Forecasting the Financial Future of Your Medical Practice


It is critical that you understand and determine how future reimbursement models will affect your organization.

Source: Physicians Practice

Health spending for 2010 in the United States was $2.6 trillion, an average of $8,402 per person. Of the $2.6 trillion 31 percent was absorbed by hospital care, while doctors and clinics absorbed 20 percent. According to the Commonwealth Fund, “National health expenditures are expected to increase from $2.9 trillion to $5.5 trillion. Businesses and households are projected to pay half of the total nation healthcare costs in 2023, while the federal government will pay 23 percent and state and local government will pay 18 percent.”

Based on the data above, reimbursement models are moving from a fee-for-service to other reimbursement models. These models may have components of fee-for-service, but also include shared savings for managing overall population health. It is critical that you understand and determine how future reimbursement models will affect your organization.

Reality check
The reality is that median incomes in the U.S. decreased between years 2010-2011 by 1.7 percent, (average family median income $62,273), according to Income, Poverty, and Health Insurance Coverage in the United States: 2011. Even though the median income levels have dropped consecutively the past two years, health insurance premiums continue to rise from 19 percent to 23 percent of the median household incomes. (Ref: CPS ASEC 2001-2012 Kaiser/HRET 2001-12 CMS OACT 2012-21)

So the question remains: How will the private practice survive these changes? The only way to survive is transitioning your practice to coincide with reimbursement models and other trends in the market. Even though the transition does not have to all take place at once, the transition needs to start immediately. The result of not implementing processes and procedures to meet the payment trends could be financial ruin.

Financial clearance
Financial clearance is no longer an option or luxury. Employers are either shifting more health insurance costs to employees, reducing health plan options, or transitioning to a consumer-driven health plan. Since employee wages have consecutively decreased and patient responsibility continues to increase (doubling in the last five years), providers have to know before treating the patients what the patient responsibility will be and collect it at the time of service. There are many automated processes and vendors that offer services to ease the burden of the providers. Many of the processes will actually feed directly into the patient’s account in the practice management software. This all can take place without requiring any actions from the practice other than reviewing the information and acting accordingly.

Automated payment options
Set up automated payments and allow patients to pay online. Offer this for times when there are remaining patient balances. Paying bills via the U.S. Postal Service is no longer a common method, although physician practices often still utilize paper statements. For many, it has become cumbersome to even find a stamp considering many bills today are paid electronically. Why not make it convenient for your patients to pay? Set up an automated online payment system at the time of service. Also, many financial institutions have wonderful solutions from freezing funds until the claim is adjudicated to setting up a set amount of money and payments until the balance is satisfied. The payments are then downloaded and electronically posted to the PM system.

Educating patients
Educate your patients on their benefits and responsibilities. Remember, healthcare is confusing and can be very overwhelming. By allowing the patients to understand their benefits and financial responsibilities, you will allow them to take ownership of their bills. This is a great opportunity to add value to your service, too.
Quality of care
Quality of care is here, but are you ready? Quality of care is no longer a value-add service you are providing to your patients; thanks to regulations, it is becoming a requirement. Reimbursement models are transitioning to bundled and value-based payments. While this will be exciting for many providers it is going to be devastating for others. Providers can take many steps now to be proactive in quality of care. These steps could include: continued training for staff, surveying patients on quality of care, or even just taking a second and ask the patient how they feel about the quality of care they are receiving as they are being treated. Just be careful...do not ask the question unless you are prepared for the answer! It may not be the answer you were expecting.
When it comes down to it, patient satisfaction will be fundamental in survival of private practices and other healthcare organizations. Providers and other healthcare organizations should be invested in providing quality care and educating patients on making wise healthcare decisions. This, in turn, will encourage patients to become vested in their healthcare benefits and spending.

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