



May 1, 2007

Senator Rhoda Perry
Representative Steven M. Costantino
Co-Chairs
Joint Legislative Committee On Health Care Oversight
The State House, Room 306
Providence, RI 02903

Dear Senator Perry and Representative Costantino:

I am pleased to submit to the Joint Healthcare Oversight Committee an final progress report of the "Professional Provider Health Plan Work Group" established under RI 42-14.3, which was put into law in 2005 and amended last session, and facilitated by this Office.

The is the second and final progress report of the Workgroup based on its statutory direction. The Workgroup has been in place since September of 2005, and has been made progress on its statutory goals, under the coordination of Patricia Huschle, Provider Liaison, of this Office. It has proven to be a promising means of simplifying and standardizing some administrative interactions between professional providers and health plans. The workgroup will continue its work based on priorities identified by the legislature and the Office of the Health Insurance Commissioner.

Copies of relevant materials are attached. If you desire further information, please do not hesitate to contact this office.

Sincerely,

Christopher F. Koller
Health Insurance Commissioner

Cc: Senator Hanna Gallo, Rep. Peter Lewiss, Marie Ganim, Patricia Huschle,
Members of the Professional Provider Health Plan Work Group

Attachments

**The Professional Provider-Health Plan Work Group
Subcommittee to the Health Insurance Advisory Council
Progress Report
May 1, 2007**

The Healthcare Reform Act of 2004 § 42-14.5-3 (d) required the creation of a subcommittee to the Health Care Advisory Council known as the Professional Provider-Health Plan Workgroup (“Workgroup”) to address specifically identified areas for administrative improvement.

This subcommittee has been charged with developing a plan to implement the following activities:

(i) By January 1, 2006, a method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

(ii) By April 1, 2006, a standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

(iii) By September 1, 2006, a uniform health plan claim form to be utilized by participating providers;

(iv) By March 15, 2007 a report to the legislature on proposed methods for health maintenance organizations, non-profit hospital or medical service corporations to make facility specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinician or physician practices in establishing the most appropriate cost comparisons.

(v) By December 1, 2006, contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; and

(vi) By February 1, 2007, a uniform process for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles.

The Workgroup was established in November 2005 and is comprised of professional provider and hospital representatives, billing agents, physician group leaders and the three major Rhode Island Health Plans: United, Blue Cross and Neighborhood Health Plan. The members are: Christopher Dooley- W&I PHO; Craig Syata-HARI; Lorraine Roberts- Lighthouse MD; Paul Carey-RI Urological Specialties; Joel Kaufman M.D.- Lifespan/Physicians PSO; Jean Amaral- Care New England. Health Plan representatives

varied by subject matter. Patricia Huschle, Provider Liaison for the Office of the Health Insurance Commissioner, chairs the group.

In March 2006 the OHIC presented a progress report detailing the workgroups efforts on activities related to items (i) and (ii) above. This report summaries the remaining activities. A copy of the Workgroup's Charter is attached, as are the final reports for each of the items identified.

(iii) Uniform claim form

For professional services the CMS 1500 form is considered the industry standard claim form. HIPAA further defines standards for electronic submission of this form. The workgroup agreed there are other administrative activities by health plans and providers where simplification and standardization would yield greater benefits.

The information health plans require on the CMS form varies slightly due to different claims processing systems. Since the logic of plans' claims systems are unique, complex and proprietary, it is not possible to standardize these form requirements short of reducing the number of health plans and payers in the system.

Health plans should be expected to communicate their specific claims submission requirements including timing of updates based on CPT standards and overview of any claims editing logic to providers on a regular basis. This expectation could be articulated in the health plans/provider contract and communicated through the provider's sections of the plans' web site. The workgroup did not attempt to establish more specific standards for these communications.

Providers for their part should be expected to stay abreast of these changes in claims logic, billing standards and coding terminology and update their billing processes to reflect them.

At the direction of the workgroup, the local health plans have agreed to keep the OHIC informed of any claims system changes that may result as the revised 1500 form becomes operational in 2007. In addition, OHIC will monitor the plans' claim processing trends under the new prompt processing regulations.

(iv) Cost and Quality Transparency

The Workgroup began meeting in October 2006 to discuss the intent of the statutory language for this activity. In addition to the added workgroup responsibility, the revised statute expanded the responsibility of the Director of Health to add "licensed health care providers" to the list of health care entities for whom it is currently required to report quality performance measures. The group discussed both of these statutory revisions and how they interrelate. The workgroup acted with the understanding that the overriding objective is to have health plans make provider cost and quality information available and accessible to consumers via their web sites.

The group understood that consumers with high deductible health plans will have a greater out-of-pocket responsibility and need better information on cost and quality in order to make the most informed choices. The group clarified that for purposes of this initiative, the definition of cost is what the plan pays to contracted provider, not the billed charge for the service. It is this amount that those consumers with high deductible plans will need to pay.

At the first meeting the group agreed to the following:

- Cost information and quality information should be reported together to be most useful to the consumer
- The group should not attempt to define/re-define quality
- Quality data is most valid if it is aggregated across all payers

The group agreed that until the DOH has established quality reporting at the ambulatory provider level, cost information should be reported in ranges of cost or averages within zip codes. This cost information may be posted in advance of public quality information being available. Once DOH quality information is available, the plans would be required to report cost and quality information at the provider level.

Recommendations for Cost Reporting

- The subcommittee recommends that the health plans' post the allowable (contracted) cost information for a definitive list of high volume "discretionary" or "elective" high dollar services (e.g. MRIs, colonoscopies etc). This detail would include both the provider and any applicable facility or technical costs. The list of services for which cost information will be available is appended to this report.
- Those services identified above will be limited to those that have an allowable amount between \$100 and \$2500. Services that are below \$100 may be too inexpensive to be significant to a consumer's decision making and services over \$2500 will most likely exceed the deductible.
- For a given service, a member could look up the allowable cost range for that service. Then the providers performing that service could be listed with an indicator as to that providers' cost relative to the posted range.
- Providers represented expressed concern that all the cost information be qualified, especially information that the costs are averages and may vary based on particular patients' medical needs and that the place of services are not all the same in terms of the scope of care readily available at each location. The group agreed to include some standard language to be posted along with cost data on the plans' web sites.

Recommendations for Quality Reporting

The workgroup believes that best information for reporting professional provider quality is aggregated information across all payers in the state and is supportive of the establishment of a statewide database and reporting mechanism that incorporates all paid claim and other collected practice information. The group envisions that this responsibility will fall to the Department of Health under its new responsibility to report on professional provider quality.

Since there are a number of organizations that require or will require providers to report information, it was agreed that anything that DOH does should “piggy-back” on those requirements rather than requiring any additional provider reporting. The quality subcommittee discussed the merits of existing standards for measuring professional provider quality, specifically the AMA and NCQA programs.

The workgroups’ recommendation to the Department of Health is included in the final report.

Summary

United currently has available a “cost estimator” that provides the estimated cost information for a number of services, both in- network and out of network benefit levels. United does not currently provide cost information at the provider level.

BCBSRI currently does not have any cost information available on its web site for consumers. BCBSRI will provide cost range information for the identified procedures by October 1, 2007.

Both Blue Cross and United will provide at a minimum for the list of services identified, provider specific cost relative to the posted cost ranges by July, 2008. Blue Cross and United are encouraged to evaluate their provider networks and make available to consumers provider specific quality information that meets NCQA and other nationally recognized standards.

In addition Blue Cross and United will incorporate the RI Department of Health provider specific quality data along with their reported cost data within 6 months of such data becoming available.

(v) Dispute Resolution

The Health Plans reported that their appeals and dispute resolution processes are already outlined in provider contracts and administrative manuals. However the providers expressed dissatisfaction with the level of detail they get from the plans about their complaints and administrative appeals. Providers also stated that appeals might be taking longer than the timeframes specified by the plans.

The group agreed that providers need more readily accessible information about the processes that are available to them to resolve disputes or complaints when they are dissatisfied with a health plan decision. To the end, the health plans have created a grid to summarize the following: how the providers may submit an appeal or complaint (verbally or in writing), the timeframe to submit an appeal request, the timeframe for the plan to respond, the levels of review available and the company name and contact information should the provider be dissatisfied with the result. The final grid has been distributed throughout the provider community and is posted on the Office of the Health Insurance Commissioner website. It will be reviewed, updated and distributed every six months.

(vi) Real time benefit and enrollment information

Prior to convening the OHIC- Professional Provider Health Plan workgroup on this topic, the office met with Laura Adams and Judy Wright of the Rhode Island Quality Institute (RIQI) who are charged with establishing a statewide inter-operable health information data exchange. As a result of their work with physicians on system design, it was established that physicians expect that any integrated health information system in the future will allow the provider easy access to members' insurance data along with their clinical information. It was agreed that the Office would coordinate with RIQI on this initiative.

The group interpreted "real time" to be "on line web access with 100% up to date eligibility and benefit information", similar to how drug coverage information is available to the pharmacist at the point of service. Currently, BCBSRI and United do provide on line look up capability that provides detail on member effective dates, co-payments, deductibles, benefit coverage and other insurance information. NHPRI does post the RIticare benefit summary on line for provider review, but does not have web based member information available.

The group acknowledged that due to the dynamic nature of claims payment and enrollment processes, deductible and eligibility information is not always up to date on the on line systems, thereby causing some frustration in the provider community. Although BCBSRI and United both have on line systems, how the data is requested and returned to the provider is not "uniform" as identified in this statute.

The health insurance industry, like other industries, understands the importance in standardizing itself. The Council on Affordable Quality Healthcare (CAQH) is a nonprofit alliance of leading national health plans that is working to improve the administration of health care industry. CAQH has established the Committee on Operating Rules for Information Exchange (CORE) who is charged with establishing a set of operating rules that create administrative interoperability between health plans and providers. With these operating rules, queries of health plans could be more uniform, as would be their responses. This approaches the "uniformity" envisioned in the statutory expectation governing this groups' work.

At a national level, United is evaluating how they can proceed to obtain certification for itself and its many affiliates. The Blue Cross and Blue Shield Association nationally has been supportive of CORE efforts and BCBSRI is currently evaluating how it will proceed in this regard. The Office of the Health Insurance Commissioner will monitor efforts of the local plans to implement these standards.

Although the timeframes for development and implementation of national standards is not in the control of the local stakeholders the workgroup decided that it would not be cost effective to establish local standards for making this data available “real time”.

CONCLUSION

The Professional Provider Health Plan workgroup has completed the tasks as outlined in the Lewiss Gallo statute. It has proven to be a promising forum to address some problematic administrative interactions between professional providers and health plans. The group is interested and will continue to meet to identify and address provider issues not identified by the statute.