STATE OF WASHINGTON

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

OLYMPIA OFFICE:
INSURANCE BUILDING
P.O. BOX 40258
OLYMPIA, WA 98504-0258
Phone: (360) 725-7000

OFFICE OF
INSURANCE COMMISSIONER

December 1, 2012

To the members of the Washington State Legislature:

It is my pleasure to forward the fourth progress report on the implementation of Second Substitute Senate Bill 5346 (2009) – Health Care Uniform Administrative Procedures Development. As in prior years, this report has been prepared by the Work Smart Institute on behalf of OneHealthPort and the Washington Healthcare Forum, the entities I appointed in 2009 to lead the work on the 16 initiatives required by the bill.

This year's report focuses on the processes and strategies used in 2012 to refine and promote adoption of the 2SSB 5346 initiatives. It has become clear that the complexity of the health care sector, plus the knowledge and technology gaps between smaller and larger provider organizations, are two major obstacles to the widespread adoption of the Provider Data Source (PDS) and the Best Practice Recommendations (BPRs) developed pursuant to 2SSB 5346.

This report also identifies another key issue and opportunity – the growing role of the federal administrative simplification efforts that are required by the federal Affordable Care Act (ACA). Provider and payer members of a workgroup facilitated by OneHealthPort have been actively engaged in the development of new national operating rules. This workgroup's contributions were included as a key component of the Interim Final Rule issued by the U.S. Department of Health and Human Services in August 2012, establishing operating rules for the HIPAA 835 Remittance Advice transaction.

In 2013, health care payers, providers, and the state will be working to implement the major insurance market reforms coming in 2014, especially those related to the establishment of the Washington Health Benefit Exchange. The challenge for health care providers and payers alike will be to successfully implement the ACA reforms while continuing to make progress on reducing health care administrative burdens and expenses.

I hope that you find this report informative and useful. If you have any questions, please feel free to contact me at (360) 725-7100.

Sincerely,

Mike Kreidler
Insurance Commissioner

Fourth Progress Report on the Implementation of SSB 5346

Submitted by:

work SMART INSTITUTE

A program of the Washington Healthcare Forum
Operated by OneHealthPort

December 1, 2012

Fourth Progress Report on the Implementation of SSB 5346 (2009)
December 1, 2012

I.   Introduction

This is the fourth progress report on the implementation of SSB 5346 (48.165 RCW
http://apps.leg.wa.gov/RCW/default.aspx?cite=48.165 and 70.14.155 RCW
http://apps.leg.wa.gov/RCW/default.aspx?cite=70.14.155) submitted to the Washington State
Legislature by the WorkSMART Institute and Insurance Commissioner Mike Kreidler. WorkSMART is
acting on behalf of the SSB 5346 Lead Organizations designated by Commissioner Kreidler, the
Washington Healthcare Forum and OneHealthPort. This progress report is designed as a companion
document to the progress reports dated December 1, 2009, December 1, 2010 and December 1, 2011.
As such, this report will not repeat the background information on SSB 5346, health care administration,
the lead organizations or the work accomplished in 2009, 2010 and 2011. This report will focus on the
progress made implementing SSB 5346 from January 1, 2012 thru November 1, 2012.

One of the key responsibilities assigned to WorkSMART and the Office of the Insurance Commissioner
(OIC) under SSB 5346 is transparent accountability. The OIC and WorkSMART have interpreted this to
mean the following;

- No secrets – all matters pertaining to the implementation of SSB 5346 are open to all interested
  parties.
- Public Reporting – on a regular basis WorkSMART shares deliverables, progress, challenges and
  opportunities with the OIC, the Insurance Commissioner's Executive Oversight Group (EOG), the
  Legislature, and Stakeholders.
- Simplified Access – make it as easy as possible for interested parties to find information about
  the implementation of SSB 5346.

To bring these principles to life, in 2011 WorkSMART enhanced its website and reorganized the SSB
5346 information. Because of the complexity and detail inherent in administrative simplification, the
enhanced website includes a number of dynamic tables. These dynamic tables are the best way to
display the progress in implementing the initiatives required by SSB 5346. Therefore, rather than simply
provide multiple pages of detailed static documents, this report will reference the WorkSMART website
with embedded links that provide the Legislature with direct access to the dynamic SSB 5346 materials.
In this context the following links provide key information relative to the progress on SSB 5346
implementation:

- All the SSB 5346 Best Practice Recommendations (BPRs) are online at
  http://www.onehealthport.com/worksmart/bproverview.php.
- Provider Data Service information is at
  http://www.onehealthport.com/services/providersource_live.php.
- Payer Adoption information is at:
  http://www.onehealthport.com/worksmart/wsadoptionmatrix.php.
- Provider Adoption information is at:
- http://www.onehealthport.com/worksmart/reporting.php.

In preparing this report for the Legislature, the Lead Organizations and the OIC recognize that the Forum, OneHealthPort and their health plan and provider stakeholders have been engaged in organized Administrative Simplification activities for the past 12 years. Since 2009, much of this work has been conducted under the auspices of SSB 5346 and the oversight of the OIC. Through HIPAA and beginning in 2010 with the Affordable Care Act (ACA), there is also a federal dimension to administrative simplification. Working for such a long period of time in a private sector context, under state law and within the federal regulatory process has given the participants unique insight and knowledge around the global issues related to Administrative Simplification. This report to the Legislature is organized around three global components, supplemented by the online information described previously:

- Process Model
- Solution Strategy
- Key Issues

Updates on specific SSB 5346 initiatives will be discussed in the context of these three major subject headings and in the final concluding section.

II.   Process Model

Simplifying health care administration is the stated objective of this work. However, in order to better understand the challenges stakeholders face, the tradeoffs around specific implementation decisions, and the process model that has evolved, it is important to dig another level down and more precisely identify what this effort is designed to achieve. At its core, the implementation of SSB 5346 has two related objectives:

- Reduce the complexity and variation of health care administrative processes without unduly impacting the underlying business requirements
- Satisfy the varying demand for administrative information by providers and plans

The issues around complexity and variation relate more strongly to process and will be addressed in this section. The issues around varying demand for information relate more strongly to solution strategy and will be discussed in the next section.

Complexity

A careful study of both public and private sector administrative simplification efforts over the past decade clearly demonstrates that the global approach to dealing with complexity is much more about coping with it than eliminating it. This direction is not the result of a conscious choice; it is related to limits on the scope of authority, the capability of the parties involved and the profoundly complex nature of the underlying system elements. In short, the coping strategy is the only realistic alternative for efforts like those sanctioned by SSB 5346.

The coping strategy developed to implement the solutions called for by SSB 5346 has one essential element that increasingly defines the nature of the process. That element is one of Continuous Quality Improvement (CQI). In SSB 5346 the Legislature directed that a CQI process be established. The Lead Organizations and the OIC have taken this to heart. As result the process model for implementing SSB 5346 has been evolving and currently has the following characteristics:

- Long term ongoing effort – To use a clinical analogy, the approach is similar to treating a chronic illness. There is no short term decisive "cure" or resolution. The time horizon is ongoing without a defined end point. This requires patience on everyone's part, alignment of expectations about results with the incremental nature of the work and ongoing support. To date the oversight of this work by the OIC and EOG has been well aligned with this CQI model. Similarly, the Washington Healthcare Forum has continued to sustain the cost of the work over the long term.

- No one gets it 100% right the first time – Even with dedicated, knowledgeable stakeholders building the solutions, the CQI process remains iterative. The effort is ongoing with repeated "PDSA" (Plan, Do, Study, Act) cycles. This cyclic trend is illustrated in Figure 1 below

Figure 1 – CQI Process
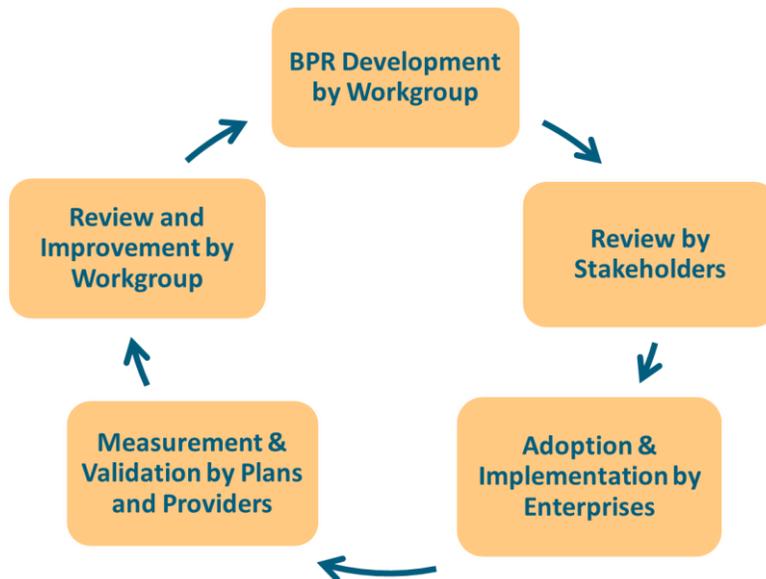
- <u>Measurement is the critical step</u> – "You change what you measure" is a familiar refrain to practitioners of quality improvement. As the SSB 5346 work has developed, the importance of measurement has become increasingly clear. While the importance of measurement is undisputed, the ability to measure Admin Simp progress is more problematic. In certain limited circumstances where a common service exists (e.g., the Provider Data Service - PDS), it is possible to measure progress centrally. However, in most cases where implementation occurs at individual provider and plan enterprises, the only way to measure progress is to leverage enterprise resources. Because enterprise systems were not designed with these measurements in mind, and because some solutions are easier to objectively measure than others, there are limited opportunities to assess Admin Simp progress effectively. The end result is that Lead Organization measurement efforts are being targeted at a limited set of the best suited SSB 5346 solutions. Furthermore, as priorities are being identified for outreach and adoption, the ability to effectively measure progress is an increasingly important determinant.

- <u>Validation, an evolving science</u> – Validation is the process where providers assess a payer's implementation of a specific Best Practice Recommendation (BPR), deliver constructive feedback to the payer and publish the results of their work to the broader community. Validation is a critical component of the CQI process. OneHealthPort's approach to validation has evolved in a manner similar to its overall approach to measurement. Early in the process the primary objectives of measurement and validation were accountability. The goal was to ensure that the payers were delivering required solutions as expected. While accountability is still important, the primary focus of measurement and validation has shifted to improvement. By delivering more descriptive information to the broader community, it increases the value of the solutions overall and better supports the CQI objectives. In fact, this shift in the validation model is entirely consistent with the second objective stated above; satisfying varied demands for information. In this case it is about providing more useful information about the implementation of the BPRs. Figure 2 below describes the evolution of the validation model to its current state:

Figure 2 – Validation Model Evolution
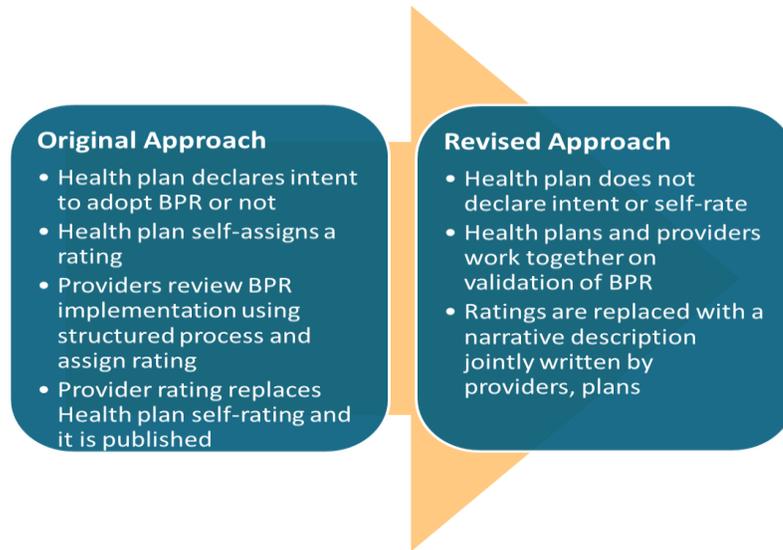
In 2012, using the new validation methodology the following BPRs have been or are currently in the validation process:

- Requesting/Receiving Coverage Information for Eligibility/Benefits (HIPAA 270-271)
- Browser Capabilities for Pre-Authorization & Admit Notification
- Processing/Reporting Remittance Information (HIPAA 835)
- Standard Coding of Denials and Adjustments for HIPAA 835 Remittance Advice Transaction
- Requesting and Receiving Claims Status Information (HIPAA 276-277)

- <u>Transparency matters</u> – Transparency is a critical aspect of the CQI process. First, SSB 5346 requires the Lead Organization to conduct its work in a transparent manner and the Memorandum of Understanding between the OIC and the Lead Organizations further highlights this requirement. Second, the shift from accountability to improvement in measurement and validation increases the importance of full disclosure. A high level of transparency ensures that overall visibility into the work being done is maintained and the performance of the parties is clear to all. Finally, in the marketplace transparency can stimulate increasingly higher levels of achievement among competitors each one striving to outdo the other and be the "best."

III.   Solution Strategy

SSB 5346 calls for development and adoption of a number of "solutions" designed to simplify health care administration. It is the responsibility of the Lead Organizations, with oversight from the OIC, to develop, implement and gain adoption of this solution set. To develop solutions for the transactions, web sites and policies, WorkSMART has adopted the Best Practice Recommendation (BPR) model described in pages 10-12 of the first progress report.
http://www.insurance.wa.gov/legislative/reports/AdminSimplification1.pdf

A BPR is a better way to get things done that is pragmatic and works for everyone. To address the other solutions called for in the bill, WorkSMART has deployed the Provider Data Service (PDS) and previously compiled reports on Medical Management and Retroactive Denial of Eligibility.

In 2012, driven by the measurement and validation process described previously and evolving capability in the marketplace, OneHealthPort has refined and improved its solution strategy. This refinement of the solution strategy links back to the high-level objective of satisfying varied demand for information.
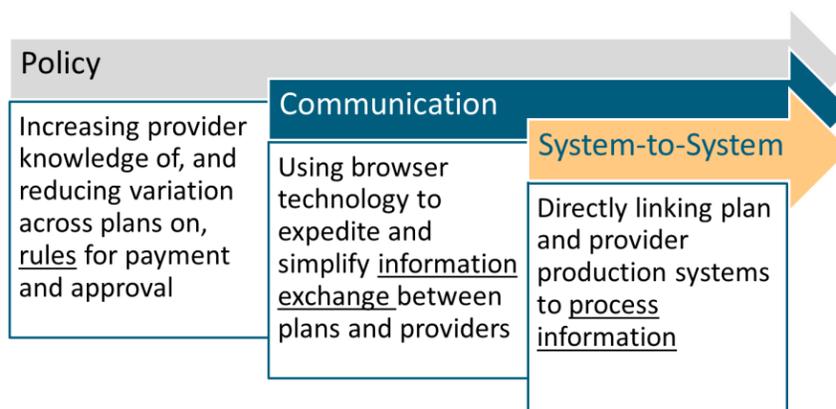
Satisfy the Varying Demand for Information

From a distance, simplification efforts often appear to be primarily about reducing complexity and variation. However, as solutions are developed and deployed, it becomes increasingly apparent that satisfying varied demands for information is just as important as reducing complexity. There are two general aspects of information demand that bear on SSB 5346 implementation activities:

- Transparency – Some of the BPRs acknowledge that variation in process and information exists across health plans and that disclosure is an important element in reducing complexity for providers. For example, in the BPR related to prior authorization, health plans are required to disclose all of their related policies on the "one-stop-shop" section of the OneHealthPort web site. This expanded visibility offers significant value to providers working across multiple conditions with multiple plans.

- Exchange – Payers have information that providers need and, in some cases, providers have information payers need. Gaining access to these information resources held by another trading partner through some form of exchange is the largest part of satisfying demand for information. The method of exchange can take a variety of forms which are explored below in Figure 3.

In looking backwards at the solutions developed to date and forward at trends developing in the market place and policies driven by state and federal regulatory activity a solution progression emerges that is illustrated in Figure 3.

Figure 3 – Solution Strategy

Policy
Increasing provider knowledge of, and reducing variation across plans on, rules for payment and approval

Communication
Using browser technology to expedite and simplify information exchange between plans and providers

System-to-System
Directly linking plan and provider production systems to process information

Policy solutions tend to be easier to deploy as they require less investment in technology. An example of a policy solution would be requiring payers to disclose the policies they use for medical management decision making and the policies on extenuating circumstances for prior authorizations.

Communications solutions introduce deployment challenges and timeframes as they require initial development and ongoing maintenance. An example of a communication solution is web site access to health plans' eligibility and benefits (E & B) information. Figure 4 below tracks the progress made in driving adoption of this solution.

Figure 4 – Provider Usage of E & B Websites
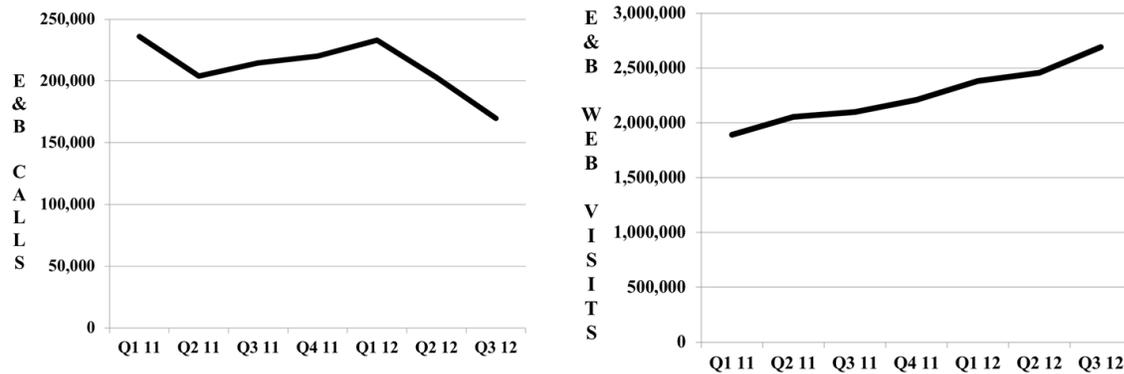
This data is contributed by four health plans (Molina, Group Health, Regence and Premera) and spans almost two years. It demonstrates some key indicators of progress:

- E & B phone calls have dropped by almost 70,000/quarter for these four health plans. With the combined cost of an E & B phone call between a provider organization and a payer at approximately $10, this reduction in calls reflects savings of close to $2.8 million/year (for these four health plans)
- Website usage is going up and has grown by close to 4,000,000 visits/year; this demonstrates strong adoption of this communication solution.
- As indicated previously, the goal is to measure progress. The ability to track E & B calls and web visits represent a significant advance in measurement.

System-to-system solutions have proven the most difficult to deploy as they require a) investment in information technology infrastructure by provider organizations and health plans and b) either mature information exchange standards or costly custom interfaces. In spite of these difficulties, the health industry on the whole is moving toward more system-to-system exchange in both the clinical and administrative areas. The reason for this broad movement is that system-to-system exchange is far and away the most efficient means to exchange large amounts of information across enterprises. It unites two disparate processes into one virtual process. By leveraging this broader trend of system integration, the Admin Simp program does not have to carry the full burden of driving adoption. A good example of a system-to-system solution is the Admit Notification Pilot summarized below:

- The pilot sits at the intersection of Admin Simp and the state sponsored health information exchange (HIE). The HIE will be used to standardize/automate hospital and health plan interactions on admit and discharge notices
- The piloted approach will satisfy the SSB 5346 best practice requirement around admit notification and it will also hopefully establish a low-cost reusable connection for ongoing plan/hospital information exchange
- Premera, CIGNA, Virginia Mason and Children's Hospital are the initial pilot participants
- The anticipated go-live date of the pilot is 11/14/12. OneHealthPort will begin recruiting additional hospitals and plans after initial pilot period

It is important to note that the three solution types displayed in Figure 3 are a progression, but an overlapping progression. This means for example, that system-to-system solutions are not a total replacement for communication and policy solutions. While providers may migrate over time from browsers to system-to-system solutions, in the near term it is expected that all three solutions types will be deployed simultaneously. . Bottom line, all three solution types are required to satisfy varied demands for information that are driven by information technology capabilities.

Some solutions cross-over and exhibit characteristics of multiple solution types. The Provider Data Service (PDS) is an example that incorporates elements of both communications and system-to-system. The Provider Data Service (PDS) is the solution implemented by the Lead Organization, OneHealthPort, for Section 6 of SSB 5346 (RCW 48.165.035) which calls for: *"…a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processe*s…" As described in the first progress report, OneHealthPort contracted with Medversant to deliver the PDS to Washington state practitioners, payers and hospitals. The initial rollout of the PDS occurred in late 2010. Progress over the last year has been uneven but is now trending in a positive direction. Figure 5 below illustrates the increasing rate of PDS provider adoption:

Figure 5 – Number of Completed Provider Records in the PDS
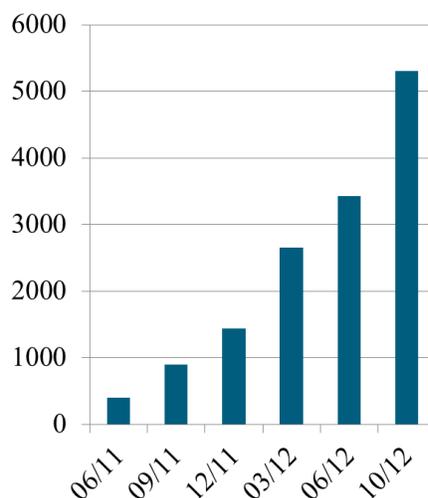
While this reflects important progress, there are a number of issues that still need to be addressed in order for the PDS to achieve its intended objectives:

- Most plans have executed agreements but their actual use of the PDS is ramping up slowly. The plans have agreed to work together promoting the PDS as the "preferred" solution but they still accept paper and other electronic solutions, which slows the pace of provider adoption.
- L & I has adopted the PDS to help build its network; this has given the system an important boost.
- A new release in November will enhance data entry by administrators acting on behalf of providers; this should help accelerate adoption by larger groups.
- Additional work needs to be done to encourage large provider groups who are delegated by their health plans to perform credentialing to participate in the PDS.

IV.   Key Issues

In assessing progress over the course of 2012, the OIC and the Lead Organizations have identified two key issues that are best discussed separately – Federal administrative simplification efforts and the knowledge gap.

A.   Federal Administrative Simplification Efforts

The Federal Affordable Care Act established several new federal administrative simplification initiatives. The Secretary of the Department of Health and Humans Services (HHS) is required to adopt Operating Rules for several HIPAA transactions, beginning with the Eligibility and the Claims Status transactions. The Operating Rules have to be developed based on input from payers and providers and recommendations from the National Committee on Vital and Health Statistics (NCVHS). HHS has designated the Council on Affordable Quality Health Care (CAQH) and its CORE program to lead the development of the first Operating Rules, using an approach similar to the "Lead Organization" model embedded in SSB 5346. http://www.caqh.org/about.php http://www.caqh.org/benefits.php

Independently and as a group, Washington State Business & Technology Workgroup members have been actively engaged in ASC X12 activities related to transaction standards and in CAQH CORE activities related to the development of National Operating Rules that govern how those standards are implemented. http://www.x12.org/   The results of Washington State BPR-related work for standardizing the usage of adjustment and denial codes on the 835-Remittance Advice transaction was adopted as the model for the Interim Final Operating Rule that was developed by a national workgroup facilitated by CORE. During 2012 Washington State stakeholders have provided direct feedback to NVCHS and CMS related to a) proposed changes in the national process for developing future operating rules and b) the finalization of Interim Final Operating Rules for the 835 Electronic Funds Transfer and Electronic Remittance Advice Transaction. To date, all of Washington State's recommendations have been adopted.

B.   Knowledge Gap

As indicated above, there is energy and movement across the provider and payer communities toward adoption of SSB 5346 solutions, particularly those that are technology based. Also, as described above, uptake in the use of browser based tools is increasing. And, at least anecdotally, there are reports of increased usage of HIPAA transactions, specifically the 835 – Remittance Advice transaction. Unfortunately, this uptake represents a relatively small percentage of the provider community. Not only are a majority of provider organizations not using these exchange tools, but more importantly they are making administrative and care decisions without the benefit of the information that comes with the use of these tools. In other words a "knowledge gap" is forming between a "leading" and "trailing" edge of the provider community that over time will disadvantage providers and patients while adding costs for payers. The knowledge gap is illustrated below in Figure 6.

Figure 6 – The Knowledge Gap
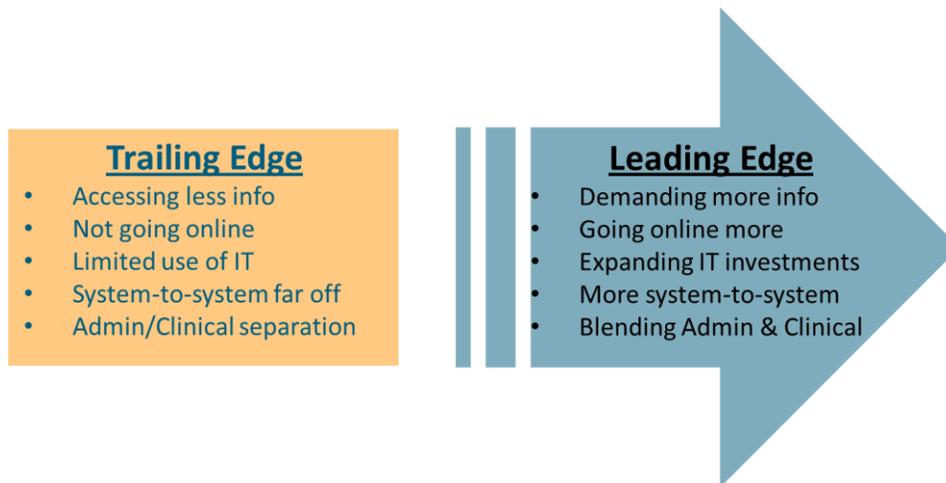
One way to measure the emergence of this knowledge gap is described in Figure 7 below. Figure 7 tracks the number of unique provider identities going online and accessing plan E & B web sites. The number of unique providers accessing the sites is relatively flat despite the fact that as illustrated previously, total web site visits have increased significantly. The implication is that the "Leading Edge" providers are accessing the websites more often while a number of the "Trailing Edge" providers are not accessing the sites at all. The dotted line "opportunity" indicates the scope of this potential knowledge gap for E & B web sites.

Figure 7 – Unique Provider Identities Accessing Plan E & B Web Sites

# of Unique Providers
Making E&B Web Requests
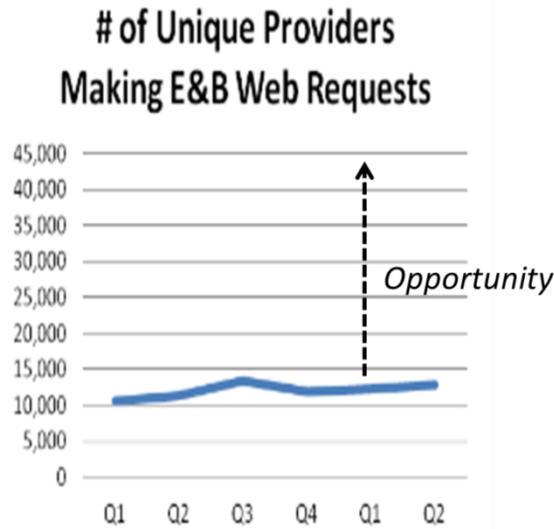
There are lots of reasons for this dynamic – not seeing the value of proactively accessing information from health plans, the difficulty in getting the word out across the provider community about new tools/approaches, the challenges of providing the requisite training, the inherent resistance to change and the cost of technology. These are all possible reasons for the development of this gap and there is no obvious single method to eliminate the gap. It is incumbent on the Lead Organizations to conduct additional research, seek a better understanding of this bimodal distribution of the provider community and work to move more providers from trailing to leading edge.

Ultimately it takes a willing partner to make change. The burden is on the Lead Organizations to adequately describe the opportunities for improvement that are available and to make it as easy as possible for enterprises to adopt these solutions. However, the best the Lead Organizations can do is deliver an opportunity for improvement to the door of the enterprise. The enterprise must be willing to embrace the opportunity and implement. It is possible that the knowledge gap is the result of conscious decision making on the part of the enterprises involved not to access information. If that is the case it will be difficult for the Lead Organizations to have much impact.

V.   Conclusion

As was noted in last year's progress report, the Lead Organizations are narrowing their focus to tasks and solutions that provide the maximum benefit to plans and providers and are consistent with SSB 5346's objectives. Figure 8 below highlights the priorities for 2013.

Figure 8 – Planned Priorities for 2013 Admin Simp Work

PDS	• Drive providers to create completed records • Drive plans to pick up completed records
Health Plan Portals	• Continue to increase usage for current adopters • Drive providers not using online services to portals
Prior Authorization	• Deploy, validate, gain adoption of browser solutions • Increase use of HIE for admit/discharge notices
CQI on BPR	• Continue to validate and improve BPRs • Establish/refine metrics
Federal/State	• Continue engagement with federal process to maximize alignment between federal/WA reforms
Other	• Explore interest in collaborative work on ICD 10 • Measure status of electronic remits

These priorities reflect the themes discussed in this report; continued refinement of the CQI process, engagement with Federal reform, and emphasizing PDS, Prior Authorization and Health Plan portals as the key solutions to promote. The Lead Organization will also make a specific effort to more precisely target outreach efforts at both current users of plan portals and those in the "trailing edge" who do not appear to be going on line.

The Lead Organizations and the OIC believe that tackling these priorities is the most likely path to making real gains in simplifying health care administration in Washington State. In support of this important work, the Washington Healthcare Forum has generously agreed to extend its financial backing of OneHealthPort's and WorkSMART's efforts. The Forum, OneHealthPort and the OIC look forward to continuing this unique public-private partnership to simplify health care administration in Washington State and are happy to address any questions the Legislature may have.