December 10, 2013

Agenda

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- Mass Collaborative Background
  - History
  - Participating members
  - Governance
  - Initial research '42 Pain Points'
- Initial Successes and Current Focus
- Future Planned Efforts and Regulatory Requirements

Why focus on Admin Simp?

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Collaborative Background

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- Mass Collaborative (formerly Mass Admin Simp Collaborative) formed from two separate groups in ealry 2009
  - Employer's Action Coalition on Healthcare (EACH)
  - MHA, MMS, and MAHP Collaborative on Admin Simp
- Group is led by a Steering Committee comprised of MHA, MMS, HPHC, BCBSMA, MAHP, MassHealth and MHDC

<u>Mass Collaborative Mission Statement</u>

Collaborate with Massachusetts healthcare payers and providers to simplify and improve healthcare administration by increasing transactional efficiency, eliminating waste, and promoting standardization.

Collaborative Participation

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- Includes:
  - All local payers in the state
  - MassHealth
  - Several national insurers
  - Mass Hospital Association
  - Mass Medical Society
  - Mass Association of Health Plans
  - Mass Health Data Consortium
  - Healthcare Administrative Solutions
  - Many facility and physician organizations

Initial Research / Prioritization

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- Mass Collaborative partnered with Deloitte to conduct extensive research
  - Numerous stakeholders interviewed including
    - Facilities
    - Provider groups
    - Health plans
    - Associations
    - Employers
- 42 'Pain Points' initially identified (see next three slides)
- Steering committee prioritized eligibility, duplicate denials, denied claim appeals, and medical policies for initial efforts

Opportunities to Reduce Administrative Complexity

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Through the provider interviews and research, 42 improvement opportunities to reduce administrative complexity in the provider value chain were identified

System-Wide Processes

- Improve communication between payers and providers
- Standardize communication channels and approaches between payers and providers
- Host collaborative sessions between payers and providers to increase knowledge of processes and partner on solutions

Front End Processes

Contracting	Scheduling	Eligibility Verification	Benefits Verification	Pre-Authorization	Referrals	Provider Care/ Case Mgt.	Hard and Soft Coding
•Ensure provider contracts can be supported by payer systems •Standardize payer requirements for pre-loading new fee schedules	•Increase education of patients regarding need for ID Card	•Develop strategy to increase adoption of electronic eligibility verification platforms (e.g. NEHEN) for eligibility transactions •Eliminate employer retroactive eligibility changes	•Create upfront price and liability transparency for members •Increase transparency of payer medical necessity diagnosis requirements	•Make payers responsible for pre-authorization requirements •Adopt the Medicare model for utilization management •Give providers responsibility for utilization management	•Reduce or eliminate referral requirements within a health system •Adopt the Medicare model for utilization management •Give providers responsibility for utilization management	•Allow providers to make medical necessity determinations	•Standardize billing codes •Increase transparency of CCI and bundling edits •Increase standardization of employer insurance plan designs

Best practice revenue cycle process redesign focuses first on the front end processes

Opportunities to Reduce Administrative Complexity (cont'd)

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Back End Processes

Billing/Claims Submission	Claim Status Inquires	Collections, Remittances and Payment Posting	Denials	Over-payment/ Under-payment	Appeals	Reporting
•Standardize claims forms and processes •Reduce clinical data and attachment requirements for small claims •Standardize payer processes for special services (e.g. transplants)	•Develop strategy to increase adoption of NEHEN for claim status transactions •Improve automation in claim status inquiry and payment processing	•Standardize payer payments via EFT •Standardize administration of NPI to eliminate misdirected provider payments •Enable claim correction and payments to be performed online •Make payers accountable for collecting all member liabilities •Transfer COB responsibility from providers to payers •Enable tracking of bill payments by line level •Process claim payments daily •Reduce number of partial payments made by payer	•Improve all payer systems' abilities to recognize multiple diagnoses •Increase transparency of CCI and bundling edits •Standardize denial codes	•Standardize payer take-back (overpayment recoveries) communication, process and time limits •Standardize late charge submission and processing	•Standardize payer filing and appeals time limits •Enable claim correction and payments to be performed online •Standardize appeal forms and allow for online submission	•Increase automation and connectivity across systems and databases •Standardize data fields and formats •Increase timeliness of data required for reporting

Initiatives to Address Administrative Complexity

The specific opportunities were analyzed for common themes and then logically grouped into 14 initiatives that spanned system-wide, front end and back end processes

System-Wide Processes

- Increase transparency of requirements between payers and providers

Front End Processes

Contracting	Scheduling	Eligibility Verification	Benefits Verification	Pre-Authorization	Referrals	Provider Care/ Case Mgt.	Hard and Soft Coding
• Standardize medical policies • Streamline provider contracting processes	• Standardize and streamline eligibility process	• Standardize and streamline eligibility process	• Standardize and streamline eligibility process	• Standardize and streamline eligibility process • Standardize medical policies	• Standardize and streamline eligibility process • Standardize medical policies	• Align financial responsibilities to payers and clinical responsibilities to providers	• Increase standardization / adoption of CCI edits for bundling • Develop standard employer plan design

Back End Processes

Billing/ Claims Submission	Claim Status Inquires	Collections, Remittances and Payment Posting	Denials	Over-payment/ Under-payment	Appeals	Reporting
• Standardize medical policies • Standardize time limits • Increase transparency of claims requirements • Clearly define claim attachment requirements • Standardize claims submission processes and codes • Establish payer "bare minimums" for claims processing capabilities	• Increase use of electronic claim status inquiries	• Standardize and streamline remittance and payment processes • Standardize time limits • Align financial responsibilities to payers and clinical responsibilities to providers	• Standardize time limits	• Standardize time limits	• Standardize and streamline appeals processes • Standardize time limits	

Mass Collaborative Focus 2013

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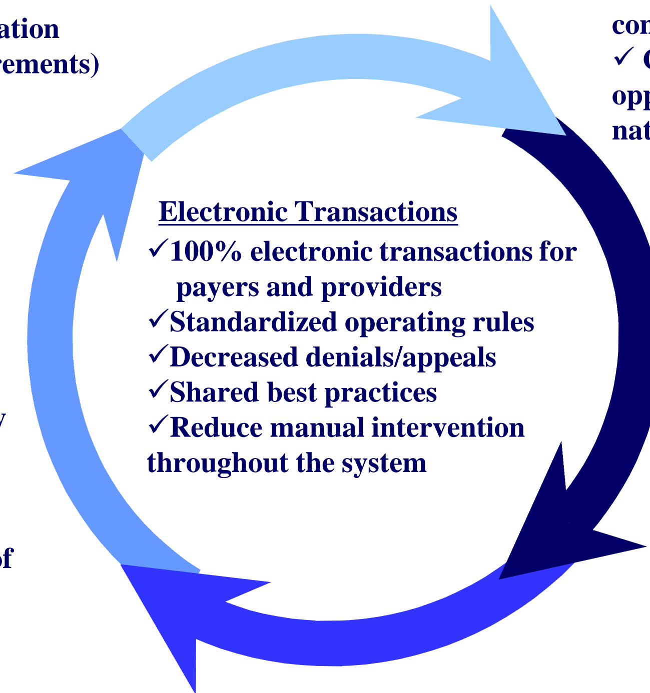
Continuing Initiatives

✓Identify and act upon opportunities to reduce overall claims life cycle turnaround time
✓Enhance the standard authorization form (including Chap. 224 requirements)
✓Streamline provider licensure
✓Streamline credentialing

Collaborative Brand

✓Be a leader in administrative simplification in Massachusetts and
✓Finalize web presence
✓Initiate community-wide communication plan
✓ Create collaborative exposure opportunities with local, state, and national entities.



Electronic Transactions

✓100% electronic transactions for payers and providers
✓Standardized operating rules
✓Decreased denials/appeals
✓Shared best practices
✓Reduce manual intervention throughout the system

Communications

✓ Identify communication gaps in system; develop solutions
✓Improve/simplify health plan policy changes; consolidate payer communications where possible
✓Improve / enhance processes for provider community to notify plans of demographic changes
✓ Create and/or support community wide training on major/national initiatives (i.e., Operating rules, ICD-10)

Advocacy

✓ As needed, provide input to state and federal entities about Mass Collaborative efforts
✓ Work with community including Beacon Hill to prioritize healthcare administrative needs
✓ Engage employer community in all efforts
✓Provide input/support for state entities around payment reform requirements

Measuring Success / Impacts

✓ Gain agreement on principles for measuring success
✓ Gather baseline metrics at the initiative and overall level
✓ Develop overall success/impact communication plan (i.e., annual report?, website, etc.)

Eligibility

✓ Assess impact of new operating rules and, if necessary, develop solutions for potential gaps
✓ Provide recommendations to DOI for regs due 2014
✓ Engage employer community to understand front end enrollment processes

Past Successes / Current Efforts

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- Denied Claim Appeals form and standardized appeal definitions
- Standardized authorization form for some services
- Alpha name normalization
- Centralized training materials
- Provider licensure, privileging, credentialing end-to-end mapping

- Denied Claim Appeals
- Authorizations
- Web page / brand awareness
- Credentialing
- Payer / provider communications
- Provider Awareness Survey
- Measuring Success

Eligibility

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- **Completed and Current Initiatives**
  - Successful implementation and updating of eligibility training materials – current hits 200/mo
  - Development of new alpha name normalization standard
    - Implementation was tied to 5010
- **National Health Care Reform Eligibility Operating Rules**
  - Eligibility rules released July 1, 2011
  - All payers/provider must comply with 1/1/13 implementation
  - DOI will promulgate regulations based on community feedback around eligibility by 1/1/14
    - Largely thought to be an effort to close 'gaps' not addressed by operating rules
- **Assess opportunities and timing to re-engage employer community**
  - Requires engagement of large and small employers to better understand employer processes, challenges, etc.

Authorizations

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- **The problem**:
  - Numerous forms for submitting an authorization
    - An informal survey showed that just among responding payers, there are 170+ different forms for submitting an authorization request
  - The volume of authorizations is increasing with new auth requirements
  - Documentation requirements also differ among payers by service type
- **Principles for developing a solution**:
  - A need to simplify the submission process reducing confusion and rework
  - A need to increase transparency of the provider requirements for submitting a successful authorization
  - Where appropriate, a need to decrease the amount of paperwork required to submit an appeal
  - A need to leverage increased electronic submissions of authorizations
    - Many authorizations are submitted via paper

Copies of forms, detailed instructions available here:

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- **www.hcasma.org**

- **The following participating health plans now accept the form:**
- Aetna
- Blue Cross Blue Shield of Massachusetts
- Boston Medical Center HealthNet Plan
- CeltiCare
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan
- UniCare
- UnitedHealthcare

Standardized Authorization Form

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Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION FORM".
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

The Standardized Prior Authorization Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

Health Plan:	Health Plan Fax #:	*Date Form Completed and Faxed:

Service Type Requiring Authorization[1, 2, 3] (*Check all that apply*)

Ambulatory/Outpatient Services	Ancillary	Dental	Durable Medical Equipment
☐ Surgery/Procedure (SDC) ☐ Infusion or Oncology Drugs	☐ Acupuncture ☐ Chiropractic ☐ IVF/ART ☐ Non-Participating Specialist	☐ Adjunctive Dental Services ☐ Endodontics ☐ Maxillofacial Prosthetics ☐ Oral Surgery ☐ Restorative	☐ Prosthetic Device ☐ Purchase ☐ Renal Supplies ☐ Rental
Home Health/Hospice	**Inpatient Care/Observation**	**Nutrition/Counseling**	**Outpatient Therapy**
☐ Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) ☐ Hospice ☐ Infusion Therapy ☐ Respite Care	☐ Acute Medical/Surgical ☐ Long Term Acute Care ☐ Acute Rehab ☐ Skilled Nursing Facility ☐ Observation	☐ Counseling ☐ Enteral Nutrition ☐ Infant Formula ☐ Total Parental Nutrition	☐ Occupational Therapy ☐ Physical Therapy ☐ Pulmonary/Cardiac Rehab ☐ Speech Therapy
Transportation ☐ Non-emergent Ground ☐ Non-emergent Air	☐ Other—please specify:		

Provider Information (****Denotes required field*)**

*Requesting Provider Name and NPI#:	*Phone:	Fax:
*Servicing Provider Name and NPI# (and Tax ID if required): ☐ *Same as Requesting Provider*	*Phone:	Fax:

Reference Guide

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STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM REFERENCE GUIDE

The Standardized Prior Authorization Request Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

What is the purpose of the form?

The form is designed to serve as a standardized prior authorization form accepted by multiple health plans. It is intended to assist providers by streamlining the data submission process for selected services that require prior authorization. It is important to note that an eligibility and benefits inquiry should be completed first to confirm eligibility, verify coverage, and determine whether or not prior authorization is required by the member's plan.

Who should use this form?

If you are a provider currently submitting prior authorizations through an electronic transaction, please continue to do so.

The standardized prior authorization form is intended to be used to submit prior authorizations requests by fax (or mail). Requesting providers should complete the standardized prior authorization form and all required health plans specific prior authorization request forms (including all pertinent medical documentation) for submission to the appropriate health plan for review.

The *Prior Authorization Request Form* is for use with the following service types:

Services	Definition (includes but is not limited to the following examples)
Ambulatory/Outpatient Services	Medical services provided to a member in an outpatient setting: hospital outpatient departments, hospital licensed health centers, or other hospital satellite clinics; physicians' offices; nurse practitioners' offices; freestanding ambulatory surgery centers; day treatment centers; members' home.
Ancillary	Acupuncture, chiropractic, infertility, other specialist care.
Dental Services	Endodontic; restorative; oral surgical procedures; maxilliofacial prosthetics; other adjunctive dental services.
Durable Medical Equipment (DME)	Equipment used to fulfill a medical purpose and enable mobility. Can be rented or purchased and can include wheelchairs, walkers, canes, med/surg supplies, renal supplies and prosthetic devices.

Denied Claim Appeals

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- **The problem**:
  - Process has historically been cumbersome for providers and payers
  - Significant volume (approximately 68k per month)
  - Historically, payers have defined denied claim review types differently along with different requirements
  - Submission forms / formats and timelines have differed among payers
- **Principles used to develop solutions**:
  - A need to increase transparency of the provider requirements for submitting a successful appeal
  - Where appropriate, a need to decrease the amount of paperwork required to submit an appeal
  - A need to leverage existing and new channels for submission of appeals (phone, fax, online, mail)
  - A need to assess opportunities for standardization of various appeal timeframes
  - A need to leverage various payer best practices
- **Current Status:**
  - Standardized Request for Claim Review form implemented
  - Standardized claim review definitions across all payers
  - Review of current documentation requirements (by appeal reason) underway to standardize across payers
  - Review of submission and response timeframes to determine feasibility of standardizing across payers

CLAIM REVIEW FORM

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Request for Claim Review Form

Reset Form

COMPLETE ALL INFORMATION REQUIRED ON THE "REQUEST FOR CLAIM REVIEW FORM".
INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

Today's Date (MM/DD/YY):		Health Plan Name:	
**Denotes required field(s)*			
Provider Information			
*Provider Name:		*Contact Name:	
*National Provider Identifier (NPI):		*Contact Phone Number:	
Contact Fax Number:		Contact E-mail Address:	
*Contact Address:			
Member / Claim Information			
*Member ID:		*Member Name:	
*Date(s)of Service (MM/DD/YY):			
*Claim Number:		*Denial Code:	

***Review Type**

Enter X in one box, and/or provide comment below, to reflect purpose of review submission.

	Contract term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms.
	Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.
	Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made:
	Duplicate Claim: The original reason for denial was due to a duplicate claim submission.
	Filing Limit: The claim whose original reason for denial was untimely filing.
	Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
	Payer Policy, Payment: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
	Pre-Certification/Notification or Prior-Authorization or Reduced Payment: The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
	Referral Denial: The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
	Request for additional information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC Codes, Home Infusion Therapy).
	Retraction of Payment: The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).
	MassHealth: The MassHealth provider has received a *Final Deadline Exceeded* error message. MassHealth providers must only use this review type to submit claims for review to MassHealth. Use of this form for submission of claims to MassHealth is restricted to claims with service dates exceeding one year and that comply with regulation 130CMR 450.323.
	Other:

Reference Guide

Reference Guide–Request for Claim Review

This guide will help you to correctly submit the Request for Claim Review Form. The information provided is not meant to contradict or replace a payer's procedures or payment policies. For-up-to-date details, please consult the respective payer's Provider Manual. Please direct any questions regarding this guide to the plan to which you submit your request for claim review.

Please note that failure to abide by the following may affect your compliance with a payer's individual policies.

Terminology/Definitions ... 3
Request for Review ... 4
Filing Limit ... 4
Request for Review Form ... 4
Address to Submit Review Requests ... 4
Fax # to Submit Review Requests ... 4
Multiple Requests ... 5
Initial Review Timeframes ... 5
Subsequent Requests to Review Same Claim ... 5
Vehicles to Submit ... 5
Request for Denied Claim Review Documentation Requirements ... 6
Contract Terms ... 6
Coordination of Benefits ... 7
Corrected Claim ... 7/8
Duplicate Claim ... 8
Filing Limit ... 9
Payer Policy Clinical ... 10
Payer Policy Payment ... 10
Precert/Notification/Authorization Denial or Reduced Payment ... 11
Referral Denial ... 12
Request for Additional Information ... 12
Retraction of Payment ... 13
Other ... 13/14

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COMMUNITY CREDENTIALING WORKGROUP

- Includes health plans, providers, MHA, MMS, MAHP, BCBSMA
- Began meeting regularly in 2007
- Mapped health plan credentialing process

First thing we did:

- Established a successful email notification program for health plans to inform providers who has been credentialed

Last	First	MI	Suffix	Degree	Pcat	IPA	Credentialing Committee Date	THP Effective Date	Specialty
El Koussaimi	Idriss			MD	PCP	50 EAST BOSTON HEALTH CENTER	12/7/2011	12/7/2011	Internal Medicine
Zimmerman	Erik	E		MD	Specialist	70 BAYCARE HEALTH PARTNERS, INC	12/7/2011	12/7/2011	Psychiatry
Evindar	Alexandra			MD	Hospitalist-Specialist	46 UNIVERSITY OF MASS MEDICAL	12/9/2011	12/9/2011	Pediatrics
Friedman	Kevin			MD	Specialist	K2 CHILDREN'S PPOC 1	12/9/2011	12/9/2011	Cardiology

But…Still a lot of noise

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- Recognition that actual credentialing process is only one part of the overall process of getting a provider "up and running" so that he/she can see patients and get reimbursed. Processes primarily addressed physicians. What about ancillary, PAs, NPs?
- Hiring/contracting; licensing through state agency; credentialing and privileging by hospital; health plan credentialing; provider enrollment

Key Findings from Mapping

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- All stakeholders acknowledge that numerous redundancies exist with regard to the credentialing process, particularly with primary source verification (PSV).
- Many stakeholders lack understanding of exactly what activities occur upstream/downstream in the process, resulting in disjointed activities, confusion and frustration.
- Many MD/DO/APRNs have extremely limited engagement in the credentialing process, which can cause delays due to submission of incomplete and inaccurate application materials.
- Processes differ at each hospital and each health plan, causing confusion for physicians and their delegates.
- Stakeholders maintain a strong focus on accuracy and precision, which promotes adherence to regulations but also results in delays when information is not submitted a certain way.
- Stakeholders recognize the importance of the credentialing process and acknowledge that the stakes are high if errors are made.
- Numerous parties involved indicate an appetite for change.

Credentialing Projects

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- Increase frequency of hospital board votes during high volume months
- Establish a standardized, dedicated process, including time frames, at plans for inquiries about status of an application
- Adopt the IMA for all provider credentialing statewide
- Establish a standardized process for notifying health plans of updates to roster
- Convene weekly meetings of BORIM board during high volume months
- Simplify instructions for the BORIM licensing application
- Utilize BORIM to conduct PSV for initial applications

Payer / Provider Communications

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- **Purpose / Goals of the Group:**
  - To identify and define best practices for payer / provider communications
  - Work with the plans to encourage adoption of best practices across all plans
- **Progress to Date:**
  - The group outlined 16 current state challenges and defined some potential opportunities for improvement based on the challenges
  - The 16 current state challenges were consolidated into 13 challenges and a survey was created in order to gain further information on which challenges are of most concern to providers
  - Survey resulted in 24 responses from PHOs, Hospitals and Physician Practices
    - Survey results showed a range of responses in how providers felt that plans did communicating with providers; some good, a lot of “fair” and some poor
  - 3 hospitals and one large physician group estimated staff expense for the amount of time and effort it takes them to investigate, summarize, and get the word out about plan changes to their providers is about $12,000 to $13,000 per year.
    - NOTE: This expense ***does not*** include other expenses like training, IT, oversight, etc.

Payer / Provider Communications

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Payer / Provider Communications Detailed Current Challenge Grid			
1	Lack of consistency- there is no consistency in the way information is communicated from heath insurers to providers	7	Provider directories not updated in timely / accurate way
2	Timeliness- newsletters are not published on a regular schedule; information not delivered in a timely manner	8	Provider relations reps no longer visit providers; often no clear rep assigned, lack of direct, consistent connection to health plan
3	Content- information provided is often broad, unclear, lacking in detail, subject to interpretation, and / or requires clarification	9	Lack of accountability- since provider reps no longer know the practices on a personal level, no confidence that issues will be resolved
4	Method of delivery- newsletters or information not sent to correct individuals or affected department; important information buried in newsletter	10	Provider's time / labor involved in transmitting information to relevant staff in hospital / medical group
5	Payer search functions- Difficult to search for policy changes since many are done through newsletter announcements; website search functions inadequate or information not available	11	Information overload due to sheer volume of changes made by insurers
6	Inability to speak with health plan experts regarding a particular topic	12	Communication to / from delegated vendors such as radiology management companies is difficult
		13	Lack of education on improvements- plans do an inadequate job of communicating positive changes or improvements to providers

Payer / Provider Communications Current initiatives

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- Identify health plan publications and associated distribution dates
- Create master calendar of publications for all providers to view
- Create/implement standardized provider demographic change form
- Work with HCAS to develop process for email sign up/distribution of health plan publications to provider practices and hospital staff who use but don’t currently receive these materials.

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Chapter 224 Requirements

- Prior Authorization
  - Uniform forms for provider office visits, Rx, imaging and other diagnostic testing, lab tests by 10/1/13 (Or when DOI issues regulations and/or bulletins)
- UR Criteria
  - Criteria must be easily accessible and up-to-date on a carrier or UR organization's website
- Medical Necessity Reviews
  - Criteria must be easily accessible and up-to-date on a carrier or UR organization's website; no new or amended requirements shall be implemented unless the website has been updated
- Transparency
  - Health plans & providers to make information available on the estimated or maximum amount for a proposed admission, procedure, or service based on the information available at the time the request is made
  - State website containing information comparing the quality, price and cost of health care service

Eligibility

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Chapter 224 Requirements

- Requires the Division of Insurance to issue regulations and/or a Bulletin regarding eligibility verification

Mass Collaborative Efforts

- Sub-group of subject matter experts gathering to discuss proposals to share with DOI before they issue regulations

Future Initiatives

The Collaborative

- Our Process
  - Annual planning process
  - Submission to the Steering Committee for review & direction

Suggestions always welcomed!

For more info, contact:

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