Collecting from patients at time of care: Understanding the challenges and solutions

By Peggy Denness, MSW
Director of Provider Advocacy
pdenness@NaviNet.net

Eight Cambridge Center, Third Floor
Cambridge, MA 02142
617.715.6000
www.NaviNet.net
Introduction

In an effort to control costs and increase access to health insurance, insurers and employers are offering different types of benefit plans, including high-deductible plans, healthcare savings accounts, flexible spending accounts and other consumer-directed healthcare (CDH) products. While these products give consumers more control over their healthcare spending, they result in an increase in patients’ out-of-pocket expenses which directly impacts provider revenue and forces changes to the practice workflow. As a result, physician practices now face the new challenge of balancing quality care delivery with managing accounts receivable and collecting revenue from patients.

Understanding the challenges facing providers

When patients need medical attention, getting care is their main concern. However, payment for services rendered is not a priority for the patient once treatment is received. According to the McKinsey & Co. report, “Overhauling the US health care payment system,” the probability of providers collecting patient payment declines dramatically once the patient walks out the office door. The report states that while a provider generally collects 95 percent of patient payment when it is received prior to treatment, that percentage falls to 18 percent of the full payment if collected just one month post visit. Additionally, McKinsey & Co. suggests that by the end of 2010, about 35 percent of a provider’s total revenue will come from patients.1

For many practices, collecting patient responsibility for services is considered time consuming, inaccurate and risky. The result of this approach is that most patient A/R either turns into bad debt or is factored out at pennies on the dollar. Benefit plan changes have resulted in patients paying more out-of-pocket and it is extremely difficult for provider offices to reconcile patient payments if payment is collected at time of care.

A recent NaviNet survey of provider offices indicated that many offices are not prepared for the changes in patient financial responsibility due to an increase in CDH. Of the NaviNet offices surveyed, over 25 percent did not have a process in place to collect payment, other than copayment, at the time of service. Of those that did have a process, the majority only collected a portion of the payment at time of service. The impact of uncollected patient debt is dramatic. 64 percent of respondents indicated they are experiencing a rise in patient-based bad debt. In fact, the majority surveyed indicated more than a 10 percent increase from previous years. 2

Despite the fiscal necessity of collecting patient payments in the office at the time of service, many practices don’t have adequate tools in place to accurately estimate the amount a patient will owe and initiate in a conversation about arranging for payment. The typical practice workflows and technologies support the process of submitting claims for patients post care. Then, once the claim is processed by the insurer, the patient is billed for their portion owed. Now is the time for practices to investigate and adopt cost-effective tools that help them predict both patient and payer financial

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responsibility, collect efficiently from all sources, and understand how to stratify and address patient debt.

**Solutions for collecting patient payment**

Due to this sweeping industry change and the financial impact on healthcare providers, practices need to take advantage of every reimbursement opportunity possible to remain financially viable. Small changes to provider offices’ current workflow can have a large impact in managing patient payment expectations. Finding the right tools to adopt in your practice is critical.

When evaluating office workflow and technology the following items should be considered:

- **Real-time eligibility determination**: Patient payment responsibility and benefit information are closely linked. By using an online portal to connect directly to insurers, providers can understand important changes to patient benefits like eligibility status, copayment responsibility, deductible remaining and other important information. Using a multi-payer solution allows for better access to multiple insurers through the convenience of a single username and password.

- **Assess your practice’s “back-end” processes**: After care is rendered, how much time is spent chasing patient payments for your practice? Can simple “front end” process changes reduce the amount of time spent? For example, implementing eligibility and benefits determination prior to the patient appointment or proactively explaining patient eligibility and benefits details prior to or at the time of visit can reduce or eliminate the chance of after-the-fact patient “surprises.”

- **Patient liability estimators**: Patient liability estimators calculate approximate payments and reimbursement based on the patient’s benefit plan and treatments provided, and is available at no cost from many insurers. This is the first step in determining payment owed.

- **Integrated patient billing**: Once patient financial responsibility is estimated, practices must have a process in place to support efficient patient payment collection. Some collection will occur at the time of service, such as the standard copayments most patients owe, but remaining payments may be subsequent. For example, a provider office may arrange to bill a patient for recurring payments over time until the balance is paid off. An efficient billing solution will support these modalities and multiple payment types and will reconcile collected funds.

- **Online patient payments**: Offer patients the convenience of online payments through a secure Web site. Additional options such as payment plans and reminders demonstrate a commitment to providing flexible options and state-of-the-art patient services.
Conclusion

The patient payment challenge is creating increasing financial hardships for providers as the patient pay portion of healthcare services continues to rapidly rise. According to the Centers for Medicare and Medicaid Services, between the years 2000 through 2007, patient out-of-pocket expenses increased by 95 percent. Additionally, medical costs are also increasing as a portion of overall household spending. Accelerated adoption of CDH products in the next few years, combined with increasingly smaller payer reimbursements and more out-of-pocket patient payments, will exacerbate this problem to the point where many practices and specialty offices could become financially nonviable. Practices should take advantage of the range of tools available today to better manage patient self-pay and improve the patient experience.

Peggy Denness, MSW

Peggy Denness is currently the Director of Provider Advocacy at NaviNet, Inc. Ms. Denness is responsible for ensuring that the experience and needs of the healthcare provider community are at the forefront of all NaviNet products and implementations. She is the chief liaison with the provider community and NaviNet end-users, and leader of the NaviNet User Experience team.

Ms. Denness holds a Bachelor’s degree from Salve Regina University and a Master’s Degree in Social Work from Boston College.

About NaviNet

NaviNet, America’s largest real-time healthcare communications network, securely links providers to leading health plans, patients and industry partners. With NaviNet, provider offices can access real-time patient information, including eligibility, benefits and claims status, through a single, secure Web portal. Decrease administrative costs while increasing revenues, collections, patient care and satisfaction. More information is available at www.NaviNet.net.

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3 Centers for Medicare & Medicaid Services