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AHC Media

ED collections starting at near-zero? Simply asking can get 300% increase

Put in a 'policy with teeth' for emergency department

While the emergency departments (EDs) at St. Luke's University Health Network in Bethlehem, PA, had a cash collection program in place two years ago, it was inconsistent and informal, according to **Annemarie Mariani**, patient access director. "Some people in the ED did a good job with asking for co-pays, while others were more uncomfortable with this aspect of the job," she says. "The result was sporadic collections that varied among the five network hospitals, with no goals or tracking systems in place."

Partnering with a consultant, a comprehensive educational program was developed and implemented. The program included the "who, what, where, why, and how" of collections. In addition, a thorough assessment of volumes and payer mix at each facility was completed to establish "collectability" standards for each hospital.

"Collection rates started to climb as we focused more and more on keeping the goals in front of the staff," says Mariani. "We also monitored patient response closely, looking for any changes in the patient satisfaction surveys or negative comments, which we have not encountered."

An incentive program was established with two goals: The facility has to meet 75% of the total monthly goal for cash collection, and each registrar

EXECUTIVE SUMMARY

Emergency department collections rose 300% in a single year at Mercy Hospital Springfield, primarily due to staff asking for payment consistently. At St. Luke's University Health Network, four of five EDs met 75% of a monthly cash collection goal. Patient access leaders made these changes:

- They publicly post amounts collected each day.
- They set individual collection goals for each registrar.
- If patients are unable to pay, staff members provide them with a receipt and a self-addressed, stamped envelope and ask them to send in payment.

must collect an average of $500 monthly over a six-month period. "If achieved, the representative gets 2% of their collections, paid semi-annually," says Mariani. "The first payout was in January 2013, and four of the five facilities achieved the 75% collection goal."

Forty-four employees received bonus payments totaling $5,162 and ranging from $50 to more than $250, reports Mariani. "We anticipate these bonuses will rise significantly in the second payout, now that staff see what may be achievable," she adds, and Mariani notes that the total collection goal for the EDs for the fiscal year ending June 30, 2013, is $1.04 million. "At the end of January, cash collection stood at $506,763 — just $70,000 below the goal."

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Just ask consistently

Simply by asking patients for payment consistently, ED collections have increased 300% in the past year at Mercy Hospital Springfield (MO), reports **Jeff Brossard**, BSHA, CHAM, director of patient access.

"Our average ED point-of-service collections per month was less than $25,000. We now collect in excess of $80,000 a month," he says. "The biggest hurdle was getting our coworkers comfortable asking for money. Once we finally crossed over that barrier, we saw drastic improvement."

While staff had collected copays in the ED for several years, this year it was made a top priority, says Brossard. "Healthcare is very unique, in that there are really no other businesses or services that you can say, 'Bill me later.' As an industry, healthcare has set that precedent," he explains. "Getting that mindset to change was probably the biggest challenge." Here are the approaches used by the department:

• Staff members consistently ask for a copay or a deposit toward services for self-pay patients.

"By no means are we bullying anyone or requiring any type of payment, but we do ask for payment consistently at time of service," Brossard says. Staff members consistently inform patients of their estimated financial obligation or what insurance says they will owe.

"Obviously, in an ER environment, people are not planning for this visit. They may not understand their benefits fully, and the tensions run high," says Brossard. "The more consistent we are with our process, the less of a shock or surprise it is to patients."

• If patients are unable to pay, staff members provide them with a receipt and a self-addressed, stamped envelope and ask them to send in payment.

"We do have people who will turn around and send the payment to us the very next day, whether it's just a copay or a large deductible," says Brossard.

• Staff members calculate the patient's out-of-pocket responsibility using a price estimation tool based on a 12-month history of average charges for the patient's acuity level.

At the time of the ED registration, staff members often don't know what tests or procedures will be done, which makes calculating an accurate estimate difficult. "Even a patient who has commercial

insurance might not have a flat rate copay," notes Brossard. A patient might be responsible for a $150 copay plus 10% of the total bill, for example.

• Collection amounts are posted publicly every day.

Brossard says he's noticed a "good healthy competition" in his department. "One thing I've noticed is that if we do not keep it in front of our eyes and theirs constantly, collections start to slack," he adds. "If we stop putting out the daily information, we see a decline over a period of just a few weeks."

• Top collectors are recognized publicly and sometimes taken to lunch.

"If the department reaches a big goal we'll have a pizza party or ice cream social," he says. A recent example: The department set and exceeded a goal of collecting $790,000 in January 2013. To congratulate the team for reaching the collections goal, Brossard's department had an ice cream party and gave each employee a star-shaped lapel pin stating "Great Job."

• Staff members are given simple scripting to rely on.

"Any time you are asking for money, you run the risk of somebody being upset about it," says Brossard. "The more prepared staff are to calmly answer the patient's questions, the easier and less frightening it is."

Brossard says scripting can be as easy as saying to the patient, "Mr./Mrs. Smith, we have verified your benefits with your insurance company, and they show that you are going to have an estimated out-of-pocket cost of X dollars. How would you like to take care of that today?"

• Monthly collection goals were set for each registrar, based on the hours and shifts worked.

"It's not a matter of, 'You didn't make goal this month so you are getting written up.' But if after a period of months, someone has not attained their goal, then you really do have to take it to the next level of counseling," he says. "We have found that it is easier to work with smaller goals."

For example, if a employee has a $5,000 monthly goal and is scheduled to work 22 days during that month, setting a $250 per day target is much easier to handle. "If the co-worker consistently works toward $250 a day, they will make their $5,000 monthly goal," says Brossard.

Still, acknowledges Brossard, "there were and still are individuals who are resistant to collecting. Putting in a policy with teeth has made all the difference." *(See related stories on self-pay payments, this page, and offering incentives for meeting collection goals, p. 40.)*

SOURCES

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• **Sherry Jones**, Patient Access Supervisor, Emergency Department, Greater Baltimore (MD) Medical Center. Phone: (443) 849-6794. Fax: (443) 849-8776. Email: sljones@gbmc.org.

• **Annemarie Mariani**, Patient Access Director, St. Luke's University Health Network, Bethlehem, PA. Phone: (484) 526-4077. Email: Annemarie.mariani@sluhn.org. ■

Self-pays asked for $25 payment

Patients educated on eligibility

At the same time emergency department (ED) registrars began asking self-pay patients for a $25 payment at St. Luke's University Health Network in Bethlehem, PA, the department implemented an onsite medical assistance program. Patients are able to meet with a representative in the ED at the time of services, reports **Sandy Sarson**, outpatient registration manager.

"Our self-pay collections have been very successful," says Sarson. "The patient can qualify for medical assistance, and if they meet all the requirements, they are ultimately reimbursed their $25."

Sarson and her team seize the opportunity to educate patients about any available program for which they could be eligible. "Anytime we have a conversation with a patient without health insurance, we review a list of questions to help us direct the person to the best program available for them," says Sarson. "The goal is to tailor their needs to existing programs and guide their applications to appropriate programs."

The questions include:

• Are you currently employed? If not, how long have you been unemployed?

• Have you had health insurance in the past six months?

• Do you have any pre-existing conditions?

• Have you ever applied to any assistance program in the past?

If a patient has a chronic condition and hasn't had health insurance coverage in six months, for example, he or she can qualify for a program that is based on income and not their assets.

"This program is very successful for us," says Sarson. "Our patients are very relieved to know that

there is help available to them, and the hospital is able to collect payment for our services." ■

'Healthy competition' comes from incentives

Set minimum standard

While some patient access representatives in the emergency department (ED) at Greater Baltimore (MD) Medical Center collected co-pays consistently, others collected almost nothing, reports **Sherry Jones**, ED patient access supervisor. To address this problem, a minimum standard was set of a monthly average of three co-pays collected per shift of four hours or more.

"I do have some people that struggle. Out of all the ED patient access representatives, I generally need to consult with a few each month," Jones says. "It's almost like sales: Some people are just naturally good at collecting, and others struggle."

Currently, more than 80% of staff members are meeting or exceeding the minimum collection standard, compared to only 30% when it was first established. "Weekly, I compile the previous week's co-pay collections. Individual collection amounts and percentages are emailed to staff and publically posted," says Jones.

Cash incentives given

If patient access representatives collect a certain amount over a specified number of shifts, they receive a cash incentive or bonus in their paycheck, says Jones. Depending on what they collect, they can receive an incentive of $20, $40, $60, $80, or $100 each pay period.

Some patient access representatives find it more difficult than others to meet collection goals because they register a larger portion of Medicare and/or Maryland Medical Assistance patients not owing a co-pay at the time of service, Jones notes.

"Occasionally, we run into situations where an employee may be intentionally avoiding Medicare and/or Medical Assistance patient registrations in order to capture a larger number of co-pays per shift," she says. "It can be challenging to definitively prove, although when it comes up. I address it with the individual employee."

The ED patient access supervisor surveyed patient access representatives via email to identify group-based versus individual-based incentives, and 77% preferred an individual-based incentive.

If an employee doesn't reach the minimum after one month, he or she is counseled, encouraged to review and practice "scripting," and offered additional training as needed. "If the same employee continues to struggle meeting the minimum collection standard for the second month, we consider formal corrective action," says Jones.

The department collects about 74% of the potentially collectable copays, compared to 32% before cash incentives and minimum standards were implemented.

"Staff is learning that a great majority of patients will pay," says Jones. "It's just a matter of asking in an appropriate manner." ■

Step forward to share access' success stories

Hospital leaders often unaware

Your tireless efforts and novel approaches might have dramatically increased revenue and satisfaction at your organization. However, hospital leaders typically don't connect these great results to the work done by patient access, unless you tell them so.

"It is up to us, as leaders in patient access, to learn how to communicate our contributions, says **Pam Carlisle**, CHAM, revenue cycle administration and system director of patient access services at Ohio Health in Dublin.

"Patient access is at the center of the patient experience. It is typically the area that has the first contact with the patient or physician office," says Carlisle.

Revenue cycle data is used to determine operational changes and process improvements, and this step, in turn, identifies the key performance indicators for the entire organization, emphasizes Carlisle. "It is often only the bottom line number that gets

EXECUTIVE SUMMARY

Patient access leaders need to communicate their contributions to hospital administrators who otherwise might not realize the revenue cycle's role.

- Bring up patient access during management meetings.
- Share monthly scorecards with impressive metrics.
- Volunteer to lead organizationwide activities.

communicated. But how did we get there? Who contributed? These are questions leaders outside of the revenue cycle don't typically get information on," she says. To let leaders know about patient access' successes, Carlisle recommends these practices:

• Produce a newsletter to share with leaders outside of the revenue cycle.

Ohio Health's patient access newsletter is sent to the chief financial officers at each hospital in the network, as well as all revenue cycle managers, managed care executives, and finance executives.

• Take every opportunity to bring up something positive about patient access during management meetings.

Talk about a successful patient experience, a thank-you note someone in your department received, a new process that will improve patient flow, or a new way to help patients with way finding created by someone in your department, suggests Carlisle.

• Make a habit of attending clinical meetings.

"Demonstrate how teamwork and working together can improve the quality of care of our patients," says Carlisle.

• Produce monthly scorecards and share these scorecards with leaders to communicate progress made by your department in key areas.

Carlisle says to include these metrics: your department's customer service scores, employee satisfaction scores, quality, cash collections, patient volumes, claims denials, and clean claim rates.

• Educate your own patient access staff members to be advocates for the front end.

• Volunteer to lead organizationwide activities, such as Heartwalks or United Way campaigns.

"Show collaboration and community involvement from an access perspective," says Carlisle.

• Schedule quarterly meetings with appropriate vice presidents to keep them posted on patient access.

"Share operational updates and challenges, even if only for 15 minutes," she says.

• Communicate with leaders simply, clearly, and concisely.

"Use data to drive your messaging, with no 'fluff,'" says Carlisle. "Make a conscience effort to educate others on the importance of the patient access family within your organization."

SOURCE

For more information on educating hospital leaders about patient access, contact:

• **Pam Carlisle**, CHAM, Revenue Cycle Administration/System Director, Patient Access Services, Ohio Health, Dublin. Phone: (614) 544-6099. Email: pcarlisl@OhioHealth.com. ■

Race/ethnicity data: Put stop to guesswork

Convey reason information is needed

Do your registrars use their own judgment to determine patients' race and ethnicity because they're too embarrassed to ask the person standing in front of them?

This behavior is happening in registration areas at some hospitals, according to **Mitch Mitchell**, president of T.T. Mitchell Consulting, a Liverpool, NY-based consulting firm specializing in revenue cycle and technology. Mitchell says he has done site visits at hospitals that instruct registrars to use their best guess as to a patient's race and ethnicity because managers are afraid of offending patients.

"It's a question that should be asked because we can't look at someone and know what they are, or what they want to classify themselves as," says Mitchell. "It's important to get it right, and it could save someone from getting into an uncomfortable position because of their assumption."

Previously, staff members often were afraid to ask about race and ethnicity, and were asking the question in various inconsistent ways, says **Sylvia C. Motta**, manager of pre-registration and the call center at Cambridge Health Alliance in Medford, MA.

"Obtaining race and ethnicity data from patients is a difficult task," says Motta. 'It involves educating staff in order to lessen patient dissatisfaction and improve vital healthcare data collection."

When patients asked for clarification, some registrars didn't know how to respond because they had no idea themselves why the information was needed. "It is important for staff to understand the reason why this data is needed, so they are prepared to ask the questions and not guess what the answers should be," Motta says.

EXECUTIVE SUMMARY

Patient access managers should educate employees on the reason for collecting race and ethnicity data, as otherwise staff might be uncomfortable asking for this information.

- Encourage registrars to take an online course in data collection.
- Inform staff how to enter more than one response as appropriate.
- Tell staff to enter "declined to answer" if patients refuse to give the data.

The pre-registration department at the Cambridge Health Alliance places a high priority on obtaining accurate race and ethnicity data collection, says Motta. Patient access employees are told that they collect this data for these reasons:

- **The data helps to identify the population served by the hospital and helps the hospital enhance care provided to a vulnerable, diverse population.**
- **The Cambridge Health Alliance is a teaching public hospital, and the quality of research depends on the collection of accurate information such as race and ethnicity.**
- **The information is used by the Department of Public Health to help build healthier communities.**

Registrars are encouraged to take an online course about how to collect data on race, ethnicity and language, which was developed internally by the hospital's information technology department. The course covers how to enter information into systems, how to ask the questions, and how to respond when a patient asks why the information is needed, and it provides definitions of race, ethnicity, and identifying language.

"I took it myself, and found it very helpful," says Motta. "The course illustrates how to enter more than one response if a patient considers themselves to be part of more than one race, ethnicity, or speak more than one language."

Ask respectfully

It is important that staff ask questions in a professional, respectful manner without offending patients or making them resistant to giving information, Motta underscores.

"For some people, being asked their race and ethnicity is a sensitive issue," she explains. "They feel they might be treated differently if they identify this statistical feature about themselves." Registrars say the following statements to patients before they ask any questions: "The pre-registration department helps in registering an appointment by collecting demographic, guarantor/billing, and insurance information over the phone. By doing this before your date of service, it will help expedite waiting time on the day of your visit. By pre-registering in advance, we can help prevent any billing issue that may occur, and also ensure accurate data collection."

Motta says, "Providing a script that has an introduction as to why we are going to ask the next few question has helped collect the necessary information with less hassle."

She reminds registrars that patients always have the right to refuse to answer, and she instructs staff not to push for the information. Instead, they enter "declined to answer" as a response in these cases.

"We also assure patients that the information collected is for statistical reasons only, and that it is to help improve the care of the community around us," she says. *(See related story, below, on obtaining other types of demographic information from patients.)*

SOURCE/RESOURCE

For more information on collecting race and ethnicity data, contact:

- **Sylvia C. Motta**, Manager, Pre-Registration & Call Center, Cambridge Health Alliance, Medford, MA. Phone: (617) 665-2532. Email: smotta@challiance.org.
- For information on standards from **The Joint Commission** regarding collection of race and ethnicity data, go to http://bit.ly/15y9HbP. ■

Asking your patients for 'sensitive' information?

Patients might want explanation

"Because it's our policy." "It's required by the state." If a wary patient asks registrars why a certain piece of demographic information is needed, these answers are likely to make matters worse.

"We train staff to avoid responses like those. That tends to just ruffle the feathers," says **Mollie Drake**, corporate director of access at Scripps Health in San Diego.

Much of the hospital's revenue stream depends on your registrars getting all the information they collect correctly the first time, notes Drake. The organization's nine-day training program for new patient access hires covers all the information gathered by patient access employees and the reason why it is collected, and all staff are required to obtain annual competencies on this information.

"I've never been a big believer in scripts," says Drake. "I prefer to help the employees understand why we collect the information, so they can explain it in their own words and not sound mechanical in their responses."

Some patients are reluctant to give their social security number to registrars, for example. In this case, patients are told that in the hospital system, they are assigned a unique medical record number under which all their medical history is filed.

Registrars explain that should a registration staff member attempt to assign a second medical record number to an existing patient, they would be stopped and alerted at the social security number field, since that number already would be on file.

"This is the only data point collected that is truly unique to that patient," says Drake. "If the patient still refuses to provide the social security number, we enter 'none' in the field."

If a patient asks why their address or phone number is needed, staff explain that clinicians may need to reach them post-discharge.

When registrars ask patients about religious preference, they explain that the hospital has a chaplaincy program and if the patient would like to declare a religion, one of the members might stop by to visit. Before asking for information on religion, registrars disclose that the patient has the right to refuse to give the information, adds Drake.

"In the event the patient returns to us in an emergency situation and can't communicate, we would want to be respectful of their religious beliefs in determining a treatment plan," she explains. ■

Offer help to patients with high deductibles

Communicate 'early and often'

If it seems like you are seeing increasing numbers of patients with high-deductible health plans, it's not your imagination.

Employers spent 4.1% more money on health benefits for employees in 2012 than in 2011, which is the smallest increase in 15 years, according to an analysis of 2,809 companies conducted by Mercer, a global consulting firm. However, the employers contained costs mainly by switching employees to high-deductible health plans, with enrollment increasing from 13% of covered employees in 2011 to 16% in 2012. The number of surveyed employers offering the plans rose from 17% to 22%.

"We are absolutely seeing more patients who have higher deductibles, co-pays, and reduced benefits," says **Darlene Powell**, CHAM, patient access manager at Bronson Methodist Hospital in Kalamazoo, MI.

The hospital's patient access leaders assembled a Financial Advocate Team for the purpose of helping patients and families with high-deductible plans, such as educating them about their options.

"We reduce their fears and help them make better choices about how they will pay for their care," says Powell. "Our approach is to meet with patients as early in the process as possible, face-to-face."

Go directly to patients

"We've improved customer service by not depending on patients and families to seek us out for answers to their financial questions," says Powell. "We make it convenient by coming to them where they are."

Financial Advocate Team members carry laptops to patient care units and the emergency department, so they can start the process immediately. "This enables us to share information and process paperwork on the spot, so patients are qualified for financial assistance as quickly as possible," says Powell.

Patients can also meet with financial advocates by visiting the Advocacy Office Monday through Friday from 8 a.m. until 5 p.m. "We are considering expanding our office hours as well as the time staff spend rounding on the units," says Powell.

Patient access leaders developed an online training course on point-of-service collections that staff members are required to complete. "The training guides staff through the collections process and offers scripting to help patients and families understand payment options and expectations," says Powell.

When patients with high-deductible plans are scheduled for admission, "communicating early and often helps everyone in the long run," says Powell. "During patient scheduling, we inform them of potential out-of-pocket costs and discuss this again at the time of pre-registration."

EXECUTIVE SUMMARY

Patient access leaders at Bronson Methodist Hospital in Kalamazoo, MI, created a Financial Advocate Team to help patients with high-deductible health plans.

- Meet with patients as early as possible in the process.
- Educate patients about their options.
- Go directly to patient care units and the emergency departments to speed the process.

SOURCE

For more information on helping patients with high-deductible plans, contact:

- **Darlene Powell**, CHAM, Patient Access, Bronson Methodist Hospital, Kalamazoo, MI. Phone: (269) 341-8640. Email: powelld@bronsonhg.org. ■

Use recorded calls to your advantage

If a physician complains that a visit should have been scheduled as 40 minutes instead of 20 minutes because of the patient's multiple diagnoses, wouldn't it be great to be know exactly what the patient said during the initial call, instead of assuming it was the scheduler's error?

"When questions or potential scheduling errors arise, we use call recordings to trace the patient's scheduling interaction," says **Lori S. Bruelheide**, assistant director of Enterprise Patient Access Services at UK Healthcare in Lexington, KY.

The recordings, along with data from scheduling and registration systems, provide patient access managers with a timeline of each step in the scheduling process. "Using the call recordings, we are able to determine what items the patient mentioned at the time of scheduling to see if the appointment duration assigned was appropriate based on the information or if additional scheduler training is necessary," Bruelheide says.

All inbound and outbound calls to the Patient Access Center for scheduling and pre-registration are recorded, and used in these ways:

• Fact-finding in the event of a customer complaint about a scheduling agent.

"The ability to hear the exact exchange has been invaluable to us as we respond to a patient's complaint about customer service," Bruelheide says.

Hearing his or her own voice on the call often allows the agent to identify any problem areas within the call on his/her own, she says. "One of our agents had a tendency to work very fast, often processing the patient's request before it was even fully articulated," Bruelheide recalls. "This agent was very customer-service oriented and was not intentionally being rude. Instead, she felt she was being efficient."

After managers played a few calls for her, the employee immediately recognized that she was interrupting and cutting off the sentences of the caller, and she became a more patient listener. "It is important to view call recordings as a process improvement tool, and not as a mechanism for assigning blame," Bruelheide adds. "We use the call recording to establish the facts of the situation, but still encourage all parties involved to provide their assessment of the interaction."

• Evaluation of processes that seem not to be working correctly.

"Call recordings of patients attempting to navigate the process can be helpful as we attempt to understand any gaps in the process," says Bruelheide. "This allows us to re-vamp inefficient processes, clear up phone-tree inconsistencies, and identify places where return phone calls to patients are being delayed."

In one of the hospital's specialty clinics, the transfer rate was averaging 14%. "We felt this was a little high, so we evaluated the calls being transferred," she says. "As we did that, we realized there were quite a few calls back to the clinic manager because the scheduling staff was unclear on the definitions and clinical needs of certain diagnoses."

To address this, managers provided scheduling agents with some basic medical terminology training for the specialty and had one of the specialty physicians educate them on the clinical nature of the diagnoses. "This helped our agents better understand what the callers were requesting and determine where to place those appointments for optimum access to our specialists," says Bruelheide. "This reduced the transfer rate by nine calls a day, to approximately 10%."

• Evaluating customer service of each employee on a monthly basis.

Two recordings per agent are reviewed and evaluated for key customer service components, such as proper identification of the clinic and agent's first name, appropriate pace and tone of the call, and use of standardized greetings and closings.

"Our quality assurance measurements are performed by a team of managers listening to and discussing the call together, so that no one person can misinterpret or misunderstand the call," Bruelheide says.

EXECUTIVE SUMMARY

Patient access leaders record all calls made and received to the Patient Access Center at UKHealthcare, and they use these recordings as a quality assurance tool to:

- identify reasons for scheduling errors;
- evaluate problematic processes;
- assess each employee's customer service skills.

SOURCE

For more information on using recorded calls for quality assurance, contact:

• **Lori S. Bruelheide**, Assistant Director, Enterprise Patient Access Services, UK Healthcare. Phone: (859) 323-0772. Fax: (859) 323-2021. Email: lori.bruelheide@uky.edu ■

Successfully collect outstanding balances

Set expectations earlier in process

At University of Pittsburgh Medical Center's Physician Division, "every interaction with the patient is designated as an opportunity to collect an outstanding balance," says **Karen Shaffer-Platt,** vice president of the revenue cycle.

"This is a culture change, as both staff and patients regard the collection of an outstanding balance as a 'back office' billing function," says Shaffer-Platt. "We are moving to a model where both patient and staff expectations are set as early as possible."

Because the revenue cycle begins at the point of scheduling an appointment, that is when staff members begin setting the expectation of outstanding balances collection, says Shaffer-Platt. "Once you set expectations for collecting at the point of service, your staff have to follow up on those," she says.

The chances of collecting significantly decrease after the patient leaves, emphasizes Shaffer-Platt. "In today's economy, medical bills take a lower priority to keeping the lights on and food on the table," she says.

After patients have received services, they often don't see paying for these as a priority, adds Shaffer-Platt. "What incentive does the patient have to pay?" she asks. "Patients are not required to pay an outstanding balance to receive future services. Medical credit reporting is not on par with other industry credit reporting."

The key is for patient access employees to have conversations with patients about their outstanding balances while the patient is standing right in front of them, Shaffer-Platt underscores. To accomplish this step, the department made these changes:

• Using automated telephone reminders and electronic messaging.

"By optimizing technology, we are setting the patients expectations and 'teeing up' the front desk for collection opportunities," says Shaffer-Platt.

• Giving patient access employees the ability to connect patients with billing experts immediately.

"Front desk and access staff have the ability to make an appointment, right from the clinic, for the patient to be contacted by customer service for in-depth follow-up and collections," Shaffer-Platt says.

• Redefining the balances that self-pay patients are asked for.

"Previously, this was defined as any amount that sits in patient responsibility, but we are redefining this as those balances that are only the patient's responsibility to pay," says Shaffer-Platt. "Self-pay will no longer include balances dropped to the patient that need intervention for the insurance company to pay."

SOURCE

For more information on collecting outstanding balances, contact:

• **Karen Shaffer-Platt**, Vice President, Revenue Cycle, University of Pittsburgh Medical Center Physician Division. Phone: (412) 432-5350. Fax: (412) 488-0040. Email: plattkl@upmc.edu. ■

New rule published on essential health benefits

The Department of Health and Human Services (HHS) published a final rule on Feb. 25 outlining essential health benefits that must be covered by all insurers wishing to participate in the new health insurance marketplaces. The rule, first released to the public the week of Feb. 18, had been long awaited by insurance companies and states looking for guidance while preparing for the marketplaces to go live in October, according to the National Association of Healthcare Access Management (NAHM), quoting "Kaiser Health News."

Within the rule, there are 10 categories of care that must be covered, including emergency services, maternity care, hospital and doctor services, mental health and substance abuse care, and prescription drugs. "Kaiser Health News" reports that these requirements apply to individual and small group plans, including plans offered in the marketplaces, and to those newly eligible for Medicaid coverage.

HHS published the rule partly to standardize plans for ease of comparisons by consumers, and partly to prohibit discrimination based on age or pre-existing conditions, as stated in the Affordable Care Act. The final version of the rule is also similar to the earlier draft version, which received about 11,000 comments when it was published in November. One change, according to "USA Today," was a shift to focus more on mental health. Some organizations are concerned that the focus may have come out of the shooting in Newtown, CT, and could prove pricey.

HHS Secretary **Kathleen Sebelius** fought back against this claim, however. In a written statement,

she cited that the new regulations close a major gap in coverage for people suffering from mental health or drug problems. Prior to the rule, almost 20% of people purchasing insurance did not have access to mental health services, and nearly one-third had no substance abuse disorder benefits. According to "The Hill," the expansion of mental health and substance abuse benefits could benefit 62 million people.

Policies specified in the rule will go into effect in January 2014. The rule can be accessed at http://1.usa.gov/13nJpJE. ■

Majority of states opt for federally run marketplaces

The deadline for states to decide on the route to take for their health insurance marketplace has come and gone without any last-minute decisions, says the National Association of Healthcare Access Management (NAHAM), quoting a story in "Kaiser Health News."

States had to decide by early February whether they wanted to set up their Health Insurance Marketplace in partnership with the federal government, or if they wanted to take no action and allow the federal government to set up the marketplace without state input. According to "Kaiser Health News," half the states — including the major population centers of Texas, Florida, and Pennsylvania, opted to do nothing, and defaulted to the federal option.

Alternatively, 17 states and the District of Columbia have been given "conditional approval" by the administration to set up their own marketplaces, without help from the Department of Health and Human Services (HHS). These states include California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington.

An additional seven states have opted for a partnership exchange. Under this marketplace type, states would approve which insurance plans could participate in the marketplace, and handle consumer assistance duties such as setting up call centers to handle inquiries. The federal government would handle the more complex duties of running the website, marketing the site, and determining the eligibility of millions of people for government subsidies which will make prices more affordable. HHS and the administration had hoped that sharing the responsibility through this type of marketplace would entice more states to take some form of an active role in the program. Partnership states include Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and South Dakota.

The remaining 25 states defaulted to a federally run marketplace, disappointing Administration officials who had hoped for more state involvement. The states that opted for a federal program cited concerns about cost, lack of autonomy, or political opposition to the healthcare law. You can view state-by-state marketplace statuses on the Kaiser Family Foundation website at http://bit.ly/oxJnR6. *(For the entire Kaiser Health News article, go to http://bit.ly/Z2x3Sb.)* ■

States rethink high risk pools

When the health insurance marketplaces open next year, it will mean that plans will be available to everyone regardless of state of residence, pre-existing condition, or potential risk to the insurance company, according to the National Association of Healthcare Access Management (NAHAM), quoting an article in "Politico." This means that individuals with existing illness and those at higher risk of becoming ill will be able to participate in the marketplace plans. From an insurance perspective, these are high-risk participants whose costs need to be offset by participation of less-costly, healthier individuals.

In the long run, federal officials expect costs attributable to high-risk participants to be mitigated by participation of younger, lower-risk individuals who also would pay into the program. In the short term, however, there are concerns that the higher cost individuals will enroll en masse, while the lower cost participants hold back. This type of enrollment could cause premiums for plans in the marketplace to skyrocket and become cost-prohibitive for the healthy participants needed to balance out the program. The law that established the marketplaces tried to anticipate the problem by including a number of mechanisms aimed at avoiding the so-called rate shock.

One such provision is known as reinsurance; a $20 billion fund run by the Department of Health and Human Services (HHS). All insurers are required to pay into the reinsurance fund, which will then be used to pay back insurance companies that carry a large share of high risk participants. The thought is that the payments will ensure that insurance companies do not have to raise premiums to

recoup short-term losses.

One problem with the reinsurance approach is that the fund is temporary and will disperse all funds in three years, but the bigger problem is that all the funds will go to insurance companies, not state high-risk pools that are carrying about 200,000 high-risk participants.

These state high-risk pools that were once planning on slowly moving their participants into the new exchanges are now likely to move them faster, before the $20 billion in funding runs out. States such as Wisconsin and Texas will cancel their plans or force participants to move to the new marketplace in 2014 when the federal reinsurance fund is expected to dole out $10 billion to insurance companies. The fund will pay $6 billion in 2015 and the remaining $4 billion in 2016.

Estimates of the impact of suddenly shifting some 200,000 people from the state pools onto the exchanges vary. According to the "Politico" article, "some actuaries say it won't make much of a difference as millions of people start getting covered; other studies see this population boosting premiums significantly in the individual market. One Indiana study projected premiums would rise by up to 45 percent." *(The entire article is available at http://politi.co/V2hA6i.)* Meanwhile, HHS contends that payments through the reinsurance program will keep premiums 10-15% lower than they would be without it. They also hope that three years will be enough time for low risk participants to enter the exchanges and naturally mitigate costs. ■

Colorado study suggests HIX website design

Health insurance exchanges (HIX) have been in the works for a number of years now. Having survived legislative, legal, and electoral challenges, the part of the Affordable Care Act healthcare reform law that mandates the exchanges remains intact. What has not yet been determined, however, is how the exchanges will look to consumers – how user-friendly on-line sites will be, says the National Association of Healthcare Access Management (NAHAM), quoting "Kaiser Health News."

The Department of Health and Human Services (HHS), the agency responsible for the set up and oversight of the exchanges, has reached out to the public to try to determine how the exchanges should look. This outreach has led HHS to change the branding of the product from "exchanges" to "marketplaces," and it might lead to a change in how the interface will look as well.

Originally, according to the article from "Kaiser Health News," the online exchanges were being designed to look like the travel website "Travelocity," where consumers could pick from different product plans. Now, users who go to select from available insurance options through the online marketplaces could see a website more similar to the tax website TurboTax, where the individual is guided through the process with a series of questions.

The change comes as the result of discussion groups held by three non-profit organizations in Colorado. They found that few of the participants in the groups said that they would feel comfortable choosing a policy on their own. Many worried that they would not understand health insurance jargon enough to make the best decision. Like paying taxes, buying insurance is a complicated proposition, and like doing taxes, buying a policy on the exchange means interfacing with state and federal government agencies. The non-profits also found that a model Colorado program would include a customer care line, where individuals could talk through their insurance options with experts.

As HHS grapples with the fact that it will have to run the exchanges in about half the states, the department will have to figure out the most effective way to do this. This study from Colorado could provide insight into the best type of website to set up, but it could also show that no matter how easy a website it to use, consumers will want to be able to talk to an expert before picking a plan. *(To see the entire article, go to http://bit.ly/WUphID.)* ■

State decision: Expansion of Medicaid coverage

When the Supreme Court ruled on the Affordable Care Act last year, it was widely hailed as a win for the healthcare reform law, according to the National Association of Healthcare Access Manage-

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ment (NAHAM), quoting an article in "Stateline." While the court upheld the law's core provision establishing health insurance exchanges, it found that the federal government could not force states to expand their existing Medicaid programs. The expansion was one of the several means established by the law to ensure that every American will be covered by health insurance.

As the Medicaid program stands now, children, pregnant women, the disabled, and the elderly can receive assistance through Medicaid if they are at, or below 133% of the federal poverty line. That qualification breaks down to about $31,000 for a family of four and $15,000 for an individual. The court struck down the provision that would have forced states to extend the program to any adult or family that is below 133% of the poverty line, regardless of their age or physical condition. That decision is left to each individual state.

According to statistics from the "Stateline" article, 21 states have accepted the expansion so far. That number could increase as well, as the Democratic governors of Arkansas, Missouri, and Montana have expressed a willingness to expand the program, despite challenges from their state legislatures. Since there is no deadline associated with this decision, some predict that it could be years before states decide if they will extend their Medicaid programs.

The federal government has pledged to pay all of the costs for the first three years of the program for any state that joins in expanded coverage, and up to 90% of costs after that. Many states, however, worry that the federal government will not be able to make good on its promise. There is also a concern that funding even 10% of the expanded program at the state level could be more than a state would be able to cover.

The decision to expand coverage is something that will likely be discussed in many state legislatures this year. Each state will have to weigh its own costs and benefits in the long run, and deal with conflicting ideas of the role of government in health care. *(To see the entire article, go to http://bit.ly/WaExUm.)* ■

Did you receive Feb. 5 ebulletin?

An ebulletin was sent to *Hospital Access Management* subscribers on Feb. 5 reporting on new research showing what obtaining prior authorizations costs providers. If you didn't receive this ebulletin, it means we don't have your email address. To ensure you receive future ebulletins, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com. ■