Patient Friendly Billing® & 501(r) Final Regulations

Terry Allison Rappuhn
Leader of HFMA’s Patient Friendly Billing® Project

Terry Allison Rappuhn, CPA,
Leads & facilitates national HFMA initiatives

Current or Previous:
• CFO of Quorum Health Group, Inc.
  QHGI owned 21 hospitals &
  managed > 200 hospitals
• National HFMA Board member
• Member, Precyse Advisory Council

Board of directors member:
• Genesis HealthCare Corporation,
  with > 200 SNFs
• AGA Medical Holdings, Inc., medical
  device innovator & manufacturer

Agenda

One • Your Patient’s Perspective
Two • HFMA Initiatives & Resources
Three • 501(r) Final Regulations
Conclusion • Priorities & Strategies for Success

One

Your Patient’s Perspective
Q. Why don’t these patients cooperate?

The Story of Sheila

ACA Enrollees Prefer Silver and Bronze Plans
These plans have deductibles ranging from ~3K to 10K

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>$5,081</td>
<td>$10,386</td>
<td>60%</td>
<td>$6,267</td>
<td>$12,569</td>
</tr>
<tr>
<td>Silver</td>
<td>$2,907</td>
<td>$6,078</td>
<td>70%</td>
<td>$5,370</td>
<td>$11,495</td>
</tr>
<tr>
<td>Gold</td>
<td>$1,277</td>
<td>$2,846</td>
<td>80%</td>
<td>$4,081</td>
<td>$8,649</td>
</tr>
<tr>
<td>Platinum</td>
<td>$347</td>
<td>$698</td>
<td>90%</td>
<td>$1,855</td>
<td>$3,710</td>
</tr>
</tbody>
</table>

Sheila’s Benefits
W/O Cost Share Subsidy

Deductible: $4,000
Inpatient & ER coinsurance: 20%
Primary care copay: $10
Maximum out-of-pocket: $5,000

Sheila’s income is 138-150% of FPG. She gets the cost share reduction.

Source: Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ASPE Issue Brief: Health Insurance Marketplace: January Enrollment Report (January 2014)

Sheila’s Benefits
W/O Cost Share Subsidy

Deductible: $4,000
Inpatient & ER coinsurance: 20%
Primary care copay: $10
Maximum out-of-pocket: $5,000

Sheila’s income is 138-150% of FPG. She gets the cost share reduction.

Source: Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ASPE Issue Brief: Health Insurance Marketplace: January Enrollment Report (January 2014)
Sheila had a heart attack. She got good care & is home now.

Deductible: $0
Inpatient & ER coinsurance: 20%
Primary care copay: $5
Maximum out-of-pocket: $600

Q. How much will Sheila owe the hospital?

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term: Deductible

Nongroup: 84%
Uninsured: 60%

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term: Premium

Nongroup: 83%
Uninsured: 52%

What types of problems have you encountered with exchange plans?

- The patient was unaware of the benefit design of their exchange plan (e.g., unaware of their deductible/co-insurance)
- The patient was unsure whether or not the provider was in the exchange plan’s network
- Claims processing delays due to unclear/unstated claims filing requirements
- The allowable amount paid by the exchange plan is different than what your organization believes is the contracted rate
- Provider was unsure whether or not the provider was in the exchange plan’s network
- Patient thought they were enrolled but the plan could not verify/confirm that the individual was enrolled/covered
- Patient had not been issued insurance card
- The patient was unaware of the benefit design of their exchange plan (e.g., unaware of their deductible/co-insurance)
HFMA Initiatives & Resources

Two

HFMA Resources to Help You Improve the Billing and Payment Experience for Patients

HFMA Price Transparency Task Force Report

• Clarifies basic definitions that are often misused
• Sets forth guiding principles
• Establishes roles for payers, providers, others
• Reflects consensus of key stakeholders

hfma.org/dollars

Definitions of Key Terms

Cost, charge, and price should not be used as interchangeable terms.
• Cost varies by the party incurring the expense.
• Charge is the dollar amount a provider sets for services rendered before negotiating any discounts.
• Price is the total amount a provider expects to be paid by payers and patients for healthcare services.
Guiding Principles for Price Transparency

- Empower patients to make meaningful price comparisons prior to receiving care
- Easy to use & to communicate
- Paired with information about value
- Provide patients with information to understand total price & describe what’s included
- Price transparency requires commitment of ALL stakeholders

Who Should Provide Price Information?

For:

- Insured patients:  Health plan
- Uninsured & out-of-network patients:  Provider

Provider Role

For uninsured patients and out-of-network care, providers should:

- Offer an estimated price for a standard procedure and make clear how complications may increase the price.
- Clearly communicate pre-service estimates of prices.
- Clearly state what services are included in an estimate.
- Give patients other relevant information, where available.

Offer a Pricing Guide to Consumers

- Describes how to request price estimates, step by step
- Clarifies what estimates may or may not include
- Explains in-network and out-of-network care
- Defines key terms
- Available for posting on your website at no charge
- Hardcopies available for purchase in bulk at a nominal price through AHA’s online store
Patient Financial Communications

Every day, we conduct sensitive financial discussions with patients. But there have been no accepted, consistent best practices for these discussions—until now.

Designed for the Most Needed Settings & Purposes

Benefit Patients & Providers

- Encourage patients to talk with financial counselor about financial concerns
- May identify additional or alternative insurance
- Have conversation about how to resolve account
- Identify patients who fall under 501(r) regulation
- Realize value of satisfied vs unhappy consumer

Achieve Recognition as an Adopter

- Recognition demonstrates commitment to best practices
- Based on HFMA review of an application and supporting documentation
- All provider organizations may apply
- Recognition valid for two years
- Adopters may use the phrase “Supporter of the Patient Financial Communications Best Practices” in their marketing materials
Best Practices for Medical Debt

By following the HFMA Best Practices for Medical Account Resolution, your organization is affirming that . . .

• We want to find solutions that are balanced, fair, and reasonable.
• We keep patients informed about payment expectations and time frames.
• The business practices that we—and our business affiliates use—have been approved at the Board level.

Selected Best Practices

• Educate patients and follow best practices for communication
• Make all bills and other communications clear, concise, correct, and patient-friendly
• Establish policies and make sure they are followed internally and by business affiliates
• Be consistent in key aspects of account resolution—from billing disputes to payment application
• Coordinate with business affiliates to avoid duplicative patient contacts

Selected Best Practices (cont.)

• Exercise good judgment about the best ways to communicate with patients about bills
• Start the account resolution clock when the first statement is sent to the patient
• Report back to credit bureaus when an account is resolved (in the event that an account is reported to a credit bureau)
• Track all consumer complaints.
• Draw on best practices, principles, and guidelines to inform your organization’s approach

Workflow

Workflow and best practices = compliance with 501(r) proposed regulations

Refer to handout or hfma.org for 2-page document.
The Revenue Cycle Model Must Change

Historical Model
- Gather basic info before & at the time of service.
- Billing process is post-service. Amount due is based on data gathered after service, calculated retrospectively.
- Patients told of financial obligations after insurance is billed & paid.

The Near Future
- Pre-Service: Prospective Data Gathering and Processing
  - Gather detailed info before & at time of service. Estimate out-of-pocket costs.
- At Service
  - Bill at or right after service. Many patients know in advance what they owe & agree on terms.
- Post-service: Retrospective Data Gathering and Processing
  - Insurance bill verifies what patient already expects.

“Price information to consumers must be meaningful to them”

What the patient is expected to pay . . . tailored to the patient's specific condition, treatment and insurance coverage . . . a patient having the ability to get an estimate . . . prior to service . . . of the amount the patient will actually owe.

Patient Friendly Billing Reports

Pre-Service: Prospective Data Gathering and Processing

At Service

Post-service: Retrospective Data Gathering and Processing

High-Performance Revenue Cycle

Characteristics:
- Organizational culture that elevates importance of revenue cycle
- Master areas important to their particular circumstances. Are good at what they need to be good at
- Accelerate improvements
  - Take action and execute well

Providing Out-of-Pocket Payment Estimates

Ready-to-Use Ideas
Financial Policies for Uninsured & Underinsured Patients

1. Who qualifies?
2. What services are discounted?
3. What discount levels are offered?
4. How are policies communicated?
5. How are unpaid accounts resolved?
6. What structures & systems are in place to administer policies?
7. What is the legal & regulatory context?

Key Considerations

Final 501(r) Important Dates

- ACA established requirements for 501(c)(3) hospitals.
- Proposed regs issued in 2012 & 2013
- Final regs issued 12-29-2014
- Final regs effective for tax years beginning after 12-29-2015
- Until then, can comply with 2012 & 2013 proposed regs

Final 501(r) Covers:

- Community Health Needs Assessment (CHNA)
- Financial Assistance Policies (FAPs) and Emergency Medical Care Policies
- Limits on Charges (amount generally billed-AGB)
- Billing & Collection
### Final 501(r) Financial Assistance Policies (FAPs)

- FAP written & clear, concise, easy to understand
- FAP, FAP application form, summary available on website, paper copies available by mail & in public locations in hospital *(at minimum ED and admissions)*
- Notify community & patients about FAP
  - Conspicuous public displays *in ED and admissions*
  - Offer to patients at intake or discharge
  - On bills *(not every one)*, including phone number and URL address for information about FAPs
  - Translation if 5% of population or 1,000 people

**Italicics signify change in Final Regs from Proposed Regs**

### Final 501(r) Billing and Collections

- Extraordinary Collection Efforts (ECAs)
  - Selling debt
  - Reporting adverse info to credit agency/bureau
  - Taking actions that require legal or judicial process
  - No ECAs until after 120 days from first post-service bill
  - No ECA until 30 days after notifying individual that may take an ECA
  - Deferring, denying care or requiring payment before providing care because of previously unpaid bills
  - Exceptions for debt/liens related to injuries when the hospital provided care and bankruptcy
- Presumptive eligibility OK, including for less than most generous assistance

**Italicics signify change in Final Regs from Proposed Regs**

### Final 501(r) Reg Resources

- 2-19-2015 HFMA webinar available at [www.hfma.org](http://www.hfma.org)
- Go to these websites. Search for 501(r). Read publications dated 2015.
  - Deloitte.com (2 page executive summary)
  - EY.com (webcast)
  - PWC.co, (5 page publication)
  - KPMG.com (15 page publication)
  - BKD.com (Slides on CHNAs)

*Use the Medical Account Resolution Workflow and best practices on slide 28!!*
Take Care of the Patient & You Take Care of Yourself, Too

Path to resolve their bills
Insurance is best for patient!

Up front:
Information about what to expect
Communication & understanding
Agreement & results

Patient Education & Access

- Partner to educate community:
  - Insurance terms
  - How to access care (e.g., clinics not ED)
  - How to understand a bill & EOB
- Learn from community & educate your staff
  - Patient language (e.g., E plan not narrow network)

Unpaid Premiums - Use 271s & 835s to Identify & Act

Patients Need to Understand:
- $ Covered if Premiums Paid
- $ Owed to Hospital (& Others) if Premiums Not Paid

Don't Assume Patients Know Premium is Due!

Understand Your Marketplace Plans

- Use Separate I-Plan Codes to Monitor
- Know How Each Plan Handles Claims

Is account being paid as expected?
If not, why not?
Follow up as soon as 14 days after billing

A Denial is bad for the patient
Work Fast
Patient Advocacy
New York Presbyterian at HFMA's 2013 Virtual Conference

- Patient financial advocacy vs adversity
- Assist patients find insurance or other coverage they didn’t know was available
- Details in background slides at end of presentation

Patient Advocacy, cont.
Results

Strategies for Success

Patient Advocacy vs Counselor
- Helping patients find solutions

Work w/ patients to get coverage – ALL YEAR
- Qualifying life event or a complex situation?
- Qualify for Medicaid or CHIP?
- COBRA, Victims of Crime, Other?

Strategies for Success

Up front
- Discuss with patient: coverage, payment expectations & options
- Have practices in place to notify patients at scheduling or registration if out-of-network

Policy Transparency
**Strategies for Success**

Analyze your post 1/1/14 experience
  • Adjust policies, procedures & training

Understand & monitor marketplace plans

Identify/contact patients w/ unpaid premiums

---

**Strategies for Success**

Become a Patient Financial Communications Adopter

Compare your practices to Medical Debt Task Force report & make changes if needed

---

**Strategies for Success**

Provide transparent pricing to uninsured and out-of-network patients

Tell your story internally and to your community

---

**Conclusion**

Questions & Discussion
Background Slides

---

**Tennessee Groups to Know**

- Tennessee Hospital Association
- Tennessee Health Care Campaign
- Get Covered Tennessee
- Enroll America
- Organizations in your Community Health Needs Assessment
- Others in your community active in enrollment

---

**Patient Advocacy**

New York Presbyterian at HFMA's Virtual Conference

---

**Patient Advocacy, cont. Services to Patients**

**Patient Financial Advocacy Project Summary**

<table>
<thead>
<tr>
<th>Service Offered</th>
<th>✔️</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of insured patient (non-jail inmates)</td>
<td>✔️</td>
</tr>
<tr>
<td>Worker's Compensation identification</td>
<td>✔️</td>
</tr>
<tr>
<td>No-Fault Insurance identification</td>
<td>✔️</td>
</tr>
<tr>
<td>Identification of Third Party Liability</td>
<td>✔️</td>
</tr>
<tr>
<td>Special Projects (KERSA etc.)</td>
<td>✔️</td>
</tr>
<tr>
<td>Inpatient Medicaid Enrollment</td>
<td>✔️</td>
</tr>
<tr>
<td>Outpatient Medicaid Enrollment</td>
<td>✔️</td>
</tr>
<tr>
<td>Charity Care Applications (CP and OPP)</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Patient Advocacy, cont.
The Process – THE HOW

Patient Financial Advocacy Process

- Medical
- Legal
- Social Worker
- High Cost/Level of Assistance
- Other

Third Party Vendor – THE HOW

- Third Party Vendor provides the following services:
  - Early out
  - Centralized call center
  - Centralized charity care
  - Billing
  - Patient Financial Advocacy
  - Staff at hospital
  - Field visits to patient homes
  - Feedback loop and consulting services to NYPH

Timeline

NYPH Patient Financial Advocacy Program Milestones:

- 2007
- 2008
- 2009
- 2010
- 2011
- 2012

Best Practice Tips

- Investigate all potential funding sources
- Centralized process
- Accountability
- A/R management
- Communication across disciplines
- Outreach to outpatient operations
- Outreach to clinicians
Patient Advocacy, cont.
Lessons Learned

- Advocacy instead of adversity
- Don’t underestimate staff’s ability to adapt to new processes and technology
- Mitigate areas of A/R risk
- Know state regulations
- Vendors need to be closely monitored

Patient Advocacy, cont.
Results

Patient Financial Advocacy
Outpatient Medicaid Approvals and Reimbursements