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Benefits of Partnering with Collection Agencies

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Many health care providers have already partnered with a professional collection agency to improve their chances of recovering past due balances. From traditional collection services to training, charity care screenings and business service operations–collection partners provide an array of services to help health care providers achieve their accounts receivable management goals.

"A collection agency is a for-profit organization, and the return on its assets is also a return to the provider," said Kevin Hough, president at Corpra Care Inc., in Houston, Texas. "The bottom line is that providers and their vendors are partners, and the relationship should be viewed as a united team effort toward profitability for both of them."

Patient self-pay responsibilities are continuing to grow and health care providers have seen their self-pay portfolios increase dramatically, creating even more of a demand for collection partners.

"The self-pay growth trend is expected to continue to grow in the future, and health care providers are not equipped to handle large volumes of smaller patient self-pay accounts because their information systems are focused on the large balance third-party insurance receivables," said Tom Gavinski, vice president of the health care division for IC System, Inc. in St. Paul, Minn.

Hospitals and health care facilities are seeing tighter operating margins with increased costs and lower reimbursement rates. According to Gavinski, liquidation of the growing self-pay portfolios is becoming even more critical to the financial success of provider organizations.

"Health care providers are strapped for capital and cannot afford to invest heavily in either additional human help or information technology within the patient collection process," Gavinski said. "Providers need to rely on outsourced vendors to help supply them with this human and technical capacity."

Collection partners can assist health care providers with their patient collection needs in several ways. For instance, collection outsource partners can provide in-house training for health care providers. Collection partners can also assist providers with necessary charity care screening and financial assistance application processing.

Gavinski stated that many health care providers have begun outsourcing most or even all of their business office collection operations. Many outsourcing partners are expanding their service offerings beyond traditional collection services to better serve the needs of their provider clients.

"We offer our clients point-of-service collections during admission, registration and scheduling with the goal of improving in-house cash collections," Hough said. "We have dramatically enhanced and updated our collection services to include exceptional customer service, which has become a larger demand since the Affordable Care Act incentivizes providers with a bonus program based on good customer care and patient experience."

Health care providers' community benefits requirements, patient collection processes and tax-exempt statuses remain under continual scrutiny. Providers need experienced and reliable partners who can protect their organizations' brand and goodwill within their communities.

"Providers must maintain a positive image with regulators, legislators, consumers and the media," Gavinski said. "A competent collection partner will help providers preserve those crucial relationships and keep them healthy."

Report States New Policies Will Reduce Costs and Improve Quality of Care for Medicare Beneficiaries

According to a Commonwealth Fund report, new policies enacted as part of the Affordable Care Act will reduce costs and improve quality of care for Medicare beneficiaries, while rewarding high-performing Medicare Advantage plans. The Medicare Advantage program, created as part of the Medicare Modernization Act of 2003, allows Medicare beneficiaries to receive Medicare benefits through private insurance plans.

The Commonwealth Fund report details how three major changes to the way Medicare Advantage plans are paid will help achieve cost savings:

- Rewards for quality: For the first time, plans that earn a four-star out of five or higher rating on the Centers for Medicare and Medicaid Services' (CMS') quality rating system will receive higher payments through increased benchmark and rebate payments. The CMS system rates how plans perform on measures including how many members are up-to-date on screenings, vaccines, and check-ups; how well chronic conditions are being managed; members' satisfaction with the plan; member complaints; and customer service.
- New benchmark rates: The bulk of the savings will come from changing the way the benchmark rates for the payments private plans receive from Medicare are set. Under the Affordable Care Act, the nation's 3,140 counties will be ranked based on their per capita health care spending for traditional Medicare, and divided into four groups with the benchmark rates for each group increasing as per capita costs decrease.
- Reduced rebates to plans: Medicare Advantage plans are currently paid a rebate that amounts to 75 percent of the difference between the set benchmark rate and the plan's bid to provide coverage to Medicare enrollees. The Affordable Care Act will reduce the rebate rate from 75 percent to 50 percent, yielding an estimated $640 million in savings per year.

The report states that, in addition to the cost savings, the changes in Medicare Advantage will likely lead to increased efforts by participating private plans to track and improve performance as they strive to receive bonus payments. The report states that reward-based payments not only have the potential to improve the care enrollees receive, but also to make Medicare participation an attractive option for health plans that provide high-quality care.

http://www.commonwealthfund.org/News/News-Releases/2012/Oct/Policies-Will-Equalize-Payments.aspx.

Census Report Shows Americans Are Visiting the Doctor Less

In 2010, working-age adults made an average of 3.9 visits to doctors, nurses or other medical providers, down from 4.8 in 2001, according to a report released by the U.S. Census Bureau. Among those with at least one such visit, the average number of visits also declined, from 6.4 to 5.4 over the period.

Other highlights from the report include:

Visits to a medical provider or dentist

- Respondents were much less likely to visit a dentist at least once in the last year than a medical provider: 59 percent compared with 73 percent.
- Medical provider visits become more likely with age, as 37 percent of young adults 18 to 24 did not visit a provider at all during the year, compared with 8 percent of those 65 and older.

Prescription medication

- More than half of the population (57 percent) did not take prescription medication at any point during the previous year, while 35 percent reported taking it regularly.
- While 80 percent of older adults (those 65 and older) reported regular prescription medication use, the same was true for 13 percent of children.

Uninsured adults

- Among uninsured adults who visited a medical provider or dentist during the year, 13 percent visited an emergency room and 10 percent visited a hospital (excluding the emergency room), while 20 percent received free services and 30 percent received a discount on services.
- In 2010, 21 percent of uninsured adults in poor health received routine check-ups, compared with 12 percent of all uninsured adults.
- People under 65 whose health was poor, fair or good were more likely to be uninsured (23 percent, 25 percent and 24 percent, respectively) than those with very good or excellent health (20 percent and 16 percent, respectively).

For further information, please view the complete report at *http://www.census.gov/newsroom/.*

ACA Submits Comments on Proposed IRS and Treasury Rules for Charitable Hospitals

ACA International filed comments in response to the U.S. Internal Revenue Service and Department of Treasury's Notice of Proposed Rulemaking for Additional Requirements for Charitable Hospitals.

"As a billing and collections service provider to charitable hospitals, ACA members welcome the opportunity to help patients gain greater access to available health care and financial assistance programs," ACA Chief Executive Officer Pat Morris said. "Our submitted comments focus on improving the patient experience and reducing confusion due to inconsistent or duplicative federal, state and local financial assistance requirements."

Clarify Statutory and Regulatory Authority: Federal authority for regulating and enforcing the collection of all debts, including health care debts, is set forth in the Fair Debt Collection Practices Act (FDCPA). ACA requests clarification as to the statutory basis to apply the proposed rules to the collection of health care debts and to explain the apparent attempt to exercise rulemaking under the FDCPA, when Congress has delegated such authority onto the Consumer Financial Protection Bureau.

Preempt Inconsistent and Duplicative Laws: The proposed regulations conflict with state and local charitable care and financial assistance laws, creating compliance challenges for hospitals and confusion for patients. ACA suggests the solution to this problem is for the final rule to clarify that the federal standards preempt state law.

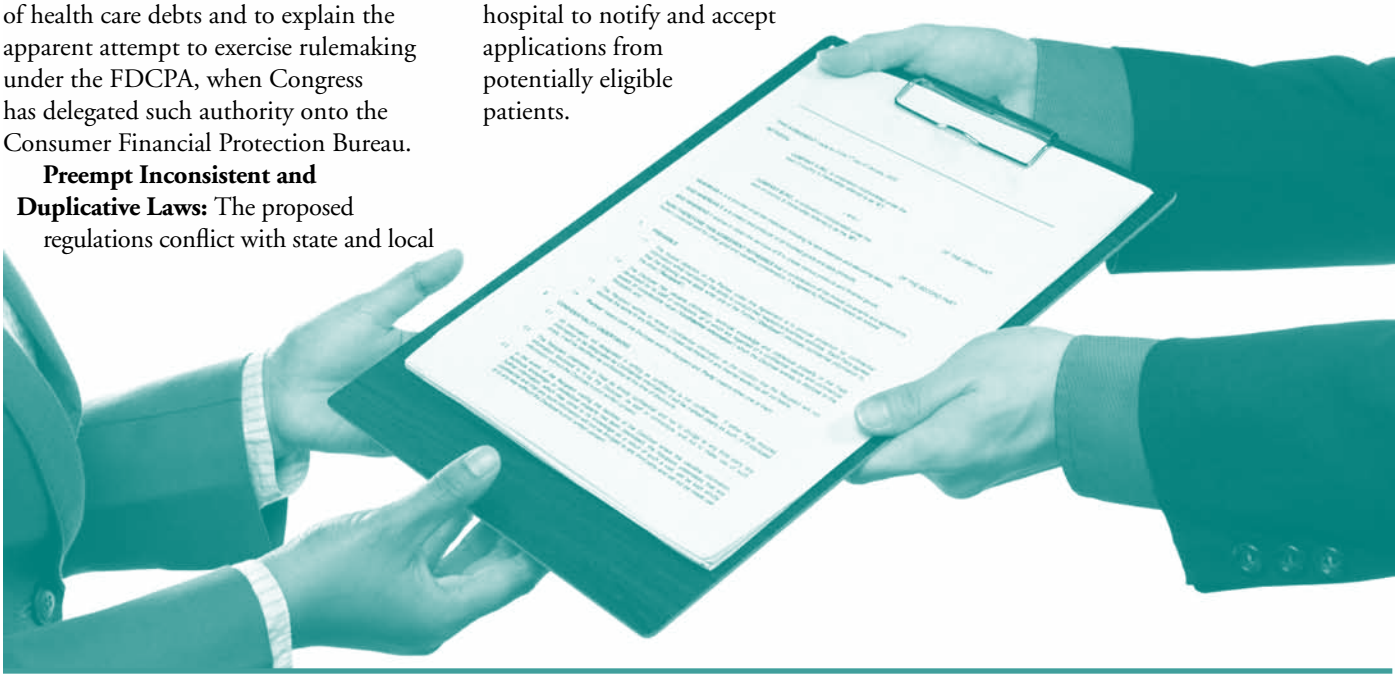
Exclude Credit Reporting from Extraordinary Collection Actions: Credit reporting of health care debt is not "extraordinary" and putting it on par with lawsuits, wage garnishment and foreclosure actions is an arbitrary and capricious interpretation of the Fair Credit Reporting Act (FCRA) and the intent of Congress. ACA suggests credit reporting be removed from consideration as an "extraordinary" collection action.

Reduce the Notification and Application Periods: The proposed 120-day notification and 240-day application periods are too long, conflict with state requirements, and interfere with the ability of charitable hospitals to recover payments from patients ineligible for financial assistance. ACA encourages a maximum 120-day period for the hospital to notify and accept applications from potentially eligible patients.

Clarify Tolling Limitations: The proposed regulations fail to address the legal effect of prohibiting the reporting of health care debts for up to 240 days after the initial bill, which reduces by one-half the period of time a hospital can recover nonpayment of a debt from a patient that does not qualify for charity care. ACA suggests that all statutes of limitations be tolled until the final determination of eligibility.

Require Patients to Cooperate with Eligibility Determinations: Health care providers and patients have a shared responsibility to promptly resolve financial assistance requests. ACA suggests the proposed regulations acknowledge that a patient seeking eligibility for financial assistance has an affirmative duty to cooperate in the process.

ACA plans to attend a hearing on Dec. 5, 2012, concerning the proposed rulemaking for additional requirements for charitable hospitals.



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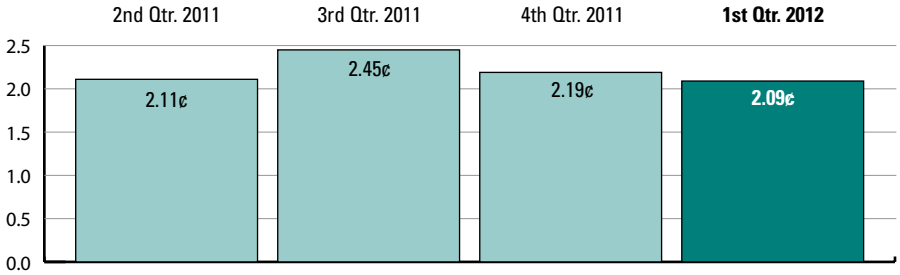
DATA WATCH

Average Cost to Collect

In the first quarter of 2012, hospitals paid an average of 2.09 cents to collect a health care dollar, down from 2.19 cents in the fourth quarter of 2011. During the last four reporting quarters, the average cost to collect was 2.21 cents, which was increased by the third quarter figure of 2.45 cents.



Source: *HARA Report on First Quarter 2012, vol.26, no.2, 2012,* with permission from Aspen Publishers, Inc., *www.aspenpublishers.com*.

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