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Statement to
National Committee on Vital and Health Statistics
Subcommittee on Standards

Administrative Simplification under the Patient Protection and Affordable Care Act
Operating Rules for Eligibility and Claims Status

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Chairpersons and members of the subcommittee, I want to begin by thanking you for the opportunity to participate in today's discussion of the Operating Rules for Eligibility and Claims Status to be developed and adopted pursuant to the Patient Protection and Affordable Care Act (ACA).

For the past 2 years my primary responsibility for the Washington State Insurance Commissioner has been to support health care administrative simplification efforts in Washington State. I have represented Commissioner Kreidler on work groups that have developed best practice recommendations for several health care transactions and processes - including the provision of eligibility and benefits information, claims status inquiries, pre-authorization processes, and my favorite – coordination of benefit processes and timelines.

Health plans and providers in Washington State began collaborative work 10 years ago on a number of voluntary administrative simplification projects, but progress was slow. In 2009, legislation was enacted to accelerate administrative simplification in Washington State. The new statutes create a framework for the private sector to take the lead in streamlining provider/payer interactions through voluntary adoption of best practices. However, if the voluntary adoption approach proves unsuccessful, the statutes also give the Insurance Commissioner authority to adopt regulations that mandate universal adoption of certain best practices by providers and payers in Washington State.

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The specific areas addressed by the Washington administrative simplification statutes include:

- The creation of a uniform process for electronic collection of data needed for provider credentialing, hospital privileges, and other health care system needs;
- Enhanced eligibility transactions – both batch processing and web-based - that include rich eligibility and benefits detail;
- A standard coding initiative, reflecting the national correct coding initiative (NCCI); and
- Requirements for plans to consider extenuating circumstances and adhere to timelines in processing requests for pre-authorization, and to simplify browser-based tools to facilitate pre-authorization requests from providers.

The statutory initiatives apply to state health care agencies, private health plans, hospitals, physician practices and many other types of providers.

The statutory initiatives have largely been carried out by work groups composed of senior systems and business operations staff employed by several health care payers and providers who volunteer their time. The Insurance Commissioner has an oversight role and is supported by an advisory group composed of executive-level representatives of health plans, hospitals, health systems/clinics, state health care agencies, and associations representing providers and health plans. The staff support for the work groups has been provided by OneHealthPort, a private entity with significant expertise in health care administration. Funding for the work is provided by health plans and large provider organizations.

Subcommittee staff has copies of reports prepared by our office and by OneHealthPort. The Best Practice Recommendations that have been developed to date – including "Requesting and Receiving Coverage Information for Eligibility and Benefits " – are available on the OneHealthPort web site.
http://www.insurance.wa.gov/publications/documents/AdminSimplification1.pdf
http://www.onehealthport.com/admin_simp/admin_simp_overview.php
http://www.onehealthport.com/worksmart/bproverview.php

In addition to the work activities initiated by the 2009 legislation, our office has also been participating for the past 9 months in the Eligibility and Claims Status CORE subgroups, and to a lesser extent on the CORE Rules work group. Our involvement has been limited since the OIC does not engage in any health care administrative transactions. However, I would feel remiss if I did not note that CAQH staff has been very encouraging and supportive of our involvement, clearly demonstrating through their actions a commitment to inclusiveness and openness to input from all parties.

The three points I would like to quickly touch upon in the remainder of my testimony today are:

- Why are we here today? Why do we need operating rules?
- What has the Washington State experience been with the development of best practice recommendations – our version of "operating rules"?
- National operating rules should set standards that are both ambitious and achievable. States should be permitted to establish higher standards that meet the needs of their providers and payers, so long as the state enhancements build upon, and are not inconsistent with, the national operating rules.

I. Why are we here today? Why do we need operating rules?

- The bottom line –we need to reduce administrative burdens and costs. There appears to be very broad agreement regarding this goal.
- We must get away from paper and get staff off the phone. For that to happen, the electronic transactions need to be used in a way that works for providers, in their varied settings and workflows - not just in a way that works for health plans.
- We need to figure out how to use HIPAA transactions as effectively as possible to reduce administrative burdens and cost. Well crafted operating rules will be a necessary precondition to broader and more consistent use of HIPAA transactions by providers.

II. What has the Washington State experience been with the development of best practice recommendations – our version of "operating rules"?

- Collaboration, inclusiveness, and transparency are critical to success.
- *"Collaboration between payers and providers, and between the private and public sector, has been the key to the engagement of our work groups and to the improvements we've experienced in Washington. The collaboration began by surveying the provider community on their top issues then tackling the most common complaints/concerns. The agenda was not driven by the health plans but all parties did agree on overall goals i.e., reduce rework, manual effort and inconsistencies between plans that caused providers to resort to the lowest common denominator. The time spent by the work groups at a detail level evaluating issues and solutions has been a key factor in the success achieved by the workgroups."* [Comments by a provider participant in one of the work groups.]
- In developing its best practice recommendations, the work groups have had to balance competing interests. For example, the payers that operate in multiple states have raised some concerns about having to make system changes to address Washington State-specific requirements. The work groups have had to balance the goals of [1] permitting payers to use a single system/process in all states – which can sometimes be helpful in minimizing variations for providers located in border areas; and [2] crafting additional requirements that could further reduce administrative burdens and costs for health care providers.
- Collaboration requires an appropriate public-private partnership. The private sector – payers (including public payers where appropriate) and providers – should be given the lead role in identifying the problems, defining the solution and promoting voluntary adoption. The public sector [HHS, through the NCVHS] role can be to act as a convener, to ensure a broad opportunity for engagement and input, and to make decisions on issues where payers and providers cannot reach significant agreement. The public sector also needs to undertake active education and enforcement efforts, as necessary.

- It is very important, and challenging, to obtain significant provider engagement – from hospitals, clinics, integrated health systems, and others. Getting input from multiple perspectives leads to improved decisions. Ideally, geographic and specialty segments need to be represented. As a practical matter it has been very difficult to engage providers in small practices and rural locations.

    - Face-to-face discussions are very helpful, especially for soliciting input from providers. Phone conference calls do not generate nearly as much give-and-take; the most aggressive are heard from frequently, the less assertive may have important information to share.

    - It is very helpful to have a skilled neutral facilitator who can promote engagement, help reduce or overcome barriers to engagement, and track and record all the different perspectives and provide written summaries following meetings. It is important that the facilitator not be perceived as having an agenda of his/her own. This has been a strength of our process to date.

    - In Washington State two key groups are represented on the various work groups: [1] health care payers – insurers and state health care agencies; and [2] health care providers – health care systems, hospitals, and large and medium sized clinics. The work groups do not generally include association or vendor representatives. The goal has been to bring together the persons who actually handle the administrative processes on a day-to-day basis, or who design or program the systems for the health plans or providers. These are the persons with the most knowledge of the current practices and issues, and the most to gain from reductions in administrative burdens. Vendors and others are welcome to participate as sources of information through their payer and provider clients.

    - Bottom line – to develop the best possible operating rules, it is very beneficial to include providers as active participants in the process. This is a great challenge - the time and expense involved are barriers that need to be addressed and providers also need to believe their needs will be heard and addressed. It is difficult to deal with these challenges working on a state or regional level; it will be an especially daunting challenge for the nonprofit organization that undertakes the development of the operating rules for Eligibility and Claims Status.

III. **National operating rules should set standards that are both ambitious and achievable. States should be permitted to establish higher standards that meet the needs of their providers and payers, so long as the state enhancements build upon, and are not inconsistent with, the national operating rules.**

- A threshold question regarding the operating rules to be adopted by HHS is whether they will be treated as a floor – a minimally acceptable level of functionality, or as both a floor and a ceiling – permitting no additional functionality requirements. We endorse the position taken by CORE that the operating rules should be treated as minimum standards that can be built upon, and that the operating rules should be updated in a phased approach.

- We agree that it is reasonable to prohibit states from mandating processes or standards that directly conflict with the national operating rules – just as they cannot create state-unique standards for HIPAA transactions that conflict with those adopted by HHS. In developing our best practice recommendations we have been committed to following to all HIPAA standards.

- However, we also believe it is important to permit states to establish requirements that "raise the bar" in ways that are consistent with and build from the national operating rules. This will enable payers and providers in interested states to explore additional ways to promote administrative simplification.

- As a general rule state administrative simplification processes can more easily engage and solicit input from providers than national processes. Very few providers will be willing and able to absorb the costs and logistical challenges of a national collaboration process. This greater engagement of providers can lead to the development of better strategies/standards and can help lay the ground work for successful and faster implementation of the desired changes.

- The best practice documents developed in Washington State provide an example of how operating rules can have two tiers of requirements. Some of our best practice documents identify two levels of acceptable performance: a minimally acceptable set of performance expectations that need to be met by the end of 2010; and a higher set of performance expectations [sometimes referred to as "beacon" expectations] that are not mandatory at this point, but might be proposed as mandatory in the future. The use of the "beacon standards" can identify system or process functionality that payers or providers may be expected to meet in the future. This is similar in nature to the approach taken by the recent HHS "meaningful use" regulations. The challenge is the same: to find the best way to set ambitious goals while also recognizing that in the short term, it will take some entities longer to make system/operational changes.

- Health plans that choose to do business in multiple states might face additional costs if states adopt higher operating rule requirements, even if those requirements build from and are consistent with the national operating rules. That expense should be viewed as a reasonable cost that results from doing business in multiple states and should not be viewed

as a basis for prohibiting states from setting higher standards that build upon and are not inconsistent with the federal national operating rules.

- In summary, the HHS national operating rules should lay out what standards need to be met by all health care payers and providers. States should be permitted to set "beacon goals", provided they build upon and are consistent with the national requirements. In this way, over time, state efforts should contribute to the ongoing enhancement of the national operating rules.

- States – especially those that have administrative simplification initiatives - may be able to supplement enforcement of the HIPPA standards and operating rules. The work of developing operating rules will be worthwhile only if the rules are universally adopted. Adequate planning and resources need to be provided for enforcement activities.