Prepare to pivot: Getting ahead of ACA disruptive forces

Despite significant uncertainty about how Congress will address Medicaid, subsidies, and the exchanges, waiting to take action is chancy – and risks substantial revenue loss for hospitals and health systems.

Given the recent events in Congress in failing to get the votes to repeal the ACA, the government’s intentions sheds some light on how additional ACA disruptions might unfold. No matter what healthcare reform evolves into, one thing is sure: transformation will hinge on access to care and financing.

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Impacts on funding and access for coverage are expected for Medicaid, health exchanges, and other types of health plans. The cost of care – and who should fund it – will remain a central issue for the next plan year. It’s pretty clear that responsibility for the cost of care will continue to shift among patients, plans, employers, providers and the government. Patients will assume more responsibility than ever for the cost of their coverage and their care in the form of growing high deductible health plans and increasing premiums.

While we may not know the full scope of future legislation, we do know hospitals and health systems must act now to head off coverage and revenue disruptions. But they don’t have to reinvent the wheel: They can leverage the ways they positioned themselves when the ACA first passed.
The key to success going forward is to get ahead of the additional disruption to come. For hospitals and health systems, that means expanding the financial workflows that protect revenue cycles today – but ensuring that those workflows are flexible enough to accommodate new realities as they appear.

**Build on recent strategies**

In addition to increasing the number of Americans covered by health insurance, the ACA has also amplified high deductible health plans. In other words, as patients have gained coverage, they have also increased their risk for medical debt. Consequently, providers have had to adjust financial workflows to accommodate patients as “the new payer.” For the most forward-thinking hospitals and health systems, this has included:

- Coupling patients with the best payment choices, whether insurance, charity, self-pay upfront, or a payment plan over time with other funding mechanisms.
- Providing patients with cost estimates in advance of service.
- Improving upfront collections (or at the very least, discussing financial obligations prior to service).
- Implementing tools to locate Medicaid coverage for those who qualify.

Such preparations over the last few years have been worthwhile. They – and the organizational goals driving them – will remain valid even as lawmakers attempt to disrupt the ACA. Now it’s time for providers to bolster those strategies in another major pivot.

**What to do as healthcare legislation unfolds**

The first thing hospitals and health systems should do to prepare for ACA disruption is to insulate the bottom line against the impact of uncertainty. Many steps in this direction – including conserving capital and incremental expense where possible – are happening already because of volatility in the market.

For example, most hospitals and health systems are holding off on campus expansions and planned capital expenditures that aren’t required immediately. For additional protection against financial disruption, providers should consider trying to gain some revenue predictability by negotiating to lock-in health plan rates over multiple years.

That’s the defensive side of readiness. At the same time, providers should play offense by making sure their teams are well prepared to handle disruptions in their patients’ health coverage.

Patients can experience changes in insured status.
because of modifications to Medicaid expansion, exchange plans participation, charity care qualifications and more. To accurately accommodate these adjustments, providers must ensure staff are both well-educated and well-equipped with the resources and tools needed to manage reform as it comes to fruition.

The core of this preparation should be a continued focus on optimizing patient financial clearance, billing and collections. The more skilled providers become at dealing with patients as the new payer, the more they can help smooth the transition for patients who find themselves suddenly dealing with new healthcare realities of their own.

It’s time to truly optimize patient payments

Regardless of the final form of ACA disruption, foremost among Congressional goals are:

- Eliminating the individual mandate;
- Replacing the subsidies that have helped cover the cost of health insurance with tax credits; and
- Curbing Medicaid expansion.

While the legislation learned some things while introducing the AHCA bill, they remain committed to an overarching goal – provide Americans choice and allow states flexibility in funding Medicaid. This can translate into additional legislation that occurs through budget reconciliation initiatives with the potential to significantly disrupt Medicaid delivery models from the States. As more patients experience coverage disruption, providers could face larger financial risk from significant changes in the number of self-pay patients. So even without exact details, the need for readiness now is clear.

Providers should direct much of their attention to the funding, income, eligibility and coverage thresholds that will impact Medicaid patients, the commercially insured, exchange enrollees, self-pay patients, charity care and bad debt cases. Specifically, it’s time to sharpen the use of tools and techniques that helped hospitals and health systems respond to the ACA in the first place.

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This includes employing analytics to identify patient payment ability and propensity to pay – differentiating a patient’s willingness and ability to pay. It also includes resolving to determine each patient’s insurance coverage and projected out-of-pocket costs in advance of service, in order to secure upfront payments or workable payment arrangements prior to care.
In addition, regardless of the funding mechanism, providers must update their billing practices to meet the expectations of patients as consumers. That means offering proactive, more effective alternatives to traditional paper-based billing. Given that the average consumer typically does not have the financial reserves to pay for most hospital procedures in their entirety, providers need to become even more adept than they are today at making it easy for patients to understand the costs of their care, as well as navigate and fund those costs over time.

The best way providers can tackle this issue is to emphasize financial counseling efforts whenever possible. Leverage analytics to proactively identify and prioritize the most at-risk patients and bills across all receivables. That way it’s possible to find opportunities for pre-care payments or financing options.

Simply put: Providers should drive decisions through analytics that uncover potential bad debt by service line. At a minimum, this could involve alerts and escalation workflows for situations such as:

- ✔ A self-pay patient being scheduled for surgery,
- ✔ An advanced imaging order for a patient with a high-deductible plan, or
- ✔ An in-house or ED patient who has not been financially cleared prior to discharge.

Such tools would enable providers to assign financial counselors to cases that represent the greatest impact, working accounts that generate the highest yield. Staff would be able to concentrate their efforts on the right things, for the right reasons, at the right time.

**Focus on value-based payment models**

Despite all the legislative noise, current discussions about healthcare access and funding actually have a lot in common with the existing ACA provisions. So, to succeed as new healthcare regulations evolve, providers must first adapt to the changes in healthcare today by continuing to invest in value-based care initiatives.

The days of health plans providing nearly all provider income in the form of fee-for-service reimbursements are well behind us. The market is already moving from fee-for-service to fee-for-value. Any future legislation is likely to keep driving cost and reimbursement as top priorities.

Looking ahead, nothing about the efforts to disrupt the ACA reverses the steady march toward value-based reimbursement models. Few provisions are currently aimed at deviating from value-based care. For now, the ACA and the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) remain in
effect, as do the various efforts of public and private health plans to move the industry toward a higher level of care value. Hospitals and health systems increasingly will be held accountable for both clinical and financial outcomes, so they will need to insulate revenue while ensuring access to care.

Even with talk about scaling back government involvement in healthcare, the Centers for Medicare & Medicaid Services will remain the single largest healthcare payer in the U.S. So, even as the federal government seeks to contain its own costs, it will continue to shape healthcare by virtue of its involvement in payment rules and guidelines. These will come with financial mechanisms designed to foster provider acceptance and adjustment. Provider organizations will need to be flexible and creative as they seek to comply.

By understanding where and why payment problems occur – and taking steps to address those problems – providers can minimize the impact of ACA disruption. The benefits of doing so will extend beyond the balance sheet; patients will be grateful for help navigating their coverages and costs. Collaborating with patients on financial options during times of great clinical need will be central to ensuring positive outcomes for everyone involved.

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Navigate change together

Hospitals and health systems are in a unique position because they are the last in line to provide care and to ensure a quality experience for patients.

For more information, visit www.transunionhealthcare.com or email hcsolutions@transunion.com.