A Brief Summary of the
Massachusetts Healthcare Administrative Simplification Collaborative Efforts to Reduce Healthcare Administrative Costs
May 2011

Executive Summary

The community-wide Administrative Simplification Collaborative continues to work on major healthcare administrative simplification initiatives that reduce unnecessary expenses for providers and health insurance organizations. The following organizations are currently actively participating in this ongoing effort:

- Massachusetts Hospital Association (MHA)
- Massachusetts Medical Society (MMS)
- Massachusetts Association of Health Plans (MAHP)
- Massachusetts Health Data Consortium (MHDC)
- All local health plans including Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, Neighborhood Health Plan, Network Health, Fallon Community Health Plan, Health New England, Boston Medical Center HealthNet Plan
- MassHealth
- Numerous provider organizations including among others, Partners HealthCare, Baystate Medical Center, Atrius Health, Wellesley Medical Associates
- Unicare / Wellpoint
- Healthcare Administrative Solutions, Inc.
- Employers Action Coalition on Healthcare (EACH)
- United Health Care

Background

In 2008, stakeholders at the national and state levels began to focus more attention on administrative simplification as an avenue to reduce costs by eliminating or modifying non-value producing administrative processes. In the Commonwealth of Massachusetts, several entities began to develop plans to address administrative burdens, including the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, and the Employers Action Coalition on Healthcare. As the various efforts began it became clear that the best results could be achieved if the parties worked together to address these issues. As a result, in early 2009 the Massachusetts Healthcare Administrative Simplification Collaborative of MHA, MMS, MAHP, and EACH, was launched.

A Steering Committee of senior executives from key stakeholders was created to govern the collaboration's efforts and was initially supported by Deloitte Consulting, LLP. After conducting a series of interviews with provider, payers, employers and industry associations, the group identified 42 opportunities for administrative simplification across 15 components of the provider revenue cycle. These opportunities included, for example, ensuring that provider contracts can be supported by payer systems, standardizing

eligibility verification processes, streamlining the claims denial process, and standardizing remittance and payment processes.

Based on scoring criteria that included financial benefit, cost to implement, feasibility, time to implement, and potential overlap/conflict with existing initiatives, the group identified the initial four areas of priority:

1. Eligibility and eligibility verification
2. Duplicate claims
3. Denied Claims Appeals
4. Payer medical policies

Progress to-date (May 2011)
1. Eligibility verification / submission process
    a. Planned reduction in unnecessary eligibility denials through enhanced / improved processes around transaction response code standardization, alpha name normalization implementation and standardized operating rules
    b. Implementations tied to migration to 5010 platform (1/1/12) and CAQH Operating rules (1/1/13)
2. Duplicate denials and pends
    a. Revised processes designed to reduce unnecessary pends. Implemented 2011 and measuring to determine impact
3. Denied claims appeals
    a. Standardized and centralized the denied claims appeals process form, format, training guide across all payers which will result in resulting in increased efficiencies for both payers and providers when implemented on 6/15/11
4. Medical Policies
    a. Investigating the feasibility of standardizing medical policies (initial focus: Observation)

Current Focus
The Collaborative is now focused on continuing work on several of the above items as well as additional items:

1. Eligibility verification / submission process
    a. Obtain RWJ grant funds to fully research CAQH proposed operating rules to identify barriers to implementation, potential gaps between rules and current experience, and forecast improvement
2. Denied claims appeals
    a. Drive required state regulations (Chapter 288, sec 57) so already completed work is used as foundation for required regulations

3. Credentialing
    a. Development end-to end flow [Board of Registration in Medicine (BORiM) – Hospital - Payer)]; Identify redundancies and mitigate
    b. Also, drive state regulations so Collaborative work is used as foundation for required regulations development
4. Authorizations / Referrals
    a. Currently working to reduce required authorization forms from 170+ to a more reasonable number as well as develop centralized common training/reference materials
    b. Drive required state regulations (Chapter 288, sec 57) so already collaborative work is used as foundation for required regulations
5. Medical Policies
    a. Continue investigating the feasibility of standardizing medical policies (initial focus: Observation)

Current Challenges / Plans
1. Resource constraints among health plan staff
2. Provider engagement – particularly smaller professional and allied providers
3. Ensuring effort remains and continues to be bilateral benefiting both providers and payers and ultimately employers
4. Engaging employers in the process
5. Coordinating / balancing collaborative efforts with evolving federal and state guidelines