AdvancedMD

Patient Payment **Best Practices**

20 years of Discovery and Refinement

20 years of payment optimizing experience has taught us many things that work to improve patient payment, and many more that don't.

Over that time span, new technologies, process improvements, and in-the-trenches work with practices have been marshalled to find the right combination of factors that result in high collection rates simultaneous with high patient satisfaction scores.

Through all this effort, three key roadblocks consistently bubble up as the greatest inhibitors to an efficient patient payment solution:

1. Unrealistic patient expectations and attitudes regarding medical bill payment.
2. High-friction systems and processes within the practice that slow reimbursement collection, reduce total amounts received, and make the patient payment journey difficult and uninviting.
3. Internal sabotage. Many practices are their own worst enemies when it comes to collecting payment from patients because of lax policies and processes, inconsistent training and execution, and counter-productive language that pushes patients away.

The Path to Understanding

To outline a best-practices path more clearly toward efficient patient payment, let's first briefly dissect each of these roadblocks to understand the challenge faced, and then detail best practice approaches proven over 20 years of live-fire scenarios to directly counter each with options that can be implemented by any practice with focused, consistent execution.

ROADBLOCKS

PATIENT EXPECTATIONS AND MINDSET

Any discussion of patient payment must start where the ultimate payment - or non-payment - decision is made: in the mind of the patient. The sometimes trivialized saying “perception is reality” is a fundamental truth at the heart of most patient payment challenges.

Most patients’ reality is based on a perception of the world of medical bills as confusing, arcane, unfair, and frightening. Consider these revealing perceptions:

- Only 4% of patients can correctly identify all four components of a medical bill (co-pay, deductible, co-insurance, and patient portion)[1]
- 72% say they are confused by medical bills[2]
- Over 50% received a bill they thought was covered by insurance[3]
- 94% received bills they considered to be too expensive[4]
- Over half said their bill was higher than expected[5]

Most telling is this startling finding: More patients fear the cost of an illness than the illness itself. A recent survey found that 40% of people say they fear the cost of an illness vs. 33% who fear the illness itself.[6]

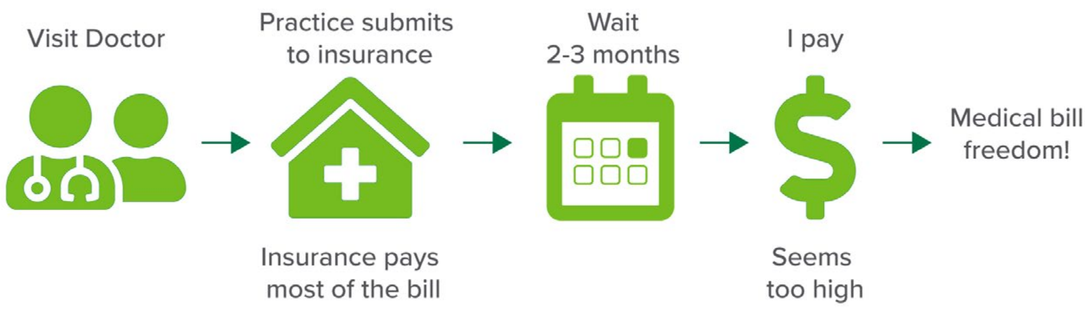
This collection of misperceptions puts patients on a perceived “Insurance Freedom” path: I see the doctor, the practice bills the insurance company, and almost all the charges are somehow magically taken care of in the mysterious insurance payment nebula. The remaining balance may be billed back to me after months of delay, but it will probably be much more than I expected or should have to pay. So, I will deal with it after I’ve paid other, more pressing bills. Oh, and did I mention I’m terrified and dread opening the bills that come.

72%

say they are confused by medical bills[2]

Medical Insurance Freedom Path

Patient perception of the medical bill world.



It’s no wonder then, that consumers relegate what they consider to be confusing, scary, and unfair bills to the bottom of their bill paying priority. In a recent consumer survey of bill paying priority, respondents ranked medical bills 7 out of 10 - below car payment, Internet service and cell phone bills.

HI-FRICTION SYSTEMS AND SLOW PROCESSES

“Slow or reduced payment is the direct result of friction in the system that can be isolated and improved.”

In this roadblock area, practices consistently neglect two fundamentals of financial and billing management that negatively impact financial results:

1

Time value of money (or the quicker, the better). This axiom is simply that a dollar today is worth more than a dollar in the future. It sounds so simple that many practices don’t seriously apply it as the yardstick across their billing systems and processes and end up with less than stellar financial outcomes as a result.

A key measure of performance in this regard is days outstanding in accounts receivable. Anything over 45 days is needlessly costing you money.

Explains Sean McAleer, senior director of revenue cycle operations at NYU Langone Medical Center in New York City: “The quicker the turnover in your accounts receivable, the less cash you have to find somewhere else.”[7]

In other words, shortening the time it takes to collect allows you to direct your cash toward productive work in the practice, rather than tying cash up funding rejected insurance claims or slow-paying patients. Additionally, the longer a bill remains unpaid, the higher the risk it will end up in collections or being written off.

Recovery value drops dramatically the longer a bill remains in accounts receivable. On average that value drops to 65% - 70% for accounts between 60 and 90 days old, and to a paltry 18% - 20% for accounts that go to collections, typically after sitting more than 200 days in A/R.

2

Identify and reduce friction. Slow or reduced payment is the direct result of friction in the system that can be isolated and improved. This can be anything from inaccurate or lapsed patient insurance coverage, failure to collect co-pays and estimated patient pay at time of service, inconsistent payment reminders with connected payment pathways, to restricted credit card payment options or unfriendly payment portals.

Bottom line: Any system or process that hinders collecting as much of the reimbursement you’ve earned as quickly as possible is creating friction and is costing you money. But it can be identified and improved.

Internal Sabotage

Even with excellent policies and systems, medical practices often become their own worst enemies when it comes to efficient patient payment. Copayment policies are inconsistently enforced, new, under-trained staff are fuzzy on policies and systems, outstanding balance discussions are awkward or avoided, and payment plan options go unexplored in favor of the easy way out of just turning the account over to collections. Even providers blur lines and overrule policies to help patients.

Let’s face it. Financial discussions with patients are uncomfortable. Most of us aren’t very good at it. But it’s a skill that can be learned, and with scripting and practice, can become a comfortable, more genuine, and more profitable way of dealing with patients.

Tips for reducing sabotage are included at various key points in the best practices explanations that follow. Study and rehearse the scripts and adapt them to your specific practice approach.

BEST PRACTICES STEPS FOR IMPROVING PATIENT PAYMENTS

So, what steps can a practice like yours take to improve patient payment results? Here are the two steps and 10 best practices keys that have proven to be most effective.

Set Patient Expectations | Collect More, Faster | Maximize Check-in
Payment Options | Credit Card on File | Automated Billing

STEP 1

START RIGHT: SET PATIENT EXPECTATIONS AND PAYMENT UNDERSTANDING

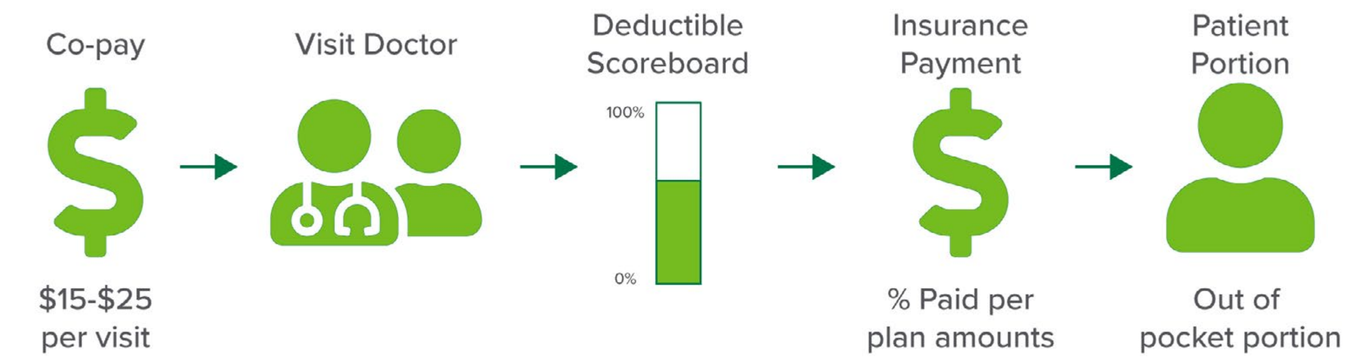
Educating patients on the fundamentals of medical billing and payments is a crucial starting point in making sure their payment expectations are in line with the practice and the realities of the healthcare reimbursement system.

In essence, the objective is to get them off the 'Insurance Freedom' path and introduce them to the 'Medical Bill Reality Road.'

As cliché as it may sound, a picture may be worth a thousand words here. Rather than having patients first read and sign a dense, wordy document about financial policies and responsibilities, start with a simple infographic type illustration (or even a short video) that explains the four key pieces of medical services payment, and the pieces (3 out of 4) and percentages (roughly 25-30% after deductible, 100% before) that they will be responsible for. See the example "Reality Road" infographic example below.

Medical Bill Reality Road

The 4 components of medical bills and patient pay percentage.



Patient % Paid					Patient total payment %
Pre-Deductible	5%	100%	0%	100% up to deductible	100%
Post-Deductible	5%	0%	60-80%%	20-40%	25-45%

You will be responsible for this much of your bill typically.

*Percentages are averages based on typical medical bills and insurance plans. Actual results may vary.

Some practices balk at this type of approach, saying, "Reimbursement is too complex, with too many variables in insurance plans and coverage, deductibles, and reimbursement rates to reduce it to a simple graphic," and thus play into keeping patients confused, frightened and clinging tightly to the Insurance Freedom mindset.

This approach doesn't eliminate the need for formal documents and agreements, which are still an important part of the overall process. But it helps patients get into a more realistic payment mindset and prepares them to better understand the forms and documents they will agree to in the intake process.

Broad, Ongoing Education

Many established patients will be stuck in the Insurance Freedom mindset as well and would benefit greatly from a mindset shift. They can be included in payment education through portal-accessible information, email messages, or during payment discussions as outlined in the following section.

Best Practice Keys

A best practices approach to starting right should include these four key components:

Key 1: New patient welcome packet - automated and online (see next section for details) and printed for in-office use. It should look professional and pleasing, and address the patient in simple, non-threatening language.

- Welcome and overview message.
- Payment education graphic or infographic, and simple explanation of the pieces a patient is responsible for, with links to videos if available. Keep it simple, upbeat, and free of legalese. The objective is to help them see where they fit in the payment picture, and how much of the cost and when they will be expected to pay.

Key 2: Financial Policies Document. Your welcome or intake packet should include these key financial policy points:

- Payment due at the time-of-service policy.
- Telemedicine visit policy. Clarify that telemedicine visits are actual billed visits with the doctor. Many patients believe they are merely talking with the doctor for a few minutes outside of a formal visit setting.
- Copay due prior to visit. Telemedicine visits will not be initiated until the copay is processed.
- Payment options – all major credit cards, online patient portal, payment plans.
- Credit-card-on-file (CCF) - explanation highlighting the many benefits of CCF for the patient, and spelling out specific elements of the service, such as monthly charge limits and timing. Include a separate CCF agreement that the patient signs.
- Payment plan policy and how the CCF will be used to automate monthly payments.
- "Budget" payment plan policy, with well-defined conditions (be specific and clear).
- Financial hardship policy, with specific, clear requirements.
- No-show policy and charges.
- Definition of your elective and/or self-pay procedures and related policy that explains 100% of charges must be paid in advance or at time of service.
- Prompt pay incentives policy.
- Other disclosure and consent documents as required by the practice.

Sabotage Buster

Glossing over policies. Rushing through and vaguely explaining policies is a common form of payment sabotage. It sends the message that these pages are merely guidelines or formalities, not serious policies. In both written and verbal interactions, be clear and firm about payment policies and what is expected of the patient.

"Mr. Jones, let me highlight our policy that copays are payable prior to visiting with the doctor, and particularly in the case of telemedicine visits, which can't begin until copay amounts are settled."

Key 3: Guarantor's Agreement. This is the legal document that holds the patient responsible for payment. Key point should include:

- Guarantee of payment and assignment of benefits.
- Acceptance of your financial policy (and where to find that policy).
- Collection and attorney fees. If this is not included in the agreement, you can't legally charge these fees.
- Actions in the case of financial default – including credit reporting.
- Interest rates charged on outstanding balances.
- No show policy and feesCredit-card-on-file authorization (see below).

Key 4: Credit Card on File. This is a crucial component of a best practices patient payment system. See Key 5 in Step 2 below for details. Language should clearly state the policy, the patient expectation, and how both parties benefit.

Sabotage Buster

Avoiding eye contact. Looking away during uncomfortable discussions is one of the most common, and hardest habits to break. It tells patients you aren't serious and they're off the hook. Look patients squarely in the eye when explaining policies or asking for payment. It's genuinely uncomfortable at first. It takes practice, but the difference in results is measurable.

Sample language for credit-card-on-file policy might include, "Our practice is dedicated to keeping healthcare costs low, working in tandem with patients to achieve that goal. To do this, we request that you pay for services at the time they are provided.

"If you have insurance that will cover a portion of the service, we ask that you sign our credit-card-on-file agreement so that any balance after insurance can be paid and we avoid the costly expense of statements. This greatly reduces costs to our practice as well as to our patients."

STEP 2

COLLECT MORE, FASTER THROUGH LOW-FRICTION SYSTEMS AND PROCESSES

Many practices are unaware of the friction points in their billing and collections systems or lack the tools to significantly improve them. These best practices keys identify the fundamental points of friction, and systems or processes to improve them.

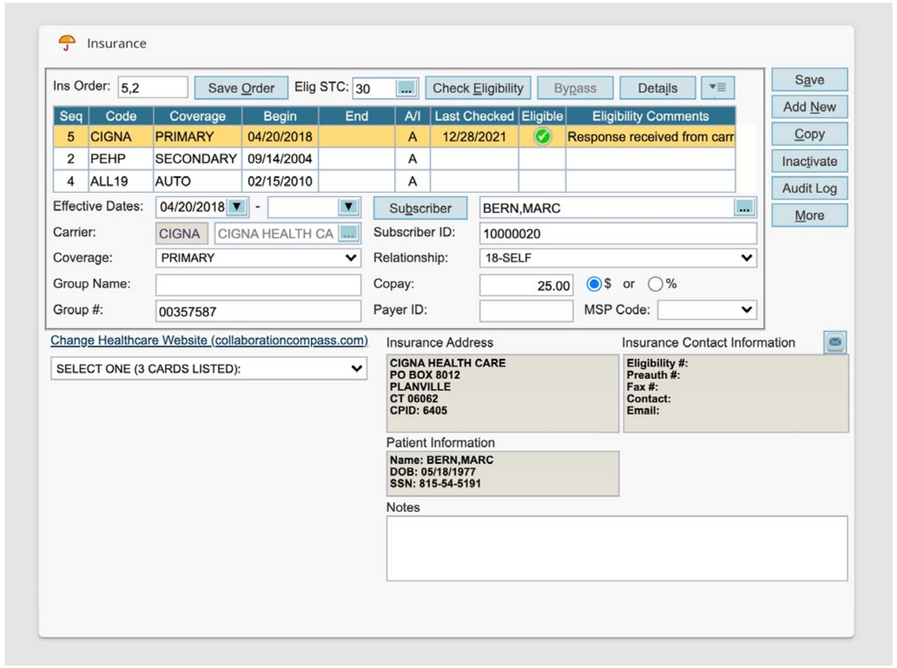
Best Practice Keys

Key 1: Insurance Verification and Update

Maintaining a high first-pass insurance claim acceptance rate is fundamental to accelerating payment and reducing accounts receivable days outstanding.

The simplest and most effective route to high acceptance is an automated insurance verification system and consistent follow up process. Here's how it works in a nutshell:

The practice management system pulls the next day's appointments and runs an automated insurance verification check on all patients. Be sure to run the check on all patients every time. Even with established patients, things change that can cause an insurance rejection. Systems like AdvancedMD can run these checks automatically and notify staff of issues.



Contact the patient to resolve any failed verifications prior to the visit. This can be done through a phone call or electronic message to the patient to remedy the problem. Many practices make this follow-up part of the appointment reminder process the day before the appointment either on the phone or digitally.

The problem could be something as simple as a name or address change, or something more serious like a change of insurance or loss of employment and benefits. For example, knowing a patient has lost insurance allows you to explore options prior to the visit (see Key #4 below) rather than being surprised after treatment.

Whatever the cause, a first pass claims rejection will cost you money, and can often be easily avoided with proactive verification and resolution prior to the appointment through an automated check and consistent follow-up.

Key 2: Automated Intake

With more patients moving to online intake, scheduling and communication, this can be another prime opportunity to boost patient payment literacy and policy understanding.

Integrated practice manage systems can auto-populate a new patient's portal with the welcome package that best suits their situation. This includes the welcome package information described above, in addition to required disclosures and consent forms.

The advantage here is that patients may be more likely to read documents and interact with financial education materials in the comfort of their own homes, rather than quickly flipping or clicking through a stack of information in the waiting room prior to their visit.

Automated reminders also help ensure completion of the packet prior to the first visit and save staff time in follow ups and tracking.

Key 3: Maximize Check-in 'Golden Time'

The 3-5 minutes spent with the patient at check-in is what claims and billing professionals consider 'golden time'. This is where a capable practice management system working in tandem with well-trained staff consistently applying best practices can significantly improve patient collections and patient relations in one go.

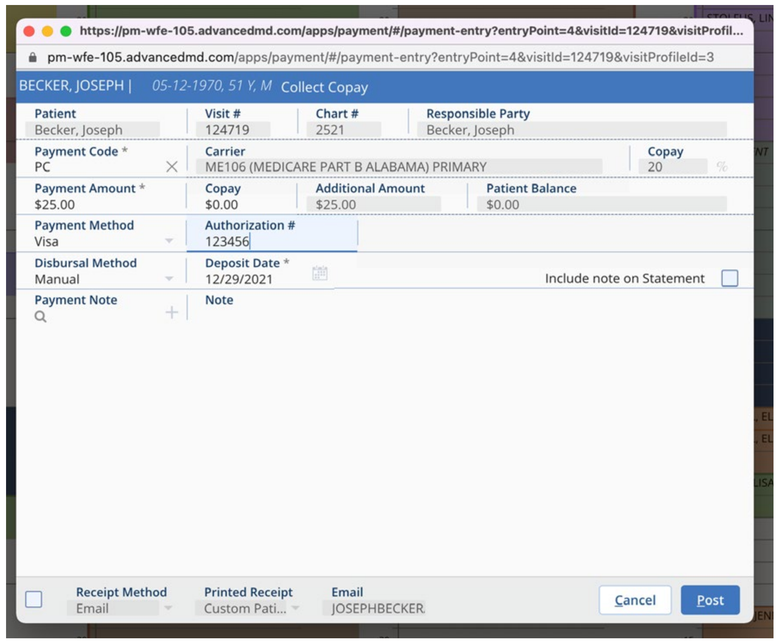
Sabotage Buster

Avoiding the Ask. Reticent staff often find it easier to skip asking for payment rather than risk a potentially awkward encounter. It's important for them to remember that asking - every time - is not bothering or pestering patients. It's consistently enforcing policies they've already agreed to.

In addition to basic clinic check-in information, the check-in should cover three important points.

1. **Insurance and Demographic Information Update.** Have the patient verify current name, address, phone number, etc. as well as insurance coverage - to validate that yesterday's automated verification matches their understanding of their insurance coverage. >>>Data on collect copay up front<<<
2. **Co-Pay Discussion.** A good practice management system will display the co-pay verified in the insurance check the day before (see example below). The staff member should always ask for payment prior to the visit, using language as suggested below.

   A note on telemedicine visits. With the recent rapid rise of telemedicine, practices have been challenged in collecting a different type of patient payment. Current best practice in this arena is to implement a strict policy of "no copay, no visit." It may sound harsh, but patients need to understand that this is a bona fide visit, not just a chat with the doc. The most successful practices ask for, and get, the copay up front.
3. **Outstanding Balance.** The system should also display any outstanding balance the patient is carrying (see below). It's important for the staff member to have this accurate amount readily available to facilitate 'golden time' collection. Similarly, the staff member can say, "I also see that you have a $79 outstanding balance on your account. We can put that on your credit card, or would you prefer to pay by cash or check?"



Sabotage Buster

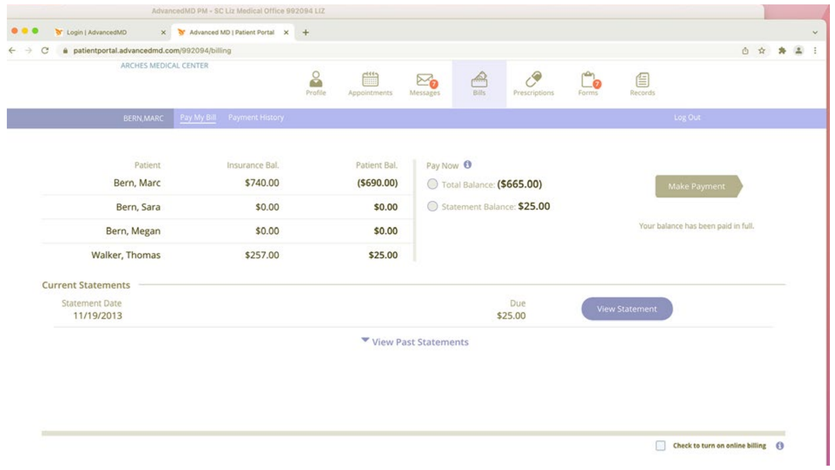
Asking open-ended questions. Open-ended questions leave patients an out, and an open invitation for giving excuses to not pay. Rather than asking, "Mrs. Smith, would you like to pay your co-pay today?" say, "Mrs. Smith, your insurance plan requires a $15 copay for each visit to our office, which is due prior to the visit. Which credit card would be most convenient for you to take care of that amount now?" or, "I see you have an $85 balance owing on your account. To settle that amount now, would you prefer to put it on your credit card, or pay with check or cash?" These conversations can happen at check in, on the reminder call, or in an online message.

Key 4: Offer Payment Options

In today's consumer-driven economy, we are offered a myriad of options for purchasing our goods and services: multiple credit cards, online payment platforms, credit and financing plans, and many more. Patient consumers are more inclined to pay if they feel they have multiple, low-friction payment options for taking care of their medical bills as well.

As a baseline, your practice must accept all major credit cards and debit cards, as well as cash and checks. PayPal and Venmo are increasingly popular options to include. Credit card processing must include payments in-office, online, and with the patient over the phone.

Equally important is a convenient online payment function on your patient portal. Many patients today prefer to log onto their account and pay online. Be sure your portal is easy to navigate, accepts multiple payment types, and provides the information patients need to bring their accounts current, including recent payments, recent charges and current balance and due date.



For patients challenged in meeting their medical bills, offering payment plans can go a long way toward keeping them out of collections (where the practice will only realize an average of $18.45 per $100 due). Getting patients committed to a payment plan is almost always a better option. Terms of the plan should be clearly spelled out in your financial policy documents. Ideal plans split a bill into equal no-interest payments over no more than 3 payments and require a credit card on file to process agreed-upon amounts on time (see Key #5 Credit Card on File).

Sabotage Buster

Stumped by Objections. Even following best practice policies and language models, staff will invariably run into pushback, excuses, and objections from patients regarding payment. Comments can range from, “My insurance will pay for that,” to “I need to check with my spouse,” or “That can’t be right.”

It’s important to remain firm and consistent with payment policies and have well thought out responses prepared in advance to deal with the most common objections logically and unemotionally. A ‘deer in the headlights’ response is a green light for patients to continue avoiding payment. Work with your staff to identify the most common objections encountered in your practice, and then create and rehearse with one another appropriate responses.

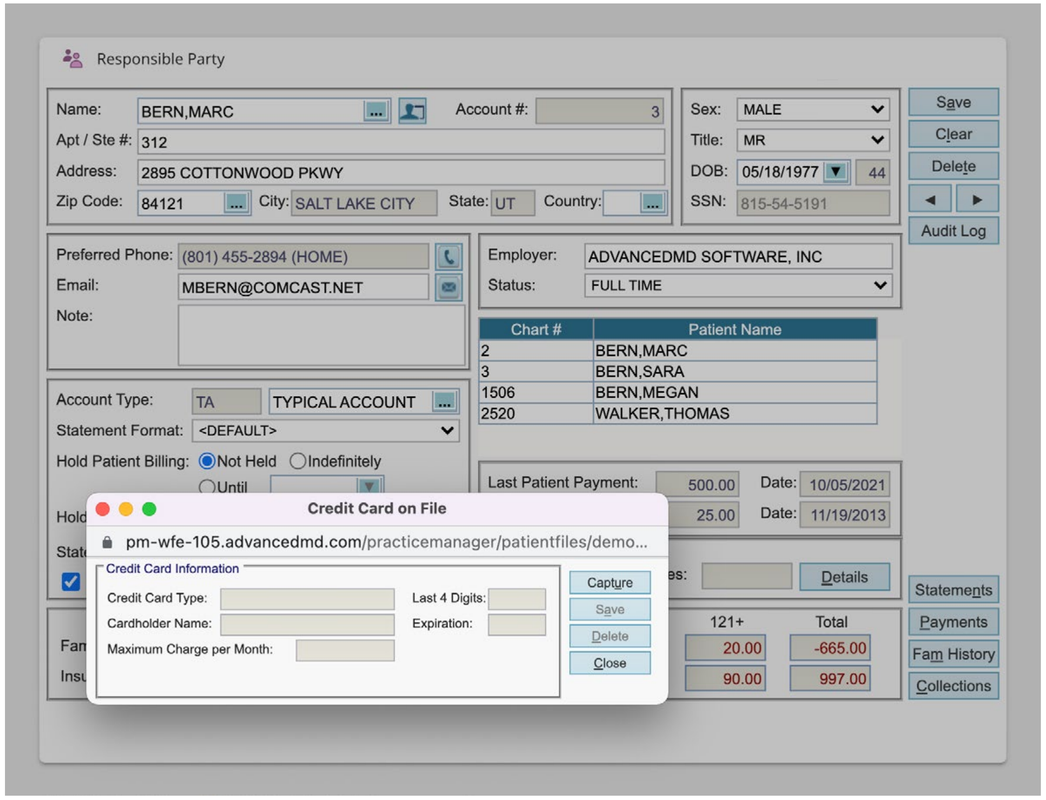
Key 5: Credit Card on File - Your Cash-Flow Secret

This technology is a must for every practice looking to systematically improve cost-effective patient payment collection. Practices who employ it have experienced significant reductions in outstanding patient balances.

The concept is like subscription models many product and service providers employ today (think cable or Internet bill). Rather than having to beg patients for payment on outstanding balances each month, the practice keeps a credit card on file and automatically debits the outstanding amount. Coupled with a patient payment plan, it ensures monthly payments are reliably collected on time at low cost with minimal patient disturbance.

A credit card on file policy and agreement should be included in your financial policy and guarantor’s agreement documentation signed by each patient. Sample language is included in the welcome package section above. Typically, you should ask patients with insurance plans to provide a credit card on file to cover the portion of visits not paid by insurance, up to a specific amount each month (approximately $XXXX at the time of this writing.)

Efficient execution relies on an automated billing system such as AdvancedMD which runs a ‘billing wizard’ and returns all outstanding balances that have a credit card on file amount that can be applied against that balance. Selected accounts are submitted for payment processing with a single click, and once authorized through your merchant account, the money is automatically applied against the balance and the funds are transferred directly to the practice’s bank account just as if the patient were there making the payment.



Don’t’ overlook this important piece of your patient payment solution. It could turn out to be your cash flow secret.

Key 6: Automated Billing Alerts and Reminders

This solution relies on unified practice management systems that combine automated messaging features with billing and account information to eliminate costly and time-consuming manual work.

The system automatically flags and pushes email, portal message or text reminders to patients whose accounts are due, overdue or who have payments coming up. Lists for follow-up phone calls can also be generated. Staff are freed up to focus solely on exceptions and escalated issues.

GET STARTED NOW

Improving patient payments is a step-by-step process of first identifying areas of greatest need, implementing one of these best practices processes, and then practicing and refining the execution to realize optimum results. The important thing is to pick an initiative and get started.

AdvancedMD experts and advisors are always available to assist in the process, so you have the best systems and technology available, honed by 20 years of best practices experience.

References

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