Consultants Corner

Thriving in Trying Times:

What Healthcare Organizations Can Do To Succeed

With the current economic downturn, healthcare executives are scrambling to ensure not only that physician compensation remains intact, but that their organizations as a whole survive.

Congress successfully staved off a nearly 11% reduction in Medicare payments to physicians, and a planned five percent cut for 2009–this is merely an 18-month "stay of execution" for providers. The federal health system–as many of you know–is in need of long-term solutions to the issue of physician reimbursement to avoid the yearly round of threatened cuts. These solutions will take time to identify and implement, however, and won't speak to your short-term concerns.

But all is not lost. I'm a realist, not an alarmist. I see these issues in our industry as opportunities for organizational improvement.

Yes, there are serious problems. There are also solutions physician practices and other healthcare entities can implement now to help offset rising costs and negate any future reductions in reimbursement.

Collecting From Insurance Carriers and Patient Co-payments and Deductibles

One area of focus with an immediate and material return-on-investment is insurance carrier and patient collections. Below I have provided you with the simple calculations you can use to figure out your collection rates.

Calculating Collection Rates

Gross Collection Rate (payments ÷ charges). Gross Collection Rates under 60% deserve a closer look (compare with net collection rate)

Net Collection Rate [payments ÷ (charges minus adjustments)]. Net collection rates lower than 95% represent an opportunity to increase collections–or to keep up with payment posting.

Aged accounts receivable

· Months of charges in A/R (total A/R ÷ average monthly charge). More than two months of charges in A/R represents an opportunity to increase collections through more aggressive follow-up and patient collections.

Example:

Over the past 90 days, a solo physician has gross charges of $80,000, $72,000 and $81,000. Her total A/R for the period is $215,000, of which:

· $100,000 is 121 days plus
· $35,000 is 91–120 days
· $27,000 is 61–90 days
· $32,000 is 31–60 days
· $73,000 is current–30 days

Where is the problem? Here is an example of a practice (I am keeping this very simple for this article) that came to us wondering why the providers were working harder, but there was no additional money coming in to show for their efforts. While this was glaring to us, it was a complete shock to the physician. As you can see the practice has approximately 40 percent of their A/R out past 121 days, which means the reality of them ever seeing that money is slim at best. The other buckets of A/R were all within reason but 40 percent is a huge amount of A/R to just walk away from, which is precisely what they were doing.

There are also some reports and other documents we believe you should be reviewing on a regular basis that will help you to track where your money is, if it is not in your bank account.

Unpaid claims report

· Pull this report by type of service, department, provider and payer to identify unpaid claims
· Unpaid claims past 45 days are problematic
· Identify the causal problem – it could be anything from a

missing zero on the end of a provider number to snafus with the electronic claim format

Electronic claim exception report

· Electronic claim submission results in an exception report that identifies claims that didn't go through. Monitor those reports to see if the claim is corrected and resubmitted

Explanation of benefit (EOB)

· The EOB includes explanations of what claims were and were not paid, along with the reason (called a reason code). Audit a sampling of EOBs when performing the coding audit to identify patterns of denials that can be fixed internally or with the payer

Financial controls begin with understanding financial statements. Are you reviewing the following reports to make sure you balance and to make sure all monies due your practice have been captured?

· Day-end reporting
· Week-end reporting
· Month-end reporting

What processes do you have in place for charge capture/coding controls? Some of the things I have in the past and continue to strongly urge our clients to use are:

· Sequential encounter forms
· Open items report that are integrated into day end reporting

A lot of times practices do not believe me when I get into discussions about collection cost. If you have not performed a cost analysis at this point I would strongly urge you to. I like to use real world examples as I illustrated above with the Family Practice client. Although it is a crude example, I think it gets the point across for this article, which is on what you can do to not only survive, but actually thrive. Remember our family practice physician above with the A/R issues. Well now lets look at what we found when we looked at her staff's collection efforts from just the patients.

Practice A

· 35 patients per day are seen
· 25 patients per day don't pay co-pay
· $20 average patient co-pay
· $500 lost revenue each day
· 5 days per week patients are seen
· $2500 per week lost in revenue
· 48 weeks per year patients are seen
· $120,000 in lost revenue per year

Now, here is another area practices continue to lose a ton of money. Collection efforts. Here is where the cost analysis I mentioned above comes into play. This is the same family practice:

Practice A

· 25 patients per day who don't pay
· 5 days per week patients are seen
· 125 statements per week sent out
· 48 weeks per year statements are sent
· 6000 statements per year sent
· 3 statements per patient average
· 18,000 total statements per year
· $8 per invoice cost
· $144,000 in real revenue lost from our collection efforts

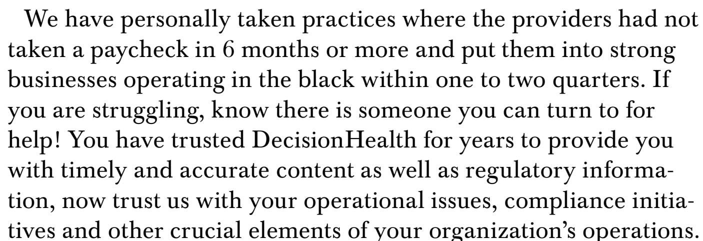
Now that we have talked about some of the most common errors made in a medical practice, let's focus our attention on some things that do not jump right out at you.

Have you:

· Reviewed your fee schedule?
· Reviewed your insurance carrier participation agreements to see if they are still worth participating with or at a minimum going back and trying to renegotiate. Please do not tell me the carriers do not negotiate because this is something our group does all the time on behalf of our clients.
· Performed a breakeven analysis to try and identify your cost associated with providing the services to the patient.
· Considered adding ancillary staff to your practice, especially if you are a surgical practice, which will free your physician(s) up to perform more high-dollar services and allow the non-physician practitioners to handle the routine follow-up and other minor services your group offers or could offer if it were staffed correctly.
· Performed an FTE analysis to ensure you are not overstaffed. This is part of what we call a comprehensive practice analysis.
· Reviewed your marketing plan
· Reviewed your strategic plan or business plan

The list goes on and on. I can spend days talking about the things providers should be doing to improve their organization financially. We realize the physician fee schedule drives a lot of what you do and what you are able to do in your organizations, but it is not the only thing. By no means are the suggestions offered in this article complete lists of what practices should be looking at, but it is a strong start.

We have personally taken practices where the providers had not taken a paycheck in 6 months or more and put them into strong businesses operating in the black within one to two quarters. If you are struggling, know there is someone you can turn to for help! You have trusted DecisionHealth for years to provide you with timely and accurate content as well as regulatory information, now trust us with your operational issues, compliance initiatives and other crucial elements of your organization's operations.



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