ECG MANAGEMENT CONSULTANTS, INC.
MAINE CHAPTER OF HFMA OCTOBER 2013 NEWSLETTER

EVALUATING YOUR ORGANIZATION'S OPERATIONAL READINESS FOR HEALTH EXCHANGE MARKETPLACES

As the first new major federal healthcare program implemented since the introduction of Medicare and Medicaid in 1965, health exchange marketplaces promise to bring numerous strategic and operational challenges for even the savviest providers. Although some providers have modeled the potential implications of health exchange product contracts, few organizations have thought through the operational realities of accepting new health exchange patients and payment rates. While initial enrollment has proceeded at a slow pace, beginning on January 1, 2014, providers across the country will be faced with an array of issues as patients with new coverage seek care. Proactively addressing these challenges head-on will help any provider achieve success as marketplaces become the norm in the new health reform era.

ECG Management Consultants, Inc., is assisting many providers with developing and implementing strategies to manage the operational impact and estimate the financial implications of health exchanges. Based on this work, we have developed four general categories of readiness requirements aimed at preparing providers for the changes caused by health exchange market-places:

- *Financial Impact* – Evaluate the financial impact of health exchanges.
- *Organizational Operations* – Prepare staff for operational changes.
- *Clinical Operations* – Organize clinical teams for new patients.
- *Educational Opportunities* – Conduct outreach and education within the local market.

A. Readiness Assessment

The impact of exchanges will be unique to each market and can manifest differently for each respective provider. Therefore, an internal assessment, spearheaded by organizational leadership, is recommended to evaluate readiness related to the categories noted above. The new health exchange products will likely impact several operational departments, including:

- Admitting/registration (patient access).
- Case management.
- Patient financial services.
- Marketing and communications.

Establishing an internal work group composed of key leaders representing the most impacted departments would serve as a good starting point, providing a forum to discuss the anticipated issues. The work group members should collaborate to answer the following questions for each department/functional area:

- What do you anticipate will be the major impact on your department/functional area?
- What action steps will be needed to plan for the managed care changes?
- What information will you need to communicate? To whom? By when?
- What are your related preparedness and action plans (to be followed before the implementation of the health exchange products and after January 1, 2014, respectively)?

Based on these discussions, the work group can outline a plan to address the identified issues, and this plan should be communicated to clinical staff, operational teams, board members, and key constituents, as necessary.

B. Evaluation Categories

1. Financial Impact

The primary task of the work group will be to estimate the financial impact of the health exchange products on your organization so that leadership has an understanding of the potential range of related outcomes. The financial model utilized to measure this impact should include the variables listed below related to the volume and reimbursement changes associated with the health exchange membership.

- Market uninsured population.
- Products available in the market.
- Contracted rates for exchange products.
- Estimated employer participation in exchanges.
- Potential impacts of disproportionate share hospital (DSH) reimbursement changes and adjustments for bad debt.

The model will measure the organization's anticipated change in volume due to the newly insured population under exchange marketplaces and Medicaid, both of which are expected to have positive impacts. Further, the negative impact of bad debt associated with many of the newly insured will likely increase. A sensitivity analysis should be created that explores the best and worst case scenarios for your organization.

2. Organizational Operations

The most significant work to prepare for health exchanges will be related to operational changes. The work group will likely need to internally address several key questions:

- Are you contracting with all the health plans offering plans in your area?
- Will there be any new or unfamiliar plans?
- What are the volume-related implications of not contracting with any of the payors?
- Will specific departments and/or functions be impacted?
- Who needs to know about the newly contracted and non-contracted plans?
- Will you accept non-contracted health plan members requesting elective services?

Depending on the current market situation, educating your staff on the likely changes will result in a smoother response during the first year. In addition, the finance department can develop policies related to cost sharing, charity care, the coverage grace period, and other issues for organizational consistency.

a. Cost-Sharing Requirements

Under health reform, patients are protected from higher co-payments and co-insurance for out-of-network emergency and other services. Consequently, a hospital ED can expect reimbursement at an amount equal to the greater of the following:[1]

- The median amount that the payor pays to in-network providers for emergency services.
- An amount calculated based upon the same methods generally used by payors to pay for out-of-network services, such as usual and customary payments.
- The amount that Medicare would pay for the services provided.

Minimum payment amounts are intended to protect patients from excessive balance billing as a result of low reimbursement to providers. After receiving partial payment from the insurance company, providers can balance bill the patient the difference between the insurance payment and billed charges, subject to limitations by state law. If patients have met their out-of-pocket maximums, payors may be subject to paying billed charges.

b. Charity Care Policies

The introduction of the exchange marketplaces is an opportunity to update your organization's charity care policy. Patients previously not eligible for Medicaid may now qualify for coverage. Instead of providing charity care, an organization may be better served to get uninsured patients signed up for a plan. In addition, providers may choose to not offer charity care to those patients who are eligible but have not signed up for insurance. Organizations should review the applicability of their charity care policies with the new products and inform their staff about any related changes.

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[1] Douglas Wolfe, Esq., "Paying for Out of Network Emergency Services Under the Affordable Care Act."

c. Proactive Grace Period Tactics

It should be noted that patients have a 90-day grace period after their last premium payment during which they are covered and allowed to receive services if they have not paid their premium. For the first 30 days after a patient has not paid their premium, the health plan is responsible for reimbursing the provider; during the ensuing 60 days, the provider is at risk of not being reimbursed for services. Also, during those 60 days, the health plan is obligated to inform the provider that the premium has not been paid and there is risk of nonpayment for services. Many organizations are adopting proactive approaches to avoiding these situations. Tactics that providers have implemented include:

- Obtaining notification at the time of eligibility verification if the patient has not paid his/her premiums.
- Asking the patient if he/she has paid his/her premiums and/or requesting proof of payment.
- Indicating on admissions forms that the patient is responsible in the event of noncoverage.
- Determining if a special consent form is needed for health exchange patients. This may vary by health plan.
- Processing a patient as self-pay if he/she has not paid his/her premium or his/her insurance cannot be verified.
- Requesting payment in advance for elective services when insurance eligibility cannot be verified.

3. Clinical Operations

Educating your patient-facing staff regarding the correct protocols for new exchange marketplace plans will be important. Staff should be aware of and able to identify the new health exchange plans; for example, they should be able to recognize the patient identification cards and correct plan codes associated with the new health exchange plans. Capturing accurate information at the time of registration will allow for tracking, claims/billing, and plan evaluation of new products. Further, identifying a new patient will be important for the following reasons:

- A new fee schedule may exist for new health exchange plans (some plans offered on the exchanges may already exist).
- Your organization may be considered an out-of-network provider for that plan, and payments for out-of-network services are expected to be limited.
- A patient's out-of-pocket expenses for co-pays and deductibles for the health exchange products will likely be higher than those of employer-sponsored health plans.
- Patients with exchange coverage that does not include your facilities may need to be directed to participating locations.

In some locations, the demand for services from newly covered patients is expected to be high. Organizations can use the volume change estimates created in the financial impact analysis to determine the amount of new patient capacity needed at a given clinic. Primary care clinics

(e.g., family practice, pediatrics, internal medicine) may want to make some additional new patient appointments available for these newly insured patients.

4. Educational Opportunities

The final piece of the puzzle will be the education and outreach that occurs in your community. Even at this late stage of implementation, families and employers are uncertain about the changes associated with and implications of exchange marketplaces. Providers who are well educated and prepared for health exchanges can better serve their communities and ensure that consumers take full advantage of the new resource. Personnel at your organization can become certified application counselors that can assist individuals with questions about health exchanges.[2]

Potential health exchange purchasers will have questions about the provider network, out-of-pocket costs, and coverage benefits. Many providers are providing clarity in their communities through multiple approaches, including:

- Town hall meetings.
- Chambers of commerce discussions.
- Parent/teacher association meetings.
- Health fairs and community festival booths.

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By surveying the issues specific to your market, you can minimize the potential stumbling blocks and ensure that the health exchange marketplace rollout goes smoothly for your organization.

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About ECG Management Consultants, Inc.
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[2] Source: *http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf*.