2013 Medicare Parts A, B, C and D Deductibles and Premiums

The Part B Medicare deductible for 2013 is $147.00.

What should you do with this information? You should avoid taking a **big financial hit** in the first quarter of 2013 by collecting deductibles at time of service. How do you do that?

- Let all patients know in advance that you collect deductibles by making it part of your communication with them. Put it in your financial policy (get a copy of my preferred financial policy below), put it on your website, and let patients know when you schedule their appointment, or make an appointment reminder with verbiage like:

> ***"We look forward to seeing you at your appointment. Please bring your insurance cards and all medications to your visit. We will collect your co-pay, your deductible, and any co-insurance required by your insurance plan."***

- Explain what a deductible is. Get my sample patient handout explaining deductibles below.
- Train front desk staff on deductibles and get them comfortable discussing deductibles with patients and answering their questions.
- Do not collect deductibles for Medicare patients who also have Medicaid, or for Medicare patients with

supplemental insurance as there most likely will not be a balance that the patient will owe.
- It is ideal to use a Credit Card On File program to charge the patient's credit card at time of service, or when the EOB (Explanation of Benefits) arrives in 15 days.

Other important Medicare numbers for 2013

Part A: Hospital Insurance Premium for 2013– $441.00 per month. Most 65+ patients get Part A for free if they already receive retirement benefits from Social Security or Railroad Retirement due to taxes paid during working years. Part A includes coverage for:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care – skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, dietary and home health aides (100% covered with no co-pay) for homebound patients after a 3-day hospital stay

Part B: Medical Insurance Premium for 2013 – $104.90 per month for most, but not all patients. Some patients automatically get Part B, others may have to pay more based on their IRS tax return from 2011. Part B includes coverage for:

- Services from doctors and other health care providers
- Outpatient care (includes emergency room and observation services for physician charges)
- Home health care – services provided to a homebound patient when the patient has not been hospitalized for 3

days prior to need
- Durable medical equipment
- Some preventive services

Part C: Medicare Advantage Plans – also called a Medicare Replacement Plan because it replaces traditional or original Medicare with a plan offered by a Medicare-approved private insurance company (BCBS, UHC, etc.) Premiums vary with individual Medicare Advantage Plans. Medicare Advantage Plans:

- Include all benefits and services covered under Part A and Part B
- Usually include Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost
- Cannot be used in combination with a Medigap policy

Part D: Medicare Drug Coverage for 2013 – monthly premiums will vary based on income, and whether or not Part D is included if the patient opts for Part C coverage. Some plans have deductibles and some do not. Most drug plans have a coverage gap referred to as the "donut hole", which means coverage is temporarily limited after the patient and drug plan have spent a certain amount for covered drugs. In 2013, once the patient reaches the donut hole, they pay 47.5% of the plan's cost for covered name-brand drugs and 79% of the plan's cost for covered generic drugs until the end of the donut hole is reached. In every successive year after 2013, the donut hole will shrink until 2020 when the donut hole will cease to exist.

Medicare Supplement Insurance (also called Medigap) – Policies are sold by private insurance companies and help pay some of the health care costs that Medicare doesn't cover. Patients

have a one-time 6-month Medigap Open Enrollment Period which starts the first month they are 65 and enrolled in Part B. This period gives patients a guaranteed right to buy any Medigap policy sold in their state regardless of their health status.

Click here to receive a free copy of a financial policy and a patient handout explaining deductibles.

CLICK HERE to Download the Financial Policy and Deductible Handout!

Collection Basics Part II: Implementing Your Financial Policy

In **Part 1 of this series** we explored payers. Now it's time to develop your financial policy. This is your foundational document for everything that happens with patient financial interactions. Your financial policy will confirm for patients and staff what your practice financial policies are, and will support the financial goals of the practice.

The road to financial health

Putting together a new financial policy or revising your existing policy is one of the most important steps to financial health. Your financial policy is your road map and

will determine how the practice will handle the collection of patient balances. The financial policy is the document you will come back to time and time again. If a question arises, ask yourself, **“What does our Financial Policy say?”**

First, decisions need to be made:

- What money will you collect before the patient is seen? Co-pays? Deductibles? Deposits for self-pay patients?
- Will you take the patient’s word for it if they say they have met their deductible? If not, what action will you take?
- Do any of your payer contracts stipulate that you cannot collect the deductible before the claim is adjudicated?
- How will you handle patients with previous balances?
- What insurance will you file? Primary? Secondary? Tertiary?
- Will you give completed claim forms to patients to file themselves?
- How will you check insurance eligibility before patients arrive?
- How will you deal with patients injured on the job or in an motor vehicle or other accident?
- What will you do if a patient arrives without their insurance card?
- With what payers does your practice have contracts?
- How will you handle patients who are electing to be seen out of network with reduced benefits, or out of network with no benefits?
- Can your practice management system calculate allowable charges so you can collect non-allowed/non-covered charges and/or co-insurance at the check-out desk?
- How will you disclose any fees that patients might incur (returned check fee, form completion fee, payment plan default fee, no-show fee, collection agency fee, interest or finance charges)?

- Do you plan to offer a cash discount to self-pay patients who pay in full at time of service?
- Do you plan to offer a financial assistance program to write-off a portion or all of the balance due to financial hardship?
- Is there an ATM near your practice that you can direct patients to if they are not prepared to pay any portion of their portion at time of service?
- What will you do if a patient checks-in without the desire or means to pay a co-pay?
- Will your practice defer seeing patients if they do not pay (excluding urgent needs)?

Because this document is so important to the healthy financial functioning of your practice, it needs to be simple and clear. I dislike financial policies that are long and wordy. I prefer a simple format that everyone can understand and use.

Your financial policy can look any way you want it to. Remember, however, that people do not absorb information well that is organized in blocks of text. They do better with checklists, tables, diagrams, and bullet points. If you'd like a copy of the format I use and recommend, email me at marypat@managemypractice.com and I will email it to you.

Educating Patients

When you put a new policy in place, you need to take every possible opportunity to educate patients about it. Some patients will resist a change in policy, regardless of the fact that collection for the patient's portion is quickly becoming the standard in medical practices.

Some suggestions to help get the word out:

- Put the policy on your website.
- Email a copy to all patients.
- Send a hard copy of the policy to all new patients.

- Mention the policy when they call to make an appointment – “We now collect co-pays when you check-in. so be sure to bring your insurance card and your co-pay.”
- Mention the policy when you call patients to remind them of their appointment. – “We are looking forward to seeing you on Tuesday, September XX at 9:00. Don’t forget to bring all your medications, your insurance card and your co-pay.”
- If you want to phase in the new policy, start prepping patients by discussing the new policy at check-in and/or check-out and let patients know it will be in effect at their next visit.
- Circle the patient’s plan on the front, have the patient sign the financial policy on the back, and give them a copy to take with them. Scan the signed side into your EMR.
- Patients will ask why you have made this change. There are a number of answers to this question, so I suggest you have a handout prepared. This is not meant to be a substitute for a discussion with patients, but something for them to read and reflect upon. It should be worded in a straightforward, non-apologetic, non-defensive way.

Remember that some patients will sign anything they are given at the physician’s office, so you will need to train your staff to take the time to explain the policy to each new patient. Patients that need more discussion on the policy can speak with the financial counselor or manager before seeing the physician. Do not forget that some patients are poor readers and will not be able to read the financial policy In English – depending on the number of English Language Learner (ELL) patients in your practice, you should consider printing the policy in more than one (1) language. If the patient needs help to complete the basic patient paperwork, it may be a sign that the patient will need special help from a staff member to complete forms and discuss the financial policy.

Educating Staff

Don't forget to educate your staff. If they have not had to discuss money with patients before, they will need some coaching and some practice. I suggest a meeting where the staff have an opportunity to guess what patient's reactions will be and role play how the staff will respond. Remember to give the staff solid answers so when the patient asks "Why?" they can say something besides "Because that's our policy now."

Can you ever divert from the financial policy?

Yes, you can make special arrangements for some patients based on their situation, but I encourage you to divert from the policy sparingly. After all, what good is a policy if you don't enforce it? Your patients will hear about it if you change the rules for one person. The word will get around your community, no matter how large it is. Do yourself a favor, and make a financial policy that works for 99.99% of your patients. Be consistent in applying the policy, always follow a fairness test on applying the policy. Be prepared to defend why you diverted from your established policy. The only reason you should ever waive a co-pay or co-insurance is for financial need.

What if the financial policy needs changed once we start using it?

No one in your practice will like the new policy. On the first day you implement it you should expect patient reactions range from challenging the policy to anger to outrage. Your brain will tell you it is the right thing, but you will certainly question your decision during the first week of the new

policy.

No matter how well you have tried to educate patients, physicians, and staff about the new process, there will be complaints. Change is very uncomfortable and everyone will let you know about it. Be patient, live through the difficult early days and you will find yourself and everyone else adjusting to the new program. If, after living with the new policy for at least thirty (30) days, you do find something that warrants a change, you can change it. Change your policy and let patients know that you have changed something when/if it affects them. You have the right to change things in the practice to keep the business viable.

How do you implement a new policy?

- Start the new policy on the least-busy day of the week, so everyone feels less stressed.
- You or your financial counselor, or someone with managerial authority should hang out at the front desk on the first day or two of the new policy. If any situations come up with patients, you can step in and model the behavior and speech you want to see your staff emulate.
- Take some benchmarks before you implement the policy so you can measure your progress afterwards. Involve the staff in moving the front desk collections toward 100% of co-pay collection, 100% of old balances (paid in full or committed to a reasonable payment plan), 100% of co-insurance and depending on your specialty, 90 to 100% of deductibles.
- Some practices reward the front desk for hitting benchmarks, but I disagree with singling out one department for a reward when it takes every member of your staff to contribute to a successful practice. If you’re going to set a reward system, involve the entire staff and develop goals appropriate for the practice as

a whole, teams of employees, or individuals, being sure to include everyone!

Collections Basics – Part 1: Know Your Payers

In a traditional healthcare setting, the revenue cycle begins with the insurance companies who pay the majority of the bill. There are multitudes of payers and each payer can have many plans. How can a healthcare organization catalog this information, keep this information updated and make this information easily accessible to staff so they can discuss payments with patients in an informed and confident way?

Start by breaking your payers into five main categories as a logical way to organize the data.

1. Payers with whom you have a contract
2. Payers with whom you do not have a contract
3. State and Federal government payers (Medicare, Medicaid, TriCare)
4. Medicare Advantage payers
5. Patients

Payers with whom you have a contract

Your organization has signed a contract with a payer and you have agreed to accept a discounted fee called an allowable, and to abide by their rules. What is the information you need to collect?

- A copy of the contract
- A detailed fee schedule, or a basis for the fees, such

as “150% of the 2008 Medicare fee schedule.”

- Any information about the fees being increased periodically based on economic indicators, or rules (notification, timeline, appeals) on how the payer can change the fee schedule.
- The process and a contact name for appealing incorrect payments.
- Information on what can be collected at time of service. Hopefully your contract does not have any language that prohibits collections at time of service, but you must know what the contract states.
- Process for checking on patients’ eligibility and benefits: representative by phone, interactive voice response (IVR), website or third-party access.

The contract allowables should be loaded into your practice management system so you can calculate the patient’s responsibility at check-out and you can identify incorrect payments at the time of check-posting. If your practice management system does not have this feature, you will need a cheat sheet for each contracted payer, showing the most common services, the allowables, and the percentages of the allowables for fast calculation of the patient’s portion at check-out. The same or a modified cheat sheet will work for the check posters so they can verify the payer is reimbursing according to the contract.

Your cheat sheet should look like this:

Plan A							
Service	Allowable	20%	40%	50%	60%	80%	90%
99213	75.00	15.00	30.00	37.50	45.00	60.00	67.50

The check-out staff will write the patient’s portion on the encounter form (you may call it a charge ticket, fee ticket, rounding slip, or superbill), add the numbers together and give the patient the total. Alternately, the computer system will total the patient’s portion based on the payer and the

plan for the check-out person.

The balance of the information collected will be used to develop a payer matrix that might look something like this:

Payer	Employers	Collectible At TOS	Elig/Benefit Verification	Plan Year	Contract Dates	How to Notify
XYZ	WalMart	Deductible & Co-Pay	website	July-June –	Exp Dec 2013, must neg. <Aug1, 2012	Call June Jones at 1-800-555-1212
	State Employees	Deductible & Co-Ins.	Website	Jan –Dec	same	same

Another excellent way your organization can catalog payer and plan information is electronically in a document management system such as **FileConnect,** which I use and recommend.

FileConnect is an electronic filing cabinet with many great attributes, one of which is particularly helpful in this scenario. Every time there is a change in a payer contract, or a new plan is added by a local employer, you can update the staff's spreadsheet tools simultaneously and the newest version will be instantly available on their desktops.

Payers with whom you do not have a contract

Your primary payers in your community or region will most likely offer you a contract. Payers with less covered lives will not find it worthwhile to contract with healthcare providers, so you must decide how you will work with these companies and with these patients.

You are not required to file claims with payers that you are not contracted with. Most healthcare providers do file claims with non-contracted payers to ensure patient satisfaction. Where providers may differ, however, is whether or not they will ask patients with non-contracted payers to pay in full at

time of service, and assign the payment to the patient OR ask the patient to pay only the expected patient portion at time of service and assign the payment to the provider. This decision will be made as part of your Financial Policy (covered in Part 2.)

State and Federal government payers (Medicare, Medicaid, TriCare)

There has been a tremendous discussion in healthcare for the last several years about physicians limiting how many Medicare patients they will see, or even discontinuing to see Medicare patients completely. The rate at which Medicare pays is not enough to support the provision of services in most ambulatory practices, so some physicians do not participate in the Medicare program but still see Medicare patients (the fee they can charge Medicare patients is federally controlled and is called the "limiting" charge) or have opted out of the Medicare program altogether and will see Medicare patients on a cash basis only.

If a practice does accept Medicare patients, whether participating or not, there are set amounts to be collected from patients with Medicare – deductibles and co-insurance, as well as services that are never covered by Medicare.

Make sure that current Medicare allowables for your locality are loaded into your computer to do the math for you. You can use the same type of spreadsheet shown above to develop a cheat sheet of 80% of the Medicare allowable.

Service	Medicare Allowable	20% Owed by Patient
99213	66.74	13.34

What is confusing to most providers is what an insurance that is secondary to Medicare will pay. Many providers do not collect any fees at time of service for Medicare patients with

a secondary payer, as there may or may not be any balance left that is the patient's responsibility.

Medicaid pays less than Medicare does, and based on the very low fee schedule, many ambulatory providers will not accept Medicaid patients. Many Medicaid patients must depend on health departments, hospital clinics, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) for care.

Tricare may be accepted on a case-by-case basis. A healthcare provider does not need to accept the health insurance for retired military across the board, and may decide individually whether to accept a Tricare patient or not.

Medicare Advantage

Medicare Advantage Plans, formerly called Medicare Choice + and now called Medicare replacement plans or Medicare Part C, are plans offered by non-government payers which replicate Medicare benefits for seniors, sometimes offering enhanced benefits as part of the package. There are several types of Medicare Advantage Plans, but the main types are local or regional HMO plans which require you to sign a contract, and the Private Fee For Service Plans (PFFS), for which no contract is required. If you see a Medicare Advantage PFFS patient, you have in essence agreed to accept their terms. The one thing you should ask prior to accepting a Medicare Advantage PFFS plan/patient, is what percentage and what year of Medicare rates are they paying.

Patients

So we finally arrive at the payer with whom most healthcare entities have the most difficulties – the patient. Why is it so difficult to collect from patients?

First, as we have seen throughout this article, insurance can

be very confusing. Without a plan for organizing and sharing information, a healthcare provider may have significant difficulty assessing the patient’s payment responsibility.

Second, it has been a cultural norm until recently that patients do not have to pay at time of service, with the exception of their co-pay, and will be billed for their portion after insurance pays.

We know now that we must collect the correct payment at time of service. This is the only way to reduce the administrative expense of billing the patient for the balance and/or refunding the patient if too much has been collected. This is also the only way to maintain adequate cash flow as much of what used to be paid to the providers from insurance companies has now become the responsibility of the patient. Higher co-pays, higher co-insurance and most of all, extremely high deductible plans have left patients owing much more out-of-pocket and largely being unprepared to pay it at time of service.

In the next part of this series, Collections Basics Part 2: Develop Your Financial Policy, we will discuss setting up your financial policy so both patients and your staff can understand it, and how to collect from patients according to your policy.