Three Strategies to Shrink Bad Debt:

Presumptive Charity Care, Propensity to Pay and Partner Management

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Bad debt is not going away.

Despite the advances of the Patient Protection and Affordable Healthcare Act (ACA) related to patient debt (establishing maximum out-of-pocket expenses and other protections), most healthcare finance analysts believe bad debt will increase over the coming years.

Even though more Americans than ever will be covered by health insurance, nearly 10 percent of the nation’s population will not qualify for any coverage under the ACA.

More importantly, new research indicates that the ACA has caused one unintended consequence: the out-of-pocket limit for healthcare exchange plans of $6,350 per year ($12,700 per family) is trending to be the standard for most healthcare plans, regardless of whether they are purchased individually from online marketplaces or provided by employers.

As these high-deductible plans become the norm, remaining balances owed by patients become harder and harder to collect. One healthcare provider recently reported that as much as 50 percent of coinsurance balances are going to bad debt.

What follows are recommended best practices from a wide range of healthcare providers who have managed to stem the tide of bad debt increases.

**Before you begin**

At the outset of any bad debt initiative, it is a good idea to take a hard look at one’s organization and financial structure. Here are three best practices:

1. **Know what bad debt is.** Healthcare providers use different models for coming up with a bad debt calculation. As one expert recently pointed out, if one does not know what model the organization employs, the changes may not be effective. Some organizations, for example, may write off accounts receivable more than 180 days old as bad debt; others may use a model that tracks populations separately, such as writing off self-pays after 30 days, co-insurance and deductibles after 90 days, Medicare beneficiaries after 120 days, and so on.
2. **Ensure accountability.** Reducing bad debt is the responsibility of the entire organization. As will become evident in this whitepaper, managing bad debt starts at the beginning of the patient finance lifecycle and extends beyond revenue cycle staff into the clinical areas.

3. **Establish lines of communication.** Bad debt can explode suddenly, many times as a result of circumstances beyond a healthcare provider’s control (e.g., changes in government regulation or contracts with payors). Not only is it important to stay on top of bad debt trends, but to communicate them in a timely fashion. Many healthcare financial professionals recommend regular meetings with the CFO or CEO beyond traditional reporting. In addition, setting up in-person reporting to clinical and healthcare revenue cycle departments can go a long way toward impressing upon all staff the importance of managing bad debt. Do not forget your partners, especially those working in accounts receivable. Another frequently overlooked stakeholder group is the payors. Hold monthly meetings to review payor issues.

**Identify the source of bad debt—the “where”**

Begin an analysis of the source of bad debt by department. While in many hospitals the majority of bad debt originates from the emergency room, other departments that may be under lesser scrutiny will often times present a substantial opportunity for staunching the flow.

While a broad examination of bad debt by department can turn up trends, a granular approach can also help. To address bad debt originating from an emergency room, one hospital analyzed the amount generated by physician and found some physicians were ordering radiology procedures based on admitting diagnosis, while other physicians (using the same diagnosis) were not. This revealed a training opportunity within the physician group. A hit to bad debt was a concern as many of the procedures might have been avoided if using best practice.

**Identify the source of bad debt—the “who”**

While self-pays have long been a major source of bad debt, another demographic that in the past has been nearly absent from the category is now emerging as one of the most problematic: American workers with access to health insurance from their employers. According to recent research, there are two major trends at work:

- **Employers shifting costs onto employees and/or employees selecting high deductible plans.** As mentioned above, high-deductible plans are becoming the norm. The percentage of employees with high-deductible plans grew from one-fifth to one third in one year, between 2012 and 2013, according to a recent report. Over 40 percent of plans provided a 100 percent coinsurance, another facet of the minimum standards of the ACA.

- **Young people choose to be uninsured.** Another report found 73 percent of those between 50-59 elect to take employer health insurance, but less than 50 percent of workers age 20-29 choose to do so.
**Pinpoint charity care**

Conventional wisdom in healthcare provider revenue cycle circles is that 20 percent to 30 percent of patients who end up in bad debt could have qualified for charity care, but somehow slipped through. The IRS wants to know how providers missed these individuals.

Healthcare providers, specifically those under not-for-profit status, are under pressure from the IRS to provide more community benefit and more charity. Non-profit hospitals must report *all* of their community benefit activities to the IRS under 501(r). For non-profit healthcare providers, the importance of identifying charity care accounts from bad debt appears in Part III on Form 990 Schedule H: “Bad Debt, Medicare, & Collection Practices.” Question 3 asks:

*Enter the estimated amount of the organization’s bad debt expense attributable to patients eligible under the organization’s financial assistance policy.*

The next question on Schedule H asks non-profits to “describe the costing methodology used in determining the amounts reported ... and rationale for including a portion of bad debt amounts as community benefit.”
501(r) tips

IRS 501(r) requires healthcare providers to upgrade and adapt their current business processes around uncompensated care and charity care. Three common challenges will make it difficult for hospitals to efficiently comply with the new regulations:

1. **Insufficient data collection.** Many hospitals are not vigilant about the financial status of their patient population. They either do not collect or do not have systems that can calculate a patient’s financial position with regard to the Federal Poverty Level (FPL).

2. **Inefficient operations.** In many cases a healthcare provider lacks resources in the form of trained staff who can elicit the proper information from patients regarding self-reported patient data, such as patient identity, address, and financial information.

3. **Ineffective reporting tools.** Ever-changing regulations make it difficult for providers to keep up with the requirements for maintaining non-profit status. More importantly, their technological tools are not flexible enough to modify reporting when requirements and regulations change.

Three steps to better comply with IRS Form 990 through proper allocation of bad debt and charity care include:

1. **Continuous tracking.** Hospitals should track charity care continuously, instead of periodically or annually, until the patient account is closed. Charity care tracking should extend to a hospital’s collection partners.

2. **Continuous testing.** Charity care testing should be conducted continuously. The financial situation of any given patient can change quickly, so healthcare providers and their accounts receivable partners should incorporate business processes that include regular examinations of whether a patient qualifies or not for charity care.

3. **Continuous policy updating.** A hospital should review its charity policy annually. This doesn’t mean it should be changed every year, but in the fluid regulatory and financial environment that is not-for-profit healthcare, the charity care policy should be examined to ensure that it meets the needs of the respective patient population and the fiscal constraints of the hospital.
The secret that many healthcare providers have found to not only satisfy the IRS requirements for charity care but also reduce bad debt is to use a process called “presumptive charity care.”

**Presumptive charity care screening**

By incorporating data analytics within the revenue cycle, healthcare providers can reduce the cost of charity care processing, which tends to be a manual, labor-intensive, and subjective process. More importantly, for most providers the process requires that patients fill out a form. Those who qualify for charity care but fail to apply typically become bad debt accounts.

Many providers have realized that since the IRS requires more documentation relating to charity care, it’s more effective to identify those who qualify programmatically, without requiring human intervention. By making charity care determinations for those who can’t afford to pay and those who won’t pay, health care providers can make the charity care/bad debt process more efficient, less costly, and, as many providers have discovered, more profitable.

Accomplishing this task means scrubbing patient accounts using the following publicly available data and consumer analysis:

- Estimated federal poverty limit score;
- Credit score;
- Estimated propensity to pay;
- Estimated propensity to pay medical bills;
- Family size;
- Estimated income.

By programmatically comparing data for each patient against the criteria of the charity care policy, a healthcare provider can automatically qualify a patient. After an initial bill is sent to that patient, if nothing is collected, the account can be written off to charity care.

**Identify propensity to pay**

The other benefit of screening for a patient’s financial condition is that a provider can predict an individual’s likelihood of meeting his or her financial obligation, or their “propensity to pay.”

Providers that have implemented a system where collectors focus on those patient accounts that had been identified as having the highest propensity to pay, rather than expending effort on the those who could not or would not pay, saw an increase in revenue and a corresponding drop in collection expense. Another benefit is that patient satisfaction increased.
Implement upstream

Management of bad debt should begin even before a healthcare provider and patient initiate contact. The key is to lock down a patient’s financial obligation before they arrive for their first appointment and collect as much revenue as possible in the registration process.

- **Pre-registration.** Every organization should be pre-registering at least 98 percent of scheduled patients to identify their insurance status or their eligibility for financial assistance before they receive service.

- **Point-of-service collections.** In these days of higher deductibles and co-insurance, the more revenue collected up front, the better. The effort expended to collect balances upstream increases revenue and reduces collection cost.

Monitor and update throughout the patient account lifecycle

Identifying a patient’s qualification for charity care and evaluating their propensity to pay should not be “one and done” activities. Since the lifecycle of a patient account can extend for weeks, months, and sometimes years, regular reassessment is necessary. Like their physical health, a patient’s financial health can change quickly.

Ideally, reassessment of a patient’s financial status should occur as frequently as checks on the status of their health insurance coverage. It is impractical and counter-productive, however, to have Patient Access or Patient Financial Services staff ask a patient about their employment status, debt load, or other financial information at every appointment (as many providers do when it comes to health insurance). Fortunately, there are tools available to providers that will manage financial screening from external sources in a process that is invisible to the patient.

For those who wish to handle the financial screening process programmatically, there are tools that aggregate and analyze patient accounts in batch form. One of the advantages of managing patient financial assessments in this manner is that it also provides a ready snapshot of your overall patient population financial health. This becomes an excellent sample for identifying trends and their potential impact to the provider revenue stream.

Extend best practices to include your collection partners

In early 2013, the U.S. Department of Health and Human Services released the massive HIPAA Omnibus Regulations. Among other changes, the new regulations clarified and strengthened the legal relationship between providers and their partners, such as collection agencies.
Under HIPAA regulations, hospitals and other healthcare providers are held responsible for the actions of their subcontractors, called business associates, as well as to the actions of their business associates’ subcontractors (at least those that come in contact with patient data).

While HIPAA regulations strengthen the legal bonds between providers and their subcontractors with regard to patient information, the aforementioned IRS 501(r) regulations do the same with regard to patient account collection practices.

But rather than be seen as a bureaucratic burden, many healthcare providers are viewing this as an opportunity to create a more seamless experience for their patients, thereby increasing patient satisfaction.

By viewing the patient accounts receivable lifecycle from first contact until the account is closed, and by regularly assessing a patient’s qualification for charity care and measuring their propensity to pay, you can help ensure that your accounts receivable management partner will be efficient at collecting patient balances, identifying qualified charity care, and reducing bad debt.
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