Collecting Patient Payments in a New Era

A Blueprint for Success

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Your Blueprint to Building A Successful Patient Collection Workflow

Introduction

Do you feel that you are falling short on your patient collection process and not receiving all the money owed to your practice? Do you find that your patients are having an even harder time lately paying for their health care bills after receiving care from your practice? If the answer is yes to either question, then Kareo's Patient Collections Blueprint for Success is for you!

There are several reasons why patients are having a difficult time paying their health care bills. Let's look at the top five:

1. More Americans are choosing high-deductible plans. According to the CDC, nearly 45% of patients had high-deductible health plans in 2018 and 9% were uninsured –nearly 30 million Americans. Moreover, 59% of patients that same year had an average out-of-pocket expense between $501 and $1,000 during a healthcare visit – up from 39% in 2017, according to a Transunion Healthcare report.

2. Employers are shifting health care costs to their employees. With higher healthcare bill amounts, it is making it more difficult for patients to take care of all or most of their financial responsibility than ever before.

3. The COVID crisis has only made matters worse. With employees being furloughed from their companies or losing their jobs altogether due to the quarantine mandate, which started in most states mid-to-late March 2020, paying their health care bills drops even further down their to-do list.

4. Patients are confused by their health care bills. When patients are not given a heads up of the approximate amount they will owe after receiving care, they get frustrated when the bill eventually comes – especially when they receive multiple bills for one procedure. They get confused and many end up ignoring their healthcare bills altogether. A recent survey found that when patients were given an estimate at the time of service, nearly two-thirds of patients (65%) said they'd be more willing to make at least a partial payment.

5. Too many errors. Whether the error is due to coding, pricing or something else, patients get upset when their health care bill is higher than they thought it should be. Also, when they don't know what the process is for following up or making an appeal to their bill, most patients don't pay anything hoping that the payer and healthcare provider will figure it out and send them a revised bill with the adjusted amount.

Your Key Efficiency Goals:

95%

Patient Collection Rate or better

100%

of patient co-payments collected at time of service

30 Days

Patient A/R

If you want to thrive financially as well as provide quality care, patient collections can no longer be an afterthought left to the end of the billing process. We created this success blueprint to help independent practices like yours to reverse the cycle of revenue decline by implementing a patient collection plan that will yield a higher rate of collections, while maintaining a positive relationship with patients.

As you go through this guide, it is important to set realistic expectations to avoid becoming discouraged and giving up halfway through it. You can adapt this blueprint to suit the needs and current state of your practice. You may even want to repeat the four stages on a yearly basis.

We've also included bonus success options to push your practice to the next level of patient collections, if you are ready do so.

Pick what seems doable right now and give it your best effort. And if you find it all a bit overwhelming, take a breath and step back for a moment, then grab your tools and jump back in, just keep moving forward. You'll be sure to see good results ahead!

Your Blueprint Toolbox

- **Tasks to Complete** – Assessments, Checklists and Inventory including:
  - Patient Collection Assessment
  - Financial Policy Checklist
  - Technology Inventory
- **Tech Tips** to show you where to leverage technology
- **Best Practices and Educational Information**
  - Scripts to prepare your team to communicate effectively
  - Glossary of Terms for Financial Policy
- **Team-building Challenges** for you and your staff to keep engaged in the process so you will follow through with the entire plan

Before we map out what you need to do, let's look at the entire patient collection process, which starts long before the billing statement, and involves your entire practice. It's important to take the time to strengthen and continually improve every step of your patient collection process.

We will take you through the entire patient collection journey from scheduling an appointment through the final adjudication by the insurance and transfer of responsibility to the patient. This will help you identify gaps in the collection process and offer you a better understanding of how to walk with patients through receiving care and financial considerations—before the visit, during the visit, and after the visit.

Ready to get started?

STAGE ONE

Prepare for Success

To start any successful project, it's important to take the time to gather what you need first. This includes having both the tools and resources, as well as mentally preparing and taking inventory of where you're starting from and where you want to end up. For this first stage, you will have four tasks and one challenge to complete.

TASK 1: Assess Your Collection Process

First, you need to assess the current level of your patient collection revenue cycle (see questionnaire on next page). This will allow you to set a benchmark to measure your progress over the next few weeks and will help identify what areas you may need to focus extra attention on.

Key Patient Collection Performance Indicators

Less than 50%
of patient A/R greater than 60 days.

More than 95%
of copays and past due balances collected at the time of service.

Less than 20%
of total Accounts Receivable is the patient balance.

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Patient Collection **Assessment**

Answer this questionnaire to assess your practice's current level of success with patient collections.

1.	Are **more** than 5% of your rejections and denials due to eligibility?	☐ **YES** ☐ **NO**
2.	Are **more** than 50% of your patient responsibility balances greater than 60 days old?	☐ **YES** ☐ **NO**
3.	Are **less** than 50% of your patient payments made online or via credit card on file?	☐ **YES** ☐ **NO**
4.	Do you send **more** than one statement to a majority of your patients before receiving payment?	☐ **YES** ☐ **NO**
5.	Do you have to send statements to **more** than 20% of your patients after adjudication?	☐ **YES** ☐ **NO**
6.	Do you collect **less** than 95% of copays and past due balances at the time of service?	☐ **YES** ☐ **NO**
7.	Do your patient receivables account for **more** than 20% of your total AR?	☐ **YES** ☐ **NO**
8.	Have your bad debt write-offs **increased** in the last 12 months?	☐ **YES** ☐ **NO**

If you answered "yes" to most of the questions, you are likely under-performing in your patient collections.

For more resources, search for Patient Collections at **kareo.com/resources** or call us at (888) 775-2736 for a free revenue assessment.

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TASK 2: Build a Financial Policy

Things have changed and a financial policy is no longer something you get signed and file in a cabinet or save on your computer and never look at again. Your financial policy is now considered one of the most important documents to have in a practice and must be understood and referred to by all staff members, including physicians. This document helps you to communicate patient financial responsibility.

> **Your financial policy will now be one of the most important documents for your practice.**

A good financial policy outlines the responsibilities of both the patient and the practice. Now, let's review your current financial policy (or create a new one) and update it to include current payment options and clear language outlining patient responsibility--providing the foundation for improved collections.

Best practice for financial policy writing

- Use clear, patient-friendly language.
- Use bullet points and section headings that help patients follow along.
- Include multiple places for patients to initial to encourage reading the whole document.
- Provide a glossary of terms to ensure that patients understand their true responsibility is for copays, coinsurance, deductibles, etc.
- Only include rules and policies that you are prepared to enforce.

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Financial Policy **Checklist**

Verbiage to Include for All Patients:

- [ ] Introduce your practice and your payment philosophy (e.g., pricing transparency, partnering to serve patients through their healthcare and financial experience).
- [ ] Specify what patient demographic and insurance information you need.
- [ ] Provide contact info for payment matters (name, phone, email).
- [ ] Clearly state penalties for no-shows, late cancellations, late payments, and any other fees.
- [ ] Tell them when you will send the patient's account to collections or stop seeing the patient until their balance is paid?
- [ ] Will you dismiss them from the practice for non-compliance with the financial policy?
- [ ] What resources are available if a patient needs financial assistance or alternative payment options?
- [ ] List payment methods, including cash, check, credit card, online, credit card on file, health- care gift cards, etc.).

Verbiage to Include for Insured Patients:

- [ ] Establish when copays, coinsurance, deductibles and unpaid balances are due.
- [ ] Add that benefits are a contract between the payer and patients. Patients have ultimate responsibility for payment.
- [ ] Remind patients that it is their responsibility to be aware of their benefits and non-covered benefits will be their responsibility.

Verbiage to Include for Self-Pay Patients:

- [ ] Present a sample of your self-pay fee schedule, typically 10% to 25% higher than your lowest contracted rate. (Stay in compliance with payer contracts.)
- [ ] Outline prompt-pay discounts, typically around 10% for paying at the time of service.
- [ ] Provide multiple payment pathways (direct self-pay, concierge/membership, Care Credit, financial assistance, etc.).
- [ ] Include financial hardship and charity care policy.

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Glossary of Essential Health Insurance Terms

Here is a collection of commonly used terms when talking about healthcare coverage and payments.

Allowed Amount - Maximum amount insurer will pay for covered healthcare services. If provider is not In Network and the charge is higher than this amount, patient may be billed for the difference.

Benefits (PE) - Services that are covered under a health insurance policy.

Coinsurance (PE) - The patient share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service.

Copay (PE) - A fixed amount paid by the patient for a covered healthcare service, usually when service is received. The amount can vary for primary care and specialty care.

Deductible - The amount a patient must pay for healthcare services before the health insurance plan begins to pay for services received. Some services do not require the deductible be met, such as some preventative services.

Explanation of Benefits (EOB) - A statement sent by the health insurer to patients after the visit explaining what portion of the medical treatment or services were covered. This usually is not a bill.

Health Insurance - A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium paid by patients. Health insurance can be provided by private companies or government programs.

High-deductible health plan (HDHP) - A health insurance plan with lower premiums and higher deductibles than a traditional health plan.

In Network - The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services, usually at a discounted rate.

Out of Network - The facilities, providers and suppliers that are not contracted with your health insurer and do not offer discounted rates. Deductibles may be higher.

Patient Responsibility (PE) - The total amount due from the patient for services received from a healthcare provider.

Premium - The amount the patient and/or employer must pay for a health insurance policy or plan.

(PE) = Patient's out-of-pocket expenses paid to the medical practice

For more terms, visit healthcare.gov/glossary. For questions about your health insurance benefits, contact your insurance provider or contact Kareo. New patients should sign the financial policy during intake and then once a year thereafter. Your staff will use this financial policy as a reference guide for answering questions and providing options to patients.

SUCCESS ADD-ON

Provide patients the financial policy and other new patient paperwork prior to the appointment and request that it be returned ahead of time so that staff can review any questions or collect missing information.

TECH TIP

Give patients a clear explanation of the convenient technology features you offer for payment, such as **saving a credit card on file.** This allows you to have a straightforward conversation about money and patient responsibility at the beginning of the patient experience.

TASK 3: Take Inventory of Your Technology

Now, let's look at your technology "specs" and see how well your current technology is supporting your collections process (see the Patient Collection Technology Inventory on the next page). If you don't yet have a tool or feature, you can adapt your current collection practices to achieve results. For instance, if you don't have a payment estimator, use your self-pay fee schedule from your financial policy to provide patients with a realistic expectation of what they could owe for a visit, particularly if they have a high deductible that hasn't been met yet. When the bill comes out to less than expected, it will be a positive experience.

TECH TIP

You will save time and effort by having an integrated technology platform where your billing and collections technology is seamlessly integrated with your EHR.

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Patient Collection **Technology Inventory**

This inventory will show you where you may need additional tools to boost your patient collection rate.

THE BASICS:

- ☐ Scheduling & Appointment reminder software
- ☐ Eligibility verification
- ☐ Billing/Practice Management system
- ☐ Payment system
- ☐ Patient portal
- ☐ Practice website

THE IMPORTANT STUFF:

Credit card on file

- ☐ Most effective payment method
- ☐ Sets maximum charge amount that can be processed automatically

Multiple payment options

- ☐ Online payment portal including credit cards and e-checks
- ☐ Mobile bill pay
- ☐ Credit card on file
- ☐ Automated payment plans

Patient estimator

- ☐ Sets expectations for patient responsibility
- ☐ Allows for discussion of payment options and methods

Patient statements

- ☐ Clear and professional layout
- ☐ Include details on multiple payment options
- ☐ Send a link to online patient portal for payment and communication
- ☐ Paper and electronic

Multiple patient communication methods

- ☐ Direct messaging to single or multiple accounts
- ☐ Appointment reminders via phone, text and email
- ☐ Post-visit lab/test results

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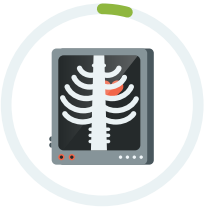
TASK 4: Prepare Your Team

Share your financial policy with your staff and get input. Along with having the right technology, your staff must be trained on how to use it to access and share the right information with patients at the right time. They also need guidance on how to talk to patients in various scenarios.

SURVEY SAYS:

96% of patient complaints are related to customer service



4% of complaints are related to quality of care

Staff Tasks

Independent practices know that to be agile and high-functioning, everyone needs to be cross-trained to fill in as needed. This has never been more important than when it comes to patient collections. While it may not be the primary responsibility of everyone in the office to collect daily patient payments, **all staff should be trained to fulfill these tasks:**

- Explain the practice's financial policy.
- Provide patients with the payment amount due.
- List the payment options, including saving a credit card on file and directing patients to online payment options.
- Collect payments.
- Provide payment alternatives if they can't pay in full in the near term.
- Offer financial counseling resources.

Consider offering staff incentives, such as gift cards or extra PTO time, for reaching patient collection goals. Be sure that the incentives include everyone in the practice to encourage working as a team. Set specific, measurable, and realistic goals and update everyone on the team's progress throughout the week. The value of the reward doesn't need to be significant. They will appreciate recognition for a job well done.

Collection Goals for Front Office

Make sure to collect **100% of copays**

Offer **credit card on file** option

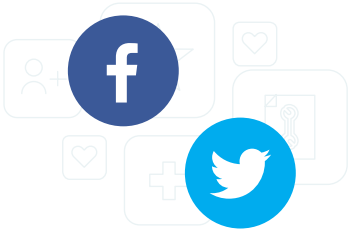
Maintain empathy and understanding

STAGE ONE

Go Practice Challenge

For a group activity, have everyone think of a challenging scenario involving patient collections and write it on a piece of paper. Collect them in a bag. Then go around and have each person pick a piece of paper and practice responding to the scenario, based on the financial policy and payment process you've outlined for your office.

Talk about it on Facebook or Twitter via @GoKareo #PatientCollections. Share your most challenging or notable experience dealing with collecting payments from patients. You're probably not alone!



REWARD YOURSELF AND YOUR TEAM

After successfully completing Stage One, bring in a treat or snack to share with the team. Encourage people to ask questions, voice concerns and make suggestions about the financial policy and payment pathways. Use this feedback to refine your financial policy and explanation of payment pathways.

STAGE TWO

Optimize Collection Before the Visit

Now, it's time to put the plan into practice. Be encouraged with the idea that independent providers have had more success with collecting pre- and at point of service collection, than hospitals or large networks. For this second stage, you will have three tasks and one challenge to complete.

TASK 1: Make the Most of Pre-Intake

Using the initial appointment-setting communication as an opportunity for a pre-intake process will help to start the patient payment conversation early. At a minimum, you should be collecting the following information for new patients:

- Patient Name, DOB, address, and phone number.
- Insurance information including policy and group number. Remind them to bring ID and insurance card with them to their visit.
- If patient is not the primary subscriber, also collect subscriber name and DOB.
- If patient has no insurance, explain the aspects of the financial policy that relate to self-pay responsibilities. If the caller asks about discounts and financial hardship policies, offer to send a copy of the financial policy and financial hardship application to them in advance.
- Provide a summary of key points in the financial policy, such as payment at time-of-service for copays and balances due to coinsurance and deductibles. Let them know that they'll be asked to sign it at the time of the visit.

For established patients, be sure to ask about changes to insurance or demographics since their last visit and remind them that they need to bring their ID and insurance card with them to every visit.

STEP IT UP!

Request a credit/debit card and keep it in a secure and compliant credit card on file (CCoF) system. Receive authorization to charge up to a specified amount automatically upon adjudication of claims. If the health care charges are over that amount, send a courtesy notice to the patient prior to charging the balance, allowing for high balances to be split into smaller payments.

TASK 2: Eligibility Check and Re-check Prior to Appointment

One of the most frustrating things you can read on an Explanation of Benefits statement is the coverage was terminated prior to the date of service, especially when you verified eligibility when your staff first scheduled the patient appointment.

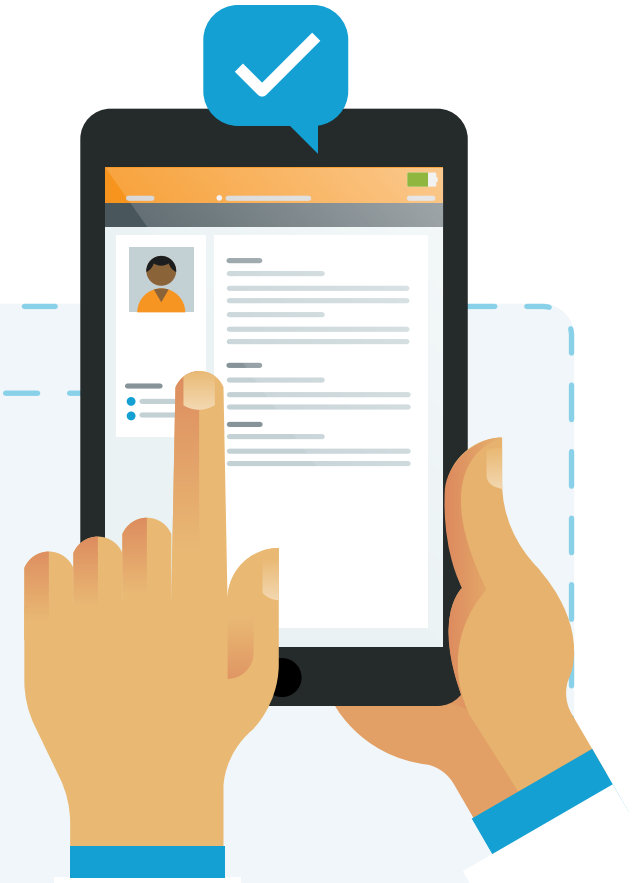
Eligibility is the main cause for rejections from payers–but it is also the most preventable. Taking the time to verify eligibility multiple times along the patient collection journey will ensure less rejections and faster payment.

While it may seem redundant to verify eligibility multiple times prior to a visit, it is much more time consuming to try to obtain updated policy information from a patient after the claim has been rejected or denied. By pushing your practice to strive for 100% eligibility verification prior to the visit, you can achieve major improvements in your overall collections.

Run eligibility as soon as the appointment is scheduled. This allows for time to correct errors in demographics that may be causing false inactive results. You also have the option to reschedule a patient for later if there are issues that need to be resolved between them and their insurance, prior to the visit. Then run it again just prior to the appointment.

Eligibility is the #1 cause for rejections in practices. Strive for 100% eligibility verification prior to the visit.

You're half way there!



TECH TIP

Eligibility check features to look for:

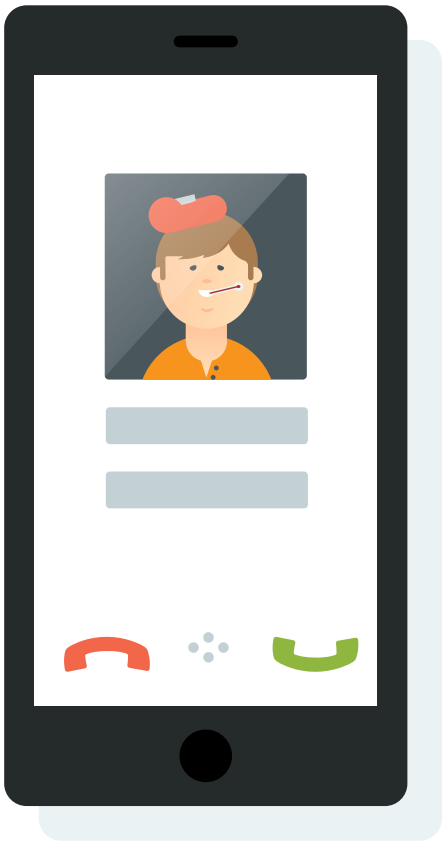
- ☐ Ability to check eligibility for the date of service.
- ☐ Group eligibility check for multiple patients to save time.
- ☐ Auto eligibility check that automatically validates insurance before a claim is submitted to reduce denials.

TASK 3: Use Appointment Reminder as Payment Notice

Now that you have confirmed patient eligibility, you can use the benefit information to calculate the potential patient responsibility for the visit prior to making your appointment reminder calls or emails. This is the perfect opportunity to prepare patients about their payment responsibility and increase the likelihood of getting paid at the time of service.

The appointment reminder is the perfect opportunity to prepare patients for their payment responsibility and increase the likelihood of getting paid at the time of service.

What to include in your appointment reminders:



- Appointment date and time.
- Reminder to bring ID and insurance card to appointment.
- Copay amount due at time of service.
- Outstanding balance from previous visits due at time of service.
- Estimated amount due for the visit for self-pay patient.
- Payment methods, including signing up for credit card on file.
- Collect payments, if possible.
- If the patient is self-pay, discuss the standard self-pay fee for initial and follow-up visits.

Sample Script: Collecting During the Appointment Reminder

Here's a suggestion of how to communicate patient responsibility over the phone or by email.

Mr./Ms. _____ , I am confirming your appointment with Dr. _____ for _____ at _____ .

According to your insurance plan, you have a co-payment of $ _____ , which will be due at the time of service. You also have $ _____ remaining on your deductible, which means that the full amount for this visit will likely be your responsibility once your insurance processes the claim. We estimate that the amount that you will be responsible for will be $ _____ .

This is an estimate of your liability based on the information available from your insurance company. This may change once your insurance company receives and processes the claim, we just want to be sure you are aware of your potential responsibility.

I also see you have an outstanding balance of $ _____ on your account. I can help you take care of that now by credit card so that you don't have to worry about it when you come in for your visit. Would you like to use Visa, MasterCard, American Express, or Discover?

Is this the card that you would like us to keep on file for future copays and deductibles?

Modification: For practices who are finding it tough collecting coinsurance or unmet deductibles prior to visit, offer patients online payment options. Remind patient that you will need to collect any remaining amounts due in full at time of visit. Sometimes both patients and staff are more comfortable using online options for handling financial transactions.

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STAGE TWO

Go Practice Challenge

Look for ways to "catch" staff successfully checking and re-checking eligibility, collecting copays and balances, setting up credit card on file, etc. Offer positive reinforcement when someone shows initiative and puts forth the effort to adopt new behaviors.

Talk about it on Facebook or Twitter via @ GoKareo #PatientCollections. Share something new you've learned on the job since you started the boot camp. Chances are it's news to someone else, too!

REWARD YOURSELF AND YOUR STAFF

Consider blocking an extended lunch hour on the schedule and provide lunch to let staff know that their efforts to improve the practice's patient collection rate is much appreciated! Use the extended time to recap the progress that has been made so far and provide an opportunity for feedback on concerns and ideas.

STAGE THREE

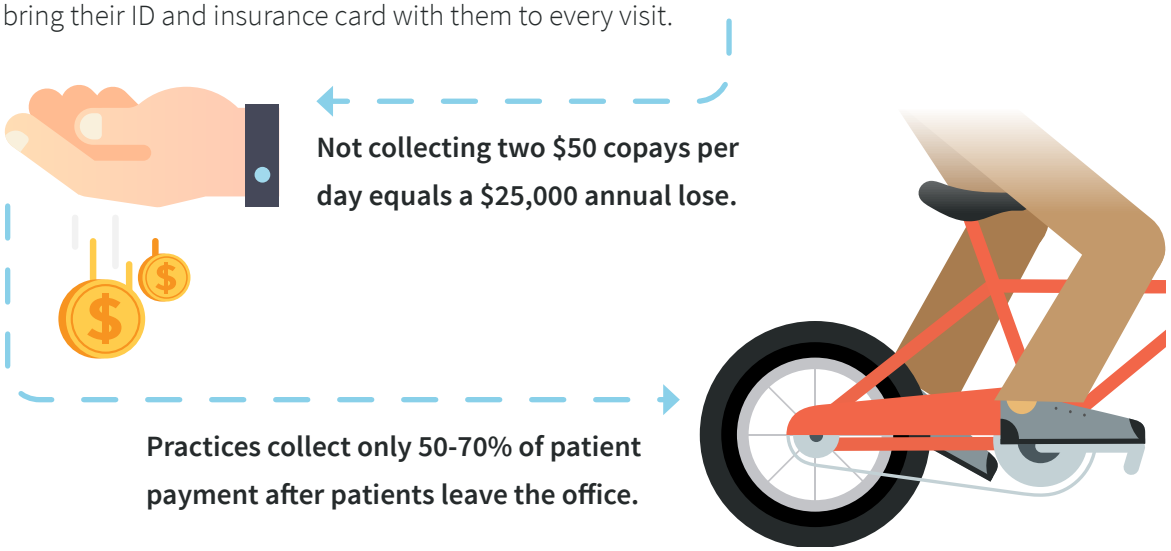
Collecting at Time of Service

Collecting patient payments at the point-of-service tends to be the least favorite task of the front office—but it is one of the most critical steps you can take to improve your collections rate. Most patients want to pay their medical bills, but don't want to be surprised by out-of-pocket expenses. By removing the element of surprise on payment amounts, you can start changing both staff and patient attitudes about collecting at the time of service.

For this third stage, you will have two tasks and one challenge to complete.

If you completed Stage Two of this blueprint, your patients and staff should be well-aware of the payment status for patients coming into the office, as well as the payment options available. Moreover, you stand to save money on the statement and collection process, increase cash flow, reduce administrative costs and staff burdens.

For established patients, be sure to ask about changes to insurance or demographics since their last visit and remind them that they need to bring their ID and insurance card with them to every visit.

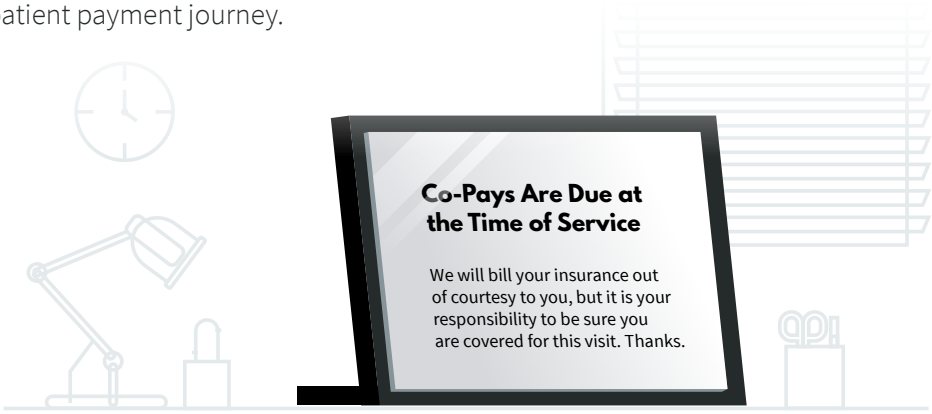


TASK 1: Review Eligibility and Estimated Patient Responsibility

Each day, here's what you should have in place to collect successfully at the time-of-service:

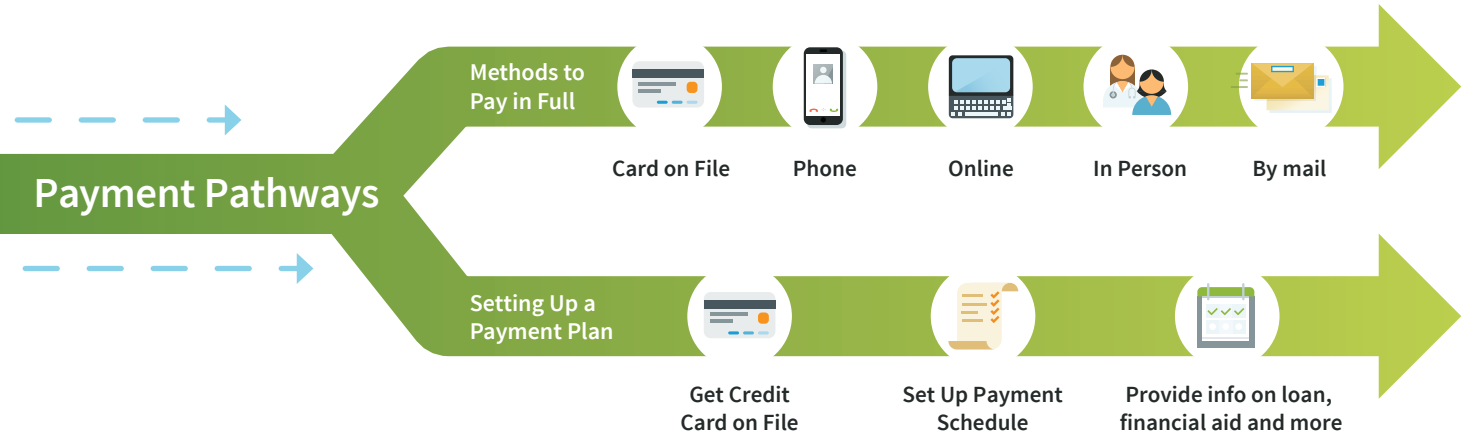
- Check and re-check eligibility for patients scheduled for the day and have an estimate of what their responsibility will be based on deductibles, co- pays, coinsurance and current balances.
- Prepare a list of patients who have balances that were not collected during the appointment reminder call.
- Display a sign prominently at check-in and check-out indicating that co- pays and past due balances are due at time- of-service so that patients will be prepared to make a payment.

You are ready to greet patients and guide them through the next phase of the patient payment journey.



THE DAILY HUDDLE:

With your team, talk through the day's scheduled patients, discussing any balances that need to be collected or special cases. This is a great time to do a quick role play for the front desk staff to practice communicating a patient's payment responsibility and options available. An empowered and prepared front desk staff is a practice's front line of improved point-of-service collections.

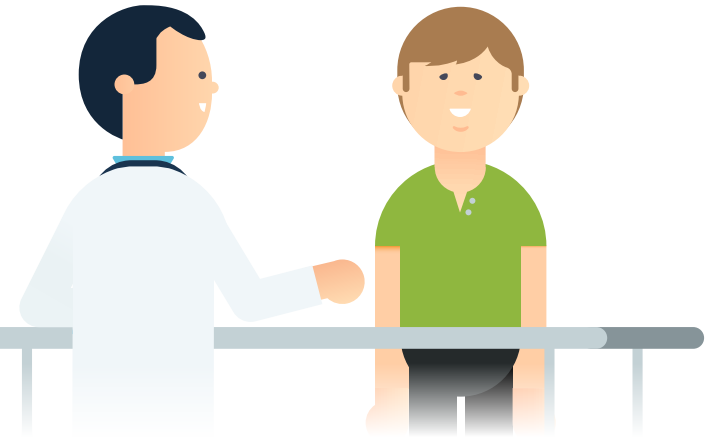


TASK 2: Communicate Amount Due, Confirm Payment Pathway and Collect

When talking to patients about their balance due, the goal for your practice is to sustain an attitude of service and empathy—to be able to put yourself in their shoes to be understanding and friendly throughout your interactions. However, practice staff should avoid showing pity and sadness in patient payment interactions. This doesn't help anybody and often hinders staff from speaking clearly and helping patients figure out the pathway to payment.

Collecting at Check-in

When patients arrive, begin by confirming patient information and completing the intake process by getting all forms filled out and signed. For walk-ins, start the intake process from the beginning. Confirm the patient financial responsibility due for the visit, collect copays and, if possible, payment for services prior to the exam room.



Designate a Private Area for Money Talk

Respect your patients' privacy by designating a private space or room to discuss patient payment responsibility and options. If your office space does not allow for a separate area, print out a statement of account to hand to the patient when requesting payment on larger or past due balances. This can avoid embarrassing the patient and also eliminates the "I never got a statement" excuse.

You can start the payment conversation by saying:

"Mr./Ms. _____ , your current outstanding balance is $ _____ .
For today's visit, your estimated fee is $ _____ . I can help you
take care of that now. We accept credit card, cash, and check."

If the patient can't pay their copay, and your financial policy states that this is a requirement for service, then you have the option of turning the patient away, if the patient is not in acute distress. Front office staff should access the patient's payment track record and consult with the physician before doing this.

If the patient can handle the copay but can't pay in full for services, use your Financial Policy to offer various payment pathways.

Collecting at Check-Out

The provider should escort the patient to the front desk, talk briefly with the staff confirming patient information was entered the EHR, and thank the patient before walking away.

Before informing patients on any care instructions and follow-ups, front office staff should let patients know about their payments due.

Sample Script: Asking for Patient Payment at Checkout

Here's a way to start the payment conversation:

"Mr./Ms. _____, according to your insurance plan, you have an estimated amount due of $ _____. This includes $ _____ for your co-payment, $ _____ for your outstanding deductible, and $ $ _____. for your coinsurance.

This is an estimate of your financial responsibility based on information from your insurance company. Additional amounts due may be billed to you after your insurance company receives and processes the claim. I can help you take care of payment today. How would you like to pay—cash, check or credit card?"

Potential Patient	Front Office Script
I can't pay all of it today.	**"How much will you be paying today?"** After the patient reply… **"Will you be paying by cash, credit card, or check today? "Ok, and for the balance, you have the option of** [offer payment pathways]**. How will you be paying the balance?"** Document the payment pathway in writing and get patient signature.
I forgot my "money, wallet, purse, etc."	**"That's not a problem. Let me show you your repayment options."** Explain your practice's payment pathways.
Patient gets embarrassed	Allow the patient to speak and listen; be understanding, not apologetic. Reply: **"We have some options available for you. Let's see if any of these will work."** Explain your practice's payment pathways. If the patient gets more upset, bring in the physician.
Patient gets angry	Quickly bring angry patients into a private area. Have another staff member with you. Allow the patient to speak uninterrupted. Listen, show understanding, and let them calm. Reply: **"I understand. Let's take a look at some options available to you and try to find a path that works for you."** Explain your practice's payment pathways and if the situation escalates, call in the physician.

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STAGE THREE:
Go Practice Challenge

- Talk openly. Knowing some of the challenges patients face in higher healthcare costs can help your team gain understanding and empathy. Some of your staff may be in similar situations as patients who are having trouble with their bills. Have an open discussion about the importance of empathizing with patients, emphasizing the importance of clearly telling patients about their payment responsibilities.

- See how close you get to these goals for the week:

  - Collect 100% of copays at the time of service.
  - Collect 100% of outstanding coinsurance and deductible balances at the time of service.
  - Collect 100% of self-pay amounts at the time of service

Talk about it on Facebook or Twitter via @GoKareo #PatientCollections. Roses and Thorns: Share your most challenging and most rewarding experience implementing the new collections processes.

REWARD YOURSELF AND YOUR TEAM

Offer a selection of free services for staff, friends, or family in the form of a certificate for better patient collection practices. Be sure to include all staff in any incentive or rewards.

STAGE FOUR

Reducing Days in A/R After the Visit

With so much of your collection work already completed, the period after the visit becomes the time to ensure accuracy, consistency and efficiency. Create the plan for better success with patient statements, text and email balance reminders, and collecting past-due amounts at next visit. **For this last stage, you will have four tasks and one challenge to complete.**

Specs to Decrease A/R

- Offer discounts for timely payment of self-pay balances. Be sure to remain compliant with payer contracts that prohibit giving preferential pricing to other payers, including self-pay patients.
- Utilize credit card on file systems to allow processing of payments for patient balances immediately after adjudication and to reduce the number of statements.
- Offer two-way communication methods between practice and patient to answer questions and clarify balance due.
- Leverage email statements and text balance reminders in addition to mailed paper statements.
- Set up email and text balance reminders.

23.5 days in A/R

Average for higher performing practices

MGMA 2015 Cost and Revenue Report

TASK 1: Review Past Due Accounts and Set Up Communication Channels

Your billing software should allow easy tracking and reconciling of patient payments already made and remaining balance. Plan enrollment, coverage limits, dependent coverage and other insurance details are all subject to change. Double-check all these things to ensure remaining balance amounts are accurate. When patients find errors on their account, they can start to distrust statements, giving them an excuse to delay payment.

Text and Email Balance Reminders

Patients expect a mobile and simplified transaction experience, much like the experience they have in the consumer world. Increase time to pay by sending actionable, electronic balance reminders via text and email. Communication outstanding balances long before the patient receives a paper statement, while their visit is top of mind.

To effectively send text and email balance reminders, follow these guidelines:

- Ensure your practice has the most up-to-date mobile phone number and email address for each patient.
- Send alerts during normal business hours.
- Routinely review communication reports to confirm message delivery and update incorrect email or phone numbers.
- Include the name of your practice and a link to your payment portal.

TECH TIP

Your Patient Portal can be a powerful tool for improving collections, in addition to communicating care-related information. For optimal efficiency, Patient Portals should be seamlessly integrated with billing information and payment options.

TASK 2: Patient Statement Best Practices

Assess the payment pathways available to patients and include the options in the statement. Send out statements with remaining balances within 24 hours of receiving the EOB. You'll ideally be sending out statements every day, and no longer waiting for the end of the month.

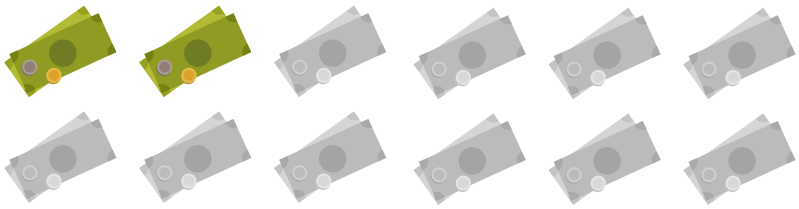
Best practice: Send out statements with remaining balances within 24 hours.

To be effective and increase willingness to pay, statements should:

- Be easy to read with explanation of bill at-a-glance.
- Provide statements electronically whenever possible.
- Clearly show amount owed and payment options, including online, credit cards accepted, etc.
- Offer the patient multiple payment pathways, such as paying online, payment plans and credit card on file.
- Provide contact information, including phone and Patient Portal.

TASK 3: Last Chance Communications

Many practices have a policy of sending 2-3 statements and then turning unpaid balances over to a collection agency. The success rate in collecting balances once turned over to collections declines significantly. A more effective method can be to communicate with the patient using the approach of helping them set up a payment plan for their past due balance. Before turning a patient over to a collections' agency, a good practice is to call the patient to discuss the balance and try to resolve any questions or disputes they may have with their bill.



16.5% AVG. recovery rate for bad debt sent to collection agency

CBM Services www.cbmservices.com/collection-rate.cfm

Sending Accounts to a Collection Agency

If you do need to send an account to collections, be sure to consistently follow your financial policy and let patients know that they will be unable to schedule an appointment for routine services until the balance is paid, or a payment plan has been put in place and multiple payments have been made on time.

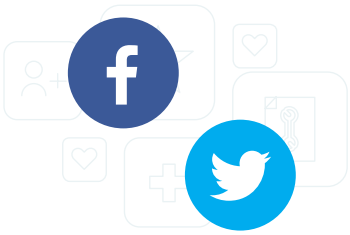
If you find that a patient continues to be in payment violation, you may need to take steps to dismiss them from your practice. Keep in mind:

- The process for this should be clearly spelled out in your Financial Policy and should be done in writing.
- Specify the amount of time that they have left before you will no longer have them as a patient, and they will need to find a new provider. Remind the patient that your office will only provide care for urgent medical needs during the transition time.
- Include resources for them to turn to for help/information.

STAGE FOUR:
Go Practice Challenge

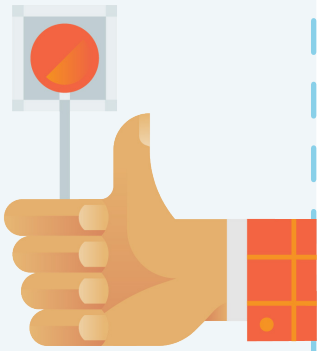
Establish a soft collections process in your practice to reduce the number of accounts sent to an external collection agency. If you approach patients with the standpoint of assuming their lack of payment is an oversight rather than intentional, many patients will want to make at least a partial payment. For those who continue to ignore your attempts to collect, stronger collection actions should be initiated as soon as it is determined that softer methods are not going to be successful. The longer a balance remains delinquent, the less chance of it being collected.

Talk about it on Facebook or Twitter via @GoKareo #PatientCollections. Share outcomes, improvements and notable changes you've experienced from implementing boot camp practices. Be sure to give kudos to staff who are in it with you!



REWARD YOURSELF AND YOUR TEAM

Congratulations on completing all four stages of the Patient Collections Blueprint for Success! Think of a way to reward and recognize your staff for their commitment to learning new practices! Perhaps with the money they will be saving you in the long run, you can give each staff member a gift card to say thank you. Also, consider another reward in 6-12 months for continued patient collection success.



Monitoring Your
Ongoing Patient Collection Fitness

Everyone knows that a crash diet or intensive workout won't have long lasting effects unless you maintain good habits.

Track and monitor these aspects of patient collections on a monthly, quarterly and yearly basis using reporting functions in your practice management tool.

- Overall patient collection rate
- Percent of copays collected at time of service
- Patient collection rate prior to, at the time of service
- A/R days after they leave the office (A/R days) - shoot for A/R within 35 days and no more than 20% of your accounts more than 90 days old.
- Patients/amounts sent to collection agency (bad debt) - should be less than 2% in financially healthy practices.
- Eligibility rejection/denial rate
- Staff time and efficiency
- Patient satisfaction - Use the survey feature in your patient portal to measure the satisfaction level of your customers.

Some Final Thoughts...

Don't forget to set goals, celebrate and reward staff when goals are met. For areas where you seem to be under-performing, reevaluate your current methods to determine what improvements may need to be made.

Improvements might involve researching new technology that can automate, speed up or improve accuracy in one or more aspects of your patient collection process. Is your practice management software working for you? Do you have easy and reliable communication path with your patients? Are your statements effective?

Also consider whether the improvements need to involve changes in your staff. If your denial rate is above the 7% industry best practice, you might need to consider hiring a designated certified biller and separating that role from your office manager, or outsource your billing and see if the higher returns in patient collections more than makes up for the cost of the service.

Be sure to adjust your process along the way and continue to track and monitor. You are now on course to reaching the holy grail of 95% or higher patient collection rate. **Great job!**

About the Author

Aimee Heckman is a Healthcare Business Consultant with more than 25 years of experience in Medical Practice Management, Revenue Cycle Management, PM/EHR implementation, and business development. As a Certified Professional Biller (CBP) and Certified Physician Practice Manager (CPPM), Aimee has demonstrated success in assisting physicians with maintaining their independence and surviving the ever-changing healthcare business environment.

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