***No! No! No!* Financing for Urgent Care**

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At the beginning of every new year, it's common to see retailers of "big ticket" goods—automobiles, furniture, appliances and electronics—advertise "**no** money down, **no** interest, and **no** payments for 6, 9, or 12 months." Although these offers are typically riddled with fine print and consumers in the long run pay more with financing versus just paying cash in a liquidation sale—"no-no-no" is still viewed as a "win-win-win." That's because the "no-no-no" enables retailers to clear out year-end inventory without discounting prices and it enables consumers (still cash-strapped from Christmas) to take home product immediately without maxing out their credit cards.

Due to their billing practices, many urgent care centers unintentionally offer a form of "no-no-no" financing. Unlike furniture and appliance retailers, such practices are not advertised, they do not draw new patients into the urgent care center, they do not increase utilization by existing patients, they lead to large write-offs to collections, and ultimately they contribute to dissatisfied patients who (knowing they owe money) won't return to the practice.

The following case study illustrates exactly how "no-no-no" functions and why it's such a bad deal for physicians.

Free Financing for an Office Procedure

In August, 2011, a patient presents at a specialist's office for a minor outpatient procedure. Upon completion of the registration paperwork, the front office staff notices the patient's insurance card does not require a co-pay but does require "20% co-insurance." Rather than tally up the day's charges and collect 20% from the patient at time of service, the staff tells the patient that "due to the co-insurance provision" they will "submit the claim through insurance and send a bill for any balance the patient owes."

The patient received services for which he did not pay anything at time of service, resulting in a form of "no-no-no" financing with the following economics:

Service Date	Services Performed	Physician Charges	Insurance Adjustment	Gross Charges	Applied to Deductible	Patient Responsibility
8/18	History, Physical, and Pre-Surgical Evaluation	$195.06	$71.76	$123.30	$123.30	$123.30
8/25	Office Procedure (including one follow-up visit included during the "global" period.)	$622.86	$363.51	$259.35	$259.35	$259.35
Total		$817.92	$435.27	$382.65	$382.65	$382.65

As the table illustrates, the specialist performed $817.92 worth of services, which were discounted 53% to $382.65 according to the terms of the insurance contract. What the staff failed to address at registration—whether or not they noticed—is that the high deductible making the patient responsible for 100% of the first $2,500 in gross charges means the co-insurance provision is irrelevant to this particular transaction. The patient is responsible for the entire $382.65.

Unlike "discretionary" goods such as appliances and electronics one could argue a consumer doesn't *really* "need," the patient in this case *did* have a sense of immediacy around his medical procedure—for both physical comfort and emotional "peace of mind." So not only was the patient *willing* to pay something at time of service, understanding his employer's health benefits, he was actually *expecting* to pay. That's why he showed up for the procedure with his checkbook in hand.

There's a saying that "cash is the lifeblood of any business," referring to the importance of *working capital* or *liquidity*—the difference between cash on hand and operating expenses due. For example, when a physician sees a patient, overhead costs including staff salaries and benefits, rent, utilities, and supplies, are incurred immediately. But due to insurance billing, there's a lag between when expenses are paid and when cash is received. Because the practice can't pay its bills with "insurance IOUs," someone must make up the cash shortfall—typically that's done by borrowing money

from a bank or foregoing the distributions normally entitled to business owners. The cost of working capital is interest paid or interest foregone. Thus, business owners are motivated to increase working capital by accelerating cash inflows and postponing cash outflows.

In the office surgery illustration, services were performed in mid-August but the practice did not submit claims to the insurance company until late September—meaning the single-physician practice effectively provided no-interest working capital to a multi-billion dollar insurance entity for 30 days. Moreover, once the insurance Explanation of Benefits revealed the patient was responsible for 100% of the balance—the practice did not bill the patient. As of December 31, the patient still had not received a bill from the practice for his balance due. The net is that the patient has received 140 days (over four months) of "no money down, no interest, and no payment" financing for the office procedure.

By the time Christmas rolls around, it's the physician whose pockets are empty—his staff, landlord and suppliers have all been paid, the insurance company is whole, and the patient has extra cash in his checking account. And although this particular patient is diligent in paying all of his bills, many other patients are not due to the time that elapses since the immediacy of the medical problem, lack of understanding of what insurance has paid and how patient balances are derived, or simply because the patient (living paycheck-to-paycheck) no longer has the cash. Consumer health care receivables are notoriously difficult to collect and often liquidate for pennies on the dollars through medical collections agencies.

Steps for Urgent Care Operators

Urgent care operators can protect themselves from the negative consequences of unintentional "no-no-no" financing through the following activities:

- **Assure front office personnel understand how insurance works.** Staff should be able to assess a patient's coverage, understand how that coverage affects the transaction at hand, and then be able to explain the coverage and transaction in terms understandable to the patient. This means staff should clearly understand differences between Medicare, Medicaid, HMOs, PPOs, HRAs, HSAs and FSAs; the structure of health insurance benefits including the differences between co-pays, co-insurance, and deductibles; the differences between primary and secondary insurance and between patients, insureds and guarantors; and reimbursement schemes such as fee-for-service, global period, and capitation.

- **Develop a financial policy and have all patients read and sign it.** The financial policy clearly outlines to patients what forms of payment are accepted, how insurance is billed, what amounts are owed by whom and when, what fees apply for late payments and returned checks, and how ancillary services by third party providers are billed. In addition to staff explaining the written financial policy, having patients review and sign document should reduce patient confusion while also providing the practice with a signed acknowledgement that the patient will cover his/her responsibility.

- **Verify insurance eligibility, benefits levels, deductibles, co-pays and co-insurance.** When a patient presents with insurance, the front office staff—using the insurance company's website or toll-free number, a third-party verification service, or functionality built into a practice management system—should verify that the insurance policy is still valid while also confirming the terms of the patient's coverage. In this economy, people change jobs frequently so just because someone presents an insurance card doesn't mean the insurance is valid. Understanding what's covered is also requisite to collecting the correct amounts from the patient at the time of service.

- **Require that patient financial responsibility be paid at time of service.** The best time to collect money from patients is when there's a sense of immediacy around their medical episode. Months later patients forget they were ill, become confused as to what has been paid, or they've already spent their money on other things. Prior to treating a patient, an urgent care practice should require patients to pay their co-pay, an estimate of co-insurance based on average charges, or if a deductible is present—an amount equal to average charge for the visit type. Past-due balances should also be settled prior to the patient incurring new, additional charges. Although collecting cash

at time of service may result in an increased number of refund checks being issued—it's far preferable for a practice to issue refunds than to write-off receivables to collections.

- **Code visits, calculate and enter charges, and submit claims immediately.** Calculating charges while the patient is still present not only provides an accurate estimate of charges if there is patient financial responsibility to collect, but it also reduces errors and omissions because providers and staff are still aware of exactly what services were performed and which supplies where used. Errors or omissions in the patient chart can be easily corrected prior to charge entry. And the faster a claim is submitted to insurance, the faster it is adjudicated meaning the practice gets paid sooner, thus increasing working capital.

- **Send clear, concise billing statements to patients as soon as possible.** Once it's known a patient balance is due, a statement should be sent to the patient as soon as possible, while the transaction is still fresh on the patient's mind. The billing statement should clearly illustrate what is owed and why—including what has been paid by insurance, applied to deductible, and what has been rejected. Not understanding physician invoices is a common reason medical bills go unpaid. Likewise, once 45 days have passed from the patient's first statement, unpaid patient balances should receive a written notice. By 90 days, those balances should be forwarded to collections. Balances turned over to a collections agency earlier (less than 120 days) not only are more likely to be paid, but agency commissions are also lower on more recent transactions.

- **Accelerate receipt of cash through electronic remittance, direct deposit, lockbox, online credit card payments and other treasury management services.** Direct deposit set up with insurance companies not only reduces float but it also reduces the risk of checks being lost or stolen before deposited to the urgent care center's checking account. Knowing money is "safe" in the bank, there is less urgency around cash posting in the center's practice management system. Same with patient receivables processed through a bank lockbox or accepting credit card payments online—the faster funds have cleared the practice's bank account, the more positive impact on working capital.

Conclusion

When an urgent care center does not verify insurance, holds insurance claims prior to submission, overlooks patient responsibility at time of service, or otherwise fails to bill and collect in a timely manner—it 's the functional equivalent of a retailer offering "no money down, no interest, no payment" financing. Not only must the urgent care operator still come up with working capital to run the business, but unlike a retailer, such billing practices result in high write-offs and negative patient perceptions. The solution lies with processes, systems, and training at the front office.