Mission Possible II: Reducing Health Care Costs through Administrative Simplification

National Health Policy Forum

Washington D.C.
About MGMA-ACMPE

• MGMA-ACMPE is the Premier association for professional administrators and leaders of medical group practices. In 2011, member of the Medical Group Management Association (MGMA) and the American College of Medical Group Executives (ACMPE) voted to merge to form a new Association.

• Since 1926, the association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals.

• MGMA-ACMPE has
  • 22,500 members…
  • Who manage and lead 13,200 organizations
  • With 280,000 physicians
  • Providing more than 40% of U.S. physician services
Why Administrative Costs Matter: Staff Costs and General Operational Costs Are Increasing

Median Total Operating Cost, Total Support Staff Cost, and Total General Operating Cost (per FTE Physician) for Not Hospital Owned Multispecialty Practices: 2000 through 2010

Source: MGMA Cost Survey: 2011 Report Based on 2010 Data
Why Administrative Costs Matter: Reimbursement Is Not Keeping Up with Either Costs or Inflation

Cumulative Percent Change Since 2001 for the Medicare Physician Payments, Not Hospital/IDS-Owned Multispecialty Group Operating Cost, and the Consumer Price Index

* 2011, and 2012 median operating cost values are three year moving average projections of previous years’ data.
* 2011, and 2012 CPI figures are the July 2010 semiannual figure.

Assumes a 29.5% reduction

-27.5%
Current State of Affairs

- Multiple credentialing processes
- Multiple clinical guidelines
- Multiple formularies
- Multiple disease management protocols
- Multiple contracts with health plans
- Multiple combinations of co-payments/deductibles
- Multiple coverage policies
- Multiple billing requirements
- Multiple coding policies
- Multiple fee schedules
- Multiple electronic interfaces with health plans

None of which adds value to the system

However, each adds to the cost of healthcare in the United States
How Much Do U.S. Doctors Spend Interacting with Insurance Payers? (Health Affairs, August 2011)

US ADMINISTRATIVE COSTS

By Dante Morra, Sean Nicholson, Wendy Levinson, David N. Gans, Terry Hammons, and Lawrence P. Casalino

US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers

ABSTRACT Physician practices, especially the small practices with just one or two physicians that are common in the United States, incur substantial costs in time and labor interacting with multiple insurance plans about claims, coverage, and billing for patient care and prescription drugs. We surveyed physicians and administrators in the province of Ontario, Canada, about time spent interacting with payers and compared the results with a national companion survey in the United States. We estimated physician practices in Ontario spent $22,205 per physician per year interacting with Canada's single-payer agency—just 27 percent of the $82,975 per physician per year spent in the United States. US nursing staff, including medical assistants, spent 20.6 hours per physician per week interacting with health plans—nearly ten times that of their Ontario counterparts. If US physicians had administrative costs similar to those of Ontario physicians, the total savings would be...
Administrative Work in the Physician Practice (Hours per Physician per Week)

<table>
<thead>
<tr>
<th></th>
<th>Authorizations</th>
<th>Formularies</th>
<th>Claims/billing</th>
<th>Credentialing</th>
<th>Contracting</th>
<th>Quality Data</th>
<th>Appts</th>
<th>Total</th>
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<tbody>
<tr>
<td>Physician</td>
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<td>1.3</td>
<td>0.8</td>
<td>0.06</td>
<td>0.05</td>
<td>0.04</td>
<td>0.5</td>
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<tr>
<td>Nursing staff</td>
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<td>3.6</td>
<td>3.2</td>
<td>0.02</td>
<td>0</td>
<td>0.01</td>
<td>1.5</td>
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<td>0</td>
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<tr>
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<td>3.0</td>
<td>0.01</td>
<td>0.13</td>
<td>0.07</td>
<td>0</td>
<td>3.2</td>
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<td>0</td>
<td>0.15</td>
<td>0</td>
<td>0</td>
<td>0.15</td>
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(includes billing Medicare/Medicaid and time seeking timely patient appointments)

### Administrative Cost of Interacting with Insurance Payers

#### Average Hours Interacting with Insurance Payers for Claims Processing per Physician per Year

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<table>
<thead>
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<tbody>
<tr>
<td>Physicians</td>
<td>46.8</td>
</tr>
<tr>
<td>Nurses</td>
<td>197.6</td>
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<tr>
<td>Clerical staff</td>
<td>2,366.0</td>
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<td>Senior administrators</td>
<td>163.2</td>
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</table>

#### Mean Cost for the Interaction with Insurance Payers for Claims Processing per Physician per Year

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<tbody>
<tr>
<td>Physicians</td>
<td>$17,775</td>
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<tr>
<td>Nurses</td>
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<td>Clerical staff</td>
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<td>Senior administrators</td>
<td>$4,712</td>
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<tr>
<td>Total</td>
<td>$82,975</td>
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</table>

Not All Costs Represent Waste

- A multipayer system has inherent costs, which must be balanced against the benefits of competition, innovation, and choice among insurance products.
- Prior authorization requirements may increase administrative costs for physicians and health plans with the potential to reduce the amount of inappropriate care.
- Credentialing and privileging providers attests to qualification and competence and defines the appropriate scope of practice.
- Evidence-based clinical guidelines provide structure to the evaluation of the risks and benefits of treatment options.
- Drug formularies improve the efficacy, safety, and cost-effectiveness of prescription drugs and may decrease inappropriate utilization.
- Individual negotiated contracts may reduce the cost of services / optimize reimbursement.
Opportunities for Reducing Administrative Costs

- Adopt common standards for electronic interactions (billing, claims payment, prior authorization, etc.)
- Standardize prior authorization processes among health plans and pharmacy benefits plans
- Use a single credentialing process for all payers (including Medicare)
- Adopt a single standard for quality measurement process and metrics
- Adopt standardized, machine-readable health identification cards for all payers and Medicare (Smartcards)
- Adopt automated verification at the point of care for patient eligibility for health insurance benefits and co-payment
- Standardize state regulations regarding benefits and handling of claims
- Eliminate prior authorization for efficient, high quality physicians/practices
Some Good News on Administrative Simplification

Several positive developments long-advocated by MGMA

• Final rule on operating rules for HIPAA transactions will make it easier for a practice to:
  – Check patient eligibility and financial responsibility / monitor status of submitted claims
  – Covered entities must comply by Jan. 1, 2013

• Standards for Electronic Funds Transfers (EFTs) and Remittance Advice- Interim Final Rule:
  – Requires the use of a trace number to link bills from providers with payments from health plans
  – All HIPAA-covered health insurers must comply with the regulations by Jan. 1, 2014
“One accurate measurement is worth a thousand expert opinions.”

Rear Admiral Grace Hopper

Are There Any Questions?

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