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New Technology Automates Old Ways\$

A new generation of financial software is helping organizations reduce manual processes and get more out of legacy systems.

By Joseph Goedert
News Editor

A year ago, less than 30% of patients having orthopedic surgery at Texas Orthopedics, Sports and Rehabilitation Associates paid their estimated co-pays and deductibles before surgery. Now, nearly 90% pay those costs at the Austin-based practice with four locations and 12 specialists.

The practice attributes the boost in payments—and subsequently cash flow—to software loaded with insurers' payment rules that help staff more accurately calculate out-of-pocket patient expenses for specific surgical procedures.

The MPV Patient Portion Pricer is a recently introduced module to the Phynance financial management software of Medical Present Value Inc., San Antonio, that identifies underpaid claims. The practice served as a beta site for the software and rolled it out enterprise-wide early this year.

Being up front

Previously, the practice handwrote estimates of out-of-pocket costs at patients' request. Now, office staff uses Patient Portion Pricer to generate and



print detailed estimates up front for all patients.

Patients seem to take a printed estimate more seriously because it looks professional and official, says Twyla Fuertes, business manager. Collecting these upfront payments increasingly is important because patients are bearing more of the financial burden for their care, she adds.

"What's happening in the insurance world today is patient deductibles are increasing and their co-pays are increasing," she says.

Any time a provider estimates the cost of a procedure, it is a sensitive subject, Fuertes acknowledges. The new, formalized estimates include a disclaimer that lists factors—such as a more complex procedure than anticipated—that could make final costs exceed the estimate.

"We go over the disclaimer and patients sign it," she says. "We've had no problems with patients misunderstanding that they paid us in advance for an estimate."

Financial and administrative information systems in some fashion have been used in the health care industry for more than three decades; their benefits are well known and accepted. But newer software products—some still in beta—are helping providers and payers reap additional benefits by automating business processes that have primarily remained manual.

Benchmark Inc., a Jackson, Miss.-based third-party administrator, has eliminated three clerical positions by using software and outsourced services from Cleveland-based ECHO Health Inc. to consolidate claims payments from the same payer to a provider organization.

Rather than receiving separate checks and explanation of benefit forms for each claim from a specific payer, provider organizations doing business with Benchmark now can receive a combined check and a consolidated EOB, explains Janie Farlee, systems administration manager.

"Each EOB that would have been sent out separately is represented on the consolidated EOB—it's just a continuous report," she says.

Benchmark started using the consolidated payments software, called ECHO-Pay, to reduce its internal costs and also at the request of employer clients that wanted a faster and simpler process for themselves, their employees and their contracted providers to track claims payments.

For instance, providers can offer patients a "family EOB" that each month shows all payments and out-of-pocket expenses. "The employees really like that, so the employers do, too," Farlee says.

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Digging deeper into data

The new generation of financial and administrative applications also is taking aim at enhancing organizations' ability to use their data to improve their financial—and sometimes clinical—performance. For instance, the University of Rochester (N.Y.) Medical Faculty Group, comprising about 850 physicians, is testing benchmarking software from IDX Systems Corp. that pulls and analyzes data from various clinical and financial administration systems.

The Metrics Manager software from the Burlington, Vt.-based vendor is a new module of the Flowcast information system. "The goal of Metrics Manager is to identify problem areas," says Martin Haibach, director of finance and administration for the group practice. "We can get information from scheduling systems on patient wait times. Then we can look for a correlation of satisfaction with how long it took a patient to get an appointment, or to wait in an examination room."

The University of Rochester Med-

ical Faculty Group is a test site for Metrics Manager and has implemented it in four departments—general medicine, surgery, neurosurgery and pediatrics.

The selected departments are "above average" users of information systems; they understand the systems better and get more out of them, Haibach says. "They're more sophisticated in their reporting capability."

But the group practice has faced some major challenges during the testing period, says Darleen Barnard, manager of financial services in the practice's shared services organization, which provides such centralized services as billing.

On the technological front, the group is having difficulty extracting data in the formats it wants. Metrics Manager resides on its own Web server, taking data from the Flowcast module and other modules that store billing and scheduling data, patient satisfaction surveys, and other information.

But getting data out of other information systems in the desired format can be tough. For example, Barnard says, data pulled from other systems into Metrics Manager showed that 100% of cancelled appointments were not rescheduled. "That's not true data because of flaws in how we were entering information," Barnard explains. "So, we needed process changes for entering data."

The practice has learned that it's tough deciding what to measure and how to design the benchmark target, she adds. The group is getting help by using benchmark data developed by the Medical Group Management Association and the University Health-System Consortium to create its own targets. A target for days in accounts receivable for certain specialties might be within 10% of the MGMA standard, Barnard says.

Managing reserves

The business side of health care organizations always has had a difficult time managing financial reserves. Reserves are the difference between the cash in the door from a claim and the amount an organization expected from the claim.

"You can book \$100, but you might not

get all of it," explains Richard Silveria, corporate director of revenue finance for Boston-based Partners HealthCare System. "So you need a reserve to add up to \$100." But reserves aren't just an accounting exercise: they represent potential revenue, Silveria says. If an organization can lower its reserves by identifying underpaid or denied claims and understanding the reasons why, it can increase revenue.

Further, changing reserves that should be revenue into "real" revenue helps an organization better understand what its losses really are.

Using existing reserve management information systems, Silveria can get a sense of why claims aren't generating the expected revenue and the degree to which this is happening. However, he can't see if certain procedural codes are being denied.

That's because many older hospital billing systems cannot attribute a denial to a specific line item—such as a procedure or diagnosis code—in a claim, Silveria says. Payer denial notices often do not get down to the line-item level. While the 835 remittance advice transaction—one of the transactions standards of the Health Insurance Portability and Accountability Act—gives line-item level data, older billing systems don't always recognize it, he adds.

So, a hospital may bill \$100 and get \$50 paid, and the remaining \$50 denied for an unbillable diagnosis. At many hospitals, staff members then must manually find the diagnosis that was denied.

This spring, Partners began a roll-out of the Reserve Analytics Application from MedeFinance Inc., Emeryville, Calif. The application is designed to enable an organization to analyze its entire receivables portfolio to more accurately determine how much can be collected.

The goals, Silveria says, are to centralize and standardize reporting to analyze claim denials and rejections from each individual payer; use the detailed data in HIPAA 837 claims and 835 remittance advice transactions to determine how charges map to procedure codes,

and do a better job developing reserve positions.

"You can take 837 and 835 data as the payer sees it, to see how the payer adjudicated the claim," he explains. "Did they cover all the lines, or change or eliminate them? You can find patterns."

Once a provider organization better understands how a payer's adjudication process works and identifies patterns, the organization can use the payer's own data from a remittance advice and seek a different adjudication outcome.

"We have found things that were just plain wrong and costing us money."

"If you're losing \$6.97 on a particular code, you can find that out and work with the payer to determine a better way to adjudicate that code," Silveria says. As Partners rolls out the MedeFinance application and becomes comfortable "with what the data is telling us," Silveria has more plans for the technology.

"I already can see that a payer turned around a claim within 21 days, but I want to know how much of that is still unpaid after 90 days," he says. "I want to really start talking meaningfully to the payer and to build up the relationship."

The provider already is finding benefits to better understanding its reserves. "We've been able to go after some payers with specific issues," Silveria says. "We have found things that were just plain wrong and costing us money."

Over time, he believes Partners HealthCare will be able to significantly lower the dollar amount threshold of claims worth fighting for. "If you have a \$5 occurrence but it is happening thousands and thousands of times, it's prob-

ably worth going after."

Another goal is to get more detailed rules put in payer adjudication engines—justified by hard data—when contracts come up for renewal, Silveria says. "We've already started having those discussions."

Revolution or bust?

Many new-generation financial applications were developed to improve the old ways of doing business. But some organizations are installing software in anticipation of significant changes in business as usual.

For example, some large health insurers are starting to offer health savings accounts and health reimbursement arrangements as their employer customers shift the health insurance programs toward consumer-directed health plans.

A 2004 survey by New York-based consulting firm Mercer Inc. showed 43% of responding employers were likely to offer one or both types of accounts in 2005, with 72% expecting to do so by 2006.

In the past year, software vendors have introduced applications to help insurers manage such accounts. Payers are starting to buy these products, but in many cases, few members have actually signed up for health savings accounts or health reimbursement arrangements, particularly HSAs, says Jacob Kurlyan, M.D., president and CEO of Physmark Inc., a Dallas-based vendor.

"Vendors are selling, but payers are still waiting for the market to develop," he adds. "They're forced to offer these plans because their large employers want them in the mix."

There is little evidence that consumers are yet embracing the highly-touted new insurance options, says Pat Kennedy, president of P.J. Consulting Inc. of Rockville, Md., which specializes in serving payers. He estimates no more than 7% of consumers have an HSA.

So are insurers developing new programs and buying software for a market that may not emerge? A late 2004 survey of 28 large payers by Reden & Anders Ltd. found that 84% of responding

payers believe consumer-directed products will dramatically change the health insurance market.

But Kennedy believes the hype is overblown. "Everyone thought consumer-directed health would change the world—it won't," he contends. "If you are in the business of servicing employers, you have to offer these options. But it won't have a significant impact on the health care market."

Kurlyan believes insurers are distracted by consumer-directed health and are buying information technology to support the programs at the expense of other I.T. projects.

Kennedy doesn't see payers neglecting their other I.T. needs. Because payers can outsource management of consumer-directed programs, launching them may not take a lot of effort, he

notes. "I just see this as an extra thing they have to do."

Blurring the lines

Even as new financial and administrative applications gain footholds in the health care I.T. market, they may be eclipsed themselves by an emerging class of "morphed" applications, some experts predict.

As the health care industry adopts standards that promote information systems interoperability, providers could see new information systems that blur the line between clinical and financial/administrative procedures, says Rachel Foerster, principal at the Beach Park, Ill.-based consulting firm Rachel Foerster & Associates Ltd.

Some vendors already offer combined clinical and financial information systems

for hospitals and physician practices that run off the same database. Widespread interoperability eventually could make this a common practice, Foerster believes. "You won't have to buy disparate systems, or best of breed," she says. "Vendors will offer integrated modules across an entire enterprise. You won't have data stored all over the place in disparate databases."

This will make it easier for clinicians and staff to access any information they need—such as eligibility and benefit determination data while discussing a possible procedure with a patient in the examination room, Foerster adds.

However, she cautions that such interoperability is not around the corner. "It's going to be a long, long time until we get to that point." •