

Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2012

The health care system, and its multiple payers, imposes significant burdens on physician practices. A typical physician practice has a contract with 12 or more health plans in addition to participating in Medicare and Medicaid and must follow each payer's requirements for contracting, credentialing, preauthorizing, coding, billing, and reimbursing. It is estimated that nearly 14 percent of physician practice revenue is consumed by billing and insurance-related functions. Further, studies by the Medical Group Management Association calculate the annual cost of administrative tasks, many of which are of dubious value, at around \$25,000 per year per physician. In addition to being costly and frustrating to physicians, administrative burdens are unnecessarily limiting physicians' ability to provide patient care.

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions, beginning in 2012, that aim to reduce administrative burdens. The ACA generally assigns the responsibility for implementation of the administrative simplification provisions to the Secretary of the Department of Health and Human Services (HHS), often referred to as "the Secretary." Many implementation activities will be handled by the Centers for Medicare and Medicaid Services (CMS), an agency component of HHS.

What health reform law-mandated efforts to streamline administrative requirements took effect in 2012?

Study to Identify Specific Administrative Transactions for Which Standard Processes Reduce Administrative Burdens

The ACA establishes a timeline for accelerating the development, adoption and implementation of a set of operating rules for specific health care administrative transactions. The law defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information..." Operating rules for different administrative transactions have different establishment and effective dates. The requirements for each type of transactional element are described throughout this guide.

The law also provides the HHS Secretary discretion to establish and implement standards and operating rules for additional administrative transactions, specifically requiring the Secretary to solicit input on the need for standards and rules for certain transactions. By January 1, 2012, the Secretary must seek input as to whether:

- The process by which physicians and other providers enroll to participate in a health plan can be made standard and electronic, including whether a uniform application form is viable. The intent is to make it easier for physicians to go through the process of being credentialed by multiple insurers. Consideration of this administrative transaction aims to assess whether the concept promoted through an initiative led by an organization established by large private payers to simplify administrative requirements imposed on physicians can be expanded. This organization, the Council for Affordable Quality Healthcare, has worked with ACP and a wide range of other stakeholders to establish a database of physician-provided credentialing information from which health plans can extract the information they need. This initiative enables physicians to provide credentialing information once instead of providing it, or a variation of it, to multiple individual insurers. While this effort is helpful, its overall impact is limited as it does not include all private payers nor does it include Medicare.
- There could be: more consistency in the process by which health plans develop the edits they include in their claim processing system that determine when to flag a claim for more information or outright deny payment for a claim; and greater transparency of the edits used by plans. Medicare develops its claim processing system edits at a national level with input from ACP and other physician organizations and

makes the edits it uses publically available. Most edits maintained by private payers, however, are considered proprietary. Increased standardization in the edits used by each payer and availability of those edits would improve the ability of physician practices to be appropriately paid for claims.

- Health plans should be required to publish their rules about the timeliness with which they pay claims. While it is likely that many health plans have nuanced claim payment rules, e.g. whether a submission is a “clean” claim that officially enters the processing system, increased availability of rules may provide payers incentive to ensure their rules are reasonable.

Establishment of System that Assigns a Unique, Single Identification Number to Each Health Plan

The ACA requires the Secretary to establish a system that provides a unique identification number for each health plan that is effective by October 1, 2012. Ensuring that each health plan has only a single identification number should improve the ability of physician practices to manage their administration interactions with health plans. The Secretary of the Department of Health and Human Services (HHS) finalized the standards for the Unique Health Plan Identifier (HPID) for health plans as well as an Other Entity Identifier (OEID) for entities that are not health plans, health care providers, or individuals that need to be identified in standard transactions. Health plans must adopt the HPID by November, 2014, while small health plans have until November, 2014 to comply with the provision. Covered entities must use the HPID in standard transactions by November, 2016.

Additional Resources

- *CMS site on “Operating Rules for HIPAA Transactions.”*

<http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/OperatingRulesforHIPAATransactions.html>