

Profit from Pressure...

Data and Tools for Independent Medical Clinics in High-Pressure Times

In the spring of 2011, **Outsource Receivables, Inc.** (ORI) conducted a survey of independent medical clinics in the Wisconsin and Minnesota region about the rising costs and complexity associated with doing business and their responses to these issues. We combined this with internal data and research on the macro-trends in the medical marketplace. We contacted just over 400 independent clinics with revenues between \$500,000 and \$5 million, and completed 142 surveys.

Independent practices face many of the same issues corporate healthcare providers do, including: rising costs, Medicare/Medicaid uncertainty, billing and collection complexity/bad debt, and selecting and implementing EMR (Electronic Medical Record) systems.¹ The independent clinics, however, typically do not have the infrastructure to manage these issues effectively.

The following data details each of these issues and gives insight on how to profit in these dynamic times.

Rising Costs

Healthcare costs have risen faster than GDP almost every year since 1960.² While rising healthcare costs are nothing new, the landscape of how these increasing costs are paid for is shifting fast. From 1960 until 2008, both public insurance (Medicaid and Medicare) costs and private insurance costs rose dramatically to keep pace with the rising costs of healthcare. During this same time period, self-pay portions (out-of-pocket expenses) rose only slightly. Currently, self-pay portions are on the rise. The Healthcare Financial Management Association (HFMA) reported, “more than **97 percent** of respondents to HFMA’s 2010 survey experienced an increase in **self-pay** accounts receivable as compared with the prior fiscal year”.³ ORI has also seen this trend across the industry. In a recent customer study, we found 24% of all claim dollars were self-pay.

The formation of shared savings plans is a significant tool being used to ease the healthcare cost problem. Medicare has launched an ACO (Accountable Care Organizations) initiative and other insurance providers have followed suit. In a shared savings plan, a network of healthcare providers contract with an insurance provider and share in the savings on the difference between the historical cost of patient care and the new cost of patient care under the new network of providers. Until now, this revenue stream and shared savings opportunity was exclusive to corporate healthcare organizations; however, the **Midwest Independent Practice Association** is now forming a shared savings network that all of its members can benefit from.

For more information visit www.midwestipa.org



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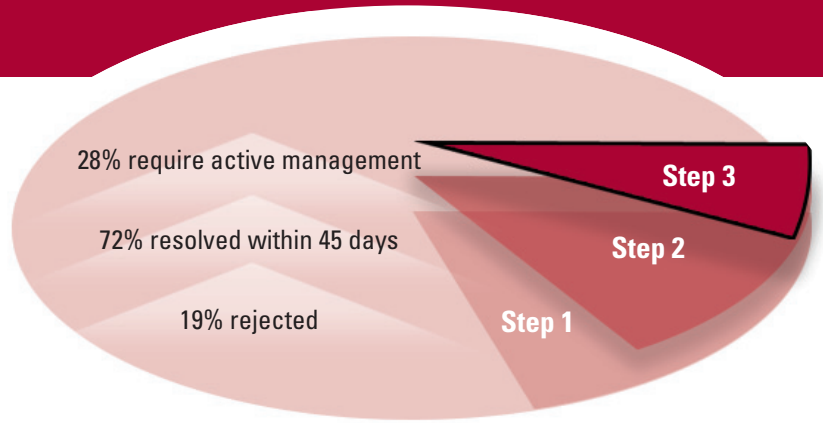
Medicare/Medicaid Uncertainty

Most proposals to reduce the national debt include some restructuring of Medicare and Medicaid. While the debate and proposals have gone on for years, some debt deal that includes changes to Medicare/Medicaid now seems imminent. This comes on the heels of a decade where shortfalls in payments for healthcare services by Medicare/Medicaid rose steadily.⁴ Currently, Medicare/Medicaid is paying approximately 90% of actual cost of services. This is largely due to adjustments in Medicare/Medicaid not keeping pace with rising medical costs. Hence it is no surprise that the MGMA saw, 'maintaining finances with the uncertainty of Medicare reimbursement rates' jump up to the number two concern in their annual member's survey in 2010.

Billing Complexity and Bad Debt

Medical receivables management is a complicated process that continues to be daunting. The pressures of rising costs, increasing self-pay portions, increasing numbers of uninsured persons, new insurance stipulations and Medicare/Medicaid shortfalls are yielding more bad debt that is sometimes as high as 15% of revenue. It is no wonder that numerous industry publications such as *Healthcare Finance News* cite effectiveness of receivables management as a strategic business issue. It is not surprising that more independent medical practices are outsourcing this key function to experts.

In order to understand the complexity, ORI conducted a study of the stages in receivables management across a range of independent medical practices in Minnesota and Wisconsin.



The picture looked like this for insurance paid claims:

Step 1 - 19% of **all** insurance claims are initially rejected by the insurance companies and require research, corrections and resubmission to process.

Step 2 - 72% are then resolved within 45 days without further action — paid per the discount arrangement with the insurance providers (typically over 50% discount)

Step 3 - the remaining 28% of receivables require active aging management. For this category, the breakdown is as follows:

- 20% will pay with simple follow-up letters and phone calls
- The remaining 80% require aggressive negotiations, research, corrections and resubmissions.

This means that 22% of the total insurance charges will **not** be collected without multiple actions, a strict follow-up regimen, and knowledge of the insurance process. This can include: requesting medical records, coordinating benefits from multiple carriers, recoding, and resubmissions.

Self-pay receivables management is not quite as complex but there are strict laws about consumer collections and rising consumer risk. Our study showed that only 40% to 50% of the billings paid without aggressively working the accounts. In part, this high percentage is due to the current recession. *Healthcare Finance News* recently reported that the "Credit Risk Index increased from 118.38 at the end of 2007 (the beginning of the latest recession) to 129.67 at the conclusion of 2009 (the latest data available) – a 9.54 percent increase". Consumers are 18% more risky than they were during the 2001 recession.



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Implementing EMR

Electronic Medical Record systems are expensive and not easily implemented, but the ROI is typically significant. The Medical Group Management Association conducted a study that found, “independent medical practices had \$49,916 greater total medical revenue per full-time-equivalent physician after operating expenses than those practices using traditional paper medical records”.⁵ The financial impact comes both from cost savings and from increased revenue. The latter is due to improved tracking such as alerts to prompt doctors to missing follow-up tests or preventive measures. Unfortunately most independents do not have an EMR. In our survey, only 21% of independents reported having an EMR. Many noted they were ‘working on it’. The American Recovery and Investment Act has helped spur the move to EMR with supportive funding, but the U.S. still lags behind European healthcare where well over 90% of clinics use EMR.

Furthermore, both Medicaid and Medicare offer significant incentives: financial support for implementation and penalties for non-implementation of EMR (or EHR, Electronic Healthcare Records, as Medicare defines it). To learn more, go to www.cms.gov/ehrincentiveprograms/ for an extensive website on the Medicare/Medicaid EHR program. Some highlights from the website are noted here:

“For Medicaid, eligible professionals can receive up to **\$63,750** over the six years that they choose to participate in the program.” For Medicare the eligible professionals can receive up to \$44,000. Program participation can begin as early as 2011.

“For 2015 and later, Medicare eligible professionals who do not successfully demonstrate meaningful use will have a payment adjustment to their Medicare reimbursement.

The payment reduction starts at 1% and increases each year that a Medicare eligible professional does not demonstrate meaningful use, to a maximum of 5%.”



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Conclusions

Four strategies for profit in these high-pressure times:

Strengthen processes and resources for receivables management.

In particular, develop separate systems and resources for handling insurance claims vs. self-pay. The two types of claims require very different skills and processes. Self-pay claims need good consumer negotiating skills and an auto-dialer for productivity. Insurance claims require insurance expertise, a strategy for separating out payer types and a workflow that identifies which claims need to be worked, how, and when. For consulting or outsourcing, contact Outsource Receivables, Inc.

Stay abreast of Medicare/Medicaid changes and actively monitor cost vs. revenue.

Solution approaches vary but some to consider include; service cost improvement initiatives, and in some cases limiting the amount of Medicare/Medicaid patients (check federal laws and guidelines).

Examine options to participate in shared-savings plans with insurance providers.

A good place to start is the Midwest Independent Practice Association.

Implement EMR taking advantage of federal support where possible.

For referral resources in this area, contact Outsource Receivables, Inc. or Midwest Independent Practice Association.

- ¹ Medical practice managers struggle most with managing costs, finances, EHR adoption. 2010. Targeted News Service, Jun 29
- ² Journal of economic perspectives /National Health Expenditure accounts
- ³ <http://www.hfma.org/pulse/>
- ⁴ American Hospital Association, Underpayment by Medicare and Medicaid Fact Sheet, December 2010
- ⁵ Greene, Jay. 2010. E-records help medical groups increase savings, study finds. Crain's Detroit Business 26, no. 46: 7-7

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