

ATTACHMENT D

Medical Clean Claims Transparency and Uniformity Act Task Force



Report to:

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

**MEMBERS OF THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE
COLORADO GENERAL ASSEMBLY**

**MEMBERS OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
COLORADO GENERAL ASSEMBLY**

**In accordance with § 25-37-106 (2)(d)(I), C.R.S. of the
Medical Clean Claims Uniformity and Transparency Act**

November 30, 2012

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INTRODUCTION

Colorado enacted House Bill 1332, the Medical Clean Claims Transparency and Uniformity Act (“the act”) in 2010. The legislation, which had broad bipartisan support, required the executive director of the Department of Health Care Policy and Financing (HCPF) to convene a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules (“standardized set”) to process medical claims. All payers having contracts in Colorado must use the standardized set and only the standardized set to edit claims starting January 1, 2015, for commercial health plans and January 1, 2016, for domestic nonprofit plans. The legislation did not provide state funding, instead it authorized the task force is to accept grants, donations and gifts.

The act established the Medical Clean Claims Transparency and Uniformity Act Task Force (“the task force”) and directed it to “submit a report and recommendations concerning the set of uniform, standardized payment rules and claim edits to the executive director of HCPF and the health and human services committees of the senate and house of representatives [of the Colorado General Assembly], or their successor committees, by November 30, 2012.”¹ A second report is due at the end of 2013.²

The report reviews the task force’s accomplishments and presents recommendations concerning the following, as prescribed by the act:

- Development of a base and complete standardized set of edits and payment rules;
- Establishment and operation of a central repository for accessing the rules and edits; and
- A schedule for commercial plans to implement the standardized set.³

The report is divided into four parts. The first outlines the act’s major provisions and reviews the problems addressed by, and goals of, the act. The second describes the task force, including its membership, the process it has used to address its charge, funding and staffing, and coordination with related efforts. The third reviews the progress the task force has made on development of the base and complete set of standardized claim edits and payment rules. The fourth discusses the

¹ § 25-37-106 (2)(d)(I), C.R.S.

² § 25-37-106 (2)(d)(III)(b), C.R.S.

³ § 25-37-106 (2)(d)(I), (III), (IV) and V(A), C.R.S.

groundwork the task force has laid concerning establishment and operation of a central repository of edits and rules. The final part presents the task force's recommendations.

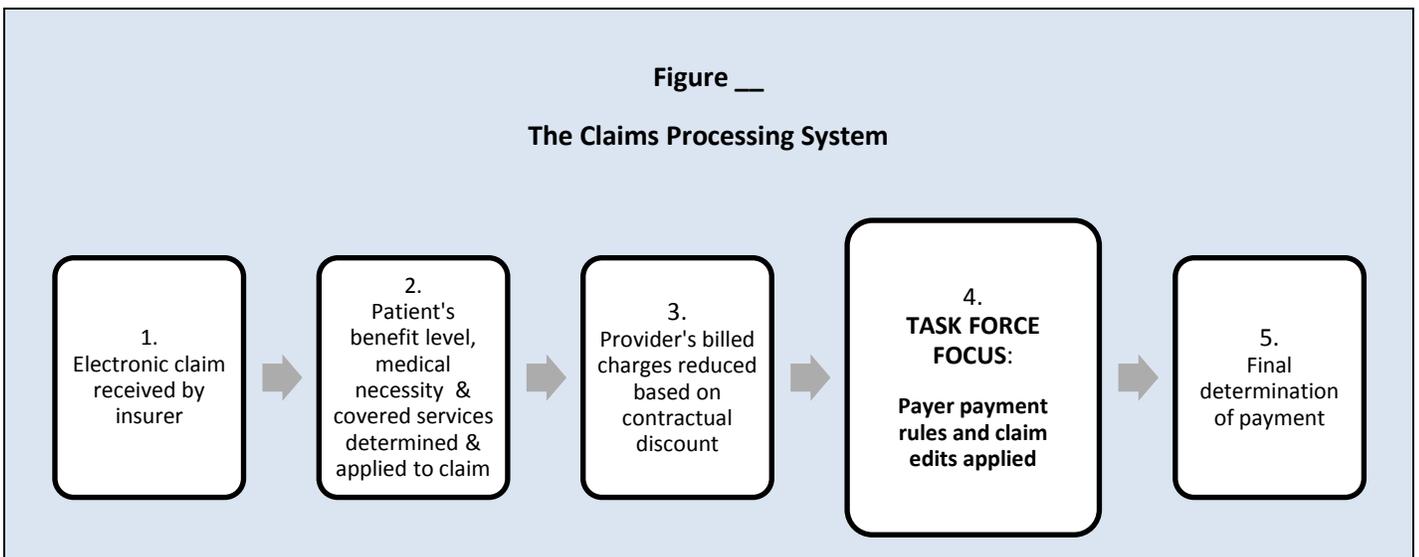
Key terms are defined when first used and are included in the glossary in Appendix __ . The first time a term is used and defined, it is shown in boldface.

I. THE MEDICAL CLEAN CLAIMS UNIFORMITY AND TRANSPARENCY ACT

The Medical Clean Claims Uniformity and Transparency Act is an important component of Colorado’s blueprint for health care for all Coloradans. It is part of the effort to make health insurance more transparent and affordable. It promises to reduce unnecessary administrative costs by simplifying the health care billing, payment and claims reconciliation process.

A. Key Provisions

The act calls for development of a standardized set of payment rules and claim edits to process claims for care delivered in Colorado (see Appendix ___ for a copy of the act). **Payment rules and claim edits** are adjustments by payers to the procedure codes physicians use to describe and bill for services that result in payment for some codes, a different code or a reduced or modified code. They are part of the process payers use to determine whether a particular claim for payment should be paid and at what level. Figure ___ describes the process and highlights the stage in the process that is the focus of the act. The act does not apply to adjustments based on fraud or abuse or a finding that a procedure is not medically necessary or not covered by the patient’s health benefit plan. In addition, it does not limit contractual arrangements or terms negotiated between providers and payers, including fee schedules.



The act distinguishes between two types of rules and edits: a base set and a complete set. The **base set** consists of rules and edits drawn from national industry sources listed in the act (e.g., the National Corrective Coding Initiative and Medicare physician fee schedule). The **complete set** includes the base set plus edits and rules for health services involved in a medical claim that are not encompassed by the national industry sources.⁴

The act establishes a task force appointed by the executive director of HCPF that is responsible for establishing the standardized set and making recommendations concerning how the set will be implemented, updated and disseminated. Part II describes the task force and its duties.

The act requires any person or entity that contracts with a health care provider in Colorado to comply with the act and include the provisions required by the act in the contract. This includes not only commercial health plans but also third-party administrators of self-insured health plans that have contracts with providers in Colorado.⁵ Enforcement of the act is by private right of action.

The act does not apply to Medicaid and Medicare. These programs use their own set of rules and edits that are the same for both government programs, with a few state-specific exceptions. The rules and edits are defined by the Centers for Medicare and Medicaid Services (CMS). While the act does not apply to Medicaid and Medicare, it does direct the task force to look to the same rules and edits used by these programs as a main source for creation of the standardized set. It also requires a representative from the Colorado Medicaid program to sit on the task force.

Once the standardized set is established and implemented, no other rules or edits can be applied to modify payment of claims, except as provided in the act.

The act requires the task force to submit reports and recommendations, and payers to come into compliance with the act, by certain dates (see Table __). It provides for the deadlines to be delayed a year if a national collaborative effort overseen by the federal Department of Health and Human Services (HHS) and consisting of a diverse group of stakeholders has not reached consensus on a complete or partial set of standardized edits before November 30, 2012. This report refers to the collaborative effort as the **voluntary national initiative**.

⁴ §25-37-106(2)(c)(I), C.R.S.

⁵ The act defines **payers** as “persons or entities that pay for health care services” § 25-37-106(2)(a)(I)(B),C.R.S.

Table __	
Statutory Deadlines	
Activity	Deadline
If, at the time the Task Force submits its report, the voluntary National Initiative <u>has</u> reached consensus on a complete or partial set of standardized payment rules and claims edits:¹	
<ul style="list-style-type: none"> • The task force shall submit a report and recommendations concerning the standardized set to HCPF and the Legislature’s health and human services committees. The report shall: <ul style="list-style-type: none"> – Make recommendations concerning the implementation, updating, and dissemination of the standardized set, including who is responsible for establishing a central repository for accessing the rules and edits set and enabling electronic access, including downloading capability, to the set; and – Include a recommended schedule for payers that are commercial health plans to implement the standardized set. 	Nov. 30, 2012
<ul style="list-style-type: none"> • The task force shall present its report and recommendations to a joint meeting of the Colorado House and Senate Human Services Committees. 	Jan. 31, 2013
<ul style="list-style-type: none"> • Commercial plans shall implement the standardized set within their claims processing systems. 	Jan. 1, 2014
<ul style="list-style-type: none"> • Domestic, nonprofit health plans shall implement the standardized set within their claims processing systems. 	Jan. 1, 2015
If, at the time the Task Force submits its report, the voluntary National Initiative <u>has not</u> reached consensus on a complete or partial set of standardized payment rules and claims edits:¹	
<ul style="list-style-type: none"> • The base set of standardized rules and claim edits shall become the standards used in Colorado by payers and health care providers.² 	Nov. 30, 2012
<ul style="list-style-type: none"> • The Task Force shall continue working to develop a complete set of standardized edits and shall submit a report and may recommend implementation of a standardized set to be used by all payers and health providers. 	Dec. 31, 2013
<ul style="list-style-type: none"> • Payers that are commercial plans shall implement the standardized set within their claims processing systems. 	Jan. 1, 2014
<ul style="list-style-type: none"> • Payers that are domestic, nonprofit health plans shall implement the standardized set within their claims processing systems. 	Jan. 1, 2016

B. Problem Addressed by the Act

The main problem the act addresses is the widely different edits and rules used by payers to process the same claim, which adds to health care costs. The example below illustrates the problem.

Bill, Tom and Mary have the same doctor but different insurance companies. Their doctor gave each of them an annual physical exam, cleaned their ears, and billed their companies for services rendered. Bill's carrier said ear wax cleaning was just part of the annual checkup and denied the charge for the ear cleaning. Tom's company said the ear procedure should have been under a separate visit and did not recognize the procedure as part of an annual exam. Mary's company said the cleaning was done as part of an annual physical and paid for the procedure at a reduced rate. Each company is employing different edits to process a claim for the same services.

Insurance companies use millions of claim edits that are specific to them, known as **proprietary edits**. The American Medical Association (AMA) estimates that there are more than two million proprietary edits currently being used by payers to deny physicians' claims.⁶ Most physicians have contracts with more than 20 payers, many with multiple products.⁷ Physician billing requires tracking the specific rules of each. The plethora of different payer processing rules increases the potential for provider and payer claims processing errors, resulting in additional appeal process costs. One study estimated that the claims payment system costs physicians an estimated 10 percent to 14 percent of revenue just to get paid.⁸

Processing the same claim differently has implications for the degree to which a particular plan is adequate to meet an individual's needs and makes it difficult to compare the value of different plans. It may result in higher out-of-pocket costs under one plan than another, something not captured in descriptions of patient co-pays, co-insurance, etc. This would occur, for example, if under one plan the doctor encourages the patient to make two visits for two procedures because that is the only way he could get paid for both under one of the plans, resulting in a second patient co-pay for the second visit. Thus coverage may not be as adequate on a particular plan as what the patient thought. Standardized claims processing rules eliminate this problem.

⁶ American Medical Association Advocacy Resource Center, *Discussion Paper: State Health Insurance Exchanges* (Chicago: AMA, 2011); <http://www.ama-assn.org/resources/doc/arc/exchange-issue-brief.pdf>

⁷ American Medical Association, *Standardization of the Claims Process: Administrative Simplification White Paper* (Chicago: AMA, June 22, 2009); www.ama-assn.org/resources/doc/psa/admin-simp-wp.pdf.

⁸ James G. Kahn et al., "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians and Hospitals, *Health Affairs*: 24 no. 6 (2005), 1629-1639; <http://content.healthaffairs.org/content/24/6/1629>.

Evidence exists for the value of a uniform, transparent, standardized set of payment rules and edits. Medicare found that use of a standardized set for Medicare claims reduced payment errors.⁹ A United Healthcare pilot found that real-time claims adjudication, which allows a claim to be submitted to an insurer and settled before a patient leaves the office, reduced accounts receivable by 13 percent and decreased the average time to collect insurer and patient payment from 45 days to six at one practice—substantially reducing claims payment administrative costs.¹⁰ This is possible only with a standardized edit set.

C. Goals of the Act

By establishing a uniform, standardized way to edit claims that must be used by all entities paying claims in Colorado, the act seeks to:

- Eliminate the excessive costs of the current claims submission, payment and reconciliation process;
- Reduce administrative redundancies;
- Remove a large element of the ambiguity and complexity of the claims process, thus enabling the adoption of point-of-service pricing;
- Make it easier for all stakeholders (including patients with high-deductible plans) to determine their financial obligations both pre- and post service;
- Promote greater payment transparency across payers; and
- Save Coloradans an estimated \$80 million annually in costs related to claims processing.¹¹

According to Marilyn Rissmiller, task force co-chair and senior director, Colorado Medical Society,

The end goal is to make health care transactions work as well as the banking industry. To do that you have to have standards that everybody follows. The ideal would be you go to your doctor, swipe your insurance card and it tells you exactly how much you owe for that visit and how much your insurance company is going to pay, or if they're not going to pay.

⁹ [NEED CITATION]

¹⁰ <http://www.ama-assn.org/amednews/2009/08/17/bil20817.htm>. [GET ORIGINAL SOURCE CITE]

¹¹ Estimate calculated as follows: 1) More than \$1.86 billion in claims are denied annually by payers due to proprietary edits. 2) Colorado's estimated share, based on Colorado's population, is \$31 million. 3) Estimated 86% of denied claims are paid on appeal. 4) AMA estimates each appeal costs providers \$100 - \$250. 5) AMA estimates claims processing accounts for 10% - 14% of all practice revenue. 6) Estimated \$800 million spent in Colorado. 7) If 10% claims cycle cost eliminated, savings is \$80 million per year.

Barry Keene, co-chair of the task force, says of the act, “by creating uniform medical claim edits and payment rules to be shared among all payers in Colorado, both payers and providers will be unburdened of tens of millions of dollars of administrative redundancy and outright waste, which can be redirected toward reducing the actual cost of care.”

II. THE MEDICAL CLEAN CLAIMS UNIFORMITY AND TRANSPARENCY ACT TASK FORCE

A. Members

The task force has 23 members appointed by the executive director of HCPF (see Appendix ___ for a list of members and alternates, titles and affiliations). The act requires the task force to include representatives from all industry segments directly affected by the act (see Table ___).¹²

Table ___	
Task Force Members by Category of Appointment	
I. Health care providers or employees thereof from a diverse group of settings	
<i>James Borgstede, University Physicians, Inc.</i>	<i>Jill Roberson, Denver Health & Hosp. Authority</i>
<i>Kathy McCreary, Univ. of Colorado Hospital</i>	<i>Ryshell Schrader, Community Reach Center</i>
II. Persons or entities that pay for health care services (“payers”)	
<i>Helen Campbell, United Health Group</i>	<i>Lori Marden, Rocky Mountain Health Plans</i>
<i>Valerie Clark, Kaiser Permanente</i>	<i>Frederick Tolin, MD, Humana</i>
<i>Mark Laitos, CIGNA</i>	<i>Beth Wright, Anthem Blue Cross Blue Shield</i>
III. Practice management system vendors	
<i>Mark Rieger, NHXS</i>	
IV. Billing and revenue cycle management service companies	
<i>Kim Davis, University Physicians, Inc.</i>	<i>Mark Painter, Relative Value Studies, Inc.</i>
<i>Amy Hodges, BloodHound Technologies</i>	<i>Robin Weston, Centura</i>
V/VI. Government payers	
<i>Carol Reinboldt, Health Care Policy & Financing</i>	
Other persons with expertise	
<i>Tom Darr, Optuminsight</i>	<i>Douglas Moeller, McKesson Health Solutions</i>
<i>Catherine Hanson, American Medical Assn.</i>	<i>Marilyn Rissmiller, Colorado Medical Society</i>
<i>Barry Keene, Keene Research & Dev.</i>	<i>Wendi Healy, Correc. Hlthcre Co’s/ CMGMA</i>
<i>Marie Mindeman, American Medical Assn.</i>	

¹² § 25-37-106 (2)(a), C.R.S.

B. Process

The task force held __ meetings between December 2, 2010 and November 14, 2012. __ were in-person meetings, the balance were conducted by conference call. Agendas and minutes for all meetings are on the task force website, <http://www.hb101332taskforce.org>. At its first meeting, the task force adopted a consensus decision making process.

Early on, the task force developed a set of guiding principles (see Table __). At its core is administrative simplicity—consistency, transparency, standardization and improved system

Table __
Guiding Principles
<p>Goal: Administrative Simplification</p> <ul style="list-style-type: none"> • Improved system efficiency <ul style="list-style-type: none"> ○ Appropriate system savings ○ Reduced administrative burden • Transparency <ul style="list-style-type: none"> ○ Access to all edits in a machine-readable format ○ Access to the source and rationale for every edit • Standardization • Consistency <p>Task Force Process: Fair and Open</p> <ul style="list-style-type: none"> • Act responsibly on behalf of stakeholders <ul style="list-style-type: none"> ○ Consider costs ○ Consider business model implications for stakeholder organizations ○ Understand impact and potential harm ○ Report identified risk to stakeholders • Value added—be clear about benefit of a changed edit, selection of one as opposed to another • Use sustainable sources of edits for the final edit set • Transparent sources—use nationally recognized sources, don't create new edits • Stay cognizant of scope parameters <ul style="list-style-type: none"> ○ Scope of charge does not include government programs ○ Scope does not include medical necessity, fraud, abuse or utilization review edits <p><i>Source: Minutes of January 25-26, 2011 task force meeting</i></p>

efficiency. The task force also committed to a fair and open process that, among other things, tries to accommodate the top concerns of stakeholders at the table (see Table __).

The task force has accomplished most of its work through four committees that have met by conference call. Appendix __ lists the members of each committee. Some committees include additional non-task force members with relevant expertise. The Edit Committee is responsible for identifying definitions and edits for the base set. It has met once every two to three weeks for the past two years. The Professional Society Committee serves as a liaison between health professional societies and the task force. It has met as needed, reaching out to the professional societies to collect information, solicit advice, and alert them of the task force’s work. The Payment Rules Committee is responsible for developing pricing rule recommendations. Since it was formed in July 2012, the Payment Rules Committee has met every other week. The Data System Repository Committee is responsible for examining how the standardized set will be maintained and sustained and has met monthly since early 2011.

Table __
Top Stakeholder Concerns
<ul style="list-style-type: none"> <p>• Providers Reduce providers’ administrative costs by developing a uniform, standardized set of edits used by all payers to ensure correct coding of procedures and services that are machine-readable for loading into a provider practice management system.</p> <p>• Payers Implement the act in such a way that it does not increase the cost of members’ care.</p> <p>• Vendors Maintain ability to work with provider and payer clients to meet their needs and protect vendors’ intellectual property.</p> <p>• Consumers Facilitate point-of-service pricing, reduce the amount of premium going for claims processing, and not increase premiums.</p> <p><i>Source: Minutes of December 28, 2011, task force meeting</i></p>

C. Funding and staffing

Funding for the task force comes from monetary and in-kind gifts, grants and donations, as authorized by the act. The task force receives no state funds. The Bell Policy Center was designated as the custodian of funds for the task force. Between November 2010 and September 2012 the task force raised more than \$85,000 in grants, gifts and donations from the following organizations: the AMA, Anthem Blue Cross and Blue Shield, Bloodhound Technologies (Verisk Analytics), Colorado Medical Group Management Association, Colorado Hospital Association, Colorado Medical Society, Community Reach Center, Keene Research and Development, NHXS, Rocky Mountain Health Plans, RT Wellter & Associates, The Colorado Health Foundation, The Colorado Trust, University Physicians, UnitedHealth Group, Wellpoint and Western Nephrology.

The task force is soliciting funding for 2013. It has had conversations with several Colorado foundations and federal health agencies and continues to pursue contributions from stakeholder groups. Funding for the task force's data analytics (see part IV) is included in Colorado's State Innovation Model Grant proposal to the Centers for Medicare and Medicaid Services (CMS). The purpose of these grants is to improve health care system performance. The grants are competitive; award announcements will be made in December 2012.

Most of the task force's work has been conducted by the members themselves. In addition to participating in an average of two to three task force and committee meetings each month, members have provided data, conducted data analyses, supplied materials for task force consideration, solicited grants and donations, and consulted with, reached out to and briefed other interested parties, including the major provider specialty societies. Part-time, contract staff have been engaged to organize committee and task force meetings and take minutes; facilitate task force meetings and draft reports; and write a request for information.¹³

D. Coordination with Other Efforts

The task force has kept abreast of, and coordinated its efforts with, other national and state groups working on similar issues. Barry Keene made a presentation to the national Workgroup on Electronic Data Interchange (WEDI) in October 2011 and to the National Committee for Vital Statistics (NCVHS) in November 2011. Both groups are exploring claim edit development, transparency and uniformity. The task force has received briefings on initiatives in Vermont and Washington and a representative

¹³ See section ___ for a description of the request for information.

from the Minnesota Administrative Uniformity Committee has participated by phone on several task force meetings.¹⁴

The task force has also coordinated its efforts with other cost containment and payment reform programs in Colorado. An important related program is Colorado's recently launched All-Payer Claims Database (APCD).¹⁵ The ability to make meaningful cost comparisons across multiple payers based on claims data submitted to the APCD would be greatly enhanced if all payers used the same claim edit set and payment rules. Another program is the Colorado Health Benefits Exchange. A primary purpose of the exchange is to allow consumers to compare supposedly equivalent products and capture a value proposition based upon actuarial value (a summary measure of a health plan's generosity) versus premium. But without a uniform set of edits and payment rules being applied to claims, it cannot present a complete picture. Non-uniform edit and payment rules affect the direct comparability of values.

E. Summary of Major Organizational Accomplishments

The task force:

- Adopted guiding principles that emphasize transparency, improved system efficiency, standardization and consistency, and a fair and open process for developing and updating the standardized set;
- Secured funding for the first two years of operations;
- Identified major stakeholder concerns;
- Formed four working committees, which cumulatively held more than 200 hours of meetings in 2011 and 2012; and
- Established relationships with other national, state and local groups working on administrative simplification and confirmed that, with respect to creating a standardized set for processing all commercial claims, Colorado is the leader.

¹⁴ The Minnesota Administrative Uniformity Committee (AUC) is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies, working to standardize, streamline, and simplify health care administrative processes.

¹⁵ For more information about Colorado's All-Payer Claims Database, go to the APCD's website, <http://www.civhc.org/CIVHC-Initiatives/Data-and-Transparency/All-Payer-Claims-Database.aspx/>.

III. TASK FORCE ACCOMPLISHMENTS—BASE AND COMPLETE STANDARDIZED SET

The task force is responsible for developing a standardized set of payment rules and claim edits to be used by all private sector payers. Table __ [TO BE INSERTED] shows an example of the application of a claim edit and a payment rule to a claim. The act requires the base set to be identified through existing national industry sources. It specifies 16 edits (e.g., unbundle, mutually exclusive, global surgery days, bilateral procedures) the task force should consider standardizing. For health care services that are not encompassed by the base set, the act directs the task force to participate in the voluntary national initiative or work with national experts. The sections below describe the progress the task force has made responding to these directives. It also reviews challenges and developments over the past two years that have affected the workload of, and timeline for, completing the task force's work.

A. Progress Report

Over the course of several meetings, the task force worked out a process for developing the standardized set (see Table __). Among other things, the process emphasizes transparent rationales and reliance on existing edits, consistent with industry trends, as noted in a 2006 white paper by Ingenix,¹⁶ an information and technology-enabled health services business:

*In the past, claims processing vendors competed on proprietary edits based on their interpretation of coding and billing regulations. But with the growing demand for standards and accountability, today's best practice is to base edits on industry-recognized third-party sources, and to clearly document the sources and explain edits in language that providers and patients can understand.*¹⁷

As discussed in part II, the task force established four committees to conduct the bulk of its work and make recommendations to the task force. Three of the committees are involved in different aspects of developing the standardized set, which is the subject of this part III. They are the Edit, Payment Rules and Professional Society Outreach Committees.

¹⁶ Ingenix is now Optuminsight, part of Optum.

¹⁷ Ingenix, *Six Best Practices of Claims Editing*, White Paper (Eden Prairie, MN: Ingenix, 2006); <http://www.optuminsight.com/~media/Ingenix/Resources/Downloads/0711027ClaimsEditingProfessionalWP.pdf>

Table __
**Task Force Process for Developing a Standard Set of
 Claims Edits and Payment Rules**

The task force adopted the following decision rule for selecting, adding, deleting, modifying and reconciling conflicting edits:

The Context

The task force is responsible for developing a standardized set of payment rules and claim edits to be used by all payers. In developing the standardized set, the task force shall consider standardizing a list of types of edits listed in the act. The base set of rules and edits shall be identified through existing national industry sources.

Creating an Initial Draft of the Complete Edit Set

- a. For the types of edits listed in the act, develop definitions, including purpose, rationale and guiding principles.
- b. Use national sources and third-party vendor edits that are in machine-readable format to be determined; are not benefit-related (e.g., Medicare G codes); and either from national sources or are sourced to a national source.
- c. For a given edit, if there is only one national industry source with a definitive edits that fits the definition/rationale, use that edit.
- d. If there are multiple national sources (e.g., HCPCS and a national medical specialty society) for the same definitive edit (e.g., age), and if all are consistent with the definition/rationale for the edit under consideration, and if the edit is not benefit-related, then establish and use a hierarchy agreed upon by the Task Force for each edit (e.g., CPT, then NMSS, HCPCS, then NCCI, etc.).
- e. For a given edit, if there is no definitive national source edit and if there is only one third-party that has done sourcing for that edit and if the third party edit fits the definition/rationale, then include the edit in the initial draft of the complete set.
- f. For all other edits , where there is multiple sourcing for the same edit, select edits to get to the initial draft of the complete set using the national hierarchy approach described above to select among edits developed through third-party sourcing (e.g., for edits developed through sourcing, start with edits based on CPT materials, then NMSS, etc.)

continued

Table __ (continued)

Public Comment on, Review and Refinement of, and Finalizing the Initial, Complete Edit Set

- a. Draft initial set available for testing, review and comment by vendors, payers, providers and others. Make it possible for interested parties, including the task force itself, to run various scenarios against the initial draft complete edit set.
- b. Require recommendations from the public (including national medical specialty societies) for additions, deletions, and modifications to the initial draft complete set to be based on a claim that: the change better fits the definition/rationale; an edit does not work for a commercial population; the original source for an edit objects to how sourcing by a third-party was done; or an edit is altogether missing from, but does not duplicate an edit, in the set.
- c. After considering comments and recommendations from the public and weighing the results of the Task Force's own modeling and testing, finalize the initial complete edit set.

Source: January 24, 2012, Task Force meeting

1. Edit Committee

The Edit Committee is tasked with examining the edits and associated rules, concepts and methodologies contained in national sources and national source guidelines; assessing their applicability to private health plan claims processing; and making recommendations to the task force on the claim edits to be included in the standardized set.

One of the committee's first tasks was to look at the system of edits Medicare uses—the National Correct Coding Initiative—to determine if it is robust enough to use for private sector claims processing. The **National Correct Coding Initiative (NCCI)** is a system used to promote consistency in claims coding and to control improper coding leading to inappropriate Medicare claims payments for professional services. (See Appendix __ for a discussion of what codes are, examples of how coding is done and how coding affects what providers are paid and how much a patient will have to pay for services rendered.) The Edit Committee, with input from the Professional Society Outreach Committee, also wanted to find out if the specialty societies were comfortable with the process NCCI uses to develop and update its edits and rules set. It concluded that the edits in the system are robust enough to cover commercial claims (e.g., they include sufficient pediatric and ob/gyn edits and rules despite being designed primarily for a Medicare population). The Professional Society Outreach Committee found that the specialty societies are comfortable with how the edits are developed, with a few exceptions.

The Edit Committee has nearly completed the difficult process of developing consensus definitions for the types of edits listed in the act. It has also begun to identify and define edits that are not mentioned in the act but that are in use by the industry. The definitions will drive decisions about which edits for the same procedure will be included in the standardized set and thus their exact wording is important. The AMA, as well as other major stakeholders, has been active in reviewing and commenting on the definitions as they have been drafted. Appendix __ lists the edit types listed in the act along with the definitions recommended by the Edit Committee and approved by the task force.

The committee solicited and has defined additional types of edits that need to be considered and defined to arrive at a complete standardized set. As of ____, additional types of edits included ____. Appendix __ describes the additional edit types and definitions the committee has agreed on, including those that have been approved by the task force.

The committee is developing a list of out-of-scope edits. The task force defines **out-of-scope edits** as edits that are not within the task force's purview because they are addressed as part of other edit types already included in the standardized set; are part of a different stage in the claims processing system; are used by the payer to administer variations in payment or benefit based on either the provider's or member's contract; or are Medicare or Medicaid-specific.¹⁸ The out-of-scope edits identified by the Committee as of ____ are shown in Appendix __. These edits are in addition to edits for medical necessity, fraud and abuse, which the act specifically identified as not part of the set of edits to be standardized.

In the course of its work, the Edit Committee has identified several payment rule issues and referred them to the Payment Rules Committee.

The Edit Committee has been working through a number of challenging issues. Several of the most difficult are listed below by way of example.

- Issue: Should the task force include in the standardized set an edit that would say sometimes pay, as opposed to always or never pay?

Resolution: In general, no. Part of the task force's charge is administrative simplification. In the automated claims processing world, "sometimes" would require manual intervention.

¹⁸ Administrative edit types were not contemplated by the legislation as many of them are in place at the "front-end" or early in the claims processing to ensure that all of the information required to process the claim has been provided, or to identify a claim that has already been processed. Pricing file or provider file related edit types are used to direct the claims processing to specific payment amounts for certain services, these are usually related to either scope of licensure or pricing differential based on the provider's credentials.

However, each issue would need to be evaluated individually taking into consideration the impact on all stakeholders in terms of administrative burden, costs, and variation from existing processes.

- Issue: Should the task force use national sources that are not updated regularly?

Resolution: It should consider them but also work with the sources to see encourage them to update their guidelines on a regular basis (i.e., at least once every year or two).

- Issue: Can a payer decide not to use an edit in the standardized set and simply process the claim as is, which could be more beneficial to the provider?

Resolution: No, as one task force member remarked, “If we don’t take this opportunity to push for uniformity and standardization, we miss the real chance to reduce administrative costs associated with filing and processing claims.” He went on to say, “To just have a repository of approved edits with the choice being left up to the health plans to use or not use them does nothing to reduce the variation, which is where the expense lies for a practicing physician.”

2. Payment Rules Committee

The Payment Rules Committee is responsible for developing and making recommendations to the task force concerning pricing rules. **Pricing rules** are rules applied by a health plan or its agent to reduce or increase, but not to reduce to \$0, the agreed fee schedule amount. An example of where a pricing rule might be applied is when several procedures are done at the same time on the same patient. In most cases, the payer will apply a payment rule that reduces by a specified percentage the amount it will pay for the second and subsequent procedures, called a **multiple procedure reduction**. The total payment is less than what it would be if the procedures were performed at different times (e.g., a month apart).

The task force established the following guidelines for the committee’s work:

- The purpose of pricing rules is to move toward a uniform, transparent practice in the marketplace.
- The Medicare pricing rules based on the resource-based relative value scale (RBRVS)¹⁹ are the recommended starting point of the discussion for the development of a Colorado payment

¹⁹ The resource-based relative value scale is a system of payments to physicians for treating Medicare patients that takes into account the work done by the physicians, malpractice insurance and practice expenses, including staff salaries, overhead, supplies, and equipment.

rule standard because they are already widely used by both public and private payers and maintain the relativity of the Medicare RBRVS.

- Pricing rules should not include budget restraints, political influences or benefit limitations. The task force understands the need for cost containment, but like the edit type “utilization review” that can be used to control costs by limiting the diagnoses or frequency of specific services, these fall outside of the scope of work for the task force and should not be included as part of a standardized set of edits and payment rules.
- The pricing rules must not affect payers’ ability to negotiate an agreed upon contracted rate with physicians and other health care providers for the performance of medical procedures and services. The pricing rules only standardize the way payment rules are applied to those negotiated fee-schedules.

The committee is using the following process to develop a recommended set of payment rules: 1) compile CPT and HCPCS modifier definitions and guidelines; 2) examine the definitions and how they fit with the work of the Edit Committee and requirements of the act; 3) select payment rules that are consistent with the guidelines for the Payment Rules Committee’s work and explain the rationale for the recommended rules; and 4) translate the rules so they can be implemented into a computerized medical claims processing system (this last step to be done by a contractor).

The committee is examining the effect of modifiers in the **Current Procedural Terminology (CPT)** and **Healthcare Common Procedure Coding System (HCPCS)** on the types of edits listed in the act (e.g., multiple procedure reduction, assistant at surgery).²⁰ **Modifiers** are used in addition to a CPT code to add more information on the claim. They state special circumstances that may affect the amount the physician will be reimbursed. For example, a modifier may indicate unusual circumstances that made a procedure more complicated and may warrant additional payment or that led to a procedure being discontinued, which may not warrant full payment.

As of August 29, 2012, the Payment Rules Committee had compiled a list of 32 CPT modifiers and modifier definitions along with Edit Committee recommendations, Medicare (CMS) guidelines, and Payment Rules Committee comments (see Appendix ___). This list is being used by the Edit Committee to identify and define the HCPCS modifiers.

²⁰ The **Current Procedural Terminology (CPT)** code set is used to describe medical, surgical and diagnostic services. The **Healthcare Common Procedure Coding System (HCPCS)** are codes based on the CPT to provide standardized coding when health care is delivered.

3. Professional Society Outreach Committee

The Professional Society Outreach Committee serves as a liaison between the national specialty societies (e.g., American Academy of Pediatrics, American College of OB/Gyns, American College of Radiology) and the task force. It is responsible for assessing if public code edit and payment policy libraries meet the needs of national medical specialty societies and state medical associations by reaching out to and obtaining feedback from these groups. Keeping medical societies informed about the task force's work and soliciting their input is critical to the success of the task force. Providers want to be sure that the standard edit system is transparent, uniform, reduces unnecessary administrative costs and results in fair reimbursement. In August 2012, at the request of the committee, the AMA sent a letter to 122 national specialty societies and 50 state medical societies encouraging them to become involved in the task force's work. The letter also was sent to representatives of the AMA's Specialty Society Relative Value Scale (RVS) Update Committee. In October 2012, the Colorado Medical Society sent letters to the local specialty society representatives advising them of the task force's activities and soliciting their involvement through the Professional Society Outreach Committee. The committee now includes a Colorado practicing physician who is available to speak directly with other physicians about the task force and its needs.

The Professional Society Outreach Committee continues to raise awareness of the task force at the national level through specialty societies, as well as through the Relative Value Update Committee (RUC). The RUC is an important link between the CPT and Medicare's NCCI. The Committee has played a key role in getting specialty societies involved in discussions with the Edit Committee at critical times.

B. Unanticipated Challenges and Developments

Several unanticipated challenges and developments added to the task force's workload over the past two years and slowed progress. Three of the most significant are discussed below.

1. The task force determined that the base and complete set needed to be developed concurrently, not sequentially.

The act directs the task force to develop the base set by December 2012 and have a complete set ready by December 2013. This directive was based on two assumptions: 1) that the base set could be dealt with first, separate from work on the final complete set; and 2) that the voluntary national initiative would be working concurrently on the more comprehensive set. With respect to the first assumption, the task force found that development of the base set is inextricably linked to producing the complete set and it is inefficient to try to separate the two tasks. After a year of

study, testing and deliberation, the task force concluded that the best way to develop the standardized set is to do them concurrently, rather than developing a base set first and then adding to it to get to a complete set. The task force found many co-dependencies in the definitions of the edits. It decided it was not appropriate to limit thinking to the base set only when developing definitions for such things as sources, as they would have to be amended later when considering the more comprehensive set. Consequently, the more difficult issues surrounding the comprehensive set of edits must be considered up front. While it is accepted among task force members that this is the right decision, it does involve a larger task scope than was planned to be performed initially. With respect to the second assumption, the voluntary national initiative folded, as discussed next.

2. The voluntary national initiative folded.

The act makes several references to the voluntary national initiative. At the time the legislation was drafted, a group of national stakeholders that included providers and payers of note had begun discussions that looked promising. However, they were unsuccessful in getting America's Health Insurance Plans—a trade association of health insurance plans—to join the discussion. In time, after Colorado's task force was formed, the Initiative dissolved. Many of the people who were at the national initiative table have been appointed to the Medical Clean Claims Uniformity and Transparency Act task force. By default, the task force has become the national initiative, if not in name then in membership. Without a complete or partial set of national initiative edits to serve as the starting point for its work, the task force has had to spend more time developing a set of edits supported by all stakeholders.

3. The standardized set could not be developed manually.

The task force originally envisioned, and the timelines in the act assumed, that the base set could be developed manually or perhaps supplemented with simple spreadsheets and human operation from task force members. However, after investing a significant amount of time and effort, the task force concluded this approach was not workable. It determined that it needed to begin with the entire universe of edits currently used by payers, which requires an electronic repository to compile the different edits currently being used. This will allow the task force to make queries to select among the edits to establish the uniform edit set. The task force refers to this as **data analytics**.

4. Some of the edits in the Medicare NCCI edit set—the primary national industry source of edits—turned out not to be based on “correct coding” protocols but rather on benefit design features and policies specific to Medicare.

The task force wanted to gain a better understanding of the magnitude of these aberrancies without having to undertake an extensive manual review of thousands of NCCI edits. The task force had great difficulty engaging with the creator of the Medicare NCCI. Finally, the task force wrote a formal letter asking how it could locate all the codes and edits created specifically for Medicare. The response it received was that “identifying which edits are based on CMS payment policy . . . would be a tedious task. It could be done, but would take a great deal of work.”²¹ The task force also asked if it could get access to the rationale used to develop the NCCI edits and was told it could not: “[although each edit] is assigned a policy statement/rationale/edit criterion . . . [that] is available to claims processing contractors, it is not publically available.”

5. The need to use an electronic data analytics system to help develop the standardized set has meant the need for a larger budget.

The original task force budget was meant to cover basic expenses but did not anticipate the need for sophisticated electronic tools, in part because the task force thought the voluntary national initiative would be addressing many of the same issues. Part IV describes the data analytics tool and functionalities the tool needs to have for the task force to complete the process of developing the standardized set. The need to contract for data analytics work has required the task force to spend additional time on fund raising.

C. Summary of Major Accomplishments Concerning Development of the Standardized Set

- After extensive examination of the NCCI system and outreach to the national health professional societies, the task force decided the NCCI system is robust enough to use for private sector claims processing and, for the most part, the specialty societies are comfortable with how the edits are developed. This, however, does not mean the task force will adopt all the edits as there are other problems with some of them.
- Based on a thorough analysis of alternative options and debate on the wording of definitions of edits types, the task force has reached consensus on 15 of the 16 types of edits in the act and is working on the last one. These definitions will drive selection of the edits in the data analytics phase of the task force’s work.
- The task force has solicited and begun to define additional types of edits that need to be considered to arrive at a complete standardized set (see Appendix ___).

²¹ Correspondence from Niles Rosen, MD, medical director, National Correct Coding Initiative, to Barry Keene, co-chair, Medical Clean Claims Uniformity and Transparency Act Task Force, October 31, 2011.

- A list of out-of-scope edits and rules is under development.
- The Edit Committee has worked through a number of challenging issues, such as use of sometimes/always/never edits, use of national sources that do not update their guidelines regularly, and required use of all edits and rules in the standardized set.
- The Payment Rules Committee has compiled a list of 32 payment rule modifiers, definitions and any associate payment rules from several different sources and is working through the difficult process of finding consensus on which rules to use.
- A formal request for specialty society involvement has been made on behalf of the Professional Society Outreach Committee. The committee is ready to receive and facilitate input from these important stakeholders. Additionally, the committee will continue to reach out to key specialties as directed by either the Edit Committee or Payment Rules Committee to assist in their deliberations.

IV. TASK FORCE ACCOMPLISHMENTS—CENTRAL REPOSITORY FOR ACCESSING THE RULES AND EDITS (DATA SYSTEM REPOSITORY)

The task force is responsible for making recommendations concerning a central **data system repository** for accessing the standardized rules and edits. The act directs the task force's recommendations to address implementation, updating dissemination, and electronic access to the standardized set, including downloading capability. The task force has identified the following groups as the main data system repository users:

- Practicing providers and medical healthcare specialties;
- Health plan personnel who provide health care coverage and claims payment in Colorado;
- Third party vendors who use repository information to provide their products and services;
- Repository administrative staff; and
- Individuals, with any other purpose, as permitted or required by Colorado law.

The task force formed a Data System Repository Committee early in 2011. Its charge is to recommend to the task force how the standardized set will be maintained, updated and sustained. The following sections describe the committee's work, review challenges and unanticipated developments, and summarize the committee's major accomplishments.

A. Progress Report

The Data System Repository has worked on seven major tasks over the past two years. First, it developed a set of principles to guide its work (see Table __).

Second, the committee debated and agreed on a list of major data system repository responsibilities and functions (see Table __). It also decided that the technical and professional functions described in the table could be performed by repository staff or advisory committees or one or both functions could be contracted out.

Table __

Data System Repository Guiding Principles

Economics

- Payers and providers currently purchase edits and supplemental software claims processing support for ongoing updates from various commercial sources. The Colorado DSR will do this work in the future. Consequently, the expense of the Colorado DSR should be a transfer of existing expense to an alternative approach and not require new monies.
- Reduce costs or at least no net increase in transaction costs
- Monies are used to create quality rules for public consumption
- Consider licensing fees as a principal revenue source

Governance

- Open process where stakeholders can have a fair hearing
- Free from influence of special interests
- Accountability: consider state oversight to insure public interests are met

Maintenance

- Expertise already exists
- Development and maintenance should be influenced by production requirements
- Seamless handoff from data analytics operator to data system repository operator
- Decentralized development and maintenance
- Allow for professional (rule making) and technical (rule distribution) components to be separate entities

Distribution

- Centralized
- Format of rules should support most efficient distribution
- Distribution should be electronic
- Distribution capability phased in

Table __
Data System Repository Responsibilities and Functions

Functions

- Accountability—To the legislature, stakeholders (e.g., consumers, providers, payers), general public, etc.
- Transparency—Ensuring that sources and rationales for edits are available as part of the library and included with the distribution and operation of the data system repository and that RFPs, mission, bylaws, etc. are transparent.
- Library maintenance—After initial standardized edit set has been established, developing and implementing policies and procedures for approving new edits, modifications and deletions as necessary, and resolving conflicts between approved sources. Reviewing and making decisions in response to requests for additions, modifications, and deletions to the existing edit set.
- Library distribution—Providing public access to the edit registry.
- Fee collection—Collecting fees and revenue from other sources to pay for repository operations, including contracted services.*
- Contracting—Issuing RFPs and contracting for services
- Management and fiduciary responsibility.
- Industry dialogue —Establishing and maintaining a method for receiving, logging, and responding to key stakeholder feedback , including complaints

Board, Technical Staff or Contractor, and Professional Staff or Contractor Responsibilities

- Repository board—accountability, transparency, contracting, hiring the executive director, budget, industry dialogue
- Technical—library distribution, display, access
- Professional—decisions about which edits are in, out or modified over time

**If the fee is collected by a third party, it would turn the money over to the data system repository or the money would be put into a fund for appropriation by the legislature to the repository.*

Third, the committee developed a detailed list of essential functionalities for the data system repository (see Appendix __). The functionalities fall into four categories: production, database service level performance, input/output and provider/user access.

Fourth, the committee took the lead in drafting a request for information (RFI).²² The purpose of the RFI, which was released May 3, 2012, was to invite input, better understand potential strategies and costs associated with the design and development of an online data repository and solicit innovative solutions. The committee included language in the RFI indicating that the task force, recognizing that no current organization or initiative includes the whole universe of existing edits, has a particular interest in creative solutions that take advantage of or blend current efforts and products. The RFI invited comments and suggestions concerning design solutions (both proprietary and commercial off-the-shelf); implementation strategies and incentives; program costs (design, development, implementation and ongoing); and administration and management services. The RFI explained that the information gathered from the RFI would help to inform a request for proposals (RFP) the task force planned to issue later in the summer or fall. The RFP would be for a data analytics contractor that would _____. Four groups responded to the RFI. [BRIEFLY DISCUSS RESPONSES]

Fifth, the committee recommended criteria for reviewing proposals submitted in response to the RFP. The criteria, which were approved by the task force, are shown in Table ____.

Table ____ Criteria for Selection of a Data Analytics Contractor	
<ul style="list-style-type: none"> • Price • Maintenance cost • Delivery date • Licensing and other contractor fees • Transition viability and scalability to permanent data system repository • Nimbleness—ability to respond quickly to requests for different arrays, analyses of edits 	<ul style="list-style-type: none"> • Articulated understanding of what is needed • Degree of architecture in place • Alignment of in-place architecture and goals • Software as a service rather than buying, unless buy is cheaper than rent • Meet minimum technical specifications

Sixth, the committee identified alternative procedures for making changes to the initial standardized set after it is implemented. Three options it is exploring in more depth are shown below; all assume a data repository board would oversee the program.

²² The RFI and responses to the RFI are posted on the task force website, http://hb101332taskforce.org/images/rfi_050412_final.pdf.

- The board or a technical group established by the board would review and approve any changes to the initial standardized set that may need to be made when a change has been made by the source of the edit (e.g., NCCI or a national specialty society). The board would consider requests from payers, providers and others for additions, deletions or modifications to the standardized set.
- Changes to the initial standardized set would be made only if updates were made by the source of an edit or rule. Stakeholders wanting other changes to the standardized set would have to go to the source and request changes to their edits, which would then become part of Colorado's set.
- Repository staff or the contractor maintaining the standardized set would inform the board when edits or rules are updated or modified based on actions at the source and ask if there are any objections. If there are no objections, the standardized set would be updated or modified accordingly. The contractor could suggest other changes not in the standardized set for board consideration. The board could also direct the contractor to make changes.

Finally, the committee has started to explore ways to ensure data system repository sustainability. The task force plans to contract with a sustainability consultant to help identify viable options for financing repository operations over the long term, provided it can secure funding for this activity. One of its assumptions is that it is unlikely that General Funds will be available to fund the repository. Another is that, while federal or foundation grants could be an important source of funding, particularly for establishing the repository, they are not a sustainable funding source over the long term.

One sustainability model the committee is looking at is having a single professional entity that would be responsible for governing the repository and would fund its operations by licensing data to companies that specialize in the development of claims payment systems and services. The professional and technical entity could be the same. The technical entity(ies) would bear the economic risk and set its own price for access to the repository. Payers, providers and claims software developers would not be required to use the vendor.

Another sustainability model is a form of public utility. The data system repository would have the same features as the first model but the state or repository board would regulate pricing. Additional regulation would be required to mandate licensing of the set for claims processing. The committee is developing and assessing the pros and cons of additional options.

B. Unanticipated Challenges and Developments

[TO BE WRITTEN]

1. RFI—Found that data analytics phase will take longer than expected-- 6-9 months before task force can see database and begin running alternative scenarios, edit sets.
2. Spent significant amount of time developing consensus as to whether it was necessary or desirable to allow proprietary edits and rules to be submitted to the task force confidentially.
3. Holding transparent discussions among commercial competitors.

C. Summary of Major Accomplishments Concerning the Data System Repository

- The task force adopted guiding principles for creation and operation of the data system repository.
- The task force approved a list of data system repository responsibilities and functions and delineated its essential functionalities.
- The task force issued an RFI concerning potential strategies and costs associated with the design and development of an online data repository to be used initially to develop a standardized set and subsequently to maintain the set and make it electronically accessible.
- An RFP has been drafted for a data analytics contractor to compile the universe of existing edits and conduct data analyzes to assist the task force in developing the standardized set.
- The task force approved criteria for selecting a data analytics contractor.
- The Data System Repository Committee identified, and is examining the costs and benefits of, alternative procedures for updating and making other changes to the standardized set after it has been implemented.
- The Data System Repository Committee is exploring ways to ensure the repository's sustainability.

V. RECOMMENDATIONS

The task force has made steady progress since it was formed two years ago. Task force members have devoted hundreds of hours to the effort and have established the framework for comprehensive data analytics that will allow it to develop and test a proposed standardized set and, following a public comment period, recommend a final set. The task force's interim report recommendations are presented below.

Recommendation 1: The task force recommends continuing its work, as provided for in the statute, to develop a standardized set.

The act requires the task force to present a report and recommendations concerning a set of uniform, standardized payment rules by November 30, 2012. However, it also provides that, if at the time of the report the voluntary national initiative has not reached consensus on a complete or partial set of rules and claim edits, the task force shall "continue working to develop a complete set of uniform, standardized payment rules and claim edits and, by December 31, 2013, shall submit a report and may recommend implementation of a [standardized set] to be used by payers and health care providers."²³ As discussed in part III, the voluntary national initiative disbanded because, unlike Colorado, it was unable to get all the major players to the table. This meant the task force did not have, as a starting point for its work, any rules and edits to process claims that stakeholders had already agreed to.

The task force recommends continuing its work on both the base set and complete standardized set. Part III reviewed the reasons the task force concluded that the base and complete sets needed to be developed concurrently as one uniform set rather than sequentially as originally conceived in the act. Work will continue as funding from grants, gifts and donations allows.

²³ § 25-37-106(2)(d)(III), C.R.S.

Recommendation 2: The task force recommends amending the act to extend by one year the deadline for the task force’s final report and the effective dates for payer implementation of the standardized set.

Table __ shows the deadlines for the task force’s final report and recommendations and the deadlines for payer and provider compliance with the standardized set. It also shows the task force’s recommended revised deadlines, which would require a statutory change. While significant progress has been made, the task force needs additional time to complete its work. It has already tackled a number of difficult issues, including developing a common lexicon, agreeing on a process to arrive at the standardized set, establishing the basic functionalities for a central repository for accessing the rules and edits, issuing a request for information and agreeing on the elements of a request for proposals for a data analytics system that will allow it to create the standardized set. There is, however, much work still to be done.

<p style="text-align: center;">Table __</p> <p style="text-align: center;">Medical Clean Claims Transparency and Uniformity Act Statutory and Recommended Revised Deadlines</p>		
Activity	Current Statutory Deadline ¹	Recommended Revised Deadline
Task Force		
<ul style="list-style-type: none"> Submit final report and recommendations concerning the standardized set and establishment and operation of a central repository for accessing the rules and edits. 	December 31, 2013 ¹	December 31, 2014
Payers		
<ul style="list-style-type: none"> Commercial health plans—implement the standardized set. 	January 1, 2015 ²	January 1, 2016
<ul style="list-style-type: none"> Domestic nonprofit health plans—implement the standardized set. 	January 1, 2016 ²	January 1, 2017
<p>¹ These are the deadlines in the act if, at the time the task force submits its November 30, 2012, report to HCPF, the voluntary national Initiative has not reached consensus on a complete or partial standardized set of payment rules and claim edits, which is the case.</p>		

The task force has laid the groundwork for a standardized set of edits and rules and creation of a central repository for accessing them. The work has taken longer than expected as a result of several unanticipated challenges and national developments discussed in parts III and IV. If the task force is not given an additional year to complete its work, it will be unable to finalize and recommend to the legislature and HCPF a standardized set by the December 31, 2013, statutory deadline. It will not have sufficient time to publish the proposed standardized set for public comment and allow payers, vendors, provider billing systems and other interested parties to test and comment on the proposed set. With an additional year, the task force will be able to complete its work and submit a final report and recommendations for a standardized set. In order for payers to have sufficient time to integrate the standardized set into their claims processing systems, the task force also recommends amending the act to allow them an additional year to come into compliance.

The recommended extension assumes the task force is able to secure sufficient additional grants, gifts and donations to fund its work through 2014. If it is unable to do so, the task force will submit a report to the legislature detailing the progress, findings, decisions and recommendations the task force is prepared to make at such time as funding has been exhausted. Also, if the legislature does not amend the act as recommended, the task force will submit a similar final progress report by the current deadline of December 31, 2013.

The task force wants to finish the job. Despite coming to the table with different concerns and perspectives, task force members have demonstrated their commitment to finding consensus on a standardized set and are well along the road to fulfilling their legislative charge. Colorado leads the nation in efforts to standardize claim edits and payment rules across private payers. It has had more success getting and keeping key stakeholders at the table and achieving consensus on difficult issues than any of the other state or national initiative. No other group, at the state or national level, has accomplished as much as the Colorado task force has. According to Walter Suarez, co-chair of the National Commission on Vital Health Statistics' committee on administrative simplification and health reform, "Colorado's [effort] remains the only significant work in this area."

Recommendation 3: The task force recommends that the General Assembly's health and human services committees and executive director of HCPF write a letter to the National Correct Coding Initiative recommending that it actively solicit and consider input from private sector payers.

[TO BE WRITTEN}

Recommendation 4: [ANY OTHER RECOMMENDATIONS?]