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DESIGNING THE HEALTHCARE FINANCIAL NETWORK OF THE FUTURE • VOLUME 3 • NUMBER 1

## Health IT leaders consult with World Bank

**N**O ONE DENIES the vital role health IT plays in our country's healthcare system, or the vital role it will play in helping to revamp both how care is paid for and delivered. The same is true in the developing world and, to help speed that process, the HIMSS G7 will hold the first ever Health Information Technology Consultation with the World Bank, Feb. 23 at HIMSS12 in Las Vegas.

The World Bank already works directly with four other industry groups representing hospitals, pharmaceuticals, insurance and medical devices in a consulting capacity as it looks to develop policy for these areas in the developing world.

To help shepherd this effort within health IT, John Casillas, HIMSS' senior vice president of business centered systems, was recently named a World Bank Fellow – a liaison between health IT companies and the World Bank.

"We wanted to have an industry World Bank Fellow, who will be the key portal between the industry and the bank," said Alex Preker, head of

the Health Industry Group, World Bank. "The idea of the fellow is to have someone in the industry who could openly discuss the business interests and allow us at the World Bank to discuss the development interests."

At the meeting in Las Vegas, the idea is to get the ball rolling and allow health IT CEOs to learn about the opportunities that exist for their products and services that are in line with the World Bank's healthcare efforts in developing countries.

"What we will be doing at this first meeting in Las Vegas is providing information to the industry and coming up with a common agenda for how to move ahead," said Casillas. "We hope to be able to leverage World Bank to gather information on the policy factors in (developing countries) that can sometimes get in the way of doing business and to provide a good voice for the industry."

Preker agrees that the wide range of policies and market conditions inher-

ent in doing business in the developing world can often bog down a company looking to expand its markets.

"One part of what we do is to let companies know where the potential markets are and to help them understand how to penetrate those markets," said Preker. "But it is also for us to help the industry understand that developing countries have special needs and what might work in the U.S. won't necessarily work in

sub-Saharan Africa, and what works in sub-Saharan Africa won't work in East Asia."

One big reason to further develop the working relationship between HIMSS and the World Bank is directly related to the bank's commitment to fund health IT initiatives as part of its development work, Casillas noted.

"They have committed about \$1.5 billion to the development of health IT," Casillas said. "This is one way they can make sure the money for that is being spent appropriately." ■



Alex Preker



John Casillas

## The changing role of data in healthcare

**Q&A: William D. Kirsh, DO, MPH**  
Chief Medical Officer, Sentry Data Systems

**W**ILLIAM KIRSH HAS MORE THAN 20 years of medical and business experience. Kirsh is involved in the development of Sentry's products where he lends his clinical and healthcare financial expertise. Kirsh recently took time to discuss the changing role of data in the healthcare system.

**Q: You say that we need to move from numerator data to denominator data in healthcare. What does that mean?**

**Kirsh:** Numerator data is event data, events that may have happened to an individual. The next evolution is to look at the population being served – the denominator – and the environment the population is in in order to develop a service model for that population. It is population-based medicine. The population could be very small, such as ones by a diseases state or location, but it is still denominator medicine. So, the information that goes into it is a little different than going to collect somebody's events that have taken place. There is a big distinction between the 1990s and the 2000s in that we are moving aggressively away from numerator medicine toward denominator medicine.



William D. Kirsh

**Q: Why is looking at huge volumes of aggregated data important in terms of improving healthcare and moving to denominator data?**

**Kirsh:** Organizations live and die by their data, but think about taking that data to the next level and being able to identify sub-segments of a population where there are adverse risks to the delivery of medication, for instance, and realize that this population is very valuable. This is because you can begin to see populations genetically that medications can be developed for. You need to be able to look at large sets of data in order to pick out those small aberrant populations and it is those aberrant populations that are valuable. But you can't identify these populations by looking at data in a small way.

**Q: Do large IDNs have enough data in-house to effectively manage the new payment and care delivery models?**

**Kirsh:** No. Data is only as good as a reference point. I can get a lot of data and turn it into some kind of a graph, but unless I have reference points, it won't mean anything. To get reference points you, would need to have other IDNs that are aggregating their data and are sharing it, in order for an IDN to get some premise of where they are as compared with some standard. They could just set their own standard and say they are going to reach that. But, when you look at financial performance and outcomes, you can't just set your own standard; you have to look at what outcomes are taking place broadly. ■

## Medical Banking in the Lime Light

By John Casillas, Senior Vice President, HIMSS Business Centered Systems

**T**HE NEW HEALTH CARE ELECTRONIC FUNDS TRANSFERS (EFT) federal rule effectively addresses multiple complex issues in the medical banking domain yet some policy issues remain. In crafting the regulation, the authors employ a series of zones, corresponding to the typical journey of an electronic payment from payer to payee – a framework that is similar to one widely published by the Medical Banking Project in 2001. The opportunity for efficiency is significant; yet the application of policy can be daunting. However, the authors of the regulation masterfully used a three-zone framework to explain this.

**ZONE 1** of the framework looks at the actors, technologies, policies and business processes that comprise the fabric of "health plan to bank" payment transmissions. The authors of the rule stress this is the *only* area where the new Health Care EFT standards apply.

**ZONE 2** of the journey is "bank to bank" transmissions; namely, the series of financial institutions and networks that move the payment to the provider's bank – from originating depository financial institution (ODFI) to automated clearing houses (ACH networks) to receiving depository financial institutions (RDFI). Zone 2 often involves two key areas – the Federal Reserve System and The Clearing House. According to the Banker's EDI Council, in 1996 there were 40 ACH networks between banks, most of which comply with operating rules created by NACHA – The Electronic Payments Association. There are, however, some large bank ACH networks that are private and have their own system of rules.

**ZONE 3** is the area between the healthcare provider's bank (RDFI) and the provider itself. If the other areas are done right the healthcare industry will experience substantial value in Zone 3. It not only marks the end of the payment journey, crediting the provider's operating account, but also is where the work of the business office begins by using the payment's associated remittance information for patient account processing. If the data associated with the payment is intact (and its often not), the provider can automate workflows and fuel business intelligence that strongly impact performance. In just this area alone, HIMSS Medical Banking Project measured a \$35 billion impact that transfers real value from paper-based payment processing to a digital platform.

A caveat in the rule is its application of HIPAA in Zone 1. The rule suggests section 1179 of the original HIPAA statute exempts banks when they perform routine banking services – and it does so specifically *when financial institutions perform banking services for other financial institutions or Zone 2 of the framework (not Zone 1)*. The section goes on to list what these services might be, all of which clearly apply to EFTs and not electronic remittance advises. This distinction is an important area of policy.

National banks are only permitted to perform services that are authorized by the Office of the Comptroller of the Currency (OCC). These services have grown through the years and of key importance, *now include medical claims processing*. Along these lines, the Federal Reserve has made an equivalent ruling. Thus if we follow the logic of the commentary in the Health Care EFT rule, even if the banking service was medical claims processing, it would be exempt thus creating two classes of healthcare clearinghouses – those required to comply with HIPAA and those that don't. This clearly wasn't the intention of Congress as stated in the legislative history of section 1179, which indicates the exemption was granted solely for consumer-initiated payment transactions like checks and credit cards, and not business-to-business payments. In this respect, the authors of the Health Care EFT rule seemed to have gone askance in the application of policy. ■

Continue reading John Casillas' assessment of the new Health Care EFT federal rule on HIMSS Blog at [blog.himss.org/author/jcasillas2](http://blog.himss.org/author/jcasillas2).

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