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Collections up 25% with this change

Move cost discussion earlier in process

"Who is in network for my plan?" "How do I sign up for coverage?" "What plans do you participate in?"

Patient access employees at Sutter Health in Roseville, CA, are fielding many such questions from patients, reports **Becky J. Peters**, registration lead, West at Sutter Shared Services.

These changes were made to improve the financial counseling process:

• The preregistration/financial clearance process was expanded.

Previously, staff reviewed patients' insurance eligibility and benefit coverage. Now they also give them an estimate of their liability after insurance, which wasn't done consistently before.

They implemented a new patient price estimator: Patient Payment Estimator, manufactured by Franklin, TN-based Passport. "This is now used as our standard across all facilities," says Peters.

The preregistration team provides patients a price estimation based on their scheduled procedure. The estimate calculates the amount of reimbursement expected from the patient's insurance and the patient's specific benefits.

"We also provide the same service for patients that are not scheduled, but come in as a walk-in for outpatient procedures," says Peters. "We saw at least a 25% increase in our upfront collections."

• Ongoing training programs are offered to update staff on constantly changing payer requirements.

"We are developing our own training unit. It will focus on all aspects of patient access services: basic registration, customer service, cash collections, technology training, compliance, and insurance," says Peters.

Training will cover identifying participating versus non-participating plans, electronic eligibility and benefit responses, Medicare plans, Medicare Risk plans, and plans available on Covered California, the state's health insurance exchange.

"We will have dedicated trainers, and we will also be doing a lot of 'train the trainer' with our management team," says Peters. "Most of the training will be mandatory."

Many different formats are used for training, including trainer-led sessions, webinars, and online educational tools. "We are developing a new hire training program, as well as ongoing competencies," says Peters.

• Patient access leaders collaborate with the hospital's third-party liability vendor.

"They assist patients in applying for federal, state, and county programs," says Peters. "They provide guidance on how to apply for Covered California plans online."

• A new patient advocate role was added at preregistration and point of service.

This individual assists patients in understanding their coverage benefits and identifying whether additional financial assistance is needed.

"The role used to be a financial counselor," says Peters. "We revised it and added responsibilities for real-time financial assistance review."

By identifying the issues earlier in the process, such as that a patient is uninsured or underinsured, staff members have enough time to work with

Focus is on education

Trinity Rock Island (IL) has cut back on the hospital's financial assistance program as a result of the Affordable Care Act, reports **Linaka Kain**, DE, an Illinois in-person counselor and lead Medicaid specialist.

"When we apply for Medicaid for patients, we ask for retroactive coverage. We use our financial assistance program as a last resort," she says. "All avenues of coverage have to be exhausted first."

Self-pay patients are now required to apply for Medicaid or the Health Insurance Exchange Marketplace before any financial assistance is offered. Written proof of an approval or denial of insurance is required.

"This has worked very well for us," says Kain.

EXECUTIVE SUMMARY

Patient access areas are moving financial discussions earlier in the process to give patients detailed information about their coverage. At Sutter Health, upfront collections rose by 25% as a result of giving price estimates when pre-registering patients. Departments are making these changes:
- implementing training programs for staff, covering all aspects of insurance;
- adding a patient advocate role at pre-registration and point of service;
- requiring patients to apply for Medicaid or other coverage before offering financial assistance.

"Registration staff calls us while they are registering the patients to counsel them." If it's not convenient for the patient at that time, staff members give them business cards with the Medicaid specialist/certified application counselors' general call line number.

"We are really concentrating on educating the patients," says Kain. "We are letting them know that we no longer just write off their bills unless they meet our criteria."

Focus is on Medicaid signups

Trinity enrolled 1,138 consumers in the last 2014 enrollment period -- 750 in Medicaid and 388 in the Health Insurance Exchange Marketplace. The department's focus is on signing up as many patients for Medicaid as possible.

"This will allow us more time for [the open enrollment period for 2015 coverage] when it starts in November 2014," says Kain.

Kain still encounters many patients who don't know what the terms "copay" or "deductible" mean.

"We have to remember that if someone has never had insurance before, they don't know all the terminology," she says. "Some people don't realize that you have to pay your premium first before the card works."

SOURCES

- **Becky J. Peters**, Registration Lead -- West, Sutter Shared Services in Roseville, CA. Telephone: (916) 297-9004. Email: petersba@sutterhealth.org.
- **Linaka Kain**, DE, Lead Medicaid Specialist, Trinity Rock Island (IL). Phone: (309) 779-2648. Email: Linaka.Kain@unitypoint.org.