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Payers are shifting liability to patient

Changes under the ACA are 'call to action'

Many hospital leaders expect that the Affordable Care Act (ACA) will increase bad debt, but “it is early in the game to know the extent of bad debt increases,” says **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Passport, part of Experian, a provider of technology for hospitals and healthcare providers. Murphy is seeing these trends in patient access areas:

- **High-deductible plans and patients' increased out-of-pocket costs are increasing the potential for bad debt.**

“As patient balances rise, so does bad debt,” says Murphy. “As bad debt grows, so does the cost to collect.”

- **Payers aren't consistently providing Health Insurance Exchange Marketplace information in their electronic eligibility transactions.**

“This makes identification of these patients more difficult at the onset,” says Murphy.

- **Payers often are slow to divulge information on whether patients have their premium paid up to an end date or whether a patient is in the “grace period” with coverage pending the patient's payment of premiums.**

“Hospitals have received conflicting information as to whether premium payments can be made by providers on behalf of the patient,” says Murphy.

Some patients receiving services during the “grace period” will never pay another premium. “Therefore, the hospital will ultimately have to

refund the payer and try to collect from a patient who is not likely to pay them either,” says Murphy.

Hospitals are giving patients deep discounts for self-pay portions, she adds. However, these might not be enough to deter the account balance from getting classified as bad debt.

Create “collections culture”

Once service is provided to a patient, “the cost to collect goes up, and the likelihood of collecting it goes down,” says **Paul Shorrosh**, CHAM, founder and CEO of AccuReg Front-End Revenue Cycle Solutions in Mobile, AL.

Patient access must be “empowered with systems, processes, and people to create a ‘collections culture,’” he urges. “This does not mean sacrificing the patient experience.”

In fact, patients appreciate knowing what their liability will be and having a plan for how they are going to pay for it, says Shorrosh. “We must consider the ACA's impact on our patient

EXECUTIVE SUMMARY

Hospitals' bad debt is expected to increase due to such factors as higher out-of-pocket costs and failure of patients to pay plan premiums. Patient access can minimize bad debt by doing the following:

- Clear patients financially prior to scheduled services.
- Automate eligibility verification and financial screening.
- Offer online options for bill payment and financial assistance applications.

population,” he adds. “Liability is shifting to the patient.”

More uninsured patients have insurance, he explains, but most patients are now underinsured and face higher deductibles, coinsurance, and co-pays. Whereas in the past, hospitals collected 80% of expected reimbursement from payers and the remaining 20% from patients, “now they collect 60% from payers and 40% from patients,” says Shorrosh. “And that ratio may turn out to be 50/50 in the near future.” (*See related story, below, on how patient access can decrease bad debt.*) ■

Take these steps to reduce bad debt

Dramatic changes in healthcare are a “call to action” for patient access, warns **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Passport, part of Experian, a provider of technology for hospitals and healthcare providers.

“You cannot expect to operate the same way and hope for different outcomes,” Murphy says.

Patient access departments can take these steps to prevent bad debt:

- **Have a comprehensive process to clear patients financially prior to scheduled services.**

If patient access doesn’t have this in place, says Murphy, “they need to develop one immediately or move to outsourcing the management of this process.”

- **Implement automated solutions to streamline eligibility verification, patient identity verification, financial screening, and charity application processes.**

“Optimize financial stratification of accounts at the earliest point in the process,” advises Murphy. “Don’t let the account become a bad debt in the first place.”

- **Prioritize which accounts should receive the most attention and what kind of attention (letter, bill, or phone call) they should receive and at what intervals.**

“Minimize the bad debt opportunity, and work with the patient for best payment outcomes,” says Murphy. “Doing this at the pre-service point or point of service — or prior to discharge, if an inpatient — is most effective.”

- **Offer user-friendly solutions such as web-**

based patient portals.

“Meet consumer expectations with online bill payment, communication, and financial assistance application processes,” says Murphy. “This will add another protective layer for the bad debt potential.”

Empower registrars

As much as 30% to 50% of bad debt likely could have been prevented through front-end denials prevention prior to service, estimates **Paul Shorrosh**, CHAM, founder and CEO of AccuReg Front-End Revenue Cycle Solutions in Mobile, AL.

According to Shorrosh, another 20% to 30% could have been diverted to charity, Medicaid, exchanges, disability, third-party coverage, prompt-pay discounts, self-pay discounts, or extended payment arrangements or charged to available credit balances, paid through non-recourse loans, or handled through other financial options.

“For both patient experience and the revenue cycle, patient access teams at every hospital in the country must change from ‘collection reluctance’ to a ‘collections culture,’” says Shorrosh.

This change requires top-down support, training, and scripting, he says, as well as automated systems for estimation, collections, and financial assistance.

“Systems have to be simple enough so that every registrar —and more importantly, pre-registrar — can divert bad debt before service is provided,” Shorrosh says. She says patient access systems should have these capabilities:

- **Systems that automatically check all self-pay patients for undisclosed coverage from top payers.**

“This alerts your registration or pre-registration employee to flip the plan code from self-pay to a payer code when coverage has been found,” says Shorrosh. “We find that 5% to 15% of self-pays already have insurance.”

- **Systems that alert registrars of the amount patients can pay on a payment plan.**

If an uninsured or under-insured patient scheduled for outpatient surgery cannot afford to pay the estimated \$5,000 liability, but can afford to pay \$1,000 in 10 monthly payments based on their credit and income scores, says Shorrosh, “the likelihood of payment versus nonpayment is much greater.”

“There is a ‘tipping point’ where patients are likely to pay nothing when faced with a sum that is completely out of their reach, as opposed to paying

what they can afford,” says Shorrosh.

Hospitals would much prefer to receive \$1,000 over time than nothing, with the added cost to collect ending in a bad debt write-off, he says. “This bad debt diversion and increased point-of-service collection can both be accomplished during registration or pre-registration,” he says.

- **Systems that automatically alert registrars that prior authorization is required for a procedure, prior to the patient’s arrival, or that the patient’s eligibility, identity, or address is in question.**

Some alerts tell pre-registrars that there is no eligibility with the insurance carrier for the date of service, that there is hidden coverage with a different payer, or that the patient’s benefits are limited or exhausted. The system tells the registrar what options to offer the patient, based on their financial status.

“Now you’re empowering a registrar to reduce bad debt prior to service, and at no additional back-end cost to the health system,” says Shorrosh. “It’s happening already, and new innovations are coming to market.” ■