**CINDY SAMORAY:** So what we're going to do is just go over some general information regarding finance and kidney transplant. I have nothing to disclose either. Just working here working for our patients.

So the best financial practice begins with the very basic accurate information, good communication between dialysis centers providers, transplant centers, and the patient. After they've had the transplant, obviously the best financial practice is their ability to maintain their transplant with their insurance coverage, whether that be through employer coverage or through whatever is going to come about with the Affordable Care Act, and Medicare, and Medicaid. And then in those rare cases when there might be some self-pay.

So what we're going to go over in my time is we're going to just understand, again, how important it is that that very first contact be accurate and complete with legible documents providing the insurance information, the demographic information, which will allow us to decrease the length of time it takes between referral and actually getting in the door. And I'm going to show you some examples of what I look at and hopefully that will make an impact on you and you'll understand what I'm talking about.

Then we're going to review, of course, how valuable it is-- patient responsibility for their transplant. Very often they're used to people taking care of things for them, and it's very important that they are their own advocate. And then I'm also going to share with you how I have increased my recommendation that people do fund raising.

Fund raising is something that I recommend everybody do because you never know what's going to happen around the corner. You've got those high deductibles or co-pays, just the insurance premiums, and then, of course, life's uncertainties, those curve balls that you get.

So the first thing I want to say is please take your time and get it right. Every line on this referral form is valuable. It's valuable to me. It's valuable to the nurses. And it's important that we have the information.

One thing I noticed, and it might just have been my packet, but when you look at the new referral form that was given to you, make sure if you don't see a line for social security number, make sure you draw one in there. Our form does have that, but I just noticed mine didn't. And that social security number is very important to me.

So to be sure that you're passing on the correct information. Diagnosis and dialysis details is also very important to me so that when I'm working with a patient or an insurance I might know they've been on dialysis for a while. They might have Medicare coming down the road. Different things like them.

And of course, as I said earlier, the accurate and current insurance information. Sometimes-- and you'd be surprised how often wrong information is sent over. And also when you send copies, I love those copies, but please hand right-- I know it seems like a lot of work and we send in the copy, but you'll see that the copies come through very, very poorly. So please take the time and write the identification number, the name of the patient clearly.

And also include-- and I know Trish talked about this earlier. When I do my part working with the insurances, some I don't have to do anything with. I just have to verify that the coverage is active. There isn't any process I have to go through.

Others I have to submit medical information and at my point all they really need is current basic labs and a good history and physical. And I do know that those are very difficult to get from a dialysis unit because you don't have that monthly history and physical done by the nephrologist.

All right. So I think we get into my examples. So here is an example of some situations. And in this case, the person's name was different in three different areas. At the top where it was circled it was one way, first, middle, last. You know, sometimes names can get complicated. I don't know what it is.

Down at the bottom where there was insurance information it was written another way. And in this case, there was no social security number so I wasn't able to find out what it was that I needed to know from this particular referral. The documentation that came with it looked like this. And this is how I can say-- you can now see why I really need you to write the information down.

Sometimes it comes through so poorly, I have no idea. But on this case with the different names the driver's license and the security card also had different names. So I know when you're seeing people it's very important to ask them, is this the correct order of your name and the spelling of your name. Please try and clarify that.

So here is an example of the information that was passed on to me. The red circle at the bottom was their insurance identification number and it was missing a number. I couldn't tell who this person was. Because I did have the social security number, and this particular one was a Medicare Blue Cross product that go by their social security number, I was able to find what I need. But it's just an example. Everybody can do that. You know, I'm guilty of transposing things once in a while, but just please try and double check when you're sending the information.

This third example was where I had no insurance provided. There was also no supporting documentation that helped me out and I didn't have a social security number to work with. And in this case, there was, as you can see, this face sheet, but it was very difficult to read. Very hard to see.

And so the insurance details was of no value to me. And I can't remember if it was a dialysis unit I called or the patient, but I needed to call them and get the information. And as Trish was talking about earlier, you get that factor of the phone tag coming into play where it can just delay the process.

This is an example of where I had insurance names, as you can see, but I had no card copies, no other supporting information for me to work with. Because I did have the social security number, I was able to find what I needed. But what I wanted to point out about that is that's not the end all be all.

Sometimes a person's Medicare is through their spouse or through their parent. So the social security number of the individual loan is not definitely going to necessarily answer all of my questions, but it's very, very helpful. So please, when you're doing that initial referral, just take the time to make sure that that information is available to me.

And I did have one last example. And this is where the insurance form-- nothing was filled out, because they thought they were sending me what I needed to know. The face sheet, I discovered, had expired insurance information. And I don't have a copy of the card in my example, but another page that sent along was difficult to read, but I was able to read the insurance name so I was able to get a clue. So again, I know it seems like double work, but that helps me when I'm reviewing your patients and getting them approved for transplant evaluation.

So my part-- once the patient referral has gone through the medical review it's sent to me for insurance approval. Sometimes it's done-- usually it's done after that medical referral has been complete. What Trish was talking about the various people calling and talking with the patients. Usually that's done when it appears that the insurance is a slam dunk. It's Medicare, it's a Medicaid, it's a Blue Cross Blue Shield. But as I found, what's on that referral doesn't necessarily mean what they actually have. So sometimes there can be some crossover.

Some insurances are a straight up, no. And I haven't listed any of them because there is really only one right now that's a straight up, no, and that's Total Health Care. They currently can't come to us. But I didn't want to list anything because those things change as contracting changes and it could be OK one month and the next month all of a sudden it's not.

Sometimes authorization can be given at out-of-network approvals. And insurance-- an example of that would be UnitedHealthcare patients. With UnitedHealthcare use-- well, UnitedHealthcare uses Optum Transplant Resources as their transplant network.

And currently, U of M is not for kidney transplant, a participating provider. So people would need to go to other facilities. Their plan may have been built around the fact that there is absolutely no out-of-network access and then other times they can use an out-of-network facility, but at drastically reduced benefits. So I have to explore those things.

When we have somebody that's from out-of-state or their insurance is an out-of-state plan, I have to review those first before we bring them in for valuation. Many times, I don't need to at this level, at this stage of the game, talk to the patient. If it's Medicare Blue Cross, if it's an employer group health plan with very reasonable, if you will, out-of-pocket expenses, I don't call the patient at that point to go over additional details.

Sometimes I do. And I appreciate the times when I am able to do that because it just gives them a leg up on the information they're going to learn. Lets them feel a little bit more comfortable about what they're getting into. Other times, I do have to speak with them, especially if it's those situations where they're out-of-network.

I want them to fully understand what they're getting into. Yes, you can come to us, but you're going to have to pay $10,000 out of pocket, as opposed to going somewhere else and paying less. The best financial practice for those patients is getting them to where their insurance is going to give them the best coverage.

So once I've given my approval, an appointment is made. And when the appointment is made quickly you know, the process goes real smoothly. But if it is in the next month or sometimes they've rescheduled it again, and again, and again, I will review their insurance each month to make sure that they're still active and ready to come in for us.

It doesn't happen often, but once in a while an insurance can change in the time between their referral and their appointment. Sometimes it's just a matter of working with something new, getting approvals in place. Other times it's changed so much so that they can't come to us any longer. And those are things that I will communicate to the patient.

And then I also try, 99% of the time, to call you as well-- the dialysis unit social workers or the case managers because you know how it goes. You explain something to the patient, but what you hear from them is not at all what I said to them. So I do appreciate the ability to talk with you, and for you to also get in touch with me when you know something is going on.

So the evaluation day, as Trish was saying earlier, is this big long day and about 30 minutes of that is spent talking with me where I give an overview of general insurance information. And patients are able to ask questions as they come along. We talk about their current coverage, their access to Medicare if they're not on dialysis already, and various things like that.

When patients go to our outreach clinics, I'm able to have this interaction with them one-on-one, which is wonderful because I'm able to give them directly information that's helpful to them. Everyone is encouraged to follow up with their financial coordinator. I've got information later for you on who those people are.

I work with people getting them in the door, sharing this initial information, and then they're followed up long term by a specific person. So when I'm meeting with them, I always encourage them to-- especially if they're going to be listed, which they'll find out later-- to call their financial coordinator. Introduce yourself, make sure they've got the correct information for you, and do that periodically throughout the listing time.

Sometimes the information that they're getting from me, especially with regard to Medicare and signing up for Medicare, can be sort of a contradictory story, information, that they've gotten from the dialysis unit. So I just wanted you to know that I'm sensitive to the-- sometimes there can be that push. You want to keep them on that employer group plan longer through Cobra, through AKF. And we're looking at what's going to work best for them after transplant.

So while they're on the wait list-- because it can be from three to seven years, it's just very important to stay in touch with their financial coordinator. Their coordinators are also going to periodically review their coverage. So if they're finding that something has changed, they will be calling the patient and discussing that with them.

But it's very important and the preferred way to go for them to-- when they know something is changing no matter how subtle it is. One Blue Cross policy to another, let us know. There could be some significant change. So we will work with them.

So we-- as I was saying earlier, how we, financial coordinators, really value your participation. You might know sooner than we do if something is going on with their insurance situation or their financial ability to maintain their co-pays or deductibles. Just let us know. Please use us as a resource.

If you know something's going on, give us a call. If we know something's going on-- well, speaking for myself. And My coworkers to do this, but I would call you right away too just to let you know, because we're a team and we want to make sure that this is well put together and the best outcome for our patients. It's always better to know sooner rather than later.

There are times when people will have enough coverage to come in and be evaluated, but not enough to be listed. Primarily, this is when someone has Medicare only. And there are a lot of times you have somebody with Medicare in the VA. The VA will not cover transplant related services here. But Medicare is enough to get you in the door to find out, are you a candidate or not. And if somebody is a candidate then they're able to make the decision on accessing that additional coverage as possible.

So we have Michigan Cross Blue Shield, the Medigap policy. A lot of you are probably very familiar with how the price increase has had such a unfortunate effect. But it's still wonderful that it's available to people, that people under 65 have that option.

Other Medicare supplement plans when you're over 65, some of them exclude you. If you have renal failure, people can look into Medicaid. If someone applies for Medicaid and they have a spend down, that's $200 or more, we are going to require them to have-- to purchase that Blue Cross policy to make sure that all of their medical needs are going to be covered post transplant.

So if somebody might come in for evaluation with Medicare only, and they would have to have a financial hold until they were able to obtain that additional information or insurance coverage, and then they could be active. While they're on the list, if their coordinator is reviewing their insurance and finds something has changed, they would have to let their nurse coordinator know. You need to place them on hold until I've been able to get in touch with them, find out what kind of insurance they have now and address that.

If someone needed a Part D, for example, for their retail pharmacy needs and they didn't have a drug plan yet, that's something that could be a very long hold because of the enrollment period. You can only access it during different times. So I, at this evaluation stage, encourage them to make sure they're opening all their mail, pay attention to everything, let us know what's going on.

Not having your Part B Medicare when it's needed is also a reason for a financial hold. And then working together with social work. If there is a clear and evident unwillingness or inability to even say, OK, yes, I can take care of that after transplant, covering their Blue Cross policy that AKF had been paying for, that's a reason for a financial hold as well.

And while they're on the wait list it's important that they keep their ducks in a row, and maintain your medical and your prescription coverage. For those with high co-pays and deductibles, I always let people know payment plans are available. And I know it's always easier said than done, but it's important that they know that. There's also no interest charged to any balances that they have here.

Stay in touch with their financial coordinator is what we want them to do to make sure that we've got the most current information. And of course, if they have any issues with their insurance plans to let us know again sooner rather than later. There might be viable solutions for them that we just have to know what's going on and we can talk about it.

And if there isn't something immediately we can do then they're on hold until they've been able to maintain some other insurance or other ways to handle their situation, which is what always leads me into fund raising. And I do recommend this very strongly and highly encourage people to consider it. Even people with excellent health coverage. They are the ones that are the most resistant to apply for their Medicare, for example or to understand that it's sometimes good just to build up a little nest egg in case you need that.

It's helpful for when AKF is paying for their insurance in some manner. Helpful for when they have those high deductibles and co-pays. Very helpful to help realize how they're going to handle expenses three years after a successful transplant if they had their Medicare only because of kidney failure. And then of course, just preparing for any time you have some sort of surprise.

So I'm happy Colleen was talking about the fund raising organizations too, and that you have information in your packets. But Help Hope Live National Foundation for Transplant and in rare cases for adults with PKD, the children's organization, it can also help them raise money.

So the reason we encourage those organizations is they specialize with people who need transplants. So I let them know. They're familiar with what kind of goals you have. You might want to [INAUDIBLE] challenges you're going to face. They don't come to their events and run them for you, but they give them a lot of information on what helps or what works for people. They can help with publicity and some other maybe printing their posters or their flyers, covering some of that cost that way.

They will open up accounts so that people can do social media fund raising. Facebook, Twitter, that sort of thing. GoFundMe is such a wonderful idea. People coming together to help one another, but what we have anecdotally learned is that through GoFundMe your nest egg is considered taxable income and an asset.

So it might kick somebody off of Medicaid if they had a GoFundMe fundraiser. Whereas, using those other organizations the money is protected. And then being proactive and preparing financially for their transplant is just another benefit of doing this fund raising because it may be the only way they're able to make it happen.

So we want to just remember insurance coverage is-- or the ability to pay for their transplant is vital to the success of their transplant. Changes happen in your job, your marital status, government programs might be changing, their ability to access insurance coverage. Communication between us, the patient, and you, the referral source, is vital from the beginning with that speedy referral process, in the middle while we're working with them to maintain the information we have, you have, and then through the years afterwards as they're keeping their kidney healthy hopefully.

Here is a list of our transplant financial coordinators. So I work again, with everybody getting them in the door. And I would most often maybe speak with some of you. After that it's an alphabet split. First letter of their last name. You can see who the different people are. Cynthia's been with the program a long time. Lauren, Jody, and Elizabeth are newer, but they are eager to do good for our patients.

So working together while they wait is what our mutual goal is. And our financial team strives to provide good communication with our folks, sharing information that we now, expecting them to get in touch with us, encouraging them to be proactive, taking care of themselves, their own information, not relying on other people to do it.

And then we want to maintain that open and as needed contact with all of you. So please call if you have any questions. And does anyone have any questions now? Yes?

Are Are you working with the Medicare patients up close to the time when the three year period ends so that a plan is being put into place? Or is it just something they're told initially, that you're going to have to have this together? And have you seen patients that have absolutely lost coverage of their medications at that three year point and subsequently lost their plan?

**CINDY SAMORAY:** OK. I'm going to have to say, we could do better with the continued communication with them as they go through this process. We do speak with it-- speak about it frequently during the whole process. But honestly, three years afterward that we're-- the financial piece is not as involved. We have had many people aware of this and contacting us proactively, and so we're able to give them some suggestions and some advice and help them along the way.

**AUDIENCE:** I think one other comment too about-- working. Oh. Is that for patients who are registered in our specialty pharmacy, they have a pharmacy financial coordinator who actually will be much more proactive about telling them you know, you're getting close, what is your plan, and really start to have those conversations.

So that is sort of a subset of our patients that we have much more interaction as far as their pharmacy and medication dispensing. So that's a good arena. But not everyone can use our specialty pharmacy. Depends on their insurance.

**CINDY SAMORAY:** Yes, good. Thanks, Colleen.

**AUDIENCE:** So if they are not able to use [INAUDIBLE] how long are they being proactively followed?

**CINDY SAMORAY:** For a year. The question was, if they can't use our pharmacy, how long are we filing them? And it's for a year. Yes?

**AUDIENCE:** And they'll lose their Medicare [INAUDIBLE] post transplant only [INAUDIBLE].

**CINDY SAMORAY:** Correct. Correct.