



- Set an out-of-pocket balance threshold at which patients are automatically given financial assistance information or routed to financial counselors
  - A North Carolina provider routes uninsured patients with **balances over $5,000** to financial counselors.
  - A Washington State organization sends patients with scheduled **procedures over $1,000** to financial counselors.
  - A CAH in Washington connects patients discharged from the ED with a history of bad debt or an estimated **responsibility of over $2,000** to financial counselors.

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Build Financial Awareness

- Who should be involved in educating patients?
  - Pre-service staff
  - Frontline access staff (e.g., registrars)
  - Price estimation staff
  - Financial counselors
  - Physicians and other clinicians

Patient Scenario	Sample Scripting
Explaining a Price Estimate	"We were able to access your benefits with your insurance company and your [type of plan (e.g., HMO, PPO)] plan benefits include an estimated out-of-pocket patient portion amount of [$XX] for your [scheduled service]. This amount is just an estimate of your out-of-pocket patient portion and is based off of your insurance benefits, which includes your level of copay, coinsurance, and deductible benefits for the service(s) you are scheduled for. How would you like to take care of that today?"

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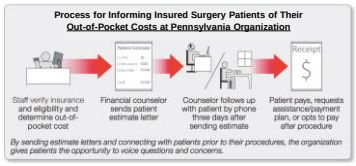
Build Financial Awareness

- Financial counselors at an organization in Pennsylvania call scheduled surgery patients three days after sending estimates to educate them about their costs and gauge their ability to pay



"Financial counselors aim to gain insight into the patient's financial situation, and, if the patient expresses hardship, they offer to help them set up a payment plan or apply for our charity program."

-Financial Counselor Supervisor

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Questions?

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