Mission Possible II: Reducing Health Care Costs through Administrative Simplification

Lewis G. Sandy MD
SVP, Clinical Advancement, UnitedHealth Group
UnitedHealth Center for Health Reform and Modernization

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Overview:

• Major opportunities exist to reduce administrative waste/complexity in healthcare, particularly on the transaction and “utility” side

• Areas of Opportunity:
  – Developing/deploying common technology, standards and operating rules
  – Leveraging technology to improve payment accuracy and speed
  – Creating/promoting broader use of industry-wide “utilities” e.g. CAQH Universal Provider Datasource and CORE

• A Policy Framework:
  – Policies that promote “spread” of existing standards and capabilities
  – Policies promoting electronic connectivity and transaction automation
  – Policies promoting multi-payer capability

• Interoperability and capability maturation should be emphasized, not just “standardization” (risk of lowest-common denominator and stasis)

• Public/private harmonization would accelerate change
The Cost of Health Care: How Much Is Waste?

Source: http://resources.iom.edu/widgets/vsrt/healthcare-waste.html
Major Cost Savings are Possible:

- Not All-Inclusive; Just 12 Fundamental Changes
- Grounded in Experience or Extensions of Experience
- Three Broad Categories
  - Standards, Enhanced Interoperability and Connectivity
  - Common Claim Handling and Clearing
  - Selective Industry Utilities

Identified $332B in Administrative Savings Over 10 Years, Plus Offered $464B in Medical Cost Savings
Where Are We Today: Some Progress, But A Long Way to Go.....

- Areas of Progress: Some standards; e-Prescribing; electronic claims submission; spread/maturation of EHRs/HIEs; operating rules
- But Miles to Go:
  - Full use of existing standards across the industry, end to end
  - The lack of significant, coordinated National Initiatives
- Healthcare trails the field when it comes to benchmarking revenue cycle, with costs several magnitudes higher than other industries
  - Back end 4% Other billing related 2.5%
  - Yet other industries report 0.25 to 0.5%
- Transaction Quality: Error rates would be unacceptable in any other industry
  - First time reject rate 10%-15%
  - Level 1 of six sigma would have an error rate less than 10%
  - Level 2 of six sigma would have level errors less than 1%
- Clinical Analytics and Useful Information At the Point of Care: Toddler Stage
Revenue Cycle Productivity by Industry

Physician Billing Staffing Compared to other Industries
Faculty Practice Solution Center Survey, 2007

Sources: MGPO Analysis using for Industries Credit Today 2005 Benchmarking Survey and for Physician Billing Faculty Practice Solution Center 2006 Billing Office Survey; Courtesy James Heffernan, MGPO
Administrative Simplification: ACA Section 1104

Section 1104 of the ACA (H.R.3590)

‘...Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs’ [CMS-0032-IFC]*

Highlights

• Updated initial August 2000 HIPAA regulation for transaction standards and code sets
• Requires the Department of Health and Human Services (HHS) to appoint a “qualified non-profit entity” to develop a set of operating rules for the conduct of electronic administrative healthcare transactions
• Administrative and financial standards and operating rules must, e.g.
  - Enable the determination of eligibility and financial responsibility for specific services prior to or at the point of care
  - Be comprehensive, requiring minimal augmentation
  - Provide for timely acknowledgment, response, and status reporting
• HIPAA covered entities, and business associates engaging in HIPAA standard transactions on behalf of covered entities, must comply
• Health plans must file a statement with HHS confirming compliance; financial penalties for health plans are significant

* CMS Interim Final Rule (IFR) [CMS-0032-IFC]
ACA: *Mandated* Operating Rule Approach

Operating rule writing and mandated implementation timeframe per ACA legislation

Adoption deadlines to finalize operating rules

- **July 2011**
  - Eligibility and Claim Status

- **July 2012**
  - Claims payment/advice and electronic funds transfer (plus health plan ID)

- **January 2013**
  - Enrollment, Referral authorization, attachments, etc.

- **2015**
  - 2016

Effective dates to implement operating rules

- **January 2013**

Notes:
(1) NCVHS is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules
(2) Statute defines relationship between operating rules and standards
(3) Operating rules apply to HIPAA covered entities but penalties only apply to health plans
(4) Per statute, documentation of compliance may include completion of end-to-end testing

Source: R. Thomashauer CAQH
What are Operating Rules and Why Do They Matter?

- Operating rules address gaps in the standards, help refine the infrastructure that supports data exchange and recognize interdependencies among transactions and the range of standards.
- *Prior to CORE*, national operating rules for medical transactions did not exist in healthcare outside of individual trading partner relationships.
  - Current healthcare operating rules build upon a range of standards – healthcare specific and industry neutral – and support national HIT agenda.
- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing – they are used by many other industries.

### Operating Rules: Key Components

- Rights and responsibilities of all parties
- Security
- Exception processing
- Transmission standards and formats
- Response timing standards
- Liabilities
- Error resolution

*Source: R. Thomashauer CAQH*
End To End Improvement: 2011 Lessons Learned through NHIRC

Productive, collaborative relationships between physicians, practice management systems and payers are important if we are going to make progress together in modernizing our nation’s health care system.

**Product Match Trigger**
- Registration staff must identify insurer and product for each patient.
- Encourage the use of the B&E transaction to identify the member’s benefit/product during the Registration process.
- Payor to provide clear product information on the 835 that allows the Physician group and the Practice Management System to point to the appropriate fee schedule.

**Fee Schedule Transparency**
- Payors must have active dialogues with Providers to ensure Contracted Fee Schedule terms are timely, clear and transparent.
- Contracted Fee Schedules must be loaded into Practice Management Systems to ensure payment accuracy.
- Contracted Fee Schedules must be tied to appropriate products.
- Payors and Providers must have a process in place for ongoing maintenance.

**Reimbursement Policy Translation**
- Driven primarily by payors and the industry.
- Payor specific reimbursement policies and edits make it difficult for Providers to track and calculate.
- The work going on in the Colorado Clean Claim Task Force that is focused on driving a standard set of edits across all payers will help improve this transparency.

### 2011 National Health Insurer Report Card Results (NHIRC)

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>UnitedHealthcare</th>
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<tbody>
<tr>
<td><strong>Metric 5—Contracted fee schedule match rate</strong></td>
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<tr>
<td>Description: On what percentage of claim lines does the payer’s allowed amount equal the contracted fee schedule rate excluding the application of claim edits and payment rules (rules that adjust the fee schedule amount)?</td>
<td>61.55% 74.34% 89.86% 92.26%</td>
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<tr>
<td>2008 2009 2010 2011</td>
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<tr>
<td><strong>Metric 6—First ERA Accuracy</strong></td>
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<tr>
<td>Description: On what percentage of claim lines does the payer’s allowed amount equal the physician practice’s expected allowed amount?</td>
<td>85.99% 90.22%</td>
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<td>2008 2009 2010 2011</td>
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Standardization vs. Interoperability

Does anyone say we need to “standardize” product features and offerings at the grocery store due to administrative complexity?
Transformational Technology: Clinical analytics at the point of care

Alerts to Track Patients with Chronic Conditions

- Total Physicians: 45% Yes, 55% No
- Specialists: 48% Yes, 52% No
- PCPs: 41% Yes, 59% No

Computerized or Automated System in Place

- Total Physicians: 65% Yes, 35% No
- Specialists: 66% Yes, 34% No
- PCPs: 63% Yes, 37% No

Opportunities To Reduce Administrative Waste:

• Improve the efficiency and quality of basic transactions throughout the healthcare system, particularly billing and eligibility, using existing and emerging standards and operating rules;
• Develop policies and programs that emphasize end to end simplification; “simplifying” just a piece of a process does not result in cost reduction;
• Promote interoperability, automated flow of information, and enhanced analytics;
• While reducing administrative/transaction costs is worthy on its own, modernizing the data/administrative infrastructure of the US healthcare system has its biggest payoff in facilitating optimal clinical care;
Thank You!