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Medical practice checklist for 2014 ACA exchange implementation

☑ Double-check whether your practice's physicians are participating with ACA exchange products.

- Check the qualified health plans participating in your state.
- Even if your group participates with a particular insurance plan, it does not mean the physicians are contracted with every product the plan offers. Double-check participation with new ACA exchange products offered by your current plans.
- Understand network issues. Continuity of care will be important for patients who are changing plans. Patients should be reminded to confirm that specialists to whom they are referred are in-network, or understand that out-of-network services may be considerably more expensive.

☑ Determine your practice's ability to accept new patients.

- Know whether **your state** is expanding Medicaid. Even if your state is not expanding Medicaid, the number of eligible beneficiaries who enroll may increase and you may have more Medicaid patients who want to make appointments.
- Carefully consider your payer mix and evaluate the opportunity to accept new patients.

☑ Train office staff who speak with callers and patients.

- Staff should have ready access to consumer resources to which they can refer patients who have insurance and enrollment questions. These might include the state exchange call center phone number and website, and personal assistance sites available through the federal exchange at **www.healthcare.gov**. You may want to provide copies of a glossary of key health insurance terms, or information on where patients can find such a glossary, (e.g., from their health plan or **online**). Know key effective dates and certain insurance details. For example, coverage from ACA exchange plans begins as early as Jan. 1 and the 2014 enrollment period ends March 31. However, patients may have later effective dates of coverage depending on when they enrolled in coverage—if they sign up on or before the 15th of the month, e.g., by Jan. 15, coverage begins on the first day of the following month, e.g., Feb. 1. If they sign up after the 15th, for example on Jan. 16, coverage does not begin until the first day of the subsequent month, e.g., March 1.

☑ As with other insurance, check patient eligibility, coinsurance, deductibles and copays for each visit.

- Take advantage of new operating rules for the HIPAA electronic standards for the insurance eligibility verification request and response (270/271). This information will be very important for a patient population that may move in and out of coverage or between private insurance and Medicaid. Eligibility should be verified before the patient arrives for an appointment and staff should be cognizant of whether the 90-day grace period—for patients with exchange plans who receive premium subsidies and fail to make a monthly premium payment—might apply.

- Practice staff should be prepared to explain to patients cost-sharing information received through eligibility verification information from payers. Benefits and cost-sharing will vary significantly, especially based on the category of plan (bronze, silver, gold and platinum), and whether the services are in- or out-of-network. This also applies to drug formularies in the exchange plans, many of which have significant patient cost-sharing and use utilization management tools.

☑ Be prepared to discuss out-of-pocket expenses and the cost of care with each patient.

- Discuss your financial policies with patients and make sure that patients understand their responsibilities to pay the patient portion due at the time of service. Many ACA exchange products have high deductibles, which makes it essential to explain cost-sharing to patients who may not realize these financial obligations. You may want to talk to patients who are in the grace period about the consequences of failing to pay their premiums on time, e.g., termination of their health insurance coverage.

- Try to collect all copayments and deductibles *when the patient checks in*. Train staff on the possible payment options for patients (payment plans, time-of-service discounts, lower-cost care options such as community clinics, etc.)

- Work with patients who owe past due amounts to set up payment plans and explain what their insurance covers and what it does not.

☑ Know the essential health benefits in your state.

- All health insurance products in a state must meet standards related to a package of benefits, known as essential health benefits. Educate office staff to answer questions on the most common essential health benefit services patients might ask about: see **healthcare.gov**. For example, patients may ask about preventive care, which must be covered with no cost-sharing in many cases, or benefits that are not required to be covered, such as infertility treatments or chiropractic care, unless they are required under state law and have been incorporated into the state's essential health benefits benchmark plan.