

Collection Agencies Impacted by Provider Consolidation

By Emily Grace, Communications Specialist

Over the past several years, the health care industry has experienced a growing trend of independent physician offices being consolidated into hospital or specialty groups. In a survey conducted in early 2010 by the Medical Group Management Association, 55 percent of the respondent's practices were hospital-owned. This percentage is an increase from 50 percent in 2008 and 30 percent five years ago.

According to a November 2010 *Wall Street Journal* article, the consolidation trend is to satisfy the needs of both the physician and the hospitals. "Many doctors have become frustrated with the duties involved in practice ownership, including wrangling with insurers, dunning patients for their out-of-pocket fees and acquiring new technology," the article states.

For hospitals, consolidation guarantees revenue. With consolidation, any care performed by the physician will generate billing for the hospital. Independent physicians can often be affiliated with multiple hospitals, consolidation assures patient volume for the hospital.

Health care reform may also affect a physician's or hospital's decision to consolidate. According to a 2010 Deloitte Report, "Health reform is substantially changing the dynamics of the health care industry. Many health plans and providers are pursuing M&A [merger and acquisition] strategies

to address the challenges posed by reform and/or to capitalize on reform's opportunities."

But what does this mean for the collection agencies servicing both hospital and independent physician providers?

For agencies who mainly service hospitals, they may now also be asked to collect for the physician practices as well.

"Over time, our hospital clients have asked us to handle more physician accounts as they acquire practices," said Moises Eilemberg, president and CEO of Avadyne Health in Moline, Ill.

While consolidation may provide more volume for the agency, physician accounts typically have lower balances. "Collecting a small physician account is much different than handling a \$3,000 hospital bill and agencies need to adapt their practices accordingly," Eilemberg said.

Patient billing practices may also need to change to accommodate the consolidation trend.

"There has been a movement in health care toward more

patient-centric or patient-friendly billing practices," Eilemberg said. "With consolidated health providers, the patient may no longer receive separate bills from the hospital, radiologist and physician."

When a patient account becomes past due, the entire bill can now be turned over to the collection agency.

"This allows the conversation with the patient to become easier," said

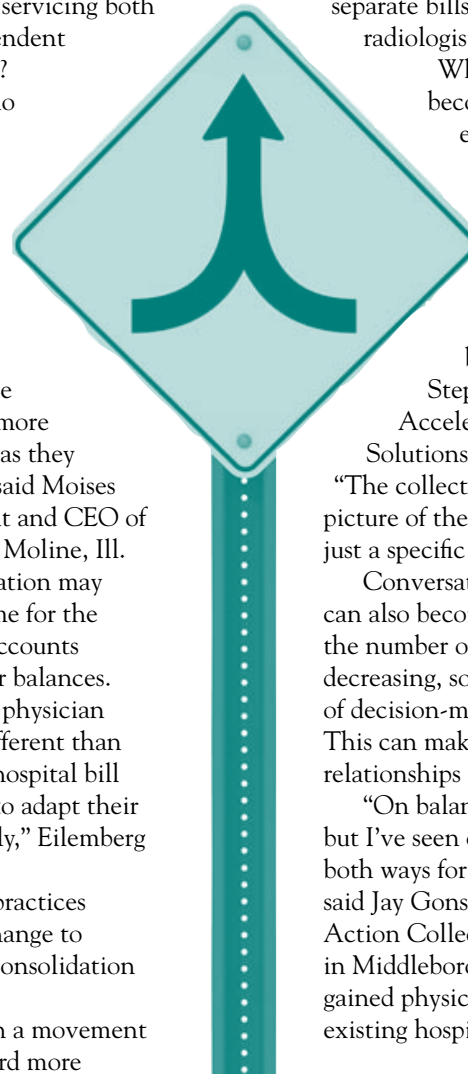
Stephen Laws, COO of Accelerated Receivables Solutions in Scottsbluff, Neb.

"The collector has the complete picture of the patient's care, not just a specific procedure."

Conversations with providers can also become easier. With the number of potential clients decreasing, so does the number of decision-making individuals. This can make managing client relationships easier.

"On balance, it's been positive, but I've seen consolidation work both ways for our company," said Jay Gonsalves, president of Action Collection Agencies, Inc. in Middleboro, Mass. "We have gained physician groups when existing hospital clients have

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Wide Variation in Private Insurer Payment Rates

Wide variation in private insurer payment rates to hospitals across and within local markets suggests some hospitals have significant market power to negotiate higher-than-competitive prices, according to a study released in November by the Center for Studying Health System Change.

Looking across eight health care markets—Cleveland, Indianapolis, Los Angeles, Miami, Milwaukee, Richmond, Va., San Francisco and rural Wisconsin—average inpatient hospital payment rates of four large national insurers ranged from 147 percent of Medicare in Miami to 210 percent in San Francisco, according to the study. In extreme cases, some hospitals command almost five times what Medicare pays for inpatient services and more than seven times what Medicare pays for outpatient care.

“The variation in hospital prices found in this study is inconsistent with

highly competitive markets—at least for markets outside of health care,” said HSC President Paul B. Ginsburg, Ph.D., an economist and author of the study.

Average inpatient hospital payment rates ranged from 147 percent of Medicare to 210 percent.

The study analyzed data on private insurer payment rates to hospitals and physician practices, focusing on variation across and within markets. Four major insurers—Aetna, Anthem Blue Cross Blue Shield, CIGNA and UnitedHealth Group—provided blinded hospital and physician payment rate data in the eight markets, reporting their contracted payment rates for

commercial insurance as percentages of Medicare payment rates.

Many factors likely play a role in the substantial variation of hospital payment rates, including the overall degree of hospital concentration in particular markets. But, according to the study, even in markets without high overall concentration, single hospital systems sometimes dominate geographic submarkets. Hospital reputation also plays an important role. Some hospitals are so highly regarded that consumers perceive any health plan network as undesirable that excludes these so-called must-have hospitals. Some markets have such marquee hospitals, but others do not.

The study’s findings are detailed in a new HSC Research Brief, “Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power,” available at <http://www.hschange.org/CONTENT/1162/>.

New Standards Helping Lower 2010 Medicare Improper Payment Rates

Following the Obama Administration’s work to more accurately account for improper payments and a renewed focus on fighting waste, fraud and abuse, the 2010 error rate for Medicare claims declined in 2010 and is on track for a 50 percent reduction by 2012. The error rate for Medicare Advantage also declined and a new component measure was developed and reported for the Part D program.

The Medicare and Medicaid improper payment rates are issued annually as part of the U.S. Department of Health and Human Services Agency Financial Report. The Medicare fee-for-service (FFS) error rate dropped to 10.5 percent or \$34.3 billion in estimated

improper claims payments in 2010. The 2009 error rate was 12.4 percent, or \$35.4 billion.

“Last year we changed how we calculate the error rate in fee-for-service Medicare to more accurately reflect improper payments and enhanced our efforts to fight waste, fraud and abuse,” said HHS Secretary Kathleen Sebelius. “This year’s lower rate reflects those changes and our focus on protecting Medicare.”

While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid or CHIP, they provide HHS, the Centers for Medicare & Medicaid Services and states with a more complete assessment of how many errors need to be fixed.

For 2010, CMS applied more stringent review criteria for measuring Medicare FFS improper payments the Agency implemented in 2009. The primary modification required adherence to the documentation requirements outlined in Medicare regulation, statute and policy, rather than allowing for clinical review judgment based on billing history and other available information.

The primary causes of errors in the Medicare FFS program for 2010 are insufficient documentation and medically unnecessary services.

For more information, visit the CMS website at http://www.cms.gov/apps/media/press_releases.asp.

ACA Submits Comments to FTC Regarding Decedent Debt Communications

Collecting from the deceased is an incredibly sensitive matter, requiring a delicate appreciation and balance for seeking recovery of legitimate financial obligations and for the context in which such collections are undertaken.

Collection efforts regarding a financial obligation where a consumer has passed away are primarily regulated by the Fair Debt Collection Practices Act (FDCPA) and state law. In collecting these debts, the FDCPA generally allows collectors to contact only the decedent's spouse, or the executor or administrator of the decedent's estate. Since the FDCPA was enacted in 1977, state probate laws have expanded the types of persons who are authorized to pay a decedent's debts from assets in the decedent's estate, beyond the categories expressly permitted under the FDCPA.

On Oct. 4, 2010, the Federal Trade Commission (FTC) issued a proposed enforcement policy statement that seeks to reconcile the FDCPA's requirements with state probate law developments. The proposed policy statement clarifies when the FTC will take action under the FDCPA and the FTC Act against companies trying to collect the debts of deceased consumers.

Under the proposed policy statement, the Commission would not take law enforcement action alleging that a collector violated the FDCPA by communicating about the decedent's debts with the decedent's spouse, the executor or administrator of the decedent's estate, or anyone else who is authorized to pay the debts from assets in the decedent's estate. The statement also provides guidance about what collectors must do to identify persons with whom they may communicate about paying the decedent's debt without improperly revealing the debt

to others. In addition, the statement emphasizes, in communicating with someone who is authorized to pay the debts from assets of the decedent's estate, collectors must avoid creating the misleading impression the person is personally liable or could be required to pay using his own assets or assets held jointly with the decedent. The proposed statement notes that to avoid this misleading impression collectors may have to disclose this is not the case.

ACA International submitted comments to the FTC on the proposed policy statement. In the comments, ACA stated the association strongly supports the Commission's effort to use the proposed policy statement to bring clarity to the complexities involved when collecting on a decedent's debt.

However, ACA's comments expressed its disagreement with the Commission's proposal that, to avoid misimpressions of personal liability for the decedent's debt, the collector disclose to the individual (1) it is seeking payment from the assets in the decedent's estate and (2) the

individual could not be required to use the individual's assets or assets owned jointly with the decedent to pay the debt.

Recognizing there may be circumstances in which the individual contacted may be jointly liable for the decedent's debt, ACA suggested the policy statement note it is not per se misleading if the collector does not make the proposed disclosure where the collector has reason to believe the individual contacted as an estate representative may also have individual liability for one or more of the decedent's debts.

Additionally, providing the Commission's required disclosure could disclose the existence of a debt to a third party, in violation of the FDCPA. ACA suggested the policy statement include a statement that where the debt collector delivers the disclosures required by the Commission, there is no third-party disclosure violation subjecting the collector to liability.

Comments regarding the proposed policy statement were accepted by the FTC until Dec. 1, 2010.

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purchased them, as well as hospital clients when they've acquired existing physician clients, but we've also lost a few physician clients."

Ultimately the purchasing entity has the final say when determining which service provider to retain. "As the larger entity, the hospital generally holds the trump card," Gonsalves said.

Consolidation may also negatively affect payment rates for collection agencies. Hospitals and

larger consolidated practices have more leverage when negotiating terms than an independent physician.

With health care provider consolidation expected to continue, collection agencies need to focus on building their provider relationships.

"With consolidation, some agencies may lose business," Laws said. "Agencies should focus on building a strong client base and developing a relationship with those clients."



DATA WATCH

Uncollectibles Comparisons

The nation's hospitals reduced uncollectible write-offs in the second quarter to 4.54 percent of total gross revenue. The last time hospitals achieved benchmark-level uncollectibles performance (below 5 percent), was in the third quarter of 2009.

	3rd Qtr 2009	4th Qtr 2009	1st Qtr 2010	2nd Qtr 2010
Bad debt	2.66%	2.92%	2.85%	2.36%
Charity	2.26	2.37	2.75	2.18
Total	4.92	5.29	5.60	4.54

Source: HARA Report on Second Quarter 2010, vol.24, no.3, 2010, with permission from Aspen Publishers, Inc., www.aspenpublishers.com.

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