



Critical Condition >>

Improving Patient Financial Account Management in the Emergency Department

An nTelagent, Inc. White Paper

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Table of Contents

Executive Summary 3

Fast and Furious: The ED Collections Challenge 5

Patient Financial Triage: Improving Collections in the ED 6

**Be Consistent and Efficient: Using Automated, Web-Based Technology to
Manage Self-Pay Accounts in the ED** 8

About nTelagent, Inc. 9

Appendix A 10

Executive Summary

Emergency departments (EDs) across the country are operating under ever-increasing pressures: overcrowded waiting rooms, workforce shortages, government cuts, stricter regulatory requirements, reimbursement issues, escalating patient volumes, and caring for a growing number of patients who can't (or don't) pay for services. Many **EDs are having to shut their doors for good due to financial strain** -- meaning less and less access to much-needed healthcare and essential community services. In fact, in California alone, 70 hospital emergency rooms and trauma centers have closed since 1990.ⁱ

A 2008 articleⁱⁱ about the potential closure of an ED in Los Angeles illustrates 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.”

An August 2008 press release from the American College of Emergency Physicians (ACEP) paints an even clearer picture: “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.**”ⁱⁱⁱ

According to the ACEP website: “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.”^{iv}

What is going on here?

Uninsured patients and their use of ED services are often pointed to as a main cause of ED financial strain. And with good reason: **About 20% of the uninsured (compared with 3% of those with insurance coverage) say their usual source of care is the emergency room.**^v

For many uninsured patients, the point of entry into the healthcare system is indeed the emergency department of their local hospital. This is because the uninsured typically have less access to primary and preventive care than their insured counterparts; thus, treatment is often

delayed and conditions go undetected and untreated. When sickness or injury does occur, they end up in emergency rooms because they have nowhere else to go, receiving higher-cost care than if they had had earlier access to primary/preventive care.

Many of these patients do not have the ability to pay out-of-pocket for the services they receive, nor are they signed up for social services assistance. An April 2008 article on the uninsured reported that one in four Americans, about 12 million people, who are uninsured are eligible for Medicaid and the State Children's Health Insurance Program, but they are not enrolled. Reasons given for this lack of enrollment include not being aware of the programs and not knowing how to enroll.^{vi}

Care is provided but never paid for, leading to bad debt and major financial strain for the ED. **According to the Centers for Medicare and Medicaid Services, 55% of medical care in the nation's hospital emergency rooms goes uncompensated.**^{vii}

But it's not just the uninsured that present a challenge for emergency departments. It is estimated that every year, hospitals write off more than \$2 billion in co-pays and

deductibles that should be coming from insured patients ... an average of \$400,000 for every hospital in the country.^{viii} Industry-wide average collection rates on emergency department co-pays and deductibles are less than 33%. When you factor in the billing cost, which can be anywhere from \$2 to \$15 per patient charge, hospitals may only be netting 15% to 20% on these uninsured patient balances.^{ix}

Another dire statistic: A September 2007 study reported that 29% of people who had health insurance were "underinsured" with coverage so insufficient they often postponed medical care because of costs. Nearly 50% overall, and 43% of people with health coverage, said they were "somewhat" to "completely" unprepared to deal with a costly medical emergency over the coming year.^x

As the number of self-pay patients -- those individuals who must pay all or a portion of their medical bill -- rises, so does the urgency for healthcare service providers to adopt systems that effectively and efficiently deal with these accounts. **And nowhere in the healthcare 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 needs and 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. In the ED, financial considerations and payment arrangements come second, and this often results in low upfront and overall collection rates. The reasons have been well-covered by policy papers and news articles, and some of them include the following:

- Because of **EMTALA regulations** (Emergency Medical Treatment and Active Labor Act), patients cannot be turned away from the ED for inability to pay. Many receive care and treatment, and then they either cannot pay or choose not to pay. (See Appendix A for basic EMTALA requirements.)
- There is often a major **lack of information**. Patients may show up at the emergency room in need of care, but without proper identification or without knowing their insurance information. They may have no means of payment to cover the co-pay amount.

In fact, many times, the ED staff is so focused on getting care to the right patient at the right time that contact and insurance information and co-pays are not even requested. After services are given, some patients simply walk out the door without paying, and the ED is left with no contact information for sending a bill or setting up a payment plan.

- It is often the case that EDs simply **do not have appropriate processes and technology in place to deal with self-pay patients** in an efficient, consistent manner. These imperfect registration and/or discharge procedures lead to missed opportunities for upfront and overall collections, as well as misclassified charity care, because adequate patient demographic information is not collected. In addition, there is often a lack of screening for financial assistance programs, such as Medicaid and other state and local social services programs.

All of these factors result in mounting bad debt within the industry, threatening the financial viability of healthcare service providers across the country.

Patient Financial Triage: Improving Collections in the ED

The good news is that in the midst of all these challenging circumstances, we can look at how well-performing hospitals and EDs manage their patient financial accounts.

The best-performing hospitals in the country achieve point-of-service collection rates in the ED between 40% and 60%.^{xi} Here are some strategies they have adopted to attain these high rates:

- **Verify patient identity and contact information at the outset.** This is a vital first step. Errors in patient data can lead to returned statements and bills and an increase in denied claims, resulting in lower collections rates and more bad debt. If a healthcare 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 is collecting adequate and accurate data at the front end, and then having it organized in a manner that allows for instantaneous, appropriate action and decision-making.
- **Determine means of payment and patient financial responsibility at point of service.** In areas other than the emergency room, ask the patient for his or her insurance information and verify the coverage prior to service being rendered. In the case of a self-pay patient, determine capacity to pay, as well as discounts and payment terms if appropriate. Screen for social services programs and charity care as soon as possible, and assist the patient in beginning the enrollment process. In the emergency room, ensure patients see a business office representative prior to leaving the facility.
- **Ask for payment upfront or once services have been rendered.** It's simple: If you don't ask, the patient won't pay. Implement price transparency for your facility's most common procedures and services. Offer the patient 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; have the patient sign the agreement.** If the charges are high, some patients will need to pay over time. Offering a payment plan will at least result in a portion of the charges being collected, if not the complete amount. Structuring a payment plan around the patient's financial needs can result in increased cash flow for the ED and higher payment rates. Ideally, the financial registrars will have access to online forms, ready for printing and signing by the patient.

Focusing on patient identity verification and obtaining upfront collections is key in ensuring your facility receives proper payment for services. However, improving post-discharge collections is important and necessary as well; think of it as a two-pronged approach. Here are some steps that can be taken post-discharge to maximize the overall collection rate:

- **Send bills out as quickly as possible** for a better chance of receiving payment. The longer the bill takes to reach the patient, the lower the chances are of receiving payment.
- Don't send complicated, confusing billing statements. Instead, **focus on keeping the bill as simple as possible** in order to reduce patient confusion. This can result in more timely payment.
- **Partner only with an experienced, respected collection company** that will follow your standards of patient respect and communication. Ensure that patients' rights are protected by applying the proper recovery strategies to each person's capacity to pay.

Be Consistent and Efficient: Using Automated, Web-Based Technology to Manage Self-Pay Accounts in the ED

Hospitals are under more intense pressure than ever to avoid bad debt expenses and reduce write-offs. Because of the urgent need for healthcare 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 upfront 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 *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, is given to patient access staff in a matter of seconds, with no need for the paper-based proofs of identity of yesterday.

After assessment and treatment, the system can determine patient payment responsibility at the point of service, including offering price transparency for the healthcare provider's most common services, as well as discounting options. The system should provide registrars and financial counselors with interactive scripts that integrate patient demographic information with each provider's unique business policies and rules. The scripts should be delivered instantaneously to the desktops of registrars and financial

counselors telling them exactly how to handle each patient account based on the level of treatment they received. **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 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-generated, printable forms 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 then alert the registrar to discounting and charity care options when applicable, and standardize policies and procedures in the reporting of charity care numbers. This results in a reduction of bad debt for healthcare providers because charity care is accurately categorized, while ensuring that patients receive the financial assistance for which they are eligible.

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

About nTelagent, Inc.

nTelagent, Inc. has developed **The Retail Application** for the healthcare industry, called the Self-Pay Management System (SPMS). Similar to applications used in the retail industry at the point of sale, the company's proprietary, automated system tells healthcare registrars and financial counselors exactly what to do and what to say to each patient at the point of service regarding financial responsibilities.

Moving workflow to the front end of the revenue cycle, nTelagent helps providers ensure a better patient experience through clearer communication and better handling of patient accounts, while improving upfront and overall cash flow, receivables and profitability by reducing bad debt.

Using non-credit scoring data, SPMS provides interactive scripts that integrate patient demographic information with each provider's business policies and rules. The system allows for price transparency and automatically identifies discounting options, social services eligibility and charity care options when applicable, ensuring that patient financial accounting -- for both insured and uninsured patients -- is handled appropriately and consistently.

Visit www.ntelagent.com for more information.

Appendix A

Basic EMTALA Requirements

To understand the key provisions of the final rule, one must first understand the original EMTALA, which was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986. EMTALA was created to discourage hospitals from what is known as patient “dumping”—ie, 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 the hospital ED and requests treatment or an MSE for a medical condition. If the examination reveals an emergency medical condition, the hospital must also 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 \$50,000 per violation. 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.

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