Three Tips to Optimizing Patient Collections

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Over the last decade, perhaps the most staggering shift in consumer-based healthcare has been the increase in patient responsibility. Due to the rise in high-deductible health plans (HDHPs), providers are now faced with the challenge of collecting an average of 35% of their revenue from patients, without a downward swing in the insured population.

Consider the following:

- In 2018, 85% of covered workers had a deductible, up from 59% in 2008.
- The average deductible in 2018 was $1,573, up 114% from $735 in 2008.
- Since 2013, the burden on patients has increased by 212% due to HDHPs.

Since the cost and effort to collect from patients is greater than that from the large commercial or government insurance plans, urgent care centers and providers across the healthcare spectrum have grappled with how to best maintain low levels of bad debt due to unpaid patient balances, while also preserving their satisfied base of recurring patients. Those that have succeeded in walking this fine line have implemented all, or a combination of, the three strategies listed below.

Standardized Time-of-Service Collection Policy

Clinics that succeed in limiting bad debt on balances after insurance understand that probability of collecting from a patient drops by up to 50% after a patient leaves the office. Per a 2017 McKinsey & Company survey on consumer health, the likelihood of a patient paying when asked prior to seeing the provider (check-in) is 90%. That drops to 70% at check-out, and an alarming 40% after the patient leaves the clinic.

Organizations should adopt a time-of-service (TOS) collections policy in line with their values and their patient base, but it should be strictly adhered to by all front desk staff and include amounts above and beyond the copayment, to the extent the patient has remaining amounts in their deductible. Considerations of how much to collect when the patient has a large amount remaining on their deductible should be made with the intent of optimizing the opportunity for on-site collections, but limiting downstream refunds, including, but not limited to:

- Average reimbursement per visit
- Visit type
- Primary insurance
- Whether the patient has secondary insurance coverage

Utilize your practice management system's capabilities to provide eligibility verification (ie, 271 responses) to discern the remaining deductible amount. Be careful not to make assumptions as to coverage, copayment amount, etc. with a quick glance, as many of these responses require a bit of scrolling to ensure the proper payer and financial information specific to urgent care.

Automated, Simple Payment Options

Even with the implementation of a solid time-of-service collections policy, it is certain that significant patient balances will be outstanding after insurance processes the claim. This is when clinics commence their standard patient billing protocol including, most commonly, the mailing of three paper statements, maybe a pre-collection letter, then a final review of the patient's account prior to sending the balance to a collection agency. This is an expensive process, not only due to postage and labor costs, but because the relative ineffectiveness and lack of response to paper statements, translating to bad debt.

Patients want easy, automated options to pay their bill. We're living in the world of Amazon and Netflix, and urgent care, as the on-demand niche of healthcare, fills that role in our industry. The automation option that best ensures timely adjudication of patient balances and most significantly eliminates bad debt risk is storing credit cards on file.

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Functionality from practice management systems differs in this regard, with some requiring a bit more manual lift, while others automate the process. Either way, most offer a secure and compliant mechanism to pass credit card information to your merchant services vendor with the ability to process payments once they become patient responsibility. When a credit-card-on-file process works as intended, patient A/R, by definition, only exists from the time of assignment of the balance and the grace period given before processing the payment. Typically, there is a message delivered to the patient—text message or email is preferable—letting them know their card will be charged in X number of days, according to your policy.

To the extent patients refuse to store their card on file and the standard patient balance protocol applies, consider the following to allow for easier ability to pay:

- E-statements as opposed to paper are cheaper and more effective, typically including a link directly to your payment portal.
- Text message balance reminders.
- If patient statements are utilized, is there an ability for the patient to scan a QR code on the statement, linking them directly to your payment portal?
- Do you accept PayPal, Venmo, etc.?

Measure and Track Your Success

Finally, clinics cannot truly be successful in managing patient A/R, or anything else for that matter, without sophisticated tracking mechanisms. Specifically, it is essential to understand the following points in order to set a baseline, and then how they trend over time, in order to identify any red flags, requirements for additional training, and execution:

- Patient collections per visit, in relation to patient bad debt per visit. In other words, what percentage of patient A/R is being collected as opposed to being written off.
- Ratio of patient payments at TOS vs after the visit.
- Statement volume and costs.
- Conversion of patients and/or visits to the credit card on file process. ■