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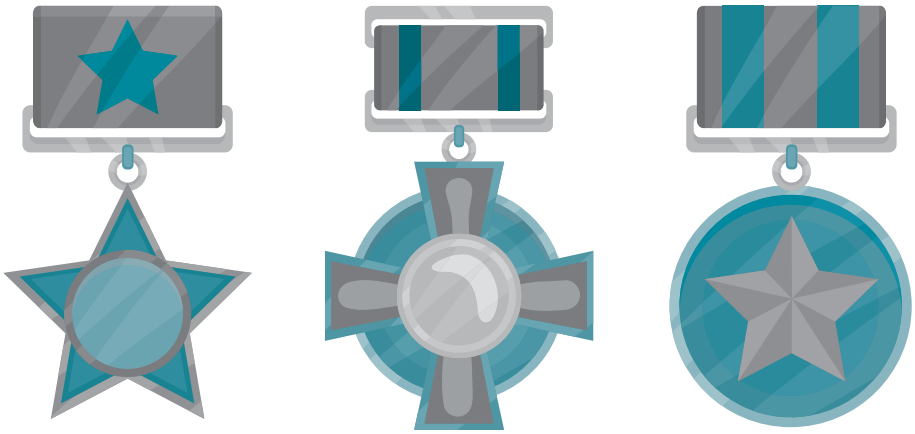
Reporting for Duty

FCRA amendments related to veterans' medical debts are effective in May.

By Laura Dadd



In May 2018, Congress passed the Economic Growth, Regulatory Relief, and Consumer Protection Act, which includes amendments to the Fair Credit Reporting Act providing special provisions for the reporting of medical debts owed by veterans. FCRA amendments related to veterans' medical debts are effective May 24, 2019.

The amendments aim to correct the issues surrounding the reporting of veterans' medical debt. The amendments include a definition of veterans' medical debt, exclusions for veterans' medical debt, a dispute process for veterans' medical debt, the creation of a database to determine whether a debt is a veteran's medical debt and provisions for credit monitoring for active duty military consumers. Data furnishers who furnish medical information will want to review their accounts and take the proper steps to ensure their treatment of veterans' medical debt follows these amendments.

For data furnishers of medical information, the act defines a "veteran's medical debt" as "a medical collection debt of a veteran owed to a non-Department of Veterans Affairs health care provider that was submitted to the Department for payment for health care authorized by the Department of Veterans Affairs; and … includes medical collection debt that the Department of Veterans Affairs has wrongfully charged a veteran."

Under the National Consumer Assistance Plan, medical debt cannot be reported until it is at least 180 days past due. However, the FCRA amendment mandates that a veteran's medical debt cannot be reported until the debt is a year past due. The act requires medical debts less than one year old to be removed from the veteran's credit report. Also, any veteran's medical debt that was delinquent, charged off or in collections must be removed once the debt is fully paid or settled.

The amendments provide a method of dispute for veteran's medical debt. If veterans dispute this type of medical debt and they provide proof of liability of the Department of Veteran Affairs for payment of the debt, the CRA must delete all information relating to the veteran's medical debt and notify the furnisher of the deletion.

The secretary of Veterans Affairs must create a database to allow CRAs to verify whether a debt furnished to a consumer reporting agency is a veteran's medical debt. The database must be established one year after the date of enactment. The database must provide sufficiently detailed information to verify whether a furnished debt is a veteran's medical debt. This will allow the CRAs to verify a debt's status as a veteran's medical debt.

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HHS Payment Model Designed to Meet Beneficiaries' Emergency Needs

Supporting ambulance triage options aims to allow beneficiaries to receive care at the right time and place.

Earlier this year, the U.S. Department of Health and Human Services (HHS), Center for Medicare and Medicaid Innovation (Innovation Center), which tests innovative payment and service delivery models to lower costs and improve the quality of care, announced a new payment model for emergency ambulance services that aims to allow Medicare Fee-For-Service (FFS) beneficiaries to receive the most appropriate level of care at the right time and place with the potential for lower out-of-pocket costs, a press statement released by HHS said.

The new model known as the Emergency Triage, Treat and Transport (ET3), will make it possible for participating ambulance suppliers and providers to partner with qualified health care practitioners to deliver treatment in place (either on-the-scene or through telehealth) and with alternative destination sites (such as primary care doctors' offices or urgent-care clinics) to provide care for Medicare beneficiaries following a medical emergency for which they have accessed 911 services. In doing so, the model seeks to engage health care providers across the care continuum to more appropriately and effectively meet beneficiaries' needs. Additionally, the model will encourage development of medical triage lines for low-acuity 911 calls in regions where participating ambulance suppliers and providers operate. The ET3 model will have a five-year performance period, with an anticipated start date in early 2020.

The ET3 model encourages high-quality provision of care by enabling participating ambulance suppliers and providers to earn up to a 5 percent payment adjustment in later years of the model based on their achievement of key quality measures. The quality measurement strategy will aim to avoid adding more burden to participants, including minimizing any new reporting requirements. Qualified health care practitioners or alternative destination sites that partner with participating ambulance suppliers and providers would receive payment as usual under Medicare for any services rendered.

The model will use a phased approach through multiple application rounds to maximize participation in regions across the country. To ensure access to model interventions across all individuals in a region, CMS will encourage ET3 model participants to partner with other payers, including state Medicaid agencies.

CMS anticipates releasing a Request for Applications this summer to solicit Medicare-enrolled ambulance suppliers and providers. In Fall 2019, to implement the triage lines for low-acuity 911 calls, CMS anticipates issuing a Notice of Funding.

There is an opportunity for a limited number of two-year cooperative agreements, available to local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches in geographic locations where ambulance suppliers and providers have been selected to participate.

For more information, please visit: https://innovation.cms.gov/initiatives/et3/ and https://bit.ly/2Ii9ZQD

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Finally, the act requires consumer reporting agencies to provide credit monitoring to active-duty military consumers, which includes members of the National Guard.

The credit reporting agency will be required to provide free electronic credit monitoring service that at minimum notifies a consumer of material addition or modification to their credit report. In order to receive this service, the consumer must provide the CRA proof that she is on active military duty and provide her contact information.

Data furnishers who furnish medical debt will want to review their policies and procedures to make sure they follow the new amendments. It may be prudent to review any medical accounts to determine if they fall under the definition of a "veteran's medical debt." If some accounts do meet the definition, data furnishers may want to flag these accounts and determine how to handle them.

Laura Dadd is ACA International's compliance analyst.

CHARITY CARE

Oregon Measure Addresses Indigent Care

A measure in the Oregon Legislature aims to ensure that hospitals are providing financial help to people who can't afford their medical bills, an article published by Public News Service stated.

House Bill 3076 seeks to change the way nonprofit hospitals handle charity care, which has dropped off by 50 percent since 2010, according to an analysis of Oregon Health Authority data.

HB 3076 would require nonprofit hospitals to cover services in full for families with household incomes below 200 percent of the federal poverty line and provide discounts on a sliding scale for families with incomes up to 600 percent of the federal poverty line. At press time, the bill was on schedule to receive a hearing in early April. There are 58 nonprofit hospitals in Oregon, the article written by Eric Tegethoff, indicated. More information: https://bit.ly/2TYH89t

> Charity Care in Oregon has declined **50%** since 2010

INSURANCE

Million-Dollar Lawsuit Results from Insurer Sending Payment to Patients – not Doctors

In a report released by CNN, a woman received nearly $375,000 from her insurance company over several months for treatment she received at a California rehabilitation facility. A man received more than $130,000 after he sent his fiancée's daughter for substance abuse treatment.

Those allegations are part of a lawsuit winding its way through federal court that accuses Anthem and its Blue Cross entities of paying patients directly in an effort to put pressure on health care providers to join their network and to accept lower payments, the article revealed.

The insurance giant is accused of sending more than $1.3 million in payments to patients -- money, the suit claims, that is owed to the facilities that treated people with addiction and mental health problems.

The suit by Sovereign Health highlights part of an ongoing war between insurance companies and providers over payment and billing issues, one that puts the patient right in the middle of the fighting by sending payments straight to patients after they seek out-of-network care. Patients are supposed to send the money on to providers. Many times, they do; other times, they don't, according to CNN.

More information: https://cnn.it/2NA0P0U

NEWS & NOTES

Nearly 1 in 5 Hospitals Mark Up Medicine by at Least 700 Percent

The Washington, D.C.-based Pharmaceutical Research and Manufacturers of America, reports hospitals markup medicine prices nearly 500 percent, and one in every five hospitals marks up the price of medicine by at least 700 percent. For a medicine with a list price of $150, this markup could cost patients up to $1,050. Even after negotiations with commercial payers, hospitals still receive nearly 2.5 times what they paid to acquire the medicine. For example, many cancer treatments are provided in a hospital facility where the hospital purchases the medicine directly and is then reimbursed by the patient's insurer—often at a steep markup. More information: https://onphr.ma/2Fu0WYn

"Planning for the Unplanned: The Soft Touch to Health Care Collections"

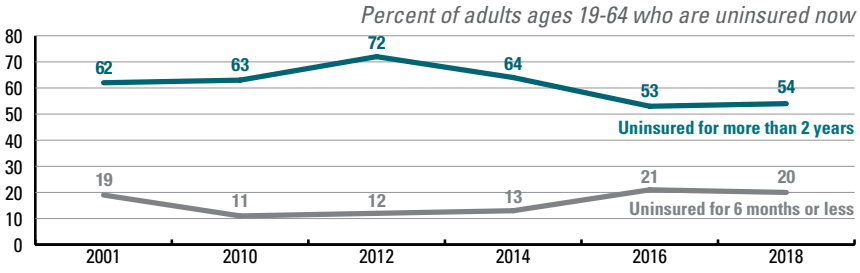
Confusion and a lack of understanding associated with health insurance coverage can leave the most financially responsible patient with a surprise bill in the mailbox. That's why accounts receivable management employees who work in this space need special training and the appropriate level of empathy to work with consumers who may be sick, recovering from surgery or unaccustomed to unpaid bills. To hear fascinating information on this topic as well as other health care collection trends including 501 (r), check out ACA International's recent ACA Cast episode titled, "Planning for the Unplanned: The Soft Touch to Health Care Collections." https://www.acainternational.org/acacast

For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse.

datawatch

Long-Term Uninsured Rates Trending Down Since Affordable Care Act

Since the passage of the Affordable Care Act (ACA), long-term uninsured rates for Americans have steadily declined, yet more consumers are underinsured, according to the Commonwealth Fund. Although the ACA has expanded and improved coverage options for people without access to a job-based health plan, the law largely left the employer market alone.



Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured (Commonwealth Fund, Feb. 2019). https://doi.org/10.26099/penv-q932

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