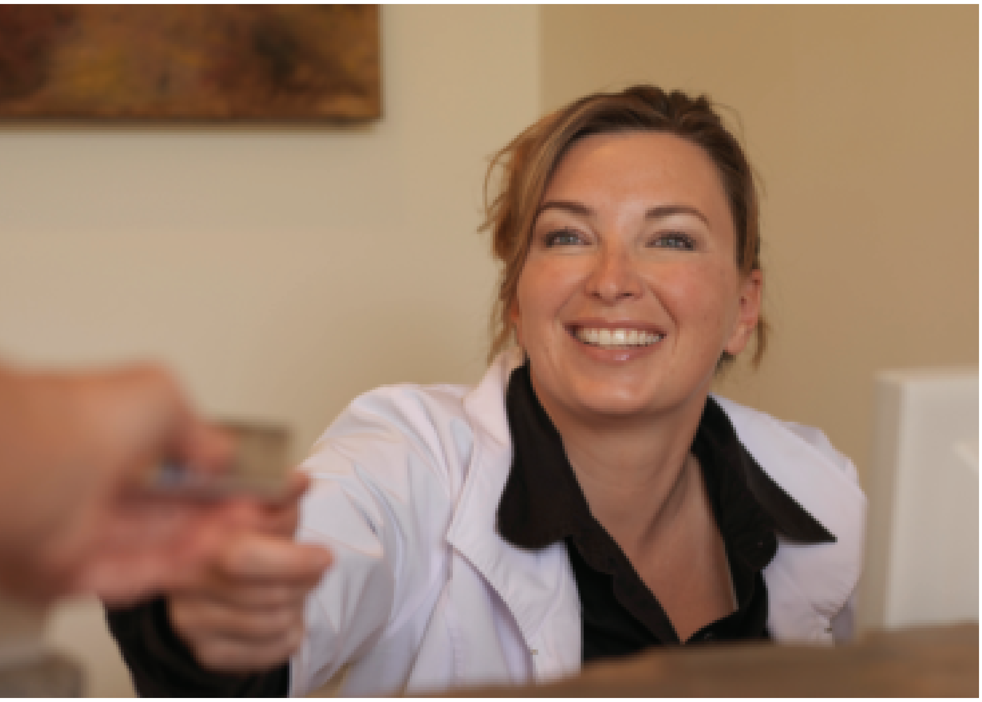
Maintaining Profitability in the Era of Consumer-Directed Health Care

BY TOM STAMPIGLIA



It's hardly news that for most medical groups, payer reimbursements are declining while costs are going up. Yet the threats to profitability aren't limited to the usual suspects of insurance carriers, government-funded health plans, suppliers, and the like. Practice revenues are at greater risk than ever before from patient bad debt and the administrative costs of pursuing it. There are, however, instructive examples of practices that are effectively addressing the growing importance of patient receipts. These practices are optimizing their revenues and preserving margins, ensuring their long-term profitability and viability while others struggle to meet the challenges.

Whether by choice or necessity, patients today bear an ever-increasing responsibility for their medical costs. Patients participating in consumer-directed healthcare (CDHC) plans, for instance, pay lower premiums but have higher deductibles. Even patients with employer-sponsored coverage are seeing their deductibles and co-payments increase substantially. And with every uptick in the unemployment rate, the ranks of the uninsured grow. Whatever the cause, patients today put more of their money on the line, and medical groups need to meet the ensuing challenges of improving customer service and protecting revenue streams.

According to the most recent census from America's Health Insurance Plans (AHIP), released in April 2008, 6.1 million Americans were covered by health savings account–enabled, high-deductible health plans in January 2008, up from 4.5 million a year earlier. With the growth in CDHC plans, more and more practices are encountering challenges regarding the patient's ability to pay higher deductibles. Consider that in 2007, 31 percent of participants in CDHC plans had less than $500 in their health savings accounts, about enough to cover one moderate ambulatory encounter.

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Many patients in CDHC plans and even in traditional plans are simply unprepared to meet the financial obligations that come with medical treatment beyond the most basic care. And because most medical groups aren't collecting up front the full amount owed by patients for services rendered, patient bad debt has become a significant, almost endemic issue for many practices. Nearly one-third of Americans surveyed last fall by the Kaiser Health Tracking Poll indicated that they had had problems paying medical bills in the previous 12 months, and 18 percent of that group had bills of $1,000 or more.

Patient receipts account for 19 percent of the average practice's accounts receivable,[1] yet collecting revenue from patients is a very challenging, expensive proposition. In fact, according to Woodcock and Associates, the administrative costs of collecting from a patient are twice that of collecting from a payer. Making matters worse, the rate of patient bad debt is rising: 50 percent of overall consumer responsibility goes uncollected,[2] and 81 percent of self-pay net revenues are never recovered.[3]

For practices committed to increasing patient revenues, however, it is important to acknowledge that few patients have a clear understanding of what medical services will cost prior to the time of service. Although the average American can estimate to within a few percentage points the cost of a new car, healthcare pricing can be notoriously opaque even for people with experience in the industry. Without widely available pricing information, it remains difficult for patients to anticipate their financial obligations for medical care.

Strategies for Financial Health

While the patient collections issue continues to grow in importance, it's just one side of the revenue equation. Physician practices still face countless challenges when it comes to capturing all of the revenue they are due from payers. With increasingly complex payer contracts and declining reimbursement, providers must take proactive steps to ensure they are paid what they are owed.

A handful of providers are addressing these challenges by employing proven tactics to maximize revenue on all fronts—from monitoring payer compliance with contract terms to improving processes for validating insurance eligibility and coverage to generating patient estimates for care at the point of service. By utilizing software solutions to streamline a number of daily processes, these groups are reaping a demonstrable return on investment and experiencing a healthier bottom line.

Step One: Get More from Your Contracts

Since payer contracts determine reimbursement for care provided, it's a great place to start when looking for ways to maximize revenue. In addition to identifying and recovering contractual underpayments, contract management systems can help medical groups to correct front- and back-office errors, negotiate better contracts, and make chargemaster adjustments.

At University Physicians, the academic faculty practice plan for the University of Missouri School of Medicine, administrators and physicians recognized that the practice's manual payment verification processes were not up to the task of identifying payment errors and enforcing compliance with contract terms. The labor-intensive process relied on combing through boxes of reports sorted by CPT code, determining an average payment, and appealing reimbursements that were below average.

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Administrators and physicians concluded that the practice could recover more revenue by implementing a contract management system that would automate and streamline the payer variance appeal process. University Physicians selected a system that, since being deployed in 2004, has enabled the group to evaluate overall contract performance, verify reimbursement, and evaluate the financial implications of new and proposed contracts.

Prior to implementation, the vendor's contract analysts defined the practice's contract terms, modeled the contracts, and loaded them into the system. The practice chose first to load and monitor the contracts that were highest in volume or had resulted in the most underpayments. Eventually, additional contracts were loaded into the contract management system, which today represents 85 percent of the group's total claims volume. Each night, the system pulls claims data from the group's practice management system and submits it to the vendor's data center, where claims and allowables are audited against payer payment policies and adjudication logic.

The practice's recovery rate for underpaid claims is now about 80 percent, which is a substantial improvement over the rate using previous manual processes. In the first three years of use, the group recovered $1.7 million, which represents about 0.5 to 1 percent of total revenue. The practice has found proactive uses for the data generated by the system, as well. The reporting tools have become indispensable parts of contract analysis, rate modeling, and fee setting, which give the practice the ability to analyze the overall performance of payer contracts when renegotiating contracts.

Step Two: Streamline Eligibility and Benefits Verification

Increasingly frequent changes to their patients' insurance plans and status represent another challenge that medical groups face when they seek to improve revenue collection and administrative efficiency. Changes to employer health plans often result in higher deductibles or reductions in coverage, meaning that patients assume more responsibility for their medical expenses. It is critical for practices to efficiently verify eligibility and benefits prior to service and accurately determine patient fees. Too often, practices bill carriers for services that aren't covered, bill the wrong carrier, or don't have the correct patient co-pay and deductible information. As a result, medical groups are at risk of increased denials, delayed payment, increased bad debt, and higher billing and collection costs.

Sansum Clinic, a 135-provider, multispecialty group in Santa Barbara County, California, began the process of addressing its eligibility and insurance verification challenges in 2006. With 16 locations and 150 employees charged with checking eligibility throughout the payment process, the practice decided that it could make significant improvements in revenue collection and administrative efficiency.

Among Sansum Clinic's primary challenges were collecting accurate patient co-payments at check-in; acquiring the correct benefits information; determining coordination of benefits; obtaining the correct address, phone number, and other demographic information; and collecting self-pay balances. To improve performance and efficiency in these areas, in February 2007 the practice implemented an automated insurance verification system that electronically gathers patient co-payment, benefit, and deductible information at various points in the billing process.

The new system has improved both results and workflows in the practice's front and back offices. For example, 7 to 14 days before a scheduled appointment, the system verifies patient eligibility and brings potential eligibility issues to the staff's attention. If necessary, back-office staff update co-payment requirements, which are then updated in the system used by check-in staff.

Sansum Clinic has realized a wide range of benefits from its automated eligibility and benefits system. Claims denials resulting from eligibility issues have decreased by 20 percent. Co-payment collections have increased by 20 percent, and the accuracy of co-payments collected has improved by 30 percent. Considering the heavy volume of patients that the practice treats, improved accuracy and collections have an appreciable impact on the bottom line. For high-value procedures, such as those performed in the group's ambulatory surgical center, collections of co-payments in the \$50 to \$300 range have risen substantially.

The patient experience has also improved, as the average check-in time at registration has been shortened from 5 to 2 minutes. And, by improving the accuracy of payment information provided to patients, average days in accounts receivable have fallen from 87 to 71, a drop the practice attributes in large part to the new eligibility system.

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Step Three: Improve Collections with Estimates

With the growth in consumer-directed care and the widespread rise in deductibles and co-payments, it is very difficult for most practices to accurately determine and collect the patient's share of medical services prior to the time of service. What makes this an especially important challenge now is that patient receipts are rising as a proportion of practice revenues. This applies especially to practices with relatively high volumes of elective procedures or therapies and services associated with high co-payments and deductibles. As consumer-directed plans grow in popularity, however, out-of-pocket payments will become an even larger percentage of overall revenues, making it even more critical for medical groups to collect these funds.

The answer to this issue is improving time-of-service patient collections, but in order to do so, practices need to be able to provide accurate, quick patient estimates prior to the time of service. For most practices, the biggest obstacle to generating estimates is that they do not know exactly what payers will allow for each procedure. Without this information, it is virtually impossible to estimate patient fees, let alone collect them, before services are performed. The right technology, however, can help practices overcome this obstacle, inform patients of costs up front, and earn their patients' good will by helping them make smart decisions through financial counseling.

Atlanta's Emory Clinic, a multispecialty practice with more than a thousand physicians that is affiliated with Emory University School of Medicine, recognized this need and took steps in 2007 to increase upfront patient collections, improve patient education on benefits coverage, and reduce bad debt. The practice began leveraging the contract data stored in its contract management system to generate estimates of the patient's portion of the bill prior to the time of service. The practice uses the estimates as a way to begin a dialogue with patients so they better understand their financial responsibility, reducing billing questions on the back end.

Emory Clinic's use of the estimating tool in all clinical departments has led to dramatic reductions in self-pay accounts receivables. When using the system to provide patients with estimates before the time of service, it realizes an 85 percent collection rate. As a result, financial counseling collections have increased by 35 percent, which equates to \$2 million annually. In addition to the positive impact on bottom-line collections, patient financial counseling at Emory enables patients to understand their financial obligations and make decisions regarding their care before services are rendered.

Conclusion

In this challenging healthcare environment, medical groups cannot afford to ignore any opportunity to preserve revenues. Fortunately, technology offers cost-effective, proven methods to overcome the issues facing today's providers so they can improve internal processes, expedite payment, and increase overall revenue. And, since many of these strategies help practices to improve service levels, they also help to enhance patient satisfaction and practice viability.

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Tom Stampiglia *is CEO of Austin, Texas-based Medical Present Value, Inc. (MPV), a provider of financial tools and services to help medical groups manage revenue processes and meet the demands of healthcare consumers. www.mpv.com*