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The Financial Ailments of a Physician's Practice: Treating Symptoms Ignores the Condition's Root Cause.

Switch from Software to a Service-Based Approach to Nurse Medical Practices Back to Financial Health

WHITEPAPER

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Introduction

Today's physician practices are showing the acute symptoms of a financial ailment that are eroding productivity and profitability. These symptoms include declining cash flow, losses from ineffective billing, and claims rejections that raise administrative costs and further extend days in accounts receivable (DAR). As a result, somewhere between 5 and 30 percent of physician cash flow is never realized, and nearly 10 percent of practice revenues are consumed by billing and collection processes.¹

In response, physician practices are seeking alternative treatments for their financial ailments, driven by an increasing dissatisfaction with the effectiveness of the market's traditional software-based practice management systems. For nearly 10,000 providers, one solution is to forego the purchase of traditional practice management software altogether, and transition to a service-based approach. The allure is that the solution itself is free, and fees for using the service are based on a percentage of revenue that is realized. In essence, practices are buying results, not software. Practices pay based on when their money is collected.

This service-based approach is often referred to as on-demand business services. It is a hybrid of multiple disciplines and technologies that combine intuitive software and proprietary knowledge with an experienced staff that works on behalf of physician practices to collect payment.

The success of this service-based approach is the result of an alignment in business goals. The business goal of physician practices is to collect payment in a timely manner for all the care that they deliver. This approach shares this goal because it is the foundation of its financial model. When providers don't get paid, neither does the service provider.

¹ Based on athenahealth actual customer experience.



Addressing the Root Cause of Physician Practices' Financial Ailments

The root cause of physicians' financial ailments is the tangled web of insurance rules that dictates the format and content - as well as the submission and remittance guidelines - of claims. At last count, there are millions upon millions of permutations of payer claims rules—and that number continues to grow.² It's simply impossible for physician practices—or even practice management software systems—to track these rules and ensure that claims are compliant before submission.

Unfortunately, most physicians are treating their financial ailments with palliative care rather than addressing the root cause of the ailment. These treatments include the purchasing of software-based practice management systems. Despite their declining cash flow, 71 percent of physician practices made large, up-front cash outlays in the last four years to purchase new practice management software.³ These systems, however, appear to be relatively ineffective, as more than 60 percent of physicians claim that their practice management systems lack much of the functionality that they need.⁴ Although the majority of practices have implemented new practice management systems, the lower end of claims rejection rates still hovers around 18 percent⁵ for most practices, with many practices experiencing rates as high as 45 percent to 55 percent.⁶

In addition, the cost of software-based practice management systems seems only to exacerbate a practice's financial difficulties. Physicians are left with less cash on hand following the purchases, plus they incur the additional burden of implementation, training and ongoing software maintenance fees. In the end, physicians are still challenged by claims rejections, but are now forced to ride out the extended DAR with even less cash on hand. In some regions, physicians are encountering such severe cash flow problems that 19 percent of them are using personal funds to finance their practice's operations. A smaller amount, 13 percent, is securing commercial loans in order to continue doing business.⁷

Finally, new trends within the marketplace, such as pay-for-performance (P4P) and consumer-directed health care (CDHC), are other factors that are making traditional practice management systems obsolete. These systems are unable to apply the P4P protocols from specific payers to the practice's billing process, nor are they able to calculate the payment responsibilities in advance for patients with high-deductible plans under CDHC. Without these capabilities, practices are losing revenue by failing to meet P4P requirements and in the administrative costs of collecting payments from patients long after the day of care delivery.

² Statistics from athenaNet® claims database, 2007.

³ "The 2006 Physicians Practice Technology Survey: Piecing IT Together." Physicians Practice, Sept. 2006.

⁴ Ibid.

⁵ "How to Optimize Your Organization's Cash Flow by Effective Denials Management." The Managed Care Information Center. Sept. 29, 2004.

⁶ "Tip Sheet: Medical Claims Denial Management." Healthcare Financial Management Association, 2003.

⁷ "TMA Survey Shows 60 Percent of Texas Physicians Are Reporting Cash Flow Problems From 'Slow Pay/No Pay.'" Published by the Texas Medical Association. March 23, 2005.



Buy Results, Not Software

Quite simply, the goal of software vendors is to sell software and generate ongoing revenue with annual licensing and maintenance fees. Vendors are not accountable for how their solutions work. They profit even if their solutions do not produce the desired results of the practices that purchase them. There is no risk sharing under this financial model.

In contrast, a service-based model is dependent upon collecting a practice's revenue in order for the service to get paid. Its existence is dependent upon producing the desired results of a practice. Financial risks are shared and business goals are aligned. To accomplish this, the service-based model focuses on:

- Front-end processes, such as ensuring that the practice is correctly registered with its payers and by verifying patient eligibility before services are delivered.
- Accurate billing to ensure that the practice charges for all the care that it delivered.
- Creating clean claims that are tested against a proprietary database of payer rules before submission to reduce rejections.
- Tracking claims to confirm payer receipt and to monitor that remittance is received under contractual timelines.
- Denial management and appeals processes to quickly resolve claims rejections that delay payment.
- Maintaining an experienced team of revenue-cycle management professionals who can be relied upon to get claims paid.



On-Demand Business Services

To achieve their business goals, many practices are now leveraging a service-based approach to their practice management through new on-demand business services. On one level, on-demand business services are a close cousin to application service providers (ASPs), since the practice management solution is hosted on a remote server and the application is accessed via the Internet using a Web browser. As with ASPs, this model reduces the cost of ownership by eliminating the need for customers to purchase, implement and maintain complex software and hardware systems. This point, however, is where the similarities between ASPs and on-demand business services end.

On-demand business services use the Internet to create a hub where physician practices can participate in a network and share intelligence. As the network grows, so does the intelligence of the service because payer rules are added to the database on a daily basis. The result is that the service can accurately review claims to see if charges reflect all the care that was delivered, and test claims before submission to reduce rejections. In cases where a claim is rejected, the service's staff members work with the payer on behalf of the physician practice to determine why the claim was rejected, then automatically add a new rule to the database to prevent similar rejections from happening in the future. This human element, where experienced professionals work on a practice's behalf, further differentiates the on-demand service from the traditional ASP.

An added bonus of participating in the network is that practices can compare their performance against peers and best practices to identify areas needing performance improvement. Practice-specific data remains secure and inaccessible from other practices, but data is aggregated for comparison purposes.

The "on-demand" aspect allows practices to subscribe to a service offering, where fees are paid as a percentage of collections. An additional benefit of on-demand business services is that they accelerate the realization of value and a practice's return on investment (ROI). Subscribers can quickly begin using the service without undergoing lengthy implementations and start-up costs are minimal. And, the service manages the electronic submissions of claims, which can reduce operational costs by \$42,000 annually per physician, according to recent surveys. As a result, ROI can be achieved within a few months and the greater level of control over the billing process enables practices to increase revenue per physician and overall cash flow within the practice.

Critical Elements for Success

For on-demand business services to successfully manage physician practices, several critical elements are needed:

Powerful and Intuitive Web-Based Application—The value of the service will never be realized if the application that fronts it is too cumbersome to use. An intuitive application coaches users through the process of data input and extraction and provides the tools for easy analysis of operations. To be effective, the solution needs to encompass all aspects of operations, including registration, scheduling, pre-visit, patient check-in, coding, check-out, appointment follow-up, revenue accounting and reporting. A workflow dashboard provides complete transparency into operations to show the status of every claim in real-time.



Payer Rules Engine—This is the heart of the service, containing state, regional, and national payer rules (including Medicare and Medicaid). "Preventive management" capabilities within the rules engine issues alerts when errors are discovered at any point in the process—before they become embedded in claims and grow into problems. When problems do occur, the engine prompts users with instructions on how to resolve them.

Experienced Professionals—This team works as a "Virtual Back Office" for the practice to increase first-pass pay rates and get practices paid in a timely manner. These professionals handle a variety of tasks, ranging from insurance package management to working directly with payers to resolve denials and create new rules for input into the rules engine.

Reporting—Detailed reports enable practices to negotiate better contracts with payers and police existing contracts to identify underperforming payers. Powerful reporting tools allow practices to increase the efficiency of operations so physicians can devote more time to patient care.

Proof of Concept

The physician practices owned by the University of Kansas Hospital use athenahealth's on-demand service to support more than 70 physicians and other providers. The increased efficiency resulting from system use has enabled KU Medical decrease the size of its staff from 40 to 25. The on-demand service allows KU Medical's Central Billing Office—along with the hundreds of users at the individual clinics who enter charges, scheduling, eligibility and other information—to leverage the payer knowledge of all providers using the athenahealth service. As a result, a claim that would have usually spent about 65 days in accounts receivable, now averages only 35 days.

Small practices also benefit from the services offered by athenahealth. Eugene Constantinou, M.D., a solo practitioner in Oxford, Conn. credits athenahealth for improving his practice's finances on two fronts. First, athenahealth enabled him to get 85 percent of his collectibles outstanding to the point where they are less than 30 days old. Second, Constantinou credits the efficiency of the athenahealth service for allowing him to maintain a smaller staff and less overhead. As a previous partner in a large group practice before going solo, Constantinou has first-hand experience with the overhead costs of maintaining a large billing staff. Now, his practice operates efficiently with a receptionist, two part-time medical assistants and a part-time office manager.

The Cure for Financial Ailments

On-demand business services allow physician practices to cure their financial ailments by focusing on the root cause of factors that impact billing and collections. Actual customer results show that subscribing to the service can dramatically reduce DAR, and increase collections per physician. When practices have the option of buying results vs. buying software, the right choice is the one that shares financial risks and reduces costs while increasing revenue.