

# Pine Tree Times

The AAHAM Pine Tree Chapter Newsletter - Volume 3, Issue 2

June 2015

High Deductible Plans  
The 21st Century Biller  
MaineCare ICD-10 Updates  
And much more!



[www.aahamme.org](http://www.aahamme.org)



# President's Message

Dear Fellow members and friends:

As we make our way into summer, I would like to reflect on some exciting events from the spring as well as exciting events to come. Paul Fitzpatrick, past president, and I represented Maine at the 11<sup>th</sup> Annual Legislative Day in Washington DC in March. We met with representatives from both Susan Collins and Angus King's office. We discussed the TCPA, Telephone Consumer Protection Act, for the 4th year and the Hospital Improvement for Payment (HIP) Act of 2015, for the first time.

The TCPA restricts the use of auto dialers and artificial or prerecorded messages and was designed to protect consumers from unsolicited telemarketing calls. The act was passed into law in 1991 and hasn't been updated since to address current technology such as cell phones. AAHAM has been lobbying to modernize the TCPA and allow auto dialers, texts, and calls to mobile phones for non-telemarketing situations. This year we gained some significant traction on the TCPA and the FCC commissioner is talking about providing clarity to the TCPA.

The HIP Act has been created in response to many of these issues that exist with the current Medicare payment systems. Such as the issues between payment systems, the current definitions of a short stay, the problems associated with the two-midnights policy, and reform to the Recovery Audit Contractors (RAC) program.

We are getting ready for board and officer elections again. Please reach out to Tim Moore at [tmoore@marcamassociates.com](mailto:tmoore@marcamassociates.com) or any current officer or board member if you are interested in becoming more involved in the chapter. We are always looking for members to become more involved either at the board and officer level or to join one of our committees.

We had our annual meeting this year on May 7<sup>th</sup> and 8<sup>th</sup>. We were back in Ogunquit at the Meadow Mere. We had great attendance, great speakers and great topics. I need to thank everyone who worked to pull this together; Tim Moore, Tim Hall, Natashia Nile, Mike Nile (or should I thank his wife, Jessica), Bonnie Richards, Annette Bradbury, Vaughn Clark, Nicci Bishop. I apologize if I forgot to mention someone. It really took the entire group to pull this great program together. We had Jim Grigsby representing HARA and he gave everyone in attendance a copy of the valuable HARA quarterly report. Jim also presented on effective business communication. Chuck Duncan presented on denial management. Lori Zindl presented on staffing and productivity. The presentation was very timely and very helpful for me. William Coz and Ryan Whiteleather shared hiring and retention tips and tricks. Robin Ingalls-Fitzgerald discussed the importance of a good clinical documentation improvement program as we transition into ICD-10. John Behn talked about how the revenue cycle can succeed in ICD-10. Trish Hunt presented Six Sigma/Lean. I hope I haven't missed anyone. Everyone I spoke to at the program and all the evaluations came back with great reviews. Everyone had a great time and learned a lot in the process.

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## President's Message (continued)

I want to send a special thank you to Vaughn Clark from The Thomas Agency for both coordinating the sponsors and participating as a sponsor. Our sponsors were very generous again this year with annual sponsorships and/or special event sponsorship. Please be sure to thank them for their support: ROI, Sandra Magaw; The Thomas Agency, Vaughn Clark; Points North Credentialing Service, Lena McDougal; ACS, Peter Allen; ParrishShaw, Julie Noel, Cardon Outreach, Jonathan West; Marcam Associates, Tim Moore; Experian, Tom Symington; HealthPort Technologies; Advanced Patient Advocacy, Annette Bradbury.

We have another exciting meeting planned for September 18<sup>th</sup> in So Portland. This will be a joint meeting with our friends at NAHAM, National Association of Healthcare Access Management. We have topics such as "Regulations affecting your revenue cycle", building your Access Team, registration accuracy, Suzanne Menard will be speaking on Registration and Insurance Verification, Six Sigma/Lean from the Maine Health perspective, Medicare Secondary Payor, and this new EMV chip card and medical payments. It looks like another very informative meeting. I hope to see you there. Until September, I hope everyone take a little time to enjoy the summer with their families and friends.

- **Vickie Heath - Pine Tree Chapter President**

## AAHAM Pine Tree Chapter Officers



**President - Vickie Heath**

**Vice President - Mike Nile**

**Treasurer - Annette Bradbury**

**Secretary - Theresa Huck**

Special thanks to the newsletter committee:  
Barbara Lynch - Sandra Magaw - Bonnie Richards

Newsletter designed and edited by Jon Menard

## Pine Tree Chapter AAHAM

### Upcoming Meetings

<b>September 18, 2015</b>	<b>Revenue Cycle Meeting</b>	<b>Portland</b>
<b>November 20, 2015</b>	<b>Third Party Payer Meeting</b>	<b>Augusta</b>

Register online at [www.aahamme.org](http://www.aahamme.org)





# High Deductible Health Plans: Increasing in Popularity with Consumers and What that Means for Hospitals

To date, the Affordable Care Act (ACA) has resulted in an estimated 32 million newly-insured Americans since 2010; nearly one-third of which purchased coverage through exchanges. On the surface, it appears that this would be nothing but positive news for health care providers, as their ability to collect for billed services should be enhanced with more insured consumers seeking care. However, taking a closer look at the plans the newly insured are choosing reveals a growing issue in collections for providers: the increasing popularity of high deductible health plans (HDHPs).

Users of the insurance exchanges and corporate consumers of health insurance are starting to shift their health plan choices toward higher deductible options. The tiered structure of offerings on the exchanges allows consumers to choose their plans based on cost. This is leading to an increase in popularity for HDHPs which typically include lower upfront premiums but higher total costs for many services. The number of HDHP enrollees rose to nearly 17.4 million in January of 2014, up from 15.5 million in 2013, 13.5 million in 2012 and 11.4 million in 2011; an average annual growth rate of approximately 15% since 2011.<sup>1</sup> As consumer preferences shift further towards these HDHP offerings, the need for hospitals to adapt their billing and collection strategy increases; otherwise bad debt and charity care could evaporate profits.

Coinciding with the increasing interest of HDHP among consumers, more employers are offering HDHPs, and in some cases offering only HDHPs, to help control costs. This trend is expected to continue as companies react to the new laws governing their benefits and try to find ways to manage the increased cost of expanded coverage while avoiding penalties such as the “Cadillac” tax. The result is increased financial burden for patients and changes in their ability to pay and their willingness to forgo treatments due to cost.

Figure 1 demonstrates HDHP enrollment levels as a percentage of total enrollees, both on and off the exchanges. The data, collected by the U.S. Department of Health and Human Services and eHealth, Inc., capture both new and existing consumers of health care plans from the ACA open enrollment periods (Oct. 1, 2013 through March 31, 2014, and Nov. 15, 2014 through Feb. 15, 2015).

**Figure 1: Open Enrollment Period - Popularity of HDHP**

	<u>2014</u>	<u>2015</u>
<b>Government Exchanges*</b>		
Silver	65%	70%
Bronze	20%	19%
<b>Off-Exchanges**</b>		
Silver	21%	25%
Bronze	47%	46%
Catastrophic	14%	9%

\* Data from U.S. Department of Health & Human Services.  
\*\* Data from eHealthInsurance 2014 & 2015 Price Index Reports.

Silver, bronze and catastrophic plans contain deductibles that meet the IRS 2015 definition of HDHP. Of these new HDHP consumers, many are forgoing the typical mitigants for high deductibles such as health care savings accounts and flexible spending accounts. The consumers purchasing coverage on the exchanges are more likely to forgo savings accounts and in many cases are not even given the option. According to the National Center for Health Statistics, 36% of Americans under age 65 with private health plans are enrolled in an HDHP, and only one-third of those consumers are enrolled in plans linked to health savings accounts. With the out-of-pocket costs for patients increasing due to the popularity of HDHPs, and with so few purchasers taking advantage of savings plans, the risk of bad debts and charity care increases for health care providers.

As consumers become responsible for a greater portion of their health care costs, hospitals will see their role as collection agent grow. The need for an effective billing and collections department will result in increased overhead and more expenses for providers. Patients who receive services may be unable or unwilling to pay their high deductibles, putting further pressure on hospitals due to lost revenue from bad debts and charity care. Some patients may even go as far as deferring or avoiding preventative care, prescription medications and other treatments due to costs, resulting in even more lost revenue for hospitals.

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# High Deductible Health Plans

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## How are Hospitals Coping?

Hope for hospitals is not lost, however. There are still benefits to the increased number of insured consumers and the preference for HDHPs is only another challenge for the industry as the effects of the ACA settle in. Many hospitals and systems have already started to put in place new programs and processes to offset some of the effects of HDHPs. Point-of-service collections, requiring whole or partial payment at the time of the appointment, are becoming an increasingly popular way for hospitals to collect payments for procedures and visits. Some providers are offering medical bill financing services, either directly or through partnerships with third-party banks and lenders. These services allow consumers to make smaller payments over time to control the burden of upfront costs, often for negotiated total amounts with little to no interest.

Most hospitals are placing an increased focus on their collections services by implementing new processes and programs to help improve billing and collections departments. Additionally, having discussions with the patient about costs throughout the entire treatment process is important. Many providers have found that focusing on communication and consumer education with regard to health care decisions, both treatments and coverage options, has created better results with both patient satisfaction and bill collection. In cases where costs to collect become too burdensome, there are an increasing number of outsourcing options that providers can consider.

With risks on the horizon due to the growth in HDHPs, it is time to revisit charity plans and examine how bad debts are treated. Charity care plans will need to start incorporating patients that technically have health insurance but are currently unable to afford the full deductible to pay for their care. Communicating with patients from the beginning of treatment plans can lead to mutual agreement about payment plans and increase the likelihood of whole or partial collections. The billing discussions can lead to better budgeting on a per-patient basis and a more accurate forecast of charity care and bad debts. Forecasting, budgeting and managing the collections could be improved through separating the HDHP accounts from other insured patient accounts.

Guidelines should be established to determine how to set up payment plans, what incentives to offer, and how much of total cost could be forgiven. Identifying which patients qualify for income-based reductions, as well as those that would benefit from financing plans, can enhance efforts to recover outstanding billings. The more providers understand about their patient's individual health care plans and financial situation early in the treatment cycle, the more accurately the provider can determine a collection plan and budget for discounts and assistance. Consideration should also be made to better define the distinction between charity care and bad debts. Providers will need to better understand and document what portions of outstanding statements are from HDHP patients, and when those amounts become bad debt and need to be written off.

## What Does this Mean for Financing?

Because of the new challenges to revenue and collections in the health care space, lenders will become more focused on accounts receivable and census mix. Providers need to be aware of the shifting focus and make sure they are paying attention to those variables. Revenue management will be more closely tracked by ratings agencies, lenders and anyone looking at hospital credit. Historically, a lender's focus on receivables has been on the aging schedule and net collections from the different payer sources. With the evolving landscape of insured private-pay patients, lenders will begin paying more attention to the charity care plans and analyzing bad debts. Being able to determine when a debt becomes uncollectable, distinguishing between the different types of payers and understanding the payment plan schedules will be an important conversation between lenders and providers.

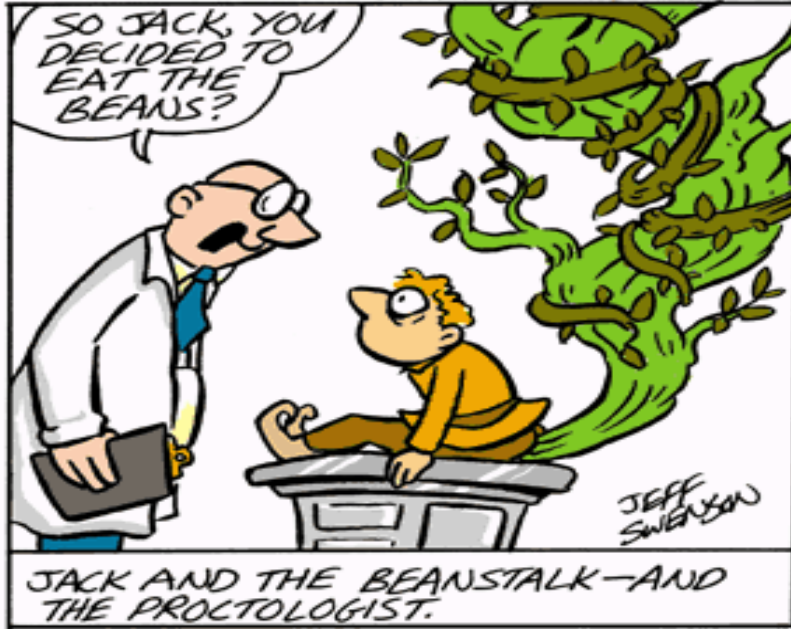
Clear, defined processes and strategies regarding billing and collections from private payers have become essential for those involved in health care financing. It is important for providers to be aware of the challenges brought on by changes in health care plan preferences and to start implementing strategies to combat those risks.



Kevin Oakley is an associate with Lancaster Pollard in Columbus. He may be reached at [koakley@lancasterpollard.com](mailto:koakley@lancasterpollard.com)

## Healthcare Humor

FRENETIC WANDERINGS WWW.SWENSONFUNNIES.COM



## Pine Tree Chapter Website

Be sure to check out our website [www.aahamme.org](http://www.aahamme.org) for event calendars, presentations, certification information and more!



## “In the News”

### ‘Underinsured’ May be the Next Healthcare Crisis

John Commins — HealthLeaders Media, May 21, 2015

"The financial health insecurity that comes from being underinsured is substantial and puts people's health and well-being at risk," says The Commonwealth Fund President David Blumenthal, MD.

High-deductible health insurance plans have been touted as a means to expand coverage to millions of people who otherwise could not afford it.

New reports out this month suggest that high-deductible non-group plans are not a silver bullet, however, and that while the premiums may be affordable, the costs of accessing care remains prohibitively high.

A survey released this week by **The Commonwealth Fund** found that 31 million adults ages 19–64 with health coverage were "underinsured" in 2014, and that oftentimes these underinsured people skimped on care because it was too expensive.

"The financial health insecurity that comes from being underinsured is substantial and puts people's health and well-being at risk," The Commonwealth Fund President David Blumenthal, MD, said at a news conference Tuesday. "If health insurance costs continue to be shifted to consumers this insecurity will deepen."

Sara Collins, the lead author of study, and vice president, Health Care Coverage and Access at The Commonwealth Fund, says "underinsured" status considers an insured adult's out-of-pocket costs during a year of coverage and the plan deductible. Premiums are not factored.

Someone is underinsured if their out-of-pocket costs excluding premiums over the 12 prior months are equal to 10% or more of household income," Collins says, "or if their out-of-pocket costs excluding premiums are equal to 5% or more of household income if their income is under 200% of the federal poverty level, which is about \$23,000 for an individual and \$47,000 for a family of four, or if their deductible is 5% or more of household income."

Read the rest of the article [here](#)

# The 21st Century Biller

By Lori Zindl, President, OS Inc.

The healthcare landscape is rapidly changing, and sitting with a front seat view is the hospital business office. The uncertainty of ICD-10, healthcare reform and changing reimbursement rates, payer rules, compliance regulations...it's a lot to take in. A business office needs to be adaptable and ready to make adjustments. With the advantage of evolving technology around claim submission and editing, that includes adjusting the roles of its personnel, namely the medical biller.



Let's look at a snapshot of how a medical biller once functioned. As claim submission is both complex and incredibly important to an organization's revenue, a biller was a fundamental, high-level position, requiring thorough understanding of complicated payer rules. He or she often needed to review each claim before it went out the door to ensure it was correct. This was the best defense against payer denials. However, there are many reasons this approach is ineffective:

- **Efficiency.** It's a slow process. A biller reviewing claims requires more hours, more FTE, and time taken away from other crucial tasks. Also, claim failures typically occur as a result of either coding or registration and have to be sent back to the respective department. Billers are often simply routing claim issues to other areas to review, basically being a middle-man resulting in claims being touched multiple times by different staff.
- **Accuracy.** It's impossible for a person to review each and every field of every claim without missing errors, which equals denied dollars and more time that must be spent on correcting and resubmitting claims.
- **Risk.** If you employ the best biller in the business, you are still taking a huge risk. The knowledge of payer rules, regulations and contracts leaves with this person should they ever move on.

Today, your claims system can be and should be handling your claim editing. Payer rules should be built right in to the system, ensuring claims go out correctly the first time. Time spent on the actual billing function should be minimal. So, what can you do with your billing staff?

- **Reallocate.** Billing staff can tackle more important issues, like tracking and analyzing denials and turning denial information into new edits.
- **Reinvent.** Many providers have implemented systems where claims are routed to the responsible area (coding, registration) depending on the edit, eliminating the need for the biller to be in the middle. Other providers are requiring billing staff be certified coders so that corrections can be made to claims without referring them to other departments for resolution.
- **Reassess.** If a biller is still reviewing every claim before it goes out the door, there's a problem with your technology. Your claim system should be able to identify and correct routine billing errors and scrub the claim. If it's not doing its job, it may be time to find a new system.

Compliance is another huge consideration. An organization needs to be aware of and track the changes being made by the biller handling the claims as a safeguard against non-compliance that could be costing reimbursement. If they are routine changes, they can be automated within your claims system.

The best defense against denials and the most effective way to increase cash and shorten the revenue cycle is to use your billing staff in new ways. The title of medical "Biller" implies heavy emphasis on billing, but today's billers really should be spending little time on billing - instead using their expertise to solve A/R issues and denials.



## ICD-10: Impact on MaineCare Providers

Have you thought about how ICD-10 impacts you? What do you need to change by October 1, 2015?

### Operational updates required:

- ◆ Business processes, systems, and paper and electronic forms may need to be modified to accommodate the new, longer codes.
- ◆ System updates, including replacement of all ICD-9 codes
  - ⇒ In most cases, there is an approximate one-to-one match but not always. One ICD-9 code may correspond to many ICD-10 codes.
  - ⇒ CMS has provided General Equivalence Mappings (GEMs) as a code tool that can assist providers in determining which ICD-10 codes to use.
- ◆ New paper claim forms
- ◆ New Prior Authorization (PA) forms

### Changes to claim submissions:

- ◆ All services, PAs, and discharges conducted after October 1, 2015 must use ICD-10 codes. If ICD-9 codes are submitted for dates of service on or after October 1<sup>st</sup>, claims will be denied.

### Training for your employees:

- ◆ Coding
- ◆ Documentation

For ICD-10 training resources and other information, please see [CMS' ICD-10 Provider Resource webpage](#). If you have questions, please contact us through the [ICD-10 Email Box](#).

## ICD-10 Provider Readiness Survey Results

Thank you to everyone who participated in the April 2015 ICD-10 Provider Readiness Survey! Below are the summarized results of the survey:

### Survey Response

OMS received 447 responses to the April 2015 survey and 310 completed the survey in its entirety. MaineCare Services has approximately 8,000 pay-to providers enrolled and close to 6% responded to the survey. It is important to note that the number of respondents for each question varies due to attrition.

### Provider Planning

More than half of the respondents to this question (70%) indicated that they either have started or completed ICD-10 transition, while 30% have not yet initiated planning efforts. The majority of respondents (50%) indicated that they will not be ready for ICD-10 until October 1, 2015.

### Pilot Testing

Over half of the respondents that completed this question (144 out of 333) expressed interest in pilot testing. We spoke with those who indicated they were interested in testing and if ready, we registered them for one of the testing cycles.

### Individual Outreach

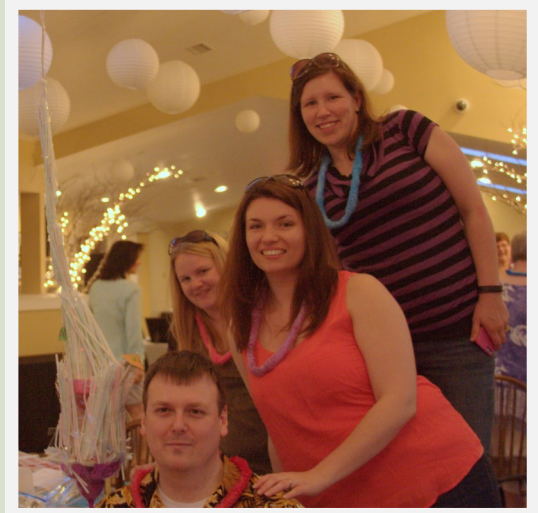
120 respondents had questions and requested individual follow up. All those requesting outreach have been contacted.

### Contingency Planning

Less than one fourth of respondents have a contingency plan if their organization will not be ready by October 1, 2015.

This survey summary will be posted on the ICD-10 website. Thank you again for taking time to answer the questions based on your organization's level of preparation for ICD-10.

# Fun times at the AAHAM Annual Conference





## 2015 Pine Tree Chapter Membership

***AAHAM is having a membership drive in 2015 and invites all members to encourage their peers to join our organization. If you are responsible for recruiting a new member, please, have the new member list your name on their membership form. The AAHAM member that recruits the highest number of AAHAM members will be eligible for a free 2016 Registration for The Pine Tree Chapter of AAHAM Annual Meeting or the Pine Tree Chapter of AAHAM will pay your national dues for 2016.***

When you renew your dues, you will have the tools to learn how to work smarter, advance in your career and have access to a wealth of revenue cycle information. AAHAM is the only national organization dedicated to the revenue cycle, both management and the front line staff. We provide education and training for staff and managers, as well as offer a nationally recognized certification program.

Renewing your membership in AAHAM, provides the necessary tools to deal with the serious issues facing hospitals today. Some of the valuable benefits of membership are:

- ⇒ Access to Member's Only Section of AAHAM's website
- ⇒ Timely legislative and government updates to help stay in compliance-The latest networking on information systems, regulations, managed care, payer issues and more
- ⇒ Local and national education meetings-including the AAHAM Annual National Institute
- ⇒ Comprehensive certification programs for executives (Certified Revenue Cycle Executive-CRCE), for managers (Certified Revenue Cycle Professional-CRCP) and front line staff (Certified Revenue Cycle Specialist-CRCS and Certified Compliance Technician Exam-CCT). By ensuring your competency in Registration, Billing, Third Party Recovery and AR Management, you can demonstrate functional knowledge of the day to day operations of your facility.

Please, renew today and continue to build your valuable relationships with other Healthcare Professionals as you gain essential knowledge. Renewing your membership in AAHAM is an investment in your professional career and personal growth.

The dues for 2015 are \$25.00. See the 2015 membership application and dues form [here](#).

If you have any questions, please, contact me.

Sincerely,

Bonnie Richards

Membership Chair

207-907-1850



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