Revenue Streams and Third-Party Payers

by Sophia Tutorial

WHAT'S COVERED

In this lesson, you will learn about the various ways healthcare organizations get paid for their services, revenue stream and the impact of third-party payers. Specifically, this lesson will cover:

1. Revenue Streams and Third-Party Payers
2. Challenges
3. Overview
   a. Third-Party Payers
   b. Managed Care
   c. CMS
   d. Claims
   e. Billing
   f. Deductiblesfre
   g. Copayments
   h. Accounts Receivable

1. Revenue Streams and Third-Party Payers

In order to be successful at financial management and healthcare, leaders need to fully understand how and from which sources money comes into their organization. These are called the revenue streams. Understanding the revenue streams of a healthcare organization can be very complicated and challenging. It's very common for a typical healthcare organization to have multiple streams of revenue.

EXAMPLE Think about a physician's office. A typical physician's office most likely would take many different types of insurance plans. Each plan may pay differently for services offered at that office. Each plan may also have different levels of co-pay, deductibles and out-of-pocket expense requirements for the patient.

2. Challenges

Given that most organizations receive a large portion of their revenue from third-party payers such as

insurance companies, Medicare/Medicaid and managed care organizations, financial management of revenue has a lot of challenges. One of the biggest challenges in healthcare is that it often takes an extended period to receive payment from third-party payers. Most third-party payers require the organization to submit claims on behalf of the patient. The payers then take time to review those claims to determine if the care provided was necessary, covered by the plan and meets the plan requirements.

Nurse managers need to be aware of the complexity related to billing. Often, payments to the healthcare organization, particularly hospitals and physician offices, are contingent on documentation supporting that claim. Today's nurse leader needs to understand the documentation needs and requirements of each health plan.

It's also important that nurse managers must remember the complexity of healthcare finance. Healthcare leaders must consider all processes related to healthcare billing. Each dollar that is billed out has costs associated with the billing process and the length of time it takes to collect from the insurance company. Managers also must remember that the insurance companies do not always pay full price for services.

EXAMPLE Managed care organizations often negotiate the price down to the lowest possible point.

Healthcare providers often get paid a different rate for the same service depending on the insurance company. This can be a huge challenge when trying to forecast future revenues. Of course, this can make it very difficult for financial decision-makers in the healthcare field and can create huge budget development challenges. Therefore, understanding the complexity of healthcare finance is so important.

3. Overview

Below are some key concepts and terms related to revenue streams in healthcare. Take some time to understand these concepts and terms.

3a. Third-Party Payers

Third-party payers are organizations or entities responsible for reimbursing the healthcare provider for care rendered. The most common third-party payers include insurance companies, government agencies, government-sponsored insurance plans such as Medicare or Medicaid and managed-care companies. Healthcare leaders need to fully understand who their third-party providers are.

3b. Managed Care

Managed care is a type of insurance that provides medical care for its members often at a reduced or capitated cost. Managed care plans vary; however, the typical structure includes limited access to providers. Managed care plans typically contract with providers to provide services at a discounted price in exchange for a higher volume of patients.

Some managed-care companies require members to get a referral from a primary care physician for any specialist services. Others allow open access, which means the patient can see a specialist without a referral. However, almost all plans limit the number of providers the members would have access to. Providers who contract with the managed care company are typically referred to as in-network providers. While managed care is very complex, healthcare leaders need to understand the basics of managed care. More and more

insurance plans use managed care.

HINT

The most common managed-care plan is the health maintenance organization known as an HMO. Another very popular and growing plan is the Preferred Provider Organization, known as a PPO.

3c. CMS

CMS is the Center for Medicare and Medicaid Services. CMS is a division of the Department of Health and Human Services. CMS typically sets standards for healthcare reimbursement related to Medicare and Medicaid. Providers of either Medicare or Medicaid often need to follow CMS guidelines when billing for healthcare services. For Medicaid, CMS works with each state individually to provide services under Medicaid. Most providers must have a contract with both the state and CMS to provide Medicaid services. Medicaid is a state-run and federally supported program. The federal government and the state split the cost of Medicaid, 50% each. With the federal government providing funding allowing the state to administer the Medicaid program the best way seen fit. Many states have Medicaid managed care programs or contracts with managed care companies. Medicare is a federal program. Medicare provides healthcare coverage for the elderly and disabled. A provider that takes Medicare must adhere to CMS guidelines.

CMS also oversees several healthcare programs. CMS is actively involved in administering the electronic health record incentive program known as the merit-based incentive payment system. Not only is it important for healthcare leaders to understand the role of CMS in healthcare finance, but they must also closely monitor CMS guidelines as they change frequently with the political environment.

3d. Claims

An insurance claim is a formal request by a provider for reimbursement or compensation related to healthcare services. Claims are typically submitted by the provider on behalf of the patient. Most claims are then paid to the provider based on a set fee schedule for services rendered. In order to be an effective financial manager, today's healthcare leaders need to have some understanding of the claims process, particularly the requirements for submitting a claim. This process can be complex, as they vary greatly from one insurance company to another.

3e. Billing

Billing is the process of submitting claims on the patient's behalf. Often billing can be very complicated due to the wide array of services covered by typical health insurance companies, as well as the need for documentation supporting the services rendered. Often, insurance companies have complicated claim forms that now need to be filed electronically through an electronic health record system. Most mid-size to large healthcare organizations have specially trained billing specialists who understand the complex healthcare billing system. Today's healthcare leader should fully understand the special skills needed for billing.

3f. Deductibles

Deductibles are the amount the patient will have to pay before their insurance kicks in to cover the cost of care.

EXAMPLE If the patient has a $1,000 deductible, they will have to pay for the first $1,000 of their care expense.

Deductibles usually reset every year and are called annual deductibles. Most health plans today cover the cost of some care prior to a patient meeting their deductibles such as physician visits, disease management, and vaccinations.

3g. Copayments

Copayments differ from deductibles. This is typically a payment required by the patient for services after the deductible is met or when the deductible is waived. Usually, this is a smaller fee that the patient must pay directly to the provider.

3h. Accounts Receivable

Accounts Receivable are monies that have been billed out by an organization but have not yet been received. This is an important financial component to the healthcare organization due to the way third-party payers reimburse the organization. Often there is an extended period between when the claim is submitted to the time it takes the insurance company to pay the provider back. This time-lapse is typically caused by the insurance company reviewing the claims to ensure the care was necessary and covered. Also, other holdups can be caused by missing required documentation, ensuring all deductibles were met and copayments satisfied by the insurance company.

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Support

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If you are having technical issues, please contact **learningcoach@sophia.org**.