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Myths About Patient Receivables: Setting the Record Straight

By Steve Levin and David Franklin

Conventional wisdom about patient receivables differs from what actually is taking place in U.S. hospitals.

Revenue from patients is the fastest growing revenue class in health care and a priority among healthcare executives. In virtually every business office, teams are busy working to improve collection performance against this unique class of receivables. Although patient receivables have been a relatively insignificant portion of a hospitals' cash flow, their increase is exposing many misconceptions and misunderstandings among management.

Theories and ideas about collecting on patient receivables abound. We tested some common myths as part of our ongoing industry research with executive teams representing more than 100 U.S. major hospitals.

WEB EXCLUSIVE!

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As you might expect, reality is more complicated than conventional wisdom. The reality also speaks to the need for some updated thinking on how business offices should operate.

Myth 1: Self-Pay Bad Debt Is All from Poor People

Conventional wisdom is that patients who are less affluent are the root of unpaid bills and hospital bad debt.

Based on research that looked at patient receivables in five different hospital systems across the United States, the facts say something different. Middle- and upper-income patients are equally guilty of not paying their hospital bills.

Among patients with payment responsibility after insurance, commonly called

INSIDE THIS ISSUE

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balance after insurance accounts, collection rates for households with income over $70,000 range from 33 percent to 50 percent. Interestingly, the middle income group is almost as responsive, despite income differences. Among uninsured patients, upper-income households pay only 7 percent to 8 percent of their balances, which is roughly equal to a 25 percent payment rate for balance after insurance patients given the contract discounts commercial payers negotiate. Clearly, upper-income households among the uninsured and insured are not paying their hospital bills. See exhibit on p. 3, top left.

Research also shows household income is something of a threshold variable in explaining payment behavior. Below a certain level, income does correlate to payment amount, but above the threshold, additional income does not actually predict increased collection.

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Myth 2: Patients Who Do Not Have Credit Scores Do Not Pay; They Are Charity Cases

A common refrain among healthcare financial executives is that it does not make sense to invest collection resources on households that do not have full files at one of the major credit bureaus. Depending on geography, these "no-credit-file" households can constitute 30 percent to 40 percent of a hospital's self-pay accounts.

The conventional wisdom about no-credit-file households goes as follows: If a household is going to have the financial capacity to pay any substantive healthcare bill, it should have established credit or other financial activity that would be reflected in traditional credit bureau files. Therefore, a no-credit-file household does not have substantial financial capability and does not merit investing scarce collection resources against balances due. The costs will outweigh the cash recovery. The typical business office process for these no-credit-file households is to either consider them charity or immediately flush them to bad debt.

Based on research involving more than 100 U.S. hospitals, the facts say something different. Patients from households without files at traditional credit bureaus represent a substantial amount of cash collection. See exhibit on p. 3, top right.

Of the total research sample, the segment composed of households that lack full credit files was 30 percent to 40 percent of receivables and 25 percent to 30 percent of cash collections—an amount that is too large to ignore. By subsegment, households with payment responsibility after insurance and without full credit bureau files pay only 14 percent less than those with a full credit file. Uninsured patients without a full credit file pay 29 percent less than those with full credit files. Although households that lack full credit files pay less, the total amount of cash they pay is meaningful and probably understates the true potential because many business offices are set up to less vigorously pursue collections among this population.

Households lacking a full traditional credit file are a complex mix, including students and recent graduates, recently divorced or widowed households, recent immigrants or foreign workers on visas, and those who have never applied for credit or who have moved to a cash/debit financial model years earlier. Although these individuals have little or no credit history, generally they regularly pay bills from landlords, utility companies, membership clubs, cell phone providers, rent-to-own companies—and hospitals.

To presume that any patient lacking a credit bureau file is without means is a rash decision, inadvisable from a cash perspective and certainly not appropriate for charity filing purposes. Using analytics and processes that rely too heavily on input from traditional credit files can lead to overlooking upwards of 35 percent of your market opportunity.

Myth 3: People Either Pay in Full or Pay Nothing

Some business office executives believe that patients either pay their bills in full or do not pay at all. Conventional wisdom is that partial payment is a truly small portion of patient accounts and not a major source of cash collections.

Based on research among millions of patient events, the facts say something else. See exhibit on p. 3, bottom.

The collection experience for the smallest patient bills—those under $100—is as expected. People either pay or do not pay, with less than 3 percent of accounts paying only a portion. However, as balance size increases, partial payments quickly become a substantial portion of collections. In the highest balance band, more people are paying partial amounts than are paying in full. Of total cash collections, the upper two balance bands represent almost 60 percent of all collections.

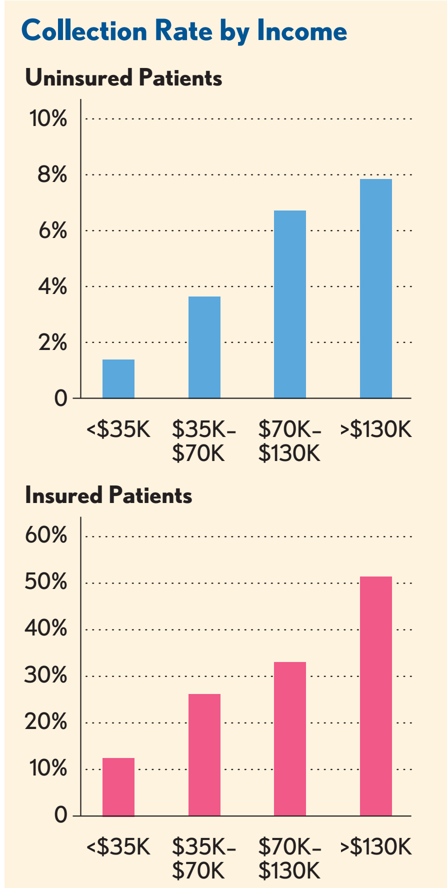
These surprising data reinforce a couple of collection principles. First, it is critical to identify early the minority of patients in the upper balance ranges that are likely to pay anything, whether in part or in full. More accounts pay nothing than pay something. Substantial business resources can be invested in no-value accounts. Large balance accounts are a great place to test the discriminatory value of business office analytics and scoring systems.

In addition, it is critical to develop settlement and payment guidelines and empower collection personnel to prosecute them systematically. Without updated settlement policies, pursuing collections on larger account balances tends to consume business office customer service representatives and trains patients to wait until late in the collection process to receive the biggest discounts.

What Should a Business Office Manager Do?

The reality today is that much of the conventional wisdom around self-pay collections is no longer appropriate. Provider business offices need to think differently about self-pay collection efforts. Central to the more effective operations are three principles.

Embrace analytics. Some of the newest predictive models (e.g., scores) can accurately predict the true cash value of an account, the type of collection effort needed to maximize recovery, and the qualification of accounts for charity discounts. The newest analytics can be deployed in many different ways



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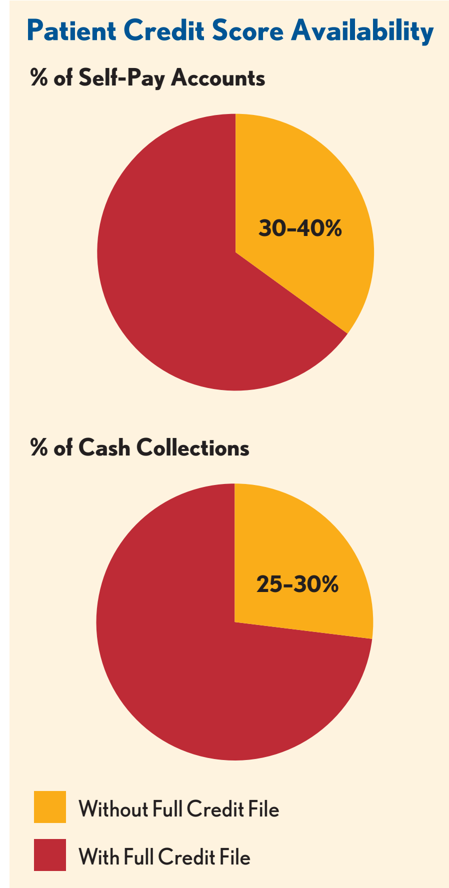

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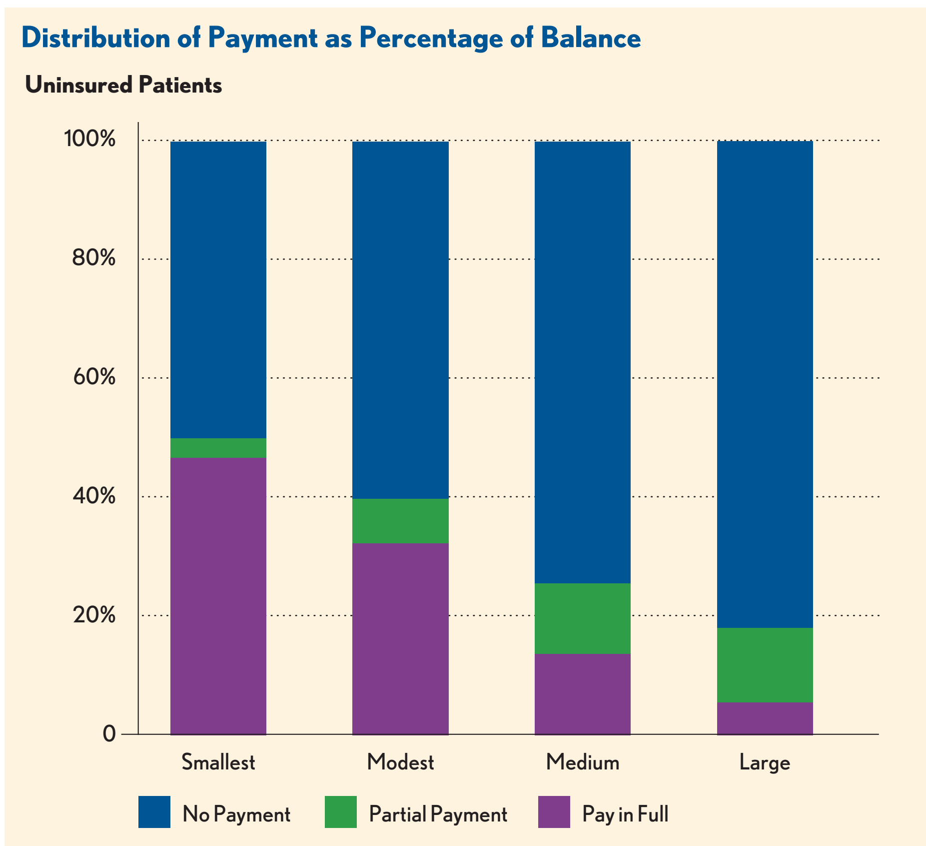

Source: Connance.

depending on the business office operating model. Analytics can segment accounts between those to keep internally and for how long and those to send to an outsource partner. Analytics can identify the specific accounts to settle quickly and guide the settlement amount. Analytics can even identify which specific accounts to connect with a service representative early and which to process through more automated systems.

Use multiple work routines. A one-size-fits-all approach to collection activity leaves money on the table. In a single work process, business offices are going to spend extra money trying to collect on many accounts while not investing enough resources on others. Analytics allow business office teams to segment accounts so that time and energy are invested against the subset of accounts that need the support to cure.

Update policies and procedures. Patient bills are getting bigger and, as a result, discounts and settlements are increasingly critical to overall performance. Recently, charity and point-of-service policies have been getting substantial attention. A similar investment and updating are needed in the business office routine where much more cash is at risk. Critical to successful updates is integration with analytics and different work routines.

In combination, these principles can dramatically improve operating budgets and cash performance. They also open up new avenues for performance improvement. As opposed to simply throwing more resources against the rising tide of patient receivables, operations that bring together analytics, multiple work routines, and policies have a chance to deliver breakout performance.

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