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Market Challenges for Providers and Opportunities for Collection Partners

By Katie Hebeisen, Communications Specialist

The current state of the health care industry presents challenges for providers, and also creates new opportunities for collection agency partners. During ACA International's Fall Forum session, *Market Challenges for Providers and Opportunities for Collection Partners*, presenters discussed the current state of the health care system and how providers can work with collection partners to create business opportunities.

Current State

While there are many factors impacting the current state of health care, one significant factor is the increase in patient responsibility.

Insurance companies are reimbursing less cost than before, making the patient responsible for more of the bill. A decrease in insurance reimbursement changes the way patients pay their providers.

"There is a need for every self-pay dollar to be collected now," said Tom Gavinski, vice president of the health care division for IC System, Inc. in St. Paul, Minn. "It used to be that self-pay made up 5 percent of a community hospital's portfolio, now self-pay makes up to 10 to 12 percent and up to 33 percent at some public hospitals."

In addition to decreased insurance reimbursement, many consumers are faced with an increase in deductibles. With the unemployment rate currently reaching 9 percent, many consumers are out of work and being forced into high deductible plans and Health Savings Accounts (HSAs). Although some low deductible plans still exist, these insurance policies are becoming less common.

"Gone are the days of the $300 and $500 deductibles," said Tony Rinkenberger, director of revenue cycle services for Ridgeview Medical Center in Waconia, Minn. "In order for employers to keep insurance plans affordable from a premium perspective, not only for themselves but for their employees, deductibles have skyrocketed."

Employers often change their benefits plans on an annual basis to keep them affordable for themselves and their employees. When employers switch health care insurance plans, they may not always do an adequate job educating their employees about what the plan changes mean for them.

"Many times employees do not know what services their plan covers," Rinkenberger said.

If an employer fails to explain benefits to the employee, then the provider is left to go through coverage concerns with them that could have been addressed at the employer level.

"Your employer forgot to tell you that you went from a PPO plan to an HSA plan and that you should have started putting money into your HSA to cover your $5,000 deductible," Rinkenberger said. "This increases the amount we have to collect from the patient when they thought they were covered."

Because employers do not communicate effectively with their employees to let them know about changes to insurance plans and benefits, the employees are unaware they should be putting money into an HSA to cover expenses.

Provider Challenges

Many hospital and clinic staff have been working in the industry for several years, and may need to learn a different skill set to adapt to today's health care environment. Employees need to learn how to discuss and request patient information, determine a patient's financial responsibility before or immediately after the services are provided, explain the patient's benefits and ask the patient for payment.

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HHS Takes Steps to Encourage use of Health IT

Health information technology (HIT) is a system designed to manage health information across computerized networks and secure the exchange of health information between consumers, providers, government and quality entities, and insurers. HIT is increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of health information delivery.

A report released by the U.S. Department of Health and Human Services (HHS) shows the adoption of HIT has doubled in the past two years. New actions to increase the use of HIT in doctors' offices and hospitals nationwide aim to improve patient care and create jobs.

Benefits of HIT

HIT can improve access to care, help coordinate treatments, measure outcomes and reduce costs all while protecting confidential patient information. One of the key benefits of HIT is it lets information travel with a patient. This allows health care providers the ability to access patient records across cities, states and counties. HIT can also help reduce errors related to prescribing drugs, care, tests and procedures.

In addition to improving the health care system, data indicates the national transition to HIT is creating jobs. According to the Bureau of Labor Statistics, the number of HIT jobs across the country is expected to increase by 20 percent from 2008 to 2018, much faster than the average.

To meet the demand for workers with HIT experience and training, the Obama Administration has launched four workforce development programs that help train individuals for a career in HIT. The training is provided by 82 community colleges and nine universities nationwide. At the end of November there were 10,065 students enrolled in HIT training programs across the nation.

Incentive Payments

New administrative actions, announced Nov. 30, 2011, aimed to make it easier for doctors and other health care professionals to receive incentive payments for adopting and meaningfully using HIT.

Under the current requirements, eligible doctors and hospitals that began participating in the Medicare EHR (electronic health record) Incentive Programs in 2011 had to meet new standards for the program in 2013. To encourage faster adoption of HIT, HHS announced it would allow doctors and hospitals to adopt HIT in 2011, without meeting the new standards until 2014.

A survey conducted by the Centers for Disease Control and Prevention (CDC) found 52 percent of office-based physicians in the U.S. intend to take advantage of the incentive payments available for doctors and hospitals through the Medicare and Medicaid EHR Incentive Programs. The CDC data also showed the percentage of physicians who have adopted basic EHR in their practice has doubled from 17 to 34 percent between 2008 and 2011.

Increased Outreach

Policy changes are also accompanied by greater outreach efforts that will provide more information to doctors and hospitals about best practices. HHS plans to target outreach, education and training to Medicare eligible professionals that have registered in the EHR incentive program but have not yet met the requirements for meaningful use of EHR.

The Obama Administration is also working to create a nationwide network of Regional Extension Centers comprised of local nonprofit organizations that will provide guidance and resources to help eligible health care providers participate in the Medicare and Medicaid EHR Incentive Programs and meaningfully use HIT.

The implementation of HIT has become increasingly important. Maintaining the availability of patient records while also keeping private information secure will be essential. HIT can help providers achieve quality, safe and efficient delivery of health information.

More information about the Medicare and Medicaid EHR Incentive Programs is available at *http://www.cms.gov/EHRIncentivePrograms*.

Did You Know?

ACA members can voluntarily commit to align their practices with ACA's *Health Care Collection, Servicing and Debt Purchasing Practices – Statement of Principles and Guidelines*. Those who are committed to the principles agree to:

- Communicate regularly with the health care provider's designated representative having authority and oversight over the collection or sale of health care receivables.
- Establish communications and appropriate information sharing protocols with the health care provider during the term of the service agreement and for a reasonable period of time following termination of the service or debt sale agreement.

To view other commitments set forth by the guiding principles, visit ACA's website at *http://www.acainternational.org/hcguidelines*.

Insurance Premiums Trend Up, Coverage Trends Down

According to the *2011 Employer Health Benefits Survey* released by the Kaiser Family Foundation, annual insurance premiums for employer-sponsored family health coverage increased to $15,073 this year, which is up nine percent from last year. On average, workers paid $4,129 and employers paid $10,944 toward annual premiums.

Premiums increased significantly faster than workers' wages (2.1 percent) and general inflation (3.2 percent). Since 2001, family premiums have increased 113 percent, compared with 34 percent for workers' wages and 27 percent for inflation.

In particular, the survey estimates that employers added 2.3 million young adults to their parents' family health insurance policies as a result of the health reform provision that allows young adults up to age 26 without employer coverage on their own to be covered as dependents on their parents' plan. Young adults historically are more likely to be uninsured than any other age group, but are now likely benefiting from the provision in the new health care law that allows them insurance coverage under their parents' plans until they turn 26.

A recent *Gallup-Healthways Well-Being Index* survey reported that, while the percentage of 18- to 26-year olds who lack health insurance has decreased, there has been an increase among 25- to 64-year olds without health insurance. While young adults are benefiting from the new health care law, none of the other components of the health law appear to be affecting coverage for older adults, who make up a larger segment of the population.

According to data from Gallup, the percentage of adults with no health insurance has been increasing in 2011, with the second and third quarters both tying with 17.3 percent who are uninsured.

Market Challenges

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Providers should make patients aware of their total out-of-pocket expenses, and ask them how they would like to pay for it. If the patient hesitates or says she cannot afford to pay the bill right now, providers should ask how much the patient can afford to pay today. It is also important to ask when the patient will be able to pay the remaining balance.

"It is important to connect the patient with their responsibility to pay," Rinkenberger said. "A simple follow up question will connect the patient with their ongoing responsibility to pay."

Personnel should strive to collect all patient information before the patient leaves the facility so the patient can be easily located for payment purposes. Having all of this information up front will allow collectors to focus on collection efforts as quickly as possible. The primary goal is a seamless transition between the pre-registration process, insurance verification, check-in, point of service collections and financial counseling.

With Challenges Come Opportunities

Providers and collection agencies can become partners in an effort to collect health care debt.

Collection agency partners can provide training on point-of-service collections. Rinkenberger suggests collection agencies may be able to offer better scripts to use while collecting patient information on the front end. That way once the account goes to collections, collectors will have better information to follow.

Collectors can also provide systems and tools to make a provider's processes more efficient and profitable.

"I don't have a predictive dialing system to do collections," Rinkenberger said. "I'm looking up each individual, dialing manually, calling and saying 'hello.'"

Rinkenberger noted his facility struggles with developing and monitoring patient payment plans – another area a valuable collection partner could provide tools and systems for.

Technologies utilized by agencies such as predictive analytics, scoring models and ROI calculators also offer value to a provider partner.

"An ROI calculator would prove that the services I'm bringing in—first-party or third-party collection services—will fly through administration and get the signature for approval," Rinkenberger said.

Providers and collection agencies can partner together to create their own unique models for collecting health care debt.

"Maybe there are models that we haven't even thought of yet where we can be partners in making sure that I get the money to keep going and to survive," Rinkenberger said.

"The growth in self-pay is good news for all of us," Gavinski said. "It's more opportunity for business with copays and deductibles."

In order for providers and collectors to be successful in working together, they need to follow a caring, compassionate and competent approach to collecting health care debt.

According to Gavinski, "What health care providers want is a trusting partner who adheres to their mission and vision."

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CMS Delays Enforcement of New HIPAA Transaction Standards

The Centers for Medicare & Medicaid Services (CMS) announced that it will not enforce compliance with the ASC X12 Version 5010 (Version 5010) standards until March 31, 2012.

Providers and other entities covered by the Health Insurance and Portability Act (HIPAA) must transition to the new standard for electronic processing of claims and other transactions by Jan. 1, 2012.

The 5010 version of the transaction standards was mandated by the Health Insurance Portability and Accountability Act, or HIPAA, and replaces the 4010/4010A1 transaction standards. The switch to Version 5010 standards is a prerequisite to the transition to ICD-10 diagnostic and procedure codes.

CMS decided to provide a 90-day discretionary enforcement period based on industry feedback revealing low compliance with the standards and reports that many covered entities were still awaiting software upgrades.

For more information, visit *www.cms.gov/ICD10*.

PULSE is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

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