

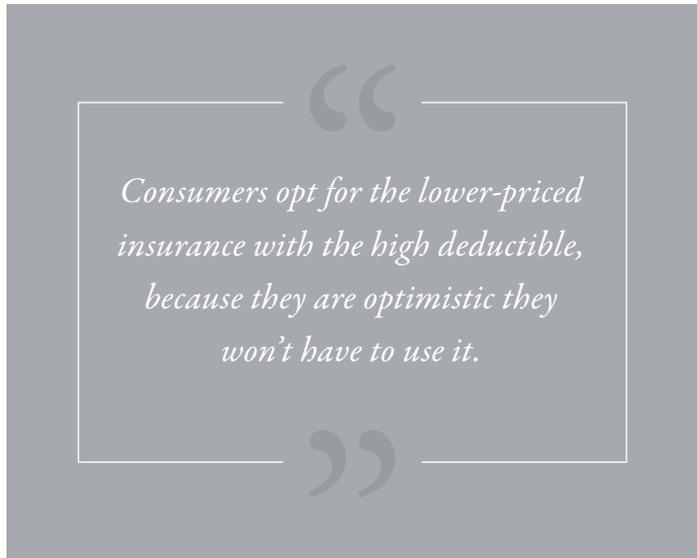
Tips to Control Practice Cash Flow

BY TODD SHRYOCK | MEDICAL ECONOMICS | PUBLISHED: MAY 25, 2017

As health insurance costs shift away from payers toward patients in the form of higher copays and deductibles, physicians must have a firm grasp of their practices' cash flow if they want to survive in a changing industry.

Experts agree that as patients are expected to pay more, the risks of a cash flow shortage for a practice increases, because consumers aren't as reliable as insurers when it comes to payments, and some patients can't pay the full bill—or any part of it—on their own.

Consumers pay more than twice as slowly as commercial payers, and rank medical bills seventh in importance, behind cell phones and internet providers, according to research from global consulting firm McKinsey & Co. Medical providers are often the last to be paid, assuming there is any money left at the end of the month. Data from the National Center for Health Statistics indicate that 25% of families have an unpaid healthcare bill, 20% are paying a medical bill over time and 10% have a medical bill they cannot pay at all.



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“Consumers opt for the lower-priced insurance with the high deductible, because they are optimistic they won't have to use it,” says Andrew Graham, MBA, president and chief executive officer of Clinic Service, a Denver-based healthcare consulting firm. **“When the deductible shows up, they are shocked. They don't always understand the deductible requires funding on their end.”**

Practices are especially vulnerable to a cash crunch in the first few months of the year when deductibles reset, shifting the entire payment burden onto the patient. With the trend of rising deductibles and more patient payment responsibility expected to increase, practices must be more vigilant about cash flow to enable them to get through the lean months and ensure they have enough cash to operate throughout the year.

“Cash flow has never been more important than it is now,” says Graham.

Collect more cash from patients

One of the easiest things a practice can do to increase collections is make it easier for patients to pay by whatever method they have available at the time of the visit, says Mat Kremke, MBA, vice president of the American Osteopathic Association (AOA), who works with physicians to better manage their practices.

This includes accepting credit and debit cards, cash or check. Practices should invest time upfront to know what insurance the patient has and what the copay will be, whether it's through a third-party or by assigning staff to look up the data before the visit.

Practices can also keep a patient's credit card on file along with an agreement that the practice can use it for billing. But Kremke warns that there are specific rules for storing this data that come from the card issuers, including tracking system access and regularly testing security.

John Kulin, DO, FACEP, chief executive officer of The Urgent Care Group in Philadelphia, says office-based physicians can use some of the same strategies urgent care centers use to collect from their patients. Urgent care centers have to collect up front or risk never being paid because of the episodic nature of patient visits.

For instance, Kulin installed a system that scans a check to the bank and treats it like cash, eliminating the problem of bounced checks. He also suggests offering a discount for paying at the time of service to entice people to pay and lessen the workload for the billing department.

“If you don't get payment when the patient is there, it's a lot harder to get it after they leave,” says Chuck Alsdurf, CPA, director of healthcare finance policy for the Healthcare Financial Management Association. “The doctor is usually the last person on the patient's list to get paid.”

Kulin says setting up a payment plan must be a formal legal document between the doctor and patient and that physicians must have the tenacity to monitor all patients who are on such plans and make sure they are keeping up with payments.

“If you don't have a system to monitor it, you could have 100 patients who have not made a payment, and that's a significant cash drain on the practice,” he notes.

Managing these financial arrangements can be tricky, says Graham, because a practice doesn't want to destroy a patient relationship because of unpaid bills, but still needs to be paid in a timely manner. **“I don't like for patient payment terms to go beyond six months, but you have to make payment plans to allow them to pay their bill and keep their personal pride and integrity.”**

He adds that a good cash flow management rule is to aim for 60% to 75% of all receivables to be paid in the first 30 days, 10% to 15% between 30 and 60 days and everything over 60 days to be in single digits.

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Billing quickly is also important, says Graham, especially in the first few months of the year. Where an insurer might pay in 14 to 30 days, when a bill is the patient's responsibility it might take the insurer several weeks to notify the practice. Then the patient has another 30 days to pay—assuming they pay on time. So the sooner the process starts, the quicker cash gets to the practice.

A possible exception to billing quickly is when a patient is scheduled for an expensive treatment with a different provider at the beginning of the year, says Joel Shalowitz, MD, MBA, FACP, an internist and professor of preventative medicine at Northwestern University.

“An internist might do a pre-op physical for a bypass surgery patient, but if the patient has a history of late payments or collection problems, the strategy might be to wait until he's had the procedure and then submit the bill because that procedure would wipe away the entire deductible,” he says. “Is it game-playing? Absolutely, but you are then dealing with the insurer for payment and not the patient.”

Reducing cash outflows

Once cash is in the practice, careful monitoring of expenditures can help keep it there.

Kulin says to start with a close look at staffing, which can account for 60% to 70% of a practice's budget. Calculate how many patients per hour each person in the practice sees, whether it's a nurse, physician or front-desk employee, and look at patient volume to determine if staffing levels are appropriate.

Also take a close look at how staffers are spending their time, says Derek Kosiorek, CPHIT, CPEHR, principal consultant with Medical Group Management Association (MGMA) in Englewood, Colorado. In one practice, a billing person was auditing the prior day's encounter forms for three hours each day, catching on average about \$150 a month in missed charges, but the monthly cost for the employee's time was \$1,200.

“Understand the cost and benefit of what you are paying employees to do,” says Kosiorek.

Leases for office space are another place to look for cash savings, but it might require paying for a real estate expert to help. “The biggest thing is to know when you are not an expert and get someone else involved that really knows that area,” says Kulin.

A landlord might be looking for a special assessment for a building repair, but does the lease allow it? “If yes, did they calculate the correct proportion that needs to be paid?” says Shalowitz. “Everything translates to cash. It all relates to good practice management.”

Also, review vendor contracts. For something like janitorial services, shopping for the lowest price is straightforward. But for something like a collections agency, the cheapest provider may not boost cash flow the most. A more expensive collection agency might collect more money, so it pays to split up collections and assign them to different companies to see who gets the best dollar-for-dollar return, says Kosiorek.

“Practices often look at expenses as a direct cost rather than a benefit over time if they spend more,” he adds. “For example, with equipment, if they invest in better quality items, they might last five years instead of two. You have to look at a long-term investment in equipment to better regulate your expenses.”

Preparing for MACRA

A careful analysis of cash flow as it relates to expenses can also produce insights into how a practice might fare under the Medicare Access and CHIP Reauthorization Act (MACRA), says Alsdurf.

“There are implications to participating; it could be very costly to build the infrastructure, hire the people and report the data,” he says. “Even if you feel good about your quality and outcomes, the costs may eat up any bonus you would get. Implementing a plan to mitigate the penalties, which you know what they are in advance, might be more effective than participating in the program.”

To better understand expenses and how a practice compares to others, Kosiorek advises doctors to look at the MGMA's benchmarks for practices of similar size in the same region. Practices can use these benchmarks to identify where to focus their cost-cutting efforts, and help them budget for the next year—something small practices often don't do.

“A budget will help them understand where their cost and expenses are going to be so they are not caught off guard,” Kosiorek adds.



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Graham agrees, adding that by carefully tracking their numbers, doctors should be able to accurately predict cash flow three to four months out.

“For any physician running a stable business with similar monthly patient numbers, procedures and strong coding practices, they should have a very predictable cash flow and know the numbers that underlie their success,” Graham says. **“A good system and process beats office manager heroics every time.”**
