SEE YOUR REV CYCLE DIFFERENTLY

PATIENT COLLECTIONS

Business critical for today's healthcare organizations

by Elizabeth W. Woodcock, MBA, FACMPE, CPC

WAYSTAR

Patient Financial Experience

Physicians and administrators face an uncertain economic future in which emerging payment models offer a seemingly endless array of reimbursement schemes. Whether it's accountable care, bundled payments or capitation, one trend remains: the portion of the payment coming from the patient is at its highest since the institution of healthcare insurance in the United States.

According to the Centers for Disease Control and Prevention, nearly 40% of Americans with employer-based health insurance were enrolled in a high-deductible health plan as of 2016.[1] Given its potential to rein in costs for payers and employers, this shift towards greater patient financial responsibility has taken firm hold and is likely to remain in place for the foreseeable future.

Historically, healthcare organizations relied on reimbursement from third-party payers for the vast majority of their revenue stream. Because of the uncertainty of success, collecting what were relatively small amounts from patients was a secondary concern for healthcare organizations. Common approaches, such as mailing statements and making collection calls—typically, months after the patient's visit—proved expensive and largely ineffective. For some, chasing down payment from their patients wasn't even worth the time, and receivables were just written off as bad debt.

Neglecting to make patient collections a business critical function of the healthcare organization can spell disaster for the organization's financial future.

1 Cohen, Robin, Ph.D., and Zammitti, Emily, M.P.H., "High-deductible Health Plans and Financial Barriers to Medical Care," National Center for Health Statistics, CDC, 2016, https://www.cdc.gov/nchs/data/nhis/earlyrelease/ERHDHP_Access_0617.pdf

Compounding the lackluster results of these inadequate collections approaches has been an insufficient knowledge base for responding to patients' questions about the cost of their care. A common response—and one still heard in many physician practices, ambulatory surgery centers (ASCs), community health centers (CHCs) and other healthcare organizations—is: "Don't worry about paying, your insurance will take care of it." Patients perceive responses of this sort as inadequate or, worse, disrespectful. Neglecting to make patient collections a business-critical function of the organization can spell disaster for the organization's financial future. The results of this oversight, moreover, can include poor service to patients, high costs to the nation's healthcare system and little return to the physician practice, ASC, CHC or other healthcare organization for its investments in physicians, employees, facilities and technology.

Clearly, the market has changed; healthcare organizations must align the work flow associated with revenue cycle management accordingly. To meet the challenges of today's reimbursement landscape, organizations must re-examine their approach to managing the patient collections process.

This white paper provides healthcare leaders proven tools to erect the effective yet patient-friendly collections infrastructure their organizations need to survive and thrive in a rapidly changing reimbursement environment.

What's inside:

1 Financial **clearance**

2 Time of **service**

3 Post-visit **collections**

Patient Financial Experience

1 Financial clearance

Traditionally, the revenue cycle began when services were provided. Today, this sequence must be initiated far sooner— before the patient walks in the door, in fact. Successful physician practices, for example, initiate their revenue cycle by deploying a financial clearance process well before patients arrive for their appointments.

In this expanded view of the collections process, the revenue cycle commences with financial clearance, which consists of several tasks. The sequence begins when patients request services from the healthcare organization, whether by a telephoned appointment request, a referral from another provider, or the scheduling of a follow up visit.

In the first phase of financial clearance, employees request patient registration information sufficient to confirm insurance coverage. Ideally, with today's automation, this task can be performed in real time. Some organizations may stop at this basic "red light/green light " step, but many benefit from a second phase in the financial clearance process: checking that the patient is eligible for the benefits that is, the services rendered at the visit. This may include assessing whether the patient 's health plan provides benefits for categories of care—prevention, for example—or for a specific service, such as an amniocentesis.

The final step of the financial clearance process incorporates a verification of patient financial responsibility. Here, an employee—or better still, an automated process—queries the practice management system or a bolt-on contract management solution about the patient's balance and calculates the amount of payment likely to be due from the patient. These calculations include the patient's co-payment, unmet deductible and co-insurance. With the expansion of high deductible health plans and the continued excess of uninsured patients, this knowledge proves valuable in defining the amounts that employees can be expected to collect at the time of service. Accuracy here helps to avoid significant underpayments or, equally troublesome in their own way, overpayments that result in credit balances.

With adequate technology in place for those who handle the scheduling of appointments, healthcare organizations can improve patient collections by putting the financial clearance information to work. 'Working' this information includes advising patients of outstanding balances and, if applicable, requesting expected time-of-service payments during the appointment scheduling conversation.

Today, every employee is a member of the business office.

The introduction of the financial clearance process into a healthcare organization represents not only a change in workflow, but also a significant cultural shift. Historically, the business office managed all aspects of the revenue cycle, with only limited involvement by the remainder of employees, if at all. Although more organizations are urging receptionists to collect co-payments, these employees typically approach this role with trepidation. Making matters worse—and contributing to poor collections results in most instances—are the conflicting objectives of the business (or 'back') office and the front office. Front office staff, including receptionists, specifically at physician practices, tend to be judged by the volume of patients they process while back office employees are assessed by the dollars brought in. Volume versus value leads to inherent conflicts, ones which are observed on a daily basis as organizations struggle to improve accuracy and timeliness while prioritizing patient flow. The walls of these historical silos simply must be dismantled. Today, every employee in the organization is a member of the business office.

Successful physician practices, ASCs, CHCs and other healthcare organizations discover that aligning the missions of these two spheres within the organization produces superior results in both efficiency and overall patient collections performance. Conducting financial clearance in concert with the scheduling of appointments offers greater efficiency because the important process of assuring the patient has the means to pay becomes a single transaction conducted by one person, not several. Of course, an organization would be wise to repeat this process as the date of service draws near, especially when appointments are booked weeks or months in advance. Changes in coverage and eligibility occur frequently. To ensure a successful outcome, financial clearance should be performed (or repeated) on the day of the visit or, at most, one work day prior.

Another clearance task that should no longer be relegated solely to the business office is identifying patients who have high or problematic balances. This task should be done—and may be automated to occur—on the afternoon or evening prior to the day of the appointment. These patients' names should be flagged in the practice management system so that employees in both the front and back offices are cued in advance that they may need to make concerted efforts to collect from these individuals. An effective method to assist employees in requesting payment from these patients is to print out the outstanding balance in a format that can be presented to the patient as he or she checks in for the appointment. Alternatively, pull the patient's explanation of benefits to indicate what actions and payments have been made by the patient's insurer, including the balance that the insurer has applied to the patient's deductible.

Although all attempts should be made to respond to patients' questions about their balances, it is wise to steer patients with queries about their deductibles, co-payments, and other coverage issues to their health plan. Doing so helps patients to recognize that the primary role of the healthcare organization is to act as their advocate for their health; understanding and abiding by the health plan agreement is the patient's responsibility.

2 Time of service

The best opportunity to collect is when the patient presents for service. Armed with accurate data about the payment due, the front office becomes pivotal to the success of the revenue cycle. Unless it was performed automatically, the financial clearance process should be initiated at the time of service to confirm current coverage, benefits and financial responsibility. Armed with accurate information, the front office employee—a person more accurately deemed the 'director of time-of-service collections'—is in good position to successfully seek payment from the patient.

Insurance denials are another pressing problem faced by many healthcare organizations. An accurate and well-functioning financial clearance process helps avoid an array of denials, such as non-covered services, ineligible subscriber and so on. To avoid generating denials in the financial clearance process, organizations must thoroughly train and assess employees in the steps of registration. Ideally, a healthcare organization will have sufficient automation to conduct these functions in real time, helping them to avoid workflow delays or placing more burden on patients after their visit to complete the payment process.

High performing healthcare organizations train employees that balances—whether they became the patient's responsibility just an hour ago or 90 days previous—must always be requested. Failing to do so degrades any post-visit collections processes. Inevitably, patients billed for co-payments or outstanding balances will wonder, "Why didn't they ask me for that when I was in the office?" And, worse, the patient may conclude: "I guess they don't need the money right away."

Time of service collection options

Option 1	Option 2	Option 3
Co-payments	**Co-payments**	**Co-payments**
Balances	**Balances**	**Balances**
	Deposits	**Deposits**
		Co-insurance
		Unmet deductibles

Based on the organization's protocols for time-of-service collections, the receptionist who has the necessary information about the patient 's account can request:

- **Co-payments and balance only (the minimum that should be collected).** Insured patients are asked for co-payments and all other historical balances.

- **Co-payments, balances and deposits.** In addition to co-payments and balances, the organization requests deposits from patients who do not have insurance and, possibly, those with high deductible plans.

- **Co-payments, co-insurance, unmet deductibles, balances and deposits.** Typically, these collections are handled by an employee at the check-out desk where the greater complexity and additional time will not disrupt the flow of patients arriving for their appointments. Furthermore, co-insurance and unmet deductibles can be accurately calculated at check-out based on the procedure codes used during the recently concluded visit, as well as the respective allowed amounts dictated by the patient's health plan.

Given the higher dollar amounts that insured patients owe at the time of service, internal cash controls are essential. Because most receptionists were not hired to be collectors, training in proper and effective collections is essential. The basics—for example, how to ask for money (see "Collectors' Checklist")—cannot be overlooked.

- **How will payments be recorded?**
- **How will payments be stored?**
- **Who is responsible for "cash management"?**
- **How will receipts be generated?**
- **Where will payments be submitted?**

Collectors' checklist

Remember that advising patients of their balances does not indicate that you do not care; rather, giving them this information shows your respect for them as capable participants in their course of treatment.

- ☐ Warmly greet each patient; customer service is an essential component of successful collections.
- ☐ Avoid asking "Would you like to pay?" Instead, state: "How would you like to take care your balance today?"
- ☐ State the balance as fact. Avoid implying that it is just an estimate or a negotiable amount.
- ☐ Use the patient's name—it helps to show respect.
- ☐ Use a gentle but firm tone when asking for payment.
- ☐ Before stating the balance, look around to see if the conversation might be overheard; if so, write the amount on a slip of paper and hand it to the patient.
- ☐ Look the patient in the eye when you are asking for payment. Write out the receipt as you are making the request, indicating to the patient that you are confident that he or she will pay.
- ☐ Avoid inappropriate facial expressions such as laughter or frowning when discussing balances or other financial matters with patients.
- ☐ Offer to take a credit card by phone or online, if applicable.
- ☐ Print a copy of the statement or offer to fax one, if the patient hedges or questions the balance.
- ☐ Use the term "small" or "minor" when referring to a balance that due—whether it's $17 or even if it is $1,700.
- ☐ Provide the patient with a printout of his or her coverage and eligibility verification information.
- ☐ Give the patient the contact information for his or her health plan if the patient has questions about coverage or benefits; indicate that the human resources office of the patient's employer may also be helpful to the patient.
- ☐ Collect all monies due at the time of service, not just the co-payment.
- ☐ Recognize how to identify any balances that have been written off as bad debt, and take action to collect the money, reverse the write-off and post the payment.
- ☐ Always provide a receipt.
- ☐ Thank the patient for paying.

While some organizations offer incentives to employees who are tasked with collecting at the time of service, consider that this role is an essential skill for the front office of the future.

While some healthcare organizations offer incentives to employees who are tasked with collecting at the time of service, consider that this role is an essential skill for the front office of the future. An organization would not offer bonuses to encourage its medical assistants to check patients' blood pressures; it is an expected responsibility for the position. So, too, is the collection of payments by receptionists. Of course, they will not be successful 100% of the time, but with training and support from technology and well-designed work processes, success rates should reach into the 90th percentile in most types of healthcare organizations. Of course, periodic incentives can provide motivation for a job that is both new and challenging.

After determining what can be collected, well-trained front office employees initiate the collections conversation in a polite but firm tone, stating simply, "Your payment today is $x. How would you like to take care of it?"

Successful healthcare organizations accept all forms of payment, and have made the modest investment in technology that can charge the amount to patients' credit cards at the time of service—or, at the very least, capture that data to securely hold "on file" for future transactions. A reputable vendor can provide systems that allow employees to submit a patient's credit card information at their workstation computers for instant and secure online data capture and storage. This process is more efficient than relying on stationary countertop credit card terminals—the traditional stand-alone 'card swipe' machines—which are often limited in number, expensive to lease and, too often, placed in locations where receptionists must leave their work areas to use. Capturing and securely storing a patient's credit card information allows flexibility for the organization to collect deposits and residual charges more rapidly or initiate effective payment plans that draw amounts from the patient's credit card account.

When the patient asks "how much?"

With the increase in financial responsibility, more patients are asking about the cost of their care. It's not unusual for patients to call several organizations requesting fees and other details. Of course, with dozens—perhaps hundreds—of payer fee schedules to contend with, not to mention the array of possible procedure codes, revealing an exact price is difficult if not impossible. But that won't satisfy all patients.

Solution? Determine a standard response to these inquiries. Consider saying, "Our charge for an office visit is typically $200 to $300, but the physician often recommends testing to provide the best care for you. That may increase the price. Because we participate with your insurance company, however, you will receive a significant discount on our charges." (The discount, of course, is the contractual adjustment, but "discount" sounds much better to the average patient).

Regardless of how you choose to respond to these inquiries, never underestimate the amount that may be due.

3 Post-visit collections

After the service is rendered, a claim is submitted on behalf of an insured patient. If services are rendered to a patient without insurance coverage, a statement is directly and immediately transmitted to the guarantor on file. For an insured patient, as soon as the claim is adjudicated, it is important to route the patient's responsibility into the statement process to the guarantor on file. Payers identify the shift in financial responsibility by marking the remittance with a PR—patient responsibility—code. Transferring (often referred to as "flipping") responsibility to the guarantor through automation avoids the delays and mistakes that can occur when information is entered manually.

If mailing a patient statement is required, discard strict alphabetical-based mailing cycles; mail statements to patients as soon as the correct balance is identified. Transmit at least two, but no more than four, billing statements. If the organization's leadership determines that more than two to four statements are necessary, then mail statements twice monthly. Make sure statements clearly indicate the amount due with the terms—for example, "pay now"—in large, bold typeface.

Payment plans can be incorporated at any point in the collections cycle. Start by developing the parameters of the plan: a minimum payment due (but no less than $25) and a maximum timeframe (for example, six months). With these guidelines, empower employees to establish plans when needed. Before presenting the plan, however, they must ask the patient: "How much more time do you need?" Allowing patients to define the plan not only engages them in the transaction, but also typically results in completion in less time than the employee would have suggested.

Always capture the initial payment up front—otherwise, it's really not a payment plan. Incorporate the residual amount in the patient's first payment. If, for example, the patient owes $251.34, the initial payment would be $51.34, with the remaining four payments of $50.00. Offer twice-monthly payment plans. These are more palatable to patients because the installment amounts are smaller—and, thus, result in successful completion of full payment.

For reporting purposes, designate a separate financial category within the practice management system for payment plans so that the business office can monitor them separately from other receivables in its reports. Because the organi-zation has, in essence, allowed these accounts to age, distinguishing these receivables, and their associated aging, is vital business intelligence.

An experienced collector allows the patient to present a solution, instead of attempting to prescribe and dictate one.

Even a relatively non-aggressive collections approach should not last longer than 90 days. After three months have passed without either a payment or a satisfactory response from the patient, initiate additional supplementary collections efforts. These approaches can include assigning experienced collections staff to call patients and assigning the account to an outside agency.

Designate an employee—or a team of collectors—to focus on internal collections efforts. Remember that there's no one-size-fits-all strategy—different patients will react to different collections strategies. Transferring accounts into a specific financial category within the practice management system will allow you to better target and monitor the effectiveness of various approaches made to patients.

The strategies deployed by the internal collections team may include:

- **Making collections telephone calls.** Begin by capturing the correct telephone number: instruct receptionists who handle registration and check-in to always ask patients for their "best" telephone number, instead of defaulting to "home" and "work" telephone numbers. Avoid programming "business office" as the caller identification in your telecommunications system; instead, use the organization's name. Telephone collectors should always introduce themselves as a representative of the organization (versus a "biller" or "collector"). After greeting the patient and stating the payment due and other pertinent facts (such as the number of days past due), the collector should, in an empathic tone, ask: "Is there a problem, Ms. Smith?" An experienced collector allows the patient to present a solution, instead of attempting to prescribe and dictate one. Frequently, the patient will suggest payment terms above the minimum amount and over a shorter period of time than the organization might have offered.

- **Mailing collection letters.** As part of a plan for sending collection letters, determine the timing of each transmission. For example, an initial letter regarding the overdue balance could be followed 14 or 20 days later by a "final notice." In both letters, list a specific due date instead of the more generic,"... the balance is due in 10 days." These letters should list a specific telephone number for the patient to call in order to establish payment arrangements. Consider having that number ring into a special extension that is monitored continuously during business hours—these calls must be answered promptly or, at the very least, returned within the hour. Allowing calls from patients with balances to flow into voicemail during business hours will blunt your best attempts to collect. Alternatively, send collections letters from a designated name that is not shared by anyone in your organization—Cathy, for example. When a patient calls and asks for Cathy, the operator will easily discern that this person is responding to a collections letter.

- **Transmitting electronic notices.** If your organization has transitioned to secure online bill payment, this communication platform can also be used to collect payments. In contrast to letters, secure email communication costs nothing to send. Be sure that these notifications follow your best practices regarding the content of traditional collections letters and, of course, are handled by secure, state-of-the-art systems.

Frequently, the strategy used to collect will differ based on the amount of the balance. Although it may seem counterintui-tive, employees may have more luck collecting small balances, as patients are more apt to conclude the process quickly by sending in a check or providing a credit card number. Instead of ignoring small amounts in favor of focusing exclusively on high balances, consider piggybacking collections on the technology the organization uses for appointment confirmations. In other words, place automated calls for small balance collections or combine these messages with appointment confirmation calls.

For patients without insurance, the best opportunity for collections success often lies in locating insurance coverage. Before moving a self-pay account out of the organization for external collections, check with your state's Medicaid database (or that of surrounding states, if applicable) and confirm the patient's registration data with the local hospital or other facilities with which you exchange patient data. Patients with expired insurance should be at the top of the list to contact for current coverage.

To prevent the reoccurrence of eligibility problems, high-performing organizations provide a means for their front office to quickly access information about patients' insurance coverage—typically, by accessing a multipayer portal or payers' websites by sending inquiries in real time or in batches. When possible, seek reports on the volume and percentage of denials based on registration data—often available in your clearinghouse solution—and tie these data to employee performance expectations.

If internal efforts to collect from patients fail, outsourcing becomes the last best resort before writing off the amount due. When organizations fail to make additional efforts to collect, patients in arrears may conclude that they can outlast your collections process.

Outsourcing options fall into two categories—companies that focus on pre-collection efforts and agencies that focus on capturing bad debt. A pre-collection strategy might be to send letters requesting payment to patients with past due accounts on behalf of the organization. Be sure that these "soft" collection attempts clearly state due dates and where to send payment. You do not want to leave these patients wondering who they should pay. Be aware also that these collections activities likely fall under the federal Fair Debt Collection Practices Act (see below) and applicable state law. Either way, migrating the account to a third-party vendor may be enough to capture the attention of—and payment from—most patients.

In addition to vendors that specialize in pre-collection efforts, there are others, typically referred to as collection agencies that may concentrate on bad debt only. Determine the best solution by evaluating the volume, age and type of patient receivables being carried by the organization, as compared to the availability of internal resources. After evaluating your need, assess options for outsourcing to a reputable, experienced debt collection firm that offers the services you seek for your organization.

Work with the agency to establish parameters for efforts such as credit bureau reporting, wage garnishments and even property liens. A capable partner can help you determine which efforts are most appropriate to make on your behalf. An additional function of an efficient debt collection vendor is to establish an open link that allows you to transmit accounts, receive payments and obtain performance reports as seamlessly as possible—ideally, electronically. Avoid manual and labor-intensive processes when possible.

Because the significant and ongoing shift of financial responsibility to patients shows no signs of fading, failure to elevate patient collections to a business critical function will spell disaster. As a result, healthcare leaders confront stark choices: alter business protocols or face the rapid erosion of the bottom line.

Fair debt collection practices act

Designed to prohibit abusive, deceptive and unfair practices by debt collectors, the Fair Debt Collection Practices Act (FDCPA) was enacted in 1977. While the FDCPA generally applies only to third party debt collectors, employees engaged in collections at a medical practice should be aware of the regulations, particularly in states like California that maintain consumer protection laws that mirror the federal rules. The FDCPA encourages collectors to avoid:

- Using telephone contact hours **outside of 8:00 a.m. to 9:00 p.m., local time.**
- **Misrepresenting oneself** or posing as an attorney or police officer.
- **Reporting or threatening to publish a false amount** on the patient's credit report.
- **Harassing a patient by calling or mailing with an intent to annoy or abuse the patient**; e.g., purposely repeatedly calling or sending a post card marked with the debt.
- Using **abusive or profane language** with a patient.
- **Threatening or using violence to harm** the patient, or his or her reputation or property.
- **Attempting to collect more** than what is justifiably due.

For more information, visit www.ftc.gov.

Conclusion

Because the significant and ongoing shift of financial responsibility to patients shows no signs of fading, failure to elevate patient collections to a business critical function will can cause healthcare organizations to lose a substantial portion of their revenue. As a result, healthcare leaders confront stark choices: alter business protocols or face the rapid erosion of the practice's bottom line.

EXPLORE OUR ALL-IN-ONE PLATFORM

Eligibility

Verify insurance coverage to reduce claims rejections and denials

Revenue Integrity

Find missing charges and capture revenue you're due

Claim Management

Automatically submit and track claims, and reduce AR days with intelligent-driven workflow

Denial Management

Prevent denials and automate appeals

Contract Management

Gain control over payer negotiations, manage your contracts and recover owed revenue

Patient Financial Experience

Collect patient payments, determine propensity to pay and improve the patient experience

Agency Management

Get insights into outsourced agency effectiveness

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