Strategies for the Future: HFMA’s Revenue Cycle Initiatives

North East Ohio Chapter
2016 GHALI
May 18, 2016

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Director – Healthcare Finance Policy
HFMA
The Initiatives

HEALTHCARE DOLLARS & SENSE™

Price Transparency

Patient Financial Communications

Medical Account Resolution

GO BEYOND
Perspectives
Background

Every day, healthcare professionals conduct sensitive financial discussions with patients. But there have been no accepted, consistent best practices to guide them in these discussions—until now.
In the Beginning, Survey Said …

• Prior to the development of the Patient Financial Communication Best Practices, my organization pursued conversations with patients less than 25% of the time – 37% of responders

• My organization has or plans to implement the best practices within the next 12 months - 71% of responders

• My organization plans to apply for Adopter status within the next 18 months – 41% of responders
Best practices for healthcare providers:
- Emergency Department
- Time of Service (Outside the ED)
- In Advance of Service
- Patient Financial Communications – All Settings
- Measurement Criteria Framework
  - Training
  - Process compliance evaluation
  - Technology evaluation
  - Feedback and response evaluation
  - Executive level metrics reporting
When and Where to Have Patient Financial Discussions

Discussions at the time of service

- In the ED
- Outside the ED setting

Discussions in advance of service
Who Participates in Patient Financial Discussions

Routine scenarios
Non-routine or complex scenarios
Topics Addressed in Patient Financial Discussions

Provision of care
Registration, insurance verification, and financial counseling
Topics Addressed in Patient Financial Discussions

Patient Share
Prior balances (if applicable)
Balance resolution

Value = \frac{\text{Quality}}{\text{Payment}}
Parameters for Patient Financial Discussions

Compassion
Patient advocacy
Education
Compliance Framework

Training program
Process compliance
Metrics reporting
Compliance Framework

Technology

Feedback process and response
HFMA’s Programs

- Education Products – comprehensive program **available now** from HFMA
- Adopter Recognition – **Available now**
- Compliance Recognition – **Available now**
- Vendor “Peer Review” program for consulting assistance on Patient Financial Communications Best Practices implementation – **Available now**
Education Program – Webinar Demo
Patients Benefit

Understands Out-of-Pocket Liability

Focus on clinical care at time of service

Single point of contact for finances

Knows how account will be resolved

Engaged

Reduces back end problems (denials, etc.)
Providers Benefit

• Opportunity to encourage patients to talk with financial counselor about any financial concerns
• Identify opportunities to locate additional or alternative insurance coverage
• Secure how accounts will be resolved through conversation
• Identify patients who fall under the 501r regulations
• Benefit from the PR value of a satisfied consumer vs. an unhappy consumer
Achieve Recognition as an Adopter

- Recognition demonstrates commitment to best practices
- Based on HFMA review of an application and supporting documentation
- All provider organizations may apply
- Recognition valid for two years
- Adopters may use the phrase “Supporter of the Patient Financial Communications Best Practices” in their marketing materials

HEALTHCARE DOLLARS & SENSE
Patient Financial Communications

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

THIS ACKNOWLEDGES THAT
THE METROHEALTH SYSTEM
HAS SUCCESSFULLY COMPLETED THE SELF-EVALUATION FOR RECOGNITION AS AN ADOPTER OF THE PATIENT FINANCIAL COMMUNICATIONS BEST PRACTICES
BY THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Renewed to May 31, 2018

MAY 31, 2016

Healthcare financial management association
Adopter Checklist

Check the boxes for items that apply to your organization. If you can check most of the boxes on this list, your organization is well positioned to apply for and receive recognition as an Adopter of the Best Practices for Patient Financial Communications. If some of these items don’t yet apply to your organization, you have identified areas for improving your approach to patient financial communication. HFMA offers an online training program that can help.

1. We have a written policy and procedures to govern patient access activities related to patient financial communications in the following situations and settings:
   a. Emergency department
   b. Unscheduled (walk-in) patients at the time of service
   c. Advance of service

2. Our financial policies specify what to do in the case of patients who have a prior balance when they present for and/or schedule care.

3. We have a toll-free number that is widely publicized that patients can call to receive assistance with financial matters and concerns.
4. I agree with the following statements:

- a. Compassion, patient advocacy, and education are a part of all patient communications at my organization.
- b. We use standard language to guide staff on the most common types of patient financial communications.
- c. Face-to-face communications are used appropriately to facilitate one-time resolution.
- d. Availability of supportive financial assistance is always communicated to the patient and the community.
- e. We initiate financial communication with patients.
- f. We include the patient’s perspective in the development of the standard language used for patient financial communications.
- g. We routinely verify patient information and the patient’s preferred methods for future communication.
- h. We respect patient privacy in all financial communications.
- i. All of our patient financial communications focus on steps toward amicable resolution of financial obligations.
5. We have technology solutions in place to support the following functions:
   - a. Insurance verification eligibility
   - b. Estimation to calculate the patient’s responsibility for services
   - c. Identification of prior balances due

6. We have a process in place to assess our performance in areas related to patient financial communications.

7. We have a training program in place for staff in the Emergency Department, Patient Access, Financial Counseling, and Customer Service who deal with patient financial communications.
8. We can provide recent year-end data on the following performance metrics (definitions and sources will be provided):
   a. Net days in A/R
   b. POS cash as a percentage of total patient cash
   c. Insurance verified encounters as a percentage of total encounters
   d. Pre-registered encounters as a percentage of scheduled encounters

9. Our CFO or Vice President of Revenue Cycle will attest to the accuracy of the information we submit in our application.
Price Transparency
Fill out the form, and then spin the wheel to get the price of your procedure.
Historical Factors Limiting Price Transparency

• Historically, prices have served a wholesale function

• Only recently have prices been viewed as retail

• Without transparency, neither consumers nor hospitals could compare hospital prices

• With thousands of items, the chargemaster is not “transparency-friendly”—and not reflective of “price”
Factors Driving Transparency Today

• Rising deductibles and out-of-pocket payments
  o Continued growth in employer-sponsored high-deductible health plans (HDHPs)
  o High exposure to HDHPs in ACA plans
• Employer pressure on private payers and providers
• Growth of third-party transparency tools
ACA Enrollees Prefer Silver and Bronze Plans

These plans have deductibles ranging from ~3K to 10K

Enrollment on Exchanges¹

Average Benefits by Plan Type²

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
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</thead>
<tbody>
<tr>
<td>Avg. Ind. Deduct.</td>
<td>$5,081</td>
<td>$2,907</td>
<td>$1,277</td>
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<tr>
<td>Avg. Fam. Deduct.</td>
<td>$10,386</td>
<td>$6,078</td>
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<tr>
<td>% Covered Expenses</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
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<td>OOP Max Ind.</td>
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<tr>
<td>OOP Max. Fam.</td>
<td>$12,569</td>
<td>$11,495</td>
<td>$8,649</td>
<td>$3,710</td>
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</tbody>
</table>

¹Source: Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ASPE Issue Brief: Health Insurance Marketplace: January Enrollment Report (January 2014)

²Source: HealthPocket.com; averages across 34 states
Ability to Pay

Most Individuals Buying Coverage in the Exchange Lack the Resources to Pay for Cost Sharing

% of Households with Liquid Financial Assets Greater than “Higher” Deductibles Compared to Distribution of Exchange Enrollees by FPL

Higher Deductible Defined as $2,500 - $5,000

Sources:
3) HFMA Analysis
Employee Cost-Sharing

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2013

- Estimate is statistically different from estimate for the previous year shown (p<.05).
- NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
Consumers Want Better Price Information

“Participants repeatedly said they wanted to see a resource, or ask their doctor, to better understand what a particular test or procedure would cost before they agreed to it, and wanted to comparison shop among providers when possible. They said that they also wanted the ability to know what a treatment *should* cost before they agreed to it, and needed more transparent information on price in order to do this….They were very interested in efforts to share information on price and quality.”

The Result

• In a system where...  
  – Charges are primarily used as a factor in a payment calculation
  – Actual prices are essentially invisible to the consumer, and...
  – Charges have little relationship to the service being acquired

... change is inevitable!

We all contributed to this situation—hospitals, physicians, payers, the business community, and even patients. We all need to work together to fix it!
HFMA Price Transparency Task Force
• Clarifies basic definitions that are often misused
• Sets forth guiding principles
• Establishes roles for payers, providers, others
• Reflects consensus of key stakeholders

hfma.org/dollars
Cost, charge, and price should not be used as interchangeable terms.

- *Cost* varies by the party incurring the expense.

- *Charge* is the dollar amount a provider sets for services rendered before negotiating any discounts.

- *Price* is the total amount a provider expects to be paid by payers and patients for healthcare services.
Definitions of Parties to a Transaction

Care Purchaser

- Individual or entity that contributes to the purchase of healthcare services.

Payer

- An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.

Provider

- An entity, organization, or individual that furnishes a healthcare service.
An Actionable Definition of Price Transparency

Readily available information on the price of healthcare services, that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.
Guiding Principles

• Price transparency information should:
  – Empower patients and other care purchasers to make meaningful price comparisons
  – Be easy to use and easy to communicate
  – Be paired with other information that defines the value of services for the care purchaser
  – Enable patients to understand the total price of their care and what is included in that price

• And price transparency will require the commitment and active participation of all stakeholders.
Roles for Key Stakeholders

• **Health plans** should serve as the principal source of price information for their members.

• **Providers** should be the principal source of information for uninsured patients and out-of-network care.

• **Referring clinicians** should use price information to benefit patients.

• **All stakeholders** can offer a price information resource to consumers.
Health Plan Role

- Health plans should serve as the principal source of price information for their members.
- Tools for insured patients should include:
  - The total estimated price of the service
  - A clear indication of whether a particular provider is in the health plan’s network
  - A clear statement of the patient’s estimated out-of-pocket payment responsibility
  - Other relevant information on the provider or service sought
Provider Role

For uninsured patients and out-of-network care, providers should:

• Offer an estimated price for a standard procedure and make clear how complications may increase the price.
• Clearly communicate pre-service estimates of prices.
• Clearly state what services are included in an estimate.
• Give patients other relevant information, where available.
Referring Clinician Role

• Physicians and other referring clinicians should
• Help patients make informed decisions about treatment plans
• Recognize the needs of price-sensitive patients
• Help patients identify providers that offer the best value
Employer Role

• Employers should continue to use and expand transparency tools that help their employees identify higher-value providers

• Self-funded employers should identify data that will help them
  – Shape benefit design
  – Understand their healthcare spending
  – Provide transparency tools to employees
All Stakeholders Can Offer a Pricing Resource to Consumers

- Describes how to request price estimates, step by step
- Clarifies what estimates may or may not include
- Explains in-network and out-of-network care
- Defines key terms
- Available for posting on your website at no charge
- Hardcopies available for purchase in bulk at a nominal price through AHA’s online store

hfma.org/tconsumer guide
ahaonlinestore.org
Example: Ensure Easy Access to Information

At St. Luke’s, we understand that price transparency is important. If you need help determining how much a procedure will cost, contact St. Luke’s price line at (319) 369-7513. You may also register for free text relay service for people with hearing loss or speech disability.

Ready to help

St. Luke’s has 15 full- and part-time financial counselors available to answer questions. Our Financial Counselors generally need one to two business days to provide an answer.

- E-mail St. Luke’s Financial Counselors

Uninsured and Underinsured

St. Luke’s Hospital provides patient care to a growing number of uninsured and underinsured patients. If you’re carrying a greater burden of your healthcare costs through increasing out-of-pocket deductibles or you lack the financial resources to secure health insurance, St. Luke’s Hospital has developed financial policies to seek fair and equitable payment based on your ability to pay.

St. Luke’s assists patients who cannot reasonably pay for some or all of the care they receive. To find out if you qualify for discounts
Example: Allow Patients to Search for Providers in Their Area
Example: Identify Key Service Components & View Range of Prices in the Area
Example: See List of Area Providers Ranked, Based on Relative Price

Provider Listing

This website displays the prices Priority Health negotiates with providers in your Priority Health network. They are grouped as:

- Green: At or below the Fair Price
- Yellow: Slightly above the Fair Price
- Red: Among the most expensive
- Black: Provider doesn’t allow contracted prices to be shown. Contact them directly.

Prices shown are lower than prices charged to the general public. They include a discount that Priority Health negotiates with providers who are part of the network for your plan. Before scheduling treatment, call health care providers to double check that they are in your plan’s network and what prices they charge for the services you need.

Facilities | Physicians | Price
---|---|---
Surgery Center T (~ 12 miles) | See doctors | Green
Surgery Center A (~ 7 miles) | See doctors | Green
Hospital B (~ 12 miles) | See doctors | Yellow
Surgery Center X (~ 15 miles) | See doctors | Red
Example: Provide Simple, Clear Estimates for Self-Pay Patients

Thank you for choosing Maricopa for your healthcare needs. As requested, this letter summarizes the deposit that will be required prior to the requested service being provided. The following anticipated charges are only an estimate for the requested procedure(s) or service(s) outlined below and does not include charges due to complications or any additional procedures.

**Patient Information**
- Patient Name: [Redacted]
- Patient Address: [Redacted]
- Patient Phone: [Redacted]
- Medical Record Number: [Redacted]
- Account Number: [Redacted]
- Estimated Date of Service: 4/3/2014
- Estimated Discharge Date: 4/3/2014

**Estimate Details**

**Services**

**Description** | **Service Amount**
--- | ---
0960-PF BX BREAST 1ST LESION STRTCTC | $1,041.00

**Estimated Charges:**
- $1,041.00
- $923.50
- $717.50

**Total Estimated Charges:**
- $1,041.00

**Adjustments:**
- Self Pay Discount: -$923.50
- Prior Unpaid Balance: $0.00

**Your Estimate:**
- $717.50

Important Notice about direct payment for your healthcare services. The Arizona Constitution permits you to pay a healthcare provider directly for healthcare services. Before you make any agreement to do so, please read the following important information:

If you are enrolled in a health plan and your healthcare provider is contracted with the health insurance plan, the following apply:

1) You may be required to pay the healthcare provider directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments.
Checklist for Preparing for Price Transparency

• Secure board and executive team support
• Identify a reasonable starting point
• Consider how care purchasers will access the information you provide
• Identify other information sources that will help patients assess the value of the services you provide
• Be prepared to explain healthcare pricing
Medical Account Resolution
Best Practices for Medical Debt

By following the HFMA Best Practices for Medical Account Resolution, your organization is affirming that . . .

- We want to find solutions that are balanced, fair, and reasonable.
- We keep patients informed about payment expectations and time frames.
- The business practices that we—and our business affiliates use—have been approved at the Board level.
Selected Best Practices

• Educate patients and follow best practices for communication

• Make all bills and other communications clear, concise, correct, and patient-friendly

• Establish policies and make sure they are followed internally and by business affiliates

• Be consistent in key aspects of account resolution—from billing disputes to payment application

• Coordinate with business affiliates to avoid duplicative patient contacts
Selected Best Practices
(cont.)

• Exercise good judgment about the best ways to communicate with patients about bills

• Start the account resolution clock when the first statement is sent to the patient

• Report back to credit bureaus when an account is resolved (in the event that an account is reported to a credit bureau)

• Track all consumer complaints.

• Draw on best practices, principles, and guidelines to inform your organization’s approach
Implementation of Patient Financial Communications Best Practices
Implementation – In the Beginning …

• Someone has to lead the charge
• C-Suite leadership is critical
• It takes a team
• What is your current performance
• What are your opportunities
It Takes a Team

- The cast of the obvious – patient access
- The cast of the less obvious – clinical leaders, ancillary department personnel
- The cast of the lesser obvious – volunteers (Pink Guys and Gals, et.al.), physicians, physician office managers, marketing/public relations personnel, members of the Board
Gap Analysis

• Comparing best practices to current practices
  – Observation of current activities
  – Documentation of gaps

• Identifying the degrees to which our organization is willing to commit to the Best Practices
  – No “one size fits all”
  – Think BIG!
  – Uses Gap analysis to identify potential policy and procedure changes
### Sample Gap Analysis Worksheet

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<tr>
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<td>2.3.2 Insurance verification - review insurance eligibility details with patient to ensure accuracy</td>
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Next Steps

• Summarize gaps by service area
• Identify potential policy changes and present to C-Suite sponsor
• Finalize policy changes!
Next Steps - Strategies

• Hire, train and motivate compassionate, service-oriented staff

• Equip staff with tools to succeed:
  - Charge estimation
  - Insurance verification
  - Prior balances
  - Financial assistance applications, process
  - Scripting
  - Ongoing refresher classes
Next Steps - Strategies

• Best Practices Training Recommendations
  - Annual program
  - Documented and shared with C-suite annually
  - Variety of methodologies may be used
  - May use internal or externally sourced program(s) and faculty, subject to review by designated quality officer
  - HFMA will offer materials by early summer, 2014
Next Steps - Strategies

• Best Practices Training Recommendations
  - Content
    o Match best practices to specific staff roles
    o Financial assistance policies
    o Available patient financing options
    o Alternative solutions for the uninsured
    o Standard language to be used in patient discussions
    o Laws and regulations specific to staff role (EMTLA, FDCPA, TCPA, etc.)
Next Steps - Strategies

• Education
  - Revenue cycle staff: change the vocabulary
  - Patient access staff: establish where, when and how to have what conversations with patients
  - Provider clinical staff: why financial conversations represent best practices; why financial care is a component of patient care
  - All other provider staff: how these best practices help our patients first
Next Steps - Strategies

• Education (continued)

- Physicians: non-interference with clinical care; why financial conversations represent best practices; why financial care is a component of patient care

- Navigators or Certified Application Counselors (CACs): keep their conversations with patients in sync with provider’s philosophies and requirements

- Volunteers: share why and how the best practices are helping patients understand the financial part of their care

- Others
Next Step - Strategies

• Patients

  - Create tools and materials to help patients understand:
    
    o Insurance verification results, especially high deductible plans, in vs. out of network plans, open enrollment period, etc.
    
    o Cost to the patient
    
    o Financial options
    
    o Financial assistance options
Next Step - Strategies

• Patients (continued)
  - Use website materials to help guide patients through the pre-service and time of service activities
  - Recognize when a patient needs help to understand the conversation - patient advocate, family member, etc.
  - Conduct patient satisfaction surveys to measure impact of best practices
  - Document everything (IRS 501r rules applying to uninsured and underinsured)
Prescription for Success – Implement!

• Make it happen – just do it!

• Never forget the importance of managing by walking around – listen to your staff; listen to your patients
Next Steps - Metrics

- What we measure, staff treat as important!
- Create the before and after picture
  - Patient satisfaction-HCACPS, etc.
  - Pre-registration
  - Insurance verification
  - Focus group results
  - % of patients participating in financial discussions
  - POS collections
  - Net A/R days
Next Step – Reporting Results

• Feedback and response protocols
• Escalation process for patient complaints
• Reporting to C-Suite on an annual basis
• Annual overall compliance report to C-suite team
Effective patient financial communications are critical

– For patient satisfaction
– For financial health of organizations

Integral part of their culture
Achieve Recognition as an Adopter

- Recognition demonstrates commitment to best practices
- Based on HFMA review of an application and supporting documentation
- All provider organizations may apply
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- Adopters may use the phrase “Supporter of the Patient Financial Communications Best Practices” in their marketing materials
What We Dare Not Do!
Questions?

Healthcare Dollars & Sense

Quicklinks
- New: Learn more about HFMA’s Patient Financial Communications Training Program
- Discover how to achieve recognition as an Adopter of HFMA’s Best Practices for Patient Financial Communications
- Download Understanding Healthcare Prices: A Consumer Guide and post it on your organization’s website. No permission needed.

“How much will I have to pay? What is included in the price? What if I have trouble paying?” Now more than ever, people are asking questions about the price of health care. They are called on to make more decisions and pay more out-of-pocket for the services they receive. They are looking for the information they need to find and pay for quality care.

Patients and other consumers are not alone in asking these questions. Employers, insurers, and public officials want to understand and get the best value for every dollar they spend. Healthcare Dollars & Sense aims to answer these questions—to help make sense of price and value in health care.

The Healthcare Financial Management Association (HFMA) convenes stakeholders from across health care—hospitals, physicians, insurers, consumers, public officials, employers, and credit agencies—to improve the way we communicate about healthcare prices. Out of these efforts have come these recommendations for all stakeholders.

Do you have a few minutes to answer two questions about HFMA’s website?

Please Click Here

http://www.hfma.org/dollars/
### Appendix: Sample Gap Analysis Worksheet

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<tr>
<td>2.1 Discussion participants-properly trained registration or discharge rep; supervisor or FC for complex cases; patients have opportunity to request advocate, designee or family member to assist</td>
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<td>2.2 Setting – during registration or discharge; during medical care as long as does not interfere and with patient consent</td>
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<td>2.3.3 – Financial counseling – if appropriate, refer patient to financial counselor or offer information regarding provider’s financial counseling service and assistance policies</td>
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<td>2.4 Provision of care-provider will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective services. Clear definitions of elective and non-elective services.</td>
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<tr>
<td>2.4.1.2 – Elective services-prior balances – patients will be informed if provider’s policies regarding prior balances mean the service will be deferred</td>
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# Sample Gap Analysis Worksheet

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<tbody>
<tr>
<td>2.4.2 – Non-elective services</td>
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<tr>
<td>2.4.2.1 – Patients will be informed that ability to resolve patient share or prior balances will not affect provision of care</td>
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<tr>
<td>2.5 Patient share and prior balance discussions – will not interfere with patient care; will focus on patient education</td>
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<tr>
<td>2.5.1.1 Patient share: list of participating providers</td>
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<tr>
<td>2.5.1.2 Costs may vary from estimates and why</td>
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<td>2.5.1.3 If appropriate, provide payment options if patient is interested in them</td>
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<tr>
<td>2.5.1.4 If appropriate, provide financial assistance program information</td>
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<tr>
<td>2.5.2 Prior balance discussions</td>
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<tr>
<td>2.5.2.1 Discuss services that led to prior balance, including DOS and $; provide list if requested</td>
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<tr>
<td>2.5.2.2 If appropriate, discuss payment options</td>
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<tr>
<td>2.5.2.3 If appropriate, provide financial assistance</td>
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<tr>
<td>2.5.2.4 Proactively attempt to resolve prior balances through insurance and financial assistance</td>
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<tr>
<td>2.6 Balance resolution, including how and timing of collection activity</td>
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<tr>
<td>2.7 Summary of care documentation: written financial assistance information, financial implications of services provided; telephone number</td>
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