Common Claims Work Group
Final Report

TO

THE COMMISSION ON HEALTH CARE REFORM

January 15, 2008

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Executive Summary

The Common Claims Work Group was created by H.861, Section 55 to design, recommend and implement steps to achieve the following goals:

1) Simplifying the administrative process for consumers, health care providers, and others so the process is more understandable and less time consuming.
2) Lowering the administrative cost in the health care financing system.

As outlined in Section 55 of H.861 (Appendix A) the work group that convened consisted of (Appendix B):

1) Two representatives selected by the Vermont Association of Hospitals and Health Systems.
2) Two representatives selected by the Vermont Medical Society.
3) One representative from each of the three largest health care insurers
4) The Director of the Office of Health Access or designee
5) Two representatives of the business groups appointed by the Governor
6) The health care ombudsman or designee
7) One representative for consumers appointed by the Governor
8) The Commissioner of Banking, Insurance, Securities and Health Care Administration or designee.

The first meeting of the work group took place on July 1, 2006 at which time Thomas Huebner was appointed Chair of the Common Claims and Procedures Work Group. Over the next two meetings, the work group developed a comprehensive seven-point work plan to be submitted by the September 1, 2006 deadline, as outlined by Section 55 of the Act. The work group has met monthly, with subcommittees meeting more frequently to focus on the details of each plan. You will find detailed backup from each group in their sections.

The work plan, outlined in Appendix C, focused on the following seven areas:

I. Standardization of Member Identification Card and Maximization of Electronic Transactions
II. Simplification of Explanation of Benefits and Patient Bills
III. Prior Authorization Pilot
IV. Credentialing
V. Improving the Efficiency of Claims Adjudication
VI. Simplification of Workers Compensation Claims Adjudication
VII. Revise work plan tasks as needed to meet the intent of the Act.

Goals and Recommendations

I. Standardization of Member Identification Cards and Maximization of Electronic Transactions

Purpose:

Primary purpose: To identify and evaluate opportunities that exist in the current electronic data sets transactions
Secondary purpose: To improve the patient and provider interaction by examining opportunities available through standardizing member identification cards.

A. Standardization of Electronic Claims Transactions

Goals:

1. Evaluate best-in-class operations that are used to increase electronic transactions while containing costs.
2. Evaluate the utilization of 837 file attachments used to capture and pass coordination of benefits information to Payers. Determine how highly used this information is and identify opportunities to replicate the functionality.

- The subcommittee recommends that the Commissioner of Banking, Insurance, Securities and Health Care Administration develop an ongoing collaborative process, similar to that used by UHIN, to aggressively seek electronic solutions to improve efficiency, reduce costs, and improve timeliness of electronic transmissions. A key to success of this recommendation is to develop a business model that allows for collaboration prior to moving an idea through the rulemaking process. A collaborative process that encourages best practices would allow BISHCA to successfully implement rules that make good business sense.

B. Develop Consumer Tools to Track Out- of- Pocket Cost

Goal:

To promote price transparency and enhance patient knowledge of out-of-pocket costs.

Recommendation:

The subcommittee has reviewed CIGNA Healthcare's "HealthePass" model for providing patient account information to its beneficiaries.

- After reviewing the tool, the subcommittee recommends that BISHCA, in coordination with the Act 191 pricing transparency process, consider this as a potential option in enhancing patient awareness. These opportunities need to be considered in conjunction with a review of the implementation cost.

C. Member Identification Cards

Goals:

1. Improve the provider interaction with the member by supplying key information needed to efficiently process health insurance claims.
2. Evaluate the available technology that would support simplified and enhanced payment processes, help patients anticipate and manage their health care costs, shorten provider revenue cycles, and help address patient delinquency.
3. Improve efficiencies of front-line staff in hospital facilities and professional physician offices by providing key insurance information up front and reducing the rework related to claims submissions.
4. Reduce call volume to payers by providing information required to collect copays, determine effective dates of coverage and complete claim processing on the member identification card.
5. Reduce contacts to Human Resource departments by providing member out-of- pocket costs on the identification card.
6. Recommend a common dataset for member identification cards to allow for ease of use.

Recommendation:

Based on the information collected, having key elements on the Identification cards would benefit the provider community through enhancing interaction with the patients, reduction of claims rejections, and increased efficiency of claims processing. It does not appear as necessary to mandate a member identification card layout as it does to require key data to be available. Based on the information reviewed, this requirement would have to be applied to all carriers doing business in the State of Vermont. At this time, all but one carrier on the workgroup had the majority of desired information on the member identification card.

- The subcommittee recommends that the following information be required on member identification cards by 2010. Payers would begin replacing cards during 2009, upon the group renewal to reduce disruption, with a requirement that the full replacement be complete by January 30, 2010.

1. Copay of Services
2. Subscriber ID
3. Primary Care Physician
4. Effective Date of Policy
5. Subscriber Name (even on dependent cards)
6. Billing Address
7. Group or Account Number
8. Subscriber Date of Birth - On all cards
9. Dependent Member Code

II. Simplification of Explanation of Benefits (EOB) and Patient Bills

Purpose:
To develop a methodology to provide clear billing information to patients.

Goal:
To produce consistent, consumer-friendly, and understandable explanations of benefits and hospital and physician office billing statements.

Recommendations:

- Adopt the attached Explanation of Benefits terms, definition, and format as the standard to be followed by all health insurance payers doing business in the State of Vermont. Carriers may add additional explanatory text if they determine a need. Begin implementation within one year and complete implementation within two years of acceptance of this report.

- Adopt the attached hospital patient statement, which is modeled after the Patient-Friendly Billing Project, and require that all hospitals in the State of Vermont use this model. Begin implementation within one year and complete implementation within two years of acceptance of this report.

- Adopt the attached physician office statement, which is modeled after the Patient-Friendly Billing Project, and require that physician offices with five (5) or more providers use this model, beginning implementation within one year and completing implementation within two years of acceptance of this report.

III. Prior Authorization Pilot

Purpose:
To review and determine if there are options for streamlining the administrative process for acquiring prior authorization approval.

Goal:
To eliminate unnecessary administrative steps and expenditures in the prior authorization approval process.

Recommendation:
Due to the success of a pilot program between Cigna and Rutland Regional Medical Center, the workgroup feels that developing a web-based prior approval process would save time and costs for physicians, facilities, and health plans.

- Require that each health plan develop a web-based prior approval process within one year of acceptance of this report.

- Require that each health plan transfer information between their utilization management and claims adjudication systems within 72 hours of the

authorization. This process should be in place within six months of acceptance of this report.

IV. Credentialing

Purpose:

To identify and evaluate opportunities for simplifying and streamlining the credentialing process.

Goals:

1. To ensure the successful implementation of the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Datasource.
2. To establish uniform time periods for organizations to act on completed credentialing applications
3. To eliminate variation between payors related to billing for physician assistants and advanced nurse practitioners.

Recommendations:

ACTIVITY 1. CAQH Universal Credentialing Datasource.

During implementation the BISHCA received questions from practitioners regarding the security of the CAQH system, and in particular the requirement to provide social security numbers when completing the credentialing application. Information is available on both the BISHCA and CAQH websites that outlines system security features to ensure the confidentiality of provider information. The online CAQH credentialing application requires practitioner social security numbers because information needed for credentialing may only be available by social security number. However, CAQH does accept the new National Provider Identifier (NPI) required by the Centers for Medicare and Medicaid Services and the Health Insurance Portability and Accountability Act (HIPAA). Currently all practitioners should have a NPI number, however, its full use has been delayed until May 2008. Until that time, CAHQ will continue to require social security numbers on the online credentialing application. Practitioners using the hard copy version of the form can check with insurers and/or hospitals to see if the social security number can be omitted. BISHCA should continue to request that CAQH end their practice of requiring the use of social security numbers.

ACTIVITY 2. Establish Uniform Periods for Organizations to Act on Completed Credentialing Applications.

All Sponsors should work together to develop a reporting process to measure success in meeting the voluntary 60-calendar day processing goal, as well as other efforts to streamline, coordinate, and improve physician credentialing and re-credentialing processes.

ACTIVITY 3. Eliminate the Variation Among Payers Relating to Billing for Physician Assistants and Advanced Nurse Practitioners

Health insurance companies have different rules regarding the ability of physician assistants and nurse practitioners to bill for health care services, which adds to the administrative burden for practices.

As shown on the attached table entitled: Questionnaire on Billing for Services of Physician Assistants and Advanced Nurse Practitioners, BCBSVT and MVP allow for the direct billing of services provided by physician assistants and advanced nurse practitioners with a note indicating that the PA/ANP provided the service.

To reduce the administrative burden for practices, it is recommended that CIGNA and OVHA adopt policies similar that of BCBSVT and MVP and allow for the direct billing of services provided by physician assistants and advanced nurse practitioners.

V. Improving the Efficiency of Claims Adjudication

Purpose:

To review and determine options for simplifying the claims adjudication administrative process. Representatives from physician offices and hospital billing departments were concerned that different insurance companies have different claim adjudication rules. The lack of consistency causes payment delays, appeals, and additional administrative burden for providers and payers.

Goal:

To eliminate unnecessary administrative steps for claims processing with emphasis on requiring insurers to provide the appropriate level of information related to claims processing rules.

Recommendation:

Over the course of the past year, the subcommittee has considered a number of different approaches to achieve the goal of increased efficiency of claims adjudication. Improving efficiency will be beneficial to four principal stakeholders - providers, payers, employer groups, and patients. The subcommittee endorses increased transparency as a key driver towards achievement of this goal.

- Adopt a rule patterned on the California Department of Managed Health Care Rules §1300.71. These Rules call for disclosing detailed payment policies and rules used to adjudicate claims, and requires methodologies to be consistent with standards accepted by nationally-recognized organizations, federal regulatory bodies and major credentialing organizations. The subject matter covered by these Rules paralleled much of the subcommittee's discussion over the past year, and the members felt that if Vermont commercial payers adhered to these rules, physicians and hospitals would gain a much greater understanding of rules used to adjudicate claims.

Although several payers were concerned about certain elements of the California Managed Health Care Rules (see Attachments 2-4), subcommittee members recommend that Vermont consider the adoption of a rule patterned on the California Department of Managed Health Care Rules §1300.71 with input into rulemaking from the provider and payer communities.

- Improved Notification - We recommend that payers improve the process by which they notify providers of material changes to claim adjudication rules. Characteristics of an improved process include:
  a. Notification should be made a minimum of 30 days in advance of the implementation date.
  b. The method of notification should be designed to reach the affected parties.
  c. Parties affected by the change should have an opportunity to comment on the planned change.

VI. Simplification of Workers' Compensation Claims Adjudication

Purpose:

To review and determine options for simplifying the claims adjudication administrative process for Workers' Compensation claims.

Goal:

To explore means to simplify the process for workers' compensation claims filing, processing and payment.

Recommendations:

We recommend that the following steps be taken to minimize costs and maximize the funding capacity of the workers' compensation program:

- Adopt the attached recommendation (Attachment F) for an amendment to Title 18 and 21 to include:
  1.) Initial complaints may be made to BISHCA by parties other than DOL, including other providers.
  2.) Require automatic interest paid to providers for lack of timely payments in alignment with medical and disability claims
  3.) Authorize the DOL to track carrier protocols for claims receipt, claims processing and claims paid, including an online claims status review option for providers;
  4.) Enable the DOL to have bill back authority for costs incurred in investigations of the WC carriers;
  5.) Insure that penalties assessed against workers' compensation carriers be deposited into a DOL administration fund to pay for tracking and enforcement activities within the division.

Timeframe: July 2008

Instead of requiring employers to file FROI (first report of injury) with the WCSD (workers compensation safety division) and report injury to carrier, we recommend that the process be streamlined and require employers to file FROI with carriers within 72 hours so that carriers can electronically file ALL FROI to the WCSD, as required by law. This would result in one copy of the FROI at the WCSD and would be received electronically creating less delay in entering into the WCSD tracking system and less entry errors to be dealt with by the Division staff.

Timeframe: March 2008

- Since the data entry staff responsibility would be greatly reduced with electronic submission of the majority of FROI, some of the four entry level staff would be freed up to monitor and track complaints about timely payments. These complaints, once verified with the provider and the carrier, would be forwarded to BISHCA for enforcement of timely payments.

Timeframe: March 2008

- Eliminate the "Pattern of Practice" requirement due to the nature of the volume of claims from an individual provider. If this is not possible, require the DOL to provide their own longitudinal study of carriers (over time) who repeatedly delay payment or wrongly deny payment across multiple provider groups, for purposes of creating in internal study of whether there is a patterned practice requiring review.

Timeframe: July 2008

- It is our recommendation that the Legislature should carefully monitor the implementation of the Texas law, which will take effect January 1, 2008, that requires electronic claims filing from the providers to the workers' compensation carriers. Added benefits to electronic filing include electronic records of claims transmissions and the savings of significant material costs involved with copying and mailing documents.

  Timeframe: February - June 2008

- It is our recommendation that the Legislature review cost savings estimated in Attachment G for analysis of the time spent by employer, physician office staff, hospital staff, WC carriers and WCSD. With these savings of time and associated costs, we believe that modifications to the existing systems would more than pay for themselves in a very short time period.

Appendix A

H. 861 Sec. 55. COMMON CLAIMS AND PROCEDURES

(a) No later than July 1, 2008, the commissioner shall amend the rules adopted pursuant to section 9408 of Title 18 as may be necessary to implement the recommendations of the final report described in subsection (g) of this section, as the commissioner deems appropriate in his or her discretion. Nothing in this section shall be construed to alter the commissioner's authority under Title 8 or chapter 221 of Title 18.

(b) No later than July 1, 2006, a common claims and procedures work group shall form, composed of:

(1) two representatives selected by the Vermont association of hospitals and health systems;

(2) two representatives selected by the Vermont medical society;

(3) one representative of each of the three largest health care insurers;

(4) the director of the office of health access or designee;

(5) two representatives from business groups appointed by the governor;

(6) the health care ombudsman or designee;

(7) one representative of consumers appointed by the governor; and

(8) the commissioner of the department of banking, insurance, securities and health care administration or designee.

(c) The group shall design, recommend, and implement steps to achieve the following goals:

(1) Simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming.

(2) Lowering administrative costs in the health care financing system.

(d) The group shall elect a chair at its first meeting. The chair, or the chair's designee, shall be responsible for scheduling meetings and ensuring the completion of the reports called for in subsection (g) of this section. Each organization represented on the work group shall be asked to contribute funds for the group's administrative costs.

(e) On or before September 1, 2006, the work group shall present a two-year work plan and budget to the house committee on health care and the senate committee on health and welfare.

(f) This work plan may include the elements of the claims administration process, including claims forms, patient invoices, and explanation of benefits forms, payment codes, claims submission and processing procedures, including electronic claims processing, issues relating to the prior authorization process and reimbursement for services provided prior to being credentialed.

(g) The work group shall make an interim report to the governor and the general assembly on or before January 15, 2007 describing the progress of the group and any interim steps taken to achieve the goals of the work plan. The work group shall make a final report to the governor and the general assembly on or before January 15, 2008 with the findings that illustrate the outcomes of implementations derived from the work group actions along with a list of future actions and goals, which shall specify cost savings achieved and expected future savings.

Appendix B

Common Claims Work Group

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2 Business Group Representatives		
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Health Care Ombudsman or Designee		
Jenny Prosser	jprosser@vtlegalaid.org	863-7155
1 Consumer Representative		
Judy Sassorossi	judys@FJGFinancial.com.	865-5000
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STANDARDIZATION OF MEMBER IDENTIFICATION CARD & MAXIMIZATION OF ELECTRONIC TRANSACTIONS

Common Claims and Administrative Simplification
(Act 191, Sec. 55)

Project Title:

Standardization of Member Identification Card & Maximization of Electronic Transactions.

Project Goals:

Identify Opportunities That Would Increase Electronic Claims Transactions:

1. Evaluate best in class operations that are used to increase electronic transactions while containing costs.
2. Evaluate the utilization of 837 file attachments used to capture and pass coordination of benefits information to payers. Determine how useful this information is and see if there is an opportunity to replicate such functionality.

Member Identification Cards:

3. Improve the provider interaction with the member by supplying key information needed to efficiently process health insurance claims.
4. Evaluate the technology available that would allow for a solution that would simplify and improve payment processes, help patients anticipate and manage their health care costs, shorten provider revenue cycles, and help address patient delinquency.
5. Improve efficiencies of front-line staff in hospital facilities and professional physician offices by providing key insurance information up front and reducing the rework related to claims submissions.
6. Reduce call volume to payers by providing information required to collect copays, determine effective dates, and complete claim processing on the member identification card.
7. Reduce contacts to Human Resource Departments by providing member out of pocket costs on the identification card.
8. Recommend a common dataset for member identification cards to allow for ease of use.

Subcommittee Members:

Name:	Organization
Emily Fair	Blue Cross Blue Shield of Vermont
Jason Soukup	CIGNA
Julie Langan	MVP
Lauren Parker	MBA Resources- Business Group Representative
Cherie Bergeron	Office of Vermont Health Access, EDS
Judy Sassorossi	Consumer Representative
Jane Vizvarie	Fletcher Allen Health Care

Summary of Workgroup Activity

Electronic Processes:

The subcommittee originally began with a scope which included payers' ability to accept electronic claims with coordination of benefits information, electronic claims remediation processes, and the standardization of member identification cards. In addition, the subcommittee evaluated opportunities to track member out- of- pocket costs and obtain the cost of healthcare services. The subcommittee also examined the concept of having a centralized location that would act as a clearinghouse for payers and providers to help reduce the cost of such enhancements.

The subcommittee identified seven states in the nation that have organizations supporting standardization of processes and electronic transactions: Utah, North Carolina, Wisconsin, Michigan, Oregon, Massachusetts, and Washington. The subcommittee successfully made contact with the Utah Health Information Network (UHIN). A representative from UHIN delivered a comprehensive overview of the organization and its role in supporting electronic transactions between payers and providers. As noted on the UHIN public website, the Utah Health Information Network (UHIN) has been a broad-based coalition of Utah health insurers, providers, and other interested parties, including State government, since 1993. This board-based steering committee works collaboratively to reach consensus on process improvements which are later adopted as administrative rules by the Utah Insurance Department. Anti-trust agreements have been instituted to deal with any issues members might have regarding the sharing of information. UHIN members have come together for the universal goal of reducing health care costs through the use of electronic data interchange (EDI). The members of UHIN have worked to provide a vehicle to pass electronic transactions from providers to payers. Currently payers are still expected to utilize internal edits to conduct data scrubbing of the information passed through UHIN. (See attachment A for UHIN presentation). At this time UHIN is working to enhance their current electronic abilities and is taking steps to include the acceptance of coordination of benefits information within the next two years. This expanded functionality is expected to further increase the electronic volume.

Members of the Common Claims Committee conducted outreach to various stakeholders who interact with UHIN and the following feedback was noted:

Stakeholder #1- Department of Banking and Insurance, Utah.

- The biggest lesson learned is to have buy-in from major players (hospitals, physicians, payers, etc.). UHIN started out as a voluntary effort between large payers, and they then asked the state to step in to make participation more of a requirement. The payers had a willingness to share information about their systems, which really was crucial to the initiative's success.
- A second lesson learned is that the initiative needs a business model that works. UHIN has a sound model that makes money. Payers are assessed a per transaction fee with an annual cap; providers pay a flat fee based on the size of the practice. The business model/fee structure is not as apparent for the clinical

transactions; UHIN is still struggling with that. The agreements with providers and payers cover all UHIN activity, so they don't have to be continuously rewritten for new initiatives.

Stakeholder # 2 – SH Management Inc (Billing Service)

The billing service does business with UHIN because it provides them an outlet to submit claims and receive payment remittances on those claims. All contacts for this activity go through one centralized organization.

- The UHIN system cuts down on manual entry and therefore requires less staffing; however, denials can at times be hard to read. In addition it would be better if UHIN did more data scrubbing on the electronic claims and didn't just act as a mailbox.

Stakeholder # 3- CIGNA Contacts from Utah

- CIGNA is contractually bound to have all clearinghouse transactions flow to CIGNA via Emdeon. A key metric for CIGNA is the electronic claim submission percent. Our January VT result was 75.84% and the UT result was 74.77%. With UHIN in place for many years yielding a rate for CIGNA that is lower than VT's and is well below our national result, CIGNA does not see any incremental value from UHIN.
- Communication is key when organizations like UHIN are created. CIGNA has had issues with UHIN advising Utah providers that they could not submit claims to CIGNA because the payer did not directly connect to UHIN. This was not the case and was later resolved but CIGNA had to take on their own communication efforts to clarify the issue.

Stakeholder # 4- Blue Cross Blue Shield of Utah

- The claims submission tools used by UHIN were actually originally developed through a partnership between the Blue Cross Plan and the HCFA organization back in the late 1980s. This was jointly funded between the two of them at an average cost of about $50,000-$100,000. The project took 6 months to 1 year to implement. The tools were implemented with Medicare in mind and once the providers got a chance to use it, they wanted to have it for all carriers. This is how UHIN came to be.
- BCBS of Utah still owns the software and keeps the systems up to date. At first there were competitive concerns with the Blues Plan being the filter but they don't do anything to scrub the data, they just act as the vehicle. This was later resolved through the enactment of anti-trust agreements.
- Providers have to pay an annual fee of $125 to be part of UHIN and the carriers are charged on a transaction level of $.017 per claim
- Overall, Blue Cross Blue Shield of Utah had very positive things to say about the program as a whole and indicated that it has really helped the providers to submit claims electronically. They also mentioned that members can use this website to check claim status.

Recommendations:

1. As noted above, there are seven known entities throughout the nation that support electronic sharing of information. Based on research and feedback, different stakeholders view the value of such organizations based on their primary interaction with them. The subcommittee is not recommending that the State of Vermont implement a UHIN- like organization at this time. However the Common Claims Work Group would like the State of Vermont to closely examine the process used by the UHIN organization to identify and implement rules. The subcommittee recommends that the Commissioner of Banking, Insurance, Securities, and Health Care Administration develop an ongoing collaborative process similar to that used by UHIN to aggressively seek electronic solutions to improve efficiency, reduce costs, and improve timeliness. A key to success is to develop a business model that allows for collaboration prior to moving an idea through the rulemaking process. A collaborative process that encourages best practices would allow BISHCA to successfully implement rules that make good business sense.

2. The Council for Affordable Quality Health Care (CAQH) has another avenue that the Common Claims Work Group feels is worth exploration. They have recently developed an initiative called CORE. CORE is intended to provide a universal vehicle for health plans and providers to use to support electronic transactions. The following is CAQH's description of CORE:

"Committee on Operating Rules for Information Exchange" (CORE™)
CAQH launched the Committee on Operating Rules for Information Exchange (CORE) based on research showing that improved electronic access to consistent, accurate, and timely healthcare administrative information would significantly reduce the resources required by providers to verify patient coverage, enable them to submit clean claims, and help eliminate bad debt.

CORE has brought together more than 100 industry stakeholders (health plans, hospitals, providers, vendors, CMS and other government agencies, associations, regional entities, standard-setting organizations and other healthcare entities) to achieve that goal. Participants collectively cover more than 130 million lives, or more than 75 percent of the commercially insured, plus Medicare and state-based Medicaid beneficiaries.

In addressing this challenge, CORE was designed to answer the question: *Why can't verifying patient eligibility and benefits and other administrative data in provider offices be as easy as making an ATM withdrawal?* The CORE vision is:

- Provider access to healthcare administrative information before or at the time of service using the electronic system of their choice for any patient or health plan.

Working in collaboration, CORE participants are building consensus on a set of operating rules that will:

- enhance interoperability between providers and payers
- streamline eligibility and benefits data transactions

- reduce the amount of time and resources providers spend on administrative functions.

Operating rules build on existing standards, such as HIPAA, to make electronic transactions more predictable and consistent, regardless of the technology. To this end, CORE will not develop software solutions, a switch, database or central repository.

According to a recent CAQH study, providers may reduce labor costs associated with verifying insurance coverage as much as 50 percent by moving from labor-intensive verification methods (web, fax and phone) to automated HIPAA transactions. Health plans also could achieve significant labor savings, as the study showed that average labor costs per phone call are $1.38 vs. $0.00 for an automated transaction.

CORE has been designed as a multi-phase initiative. Phase I rules will help providers:

- determine whether a health plan covers the patient
- determine patient benefit coverage
- confirm coverage of certain treatments and the patient's co-pay, coinsurance and base deductible (as defined in the member contract)

To date, nearly fifty organizations are certified as complying with or endorsing the CORE rules. Several additional organizations are committed to completing the certification process by the end of 2007, and others are preparing for 2008/2009. The Initiative's second set of rules, expected to be announced early in 2008, will address more complex eligibility components and claims status, both included under HIPAA.

Interoperability will be the foundation for any long-term solution to improve healthcare administration, and CORE is an important step toward achieving that goal. The CORE rules are being integrated into national initiatives to harmonize technology standards; and as state health information initiatives across the country discuss ways to address interoperability, they are considering the CORE rules as a component of their collaboration".

Timeline:

- Evaluate existing organizations or initiatives in a formal learning process in 2008-2009.

- Determine if there is a need to implement late 2009.

Consumer Tools to Track Out-of-Pocket Costs:

After the evaluation of electronic claims options was concluded, the subcommittee began to review options that would help consumers anticipate healthcare costs and track out-of-pocket expenses, as well as assist providers with timely collection of consumer payments. The industry has been observing a more pronounced need for such technology as more consumers move to high-deductible health plans. On October 31, 2006 CIGNA issued a press release regarding a new technology called HealthePassSM. The following details

were taken directly from the press release outlining this new tool for consumers. (Attachment B) HealthePassSM features a state-of-the-art "hold-and-settle" process that reserves the patient's payment from their funding source, such as a health savings account or line of credit, and releases the patient payment at the same time the insurance claim is settled.

The intent was to make this available at no additional cost for providers who accept credit cards. This solution leverages best-of-class capabilities provided by Metavante and Thomson Medstat to streamline all the financial facets of a visit to the doctor's office or a hospital stay. Using HealthePass, both the patient and the provider will know the patient's estimated costs up front and be able to ensure funding so the provider does not have to bill the patient separately.

How HealthePassSM will work:

- Patient Obligation Estimator - HealthePassSM will provide patients and their providers with real-time treatment cost estimates that reflect the patient's specific co-pays, deductible balances, coinsurance, and other factors. The itemized cost estimate is generated by Thomson Medstat's proprietary treatment cost calculation tool and backed by its deep analytic and predictive modeling expertise. Providers can quickly obtain estimates using their method of preference: desktop interface, phone, or fax.
- Flexible Payment Options - Using a financial institution payment network and functionality, HealthePass will feature an integrated, "multi- purse" card that will provide consumers with access to available health fund accounts and consumer credit and debt financing.
- Simpler Payment Process – Using a financial institution "hold-and-settle" process, HealthePass will allow patients to reserve payment from their health funding accounts - right in the doctor's office. HealthePass offers providers financial assurances that those amounts will be paid quickly and efficiently, and will eliminate the time and expense of patient collections. The payment process will be supported by Metavante Healthcare Payment Solution technology.

CIGNA HealthCare plans to launch HealthePassSM with select employers, members and providers in 2007, with subsequent rollouts across the country.

The cost behind this type of technology is yet to be determined. The HealthePassSM could be very beneficial to both members and providers as they attempt to calculate expected cost and collect payments. It could, however, prove to be costly to implement depending on the size of the health plan.

Recommendation:

CIGNA began piloting the HealthePassSM in their Arizona market in 2006. This Pilot is intended to continue through the first half of 2008. The pilot is going well and CIGNA feels that the cost estimator portion of the product has been refined; however, the financial institution that will perform the hold and settle function is TBD. CIGNA has made a strong recommendation to their product development team to use VT as a Pilot

market as well. This Pilot would require collaboration from a large provider in the state, such as Fletcher Allen Health Care.

If this pilot is successful, there should be consideration of broadening the functionality to other users outside of CIGNA in 2009.

Member Identification Card:

The last item evaluated by the subcommittee was the member identification card. The team evaluated the options of standardizing the data elements captured on the member identification card because the following opportunities were identified:

- Providers need certain key elements to submit claims or collect copays at the time of service. When that information is not captured on the member identification card, it may cause incorrect claims rejection, rework, and collection issues on the backend.
- Certain payers also reported receiving phone calls from providers when effective dates, member codes, and copayments were not shown on the card.
- Lastly, providers indicated that it is often necessary to make photocopies of member insurance cards for billing purposes and the material or colorations do not always copy in a way that is readable.

In an effort to identify the current state, as well as the future needs, the subcommittee created a matrix of all the data elements captured by health payers who were represented on the Common Claims Committee. (Attachment C) In preparation for improving the identification cards, a survey was sent to providers requesting their feedback on which possible elements would be most beneficial to include, as well as any other feedback they have about the identification cards in general. As of August 27, thirteen responses have been received from eleven different organizations. Table 1 includes the average ranking of the importance of the elements that could be included on the member identification card.

Table 1: Average rating of possible elements for Identification Card and additional elements suggested. (Elements were ranked 1-5 with 1 being most important and 5 being least important.)

Element	Ranking (avg.)
Copay amount Primary Care Provider	2.12
Copay amount Specialty	2.43
Copay amount Emergency	1.68
Copay amount Inpatient	1.95
Copay amount Outpatient	1.68
Copay amount Prescription	3.23
Subscriber ID	1.31
Primary care physician	2.69
Effective date of policy	2.19
Subscriber name even on dependent cards	1.81
Billing address	2.15
Prescription benefit information	3.25

Group or Account Number	1.38
Subscriber Date of Birth - On all cards	1.58
Dependent Member Code	2.38
Employer Name(for large group)	2.63
Additional Elements Suggested	
Electronic Payer ID	2
Medicare Health Plan/Advantage Plan	2
Phone Number for Customer Service and Mental Health	1
Prescription Phone Number (two responses)	5
Type of Plan(PPO, HMO…) (two responses)	1.75
Date Card Issued (Currently, the printed date is shown on the back of the BCBSVT ID card)	1
Insurance log if part of a network-ID for contracts	1
Annual Deductible	2

Responses varied a great deal according to the function of the person completing the survey, but this is to be expected. For instance, someone from a specialist's office would rank the specialist copay higher than the primary care physician (PCP) co-pay, as it impacts their daily work more. The reverse was also true as PCP offices did not feel they needed to know the specialist copays. Some facility results were only concerned with information that allows them to process billing correctly (Subscriber ID, Name and Group/Account Number for example). There was not wide variation in the ranking results.

In addition to the desired elements, the subcommittee asked providers to outline other benefits they would foresee getting, both soft as well as cost reductions. The following came out of that exercise.

1) Improved interaction with the member by supplying key information needed to efficiently process health insurance claims.
2) Improved efficiencies of front-line staff in hospital facilities and professional physician offices by providing key insurance information up front and reducing rework related to claims submissions.
3) Reduction in call volume to payers by providing information required to collect copays, determine effective dates, and complete claim processing on the member identification card.

Also, providers were asked to identify any additional outcomes that they felt would be possible. All additional outcomes that providers identified as beneficial are indicated in Table 2.

Table 2: Possible benefits not included as part of the survey.

Benefit	**Projected Yearly Savings**
Increased productivity of four staff members	$7,500 per year (facility)
Increased patient satisfaction	"priceless"
Reduced denials, reduced self-pay collection costs, reduced bad debt	"could be significant"

Reduced patient conflicts/issues post billing and increased patient satisfaction	(savings not indicated)
Less time spent on the phone for prior authorization if not needed (two responses for this)	(savings not indicated)
Subscriber date of birth saves paper claims to insurance and telephone calls to patient for info.	(savings not indicated)
Copays save telephone calls to insurance	(savings not indicated)
Ability to access information quickly	1 hr per day x 250 (working days per year) x $14 per hour=$3,500
Reduction in re-work and follow-up	Likely an FTE change
Acceleration in cash with correct billing	Unable to quantify
Fewer patient collection calls. We made 262 calls in a 10 day period that were associated with co-pays.	Estimate of 6,650 phone calls regarding co-pays in one year
Reduced cost to collect by enabling upfront collections (reduced statement costs and bad debt expense/commissions)	Savings for the 5 depts. currently doing upfront collections would be $12,410. Add statement costs and more depts. collecting upfront, total savings of at least $31,500.

The responses noted in table 2 showed a lot of variation. Smaller physician offices could more easily quantify the benefits, while larger facilities had difficulty doing so.

The subcommittee also asked Blue Cross Blue Shield of Vermont, MVP, and CIGNA to assess the costs and benefits of the additional elements for their organizations. For the most part the payers reported that this would just result in a cost for them and yield little benefits, with the exception of Blue Cross Blue Shield of Vermont, which projected a $20,000 savings per year from a reduction in phone calls to the Plan. The three payers reported that the average cost to reissue a member identification card would range from $1.00-$1.10 per member. The detailed feedback by payer is listed below:

Payer 1- Blue Cross Blue Shield of Vermont:

- Currently BCBS of Vermont does not have copayment information or member effective dates on the identification card. The reduction in calls was calculated using an estimate of how many calls the Plan gets each year for copayments and effective dates.

Payer 2- MVP

- MVP did not anticipate any savings at all due to the proposed changes to the identification cards; in fact it's quite the opposite.
- Including the PCP information on the ID card is not an option for us at this time for the following reasons:

1) Not all products require a PCP so the information is not captured for these individuals

2) Not all individuals requiring a PCP actually choose a PCP; this will delay the processing of cards and cause member dissatisfaction we are not willing to undertake.

3) The cost to send cards out based upon a change in PCP is exorbitant

Payer 3- CIGNA Healthcare:

- Mandating benefit data as depicted in the survey will increase administrative complexity and potentially cause additional confusion with providers and members. Space constraints that exist on cards today do not always allow full clarity in benefit information to be meaningful at the point of service, potentially causing more member and provider confusion. Our immediate goal is to bring cutting edge products to the marketplace and our resources (both financial and operational) are wholly focused on delivering those products. We are always evaluating ways to improve the provider and member experience with us through our product upgrades, and electronic web services are generally preferred over detailing benefit information on a physical ID card.
- In addition CIGNA also had the following comments regarding the data elements captured on the card.
    - Subscriber ID - This element should be renamed member ID.
    - Primary care physician - This element should include the caveat, if applicable. Many plans do not require the member to select a primary care physician.
    - Subscriber name, even on dependent cards, and #8 Subscriber date of birth on all cards - These elements are not necessary on ID cards.
    - Dependent member code - This element should include the caveat, if applicable. The member dependent code is included as part of the member ID number, as it is not a separate number.

Recommendation:

Based on the information collected, having key elements on the member identification cards would benefit the provider community through enhancing interaction with the patients, reducing claims rejections, and increasing the efficiency of claims processing. It does not appear as necessary to mandate a member identification card layout, as it does to require key data to be available. Based on the information reviewed, this requirement would have to be applied to all carriers doing business in the State of Vermont. At this time, all but one carrier on the workgroup had the majority of desired information on the member identification card. It would be the recommendation of the sub-team that the following information be required on member identification cards by 2010. Payers would begin replacing cards during 2009, upon the group renewal to reduce disruption, with a requirement that the full replacement be complete by January 30, 2010.

1. Copay amount Specialty
2. Copay amount Emergency
3. Copay amount Inpatient
4. Copay amount Outpatient
5. Copay amount Primary Care Physician
6. Subscriber ID
7. Primary care physician
8. Effective date of current policy
9. Subscriber name even on dependent cards
10. Payer Billing address
11. Group or Account Number
12. Subscriber Date of Birth - On all cards*
13. Dependent Member Code
14. Subscriber name even on dependent cards

* The use of date of birth, although requested, is cautioned due to personnel health information (PHI) exposure should the member lose the insurance card

Attachment B

News Releases

>> [Back to News Releases]

CIGNA HealthCare to Launch HealthePass(SM) to Assist Patients in Paying for Health Care
New Solution to Leverage American Express Healthcare Payment Capabilities

BLOOMFIELD, Conn., Oct. 31, 2006 /PRNewswire-FirstCall/ -- CIGNA HealthCare today announced HealthePass[SM], a comprehensive new solution designed to simplify and improve payment processes to help patients anticipate and manage their health care costs, shorten provider revenue cycle and help address patient bad debt.

HealthePass will feature American Express' state-of-the-art "hold-and-settle" process that reserves the patient's payment from their funding source, such as a health savings account or line of credit, and releases the patient payment at the same time the insurance claim is settled.

HealthePass will be made available by CIGNA at no additional cost for providers that accept credit cards. This solution leverages best-of-class capabilities provided by Metavante and Thomson Medstat to streamline all the financial facets of a visit to the doctor's office or a hospital stay. Using HealthePass, both patient and provider will know the patient's estimated costs up front and be able to ensure payment funding so the provider does not have to separately bill the patient. An online demonstration of HealthePass is available online.

HealthePass has sparked interest in the provider community, including the Hospital Corporation of America (HCA) which owns and operates approximately 182 hospitals and 94 freestanding surgery centers in 22 states. Said HCA East Florida Division President, Stephen L. Royal: "CIGNA HealthCare is clearly listening to providers' concerns about reducing administrative costs and alleviating business complexity.

"We are pleased that CIGNA understands provider concerns regarding challenges in collecting member responsibility and is taking positive steps to address them," Royal said. "The fact that HealthePass is being designed so that providers do not have to purchase new equipment or change business processes, and may use the system for a number of different payers, demonstrates that CIGNA is committed to a 21st century solution for the provider community."

According to CIGNA HealthCare President David Cordani, the goal is to remove issues that may become a distraction in the patient/physician relationship: "We are taking a collaborative approach that replicates the ease and simplicity of a typical retail transaction in order to address patient and provider concerns about how services will be paid, so that all parties can focus on what matters most - health and wellness.

"Using the expertise and capabilities of one of America's leading consumer and business financial services firms is an important attribute of the HealthePass solution," he added.

David Bonalle, Vice President of Healthcare at American Express, concurs: "By teaming up with CIGNA, our cutting-edge technology and capabilities will offer consumers and providers the financial assurances they need. Consumers will have flexible financing options and access to available health fund accounts, while providers can now be paid quickly and efficiently, and eliminate the time and expenses associated with patient collections."

How HealthePass will work:

- Patient Obligation Estimator - HealthePass will provide patients and their providers with real-time treatment cost estimates that reflect the patient's specific co-pays, deductible balances, coinsurance, and other factors. The itemized cost estimate is generated by Thomson Medstat's proprietary treatment cost calculation tool and backed by its deep analytic and predictive modeling expertise. Providers can quickly obtain estimates using their method of preference: desktop interface, phone, or fax.
- Flexible Payment Options - Utilizing American Express' payment network and functionality, HealthePass will feature an integrated, "multi- purse" card that will provide consumers with access to available health fund accounts and consumer credit and debt financing.
- Simpler Payment Process - Using the American Express "hold-and-settle" process, HealthePass will deliver the ability for patients to reserve payment from their health funding accounts - right in the doctor's office. HealthePass offers providers financial assurances that those amounts will be paid quickly and efficiently, and will eliminate the time and expense of patient collections. The payment process will be backed by Metavante Healthcare Payment Solution technology.

CIGNA HealthCare plans to launch HealthePass with select employers, members and providers in 2007, with subsequent rollouts across the country.

About CIGNA HealthCare

CIGNA HealthCare, headquartered in Bloomfield, CT, provides medical benefits plans, dental coverage, behavioral health coverage, pharmacy benefits and products and services that integrate and analyze information to support consumerism and health advocacy. "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation (NYSE: CI). Products and services are provided by these operating subsidiaries and not by CIGNA Corporation.

About American Express

American Express Company (http://www.americanexpress.com/) is a leading global payments, network and travel company founded in 1850. (NYSE: AXP)

About Metavante

Metavante Corporation delivers banking and payments technologies to financial services firms and businesses worldwide. Metavante products and services drive account

processing for deposit, loan and trust systems, image-based and conventional check processing, electronic funds transfer, consumer healthcare payments, and electronic presentment and payment. Headquartered in Milwaukee, Metavante (http://www.metavante.com) is wholly owned by Marshall & Ilsley Corporation (NYSE: MI).

About Thomson Corporation

The Thomson Corporation (http://www.thomson.com/), with 2005 revenues of approximately $8.40 billion, is a global leader in providing integrated information solutions to business and professional customers. Thomson provides value-added information, software tools and applications to more than 20 million users in the fields of law, tax, accounting, financial services, higher education, reference information, corporate e-learning and assessment, scientific research and healthcare. With operational headquarters in Stamford, Conn., Thomson has approximately 40,500 employees and provides services in approximately 130 countries. The Corporation's common shares are listed on the New York and Toronto stock exchanges (NYSE: TOC) Toronto. Thomson Medstat (http://www.medstat.com/) solutions - including business intelligence and benchmark databases, decision support solutions, and research services - help employers, government agencies, health plans, hospitals, and pharmaceutical companies manage the cost and quality of healthcare.

SOURCE: CIGNA HealthCare

CONTACT: Joseph Mondy of CIGNA HealthCare, +1-860-226-5499, or joseph.mondy@cigna.com

Web Site: http://www.americanexpress.com/
http://www.cigna.com/
http://www.medstat.com/
http://www.metavante.com/
http://www.thomson.com/

Attachment C

Standardization of Member Identification Card Survey Results
August 27, 2007

In preparation for improving our identification cards, a survey was sent to providers requesting their feedback on which possible elements would be most beneficial to include for them, as well as any other feedback they have about the identification cards in general. As of August 27, thirteen responses have been received from eleven different organizations. One response was also received from a payer, which was not included in this report as the intent of the survey was to capture feedback from providers. Table 1 includes the average ranking of the importance of the elements that could be included on the member identification card.

Table 1: Average rating of possible elements for Identification Card and additional elements suggested. (Elements were ranked 1-5 with 1 being most important and 5 being least important.)

Element	Ranking (avg.)
Copay amount Primary Care Provider	2.12
Copay amount Specialty	2.43
Copay amount Emergency	1.68
Copay amount Inpatient	1.95
Copay amount Outpatient	1.68
Copay amount Prescription	3.23
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Billing address	2.15
Prescription benefit information	3.25
Group or Account Number	1.38
Subscriber Date of Birth - On all cards	1.58
Dependent Member Code	2.38
Employer Name(for large group)	2.63
Additional Elements Suggested	
Electronic Payer ID	2
Medicare Health Plan/Advantage Plan	2
Phone Number for CS and MH (two responses)	1
Prescription Phone Number (two responses)	5
Type of Plan(PPO, HMO…) (two responses)	1.75
Date Card Issued (Currently, the printed date is shown on the back of the BCBSVT ID card)	1
Insurance log if part of a network-ID for contracts	1
Annual Deductible	2

Responses varied a great deal in response to the function of the person completing the survey, but this is to be expected. For instance, someone from a specialist's office would

rank the specialist copay higher than the PCP copay, as it impacts their daily work more. The reverse was also true as PCP offices did not feel they needed to know the specialist copays. Some facilities were only concerned with information that allows them to process billing correctly (Subscriber ID, Name and Group/Account Number for example).

Three possible outcomes were identified and Section 2 of the survey asks if the provider agrees with those outcomes. Every response received has agreed that these are possible outcomes of the improvements to the Identification Cards. The identified possible outcomes are:

- Improve the provider interaction with the member by supplying key information needed to efficiently process health insurance claims.
- Improve efficiencies of front-line staff in hospital facilities and professional physician offices by providing key insurance information upfront and reduce the rework related to claims submissions.
- Reduce call volume to payers by providing information required to collect copays, determine effective dates, and complete claim processing on the member identification card.

Also, providers were asked to identify any additional outcomes that they felt would be possible. All additional outcomes identified by providers as of August 27, 2007 have been identified as beneficial and are indicated in Table 2.

Table 2: Possible benefits not included as part of the survey.

Benefit	**Projected Yearly Savings**	**Organization**
Increase productivity of four staff members	4,160 hours per year = $75,000.00	Copley Hospital
Increased patient satisfaction	"priceless"	Copley Hospital
Reduced denials, reduced self-pay collection costs, reduced bad debt	"could be significant"	North Country Hospital
Reduced patient conflicts/issues post billing and increased patient satisfaction	(savings not indicated)	North Country Hospital
Less time spent on the phone for prior authorization if not needed (two responses for this)	(savings not indicated)	John Coco's Office (both responses)
Sub DOB saves paper claims to insurance and telephone calls to patient for info.	(savings not indicated)	Dianne Bolza
Copays save telephone calls to insurance	(savings not indicated)	Dianne Bolza
Able to access information quickly	1 hr per day x 250 (working days per year) x $14 per hour=$3,500	Dave Jillson
Reduction in rework and follow-up	Likely an FTE change	Fletcher Allen Health Care

Acceleration in cash with correct billing	Unable to quantify	Fletcher Allen Health Care
Fewer patient collection calls. We made 262 calls in a 10 day period that were associated with co-pays.	Estimate of 6,650 phone calls regarding co-pays in one year	MBA Resources
Reduced cost to collect by enabling upfront collections (reduced statement costs and bad debt expense/commissions)	Savings for the 5 depts. currently doing upfront collections would be $12,410. Add statement costs and more depts. collecting upfront, total savings of at least $31,500.	Rutland Regional Medical Center

SIMPLIFICATION OF EXPLANATION OF BENEFITS AND PATIENT BILLS

Common Claims and Administrative Simplification
(Act 191, Sec. 55)

Project Title: Simplification of Explanation of Benefits and Patient Bills

Project Goal:

To produce consistent, consumer-friendly, and understandable explanations of benefits and hospital and physician office billing statements to minimize confusion and improve consumer satisfaction.

At the conclusion of our work, we will produce two items:

1. A common terminology and definition list and a minimum content data set and layout for payer explanations of benefits which are mailed to patients
2. A common terminology and definition list and a minimum content data set and layout for hospital and physician statements to patients.

Subcommittee Members:

Kathy Peterson, Director of Patient Accounting, Rutland Regional Medical Center
Ann Lefevre, Associates in Orthopaedic Surgery
Jaime Ellermann, CIGNA
Deb Dion, MVP
Michelle Shader, MVP
Emily Fair, Blue Cross Blue Shield of Vermont
Lauren Parker, MBA Resources
Cherie Bergeron, EDS

Summary of Subcommittee Activity:

In preparation for establishing common terminology and designing explanations of benefits from payers and statements from hospitals and physician offices, the subcommittee did the following:

- Collected and analyzed Explanations of Benefits from MVP, Blue Cross Blue Shield of Vermont and CIGNA.
- Collected and analyzed patient statements from most of the hospitals in Vermont.
- Analyzed the differences in terminology used by hospitals and payers, with great variation noted from payer to payer as well as hospital to hospital.
- Explored the opportunity of conducting focus groups in local areas to establish consumer needs.
- Prepared a Request For Information to conduct focus groups, and reviewed and analyzed the responses. A determination was made that conducting our own

focus groups was cost prohibitive and there were other resources available which could provide us the information on consumer needs in this area.
- Gathered the focus group results and documentation from the Healthcare Financial Management Association's Patient Friendly Billing Project and used these results as a basis for our design work.
- Gathered data on the most common patient questions from MBA resources, which bills for 45 practices with 175 providers.

After the above data was reviewed and analyzed, the group:

- Developed the items needed on an Explanation of Benefits that would mathematically equate and would allow patients/consumers to follow the mathematical logic and easily determine what the insurance paid and what remained as their payment responsibilities.
- Developed the definitions for the terminology on the Explanation of Benefits and had this reviewed by a reading level specialist for grade level determination. This single common terminology will then be used on all Explanations of Benefits from all payers. (see attachment 1)
- Developed the layout and design of the Explanation of Benefits. This process encompassed much feedback from the major payers, as well as providers, to meet the needs of everyone to the greatest extent possible; all the while keeping in mind that we are trying to simplify the layout and terminology for the end consumer. After much discussion and multiple tries and revisions, the team developed a layout that allowed both the payers and providers to communicate key information to the consumer in a simplified manner. We wanted to make sure that the patient responsibility portion was stated multiple times and listed clearly so the consumer could match this up with the statement received from the hospital or physician office. (See attachment 2)
- Circulated the draft Explanation of Benefits to the business community representatives and consumer representatives on the group to disseminate to their respective peer groups for feedback. This feedback was incorporated into the final design of the Explanation of Benefits. Additionally, CIGNA provided the following feedback: CIGNA is supportive of administrative simplification efforts, but is concerned with adoption of a Vermont specific EOB. A state specific EOB adds administrative cost and complexity to the health care system. In addition, a Vermont specific EOB could stifle innovation and improvements to consumer disclosure efforts.
- Developed minimum requirements for EOB's for payers to follow (see Attachment 7)
- Developed items needed on patient statements from hospitals and physician offices based on the Healthcare Financial Management Association's Patient Friendly Billing Project recommendations.
- Developed the definitions of terminology for patient statements to coincide as closely as possible to the Explanation of Benefits. (see Attachment 3). The team was unable to make this match completely, as the Explanation of Benefits and the patient statements serve completely different purposes. The Explanation of Benefits is a one- time statement of a benefit, whereas the patient statement is an

ongoing statement of debits and credits of a balance owed (much like a bank statement). Therefore, the terminology could not be aligned completely.

- Developed the layout and design for the hospital patient statement based on the Healthcare Financial Management Association's Patient Friendly Billing Project recommendations. (see attachment 4).
- Distributed the hospital statement to all hospitals in the State of Vermont for comment and feedback and incorporated that feedback into the final design. Northwestern Vermont Medical Center provided a letter stating they believe participation should be voluntary and that the Patient Friendly Billing Project format should be followed. The Patient Friendly Billing Project format was indeed followed and used for the development of the statements.
- Developed the layout and design for the physician office statement, again following the guidelines set forth by the Healthcare Financial Management Association's Patient Friendly Billing Project. (see Attachment 5)
- Developed guidelines for hospitals and physicians to follow as to what elements are required and what is customizable to the hospital and physician office (see Attachment 6).
- Gathered cost and benefit information from payers and hospitals regarding the implementation of this project (see Attachment 8).

Recommendations:

- Adopt the attached Explanation of Benefits, terms, definition and format as the standard to be followed by all health insurance payers doing business in the State of Vermont. Carriers may add additional explanatory text if they determine a need. Begin implementation within one year and complete implementation within two years of acceptance of this report.

- Adopt the attached hospital patient statement which is modeled after the Patient Friendly Billing Project and require that all hospitals in the State of Vermont use this model. Begin implementation within one year and complete implementation within two years of acceptance of this report.

- Adopt the attached physician office statement, which is modeled after the Patient Friendly Billing Project and require that physician offices with five (5) or more providers use this model, beginning implementation within one year and complete implementation within two years of acceptance of this report.

DEFINITIONS OF EOB TERMINOLOGY

BILLED CHARGES – Amount billed for the service.

NOT ALLOWED – An adjustment made by your plan including items not billable to you.

NOT COVERED – Any billed charges not covered by your policy including services provided by an out-of-network or non-participating provider.

ALLOWED AMOUNT – The amount a plan will pay a provider for this service(s).

OTHER INSURANCE PAYMENTS – Any payment made by another policy that covers you.

COPAY – The fixed dollar amount you are required to pay your provider for this service.

DEDUCTIBLE – The amount applied to your annual deductible. You are required to pay this amount to your provider.

COINSURANCE – The percentage of covered charges that you are required to pay your provider.

AMOUNT PAID BY PLAN – The amount paid by the plan for this service.

PATIENT RESPONSIBILITY – The amount you may be billed.

NOTE: Services provided by a non-participating provider can be billed at charge and you may be held responsible for the difference between the billed charges and the paid amount.

Attachment 1

Explanation of Benefits

Insurance ABC
123 Elm St
Hometown, USA 01234

Mr. John Smith
520 Pleasant St.
Hometown, IL 60610

Patients Name: John Smith
Date of Service: 1/27/07 - 2/4/07
Provider: Hometown Health

Date: 01-Apr-07

Amount Paid by Plan:	$6,000.00
Amount you May be Billed:	$100.00
Your Annual Deductible:	$0.00
Year to Date Deductible Met:	$0.00

Date of Service	Type of Service	Billed Charges	Not Allowed/Not Covered		Equals Allowed Amount	Minus Other Insurance Payments	Patient Responsibility			Equals Amount Paid by Plan	Total Patients Responsibility	Reason Code
			Not Patient Responsibility	Patients Responsibility			Minus Co-Pay	Minus Deductibles	Minus Co-Insurance			
1/27/2007	Inpatient	$7,500.00	$1,400.00	$0.00	$6,100.00	$0.00	$100.00	$0.00	$0.00	$6,000.00	$100.00	90
Total:		***$7,500.00***	***$1,400.00***	***$0.00***	***$6,100.00***	***$0.00***	***$100.00***	***$0.00***	***$0.00***	***$6,000.00***	***$100.00***	

MidTown Orthopaedics

123 Midtown Blvd.
Midtown, IL 60610

July 1, 2007

Ms. Julie Smith
472 Adams Road
Midtown, IL 60610

DOCTOR BILL

Patient Name	Account Number
Julie Smith	0123-4567-89
Responsible Party	**Insurance/Plan Name**
Julie Smith	CIGNA

For questions or information, please call 1 800 555-5555 or visit www.hometownhealth.com

DATE OF SERVICE	TYPE OF SERVICE	DATE	Pt. Responsibility	CHARGES	PAYMENT S/ADJUSTMENT	PATIENT RESPONSIBILITY
3/22/2007	Office Visit					
	New Patient Office Visit			$155.00		
	X-Ray Knee 2 Views			$79.00		
	Knee Immobilizer			$57.00		
	CIGNA Payment	4/15/07			$113.47	
	CIGNA Adjustment	4/15/07			$104.61	
	Amount Due from Patient:		$52.92			
	Patient Payment	5/1/07			$25.00	
	Balance due					$27.92
			SUBTOTAL	**$291.00**	**$243.08**	**$27.92**
4/19/2007	Office Visit					
	Est. Pt. Office Visit			$85.00		
	X-Ray Knee 2 views			$79.00		
	CIGNA Payment	5/22/07			$45.09	
	CIGNA Adjustment	5/22/07			$68.78	
	Amount Due from Patient:		$50.13			
	Patient Payment	6/1/2007			$50.13	
	Balance Due					$0.00
			SUBTOTAL	**$164.00**	**$164.00**	**$0.00**
	TOTALS			**$455.00**	**$407.08**	**$27.92**

DUE FROM PATIENT: Please Pay This Amount By: July 1, 2007 **$27.92**

This Bill represents charges only. You may receive additional bills from the radiologist, pathologists, etc (This would be hospital specific).
For billing inquiries: 1-800-555-5555, weekdays 9:00 a.m. until 8:00 p.m., Saturday 9:00 a.m. until 2:00 p.m.
Or Dunning Messages

Please return bottom portion with your payment (Allow 7-10 days for postal delivery)

Due Date	Account Number	Write account number on check. Make check payable to Hometown Health	Please Pay This Amount
July 1, 2007	0123-4567-89		$27.92

Fill out below for credit card payments

[ ] Master Card [ ] Visa [ ] American Express [ ] Discover

PRINT NAME ON CARD

CARD NUMBER EXPIRATION DA

SIGNATURE

Midtown Orthopaedics
123 Midtown Blvd.
Midtown, IL 60610

Hometown Health

HOSPITAL BILL

312 Simpson Avenue
Hometown, IL 60206

August 1, 2007

Mr. John McGuirk
520 Pleasant Street
Hometown, IL 60610

Patient Name	Account Number
John McGuirk	0123-4567-89
Responsible Party	**Insurance/Plan Name**
John McGuirk	Blue Cross Blue Shield

For questions or information, please call 1 800 555-5555 or visit www.hometownhealth.com

DATE OF SERVICE	TYPE OF SERVICE	DATE	Pt. Responsibility	CHARGES	PAYMENT/ADJUSTMENT	PATIENT RESPONSIBILITY
1/27/2007 - 2/04/2007	Inpatient Medical					
	Billed Charges			$7,500.00		
	Blue Cross Payment	4/1/07			$6,000.00	
	Blue Cross Adjustment	4/1/07			$1,400.00	
	Amount Due from Patient:		$100.00	-		
	Patient Payment	4/30/07			$50.00	
	Balance due			-		$50.00
			SUBTOTAL	**$7,500.00**	**$7,450.00**	**$50.00**
				$7,500.00	**$7,450.00**	**$50.00**

DUE FROM PATIENT: Please Pay This Amount By: August 1, 2007 — $50.00

This Bill represents charges only. You may receive additional bills from the radiologist, pathologists, etc (This would be hospital specific).
For billing inquiries: 1-800-555-5555, weekdays 9:00 a.m. until 8:00 p.m., Saturday 9:00 a.m. until 2:00 p.m.
Or Dunning Messages

Please return bottom portion with your payment (Allow 7-10 days for postal delivery)

Due Date	Account Number	Write account number on check. Make check payable to Hometown Health	Please Pay This Amount
August 1, 2007	0123-4567-89		$50.00

Fill out below for credit card payments
[ ] Master Card [ ] Visa [ ] American Express [ ] Discover

PRINT NAME ON CARD

CARD NUMBER EXPIRATION DA

SIGNATURE

Hometown Health
312 Simpson Avenue
Hometown , IL 60206

DEFINITIONS FOR PATIENT STATEMENT

Billed Charges: The amount billed for the service.

Amount Paid by plan: The amount paid by your plan for this service.

Plan Adjustment:

Non-Allowed – An adjustment made by your plan including items not billable to you.

Not Covered – Any billed charges not covered by your policy including services provided by an out- of- network or non-participating provider.

Patient Payments: The dollar amount you have already paid.

Patient Responsibility: The amount you owe.

Attachment 3

MINIMUM REQUIREMENTS FOR PATIENT STATEMENTS

1. You can put whatever dunning messages you want on your statements

2. The font should be as large as possible

3. The size of the paper is your choice (i.e. 8 ½ x 11 or 8 ½ x 14).

4. The statement can have one encounter or multiple encounters per statement—however you do it now. The sample had multiple encounters just to show what that would look like. Not everyone does it that way and that is fine.

5. Frequency—a minimum of one statement a month would be required.

6. The type of service description would be unique to each hospital or office. You can make that as descriptive as you need to describe the service provided.

7. It would be required that every patient payment would be required to be listed separately so the patient can see that all payments have been applied.

Attachment 6

MINIMUM REQUIREMENTS FOR EXPLANATIONS OF BENEFITS (EOBS)

1. Company branding/logos can be individualized and placed anywhere on the EOB.

2. The font should be as large as possible.

3. The size of the paper is your choice (i.e. 8 ½ x 11 or 8 ½ x 14)

4. The EOB should be sent out at a minimum of once a month but preferably on a more frequent basis.

5. All the data elements on the sample EOB must be present.

6. Reason codes and definitions of those are either the standard HIPAA reason codes or specific to the insurance.

Attachment 7

	COST/SAVINGS FROM EOB PROJECT		
ENTITY	**COSTS**	**SAVINGS**	**COMMENTS**
NORTHEASTERN (NVRH)	**$10,000**		**4,000/HOSP 6,000/MD**
NORTH COUNTRY	**?**	**$0**	
NORTHWESTERN	**?**	**?**	
RUTLAND (RRMC)	**$1,500**	**$4,750**	**REDUCTION IN CALLS**
SOUTHWESTERN (SVMC)	**?**	**$0**	
FLETCHER ALLEN (FAHC)			**40 HRS INTERNAL PROGRAMMING, 80 HRS TESTING**
MVP	**$4,500**	**$0**	
BLUE CROSS	**?**	**$9,234**	
CIGNA		**$0**	
ASSOCIATES IN ORTH SURG	**$1,200**	**?**	

PRIOR AUTHORIZATION PILOT

Common Claims and Administrative Simplification
(Act 191, Sec. 55)

Project Title: Prior Authorization Pilot

Project Goal:

Initial Goal - To develop a pilot program that will eliminate prior authorizations for selected high volume radiology procedures. Suggested procedures to be included in the pilot: CT and MRI of the pelvis, CT and MRI of the abdomen, and MRI of the upper/lower extremities.

Work Group Members:

- Gisele Carbonneau – Lead - MVP
- Kathy Peterson – Rutland Regional Medical Center
- Jason Soukup – Cigna
- Cherie Bergeron – EDS
- Steve Perkins, MD – BC/BS

Summary of Workgroup Activity:

Work group members were asked to contact their respective Medical Directors to participate in a conference call. The first call occurred on July 18, 2006. Participants included:

BC/BS
Steve Perkins, MD
Cigna
Robert Hockmuth, MD
Bretta Karp
Jamie Ellerson
MVP
Tony Mangiapane, MD
Gisele Carbonneau
Nancy Dahm
OVHA
Esther Perlman
Scott Strenio, MD
Erin Cody-Reisfeld, MD
Pat Densmore, RN
John Dick
Rutland Regional Medical
JC Biebuyck, MD (radiologist)
Kathy Peterson

The conference call participants were given information on how the workgroup was formed and informed of the charge from the larger Committee. The "goal" statement was read to the group.

Summary of July 18th meeting (see attachment for full transcript of the meeting):

- Dr. Perkins of BS//BS explained that they have prior approval requirements for MRIs of the abdomen and pelvis. They do not require prior approval for any CTs or MRIs of the joints.
- Dr. Hockmuth of Cigna .reported the same process for Cigna.
- Dr. Mangiapane of MVP stated that most CTs and MRIs have to be prior authorized for MVP, however, medical review only takes place when ordered by a Primary Care Physician (PCP).
- Dr. Biebuyck, a Radiologist from Rutland, gave the group a radiologist's perspective. They do not get involved in the prior approval process. Each payer requires the ordering physician to obtain the prior approval. He stated that he feels that there is tremendous overutilization of MRIs and CTs in Rutland. When a scan is ordered and the Radiologist does not agree with the scan that has been ordered, they have a conversation with the ordering physician. This often results in a more appropriate scan being performed. The workgroup participants felt that Rutland was not representative of other areas of the state and that inappropriate scans occur quite frequently in all facilities statewide. Dr. Biebuyck stated that MVP's process was worth looking at further (only requiring medical review for a PCP ordered scan).
- Discussion ensued about approval guidelines. Each payer uses nationally recognized criteria. Dr. Biebuyck stated that it is difficult to get the physicians to look at the guidelines before they order a test.
- All Medical Directors expressed concern about removing prior authorization for these high volume scans. Each were tasked with going back to their respective organizations and gathering data for the next meeting.
- There was discussion about how to frame the pilot. Kathy Peterson suggested that a staged approach be used.
- OVHA stated that if a pilot were to be developed, it would have to be statewide as they could not do only certain counties or facilities. They also stated that they would not participate in the workgroup further,as they do not require prior authorization for the scans in question.

The meeting was discussed with the full Committee. It was recommended that the goal statement be revised.

Project Goal 2 To develop a pilot program that will test whether prior authorizations bring value in controlling inappropriate utilization and potentially eliminate prior authorizations for high volume radiology procedures.

Summary of November 10, 2006 Conference Call (for full transcript, please see attachment).

Participants included:

BC/BS
Steve Perkins, MD
Cigna
Robert Hockmuth, MD

MVP
Gisele Carbonneau
Tony Mangiapane, MD
Rutland
JC Biebuyck, MD.

- Gisele read the new goal statement. She asked if the Medical Directors had reviewed the data from their respective organizations.
- Dr. Hockmuth from Cigna told the group that Cigna would not be able to participate in a pilot. While Cigna is very willing to be engaged in the simplification overall of the greater committee and to try and work with the group in terms of trying to reduce administrative burdens, he had reviewed the data as requested and Cigna's utilization reports show that they are higher in Vermont than anywhere else in the country. He reiterated that, at this time, Cigna was unwilling to change their approach to prior authorizations until they see a change in utilization.
- Dr. Biebuyck asked if Cigna was willing to share their utilization data with the group as it relates to Vermont vs. national. He (Dr. Biebuyck) was surprised that the utilization in VT was higher than the national level. Dr. Hockmuth stated he would need to get permission from his legal department to share any data with the workgroup. He would be willing to share it with Dr. Biebuyck directly.
- Dr. Perkins stated that since OVHA and Cigna won't participate, we were up against a wall. Dr. Perkins mentioned that BC/BS and Rutland are already doing a pilot surrounding breast imaging. He also mentioned at the last meeting that a key component of any change in the ordering of tests is education to the provider community. To go to a pilot without an educational piece would be problematic.
- Dr. Mangiapane also expressed concern. What is the end point of the pilot? And for what purpose? He felt that to remove prior authorization would increase utilization where there is significant over-utilization already.
- Gisele reiterated that the goal of the larger Committee was to reduce administrative costs and burdens for providers.
- Dr. Biebuyck stated that he and BC/BS had just completed a very successful breast-imaging pilot and they were developing a pilot program for PET scans. A lot of the success of these programs depends on education to the providers. One of the frustrations from the providers is that there is not a standard among payers regarding approval guidelines for the scans. It is very difficult to know what scan will be approved, as each of the payers may have a different set of criteria. One of the things we may be able to do is to set parameters for all the different payers. He felt that would be useful.
- Dr. Hockmuth wondered how different the criteria was between the plans. He mentioned that he was not sure he could share Cigna's criteria.
- Dr. Perkins stated that each payer wants to make sure they are up-to-date on all the possible studies that are available. He thinks (similar criteria) may have a little more potential than the project, as it was framed before (removal of prior authorizations). He mentioned that BC/BSs criteria is on their website and available to everyone. He does not feel that sharing this information would be an issue.
- Dr. Mangiapane stated that MVP uses InterQual® criteria that is proprietary. We do provide the criteria to any provider who requests it for a particular scan.

- Dr. Perkins asked if we took one or two scans (extremities and pelvis), would MVP be able to share their guidelines. Dr. Mangiapane thought that we could however, he wanted to run it by MVP's legal department before committing.
- The Medical Directors stated that a pilot for removal of prior authorization was not possible at this time. Payers continually review their lists of what requires prior authorization and, if there is any change in utilization pattern, the procedure is removed (or added) to the list.
- The Medical Directors also wanted to explore possible standardization of approval criteria for a few scans. They suggested having physicians from a few select areas of the state join our next call. It would be useful to delve into the cause of frustration surrounding approval guidelines.
- Dr. Hockmuth stated that while he was not certain that he could share Cigna's criteria, it may be helpful to this group to see where the discrepancy is and then do a joint educational letter to the provider community.
- Dr. Perkins feels that this is a good idea, similar to what the plans did with asthma guidelines.
- It was decided to invite 3 PCP's to our next discussion. One from Burlington, one from Rutland, and one from a more rural area.

Gisele reported to the larger Committee that the workgroup was stuck. Discussion about the new focus of the workgroup ensued. The Committee was concerned that this new approach would not meet the intent of the legislation, however, a new goal statement was developed. Mr. Huebner asked if each payer would be willing to share current prior authorization requirements (not just radiology) with the Committee. Each payer was asked to respond by January 5, 2007 if willing to share their list.

The Committee revised the goal statement a third time.

Goal statement #3 –To minimize impact (cost and time) on providers/facilities by eliminating or developing common approval criteria where there is existing commonality amongst BC/BS, Cigna, MVP and OVHA.

Kathy Peterson, on behalf of the facilities, stated that the issues surrounding prior approval were not the approval guidelines, but rather: 1) the amount of time that they spend to get prior authorizations and then at times, the claims are still denied 2) when a claim is denied, it takes more time to hunt down the authorization information and then to work with the payer to get the claim paid.

The Medical Directors already stated that they were unwilling to do away with prior approvals on the high volume radiology procedures. Mr. Jillson mentioned that his office (specialty) very rarely gets denials yet, they have long wait times on the telephone to get approval. Mr. Harrington suggested a side-by-side review of each carriers prior approval list be done. The goal of this review would be to choose 6-12 items where there is commonality amongst the carriers and determine if any could be considered for removal from the prior authorization requirements or there could be a standardization of criteria.

It took several months to get a list from the carriers, however, a side-by-side comparison was done (please see attachment). Gisele sent the completed comparison out to BC/BS,

Cigna and OVHA to be certain it was appropriate. Only Cherie Bergeron of OVHA responded. The list was distributed to the larger Committee.

The Committee suggested that Gisele work with the MVP Medical Director to select the 6-12 items, as getting the Medical Directors together at the same time was challenging and took several weeks to plan.

After reviewing the procedures where commonality exists, the larger Committee felt that we needed to switch plans again, as the selected procedures were very low volume and would not save time and costs for the provider offices.

Much discussion ensued and the group decided to look at where each payer was in terms of developing an electronic prior approval process, and, how long it would take to feed that information back to their claims system. There was concern on the part of the providers and facilities on the workgroup that, even though the providers took the time to get a prior approval, the information is not loaded from one system to another, resulting in inappropriate denials for no prior authorization.

BC/BS reported that for managed care, prior approvals were processed within 3 days, for indemnity within15 days. They have a separate utilization system, however: managed care authorizations (regulated) are loaded directly into the claims adjudication system. BC has evaluated the functionality of an on-line prior approval process, however, there is no timeline for this process to be put in place.

Cigna reported that prior authorization requests are processed within 2 days. They also do not use the same system for UM and claims payments. Authorizations are transferred between systems within 5 days. Cigna is in the process of piloting an on-line prior authorization process in other parts of the country.

MVP reported that prior approval take 3 days upon receipt of all necessary information. They also use two different systems. Authorizations are transferred nightly or within 24 hours. MVP is looking at the feasibility of completing prior approvals on –line but they also do not have a timeframe for getting this in place.

Goal Statement #4 –Evaluate an electronic prior authorization process to streamline the administrative function for providers and payers.

Cigna agreed to bring an electronic prior authorization pilot to Rutland. The pilot included billing representatives from Rutland Regional Medical Center and a high-volume orthopedic office in Rutland. RRMC was to submit a variety of prior approval requests through an on-line portal from September 4-7th. This process will allow RRMC to do the following:

- Determine if prior approval is required for the procedures being requested.
- Submit prior approval requests on-line.
- Check the status of the submitted requests.

It should be noted that Cigna uses NaviMedix as a vendor for this process.

Result of the pilot: It was felt by all (providers and Cigna) that the pilot was a success. The electronic process saved significant time and was easy to use. It is too soon to tell if this will translate to no claims denials for "no prior authorization". Those results should be in by early November. Due to the overwhelming success of the nationwide pilot, Cigna implemented an electronic prior approval process as of September 24, 2007.

Recommendation:

- It is clear that each payer organization feels that their prior authorization requirements are necessary and useful in controlling costs. Further, these organizations review each procedure selected for prior approval to determine if it can be removed from the list on a regular basis (no less than annually).

- Require that each health plan develop a web-based prior approval process. Due to the success of a pilot program between Cigna and Rutland Regional Medical Center, the workgroup feels that developing a web-based prior approval process would save time and costs for physicians, facilities and health plans.

- Development of a web-based prior authorization solution should occur within one year of acceptance of this report.

- BC/BS, MVP and Cigna use two different systems for prior authorizations and claims adjudication. BC/BS reports that they load authorizations directly into their claim adjudication system. The time transfer of data between the two systems (claims and UM) varies for each payer (Cigna – 5 days; MVP – 1 day; BC/BS - 0 days).

- The workgroup concluded that if providers are submitting claims electronically, and there is a delay in loading the authorizations from the utilization management system to the claims adjudication system, there maybe inappropriate claims denials for no prior authorization. This creates rework for providers, facilities and the health plan.

- Require that each health plan transfer information between their utilization management and claims adjudication systems within 72 hours of the authorization. This process should be in place within six months of acceptance of this report.

CREDENTIALING

Common Claims and Administrative Simplification
(Act 191, Sec. 55)

Project Title:

Credentialing

Project Goals:

4. To ensure the successful implementation of the CAQH (Council for Affordable Quality Healthcare) Universal Credentialing Datasource called for in Section 56 of Act 191 of the 2006 General Assembly;
5. To establish uniform periods in which organizations act on completed credentialing applications; and
6. To standardize and eliminate variation amongst carriers on provider billing eligibility regarding Physician Assistants and Advanced Nurse Practitioners.

Subcommittee Members:

Paul Harrington, Vermont Medical Society
Baxter Holland, M.D., Rutland Regional Medical Center
David Jillson, Associates in Orthopaedic Surgery
Jason Soukup, CIGNA
John Dick, OVHA
Pat Jones, BISHCA
Sharon Winn, BCBSVT
Tina Nyland, MVP

Summary of Workgroup Activities:

ACTIVITY 1. Implementing CAQH Universal Credentialing Datasource.

A typical physician contracts with multiple healthcare organizations, each of which requires the physician to complete an extensive separate credentialing application. When implemented, the CAQH (Council for Affordable Quality Healthcare) Universal Credentialing Datasource called for in Section 56 of Act 191 will simplify this process by enabling physicians and other health care professionals to submit one standard credentialing application.

In 2006 the Vermont General Assembly enacted 18 V.S.A. § 9408a, directing the Vermont Department of Banking, Insurance, Securities and Health Care Administration to require health insurers and hospitals that credential practitioners for their networks or staff to use the credentialing application form developed by the Council for Affordable Quality Healthcare (CAQH), or a similar nationally recognized form, beginning January

1, 2007. The goal was to reduce administrative costs to practitioners by allowing them to complete only one form for credentialing (rather than different forms for each insurer and hospital), and allowing practitioners to simply make changes in their credentialing information as they occur rather than completing the entire form again. The Department considered the requirements of the statute, explored alternatives, and selected the CAQH form as the uniform application for practitioners to complete during initial credentialing and recredentialing with insurers and hospitals. The Department issued Bulletin HCA-122 announcing the selection of the CAQH credentialing application, developed educational materials, and worked with CAQH to offer a series of training sessions on the use of the form.

Practitioners can choose to complete the CAQH application online, or they can print a hard copy application, complete it manually and mail or fax it to CAQH, the insurer or the hospital. The practitioner is not charged for this service. If insurers or hospitals elect to participate in the CAQH online system and receive practitioner credentialing data electronically from CAQH (as opposed to working with hard copy applications), they are charged an annual fee and a per practitioner fee. MVP Health Plan, Blue Cross Blue Shield of Vermont, The Vermont Health Plan, and CIGNA HealthCare currently participate in CAQH's online system; and the Vermont Association of Hospitals and Health Systems has just completed an agreement with CAQH allowing its member hospitals to access the CAQH online system. Almost all of Vermont's 1,600 actively practicing physicians are now credentialed in the CAQH system, and other types of practitioners are also using the credentialing application form when they seek initial credentialing or recredentialing. Vermont Medicaid only requires a valid license from the state where the practice is located.

ACTIVITY 2. Establish Uniform Periods for Organizations to Act on Completed Credentialing Applications.

Section 56 of Act 191establishes uniform time periods within which an organization must notify a provider concerning the status of a completed credentialing application. However, there is currently no time period within which an organization must act on a completed credentialing application. Establishing a uniform period within which an organization acts on completed credentialing applications will help to reduce revenue loss for health care services provided while an application is under review.

The Vermont Medical Society, the Vermont Association of Hospitals and Health Systems Blue Cross & Blue Shield of Vermont, MVP, and CIGNA recognize the vital importance of adding qualified physicians to health insurance plan networks in a timely fashion to ensure that enrollees and patients have access to needed health care services. The provisions included in this Statement have been developed by representatives from Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, Blue Cross & Blue Shield of Vermont, MVP and CIGNA (hereinafter collectively referred to as "Sponsors").

18 V.S.A. § 9408a mandates that the Vermont Department of Banking, Insurance, Securities and Health care Administration prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), or a similar, nationally

recognized form, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing.

18 V.S.A. §9408a also requires that an insurer or a hospital notify a provider concerning a deficiency on a completed credentialing application form not later than 30 business days after the insurer or hospital receives the completed credentialing application form; and an insurer or a hospital shall notify a provider concerning the status of the provider's completed credentialing application not later than sixty days after the insurer or hospital receives the completed credentialing application form; and every 30 days thereafter until the insurer or hospital makes a final credentialing determination concerning the provider.

The Sponsors believe that any strategies to streamline credentialing must be in compliance with existing Federal and State laws and regulations, and with accrediting organization standards and guidelines, and may therefore require change as those laws, regulations, standards and guidelines change. Sponsors therefore endorse provisions designed to streamline, coordinate, and improve physician credentialing and re-credentialing processes throughout the State of Vermont as follows:

- Participating health insurance plans and hospitals shall strive to act upon and finish the credentialing process of complete initial credentialing applications submitted by or on behalf of a physician applicant within 60 calendar days of receipt of a complete application;

- All sponsors agree to work together to identify process improvements in the physician, hospital and payer settings to expedite the credentialing process;

- Hospitals shall strive to reply to each request from physicians and/or participating health plans for verification of credentialing and privilege status within 30 calendar days of the date of request; and

- Health insurance plans shall strive to communicate to the physician applicant or designee within seven calendar days of the credentials committee date, informing them of the committee's decision and date of the decision.

All Sponsors agree to work together to develop a reporting process to measure success in meeting the voluntary 60-calendar day processing goal described herein.

ACTIVITY 3. Eliminate the Variation Among Payers Relating to Billing for Physician Assistants and Advanced Nurse Practitioners

Health insurance companies have different rules regarding the ability of physician assistants and/or advanced nurse practitioners to bill separately for health care services. Some payers allow for direct billing by physician assistants and/or advanced nurse practitioners, while others require that the billing be done under a physician's name and number. Eliminating this variation will reduce the administrative burden for practices.

To determine the amount of variation among payers, the Credentialing Subcommittee surveyed four major payers on fourteen questions related to their reimbursement policies for physician assistants and nurse practitioners. The attached table entitled:

Questionnaire on Billing for Services of Physician Assistants and Advanced Nurse Practitioners documents the policy of BCBSVT, CIGNA, MVP and OVHA on these issues.

Recommendations:

ACTIVITY 1. Implementing CAQH Universal Credentialing Datasource.

During implementation, BISHCA received questions from practitioners regarding the security of the CAQH system, and in particular the requirement to provide social security numbers when completing the credentialing application. Information is available on both the BISHCA and CAQH websites that outlines system security features to ensure the confidentiality of provider information. The online CAQH credentialing application requires practitioner social security numbers since information needed for credentialing may only be available by social security number. However, CAQH does accept the new National Provider Identifier (NPI) required by the Centers for Medicare and Medicaid Services and the Health Insurance Portability and Accountability Act (HIPAA). Currently, all practitioners should have a NPI number, but its full use has been delayed until May 2008. Until that time, CAHQ will continue to require social security numbers on the online credentialing application. Practitioners using the hard copy version of the form can check with insurers and/or hospitals to see if the social security number can be omitted. BISHCA should continue to request that CAQH end their practice of requiring the use of social security numbers, as soon as possible.

ACTIVITY 2. Establish Uniform Periods for Organizations to Act on Completed Credentialing Applications.

All Sponsors should work together to develop a reporting process to measure success in meeting the voluntary 60-calendar day processing goal, as well as other efforts to streamline, coordinate, and improve physician credentialing and re-credentialing processes.

ACTIVITY 3. Eliminate the Variation Among Payers Relating to Billing for Physician Assistants and Advanced Nurse Practitioners

Health insurance companies have different rules regarding the ability of physician assistants and nurse practitioners to bill for health care services which adds to the administrative burden for practices.

As shown on the attached table entitled: Questionnaire on Billing for Services of Physician Assistants and Advanced Nurse Practitioners, BCBSVT and MVP allow for the direct billing of services provided by Physician Assistants and Advanced Nurse Practitioners with a note indicating that the PA/ANP provided the service.

In order to reduce the administrative burden for practices, it is recommended that CIGNA and OVHA adopt policies similar that of BCBSVT and MVP and allow for the direct billing of services provided by Physician Assistants and Advanced Nurse Practitioners.

Credentialing Subcommittee, Common Claims Committee Questionnaire on Billing for Services of Physician Assistants and Advanced Nurse Practitioners

Question	BCBSVT	CIGNA	MVP	OVHA
1. Does your organization allow for the direct billing of services provided by physician assistants? If not, how does your organization reimburse for these services?	Physician offices may bill for PA services. The claim must note the PA provided the service.	CIGNA does not currently contract with Physician Assistants. Therefore, if a non contracted Physician Assistant were to bill for services they would be processed as out of network	Yes, with supervising physician info	See end of document for response
2. Does organization allow for the direct billing of services provided by advanced nurse practitioners? If not, how does your organization reimburse for these services?	Physician offices may bill for ANP services. The claim must note the ANP provided the service. ANP may bill independently in circumstances where the Plan's standards for access to care cannot be otherwise met.	CIGNA does contract with ARNPs and therefore a contracted ARNP may bill CIGNA directly for services and be paid at an in-network rate.	Yes, with supervising physician info	See end of document for response
3. Does your organization require that each physician assistant obtain and use a NPI	Yes, any PA providing services to BCBSVT members must have a NPI number	If a Physician Assistant bills for services, they should include their NPI number.	Yes	They must enroll their NPI in order to have their prescriptions approved for payment by

Question	BCBSVT	CIGNA	MVP	OVHA
number?	and the billing practice must display the PA as the rendering provider in 24J of the HCFA form.			OVHA
4. Does your organization require that each advanced nurse practitioner obtain and use a NPI number?	Yes.	Yes	Yes	Yes
5. Does your organization allow for the billing of "incident to" services by physician assistants and is it applicable in the ED?	BCBSVT does not permit medical practices to bill the MD as the rendering provider (field 24J) for services provided by the PA. The PA NPI # should appear in 24J. Same for ED – hospital should display PA as the provider who provided the service. Payment will be made to the group or hospital.	CIGNA does not currently contract with Physician Assistants. Therefore, if a non contracted Physician Assistant were to bill for services they would be processed as out of network. Typically, services in the ED would be covered at an in-network level.	MVP requires the rendering provider to bill for the services. The PA's NPI should appear in 24J (same for ED). Payment will be made to the hospital or collaborating physician.	Technically, no.
6. Does your organization allow for the	BCBSVT does not permit	Yes	MVP requires the rendering provider to bill	No.

Question	BCBSVT	CIGNA	MVP	OVHA
billing of "incident to" services by advanced nurse practitioners and is it applicable in the ED?	medical practices to bill the MD as the rendering provider (field 24J) for services provided by the ANP. The ANP NPI # should appear in 24J. Same for ED – hospital should display ANP as the provider who provided the service. Payment will be made to the group or hospital.		for the services. The ANP's NPI should appear in 24J (same for ED). Payment will be made to the hospital or collaborating physician.	
7. Does your organization require the use of modifiers associated with the billing of services by physician assistants?	As applicable. As an example, if the PA is assisting at surgery, then modifier 81 is required.	No	Yes	Sometimes. See response to #1 at end of document.
8. Does your organization require the use of modifiers associated with the billing of services by advanced nurse practitioners?	No.	No	Yes	Sometimes. See response to #2 at end of document.
9. Does your organization treat physician	No, PA may not hold a patient panel.	No	Yes, however, MVP does not allow them to	OVHA does not use networks.

Question	BCBSVT	CIGNA	MVP	OVHA
assistant as network providers?			hold a patient panel.	
10. Does your organization treat advanced nurse practitioners as network providers?	Yes, but only in the very narrow circumstance that Plan geographic access standards cannot be met without the participation of the ANP.	Yes	Yes	OVHA does not use networks.
11. Does your organization include physician assistants in its provider directory(ies)?	Yes, if the PA or practice requests the listing.	No	Practitioners who are credentialed are listed in the directory.	Yes
12. Does your organization include advanced nurse practitioners in its provider directory(ies)?.	Yes, if the ANP or practice requests the listing.	Yes	Practitioners who are credentialed are listed in the directory	Yes
13. Does your organization permit members to select a physician assistant as their primary care provider?	No.	No	No	No
14. Does your organization permit members to select an advanced nurse practitioner as	Yes, but only in the very narrow circumstance that Plan geographic access standards	Yes	No	Yes

Question	BCBSVT	CIGNA	MVP	OVHA
their primary care provider?	cannot be met without the participation of the ANP.			

1. **Does your organization allow for the direct billing of services provided by physician assistants? If not, how does your organization reimburse for these services?**

OVHA Response: Our Provider Manual requires the following:

PHYSICIAN'S ASSISTANT
The services of a physician's assistant are limited to those, which the practitioner is licensed to provide as contained in protocols approved by the Vermont Board of Medical Practice. Physician's assistants may not bill independently in most cases; therefore, the attending provider NPI must be that of the responsible physician.services rendered by a physician's assistant must be billed with one of the following modifiers:
AM-service was performed by the physician assistant him/herself.
Services for hospital inpatient consultations may be billed with CPT codes 99241 – 99275 with the “AM” modifier and the responsible physician’s NPI number must be given as the attending on the claim.

- Consultations are limited to one unit per date of service
- Initial consultations are limited to one consult per related diagnosis per attending provider.

Physician’s assistants may bill the following without a modifier, with the responsible physician’s NPI number.

- Laboratory tests in the CPT code range 80000 - 89399.
- Injected Medications – 90281-90399, 90476-90749, 90799 and the J Codes

2. **Does organization allow for the direct billing of services provided by advanced nurse practitioners? If not, how does your organization reimburse for these services?**

OVHA Response: Our Provider Manual requires the following:

NURSE PRACTITIONERS
The OVHA enrolls and reimburses nurse practitioners licensed in Vermont. Payment will be made for reimbursable services that are also contained in protocols approved by the Vermont Board of Nursing.
Nurse Practitioners must be identified with the use of the modifier SA, with the exception of the following:

a. Laboratory tests
b. Injected Medications
c. Immunizations

IMPROVING THE EFFICIENCY OF CLAIMS ADJUDICATION

Common Claims and Administrative Simplification
(Act 191, Sec. 55)

Subcommittee Members
David Jillson, Chair, Associates in Orthopaedic Surgery
Cherie Bergeron, EDS
Pam Biron, Blue Cross Blue Shield of Vermont
Kathy Bonanno, MVP
Mickey Gleeson. MVP
Lauren Parker, MBA Resources
Kathy Peterson, Rutland Regional Medical Center
Jason Soukup, Cigna

Why was the Subcommittee formed?
Representatives from physician offices and hospital billing departments were concerned that different insurance companies have different claim adjudication rules. The lack of consistency causes payment delays, appeals, and additional administrative burden for providers and payers.

1. Initial Goal:
Evaluate the feasibility of requiring payers to use National Correct Coding Initiative (NCCI) edits to adjudicate physician claims.

Initial Tasks:
1. Determine which payers use NCCI edits.
2. Evaluate information technology issues that may inhibit adoption of NCCI edits.
3. Determine cost of conversion to NCCI edits.
4. Determine feasibility of requiring small payers to use NCCI edits.

Payer response: Payer representatives stated that claims auditing software systems have a claims edit foundation based on the NCCI claims edits, and these systems can then be supplemented by both the software vendor and payers using different industry edits because NCCI is based on Medicare guidelines. Payers then may add customization to support state mandates and proprietary payer specific medical management, business and policy practices. Therefore, the majority of services are adjudicated in a relatively uniform methodology across various payers. However, a subset of claims is adjudicated under varying methodologies by payers because they are based on these customized proprietary payer specific rules. It is this subset that is problematic for providers.

2. Types of Inconsistencies That Cause Adjudication Problems.

Based on the Subcommittee's findings with regard to the evaluation and use of NCCI edits by all payers the Subcommittee agreed that we should focus on remedying some common inconsistencies that can cause payment delays, appeals, and additional administrative burden for providers and payers. Significant issues identified by provider representatives were:

- **Bill Type** is a field on a facility (e.g. hospital) claim that is used to indicate what type of claim is being submitted - 1st inpatient claim, subsequent inpatient claim, replacement claim, etc. If a payer ignores or cannot accept Bill Type, then the claim may be rejected as a duplicate.

  Status: Current industry standard "Bill Types" can now be accepted by all payers.

- **Assistant Surgeons** are sometimes used to help the primary surgeon during more complex procedures.

  Identified Issue: Medicare publishes a list of procedures where an assistant surgeon is permitted, but commercial payers' business rules with regard to assistant surgeons are not uniform and are not always aligned with Medicare.

- **Modifiers** are standardized codes developed by the American Medical Association, and are recognized by Medicare and many commercial payers. Modifiers are often used to provide additional information about the procedures that were billed.

  Identified Issue: Payers do not accept, recognize, or act on all industry standard modifiers when submitted by providers. Payers often 1) ask for chart notes when a modifier is used, 2) deny the claim, or 3) simply do not pay the procedure with modifier. Commercial payers' business rules with regard to modifiers and adjudication of modifiers are not uniform and are not always aligned with Medicare.

- **Claims Bundling/Unbundling** is the term used when a provider lists several similar procedures that were performed on the same date of service. For example, a surgeon should not report closing the wound and suturing in addition to reporting a total hip replacement, because the hip replacement code includes suturing.

  Identified Issue: The Medicare program developed NCCI edits to ensure the most comprehensive groups of codes are billed rather than the component parts, and to check for mutually exclusive code pairs. However, because many commercial payers have customized some of their claims adjudication methodologies based on proprietary payer specific medical management, business and policy practices, the claim may be denied. Commercial payers' business rules with regard to claims bundling/unbundling are not uniform and not always aligned with Medicare.

Payer response: Three of these topics: assistant surgeons, modifiers and claims bundling / unbundling fall within proprietary payer specific medical management, business and policy practices. The Subcommittee would need to present a clear business rationale including cost benefit analysis to support any recommendations about these topics.

3. Disclosure of Claims Adjudication Rules/Policies:

The Subcommittee discussed the value of having payers disclose their claims adjudication rules so that providers know in advance how claims will be adjudicated.

Payer responses:

- MVP reported that as a result of New York law, all payers licensed in NY must disclose commercial software used by the Plan to accept and edit claims. The Plan must describe Plan edits in sufficient detail to enable contracted providers to understand modifications made to their software. MVP applies this practice to Vermont providers as well.

- Cigna reported its transparency initiatives and capabilities. Currently, CIGNA utilizes a web-based transparency tool. A contracted provider (either physician or hospital) can enter proposed CPT codes to be billed into the web site, and the program will show how the codes would be adjudicated.

- BCBSVT reported that the Plan maintains and updates regularly a Professional Provider Manual which has a section specific to general claim information regarding claims submission and reimbursement guidelines. Within the manual the Plan discloses what claims auditing software system is utilized by the Plan. The Plan has a provider notification process in place in the event that guidelines are changed. BCBSVT's claims auditing software system is scheduled to be upgraded and enhanced to include a transparency tool by which a contracted provider (either physician or hospital) can enter proposed codes to be billed, into our web site and the program will show what editing will occur.

On 7/23/07 the Subcommittee agreed to amend its workplan to add some additional tasks.

1. Survey the activity of other states to determine if other approaches may be adopted.
2. Consider recommending a notification process when claim adjudication rules have changed.
3. Consider recommending a process to educate providers on the various claims adjudication rules used by payers.

- Regarding the first task, the Subcommittee reviewed "Select State Efforts to Regulate Issues Related to Disclosure of Claims Payment Practices" prepared by the McKesson Corp. Information from 4 states was presented: Texas, North Carolina, California and Minnesota. Provider representatives agreed that the summary of rules adopted by California were thorough and well-worded (see Attachment 1). Payer representatives agreed to review the language and report whether any elements were objectionable. Cigna stated that the language was acceptable. Blue Cross, MVP, and the Office of Vermont Health Access all made comments on the language, and their reports are attached as Attachments 2-4.

- Task 2 – Payer representatives have communicated that they all have contractual notification processes in place. Provider representatives identified the need to ensure the following:
    1. Notifications are timely, clear and concise.

2. Payers follow what they have communicated.
3. Payers regularly *"check"* the effectiveness of the methods of delivery (e.g., mailings, fliers, news letters, provider manuals, web, etc.)
4. Payers regularly *"check"* the effectiveness of the notification lead time to providers (e.g., is it sufficient? should the notification lead time be longer, etc.)

As a result of a recent issue in the state regarding processing changes by a payer which weren't clearly communicated and caused thousands of denied claims at all hospitals in the state, the Subcommittee recommended that:

Notification of changes to claims processing should be clearly stated and sent in multiple ways. This includes, e-mail, a direct letter detailing the change as well as putting the information in their monthly newsletter/bulletin. The notification should be mailed to the patient accounting department directly. The notification should be at least 30 days in advance of the change and should give the providers an opportunity and avenue to comment and get clarification if needed.

- With respect to task 3, provider representatives believe that that there is a role for enhanced provider education. Because claims adjudication rules are complex and vary from payer to payer, provider representatives feel there is a need for an independent organization that has access to the specific payer rules, and can educate providers on how best to submit clean claims for services rendered. Payer representatives were not in favor of establishing an organization to educate providers on claims adjudication rules for the following reasons:
  1. Commercial Plans were not willing to share information on claims adjudication rules with an entity that was not a contracted provider.
  2. Payers represented that their Provider Relations departments conduct outreach and education to providers, and were concerned that another entity would create duplication and add administrative costs.

  The provider community will pursue this initiative independently.

Recommendations: Over the course of the past year, the Subcommittee has considered a number of different approaches to achieve the goal of increased efficiency of claims adjudication. We believe that improving efficiency will be beneficial to four principal stakeholders - providers, payers, employer groups and patients. The Subcommittee endorses increased transparency as a key component to this goal.

- <u>Adopt a rule patterned on the California Department of Managed Health Care Rules §1300.71.</u> These Rules call for disclosing detailed payment policies and rules used to adjudicate claims, and requires methodologies to be consistent with standards accepted by nationally recognized organizations, federal regulatory bodies and major credentialing organizations. The subject matter covered by these Rules paralleled much of the subcommittee's discussion over the past year, and the members felt that if Vermont commercial payers adhered to these rules, physicians and hospitals would gain a much greater understanding of rules used to adjudicate claims.

Although several payers were concerned about certain elements of the California Managed Health Care Rules (see Attachments 2-4), Subcommittee members recommend that Vermont consider the adoption of a rule patterned on the California Department of Managed Health Care Rules §1300.71 with input into rulemaking from the provider and payer communities.

- Improved Notification - We recommend that payers improve the process by which they notify providers of material changes to claim adjudication rules. Characteristics of an improved process include:

a) Notification should be made a minimum of 30 days in advance of the implementation date.
b) The method of notification should be designed to reach the affected parties.
c) Parties affected by the change should have an opportunity to comment on the planned change.

Attachment 1.

California Department of Managed Health Care Rules §1300.71
"… (o) Fee Schedules and Other Required Information. On or before January 1, 2004, (unless the plan and/or the plan's capitated provider confirms in writing that current information is in the contracted provider's possession), initially upon contracting, annually thereafter on or before the contract anniversary date, and in addition upon the contracted provider's written request, the plan and the plan's capitated provider shall disclose to contracting providers the following information in an electronic format:

(1) The complete fee schedule for the contracting provider consistent with the disclosures specified in section **1300.75.4.1(b)***; and

(2) The detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims, which shall, unless otherwise prohibited by state law:

(A) when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations;

(B) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and

(C) at a minimum, clearly and accurately state the policies regarding the following: (i) consolidation of multiple services or charges, and payment adjustments due to coding changes, (ii) reimbursement for multiple procedures, (iii) reimbursement for assistant surgeons, (iv) reimbursement for the administration of immunizations and injectable medications, and (v) recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience and competence in claims processing can determine the payment to be made according to the terms of the contract…."

***1300.75.4.1. Risk Arrangement Disclosure**

(b) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization shall require the plan to disclose, on or before October 1, 2001, and annually thereafter on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, and further specify the Medicare RBRVS year if RBRVS is the methodology used for fee schedule development. For any proprietary fee schedule, the

contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

Attachment 2.

MEMORANDUM

TO: Claims Adjudication Sub-Committee of the Common Claims Committee

FROM: BCBSVT

DATE: September 27, 2007

SUBJ: California Department of Managed Health Care Rules § 1300.71

This memo is to provide a formal response to the Claims Adjudication Sub-Committee's request that payers review and respond to the California Department of Managed Health Care Rules § 1300.71 language and report whether any elements were objectionable. The Plan will comment more fully upon the development of such a rule in the future.

BCBSVT has reviewed the language and our comments and/concerns are noted within the following categories:

- Antitrust
- Protection of Proprietary Information
- Cost
- Rule Language (Clear & Concise)

Antitrust

We recognize that access to accurate information is vital to the efficiency of any claims adjudication process. We are concerned however with any requirement that could promote anti-competitive behavior with the information that is required to be disclosed. We believe such uses or disclosures have the potential to run afoul of the Statements of Antitrust Enforcement in Health Care[1] numbers 5 and 6 published by the Federal Trade Commission (FTC) and the Department of Justice (DOJ). We encourage the working group to include safeguards in any proposal that would prohibit the anti-competitive use or dissemination of fee and fee related information. We think it should make clear that disclosure is not required if such disclosure would violate state or federal law.

Protection of Proprietary Information

Fee and fee related information that is required to be disclosed under the California Managed Health Care Rule § 1300.71 appears to include proprietary information. We don't think the California rule goes far enough in recognizing that fact. The working group should incorporate safeguards against any further use of this information by providers for any purpose other than handling claims.

[1] http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm

Cost

To fully comply with this type of rule could require significant investment by a payer to include both upfront investments and continued investment to maintain compliance. This is difficult to quantify at this point as the California rule is not at a granular level to assess/establish investment and resource requirements. The working group should keep in mind and consider the potential cost to payers to comply with and maintain administration of a rule such as this as part of the rule development process. Once a draft rule is developed and the detailed requirements are fleshed out payers will then be in a better position to review and respond on investment, resources and their capability to comply.

Rule Language

The language within the California rule is fairly vague and could be left to different interpretation by the various payers impacted. If a rule was to be established and implemented in Vermont it would need to be clear and concise to ensure it was administered and interpreted consistently by all payers.

In conclusion, it should be noted that there are provisions based on BCBSVT's interpretation of the California Department of Managed Health Care Rules § 1300.71 that the Plan cannot administer for example 1300.71 (B) and areas where the Plan has made business decisions and believe what we are presently administering is sufficient for example 1300.71 (A).

California Department of Managed Health Care Rules § 1300.71		
(A)	when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations;	**Professional/Facility:** The Plan's directive is to be consistent with industry practices with regard to coding and standards (e.g., CPT-4, HCPC Level II, UB-04 and other industry standards). When we are not aligned with the industry practice (non-standard coding methodologies) we communicate via a provider notification.
(B)	clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and	Based on the Plan's interpretation of the California Department of Managed Health Care Rules § 1300.71 the Plan cannot administer

BCBSVT would request the Department to give all payers an opportunity to provided feedback and input as part of the rule development process if a rule of this type is pursued in the future.

Attachment 3.

To: COMMON CLAIMS COMMITTEE
Claims Adjudication Subcommittee
From: William Little, Vice President, MVP Health Care
Re: Response to committee recommendations for requirement that VT payers adhere to the requirements specified under the California Department of Managed Care Rules
Date: 10/5/2007

MVP is appreciative of the work this subcommittee has undertaken and its mission to offer to the legislature innovative ideas on how to reduce the administrative burden of running a practice.

The specific language in the California Rule 1300.71 regarding fee schedule disclosure is unacceptable to MVP. A health plan's fee schedule is proprietary and should not be subject to public disclosure primarily because doing so would promote artificial price increases through anti-competitive behavior. Indeed, the statements of Antitrust Enforcement in Health Care numbers 5 and 6 published by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) prohibit such disclosures to prevent anti-competitive conduct in the health care market. We cannot support any proposal that would violate federal authority and which could artificially increase the cost of health care in Vermont.

The disclosure of fee schedules could also cause anti-competitive conduct among the health plans, causing an artificial decrease in health care costs. MVP is often told we are "one of the better payers", but if I discovered my competitors were reimbursing at a lower rate and providers were agreeing to it I'd be inclined to renegotiate contracts for the lower rates. I would have an obligation to do so on behalf of all Vermont MVP rate payers -- businesses and individuals.

While we do not expect providers to contract with the plan without first knowing how they will be paid, we have never had to disclose our entire fee schedule to meet their need for information prior to joining our network. We typically provide a small sample of reimbursement rates, which give them a good sense of how we compare to other payers. For certain specialties, in specific geographic areas we have modified our standard schedule in order to be competitive and contract with the provider.

Other aspects of the California legislation are also objectionable because they are typically issues that are most appropriately addressed on a case-by-case basis in each contract to meet the specific business needs of the providers and the plans, and communication around those needs flows freely between MVP and providers. The MVP Provider Manual, provider website, regular newsletters and provider relations team ensure providers are fully informed prior to and during their affiliation with MVP. MVP does not think it is in the best interests of the health care delivery system for the legislature to negotiate specific contract terms between MVP and Vermont providers.

Attachment 4.

Memorandum

To: *Nancy E. Clermont*

From: *John B. Dick*

Date: *March 7, 2008*

Re: *Common Claims Request*

I have reviewed the California language as proposed. I find it quite difficult to analyze because it is lacks precision on how Vermont would apply the ideas in the California rules. Nevertheless, I have the following comments.

OVHA does not formally contract with any provider. Most providers enroll in our program and agree in advance that if they submit a claim for services rendered to accept our "payment" (including denials) as payment in full. Will the Vermont requirement be limited to those that contract? Will it apply to all providers that we pay, such as Vermont public school districts, SRS, etc?

A "complete fee schedule" is quite a vague term to implement. (The California definition in the statute was not provided.) If it were interpreted to mean our CPT and DME fee schedules as published today on the EDS web site, compliance might be easy. If that is not "complete", then it would be very difficult for us to be more comprehensive. There are a number of codes for which we pay different providers a different amount. Some code modifiers change payment. How would that be managed? There are a number of codes that do not have a price on file such as the miscellaneous (xxx99) codes which we often pay per invoice cost or other calculated amounts. Some codes have provider specific payments. The ease, or difficulty, of this requirement depends on the details as applied in Vermont. I think we have extracted as many procedure code fees from our system as we can. Going beyond our current disclosures will demand more system capacity than now exists.

The request for "detailed payment policies and rules" might be met today with our current text in the Provider Manuals, or it could be interpreted to be asking for much more than is on hand. I do not understand what is meant by "non-standard coding methodologies used to adjudicate claims". The last paragraph suggests an answer. If taken literally, it would insist that we disclose enough information to enable any provider to calculate expected payment for every services or items provided to Medicaid. If this is the intent, we are a long way from that today. This would be a significant undertaking that would demand many resources that are not yet planned. OVHA over the last 10 years has tried to dedicate time and energy to get us to where we are today. We continue to make improvements in our manuals to help clarify our payment policies and claims processing requirements, but we have never tried to cover all possible cases. If this is the intent, would we also have to describe how we pay when we are the secondary payer, the tertiary, etc?

The excerpt also suggests when it says "… for the contracting provider" that the materials would have to be organized on a provider specific basis, such as physician policy, psychologist, hospital, etc. This is very different from our current method where we have the general rules in the Provider Manual for all providers and then additional Manuals organized by claim type, (1500 and UB). Reorganizing these instructions by provider type would demand a huge rewrite of our current manuals. But the California language seems to demand much more than we currently have in writing.

We will have to see many more details filled in before we could begin to clearly estimate if we could comply or not. If the last paragraph sets out Vermont's desired outcome as the ability to forecast claim payment, I think our current materials fall far short of that mark. Consider how would we comply with this for hospital inpatient care paid on a DRG basis? It would be more complex to describe the rules for APCs payment for outpatient care. Most hospitals have the software to make these forecasts with a high degree of accuracy. How would publishing fee schedules and payment rules add value to the current capacity?

Much more is needed before we could determine our ability to meet the objectives.

Cc: File

SIMPLIFICATION OF WORKERS COMPENSATION CLAIMS ADJUDICATION

Common Claims and Administrative Simplification
(Act 191, Sec. 55)

Project Title: Simplification of Workers' Compensation Claims and Adjudication

Project Goal: Explore means to simplify the process for workers' compensation claims filing, processing and payment.

Work Group Members:

- Kathy Peterson, Director of Patient Accounting, Rutland Regional Medical Center, Rutland, Vermont
- Lauren Parker, Vice President, Medical Business Administration (MBA) Resources, So. Burlington and Montpelier, Vermont

Advisory External Resources:

- Steven Monahan, Director, Workers' Compensation and Safety Division, Department of Labor
- Michael Del Trecco, Director of Finance, Vermont Association of Hospitals and Health Systems
- Pat Jones, Department of Banking, Insurance, Securities and Health Care Administration
- Attorney John Hollar
- Attorney Clare Buckley
- Jonathan Nutt, Insurance Carrier Representative, AIG
- Steve Bennett, Carrier Group Representative, American Insurance Association

Summary of Sub-committee Activity:

The Workers' Compensation Sub-committee of the Common Claims Work Group was formed in September of 2006. The Sub-Committee was directed to study Workers' Compensation protocols, procedures, rules and existing law. Our mission was to define impediments in the existing processes and to advise legislators of potential changes in protocol or law that might result in the workers' compensation claims process becoming more cost effective, more timely and better defined for all parties involved including employers, employees (who are also patients), physicians, hospitals, workers' compensation carriers and the Department of Labor.

The vast majority of services by doctors, hospitals, and other medical providers are billed and paid electronically. The mainstream method is a national e-billing format promulgated by the federal government. Workers' compensation is probably the biggest single source of non-conformance with this uniform national standard. Providers

chronically complain of the difficulty of getting their bills through a system that differs not only from state to state but also from payer to payer.

As with general health insurance, there is interest in defining administrative cost savings to all parties from a uniform electronic system of billing and correspondence. Texas and California have taken the lead in developing good systems for e-billing that serve the needs of these two complex systems. By design, their systems could also accommodate the needs of almost any administrative requirement of another state.

Since late 2005, a special committee of the International Association of Industrial Accidents Board Association (IAIABC) has been working on developing a model set of electronic standards for medical billing and payment. They are taking a systemic approach and considering all the related communications and transactions, such as sending attachments, correcting errors, or updating bills with new information. The Director of the WCSD is an active member of this group and this sub-committee has been in contact with IAIABC.

With a focus on what we could do to support this standards review and other improvements to the system, we created the following goals:

1.) Define existing processes from the providers, the carriers and the Workers' Compensation and Safety Division (WCSD) of the Department of Labor.
2.) Determine what changes could be implemented to improve the filing process and the follow up process without impacting the desired outcome which is efficient and accurate claims processing.
3.) Educate all parties as to the legislated and preferred protocols.

GOAL 1 – Definition of Process

Definition of Provider Claims Processing

Our group started by comparing processes from the provider side – both hospital and physician office settings. The goal was to determine where the bottlenecks occur and determine if by changing the process, we could improve the outcome. The details of the actual processes can be viewed in Attachment A, A-1 and A-2.

We then compiled lists of issues faced by both the hospital and physician practice billing departments. We presented the process descriptions and the list of issues to the WCSD at a meeting held at the Department of Labor in January, 2007. The major areas of concern with reported examples from providers are outlined in italics below:

a) **Carriers are not following Vermont's timely payment law** and claims are "lost" in the system.

i. *In a Vermont physician practice where WC is a significant payer (approximately 20 percent of total office charges), 60 percent of those WC claims are aged over 90 days. The timely payment law indicates that a claim should pay or deny within 45 days.*

ii. *In a study of 42 physician practices: for WC claims that are not paid within the first 30 days, in 50-80 percent of calls made to the WC carriers, the carriers claim that there is "no record of the claim on file". This response requires faxing (where allowed) or re-mailing, via regular or certified mail, the claim form and the attached visit note or operative note, often several times before the carrier can "find" the claim.*

iii. *In a typical claim billed to a non-contracted Medical insurance carrier, if a claim is not paid in a reasonable amount of time, the claim may be transferred to the patient to have them follow up with their employer or insurance carrier directly. This encourages the patient to deal directly with their employer who has engaged the carrier and elicits the customer relationship to call action to their effectiveness and pursue alternatives if the carrier is found to be ineffective in this regard. This action would be illegal in VT Workers' Compensation claims review.*

b) **Problems with access to information about the First Report of Injury (FROI):** By law, Vermont employers must file a FROI with WCSD within 72 hours of learning of an employee being injured on the job.[2] Employers are also required to report the injury to their WC carrier. Title 21 of Vermont Law (see below) indicates that the carrier is to file the FROI electronically. This suggests that WCSD has two copies of the FROI on file and indicates that there could be manual versions of the FROI needing input by data entry staff. We also determined that forms entered manually often had errors that prevented the FROI from being found (errors in spelling name, wrong name, etc). If the report was received electronically, these errors would be minimized and the need for data entry staff to enter them and correct errors would be greatly reduced.

c) **TITLE 21, CHAPTER 9. EMPLOYER'S LIABILITY AND WORKERS' COMPENSATION § 660a. Electronic filing of reports of injury** (e) No later than July 1, 2004, all first reports of injury shall be filed by the insurance carrier

[2] Department of Labor, Workers' Compensation Rule 1-46, Rule 3.0500

electronically. The commissioner may grant an insurance carrier a variance if the insurance carrier documents to the satisfaction of the commissioner that compliance would cause the insurance carrier "undue hardship," which, for the purposes of this section, means significant difficulty or expense. (Added 2001, No. 105 (Adj. Sess.), § 1, eff. May 15, 2002.)

Physicians and hospitals that provide care to Vermonters' injured on the job must confirm that a FROI has been filed and that the appropriate WC carrier can be billed.

i. *Often the FROI is apparently not on file with the WCSD. The reasons for this missing information may be a result of employers not submitting the FROI as is required by law or from manual forms requiring data entry. Manual forms may result in delays and errors at WCSD, leading to lost or inaccessible information. The inability to access the FROI occurs frequently and leads to significant delay in processing these claims.*

WCSD should enforce regulations regarding employers filing timely reports to their insurance carrier so the carrier can file the electronic FROI. If the carrier does not have a FROI and WCSD cannot find the FROI, the charge may be transferred to the patient as a non-work comp claim. If this filing of the FROI is not done in a timely manner, employees (patients) are likely to receive bills for their medical services which they believe to be work related.

d) **Carriers are not following the Department of Labor's hospital fee schedule rule**:

i. *Some carriers elect to disregard the DOL Rule 40 that requires that hospitals be paid a percent of charge (currently 83 percent but is adjusted annually by the DOL). Carriers don't disagree that the claim is valid but just decide to pay less than required by the rules. This puts the burden on hospitals to chase the carrier for the full amount required by law.*

ii. *Some carriers disregard the provisions in Rule 40 and require invoices for non-Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) such as screws and plates for hip/knee surgeries. The WC carriers demand to see the hospital's invoice even though the rule in section 40.021(e) says "Individual Invoices are not required". This leads to significant delays in processing and payment of these claims and requires intense efforts on the part of the providers to resolve these issues including seeking assistance from the WCSD.*

e) **Processing and following up on WC claims is manual in nature and very time consuming**:

i. ***The claims filing process*** *is manual and cumbersome. All claims for every visit must be sent in with documentation of each visit. These notes are reviewed for validity as a work related claim (and that no other medical condition is included) prior to moving the claim to the processing mode.*

ii. ***The follow up process*** *is more onerous – the carrier must be called with each claim (there is no on-line access to status). Information is given to find the claim in the system. If there is no First Report of Injury on file, a call must be made to the WCSD for confirmation. If there is no report, the*

services are billed to the patient advising that no report has been made. If the FROI is found at WCSD the carrier is called again regarding the claim.

iii. *With the FROI confirmed by WCSD the carrier is called again.* ***If the claim is not found*** *in the WC carrier's system, a new claim must be sent or faxed to the carrier (some carriers will not accept a faxed form because it must be the original Red CMS 1500 form). There have been regular reports of having to submit the same paperwork 3 or 4 times including having to send certified mail to get the claim to the point of consideration. This can take upwards of 6-9 months on the average and many WC claims are known to take well over a year to resolve.*

Definition of the Department of Labor Processes

At the meeting with WCSD, it was determined that existing law, namely a provision related to timely payments of WC insurance claims, 18 V.S.A. § 9418(c), was in conflict with DOL rules.[3] Regardless of this conflict, the WCSD was not enforcing the terms or the statute or the rule due to lack of staffing at the WCSD. The Director was also very clear that they viewed their role as that of mediator in a defined dispute and preferred that the providers and carriers work out the differences amongst themselves.

Statewide hospital and physician office manager and billing groups (Hospital group – Vermont Patient Account Managers or VPAM and Physician Group – Vermont Medical Managers Assoc or VMMA) were approached by committee members in early 2007 with the timely payment provision in 18 V.S.A § 9418(c) which reads as follows:

> If the claim submitted is to a health plan that is a workers' compensation insurance policy,
> (1) The health plan shall within 45 days following receipt of the claim: (A) pay or reimburse the claim; or (B) notify in writing the claimant and the commissioner of labor that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.
> (2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of chapters 9 and 11 of Title 21
> (3) The commissioner of labor may assess interest and penalties as provided in subsections (e) and (f) of this sections against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.

The full text of the statute, in Title 18, is attached as Attachment B. The referenced section of Title 21 is attached as Attachment C.

[3] The statute states that workers' compensation carriers have 45 days from receipt of a claim to either pay it or notify the claimant AND the DOL that the claim is contested or denied. DOL Rule 40.021(c), provides that claims must be paid or contested within 30 days and sets up a different collection process.

Automatic Interest:
Please note that in Title 18 V.S.A. § 9418, automatic interest must be paid to the provider for medical and disability claims that are not paid in a timely manner. Since there has been a precedent set for medical and disability insurance, the committee suggests that the law be changed to allow for automatic interest on workers' compensation claims not paid or denied within the required timeframe.

Pattern of Practice:
It has been reported by the WCSD that a carrier must display a pattern of practice to indicate review by the DOL (18 V.S.A. § 9418, 2, i). It is understood that this is the case for BISHCA in determining wrong-doing for medical claims but Workers' Compensation is administratively different. Due to the nature of the carrier's non-contracted relationship to the provider, the relatively few cases that any given provider might have with a carrier and the many carrier options available to employers, there may not be enough claims to produce a pattern of practice. It will be the recommendation of this committee that each claim be considered individually on its own merit.

Both provider billing groups were advised to adjust their in-office protocols to follow the stated requirements in the law to see if this would improve how claims were being processed and paid and report back to the committee members. (Sample Protocol Attachment D)

After several months of communication, it appeared that there was no change in the enforcement of the law by taking action against WC insurance carriers who were not paying, denying or notifying the claimant (provider) or the DOL that they were contesting within the 45 day period. This resulted in a follow up meeting to try to clarify how the WCSD viewed the lack of enforcement of the law.

We agreed to meet as a larger group to include VAHHS, BISHCA and the Commissioner of the Department of Labor in June, 2007.

At this meeting:

- It was agreed that there would be value in bringing representatives of the insurance carrier community to the table to discuss where the impasses were occurring.
- We were advised that WCSD was not staffed to carry out the law as the sub-committee interpreted it* and that the presiding role of the Division was to mediate between the carrier and the provider when they had a proven impasse.
- We were advised that the DOL rules would be revised to match the letter of the law. The revision of the Rules was to begin in the summer of 2007.

  *__Staffing at the WCSD__ has been defined as 4 data entry staff (correct errors in forms, enter the manual FROI, follow up on cases where the FROI is not filed, etc); 7 specialists who deal with complaints (3 low level and 4 higher level – major tasks are benefits discontinued or claim denied as not work related); fraud investigator and hearing officer.

Definition of the Workers' Compensation Carriers Claims Processing

The meeting with carrier representatives took place in August, 2007, and was a very informative discussion among the payer community, the lawyers who represent both providers and payers and the provider community in attendance. There were several areas defined as working points.

- **Timely payment law was discussed**. The law allows for the Department of Labor to assess penalty and interest to any carrier not abiding by the timely payment portion of the law, as set forth in 18 V.S.A. §9418. This section of the law was discussed in great detail. Many WC claims are not paid or denied in the 45 day window. The carriers were not notifying the Department of Labor or the claimant. There are limits to which claims can reach the dispute level, due to availability of staffing at WCSD. Therefore, few claims ever reach the Commissioner for assessment of penalty and/or interest.

  There was discussion of the possibility of automatic penalty. The attorneys representing the carriers and the carrier representative present argued that amending the statute to mandate automatic assessment of penalty would be unfair in the workers' compensation context and would often be disputed because they believe that the carrier could prove they had taken action (requested more information) on the account that would relieve them of the penalty.

  All present agreed that if existing law was enforced it would speed up the payment/resolution cycle of the claims, thereby reducing time and paperwork associated with claims follow up.

- **Efficiency of the Submission of Claims:** Due to the overreaching assessment that the process has become tedious, time consuming and costly for all, a major concern related to the possibility of electronic transmission of claims from the provider to the WC carrier with the required associated medical record note. Insurance carrier representatives said that due to the state of technology in this area on a national level, this would be challenging to mandate and accomplish. This fact has been confirmed with three different Electronic Clearing House companies doing business in Vermont. Be advised that the majority of Vermont medical health insurance claims are submitted electronically directly to the carrier or through a claims clearing house.

  We learned that the state of Texas has mandated the electronic transmission of claims effective January 2008. We were advised that the major insurers are working toward compliance with the legislation but that smaller carriers would be exempted due to their size and ability to adopt the regulation. Similarly the providers have an exemption that would exclude smaller facilities (physician offices and smaller hospitals). It was the opinion of the presenter that due to these exemptions, only a small number of Texas providers and WC carriers would be subject to the new law. (Texas legislation: House Bill (HB) 2511, enacted by the 76th Texas Legislature, Regular Session, added Labor Code §401.024, which was amended by HB 7, 79th Legislature, Regular Session)

- **The Processes at the Carrier and WCSD Level**: We received a working description of the processes at the carrier level and why an electronic claim was difficult to incorporate into the WC liability carrier world. When a claim is received by the payer, the actual claim is removed from the attached note and both are routed to different departments for settlement in a timely manner.

  The note is reviewed for validity of the work related injury. The claim is processed with attention to the reason for the encounter and the resulting procedure(s). When both have passed the required review, they are joined back together in their system and approved or denied for payment. One carrier representative present at the meeting indicated to the group that his company provides incentives for claim reviewers and adjudicators to settle claims in 30 days or less.

  A Workers' Compensation carrier has a very different task at hand than a medical health insurance claims carrier. The medical carrier pays based on two primary factors – is the patient an active member of the plan and is the procedure that is being submitted an approved service under that same plan.

  The WC carrier has to first ascertain from the written word of the provider whether the condition reported is clearly the result of a workforce related situation. Once it is, they have to determine if the procedure codes submitted are all necessary and allowed (some services are considered to be included in others and this must be looked at for cost savings). The carrier needs to confirm the filing of the FROI or may sometimes be the submitter of the FROI.

  The final step is to notify the provider of whether or not the service would be paid or denied. According to Title 18, they must also notify the commissioner of labor if the claim is denied. It would be assumed that this would initiate an update of the record for this incident and would be accessible in the associated file for this FROI.

  Once the provider receives the payment or denial, they may appeal any decisions that are unacceptable to the practice or do not follow the Vermont State guidelines already defined by law. These appeals can be made directly to the carrier or can request the involvement of the Department of Labor, WCSD.

  It is important to acknowledge that the majority of the WC carriers are equipped to receive and send the First Report of Injury (FROI) electronically, as required by Vermont law. However, many small employers in VT are exempted from this requirement due to their financial ability to incorporate software to allow an electronic filing. Since it is the responsibility of the employer to file this report, many manual forms are submitted to WCSD because the employer is not equipped to electronically submit the form. The manual forms submitted can be difficult to read, leave room for data entry errors upon receipt at the WCSD and the reports themselves are often behind in getting into the system because they require someone to manually enter the information into the system.

If there is no FROI, the claim (having no validity) can be filed as unresolved or destroyed at the carrier level. Similarly, if there is information sent to the WCSD and they can not find the FROI to attach the claim to, they are also left with the option of destroying the paperwork as it has no file in the system. The decision to destroy the "invalid" claim is often not communicated in the form of a denial to the provider of service. When calls are made regarding the status of the claim, there is no record of the claim because there is no file.

GOAL 2 - Recommendations

This sub-committee has made strides in understanding the perspectives of the liability carriers, the **Department of Labor and the provider community. We also are cognizant of the frustration experienced** by employers and employee/patients in the time involved in settling claims as well as the costs associated with all workers' compensation cases.

We recommend that the following steps be taken to minimize costs and maximize the funding capacity of the workers' compensation program:

- Adopt the attached recommendation (Attachment F) for an amendment to Title 18 and 21 to include
    6.) Change the law to transfer enforcement portion of Timely Payment Statute over to BISHCA in consultation with DOL to enforce current requirements. Initial complaints may be made to BISHCA by DOL or other parties, including providers;
    7.) Require Automatic interest paid to providers for lack of timely payments in alignment with medical and disability claims
    8.) Authorize the DOL to track carrier protocols for claims receipt, claims processing and claims paid, including an online claims status review option for providers;
    9.) Enable the DOL to have bill back authority for costs incurred in investigations of the WC carriers;
    10.) Allocate that penalties assessed against workers' compensation carriers be deposited into a DOL administration fund to pay for tracking and enforcement activities within the division.

  Timeframe: July 2008

- Instead of requiring employers to file FROI with WCSD and report injury to carrier, we recommend that the process be streamlined and require employers to file FROI with carriers within 72 hours so that carriers can electronically file ALL FROI to the WCSD, as required by law. This would result in one copy of the FROI at WCSD and would be received electronically creating less delay in entering into the WCSD tracking system and less entry errors to be dealt with by the Division staff.

  Timeframe: March 2008

- Since the data entry staff responsibility would be greatly reduced with electronic submission of the majority of FROI, some of the four entry level staff would be freed up to monitor and track complaints about timely payments. These complaints, once verified with the provider and the carrier, would be forwarded to BISHCA for enforcement of timely payments.

  Timeframe: March 2008

- Eliminate the "Pattern of Practice" requirement due to the nature of the volume of claims from an individual provider. If this is not possible, require the DOL to provide their own longitudinal study of carriers (over time) who repeatedly delay payment or wrongly deny payment across multiple provider groups, for purposes of creating in internal study of whether there is a patterned practice requiring review.

  Timeframe: July 2008

- It is our recommendation that the Legislature should carefully monitor the implementation of the Texas law, which will take effect January 1, 2008, that requires electronic claims filing from the providers to the workers' compensation carriers. Added benefits to electronic filing include electronic record of claims transmissions and the savings of significant material costs involved with copying and mailing documents.

  Timeframe: February - June 2008

- It is the recommendation of the subcommittee that the Legislature review cost savings estimated in Attachment G for analysis of time spent by employer, physician office staff, hospital staff, WC carriers and WCSD. With these savings of time and associated costs, the subcommittee believes that modifications to the existing systems would more than pay for themselves in a very short time period.

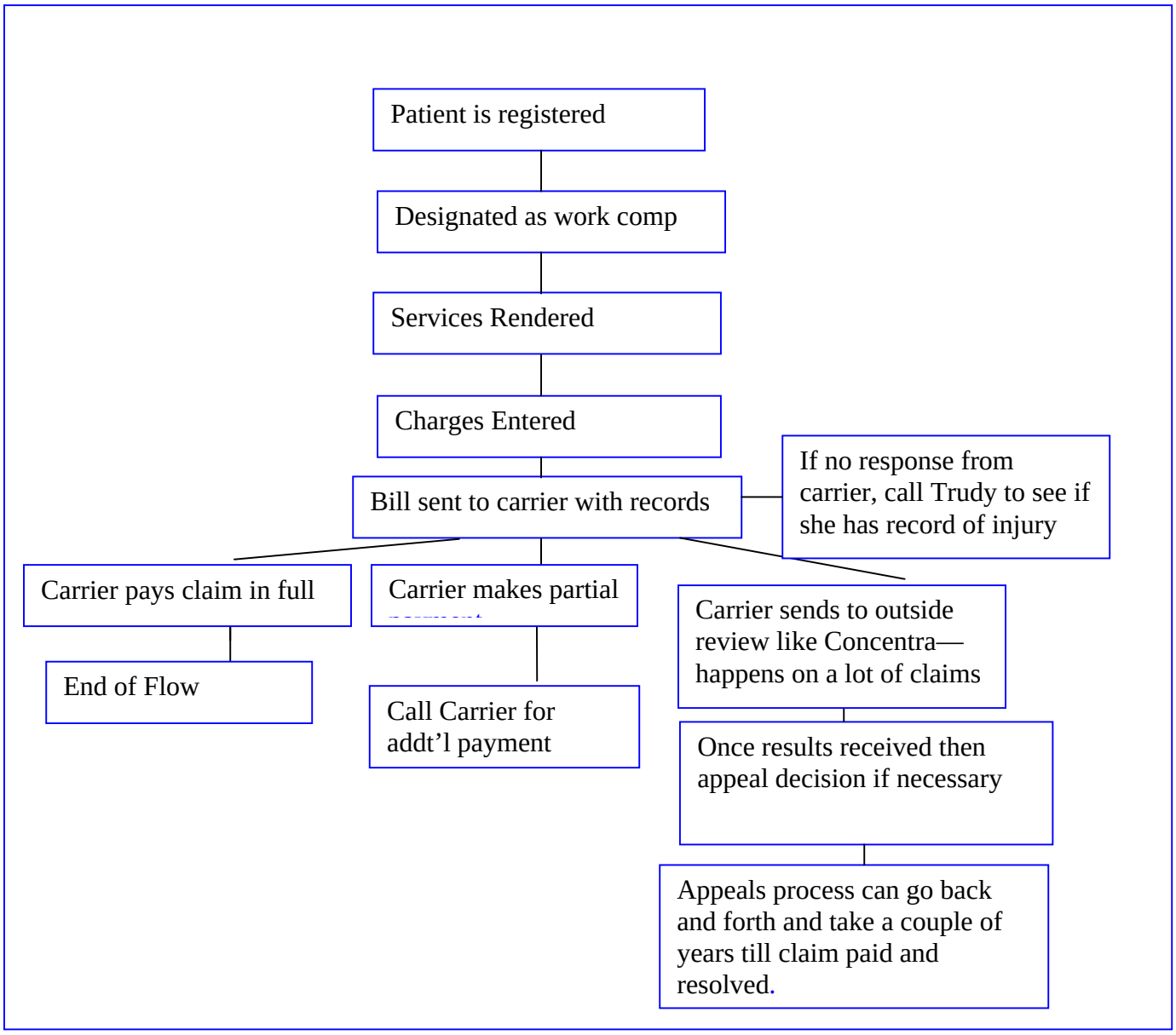
Goal 3 – Education and Implementation of Legislated Processes

It is the belief of this subcommittee that once the laws are defined, established and staffed for enforcement, there are mechanisms in place to educate and advise all providers of the rules and regulations of Workers' Compensation Claims filing. This process will be assisted by the hospital group - VPAM, the physician group - VMMA, The Vermont Medical Society, The Vermont Association of Hospitals and Health Systems and the Department of Labor.

We believe that a memo outlining the enforcement of the law and the updated rules associated with the law should be sent in multiple media (letter, email, legal posting) to all Workers' Compensation Carriers doing business in Vermont.

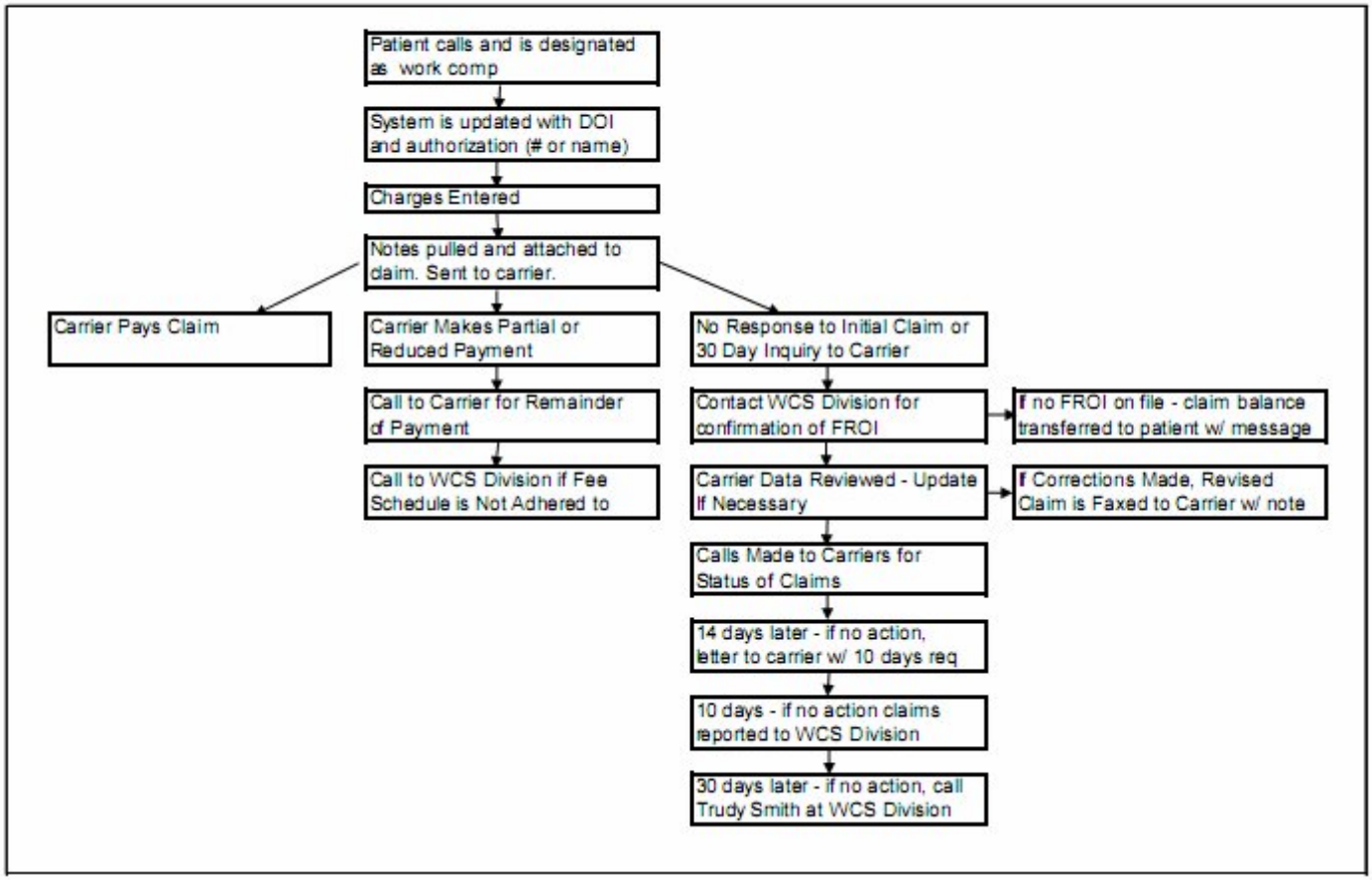
Attachment A

HOSPITAL WORKER'S COMPENSATION WORKFLOW



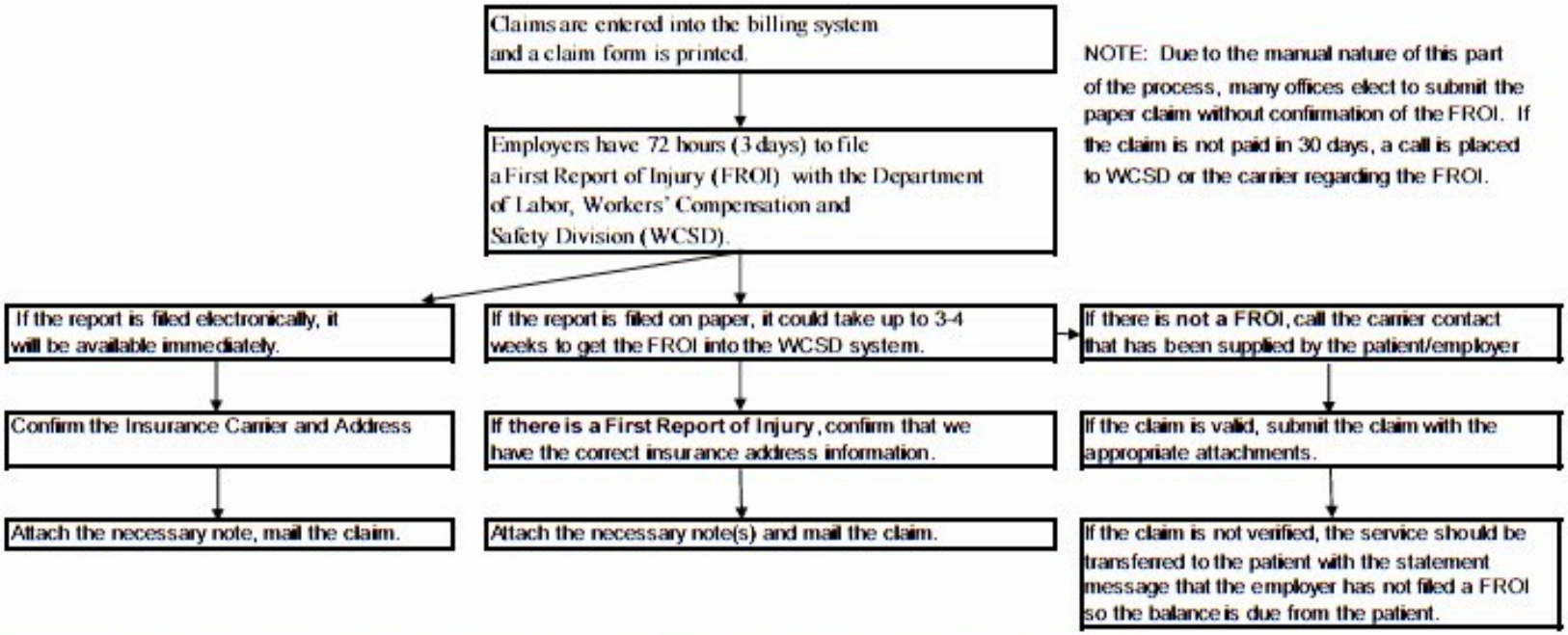
Attachment A-1

PHYSICIAN'S WORKERS' COMP FLOW

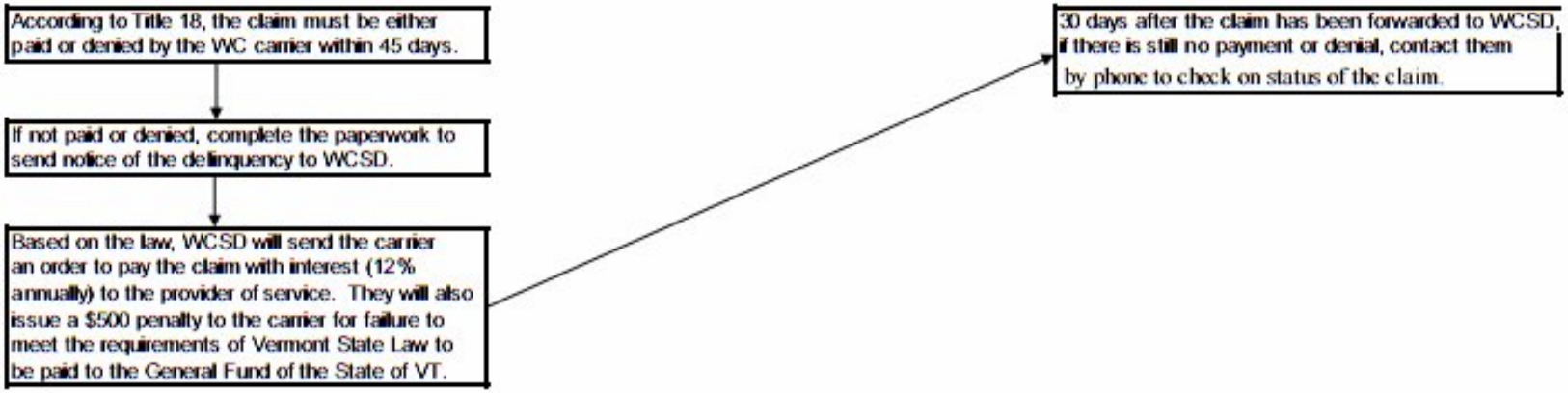


Attachment A-2

WORKERS' COMPENSATION PROTOCOL - STEPS PRIOR TO SUBMITTING THE INITIAL CLAIM



WORKERS' COMPENSATION PROTOCOL - AFTER THE CLAIM HAS BEEN FILED WITH NOTES



Attachment B

The Vermont Statutes Online

Title 18: Health

Chapter 221: HEALTH CARE ADMINISTRATION

18 V.S.A. § 9418. Payment for health care services

TITLE 18
Health
PART IX
Unified Health Care System
CHAPTER 221. HEALTH CARE ADMINISTRATION
Subchapter I. General Provisions

§ 9418. Payment for health care services

(a) As used in this section,

(1) "Health plan" means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation or a workers' compensation policy of a casualty insurer licensed to do business in Vermont. "Health plan" also includes a health plan that requires its medical groups, independent practice associations or other independent contractors to pay claims for the provision of health care services.

(2) "Claim" means any claim, bill or request for payment for all or any portion of provided health care services that is submitted by:

(A) A health care provider or a health care facility pursuant to a contract or agreement with the health plan; or

(B) A health care provider, a health care facility or a patient covered by the health plan.

(3) "Contest" means the circumstance in which the health plan was not provided with:

(A) Sufficient information needed to determine payer liability; or

(B) Reasonable access to information needed to determine the liability or basis for payment of the claim.

(4) "Denied" or "denial" means the circumstance in which the plan asserts that it has no liability to pay a claim, based on eligibility status of the patient, coverage of a service under the health plan, medical necessity of a service, liability of another payer or other grounds.

(b) No later than 45 days following receipt of a claim, a health plan shall do one of the following:

(1) Pay or reimburse the claim.

(2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.

(c) If the claim submitted is to a health plan that is a workers' compensation insurance policy,

(1) The health plan shall within 45 days following receipt of the claim:

(A) pay or reimburse the claim; or

(B) notify in writing the claimant and the commissioner of labor that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.

(2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of chapters 9 and 11 of Title 21.

(3) The commissioner of labor may assess interest and penalties as provided in subsections (e) and (f) of this section against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.

(d) If a claim is contested because the health plan was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by subdivision (b)(2) of this section, then the health plan shall have 45 days after receipt of the additional information to complete consideration of the claim.

(e) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as follows:

(1) For a claim that is uncontested, from the first calendar day following the 45-day period following the date the claim is received by the health plan.

(2) For a contested claim, for which notice was provided as required by this section, from the first calendar day after the 45-day period following the date that sufficient additional information is received.

(3) For a contested claim for which notice was not provided as required by this section or for which notice was provided later than the 45 days required by subdivision (b)(2) of this section, from the first calendar day after the 45-day period following the date the original claim was received by the health plan.

(4) For a claim that was denied, from the first calendar day after the 45-day period following the date of a final arbitration award, judgment or administrative order that found a plan to be liable for payment of the claim.

(f) The commissioner may suspend the accrual of interest under subsection (e) if the commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster, act-of-God or unanticipated major computer system failure or that the action is necessary to protect the solvency of the health plan.

(g) All payments shall be made within the time periods provided by this section unless otherwise specified in the contract between the health plan and the health care provider or the health care facility. The health plan shall provide notice as required by subsection (b) of this section and pay interest on uncontested and contested claims as required in subsection (d) of this section from the day following the contract payment period, unless otherwise specified in the contract.

(h) Any dispute concerning payment of a claim or interest on a claim, arising out of or relating to the provisions of this section shall, at the option of either party, be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the arbitrator's award may be entered in any court having jurisdiction.

(i) If the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than $500.00 for each violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:

(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.

(2) The gravity of the violation or practice.

(3) The history of previous violations or practices of a similar nature.

(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.

(5) Any other relevant factors. (Added 1997, No. 159 (Adj. Sess.), § 14a; amended 2005, No. 103 (Adj. Sess.), § 3, eff. April 5, 2006.)

Attachment C

Title 21: Labor

Chapter 9: Employer's Liability And Workers' Compensation

688. Administrative penalties; insurance company's license suspended

§ 688. Administrative penalties; insurance company's license suspended

(a) The commissioner, after notice and opportunity for a hearing, may assess administrative penalties of not more than $5,000.00 against any employer, insurance company, or their agents that the commissioner finds has refused or neglected to comply with the reasonable rules and regulations of the commissioner or any orders issued by the commissioner, or to adjust and pay compensation and medical bills in accordance with the provisions of this chapter.

(b) The notice and opportunity for a hearing under this section shall be in accordance with chapter 25 of Title 3. The commissioner shall adopt rules regarding the amount and imposition of penalties.

(c) In addition to assessing administrative penalties, the commissioner may refer to the commissioner of banking, insurance, securities, and health care administration any insurance company authorized to transact workers' compensation insurance in this state which refuses or neglects to comply with the reasonable rules and regulations of the commissioner or which neglects or refuses to properly and promptly adjust and pay compensation and medical bills in accordance with the provisions of this chapter. If, after hearing, the commissioner of banking, insurance, securities, and health care administration finds that the insurance company has failed to comply with the rules and regulations or orders issued by the commissioner of labor or has failed to properly and promptly pay compensation and medical bills as provided by this chapter, the commissioner of banking, insurance, securities, and health care administration may take appropriate action against the insurance company as provided in Title 8. (Amended 1989, No. 225 (Adj. Sess.), § 25(b); 1993, No. 225 (Adj. Sess.), § 15; 1995, No. 180 (Adj. Sess.), § 38(a); 2005, No. 103 (Adj. Sess.), § 3, eff. April 5, 2006.)

Attachment D

Workers' Compensation Protocol for Claims Follow-up

Revised: **May 21, 2007**

1. Claims are entered into the billing system and a claim form is queued up.

2. First Report of Injury. Employers have 72 hours (3 days) to file a FROI with the Department of Labor, Workers' Compensation and Safety Division (WCSD). If the report is filed electronically, it will be available immediately. If the report is filed on paper, it could take up to 3-4 weeks to get the first report of injury into the WCSD.

3. Prior to tracking down the necessary notes to send the claim out, call the carrier that has been supplied by the patient/employer to the doctors office. If they confirm that the claim is valid, note the first report of injury date and submit the claim with the appropriate attachments. Confirm that we have the correct insurance address information.

4. If the claim does not have a First Report of Injury, the claim should be transferred to the patient with the statement message that the employer has not filed a first report of injury with their carrier so the balance is due from the patient.

5. Claim follow up is done at 30 days from the billed date. If the carrier states that they have no claimon file, fax the claim and note attached. If they will not accept a fax, ask for name and address of appropriate person – the claim will be sent return receipt requested to that person. Call that person 3 days later for confirmation.

6. Once the claim has been filed and received with notes. According to the new law, 45 days after receipt of the claim and notes, the claim must be either paid or denied by the WC carrier. At 50 days, complete the paperwork to send notice of the delinquency to Trudy.

   Based on the new law, Trudy will send the carrier an order to pay the claim with interest (12% annually) to the provider of service. She will also issue a $500 penalty to the carrier for failure to meet the requirements of Vermont State Law to be paid to the General Fund of the State of VT.

7. 30 days after the claim has been forwarded to Trudy, if there is still no payment or denial, contact Trudy by phone to check on status of the claim and advise Trudy that there is no resolution. It is yet unclear if the carrier would be assessed another penalty. We need to find this out.

Attachment F

The purpose of these amendments is as follows:

Sec. 1: To transfer the enforcement of the existing timely payment statute for workers' compensation claims from the Department of Labor to the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) in consultation with the Department of Labor. Further, to require automatic interest payments if a workers' compensation carrier does not pay claims in a timely manner as required by law, which is already the case with health or disability insurance claims.

Sec. 2: To authorize the Department of Labor to issue an order requiring workers' compensation carriers to institute claims processing practices to ensure claims are received and processed in a timely manner, including an on-line claim processing system accessible by providers and the department so that the status of claims can be tracked.

Sec. 3: To enable the Department of Labor to have similar bill back authority to hire consultants and pay for investigations of workers' compensation carriers and other persons regulated by the Department similar to BISHCA's existing bill back authority.

Sec. 4: To require that all penalties assessed against workers' compensation carriers by the Department of Labor be deposited into the workers' compensation administration fund to pay for enforcement activities within the department.

PROPOSED AMENDMENT

Sec. 1: 18 V.S.A. § 9418 is amended to read as follows:

§ 9418 Payment for health care services

(a) As used in this section,

(1) "Health plan" means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation or a workers' compensation policy of a casualty insurer licensed to do business in Vermont. "Health plan" also includes a health plan that requires its medical groups, independent practice associations or other independent contractors to pay claims for the provision of health care services.

(2) "Claim" means any claim, bill or request for payment for all or any portion of provided health care services that is submitted by:

(A) A health care provider or a health care facility pursuant to a contract or agreement with the health plan; or

(B) A health care provider, a health care facility or a patient covered by the health plan.

(3) “Claimant” means the health care provider or health care facility providing the health care services or the patient covered by the health plan, depending on who files the claim, bill or request for payment for all or any portion of health care services.

~~(3)~~(4) "Contest" means the circumstance in which the health plan was not provided with:

(A) Sufficient information needed to determine payer liability; or

(B) Reasonable access to information needed to determine the liability or basis for payment of the claim.

~~(4)~~(5) “Denied" or "denial" means the circumstance in which the plan asserts that it has no liability to pay a claim, based on eligibility status of the patient, coverage of a service under the health plan, medical necessity of a service, liability of another payer or other grounds.

(b) No later than 45 days following receipt of a claim, a health plan shall do one of the following:

(1) Pay or reimburse the claim.

(2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.

(c) If the claim submitted is to a health plan that is a workers' compensation insurance policy then the commissioner shall enforce this law in consultation with the commissioner of the Department of Labor,

(1) The health plan shall within 45 days following receipt of the claim:

(A) pay or reimburse the claim; or

(B) notify in writing the claimant and the commissioner ~~of labor~~ that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.

(2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of Title 8 and chapter~~s~~ 9 ~~and 11~~ of Title 21.

~~(3) The commissioner of labor may assess interest and penalties as provided in subsections (e) and (f) of this section against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.~~

(d) If a claim is contested because the health plan was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by subdivision (b)(2) or (c)(1)(B) of this section, then the health plan shall have 45 days after receipt of the additional information to complete consideration of the claim.

(e) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as follows:

(1) For a claim that is uncontested, from the first calendar day following the 45-day period following the date the claim is received by the health plan.

(2) For a contested claim, for which notice was provided as required by this section, from the first calendar day after the 45-day period following the date that sufficient additional information is received.

(3) For a contested claim for which notice was not provided as required by this section or for which notice was provided later than the 45 days required by subdivision (b)(2) or (c)(1)(B) of this section, from the first calendar day after the 45-day period following the date the original claim was received by the health plan.

(4) For a claim that was denied, from the first calendar day after the 45-day period following the date of a final arbitration award, judgment or administrative order that found a plan to be liable for payment of the claim.

(f) The commissioner may suspend the accrual of interest under subsection (e) if the commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster, act-of-God or unanticipated major

computer system failure or that the action is necessary to protect the solvency of the health plan.

(g) All payments shall be made within the time periods provided by this section unless otherwise specified in the contract between the health plan and the health care provider or the health care facility. The health plan shall provide notice as required by subsection (b) and (c) of this section and pay interest on uncontested and contested claims as required in subsection (d) of this section from the day following the contract payment period, unless otherwise specified in the contract.

(h) Any dispute concerning payment of a claim or interest on a claim, arising out of or relating to the provisions of this section shall, at the option of either party, be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the arbitrator's award may be entered in any court having jurisdiction.

(i) If the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than $500.00 for each violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:

(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.

(2) The gravity of the violation or practice.

(3) The history of previous violations or practices of a similar nature.

(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.

(5) Any other relevant factors.

Sec. 2: 21 V.S.A. § 688c is added to read:

§ 688c Workers' Compensation Carrier Claims Processing Practices

The commissioner shall issue an order requiring workers' compensation carriers to institute claims processing practices to ensure claims are received and processed in a timely manner. Carriers shall file their written claims processing practices with the department of labor by January 1, 2009, and shall include an on-line claim processing system accessible by providers and the department so that the status of claims can be tracked.

Sec. 3: 21 V.S.A § 688b is added to read:

§ 688b Charges for examinations, reviews and investigations

Every person subject to regulation by the department shall pay the department the reasonable costs of any examination, review, or investigation that is conducted or caused to be conducted by the department of such person, or of any examination, review, or investigation of any order or decision issued by the commissioner, at a rate to be determined by the commissioner. The department may retain experts or other persons who are independently practicing their professions to assist in such examination, review, or investigation. The department shall be reimbursed for all reasonable costs and expenses, including the reasonable costs and expenses of such persons retained by the department, by the person examined, investigated, or subject to or under the jurisdiction of an order or decision issued by the commissioner under this title. In unusual circumstances, the commissioner may waive reimbursement for the costs and expenses of any review in the interests of justice. The commissioner shall upon petition by any person who is required to pay costs and expenses under this section, review and determine, after opportunity for hearing, having due regard for the size and complexity of the project, the necessity and reasonableness of such costs, and may amend or revise such costs and expenses as necessary.

Sec. 4: 21 V.S.A. § 688a is added to read:

§ 688a. Penalties

All penalties assessed against workers' compensation carriers by the department of labor shall be deposited in the workers' compensation administration fund to offset some of the expenses involved with contracting for consultants to oversee the workers' compensation claims processing system and ensure that workers' compensation claims and payments to providers are processed in a timely manner accord

Attachment G

Savings Estimated

	WC Employees	Total Unpaid claims Staff	WC Hours Per Month	WC Claims Per Month	Percentage Total Claims	Percentage Billing Sta	Cost / mo $14/hr*
Employer: **NOT ENOUGH INFORMATION PROVIDED TO ANALYZE**							
Time to complete FROI:							
Time following up on outstanding cases:							
Other operational expense:							
Provider - Physician - 42 practices, 140+ physicians:							
Time following up on outstanding cases:	1.5 FTE's	9 FTE's	350	575	3%	16%	$ 5,880
Time management oversight for contested claims:	.5 FTE	1 FTE					
Provider - Hospital:							
Time following up on outstanding cases:	1 FTE	16 FTE's	175	350	1%	7%	$ 2,940
Time management oversight for contested claims:							
Workers' Comp and Safety Division:							
FROI – manual entry, correcting data, tracking unfiled:	4 FTE's						
Review if unresolved/disputed claims:	7 FTE's						

*plus 20% overhead expense

ADDENDUMS

August 27, 2007

Mr. Michael Del Trecco
Vice President Finance
Vermont Association of Hospitals and Health Systems
148 Main Street
Montpelier, Vermont 05602

Dear Mike:

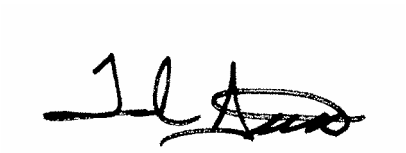
Recently I became aware of the Vermont Common Claims Workgroup, that is among other things, working to standardize hospital and physician patient billing statements. As I have indicated to you and the Vermont hospital CFOs, I am concerned that the workgroup's efforts are duplicative of work already done by the health care industry on this subject and may result in a significant financial burden to Vermont hospitals for computer reprogramming.

As you may know, there was a Patient Friendly Billing Task Force convened a few years ago which included representatives from the Medical Group Management Association (MGMA), the Healthcare Financial Management Association (HFMA), and the American Hospital Association (AHA). This group spent nearly a year examining billing problems and solutions. The study included several focus groups of patients. The result of the Task Force's work as well as their recommendations was published and includes a checklist for improving patient billing and follow-up and recommended components of a patient bill, among other things. This report and its recommendations have been widely accepted by the industry and essentially have established the standard for patient billing.

I strongly encourage the Vermont Common Claims Workgroup to not recreate the wheel in developing a common bill that every hospital and physician must adhere to. Instead, they should use the work that has already been completed by the Patient Friendly Billing Task Force as a basis for hospitals and physicians to comply with. As a first step, the State could request each hospital to sign a statement that they will substantially implement the recommendations of the Patient Friendly Billing Task Force and indicate if they currently are in compliance with its recommendations or not. I can tell you that our facility currently is not substantially in compliance; however, we are in the process of complying.

I certainly support the need to have a patient friendly bill and feel we already have industry guidelines that have been very thoughtfully and carefully developed available to us. In my view, it would be a waste of time and precious hospital resources to implement another set of billing rules dictated by the State.

Yours truly,



Ted D. Sirotta
Chief Financial Officer

cc: Peter Hofstetter, CEO – Northwestern Medical Center
Linda Renaudette, Manager of Patient Financial Services – Northwestern Medical Center

Vermont . . .

Department of Banking, Insurance, Securities and Health Care Administration

To: Members of the Common Claims Work Group
From: Herbert W. Olson, General Counsel
BISHCA representative to the Work Group
Date: December 28, 2007
Re: Comments concerning the Final Report of the Work Group

This note is intended to supplement comments made on behalf of BISHCA at the last meeting of the Work Group on December 17, 2007.

First, as BISHCA's representative on the Work Group (with the capable assistance of Pat Jones, Director of Health Care Quality Improvement, Division of Health Care Administration), I commend members for their hard work and serious effort to address one of the most vexing problems facing Vermont' health care system: the frustration and unnecessary costs resulting from the health insurance claims administration system.

In accordance with the statutory directive (Sec. 55, of Act 191: 2006), once the Final Report has been submitted to the Governor and the General Assembly, the Commissioner of BISHCA is called upon to amend "the rules adopted pursuant to the final report * * *, as the [C]ommissioner deems appropriate in his or her discretion." Subsection (a) of Sec. 55.[i] I am confident the Commissioner will carefully consider the many excellent recommendations for positive action to reduce administrative costs and complexity, and that the Department soon will begin the process for amending its current administrative rule including, but not limited to the following matters:

- Member identification cards and member information.
- Adoption of a uniform Explanation of Benefits standard, and uniform hospital and physician Patient Statements.
- Standards for a web-based prior approval process.

Second, I would like to express my hope that the Work Group will support more aggressive opportunities to reduce administrative costs and complexity. I am reminded of the statutory goals of the Sec. 55 Work Group:

1. "Simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming.
2. "Lowering administrative costs in the health care financing system."

Sec. 55, subsection (c).

From the outset of this process, the Department has urged the Work Group to seriously consider the possibility of enhanced standardization of the electronic claims administration and claims adjudication process. No one suggests that standardized electronic claims administration and adjudication is a cost containment "silver bullet"; but there can be little serious argument that hospitals, physicians and other providers, and consumers would realize economic benefits and less frustration from using a uniform language and common protocols for submitting claims, responding to claims, and adjudicating claims.

At the request of BISHCA, the Work Group undertook a review of electronic health information networks such as the Utah Health Information Network (UHIN). UHIN is a non-profit organization of all participants of the Utah health care system which has developed a collaborative process to develop claims administration and adjudication standards for all payers and providers in Utah. UHIN develops, through a consensus process, standards for claims administration after careful consideration of national standards, and upon adoption forwards the standards to the Utah Department of Insurance. The Utah Department of Insurance then implements the standards through administrative rules. The federal Health Insurance Portability and Accountability Act (HIPAA) has made some progress towards standardization and simplification, but Utah has been able to make much greater progress than is embodied in the HIPAA standards. For example:

- UHIN has developed a standard for anesthesia claims that is more specific and uniform than the HIPPA standard.
- UHIN has adopted a standard for the submission of home health service claims.
- UHIN not only requires the acknowledgment of a provider claim, but a detailed explanation of whether the claim has been processed, and if deficient the payer must state the reasons why the claim was not accepted for adjudication, all within 24 hours of submission of the electronic claim.
- UHIN has standardized interpretations of HIPAA standards, so that hospitals and providers do not need multiple "translators" to submit claims to different payers.

The important point to be made concerning UHIN is not that Utah's standard-making and electronic system is the best model, or even that any of its specific standards are suitable for Vermont; rather, Utah and other similar systems[ii] are convincing proof that significant progress can be made, beyond the cautious HIPAA standards, towards simplifying the claims administration system, and towards lowering transaction costs for hospital, providers, and health insurance plans. Ultimately it will be consumers and public and private health insurance plans who pay premiums and claims that will benefit from claims administration reforms.

I am pleased that the Work Group has amended its draft report, and that the Group now supports a recommendation to "develop an ongoing collaborative process similar to that used by UHIN, in order to aggressively seek electronic solutions to improve efficiency, reduce costs, and improve timeliness". I am also pleased that the Work Group has rejected the proposed language of the draft report suggesting that further extensive and time-consuming research and evaluation is needed before starting work on this important initiative. I will urge the Commissioner to work with a broad group of participants in Vermont's health care system and commence implementation of a UHIN- or CORE-type initiative in a rational manner, but with a sense of urgency, to more aggressively seek cost-effective improvements to, and standardization in the administration and adjudication of health insurance claims in Vermont.

Finally, I acknowledge that the Work Group has made a commendable effort to address the issue of simplification of workers' compensation claims adjudication. I am concerned, however, about the Work Group's recommendations which would amend the Prompt Pay statute (18 V.S.A. section 9418). The proposed amendments seem to leave unclearly defined the respective roles and responsibilities for the Department of Labor and BISHCA. For example, the proposed amendments appear to confer timely payment enforcement authority responsibilities on BISHCA, but the proposed amendments also appear to retain enforcement authority with the Department of Labor. I worry that in the absence of defined authority and accountability the bifurcated system of

enforcement might not be effective in its goal of improving the workers' compensation claims administration system.

In conclusion, I appreciate the efforts of the Work Group. I look forward to the members' participation in the Commissioner's administrative rule-making process called for by Act 191 to implement the Work Group's recommendations, as well as to implement other measures designed to simplify the claims administration process and reduce administrative costs.

cc: Governor Jim Douglas
Paulette J. Thabault, Commissioner
Senator Jane Kitchel, Co-Chair, Commission on Health Care Reform
Rep. Steve Maier, Co-Chair, Commission on Health Care Reform
Jim Hester, Jr., Executive Director, Commission on Health Care Reform
Susan Besio, Director of Health Care Reform Implementation

[i] The current administrative rule, Regulation 93-4, "Uniform Claims Forms and Uniform Standards and Procedures for Processing", is in need of substantial modernization, both to reflect at a minimum transaction standards required by HIPAA regulations, and to take advantage of technical progress made in information technology and electronic communications since its adoption.

[ii] Other states are considering the adoption of an information interchange network such as Utah's. Wyoming and North Dakota are actively considering directly participating in UHIN. CAQH is developing its own standards through the Committee on Operating Rules for Information Exchange "CORE".