

Your Communication Strategy for Effective Receivables Management

Current levels of outstanding debt for hospitals are astoundingly high. According to the American Hospital Association, the nation's hospitals provided approximately \$28.8 billion of uncompensated care in 2005, a greater than 25 percent increase from 2000.¹ Handling delinquent accounts and bad debt not only is expensive and time-consuming, but also can erode community trust if collection tactics are heavy-handed. A crucial component of receivables management therefore involves careful communication with patients during the collections process. When a hospital utilizes debt sale to third-party purchasers and servicers, effectively communicating with patients throughout the process is particularly important. In this roundtable, sponsored by CarVal Investors, financial executives and other experts identify principles and practices of effective communication for both hospitals and outside collections firms, with special attention paid to those purchasing accounts receivable.

What do you consider to be core principles of communicating with patients when managing accounts receivable?

Calder: Unfortunately, one of the last bills that patients pay is their medical bill. That's just the reality. It is very difficult to collect on the back end of the revenue cycle process, because people often treat paying their healthcare bill as a low priority. One of our core principles, therefore, is that it is important to do a good job on the front end of the revenue cycle, particularly in terms of education and communicating with patients during the financial screening and collection processes.

For people who are uninsured or underinsured, we work very hard to see whether they can qualify for Medicaid. If a patient doesn't qualify for Medicaid, we then try to qualify the patient for our financial assistance and charity care program. Once a patient has failed to qualify for Medicaid or the financial assistance program, only then do we drop the bill into receivables, as a true self-pay. The procedure we follow is to hold accounts in our DNFB [discharged not final billed] file until we go through the eligibility process. Collecting point-of-service deductibles and copays on the front end is critical to reducing an organization's bad debt liability.

Andersen: From a collection standpoint, the first goal in communication is to make sure the collector is

communicating with the correct person—the person who is responsible for payment of the healthcare debt. Second is to be sure the person who owes the debt is fully informed of any charity care programs available through the hospital and to apprise the person of his or her right to access charity care program benefits if the individual's financial situation warrants such assistance. Third is to make sure the person responsible for payment has a clear understanding of the portion of the bill that is his or her obligation. Often within the healthcare billing cycle, confusion arises over the portion of the bill that will be covered by a third-party payer and the portion that remains the responsibility of the patient.

Lawrence: Our communications are based on the premise that as time moves forward, the probability of collection diminishes. So we have what we call an early out program, which is a precollection function of the business office. We work with a firm that handles the billing statements that are sent to patients as well as telephone communications and some charity care applications. Our preference is to put customer service first. This is not a hard sell; it is a soft sell. We send the firm guidelines that they must follow when they are representing us and tell them to do whatever they can to make the patient comfortable with the process.

¹ *Uncompensated Hospital Care Cost Fact Sheet*, American Hospital Association, October 2006.

When a hospital is collecting new and aging accounts, what is usually done in-house and what is handled by an outside firm?

Sherman: All insurance accounts are worked in-house by our staff. When our staff is unable to bring accounts to a resolution, we outsource them to firms specializing in third-party billing/follow-up. We also engage external vendors to assist our patients in filing Medicaid applications in those instances where the patient is unable or unwilling to work with our own financial counselors.

Also, we use an external vendor to process our self-pay accounts. This vendor sends the patient three statements and makes an effort to contact the patient to discuss the bill and explore other options for payment. They will work these accounts for a period not to exceed six months, and then return all uncollected accounts. The uncollectibles are reviewed by our patient accounts department, which determines those that are appropriate for referral to our collection agencies.

Andersen: Most typically, once a debt becomes delinquent and has been charged off to profit or loss, the account is forwarded to a collection agency for collection. However, outside firms may be inserted into the receivables process as early as patient intake. Some hospitals bring in outside firms at a very early stage in the healthcare delivery process to obtain the correct information from the patient at the time of admission, to evaluate the patient for third-party payer opportunities and charity care programs, and to conduct third-party processing.

Since third-party firms may communicate with patients on the hospital's behalf, how should these arrangements be structured?

Andersen: The relationship between a hospital and an outside collection firm is evidenced by both a business associate agreement as well as a servicing agreement. Any

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outside firm working on behalf of a healthcare provider can only access and use the minimum amount of protected health information necessary for it to perform its service functions subject to a business associate agreement as defined by HIPAA. That allows the healthcare provider to share protected healthcare information for payment purposes with an external collection agency. The servicing agreement details the specific services that the hospital wishes the firm to provide. Collection agencies do not act independent of the hospital. Rather, they act at the direction and control of the hospital. For this reason, all decisions about the collection process must be fully vetted between hospital management personnel and the collection agency. Topics of discussion should include the text of collection letters, the frequency of letters and telephone calls to patients, credit reporting practices, and the specific remedies authorized for collection recovery.

Why sell accounts to a firm, and how did you structure the arrangement to address the concerns of the community?

Calder: St. Vincent's Hospital has been in bankruptcy for more than two years. One of the projects we did recently was to securitize our bad debt to a company in order to maximize our liquidity so we can pay down our debt and fund more capital projects. What does that mean? That we have sold the bad debt, and we have walked away from it? Absolutely not. Part of the reason for selling the bad debt to an outside company is that we are not staffed to aggressively pursue patients, in terms of making outbound calls and collecting our debt. We needed to spend our limited resources on going after the insurance dollars from our managed care and insurance companies. The outside company has the technology, staff, and expertise in terms of collecting within applicable federal and state collection laws, which are followed very closely based on contract terms.

Part of the contract with the company is that they have to follow our financial assistance policy. So although they have purchased this asset, upon determining that a patient may qualify for financial assistance and charity care, they contractually have to collaborate with us to qualify that patient. We also sign off on all collection letters that are mailed out to our patients, and we ensure the company follows our policies and procedures with regard to collection protocols.

The collection process involves joint collaboration and cooperation between our new business partner and us. The strategy is to obtain more liquidity for our bankrupt organization while at the same time being supersensitive with respect to our patient relations and our responsibility to the community.

What are some ways to help ensure those purchasing the hospital's receivables communicate with patients appropriately?

Zmrhal: We have a contract that is probably 10 or 12 pages that carefully outlines roles and responsibilities, accountability, and policies.

Care is needed with such a critical function. Once an organization sells bad debt, it's out of the hospital's hands. It's like selling my car to you. I don't have it anymore, and you would have title to the car. Even though the purchaser has "title" to these accounts, we still have to ensure that we have certain rights. Let's say that for whatever reason, an account got to the company in error. We need to be able to call that account back so the patient isn't pursued incorrectly.

Calder: We spent more than six months with the company negotiating purchase, interviewing the company, educating the company on our policies and procedures, and having the company educate us on its policies and procedures. We put language into the contract with regard to our ability to call back accounts without cause. We can therefore recall any accounts, as long as we make a financial reconciliation with the company. Although the company has purchased the bad debt, it cannot initiate legal proceedings without our approval.

People from the company work on-site, side by side with our customer service people when managing these accounts. We also have weekly/monthly meetings with the company with regard to issues that arise. There is constant communication and collaboration with both teams with regard to patient and community relations, collection issues, and mission of our organization.

How might a provider determine whether the debt purchaser will support their goals and communication principles?

Andersen: The hospital should first assess the experience and knowledge of the agency that will actually be collecting the purchased healthcare debt and assess the collection agency's training program for those individual debt collectors who will be dedicated to collection of the hospital's accounts. Such training will typically include compliance requirements of the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, state consumer project laws, and, of course, HIPAA. The purpose of this assessment is to determine whether the agency's collectors understand the unique attributes of a healthcare receivable, particularly regarding projected information and the fact that patients are very sensitive about that information.

All collectors should be cognizant of the culture of the organization for which they are collecting debt. By culture, I mean its mission, tax-exempt status, position within the community, and commitment to its patient population. It is incumbent on the debt collector to understand the health-care provider's culture and attitude about its patients in order to carry that through to the collection conversation.

ACA International also recommends all hospitals become fully versed in the American Hospital Association's Statement of Principles and Guidelines for the Billing and Collection of Healthcare Debt, HFMA's *PATIENT FRIENDLY BILLING*® practices, and ACA International's Statement of Principles and Guidelines for the Collection, Servicing, and Purchase of Healthcare Debt. Together these documents provide hospitals with an excellent road-map for addressing their questions about the management of their healthcare receivables.

Is there anything particularly important to look for in a debt purchaser?

Zmrhal: We reviewed the company's history and references and examined how it has conducted itself. In particular, we didn't want the company selling the accounts elsewhere. The company we work with is the ultimate buyer—so the accounts rest only with this company.

Sherman: Regardless of whether we are selling accounts or only referring accounts to a collection agency, we only utilize entities that are experienced in handling healthcare receivables. Also, we operate under the assumption that a healthcare obligation is different than most other obligations. Generally, healthcare debts are not voluntarily incurred and usually arise at times when people can least afford them. Organizations skilled in collecting only other



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types of debt may not understand the way most healthcare organizations wish their accounts to be pursued. Furthermore, special rules such as contractual allowances, HIPAA, and the like need to be built into the collection process and “newcomers” to the field of healthcare collections may not be equipped to deal with these special circumstances.

Are there actions hospital leadership should take to help ensure communications with patients continue to reflect the values of the organization after receivables are sold?

Sherman: We speak to the firm’s references and perform site visits to observe the conduct of the collectors and the agency office. We meet with agency management and ask questions about their process and how they handle various situations. We inquire about any lawsuits that may be pending against the agency or its employees, and we build penalties into our collection contract that could result in a reduction of fee or contract termination.

Andersen: All letters that are sent from an outside firm to patients should be sent to someone inside the hospital. This is called letter seeding, and it means that someone inside the hospital is literally reading the correspondence that the firm is sending to the hospital’s patients. Another method that many healthcare providers use is to maintain an ongoing dialogue with the outside firm about any disputes that patients may raise about their debts. This dialogue helps the hospital and its collection agency together identify the root cause underlying the dispute: Was it a problem related to the bill, an insurance coverage issue, a misunderstanding in the amount the patient is responsible to pay or the allocation of the amount being paid by the third-party insurer? Understanding a patient’s basis for dispute is important for the hospital and the debt collector so they can adjust their practices, if necessary.

How can hospitals monitor and assess whether communications in the collection process for either new or aged receivables are effective?

Sherman: On the internal side, we’ve set benchmarks for receivable days outstanding, and as we introduce new processes, we monitor their impact on patient satisfaction and outstanding receivables. Naturally, the ideal situation is for both complaints and days outstanding to be going down.

As for our agencies, we receive agency reports and monitor how effective the agency is performing. If an agency is able to liquidate claims quickly, we know it is an efficient organization and is doing the job well. If an agency is sending a lot of work out to law firms to file a lawsuit or is slow in collecting our accounts, we become concerned that the agency does not have employees with appropriate communication skills and that it is negatively impacting their performance on our behalf.

Andersen: In the past, communication often was at the level between the collection agency and the patient account manager, and little moved to higher levels of the organization in terms of the challenges or successes a collection agency is having or how well the charity care policy is working. There is a lot that hospitals could learn by having a closer working relationship with its collection agencies, and I mean from the top down. Collection agencies should be considered part of the hospital’s overall accounts receivables management process. The monitoring piece is key. Collection services should not be reduced to an analysis of the percentage of recovery on outstanding debt. Hospitals should look beyond the numbers. They should look at the quality of communication and the level of patient satisfaction and drill down to be sure patients are treated with integrity and respect.



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