Payer Payment Optimization
Practical considerations for provider organizations seeking to improve payer payment and remittance processes.
When attempting to improve payer payment processing and collections—specifically, the payments and remittance advices received either electronically or via paper from commercial insurance payers or government payers (“payers”)—there are a number of challenges that healthcare provider organizations face. These can include:

**Technical challenges**
- Building out more direct connections to payers
- Improving clearinghouse connectivity and transaction processing
- Integrating better remittance and payment data from payers (and/or banks, if using a bank lockbox)
- Optimizing the use of IT systems (e.g., using patient accounting systems to process claims, remits and payments more efficiently at service-level detail)
- Addressing the increased technical complexity for healthcare provider organizations that have disparate IT systems and multiple billing departments processing payments on behalf of multiple business entities (e.g., hospital/institutional billing versus medical group/professional billing)

**Operational challenges**
- Shifting the focus from payment posting to a focus on exceptions management (e.g., denials, late payments, short payments, etc.)
- Dealing with paper from payers (e.g., remittance advices, checks, correspondence, indexing, etc.)
- Automating posting and reconciliation (e.g., posting to the patient accounting system and posting to the general ledger, or G/L)
- Centralizing and consolidating efforts (e.g., lockboxes, accounts, billing departments, etc.)

**Strategic challenges**
- Impacting business plans
- Centralizing billing and operations
- Optimizing information technology investments
- Improving bond ratings
- Enabling new business and payment models

If Patient Accounting and Collections is a healthcare provider organization’s revenue engine, payment processing is the fuel. Payment optimization initiatives deliver tremendous value, helping healthcare systems compete in rapidly evolving and uncertain markets.
Trends and Challenges Impacting Payer Payments

WHY FOCUS ON PAYER PAYMENT OPTIMIZATION?
1. Payer payments are complex, and there remains a significant amount of paper and manual processing. As a result, provider organizations continue to spend time working on less valuable parts of the revenue cycle and collections processes (e.g., posting), rather than focusing on the more valuable parts, such as time working exceptions (e.g., late payments and denials).

2. Patient Accounting Systems and modules have gotten better at helping organizations realize a number of operational improvements, enabling better exceptions management, quicker and more automated posting and reconciliations processes, and easier direct connectivity to payers.
   - However, Patient Accounting systems are not yet “optimal,” and provider organizations are continually pressuring vendors to add modules that will improve payment processing (e.g., cash management and forecasting, cash reconciliation to the G/L).
   - Efforts to digitize, automate, consolidate and centralize are often left to the provider organization to develop. This means vendors participate in the implementation phase but not the optimization phase, much less any “enterprise-level” work (e.g., integrating image archives, posting from patient accounting to the G/L, etc.).

3. The Affordable Care Act (ACA) has impacted payer payment and remittance transaction processes by mandating electronic remittance advices (ERAs) and payments (EFTs) in updated and upgraded formats. These updated HIPAA- and ACA-compliant ERA and EFT transactions greatly improve payment re-association, posting and reconciliation processes. This, in turn, should lead to provider organizations increasing their direct connections to payers, as well as their percentage receipt of ERAs and EFTs (perhaps via clearinghouses) and improving downstream processing of “data and dollars” (ERA data and EFT dollars).

Many provider organizations are benefiting from government reforms that have impacted direct payer connectivity, electronification and automation initiatives. However, there is still a lot that can be done to optimize payment and remittance advice processing and impact key performance metrics related to payer receivables.

Payer Payment Optimization Methodology

There are four steps to a comprehensive payment optimization plan:
1. **Evaluate the current situation:** Where are we now?
2. **Set clear goals and objectives:** Where do we want to be?
3. **Assess the value of change:** Why are we changing, or where is the inertia for change? (This can help to garner funding for projects or prioritize projects when there are too many to entertain at once.)
4. **Establish key initiatives:** How are we going to get to where we want to be?

Each stage of the optimization plan can then be divided into three levels: payments, processes and performance.

Important questions include:

- Where are we with regard to payment/remittance types, process improvements and performance metrics?
- Where do we want to be?
- How are we going to get there?
- What is the value of these initiatives?

**Payments**

Basic payer payment optimization means improving the transactions that arrive **balanced, funded and ready to post**, namely, 835 data and payment data (**data and dollars**) that can flow through to automatic posting in the patient account and G/L. Many provider organizations receive a mix of electronic remittances/835s, paper remits (explanation of benefits, or EOBs), electronic payments (electronic funds transfers, or EFTs) and checks. The goal is to prepare these in ways that enable easier, automated payment re-association, claim and remittance reconciliation, and remittance to payment reconciliation, all of which are automatically posted to patient accounts.

Successful organizations should strive to increase direct connectivity and clearinghouse ERAs to drive higher electronification and automation rates. Targets for elimination include paper payments and remittance advices, as well as virtual card (credit card payments) from payers.
Processes
Process optimization includes two key steps: 1) payment and remittance advice receipt; and 2) workflow optimization for back-end processes (posting, reconciliation in the patient account and reconciliation in the G/L). Specific attention should be paid to commercial insurance payments and remittance processing, since government payments are often straightforward and timely.

Performance
Measuring performance requires organizations to answer a number of key questions, including:
• How do payment processes impact financial performance, cost savings and operational efficiencies?
• What is the value of change and the return on investment (ROI)?
• How have improved payment processes impacted business plans and strategic initiatives?
• What are the performance metrics for commercial insurance payments and remittance advices versus government payments (e.g., days to post in the patient accounting system, impact on working capital by payer/payment/remittance type, etc.)?

LEVEL I. PAYMENTS: OPTIMAL PAYMENT AND REMITTANCE PROCESSES
Providers should be able to actively manage their payer remittance and payment channels to move up the “paper-clearinghouse-direct payer” continuum to payment processes that drive improved operational efficiencies (higher electronification and auto-posting rates), improved financial performance (lower costs, lower A/R days) and better exceptions management (improved downstream processing for denials management, secondary billing, short/late payment collections, etc.).

Paper Processing: Checks and Explanation of Benefits (EOBs)
There are several challenges that emerge in paper processing. Paper can be expensive to process and often requires manual processing in order to post. In addition, challenges in paper processing arise from non-standard transactions (e.g., reason/remark/denial codes; formats; contents), and they are often impossible to convert to a “clean” 835, given missing data. With these challenges, the goal is to convert as many EOB-remitting/check-paying payers to ERAs/EFTs as possible. Though this may vary by region given a provider’s payer mix, most providers are aiming for better than 90 percent of receivables being ERAs and EFTs in updated (compliant) formats.

PAYMENT OPTIMIZATION PLAN

Base-Level Electronic Remittance Advices (Clearinghouse ERAs)
Challenges are also present in base-level remittance advices. One such challenge is that because of the Affordable Care Act (ACA) ERA/EFT mandate, which went into effect in 2014, there are many more payers on the clearinghouse claims/remittance networks. What is more, with regard to payment re-association or auto-posting, some clearinghouse transactions do not perform as well as direct ERAs/835s. This is because clearinghouse ERAs may not be “balanced, funded, ready to post,” as clearinghouses do not have bank payment data (i.e., ERA data and dollars do not arrive at the same time).

Thus, providers should evaluate clearinghouse ERA performance all the way through—from the ability to post automatically in consuming systems (e.g., patient accounting modules) to the quality of the data contained in the ERA (e.g., do the reason/remark/denial codes allow for effective exceptions management). If clearinghouse ERAs, plus bank-supplied EFT payment data, enable high rates of auto-posting and good quality data for downstream exceptions management processes (e.g., denials management, coding analysis), then providers should consider consolidating other clearinghouse transactions through this better channel. In other words, consider replicating the success of better clearinghouses.
As payers have adopted updated adjudication systems and delivered more standardized ERA transactions, the quality of clearinghouse data has improved. By now, hopefully providers have access to good “all payer” clearinghouses that can augment their direct payer connections. Thus, a primary goal is to increase clearinghouse remittance advices as a percent of revenue.

For organizations for which two-thirds to three-quarters of payer revenue is delivered via direct connections, clearinghouse ERAs can increase the percentage to more than 90 percent (or even 95 percent) of electronic remittance advices and payments. Clearinghouses help provider organizations deliver hundreds of payers’ remittance advices electronically, if the top 10 to 15 payers that can be delivered directly (without a clearinghouse) are two-thirds to three-quarters of payer receivables, it often requires hundreds of payers’ worth of payments and remittance advices to achieve another 10 percent to 20 percent of electronic payments. Ranking payers by remit volume or dollars can help determine good candidates for direct connectivity, and ranking EOB-remitting payers by volume can help determine good candidates for clearinghouse remittance processing (if not direct connectivity).

**Direct Electronic Remittance Advices (Direct ERAs): 835s via Direct Connectivity With Payers (No Clearinghouse) and EFTs to the Bank**

Direct connectivity between payers and providers can often result in higher-quality ERA data, since payers remit in the updated 835 formats. This can improve auto-posting rates, resulting in higher-quality ERA data (e.g., standardized reason/remark/denial codes) and possibly lower costs (e.g., clearinghouse and bank costs)—that is, if payers are directly remitting in compliant 835 ERAs and paying via EFT.

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**PAYER REMITTANCE AND PAYMENT CONTINUUM**

Payments and Remittance Advices From Commercial Insurance and Government Payers

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Provider billing systems need to be set up to manage direct consumption of 835s, as well as bank data, and be able to re-associate payment, claim and remittance data at the claim and service level. Many providers have updated billing modules that are getting better at providing this level of functionality, utilizing strong workflow management tools for posting and exceptions management.

One goal is to increase direct connectivity as a percent of revenue. In 2016, most provider organizations connect directly to Medicare, Medicaid, Aetna, CIGNA, United and Blue Cross Blue Shield—as well as some regional payers or contracted payers—to consume ERAs. A common goal is the receipt of the majority of ERAs via direct connections representing most payer revenue (sometimes as much as 75 to 80 percent of revenue, depending on location). After accomplishing this, the focus becomes how to reach 90 percent and beyond via a combination of additional direct connections or clearinghouse connections to payers.
LEVEL II. PROCESSES: OPTIMIZING PAYER PAYMENT PROCESSES

With a solid understanding of the payer continuum, provider organizations can focus on process improvements like electronification and automation, depending on how many payers can be re-credentialed to direct or clearinghouse channels from the EOB remittance and check payment method. There are additional process improvements that providers can include in their key initiatives.

Transition to an Exceptions Management Organization (From a Predominantly Posting-Focused Organization)
Once provider organizations begin improving electronification and automation rates, they will be able to focus attention on moving from a (predominantly) cash posting organization to an exceptions management organization. Payer payment processing has historically meant spending the bulk of people-time posting the payments received, engaging in payment re-association, claim-remit reconciliation, and payment posting in the patient accounting system. Now, as data quality has improved due to upgraded remittance and payment formats, and as billing modules have improved in functionality, provider organizations are focused on auto-posting rates so staff can concentrate on more valuable parts of the collections process, namely, exceptions management (denials, late payments, missing payments, unassociated payments, etc.). This can have a significant impact on the bottom line as collections rates improve, days in accounts receivable (days A/R) go down, write-offs fall, and other benefits arise. Downstream processes like analysis of denials and reason codes can impact coding and billing in ways that reduce exceptions and provide significant operational impact (e.g., reducing people-time on lower-value processes).

Improved Paper Processing
Paper remittance advices (EOBs), payments (checks), correspondence and non-standard transactions are the bane of any highly functional billing operation. These receivables take considerable up-front work to index, re-associate to claim and remittance data, and then post to patient accounts. Paper remittance advices also include non-standard reason/remark/denial codes. As such, they can be challenging to dispute, manage exceptions and reconcile in a timely manner, if at all; more challenging still is analyzing paper remittance over time to improve exceptions rates and collections processes.

There are improved solutions for processing all of this paper. This includes not just the legacy EOB conversion solutions but also correspondence indexing and imaging of non-standard transactions (e.g., workers compensation and auto claim remits and payments). By the time healthcare provider organizations reach 80 to 90 percent of revenue paid via ERA/EFT channels (direct or clearinghouses), the remaining paper is almost by definition non-standard and difficult-to-impossible to convert to clean 835s that are ready to post and that can positively impact downstream exceptions management processes without human intervention (usually manual posting or keying from an image). Updated solutions based on modern technology can now more efficiently and more cost-effectively convert EOBs to 835s, as well as index correspondence, and help with everything else that arrives from payers in the form of paper. Improved paper processing is a common initiative and can lead to downstream process improvements, cost savings, improved collections and better speed to cash—and all at much more competitive prices than only a couple of years ago.

Eliminate Virtual Card Payments
Virtual card payments are not compliant with the ACA, and if possible, all of these payments should be rejected and payers required to remit in the HIPAA- and ACA-compliant ERA and upgraded EFT formats. For payments from “rare” payers (i.e., those payers with whom providers rarely deal, perhaps only several claims per year), virtual card payments can be a valid payment option. Providers, however, need to decide at what point it is worth denying this payment and credentialing with a payer to receive payments via preferred tender types.

New advances in processing paper can yield better results from computerized scanning, indexing and conversion. More than just EOB conversion solutions (converting paper EOBs into 835s), given the problematic nature of EOB conversion, there is high demand for correspondence indexing services.
Centralization of Billing, Consolidation of Lockboxes and Accounts

Centralization and consolidation of billing operations is an ongoing trend. As more healthcare systems process claims, remits and payments at service level in their hospital billing departments (for institutional claims), they are more commonly combining hospital and professional billing departments, consolidating their IT, and training their staffs across broader collections processes. Additionally, improved IT systems and patient accounting modules can better support centralized billing or single billing offices. With trends like the move to a single patient statement, combined with the desire to have a single customer service point of contact as it relates to billing and collections, there is a desire to centralize multiple departments.

Outsourcing

Increasingly, larger healthcare systems are entertaining more outsourcing, from increased use of third parties (e.g., paper processing services and multiple clearinghouses) to the complete outsourcing of billing operations (in part, such as outsourcing professional billing, or, in whole, outsourcing professional and hospital billing). Considerations for provider organizations include:

- **Costs:** The biggest consideration is cost, as many outsourced billing companies and their vendors can be expensive (e.g., a percentage of revenue collected), and technology has greatly improved the payer collections piece of revenue cycle and helped to drive down costs.

- **Control:** Considerations for the “control environment” include a broad range of topics, such as control of the billing process and making it a core competence area critical to a business plan, and control over data, cybersecurity and compliance. Outsourcing can add risks across the control environment spectrum.

- **“Bank Agnostic” Solutions:** Outsourcing options often come with strings attached as it relates to payment processing, but a provider organization should consider solutions that allow for personal selection of payment processors and other integrated third parties, especially when considering long-term ramifications on transactions processing costs.

Improved Analytics & Reporting

Visibility into processes and performance is essential, and better reporting can help with all process improvements. Critical questions include:

- What are the key metrics, and how are they collected and reported?

- Is there an operational dashboard that can easily display electrification and automation rates, people-time on posting versus exceptions management, the volume of virtual card payments, speed to cash (days A/R) by payer, a payer list force-ranked by payment and remittance type, etc.?

- Are exceptions management and denials processes impacted by much clearer data on why payments are late, short-paid and/or denied?

LEVEL III. PERFORMANCE: IMPACT OF PAYER PAYMENT OPTIMIZATION INITIATIVES

The goal of patient payment optimization is to improve key performance metrics, including:

1. Financial Performance

Payment optimization initiatives, such as adding payment types and integrating improved payments into collections workflow, can have a profound impact on financial performance. Make sure you evaluate the impact on specific financial performance metrics such as revenue, collections, costs, days accounts receivable (by patient type, payer type, etc.) and reduced write-offs. For example, how might moving from 60-day-old mailed payments to 30-day-old electronic payments impact your cash flow? Can revenue leakage be mitigated by encouraging patients to make payments as soon as possible? What are the cost-benefits and ROI of optimization projects, especially if they include the addition of third parties or outsourced solutions?

2. Operational Efficiencies

Consider the impact on operational performance metrics, including electronification rates (e.g., elimination of checks and patient coupons in favor of electronic payments) and automation rates (e.g., autoposting to patient accounts, autoreconciliation of bank deposits to patient accounts and autoposting to the general ledger) and people or full-time equivalent (FTE) time. Have electronification and automated payments lowered FTE processing times? Not only does less time mean cost savings for your organization, but spending less time on lower value processes can allow the reallocation of resources to more valuable processes.

3. Patient and Customer Satisfaction Rates

Billing and collections, and the subset that is payment processing, are increasingly important parts of patient and customer satisfaction rates. How do payment optimization initiatives directly impact customer satisfaction? How does this impact your ability to compete?

4. Business Plans, and New Business and Payment Models

The retailization and consumerization of healthcare are key trends that have healthcare provider organizations competing with big box retailers, retail pharmacies and urgent care clinics. Do payment processes support this move toward retail, consumer-oriented businesses? Consider your experience as a consumer with other large retailers and the differences between engagement in retail and Web transactions versus those of a traditional healthcare organization. What other business and payment models require updated payment types or transaction processes—and what does your organization need to do to plan for these?
Example Payer Payment Optimization Initiatives

Payment optimization can be a daunting task. Providers want comprehensive and robust plans to move more payer remittance advices and payments up the quality continuum from paper to electronic processes, improve workflow and transaction processes, and significantly impact performance metrics. While there are numerous payment types, processes and performance metrics to consider, you may also want to distill this process down to several key initiatives that can have optimal impact.

Healthcare provider organizations can consider shorter-term initiatives (e.g., “2017 Key Initiatives”) or longer-term plans (e.g., a “2020 Plan”). For each payment optimization initiative, you should be able to clearly articulate a business case or justification for the initiative given the current situation, the objectives and goals, and the value of change.

A few example initiatives include:

**Electronification Initiative**

This is an electronification of paper remits and payments (from EOBs and checks to ERAs and EFTs). Even if a provider organization’s payer receivables and remittance advices are 70 percent to 80 percent electronic, there is still justification for an electronification initiative.

**For payments:**

- Focus on paper EOBs and checks and gauge how many payers can be re-credentialed for electronic receipts
- Consider adding direct connections for the next few payers that represent the most volume
- Eliminate virtual card payments

**For process and workflow improvements:**

- Consider upgraded EOB conversion (to 835) and correspondence indexing solutions

**For performance metrics, goals and value, look at:**

- Costs of processing paper payments and remits versus spending the resources and capital required to re-credential with these payers via electronic channels (direct or clearinghouses)
- Costs of processing paper EOBs and correspondence versus outsourcing (lockbox, conversion, indexing costs)
- Impact of improved electronification rates on financial performance metrics (e.g., collections rate, Days A/R, collected-to-billed ratios, etc.)
- Impact of improved automation rates on operational efficiencies metrics (e.g., auto-posting, FTE time)

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THE VALUE OF MOVING THE NEEDLE

In the context of key financial and operational performance metrics, “moving the needle” can mean making very small improvements. For example:

- Impacting revenue or collections rates by 1 percent, or reducing days accounts receivable by 1 day
- Reducing full-time equivalent (FTE) time by 5 percent
- Spending more time on exceptions management (denials, late payments) instead of posting because of a slight increase in auto-posting rates
- Lowering costs by a few percentage points

These small changes in performance can have a significant impact. More efficient billing, collections, and payment processes can impact not only collections rates, but also, an organization’s ability to compete.

For example, an organization with several hundred million dollars in patient collections that makes a small improvement in key performance metrics can see millions of dollars in cash or revenue. It can also:

- Free employees to work on more valuable processes that impact the bottom line
- Improve customer satisfaction
- Improve bond ratings because ratings agencies increasingly look for competence in managing patient responsibility and patient collections
- Offset the cost of new technology or outsourced services (provide a positive ROI or cost-benefit)
Automation Initiative

For payments:
- Focus on lower-quality ERAs via clearinghouses (those that do not auto-post consistently) and gauge if there are some that should be received directly from payers in upgraded/updated formats (835s)
- Develop auto-posting reports by payer and by payment channel so problematic payers can (possibly) be improved (e.g., source remittance data through alternate channels, if possible)

For process and workflow improvements:
- Whenever possible, work with clearinghouses, banks and third-party transaction processors to receive “balanced, funded, ready to post” 835s and supporting payment data
- Work with IT/patient accounting system (PAS) vendors to improve auto-posting capabilities and rates
- Take on an “enterprise-level” project to better integrate patient accounting systems with the G/L to improve the cash posting and deposit reconciliation process

For performance metrics, goals and value, look at:
- Days A/R from posting, reconciliation in the patient account, and reconciliation in the G/L
- People-time spent posting versus FTE time on exceptions management (which has a direct impact on the bottom line)

Exceptions Management Initiative

For process and workflow improvements:
- Electronification and automation initiatives must deliver higher-quality reason/remark/denial code data, as well as reports on why payment is denied/late/short, which impact improved exceptions management processes and give organizations more people-time to engage in more valuable processes

For performance metrics, goals and value, look at:
- Denial rates, short payment amounts, Days A/R, and other performance metrics that an exceptions management initiative can impact

Operational Efficiencies Initiative

For payments:
- Promote electronic transactions that can automatically post (rather than manually processed paper transactions)
- Outsource payments or embed payment processing in third-party applications (if in-house payments are manually processed)

For process and workflow improvements:
- Improve posting and reconciliation processes
- Control environment enhancements (including data security, cybersecurity and fraud protection improvements and solutions)
- Improve reporting, dashboards and visibility into performance
- Set internal project benchmarks (“before and after”) and external peer benchmarks (if possible)

For performance metrics, goals and value, look at:
- Reducing people-time on lower value processes (e.g., check processing and payment posting) in favor of people-time on more valuable processes (e.g., exceptions management)
- Improving electronification and automation
- Lowering the cost of compliance audits
Conclusion

Government regulations, provider organization initiatives, and technology improvements that impact transaction processing have significantly improved payer remittance and payment processes. However, there remain many steps that even the most electronic and automated billing operations can take to drive more operational efficiencies, improved financial performance, and better exceptions management.

Providers can strive to achieve 90 to 95 percent electronic transaction processing and auto-posting rates, thereby saving on transaction processing costs, improving collections, lowering days A/R and freeing up staff time to focus on improved exceptions management. Improved paper processes can impact the remaining balance of paper remittance advices and payments.

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Jeffrey Eyestone and Matthew Rozen are Executive Directors and Healthcare Solutions Specialists with J.P. Morgan Treasury Services. They have over 35 years of combined experience in healthcare information technology, consulting, revenue cycle process improvement, product management and treasury services.

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