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Innovative News for Healthcare Executives

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CLOSING THE LOOP BY SELLING BAD DEBT

The sale of bad debt may offer an attractive source of income for hospitals struggling to collect patient payment.

by Richard R. DeSoto | Principal & CEO, DeSoto Healthcare Solutions, LLC

From a patient's perspective, the status of being a patient ends once medical care is done and normal daily life has recommenced. From the healthcare organization's perspective, the treatment may be finished but the work is far from over, with most of the revenue cycle work just beginning. By the time a patient completes treatment, a health plan or government payer likely has been billed, and the medical provider's collection team is working to collect the remaining balance from the patient.

Healthcare providers are not like banks, credit unions, or other institutions that will refuse business to customers whose credit is not good. The provider's principal goal is to ensure each patient receives high-quality care that enables him or her to return to everyday routines; however, if the bill for services is not paid in a timely manner, the patient effectively becomes a "debtor" until charges are paid.

Moreover, as patient responsibility increases with the popularity of high-deductible health plans, healthcare organizations face a challenge in collecting higher amounts from patients who may be unable to pay. Hospital, pharmacy, and medical-practice bad debt amounts to about $120 billion annually, 4 percent of all healthcare spending.[a]

Healthcare organizations obviously have processes in place in which they make every effort to collect patient payment. However, if the provider's efforts to collect the patient's balance are still unsuccessful even after multiple bills and patient statements have been sent and perhaps several telephone calls attempted, the provider must accept the fact that its collection staff will be unable to collect the debt.

At this point, the account is likely to be moved from active accounts receivable (A/R) status to bad debt receivables status. For most organizations, this internal accounting process does not relieve the patient of his or her debt, but it removes the debt from active internal collection efforts and allows the provider to write off the debt for tax purposes as an expense of doing business.

At this stage, most providers also will use outside resources and programs such as collection agencies in an attempt to recover some or all of the patient's balance, although

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a. This statistic is from a calculation, drawing from AHA, MGMA, and other sources, by Dan Munro, a healthcare writer and contributes at Forbes. See Munro's answer to the question "How much 'bad debt' do physicians write off nationally per year due to patient non-payment?" at quora.com/ Dan-Munro.

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the expectation of collection has diminished considerably. This process requires diligence and knowledge on the part of providers to establish effective working relationships with these outside agencies that are of high integrity and do not raise any concerns that could adversely affect the organization's reputation, or even jeopardize its tax-exempt status.

Working with and hiring a collection agency deserves the same due diligence a hospital or health system would spend hiring staff. When pursuing such an arrangement, healthcare organizations should conduct in-depth interviews with the agency's senior leaders and make on-site visits to conduct interviews with the collection agency staff that will be assigned to the organization's account. Healthcare organizations should hold their vendor partners to the same personal and professional commitment to the community that they have outlined in their mission statements.

Working Effectively With Collection Agency Partners

An effective working relationship between a hospital and a collection agency begins with clearly established expectations regarding policies and practices.

For example, an important consideration for hospitals in working with collection agency

partners is ensuring that collection efforts focused on Medicare accounts are recorded and tracked separately from those focused non-Medicare accounts. Although the efforts to collect these bad debts will be similar, any time the collection agency fails to collect unpaid deductibles or coinsurance from a patient using Medicare, this amount can be recorded with the hospital's Medicare Cost Report.[b]

Hospitals also are well advised to define a time limit for the collection agency to collect the account, as collectability decreases with time. Six months after a collection agency takes responsibility, the bad debt will have an age of 10 months to a year or more. At this point, the agency should be able to show its efforts have either resolved the debt or established a solid payment plan with the patient. If the agency cannot accomplish this objective in a six-month time span, the hospital should have the agency close and return any unresolved accounts.

At this time, the hospital also may choose to place the bad debt account with a second collection agency partner. Such an arrangement, however, may do no more than delay the inevitable write-off. For Medicare accounts, continued collection efforts also can stand in the way of recording Medicare bad debt. For reporting purposes, some fiscal intermediaries will consider the use of a primary and/or secondary collection agency as part of the provider's routine collection process. Although there have been rulings supporting the position of hospitals that once an account has been written off as bad debt, it is to be considered uncollectable, fiscal intermediaries still may deny accounts as valid Medicare bad debts if collection efforts are still active at a collection agency. Therefore, if non-Medicare accounts are sent to a second placement collection agency, an organization should do the same for Medicare accounts. As noted, this step could add months to the reporting of Medicare bad debt.

Hospitals have used collection agencies to collect unresolved A/R as standard practice for as long as there has been bad debt. But as self-pay accounts and bad debt increase, hospitals must be prepared to face the challenge of collecting higher amounts from a greater number of patients.

b. Refer to the Medicare Provider Reimbursement Manual 15-1, Chapter 3, Section 308 for more information on Medicare bad debt reporting requirements

According to a survey conducted by the Association of Credit and Collection Professionals, hospitals' average recovery rates are only 15.3 percent.[c] At such rates, a failure to collect on rising patient balances can have significant financial consequences.

When a patient is unwilling or unable to pay despite the best efforts of the A/R team, a hospital may choose to sell the bad debt to close the account and raise much needed cash from a revenue source that has remained dormant. To make the sale of bad debt advantageous for the hospital, several key issues must be considered.

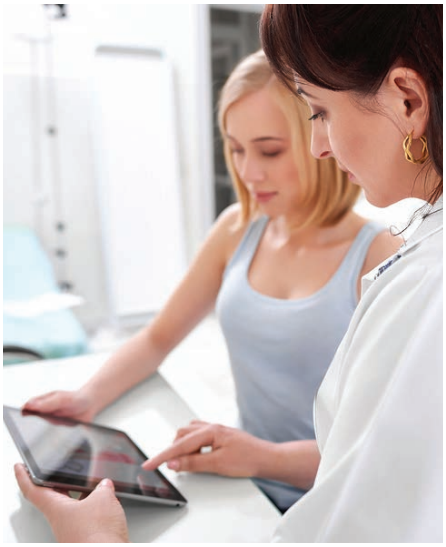
Establishing and Communicating Financial Policy

It should go without saying that hospitals leaders should make every effort to protect the financial well-being of their organizations. Failing to make efforts to collect patient payments can even lead to financial disaster. Rural facilities are among the hardest hit, with more than 600 currently in danger of closing because of financial trouble.[d] Patient payment clearly is a major component to a healthcare organization's financial stability.

A key first step—and one that is required of tax-exempt providers—is making patients aware of their responsibility and establishing a protocol for collection through a financial assistance policy. Section 501(r) of the IRS code requires that hospitals establish written financial assistance and emergency medical care policies, limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy, and make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual.

Hospital providers should become familiar with financial assistance requirements. Recommended inclusions in such a policy include the following:

- Patients must pay at the time of service or when they are notified of their responsibility.
- Financial assistance (i.e., a payment plan) is available on a case-by-case basis and based on established financial or special needs criteria.
- The provider should work to identify patients covered by Medicare, Medicaid, or private insurance to avoid unnecessary bad debt.
- Patient consent forms should be modified to alert the patient that the organization and its approved business associates will use various



means of communication, including a mobile phone, to collect unpaid balances.

- The provider may retain outside professional collection agencies to assist in the collection of any unresolved debt.
- The patient should be informed that after reasonable collection efforts have failed, the organization retains the right to sell the medical debt to a debt purchasing/collection agency. Moreover, this sale, as well as the procedure of advising patients of it, should be standard practice in a written policy approved by the appropriate body within the organization.
- The collection policy and procedure should be communicated through collection notices and statements, websites, updated consent/patient responsibility forms, and other printed material.

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c. www.acainternational.org
d. Laureman, J., "American Hospitals Are Disappearing—and Repealing Obamacare Will Make It Worse," Bloomberg, Jan. 13, 2017

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Managing Expectations

Healthcare finance leaders should investigate the consequences of selling bad debt before entering any such agreement.

One of the first things to identify, of course, is the cash upside and how it will affect the financial operation of the organization. The organization should determine and document plans for the income gained from the sale of bad debt. Most organizations put such income into daily operations; however, some organizations are investigating ways to use this income to reduce bad debt in the future. It may be possible for a hospital to provide its charitable foundation with this cash with the sole purpose of helping community members pay for health insurance premiums. By identifying patients in need, who frequently use the emergency department or require extensive medical care, an organization can contribute to population health in its community and reduce bad debt. It is important to ensure this practice is allowable under foundation rules and guidelines as well as federal and state law. Organizational leaders considering this practice should read the Office of Inspector General Advisory Opinion No. 15-06 issued May 28, 2015, and posted June 4, 2015.

The organization should confirm that all of what's been identified as bad debt truly is bad debt and eligible for sale. A coding error may have led to an account being categorized as bad debt when the account actually is payable by a health plan, Medicaid, or Medicare. IT resources should be put in place to easily identify such accounts.

Steps also should be taken to ensure all balances are correct and contracts current as of the date of sale. The provider should be able to submit documented evidence of the debt so there is no additional support or customer service required.

A provider also must ensure its bank covenants allow for the sale of the bad debt. There may be essential to ensure the bad debt no longer is considered an asset and has no value on the financial statement. A process also should be established for when a patient submits payment not to the purchasing organization but to the hospital.

Before selling, a provider also should investigate what the purchasing agency plans to do with the debt. Not all agencies work to collect purchased debt but instead resell it. Providers should be hesitant about working with organizations that continually resell debt, as such a practice could have a negative effect on patient satisfaction and lead to an increased burden on customer service personnel when patients call to inquire about their accounts.

Each of these issues highlights the importance of screening potential vendor partners. As previously noted, the purchasers of an organization's medical bad debt will become part of the overall collection process and should support the overall mission of the provider and

revenue cycle. Healthcare organizations should choose vendor partners that specialize in debt collection, and contract language should be added to say the purchaser is not permitted to resell the medical bad debt for any purpose.

In 2016, a federal jury convicted four people for their involvement in a Ponzi scheme in which they claimed to pay investors with proceeds from the collection of medical bad debt but in reality were paying with monies collected from new investors. Altogether, the scheme cost investors $278 million.[e] Although this case certainly was an outlier, it underscores the need for healthcare organizations to do their homework when choosing an agency to handle their bad debt.

Continuing Responsibility

A healthcare provider also should understand its continued responsibility after the sale is completed. A bad debt purchasing agency is an important component in an organization's overall collection processes, so it is crucial to make sure the agency follows ethical and legal standards of excellence. If the debt is placed with a credit reporting agency and a lawsuit is filed against the patient, a representative from the provider organization may be called as a witness to validate the debt. If this is a frequent occurrence, it should be factored into the purchase price and may lead provider organizations to sell to a different agency. If bad debt sales will become a continuing part of the A/R collection process, the contract should contain language allowing renegotiation of rates on a periodic basis.

Purchasing agencies should have processes in place to respond to customer service issues as well as a patient advocacy program for patients with legitimate financial needs. A provider organization should ensure the purchasing agency has a solid reputation for good customer service with minimal complaints and a process to handle complaints. There should be some written contract language regarding the closure and return of accounts on an exception basis—for example, an account that the hospital accidentally coded as self-pay when it should have been covered under a grant fund, or the account of a patient who was eligible for financial assistance that was not updated to reflect such eligibility.

Weighing the Options

The increase of bad debt across health care should prompt all provider organizations to take a hard look at how much is written off as bad debt and compare that amount with the amount recovered by collection agency partners. It is time for hospitals to evaluate their current collection procedures and consider other sources of collection activity to increase cash and resolve each claim. The sale of non-monetized/uncollectible receivables closes the revenue cycle loop and supports the financial obligations of the organization's revenue cycle and the overall mission of the organization.

e. "Federal Jury Convicts Final Conspirator in $278 Million Investment Fraud Scheme," u.S. Department of Justice, u.S. Attorney's Office, May 3, 2016.

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Formerly, he was the Regional VP of Operations and CIO/CTO with Dell/Perot Systems revenue cycle solutions group. During his tenure, he directed and simultaneously managed the revenue cycle operations for multiple hospital customers.

Richard is a member of Healthcare Financial Management Association (HFMA) and American Association of Healthcare Administrative Managers (AAHAM) and is a Certified Revenue Cycle Executive. He is a past chapter president for the South Florida Chapter of AAHAM and served on the National Board of Directors for AAHAM. He also has served on the State of Texas Medicaid Advisory Group for electronic billing and was selected to serve as a member of the HCFA (CMS)/NHO Advisory Group on Hospice Cost Reporting. He participates as a member of the Capio Partners Advisory Board. He has an associate of science degree in business management from Indiana University. He also served in the United States Army as a field artillery officer and was honorably discharged with the rank of Captain. Awarded the Bronze Star for service in Vietnam and has authored a book titled "Never A Hero" which documents his combat service.

25 WAYS TO BOOST YOUR REVENUE CYCLE

by Phil Solomon | Vice President of Marketing Strategy for MiraMed

Optimizing your revenue cycle processes is a key component for addressing a multitude of industry trends such as changes in regulations, consumerism and new reimbursement structures.

Today's patient centric revenue cycle requires the right systems to drive performance; however, employing systems based solely on their robustness does not guarantee success. Optimal financial performance is only achieved with a careful balance of people, processes and technologies.

High-performing healthcare organizations that operate best practice revenue cycles use the revenue cycle to continually enhance their day-to-day operations and improve patient experiences and financial recoveries. These best practices give organizations looking to make positive changes in revenue cycle management numerous areas in the revenue cycle on which to focus their attention.

Today's healthcare environment of increased regulations, growing patient payment liability, and risk-based pay-for-performance models and diminishing reimbursements necessitates revenue cycle strategies that meet industry standards. From pre-schedule to accounts receivable payment and cash posting, revenue cycle processes must be aligned in order to secure proper reimbursement from payers and patients. The following are 25 Ways to Boost Your Revenue Cycle which, when implemented, will drive positive financial outcomes and improve the patient's overall experience.

1. Implement an all-encompassing strategy that measures collection goals, workflow benchmarks, policy adherence and key performance indicator milestone attainment.
2. Post and communicate to patients the hospital's financial assistance, discount and prompt payment policies.
3. Remind patients of their payment obligation and attempt to collect the patient portion when performing appointment scheduling confirmation calls.
4. Educate patients to be prepared to pay for services upon arrival at the hospital or clinic.
5. Utilize integrated scheduling and registration tools to handle patient visits and accurately move patients through the billing process.
6. Use a registration quality and scoring technology to accurately classify self-pay patients at point of service to improve collections.
7. Employ real-time technologies that notify registration staff of Red Flags Rule irregularities and fraud alerts.
8. Help patients understand what they will owe at pre-registration, registration and patient check out with an effective bill estimator.
9. Partner with a vendor who offers a cost-effective, unlimited-use real-time insurance eligibility verifying program to check eligibility of patient accounts at

any point throughout the revenue cycle collection process.

10. Introduce a comprehensive program to help patients apply and qualify for various state and federal financial assistance programs.
11. Install a web-based patient intelligence platform to analyze real-time workflow performance.
12. Leverage call center technology to manage call volumes, improve customer service, improve time efficiencies and increase first call resolutions.
13. Post patient financial services staff in the emergency department to collect co-pays, deductibles and self-pay balances.
14. Collect a pre-determined deposit from emergency room patients during quick registration and reconcile total estimated payment due through a bill pay estimator.
15. Preauthorize credit cards and checks at the time of scheduling, registration or any other collection checkpoint.
16. Apply a self-pay point of service collection strategy for collecting previous and current balances.
17. Use a self-pay collection scoring technology that creates workflows through algorithms that estimate the ability and propensity of payment.
18. Implement a self-pay charity scoring workflow that estimates charity and financial discount write-offs before bad debt placement.
19. Use an integrated scanning technology to maintain accuracy while improving the identification and proper storage of patient records.
20. Implement an advanced technology to collect credit card, debit card and Automated Clearing House (ACH) payments.
21. Offer a web-based payment portal for patient bill pay.
22. Implement e-cashiering to give patients additional options to pay.
23. Utilize a predictive dialer that blends inbound and outbound calls, closely monitors right-time calling analytics and sends out-patient friendly statements.
24. Provide ongoing face-to-face and web-based collection and customer service training with the goal of ensuring that all self-pay patients are treated with respect, dignity and professionalism.
25. Offer continuous training programs to educate staff on their responsibilities.

Summary

To maximize revenue cycle efforts, healthcare organizations need suitable technology, adequate internal work processes, experienced people and appropriate metrics. Without these pillars, organizations will struggle to operate efficiently. Focusing inward on revenue cycle best practices is crucial for maintaining operational excellence without losing sight of the impact of a positive patient experience on revenue cycle performance.

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