

healthcare registration

ASPEN PUBLISHERS

November 2008 • VOLUME 18, NO. 2
EDITOR: LAURA J. MERISALO

Critical Condition

Patient access role in improving ED revenue cycle management

Emergency departments (EDs) across the country are operating under ever-increasing pressures: overcrowded waiting rooms, workforce shortages, government cuts, stricter regulatory requirements, declining reimbursement, escalating patient volumes, and the 24/7 demand to care for a growing number of patients who can't—or won't—pay for services.

Many EDs are shutting their doors for good, due to the myriad pressures that result in financial strain. Fewer EDs means reduced access to much-needed health care and essential community services. In fact, in California alone, 70 hospital emergency rooms and trauma centers have closed since 1990.¹

A recent article about the potential closure of an ED in Los Angeles underscores the problem:

The potential loss of another emergency room in Los Angeles, in particular, is a major concern to local health officials. Emergency rooms throughout the region are swamped with the sick, injured and uninsured—and the loss of any ERs would exacerbate the problem, officials say. ...

“We have lost 10 ERs in the past five years and this is such a critical situation that we cannot afford to lose even one more,” said Carol Meyer, director of governmental affairs at the Los Angeles County Department of Health Services.²

An August 2008 press release from the American College of Emergency Physicians (ACEP) paints an even clearer picture. As stated in the report:

Visits to emergency departments climbed to a record high of 119.2 million in 2006, up from 115 million in 2005, with an average of 227 visits per minute, according to a new report from the Centers for Disease Control and Prevention (CDC). ...

The new CDC report said, in one decade—from 1996 to 2006—the number of emergency patient visits rose from 90.3 million to 119.2 million, an increase of 32 percent, or an average annual increase of nearly 3 million visits (2.9 million) per year. The number of hospital emergency departments decreased from 4,109 to 3,833.³

According to the ACEP Web site, “U.S. hospitals, over the past 10 years, closed more than 100,000 inpatient beds and nearly 8,000 intensive care beds in an effort to control costs. The majority of the nation’s 4,600 hospital emergency departments report that they are operating ‘at’ or ‘over’ critical capacity.”⁴

What is going on here?

Sources of Financial Strain in the ED: The Uninsured and the Underinsured

Uninsured patients and their use of ED services often are pointed to as a main cause of ED financial strain, and with good reason. About 20 percent of the uninsured (compared with 3 percent of those with insurance coverage) say their usual source for medical care is the emergency room.⁵

For many uninsured patients, the initial—and sometimes sole—point of entry into the health care system is the emergency department of their local hospital. The reason: the uninsured typically have less access to primary and preventive medical care than their insured counterparts; thus, medical

treatment often is delayed and conditions go undetected and untreated. When sickness or injury do occur, uninsured patients end up in emergency rooms because they have nowhere else to go, requiring higher cost care than if they had had earlier access to primary or preventive care.

Many uninsured patients do not have the ability to pay out-of-pocket for the services they receive in an ED, nor are they enrolled in local, state, or federal medical assistance programs. An April 2008 article on the uninsured reported that one in four uninsured Americans, or about 12 million people, are eligible for Medicaid and their state's Children's Health Insurance Program, but they are not enrolled in these medical assistance programs. Among the reasons given for this lack of enrollment include not being aware of the programs and not knowing how to enroll.⁶

Thus, emergency medical care often is provided but never paid for, leading to bad debt and major financial strain for the nation's EDs. According to the Centers for Medicare & Medicaid Services (CMS), 55 percent of medical care in the nation's hospital emergency rooms goes uncompensated.⁷

But it's not just the uninsured that present a challenge for emergency care providers. It is estimated that, every year, hospitals write off more than \$2 billion in copayments and deductibles that should be paid by insured patients—an average of \$400,000 for every hospital in the country.⁸ Industry-wide average collection rates on emergency department copays and deductibles are less than 33 percent of the total amount owed. When billing costs are factored into the equation, which can range from \$2 to \$15 per patient charge, hospitals may net only 15 percent to 20 percent of costs on underinsured patient balances.⁹

Another dire statistic: A September 2007 study reported that 29 percent of people with health insurance were “underinsured,” with coverage so insufficient they often postponed medical care because of costs.¹⁰ Nearly 50 percent of survey respondents in this study, 43 percent of whom reported having health coverage, said they were “somewhat” to “completely” unprepared to deal with a costly medical emergency in the coming year.¹¹

As the number of self-pay patients—those individuals who must pay all or a portion of their medical bills—rises, so does the urgency for health care service providers to adopt systems that effectively

and efficiently deal with these self-pay account balances. And nowhere in the nation's health care delivery system is the need more urgent than the emergency room.

Fast and Furious: The ED Collections Challenge

Emergency departments. They are busy. They are chaotic. There are long wait times and overcrowded waiting rooms. There is tension in the air. There are people with urgent, life-threatening medical needs, as well as people with not-so-urgent needs.

In this environment, the emergency department's patient registration staff is concerned first and foremost with getting patients seen by the medical staff as soon as possible, by mission and by federal law. In the ED, financial considerations and payment arrangements come second, and this often results in low up-front and overall collection rates of patient-pay ED balances. The reasons have been well-covered in policy papers and news articles, and include the following:

The Emergency Medical Treatment and Active Labor Act (EMTALA)

Under this federal regulation,¹² patients cannot be turned away from an ED due to an inability to pay for medical services. Thus, many ED patients receive care and treatment they either cannot pay or choose not to pay.

Lack of Information

Patients may show up in the emergency room in need of care, but without proper identification or without knowing their insurance information. These patients may have no financial means to cover the ED copayment amount. In fact, many times, the ED staff is so focused on getting care to the right patient at the right time that patient contact and insurance information and copays are not even requested. After services are provided, some patients simply walk out the door without paying, and the ED provider is left without contact information for sending a bill or setting up a payment plan.

- Lack of Appropriate Processes and Technology to Manage Self-Pay Patients

Many EDs simply lack an efficient, consistent process to manage self-pay patients. These imperfect registration and/or discharge procedures lead to missed opportunities for up-front and overall collections, as well as misclassified charity care, because

adequate patient demographic information is not collected at the time of service. In addition, there often is a failure to identify patients who may be eligible for financial assistance programs, such as a Medicaid and other state or local medical assistance programs.

All of these and other factors result in mounting bad debt within the health care industry in general, and in the nation's EDs in particular, threatening the financial viability of health care service providers across the country.

Patient Financial Triage: Improving ED Collections

The good news is that, in the midst of all these challenging circumstances, there are well-performing hospitals and EDs that effectively manage their self-pay patient financial accounts. The best-performing hospitals in the country achieve point-of-service collection rates in the ED between 40 percent and 60 percent.¹³ Here are some strategies top-performing ED providers have adopted to attain these high ED collection rates:

- Verify patient identity and contact information at the outset.

Verification of patient identity is a vital first step. Errors in patient demographic data can lead to returned statements and bills and an increase in denied claims, resulting in lower payment collection rates and increased bad debt.

If a health care facility cannot absolutely prove that individuals are who they say they are, there can be other negative consequences: higher fraud rates, including people using multiple identities; the potential delivery of incorrect medical treatment; and the possibility that charity care and government assistance programs are not being properly allocated. The key to avert such negative consequences is to collect adequate and accurate patient demographic data on the front end, and to have it organized in a manner that allows for instantaneous appropriate action and decision-making.

- Determine means of payment and patient responsibility at the point of service.

In areas other than the emergency room, ask patients for their insurance information and verify the coverage and benefits prior to service being rendered. In the case of a self-pay patient, determine the patient's capacity to pay, as well

as discounts and payment terms, if appropriate. Screen for the patient's eligibility to enroll in medical assistance programs and/or charity care as soon as possible, and assist the patient in the enrollment process.

Gathering such information in the ED is possible, and in compliance with EMTALA, as long as the gathering of such data does not delay the medical screening examination and the provision of needed medical care. In addition, in the emergency room, ensure patients see a business office representative prior to leaving the facility.

- Ask for payment up front, once services have been provided.

It's that simple: If you don't ask for payment, patients won't pay. Implement price transparency for the most common procedures and services. Offer patients several options for payment, including cash, check, and credit card. Make sure all patients (even in the emergency room) are discharged through the business office.

- Offer financial counseling and payment plan terms, and have the patient sign a payment agreement.

If charges are high, some patients may need to pay over time. Offering a payment plan will at least result in a portion of the charges being collected, if not the entire amount.

Structuring a payment plan around the patient's financial needs can result in increased cash flow for the ED and higher payment rates overall. Ideally, patient access employees in the ED will have access to online payment forms that can be printed and signed by the patient while the patient is at the facility.

Focusing on patient identity verification and obtaining up-front collections are keys to ensure a facility receives proper and timely payment for services. However, improving post-discharge collections is important and necessary as well. Think of it as a two-pronged approach that requires effective integration of patient access and patient financial services. Here are some steps that can be taken post-discharge to maximize the overall ED collection rates:

- Send out bills as quickly as possible to improve the likelihood of receiving payment. The longer a bill takes to reach a patient, the lower the chances of receiving payment;

- Don't send complicated, confusing billing statements. Instead, focus on keeping the bill as simple as possible, to reduce patient confusion, which can result in more timely payment; and
- Partner only with an experienced, respected collection company that will follow the facility's standards of patient respect and communication. Ensure the patient's rights are protected by applying the proper payment recovery strategies based on each patient's capacity to pay.

Be Consistent and Efficient: Tap Technology to Manage Self-Pay ED Accounts

Hospitals are under more intense pressure than ever to avoid bad debt expenses and reduce write-offs. Because of the urgent need for health care providers to better manage the accounts of self-pay patients, there is a large and growing need for self-pay management strategies in the ED environment.

Implementing an automated, Web-based self-pay management system can improve up-front and overall cash flow in the ED by reducing bad debt and improving the revenue cycle process for self-pay patients. An effective self-pay management system can verify patient name and address real time, while the patient is being assessed and treated. Verification of a patient's identity and contact information, as well as his or her capacity to pay for services, then is available to patient access staff members in a matter of seconds, with no need for the paper-based proofs of identity of yesterday.

After assessment and treatment, an automated self-pay management system can determine patient payment responsibility at the point of service, including offering price transparency for the health care provider's most common services, as well as discounting options. The system should provide patient access employees and financial counselors with interactive scripts that integrate patient demographic information with each provider's unique business policies and rules.

Such interactive scripts should be delivered instantaneously to the desktops of patient access employees and financial counselors, outlining for employees exactly how to handle each patient account based on the level of treatment they received and their capacity to pay. The scripts allow the patient access staff member to completely resolve the account at the point of service, or in the case of the ED, after services have been rendered but before the patient leaves the facility. This process is similar to how

retail-based applications handle customer encounters at the point of sale.

Going one step further, the system should provide patient access staff with access to online forms that can be generated and printed for the patient to sign at point of service, including promissory notes that include agreed-upon payment terms.

The system should work to automatically identify truly needy patients and to alert patient access employees to discounting and charity care options when applicable. The system also serves to standardize policies and procedures in reporting charity care numbers. This results in a reduction in bad debt for health care providers, with charity care accurately categorized, while ensuring that patients receive the financial assistance for which they are eligible.

Finally, an automated self-pay management system will result in improved ED patient experiences, by ensuring that all patients are treated in a consistent, non-discriminatory manner, irrespective of a patient's financial profile, insurance status, or health care condition. ■

Notes

1. "Los Angeles Emergency Care Crisis Deepens," *The New York Times*, August 21, 2004.
2. http://www.latimes.com/business/la-fi-century4-2008aug04_0,4876061.story.
3. <http://www.acep.org/pressroom.aspx?id=40542>.
4. <http://www.emergencycareforyou.org/>.
5. The Henry J. Kaiser Family Foundation, "The Uninsured: A Primer, Key Facts about Americans without Health Insurance," October 2006, at <http://www.kff.org/uninsured/>.
6. "1 in 4 Uninsured Are Eligible for Aid But Aren't Enrolled," *Washington Post*, April 25, 2008.
7. http://www.comnpost.com/localnews/ci_10098562.
8. http://wiki.hmccentral.com/index.php?title=Improving_Emergency_Department_Copay_Collection.
9. <http://mgtconsultinginhealthcare.com/copays.aspx>.
10. *Consumer Reports*, "Are You Really Covered?" September 2007.
11. *Id.*
12. EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 and was created to discourage hospitals from a practice known as "patient dumping"—*i.e.*, rejecting patients, refusing to treat them, or transferring them to "charity hospitals" or "county hospitals" because they are unable to pay or are covered under the Medicare or Medicaid programs.

EMTALA requires a hospital to provide an appropriate medical screening examination (MSE) to any person who comes to a hospital ED and requests treatment or an MSE for a medical condition. If the examination reveals an emergency medical condition, the hospital also must provide either necessary stabilizing treatment or an appropriate transfer to another medical facility.

EMTALA applies to all hospitals that participate in the Medicare program and offer emergency services, and covers

all patients treated at those hospitals, not only those who receive Medicare benefits. Hospitals that violate EMTALA may have their Medicare participation terminated and may be subject to civil money penalties of up to \$25,000 against smaller hospitals with fewer than 100 beds and up to \$50,000 against larger hospitals for each instance. Individuals who have suffered personal harm and hospitals to which a patient has been improperly transferred and that have suffered financial loss as a result of the transfer are also provided a private right of action against hospitals that violate EMTALA.

13. http://wiki.hmcentral.com/index.php?title=Improving_Emergency_Department_Copay_Collection.

Reader's Resource

This article is reprinted with permission from an nTelagent white paper, September 2008, "Critical Condition: Improving Patient Account Financial Management in the Emergency Department." For more information, go to the nTelagent Web site, at www.ntelagent.com.

Reprinted from *Healthcare Registration*, November 2008, Volume 18, Number 2, pages 1, 5 to 8 with permission from Aspen Publishers, Inc., a Wolters Kluwer business, New York, NY, 1-800-638-8437, www.aspenpublishers.com.