Healthcare Reform 2008

The Number One Issue: Cost of Collection

John R. Thomas
President and Chief Executive Officer
MedSynergies, Inc.
Healthcare Reform 2008  The Number One Issue: Cost of Collection

With healthcare reform as the number one domestic issue, many providers are wondering whether real change will occur and the impact it will deliver this time around. There is little doubt that the annual provider fee schedule reduction will ultimately become a reality due to the compounding annual increase in healthcare expenditures. Regardless of the form the changes take, providers will be paid less with higher costs of delivery in the near future.

This year, the driver of healthcare reform is different. In the early nineties, the stalled reform effort generated a series of payer and hospital consolidations that have born fruit in the last few years as hospitals and payers are performing much better financially. Physicians attempted, but did not complete, any material consolidation to acquire market power during this time. The Physician Practice Management Company (PPMC) industry arose and failed rather quickly. The current reform effort is radically different. Instead of payer, physician or hospital consolidation, employers are demanding cost reductions as well as proof of quality of care improvement. The pace of healthcare cost increases are outstripping the growth rates of many large companies. Providers are faced with proving quality to meet the demands of the employer marketplace. Under any circumstances, proving and increasing quality while reducing costs is difficult to complete for all providers. With over 750,000 licensed physicians with an average group size of less than 10 providers, this task is insurmountable.

While the national healthcare debate centers on quality issues, the main concern should be how to acquire additional funds to invest in the healthcare delivery model. For physicians, the real question is how to participate in any portion of the additional healthcare funds in the future. Many national political platforms focus upon funding healthcare via restriction of care delivery through existing financial models or by increasing federal taxes. However, all of these ideas miss the central problem with healthcare delivery. The cost of collection is too high. In fact, the cost of collection might be the real number one healthcare issue, not quality of care. While quality of care is difficult to measure, the cost of collection has a definitive dollar impact. Unfortunately, many of the quality initiatives, like PQRI, increase the cost of collection due to coordination of benefits and secondary insurance participation. A McKinsey study stated that over $300 billion dollars were involved in the collection effort of a $1.7 trillion dollar industry.*

Based on our analysis over the past 11 years, the cost of collection approaches 20 percent of the healthcare benefit. There is no known correlation between the dollar value, complexity, or time of collection and the cost of collection. This economic model is alien to other retail businesses where the cost of collection is commensurate with the dollar value and is less than one percent of the benefit. If healthcare continues to move toward a retail delivery model, then the cost of collection economics must move accordingly, and in rapid fashion.

What Should a Medical Provider Do?

With an eventual reduction in fee schedules on the near horizon along with increases in labor costs, system costs, and quality initiatives, medical providers are seeking out solutions to manage their ever-shrinking margins.

Three alternatives:
- No decision
- Aggregation
- Staff leverage strategies

No Decision is a Big Decision
Unfortunately, no decision to enact a strategy to offset this industry eventuality is a decision that will have long-term ramifications on medical practices. The provider community is not cohesive or large enough to have a seat at the table when the opportunity exists to acquire any potential new funds. The PQRI initiative is a great example of little money for a tremendous amount of effort with no insight into the adverse impact on the cost of collections. A provider cannot afford to ignore strategies to maintain and improve operating margins. Ancillary investments are not sufficient alone to manage the practice on the margin in his new era of employer-driven healthcare. Physicians must look for ways to increase their revenues on a per unit or CPT basis while reducing the cost of delivery by leveraging their existing staff.

Aggregation Strategy Revisited
Physicians and hospitals are revisiting the various aggregation strategies to achieve operating expense savings accruing to a larger group. These potential operating savings include:

- Health insurance premiums for both physicians and staff
- Information technologies
- Software applications
- Management oversight
- Managed care contracting
- Rent

All of these categories can result in operating expense savings due to the cost allocation over a larger group. Many of these costs are the same for either a solo physician or a group of five or more physicians. Physicians must take advantage of these opportunities when available as they do not compromise the independence of the practice but can increase the operating margin of the practice. While these same opportunities were promised in the last round, there are many new delivery models for these services that provide the benefit without the limitations on the practice. In this new era of employer driven healthcare reform, the employer will not compensate the medical provider for not capturing these inefficiencies in the delivery of care.

Aggregation is taking two primary forms: (a) hospital-centric, and; (b) specialty-centric. Hospitals have a financial need to have some influence over the medical providers that operate in their marketplace. This influence may be benign and supportive in many types of aggregation arrangements. In other cases, these hospital/physician relationships are not good solutions. Each market, specialty and physician must review the process and intention for these hospital/physician relationships. Like all business deals, the ultimate outcome is based upon relationships and economics.

Specialty physician-centric models are gaining some traction as a means to garner operating efficiencies, increase influence on managed care contracts, and counter single hospital aggregation models. Not all aggregation models have good track records. However, there are many new solutions and options to aggregate for operating expense leverage while maintaining the individual practice goodwill and independence.
Staff Leverage Strategies

Non-physician employee cost is the single largest overhead contributor to a medical provider. With increases in health insurance and technology requirements, many practices are feeling the pressure of adding new employees to a relatively fixed revenue stream. The result of adding employees without incremental revenue is a reduction in operating margin. Temporary help expense and overtime are two distinct factors for staff additions or management review. In both scenarios, there is a problem that must be addressed. For example a $15 per hour employee has a total cost of $18.75 an hour. Just to cover the incremental cost of an additional $15 per hour employee, a physician must see eight more established patients per day. Furthermore, eight established patient exams only cover the incremental employee cost and do not improve operating margin.

What are the options for leveraging a practice’s staff? First, clinical delivery is the revenue generating activity of the practice and medical providers should review their practice methods to extend the patient encounters per hour with their staff. Clinical delivery is an individual strategy and each practice must determine how to improve clinical efficiency and extension of the physician time. Clinical delivery cannot be outsourced to improve operating margins. EMRs and technology may help over the long run but a practice must make investments to achieve these incremental benefits. Each practice must investigate the number and intervals of patients being seen to navigate the clinical and financial chasm.

There are multiple delivery models for business operations that allow the medical provider business office to become much more efficient. There are four such areas that will provide significant operating leverage within a practice:

- Payment processing
- Secondary claims production
- Self-pay collection
- A/R management

Payment processing involves the reconciliation, posting, imaging and indexing of all correspondence (electronic, paper, money, no money) to the CPT code level. There are options to move this data entry function from a practice into a high-capacity and predictable service that provides these functions on a continuous basis. With floor accuracy rates and posting overnight, a medical practice office benefits from replacing eight hours per day of posting time with other activities. Additionally, having the deposit reconciled with all paper and electronic correspondence—which are imaged and indexed—benefits the complete revenue cycle of a practice.

Secondary claims continue to be a paper-based, manual process. These claims are becoming an even more important source of revenue due to the higher number of working retirees and increases in the Medicare population. The cost to acquire a paper explanation of benefits runs from $3.00 to $6.00 per primary EOB. With a 40 percent Medicare payer mix, a medical practice must have a consistent and cost-effective solution for processing secondary claims. In most cases, the lack of a real-time imaging and indexing system prevents a medical business office from having a cost-effective secondary claims function. Medical practices must find a solution to leverage staff while taking advantage of the revenue benefits from secondary claims. With self-pay as the “second largest payer” in a practice, secondary claim processing is important today but will be much more important in the near future.
Self-pay collection continues to be an ever-increasing, nebulous process of getting patients to pay for the services they have already received and have little or no intention of paying. Patients have not been required to pay for their healthcare services in the past so the change management process to improve self-pay collections entails a massive effort involving all participants in the practice. The physicians, nursing staff, reception and billing office must all be on the same page to make any progress. Cold calling self-pay accounts is a very expensive and unproductive process employed by many medical providers. The existing process is not consistent in its delivery and payment is the exception versus the rule. A medical provider must use technology to provide a consistent, self-pay delivery model to reach patients who owe balances on their accounts. While in-bound calls from patients are good uses of either clinical staff or outside parties who specialize in customer care and collections, producing statements and cold calling efforts are neither effective nor cheap.

A/R management is an intimate function traditionally performed in the medical provider billing office. The tools for this process are cumbersome, duplicative and do not normally allow for reporting on the entire revenue cycle of the practice. The average A/R person can manage between 25 and 35 accounts per day. On average, A/R follow-up activity costs $8 per account. With reimbursement for established patient exams between $37 and $58, a medical practice must bill for these encounters correctly and spend no time on A/R follow-up. The resulting strategy is to increase both the throughput of the A/R staff and the accuracy of the effort. Putting extensive notes into the Task Management system does not get a claim paid, but only proves that the staff person “worked” the account. An account “worked” without a claim date cannot be paid by anyone. Claim date management through a Denial A/R process will re-focus the billing office on efficiency and effectiveness.

A/R staff effectiveness is achieved by utilizing the following tools:

- Front-end denial reporting to reduce the incoming denied claims
- Correspondence imaging and indexing system to deliver all the payer information to the A/R staff
- A denials-based A/R system versus Task Management
- A segregated self-pay system to allow insurance billing staff to focus only on insurance balances owed by patients
- Segregation of claims production issues and credit balance issues from the A/R staff

By employing these tools, your business office can be streamlined and can grow incrementally above the need for more staff.

Summary
There is no doubt that medical providers will be faced with a declining operating margins by reductions in fee schedules and increases in operating expenses. The revenue reduction is inevitable and can only be managed through physician aggregation within a market to have some voice in the payment process of care delivery. Operating expense increases can be managed very effectively in a number of ways through a number of delivery models that provide benefits in staff management and increased leverage of technologies and services. In the new era of employer-driven healthcare, the employer will not pay for the current inefficiencies of our healthcare delivery model. In this environment, doing nothing is the alternative with the biggest, but most negative, impact to your business.
John R. Thomas
President and Chief Executive Officer

John Thomas has been with MedSynergies since its inception in 1996, when he began as senior vice president and managing director of development. While at MedSynergies, Mr. Thomas has held positions such as senior vice president and chief financial officer, and has been a member of the board of directors since 1999.

Prior to joining MedSynergies, Mr. Thomas was the vice president of the newly formed HealthCare Finance Group for Bank One. He was also the assistant vice president for Texas Commerce Bank, where he focused on hospitals and emerging healthcare markets.

Mr. Thomas is a national speaker on topics such as revenue cycle management, billing and collections processes, capitalization, and turnarounds.

Mr. Thomas received his Master of Business Administration, with honors, from the University of Texas Graduate School of Business. While at the University of Texas, he focused on finance and management and was selected as the Sword Scholar and received the Dean’s Academic Award. Mr. Thomas received his Bachelor of Arts from the University of Arkansas.

About MedSynergies, Inc.

Now serving 2,300 healthcare providers in 27 states, MedSynergies provides revenue cycle services and integrates leading software programs into the daily operations of healthcare organizations. Founded in 1996, MedSynergies serves physicians in hospitals, specialty medical groups, ambulatory surgical centers, rehabilitation centers, and independent practice associations (IPAs). Based in Irving, Texas, the company has regional offices across the United States. For more information on MedSynergies, please visit www.medsynergies.com.