Report to the Governor and the Legislature
Top Five Health Care Administrative
Simplification Priorities,
and a Plan to Achieve Those Goals

December 1, 2008

Washington State
Office of the
Insurance Commissioner

Mike Kreidler - *State Insurance Commissioner*

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STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

December 1, 2008

The Honorable Christine O. Gregoire
Governor of Washington
PO Box 40002
Olympia, WA 98504-0002

Dear Governor Gregoire:

The 2008 Legislature directed my office to submit a report identifying "the five highest priority goals for achieving significant efficiencies and reducing health care administrative costs, and a plan to accomplish these goals."

This report reviews administrative problems created by our complex and fragmented health care financing system, identifies five areas where significant progress can be made, and presents a strategy on how to achieve results.

In addition to this formal report, I wanted to share some personal insights that I have gained through this process. I have acquired a new appreciation of the complexity of these issues, and I realize that no single entity can implement this level of changes on its own. Real change requires cooperation from all of the participants in the process – insurance carriers, providers, clinics, hospitals - and state government both as a purchaser and as a regulator.

I discovered that a great deal of good work has been done on administrative simplification in this state as well as in others. I found it encouraging that much consensus exists in the areas to be targeted for simplification and streamlining. I learned, too, that creating common standards and practices is only half the battle – ensuring adoption will also be a major challenge. While it is likely that most solutions will come from the private sector, I believe there is also an important role for government.

As these discussions have progressed, it has become increasingly clear that, while our efforts to improve administrative simplification are very important, they are much like putting an ice pack on a broken leg. While these efforts may improve the current situation, they do not directly address the underlying problems inherent in a fee-for-service system. But that conversation will have to wait for another day.

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

Executive summary

In 2007, as part of the Washington State Blue Ribbon Commission on Health Care Costs and Access, the Office of the Insurance Commissioner (OIC) prepared a report assessing possible avenues for reducing the administrative cost of health care. In that report, the Commissioner recommended that the state create a venue for administrative simplification efforts and seek increased collaboration with private sector organizations.

As a result, the 2008 Legislature directed the Commissioner to work with a cross-section of the health care industry to identify the top five administrative simplification goals, and create a plan to achieve those goals. This report summarizes the results of the ensuing eight-month effort.

The Legislature's charge to the Insurance Commissioner

In March 2008, the Legislature added funding to the OIC budget:

"for the insurance commissioner to convene a work group of health care providers, carriers, and payers, to identify and develop strategies to achieve savings through streamlining administrative requirements and procedures, as recommended in the [2007 OIC report]. By December 1, 2008, the commissioner shall submit a report to the governor and legislature that identifies the five highest priority goals for achieving significant efficiencies and reducing health care administrative costs, and a plan to accomplish these goals.[1]"

This report reviews recent administrative simplification activities and reports from both the public and private sectors. Using this work as a baseline, we identify five priority goals and provide background on the opportunities they present. We also lay out a framework for a formal public/private partnership to ensure that common standards and processes developed by the private sector are widely adopted in a timely manner.

For the purposes of this report "administrative functions" include most activities of health care plans and providers that are not part of the delivery of clinical care. This includes functions such as determining eligibility for insurance or other health plan coverage, determining covered services, submitting claims, processing claims, resolving appeals related to denied claims, provider credentialing, and collecting payments from patients. For health carriers, it also includes underwriting, marketing, commissions, provider contracting and relations, etc.

Functions that are directly involved with the delivery of clinical care – such as the use of electronic medical records or the development of interoperability standards for sharing medical records – are not considered "administrative functions." These aspects of the medical system are the subject of a tremendous amount of attention and activity, including the Washington State Health Care Authority's efforts to promote the use of electronic medical records in Washington state.

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1 Section 141, Chapter 239, Laws of 2008.

Administrative simplification – not so simple

Unfortunately, administrative simplification is not a simple task. As the Office of the Insurance Commissioner has become more involved with health care administrative simplification efforts, it has become clear that achieving significant efficiencies and reductions in costs will be a daunting challenge. This report has identified three significant challenges:

- Identifying unnecessary variations.
- Developing consensus around standardizing the variations.
- Reducing variations using only a voluntary process.

Administrative simplification– five priority goals

Using the nine priorities identified in the 2007 report as a starting point, the agency carefully evaluated similar studies and recommendations and work being done in other states to determine these five highest priority goals for achieving significant efficiencies and reducing health care administrative costs:

1. Establish a standardized process and central data source for provider credentialing and other provider demographic data needs.

2. Amend state regulations regarding coordination-of-benefits claims processing to eliminate estimated payment requirements.

3. Expand electronic sharing of patient eligibility and benefits information and efficient patient cost share collection processes.

4. Standardize use of pre-authorization requirements and introduce transparency of variations where standardization is not reasonable.

5. Standardize code edits and payment policies, and introduce transparency of variations where standardization is not reasonable.

A plan to achieve these goals

Washington state is fortunate that there has been a great deal of effort put into administrative simplification efforts by the Washington Healthcare Forum and its affiliates. While progress has been made, widespread adoption of their proposals has been challenging.

After our research, analysis and experience, we believe there are three key roles for government to play in support of this private sector work:

1. Ensure that all parties that should be involved in developing the common standards and processes have a reasonable opportunity to do so.

2. Bring state agencies that purchase health care or regulate carriers and providers to the table.

3. Supplement the private sector-led voluntary initiatives with regulatory requirements, where necessary, to encourage and enforce adoption.

In order to expedite health care administrative simplification in Washington state, a decision-making and implementation framework is needed – an organized structure for promoting collaborative and well-informed discussions and decisions, and for bringing about broad adoption of the common standards and processes necessary for administrative simplification and cost reduction.

By formalizing a public/private approach between affected entities, administrative simplification is more likely to occur with greater acceleration than if attempted on an ad hoc or piecemeal basis.

Conclusion

The Insurance Commissioner recommends that the state establish a formal public/ private partnership to develop and promote standards for simplifying health care administrative processes in Washington.

Legislation establishing the program should include:

- Clearly defined public policy goals.

- Goals for achieving a reasonable degree of standardization for certain key administrative functions.

- Specific timelines for reaching agreement on common standards and processes, and for their implementation.

- Identification of a principal state agency to provide support for collaborative efforts led by private sector payers, providers and other key parties.

- A requirement that state agencies that purchase health care services or regulate carriers or providers participate in the program.

- Authorization for state agencies to adopt into rule common standards that are created through collaborative efforts when necessary to achieve widespread adoption.

I. Background

Delivering health care - and paying for it - is a complex business.

In Washington state, administrative activities consume approximately 30 percent of the health care dollar. In 2007, the eight largest health carriers - Regence, Group Health Cooperative, Premera, UnitedHealth, Molina, Community Health Plan of WA, Kaiser and Aetna - wrote almost $10 billion in premiums for insured plans in this state. Approximately $3 billion of this was spent on administrative functions[2]. This does not include administrative expenditures related to funds provided by large self-funded employer ERISA plans (such as Boeing and Microsoft) or state and federal health care programs (such as Medicare and Medicaid). When all sources are included, more than $36 billion was spent in the health care sector in Washington state in 2007, about $6 billion of which was spent on administrative functions related to privately financed health care[3].

These administrative expenses are spread among thousands of entities in the state's health care sector, including more than:

- 100 hospitals and almost 300 ambulatory surgery centers, or other facilities that perform medical procedures on an out-patient basis.

- 23,000 licensed medical doctors and osteopathic doctors.

- 100,000 people licensed as other kinds of health care professionals – i.e., chiropractors, dentists, nurses, physical and occupational therapists.

- 100 licensed accident and health insurance companies offering hundreds of different health benefit designs and even more government health care programs and employer self-funded health plans.

These entities are subject to a complex web of regulatory oversight involving many state and federal agencies and rules:

- The financial solvency and operations of insurance companies and health carriers are subject to oversight by the state insurance commissioner.

- The licensing requirements for health professionals and the licensing and financial reporting responsibilities of hospitals are subject to oversight by the state Department of Health.

- The financial solvency and operations of employer self-funded plans are subject to oversight by the federal Department of Labor.

- The Medicare and Medicaid programs are subject to oversight by the federal Centers for Medicare and Medicaid.

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2 Source: Insurance Commissioner's Annual Report for 2007

3 The information in this paragraph is based on the conclusions in the Commissioner's 2007 report on administrative expenses.

In addition to this large number of providers and payers operating in a highly-fragmented regulatory structure, there are also thousands of private vendors providing a wide array of administrative support products, services and systems for state agencies, health care payers and providers.

A 2005 report by the Medical Group Management Association pointed out the administrative challenges that providers face:

> *"More than 1,000 companies offer health insurance products in the United States and each offer multiple products, varying in copayments, deductibles, and services covered and excluded. So, during each patient encounter, providers must verify each patient's eligibility, coverage and any copayment or deductible provisions each time the patient seeks care. Insurers' verification processes vary wildly and there is no standard content, format, or response time.[4]"*

A. Commissioner's Executive Oversight Group

In February 2008, Commissioner Kreidler established an Executive Oversight Group (EOG) to review health care administrative costs and make recommendations to him about the priorities listed in his office's 2007 report. The EOG is a representative, broad-based group whose members have authority to commit their organizations to specific changes and activities. EOG membership includes representation from carriers, providers, state government, and other health care industry organizations[5].

The role of the EOG is to advise the insurance commissioner on strategies to achieve savings through streamlining administrative requirements and procedures, and to ask questions and provide feedback on specific projects.

B. Private sector initiatives in 2008

1. Washington Healthcare Forum - OneHealthPort - WorkSMART Institute– Work Groups

The Washington Healthcare Forum is a coalition of several of the largest health care-related businesses in Washington state – primarily health plans, but also some provider organizations, hospitals and a business organization. Its mission is to streamline and simplify health care financing and delivery across the state and to advance a public dialogue on sustainable solutions to the challenges facing the health care system[6].

The Forum established a Network Advisory Group in 1999 to implement electronic solutions for exchanging information between health plans and providers, and the Administrative Simplification Steering Committee in 2000 to identify and address

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4 Source: http://www.mgma.com/workarea/showcontent.aspx?id=800

5   See Appendix D.

6 Source: http://www.wahealthcareforum.org/aboutforum/index.htm

opportunities to simplify the administration of health care. The steering committee work led to the development of 10 dynamic reports[7] and 23 policies/guidelines in three focus areas:

- Claims processing.
- Referrals and prior authorizations.
- Practitioner credentialing.

The dynamic reports provide a Web-based means for providers to look for information about the varying requirements that health plans have for several administrative functions. These policies and guidelines are voluntary and not all Forum-affiliated organizations have adopted them.

In 2001, as an outgrowth of the Network Advisory Group work, several members of the Forum formed a new corporation - OneHealthPort[8] - with the goal of improving health care efficiency and effectiveness by applying collaborative information technology solutions. Currently, the organization's primary mission is to promote the use of secure portal technology to support and accelerate the exchange of business and clinical information between health plans and providers in Washington state[9].

Because the work of the Forum and its affiliates has been based on consensus, and the adoption of agreed-upon guidelines and policies has been voluntary, progress has been slow and uneven. Following the Blue Ribbon Commission's interest in this area and the Commissioner's 2007 report, the level of activity in the private sector has picked up dramatically.

In 2007, the Forum contracted with OneHealthPort to provide leadership support for the Forum's health care administrative simplification work. This relationship was expanded in 2008 with the WorkSMART Institute program[10], the Forum's newest improvement effort, which will be managed and operated by OneHealthPort.

In collaboration with the Commissioner's Executive Oversight Group, OneHealthPort has created three workgroups to help carry out the work of the new WorkSMART Institute. Drafts of these groups' products are shared through a process that gives a wider group of organizations an opportunity to review and comment on recommendations.

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7 Included as Appendix A.

8 The founders of OneHealthPort include the Everett Clinic, First Choice Health Network, Group Health Coopera-tive, Premera Blue Cross, Regence BlueShield, Providence Health and Services, and Swedish Hospital. Subsequently the Washington State Medical Association and the Washington State Hospital Association also appointed representa-tives to the board.

9 Source: http://www.onehealthport.com/pdf/ohp_overview_tearsheet.pdf

10 A report describing the WorkSMART Institute is included as Appendix B.

- **The Business and Technology Workgroup**, formed in 2006, is comprised of about 25 Washington health plan and provider staff who have responsibility for information management, business operations and customer relations. The group has produced three work products: a companion document for HIPAA 835 transactions (remittance advice statements); best practices recommendations for providing enhanced HIPAA 270/271 transactions (health care eligibility and benefit inquiries and responses); and best practices recommendations for coordination-of-benefits procedures.

- **The Managing Patient Payments Workgroup**, formed in 2007, is comprised of about 40 health plan and provider staff knowledgeable about the process used to determine or collect patient payments. This group conducts most of its work in three subcommittees – a Western Washington hospital group, a Western Washington physician/clinic group, and an Eastern Washington combined group. The group has been reviewing possible technology, tools and work-process changes that providers can use to more efficiently and successfully collect the increasing patient share of payments.

- **The newest group**, **the Payment Policies Workgroup,** was formed in the summer of 2008, and is comprised of about 35 health plan and provider staff involved with claims payment policies and operations. This group has begun its work as two separate sub-groups – one working on issues related to pre-authorization requirements and processes, and another working on issues related to claims codes and edits.

II. What we've learned: significant challenges

A. Identifying the widespread variation in administrative standards and processes

As the Insurance Commissioner's Office has become more involved in health care administrative simplification efforts, it's become clear that achieving significant efficiencies and reductions in administrative costs will be a daunting task.

Simply identifying the widespread variations in administrative standards and processes is a huge challenge. There is no centralized source of information about the administrative processes and expenditures of hundreds of health care payers, hundreds of medical facilities and thousands of medical providers. While there is general consensus that the highly variable administrative processes and rules are wasteful, exactly how much we could save and exactly which processes are best to use remains unknown.

The Washington Healthcare Forum promotes increased transparency regarding some functions that have been reviewed as part of its administrative simplification efforts. However, there is still considerable variation in standards and processes, and much of the variation is still not transparent to providers, patients or other interested parties.

B. Standardizing variations

Variations in standards, codes, processes and systems create administrative complexity in the health care system. Three factors make it difficult to achieve broad-based standardization:

- Lack of a common regulatory framework for health care payers – carriers, self-funded employer plans and government health plans – makes it impossible for any one agency to establish and enforce standards.

- Lack of agreement regarding what the appropriate clinical standards are for specific situations.

- The cost and time needed to modify large information systems that carry out administrative functions.

Many of the variations in standards and processes are the result of independent development of business processes and systems by each health care payer, and do not reflect significant differences in policy or clinical goals between those payers. In these situations, the primary barrier is often the cost of making information system changes. As discussed on page 25, the challenge is sometimes the limitations of a key vendor's information system.

In other cases – especially in the area of medical management standards and pre-authorization requirements – the differences in standards reflect significant differences on the best approach to managing care or costs for specific situations.

The goal should be to achieve an appropriate balance between adopting standards for as many situations as possible where there is general agreement and making it easy for providers to quickly identify situations where payers have different standards, and the standard for a specific payer.

C. Reducing variation using a voluntary process

As was noted in the introduction to the WorkSMART Institute report, "Adoption is the daunting challenge and golden opportunity."

The Washington Healthcare Forum began its administrative simplification work in 1999. Through OneHealthPort and its sponsored work groups, numerous reports, policies and guidelines on simplifying various administrative functions have been developed.

However, the Forum's administrative simplification work assumes that simplification efforts are voluntary for payers and providers. While its efforts have made it easier for providers to look up the different requirements of various plans, and for payers and providers to identify suggested best practices for a range of administrative functions, adoption of more efficient tools and business processes is slow[11]. Neither providers nor payers have broadly adopted the best practices

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11 See Appendix A.

tools and work process guidelines. As a result, providers continue to spend large amounts of time and effort sorting through significant variations in payer standards and processes.

III. Health care administrative simplification priorities – a common framework

There are many administrative functions involving the financing and delivery of health care services, most of which have wide variations in standards and processes between different payers and providers. The Insurance Commissioner's Office consulted a number of sources in developing its recommendations to the Legislature and Governor for the five highest priorities for administrative simplification efforts in the next few years.

The agency's 2007 report included background on the different types of administrative costs incurred by health carriers, hospitals, physicians and other medical providers. Many of the health care system's administrative functions include important and valuable services such as care coordination, disease management, quality improvement, patient safety and customer service programs.

The goal is not to eliminate all administrative functions and expenses, but rather to minimize duplication and variations that do not contribute to better patient care. Administrative functions that can benefit from simplification include determining eligibility for insurance or other health plan coverage, determining covered services, submitting claims, processing claims, resolving appeals related to denied claims, provider credentialing, collecting payments from patients, etc.[12]

In the 2007 report and in this report, the Insurance Commissioner's Office defines "administrative functions" as those functions that are not directly involved with clinical care. For this reason, the agency's reports omit issues related to electronic medical records, the sharing of medical records and data or other activities that primarily support the delivery of clinical services. These aspects of the medical system are separately the subject of a tremendous amount of attention and activity. They will have increasing impacts on administrative functions as payers move increasingly to pay-for-performance models that track and evaluate clinical care. Additionally, as standards evolve for clinical and administrative functions, it would be ideal to host these standards on common technology platforms. However, these clinical activities are not included in the scope of this project. The Washington State Health Care Authority leads efforts to promote the use of electronic medical records in Washington state[13].

A number of organizations have prepared detailed evaluations of administrative simplification priorities. The recommendations of the Medical Group Management Association, the agency's Health Care Administrative Expense Report and the

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12 Source: http://www.insurance.wa.gov/consumers/documents/BRC_Efficiencies_Report.pdf

13 Online at http://www.hca.wa.gov/hit.

Washington Healthcare Forum's WorkSMART Institute Introduction Report each point out opportunities for improvement.

A. Medical Group Management Association priorities (2005)

The Medical Group Management Association (MGMA) has 21,500 members who lead and manage more than 13,500 organizations in which almost 270,000 physicians practice. The MGMA has a research center that conducts quantitative and qualitative research on the art and science of medical group management, and a Group Practice Research Network funded by the federal Agency for Healthcare Research and Quality.

One of the first studies, conducted in 2005, by the Group Practice Research Network was on the impact of administrative complexity in group practices. The research project focused on the impact that six areas of complexity were having on day-to-day operations of practices. The project focused on groups that, overall, were considered to be successful. The belief was that, if high-performing groups were facing issues on systemic administrative variation, redundancy and inefficiency as part of their daily routines, the problem must be even greater across the entire health care system.

The project team received 94 responses. More than half of the respondents described insurance product design, payer and provider contracting, billing and payment processes, credential verification and health care fees as areas that represent a major or significant problem in their daily activities.

In 2005, the MGMA identified six areas of administrative complexity that should be addressed to create a simplified payment system[14]:

- **Simplify insurance product design** - Limit the number of policy forms and plan designs offered by insurance companies and employers under ERISA.

- **Simplify payer and provider contracting** - Standardize basic terms of provider and payer contracts, and use a single contract form. Separate provider payment terms from the rest of the contract, and standardize the effective date and term of provider and payer contracts.

- **Simplify billing and payment processes** - Standardize the form and content of patient bills. Develop a standard Web-based system that providers can use to verify patient eligibility and insurance coverage. Develop standard rules for claims submission, including common documentation standards and coding policies.

- **Simplify credentials verification** - Develop a state–specific standardized application form and data set, and require health plans, hospitals and other

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14 Source: www.mgma.com/workarea/showcontent.aspx?id=800
     Homepage: www.mgma.com

organizations to use it for physician credentialing. Authorize a single "public utility" organization to verify credentialing information.

- **Simplify health care fees** - Establish a standard physician fee structure (not uniform fees) for all insurers. Standardize measures used for pay-for-performance incentives.

- **Simplify clinical care management** - Standardize clinical guidelines for common conditions and disease management protocols and processes. Eliminate prior approval, except where proven effective, and standardize remaining requirements among all payers. Standardize drug formularies and the use of hospitalists.

B. 2007 Health Care Administrative Expense Report priorities (2007)

The Insurance Commissioner's 2007 report listed nine top priorities:

- **Claim codes and payment policies** - Standardize the most commonly used claim adjudication edits and payment policies, and standardize the use of claim payment codes.

- **Eligibility and benefits information** - Provide enhanced eligibility and coverage information to providers, both online at the time of service and through batch processing for pre-service reviews.

- **Collecting patient payments** - Provide better information and systems for providers to collect a patient's cost share at the point of service.

- **Referrals and care plans** - Streamline and standardize carrier requirements for referrals, care plans and other documentation-related processes.

- **Standardized credentialing/provider information** - Create a single online, streamlined credentialing process and data source for use by health plans and hospitals.

- **Electronic remittance advice, posting, and reconciliation** - Expand provider use of health plan electronic remittance advice systems.

- **All-payer portal** - Expand upon the success of the widespread adoption of OneHealthPort's common Web-based portal. Include state programs such as Medicaid, worker's compensation, Uniform Medical Plan and the Basic Health Plan.

- **Common forms and administrative rules** - Increase the number of standardized administrative forms and require their use by health plans.

- **Simplify coordination-of-benefits processing** - Modify administrative rules to eliminate the estimated payment requirement added in 2007, and review other possible changes to promote prompt and efficient processing of claims.

These priorities reflect input solicited through a Web survey and numerous conversations with health insurers, health care providers and office staff in the summer and fall of 2007. The agency also looked to national organizations and other states to identify possible priorities. This included state initiatives in Minnesota, Ohio, Colorado, and Utah, and the work of the American Medical Association, the Council for Affordable Quality Healthcare and the Medical Group Management Association. Of these Minnesota and the MGMA had the broadest engagement on administrative simplification efforts.

C. WorkSMART Institute priorities (2008)

The 2008 WorkSMART Institute Introduction Report includes an initial workplan identifying 16 initiatives, grouped into three major tracks[15]. The plan provides for work on 13 of the 16 initiatives in 2008, and ongoing work on all of the initiatives from January 2009 through June 2010.

1. Simplify the provider payment process

Track 1 focuses on reimbursement of providers by health plans and patients and includes ten simplification initiatives:

- **Enhanced eligibility** – Modify health plan information systems to deliver more detailed eligibility and benefits information to providers.

- **Patient estimation** – Provide information, tools/technology and workflow changes to providers to make it possible to accurately estimate a patient's cost share at or before the time of service.

- **Patient payment financing and collection** – Provide information, tools/ technology and workflow changes to providers to make it easier to collect from patients at or before the time of service.

- **Real time adjudication** – Make it possible for providers to get authorization and payment from health plans for services at the time the service is provided.

- **Electronic remittances** – Increase the number of providers whose fiscal systems can receive and process electronic payments.

- **Claims status** – Develop more efficient means for providers to check with health plans on the status of claims.

- **Plan pre-authorizations and referrals** – Identify and implement the optimal balance between the goal of establishing standardized pre-service requirements and the goal of permitting innovations to promote good care management.

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15   See Appendix B.

- **Plan claims coding and edits** – Reduce the variation between policies related to claims coding and edits.

- **Plan forms** – Promote use of common paper forms by health plans, but only as a transition step towards universal use of electronic forms and processing.

- **Coordination-of-benefits process** – Draft and adopt a set of best practices for processing claims, and revise the rules as needed to support the best practice recommendations.

2. Strengthen directory services

Track 2 addresses finding and matching provider and patient records and includes four initiatives:

- **Provider demographics** – Create a common directory for provider demographic information.

- **Patient ID search/master person index** – Establish an indexing process to allow for the gathering of a patient's clinical information when listed under different patient IDs in multiple systems.

- **Patient record search/record locator service** – Establish a way to find the location of all records associated with a specific patient.

- **Credentialing and re-credentialing** – Create a standardized process and database to collect and maintain information used for credentialing, re-credentialing, and other related activities.

3. Improve authorized access to high value clinical data

Track 3 addresses providing important clinical data sets to practitioners at or before the point of care.

- **Medication Information eXchange** – Make it easier for providers to electronically access local medication information through the Rx Hub system.

- **E-prescribing** – Promote the use of electronic systems to transact original and refill prescriptions between physicians and pharmacies.

D. Cross-walk of top priorities

The comparison on the next page illustrates the industry's alignment with the priorities identified by the insurance commissioner on which administrative functions could benefit from simplification and standardization efforts.

Opportunity	OIC	WSI	MGMA
Standardize claims adjudication	#1	#8	#3
Enhance eligibility and benefits info	#2	#1	#1, #3
Improve collection of patient cost share	#3	#2, #3	#1, #3
Standardize medical management	#4	#7	#6
Standardize credentialing	#5	#14, #11	#4
Promote use of electronic remittances	#6	#5	#3
Create a single portal	#7	-	-
Promote common forms	#8	#9	#2, #3
Adopt coordination-of-benefits improvements	#9	#10	#3

The challenge is to determine what approach and commitment of resources support the greatest possible progress in the areas of common concern, with the least duplication of efforts.

IV. Five highest priority goals for achieving significant efficiencies and reducing health care administrative costs in 2009-2011

A. Context for setting priorities

Given the wide range of entities, functions, and business and information systems involved in health care administration, simply selecting the priorities for administrative simplification efforts is a challenge. A logical first step would be to identify functions that involve significant variances or redundancies and consume significant resources. Unfortunately, comprehensive and reliable data are not available to determine the amount spent on administrative functions by different organizations in the health care sector. Health insurers report some data to the National Association of Insurance Commissioners (NAIC), and hospitals report some data to the Washington State Department of Health, but those reports do not break out expenses by administrative functions. Some providers participate in various national cost surveys. Neither self-funded employer plans or public sector plans, nor physician practices and clinics report administrative expenses to any repository we have identified. Without such comprehensive and reliable data, setting priorities is based on informed guesses about which functions have the most potential for simplification and cost savings.

In the absence of broadly accepted objective standards for measuring the potential for improvement among simplification opportunities, survey information from

national and local provider organizations, one-on-one meetings and group dialogue at Executive Oversight Group meetings were used to propose and confirm priorities. A key consideration has been the priorities adopted by those already engaged in simplification activities, especially the WorkSMART Institute. The willingness of several organizations to commit time and resources to working on a set of simplification initiatives, and to commit to adoption of the innovations, is a concrete statement of their belief that those initiatives will be of significant value.

In the years to come, it will be important to continue a transparent and inclusive discussion about the administrative simplification priorities for the entire healthcare industry. No one constituency or group should dominate the priority-setting process.

Administrative simplification requires organizational change-management skills; the level of organizational capacity for change affects the functions that can realistically be reviewed and simplified within a reasonable timeframe. The 2008 WorkSmart Institute Introduction Report[16] discussed this question and stated:

> "…by far the most salient rate limiting factor in changing health care work and information flow is the ability of health care organizations to process and manage change."

> "… There are multiple initiatives underway in this and other markets to improve performance and manage costs. These efforts all call on many of the same human resources to plan, lead and implement change. The Institute founders recognize the initiatives they are championing must fit within the larger demand for change within the industry."

Health plan and provider change-management skills will face significant challenges from the federal government over the next few years. On August 22, 2008, the Centers for Medicare and Medicaid published two proposed rules[17] that will require significant information system changes for all health care plans and providers:

- One proposal adopts a new set of HIPAA transaction standards (known as "version 5010").

- The other proposes to adopt a new ICD-10 diagnostic code set to replace the ICD-9 code set currently used by all health plans and providers.

Focusing on a reasonable number of administrative simplification initiatives at any one time will increase the probability of successful implementation and adoption. This graduated approach must be balanced with a sense of urgency about making progress and solving problems.

For many initiatives, it may seem that much of the change sought will be borne primarily by health plans. In reality, all efforts to simplify administration will need

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16 See Appendix B.

17 Online at http://www.hhs.gov/news/press/2008pres/08/20080815a.html.

to engage all parties. Practices and hospitals are unlikely to reap the benefits of changes made by plans unless they also adapt their own business processes and vise versa. This mutual dependency means all participants are invested in finding the right balance between progress and patience. Moving too slow will result in limited relief from burdensome and inefficient practices. Moving too fast will overtax change management resources and runs the risk of doing many things poorly. The middle path offers the highest probability for change that is meaningful and can be broadly implemented and adopted.

In identifying priorities, we have attempted to blend and balance the scope of the simplification work underway with the limited resources available for implementation and adoption. Although the agency has received input from many organizations, currently, the major collaborative effort in Washington state is the WorkSMART Institute. We relied heavily on the experience and expertise of this group and its constituents in recommending the following five priorities.

B. Step One: Short-term priorities

The first step should be to continue work on two initiatives that can be successfully completed in 2009.

1. Establish a standardized process and central data source for provider credentialing and other provider demographic data needs

All sources indicate that provider credentialing is a source of administrative variation and waste that generates significant provider frustration. However, it does not appear to be a major source of cost to providers, plans or hospitals. In its study in 2002, the Washington Healthcare Forum estimated that the average health plan spends approximately $500,000 per year on credentialing activities and the average provider up to 6.5 hours per provider per year in completing forms and following up. A standardized system will reduce these costs but not eliminate them entirely. The exact amount of potential savings is still being investigated.

Despite being a small portion of total costs, the current redundant process should be streamlined and, if possible, standardized onto a single statewide database. A standard process for collecting provider data and a common data platform for storing that data could generate efficiencies and savings for a variety of processes in addition to health plan and hospital credentialing. Some possibilities include:

- State certification of a credentials verification service that health plans and hospitals could use, rather than doing independent verification.

- Linkage and integration with state health professional licensing functions.

- Integration with federal and state provider-sanctioned information sources.

- Integration with state health resource and capacity planning processes.

- Integration with emergency responder databases.

- General use as the primary source for the most current provider demographic data, such as for use in provider directories.

The Insurance Commissioner's Office has taken the lead in establishing a workgroup to develop a proposal for a standardized data collection system to aid in provider credentialing and other related processes. After the workgroup's initial meeting in August, it became clear that a common credentialing data platform should be expanded in scope to a single statewide source of provider demographic information for a variety of health care system needs.

The project is headed by consultant Howard Thomas and the workgroup is composed of 18 credentialing experts from health plans, hospitals, state agencies and other organizations. The project staff also routinely work with provider organizations, such as the Washington State Medical Association for provider input.

The Insurance Commissioner's Credentialing Standardization Workgroup assessed two options for implementation of a common credentialing system: Build a system or buy a system (such as the Universal Provider Data Source offered by CAQH) from an existing vendor and CAQH appears the likely candidate in this model.

The build model carries the risk inherent in any information-technology project related to cost, timeliness and usability. For these reasons, the Insurance Commissioner's Office and the Executive Oversight Group concluded that the optimal solution was to pursue the buy option at this time.

It's important to note that the buy option is not risk free:

- Buying this service will effectively create a monopoly.

- CAQH is a private entity governed by large national health plans. While CAQH is a nonprofit organization, the credentialing service itself is operated by a large for-profit technology vendor.

- If the price is too high, administrative costs will increase rather than decrease.

- If data ownership is not clarified, the community would be held hostage because the switching costs would be too high and in the case of business failure there would be no recourse.

To mitigate these risks, we recommend the following protections:

- CAQH will own and provide access to the application. Each provider's individual data will be owned solely by that provider. The provider shall have discretion to request data be sent to any entity (health plan, hospital, other) of their choice. The entity that is granted access to the data at that point shall have ownership of the data it is allowed to use.

- CAQH will not have ownership of any data. In the event the providers and or entities elect to transition the service from CAQH or repurpose the data, CAQH will be required to facilitate such transfer on reasonable terms.

- CAQH will be required to integrate the credentialing service with existing information exchange infrastructures in Washington state. Creation of another proprietary silo is not a step forward; this key consideration will need to be resolved with any vendor.

- CAQH will be required to provide the service at reasonable prices that reflect the economies available from coordinated implementation.

If this level of risk mitigation can be satisfactorily achieved, CAQH will be the preferred option for implementing of common credentialing in Washington state. If not, the build option should be revisited. Legislative action may be required as part of the implementation work plan.

2. Amend rules regarding coordination-of-benefits claims processing to eliminate the estimated payments requirement

Coordination-of-benefits (COB) processing has become a less-frequent requirement over the last few years as the number of people with two or more sources of health insurance coverage has declined. According to recent estimates, less than 10 percent of people with insurance now have dual coverage. However, insurers indicate it is still a very costly source of administrative workload.

In 2007, the insurance commissioner adopted changes to the agency's administrative rules applying to COB situations. Effective in 2008, the Commissioner's amendments clarified aspects of secondary plan payments, and adopted many aspects of the National Association of Insurance Commissioners model COB rule.

During the course of this study, and in discussions with representatives of health plans and medical groups in 2007 and 2008, the rule change to require secondary plans to make estimated payments in certain circumstances had the unintended consequence of forcing increased manual processing of claims by medical providers and health plans, creating additional reconciliation and recovery costs and unnecessary complexity.

One of the state's larger insurers believes that the new rules generate approximately $1.6 million in overpayments every year, which require additional and special administrative processes to reconcile. The company that administers claims for the Uniform Medical Plan also reports very significant administrative burdens as a result of the change.

According to the provider representatives on OneHealthPort's Business and Technology Workgroup, the new requirement also is causing significant rework and patient frustration in medical practices because estimated payments require many

additional accounting entries and time-consuming reconciliations.

The WorkSMART Institute's Business & Technology Workgroup took up the COB issue in 2008. The group reviewed concerns with the rule change and developed a best practice recommendation to correct the problems. In June 2008, the agency began a review of the COB rules, specifically the requirement in Washington Administrative Code 284-51-215 and 284-51-260 that secondary plans make estimated payments to providers. The rule-making notice stated:

> *"Concerns have been raised that the requirement that a secondary plan make an estimated payment to a provider creates significant administrative complexity and workload for both plans and providers. The Commissioner will consider whether the elimination of the estimated payment requirement would be of benefit to providers, and would not harm consumers. The commissioner will also consider whether other changes should be made to promote more timely and efficient coordination of benefits and to establish protections against inappropriate patient billings in COB situatio*ns."

The Insurance Commissioner's Office solicited and received comments from health plans and provider organizations on its proposed rule-making. Using this feedback, the agency will file proposed rule changes that:

- Eliminate the estimated payment requirement.

- Establish payment sequence, so that providers submit their claim first to the primary plan, then to the secondary plan after payment by the primary plan.

- Clarify payment timelines for secondary plans, requiring the plan to pay as though it is the primary plan no later than 90 days after the claim was submitted if it has not received coordinating information.

- Require plans to resolve which plan is primary within 30 days of notice that more than one plan covers the enrollee for the claim, except in situations where the information needed to determine primary and secondary status - such as a court order for dependent coverage - has not been provided to the plans.

The agency intends to complete this rule-making by early 2009, followed by additional rules to adopt clearer and more easily enforced rules addressing prompt claims payment. The COB initiative demonstrates how the public and private sector can work together and blend best practices with regulation to the betterment of all parties.

These two initiatives address administrative functions that impose frustrating administrative burdens on providers and payers alike. Because they are already in progress and the amount of work involved is largely known, significant simplification noticeable to providers and payers can be achieved for both in the upcoming year.

However, since the amount currently spent on these two functions is not a large component of administrative expenses, these simplification efforts are not expected to generate dramatic cost savings. More importantly, making significant progress on these two initiatives in 2009 will demonstrate how an investment of time and effort on simplification efforts can bear fruit and build relationships across the industry and agencies.

C. Step Two: Larger and longer-term challenges and priorities

The following three top priorities would achieve significant long-term efficiencies and reductions in health care administrative costs.

1. Expand electronic sharing of patient eligibility and benefits information and efficient patient cost-share collection processes

Expanding the amount and type of eligibility and benefit information providers access before or at the time of patient care has nearly universal support among health plans and health care providers. There is wide agreement that both the patient and the provider should have quick, easy access to complete and reliable information in at least two areas:

- Whether a medical procedure is covered by a health plan.

- The amount of the patient's share of the cost – whether it be a co-pay, a remaining deductible or a co-insurance share.

As described on the Web site for the Council for Affordable, Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE)[18]:

"The benefits of an interoperable health care system are well understood. The availability of information in real-time at the point of care can reduce medical errors, allow physicians and their patients to make informed decisions about treatment options, and reduce administrative burdens. The challenges are equally well understood. Technology adoption rates, data security, and inconsistency associated with transactions and interactions between stakeholders are limiting the ability to realize a complete solution.

Through CORE, CAQH is working to make it easier for physicians and hospitals to access eligibility and benefits information for their patients at the point of care. CORE operating rules will allow providers to submit a request, using the electronic system of their choice, to obtain a variety of coverage information for any patient and from any participating health plan. Providers will receive more consistent and predictable data, regardless of health plan."

This goal, also identified as a high priority by the MGMA in 2005, has also been a top priority for the Washington Healthcare Forum and OneHealthPort over the past two years. In 2007 and early 2008, the OHP Business and Technology

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18 Source: http://www.caqh.org/benefits.php

Workgroup developed a Best Practices Recommendations (BPR) document for providing enhanced health care eligibility and benefits information via electronic communications (HIPAA 270/271 transactions). The recommendations are consistent with the CORE standards developed by CAQH, and include additional data elements not yet included in the CORE standards.

Several carriers in the Washington market have made many of the information system changes needed to deliver the enhanced information. Testing of those changes began in October 2008, with a goal of making the enhanced eligibility and benefits transactions widely available in 2009.

In addition to having health plans provide more accessible, detailed information about a patient/member's eligibility and benefits, this recommended priority includes a goal of helping providers to more efficiently determine and collect patient payments.

The WorkSMART Institute's Managing Patient Payments Workgroup has been identifying possible technology, tools and work process changes that providers can use to more efficiently and successfully collect the increasing patient share of the payment for their services. Some of the hospital members of this workgroup conducted pilot projects in 2008 to evaluate specific tools and vendors that will promote better management - and collection - of patient payments. The workgroup also promotes sharing best practice recommendations among providers.

These private sector work efforts should lead to improved tools and processes for providers beginning in 2009 for determining patient eligibility and benefits and for determining and collecting the patient's share of the cost of medical services. The process of adoption necessary for achieving widespread improvements in provider management of patient payments will likely extend over several years.

These initiatives will lead to a significant reduction in the bad debt written off by providers – an issue of rapidly growing concern as an increase in deductibles and co-insurance result in patient cost shares being a much larger source of provider revenue.

2. Standardize use of pre-authorization requirements and introduce transparency of variations where standardization is not reasonable

Providers consistently point to the wide variation in health plan payment and medical management policies, and the difficulty in identifying and tracking the variations, as a problem area.

Pre-authorization requirements are health carrier payment policies predicating payment on advance approval by the carrier before the service is rendered. A variation of these policies requires pre- or post-service notification; some health plan policies include provisions for denying claims if a provider fails to notify the plan of the service.

A report prepared by the WorkSMART Institute for the Washington Healthcare Forum in July 2008 provided a framework for reviewing the two areas being addressed by the Institute's new Payment Policies Workgroup:

> *"Care Management & Utilization Review programs are at the core of most health plans' business strategy. These programs evaluate the medical appropriateness of requested/ delivered services and determine if they are covered under a member's benefits. The programs ensure clinical quality thereby reducing clinical risks and minimize inappropriate services thereby reducing a health plan's costs.*

> *The Pre-Authorization (Pre-Auth) process and Code Edits are two elements of a Care Management & Utilization Review program. Pre-Auths are typically a 'pre-service' clinical review process that double-checks the clinical appropriateness of a particular service in order to determine eligibility for coverage. Code Edits are a 'post-service' audit process that verifies whether the billing for care services is compliant with clinically accepted nomenclature and rules. Both of these steps are typically supported by clinical criteria.*

> **Pre-Auth and Code Edit variations across health plans create complexity for providers.**

> *Most health plans have implemented some form of Pre-Auth and Code Edits. Though the strategic objectives of these process steps tend to be standard across health plans, the implementation varies from health plan to health plan. These variations create complexity as providers must become familiar with and comply with the unique requirements of each health plan.*

> **Two hurdles stand in the way of broad base standardization.**

> *Achieving some level of standardization in Pre-Auth and Code Edits is a worthy objective, but two hurdles are in the way.*

> 1. *Agreement must be reached across a continuum of health plans, including regionally-based fully insured commercial plans, nationally-based fully insured commercial plans, federal and state public plans, and self insured plans. From logistical, legal and regulatory perspectives, getting consensus on a common set of standards is likely to be exponentially more difficult as you move along that continuum.*

> 2. *Health plans and providers purchase software and services from an array of national vendors in order to support Pre-Auth and Code Edits. Variations exist across these vendors' offerings that create additional confusion as health plans and providers exchange information. It is unreasonable to believe that all health plans and providers will adopt the same vendor or to believe that all variations can be eliminated across all vendors."*

Eliminating all variations in medical management and pre-authorization requirements isn't operationally practical, and may affect clinical outcomes. Pre-

authorization can often help providers in situations where medical necessity standards require interpretation before coverage is extended. However, it should be possible to promote broader agreement and use of common processes and standards for certain medical procedures provided in specific situations.

For example, an insurer's requirement that a doctor obtain pre-authorization for an X-ray for a suspected broken arm is clearly not supported by clinical standards and appears to the provider to be an additional hurdle intended to avoid reasonable claims.

On the other hand, many procedures exist for which there is significant disagreement on when the use of the procedure is appropriate. Bariatric surgery is one such example. For these kinds of procedures, the goal should be to make it quick and easy to learn about the pre-authorization and underlying clinical quality assurance requirements, beginning with the fully insured commercial plans, state plans, and others that participate in the WorkSMART Institute's workgroups.

The Insurance Commissioner's Office supports the efforts of the workgroup charged with developing a set of clearly-defined best practices for pre-authorization processes and standards, as a first and valuable step towards greater standardization across the medical management area.

3. Standardize code edits and payment policies and introduce transparency of variations where standardization is not reasonable

One of the most complex aspects of health plan payment policies involves the requirements that providers use certain combinations of codes when submitting claims for services. These coding requirements frequently vary between plans for certain services provided in relation to certain diagnoses or in certain circumstances.

A report prepared by the WorkSMART Institute in July 2008 described the role played by code edits in plan payment policies:

> *"Code Edits are a 'post-service' audit process that verifies whether the billing for care services is compliant with clinically accepted nomenclature and rules. Code Edits fall into two general categories:*
>
> > *1) Edits to verify that services are billed with valid codes (nomenclature); and*
> >
> > *2) Edits to prevent improper payment when incorrect code combinations are billed (rules).*
>
> *The controversy around code edits primarily relates to category #2 – bundling/ unbundling rules. It is in these areas where edits have a significant impact on providers' revenue.*

Background

Code Edits are program logic that is contained in computer software. This logic verifies that the combination of billing codes used on a claim is appropriate to the patient condition. The program logic is an interpretation of a set of rules or guidelines.

Code Edits generally fall into one of two types: 1) Correct Coding Initiative (CCI) edits and 2) Clinical edits. CCI edits are broadly accepted as the industry standard baseline. They are an interpretation of a set of rules defined by Medicare in the National Correct Coding Initiative Coding Policy Manual for Medicare Services."

The Centers for Medicare and Medicaid Services developed the National Correct Coding Initiative to promote a national set of common coding methods and to control improper coding for Medicare Part B claims[19]. The coding policies are based on coding conventions defined in the American Medical Association's Common Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national specialist groups and other sources. Edits are updated on a quarterly basis.

The WorkSMART Institute's July report included the following overview of clinical edits:

"Clinical edits are in addition to CCI edits. They address conditions and situations that are not typically covered by Medicare. Clinical edits are a set of rules defined by a variety of specialty-oriented, clinical societies and associations, e.g. American Academy of Orthopedic Surgeons. Medicare rules and rules from clinical societies change on a periodic basis as clinical technologies evolve.

The appropriateness of a Code Edit is determined by the clinical situation, i.e. a patient's presenting disease and the clinical requirements of treatment. The Code Edit itself may not be adequate to address complex clinical situations that are covered by a specific rule. As such, Code Edits should be supported by and used in conjunction with a 'source rule', either Medicare's Policy Manual or documentation from a reputable clinical society. The rule itself, and not the Code Edit, is generally seen as the final arbitration of a usage controversy.

Software vendors, such as McKesson and Ingenix, implement the logic for these edits into their software offerings and promote their offerings as having CCI edits and clinical edits.

Most health plans and providers purchase Code Edit software from software vendors or clearinghouses. (The code combinations are too complex and dynamic for organizations to program and maintain on their own.) In some cases, providers may have programmed edits that are relevant to their practice directly into their billing system – but that is becoming the exception and not the rule.

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19 Source: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

On occasion, a health plan may modify a code edit that was programmed by the vendor. A modification is typically triggered when conflicting edits are identified or when a health plan selects an alternative set of clinical rules that those that were used by the vendor. This type of Edit is commonly referred to as a custom edit."

It should be possible to achieve universal use of common edits for most situations. Most health plans and provider systems have already adopted or intend to adopt and implement the CCI standards. However, situations exist where a plan may wish to vary from the standards. These variations may be made for cost-control reasons, to provide more flexibility to a provider or for the convenience of a patient.

For example, the state Medicaid program permits the grouping of certain procedures in one office visit that are not consistent with the CCI edits. It does this because it pays for the transportation costs incurred by Medicaid enrollees to get to doctor's office. It is more convenient for the patient, and less expensive to the program, to permit some combinations of services in a single office visit that would not be permitted under standard CCI edits.

The broad adoption of CCI edits should be combined with the goal of making it easy for providers to identify situations where some plans permit a variation from the standard edits.

In addition to promoting the use of CCI edits, the WorkSMART Institute Payment Policies Workgroup should review other variations to identify additional edits that should be adopted as a common standard.

V. A plan to accomplish the priority goals

A. Develop a framework for decision-making and implementation

In order to review and simplify health care administrative functions in Washington state, a decision-making and implementation framework is needed – an organized structure to promote collaborative and well-informed discussions and decisions, and to bring about broad adoption of the common standards and processes necessary for administrative simplification and cost reduction.

By formalizing a public/private approach between all affected entities, administrative simplification is more likely to occur with greater acceleration than if attempted on an ad hoc or piecemeal basis. The framework should include clearly defined roles for both the public and private sectors.

B. Define appropriate roles for the private and public sectors

Neither the private sector nor the public sector can bring about health care administrative simplification alone – each has an important role to play.

The private sector has the lead role in developing common standards and processes. Health plans and providers who provide coverage and services on a daily basis are the parties best prepared to evaluate and balance competing interests and goals to develop an optimum set of administrative standards and simplified processes. Those who have clinical expertise are best prepared to evaluate which aspects of payment policies should be made more uniform, which should continue to have variations, and which process would best promote transparency and the underlying rationale of the variations.

The WorkSMART Institute is currently the organization leading much of the private sector administrative simplification efforts. WorkSMART has a number of unique attributes:

- Significant and unique experience and expertise with a range of administrative simplification initiatives.

- Shared technology services.

- Significant outreach and adoption capability.

- Emerging workflow innovation tools.

- Sustainable source of private funding that greatly reduces the need for public funding

State government has three key roles to play in supporting the private sector-led work:

- **Transparency** - The state should ensure that all committed, knowledgeable parties have a reasonable opportunity to participate. It should not be limited to the largest organizations that have the most market leverage. Transparency and broad participation by providers and provider groups is an important goal.

- **Participant** - State health care programs such as the Medicaid program, Uniform Medical Plan and workers' compensation, need to be included in developing and adopting common standards and processes, and must invest in the technology and program changes needed to adopt common standards and processes.

- **Compliance** - If plans and providers are unable to agree on specific standards or processes, state government should have the ability to establish standards or requirements in rule. This ability would be limited to promoting wider adoption of a standard agreed upon by most plans and providers.

A few other states also have begun health care administrative simplification efforts[20]. They have used different approaches, but each appears to include features common to those recommended by the Insurance Commissioner:

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20 See Appendix E.

- Private sector entities take the lead development role.

- One agency is given lead responsibility for the state's contribution to change efforts and implementation of common standards.

- The lead agency works jointly with health carriers, providers and other key entities.

- The lead agency dedicates staff and other resources to the work.

- The lead agency's scope of authority is clearly defined – sometimes in statute and sometimes in administrative rule.

Create reasonable timelines for progress

In states such as Minnesota or Utah, where administrative simplification has been a priority for almost a decade, the elements of reform have been introduced incrementally. New initiatives build on the experience of prior efforts. It is not practical to work on all worthwhile initiatives at the same time. Many simplification initiatives require ongoing trust-building among competitive interests and significant changes to complex information systems – changes that cannot be made too quickly without risking disruption to current health plan and provider operations.

Success requires sufficient time to develop and test common standards and processes and to plan and carry out those changes across a highly-diverse and fragmented industry. The state should give current efforts, such as the WorkSMART Institute initiatives, an opportunity to achieve their stated goals within a reasonable period of time. However, the state should also establish reasonable deadlines for progress in specific areas in order to provide a sense of appropriate urgency to the parties that are working on the development of common standards and processes.

In situations where workgroup participants have different systems, goals, etc., progress towards reaching agreement is likely to be slow unless the parties know they are under a deadline. Certainly, as most students know, there is nothing quite like a looming deadline to motivate a person to give an assignment his or her full attention and sustained effort. Whether the work product is a term paper or a set of common pre-authorization standards for a defined group of services, the principle is the same. A deadline helps promote a sense of urgency and focus.

VI. Conclusion

A program should be established to create a formal public/private partnership to develop and promote standards and simplification for health care administrative processes in Washington state. Such a program would build on private sector efforts such as the WorkSMART Institute and promote increased statewide awareness and adoption of administrative simplification initiatives.

The new program should:

- Identify and prioritize areas that would benefit from increased innovation and collaboration.

- Review innovative ideas and brainstorm solutions.

- Review voluntary efforts and private-sector plans and initiatives.

- Promote broad stakeholder feedback and a wider awareness and adoption of common standards and processes across the state.

- Provide input on regulatory initiatives to promote standardization, cost reduction efficiency and increased adoption.

- Provide regular reports to the Legislature and the Governor.

We further recommend that legislation establishing such a program do the following:

- Clearly define public policy goals for the program.

- Clearly define roles for the public and private sector.

- Clearly define goals for achieving a reasonable degree of standardization for certain key administrative functions, such as providing eligibility/benefits information, claims coding, credentialing and contracting.

- Set specific timelines for key stakeholders to reach agreement on what is a reasonable degree of standardization, and on the common standards and processes.

- Define a specific process for establishing implementation timelines.

- Identify a principal state agency to take the lead in providing support for collaborative efforts led by the private sector.

- Require all agencies that purchase health care services or regulate carriers or providers to participate in the collaborative effort.

- Allow - to the extent permitted by federal law - state agencies, including the OIC, DOH and DSHS, to adopt rules on the standards created through the above process in order to achieve widespread adoption.

The health care industry does not suffer from a scarcity of ingenuity and creativity. With clear public policy guidance, strong private-sector leadership, strategic

direction and facilitated support, health care costs can be reduced through simplifying common administrative practices. However, it will take time and focus to create meaningful improvement that can be adopted across the fragmented industry.

Afterward: Fee-for-service conundrum

The three priority initiatives discussed under "Larger and longer-term challenges and priorities" are all intended to make current fee-for-service billing and payment processes more efficient for providers. Fee-for-service billing is by far the most common approach to paying for health care services in this country. However, this approach has come under increasing criticism in recent years for its failure to provide adequate incentives for preventive care and high-quality, well-coordinated care.

This approach also has been criticized for giving providers financial incentives to recommend and provide additional services, even where the additional services do not promote better health outcomes. The case has been made that a fee-for-service approach actually provides an incentive for ineffective treatment of chronic conditions such as diabetes because providers receive higher compensation for addressing all the medical problems arising from poor diabetes management than they can receive for effective diabetes management.

For this reason, one of the major themes for health care reform in recent years generally has been the need to move away from the fee-for-service approach to financing health care services and toward an approach that pays health plans and providers for effective promotion of good health and good health outcomes. This was stated in the first recommendation of the 2007 final report of the Blue Ribbon Commission on Health Care Costs and Access, and in the legislation implementing that recommendation - section 1 of Senate Bill 5930 (2007)[21].

Moving the health care sector away from a predominantly fee-for-service approach to paying for health care outcomes is likely to be a long, slow process, if it occurs at all.

Some health plans are experimenting with payment policies that include a mix of fee-for-service and financial incentives for efficient, high-quality care.

Changes made to simplify and reduce administrative costs are likely to provide savings for many years even as different approaches to health care finance evolve over time. Health plan and provider collaborative work on simplifying and standardizing aspects of fee-for-service payment policies can lay a foundation for additional transformational changes in years to come.

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21 Sources: www.hca.wa.gov/brc.html and www.hca.wa.gov/documents/brc/5930-1_final_092107.pdf.
See also www.commonwealthfund.org/publications/publications_show.htm?doc_id=716275.

Appendix A - The Washington Healthcare Forum's work products

Dynamic reports

The following reports provide a Web-based means for providers to look for information on the different requirements health plans have for the listed administrative functions.

- **Adjustments to Payments:** How health plans (9) handle adjustments to payments.

- **Using Common Modifiers:** How health plans (12) handle the twenty-five most commonly questioned modifiers.

- **Splitting Claims:** The conditions under which health plans (11) will split a claim.

- **Injury Codes:** When health plans (10) require accident information to be included with a claim form.

- **Referral Guidelines:** Which services require referrals for health plans (7).

- **Prospective Review Guidelines:** Which services can be prospectively reviewed by health plans (7).

- **Inpatient Stay Review:** Answers to common processing questions about health plans' (7) reviews of inpatient stays.

- **Solutions Finder:** This report allows an end user to drill down to solutions by selecting the area with which s/he needs help.

- **Health Plan Contacts:** Contact information for [1] accountable parties who participate in the Washington Healthcare Forum's administrative simplification effort, including ten steering committee members and thirteen health plans; and [2] submitting operational questions for administrative processes for health plans (13).

- **Where to send required documentation** for health plans (13).

The Washington Healthcare Forum also has created an Adoption Matrix that shows which of 13 participating health plans have adopted some or all of the Forum's 23 policies on administrative simplification.

Policy statements

Twenty-three policies have been implemented to address the following administrative functions.

Claims processing

Submitting Supporting Documentation

Submitting Corrected Claims

Follow-Up on Processed Claims

Using Common Modifiers

Anesthesia Standards

Claims Receipt & Processing Standards

Reasons for Splitting Claims

Handling Injury Claims

No Paper EOBs

Resubmission of Electronic Claims

No Clinical Notes with ER Claims

Patient Insurance Card Not Required

Adjustments Made to Paid Claims

Referral and prospective review

One-Stop-Shop Processing Requirements

Standard Referral Actions

Self Referrals for Women's Healthcare

Numeric Billing Codes on Referrals & Authorizations

Tolerance Days for Referrals

No Referrals to Hospital Emergency Rooms

Requesting a Prospective Medical Clinical Review

Credentialing

Credentialing Handbook

Confirmation of Receipt of Credentialing Application

Adjudicating Claims as of Credentialing Effective Date

Web links

www.wahealthcareforum.org/Accelerate/tools.htm

www.wahealthcareforum.org/AdminSimp/index.htm

www.wahealthcareforum.org/healthplaninfo/AdoptionMatrix.htm

Appendix B – WorkSMART Institute Introduction (May 2008)

Following is the introduction from OneHealthPort's report.

It's all about adoption. Adoption is the daunting challenge and the golden opportunity for anyone seeking to improve work and information flows in the health care industry. Tools, technologies and other solutions designed to improve efficiency and manage cost add little value unless broadly adopted. Any solution strategy in this space has to be imbued with a relentless focus on adoption. The purpose of this document is to describe just such an approach crafted by the Washington Health Care Forum. The Forum's newest improvement effort is a program called the WorkSMART Institute.

The WorkSMART Institute makes it easier for patients, practitioners, hospitals and health plans to work together by reducing waste and streamlining the flow of information. The Institute delivers a market-driven blend of information technology and workflow innovation that frees doctors and nurses to concentrate on what matters most—taking care of their patients. The Institute, led by the Forum, will be managed and operated by OneHealthPort. The WorkSMART Institute has chosen not to define itself as either an administrative simplification effort or a clinical health information exchange initiative. The Institute will work across the continuum to improve work and information flow in both areas.

The founders of the WorkSMART Institute strongly believe that solving the work and information flow problems of the health care system requires a "product delivery" rather than a "consensus" oriented organization and have structured governance accordingly. The Washington Health Care Forum will provide strategic governance for WorkSMART. The OneHealthPort Board will provide operational governance. The Institute believes it is possible to enjoy the benefits of expedited governance and still provide sufficient transparency and engagement for customers and partners to feel their needs are being met. To create a sense of openness around the WorkSMART program the Institute plans, among other things, to establish an advisory group that will help guide the effort. The current Executive Workgroup convened by the OIC may be an excellent fit for such an advisory body

The WorkSMART Institute has been designed to operate as a private sector organization with public sector participation. This frees the Institute to use a more expedited private sector process designed to bring solutions to market, while also freeing the public sector, with its requirements for a more open and consensus oriented process, to adopt or not any of the products and services offered by the Institute. The survey in the Blue Ribbon Commission (BRC) report confirmed that for many providers the participation of public payers in any improvement initiative is highly desired. Like private plans, public payers should commit to full participation in the WorkSMART Institute's improvement efforts.

Many people, including different founders of the WorkSMART Institute might disagree on how much of global health care cost goes to administration vs. clinical

care and what percentage of administrative and clinical cost is "waste." However, many of these same people can probably agree on three things:

- There is ample waste in both the clinical and administrative areas, this presents numerous targets for improvement

- Time is better spent solving shared problems than arguing over measurement methodologies for global cost questions

- It is critically important to develop and monitor metrics for the Institute's programs

Similarly, reasonable people can disagree on the applicability of other solutions to Washington state's problems. The Blue Ribbon Commission (BRC) report focused a great deal of attention on the Utah Health Information Network (UHIN). The founders of the WorkSMART Institute believe the focus on UHIN is a distraction from the task at hand. Similar to all other states outside Utah, Washington state will make progress more rapidly by leveraging the investments that have already been made here, rather than attempting to recreate a UHIN model that was designed for a different time and place.

While the effectiveness of the managing entity will always have some influence on the success of any collaborative initiative, what really matters is the willingness and ability of the health industry participants to adopt solutions and change what they do. Particularly in smaller provider organizations, but even across larger health care organizations, the capacity for change management is fairly limited. Currently this limited capacity is under significant pressure. The Institute founders recognize the initiatives they are championing must fit within the larger demand for change within the industry.

The WorkSMART Institute has developed an initial work plan designed to reconcile the limited change management capacity of the industry with the universal desire for rapid and substantial progress. The work plan is ambitious in the aggregate yet offers individual initiatives scaled to fit the needs of busy health care organizations. The work plan is divided into three major tracks:

- **Simplify the provider payment process** – reimbursement of providers by plans and patients.

- **Strengthen directory services** – finding and matching provider and patient records.

- **Improve authorized access to high value clinical data** – getting the most important clinical data to practioners at or before the point of care.

Within each track, specific program initiatives are defined. These 16 individual initiatives have been parsed into three phases of work beginning in June 2008. It is important to stress the preliminary nature of this work plan. Over time, the specifics are likely to change as new knowledge is gained, adoption occurs

(or not) and the external environment evolves. To accomplish this work plan the WorkSMART Institute will invest approximately $1,500,000 per year in key operational components:

- **Business infrastructure** – staff, systems and operating capability

- **Best Practice Recommendation Work Groups** – facilitated forums to develop optimal policies, work flow and standards

- **Common Application Platform** – a common portal and single point of connection for information exchange

- **Adoption** – tools, techniques and resources to support and encourage usage of the Institute's solutions

The principle of critical mass and a "follow me" style of leadership will play an important role in the WorkSMART Institute's approach to the market. Working with customers and partners the Institute will define and seek a measurable commitment to participate from leading public and private sector payers and provider organizations. Willingness to make and deliver on this commitment will be the most important metric the Institute tracks in its early phases. The WorkSMART Institute looks forward to working with health plans, practioners, hospitals, patients and the public sector to eliminate waste, streamline the flow of information and improve the overall performance of the health care system.

Note: For a copy of the full report, contact OneHealthPort, 206-624-3128, info@onehealthport.com or www.onehealthport.com.

Appendix C - Council for Affordable, Quality Healthcare (CAQH) Universal Provider Data Source (UPD)

The UPD system is designed to collect broad and robust data directly from providers once, and to accommodate multiple administrative needs for multiple health care organizations. The basic data set includes:

- Demographics, licenses and other identifiers (including NPI)
- Education, training and specialties
- Practice details
- Billing information
- Hospital credentials
- Malpractice liability insurance
- Work history and references
- Disclosure questions
- Images of supporting documents

Currently, the UPD system has been adopted in 15 states and CAQH reports the following adoption statistics as of September 2008:

- Over 450 health plans, hospitals and networks participate across the country.
- 620,000 unique providers are registered with the service with approximately 10,000 new providers registering each month.
- In Washington state, more than 10,300 providers are currently registered.
- In Washington state seven national health plans are using the system as their primary credentialing data source.

Adoption by States, Washington Insurers, and Endorsements – September 2008

CAQH is gaining national momentum.

Indiana – more than 18,500 (87% of available providers) – mandated application

Kentucky – more than 13,600 (86% of available providers) – mandated application

DC - more than 3,200 (58% of available providers) – mandated application

Maryland - more than 15,600 (58% of available providers) – mandated application

Ohio - more than 28,000 (79% of available providers) – mandated application

Vermont - more than 3,300 (79% of available providers) – mandate includes hospitals

Louisiana - more than 6,600 (73% of available providers) – one of two accepted forms

New Jersey - more than 24,600 (72% of available providers) – one of two accepted forms

Tenn. - more than 14,300 (80% of available providers) – one of two accepted forms

Kansas - more than 5,300 (66% of available providers) – state supported voluntary

Rhode Island - more than 6,000 (81% of available providers) – state supported voluntary

New York - more than 63,600 (78% of available providers) – industry voluntary

Michigan - more than 27,900 (77% of available providers) – industry voluntary

Massachusetts - more than 33,600 (80% of available providers) – industry voluntary

Washington insurers
- Aetna
- Cigna
- First Health/CCN Network
- Great West
- Humana/Choice Care Network
- Molina
- TRIAD Healthcare Inc
- United Healthcare

Provider organizations endorse the solution
- The American Academy of Family Physicians
- The American College of Physicians
- The American Health Information Management Association
- The American Medical Association
- The Healthcare Administrative Simplification Coalition
- The Medical Group Management Association

Web link: www.caqh.org/ucd.php

Appendix D – Administrative Simplification Executive Oversight Group

Insurance Commissioner Mike Kreidler

Eight providers - Organization/Name

Thomas C. VanSweringen	Vancouver Clinic
Patricia Briggs	Northwest Physicians Network, Tacoma
Richard Cooper	The Everett Clinic
Shaun Koos, Jay Johnson	Wenatchee Valley Medical Center
David Page	Physicians Clinic of Spokane
Rodger McCollum	Snoqualmie Valley Hospital
Chrissy Yamada	Evergreen Healthcare, Kirkland
John Fletcher	Providence Health System

Six associations - Organization/Name

Bob Perna	Washington State Medical Association
Leo Greenawalt	Washington State Hospital Association
Rick Rubin	OneHealthPort
Don Brennan, Abbi Kaplan	Washington Healthcare Forum
Sydney Zvara	Association of Washington Health Plans
Mary McWilliams	Puget Sound Health Alliance

Seven payers - Organization/Name

Brian Ancell, Rich Maturi	Premera Blue Cross
Joel Suelze, Scott Plack	Group Health Cooperative
Laurel Lee	Molina Healthcare
Jonathan Hensley, Nancy Ellison	Regence BlueShield
MaryAnne Lindeblad	DSHS [Medicaid]
John Williams	Health Care Authority
Jonathan Seib	Governor's Executive Policy Office

The Executive Oversight Group met three times in 2008:

- In February, to review the Insurance Commissioner's 2007 report and its recommendations; to be briefed on the work of the Washington Healthcare Forum and OneHealthPort; and to discuss other priorities.

- In June, to discuss the vision, purpose and roles for a state health care administrative simplification program; and to review current simplification initiatives – standardized credentialing, coordination-of-benefits rule changes, and the new WorkSMART Institute program.

- In October, to review progress on the WorkSMART Institute initiatives and the Insurance Commissioner's standardized credentialing project; and to discuss the top priority goals to be recommended in this report.

Appendix E – Web Links to Health Care Administrative Simplification Work by Other States and Groups

Minnesota:

- Department of Health – Division of Health Policy
  www.health.state.mn.us/divs/hpsc/index.html

- Center for Health Care Purchasing Improvement
  www.health.state.mn.us/divs/hpsc/chcpi/index.htm
  www.health.state.mn.us/divs/hpsc/chcpi/adminsimp.html

- Administrative Uniformity Committee (AUC)
  www.health.state.mn.us/auc/index.html

Utah:

- Utah Health Information Network
  www.uhin.com/

- HB 133 – Utah Health System Reform Task Force 2008
  www.le.utah.gov/~2008/bills/hbillenr/hb0133.pdf
  www.le.state.ut.us/asp/interim/Commit.asp?Year=2008&Com=TSKHSR

Ohio:

- Ohio State Medical Association – HB 125 Implementation
  www.osma.org/i4a/pages/headlinedetails.cfm?id=783&archive=1
  www.osma.org/i4a/pages/headlinedetails.cfm?id=709&archive=1

- Ohio Department of Insurance – Prompt Payments and HB 125
  www.ohioinsurance.gov/company/insprmpt.htm
  www.ohioinsurance.gov/consumers/pca/index.aspx?id=1

Colorado:

- Colorado Medical Society – SB 79 (2007) Implementation
  www.cms.org/HomeLinks/SB79Q%26A.pdf

American Medical Association:

- "Heal the Claims Process"
  www.ama-assn.org/ama/pub/category/18658.html
  www.ama-assn.org/ama/pub/category/18660.html

- Administrative costs of health care coverage
  www.voicefortheuninsured.org/pdf/admincosts.pdf

American Academy of Family Physicians:

- Administrative Simplification Advocacy
  www.aafp.org/online/en/home/policy/privatesector/topics/admin-simp.html

2196-OIC-Leg report-Administrative Simplification