Improving Your Bottom Line through Bad Debt Management
Meet the presenters

Karen Matjucha, Principal, Deloitte Consulting LLP

- Northeast Lead for the Health Care Provider Practice, and one of the organization’s leaders in Revenue Cycle and Performance Excellence within the health care industry

- 20 years of consulting experience at Deloitte with experience in revenue cycle, ERP/CIS system implementation and enhancement, supply chain management, and operational performance improvement

Christopher Giuliano, Senior Manager, Deloitte Consulting LLP

- 20 years revenue cycle experience focused on improving operations, increasing revenue and accelerating cash collections for both acute and post acute providers. He has extensive experience managing end-to-end revenue cycle transformation engagements and is currently supporting Deloitte’s ICD-10 efforts in the Northeast.

- Served for two years as the Chairman of the New York Metropolitan HFMA Patient Accounting Education Committee and is a Fellow of the Healthcare Financial Management Association (FHFMA) with a specialty in Patient Financial Services.
Section I

Understanding the Problem
Uncompensated Care is Hurting Providers

1. Uncompensated care is when care is provided and no payment is received from Patient or Insurer

2. Uncompensated care includes bad debt and charity care since hospitals often have difficulty in distinguishing bad debt from charity care. Charity determination takes place prior to service

3. Uncompensated care is often expressed as a percentage of hospital charges, but charge data can be misleading. AHA calculates uncompensated care as a percentage of costs.

4. According to AHA- 2009 rate of National Uncompensated Care (Based on Cost) is 6% versus 5.8% in 2008

Providers should implement immediate strategies to address uncompensated care

Source: American Hospital Association Uncompensated Hospital Care Cost Fact Sheet - December 2010
"Patient Protection and Affordable Care Act's (PPACA) significant impact will likely be felt in 2014 with Medicaid expansion, individual mandates, employer penalties and start of state run healthcare exchanges."
Bad Debt – Attributes & Challenges

Health Reform endeavors to increase the number of Americans who have health insurance. While this is great, what is concerning is the increase in bad debt from patients with insurance. In fact, the bad debt attributable to insured patients is steadily increasing over the past 3 years.

Current Issues

• Increase in Self-Pay receivables

• Migration from co-payments (fixed amount) to co-insurances, where the patients owe a portion of the total bill

• With high rates of unemployment, declining rate of ability to honor payments

• Increasing costs for dispensing care

• Lack of vendor accountability on both Patient Access (PAS) and Patient Financial Services (PFS)

• Abbreviated use of available self pay scoring technology used to segment self pay population according to the patient’s likelihood to pay

• Non-standardized approach to identifying and collecting outstanding patient liabilities at the point of service
Bad Debt – The Problem is Here for a While …

Unemployment

- Each 1% increase in unemployment leads to a loss of employer sponsored coverage for an estimated 2.5 million employees and dependents nationally
- NJ has 9.5% unemployment rate lower than national average of 9.8% but still very high
- NJ unemployment rates dropped to 9.1% at the end of 2010 but are back up to 9.5% in July

Source: New Jersey Department of Labor and Workforce Development
Cost Shifting: Deductibles have Risen Sharply, Especially in Small Organizations

Mean deductible for single coverage (PPO, in-network)

## Medical Bill Problems and Accrued Medical Debt, 2005–2007

<table>
<thead>
<tr>
<th>Percent of adults ages 19 – 64 who…</th>
<th>2005</th>
<th>2007</th>
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<tbody>
<tr>
<td>In the past 12 months:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had problems paying or unable to pay medical bills</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>39 million</td>
<td>48 million</td>
</tr>
<tr>
<td>Contacted by collection agency for unpaid medical bills</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>22 million</td>
<td>28 million</td>
</tr>
<tr>
<td>Had to change way of life to pay bills</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>24 million</td>
<td>32 million</td>
</tr>
<tr>
<td>Any of the above bill problems</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>48 million</td>
<td>59 million</td>
</tr>
<tr>
<td>Medical bills being paid off over time</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>37 million</td>
<td>49 million</td>
</tr>
<tr>
<td>Any bill problems or medical debt</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>58 million</td>
<td>72 million</td>
</tr>
</tbody>
</table>

Section II

Tactical strategies to help manage self pay accounts receivable in order to reduce bad debt
### Revenue Cycle A/R Management Strategies to Consider

#### Pre-Service
- Collection Policies
- Patient Liability estimator
- Patient Credit Scoring
- Use historical paid database to create “ability-to-pay” scores based on zip codes, etc.
- Monitor outstanding patient balances
- Deferral Policy
- Healthcare Credit Card or other funding sources

#### Point-Of-Service (POS)
- Layout of facilities / where patients register has an impact on ability to collect
- Financial Counselors – hours of coverage – need 24/7
- Bedside Financial Counseling
- Provide clearly stated financial policies
- True Self-Pay Discount
- Offer payment options

#### Post-Service
- Prompt pay discount
- Collection agency
- AR Scoring
- Sale of AR – Exchange
- Aggressive vendor management

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**Claims Processing**

**A/R Follow-Up**
The Importance of Collecting Co-pays

*The slippery slope of not collecting co-pays…*

The opportunity to collect patient responsibilities is considerably reduced once the patient has received services and left the facility.

If an employee neglects to collect two $50 co-pays every day, it could add up to a loss of approximately $30,000 per year.
Potential Benefits of Pre- and Point-Of-Service Collections

Improvement in upfront co-pay collections can:

- Increase overall revenue
- Increase cash flow
- Reduce volume of accounts sent to collections and/or resulting in bad debt
- Prevent a backlog of patient statements resulting in large past due bills
- Reduce patient billing costs
- Improve the quality of provider services by decreasing the effort to collect patient responsibilities on the back-end
- Increase customer service and patient satisfaction
Pre- and Point-Of-Service Collections Standardization

Efforts should be made to collect patient co-pays prior to or at the point-of-service

Implement standard processes and training programs for upfront co-pay identification, collection, and documentation.

- **Co-Pay Identification**
  - Patient access employees contacting an insurance company regarding a patient should regularly inquire about patient co-pays, coinsurance, and deductible
  - Anytime a patient insurance card is copied or scanned, the patient access employees should review for co-pay and deductible information
  - All information should be documented accordingly in the patient accounting system

- **Steps for Successful Upfront Collections**
  - **Introduction**: Maintain a positive attitude and professional demeanor
  - **Discuss Topic of Payment**: Explain insurance vs. patient responsibility
  - **Request Payment**: Handle payment objections and be able to explain policies
  - **Collect Money or Provide Options**: Arrange payments via Financial Counselors, etc.
# Techniques for Asking for Money

Altering the way staff asks for money can increase the likelihood of the patients to pay and their satisfaction with the process.

<table>
<thead>
<tr>
<th>Instead of Saying…</th>
<th>Say…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to pay?</td>
<td>The co-pay for your service/procedure is …</td>
</tr>
<tr>
<td>We expect payment…</td>
<td>Do you prefer to pay by cash, check, or credit card?</td>
</tr>
<tr>
<td>Hospital requires…</td>
<td>We ask our patients to pay…</td>
</tr>
<tr>
<td>The charges are…</td>
<td>Hospital’s policy is…</td>
</tr>
<tr>
<td>The cost is…</td>
<td>To take care of your bill…</td>
</tr>
</tbody>
</table>
## Sample Collection Scripts

Sample co-pay collections scripts have been created to help you address this potentially sensitive issue.

<table>
<thead>
<tr>
<th>Patient Issue</th>
<th>Sample Script</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I have insurance and they will pay.” or “Won’t my insurance cover this?”</td>
<td>“We verified your insurance and, per your policy, you are responsible for a portion of your bill. The amount is $ _____ . Would you like to pay by cash, check, or credit card?”</td>
</tr>
<tr>
<td>“Just send me a bill and I’ll pay it then.”</td>
<td>“Our Hospital policy is that you pay your co-pay liability on your day of service. How would you like to pay?”</td>
</tr>
<tr>
<td>“I have never had to pay before.”</td>
<td>“We have begun collecting payment upfront so that you are aware of your co-pay responsibility and won’t have to worry about a bill later. Would you like to pay by cash, check, or credit card?”</td>
</tr>
<tr>
<td>“I don’t have my checkbook with me.”</td>
<td>“We also accept cash or credit cards.”</td>
</tr>
<tr>
<td>“You are more interested in money than my health.”</td>
<td>“I can assure you that your care is our priority. I apologize if it appears that the emphasis is on payment. We have to make sure we can pay for that care and offer the highest quality of care possible for all our patients.”</td>
</tr>
<tr>
<td>“My ex-spouse is responsible for my child’s medical bills, so send him/her a bill.”</td>
<td>“I understand that you may have an agreement with your former spouse. I will be glad to give you a receipt so that you can be reimbursed for today’s payment.”</td>
</tr>
<tr>
<td>“I’m not employed, so how can I pay? Just bill me.”</td>
<td>“You may qualify for a government program. Let me page one of our Financial Counselors who can assist you further.”</td>
</tr>
<tr>
<td>“I don’t have anything on me, I was at the beach.”</td>
<td>“Here is a letter that outlines your financial responsibility and we would appreciate it if you would return it with your payment, or you can call in a credit card payment.”</td>
</tr>
</tbody>
</table>

*If the patient pays, thank the patient!*

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**Efforts should be made to collect a patient’s co-pay. If difficult circumstances prevail, the co-pay may not be collected, and a bill will then be issued to the patient.**
Patient Liability Estimator

Establishing financial responsibilities prior to service can increase likelihood of payment

A patient liability estimator should be accessible by Registration, Insurance Verification, and Financial Counseling staff

- Tool should aggregate historical data to determine average procedure costs
- Should be used for Self-Pay patients and Commercial patients with coinsurance and/or high deductible plans
- Inputs should be available for co-pays, deductibles, and coinsurance to provide specific liability estimates
Patient Credit Scoring

Screening patients prior to and at the point-of-service can reduce financial risk associated with unpaid balances.

Credit score review vendor can be utilized to determine patients’ ability-to-pay and financial risk associated with each patient prior to the date of service:

- Patients deemed “high risk” are required to make payment prior to, or at point-of-service.
- Payment can be requested from patients deemed “low risk”; however, service will not be refused if they are unable to make payment.
- Follow-up policies can be adjusted depending on the patients’ ability-to-pay risk level.
Monitor Outstanding Patient Balances

Screening patients prior to and at the point-of-service can reduce financial risk associated with unpaid balances

- For upcoming patient visits, if a patient has failed to remit payment for last visit, service can be refused until payment is made

- Outstanding balances should be aggregated to determine total amount due from patient

- Notice requesting payment and detailing service refusal can be sent to patient prior to visit

- If patient presents for service and payment has still not been made, it should be requested at that time, or service refused for non-emergent services
## Pre-Service Financial Screening

### Cleveland Clinic Charity Care Reduction Example

In an effort to combat rising charity care and preserve resources for patients with the highest need, the Cleveland Clinic “cut charity care to some patients” and is “requir[ing] those with insurance to pay for care not covered by their plans”. Effective January 1, 2011, the Clinic is no longer accepting non-emergent patients who meet the following criteria:

- Earn between 250% and 400% of the Federal Poverty Level
- Reside further than 150 miles from Cleveland Clinic
- Unable to pay for services rendered

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Source: The Plain Dealer, *Cleveland Clinic to cut charity care for those who live more than 150 miles from the city*, December 4, 2010.
Deferral Policy

The purpose of the Deferral Policy is to prevent avoidable financial losses by deferring or rescheduling non-emergent services

A deferral policy should apply to all non-emergent, non-financially cleared, scheduled patients who are unwilling to make payment arrangements prior to services being rendered – unless the physician deems the service medically urgent

• **Conditions** - The deferral policy is in effect if one or more of the following conditions are met:
  1. The insurance company has not authorized the procedure / service
  2. Medical necessity is required and failed
  3. Critical data elements necessary to determine coverage have not been collected
  4. A patient who is not insured, has been screened for his or her ability to pay, does not qualify for charity or government programs, and is unwilling to establish alternative payment arrangements prior to the service being rendered

• **Overrides** - The Deferral Policy should be overridden if the patient is not financially cleared and any of the following occur:
  1. The patient agrees to pay and provides method of payment
  2. The patient is rescheduled per the physician’s approval
  3. The treatment is rendered per the physician’s approval
Financial Counseling

The process of working with patients who have, or potentially have, high liabilities, and assisting them in identifying possible alternate funding sources, arranging acceptable payment plans, etc.

All non-financially cleared patients should be referred to financial counseling either before service or prior to discharge. The financial counselor should attempt to:

- Determine patients’ financial responsibilities
- Educate patients regarding their financial responsibilities
- Educate patients regarding Hospital’s financial policies
- Collect patient’s financial responsibilities, including previous account balances (if applicable)
- Seek potential funding sources including Medicaid/CMS sponsorship assistance and other available programs
- Assess the patient for Hospital’s discounts/Charity Care
- Establishment of reasonable payment arrangements, if necessary

Financial Counseling should also be offered as a **bedside service** to patients who are in-house
- Counselors should review worklists with all in-house patients identified as self-pay
- Bedside counseling should be provided to assess patient’s insurance, ability-to-pay, etc.

For most effective coverage, counselors should be available 24 hours a day/7 days a week
Emergency Department Point of Service (POS) Collections

All Emergency Department co-pays should be collected while patient is at facility

POS collections in the Emergency Department can occur at various points during the visit:

• Compliance with EMTALA is first priority

• When patient presents for treatment
  – If a patient offers to pay during the initial registration process, co-pay should be collected

• At discharge/check-out
  – All patients, regardless if they have paid or not, should be directed to a check-out kiosk in the Emergency Department prior to leaving

• Check-out kiosks are most effective if positioned between Emergency Department treatment areas and exit door
Self-Pay Discount Policy

Implementing self-pay discount can improve recovery opportunities

Determine if patient is a “True Self-Pay”

- Review account and conduct patient interview
- Complete Medicaid application process, if patient is eligible
- Initiate Charity Application
- Communicate outcome to patient
- Review for catastrophic discount, if applicable

Patients verified as “True Self-Pay” should be provided a discount rate from billed charges

- Self-Pay patients are often being charged full billed charges, which is far greater than discounted rates offered to contracted payers
- Offering a pre-/point-of-service discount should incentivize patients to remit payment sooner
  - Consider requiring 50% deposit to be paid upfront
Processing Self-Pay Accounts

- Process self pay accounts in-house and or longer prior to outsourcing to vendor or bad debt

- Verify other accounts of the patient for existing insurance or updated contact information - Name based searches, account level follow-up against encounter level follow-up

- Patients with self-pay balances after insurance have more likeliness to pay or have secondary insurances. Identify efforts internally or for vendor follow-up with specialized payer-based skills to handle these accounts

- Predictive dialer technology for calls at specific periodic intervals. Include a clear message and confirm the customer service line has sufficient coverage during peak hours

- Include calls to guarantor in the contact strategy. The chances of obtaining updated contact information for the patient increase significantly

- Aggressive vendor management with specific targets and weekly status reporting

In-sourcing or reducing the volume distributed to vendors would increase fixed and operating expense, reduce scalability, and push the net benefit realization to long term
Financing Maneuvers - Factoring

- Eligible net receivables, defined by the provider are purchased at a discount from face value by a vendor

- Cash collections resulting from the difference between the face and discounted values of the purchased receivables are passed on to the factor

- In some cases, along with the discounted purchase, the cost to participate could include a factoring fee, usually a percentage of the sold receivable

- Typically, the purchaser assumes full control and responsibility for collection and follow-up activities of the sold receivable

- Allows advanced funding and immediate cash flow to providers

- Reduces cost to collect and staffing efforts

Factoring has grown significantly in the past two years as banks have pulled back on lending. As this is not a loan, it should not negatively affect the balance sheet.
Vendor Management

• Determine the accounts which should to be transferred to vendors based on:
  − Alpha-split
  − Foreign nationals (International accounts)
  − Out of State
  − True Self-Pay vs. Self-Pay after insurance
  − Aging criteria
  − Specialty reimbursement

• Develop methodologies to reconcile transferred accounts (weekly or at least monthly) to confirm that accounts do not fall through the cracks (e.g. provider assumes a certain portion being worked by vendor and vendor does not have the accounts)

• Develop a systematic process to collect on high volume/low dollar self-pay accounts; these accounts usually form a majority of bad debt due to low levels of follow-up intensity

• Dashboard reporting to monitor collection milestones/metrics

• Traditionally, splitting the A/R between multiple vendors creates manageable “chunks” with clearly laid out collection goals
### Key Metrics to Measure:

**Revenue Cycle Leadership Should Establish Self-Pay Dashboard**
**Tracks & Trends Key Metrics and Responsible Owners**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Frequency</th>
<th>Responsible Owner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total uncompensated care as percentage of costs</td>
<td>Monthly</td>
<td>• Revenue Cycle Departments</td>
</tr>
<tr>
<td>• Total uncompensated care as percentage of gross revenue</td>
<td>Monthly</td>
<td>• Revenue Cycle Departments</td>
</tr>
<tr>
<td>• Total patient liabilities (co-pays /deductibles past balances) collected prior to service in $’s</td>
<td>Daily/ Weekly</td>
<td>• Patient Access Departments</td>
</tr>
<tr>
<td>• Pre-service liability collection rate : ( total patient liabilities collected ÷ total possible pre-service collections)</td>
<td>Daily / Weekly</td>
<td>• Patient Access Departments</td>
</tr>
<tr>
<td>• Self Pay receivables &gt; 90 days</td>
<td>Monthly</td>
<td>• Self Pay Collections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient Financial Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vendors</td>
</tr>
<tr>
<td>• Vendor collection rate</td>
<td>Monthly</td>
<td>• Vendors</td>
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