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Patient Access and the PPACA

Early identification of patients in need of financial assistance is key

The face of health care is changing, and this new face prominently features patient access. Although patient access increasingly is recognized as a critical and integral asset in effective revenue cycle management, recent and evolving health care reform initiatives underscore the critical value of such early proactive management of patient accounts.

Among the recent health care reform initiatives that place the face of patient access front and center is Section 9007 of the Patient Protection and Affordable Care Act (PPACA), which includes regulations that must be met beginning in tax years after March 23, 2010. The PPACA is replete with new requirements for health care provider organizations, many of which carry stiff penalties and/or ramifications for failure to meet those requirements.

Section 9007 of the PPACA addresses new requirements to qualify as a 501(c)(3) hospital, including specific requirements regarding health care provider organizations' financial assistance policies. Even without the new requirements, best practice to most effectively manage financial assistance issues requires early action at patient access, prior to or at the point of service, to identify patients in need of and eligible for such assistance. The PPACA, however, underscores this best practice with a greater sense of urgency, in no small part through the potential for stiff penalties if the new requirements are not met. Specifically, failure to comply and meet the new requirements will be costly—to the tune of a \$50,000 tax.

Although Section 9007 has direct implications for patient access, Section 9007, as well as the entire PPACA, is critical new legislation that must be

embraced by the entire organization. Thus, patient access professionals charged with carrying out the responsibilities and functions required under Section 9007 of the new law must have support from chief executives and the board of directors, through to medical staff leaders, nursing and patient finance staff leaders, and employees, among others, to most effectively and fully ensure compliance with this new law.

Overview of Financial Assistance Policy Requirements

In general, the PPACA requires that each hospital have a written financial assistance policy. Compliance with this requirement means that hospital written financial assistance policies include the following:

- Eligibility criteria for financial assistance—and whether such assistance includes free or discounted care;
- Basis for calculating amounts charged to patients;
- Method for applying for financial assistance;
- Actions the hospital may take in cases of nonpayment; and
- Measures to widely publicize the policy within the community served by the health care provider organization.

Further, under Section 9007:

- Hospitals must limit the amounts charged to patients eligible for financial assistance who receive emergency or other medically necessary care to no more than what is generally charged to insured patients and must prohibit the use of gross charges.

- Hospitals also must have a written policy that requires the organization to provide emergency care to individuals regardless of their eligibility for financial assistance. (This ties to the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires that hospitals provide patients who present with emergency conditions a medical screening examination and stabilizing treatment, as appropriate, regardless of patients' ability to pay.)
- Facilities cannot pursue "extraordinary" collection efforts prior to determining patients' eligibility for financial assistance.

Under the PPACA, Section 9007 applies to organizations that are required by the state to be licensed as a hospital and any other organization determined by the Department of Health and Human Services Secretary to have as its principal core function the provision of hospital care. In addition, health care provider organizations with more than one hospital facility must meet the requirements outlined in Section 9007 separately at each facility.

Financial Toll Beyond Penalties

Failing to comply with Section 9007 of the PPACA also has significant implications beyond the potential financial penalties and potential loss of tax-exempt status as outlined in the new regulations. Indeed, as noted in a recent webinar with Irene Barron, chief operating officer with nTelagent, Inc., failure to implement and aggressively pursue a proactive financial assistance process that begins at patient access takes a huge financial toll on health care provider organizations, beyond any financial penalty that may be assessed for failure to comply with the new Section 9007 requirements.

Barron notes that failure to identify patients who may qualify for financial assistance at the point of service results in hospitals facing major obstacles to achieving high levels of financial success. And, although identifying patients' potential eligibility for financial assistance may increase registration time, it is time well spent. As Barron notes, it is essential that health care provider organizations identify patients who potentially may qualify for financial assistance prior to or at the point of service, as the ability to obtain the required documentation to determine if patients qualify is nearly impossible after the patient leaves the facility.

As for the obstacles and implications of failing to proactively identify patients in need of financial assistance, Barron provides a few examples. Specifically, failure to initiate action to identify patients eligible for financial assistance may result in any of the following:

- Reduced up-front collections;
- Increased days in accounts receivable (A/R);
- Increased bad debt; and
- Decreased cash on hand.

Reduced Up-Front Collections

Patients who potentially qualify for assistance can be charged only what insured patients normally would be charged.

Increased Days in A/R

Delays in obtaining documentation from patients, uncertainty of what should be charged, and an inability to know which patients may qualify for financial assistance will result in unpaid A/R.

Increased Bad Debt

If health care provider organizations lack timeliness in qualifying patients for financial assistance, the results will be delays in billing and, thus, delays in collection. Any delay in identifying and collecting patient-pay balances poses significant risk of financial losses, as patient-pay balances will then be left to linger in A/R for extended periods of time—and such balances often are likely to end up being written off as bad debt. To put this in perspective, Barron notes that the value of the health care dollar decreases significantly once a patient leaves a facility—with that dollar diminishing to a mere 33 cents within six months, and plummeting to a paltry 12 cents in one year. (*See Exhibit 1, "Value of the Health Care Dollar."*)

Decreased Cash on Hand

Simply, failure to identify patient-pay balances at the time of service and to determine patients' ability to pay make it impossible to collect from patients at the time of service, be it all or part of the patient-pay balance.

Developing Financial Assistance Policies

To comply with Section 9007, health care provider organizations must develop written financial assistance policies. (*See Exhibit 2, "Sample Financial Assistance Policy and Procedure: Emergency Department."*) Although most health care provider organizations have financial assistance policies on file, a critical factor now is to ensure that those policies spring to life, are actionable, and are actively applied. Financial assistance policies must outline the following:

- Criteria to determine a patient's eligibility for financial assistance;
- Formula for how financial assistance is calculated;

Exhibit 1. Value of the Health Care Dollar						
Pre-Care	Point of Care	3 Months After Care	6 Months After Care	1 Year After Care	2 Years After Care	5 Years After Care
\$1.00	0.95	0.87	0.33	0.12	0.05	0.01

Source: nTelagent, Inc.

Exhibit 2. Sample Financial Assistance Policy and Procedure: Emergency Department		
Department: ED registration	Original:	Page: 1 of 5
Policy: ED treatment, financial screening, and collections	Reviewed:	
Approval:	Date:	Revised:
Policy	It is the policy of (XYZ Hospital) to provide emergency medical treatment to all patients presenting to the ED according to the guidelines set forth by the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Patient Protection and Affordable Care Act (PPACA).	
Purpose	This policy ensures the availability of emergency medical care resources for all patients presenting in the ED with emergency medical conditions, while protecting the financial viability of the facility. It also is intended to improve the health status of non-emergent patients by referring non-emergent patients to an appropriate medical setting suited to handle their medical care needs.	
Objective	This policy is intended to provide quality health care to patients with emergency medical needs and conditions by decreasing congestion in the ED created by non-emergent patients utilizing the ED to gain access to routine, primary medical care.	
Procedure	All patients presenting to the ED will be given a medical screening examination by appropriate medical staff and/or ED physicians, regardless of ability to pay. ED medical staff members will notify the ED registration staff upon completion of the medical screening examination regarding the patient's medical status. Once notified by ED medical staff that the patient is in a stable and/or non-emergent condition, registration staff will initiate and/or complete the patient registration process. For patients receiving emergency services, financial counseling will be completed after stabilizing treatment and services have been provided. At no time will patient access to a medical screening examination and, as appropriate, stabilizing treatment be delayed in order for financial counseling of the patient to occur.	
Financial Assistance	Registration employees will work with all emergency patients, in compliance with EMTALA, who may qualify for financial assistance to determine a patient's eligibility and/or qualification for such financial assistance. ED registration employees also will identify and communicate to patients the appropriate charges, available discounts, payment terms, and/or other steps to be followed for all patients who have received emergency care and who have a patient-pay balance due for the services provided.	

Source: nTelagent, Inc.

- Methods on how the policy will be publicized to the community served;
- Methods to be used for patients to apply for financial assistance; and
- Actions that will be taken in the event of non-payment.

A key element to outline in financial assistance policies is the responsibility of the patient to provide necessary documentation to determine if the patient qualifies for financial assistance. This section of the financial assistance policy also should include the following:

- Forms provided to the patient for completion or instruction;
- Necessary documentation required from the patient, to be returned for approval of financial assistance eligibility;
- Maximum time for a patient's documentation to be returned to the facility; and
- Consequences if the patient fails to return documentation required to apply and qualify for financial assistance.

The policy also must cover how to handle patient accounts when a patient applies but does not qualify for financial assistance. This section of the policy should outline the following:

- Acceptable prompt-pay discounts;
- Acceptable payment arrangements; and
- Consequences if accounts are not paid.

Financial assistance policies also must address emergency care situations, to ensure compliance with EMTALA. Key issues to address in financial assistance policies to ensure EMTALA compliance include the following:

- Process followed in the ED to comply with EMTALA, which includes that every patient has a right to a medical screening examination regardless of ability to pay and that treatment cannot be delayed to gather patients' financial information;
- Process for screening for financial assistance and collection of ED accounts, including a method to determine if patients qualify for financial assistance and related documentation of this process; and

- Steps to be taken for collecting patient-pay balances from patients if a medical screening exam determines that no emergency exists. Medical staff should be solicited for help in documenting in the patient record when a patient presenting in the ED is determined not to have an emergent condition, which determines subsequent steps to collect on the account.

Under Section 9007, the financial assistance policy also must note limitation of charges. Regarding the limitation of charges, the policy must include the following:

- Process for how patients who qualify for financial assistance will be billed in accordance with the guidelines stated, and no more than the amount generally billed to individuals who have insurance covering such care; and
- Method for calculating charges. For example, patients qualifying for financial assistance will be billed the average approved charge in accordance with the facility's five major managed care contracts. (Note: Health care provider organizations should review all contracts immediately to determine an average of approved charges on managed care contracts as well as Medicare.)

Best Practices to Comply with Section 9007

Although health care provider organizations typically have financial assistance policies in place, with the implementation of Section 9007 it is imperative that, as noted, those policies are transformed into living, actionable documents and processes. As nTelagent's Barron notes, many health care provider organizations will need to enact process changes to comply with Section 9007 and, in turn, to more effectively manage patient accounts.

Process changes required to comply with Section 9007 will vary by facility, depending on policies and processes already in place (or lacking). The necessary process changes to consider, according to Barron, center on the ability to do the following:

- Identify at the time of service patients who may qualify for financial assistance. The system to determine patient eligibility for financial assistance should be in place using the federal poverty guidelines in patient access services to determine patients who may qualify for such assistance;
- Document and clearly define for patients the patient responsibility in providing proof of

eligibility. This documentation should be provided to patients at or prior to the point of service. In addition to providing patients with this information, patient access employees also should secure the patient's signature on a form that indicates that the patient has a clear understanding of the time-frame within which proof of potential eligibility for financial assistance must be returned in order for the patient to qualify for such assistance; and

- Ensure patient access employees have the tools and, preferably, automated systems to:
 - Determine patients who may qualify for assistance;
 - Guide employees through steps that should be taken to determine patient eligibility; and
 - Provide easy access to forms that can be printed and completed at patient access to initiate the financial assistance process and sample scripts and other information for front-end employees to ensure adequate communication with patients.

Of course, Barron notes, there are patients who may apply for but fail to qualify for financial assistance. Processes also must be in place for such instances, and should include the following:

- Steps to take at the point of service for patients who do not qualify for financial assistance;
- A procedure for collecting deductibles, copayments, and coinsurance at the point of service in order to offset the financial impact of determining patients who may qualify for financial assistance. This process should include insurance verification at the point of service and the ability for patient access employees to negotiate immediate prompt-payment discounts and/or payment terms for patients who do not qualify for financial assistance;
- Clear guidelines for patient access employees to effectively communicate with patients who face financial difficulties but fail to qualify for financial assistance. Training on this aspect of the financial assistance process is critical to maintain good patient relations, regardless of whether financial assistance is extended;

- Tools, including automated systems, to increase the level of registration accuracy, provide address verification, and improve accuracy of insurance information to eliminate returned mail and payment denials;
- Review of managed care contracts. This review should occur annually, Barron notes, to guarantee fair financial return for patients treated under managed care contracts; and
- Discount policy for self-pay patients. Barron cautions that providers must keep in mind when developing discounting policies that a policy that discounts self-pay patient balances at a level lower than managed care contracted rates encourages patients who may be insured to present as uninsured, resulting in revenue losses for the organization.

In Summary

As with any new rule or regulation, there remains some uncertainty surrounding Section 9007 and the PPACA. What is clear, however, is that action to comply with this new regulation is essential, and that action must begin at patient access.

As Barron notes, "While some uncertainty remains . . . one conclusion is clear: Hospitals must implement an automated, streamlined system that will help them to comply with PPACA's new requirements. Manual, binder-based processes won't suffice."

For example, Barron notes that, under Section 9007 of the PPACA, hospitals must be able to consistently identify patients who qualify for financial assistance at the point of service. Further, the policy must rely on a method to easily and accurately determine the appropriate amount to charge for services provided to patients who qualify for financial assistance. To suggest that patient access employees attempt to fulfill these critical and complex requirements based on a manual process is nearly impossible, according to Barron, placing the organization at risk of non-compliance, stiff penalties, and loss of revenue. ■

Reader's Resource

Irene Barron is chief operating officer with nTelagent, Inc. For more information, go to www.ntelagent.com.

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