

MCCTF LEGISLATIVE PRESENTATION

02/20/13, by Barry Keene Co-Chair Clean Claims Task Force

Esteemed Committee members; It's about bricks.

Bricks aren't exciting shiny new things with great promise like:

- Accountable Care Organizations

- Insurance Purchasing Exchanges

- Integrated Electronic Medical Records

- All Payer Claims Data Bases (APCD)

- And many more of the leveraging tools emerging in health care

Bricks are mundane, indeed almost invisible. When we look at attractive architecture we see the whole, not the smallest of its pieces.

Yet who would deny that uniformity and integrity in its smallest pieces is absolutely crucial to the integrity of the whole?

Bricks are among the most basic and smallest pieces. What if bricks varied in their dimensions even slightly? It is easy to imagine the impact this would have before you got very far in constructing the building.

You would have to implement all sorts of adjustments, alterations and contingencies to get to a finished product and even that would be badly compromised.

Claim Edits and Payment Rules are the bricks of the entire medical claims processing system.

What the Clean Claims Task Force has been working diligently and productively on for the past 2 years is nothing short of our most basic administrative building blocks.

All of the emerging promising innovations will still be built with these bricks.

WHAT WAS THE GRAND GOAL? problem to be solved

1996 HIPPA Act adopted the CPT codes but not the guidelines and conventions.

Therefore payers were left to their individual interpretations of code business rules.

Reduce complexity of medical claims submission and thereby reduce administrative costs of claims processing.

HBMA & AMA data suggests \$10s of millions consumed w/out value added; rejections, resubmissions, appeals, over submissions. <90% ultimately paid

WHY A TASK FORCE WAS NEEDED

The full spectrum of stakeholders need to feel heard and in control

To accomplish the goal a broad band width of expertise and opinion is needed at a very technical level for considerable time.

It is difficult for competitors to convene voluntarily, anti-trust issues. This was a roadblock to the national initiative. AHIP feared Colorado Sunshine Law.

Our membership is a default national initiative, with members from more than 10 states.

Decision rules; consensus; 2/3 quorum prevents leaving a stakeholder group out

All our work is transparent and in the open

We address challenges as they come

WHAT WE HAVE ACCOMPLISHED

Established a common lexicon among stakeholders

Negotiated most rules definitions and ancillary parameters that will drive machine language of analytics

Self-funded 2 years (\$95,000) of process; approx. ½ foundation & ½ private stakeholders

Absorbed scope that was the national initiative earlier than statute timeline

PERIPHERAL BENEFITS OF OUR WORK

APCD data comparability across multiple payers improved

Point of care pricing and patient responsibility

More transparent value proposition in insurance exchanges

Build trust between providers & payers through transparency! Explain big deal

WHAT IS LEFT TO BE DONE

Raise funds for 2013

Finish Edit & Payment Rules committee definition work to drive analytics

Release Analytics RFP and procure vendor

Run analytics to create the common edit set

Conduct public trials and iterate edit set accordingly

Establish the DSR governance & sustainable business model

We are beginning a test of governance currently

Bring Fed H&HS aboard if possible