

**Bringing Better Value:
Recommendations to Address the Costs and
Causes of Administrative Complexity in the
Nation's Healthcare System**

HASC Summit on Administrative Simplification Final Report

July 2009

www.simplifyhealthcare.org

Summit on Administrative Complexity

The Healthcare Administrative Simplification Coalition (HASC) sponsored a Summit on Administrative Complexity in Washington, D.C., on November 13, 2008. The Summit included participants from government agencies, health plans, health plan associations, physician and hospital organizations, and health information organizations. Summit discussions have led to the development of this report, which frames administrative complexity in health care around several process topics related to payment.

Brief Summary

HASC calls on key industry stakeholders to move forward to leverage health information technology and the use of industry standards to streamline critical areas of healthcare administration. This Final Report offers recommendations to educate, collaborate, and adopt simplified administrative technologies and processes. The Report focuses on several important areas of administration that, if appropriately reengineered, could yield significant efficiency and cost savings to the industry. The Report also addresses the following topics: the costs of healthcare complexity; practitioner credentialing; health insurance verification; the use of standardized, machine-readable health identification cards; and prior authorization processes.

About HASC

Unnecessarily complex or duplicative administrative processes waste billions of dollars in our nation's healthcare system each year. The goal of HASC is to identify areas where administrative complexity can be simplified and healthcare costs can be reduced. HASC was organized in 2005 by the American Academy of Family Physicians (AAFP), the American Health Information Management Association (AHIMA) and the Medical Group Management Association (MGMA).

HASC Members

HASC members include the nation's leading physician and hospital organizations, health and benefits plans, employers, government agencies and other groups that share HASC goals.

NOTE: HASC advocacy and other positions are determined by majority vote of its members and do not necessarily represent the position of all of its members.

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Executive Summary

The current levels of administrative complexity and redundancy in the nation's public and private healthcare financing programs divert billions of dollars annually from patient care. About one quarter of total U.S. health care spending goes to administrative functions instead of actual services provided to patients.

HASC estimates that even a modest 10 percent optimization of administrative processes and technologies would save the U.S. health care system approximately \$500 billion over ten years.ⁱ⁻ⁱⁱ

The following are the HASC recommendations:

Simplify Practitioner Credentialing

Challenge – Practitioners typically need to complete separate credentialing processes for several different health insurance companies each year. The verification process of practitioners' qualifications and history is critical, but costly and time-consuming.

Opportunity – HASC encourages the universal use of the Council for Affordable Quality Health Care (CAQH) Universal Provider Datasource™ (UPD), a credentialing tool that has already proven successful. If developed by the Centers for Medicare & Medicaid Services (CMS), an electronic data interchange would allow credentialing information to flow between its Medicare Provider Enrollment and Chain/Ownership System database and UPD. All Medicaid agencies should be allowed access to exchange information.

Improve the Healthcare Insurance Eligibility Process

Challenge – Patient eligibility and benefits must be correctly identified for billing purposes. Costs related to claims processing are estimated at up to 14 percent of physician practices' annual gross revenue; 8 percent of hospitals' annual gross revenue; and up to 11 percent of private insurers' annual gross revenue.ⁱⁱⁱ

Opportunity – HASC estimates labor costs related to insurance billing processes could be reduced by as much as 50 percent. HASC urges health plans, billing clearinghouses, practice management systems, and electronic data interchange vendors to seek certification with the CAQH Committee on Operating Rules for Information Exchange (CORE).

ⁱ Woolhandler, S., Campbell, T, and Himmelstein, D. Costs of Health Care Administration in the United States, New England Journal of Medicine, Volume 349:768-775, August 21, 2003.

ⁱⁱ Accounting for the Cost in the United States: Accounting for the Cost in the United States, The McKinsey Global Institute, January 2007.

ⁱⁱⁱ Kahn J, Kronick R, Kreger M, Gans D. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. Health Affairs 2005 24;1635. <http://content.healthaffairs.org/cgi/content/full/24/6/1629>. Accessed July 10, 2009.

Standardize Machine-Readable Health Identification Cards

Challenge – Health insurance identification (ID) cards vary widely in terms of the type and amount of information that they convey about the policyholder and the plan. A frequent result of this inconsistency is a clerical error that results in a rejected claim, which must be re-worked and re-submitted. Correcting these problems costs providers and payers countless staff hours. A consistent approach to the type and amount of information on ID cards would reduce the number of clerical mistakes on claims and, as such, reduce the amount of time spent on their re-submission.

Opportunity – Standardized machine-readable health ID cards and a low-cost software interface in practice management software systems and electronic health records (EHR) systems would help prevent and reduce clerical errors.

Standardize Prior Authorization Processes

Challenge – The wide variation in prior authorization requirements and criteria among payers adds complexity and cost. One study found that the average yearly cost for a 10-physician practice to deal with pharmacy-related issues alone was approximately \$137,000.

Opportunity – Automated, simplified, transparent, and, to the extent possible, standardized prior authorization processes among all health, radiology and pharmacy benefits plans would help reduce costs.

Conclusion

Although several areas of administrative complexity remain to be addressed, the adoption of the recommendations presented in this report could save billions of dollars. As the U.S. healthcare system reform faces significant challenges, voluntary and mutually beneficial solutions such as the ones described in this report need to be on the agenda. HASC will continue to work to identify areas of duplication, lack of uniformity, and other components of healthcare administration that lead to unwarranted waste that our healthcare system can no longer afford.

The Costs of Healthcare Complexity

Introduction

While the U.S. healthcare system is considered one of the most technologically advanced in the world, it is also the most expensive. Based on 2007 figures, the United States spends \$7,421 per capita on health care^{iv}—twice as much as other nations spend—while more than 45 million Americans lack healthcare insurance. HASC is committed to reducing the administrative costs and complexity that generate unnecessary costs in health care.

In addition to the availability of expensive high technology and consumer demand for services, a surprising portion of high costs of health care in the United States is the result of administrative expenses that provide little direct benefit to patients. Hospitals, physicians, medical administrators and insurance companies spend excessive amounts of time on paperwork—time that could otherwise be spent on patient care.

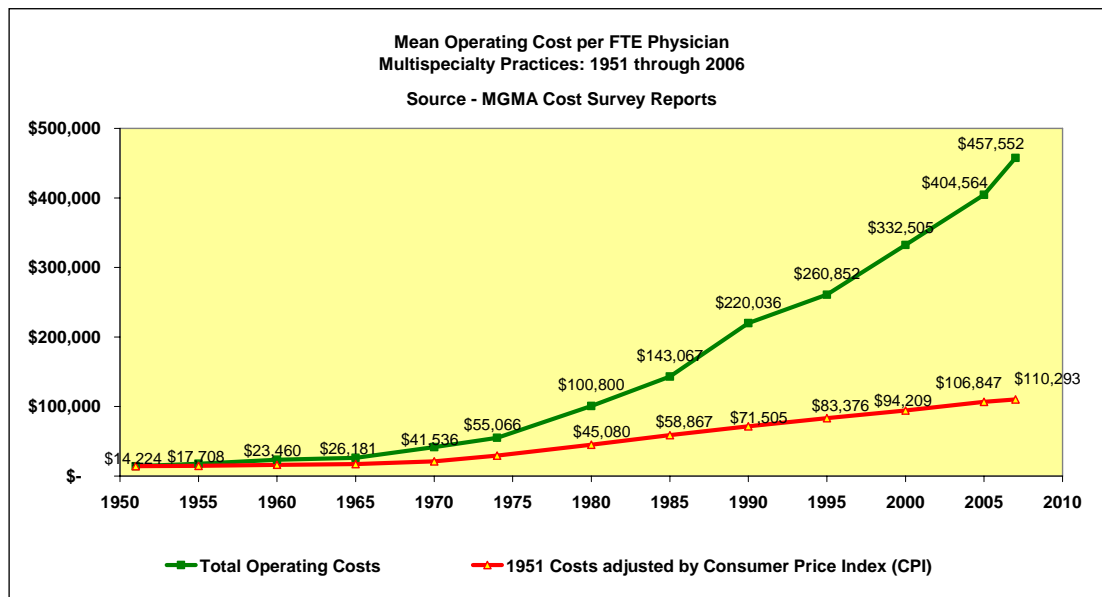
This report looks broadly at the cost of healthcare complexity and the opportunities for savings. It focuses on shared responsibility for where the healthcare system is and where it needs to go in order to minimize administrative costs.

Background

The Medical Group Management Association (MGMA) Cost Survey Report, which describes medical group financial performance, shows that multispecialty medical groups total operating costs have increased at a rate that exceeds the variation in the national Consumer Price Index (CPI) for more than 50 years (*Table 1*). The fourfold increase in total operating costs in comparison with the variation in the national CPI illustrates the problem facing the U.S. healthcare system. More widespread use of new technologies, acquisition of new equipment and training of technicians are some of the factors that contribute to increased operating costs. Furthermore, a shift of healthcare services from the hospital to the physician's office has required an increase in staff hiring to assist physicians in the office-based care of more acutely ill patients. Finally, escalating administrative complexity and fragmentation of the U.S. healthcare system have also contributed to cost increases.

^{iv} National Center for Health Statistics. With chartbook on trends in the health of Americans. Health, Hyattsville, Ma: 2007;391-3.

Table 1



U.S. healthcare expenditures total more than \$2 trillion dollars per year, 16.2 percent of the U.S. Gross Domestic Product (GDP) in 2007. This amount continues to increase in excess of 7 percent per year, exceeding the rate of annual growth in the U.S. GDP. Expenditures per capita continue to show an increase, of 6 percent each year.^v

Administrative costs account for an average of 25 percent of healthcare spending, with a sizable portion attributed to billing and insurance-related functions. Studies into the cost of administration and insurance billing indicate that private insurers spend approximately 9.9 percent of revenue on administration and an additional 8.4 percent on billing functions; physician offices spend 27 percent of revenue on administration and 13.9 percent on billing; and hospitals spend 21 percent of revenue on administration and 7 percent to 11 percent on billing activity.^{vi}

Challenges

Administrative redundancy and unnecessary complexity in public and private healthcare financing programs divert billions of dollars from the provision of healthcare services into administrative processes. Many such processes were originally introduced to control spiraling costs, but have failed to evolve and leverage the process improvement opportunities that new technologies present, contributing to the financial impact on patients, employers, payers, physicians, and healthcare administrators.

According to MGMA studies, the annual cost of redundant clerical work approaches \$25,000 per physician. In addition to the administrative work that is essential to the normal

^v National Center for Health Statistics. 2007.

^{vi} Kahn, et al.

operations of a busy practice, the typical 10-doctor medical group spends \$247,500 on regulation- or contract-required but unnecessary administrative tasks that provide little benefit to patients.^{vii} The cost of physician and staff hours spent on administrative tasks related to pharmaceutical formularies, prior authorizations, claims and billing, credentialing and contracting are estimated to range from \$23 billion to \$31 billion annually.^{viii}

Medical groups also spend a great amount of time and money on clerical tasks. For example, the yearly average number of credentialing applications submitted by medical groups is 13.2 for insurance companies; 3.7 for hospitals; 0.5 for ambulatory surgery centers; and 0.4 for other health entities.^{ix} These separate credentialing applications are identical in scope and content. However, costs incurred by each receiving organization are maximized because applications are processed separately.

Opportunities

The simplification of clerical work would potentially reduce healthcare costs by at least 10 percent without affecting the quality of care or having any substantial negative effects. While even greater cost savings are conceivable, a 10 percent elimination of unnecessary clerical work would generate annual savings of as much as \$57 billion on health care.^x

HASC has sought to identify options and solutions to streamline and eliminate redundancies in administrative processes and to better coordinate services in order to reduce costs. It has focused on the implementation of sensible, meaningful administrative simplification. This coalition is also examining solutions to leverage information technology in order to reduce costs and improve patient care.

^{vii} Medical Group Management Association (MGMA) Center for Research. Analyzing the cost of administrative complexity, new research findings support current initiatives to simplify health care payment system. September 2004. Available at: <http://www.mgma.com/about/default.aspx?id=280>. Accessed July 10, 2009

^{viii} Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, et al. What does it cost physician practices to interact with health insurance plans? *Health Affairs* 2009;28 (4).

^{ix} Pope C. The cost of administrative complexity. *MGMA Connexion*. November/December 2004.

^x Heffler S, Smith S, Keehan S, Clemens MK, Won G, Zezza M. Health spending projections for 2002-2012. *Health Affairs* 2003; W3;54-65.

1. Simplification of the Practitioner Credentialing Process

Introduction

Credentialing, a common healthcare industry process for collecting and verifying practitioner qualifications and practice history, can be time-consuming and costly. Health insurance companies, hospitals and other healthcare organizations verify physicians' credentials before physicians can treat and receive payment for services provided to patients. A standardized electronic data collection tool would optimize credentialing-related clerical work for physicians and their staff, and data collection and processing for hospitals, insurance companies and other entities, while lowering administrative costs.

Current Environment

Except for minor differences, the information required by health insurance companies, Medicare, Medicaid, and hospitals from physicians and other health care providers to complete the credentialing process is essentially the same. However, in the current environment, each organization has to individually and independently complete the review and approval of the credentialing process, an important risk management function for health plans specifically. The credentialing process is linked to the framework of the Health Care Quality Improvement Act of 1986 to ensure review of quality-related credentialing criteria, and high quality process standards should be maintained under any model of credentialing that drives uniformity.

Adding to the workload, health care providers are also required to maintain their credentialing information current with each organization with each they are associated. Health plans may require a recredentialing process every three years. Additionally, health care providers must provide similar information to hospitals during the initial application process, and then every two years as part of their recredentialing.

All of the clerical work involved in the credentialing and recredentialing processes is time consuming and adds to administrative costs. As a result of multiple submissions to different organizations, the risk of errors is increased, and the time spent correcting such errors represents additional administrative costs for practitioners, health plans and other health organizations.

According to industry data, a typical 10-physician practice conservatively spends more than \$7,600 in staff time, or \$45 per application, every year on the submission of credentialing applications. The average amount of time spent annually per application is more than 11 minutes for physicians and nearly 70 minutes for support staff.^{xi}

CAQH Universal Provider Datasource (UPD), which was launched in 2002, allows registered physicians and other health professionals in all 50 states and the District of

^{xi} MGMA Center for Research. September 2004.

Columbia to electronically enter their credentialing information into a single, uniform online system that meets the credentialing data requirements of health plans, hospitals, and other healthcare organizations. This electronic solution, offered free of charge, optimizes the credentialing process for providers. Several states mandate the use of a uniform credentialing form, and some actively promote the CAQH UPD credentialing process.

More than 735,000 providers are registered to use the UPD service to share their credentialing information electronically with more than 500 health plans, networks and other organizations across the country. Based on figures from a September 2004 MGMA cost analysis report, this has resulted in savings of more than \$92 million per year or more than 3.2 million hours (or the equivalent of 1,500 full-time employees) of provider and support staff time.^{xiii} More than 8,000 new providers sign up to use the UPD service each month. CAQH estimates that as more organizations replace the use of paper applications with UPD, the savings will continue to increase with a potential to eliminate an additional \$150 million to \$200 million in unnecessary administrative costs if everyone participated.

Opportunities

Providers. Universal adoption of a standardized electronic data collection tool would further extend the benefits accomplished where UPD is in use. These include:

- Simplification of credentialing process;
- Fewer errors;
- Lower practice operating costs;
- Shorter wait for practitioners to begin to treat patients;
- Increased patient satisfaction (as a result of ability to obtain an appointment more quickly with a new practitioner);
- Simplification of recredentialing process because only information that has changed since the initial credentialing must be submitted.

Health plans and administrators. Simplification of the provider credentialing process through the adoption of a standardized data collection tool, elimination of individual credentialing applications and the outsourcing of the data collection component of the credentialing process has produced measurable improvements for health plans and administrators. Where implemented, it has

- Reduced time and costs associated with developing an individualized credentialing application;
- Reduced the number of errors and costs associated with errors made by practitioners and their staff when completing the applications;
- Lowered costs associated with the collection of data because the costs are amortized over a large number of organizations, including hospitals, health insurance plans and others;
- Increased the number of providers participating in networks (reduction of paperwork makes participation in multiple health plans easier and more appealing);

^{xiii} MGMA Center for Research. September 2004.

- Increased the likelihood that practitioners will update their credentialing information within required timeframes, while decreasing the costs associated with recredentialing.

Additionally, the UPD data-collection service has eliminated approximately 2.5 million legacy credentialing applications across the industry to date. The system requires that physicians and other health care professionals update their credentialing information throughout the year, eliminating the need for recredentialing applications among users.^{xiii} This process reduces the risk of errors or omissions.

Patients/consumers. Broader adoption of a standardized electronic data collection tool would promote the following benefits:

- Reallocation of funds and time to patient care;
- Access to new practitioners more quickly;
- Increased access to practitioners disinclined to participate in certain health plans because of the burden associated with credentialing;
- Consistent and timely data that can be used to update and maintain payer provider directories.

Employers. Simplification of provider credentialing processes would promote the following benefits:

- Decreased administrative costs associated with health care, which would translate into decreased administrative costs;
- Decreased employee complaints regarding the data accuracy of payers' provider networks.

^{xiii} MGMA Center for Research. September 2004.

HASC Recommendations: Simplification of Practitioner Credentialing *

- a) **Full participation in the CAQH Universal Provider Datasource™ (UPD) and use of the UPD tool as the primary practitioner data collection tool for all health plans and hospitals that require contracted providers to be credentialed.**
- b) **Development of an electronic data interchange by the Centers for Medicare & Medicaid Services (CMS) for the communication of provider credentialing information that will allow for sending data from the Universal Provider Datasource™ (UPD) to the web-based Medicare Provider Enrollment and Chain/Ownership System (PECOS) database.**
- c) **Education of employer organizations to heighten the awareness of cost saving opportunities associated with the use of UPD, and support for the inclusion of UPD in their requests for proposal to health benefits organizations.**
- d) **Support for the review and use of UPD by State Medicaid agencies for provider data collection and maintenance requirements.**

*An assessment of state laws and accrediting entities (e.g., National Committee for Quality Assurance [NCQA], Utilization Review Accreditation Commission [URAC]) impact on credentialing requirements will be performed to assist in the development of state- or accreditation-specific strategies.

2. Simplification of the Healthcare Insurance Eligibility Process

Introduction

The simplification of provider payment administrative processes would result in time and cost savings. Estimates show that that unnecessary spending in the U.S. healthcare system reaches \$1.2 trillion of the \$2.2 trillion total spent nationally.^{xiv} Studies indicate that automation, simplification of processes, or a combination of both could generate savings ranging from \$21 billion^{xv} to up to \$300 billion.^{xvi}

Government-mandated electronic data interchange (EDI) standards (through the Health Insurance Portability and Accountability Act, HIPAA) are in place for healthcare transactions associated with the payment process cycle, as it relates to eligibility verification and notification of processed claims. Yet, the interpretation, utilization and application of the standards vary widely among EDI entities (e.g. payers, claims clearinghouses, and practice management software vendors). This section will identify the main challenges and costs associated with the payment process, and highlight opportunities and recommendations that will lead to improved efficiency, reduced administrative costs, and elimination of frustration among patients, providers, and payers. Success will rely on increased transparency and the collaborative development and adoption of operating rules for EDI transactions.

Current Environment

HIPAA addressed issues related to data content and format for health care-related EDI transactions. However, there is still a lack of uniformity in the flow and access to data that leads to variability in the execution of transactions, which results in waste in the system. A recent study indicates that administrative activities spending on claims processing ranges from 10 percent to 14 percent of gross revenue for physician practices, 8 percent for hospitals, and 7 percent to 11 percent for private insurers.^{xvii}

Opportunities

The verification of patient eligibility and benefits process represents a costly administrative burden on providers and payers. A study shows that labor costs associated with the verification of insurance coverage could be reduced by as much as 50 percent with the adoption of automated HIPAA eligibility transactions, as opposed to labor-intensive and time-consuming insurance verification methods (e.g., the web, fax, and phone). Labor

^{xiv} PricewaterhouseCoopers Health Research Institute. The price of excess: identifying waste in healthcare spending. April 2008.

^{xv} PNC Financial Services Group White Paper. Automated billing/payment process can reduce U.S. health care costs without sacrificing patient care. November 2007.

^{xvi} Heffler S, Smith S, Keehan S, Clemens MK, Won G, Zezza M. Health spending projections for 2002-2012. Health Affairs 2003; W3;54-65.

^{xvii} Kahn, et al.

costs estimated at \$1.38 per call could be eliminated if insurance coverage verification were automated.^{xviii}

The CAQH Committee on Operating Rules for Information Exchange (CORE) continues to develop voluntary operating rules for electronic data interchange to improve administrative efficiencies in health care. CORE's operating rules have addressed eligibility verification and benefits information, claims status, and are now addressing additional transactions. CORE's efforts model those of the banking industry, which developed operating rules for electronic transactions (e.g., electronic funds transfers). CORE's goal is to push the industry to make CORE-certification the norm.

HASC Recommendations: Simplification of the Healthcare Insurance Eligibility Process

- a) **Adoption of voluntary certification with the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I and II rules by health plans, clearinghouses, and practice management systems and electronic data interchange, as well as active participation in CORE Phase III.**
- b) **Development and dissemination of standardized materials to educate the provider community about the CAQH CORE Phase I and II rules, and CORE certification for vendors and practice management systems.**
- c) **Streamlined implementation of new or substantially revised HIPAA standards by support of pilots that test standards prior to adoption.***

*On January 5, 2009, CAQH announced a partnership with CMS, the Blue Cross and Blue Shield Association (BCBSA), Integrating the Healthcare Enterprise (IHE), and the Healthcare Information and Management Systems Society (HIMSS) that is focused on demonstrating how the CORE Phase I and II rules are already requiring, and thus pre-testing, for aspects of the "new HIPAA" transactions (new regulation under HIPAA will be slated for 2012). HASC wants to use real-world efforts like this to show that the industry can embrace, test, improve, and use standards before they are required for adoption.

^{xviii} Kahn, et al.

3. Standardized, Machine-Readable Health Identification Cards

Introduction

Health insurance identification (ID) cards vary widely in terms of the type and amount of information they convey about the policyholder and the plan. This type of inconsistency results in a significant percentage of rejected claims, which must be re-worked and re-submitted, costing providers and payers countless staff hours.

Machine-readable health ID cards have the potential of optimizing this process by accurately capturing and transmitting the policyholder information directly into the provider's electronic patient management system, which is used to generate and track claims. However, health ID cards are only one eligibility verification option. Other options used to access policyholders' information are available, and will continue to evolve as technology progresses (e.g., web-based queries based on patient information such as first name, last name, date of birth and ZIP code and/or drivers' license number). In case a health ID card is not available, rules to ensure real-time, robust, accessible and consistent data across payers must be in place. Without structure, such as rules, the ID card won't have the information to access, or any consistency on how fast the information flows, how to get access, etc.

Current Environment

Estimates indicate that a significant number of physician claims are rejected by health plans because of incorrect patient identification. As a result of wide variation in the type and amount of information conveyed in health ID cards, and poor image quality of photocopied or scanned cards sent to payers, errors in the identification of policyholders are likely to occur when the claim is submitted to a health plan. Even when policyholders can be correctly identified, certain health ID cards do not contain all the necessary information to allow providers to file claims and appropriately manage third-party payment issues.

The *Health Identification Card Implementation Guide* was approved by the Workgroup for Electronic Data Interchange (WEDI) in November of 2007. The Guide, based on standards developed by the X12 and American National Standards Institute (ANSI) standards organizations, includes specifications for machine-readable ID cards, as well as required data elements that need to be included on the cards. Several large health plans have adopted the WEDI Guide.

The CAQH CORE Phase III is currently examining opportunities to address the use of the WEDI format for the cards in collaboration with WEDI. Should they be adopted, these rules will require that any CORE-certified plan, vendor or practice management system using a health ID card for verification purposes follow the WEDI ID Card standard. The rules will help ensure a common implementation of the standard, taking into consideration that certain aspects of the WEDI are optional or provide options. This will allow vendors and providers to have a consistent approach across all payers.

Opportunities

Government and private sector entities need to address the standardization of health ID cards as a part of a broader administrative simplification and health information technology effort. Currently, CORE certifies vendors and practice management systems, plans, and large providers for administrative transactions. Several practice management software systems are Phase I-certified and their vendors are committed to Phase II certification by the last quarter of 2009.

The following are qualitative and quantitative benefits expected from the use of WEDI-compliant machine-readable health ID cards with standard card issuer identification:

Providers. WEDI-compliant machine-readable health identification cards will:

- Reduce errors in policyholder and insurance benefit identification information from health ID cards;
- Reduce administrative costs associated with rejected claims;
- Optimize lengthy admission processes;
- Simplify clerical processes;
- Enhance the provider-insurance plan relationship as a result of fewer claim errors;
- Optimize staff time and eliminate costs associated with photocopying and filing of health ID cards, manual information lookup and data entry;
- Facilitate immediate automatic transactions, such as eligibility inquiries, when integrated with enhanced provider systems;
- Convey insurance benefit information and medical record identification more accurately, efficiently and promptly when combined with rules;
- Contribute to higher levels of patient satisfaction as a result of more efficient and effective means to share accurate, timely policyholder identification information.

Health plans and administrators. WEDI-compliant machine-readable health identification cards will:

- Reduce errors in patient identification information from health ID cards;
- Improve employer and health plan sponsor satisfaction;
- Reduce costs associated with rejected claims reconciliation as a result of availability of eligibility and other claims-related data on health ID cards;
- Significantly reduce costs associated with help desks and administrative record searches for providers and policyholders;
- Allow the use of the universal health plan identifier conveyed by the card, which will improve coordination of benefits,.

Patients/consumers. WEDI-compliant machine-readable health identification cards will:

- Reduce errors in policyholder and insurance identification information from health ID cards;

- Allow use of a single health ID card to access to information about multiple benefits (Note: due to privacy concerns, health ID cards do not hold data, but rather serve as a key to access data);
- Allow patients to share essential identifiers from a card with providers more easily and accurately (e.g., via phone, fax, or web);
- Allow option to combine health benefits and bank account (e.g., health savings account) information on the same card;
- Significantly reduce problems associated with policyholder identification and benefit eligibility, and increase patient and subscriber satisfaction.

Employers. WEDI-compliant machine-readable health identification cards will:

- Increase employee satisfaction with company's health benefits;
- Reduce staff time and costs spent on assisting employees resolve insurance benefit problems;
- Allow employers to provide employees with a single, multifunctional card, even when purchasing multiple benefits from different administrators.

Clearinghouses. WEDI-compliant machine-readable health ID cards will:

- Potentially provide the option to use a standard health plan identifier, as noted in the WEDI health ID card standard;
- Assist ID card-driven health plan claim routing without requiring translation of trading-partner specific patient identifier;
- Reduce errors and associated expenses;
- Enable clearinghouses to support increased value to providers by using multiple-benefits cards (i.e., health and financial information);
- Lead to increased satisfaction.

HASC Recommendations: Standardized, Machine-Readable Health Identification Cards

- a) Adoption of machine-readable health ID cards that are compliant with the WEDI Health Identification Card Implementation Guide by public and private payers.***
- b) Development and dissemination of low-cost software interface solutions by practice management software system and/or electronic health record vendors to allow the incorporation of machine-readable health ID cards utilizing the WEDI Implementation Guide into providers' organizational workflow.**
- c) Development and dissemination of standard educational materials to inform providers, vendors, and health plans about the value of issuing, supporting, and utilizing machine-readable health ID cards that are compliant with the WEDI Implementation Guide.**
- d) Development and funding of a pilot program by CMS and private payers to identify opportunities to simplify administrative processes and challenges related to the use of a standardized machine-readable health ID cards for Medicare beneficiaries.**
- e) Support of CORE Phase III certification by practice management systems/front-end vendors and plans, should CORE Phase III require use of the WEDI health ID card standard and related requirements associated with data accessed by cards.**

4. Simplification of Prior Authorization Processes

Introduction

Prior authorization, also referred to as preauthorization, precertification or predetermination, was instituted for certain health benefits and services as a cost containment strategy and as a result of increased healthcare expenditures. Prior authorization programs establish that the health insurers' medical necessity guidelines have been met for the service requested by a provider based upon a patient's diagnosis and history, and that services are being provided in the most cost-effective manner. The prior authorization process includes a review of the treatment plan and service requested to determine the patient's eligibility; the date, place, and type of service; and the CPT code to be used. The process is highly complex and lacks transparency, and criteria, policies, and processes vary significantly among health and pharmacy benefits entities.

The prior authorization process is costly and time consuming for physicians, providers, and insurers. Streamlining the prior authorization process would reduce administrative costs for payers and for providers. Prior authorization programs include a considerable number of medical services and prescription drugs, and prior authorization requirements vary widely among health plans. However, radiology and advanced imaging and pharmacy benefits seem to be the two types of health services that represent a clear and significant administrative load for providers.

Background: Radiology Benefits Management

Cost containment is important in the area of advanced imaging services, including magnetic resonance imaging (MRI), computer tomography (CT) scans, positron emission tomography (PET).^{xix} The annual growth rate in the number of CT scans performed in the United States per 100 people between 2000 and 2005 was 13 percent. The number of CT scans performed in the U.S. rose from 12 CT scans per 100 people in 2000 to 22 CT scans per 100 individuals in 2005.^{xx}

Medicare spending for imaging services more than doubled, increasing to about \$14 billion, according to Medicare claims data from 2000 through 2006. Spending on advanced imaging, such as CT scans, MRIs, and nuclear medicine, rose substantially faster than other imaging services such as ultrasound, X-ray, and other standard imaging.

Diagnostic accuracy, greater affordability of equipment, and more opportunities for revenue generation that have lead nonhospital sites to supply these services are some of the reasons for the rise in the number of CT scans performed.^{xxi}

^{xix} Tynan A, Berenson RA, Christianson. Health plans target advanced imaging services. Center for Studying Health System Change 2008. Available at: <http://www.hschange.com/CONTENT/968/#ib2>. Accessed July 10, 2009

^{xx} U.S. Government Accountability Office. Medicare part B imaging services: rapid spending growth and shift to physician offices indicate need for CMS to consider additional management practices. GAO Report to Congressional Requesters 2008. Available at: <http://www.gao.gov/new.items/d08452.pdf>. Accessed July 10, 2009.

^{xxi} Bagley B. American Academy of Family Physicians. Medical Director, Quality Improvement. March 2007: personal communication.

Challenges: Radiology Benefits Management

As health plans attempt to rein in expenses related to the rise in the number of diagnostic imaging performed (second only to pharmaceuticals in terms of annual spending and growth), a new industry of radiology benefits managers (RBMs) has emerged to handle preauthorization of physician imaging orders. Approximately 90 million individuals, half of those privately insured, were covered by RBMs in the United States in 2008.^{xxii}

Medicare Payment Advisory Commission (MedPAC), a Medicare advisory board focused on payment policy, has urged CMS to consider how the private sector utilizes a privileging process for physicians who bill Medicare for performing and interpreting diagnostic imaging studies. MedPAC's goal is to improve affordability and the quality of care delivered to Medicare beneficiaries.^{xxiii} Further, in June 2008, the Government Accountability Office (GAO) provided Medicare with a report on Part B Imaging Services that included recommendations for Medicare to implement prior authorizations for advanced imaging services. This recommendation became part of the passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that includes a requirement for providers of advanced imaging services to be accredited by January 1, 2012. This would be a fundamental shift in how Medicare operates.

Background: Pharmacy Benefits Management

Pharmacy benefit managers (PBMs) are organizations that provide administrative services in the processing and analysis of prescription claims for pharmacy benefit and coverage programs. PBMs provide plan members with access to a broad spectrum of medically necessary drugs while attempting to reduce costs. The three largest PBMs are Medco Health Solutions, CVS Caremark, and Express Scripts, which collectively covered a combined 190 million members and managed a combined \$80 billion in drug spending in 2004.^{xxiv}

PBMs implement cost containment programs that require prior authorization of certain medications on formulary preferred drug lists before prescriptions are filled. Some formularies are composed of five tiers (levels from generics to non-brand). This means that patients may experience quantity limitations and step-therapy (fail first on a less costly medicine approach) requirements imposed by the pharmacy benefits plan. Three types of quantity limits are typically in place: (1) dose efficiency edits (limits coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing); (2) maximum daily dose (an informational message is sent to the pharmacy if prescription falls outside recommended minimum and maximum doses); and (3) quantity limits over time

^{xxii} Mathews AW. Insurers hire radiology police to vet scanning. Wall Street Journal November 6, 2008. Available at: <http://online.wsj.com/article/SB122591900516802409.html>. Accessed July 10, 2009.

^{xxiii} MedPAC Recommendations on Imaging Services. March 17, 2005. Available at: http://www.medpac.gov/publications/congressional_testimony/031705_TestimonyImaging-Hou.pdf. Accessed July 10, 2009.

^{xxiv} Atlas RF. The role of PBMs in implementing the Medicare prescription drug benefit. Health Affairs 2004;W4:504-6. Available at: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.504>. Accessed July 10, 2009.

(limits coverage of prescriptions to a specific number of units over a defined amount of time).^{xxv}

Challenges: Pharmacy Benefits Management

In order to meet the PBM requirements described above, physicians must verify patients' insurance benefits and know what to do when the drug prescribed requires prior authorization. This process is challenging and time consuming as a result of the multitude of formulary configurations. The method by which therapeutic interchanges take place (fax) also increase costs and cause workflow disruptions to physician-prescribers. In order to make a decision, physicians must access patients' medical records, review them, and decide whether to authorize the change, contact the patient, or discuss the option the next time the patient is seen in the office. Physicians are not paid for the time spent on these administrative activities. According to a MGMA survey, pharmacy-related administrative processes (prior authorization, pharmacy call-backs, etc.) cost the average yearly cost for a 10-physician practice approximately \$137,000.

The challenges posed by PBMs and RBMs illustrate the issues faced by physicians and other providers in the prior authorization process. Variation in prior authorization program policies, requirements, and criteria only magnify the problem. It is important to develop a systematic approach to ensure that appropriate care is provided without limiting innovation, risking financial losses, and causing increased administrative complexity. Program goals include transparency and optimization of administrative processes, as well as the promotion of learning and improvements in quality of care.

^{xxv} Drug formulary frequently asked questions, Michigan BlueCross BlueShield, http://www.mibcn.com/medicareAdvantage/member_benefits/medicare_formulary_faq.shtml, accessed July 13, 2009.

**HASC Recommendations:
Simplification of Prior Authorization Processes**

- a) **Health plan support of automation, simplification, transparency, clear communication, and, to the extent possible, standardization of prior authorization processes among health plans and pharmacy benefits plans.**
- b) **Identification of methods to research the impact that prior authorization programs may have on cost-effectiveness and quality of care.**
- c) **Support of electronic prescribing (e-prescribing) national networks, such as SureScripts[®], in product offerings by EHR vendors, health plans, and PBMs to achieve the goal of providing real-time, patient-specific formulary access into e-prescribing functionality.**
- d) **Support the CAQH CORE Phase III rule writing process, which includes a review of the current 5010 version of the HIPAA 278 standard transaction, *Health Care Services–Request Authorization*, with the goal of determining if the need for operating rules to support this transaction exists.**

Conclusion

HASC acknowledges that the opportunities to simplify administrative processes would not be completely addressed even if all of the recommendations in this report were implemented. HASC intends for these recommendations to reflect the need to address some of the issues faced by the healthcare industry currently. The membership of HASC is committed to not only the actions suggested in this report, but also to further address the duplication, lack of uniformity, and other components of healthcare administration that lead to waste. HASC invites all those concerned with administrative costs in healthcare to join us. The time to act is now.

Appendix A:

Complete HASC Recommendations (July 2009)

1. Simplification in Practitioner Credentialing*

- a) Full participation in the CAQH Universal Provider Datasource™ (UPD) and use of the UPD tool as the primary practitioner data collection tool for all health plans and hospitals that require contracted providers to be credentialed.
- b) Development of an electronic data interchange by the Centers for Medicare & Medicaid Services (CMS) for the communication of provider credentialing information that will allow for sending data from the Universal Provider Datasource™ (UPD) to the web-based Medicare Provider Enrollment and Chain/Ownership System (PECOS) database.
- c) Education of employer organizations to heighten the awareness of cost saving opportunities associated with the use of UPD, and support for the inclusion of UPD in their requests for proposal to health benefits organizations.
- d) Support for the review and use of UPD by State Medicaid agencies for provider data collection and maintenance requirements.

*An assessment of state laws and accrediting entities (e.g., National Committee for Quality Assurance [NCQA], Utilization Review Accreditation Commission [URAC]) impact on credentialing requirements will be performed to assist in the development of state- or accreditation-specific strategies.

2. Simplification in the Healthcare Insurance Eligibility Process

- a) Adoption of voluntary certification with the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I and II rules by health plans, clearinghouses, and practice management systems and electronic data interchange, as well as active participation in CORE Phase III.
- b) Development and dissemination of standardized materials to educate the provider community about the CAQH CORE Phase I and II rules, and CORE certification for vendors and practice management systems.
- c) Streamlined implementation of new or substantially revised HIPAA standards by support of pilots that test standards prior to adoption. *

*On January 5, 2009, CAQH announced a partnership with CMS, the Blue Cross and Blue Shield Association (BCBSA), Integrating the Healthcare Enterprise (IHE), and the Healthcare Information and Management Systems Society (HIMSS) that is focused on demonstrating how the CORE Phase I and II rules are already requiring, and thus pre-testing, for aspects of the “new HIPAA” transactions (new regulation under HIPAA will be slated for 2012). HASC wants to use real-world efforts like this to show that the industry can embrace, test, improve, and use standards before they are required for adoption.

3. Standardized, Machine-Readable Health Identification Cards

- a) Adoption of machine-readable health ID cards that are compliant with the WEDI Health Identification Card Implementation Guide by public and private payers.*
- b) Development and dissemination of low-cost software interface solutions by practice management software system and/or electronic health record vendors to allow the incorporation of machine-readable health ID cards utilizing the WEDI Implementation Guide into providers’ organizational workflow.
- c) Development and dissemination of standard educational materials to inform providers, vendors, and health plans about the value of issuing, supporting, and utilizing machine-readable health ID cards that are compliant with the WEDI Implementation Guide.
- d) Development and funding of a pilot program by CMS and private payers to identify opportunities to simplify administrative processes and challenges related to the use of a standardized machine-readable health ID cards for Medicare beneficiaries.
- e) Support of CORE Phase III certification by practice management systems/front-end vendors and plans, should CORE Phase III rules require use of the WEDI health ID card standard and related requirements associated with data accessed by cards.

4. Simplifying Prior Authorization Processes

- a) Health plan support of automation, simplification, transparency, clear communication, and, to the extent possible, standardization of prior authorization processes among health plans and pharmacy benefits plans.
- b) Identification of methods to research the impact that prior authorization programs may have on cost-effectiveness and quality of care.
- c) Support of electronic prescribing (e-prescribing) national networks, such as SureScripts[®], in product offerings by EHR vendors, health plans, and PBMs to achieve the goal of providing real-time, patient-specific formulary access into e-prescribing functionality.

- d) Support the CAQH CORE Phase III rule writing process, which includes a review of the current 5010 version of the HIPAA 278 standard transaction, *Health Care Services–Request Authorization*, with the goal of determining if the need for operating rules to support this transaction exists.