Second Progress Report on the Implementation of SSB 5346

Submitted by:

A program of the Washington Healthcare Forum
Operated by OneHealthPort

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I. Introduction

This is the second progress report on the implementation of SSB 5346 submitted to the Washington State Legislature by Insurance Commissioner Mike Kreidler and the WorkSMART Institute. WorkSMART is acting on behalf of the SSB 5346 Lead Organizations designated by Commissioner Kreidler: the Washington Healthcare Forum and OneHealthPort. This progress report is designed as a companion document to the first progress report dated December 1, 2009. As such, this report will not repeat the background information on SSB 5346, health care administration, the lead organizations or the work accomplished in 2009. This report will focus on the progress made implementing SSB 5346 from December 1, 2009 thru November 30, 2010.

Following the Introduction and Executive Summary, this report is organized by key subject matter sections including:

- Solutions
- Provider Data Service
- Medical Management
- Adoption
- Going Forward

II. Executive Summary

This is the second progress report on the implementation of SSB 5346 submitted to the Washington State Legislature by Insurance Commissioner Mike Kreidler and the WorkSMART Institute. WorkSMART is acting on behalf of the SSB 5346 Lead Organizations designated by Commissioner Kreidler: the Washington Healthcare Forum and OneHealthPort.

Significant progress has been made over the past year on solution development. Of the 16 tasks assigned to the lead organization, 15 have been completed. This progress reflects the diligent effort applied by WorkSMART, the OIC, and most importantly the providers and payers who participate in the improvement effort. Literally, thousands of hours have been contributed by payer and provider organizations to craft and refine the SSB 5346 solutions. It is this commitment to improve from participating providers and payers and the donation of skilled and experienced people that has made possible the progress described in this report. The voluntary collaborative effort of the Washington state health care community is the foundation upon which the successful development of SSB 5346 solutions over the past year has been built.

One high visibility solution is the Provider Data Service (PDS). The PDS is the solution implemented by OneHealthPort, for Section 6 of SSB 5346 (RCW 48.165.035) which calls for:

> *"…a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processe*s…"

As described in the first progress report. OneHealthPort contracted with Medversant to deliver the PDS to Washington state practitioners, payers and hospitals. The two partners have worked hard to bring the PDS to market. They have been greatly aided in this work by many stakeholders who have participated in work groups and served as testers. At the organizational level; the Washington State Association Medical Staff Services (WAMSS), the Washington State Medical Association (WSMA) and the Washington State Hospital Association (WSHA) have been particularly helpful. The efforts of these organizations and individuals recently came to fruition as the PDS went live to the provider community on November 3, 2010.

A second high profile solution was Medical Management. On behalf of the Washington Healthcare Forum, as directed by Section 10 (2) of SSB 5346, WorkSMART engaged stakeholders in a structured process to propose a set of goals and work plan for the development of medical management protocols. The stakeholder recommendations promote strategies and methods for more broadly incorporating evidence-based decision criteria into provider practices to control costly, unwarranted clinical variations. In parallel, they also promote streamlining the pre-authorization process across health plans so that it less of an administrative burden. The recommendations do not promote efforts targeted at standardizing evidence-based clinical review criteria across major, commercial health plans as those efforts are unlikely to have any significant impact on the cost of care or the administrative burden of medical management

Ultimately, adoption is the key to the success of all the SSB 5346 solutions. For either providers or payers to realize value from the solutions developed under SSB 5346, both parties will have to adopt across a critical mass of their community. The nature of the information exchange means neither party can unilaterally solve their problems. Mutual adoption is a requirement. Over the past year WorkSMART, the OIC and the stakeholders have assessed the optimal approach to driving adoption of the SSB 5346 solutions. As of December 2010, the following adoption model is being pursued:

- Payers first – In many cases payer solutions must precede provider adoption (i.e., providers can't adopt the solution until payers deploy it) and most payers have greater capability to manage change. As such, WorkSMART has focused its initial attentions on the payer community. Early estimates indicate most payers will voluntarily adopt most solutions.
- Prioritizing solutions – On the basis or stakeholder research and expert opinion, WorkSMART has decided to prioritize the transactional and web solutions and the PDS over the policy solutions. The electronic solutions are seen by the community as being of higher value, easier to promote and more likely to be adopted by providers.
- Change what you measure – At the heart of the Continuous Quality Improvement (CQI) model embedded in SSB 5346 is the concept of measurement. Measurement is critical to CQI and WorkSMART has begun to pilot a measurement approach designed to support improvement and accountability.
- Provider awareness and training – In its work with stakeholders WorkSMART identified the importance of training as a key element in adoption. As such, WorkSMART is currently working with payers and providers to deliver an expanded menu of training tools and services. However, in order to take advantage of training and the SSB 5346 solutions, providers must be aware of the opportunity. WorkSMART has worked aggressively in 2010 in multiple venues to raise awareness.

As we consider how best to move forward with simplifying health care administration in Washington State it is worth considering what we have learned to date from the SSB 5346 experience. The ongoing SSB 5346 implementation effort has surfaced a number of issues including:

- The benefits and long-term sustainability of the lead organization model
- The juxtaposition of state reform and federal reform
- How to measure the benefits realized
- How best to promote adoption - regulation vs. voluntary collaboration
- The challenges posed to providers and payers by additional administrative simplification legislation

The Forum, OneHealthPort and the OIC all appreciate the opportunity to work on this innovative improvement program and we look forward to addressing these and other issues in the year ahead. We are very grateful to the many public and private sector organizations and individuals who have participated in and contributed to the initial success of the SSB 5346 implementation effort. We look forward to continued work and success in this area and we are pleased to address any questions the legislature may have regarding the implementation of SSB 5346.

III. Solutions

SSB 5346 calls for a number of "solutions" designed to simplify health care administration. There are sixteen different solutions called for in the bill. It is the responsibility of the Lead Organizations, with oversight from the Office of the Insurance Commissioner (OIC), to develop, implement and gain adoption of this solution set. The WorkSMART Institute has grouped the sixteen solutions called for under SSB 5346 into five different types:

- Provider Data Service – relates to the implementation of the Provider Data Service (data collection to support provider credentialing and privileging)
- Transaction – relates to an electronic system-to-system transaction between payer and provider
- Web – relates to providers accessing payer web sites
- Policy – relates to a policy matter between providers and payers
- Report – relates to recommendations for additional phases of work

Below in Figure I is a chart that lists each of the sixteen solutions, the solution type, and the current status. Online, additional information can be found at: http://www.onehealthport.com/admin_simp/admin_simp_overview.php.

FIGURE I – SSB 5346 Solution Type/Status

Task	Solution Type	Status
1. Electronic credentialing process	PDS	Implemented
2. Interoperability between credentialing/licensing	PDS	Pending action from DOH
3. Enhanced eligibility (system-to-system)	Transaction	Complete/adoption in progress
4. Enhanced eligibility (browser-based)	Web	Complete/adoption in progress
5. Retro eligibility denials	Report	Complete/pending OIC decision on WAC
6. CCI edit policy	Policy	Complete/adoption in progress
7. Publishing variations from CCI policy	Policy	Complete/adoption in progress
8. Remark, group, reason codes on remitts	Transaction	Complete/adoption in progress
9. Processing corrected claims	Transaction	Complete/adoption in progress
10. Standard payer reconsideration process re: codes	Policy	Complete/adoption in progress
11. Next phase of coding standardization work	Report	Complete/submitted
12. Extenuating circumstances denials of pre-auths	Policy	Complete/adoption in progress
13. Timely response on pre-auth requests	Policy	Complete/adoption in progress
14. Common web site payer pre-service requirements	Web	Complete/adoption in progress
15. Payer pre-auth web site	Web	Complete/adoption in progress
16. Goals/work plan for med management protocols	Report	Complete/submitted

To develop solutions for the transactions, web sites and policies, WorkSMART has adopted the Best Practice Recommendation (BPR) model described in the first progress report. A BPR is a better way to get things done that is pragmatic and works for everyone. BPRs:

- Can describe a policy, procedure or a technology
- Move the industry toward best practice as opposed to just simplifying or standardizing current practice
- Leverage national standards where available
- Favor electronic as opposed to paper or manual solutions
- Are voluntary in nature

WorkSMART structured the process for developing BPRs specifically to address the requirements for transparency and inclusiveness. The BPR process has the following components:

- Identify strategic priorities – The Forum Board sets the strategic direction within the framework created by the Legislature. In this case, it was to prioritize the implementation of 5346 over other activities.
- Scope the issue – OneHealthPort staff interviews subject matter experts within a given problem space to define the parameters of the problem and potential solutions.
- Set direction – The OneHealthPort Board approves the scope of the problem/solution to be considered based on the staff summary of subject matter expert recommendations.
- Convene work group – A work group consisting of provider and payer subject matter experts is convened by OneHealthPort to develop draft BPRs for specific issues. Work groups meet face-to-face, usually on a monthly basis and are limited to 20-25 people in order to facilitate rapid progress.
- Review with stakeholders – The draft BPRs developed by the work group are reviewed with the stakeholder group. Stakeholders can sign up on the OneHealthPort web site to participate and do their work virtually http://www.onehealthport.com/worksmart/stakeholder_group.php. As such, there are no limits on the size of the group, and all interested parties can participate.
- Finalize the BPR – Based on stakeholder feedback, the work group finalizes the BPR and it is posted on the OneHealthPort web site for public viewing at: http://www.onehealthport.com/worksmart/bproverview.php.
- Develop monitoring approach – For each BPR, the work group develops a monitoring/measurement strategy. This may take the form of a formal validation process as in the case of an electronic transaction (e.g., enhanced eligibility), it may be more of a yes/no as with adoption of a policy (e.g., extenuating circumstances for pre-authorization), or it may involve tracking utilization as with the use of a browser for pre-authorizations.

- Study and improve – Consistent with the direction of the Legislature to establish a continuous quality improvement environment, the work group will study results from the implementation of a BPR, identify needed improvements, appropriately modify the BPR and put it back through the review and finalization cycle.

In this context, the status column in Figure I applies five different terms to describe status:

- *Implemented* – The PDS is operational (the PDS is discussed in more detail in section IV)
- *Pending action from OHP and DOH* – Interoperation between DOH's licensing system and the PDS is pending action from OHP and DOH. OneHealthPort focused its efforts in 2010 on getting the PDS operational and was not able to engage with DOH on the PDS until late in 2010. As such, this description is not intended in any way to reflect inaction on DOH's part. Furthermore, DOH may require financial resources in order to support interoperability. OneHealthPort looks forward to working with DOH on this question in 2011.
- *Complete/adoption in progress* – The BPR has been finalized and work is underway to encourage adoption by payers and providers (issues related to adoption are discussed in section VI).
- *Complete/pending OIC decision on WAC* – The BPR or Report was completed, but implementation is dependent on a WAC. In the case of Retro Eligibility Denial, the WorkSMART report included a recommendation that the OIC write regulations. The OIC is currently considering this recommendation
- *Complete submitted* – The report has been completed and submitted to the OIC.

As can be seen in Figure I, significant progress has been made over the past year on solution development. Of the 16 tasks assigned to the lead organization, 15 have been completed. This progress reflects the diligent effort applied by WorkSMART, the OIC, and most importantly the providers and payers who participate in the improvement effort. Literally, thousands of hours have been contributed by payer and provider organizations to craft and refine SSB 5346 solutions. It is this commitment to improve from participating providers and payers and the donation of skilled and experienced people that has made possible the progress described above. The voluntary collaborative effort of the Washington state health care community is the foundation upon which the successful development of SSB 5346 solutions over the past year has been built.

IV. Provider Data Service

The Provider Data Service (PDS) is the solution implemented by the Lead Organization, OneHealthPort, for Section 6 of SSB 5346 (RCW 48.165.035) which calls for:

> *"…a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processes…"*

As described in the first progress report. OneHealthPort contracted with Medversant to deliver the PDS to Washington state practitioners, payers and hospitals. OneHealthPort and Medversant have worked together closely over the past year to:

- Finalize a contract
- Refine requirements and specifications for the PDS
- Develop and test the PDS provider and client facing applications
- Identify and resolve operational issues
- Take the PDS to market

OneHealthPort has been greatly aided in this work by many stakeholders who have participated in work groups and served as testers. At the organizational level; the Washington State Association Medical Staff Services (WAMSS), the Washington State Medical Association (WSMA) and the Washington State Hospital Association (WSHA) have been particularly helpful. The efforts of these organizations and individuals recently came to fruition as the PDS went live to the provider community on November 3, 2010.

Practitioners will now be able to enter their data one time, in one place and have all the hospitals and payers who need the information to make credentialing and privileging decision pick it up from the PDS. Hospitals and payers will benefit by not having to spend time collecting and editing data. Their staff can focus on making credentialing and privileging decisions. Delegated practices will be able to upload the data they currently collect directly to the PDS.

In addition to bringing new efficiency to practitioner credentialing and privileging, the PDS offers long term potential to meet a series of other provider data management needs as illustrated in Figure II below:

FIGURE II

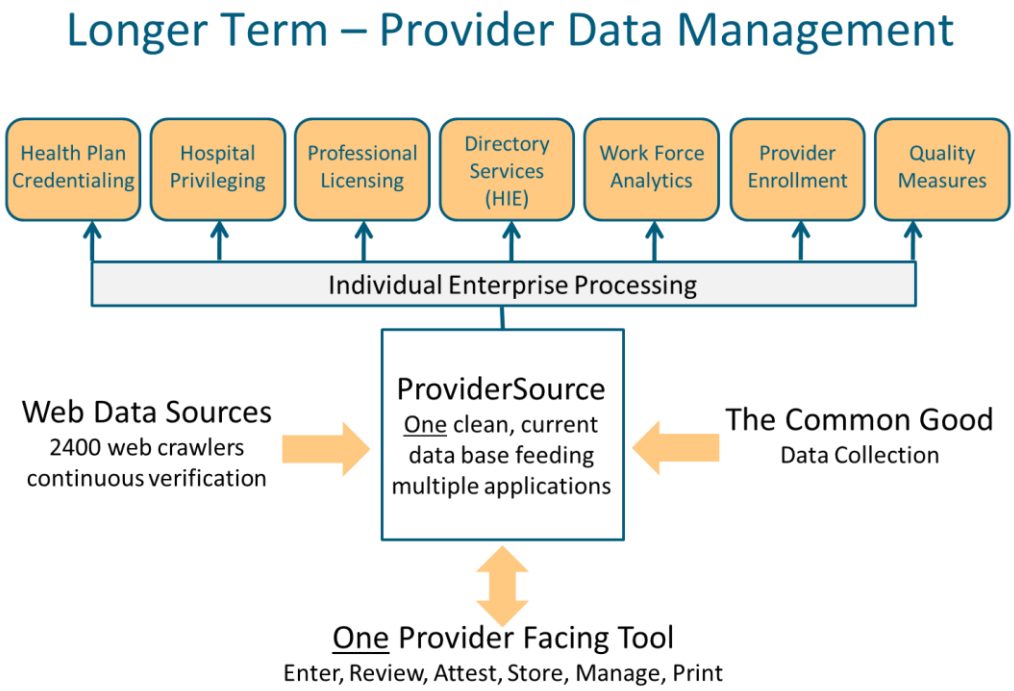

Figure II illustrates a number of enterprise processes that require provider data. The PDS has the potential to reduce data collection costs for all of these processes over time. OneHealthPort will explore these additional applications of the PDS after the service is up and running and satisfactorily meeting its SSB 5346 requirements.

In bringing the PDS market OneHealthPort, the stakeholder community and the OIC have encountered a number of issues that required resolution:

- Privileging – Unlike credentialing, there is no standard data set for privileging. Therefore, there is no easy place to start in developing the uniform privileging data set required by SSB 5346. The diverse nature of privileging has also raised concerns in the hospital community about the feasibility of achieving the standardization goals described in SSB 5346. OneHealthPort has elected to work with the hospital community in an incremental manner. The first step will be to host various hospital privileging forms in the PDS. This will allow providers to still go one place, though it won't initially be a standard dataset. OneHealthPort has also constituted a privileging work group to review the data forms received. Over time, OneHealthPort and the work group will attempt to craft a standard privileging data set from all the information gathered.
- Chicken and egg – The value to the providers is highest when all payers and all hospitals subscribe to the PDS. The value to payers and hospitals is highest when all providers enter their data in the system. To gain a critical mass of both parties, someone has to go first. OneHealthPort has attempted to solve this problem by signing payers and hospitals to the PDS

contracts in advance of the system-go-live. Figure III lists the payers and hospitals currently signed up for the PDS. Other payer and hospital organizations are in progress. And, we have heard from a small number of hospitals that they do not intend to participate. In addition to pursuing payers and hospitals, OneHealthPort is aggressively marketing to providers. Until all payers and hospitals are using the system, providers can enter their data, print the form and fax or mail it to the organization in question. In this sense the provider data entry burden is minimized during the start-up phase.

Figure III – Hospitals and Payers Currently Signed to PDS Contracts

Payers – Signed Contracts

- First Choice Health
- Premera
- Regence
- Group Health Cooperative
- KPS (in GHC contract)
- AETNA
- CHPW
- CIGNA
- PSHP

Hospitals – Signed Contracts

- Snoqualmie Valley Hospital
- Capital Medical Center
- Prosser Memorial Hospital
- Garfield County Public Hospital District
- Overlake Medical Center
- Pullman Regional Hospital
- Lourdes Hospital
- Fairfax Hospital
- Kittitas Valley Community Hospital
- Island Hospital
- Group Health Hospital
- Klickitat Valley Health
- Southwest Washington Medical Center
- Evergreen Hospital Medical Center
- Newport Hospital &Health Services
- MultiCare Health System

- Utility Model – Unique among the SSB 5346 solutions, credentialing and privileging required the establishment of a business service and a contract with a vendor. This posed some challenges for OneHealthPort and the OIC because OneHealthPort is a private organization and use of the PDS is required of all hospitals, payers and providers. The parties addressed this concern by drafting a Memorandum of Understanding (MOU) that covers the operation of the PDS. Key elements of the MOU include:
    - Oversight of the PDS by the OIC;
    - Agreement by OneHealthPort to operate the system "at cost" and not seek to profit. In fact, OneHealthPort estimates it will lose approximately $500,000 on the PDS over the first five years of operation.
    - Exit provisions that protect OneHealthPort's investment and the public interest in the operation of the PDS; and
    - Confidentiality and privacy provisions.

- Confidentiality – Much of the provider data in the PDS is non-sensitive and public. However, there are certain data elements that are confidential and must be scrupulously protected. The PDS data policy delineates the data items that are confidential. By definition all other data items are non-confidential. Confidential data items are only available to legitimate credentialing and privileging entities that are identified by the provider as needing access to his/her private data. Confidential data items as defined by the PDS policy include:
    - SSN or Tax Identification Numbers;
    - Malpractice history;
    - The peer review process (references, evaluations and annual reviews);
    - National Practitioner Data Bank information;
    - Information related to participation in an industry program for the treatment of impairment due to alcohol, drugs or other physical or mental condition;
    - Any affirmative response to Disclosure, Attestation, or Release questions in a license; and
    - All data contributed by a Customer not generally available through public sources.

V. Medical Management

On behalf of the Washington Healthcare Forum, as directed by Section 10 (2) of SSB 5346, [RCW 48.165.050], WorkSMART engaged stakeholders in a structured process to propose a set of goals and work plan for the development of medical management protocols. The stakeholder consensus that emerged from that process was presented in two companion documents. The first document titled 'Medical Management - Scoping Document - February 26, 2010' discussed the challenges of medical management and defined the scope of possible opportunities for optimizing its effectiveness while minimizing its administrative burden. The second document, 'Medical Management Strategies and Recommendations – October 31, 2010' detailed two strategic imperatives for improving medical management and recommends specific action steps for making an impact.

As discussed in the October 31 document, medical management is a worthwhile and necessary process for minimizing unwarranted variations in patient care delivery to ensure that care is cost effective and of high quality. However, as currently implemented, medical management is not as effective or efficient as it might be. The wide variation in physician practice demonstrated by the underuse, overuse, and inappropriate use of services as well as the use of more expensive services when less expensive services are of equal benefit to patients contributes to the upward spiraling cost of care. The wide variation in health plan operational processes, especially those related to pre-authorization, contributes to the administrative cost of medical management. The reduction of both types of variation provides the greatest opportunity for controlling costs while maintaining, and potentially improving, the quality of care that is delivered.

Two strategies were identified that hold promise for controlling these variations. Those strategies are:

- Streamline current health plan methods and provider interaction with them
- Strengthen medical management practices of physicians

Streamlining health plan methods and provider interaction with them will reduce administrative burden on providers. Significant training and institutional knowledge is required for provider staff to keep track of which health plan requires a pre-authorization for what services, what specific procedure needs to be followed to get an authorization decision, and what information must be provided. The pre-authorization burden is especially acute for pharmaceuticals. Harmonization of operational processes across health plans and automation of these processes are essential for streamlining the pre-authorization process. To ease the administrative burden, provider organizations as well as health plans must incorporate the use of automated tools into their workflow processes. Otherwise meaningful efficiencies cannot be realized.

Strengthening medical management practices of physicians will improve patient outcomes at lower cost and with less administrative burden. Stakeholders judged this strategy likely to yield greater benefits than the prior strategy. However, this strategy is a monumental undertaking in that it is more challenging to implement, requiring fundamental change. For this strategy to take hold, a) provider reimbursement must reward clinical outcomes rather than service volume, b) meaningful, evidence-based information must be available to providers, and c) providers must adopt automated systems and

workflows so that this information can be used in real time to make appropriate care decisions for each and every patient. As these mechanisms are put in place, health plans can delegate more of the medical management to provider organizations and increase their value as an information resource.

Not enough is yet known to recommend a specific solution or set of solutions for the challenges of medical management. It will take some time to figure out what works. The work group did not recommend any legislative mandates in regard to medical management. Instead, it recommended that coordinated action steps be taken to test out new approaches for physician practice, to broadly communicate learnings, and to encourage best practices to be put in place. In the meantime, streamlining the pre-authorization process, especially for pharmaceuticals, will ease some of the administrative burden.

Collaborative efforts to minimize unwarranted clinical variation and reduce costs are emerging across the healthcare community in the form of pilots/demonstration projects. These pilots are incubators of creative approaches and possible solutions. Additional, similar efforts should be convened. Coordination will be required to monitor and highlight well-targeted pilots so as to increase the likelihood that promising ideas are pursued in a standardized non-duplicative manner, results are verified and fundamental learnings are formalized and communicated.

Ideas emerging from these pilots that demonstrate results must be encouraged to take root across the provider mainstream. Nurturing these ideas will require innovation on the following fronts; a) developing an Incentive/Reimbursement framework that rewards outcome driven care, b) encouraging and enabling provider adoption of evidence-based systems and workflows, and c) implementing a communication/education infrastructure for engaging the provider community in ideas and approaches that demonstrate results.

Bottom line, in response to the SB5346 request, a set of goals and work plan for the development of medical management protocols are recommended in the October 31, report. These recommendations promote strategies and methods for more broadly incorporating evidence-based decision criteria into provider practices to control costly, unwarranted clinical variations. In parallel, they also promote streamlining the pre-authorization process across health plans so that it less of an administrative burden. The recommendations do not promote efforts targeted at standardizing evidence-based clinical review criteria across major, commercial health plans as those efforts are unlikely to have any significant impact on the cost of care or the administrative burden of medical management

VI. Adoption

Ultimately, adoption is the key to the success of SSB 5346. For either providers or payers to realize value from the solutions developed under SSB 5346, both parties will have to adopt across a critical mass of their community. The nature of the information exchange means neither party can unilaterally solve their problems. Mutual adoption is a requirement. Over the past year WorkSMART, the OIC and the stakeholders have assessed the optimal approach to driving adoption of the SSB 5346 solutions. As of December 2010, the following adoption model is being pursued

A. Payer Adoption First

In the long run, provider and payer adoption will receive equal emphasis. However, payer adoption will be the initial focus of the adoption effort. The rationale is three-fold:

- There are far fewer payers and they are easier to identify and contact;
- Payers have greater access to change management resources and are more likely to be able to implement change rapidly; and
- Many of the SSB 5346 solutions require payers to deploy capability before providers can adopt it.

For these reasons WorkSMART conducted an initial survey of payer intent to voluntarily adopt the SSB 5346 solutions that were delivered as Best Practice Recommendations. Figure IV below describes the findings from WorkSMART's recent survey of payer intent to adopt the BPRs listed. As noted in the exhibit, survey responses indicate that most payers are adopting most BPRs in a timely manner on a voluntary basis:

FIGURE IV PAYER INTENT TO ADOPT BPRs

BPR	Fully Adopt[*1] with Implementation Date	Partially Adopt with Implementation Date	Not Reported or Reported as 'To Be Determined', 'Not Adopting' or 'Not Applicable'
Policy BPRs: Best Practices related to an operational policy			
Reconsideration of a Health Plan's Policy Regarding Code Edits	**Implementation by 12/2010** – Cigna – FCHA – GHC – Kaiser (Link reported as N.A.) – LifeWise of WA – LNI – Molina – Premera – Regence **Future Implementation** – KPS-12/2011 – Medicaid 07/2011	**Implementation by 12/2010** – Aetna – United **Future Implementation** – PacifiCare - T.B.D.	– CHPW - Not Applicable – CUP
Claim Coding Policy & Edits: Standardization and Transparency	**Implementation by 12/2010** – Aetna – Cigna – FCHA – GHC – Kaiser (Link reported as N.A.) – LifeWise of WA – Molina – PacifiCare – Premera – Regence – United **Future Implementation** – Medicaid - 07/2011 – KPS-12/2011 – LNI - Unknown		– CHPW - Not Applicable – CUP
Extenuating Circumstances - Pre-Auth/Admit Notification	**Implementation by 12/2010** – Cigna – FCHA (Link reported as N.A.) – GHC – Kaiser (Link reported as N.A.) – KPS – LifeWise of WA – Medicaid (all but link) – Molina – PacifiCare – Premera – Regence – United	**Implementation by 12/2010** – CHPW	– Aetna - To Be Determined – CUP - Not Applicable – LNI - Not Applicable

BPR	Fully Adopt[*1] with Implementation Date	Partially Adopt with Implementation Date	Not Reported or Reported as 'To Be Determined', 'Not Adopting' or 'Not Applicable'
Web/Transaction BPRs: Best Practices related to web site content and/or HIPAA transaction content			
Browser Capabilities for Pre-Auth and Admit Notification	**Web - Implementation by 12/2010** – Cigna – FCHA – LifeWise of WA – LNI – PacifiCare – Premera – Regence – United **Web - Future Implementation** – KPS - 12/2011 – Molina - 12/2011 – GHC - To be determined – Medicaid - To be determined	**Web - Implementation by 12/2010** – Aetna (at HIPAA 278 level) – CHPW	– CUP - Not Reported – Kaiser - Not Applicable
Requesting & Receiving Coverage Information for Eligibility & Benefits (Web Site & HIPAA transaction)	**Web - Implementation by 12/2010** – CUP – FCHA – GHC – KPS – LifeWise of WA – Premera – Regence – United **Web - Future Implementation** – Molina - 01/2013 – Medicaid - To be determined	**Web - Implementation by 12/2010** – Aetna (at CORE Level) – Cigna (at CORE Level)	**Web** – CHPW - Cost Prohibitive – Kaiser – LNI - Not Applicable – PacifiCare - TBD
	Transaction- Implementation by 12/2010 – FCHA – GHC – LifeWise of WA – Premera – Regence – United **Transaction - Future Implementation** – KPS - 06/2011 – PacifiCare - 01/2012 – Molina - 01/2013 – Kaiser - 12/2013 – Medicaid - To be determined	**Transaction - Implementation by 12/2010** – Aetna (at CORE level) – Cigna (at CORE level)	**Transaction** – CHPW - Cost Prohibitive – CUP - Not Reported – LNI - Not Applicable

BPR	Fully Adopt[*1] with Implementation Date	Partially Adopt with Implementation Date	Not Reported or Reported as 'To Be Determined', 'Not Adopting' or 'Not Applicable'
Transaction BPRs: Best Practices related to HIPAA transaction content			
Standard Coding of Denials and Adjustments on the 835RA	**Implementation by 12/2010** – CUP – FCHA – GHC – LifeWise of WA – Molina – Premera – Regence **Future Implementation** – Medicaid - 06/2011 – CHPW - 07/2011 – LNI - Unknown	**Implementation by 12/2010** – Aetna – Kaiser – United **Future Implementation** – Cigna (at CORE level) - 06/2011 – PacifiCare - T.B.D.	– KPS - Not Applicable
Electronic Processing of Corrections to Institutional Claims	**Implementation by 12/2010** – Aetna – Cigna – CUP – FCHA – GHC – Kaiser – KPS – LifeWise of WA – Medicaid – Molina – PacifiCare – Premera – Regence – United **Future Implementation** – LNI - 06/2011		CHPW - Cost Prohibitive
Electronic Processing of Corrections to Professional Claims	**Implementation by 12/2010** – Aetna – Cigna – CUP – FCHA – GHC – Kaiser – KPS – LifeWise of WA – Medicaid – Molina – Premera – Regence – United **Future Implementation** – LNI - 06/2011		– CHPW - Cost Prohibitive – PacifiCare - TBD

B. Prioritizing Solutions

In working with providers and payers to develop the solutions called for in the bill it has become obvious that the perceived value of the solutions is not equal. Some solutions are seen as having greater potential to simplify administrative processes than are some other solutions. In addition, the adoption and measurement challenge for some solutions is seen as greater than for other solutions. This assessment is based on informal surveys among work group and stakeholder participants, expert opinion, efforts to develop measurement methods and ongoing discussions with providers and payers. Fortunately, the solutions that are perceived to have higher value also tend to be the solutions that are seen as easier to promote, measure and gain adoption of. In general:

- Based on experience to date, higher adoption results from promoting services (e.g., the PDS, etc.) or electronic solutions than promoting policy solutions;
- It is easier for payers and providers to measure/validate services and electronic solutions;
- The ultimate value of electronic solutions and services is higher for payers and providers; and
- Policy solutions are seen as conferring less value and are harder to measure and promote.

As such, in designing the adoption campaign, priority will be given to the PDS, web solutions, and electronic transactions. Policy solutions will be a lesser priority.

C. Change What You Measure

To make change, particularly in a CQI setting, measurement is critical. However, with the exception of the PDS, there is no central way to measure either payer or provider adoption. The only practical way to measure payer adoption is through provider validation. The only practical way to measure provider adoption is through payer tracking. In absence of validation and tracking by the other party, self-reporting similar to Figure IV is the only alternative. Cost and complexity are also important factors in developing measurement methodologies. It makes no sense to create a complex and costly system to track the implementation of solutions designed to reduce cost and complexity.

Operating in this context dictates some key elements of the adoption/measurement approach:

- WorkSMART will work with the payer community to leverage their existing efforts to track web usage and transaction volumes.
- WorkSMART will continue to recruit members of the provider community to validate payer web sites and electronic transactions.
- Payer adoption will be measured at the individual payer level.
- In general, provider adoption will be tracked at the aggregate level, however there may be some cases where large provider organizations are measured individually.
- OneHealthPort will track adoption of the PDS by providers, hospitals and payers centrally at both the aggregate and individual level.

This measurement strategy is summarized in FIGURE V below:

FIGURE V – MEASUREMENT METHODS

Measurement Model	Measurement Type	Description
Central	PDS	OHP tracks and reports usage of PDS by providers, hospitals, payers to public and OIC
Payers self-report, validated by providers	Payer adoption of transaction/web BPRs	Payers self report, provider volunteers validate*, OHP reports back to payer, public, OIC
Payers self-report not validated by providers	Payer adoption of policy BPRs	Payers self report, OHP reports to public, OIC
Payers measure/report aggregate provider adoption	Provider adoption of transaction/web BPRs	Payers measure aggregate (%) adoption by providers, OHP reports to public, OIC
No measure of provider adoption	Provider adoption of policy BPRs	No organized effort to measure provider adoption

*In the absence of provider volunteers to validate, self-reporting by payers will stand

D. Provider Outreach - The Primary Focus for 2011

Over the past two years, WorkSMART has experimented with a variety of outreach tactics and consulted with providers and payers about how best to reach the shared community of interest. This process has led to the development and implementation of a provider outreach campaign for 2010 and 2011. The campaign will be a top priority for 2011 and features a series of related and parallel efforts as described below:

- General awareness – WorkSMART has made over 15 appearances at a variety of venues to engage with the provider community. This face-to-face work is supplemented with electronic communications distributed through WorkSMART's own channels and the channels of payer and association partners. This general outreach will continue in 2011.
- PDS – With the rollout of the PDS, WorkSMART is commencing a series of face-to-face presentations and electronic promotions targeted at the provider community to encourage enrollment. Simultaneously, WorkSMART continues to aggressively pursue the lists of payers and hospitals prompting them to execute participation agreements.
- Training – Across the board, the most consistent request from providers is more training. Awareness is critical to getting the provider community's attention. However, once that is accomplished, training the providers in how to make the best use of the SSB 5346 solutions is the key to ultimately making change. WorkSMART is working collaboratively with payers and providers to design and deploy a variety of training tools ranging from in-person instruction to online videos, webcasts and manuals. This training program will be refined and improved over the course of 2011.

- Linkage to HIE – On another track, OneHealthPort is leading the state's Health Information Exchange (HIE) effort. The first service to be deployed is a HUB for secure exchange of messages. The HUB is well positioned to accelerate adoption of the transaction oriented solutions in SSB 5346. The upcoming outreach campaign focused on the HUB will also have significant benefit to the simplification of administrative information exchange.

VII. Going Forward

As we consider how best to move forward with simplifying health care administration in Washington State it is worth considering what we have learned to date from the SSB 5346 experience. The ongoing SSB 5346 implementation effort has surfaced challenges and opportunities.

A. The Lead Organization Model

To date, the Lead Organization model appears to have accomplished the objectives of all parties in a satisfactory way:

- The state secured the cooperation, knowledge and resources of the private sector in its effort to simplify administration. This allowed the effort to move forward faster, more effectively and at much lower cost to the state than would be likely under a traditional public sector model.
- The private sector retained discretion relative to work products and implementation and avoided a regulatory approach that is not preferred by most private sector organizations
- The partnership between WorkSMART and the OIC has been a strong, effective and cordial relationship. From the beginning, the OIC clearly defined the public interest and related expectations regarding the implementation of SSB 5346. As long as WorkSMART met these expectations and operated in the public interest, the OIC allowed it significant discretion in day-to-day management. The legislature also provided funding for a full-time OIC staff position to support the administrative simplification work. This has provided two big dividends; 1) the OIC has independent knowledge and insight into the issues at a detailed level; and 2) the OIC staff time with the work groups established a trusted relationship that greatly facilitates the work of all parties. Similarly, WorkSMART conducted its work in a transparent and open manner. Every effort was made to engage and inform interested parties. Both WorkSMART and the OIC have worked under a "no secrets" policy that enables both parties to anticipate and resolve issues before they become problems. Finally, WorkSMART and the work group participants made a strenuous and successful effort to deliver the required solutions on time. The collaborative development of the solutions required by SSB 5346 in less than two years is evidence of the value of the Lead Organization model for doing this type of work.

While the current implementation of the Lead Organization model has gone very well, there are issues to note when considering the long term viability of the approach:

- Part of the success of the current model is built on personal trust and long standing relationships. The informal nature of the relationship between the parties, more than a handshake, less than a contract, necessitates the presence of trust and harmonious working relationships. It is unclear that it would be feasible to retain the qualities that have made the relationship work well in a more formal, structured and contractually oriented model. For example, it would be challenging to create a viable and equitable contractual relationship under the state model in the absence of any compensation being paid.

- The ability of WorkSMART to undertake the Lead Organization work at no cost to the state is based on the generosity and commitment to public service of the Washington Healthcare Forum, its constituents and the OneHealthPort investors. These are the parties that provide the financial resources that sustain WorkSMART's effort as Lead Organization. At this time the future funding stream to support the ongoing effort has not been clearly identified. In the 12 month time period covered by this report, WorkSMART's costs were approximately $750,000.
- Section 1 of SSB 5346 [RCW 48.165.005] states: *"To address these inefficiencies, constrain health care inflation, and make health care more affordable for Washingtonians, the legislature seeks to establish streamlined and uniform procedures for payors and providers of health care services in the state. It is the intent of the legislature to foster a continuous quality improvement cycle to simplify health care administration. This process should involve leadership in the health care industry and health care purchasers, with regulatory oversight from the office of the insurance commissioner."* Achieving the goals in RCW 48.165.005 will require sustained effort and resources over time from health care payers and providers, and from the state. In 2009 and 2010 almost all SSB 5346 related work has been managed or facilitated by OneHealthPort.
- To carry out a significant level of ongoing administrative simplification work it will be necessary both to identify the level and sources of funding needed, and what organization(s) have staff resources available for the work. To date, Minnesota is the only state that has funded broad public-private administrative simplification efforts over a long period of time.

One of the key objectives for all parties in 2011 should be to review our experience with the Lead Organization model and to determine whether it should be sustained and if so how, or whether it should be replaced, and if so with what?

B. State Reform vs. Federal Reform

Over the past few years there has been an ongoing tension between those who believe health care administrative simplification is best addressed at the local or state level and those who believe a national or federal approach makes more sense. This issue was brought into a starker focus by the recent passage of federal health care reform which contains administrative simplification provisions that overlap with, and may in some cases potentially conflict with, some elements of SSB 5346.

When SB 5346 was introduced in 2009 the federal government was not actively leading or promoting health care administrative simplification efforts. Sections 1104 and 10109 of the 2010 federal health care reform legislation have changed that by establishing a much expanded federal leadership role. The bill requires the Secretary of the Department of Health and Human Services (HHS) to adopt regulations and operating rules between 2011 and 2016 that address a wide variety of administrative simplification opportunities.

HHS is required to adopt <u>operating rules</u> to provide more uniformity in the use of the following administrative transactions:

- Eligibility/Benefits (270/271), and Health Claims Status (276/277) – by July 2011;
- Payment and Remittance Advice (835), and Electronic Fund Transfer – by July 2012; and

- Health Care Claims (837), Enrollment and Disenrollment (834), and Referral Certification and Authorization (278) – by July 2014.

HHS is also required to adopt final regulations that establish requirements in three areas: Unique Health Plan Identifiers; Electronic Fund Transfers; and Health Claims Attachments. In addition to the new operating rules and regulations, HHS is also directed to assess by January 2012 whether there is a need for additional administrative simplification standards for the following areas:

- Electronic provider enrollment process and application form;
- Application of HIPAA standards and operating rules to the health care transactions of auto insurance, industrial insurance, etc.;
- Standardized forms for financial audits by health plans and by state and federal agencies; and
- Greater transparency and consistency of methods and processes used to establish health plan claim edits; and Publishing health plan timeliness of payment rules.

HHS will rely on the National Committee on Vital and Health Statistics (NCVHS) as its primary source of guidance for proposed operating rules, final regulations, and additional administrative simplification standards. The NCVHS Subcommittee on Standards met in July 2010 to consider the first issues requiring HHS action: Operating Rules for Eligibility and Claims Status transactions, and the establishment of Unique Health Plan Identifiers. Two states – Minnesota and Washington – were invited to participate in the Subcommittee hearing.

The Subcommittee on Standards has recommended that the Council for Affordable Quality Health Care (CAQH) be designated as the lead organization for developing proposed operating rules for eligibility and claims status transactions, for all health care other than retail pharmacy transactions. CAQH has been working with health carriers, vendors, and providers on the development of operating rules for these transactions for several years through its Committee on Operating Rules for Information Exchange (CORE) program.

The NCVHS will make recommendations by the end of December 2010 to the Secretary of HHS regarding the Eligibility and Claims Status operating rules. HHS will then initiate its rule-making process with a goal of formally adopting the operating rules prior to the statutory deadline of July 1, 2011, with an implementation deadline of January 1, 2013. In December the NCVHS also began work on the development of operating rules for Payment and Remittance Advice transactions and for Electronic Fund Transfers.

It is not clear how the new HHS operating rules and regulations will impact the administrative simplification efforts in Washington State. Two key questions that are not clearly answered by the federal law are:

- To what extent will the HHS operating rules apply to web-based interactions as opposed to electronic transactions? SSB5346 specifically calls for increased standardization on health plan

web sites as well as the associated HIPAA transactions. The federal law does not indicate whether HHS operating rules will apply only to the HIPAA transactions.

- Will the HHS operating rules and other standards establish a floor - or a ceiling - for transactions? Can Washington State establish higher standards for transactions in this state, so long as those standards expand upon and are consistent with the HHS operating rules or regulations?

Clarifying the respective roles of the coming federal operating rules and regulations and state-specific initiatives will be a major challenge for 2011.

On the private sector side neither the Washington Healthcare Forum nor OneHealthPort have taken a formal position in the federal vs. state debate. However, both organizations would observe that unless and until the relationship between the federal requirements and state based efforts like SSB 5346 is clarified implementation of SSB 5346 will be complicated in the areas of overlap.

While there are different perspectives on the preference for federal or state based reform, the private sector is united around the following beliefs:

- No one wants to undo or redo work that has already been done. Parties are unlikely to "retreat" from current implementations on a voluntary basis and would be very disappointed to be required to do so on a mandated basis.
- The respective roles of the federal and state requirements must be clarified before additional state administrative simplification legislation is passed that might overlap with federal requirements. Parties do not want to have to pursue multiple paths to be in compliance nor do they want to expend energy and resources on state legislative models that are going to be preempted by federal law.

While OneHealthPort and the Forum have not taken a position, Insurance Commissioner Kreidler has submitted a letter to the National Committee on Vital and Health Statistics that stresses the importance of preserving the authority of states to establish administrative simplification standards that build on national operating rules adopted by the federal department of Health and Human Services. The Commissioner pointed out that the benefits of the administrative simplification efforts undertaken in Washington could be lost or limited if the future HHS operating rules establish a "ceiling" and not just a "floor" for simplifying key administrative transactions. It is also much more feasible to effectively engage payers and providers at the state level rather than a national level and such engagement is critical for building the working relationships needed for an on-going continuous quality improvement approach.

C. Realization of Benefit

The State's primary interest in passing administrative simplification legislation was to recognize cost savings. There is some dispute among stakeholders regarding the importance of administrative cost relative to overall health care costs and other drivers. However, all parties would agree that health care administration can be made more efficient then it is today. The challenge lies in defining, calculating and realizing the benefit of such gains in efficiency.

WorkSMART believes that solutions called for in SSB 5346 are most accurately viewed as opportunities for improvement within given enterprises. Each enterprise may capitalize on the improvement opportunity in different ways based on:

- Structural differences between organizations
- Where they started from versus where they ended up
- How effectively they deployed the solution
- How efficient they were at capturing the benefits from the implementation
- How they deployed whatever benefit they captured

The effort described earlier around adoption and measurement of adoption will help the State understand how many enterprises are taking the initial steps toward benefit realization by adopting the improvement opportunities offered in SSB 5346. However, this measurement of adoption will be of little value in assessing what if any "savings" emerge and/or how such savings are recognized. These questions of "who benefits, how much" arise in regard to many improvement efforts. Attributing a given outcome to any specific intervention is equally difficult in the clinical improvement space.

The WorkSMART Institute makes the following recommendations regarding benefit realization:

- Measurement of adoption offers the best marker of overall progress for system wide improvement and should be pursued.
- Efforts to identify, attribute and recognize specific cost savings from administrative simplification are unlikely to generate valid and useful results. As such, it would not be useful to expend resources on this type of analysis.
- Payment reform that rewards efficiency and lower costs offers the best method to realize benefit from administrative simplification and will hopefully be pursued.

D. How to Best Promote Adoption - Regulation vs. Voluntary Collaboration

SSB 5346 provides initial emphasis on voluntary collaboration and adoption, with potential for subsequent regulatory intervention if deemed necessary by the Insurance Commissioner. Early findings appear to validate the concept of relying initially and primarily on voluntary collaboration and adoption.

- Payers and providers have engaged in the work group effort to develop solutions
- Payer self-reports indicate a high level of intended adoption
- Both hospitals and payers are executing agreements to participate in the PDS
- Initial validation efforts seem to show payer implementations are on target

These are obviously very early and incomplete indicators but they are promising. Over the next 18-24 months it will become clearer how well the voluntary adoption model is working to reduce administrative burdens and expenses. The experience to date with solution development and adoption has raised a number of interesting questions regarding the effectiveness of using voluntary collaboration versus regulation to promote widespread adoption of administrative simplification opportunities:

- There is significant complexity embedded in administrative simplification. The process of designing and implementing the SSB 5346 solution set has illustrated how absolute standardization across provider and payer organizations and systems is often unachievable. For this reason the focus has increasingly been on "harmonization" or moving toward equivalent approaches. It would be very challenging to draft regulations that are precise and enforceable yet also provide enough flexibility to allow for a "harmonization" approach to setting standards. Rule-making may therefore be more problematic than using a voluntary adoption model.
- In RCW 48.165.005 the legislature expressed its interest in creating a "continuous quality improvement (CQI) cycle" for administrative simplification. The legislature recognized that innovating in this area requires an ongoing process. The initial experience of the work groups confirms the wisdom of the legislature's intent in regard to CQI. Some of the Best Practice Recommendations developed pursuant to SSB 5346 have already been amended, sometimes more than once. A flexible, voluntary adoption model allows for easier fine-tuning of standards than rule-making, and therefore is better suited for the CQI process than a more rigid regulatory model.
- The health care industry is large and diverse. There are tens of payers, hundreds of hospitals and thousands of practices performing millions of administrative transactions on a wide variety of systems. Enforcing regulatory requirements across such a diverse landscape is challenging in the best of times; in times of limited state resources, it becomes even more difficult. In this context, whether the solutions are established through regulation or are voluntarily adopted, as a practical matter there is not likely to be resources available for significant enforcement so improvement in the industry will largely be self-enforced and monitored by payers and providers rather than by a state regulator. Adoption of regulations without a commitment to active education and enforcement will not likely result in rapid, wide spread adoption. SSB 5346 provides an excellent opportunity to develop a model for voluntary improvement with measurement and oversight that has broader applicability across the health care system.
- While SSB 5346 is built on a voluntary adoption model, the bill also includes a "regulatory trigger." The OIC has the discretion to write regulations and compel compliance if voluntary adoption does not work. An objective assessment of the progress made on administrative simplification efforts prior to 2009 and after SSB 5346 was passed would seem to indicate that the legislation and its potential regulatory trigger have been helpful in accelerating both the scope and pace of voluntary improvement efforts. The OIC will have the opportunity in late 2011, after a review of the payer implementation shown on pages 10-12 and several months experience with the provider outreach efforts discussed on page 13, to evaluate the success of the voluntary adoption strategy. It would be premature to make a decision regarding possible rule-making prior to gaining this additional experience.

E. Legislation

One of the questions WorkSMART and its constituents have pondered is whether additional administrative simplification legislation is beneficial at this time. SSB 5346 includes specific assignments related to the next phase of coding standardization work and a medical management work plan that prompt consideration of this question. WorkSMART and its constituents strongly believe additional legislation at the state level should not be pursued at this time in the area of coding standardization, medical management or any other aspect of administrative simplification for the following reasons:

- The scope of SSB 5346 is very broad – more so than any other state administrative simplification initiatives other than perhaps Minnesota and Utah. The Lead Organizations, the OIC and the state's payers and providers still have lots of work ahead, deploying, adopting and measuring the solutions called for in SSB 5346. Adding additional statutory requirements at this time would be burdensome at a time when health plans and providers have to make so many other changes.
- The first phase of implementation has been focused on solution development. Improvement is really related to the second phase – adoption. It is important to "finish the job" defined in SSB 5346 by driving adoption and realizing improvement before adding additional development work.
- As noted above, there are important unresolved questions related to how federal administrative reform will impact state administrative reform. Until the respective federal and state roles are clarified passing additional state legislation could lead to a risk of consuming additional public and private resources in a fruitless effort that ends up being preempted by the federal government.
- There are a number of improvement efforts currently being pushed in the local health community including the transition to version 5010 of the HIPAA transactions and to ICD-10, the federal administrative simplification initiatives, Meaningful Use of Electronic Health Records (EHRs), deployment of a statewide Health Information Exchange (HIE), development of an Insurance Exchange, implementation of new insurance regulation, a variety of quality improvement efforts and significant activity in the market around consolidation. Most health care organizations have very limited change management resources. In many cases, these improvement initiatives tax the same resources within organizations. At this time there is very little band-width remaining to take on additional improvement work. Additional administrative simplification legislation raises the risk of "doing many things badly" rather than trying to do a smaller number of things well.

VII. Conclusion

The Forum, OneHealthPort and the OIC all appreciate the opportunity to work on this innovative improvement program. We are very grateful to the many public and private sector organizations and individuals who have participated in and contributed to the initial success of the SSB 5346 implementation effort. We look forward to continued work and success in this area and we are pleased to address any questions the legislature may have regarding the implementation of SSB 5346.