

Paving the Way for Medical Banking

Other industries have relied on banking automation to improve the speed and efficiency of payment processes and reduce transaction costs. Can health care optimize electronic payment posting and remittance data exchanges for similar benefit? In this roundtable, healthcare providers and a banking representative explore the potential roles of banking in health care. They describe their experiences and expectations of ideal lockbox and other banking transactions, and weigh potential benefits and challenges associated with implementing the banking industry's technology solutions.

Moderator: Lockboxes have been a tool in the healthcare industry for several years with limited acceptance. In this new age of consumerism, some hospitals are examining electronic remittance as a foundation for an electronic claims processing process for payer and consumer payments and for other process and posting improvements. What has been your experience in this area, and what do you see as primary benefits and challenges associated with using a lockbox for receiving payment?

Robert Hemker: We have explored the plusses and minuses of using a lockbox to shorten the posting cycle. Cost was a primary consideration when we decided not to get a lockbox.

On the plus side, though, a lockbox could help us better deploy the resources that are going into the reconciliation process and could improve the timeliness of posting. So we're keeping the lockbox option open, it's just not a clear hands-down solution.

Mary Lee DeCoster: We use a lockbox for consumer and insurance payments. More than half of our business comes from Arizona Medicaid plans, which cannot send us payments electronically. So the lockbox helps us save a day. As a safety net healthcare system, my organization counts cash very closely, and the lockbox makes a difference. But we want more services from our lockbox. We can't yet accept electronic payments from our self-paying patients, so we're still doing a lot of manual posting. We have seven cash posters in addition to the lockbox. To me, there's something wrong with that picture.

Belle Butler: We also use a lockbox. The primary benefit of the lockbox is in managing high volume. We have approximately 2,500 patient payments per month that come in

through the lockbox. Payments from some of our smaller payers also come in through the lockbox; they're not all electronic. The lockbox does give us a bit more control on the cash side. And it's preferable to having our accounting department handle the checks. Ideally, all of our payments would come in electronically and we wouldn't have to do any manual posting.

Michael Bernick: We don't use a lockbox; we probably don't have quite enough volume for it to make a real difference for us.

Fred Pigeon: We don't use a lockbox, either. We looked into it and concluded that the expenses associated with the lockbox were not warranted. We did want to find a way to regain the day we lost while the armored truck was delivering checks to the bank, however, so we bought a desktop deposit system and recaptured that day.

Brian Kay: We've looked into the feasibility of getting a lockbox, but concluded that our cashier's office is a better solution. They handle mail-in payments as well as payments from walk-ins. So there really isn't any additional cost for processing the mail-in payments, since we want to keep an open cashier's window, whereas there would be cost associated with a lockbox.

Janey Ladd: Our self-pay patient base is so small that a lockbox is not cost-effective.

Scott Nelson: We use a lockbox for patient payments. Most payers send us an electronic remittance advice and the money goes directly to the bank. But we don't have that capability for patient payments, so that's where our lockbox comes in.

Overall, we don't have any trouble with the lockbox for patient payments. Occasionally payers will make changes or upgrades that will take a while to straighten out, but that's a minor inconvenience.

Moderator: Has anyone tried to automate the reconciliation process, so that payments and remittances are matched before payments are posted?

Robert Hemker: You can't take advantage of electronic reconciliation technology unless you have electronic posting on the bank side as well as the lockbox side.

Mary Lee DeCoster: We have occasional discrepancies between the lockbox and the deposit. Being a veteran patient accounts professional, I regard the lockbox report with a fair degree of skepticism—we double-check it.

Fred Pigeon: That's right. For electronic remittance posting, we verify that the remittance matches the electronic fund deposit before it's posted. And we have a spreadsheet where we document what we posted. Then we have someone else look at what was posted, and then we have the accountants check that. So we build in manual checkpoints throughout the process.

Moderator: What would it mean to your organization to have automated posting and reconciliation processes?

Catherine Warren: I think it's important to define what we mean by automated posting and reconciliation. Until very recently, traditional lockbox services have not added

significant value for hospitals. The manual posting and intervention issues that people here are describing have limited the value the lockbox can deliver. But newer medical lockbox technology can offer hospitals benefits that go beyond fast deposit services. These benefits include imaging the paper, capturing the data on the EOBs [explanation of benefits] and re-associating the EOBs with the deposit so that you're getting the data when the dollars come in. In some cases, you could actually get the data converted to an 835 [the HIPAA healthcare claim payment/advice transaction set] or a file that can be delivered to your patient accounting or other receivables system. You may even be able to reconcile the data with your open claims file. In health care, we're starting to be able to do invoice matching, as other industries do. So that's what a fully automated process would look like: the payment comes into the lockbox, the check is matched with the data, which could be paper if you're not getting ERAs [electronic remittance advices], and all of that is converted into an ERA from the bank to you.

Robert Hemker: You're describing what it would be like to apply the process that has been used successfully for many years in accounts payable to the receivables side of the business. Yes, that could add value. It creates an opportunity to redeploy human resources to something other than commodity processing, which is always a good thing. But how many FTEs can actually be redeployed by adopting this technology? That is at the heart of the cost-benefit analysis.

Michael Bernick: People are doing this reconciliation process manually every day in my office. I agree that there is value in automating that process.

Janey Ladd: I found the automated reconciliation process very difficult when I worked with an insurance company. It was a monumental job; the volume was too high to allow us to balance and reconcile.

Robert Hemker: When you stop to think about it, this is still an antiquated process. We're still talking about a lot of paper here. Why haven't we moved beyond paper to true electronic technology? We're just shifting the manual process from our shop to the bank's shop. How do we take that a step further, as the personal banking industry has done? A more paperless process would help eliminate the risk of error that is introduced during data entry.

Catherine Warren: The bank uses OCR [optical character recognition] technology, not people who are keying in the data. The data are digitized. The data go through human verification, but that's much faster than manual data entry. It's true that we are still just digitizing from the bank to the

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provider, just that one piece of the process. Transactions on the payer side are not yet fully automated. Clearly, that is where we ultimately need to go.

Mary Lee DeCoster: I think Bob Hemker's remarks were visionary. We're missing a couple of players at the table. We don't have the payers. And the payers are a key stakeholder in the process in terms of what they output from their systems. In Arizona, the Medicaid plans produce paper, irrespective of the HIPAA and 835 standards that have been defined. They ignore them and there is nothing we can do about it. We've been looking for an OCR scanning system to bring in-house to eliminate some of the manual processes and to automate the posting. Our current lockbox vendor can't do this for us.

Janey Ladd: My question to the banking industry is, how are you going to make all of those files HIPAA-compliant? How are you going to coordinate with the payer to download to you and then download to me electronically?

Catherine Warren: We image the paper, and then we put the paper data into templates. We have tens of thousands of templates that we change regularly as payers change their EOB formats. When we pick it up off the paper, we convert it into a HIPAA-compliant 835 and drop it into your patient accounting system.

Moderator: Given all the issues around HIPAA and other regulatory compliance, how would this technology change your organization and the way you do business?

Janey Ladd: I'm not sure this would change the way we do business. We already have these capabilities through the clearinghouse with our payers, and our self-pay segment is so small that we wouldn't use a lockbox for that.

Brian Kay: For those who are not using lockboxes and missing out on that day, there is an opportunity to negotiate sweeps and earn overnight interest at fairly high rates. With quantities of several million dollars, that can add up over the course of a year. But looking at this lockbox issue in a larger sense, there are a couple of hurdles to overcome. One hurdle is pride: we can do this ourselves, and we don't want to outsource it. The other issue relates to community service. If we started using a lockbox, we would probably eliminate the cashier's window that people appreciate having.

Belle Butler: To the extent that you can go directly to the payers on your own, that's what you would want to do. But when that's not possible, there are advantages to having the bank do it for you. It would free up time that employees spend posting cash and reduce errors. I see it as a positive thing.

Scott Nelson: There is still a small percentage of claims—it could be anywhere from 2 percent to 5 percent—that need to be reconciled manually. For example, when patients have multiple accounts, to which account should a payment be applied? Our people rely on the comments in our internal system in cases like that. The bank would need total access to our system to apply some of these payments correctly. That's where we think it would be really tough for bankers.

Fred Pigeon: Another consideration is that a lot of additional information comes on the remittances, not just the payment information. Claim statuses, rejections, and denials all come in electronic files. You have to consider how you're going to map all those pieces into your system when you're considering electronic banking. The electronic 835 side remittance doesn't automatically post to our system. It's read in, so it eliminates the data entry step, but accounts receivable staff is still responsible for making sure that the remittance looks correct. If it's a supplemental payment and the payer sent a contractual adjustment that doesn't apply, the accounts receivable department has to step in so we don't just shift that work down to the patient financial services staff. So there is a lot of activity that goes on beyond just automatically posting those transactions.

Moderator: Let's take a step back for a moment and talk about how you envision the general role of banks in health care.

Robert Hemker: Why shouldn't we use banks rather than spending our limited capital dollars to implement technologies like OCR internally? It's not a revenue dollar or a revenue-producing asset. This is a classic case where it doesn't make sense to reinvent the wheel. The banks can do it faster and cheaper than we can.

Fred Pigeon: The banking industry has done a wonderful job of bringing electronic processes to debit and credit card transactions. In health care, we need to learn from that.



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Moderator: The point-of-service payment has been described as the Holy Grail of the whole movement toward consumer-directed health care.

Fred Pigeon: Yes. That's why we need the payers. Real-time claims adjudication is what we all need.

Michael Bernick: Banks can certainly help with credit cards or debit cards. But the electronic remittance should come through the vendor. Getting a bank involved just adds an extra step.

Moderator: I'm sensing a hesitance to invite banks into the process unless they can justify their presence. Is that right?

Mary Lee DeCoster: A bank approached us eight years ago and promised to provide us with electronic remittances and an automated lockbox for all of our patient payments. But they couldn't deliver.

Health care is a complex industry. Banking went through its "evolution revolution" in the 1980s and automated its processes, and these processes are very streamlined now. I value the experience and knowledge that banks bring, but I think they're going to have to study health care for a while and figure out what we're doing. It isn't as straightforward as automating hotel checkouts, for example, where they swipe your credit card when you check in and print the final bill before you check out. We don't know what the final cost is going to be for a patient encounter until the doctor sees the patient.

Scott Nelson: We can envision a scenario where the patient swipes a card—even though we don't know what the final bill will be—and the bank posts that payment directly into our system, which saves a step for us. That's probably not too far off. We're also looking forward to the time when

real-time claims adjudication becomes a reality. It would require a lot of work on our end, but that's the vision. Deductibles, coinsurance, HSAs [health savings accounts], all of those would be factored in, and patients could just swipe a card to pay for their portion of the bill. The bank could post the payment into our system and save us time.

Brian Kay: I look at banks like any other outsource; they have to make a profit. If we can handle the process in-house, we can eliminate that additional layer of cost. But if cost, capital, size, or technology limit your ability to do it yourself, then it just makes sense to use outsourcing.

However, I haven't seen a product in the marketplace that offers the whole package, with all the services we would want. Take collections, for instance. It would be glorious for CFOs if collections were handled in a standardized way across the country, and we didn't have to manage that. But existing products don't offer the complete package. They just add an extra step, another silo. They create complexity rather than simplicity.

Catherine Warren: We hear from providers in various areas of the country that automated reconciliation on the commercial payer side is not always consistent. Some providers still have a tremendous amount of paper coming into a lockbox, or they have checks with a huge amount of EOB data that require a phenomenal amount of resources to post, reconcile, and balance against the payments that are coming into the lockbox. What we're really trying to do is streamline the process on the commercial payer collection side.

We recognize that there are also opportunities to help providers deal with the self-pay side, as payment responsibilities shift to the consumer. And we want to help you figure out how to efficiently capture self-pay data so you don't have to print out reports and post them manually. But the collections function on the commercial payer side is the area we currently are focused on [in lockbox].

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