In the last several years, the Affordable Care Act has changed how consumers access healthcare as well as how providers and the collection agencies they work with navigate the healthcare receivables landscape.


Healthcare receivables in 2015 and beyond are different than they have been in the past. Patients are expected to pay more of each healthcare dollar while regulators are focusing on medical debt, price transparency and financial assistance policies.

An increase in self-pay for medical costs, high-deductible health plans as well as the final 501(r) regulations for nonprofit hospitals are some of the changes occurring as a result of the Affordable Care Act that collection agencies and providers need to work through. However, they also need to focus on the basics of meeting each other’s needs with the ultimate goal of resolving patients’ accounts.

Rappuhn said healthcare providers have several priorities when working with a collection agency to resolve patients’ accounts.

“Trust and integrity are the most important things,” Rappuhn said. “They want you to match their collection philosophies and they want you to treat their patients like they do. I think in small communities this is really important because you see people you know more. It’s still important in the bigger communities because you are dealing with human beings having a medical crisis.”

Healthcare providers should clearly explain their collection expectations to their collection agency partners and the extent they would like them to connect with their patients.

Rappuhn said other healthcare providers she’s talked with have also emphasized that it’s important for collection agencies working on behalf of a hospital or physician to engage with patients in a way that meets their needs while keeping in mind what the patient may be going through.

Some providers want their collection agency partners to be a one-stop-shop for information on resolving accounts, including balance owed after insurance and financial assistance policies, for example. Others want all patients referred back to the provider with questions about financial assistance to maintain that personal relationship.

Nevertheless, it’s important for agencies specializing in healthcare collections to understand the

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HEALTHCARE RECORDS:

CMS Proposes Simplified Electronic Health Reporting Rule

The Centers for Medicare and Medicaid Services has issued a new proposed rule for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program to “allow providers to focus more closely on the advanced use of certified EHR technology to support health information exchange and quality improvement.”

According to CMS, electronic health records are the next step in the continued progress of healthcare that can strengthen the relationship between patients and clinicians.

The new proposed rule would streamline reporting requirements by:

- Reducing the overall number of objectives to focus on advanced use of EHRs;
- Removing measures that have become redundant, duplicative or have reached widespread adoption;
- Realigning the reporting period beginning in 2015 so hospitals would participate on the calendar year instead of the fiscal year, and;
- Allowing a 90-day reporting period in 2015 to accommodate the implementation of these proposed changes in 2015.

“The proposed rule is just one part of a larger effort across [the Department of Health and Human Services] to deliver better care, spend health dollars more wisely, and have healthier people and communities by working in three core areas: improving the way providers are paid, improving the way care is delivered, and improving the way information is shared to support transparency for consumers, healthcare providers and researchers and to strengthen decision-making,” according to CMS.

Initially, the proposed rule required a full-year of electronic health record reporting in 2015. CMS reduced the reporting period from one year to 90 days after repeated requests from hospital advocates, according to the Health Care Financial Management Association.

A draft of the final rule could be issued this summer, according to the HFMA.


Trends & Challenges: A Look at the Future of Healthcare Receivables

requirements providers have to work with their patients when it comes to insurance, billing and payments. They should also take into account the extent medical debt has become a problem for consumers, and consider helping by offering alternative payment methods.

During Rappuhn’s presentation, an attendee said more and more of his provider clients are asking for the collection agency’s input on handling patient accounts.

Rappuhn said it’s important for collection agencies to discuss their client’s expectations with representatives in the revenue cycle department as well as leaders in other departments that interact with patients to make sure needs are met across the board—from collections to community relations.

Collection agencies working with healthcare provider clients should also be in tune with basic facts about their communities related to the Affordable Care Act and insurance plans.

For example, it’s helpful for agencies to know if a Medicaid expansion under the Affordable Care Act has occurred in their state; the general types of community employers and insurance plans they offer; and if their healthcare provider clients are in-network or out-of-network under those plans.

Rappuhn recommended several resources to help providers and their collection agencies make sense of the healthcare and patient billing experience and, ultimately, better serve the patients. These resources include:

- **HFMA Price Transparency Task Force Report.**
  - Clarifies basic definitions that are often misused.
  - Sets forth guiding principles.
  - Establishes roles for payers, providers and others.
  - Reflects consensus of key stakeholders.

- **Patient Financial Communications.**
  Hospitals conduct sensitive financial discussions with patients. Now there are accepted, consistent best practices for these discussions, including:
  - Identify additional or alternative insurance coverage.
  - Determine how accounts will be resolved through conversation.
  - Identify patients who fall under 501(r) regulations.
  - Benefit from a satisfied consumer vs. an unhappy consumer.

- **Best Practices for Resolving Patient Medical Accounts from HFMA and ACA International.**
  - Improve patient education and communication.
  - Make bills patient-friendly.
  - Establish policies for account resolution and ensure that they are followed.
  - Report back to credit bureaus when an account is resolved.
  - Track all consumer complaints.

Use established HFMA and ACA best practices, principles and guidelines to inform your organization’s approach to medical account resolution.

The Commonwealth Fund recently studied healthcare coverage among residents of the four largest states in the U.S.—Florida, Texas, New York and California—and found notable variations in the percentage of adults with medical-related financial struggles in 2014.

Four in 10 adults in Florida and Texas reported they had trouble paying their medical bills or were paying off medical debt over time in 2014, compared to one in four in California and three in 10 in New York, according to the study, based on findings from the Commonwealth Fund 2014 Biennial Health Insurance Survey of working-age adults.

The study also found higher proportions of people in Florida and Texas had trouble getting needed healthcare because of the cost than in California and New York. More than four in 10 adults in Florida (43 percent) and Texas (43 percent) said they did not see a doctor when sick, did not fill a prescription, skipped a test, treatment or follow-up visit, or did not get needed specialist care in the past 12 months for cost reasons, compared to three in 10 in New York, according to the study, based on findings from the Commonwealth Fund 2014 Biennial Health Insurance Survey of working-age adults.

The study found significant differences among the four states in rates of health insurance coverage, delays in care because of cost and problems paying medical bills. Twenty-one percent of adults in Florida reported being contacted by a collection agency for unpaid medical bills in past year, compared to 9 percent in California and 11 percent in New York.

Moving Forward

Despite significant declines in uninsured rates following implementation of the Affordable Care Act, millions of people lack access to affordable health insurance in states that have not yet expanded their Medicaid programs, according to the study.

“The bottom line is that states’ health policy decisions are a factor in whether or not millions of people have health insurance coverage,” said Commonwealth Fund President David Blumenthal, M.D. “If states don’t take the necessary steps to help their residents obtain insurance, we may see ever-widening disparities between states in their residents’ coverage and the financial protection it provides.”


More healthcare collection news, visit ACA’s Healthcare Collections page at www.acainternational.org/healthcare

HEALTHCARE COSTS:

Commonwealth Fund Study Finds Medical Bill Problems Continue in Nation’s Largest States

HHS Introduces Network to Advance Quality of Care

HHS has launched a network of payers and providers to engage private sector leaders in building upon the success of the Affordable Care Act model of rewarding quality of care. The network will accelerate changing the healthcare delivery system to one that achieves better care and smarter spending by supporting the adoption of alternative payments models. http://1.usa.gov/1HECwHX

Consumers’ Views on the Affordable Care Act Hold Steady

Public opinion on the Affordable Care Act is holding steady and is closely divided, according to a Kaiser Health Tracking Poll. The share of consumers expressing a favorable view exceeds the share with an unfavorable view for the first time since November 2012. The poll also finds that most Americans (56 percent) say the healthcare law has had no direct impact on their families. http://bit.ly/1KXIIXA

Insurers Continue Compliance with Medical Loss Ratio Requirement

The Affordable Care Act’s medical loss ratio provision yielded more than $5 billion in consumer benefits from 2011 through 2013, according to the Commonwealth Fund. In 2013, insurers paid out $325 million, down from the $513 million paid to consumers in 2012 and the more than $1 billion paid in 2011. http://bit.ly/1D5t8Wv

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Cost to Collect

According to the Wolters Kluwer quarterly Hospital Accounts Receivable Analysis report, "In the third quarter of 2014, the average cost to collect swelled to 2.18 cents. This comes after a slight decline reported in the second quarter. Hospitals with 100-199 [beds] have been most efficient in this category and that did not change in the third quarter. The group reported spending 1.30 cents to collect a healthcare dollar. Small hospitals with fewer than 99 beds spent the largest amount at 2.73 cents."