What's Happening Today in Healthcare: Exchanges, 501r, IPPS, and ICD.10

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Agenda

- Overview of Healthcare Topics i.e. Obamacare, 501r, IPPS, and ICD.10
- Potential Impact to Patient, Provider, and Industry
- Jeopardy

Obamacare Exchanges Overview

- Improve Quality
- Increase Access
- Improve Price

Fact

- Of the 8M enrolled in 2014 with the marketplace
  - 54% are female and 46% male
  - 34% are under the age of 35
  - 65% selected a Silver plan and 20% Bronze
  - 85% selected a plan with financial assistance
- Of the 7M enrolled in 2014 with Medicaid Expansion almost one million were enrolled earlier in the seven states.
- 2.6M young people under 26 were enrolled on to their parent's plan.

Fact

- So the final tally:

  11 million adults

  - +2.6 million under the age of 26
  - -.0.8 million non-payment (assumes 90% will pay)
  - +1.5 million children
  - +0.95 million early expansion

    TOTAL: 15.25 MILLION GAINED INSURED DUE TO OBAMACARE AS OF APRIL 2014—assumes a 4.6% drop on a population of 240M adults in the USA*

  - *www.hhs.gov, www.gallup.com, and acasignsup.net

Obamacare Impact to Self Pay

- Estimated 2M as of 2015 that did not pay their premium
  - Payers and provider denial processes are inconsistent and engage the patient
  - Penalty for “no coverage” is weak
- Providers closing the door on Marketplace
  - “Back to the *Out of Network* denial world and the ED as a Dr’s office”

Obamacare Impact to Self Pay

- 75% of healthcare exchanges are in high deductible plans
- Silver plan has 30% out of pocket, bronze 40%
- “Gone are the days of the peak in collections with tax returns”

501(r) Overview

- Established by the IRS code by the PPACA that imposes new requirements to maintain their 501(c) (3)-non profit status

- The three C's of 501 (r) include:
  - Community Health Needs Assessment (CHNA)
  - Communications-120 days vs 240, PL Summary, P&P
  - Charging-AGB- Average Generally Billed

- Extraordinary Collection Actions (ECA) : Liens, Interest, and Credit Reporting

- Final ruling January 2015 with a mandate of December 29 2015

501 (r) Impact to Self Pay

- Operational Impact with your Medicaid eligibility, early out program, and collections processes.
- Redundant processes with your collection processes and poor customer experience.
- Impact to collection agency and Medicaid eligibility reporting-- net versus gross.
- Negative consequences to agency communications to follow provider policy and procedure.
- Delayed payment due to Financial Assistance Process-poor “best practices”
  - Increased aging to collection activity?
  - What does this do to POS collections?
  - Operational impact to refunding patients, removing ECA, etc.
  - Emergency room following hospital FAP

IPPS History

- IPPS published in the Federal Register, April 20, 2015
- Comment Period Ended June,16 2015
- Final Rule and Responses August 1,2015

IPPS HIghlights

- 1.2 Billion Dollar Payment decrease from 2015 to 2016 or 6.4 Billion in UC Payments
- As part of PPACA DSH will be reduced by 75% or 49.9 Billion, by 2019
- Two Midnight Rule policy is to be addressed in the 2016 Outpatient Prospective Payment System (OPPS) rule

IPPS Hightlights

- Hospitals with the poorest performance in reducing Hospital Acquired Conditions (HACs) will have their Medicare payments docked by 1%
- CMS has added seven new measures to the Hospital Inpatient Quality Reporting (HIQR)- four in 2018 and three claims based in 2019
- CMS is discussing the expansion of the Bundled Payment for Care Initiative (BCPI)

Final Payment Update

- CMS recommended that acute –care hospitals THAT REPORT their quality data AND are meaningful use providers of EHRS receive a 0.9 increase percent in Medicare operating rates.

- Penalty: Hospitals that do NOT submit the quality data will loose 2.4% of the market basket **or one quarter**

- Hospitals that are not meaningful users of EHRS's would loose **one half** of the market basket in FY2016

Potential Impact of IPPS on Patients[

- Providers are responding differently to “medically necessary services” and claims denied for readmission
- Patients are receiving billings for HAC denials
- Providers are stressing the bundled payments are too difficult to manage operationally and “a bundled payment does not mean a full payment”

Potential Impact to Patients IPPS

- How providers respond to “not medically” necessary claims or rejections for readmissions.
- Clarification on HAC’s and were they admitted with the former condition and then engaging the patient.
- A bundled payment doesn’t mean full payment and will provider engage the patient.

ICD.10 Overview

- ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health
- Migrates from ICD.9 five digit numeric codes to seven digits alpha numeric and moves IP procedure codes from 4K to 72K
  - Overall the change for ICD.9 to ICD.10 moves from 18K to 140K code
- Objectives:
  - Improve quality outcomes, patient safety, enhance public health-disease reporting, and promote more accurate reimbursement
- Impact to: Providers, Payers, and Vendors- what about the patient?
- Mandate October 1, 2015

ICD.10 Facts

- Crosswalk for ICD.9 to ICD.10 is on average 87% BUT ICD.10 to ICD.9 is less than 1%.

- Two components: Procedure Coding System (PCS) and General Equivalence Mapping (GEM)

- Reimbursement is impacted and three specialties have high indicators:
  - Cardiology
  - Neurosurgery
  - Orthopedics

- CMS ”impact analysis”/ testing is reflecting a positive outcome but commercial payers are demonstrating challenges

  Denials are inconsistent and reflecting increases from 3 to as high as 30%.

ICD.10 Impact to Self Pay

- Engaging the patient due to:
  - Improper/inconsistent denial mapping
  - Volume increases
  - Provider, payer, and vendor readiness

Lack of industry partners to support the coding, follow-up, denial management, and contracting challenges

- Delayed reimbursement and aged transfers to collections

- Third Party public relation and operational challenges

Poor Patient Relations

SELF PAY IS NOT GOING AWAY! FACTS

- Three definitions : “true self pay”/under-insured, “balance after insurance”-under-insured, and combined are “patient responsibility”
- Patient responsibility outcomes: Paid, Charity, and/or Bad Debt
- American Hospital Association reported in 2011 that uncompensated care was at 41.1 billion on average it has continued to increase by 8% and expected to double by 2016:

  2011--- 41 BILLION TO 72 BILLION IN 2016 OR A 16% INCREASE!
- 90% of providers note the growth of high-deductible plans among their patients and 75% of them are in healthcare exchanges.

SELF PAY IS NOT GOING AWAY! FACTS

- Regulators in the industry are: Federal Trade Commission (FTC), Fair Debt Collections Act, and Consumer Financial Protection Bureau (CFPB)

- Self Pay Management Best Practices:
  - Loan Programs- recourse
  - Early Out Programs- 501R
  - Letter Series-extended business offices
  - Collection Agency “shared risk model”
  - Debt/Asset Buyers-”unfound cash”

SELF PAY IS NOT GOING AWAY! FACTS

- 81% of “true” self pay responsibilities are never recovered.
- 55% of the patients financial responsibilities are never recovered.
- It cost 3X to pursue the patient vs. the payer.
- Historically hospitals have written off about 3-5% to bad debt and today that number is 7-9% with the majority of it related to the “underinsured”.

SELF PAY IS NOT GOING AWAY!
FACT!

Patient Responsibility or Self Pay is now a provider's number three payer behind Medicare and Medicaid!

Questions? Feedback!

Contact

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