

Claims Automation In a New Environment

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Providers and payers who want to automate more transactions face many challenges, including a major change in the clearinghouse market.

By Joseph Goedert, News Editor

When a physician refers a patient to a specialist, the patient often arrives at the specialist's office before the requisite clinical and administrative information. This is not a "dirty little secret" in health care. It's a fact of life.

St. Joseph Health System, however, is combating this problem by using electronic data interchange technology to automate the flow of information among physicians. It's rolling out Web-based referral management software from Irving, Texas-based Healthvision Inc. And half of the delivery system's 300 primary care and family physicians already are using it.

The software automates verification of eligibility for specialist treatment, transmits the referral request to a utilization review manager if necessary, and automatically updates St. Joseph's practice management software, says Larry Stofko, vice president of strategy and innovation at the Orange, Calif.-based delivery system. The software then links-via URL Web site addresses-transcribed reports, laboratory reports and other inpatient clinical data to the referral before transmitting it to the specialist.

Like St. Joseph Health, many other provider organizations are using EDI for far more than claims submission. For example, they're using EDI to check patient's insurance eligibility, to inquire about the status of a pending claim, and to receive and post electronic remittance advice to patient accounts.

One catalyst for the growth in these and other claims-related electronic transactions is the HIPAA transactions and code sets rule. But the promised cost-saving benefits of the HIPAA rule's so-called "standards" have not yet fully materialized-nor will they until the transactions are truly standardized, many experts say.

"I'm in meetings where someone asks, 'Aren't these already standardized, since we did all that work?'" laments Stofko. "And the answer is 'No'".

The HIPAA rule actually permits payers to add optional data elements to standard electronic claim forms, resulting in hundreds of versions of a "standard" format and hampering the industry's ability to improve efficiency through standardized claims. Consequently, some observers fear that the proposed national health information network would not yield anticipated efficiencies unless its voluntary standard clinical data elements become mandatory.

Competitive landscape

In recent years, there's been a slow, steady shift toward providers submitting claims to payers directly over the Internet, bypassing claims clearinghouses. But still, the vast majority of claims travel from a hospital or a clinic to a clearinghouse, which typically edits claims and then routes them to appropriate payers. And many clearinghouses are handling a growing list of claims-related

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transactions and offering other new services in hopes of convincing providers not to file claims directly via the Internet.

One change last year in the claims clearinghouse competitive landscape could have major consequences.

Elmwood Park, N.J.-based WebMD Corp., which operates the nation's largest claims clearinghouse, is changing its business relationships with other clearinghouses.

For many years, these other clearinghouses have routinely routed claims destined for certain payers through the WebMD clearinghouse, which has served as an extra middleman. That's because the WebMD clearinghouse (formerly known as Envoy and NEIC) has well-established links to these insurers, some of which date back to the 1980s.

In the past, the other clearinghouses shared in the transactions fees that WebMD received from payers. But last year, WebMD signed "exclusive" or "near-exclusive" contracts with at least 10 payers. These include Aetna Inc., Cigna Healthcare, Horizon Blue Cross and Blue Shield, John Deere Health and Medical Mutual of Ohio.

An exclusive contract means a payer will accept electronic claims-excluding those directly submitted by providers-only through WebMD. Some payers signed near-exclusive contracts to send most of their claims through WebMD, but they maintained connections with a small number of other clearinghouses.

In the late '90s, WebMD started signing payers to exclusive contracts but continued to share the revenue from these payers with other clearinghouses. What's different now, payers, industry observers and other clearinghouses say, is that WebMD has negotiated substantially reduced transactions fees with its exclusive and near-exclusive payers. To make up the funds, it has reduced the revenue sharing with other clearinghouses to a fraction of what it was, or has eliminated it altogether.

As a result, a clearinghouse that, for many years, may have gotten 15 cents for sending a claim to a payer with WebMD as an extra middleman now may be getting only five cents, if anything, some observers say.

For its part, WebMD acknowledges that it lowered its fees to payers in a number of its new contracts in 2004. But the company has not lowered fees across the board, says Kevin Cameron, CEO.

If WebMD now gets less revenue from a particular payer, "we're taking that hit, and so are the other folks in the process," he says, referring to other clearinghouses that funnel claims through WebMD and now get lower fees.

Misys Healthcare Systems, Raleigh, N.C., operates a clearinghouse that has seen a significant decline in its revenue as a direct result of WebMD's new contracts, says Ray Eearmitt, vice president of sales and marketing for the transactions services unit.

The Misys clearinghouse serves physicians using its practice management software. Misys is one of WebMD's largest submitters of claims.

Now, Misys has sent a letter to WebMD terminating its contract with the company. Misys expects to connect directly to many payers; it recently linked with Minneapolis-based United Healthcare Group.

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It also will use the payer connections of other clearinghouses. Misys hopes to ink a new contract with WebMD, under which it would submit far fewer claims to the WebMD clearinghouse.

Forced fees

One potential impact of WebMD's new payer contracts, observers say, is that other clearinghouses will be forced to raise their fees to make up for the lost revenue.

"Although we would hope to see the health plans pass on their savings to providers and/or consumers, this is unlikely," says Robert Tennant, senior policy advisor at the Medical Group Management Association, Englewood, Colo., a trade organization for group practices.

"Clearinghouses are going to have to increase their fees levied on providers to make up the loss in revenue."

"Providers will foot the bill for WebMD," adds Charlotte Martin, president and COO of Gateway EDI Inc., a St. Louis-based clearinghouse. "Payers are subsidizing the cost of electronic claims. If they don't, someone will have to pay it. We're not nonprofits."

Gateway funnels only about 10% of its claims via WebMD, and Martin does not expect to raise fees. No clearinghouse executives interviewed for this story acknowledged they will have to raise fees; some said the decision has not yet been made.

But if a clearinghouse's business model is predicated on reimbursement from WebMD, they could be in trouble, says James Brady, president and CEO of Payerpath Inc., a Richmond, Va.-based clearinghouse. "Changing economics are causing some clearinghouses to reconsider their business model. Too many clearinghouses have relied heavily on WebMD reimbursement."

ProxyMed Inc. of Atlanta is particularly vulnerable to the possibility of reduced revenue as WebMD's new contracts kick in, the company acknowledges. Through acquisitions, however, the company is changing its business model to provide a variety of cost containment services to payers, says Nancy Ham, president and COO.

These services, including claims repricing, automated inputting of provider demographic data into an adjudication engine, and automated eligibility determination before a claim is put in an adjudication engine, result in cleaner claims being submitted-and higher automated adjudication rates, Ham explains.

The revenue from these services-and from electronic prescription transactions-should far exceed revenue lost because of WebMD's new payer contracts, she contends.

Still, WebMD's new relationship with some payers does not bode well for other clearinghouses, especially as providers start adopting additional transactions, Ham believes. "If payers cut revenue streams to their connectivity partners, those partners have to make a living and there inevitably will be some cost-shifting to providers."

The payer view

Health insurers with exclusive WebMD contracts continue to accept claims directly submitted from provider organizations, notes Paul Keyes, director of EDI service operations at Cigna HealthCare, Bloomfield, Conn.

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The insurer offers free to providers software from Middletown, Conn.-based Post-N-Track Corp. to submit claims directly, and receive acknowledgements, claims status and remittance advice transactions back from Cigna.

However, several payers privately acknowledge they now are paying WebMD significantly lower transaction fees-up to half the previous rate. Some say they were not aware that WebMD's vendor partners were bearing the brunt of the discounts, or that other payers were signing similar contracts.

But the reality is that in recent years, EDI transaction fees have fallen sharply in various industries, but not health care, says Chuck Emery, CIO and senior vice president at Horizon Blue Cross Blue Shield of New Jersey, Newark. "I would contend that if you are a clearinghouse operator, your costs should be going down," he says. "If you haven't figured out how to reduce the cost line, you're going out of business."

Lower transaction fees are not the only efficiency insurers get out of the WebMD contracts, Emery notes.

The Blues plan now gets all electronic claims through WebMD except those that providers-particularly hospitals-directly submit. That means the plan is not maintaining connections with multiple clearinghouses.

"Every interface requires maintenance," Emery says.

Further, an exclusive clearinghouse arrangement will ease the costs and headaches of reprogramming and testing each time the HIPAA transactions are changed, says Keyes of Cigna. "As HIPAA is updated, if you're dealing with one clearinghouse you have one work effort to do."

Moline, Ill.-based John Deere Health previously connected to three clearinghouses but now links only through WebMD. "There's a lot of cost and overhead associated with dealing with three clearinghouses," says Kenneth Marinangeli, manager of e-business.

In addition to WebMD concerns, many clearinghouses face difficulties as providers increasingly use the Internet to communicate directly with payers, Marinangeli says. "In three to five years, clearinghouses will have to change their business model to get revenue from new sources."

Emery acknowledges the new contracts with WebMD have their pros and cons. For instance, the efficiencies are offset by heavy reliance on a single vendor and risks associated with less competition.

Fewer choices?

WebMD's new payer contracts are in various stages of implementation. Some clearinghouses, for instance, won't lose their direct payer connections for several months.

Consequently, many providers haven't seen an impact yet and, depending on how dependent their clearinghouse is on WebMD, may or may not see increases in their clearinghouse fees.

The problem, says Philip DeAngelis, director of reimbursement services for Great Valley Health, the physician services organization of Bryn Mawr, Pa.-based Main Line Health, is if the changing EDI environment results in leaving only one or a few large clearinghouses still in business.

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"We see a danger of little or no competition. Our clearinghouse, and other small ones, give a level of service we don't see from the larger clearinghouses," he contends. Great Valley uses the services of NaviMedix Inc., Cambridge, Mass.

The possibility of less competition also concerns the American Medical Association, which has sparred with WebMD in the past year over the quality of its services to physicians.

In a statement to *Health Data Management*, AMA President John Nelson, M.D., said, "The AMA believes that the needs of patients are best served by free market competition and free choice by physicians of the vendors that they may wish to use for electronic transactions in the health care system. The AMA would be concerned if agreements among vendors and health plans foreclose access of physicians to all the potential services offered by vendors in a competitive marketplace."

Sour grapes?

WebMD portrays the controversy over its new payer contracts as overblown. "There are some competitors who have gone to great lengths to make this an issue," says Cameron, WebMD's CEO.

A number of other clearinghouses competed against WebMD for some of the new payer contracts, Cameron notes. "For these people to be critical now is somewhat ironic," he adds.

For many payers, the percentage of claims they receive electronically from providers-and the price they pay for these automated claims-has not appreciably changed in the past four or five years, Cameron says.

Building and maintaining a clearinghouse connection is costly for payers, Cameron says, and many payers have yet to see a payback on this investment.

One reason for the lack of payback is that too many claims contain errors or omissions, so they cannot be auto-adjudicated.

As a result of recent acquisitions, WebMD now can offer payers a variety of services to better "clean" claims and apply consistent edits, which results in higher auto-adjudication rates, Cameron contends.

WebMD believes improving service to payers will benefit providers by lowering the amount of problem claims being rejected and returned, reducing provider re-keying of explanation of benefits data in practice management systems and bringing other efficiencies that lower costs, Cameron says. "There's a lot of rework that occurs in provider offices."

Technology expands EDI boundaries

Some Blue Cross and Blue Shield plans are starting to test-with patient permission-sending physicians a patient's medication, laboratory, procedure, diagnosis and surgical histories, along with the reply to an electronic insurance eligibility inquiry.

That's one way that health care electronic data interchange soon will move beyond the transmittal of claims and related transactions, says Patrick Kennedy, president of PJ Consulting, Rockville, Md.

He also envisions payers sending preventive care reminders with eligibility replies, and one-stop "EFT clearinghouses" to facilitate electronic funds transfer and remittance advice transactions

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between payers, banks and providers. "A doctor isn't going to want to sign up for EFT with dozens of payers."

Insurers and third party administrators also need new technologies to automate transactions, especially as more consumers use health savings accounts, health reimbursement accounts and similar programs.

Self Insured Plans of Naples, Fla., helped software vendor The TriZetto Group Inc., Newport Beach, Calif., develop an application to automate health reimbursement account transactions. These include reconciling a claim against a patient's HRA account to ensure the patient has enough funds, deducting the funds and cutting the check for the provider.

The software enables Self Insured Plans to adjudicate nearly all claims involving an HRA within a day, compared with up to two weeks through manual processes, says Stephen Rasnick, president and CEO. Further, the company received a return on investment within two months because its cost per transaction fell from \$2.50 to about 60 cents. "These are fixed cost savings that go right to the bottom line and allow us to be more aggressive in pricing," Rasnick says.

Some insurers, including John Deere Health in Moline, Ill., see real-time claims adjudication as a way to improve provider relations and also support health savings accounts. "You really need real-time adjudication to properly determine an HSA member's responsibility for a service," says Kenneth Marinangeli, manager of e-business.

Other new or emerging EDI services include:

National Electronic Attachments Inc. of Atlanta since 1998 has facilitated the electronic exchange among dentists and payers of X-rays, periodontal charts and other attachments to support claims. About 135 of 400 dental payers now accept electronic attachments using the vendor's service, says Thomas Hughes, CEO. Now, the company is pilot testing an electronic attachment service with medical payers, starting with several Blue Cross and Blue Shield plans that are part of WellPoint Health Network, Woodland Hills, Calif.

NextGen Healthcare Information Systems Inc., Horsham, Pa., this year will test electronic attachments for Medicare claims with Empire Medicare Services in New York. Such tests, using the ANSI 275 and 277 standard transaction sets, could make a forthcoming HIPAA electronic attachments standard easier to implement, says Tim Eggena, a vice president with NextGen, a vendor of physician practice management and electronic medical records software. "Let's go pilot this before the rule's finalized and see how it works."

The Council for Affordable Quality Healthcare, a consortium of health insurers, in 2004 accelerated the rollout of its Web-based, uniform physician credentialing service, now available in 48 states. The council also has expanded the program to include the nation's 800,000 allied health providers.

Atlanta-based Navicure Inc. recently introduced software that uses data from electronic remittance advice transactions to simplify creation of secondary claims. Making the task easier means providers can afford to submit secondary claims for smaller amounts than they previously would have bothered with, says James Denny, president.

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Industry awaits HIPAA's promise

More than eight years after Congress enacted the Health Insurance Portability and Accountability Act, the promise of its administrative simplification provisions have not been realized, providers, payers and others say.

In part, that's because the rules process was slow and all sides had difficulty implementing the complex standard claim forms. But the big reason is because the claims still aren't standard. The transactions include a variety of optional data fields, enabling payers to customize claims to meet their business needs. This has resulted in providers and vendors not only having to follow requirements of the claim transaction implementation guides, but also hundreds of payer "companion guides" that show how individual payers want their claims formatted.

HIPAA was implemented well after electronic claims were the norm and the best intentions of the law ran into established business practices of health insurers. "HIPAA was a great idea, it was just 25 years too late," says Charles Emery, CIO and senior vice president at Blue Cross Blue Shield of New Jersey in Newark.

But even many payers recognize companion guides must have a limited future, or at least be drastically scaled back. "We have to tighten the transactions," says Kenneth Sidon, CIO and executive vice president of Cleveland-based Medical Mutual of Ohio. "We're miles ahead of where we were, but there's still too much variation out there."

HIPAA's rules have cost providers and payers dearly in time and money, but some benefits are starting to show. Providers, for instance, increasingly are taking advantage of the eligibility and claim status transactions. "We have a big opportunity there," says Edward Gallo, vice president and general manager of the hospital business unit at NDCHealth Corp., Atlanta.

Further, HIPAA's privacy and security rules have clearly enhanced the protection of electronic transactions and resulted in the Internet becoming a common conduit for electronic claims and related transactions.

The forthcoming national provider identifier mandated under HIPAA will substantially benefit providers, says John Osberg, president of the Marietta, Ga.-based consulting firm Informed Partners LLC. "It's poised to quickly show benefits if done properly."

Because the standard ANSI 835 remittance advice transaction facilitates automated posting of payments to patient accounts, providers now can "smell" the benefits that HIPAA can bring, says Tim Eggena, a vice president for software vendor NextGen Healthcare Information Systems Inc., Horsham, Pa.

Further, dealing with HIPAA transactions has forced providers to increase the skill level within their billing departments, and now they want to use the transactions more, adds Ana Croxton, NextGen's claims product manager. "The providers have reached another level of knowledge and ownership in this process."

Sending HIPAA claims to payers and using the other transactions is speeding payment and improving cash flow for physicians aligned with Great Valley Health, the physician services division of Main Line Health, Bryn Mawr, Pa.

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That's because under HIPAA, payers have to be able to accept electronic HIPAA transactions, says Philip DeAngelis, director of reimbursement services. "We definitely see improved liquidity in our receivables. We're having much quicker turnaround."