President’s Message by Dilys Krueger, MSHA, CHAM

Last week I went to the movies to see The Chronicles of Narnia: Prince Caspian from the Nardia Series written by C.S. Lewis. The movie was great! Besides the 7 books in the Nardia series, C.S. Lewis has written many other books. In *Mere Christianity*, C.S. Lewis says, “I do not believe one can settle how much we ought to give. I am afraid the only safe rule is to give more than we can spare”. At our June 6th meeting you showed that you could give! The raffle prizes donated by our corporate sponsors were amazing and took in $417.00. The Western Reserve Board matched that and rounded off our donation to Harvest Home to $850.00. Thank you Corporate Sponsors and to everyone who attended and donated to such a worthy charity.

If you missed this opportunity to give, please plan to attend our 2-day educational meeting September 11 and 12th. Besides sponsoring another charity you will hear “nuts and bolts” presentations designed to assist you in your operations. You won’t want to miss hearing Tanja Twist from California who is coming in to discuss her legislative work and first hand experience with the RAC. Tanja accompanied me to Senator Voinovich and Senator Brown offices in March.

The board of directors is giving more than they can spare in planning every detail that goes into running our successful growing organization. You the members and guests who take time out to attend the meetings are giving of your time away from work to learn and share with others. We have seen registrations in the 60-70’s for each meeting this year with many offering to help in so many practical ways.

Today more than ever, I am convinced that together we can weather the storms of change that surround our healthcare industry. The Western Reserve Chapter of AAHAM is here to help light the way…

Sincerely,

Dilys Krueger
President Western Reserve Chapter
AAHAM
**Friday, December 12**

AAHAM Meeting – 11:30 a.m. – 4:00 p.m

Holiday Meeting
Akron General Health and Wellness Center West, "Summit" Meeting
Room
4125 Medina Rd.
Akron, OH 44333
330-665-8000
330-665-8091 Fax

**Thank You!**

2008 Corporate Sponsors

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- Team Recovery
- Terry J. Reppa & Assoc.
- UCB
- Wise Management Services

**Membership Update**

A very special THANK YOU to Diane Murray, Debbie Becker and Sharon Daugherty from HRSI/FCI for taking care of the reservations desk at the June 6th meeting.

We currently have 87 members in the Western Reserve Chapter. We had 17 non-renewals that have been contacted by email with a very inviting letter written by Diane Murray explaining all the wonderful learning opportunities and great people you can meet and talk with at our Chapter meetings. We do invite non-members that many of us know and have passed the names on to me to add to the invitation list. Please continue to do that, as it is one of the best ways to grow our membership. Thank you also to Steve Rybka, as he does a great job of sending me names of people through the Corporate Partners to invite to our meetings. Diane and I have a lot more work to do to get the word out that we are “Lighting the Way”.

I appreciate everyone handing their name badges back in after the meeting as it has saved me a lot of time in preparing for the meeting.

Have a safe and enjoyable summer,

Patti Day
First Vice President

**Education Update** by Cindy Anderson, 2nd VP Education

**Late Summer Meeting on the North Coast**

Technically, it will still be summer when we meet at Geneva Lodge and Convention Center in Geneva Ohio on September 11th and 12th. Nestled right on the Lake Erie shoreline, the Lodge is a perfect spot for this type of
education getaway. Walking and bike trails surround the property along with the feel of a small country town surrounding us. Our last event there in 2006 proved to be one of our favorites and this year’s plans should be no different.

The round bar will be a meeting place on Wednesday night for sure and the meeting starts early Thursday morning in “The Western Reserve Room”. By the time our first break comes around, our valued vendors will have their booths set up for Vendor Fair that will run through the day on Thursday. Free time Thursday will include wine tasting at a local vineyard, shopping trip to Ashtabula or you and your spouse enjoying some time together by the lake. Thursday evening brings our chapter dinner followed by the second annual Western Reserve Cornhole Tournament. As last year, trophies and prizes will be awarded to the 2 top teams so get your arms ready. After a fun evening with an open bar, it’s back to our rooms for an early start on Friday morning. Now that’s a way to start the weekend!

Scheduled speakers include:
Lyman Sornberger (back by popular demand)
Jennifer Tirotta – NGS
Cliff Johnson – on Diversity in the Workplace
Charles Cataline (always a favorite)
Tanya Twist - RAC

An event to remember coming in September! Watch for your registration coming soon.

Respectfully,

Cindy Anderson
Regional Director Patient Financial Services
Humility of Mary Health Partners
phone: (330) 884-7076
fax: (330) 744-1447
email: cynthia_anderson@hmis.org

Certification Corner

2008 Certification Calendar
August 1, 2008 - Registration deadline for Fall CPAM/CCAM exams
August 11-23, 2008 - CPAT/CCAT/CCT exam period
September 1, 2008 - Registration Deadline for November CPAT/CCAT/CCT
September 27, 2008 - Fall CPAM/CCAM exams
November 10-26, 2008 - CPAT/CCAT/CCT exams
December 1, 2008 - Registration deadline for February 2009 CPAT/CCAT/CCT

Congratulations to these individuals who passed their technical certification exam in May 2008:

Theresa Carter, CPAT
David Falk, CPAT
Lisa Lockhart, CPAT
Kimberly Wetherbee, CPAT

Certification Chairperson Contact:
Pamela McFarland, CPAM
Senior Consultant
Masters Associates Receivables Management, Inc.
Office: 419-534-2852 - Fax: 419-534-2798 - Mobile: 330-495-7947
pam@mastersasssoc.com
Vendor Spotlight

Credit Solutions, LLC

Credit Solutions is an A/R Management Company backed with many years of proven success in the ever changing and complex healthcare industry. As an active member of ACA International, AAHAM, COPAM and HFMA, our team understands the intricacies and workings of delinquent accounts. With trained and certified recovery specialists, we work diligently as an extension of your business office, offering a high degree of professionalism, ethics and excellence. When hospitals choose Credit Solutions to handle their accounts, they are choosing a company that understands the importance of good public relations as well as the poise associated with collecting on slow pay and bad debt accounts. With a high level of expertise, Credit Solutions provides a number of services including:

- Pre Collect Services
- Extended Business Office Services
- Third Party Collection Services
- Legal Collection Services
- Payment Plan Maintenance Services
- Insurance Follow Up Services
- Bad Check Recovery Services
- Skip Tracing
- Letter Outsourcing
- Consulting
- On-Site Training

The process of choosing a collection agency can often be difficult. We all know that results are important, but so is the approach that yields the desired outcome. At Credit Solutions, our proven track record gives you the confidence that you need, as well as the assurance in knowing that you’ve made the right choice. If you are looking for a fresh and vibrant accounts receivable partner who’s committed to being more than just a vendor, then give us a call. We would thoroughly enjoy meeting with you and sharing with you more about our company. Our team is readily available to demonstrate our skills and expertise.

Contact Information:
Bobby Rumer, VP of Sales
Credit Solutions
3290 Blazer Parkway, Suite 100
Lexington, Kentucky 40509
859-433-4002 (Direct Line)
859-273-2477 (Office)
859-2732539 (Fax)
bobby@cs-llc.com
This article has been reprinted with permission. It first appeared in "On Target," the on-line newsletter of DEKAYE Consulting, Inc. (www.dekaye.com) in the October, 2005 issue. For more information, contact, Allan P. DeKaye, MBA, FHFMA, at: (516) 678-2754, or email dkconsult1@aol.com.

Enter Consumer-Driven Health Plans (CDHPs)

Consumer-Driven Health Plans (CDHPs) are here! What are they, and how will they affect healthcare revenue cycle operations is a question that CFOs and PFS and Access Directors will need to answer. In order to better understand how to address them from an operational perspective, there needs to be a better understanding of what they are, how they work, and what the impact will be on the patient/provider relationship.

What are CDHPs?

CDHPs developed in response to the ever-increasing insurance premiums being paid by corporations and individuals for healthcare policies. While the general population has been faced with increasing deductibles and co-payment levels, companies and individuals continue to find that the premium levels were increasing at a continuing level. Whether evidenced by the continuous advances in medical technology, the introduction of life-saving procedures, tests and medications, or simply the confluence of profit-margins and the ability for insurers to assert the need to pay for these services, CDHPs grew out of this sense of higher and higher prices.

Although these factors are all related to the increase in the uninsured number of Americans, CDHPs really provides some options for those who are insured, or willing to assume a larger portion of the cost in return for a decrease in premium payments. For many years, companies and employees enjoyed the benefit of medical savings accounts (MSAs). MSAs allowed employees to save some portion or all of their out-of-pocket medical expenses (e.g., deductibles, co-payments and to some extent non-covered costs) with pre-taxed dollars set aside through payroll deductions. Usually this "use it or lose it" formula was used by many to foster some offsets to costs.

How do CDHPs Work?

CDHPs grew out of this concept. However, there were salient differences. Employers and employees could still obtain healthcare coverage, but with lower premiums in exchange for accepting higher deductibles. To offset the cost of these deductibles, employers and employees could place money into HSAs or health savings accounts. Again, with pre-tax dollars set aside, employees would be issued either debit-like cards or checks to be used to pay for their medical expenses. The major difference would be that unlike the "use it or lose it" requirement of MSAs, unused HSA monies could be carried forward indefinitely for the employee's continued use for medical care in subsequent years. And, the balances could accumulate much like an IRA-type savings
account with monies available for other uses at some future time frame. This created an attractive, almost investment like quality for CDHPs/HSAs. As insurance companies begin to rollout these high deductible health plans, healthcare providers will need to react to this new category of plan, and the attendant policy and procedural issues surrounding this new type of coverage.

Assessing the Impact of CDHPs on Providers

When managed care plans, notably HMOs, and later PPOs, POS and other type benefit plans first entered the scene, providers, both hospitals and physicians, struggled. One of the key elements of operational concern was learning how to recognize the difference in plan code types. Second, the ability to understand the extent of coverage, prior approval and authorization requirements was problematic given the difficulty in differentiating plans. Even assigning the proper plan code to be used in hospital information or physician practice management systems is a problem that still negatively impacts the registration, billing and collection functions today.

While improvements in payer support of electronic eligibility transactions (“270/271” or electronic eligibility inquiry and response) has improved, as has direct payer access through web sites and advances in technology, this new type of plan will present new challenges.

Recognizing a CDHP Plan

A patient’s insurance identification card will still be the primary aid in determining the type of plan an individual has. However, the same could be said with today’s panoply of cards adorned with corporate logos and demographic and payer information. While staff might be doing better recognizing cards today, they are likely to be visually challenging with CDHP plans, especially as it relates to the presence of a high-deductible amount that the patient has contractually agreed to be responsible for.

Even if insurers do a good job in reissuing plan identification cards with clearly delineated plan types, and show the annual deductible amount, the collection process will face a series of new challenges that are discussed in the next section.

So You Collect at the "time and point of service” (TOS/POS)

Providers often indicate that they do collect patient responsible amounts at TOS/POS. Both TOS and POS are enumerated, since “timing” may relate to a pre-admission event, while the “point” may refer to an actual service location. Some have been far more successful than others, but many providers are only able to make that claim because they can at least determine that more money was collected TOS/POS in the current month vs. the prior month. Fewer providers can differentiate their TOS/POS collection capability when asked:

What percentage of patients presenting with responsible amounts due did you collect from? What percentage of total amounts due at TOS/POS were collected? Did the provider have the wherewithal to collect at every clinical service area? What was the average amount collected?

The ability to answer these types of questions is very important when it comes to handling patients with CDHPs.

While insurance policies will differ, it will not be unusual for patients to have selected plans with annual deductibles ranging between $2,000-$3,000 per person. If this is a family insurance plan, then the importance of linking the accounts of spouses, children and any other covered dependents will take on even more significance than today.

If a provider were able to answer question #4 posed above, the answer would likely be in the $10-$50 range, with a modal value (i.e., the one that occurs most frequently) to be $20-$25. Now staff will need to ask for considerably larger sums, and patients will need to be prepared to pay these amounts!
Sticker Shock

When those CDHP policyholders, many of whom were probably previously PPO or POS contract holders, seek access to care under their plans, they are likely to experience “sticker shock.” The $20 office co-payment will probably be between $100-$200 or more depending on whether it’s a follow-up visit to an internist, an annual physical or a specialist consultation. The chest x-ray (maybe $150), the MRI, CAT Scan or other diagnostic test may well consume the entire amount of the patient’s high deductible amount. While this may help a patient reach the point where insurance coverage begins (possibly at 100%, maybe at 90%–resulting now in a co-insurance condition), the question of the patient paying this high amount will become the focal point.

Issues will range from not only how much of the deductible remains unpaid, but how much is available in the patient’s HSA account? What if annual contributions (from the employer and employee) is made on a pro-rata basis out of each paycheck? Suppose there are insufficient funds in the HSA checking account or available (credit) balance on the specially issued HSA Visa or Master Card? If the card is a debit card, will the provider have the right equipment to handle the transaction? And what will happen if the patient doesn’t pay in full?

Policy and Procedure

We know from experience that many managed care and HMO contracts precluded taking collection actions against their enrollees for non-payment, such as deductibles or co-payments. A daunting question is will this be the case with CDHPs? While most hospitals have policy guidelines about pre-admission deposit requirements for elective, non-emergent services, CDHPs will present new challenges. First, of course, will be the ability to identify this type of plan. Second, the amount of deductible remaining, and the assumption of coverage for service by the insurer for amounts in excess of the out-of-pocket amount.

Next will come handling if the amount needs to be paid prior to, or at the time of service. For anyone that has had to have a car repaired after an accident or other mishap knows all too well the process for having insurance estimate the covered amount, approve and pay the claim–less the insured’s deductible! Providers will be faced with this same scenario. We should not be surprised with the patient’s reaction either. We can expect that they may not have understood it quite the same way. Additionally, the question of whether the entire annual HSA amount to be spent (annual deductible) must be paid by the patient, and then be reimbursed by the HSA to the patient isn’t clear.

Should a provider, willing to accept a partial payment, be able to send dunning notices for the remaining deductible? Would non-payment result in the account being turned over to collection? The patient would continue to be presumed liable, but what about the HSA administrator? The employer? This is still uncharted territory, but nonetheless needs to be raised in this context.

Even more perplexing, could a patient covered by a CDHP/HSA plan be eligible for charity care? With all the attention being paid to how hospitals, in particular, administer their charity care policy, where would these patients fit in, if at all? While it will be up to each provider to make that determination, it will need to recognize the potential for uncollectible amounts, and the resulting issues that will emanate.

Tools, Techniques and Technology to Tackle CDHPs

Although CDHPs are not likely to start off with a significant enrollment base, there may be a shift from existing plan types to this type of coverage, if the concept and perceived benefits materialize as expected. Since hospitals and physicians can all benefit from improvements in this area of better patient identification and TOS/POS collections, there are available technologies to assist in this process, along with tools and techniques that when integrated into operations reduce vulnerability and exposure
to related claim denials.

**Tools and Techniques**

Most providers’ weakest link occurs at the point of pre-registration or the actual registration process itself. Ineffective interview skills and poor intake procedures leave many providers with incomplete and/or inaccurate data capture and system entry. Failure to capture the right information will negate and diminish billing and collection capabilities.

Staff education remains one of the most valuable investments providers can make in revenue cycle staff. However, in order to create the type of learning that will solve the problem, management must begin by identifying which of their major insurers (usually measured by volume of admissions or revenue generated) are offering CDHPs. Once determined, the ability to secure information from the payer about identification card information, and web site or Internet reporting for 270/271 needs to be obtained and disseminated to the staff in easy to understand terms.

If the amounts to be collected are going to increase exponentially as noted above, then setting a policy that clearly outlines what the TOS/POS collection expectation is will help alleviate uncertainty by the staff. With collectible amounts potentially resembling what most of us would call major purchases, providers need to begin to adopt similar techniques to ensuring that the payment occurs.

**Credit History**

Providers continue to be resistant to obtaining credit data about patients. Yet for most major purchases that are made, from cars to homes to plasma screen televisions, etc., consumers are credit checked. As we’ve learned from news and print media, lower interest or mortgage rates may apply to consumers with better credit than those without. We need to ask the question, if we credit check a consumer for a $30,000 car, a $300,000 home or a $1,000 large item purchase, why wouldn’t we do the same for a patient expected to have a $10,000 or higher hospital bill? And especially, if $2,000-$3,000 may be expected as the patient’s responsibility resulting from a CDHP plan?

Hospitals have what the credit bureaus and regulators call, "permissible purpose." For those who extend credit, they have a legitimate right to know the likelihood that a consumer (patient) has the wherewithal and propensity to pay and manage debt. Credit-scoring and obtaining other credit attributes is not a guarantee of payment; but rather, it is an indicator of how well a consumer (patient) behaves from a credit history perspective. The industry has studied this behavioral pattern, and found to a large extent correlation between a consumer’s credit score, and the propensity for the consumer, when assuming the role of a patient, to pay their healthcare debt in a manner similar to paying other debt.

Similarly, credit data can alert a healthcare provider about possible fraud and identity theft, as well as changes in address and financial solvency (e.g., notice of bankruptcies and recorded deaths are usually noted in the credit file). Whether it’s the improper use of a never-issued social security number, or one that belonged to a deceased individual, or merely the mis-keying of a valid number, this type of information can help providers better identify its patients. Even in a HIPAA compliant environment, safeguarding PHI (protected health information) seems rather incongruent, if the information is incorrect to start with.

**Technology**

Legacy systems, whether hospital information or physician practice management systems, may not have all of the functionality needed today to cope with current Access and PFS issues, let alone the challenges presented by CDHPs. Add-on or bolt-on technology does exist that can seamlessly integrate new functionality to enhance the patient registration, billing and collection processes.
Most technology trading partners are integrating their applications, so that they can establish two-way communications with legacy systems. By using standard protocols (e.g., HL-7), the ability to introduce new software applications is akin to purchasing a new computer software program. Often the challenge that results is the need to provide the initial interface, and ensure distributive processing across often vast networks of linked computer workstations.

In order to address CDHP, the availability of rules based logic that can interact with, and oftentimes become the platform from which staff see and transact on can fill in the gaps where current system limitations prevail. For example, a software application that can list the benefit coverages of a CDHP, and automatically warn staff that a prior approval is needed, or that $1,500 of the high deductible amount remains unpaid would be beneficial. More importantly, if such a CDHP patient is registered without an insurance verification, the system could automatically trigger a 270/271 inquiry, or query the payer for an approval. If the system could simultaneously warn the staff, but also the supervisor or clinician of a problem, providers would be better positioned to react before an errant event where to occur. However, all of the bells and whistles that technology brings will have little demonstrable impact without staff who are educated, not only on how to use the tools and techniques, but with an understanding of the underlying principles upon which the revenue cycle operates.

The same is also true of online cashiering applications that can turn any networked workstation into a satellite cashier capable of processing credit cards. With the right equipment configuration, debit cards and check authorizations can also be accommodated. While the security of offsite cashiering stations are always a concern, the technology can allow audit and control functions to be automated, while allowing remote locations to become fully participating in the TOS/POS collections process. The two-way communications afforded between adjunct applications and mainframe data bases can keep both systems in synchronization.

Where Do We Go From Here?

"It’s a long, long way to Tipperary!” But most challenges are often overcome by taking the first step. CDHPs will provide a new set of impacts, but nothing fundamentally will have changed. However, the operational areas and workflow sequences that produce errors today, will continue to negatively impact cash flow, as CDHP errors will be added to the list of problems. We often see the mantra, “denial management;” the focus needs to be changed to “denial prevention.” Taking a proactive series of steps, some of which have been outlined in this article will help providers prepare for CDHP, as well as improve their overall capabilities to register, bill and collect for patient care services.