# 8 Ways to Reduce Bad Debt (ANI)

Kerry Hill, Vice President – Finance, Rockford Health System
Francis Hollweck, Senior Manager, Crowe Horwath LLP
Brian Sanderson, Partner, Crowe Horwath LLP

## TODAY'S SPEAKERS

**Kerry Hill** is the Vice President of Finance for Rockford Health System in Rockford Illinois. He has over twenty years of healthcare experience and has served in several management roles since beginning at Rockford Health System in 1993. He has responsibilities for Patient Financial Services, Patient Access and Scheduling, Medical Records, Finance and Reimbursement, Accounting, and Decision Support. He is a current member of Healthcare Financial Management Association - First Illinois Chapter.

**Francis Hollweck** is a Senior Manager within Crowe's Healthcare Performance practice, based in Chicago. He has greater than 12 years of healthcare experience within two Big Four firms, focusing primarily on finance and revenue cycle related projects. He has assisted large health systems in revenue recognition studies and has constructed various financial models for executive use. He is a member of HFMA's First Illinois Chapter.

**Brian Sanderson** is a Partner within Crowe's Healthcare Performance practice, based in Chicago. He has 20+ years of experience in the areas of revenue management and cash improvement for hospitals, as well as large physician group practice revenue improvement. Prior to joining Crowe Horwath LLP, Brian was a Partner at a Big Four accounting/consulting firm for seven (7) years. He was also a manager for Northwestern Memorial Hospital (Chicago) and Hinsdale Hospital (Hinsdale, IL). Brian graduated from the Kellogg Graduate School of Management at Northwestern University with a Master of Management degree focusing on finance and healthcare management. He is a member of HFMA's First Illinois Chapter.

## TODAY'S ENVIRONMENT

- Economic market conditions + health care (payment) reform = greater out of pocket liabilities
- Significant pressures associated with tax exempt status and ability to fortify charity care (delineated from bad debt)
- Increasing instances of "medical theft" (bogus identity, purposeful exit without paying, mock symptoms for pharmaceuticals)
- Cost pressures affecting non-clinical "FTE per"

3

## OPERATIONAL EXCUSES - or - IMPEDIMENTS

| | EXCUSE | | IMPEDIMENT |
|---|---|---|---|
| EMTALA | ☐ | ✓ | ☐ |
| Uncomfortable asking for money | ☐ | | ☐ |
| Clinicians won't cooperate | ☐ | | ☐ |
| ↑ Administrative complaints | ☐ | | ☐ |
| Don't have time to collect money | ☐ | | ☐ |
| Illegal aliens | ☐ | | ☐ |
| Lack of tools | ☐ | | ☐ |
| Lack of management support | ☐ | | ☐ |

4

OPPORTUNITY

As an expense line item, each $1 reduction in bad debt results in a $1 increase in operating income

**Sample Not-For Profit Hospital**
**Statement of Operations**
**For the Years Ended December 31, 20X1 and 20X0 (in '000)**

| | 20X1 | 20X0 |
|---|---|---|
| *Unrestricted Revenues, Gains, and Other Support* | | |
| Net Patient Service Revenue | $85,156 | $78,942 |
| Premium Revenue | 11,150 | 10,950 |
| Other Revenues | 2,601 | 5,212 |
| Net Assets Released from Restriction Used for Operations | 300 | 0 |
| *Total Revenues, Gains and Other Support* | 99,207 | 95,104 |
| *Expenses* | | |
| Salaries and Benefits | 53,900 | 49,938 |
| Medical Supplies and Drugs | 26,532 | 22,121 |
| Insurance | 8,089 | 8,526 |
| Depreciation and Amortization | 4,782 | 4,280 |
| Interest | 1,752 | 1,825 |
| Provision for Bad Debts | 1,000 | 1,300 |
| Other Expenses | 2,000 | 1,300 |
| *Total Expenses* | 98,055 | 89,290 |
| Operating Income | 1,152 | 5,814 |
| Other Income | | |
| Investment Income | 3,900 | 3,025 |
| *Excess of Revenues over Expenses* | 5,052 | 8,839 |

5

SURVEY

6

Rockford Memorial Hospital

## OVERVIEW

Rockford Memorial Hospital, the community's first hospital, opened its doors in 1885. Over the years, the organization built its reputation on its quality doctors, leading-edge technology, comprehensive services, and outstanding facilities.

Today, Rockford Memorial Hospital is a 396-licensed-bed health care facility focused on one mission: "Superior care. Every day. For all our patients." Our dedication to patient satisfaction will continue to make us the region's health care leader.

Outstanding programs - The Children's Medical Center with the area's only Pediatric Intensive Care Unit and Level III Neonatal Intensive Care Unit, The Heart and Vascular Center, the Brain and Spine Center, and our Level I Emergency/Trauma Services Department - are second-to-none and provide the expertise and care you and your family need in the most difficult circumstances.

Rockford Memorial Hospital (part of Rockford Health System) was identified as a recipient of the 2009 HealthGrades Patient Safety Excellence Award™. The top five percent of all hospitals in the U.S. were recognized with this award in a report by the leading independent healthcare ratings organization.

hfma

7

## ROCKFORD HEALTH SYSTEM PROFILE

Total Patient Revenues: $700m+

Daily Census: approximately 200

Payor Mix (estimated from Gross Revenues)
- Medicare/Medicaid – 61%
- Managed Care – 31%
- Commercial – 3%
- Self Pay/Other – 5%

Days in A/R (net): 54.4

Bad Debt Expense (% of Gross): 2.4% (YTD) (3.6% in 2008)

Approximately 4,000 ED visits per month

hfma

8

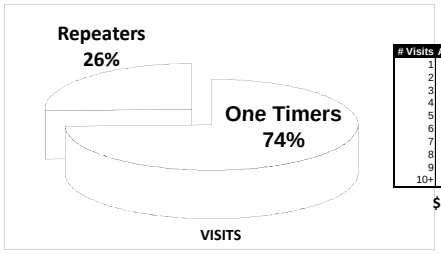
## RHS BAD DEBT CHALLENGES

- Challenging economy – a large local plant had closed, economically challenged demographics
- Staffing –
  - FTEs were down compared to budget in critical patient access areas (i.e., ED, scheduling, registration)
  - Staff were uncomfortable making requests for copays/deductibles
- Processes – While some policies were in place, many were not routinely adhered to (i.e., requesting copays/deductibles, minimum SelfPay payments, etc). No formal ED discharge process in place.
- Tools –
  - The ability to estimate patient portions was not utilized
  - Not all patient access staff were educated on how to read and identify patient liabilities from Payor websites
  - Reporting of Patient Access metrics limited management's ability to target leakage points and provide corrective action
  - Staff job descriptions did not state collection performance metrics

9

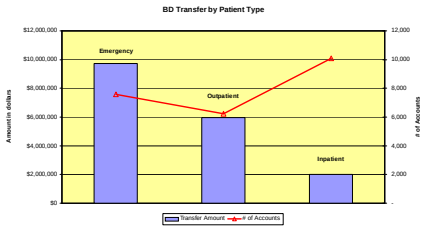
## ANALYTICS

| FC Description | Total Txf Balance | % of Total |
|---|---|---|
| SELF PAY | $ 13,745,911 | 57% |
| PPO | $ 3,521,273 | 15% |
| BLUE CROSS | $ 3,498,909 | 15% |
| COMMERCIAL INSURANCE | $ 1,714,857 | 7% |
| MEDICARE | $ 393,831 | 2% |
| OTHER GOVERNMENT | $ 232,845 | 1% |
| HMO | $ 176,805 | 1% |
| RMH | $ 162,432 | 1% |
| MEDICAID | $ 157,058 | 1% |
| WORKMANS COMPENSATION | $ 146,905 | 1% |
| AUTO INSURANCE | $ 120,607 | 1% |
| RMCG - RMHSC | $ 31,211 | 0% |
| PHYSICIAN ENTERPRISE MD LAB | $ 10,685 | 0% |
| MEDICARE HMO | $ 7,642 | 0% |
| CLINICARE | $ 1,640 | 0% |
| Purged (Historic) Account | $ 808 | 0% |
| Total | $ 23,923,418 | 100% |




| # Visits | Accounts |
|---|---|
| 1 | 50% |
| 2 | 21% |
| 3 | 11% |
| 4 | 6% |
| 5 | 3% |
| 6 | 3% |
| 7 | 2% |
| 8 | 1% |
| 9 | 1% |
| 10+ | 2% |

$$$

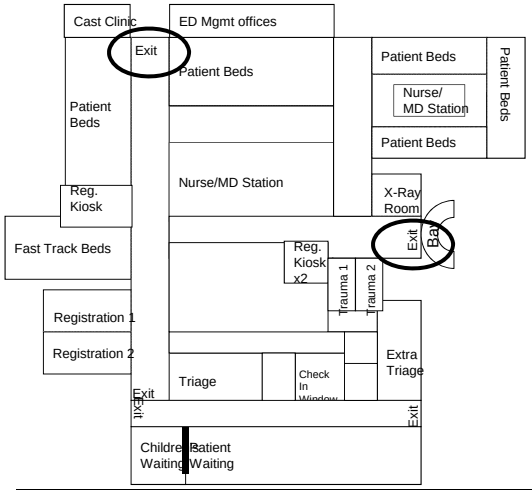



Most common BD transfer amounts (RMH only)

| # | Transfer Amount | Description |
|---|---|---|
| 1 | 123.70 | Common Charge (ER Lvl charge) |
| 2 | 209.30 | Common Charge (ER variable) |
| 3 | 100.00 | Copay/Deductible |
| 4 | 75.00 | Copay/Deductible |
| 5 | 50.00 | Copay/Deductible |
| 6 | 365.90 | Common Charge (ER Lvl charge) |
| 7 | 952.00 | Copay/Deductible (Medicare) |
| 8 | 132.40 | Common Charge (ER Lvl charge) |
| 9 | 150.00 | Copay/Deductible |
| 10 | 200.00 | Copay/Deductible |
| 11 | 250.00 | Copay/Deductible |

10

## ED LAYOUT




- Multiple exits exist for patients; however, most exits are now monitored.
- Now locked ED entrance adds security for staff.
- Mobile computer stations allow bed side registration, yet were not used in pt rooms due to connectivity issues.
- Registration able to accept most forms of payment, but could not issue change.

11

## KEY ACTIVITIES

- Develop and educate Patient Access staff on revised policies and procedures (e.g., review each account for prior bad debt and/or open balances)
- Implemented enhanced patient interactions within the ED and Non-ED settings to increase awareness/education of patient expectation to pay for services
- Embed revised scripting for pre-service and time of service patient interactions (including “push-back” scripting)
- Integrate new tracking logs and tools to monitor staff performance (e.g., missed collection opportunity logs, POS transaction codes, repeaters, etc)
- Created feedback loop for open / enhanced communication between Patient Access staff, Business office staff, and executive management to monitor performance
- Create an atmosphere of accountability and self responsibility for meeting organizational goals

12

## THEN and NOW

- Limited focus / awareness on lost collections opportunities.
- Staff not aware of, or had differing interpretations, of patient access policies.
- Tools to identify patient liabilities (payor websites, etc) not used to potential.
- ED patient interactions highly focused on clinical care, less focused around the completion of registration / eligibility functions.
- Little attention to copays/deducts in non-ED settings.
- Limited accountability for BD performance within Patient Access

- Enhanced reporting, tracking, and communication of collection activity.
- Staff completed half day in-services to discuss revised policies and procedures for clarification of duties
- Payor websites are used to their potential, and staff are trained on estimating liabilities for common procedures.
- ED registration activities demand insurance eligibility checks and a patient financial triage discussion.
- Heightened attention to copays/ deducts and use of tools in non-ED settings. New scripting in place.
- Job descriptions altered and specific metrics are tracked and communicated to stakeholders.

13

## FINANCIAL TRACKING

Monthly BD Transfer Data

| Payor Class | Monthly Baseline (Assmt) | | January | | February | | March | | April | | May | | Project to Date (PTD) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | $ | # | $ | # | $ | # | $ | # | $ | # | $ | # | $ |
| AUTO INSURANCE | 2 | $ 10,051 | 12 | $ 9,645 | 13 | $ 59,639 | 12 | $ 19,349 | 9 | $ 34,189 | $ 16 | $ 105,359 | 250 | $ 1,159,378 |
| BLUE CROSS | 69 | $ 139,071 | 169 | $ 135,215 | 148 | $ 99,929 | 143 | $ 156,041 | 240 | $ 200,794 | $ 150 | $ 124,635 | 2,858 | $ 4,083,112 |
| COMMERCIAL INSURANCE | 43 | $ 142,905 | 24 | $ 111,463 | 40 | $ 56,518 | 26 | $ 72,570 | 32 | $ 73,954 | $ 13 | $ 22,799 | 606 | $ 1,392,603 |
| HMO | 32 | $ 14,734 | 11 | $ 3,027 | 15 | $ 5,341 | 20 | $ 7,180 | 19 | $ 3,052 | $ 12 | $ 2,813 | 370 | $ 142,296 |
| MEDICARE | 96 | $ 32,816 | 79 | $ 30,826 | 94 | $ 29,440 | 91 | $ 27,624 | 94 | $ 44,086 | $ 82 | $ 45,111 | 1,869 | $ 708,308 |
| MEDICAID | 11 | $ 13,088 | 5 | $ 2,831 | 5 | $ 8,866 | 1 | $ 809 | 2 | $ 971 | $ 4 | $ 38,797 | 117 | $ 166,993 |
| MEDICARE HMO | 4 | $ 637 | 46 | $ 9,149 | 36 | $ 7,226 | 35 | $ 8,352 | 45 | $ 13,464 | $ 23 | $ 7,691 | 763 | $ 179,257 |
| MEDICAID PENDING | 0 | $ - | 0 | $ - | 0 | $ - | 0 | $ - | 0 | $ - | $ - | $ - | - | $ - |
| OTHER GOVERNMENT | 31 | $ 20,431 | 10 | $ 20,076 | 4 | $ 95,931 | 6 | $ 11,892 | 10 | $ 7,429 | $ 5 | $ 14,626 | 144 | $ 400,115 |
| PPO | 448 | $ 293,439 | 309 | $ 269,507 | 388 | $ 244,531 | 358 | $ 300,163 | 366 | $ 252,028 | $ 259 | $ 165,023 | 6,846 | $ 5,197,733 |
| RMH | 40 | $ 13,536 | 30 | $ 8,284 | 35 | $ 13,968 | 16 | $ 7,498 | 48 | $ 18,528 | $ 13 | $ 5,590 | 599 | $ 214,855 |
| RMCC - RMHSC | 9 | $ 2,601 | 10 | $ 4,723 | 8 | $ 2,245 | 8 | $ 4,004 | 17 | $ 3,464 | $ 3 | $ 505 | 176 | $ 62,620 |
| SELF PAY | 603 | $ 1,145,560 | 586 | $ 1,067,520 | 692 | $ 1,114,023 | 529 | $ 703,342 | 698 | $ 986,396 | $ 347 | $ 707,413 | 11,131 | $ 16,978,245 |
| WORKMAN'S COMPENSATION | 11 | $ 12,242 | 3 | $ 66,262 | 3 | $ 1,866 | 4 | $ 6,496 | 8 | $ 7,480 | $ 6 | $ 9,152 | 142 | $ 286,755 |
| Totals | 1400 | $ 1,841,113 | 1294 | $ 1,739,527 | 1481 | $ 1,739,324 | 1249 | $ 1,325,321 | 1588 | $ 1,645,834 | $ 933 | $ 1,249,715 | 25,894 | $ 30,972,179 |
| BD Txfrs / Gross Rev (120 days) (i.e., May BD / Jan Revenue) | | | 1-Month | 3.65% | | 2.92% | | 2.45% | | 2.98% | | 2.03% | | 3.08% Current Month PTD |
| | | | 2-Month | 3.45% | | 2.98% | | 2.70% | | 2.72% | | 2.48% | | 3.16% Prior Month PTD |
| | | | 3-Month | 2.96% | | 3.27% | | 2.92% | | 2.79% | | 2.47% | | 3.20% Penultimate Month PTD |

- The data above shows the bad debt transfers by month as compared to baseline. Of significance is the reduction in the Self Pay category.
- Data below shares the cumulative trending of transfers over time and the BD rates as a % of gross revenues. Immediate impacts were witnessed in August (120 days post implementation activities).

| | 120 Day Grace Pd | Tracking | Tracking | Tracking | Tracking | Tracking | Tracking | Tracking | Tracking | Tracking |
|---|---|---|---|---|---|---|---|---|---|---|
| | July YTD | August | September | October | November | December | January | February | March | April |
| Baseline PTD BD % | 3.60% | 3.60% | 3.60% | 3.60% | 3.60% | 3.60% | 3.60% | 3.60% | 3.60% | 3.60% |
| Current Month PTD BD % | 3.92% | 3.44% | 3.36% | 3.40% | 3.31% | 3.36% | 3.32% | 3.29% | 3.20% | 3.16% |
| Variance | -0.32% | 0.16% | 0.24% | 0.20% | 0.29% | 0.24% | 0.28% | 0.31% | 0.40% | 0.44% |

14

## EIGHT (8) DIFFERENTIAL PRIORITIES

1) **Financial Advocacy**: to triage patients in order to better understand their financial means.
2) **Department Accountability**: to establish mechanisms to detect and reduce payment risk policies and procedures.
3) **Patient Flow**: to develop appropriate processes for patient interaction (and flow) without *Emergency Medical Treatment and Active Labor Act* (EMTALA) risk.
4) **Estimating co-pays and deductibles**: to link patient services with their coverage options.
5) **Pre-service collections**: to institute appropriate tools and scripting – perhaps even incentives – to encourage collection efforts before or at time of service.
6) **Connectivity to Medicare Bad Debt**: to build standardized processes and data sets for capture of reimbursement add-ons.
7) **Charity care / Other Program Workflow**: to use Financial Advocacy to initiate the charity care (or other programs) process before it clogs the collections portfolio.
8) **Management Reporting**: to monitor, track, and manage uncompensated care performance metrics for sites of service, workflow productivity, and/or budgeting/reserve/hindsight analytics.



## FINANCIAL ADVOCACY

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

## DEPARTMENT ACCOUNTABILITY

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

hfma

17

## PATIENT FLOW

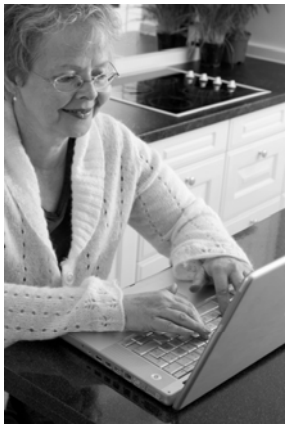
1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

hfma

18

## ESTIMATING CO-PAYS & DEDUCTIBLES

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING



hfma

19

## PRE-SERVICE COLLECTIONS

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

hfma

20

## CONNECTIVITY TO MEDICARE BAD DEBT

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

hfma

21

## CHARITY CARE/OTHER PROGRAM WORKFLOWS

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

hfma

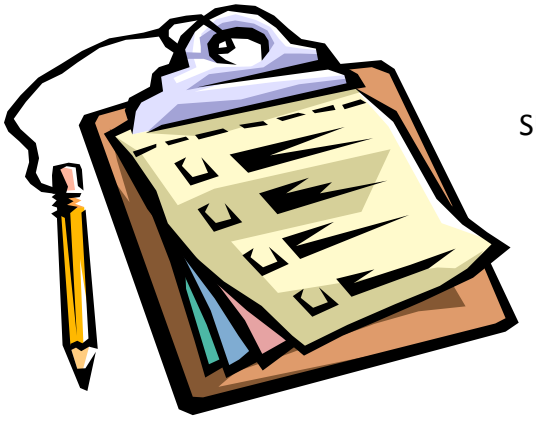
22

## MANAGEMENT REPORTING

1) FINANCIAL ADVOCACY
2) DEPARTMENT ACCOUNTABILITY
3) PATIENT FLOW
4) ESTIMATING CO-PAYS & DEDUCTIBLES
5) PRE-SERVICE COLLECTIONS
6) CONNECTIVITY TO MEDICARE BAD DEBT
7) CHARITY CARE/OTHER PROGRAM WORKFLOWS
8) MANAGEMENT REPORTING

hfma

23



## SURVEY RESULTS

hfma

24