RevCycle HERO

How to Optimize Your Revenue Cycle with Dignity

RevCycle, Inc.
CUSTOMIZED REVENUE CYCLE SOLUTIONS

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How to Optimize Your Revenue Cycle With Dignity

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Provided as an educational service by RevCycle, Inc., specialists in healthcare revenue cycle management.

www.RevCycle.com

Revenue Cycle Management is every bit as important to healthcare providers as the doctors who are caring for patients. After all, a healthcare provider who is forced to close its doors due to financial pressures can no more deliver healthcare than a provider with no doctors.

In today's society, doctors are often viewed as the heroes who save lives and improve quality of life. This ebook will help put you on the path to making you and your revenue cycle staff heroes in your own right (although perhaps less appreciated) by giving you the tools to ensure the financial survival of your institution.

Introduction

The revenue cycle can be broadly defined as beginning with the appointment process and running through the point where the account balance is zero.

The healthcare marketplace is more competitive than ever before, making the entire revenue cycle a crucial element in customer retention. More consumers are electing high deductible health plans causing higher out-of-pocket expenses, which prompts more comparison shopping.

With all the changes and uncertainty in the healthcare industry, there are several moves you can make that will enhance your institution's reputation while capturing potentially lost revenue.

By the time you are finished reading this book you will understand the inherent obstacles that have been hindering your organization’s performance and how you can successfully clear these hurdles in order to maximize your revenue cycle potential.

Our Approach

RevCycle, Inc. has developed a comprehensive suite of revenue cycle products that give healthcare providers the opportunity to partner with a single vendor to optimize all their revenue cycle processes quickly, affordably, and efficiently. Our mission is to treat our clients’ patients with the dignity and respect they deserve during each phase of the revenue cycle.

Content Overview

Chapter 1

Dignity Rating

Inside Chapter 1:

- Revenue Cycle as a Customer Retention Tool
- Enhancing Revenue Cycle Effectiveness while increasing Patient Satisfaction

1. Dignity Rating

This chapter explains how to increase patient satisfaction by implementing RevCycle's Dignity Rating concept. The Dignity Rating system is designed to enhance patient satisfaction at each touch point in the revenue cycle by setting the expectation with the consumer that they will be treated with dignity and respect and then asking the consumer to confirm that they feel that expectation has been met.

Dignity Survey

Problem: The lack of a proactive approach to achieving patient satisfaction results in reduced utilization of available services and the loss of business to your competition.

Solution: Implement a Dignity Survey to improve patient experience and identify opportunities to enhance your customer service.

Your revenue cycle cannot by fully optimized unless it is treated as a tool for patient retention. Every patient touch point can be an opportunity to build customer loyalty and increase the probability they will utilize your services in the future. Inversely, even a patient that had an exceptional experience with your medical staff can be lost to the competition if they become dissatisfied with your revenue cycle processes.

In our experience, we have found that there is a simple and easy way to implement solutions that can almost instantaneously increase patient satisfaction throughout the revenue cycle. This step is the implementation of what we call the Dignity Survey.

The Dignity Survey has two elements. The first element is to make the patient aware of your commitment to maintaining their dignity. This should be done near the beginning of each patient interaction.

Our staff at RevCycle use the statement, ***"My goal is to treat you with respect and to maintain your dignity during each and every communication, and if you will allow me, I would like to ask you to confirm if I have been successful at the end of our call today."*** We have found that this first element works wonders on multiple levels. As you might imagine, this statement serves to disarm an initially frustrated consumer and helps set a positive tone for the remainder of the call.

What you may not have guessed is that our staff has overwhelmingly reported that they find incredible value in this statement helping them remember that this is their top priority as they are working with difficult consumers. Even during what have historically proven to be the most challenging patient interactions such as "bad-debt collections", the real world benefits of delivering this message to the patient is staggering.

For example, the percentage of outbound phone attempts in which the consumer hangs up on us has dropped by over 75% since the implementation of our

Dignity Survey. Apparently, patients find it difficult to be rude to someone that has just expressed their intent to treat them with respect.

The second element to the Dignity Survey is the collection of data on how the consumer felt about the interaction. Our staff at RevCycle ask, ***"As I stated at the beginning of the call, my goal has been to treat you with dignity and respect, have I been able to accomplish that for you today?"*** The results are then documented by our staff and also verified by our speech-to-text call analytics software.

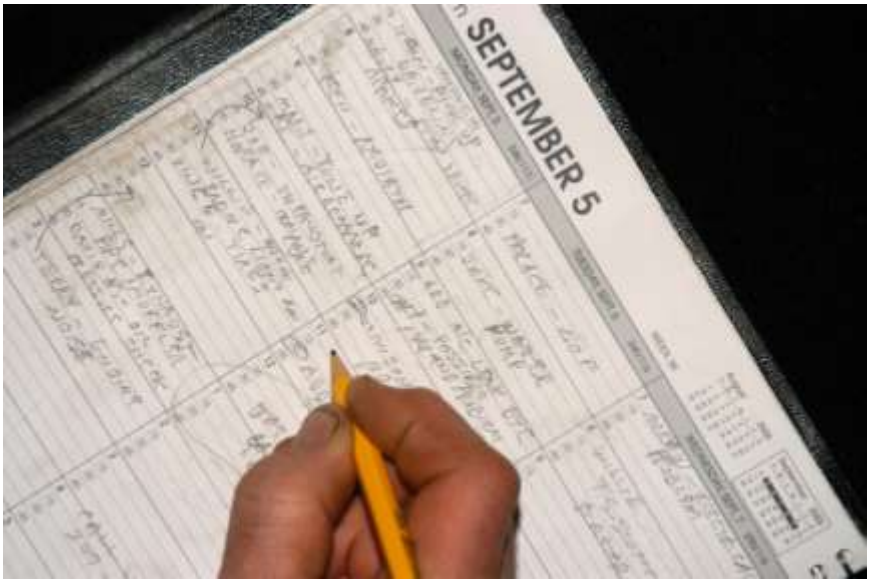
The combination of these two elements results in not only an inherently better patient experience, but also provides a mechanism to identify interactions in which the patient was not satisfied so that we can focus on those interactions to identify opportunities for process improvement.

Dignity Certification

We found the implementation of a Dignity Survey to be so powerful that we decided to share it with the healthcare industry free of charge. Any healthcare provider who implements this system and achieves results that meet or exceed the current industry benchmarks, will receive a copy of our Dignity Certification Seal which you are free to place on your website or on any other printed or electronic form. You will also be recognized on our website as a Dignity Certified organization. For more information on current benchmarks or how to apply for certification, please visit our website at www.revcycle.com/dignity-certification

Chapter 2

Pre-registration



Inside Chapter 2:

- Appointments and Scheduling
- Insurance Verification
- Bill Estimation
- Ability-to-Pay Scoring
- Eligibility Screening

2. Pre-registration

This chapter will highlight four opportunities for improvement in the pre-registration phase that will reduce costs and increase the effectiveness of your revenue cycle.

Appointments and Scheduling

Problem: Missed appointments or "no-shows" reduce potential revenue and increase the average cost to provide service.

Solution: Utilize automated appointment reminder technology that maximizes effectiveness by including features such as "text-to-speech" and real-time call transfers to your appointment desk.

Providers are well aware of the direct loss in revenue that

results from missed appointments. In addition to the obvious loss of revenue from the appointment itself, which for many providers can average between $400 and $800 dollars, the problem is compounded because the fixed costs of idle medical staff are not mitigated during the gaps in the work day.

What is more difficult to quantify is missed opportunities for revenue from follow-up appointments, tests, and surgeries that would have existed if these appointments were kept.

A study performed by *The American Journal of Medicine* in 2010, demonstrated that telephone appointment reminders can be an effective way to reduce these losses.

According to the study, automated appointment reminders resulted in a 25% reduction in "no-shows" compared to no phone reminder.

Manual staff-performed reminder calls were even more effective with a 40% reduction in "no shows". However, the cost of having staff performing manual calls is significantly higher and runs the risk of being overlooked when other job functions take priority.

Much of the added effectiveness of staff-performed calls can be attributed to the ability for patients to cancel or reschedule on the spot. Otherwise, scheduling changes rely on them to write down a call-back number and take the time to call the appointment desk.

Advances in technology provide a "best of both worlds" solution to this problem.

Some automated appointment reminder systems now have the ability to give your patients the option to be transferred in real-time to the appointment desk to make appointment changes. This, combined with other advanced

features, provides the effectiveness of manual calls plus the affordability and consistency of automated calls.

Advanced features have the ability to automate patient-specific reminders, such as:

- to bring medications to the appointment
- to remember diet restrictions prior to a lab visit
- to bring current insurance information

Surprisingly, many providers do not use automated reminder systems. Many of those who do, are not utilizing today's advanced feature sets.

This could be because smaller practices believe the technology requires a large investment that only the large networks can afford.

Or perhaps it is just being overlooked as a practical opportunity to save time and improve systems.

The reality is that the technology does not have to be purchased but can be performed as a service at a very affordable rate for even the smallest medical practices.

Insurance verification

Problem: Incorrect or inaccurate insurance coverage information is the leading cause of claim denials resulting in costly re-work in your billing department.

Solution: Perform electronic insurance coverage verification prior to service.

Performing electronic insurance coverage verification prior to registration can be one of the most cost-effective improvements in revenue cycle operations.

Most studies show that 30-45% of all denied claims are related to eligibility or incorrect coverage information, making it by far the most common denial reason.

A study perfomed by the Medical Group Management Association (MGMA) shows the average cost for a healthcare provider to work and resubsmit a denied claim is $25.

Let's consider a hypothetical provider who submits 50,000 claims per month and has a 10% first pass denial rate.

This provider would experience 5,000 denials of which 1,500-2,250 are related to eligibility. At a cost of $25 per denial, our hypothetical provider would be spending from $37,500 to $56,250 per month working on denials that never had any hope of being paid.

This is compounded by the initial investment of resources in creating and submitting the original claim, plus countless

hours spent in contacting the consumer to obtain current and accurate information. As you would imagine, getting the correct payer information after the fact is sometimes not possible and the balance often has to be dropped to patient responsibility and is sometimes never paid.

Most, if not all, providers have policies to collect this

information at registration or admissions. In our experience, staff tend to breeze by this step when they see coverage information already in the system. They may ask something like *"Is your insurance still through Blue Cross?"* and leave it at that. Many times the consumer may have changed jobs and under a different group number.

By performing electronic coverage verification, providers can identify patients for whom the provider's coverage information will not adequately match the payer's. This will flag those accounts to request full coverage specifics from the patient on their arrival.

It will also allow you to identify patients who are now uninsured prior to providing service, allowing you the opportunity to route them to a financial counselor or to more effectively perform your point of service collection efforts.

Bill Estimation

Problem: The inability to provide consumers with an upfront estimate of their financial responsibility creates patient dissatisfaction and makes the implementation of Point of Service Collection programs more difficult.

Solution: Implement a Patient Financial Responsibility Estimation tool.

Of all the recommendations made in this ebook, implementing a quality bill estimation process may seem the most difficult because there are so many variables.

An accurate estimate is dependent on an accurate cataloging of the discounts contained in each payer contract, as well as accurate data about the patient's specific health plan, including details such as remaining deductible and co-insurance. Luckily, a quality partner will have experts who can extract the contract data for you.

When combined with the insurance verification service discussed in the previous section, it is possible to create reliable fee estimates.

One important feature to look for when selecting a vendor to create these estimates is the ability to track and trend the variance between the estimate and the actual charges. This important feature will allow for the continuous enhancement of your estimation process and will result in increasingly more accurate estimates as time goes on.

Ability-to-Pay Scoring and Program Eligibility Screening

Problem: Failure to identify consumers who should be routed to financial counselors.

Solution: Perform electronic assessment of consumer's ability-to-pay as well as their likelihood to qualify for government programs or financial assistance.

Ability-to-pay scoring is another relatively inexpensive tool that can be used to optimize your revenue cycle efforts. This tool not only estimates a consumer's ability-to-pay in order to better focus point of service collection efforts, but can also provide additional information that can be used to increase reimbursement. By receiving estimated household size and income, providers can identify consumers who are likely to be eligible for government programs like Medicaid.

This information can also be used to estimate the consumer's income compared to the Federal Poverty Line to determine if they are likely to qualify for the provider's

internal Financial Assistance Policy. Either way, providers can use the information to route the consumer to a financial counselor who can assist them in applying for assistance, or to more effectively perform point-of-service collections.

Pre-registration Checklist

- ✓ *Implement automated appointment reminders which incorporate real-time transfers to your appointment desk.*
- ✓ *Perform electronic verification of patient insurance coverage to reduce subsequent denials.*
- ✓ *Implement a bill estimation tool which can be used to facilitate a point of service collections program.*
- ✓ *Utilize Ability-to-Pay scoring to effectively route patients to financial assistance of point of service collections programs.*

Chapter 3

Point of Service

Inside Chapter 3:

- Registration
- Point of Service Collections
- Staff Training

3. Point of Service

In healthcare, just as in all other industries, the faster you are reimbursed for services, the more of each dollar goes to the bottom line. This is true not only due to the time value of money, but because as time passes additional actions need to be taken and each of those actions has an associated cost in terms of both manpower and other resources.

The previous chapter is focused on steps that can be taken prior to patient registration. Those steps are designed to give providers all the tools they need to reduce the cost to collect for services provided.

The point of registration is the culmination of these early efforts and is the critical piece to reducing the overall cost to collect.

Registration

Problem: Failure to obtain valuable data elements from the patient at the point-of-service reduces the effectiveness of the billing and collections processes and increases the average “cost to collect”.

Solution: Utilize technology that allows your registration staff to quickly identify missing or inaccurate data elements and guide them in requesting this information from the consumer.

Here is how the staff will be immediately guided:

- If insurance coverage information was not able to be confirmed during the pre-registration process, it needs to be collected.
- If a patient may qualify for financial assistance, the patient needs to be routed to a financial counselor.
- If you are going to optimize your revenue cycle efforts, a point of service collection effort needs to be made.

With the point of registration being the only guaranteed opportunity for your staff to communicate directly with the patient, it also becomes the ideal opportunity to implement any additional items that can have a positive impact on the revenue cycle.

For example, requiring patients to sign an acknowledgment of your financial policy that includes express consent for you or your agents to contact them on their cell phone using an auto-dialer can have a significant positive impact on the results you realize from your bad-debt collection agency.

Another valuable opportunity that you can take advantage of is to get signed authorization to discuss any outstanding bill with a third party for consumers that do not have a phone. This is especially common in our home state of Wisconsin which has a large Amish population and it is

beneficial for the consumer and the provider to have advance permission to speak with the elder of the consumer's community.

If your current software doesn't have tools that can support your registration staff's focus on these areas, there are bolt-on packages available to meet this need.

For example, RevCycle Inc. offers a product called the **Registration Assist Module,** which sits on your staff's desktop providing a handy summary of all pre-registration data collection. It also includes other tools such as fraud risk alerts and script wizards to guide your staff through the patient interaction and help ensure up-to-date demographic information is collected.

Point-of-Service Collections

Problem: Failure to secure payment of patient responsibility balances at the point-of-service increases the "cost to collect".

Solution: Implement a point-of-service Collection Program.

Point-of-service collections has only recently become a common practice for most healthcare providers and many are still resistant to its implementation. Many providers fear the backlash from a patient population that is accustomed to

being billed later. *Healthcare providers lag behind other industries in this regard.*

When was the last time you heard a consumer upset

because they were asked to pay immediately at the hairdresser or at the auto repair shop? So why is it so common for healthcare providers to provide service without requesting payment?

We believe this is because, until recent years, there were not adequate tools available to estimate what the cost of the service would be and due to the lack of an efficient method to determine what the co-pay or deductible would be for patients who have insurance.

With these tools now readily available, it only makes sense that more and more providers are increasing their reimbursements and reducing their cost to collect by requesting payment at the time of service. *It seems no provider wants the backlash of being the first in the community to request payment up front.*

Uunder today's financial pressures can you afford to wait to get paid?

An effective point of service collection effort is dependent on the utilization of the tools previously mentioned, such as insurance coverage verification and bill estimation.

Once the prerequisite tools are implemented, the next step is to create the policy of payment expectation. This policy should consider items such as how you will define and separate services which are “medically necessary” from those that are elective in nature.

Your policy will also need to be clear on what the protocol will be for instances where the patient is without a method of payment in hand. When will you refuse service? Will the decision be based on account history such as prior bad-debt placements, or will it be based on the “ability-to-pay score” you gathered during the pre-registration phase?

With your completed policy in hand, the final step is to provide the proper training to arm your staff with the skills they will need to be successful.

Companies that specialize in collections can often be a great resource to help create the appropriate training material to use with your staff.

Available Training Classes

The training classes below are examples of some of the courses RevCycle Inc. offers its clients that have proven useful in preparing staff to request payment at the point of service.

1. **Disarm with Charm**
   Understanding what puts consumers on the defensive and how to tactfully negotiate those obstacles are key elements in maintaining healthy relationships. This course provides awareness and education on communication techniques that leverage positive personality traits to build rapport and gain positive control over difficult interactions.
2. **Hostile to Hopeful**
   Dissatisfied or hostile consumers can be the most costly in terms of time, money, resources and public image. This course specifically addresses techniques used in communicating with the most difficult consumers in an attempt to contain problematic issues and regain a healthy provider/patient relationship.
3. **Selling Beliefs**
   Unlike secured debt where collateral could be in jeopardy, unpaid healthcare debt is not generally viewed by consumers as a priority. Collecting on these self-pay balances is about selling ideas in a meaningful and helpful way. This course focuses on positive collection strategies and techniques to help shape consumers'

belief in the importance of paying unpaid balances to their healthcare provider and giving those balances rightful priority when budgeting their finances.

4. **Master Communicator**
   This class teaches students to deliver clear professional messages and become the Master of Communications by exploring practical applications of what we say and how we say it. Staff are trained on techniques such as asking directed questions such as, “Will you be paying by Check or Credit Card?” as opposed to “open-ended” questions such as, “Do you want to pay now?”

Point of Service Checklist

- ✓ Implement technology that provides your Registration Staff with a summary of the data collected during the Pre-registration Phase.
  - Focus registration staff on collecting any missing data.
  - Implement additional steps to better facilitate future recoveries.
- ✓ Implement a Point-of-Service Collection Program.
  - Provide staff with proper training.
  - Utilize available tools to effectively route patients to financial assistance.

Chapter 4

Financial Assistance Program

Inside Chapter 4:

- 501(r)
- Financial Assistance Policies
- Charity Care Investigations
- Case Study

4. Financial Assistance Program

Problem: Overly complicated or strict Financial Assistance Policies (FAP) result in unnecessary administrative burden and can lead to the denial of assistance to patients truly in need.

Solution: Design a policy which eliminates unnecessary bureaucracy and is supported by Application Investigations.

With more than 3,000 tax-exempt hospitals nationwide now subject to the new 501(r) regulations, Financial Assistance Policies have become an extremely hot topic. Although 501(r) does set requirements that these hospitals must have a FAP and includes specific mandates regarding items such as how the FAP is publicized, it does not set forth any minimum eligibility requirements or guidance on how the FAP should be structured.

There is a wealth of information available, from organizations like HMFA, meant to assist hospitals in understanding how 501(r) affects them and offering

guidance in complying with 501(r) requirements, so I will not attempt to duplicate that in this ebook. I will, however, share some valuable lessons learned through the course of consulting with clients on refining their FAP.

Creating Community Benefit

There are many ways in which healthcare providers create community benefit, and one of those is certainly by providing access to care for low-income individuals through financial assistance programs. The intention of these programs is to provide charity care to the deserving. But how do you define who is in need of this financial assistance, and how do you ensure those who are not in need do not take advantage of the system? *It is these questions that help clarify exactly why financial assistance policies are an important component of revenue cycle optimization.*

There are obvious negative consequences on the revenue cycle when an account balance is written off for a consumer who would have had the ability-to-pay. At the same time, continued collection efforts on the account of a consumer who truly is unable to pay has an associated cost which has a negative impact on the revenue cycle as well.

There is no such thing as a one size fits all Financial Assistance Policy. An appropriate balance, which results in a policy which is both fiscally responsible and also creates the desired community benefit, will be different for every provider. Although we can't tell you what that ideal balance is for you, we can offer some information that may assist you in avoiding some common pitfalls when creating your FAP.

We have learned through experience that trying to get too complicated when crafting your FAP can be counterproductive. For example, many providers utilize indigent drug programs which are run by pharmaceutical companies to provide free medications to people who cannot afford their medicine. These programs often require providers to demonstrate that free medications are only being administered to patients who fully meet the criteria of your FAP. If your policy is extremely complicated, it can make it difficult to demonstrate that it is being enforced to the letter.

Following are some best practices that can be used to ease the administrative burden of managing your FAP.

Flexibility in Supporting Documentation

The ideal policy is one that is worded in such a way that it allows some flexibility in items such as required supporting

documentation. For example, some FAPs require Social Security recipients to provide a copy of the actual award letter they received, but many applicants will no longer have that and will give up on the process resulting in a noncompliant denial. Instead, consider allowing applicants to provide copies of bank statements indicating their Social Security deposits.

Requirement to Apply for Other Programs

Requiring FAP applicants to apply for government programs prior to being eligible for assistance under your policy can be beneficial. Many of the patients seeking assistance are not sophisticated in the world of available government programs. By screening patients for likely government program eligibility and assisting those patients through the application process, the need for the same patient to require assistance from your organization's FAP and provide them with increased access to care is reduced.

Commercial Insurance Requirement

There are patients who had access to affordable health insurance, but chose not to participate. When these patients incur unexpected medical expenses, they may turn to your FAP as a form of free insurance. By including a premium affordability measure, using Medicaid guidelines as a benchmark, your policy can differentiate those who truly couldn't afford the premium.

Create Clear Application Investigation Protocols

RevCycle, Inc. as well as some other quality vendors, offer services which will review FAP applications and supporting documentation, as well as perform additional research using tools such as real estate records or motor vehicle asset searches to determine applicants' true eligibility under your FAP. The creation of clear protocols for your staff to use during the evaluation process will expedite the review and result in unbiased conclusions.

For example, when calculating the true income of self-employed applicants, your staff will benefit from the development of clear guidelines on what areas of a tax document can be "added back" to income. For instance, the Earned Income Tax Credit is not an out-of-pocket expense, and although an allowable deduction when determining taxable income, it is available income to the applicant. Other examples of possible add backs include, depreciation found on line 13 of a Schedule C, or Additional Child Tax Credit on line 65 of form 1040. Identifying items like these along with the lines on the tax documents they appear will create clarity for staff.

Financial Assistance Policy Checklist

- ✓ Ensure FAP is not overly complicated.
- ✓ Incorporate some flexibility in patient requirements for supporting documentation.
- ✓ Utilize requirements to apply for other programs and/or commercial insurance.
- ✓ Create clear investigation procedures.
- ✓ Consider the use of Presumptive Eligibility Scoring.

Chapter 5

Denial Management and Insurance Follow-up

Inside Chapter 5:

- Claim Denial Analytics
- Payer Trend Analysis
- Insurance Follow-up

5. Denial Management and Insurance Follow-up

Claim Denial Analytics

Problem: The failure to correct systemic billing issues results in unnecessarily high work volumes for insurance staff and increases the average cost to collect.

Solution: Implement a denial management analytics package to identify process improvement opportunities.

Industry averages for first pass denials range from 20-30% and studies performed by HFMA have indicated that up to 90% of those denials are preventable. Denials resulting from registration inaccuracies, insurance eligibility, charge bundling, and pre-authorizations, are all examples of issues that could have been prevented with improvements to front-end processes.

Failure to correct the systemic issues causing these denials can be incredibly expensive.

A study performed by the Medical Group Management Association (MGMA) shows the average cost for a healthcare provider to create and submit an initial claim to be about $5. However, the cost to work and resubmit a denied claim averages an additional $25.

Today's denial management tools allow providers to perform payer trend analysis, which can help identify preventable denials. Many healthcare providers are still trying to correct individual claims instead of identifying and correcting the systemic issues that are the root cause of the denials.

A quality payer trend analysis will allow you to identify and focus on the biggest opportunities for process improvement specific to your organization whether they are in coding insurance information accuracy, pre-authorization, or others.

Insurance Follow-up

Problem: Limited resources cause many healthcare providers to focus only on balance size and age to prioritize their work lists.

Solution: Implement an efficient work-flow supported by automated claim status checking and web based follow-up tools.

By working the highest balance accounts first and diverting their attention to smaller balance accounts only as they approach timely filing deadlines, many providers find themselves playing a never ending game of "catch-up". This can prove to be a game you can never win, especially if you are still performing follow-up on a claim-by-claim basis.

Typical inefficiencies in insurance follow-up work-flows go deeper than simple sorting and prioritization. It is common for a provider's insurance staff to be required to research each and every denial, and then in many cases, forward the account to another department for resolution. However, truly

advanced work-flow engines, such as the one offered by RevCycle, Inc., utilize and link 837 and 835 data to pre-status accounts by “likely next action”.

This feature creates efficiency for your insurance staff because they can more quickly resolve accounts when they know ahead of time what the probable issue is. Accounts in which the denial indicated “patient deductible” are grouped separately and staff can much more quickly review and drop the balance to patient responsibility.

This type of segmentation also allows for the ability to intelligently route denials to different types of staff depending on the anticipated issue. For example, coding errors can be segmented into their own work list for review by your coders, without having to be reviewed by insurance staff.

Batch Automation

Another benefit of advanced work-flow tools is the ability to create automation. Claims submitted with no record of a corresponding remit can have automated 276/277 electronic claim status checking performed before your insurance staff works the account. Batch automation also becomes possible. For example, accounts in which the payor balance equals the amount denied as a contractual discount can

have the adjustments made via an automated batch process without the manual effort of insurance staff or cashiers.

More efficient web-based follow-up tools are another advancement that can create an incredible level of efficiency for your staff. In cases where 276/277 electronic claim status checks are not possible, staff can navigate through payor websites, including the entry of usernames, passwords and subscriber information with a single click and arrive at the claim detail screen instantaneously.

Denial Management Checklist

- ✓ Utilize payer trend analysis and analytics to identify process improvement opportunities.
- ✓ Implement insurance follow-up technology to significantly reduce costs.

Chapter 6

Patient Responsibility Balance

Inside Chapter 6:

- Payment Policy
- Patient Billing Statements
- Patient Follow-up (Self-pay Collections)

6. Patient Responsibility Balance Recovery

Payment Policy

Problem: The absence of a well-designed and consistently enforced payment policy, negatively impacts the aging of your AR and increases the average "cost to collect".

Solution: Implement a formal payment policy which provides a practical option for all potential patients.

An effective payment policy is the foundation for creating efficiency and effectiveness in recovering patient responsibility balances.

The goal should be to recover the full balance owed as quickly as possible, however realistically only a small portion of the population have the financial resources to do so. It is still a best practice to send initial patient billing statements requesting the full balance to be paid immediately.

Obviously, the hope is that as many patients as possible pay their full balance on the first statement they receive. *But what is the ideal strategy for patients that don't have the ability to pay the full amount immediately?*

Providers who implement a payment policy which is too strict, risk alienating a valuable portion of the patient population, while providers with too soft of a payment policy risk suffering the financial consequences of ever increasing volumes of outstanding and aging A/R.

An even greater risk than being too strict or too soft, is to have no formal payment policy at all.

I have seen many providers who do not have a formal payment policy resulting in inconsistent experiences for patients with some accounts being allowed to make payments as low as $25 per month on balances of several thousands of dollars. Other patients who had the ability to make reasonable monthly payments, end up in collections because they were told they must pay the full balance.

First and foremost, it is recommended that providers create a formal policy and enforce that policy. Exceptions are made in only the rarest cases.

If moving from a lax or non-existent payment policy to a formal policy which is regularly enforced, providers can expect some growing pains. However, doing so will condition your patient population for payment and over the long-term will result in more patients paying proactively and less effort needed from your staff to contact patients to request payment. I would argue that almost any formal payment

policy is better than none at all, but in order to maximize recoveries, it is well worth spending the time to create the best possible policy.

One consideration in forming your policy should be your local competitors. Having a policy which is stricter than other providers can reduce patient satisfaction and give an advantage to your competitors. The goal shouldn't be to have the softest policy in the area, but simply one that is on par.

A survey of providers in our home state of Wisconsin indicated that a competitive payment policy would be one which required approximately 10% of the patient balance be paid each month.

The true test of a quality payment policy is determining if the policy provides most, if not all consumers with a viable option. The most common flaw we see with payment policies is that they leave a gap between the patient population that can afford to meet the minimum criteria and the population that is eligible for financial assistance, charity care, or government programs.

*We recommend to our clients that they bridge the payment gap by implementing an **internally funded loan program** that allows patients to extend the term of their repayment in exchange for signing a loan contract with a reasonable interest rate.*

Payment policies that do not have a mechanism to bridge the gap are often unintentionally creating an incentive for consumers to allow their account to go to bad debt.

RevCycle Hero:
How to Increase Your Cash Flow with Dignity

RevCycle, Inc. has always believed in establishing reasonable payment arrangements to bridge the payment gap based on the consumer's true ability to pay. During the

course of performing bad debt collections, we have all, too often, heard consumers tell us that they would have never gone to collections if the provider would have allowed the same arrangement that the collection agency accepted.

That can be a costly mistake for providers as they have not only delayed recovery of the balance but also incur the commission expense that results for having the collection agency recover the balance on their behalf.

Case Study: Marshfield Clinic

Situation Summary:

Marshfield Clinic, a large healthcare operation which employs over 700 doctors and more than 6,000 additional support personnel, was interested in capturing a higher percentage of lost revenue. At the time, the clinic's financial policy included two options for patients who did not have the means to pay in full.

The first option was a payment plan which allowed patients to split the balance into as many as 9 monthly payments (or 12 monthly payments if the bill was over $5,000). The second option was to apply for Charity Care which provided either full or partial write-offs of balances for extremely low income households.

Although Marshfield's payment policy was superior to providers that had no formal payment policy in place, it was still under-serving a large portion of the patient population which lacked the financial means to pay under the terms of

the payment plan yet exceeded the income limits to qualify for Charity Care. Patients who fell into this gap found themselves at risk of being placed in collections.

RevCycle's, Inc.'s Strategy:

Our strategy to fill this payment policy gap was to implement an internally funded loan program that would allow the patient to split their balance over up to 48 months. The patients would be automatically approved without credit checks or underwriting. They simply sign and return a loan contract. We knew that keeping it simple would result in the highest volume of successful debt-to-loan conversions.

The additional recommendation was to add an interest rate of 7.9%, which was determined to provide patients an extremely low no-collateral rate. Plus, the rate was determined to be high enough to guarantee Marshfield Clinic extra income to compensate for the additional delay in reimbursement.

The addition of the loan program not only provides an option to patients who would have otherwise faced collections, but it also allows the Marshfield Clinic to increase recoveries without any additional risk. After all, even with no credit checks or underwriting, the worst case scenario is that the patient fails to fulfill their loan obligation and would be placed in collections, which was already the inevitable result for this portion of the patient population prior to the implementation of a loan program.

The big picture is that the Marshfield Clinic now has a comprehensive financial policy which allows them to serve all patients from those who can afford to pay in full to those

in need of Charity Care, and everyone in between. The result is less patients being placed in collections, more dollars being recovered, and a higher rate of return compared to collections as the only option.

The Results:

Marshfield Clinic's average gross recoveries under the loan program equal 98.5% of the initial principle balance by the 48th month from conversion. As you can surmise, the interest rate was able to offset most of the defaults.

2010 Comparison			
Internally Funded Loan Program		***Collection Agency Only (No Loan Program)***	
Principle Balance Converted to Loan	$4,383,947	$4,383,947	Dollars at Risk of Collections
Gross Recoveries	$4,345,752	$876,789	Projected Recoveries by Collection Agency (Industry Avg 20%)
Loan Servicing Fees	$325,931	$175,358	Projected Collection Agency Commission
Net Recovery	$4,019,821	$701,432	Projected Net Recovery

A comparison of actual data from 2010 shows the Loan Program increased recoveries for this portion of the patient population by 5.73 times and yielded a single year benefit to Marshfield Clinic of $3,318,389.

Performing Patient Responsibility Collections

With the solid foundation of a formal payment policy in place, providers can then focus on maximizing their patient responsibility balance collections. These collection efforts typically include a combination of mailing billing statements and performing outbound follow up calls.

Billing Statements

Problem: Even "patient friendly" billing statements result in patient dissatisfaction because of the confusion caused by separate statements for each encounter, each facility, or the separation of facility and professional charges

Solution: Implement an enterprise-wide Combined Guarantor Billing Statement which is in harmony with your Patient Responsibility Balance collection efforts.

"Patient Friendly Billing" has been a focus of the healthcare industry as a whole in recent years. The initiative has been spearheaded by the Healthcare Financial Management Association (HFMA), and has been widely successful in creating guidelines that have assisted providers in creating billing statements which are more clear, concise, correct, and patient-friendly.

HMFA created their Patient Friendly Billing initiative with purpose of producing:

- Higher patient satisfaction

- Better informed and more medically compliant patients
- More accurate billing statements
- Fewer patient questions about billing statements
- Higher percentage of collections of billed charges
- Faster collections from patients of the balances owed

There is no question that each bullet point is directly tied to an efficient revenue cycle. However, even when following all published Patient Friendly Billing best practices, most providers aren't doing enough to maximize the potential benefits of an exceptional patient billing process.

Even with the strides the industry has made in making individual statements easier to understand for the average consumer, the overall billing process still creates widespread

confusion and dissatisfaction. This lingering confusion results from a disconnect between the overall patient experience and billing practices.

For example, one common healthcare billing practice is to send the patient separate statements for facility and professional charges even when both are part of the same health system. This can be understandably confusing for a patient who experienced a single instance of treatment but received two bills.

Another common point of confusion occurs when a patient has multiple encounters at a hospital within a short period of time. In these cases a patient may receive multiple statements from a hospital reflecting different amounts due.

An exceptional patient billing process is one that is in alignment with the patient experience. *One way to achieve this alignment is by creating a combined guarantor billing statement which is tied directly to all other elements of your self-pay collection efforts*.

A true combined guarantor billing statement should include all balances owed by a consumer to a single health network, and should include both facility and professional charges spanning all facilities.

Health systems considering a combined guarantor billing process face an intimidating list of challenges. These can include technical challenges, such as merging data from multiple patient accounting systems which have no unique

patient identifier, and political challenges such as how to prioritize allocation of patient payments.

RevCycle, Inc. has developed a custom software package which effectively overcomes these challenges. By accepting the native exports from each disparate HIS system, The RevCycle software is able to create a combined guarantor level account. This not only produces the combined guarantor billing statement, but also has the basis for a combined guarantor work-flow. The result is that the overall patient responsibility balance collection efforts are in harmony with the patient's experience.

Additional benefits of the RevCycle software system are:

- the ability to place individual encounters or charge-lines on hold without impacting the entire billing process
- the ability to accept a single repayment arrangement from the patient and have that single payment automatically allocated to or split between the various patient accounting systems according to any desired pre-defined rule set
- providers are able to create a truly patient-friendly billing process by incorporating HFMA's Patient Friendly Billing guidelines with the combined guarantor billing concept

Patient Follow-up

Problem: Ineffective or inefficient Patient Responsibility Balance collection efforts cause reduced reimbursements, increased aging of AR, and an increased average "cost to collect".

Solution: Utilize a separate staff who specializes in, and focuses solely on, collection efforts.

Utilizing a combined guarantor patient account certainly goes a long way in creating effectiveness and patient satisfaction in the collection process, but there are a few other pitfalls to watch out for.

Pitfall 1: For those who in-source their collection efforts, the most common mistake is to assign responsibility for collections to the same staff who are handling general customer service and insurance related questions, which means collections will be the most uncomfortable part of their job. *As a result, human nature will lead them to make it the lowest priority when they get busy.*

If your organization desires to keep collection efforts in-house, you can achieve the better results by designating a group of employees to specialize entirely on collection efforts. Not only will this allow you to ensure there is a consistent focus on collections, but you can achieve a higher level of training in collection specific communication techniques for dedicated staff, which is critical to realizing good results.

Pitfall 2: Almost as important as a dedicated collection staff, having an effective work-flow plays a huge role in achieving a quality result. Unfortunately, most patient accounting systems fall short of providing the flexibility to implement an effective work-flow, which is important because:

- First, it is the mechanism to ensure that each and every account receives an appropriate level of effort, and that those efforts are timely.
- Secondly, it is crucial in enhancing patient satisfaction.

In the absence of a quality work-flow, not only is your staff less efficient, but accounts can often get “lost” for extended periods of time which slows overall recoveries and can cause patient complaints.

Work-Flow Tips

The complexities of developing a quality work-flow are too detailed to fully explore in this short ebook, however I can give you a few valuable pointers.

1. Use "account segmentation" in your outbound contact efforts. For example, if you segment the accounts which have made a recent payment that fell short of meeting your payment policy criteria into their own "pool", your staff can begin those specific calls. They can start by thanking the patient for their recent payment, as opposed to fumbling though the first portion of the call while they read the account history in an attempt to give the patient specifics about the reason for today's call. This saves time and allows your staff to be able to make more calls each day, and it results in a more positive experience for the patient.

2. Use exception reporting to identify accounts which have not had sufficient collection activity. When new clients come to RevCycle looking for help managing their collection efforts, we have uncovered countless horror stories where clients have had staff put accounts on hold and forget about them. This resulted in surprisingly high volumes of accounts in which the patients have not been billed or contacted about their balance for extended periods of time, *in some cases years!*

Case Study: Ministry Health Care

Situation Summary:

Ministry Health Care believed their internal Patient Responsibility Balance collection efforts were very effective. Due to staffing shortages, Ministry Health Care decided to outsource their Patient Responsibility Balance collections to RevCycle Inc., so that their existing staff could focus on working insurance payments and denials that were piling up.

RevCycle's Results:

Ministry Health Care's average recovery percentage increased by 24.5% over previous levels resulting in an average monthly increase in patient payments of over $800,000.

Missed Opportunities:

- Not having dedicated staff; multiple duties, including insurance, pushed off because it was less comfortable with collections
- Staff wasn't trained in negotiation
- Didn't have a segmented workflow to ensure.

Summary:

It did not take long before RevCycle identified their systems' weaknesses and implemented procedures - both digital and for the staff - that, when put in place, changed the scope of their revenue cycle results. Most health care companies would find similar results.

Patient Responsibility Balance Checklist

- ✓ Implement and enforce a formal payment policy.
- ✓ Implement an internally funded loan program to bridge the gap between your payment policy and your FAP.
- ✓ Enhance patient balance collections and patient satisfaction with a true Combined Guarantor Statement.
- ✓ Optimize patient follow-up calls by designating dedicated staff to the collections function.
- ✓ Utilize account segmentation strategies to increase efficiency and further enhance patient satisfaction.

Chapter 7

Bad Debt

Inside Chapter 7:

- Choosing a Collection Agency Partner
  - Cultural Alignment
  - Cost and Value
  - Effective Placement Strategy
  - Measuring Partner Performance

7. Bad Debt

Since nearly all bad debt collection is outsourced, the difficult undertaking of choosing the right collection agency partner(s) and placement strategy is one that is faced by CFOs and Revenue Cycle Directors across the country.

According to a 2013 study commissioned by ACA International, third-party collection agencies recover over 20 billion dollars annually of behalf of the healthcare industry. With so many dollars at stake, choosing both the right collection agency partner(s) and placement strategy is critical.

In addition to their importance, these decisions also tend to be difficult to analyze. I was recently told by a hospital CFO that over the years he has reviewed dozens of collection agency proposals and that there appears to be very little difference between agencies on paper.

Every agency claims to have the highest level of performance in dollars recovered, patient satisfaction, client service, compliance, reporting, security, and technology. In order to cut through the marketing and make informed

collection agency strategy decisions, providers need a better understanding of candidate agencies than can be supplied by their proposals alone.

Providers should verify agency healthcare experience and talk to references with a focus on culture and complaint history. Agency-provided performance metrics should be disregarded in favor of provider-created comparative scorecards to create a more accurate picture of relative agency performance.

Advertised agency commission rates should be considered only as a piece of a larger formula used to determine real world value. And finally, ongoing agency performance should be measured on consistent metrics that have proven statistical validity.

This chapter will give you the tools you need to make an informed decision in these areas by breaking the evaluation process down to 4 steps:

Step 1: Cultural Alignment

Step 2: Cost and Value

Step 3: Effective Placement Strategy

Step 4: Measuring Partner Performance

1. Cultural Alignment

Choosing a partner with cultural alignment may be the most important step in developing your Collection Agency Vendor Strategy.

Healthcare differs from other industries in that a consumer's bad debt doesn't necessarily signal the end of the relationship. For a lender specializing in car loans, preserving the customer relationship with a consumer who has defaulted on a loan contract may not be critical. After all, it is extremely unlikely that the lender would choose to do business with that consumer in the future.

However in healthcare, consumers often incur debt unexpectedly, and if handled correctly, have the potential to continue to be valued consumers in the future. Additionally, healthcare providers are often held to a higher standard in the court of public opinion. Again, the lender issuing car loans may not lose many future customers for their less than empathetic approach to recovering bad debt, but in healthcare, a similar approach can result in a public relations nightmare. For this reason, evaluating the cultural alignment of potential collection agency partners should be your first step in your selection process. Potential vendors who do not measure up in this area should be excluded from

consideration immediately. This has the added benefit of reducing the number of agencies to perform more in depth evaluations on in the subsequent steps.

Cultural Alignment Checklist

- ✓ Evaluate agency experience specific to healthcare providers.
- ✓ Evaluate agency's consumer complaint log and complaint resolution protocols.
    - Steer clear of agencies who claim they have never received a complaint or are not able to produce a complaint log or detailed complaint resolution procedure.
    - Check with the CFPB and State Attorney General offices for complaints not appearing on log.
    - Does agency record all collection calls and do they make these recordings available to their clients for review?
- ✓ Ask agency for a detailed history of any lawsuits filed against them by consumers.
    - What was the basis of each suit and how have they subsequently changed their practices?
- ✓ Evaluate agency's mission statement.
    - Ask agency to detail their philosophy on consumer interactions.
- ✓ Make sure to call agency references.
    - Get references about agency complaint volumes and patient satisfaction levels.

2. Cost and Value

Choosing a partner on cost and value is probably the most confusing step. Most collection agencies operate on a contingency fee structure. This means that their compensation is directly tied to their gross recoveries on your behalf. Because of this, it is not possible to compare the price of two competing agencies based on the face value of their commission rate alone. The chart below better illustrates this concept.

	Agency 1	Agency 2
Commission Rate	25%	18%
Bad Debt Placements	$30,000,000.00	$30,000,000.00
Average Recovery %	21.6%	16.4%
Gross Amount Collected (Placements *Recovery %)	$6,480,000	$4,920,000
Commissions	$1,620,000	$885,600
Net Back Recovery	**$4,860,000**	**$4,034,400**

In the above example, both the commission rate and the commission dollars paid to Agency 2 is lower. At first glance this would lead you to believe that Agency 2 has a better price. But after a closer look, you will see that Agency 2 actually cost the provider $825,600 more than the cost of Agency 1. This is calculated by taking the total collections achieved by each agency and then deducting the

commission dollars that would be paid to each, thereby arriving at the dollars actually returned to the provider, called "netback".

Once this concept is understood, the next step is to determine each agency's projected recoveries. Unfortunately, this is more difficult than it sounds. If you were to ask 10 potential agency partners to provide their typical recovery rates, you would likely receive responses that were calculated 10 different ways.

Recovery rates are generally understood to be calculated by dividing dollars recovered - by dollars listed.

Some agencies deduct dollars from accounts that are now closed from the original amount listed before performing their calculation. Other agencies may only quote the average recovery rates they have achieved on their best performing clients.

The bottom line is that agency self-reported recovery projections are unreliable for performing comparisons. To complicate the issue even more, consider the differences between the clients that each agency serves.

For example, if Agency 2 serves a hospital which provides predominately emergency services in a lower income urban area, and Agency 1 serves a physician clinic in a wealthy suburban area, Agency 1 would be likely to achieve much higher recovery rates. If you also consider differences between each provider's internal processes such as billing, coding, claims management, and add to that payer mix

differences it becomes apparent that comparing how one agency performed at one facility to how a different agency performed at a separate facility is not apples to apples.

The best solution for measuring agency recovery performance is to learn from the experience of other providers.

Ask each agency for the most recent copy of all scorecards provided by their current client base. This will give you a good sense of how each agency has performed relative to their competition on the clients they currently serve.

Is an agency under consideration typically in the middle of the pack on their scorecards, or are they almost always the top performer? In many cases you will find that several agencies under consideration already compete with each other on several clients/providers and the scorecards will give you real apples to apples comparisons to project how each agency will perform relative to one another.

Once you have compiled your best assessment of relative performance, you can start plugging numbers into an Excel spreadsheet to better analyze the cost of each agency using the “netback” concept.

RevCycle Hero:

How to Increase Your Cash Flow with Dignity

Agency	Agency 1	Agency 2	Agency 3	Agency 4	Agency 5
Proposed Commission Rate	28%	22%	18%	15%	11%
Sample Placement Volume	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Target Recovery Rate	25%	25%	25%	25%	25%
Relative Performance	100%	94%	86%	77%	73%
Projected Recovery Rate	25.00%	23.50%	21.50%	19.25%	18.25%
Projected Dollars Recovered	$250,000.00	$235,000.00	$215,000.00	$192,500.00	$182,500.00
Projected Commission Expense	$70,000.00	$51,700.00	$38,700.00	$28,875.00	$20,075.00
Projected Netback Recovery	$180,000.00	$183,300.00	$176,300.00	$163,625.00	$162,425.00

Example 2

In the example above, the best pricing comes from Agency 2. They didn't have the lowest commission rate, or even the highest relative recovery, but their combination of proposed commission rate with strong recoveries resulted in the best value. In this case Agency 5 was the lowest rate offered, but would actually cost $20,875.00 more for each one million dollars placed with them. For a provider with $30 million in annual bad debt listings, choosing the agency with the lowest advertised commission rate would equate to a $626,250.00 mistake!

Of course there are other items that should be considered in a value analysis. What is included in each agency's base rate? Some agencies charge extra for things like custom reports or bankruptcy scrubbing. Some agencies provide better client service than others. Be sure to read each proposal carefully, and don't be afraid to put a dollar value on extras some agencies include in their base rate.

Cost and Value Checklist

- ✓ Understand "netback" concept
- ✓ Evaluate provider created scorecard data
- ✓ Create relative performance ranking
- ✓ Use Relative Performance Data and Agency Rate Proposals to determine true pricing
- ✓ Make adjustments for each agency's unique value proposition

RevCycle's programs can keep your revenue cycle as healthy as you keep your patients!

3. Selecting an Effective Placement Strategy

Selecting an effective placement strategy now becomes the next critical decision in the process.

Should you partner with a single agency, or use multiple agencies?

Should all placements remain with the agency(s) indefinitely, or should accounts be recalled at some point for placement with a secondary agency?

There is no single correct answer to these questions. There are inherent advantages and disadvantages to each.

Single Agency vs. Multiple Agencies

Choosing to use a single agency reduces the provider's administrative costs. There is efficiency in working with a single point of contact for questions and concerns. There is only one style of report to become familiar with. Your IT department doesn't need to create multiple import and export routines to place, track and recall accounts from the agencies.

In the event of a patient complaint, you will know exactly where to begin your investigation and you will develop a stronger partnership as the agency and provider learn how to work together to achieve the best results with the least amount of effort and administrative burden.

Additionally, by leveraging your entire potential placement volume, you may be able to negotiate a lower rate with the single agency of your choice. However, when using a single

agency, there is no benchmark to gauge future performance. You are essentially left in a situation where you hope that you chose the best agency, but don't have any ongoing comparative data to validate this.

Let's use the 5 agency comparison chart we used during the value analysis to better understand our options.

Agency	Agency 1	Agency 2	Agency 3	Agency 4	Agency 5
Proposed Commission Rate	28%	22%	18%	15%	11%
Sample Placement Volume	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Target Recovery Rate	25%	25%	25%	25%	25%
Relative Performance	100%	94%	86%	77%	73%
Projected Recovery Rate	25.00%	23.50%	21.50%	19.25%	18.25%
Projected Dollars Recovered	$250,000.00	$235,000.00	$215,000.00	$192,500.00	$182,500.00
Projected Commission Expense	$70,000.00	$51,700.00	$38,700.00	$28,875.00	$20,075.00
Projected Netback Recovery	$180,000.00	$183,300.00	$176,300.00	$163,625.00	$162,425.00

If a provider with 30 million in annual bad debt listings chose to split their business between Agency 2 and Agency 3, the result would be $105,000 less netback recoveries than using Agency 2 alone.

That is an expensive way to validate that Agency 2 was the best choice, and that is just the start. The $105,000 is just the lost opportunity from the first year of placements. Over the long-term, that number should be multiplied by the number of years this structure remained in place.

On the other hand, if a provider had chosen to place exclusively with Agency 3, the provider would be losing $210,000 per year and not have the comparative data available to realize it.

In the end, if you trust your decision process and your agency partner, using a single agency has the potential to provide the greatest value by providing leverage to negotiate the best possible rate with the best agency - in addition to reducing internal administrative costs of managing multiple agencies.

Secondary Agency Placement Strategy

Deciding whether or not to use secondary placements as part of your strategy should be considered as well. There is a thought that a primary placement agency only invests their maximum effort on accounts for a short period of time after placement.

This theory leads to the belief that recalling accounts from the primary agency and re-placing with a secondary agency renews the level of effort made on your accounts and results in a higher return. In some cases this may be partially true.

Primary placement agencies typically have the lowest commission rates and in order to remain profitable at those rates, they may focus their efforts on the accounts they

deem most likely to be collected. This determination is sometimes made by using analytic models, but is also made by assessing the results of preliminary collection efforts. In short, some agencies give up on accounts that prove difficult to collect.

Determining the value of utilizing a secondary agency placement strategy depends largely on the primary agency you have selected. In today's collection industry, many agencies have found that despite the concepts detailed in this whitepaper, many providers choose their agency partner based only on the lowest advertised commission rate.

In order to continue to sign on new clients, some agencies engage in rate wars and offer lower and lower rates. The resulting competitive environment would seem to create a soft market that would benefit healthcare providers. However, the reality tends to be the opposite. It is actually this particular dynamic that leads to Agency 5 from the example above to be the worst value of all the available choices. As a result of the low rates they offer, these agencies have no choice but to "cherry pick" the easiest to collect accounts and are unable to invest in producing best in class results.

These are the very agencies whose initial performance seems to flatten out very quickly, and from whom it makes the most sense to recall accounts from and place with a secondary agency.

However, secondary agencies' rate structure is much higher and often times the combination of a low rate primary agency followed by a secondary agency, produces less

value than utilizing a high quality primary agency who will continue to perform well over the long-haul. Consider the following example of the two competing concepts.

	Low Rate Primary + Secondary Placement Strategy			High Quality Primary Only Placement Strategy
Agency	Primary Agency	Secondary Agency	Primary + Secondary Total	High Quality Primary Agency
Proposed Commission Rate	11%	28%	11%/28%	22%
Sample Placement Volume	$1,000,000	$920,000	$1,000,000	$1,000,000
Placement Period	6 months	54 months	60 months	60 months
Projected Recovery Rate	8.00%	15.00%	22%	25%
Projected Dollars Recovered	$80,000.00	$138,000.00	$218,000.00	$250,000
Projected Commission Expense	$8,800.00	$38,640.00	$47,440.00	$55,000
Projected Netback Recovery	$71,200.00	$99,360.00	$170,560.00	$195,000

In the example, a provider using the primary plus secondary placement strategy would cost $24,440 (per one million dollars placed) more than using the primary only placement strategy. For a provider with annual bad debt listings of $30 million, that is a $733,200 difference each year.

The unique dynamic of the healthcare industry tends to create other issues with utilizing a secondary placement strategy. In contrast to other industries, such as loan companies previously mentioned, bad debt in healthcare does not necessarily end the relationship with the consumer.

As a result, it is quite common to have a consumer who already has a bed debt account placed with an agency to incur new charges which flow separately through the process and may ultimately lead to multiple accounts in bad debt for the same consumer.

Healthcare providers who use secondary agencies will inevitably have consumers who concurrently have accounts from a single provider placed with two separate agencies (primary and secondary).

<u>This scenario presents the following challenges:</u>

1. **Concurrent collection efforts from multiple agencies on behalf of a single provider causes confusion for the patient and increases the administrative burden on providers.**
    - Consumers who are contacted by multiple agencies regarding balances from a single creditor tend to want proof on EVERY debt as to which charges are with which agency, to be sure they are not double paying for the same charges.
    - It is common in these cases for consumers to believe they paid their entire debt when reaching a zero balance with one agency. This results in a flood of requests for old itemized statements which increases the administrative burden on the provider's staff.
2. **Using a secondary agency would create a conflict of interest in terms of which debt needs to be paid first.**
    - Each agency works on commission and will tend to communicate to the consumer that the portion of the debt being handled by them is the most urgent to pay first.
    - In some cases a consumer may be making regular payments to the one agency, but the

other agency, being unaware of this, initiates legal action against the consumer.
- It looks bad in the courts and to the public when a consumer who is making payments gets sues anyway.

3. **Multiple concurrent agencies create inefficiency in that both debts cannot be set up on a single continuous payment plan adding unnecessary financial pressure on your patients.**

- This can result in lower combined recoveries because all agencies skip-tracing efforts are not equally effective.
- Lower priced agencies don't spend as much money on skip-tracing and therefore will not have correct contact information for all consumers, possibly resulting in one portion of the bad debt being recovered while the other is needlessly never recovered.

With the added draw backs of using a secondary agency placement strategy and the sole advantage being to mitigate the shortcomings of the primary agency(s) selected, it is recommended that providers focus on selecting the best possible primary agencies and avoid secondary placements, if possible.

Checklist for Selecting an Effective Placement Strategy

To evaluate the pros and cons of a single agency versus multiple agencies:

- ✓ Ask each agency to provide pricing based on both your full placement volume and based on a portion of your total placement volume.
- ✓ Calculate projected impact on recoveries by using an agency "relative performance" grid.
- ✓ Estimate the additional administrative costs of managing multiple agencies.

To evaluate the pros and cons of including a secondary placement agency in your strategy:

- ✓ Evaluate the long term recovery trends supplied by your chosen Primary Placement Agency(s).
- ✓ Identify the point in which primary agency performance flattens to determine best timeframe for secondary placements.
- ✓ If chosen, Primary Placement Agency shows strong long term recoveries, avoid secondary placement strategies.

4. Measuring partner performance

Measuring partner performance is the final step in your overall process of creating a collection agency vendor strategy. As agencies adapt their practices to survive a rate war environment, their performance and effectiveness can drop. It is important to implement an effective performance measurement process to ensure that the historically strong performance of the agency(s) you selected continues to meet your expectations in the future.

There are obviously many different metrics that should be used in measuring your agency partner. Complaint volumes, call quality scores, and others are critical to measuring your agency. However, this ebook focuses on the most confusing area with is collection recovery performance.

Similar to the value analysis you performed in step 2, measuring ongoing performance can be tricky. There are a lot of canned performance reports agencies typically provide their clients that can be misleading, at best. This is especially true when attempting to use agency provided reports to measure relative agency performance in a multiple agency placement strategy. It is difficult to be certain that each agency is using the same formula to calculate each metric. There are also commonly used metrics in the industry that are inherently misleading even when each agency is using identical calculations.

For example, many agencies provide a form of a recovery percentage metric, which compares monthly combined recoveries to placement volumes in the same month. This metric is misleading because the majority of an agency's collections in any given calendar month will be a product of cumulative placements from prior months and are only slightly affected by the current month's listings.

Although the metric is often assumed to be an indicator of agency performance, it is actually more heavily affected by variations in the provider's placement patterns than it is Using hyperbole to illustrate the point, consider a provider who typically places $2 million with their agency each month, and an agency who averages $500k in monthly collections… Let's say that the provider had a system issue that prevented them from transmitting the majority of their regular placement files for a month and as a result only listed $200k for the month.

It is probable that the agency would still collect $450k for the month from the existing inventory. However the normal metric of a 25% recovery rate in previous months would spike to 225% in the current month, but would tell us very little about agency performance.

One of the most effective ways to measure agency performance is through "batch reporting" analysis. This is done by taking your total placement volume for a given calendar month and tracking the collections for only those accounts at specific milestones.

For example, what is the cumulative percentage of your January placements that had been collected at the point six months had passed? At the point 12 months had passed? At the point 24 months had passed?

Track and trend these values for each month's placement batch over time and use the milestone averages to measure your agency performance. This will give the most accurate picture of agency recovery performance.

In order to avoid incongruities in the way your agencies report their monthly performance, it is recommended to use your own system to create these reports. The difference between dividing collections by original listing volume or by listing volume after deducting recalls, is much less important than ensuring that all calculations are performed the same. Using the data available to you in your own system is one way to ensure this.

Checklist for Measuring Partner Performance

- ✓ Avoid relying on agency supplied reporting.
  (This is especially true if comparing the performance of multiple agencies.)
- ✓ Utilize a batch recovery at milestone methodology.

Case Study: Wisconsin Healthcare Clinic

Situation Summary:

A large Wisconsin healthcare client split their placements between RevCycle and another competing collection agency. The competing agency's contracted commission rate was 26.6% lower than that of RevCycle.

The Result:

After 3 years of placements, RevCycle collected $1,361,407.00 more that the competing agency on the same placement volumes.

Even with the higher commission rate Alliance returned $862,739.70 more to the client that the competing agency.

Summary

I hope you have been able to glean the most important and necessary changes you can take within your healthcare facility that will make the biggest differences in both short- and long-term debt recovery.

Although it may seem like a tumultuous undertaking at first, however, when batched down to the actual steps you will see the efficacy of our strategies.

By deconstructing each problem area within the revenue cycle, we have been able to successfully overcome traditional obstacles and develop a variety of methods to increase total revenue collection.

Depending on your current staffing level and outstanding collections, you may elect to handle all or none of these tasks. But, now you know our strategies to overcoming the inherent problems you've likely faced up until now.

Or get a FREE Quick Start Consultation
with our RevCycle experts!

You'll be a RevCycle Hero in no time!

Call 888-576-5290 or email us directly at:
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During his 17 years of collection industry experience, Brent has served in multiple roles ranging from Collection Floor Manager to Director of Client Services and even IT Manager. This diverse experience has proven invaluable in his current role as Chief Operations Officer. He brings a tech savvy approach to process improvement and continues to drive progress by integrating collection strategy with technology.

In his role as COO, Brent is responsible for overseeing all day to day activities of RevCycle, Inc.

Brent has worked extensively with several of our current clients sharing his expertise in telephony and dialer strategy, providing them with additional value for their partnership with RevCycle, Inc. by helping to improve their processes while our collection staff maximizes their accounts receivables. He is active in his community and has served as president of the Marshfield Optimist Club (a non-profit focused on benefiting area youths). Brent is an avid sports enthusiast and spends much of his free time participating in various outdoor activities as well as following his favorite sports teams.