

How Hospitals are Juggling Insurance Payors and Costs

By Debra Wood, RN, contributor

May 26, 2010 - Healthcare is a complex business and facilities are feeling the strain these days of tight reimbursement and challenging payor rules. Some of the largest players are in duress. St. Vincent's Hospital Manhattan in New York recently closed, citing financial constraints. Grady Memorial Hospital in Atlanta has struggled for a while, although recently indicating they were now turning a profit, and Jackson Memorial Hospital in Miami remains at risk, with the facility saying it is "in the midst of a financial crisis."

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Hospitals must operate more efficiently and boost revenue to survive. Medicare beneficiaries represent about 40 percent of admissions and Medicaid 10 percent to 12 percent, according to Nathan Kaufman, managing director and founder of Kaufman Strategic Advisors of San Diego, Calif. The government sets Medicare and Medicaid rates, which do not cover the full cost of services. In addition, the rates are stable, with expected declines in reimbursement. Consequently, hospitals shift costs to private payors.

"If 40 percent of your business has to make up for fact the other 60 percent isn't giving a raise, you need a solid 10 percent increase to give nurses increases [in salary]," Kaufman says. "If you look at the 30 percent of the hospitals losing money in this country, the primary factor is the inability to get the necessary subsidization or cost shift from the payors."

That can be a tough sell. Health plans are businesses, aiming to make money and return shareholders' investments.

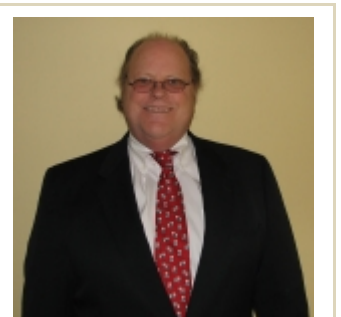
Hospital executives responding to the 2010 National Payor Survey said increasing the facility's rate with its largest payor was the most important issue to the organization's success, followed by increasing rates with the second and third largest payors. The research firm Fabrizio, McLaughlin & Associates of Alexandria, Va., completed the payor survey for Revive Public relations of Santa Barbara, Calif., collecting data from 225 hospital executives from all 50 states, representing 24 percent of hospitals.

Even if hospitals succeed in securing a better overall rate, that might not be enough, said Bruce Hallowell, a partner and national director for revenue and finance practice for the consulting firm CSC in Worthington, Ohio.

"It's deeper than looking at it in the overall," Hallowell said. "If I don't get a 3 percent increase overall but I get an 8 percent increase in specific services that have a higher impact, where I have high volumes, I generate an overall net increase."

Hallowell recommends going into the negotiations knowing what services are reimbursed at a loss and which ones can earn the facility the most money.

Kaufman reported some hospitals that are geographically indispensable to health plans



Bruce Hallowell suggests hospitals decrease denials by following insurers' rules and collecting patient

have succeeded in achieving better reimbursement, which affects the viability of the organization.

**co-pays and deductibles
up front.**

“We are seeing around the country huge battles between insurance companies and hospitals over increases,” Kaufman said. “There’s a huge differential between what some of the more powerful hospitals have been able to get and what the weaker hospitals are able to get.”

Following the rules

“What happens in the healthcare arena is we’re signing contracts with these people and don’t actually make sure the contract is operational and then follow the rules,” Hallowell said. “They often don’t make an effort to understand the rules.”

Hallowell indicated that stems from a desire to treat everyone the same. While he acknowledges that equal treatment is admirable from a clinical perspective, insurers require that their members meet different requirements. For instance, the hospital may need to obtain preauthorization from some plans before providing a service.

“Payors will deny [the claim] if there was no preauthorization,” said Hallowell.

A simple query to the insurer before rendering care will outline what rules the facility must follow to receive payment. However, he said, some hospitals do not do that for fear of inconveniencing the patient. Yet some hospitals have successfully mastered that challenge.

Asking for co-pays up front

Another revenue opportunity many hospitals miss is collecting co-pays and deductibles from patients before performing the service.

“By not asking for money up front, hospitals are extending credit to people they may get denied for,” Hallowell said. “They are leaving money on the table.”

An interim report from the Internal Revenue Service Hospital Compliance Project found only 14 percent of the 481 nonprofit hospitals responding to its survey require patients to pay up front or make arrangements for payment before providing inpatient services, and 15 percent of 480 facilities required it before outpatient services.

Orlando Health in Orlando, Fla., has been collecting up front for more than 15 years and finds it cuts down on the cost of billing and reduces bad debt write offs. The hospital system’s call center contacts the patient in the evening and secures a credit card number to pay the deductible or copay. On the day of service, the visit progresses smoothly, without payment glitches.

The Florida Hospital system in Orlando has been collecting in advance of treatment for more than seven years. Hospital staff members call patients scheduled for a procedure and ask them to come in to preregister. Patients pay their share at that time.

Hallowell also recommends hospitals verify insurance with the payor at every visit. Patients may have lost a job and their coverage. And Medicare Advantage patients may have switched plans.

Healthcare reform's effects

More than 67 percent of respondents to the National Payors Survey indicated they thought health reform would result in a decrease in reimbursement rates from private payors, and 68 percent do not believe a reduction in the number of uninsured generating charity care will make up for the lower rates. Forty-seven percent of survey responders also said the healthcare legislation would give them less leverage negotiating with private payors.

Hallowell agrees that health reform legislation will not improve reimbursement, just increase volume.

On the other hand, the bill sets the medical loss ratio – what insurers pay out for healthcare – at 80 percent for individuals and small groups and 85 percent for large groups. They either must spend that much on care or pay it back to beneficiaries.

“I don’t think anyone can predict how all of this will work out,” Kaufman said. “But in the short term, if the hospitals don’t get the increases they need to stabilize their financial position, they are going to experience distress.”

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