KeyBank | White Paper

From Crawl to Walk to Run: Automation to Optimize Receivables in a Changing Payment Landscape

Introduction

Despite significant progress in moving from the world of paper transactions, telephone collection calls and spreadsheet accounting to fully automated business processes, the health care industry has a long way to go to achieve the kind of efficiencies found in other industries.

Progress has been stymied by the growth and complexity of newly merged health systems and a tectonic shift in insurance to high-deductible health plans. Both developments—along with new uncertainties around reform stemming from the 2016 presidential election—are challenging providers' efforts to optimize the collection, posting, reporting and reconciliation processes.

Over the past 10 years, many providers have moved much of their receivables to electronic remittance advice (ERA), which provides claims payment explanations in HIPAA-compliant files. They have also begun to use electronic funds transfer (EFT) for commercial payments and, more recently, the patient's share of the bill. Together, ERA and EFT now account for more than 70% of transactions. Although these are high percentages, they do not necessarily reflect the state of other back-office activity, which may not be working optimally.

The CAQH Index (see, e.g., the 2015 report at www.caqh.org/sites/default/files/explorations/index/report/2015-caqh-index-report.pdf) tracks health care transactions in six categories: claims submission, status inquiry, payment, eligibility and benefit verification, prior authorization and remittance advice. In 2014, the index showed an average increase in adoption of automated transactions of 4.5%, compared to 3% in 2013. Of note, the greatest increases in adoption in 2014 were for claim status inquiry (6.9%) and eligibility and benefit verification (5.2%), for which compliance was mandated by operating rules for HIPAA standards that became effective in 2013.

Transitioning from fully manual to fully electronic processes for the six transactions studied could save commercial health plans and health care providers approximately $8.5 billion annually, CAQH reports. It calculates that the costs of ERA and EFT are 43% lower than for paper remittance advice and manual claims payment.

According to a 2015 publication by InstaMed titled *Trends in Healthcare Payments, Sixth Annual Report*, 94% of providers said they still collect paper checks from patients, and 41% said they typically did not know the extent of a given patient's financial responsibility at the time of the patient visit. Currently, 87% of consumers report getting health care bills in the mail. Almost two-thirds have expressed interest in using mobile payment systems, such as Apple Pay, for health care bills, but often those options are not presented to them.

Adoption of fully electronic transactions varies significantly

93.8%
Claims submission

70.5%
Eligibility and benefit verification

61.4%
Claims payment

56.5%
Claim status inquiry

51.1%
Remittance advice

48.7%
Coordination of benefits claims

10.2%
Prior authorization

6.2%
Referral certification

Source: 2014 data from CAQH based on HIPAA standards

Streamlining Business Processes

With so many mergers, acquisitions and joint ventures undertaken in recent years, providers do not have an easy way to establish a single process for payment automation and posting. Gaps in nuanced understanding and training also exist between multiple patient accounting systems and cultures.

Providers can no longer "throw bodies" at their processes to increase speed, accuracy or both. They must take a proactive approach by building automation around the remittance collection process.

Through KeyBank's interactions with clients over the years, they've observed once a decision has been made to retain a patient accounting system, the process begins for sunsetting the legacy systems. This process could take place as often as an acquisition, perhaps up to a few times a year. To ensure a smooth transition, providers should make sure to take the time to review their internal processes in-depth. Following the entire process of a patient coming in, staff processing the payment through the system, what reports are used, how data is managed and how many touch points a case involves can serve as an audit of the revenue cycle to ensure maximum efficiency and visibility.

As a result of having so many legacy systems, some revenue cycle teams must apply as many as 40 processes just to complete a patient payment. The more legacy groups, the more manual the process is—and the more error-prone.

Providers can no longer "throw bodies" at their processes to increase speed, accuracy or both. They must take a proactive approach by building automation around the remittance collection process.

New Tools Abound

A variety of tools and solutions are available that allow providers to manage their payer mix and payments in a more efficient manner than in years past. Reconciliation tools use preprogrammed logic to match a payer remittance to the payment using patient number, date of birth or another data point, making posting less time consuming and allowing providers to focus on exceptions that fall outside the preprogrammed data.

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Charles Arenas, senior vice president, KeyBank Enterprise Commercial Payments

The business staff need only pull the file, upload it to the patient financial software and automatically log payment. This straightforward process is far more efficient than logging into a bank account, pulling up payment history reports, printing them and matching them manually with remittances, going through them line by line, logging into patient financial management software and keying in payments to apply to accounts.

Automated work queues and flows allow work to move through the process smoothly and provide transparency into reimbursement by payer. Ticking off the transactions and tying the dollars at the bank, patient accounting system and general ledger are required activities for any provider; automating this process ensures that the provider can focus on what it does best—administer good care to patients. KeyBank uses the analogy of "crawl, walk, run" to exemplify this advance. Crawling is the simple awareness of the problem posed by a lack of automation and what is needed to get to the low-hanging fruit. Walking is embracing some of the technology, tools and methodologies, paring most of the legacy systems and automating as many transactions as possible. Running is the strategic piece, taking advantage of technology and processes and also being forward-thinking about how to improve efficiencies in a dynamic payment market.

Though much migration from crawl to walk has occurred, few health systems are running from a business process point of view. "Now is the time to get to that fully deployed run mode, taking advantage of technology and processes as well as forward-thinking," says Charles Arenas, senior vice president, KeyBank Enterprise Commercial Payments. Many organizations have not taken full advantage of the systems they already have, such as Epic's real-time integration capability, which frees employees from the reconciliation process.

The leading areas needing improvement are upfront collections, business process (cash posting) and reconciliation, and the patient experience of the billing process. Outside consultants and financial partners abound; most can help prioritize areas to work on.

With a new administration in Washington, D.C., that will likely make changes to the overarching strategy of health care reform, it is important from a provider perspective to be able to pivot in strategy over the next few years. At this point, nobody knows what that is going to look like, but providers should be aware that they need to stay ahead of the curve.

Five questions CEOs should ask about their current payment management strategies

1

What are the top areas for improvement?

- Upfront collections
- Business process (cash posting), reconciliation
- Patient experience

2

When was the last in-depth review of internal processes conducted?

The review serves as a diagnostic tool to help providers with their front- and back-end office activities, systems integration, and matching the dollars to the data and reconcilement.

3

What technology and tools does the organization have available to automate and streamline the remittance process?

These tools should not only help automate and streamline these transactions but also help convert the paper explanation of benefits (EOB) to an electronic file that is ingestible into the patient accounting system. Automation should be tied to the import of the dollars posted to the general ledger platform.

4

Can the organization better monitor the range of payers out there today?

Reconciliation tools that use preprogrammed logic to match a payer remittance to the payment make posting less time consuming, allowing providers to focus on the exceptions only. Automated work queues and flows allow work to move through the process smoothly and provide transparency into where things sit with their payers.

5

Is the process scalable?

Automation of the remittance collection process ensures smooth transitions, efficiency and visibility across health care settings.

Educating the Health Care Consumer

"Whatever happens with reform, patients have gotten more aware that they are responsible for a more significant share of the health care spending dollar, and providers are more savvy about the need to collect upfront," says Arenas. However, this entire process must become far more fluid than it is currently.

A "payment assurance" strategy is needed by providers for both educating patients and collecting providers' due.

Consumer payments are becoming a bigger source of providers' income stream compared to 10 years ago:

- In 2016, the cost of health care for a typical American family of four covered by an average employer-sponsored preferred provider organization plan was $25,826, according to the 2016 Milliman Medical Index (visit http://us.milliman.com/mmi/). That figure is triple what it was in 2001.
- Examining the health insurance marketplace plans for 2017, HealthPocket, a technology company that compares and ranks the health plans, found the average premium nationwide for bronze plans—the most popular option for consumers—rose by 21%, and the average deductible is now $6,092.
- The Consumer Financial Protection Bureau released a report in December 2015 that found medical debt has a significant impact on consumer credit, with 43 million Americans having overdue medical debt on their credit reports.

The shift to patients being responsible for much more of the cost of care has many providers throwing up their hands, saying they simply cannot collect a significant proportion of this revenue. How much of that reaction is supported by fact? Organizations that are most successful in adapting to this new world look to establish a partnership with patients and performance accountability with doctors and business staff.

A "payment assurance" strategy is needed by providers for both educating patients and collecting providers' due. Providers can institute payment assurance by first educating their staff and measuring their payment success rate.

All these pay-related activities are closely tied to the patient experience, which does not end with when the patient walks out of the office, but rather when he or she receives a bill from the provider in the mail. Studies of patient experience have found that one negative interaction can overwhelm all the positive experiences of quality care delivered. Patients may take to social media to blast the organization, and the subsequent hit to its reputation can be substantially larger than the unpaid bill.

Clear and upfront communication at the time of service helps mitigate the negativity around this experience. Already, more patients are aware of and expect to pay something at time of service. For this reason, providers need an effective customer relationship strategy and to offer convenient payment options, from credit card payment to a self-servicing web portal to EFT to mobile pay to flexible-schedule payment options.

"Before that patient walks out that door, you have got to have payment terms set."

Stephanie Blankenship, product manager, KeyBank Enterprise Commercial Payments

Today, consumers are equipped to shop for certain procedures, such as an MRI (magnetic resonance imaging) scan, because the market has demanded it. One can search for an MRI with and without contrast and choose the best price or location based on one's need—similar to shopping online for a car.

Dental practices have a longer experience with self-pay, the result of the demise of most dental insurance. A patient can visit the dentist office and, on the basis of his or her initial exam, receive a menu of services and corresponding prices that can be assessed and prioritized in terms of perceived value.

KeyBank has a price transparency tool called an estimator. Providers input their own fee schedule and have the ability to auto-check coverage levels against their fee schedule, so the patient knows what those charges will amount to. The provider knows how much is due and how much it is required to collect up front.

Many providers and patients have embraced payment plans. "Flexibility in payment plans is key, and most providers understand patients are not going to be able to pay full balances with deductibles in the several thousands of dollars. The conversation has to happen up front. Before that patient walks out that door, you have got to have payment terms set," says Stephanie Blankenship, product manager, KeyBank Enterprise Commercial Payments. A larger bill is broken into smaller payments, with automated withdrawal from a bank or checking account. Patients receive advance notification of the next payment, giving them time to either cover the payment or contact the business office to discuss options if they cannot afford it.

Most patients simply need to be educated on how the process works. Providers must have business staff available to walk patients through it, starting as early as possible, such as at preadmission.

Five strategies for improving patient relations in the front office

1. **Scripting**
   The front-office staff must know how to communicate the new payment process with patients. Scripts can be an easy tool for staff to use as they learn how to navigate new communication and dialogue.
2. **Education**
   Staff need to be trained on new processes and changes, and how they will impact patients, to communicate and follow processes appropriately.
3. **Role playing**
   Role playing the scripting with staff and critiquing the responses is an important method of incorporating the appropriate responses into the front-office interactions. With the role play, start with the check-in script and have the "patient" ask the questions. Staff members should do this role play until they are comfortable with the scripted responses.
4. **Proficiency exam**
   Once staff understand how the solution works and are comfortable communicating it to patients, they should take a proficiency exam to validate the concepts and new process.
5. **Retrain, listen, retrain**
   A key component of the program's success is retraining the front-office staff. This is a new process, and like most new processes, it takes time to become proficient and for patients to get acclimated. Invest time in continued training. Listen to how patients respond, and then retrain based on results.

Conclusion

With health care reimbursement from public and private payers in flux, health care providers must look at best practices for communicating with patients about prices, billing and payments. Ultimately, they can lower the cost of staff time formerly devoted to largely fruitless pursuit of mostly small balance accounts after the procedure is completed.

Automation of the payment process and actions to improve and automate collections from patients is imperative for organizations that want to succeed in the age of health care consumerism and high-deductible health plans. Establishing payment plans is a strategy both for improving collections and establishing strong relationships with patients.

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