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Memo

To: Senator Irene Aguilar
From: Matt Mortier
Cc: Executive Director Barbara Kelley, Commissioner Marguerite Salazar
Date: February 4, 2014
Re: Division of Insurance Administration of Standardized Health Care Claim Edits Database Program

Issue

Examine the possibility of the Division of Insurance (DOI) implementing and administering the development and management of a standardized health care claims edits and payment rules database.

Response

This is a program that could be undertaken by the DOI, but it presents significant challenges and could possibly require the restructuring of the DOI. The undertaking of this program would require extensive legislative changes to current Colorado statutes to increase the regulatory and enforcement authority of the DOI beyond its current scope and jurisdiction, and would involve the hiring of and/or contracting with additional staff with the necessary management, medical and billing expertise. It is estimated that a minimum additional 5 FTE would be needed (both complaint-related and project management staff), as would approximately \$500,000 for legal and mediation services. It is also estimated that approximately \$1-1.5 million would be needed to contract with an outside vendor to host the standardized health care claims edits and payment rules database, provide professional services to evaluate and provide future updates to the payment rules and claim edits, and collect fees to help support the program costs. The creation of a new section within the DOI (or DORA) to oversee the project would need to be considered.

As the Medical Clean Claims Task Force (CCTF) nears the testing phase, the best approach would be to establish a model for a future national-level expansion through this project. A federal-state partnership that would involve federal expertise and funding would help this program serve as a national model, and possible future federal repository. It is anticipated that the state should expect to fully fund this project for the first five years, as the ability of the program to become self-sustaining through fees and potential federal funding are not known at this time.

Background

In 2010, Colorado enacted the Medical Clean Claims Transparency and Uniformity Act (HB10-1332), which established a Medical Clean Claims Task Force (CCTF) comprised of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. This Act requires the task force to submit a report to the General Assembly and the Colorado Department of Health Care Policy & Financing (HCPF) with recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The task force has been charged with identifying the standardized set of rules and edits through existing national industry sources including: National Correct Coding Initiative (NCCI); Centers for Medicare & Medicaid Services (CMS); the Medicare physician fee schedule; the CMS national clinical laboratory fee schedule; the Healthcare Common Procedure Coding System (HCPCS) coding system and directives; the Current Procedural Terminology (CPT) coding guidelines and conventions; and national medical specialty society coding guidelines. The task force has not been charged with developing rules or edits that are used to identify potential fraud and abuse or utilization review.

The goal is to establish a complete set of uniform, standardized payment rules and claim edits that would be used by all carriers within the state, rather than continue the current practice of each carrier utilizing its own proprietary list of claim edits. The task force is currently expecting to have completed its review of their developed recommendations sometime in 2014. Currently, there is a statutory deadline for the CCTF to report its recommendations to HCPF and to the Colorado House and Senate Committees no later than December 31, 2014 (SB13-166).

It is expected that the claim edits' database system will continue to require review, revision, and monitoring on a go-forward basis, and as such, the CCTF will continue to be involved after the roll-out of the developed database.

Program Scope

Under SB13-166, as adopted, all payers for commercial health plans must only use the developed standardized set of health care claim edits beginning on January 1, 2016, or based on an implementation schedule established by the CCTF. To that end, the CCTF has reached the point of finalizing its recommendations on the codes to be included in the standardized set, and is moving toward the establishment and testing of a central repository for accessing the payment rules and claims edits.

The CCTF is composed of 28 industry experts, including representatives from the national headquarters of national carriers, as well as provider, vendor, and regulator representatives. The participation of national carrier executives in the CCTF demonstrates the belief among national carriers that the standards adopted will not be limited only to business in Colorado, but will be adopted on a national basis going forward.

To successfully implement this establishment and testing, the following aspects of this program must be considered:

- Technology infrastructure and data warehousing would be provided by a contractor that would host the repository, provide professional services to evaluate and provide future updates to the payment rules and claim edits, and collect fees to help support the program costs.
- This could involve soliciting bids from private sector companies to act in partnership with the implementing agency and/or division in creating a scope and budget for the hardware requirements of the program. These requirements would involve hardware for hosting the database, as well as the maintenance and security needs of such a system. **The CCTF has been unable to solicit bids from vendors due to the cost of this program, and the uncertainty of the continuation of the CCTF into the future.**

- A staffing and legal services budget would need to be developed and funded. Creating an accurate and reasonable staffing plan would be necessary to ensure that the central repository would be maintained, updated, reviewed, and kept secure, and to allow for any analytics that would be requested of the system. A legal services budget would also be a key component of the program, as there are likely to be many carrier/provider disputes over issues relating to the database that would pull the administering/managing state agency into any resulting legal conflict.
- Statutory changes would need to be made in order to give sufficient and appropriate authority to the administering/managing state agency to implement the program. It is likely that additional enforcement and regulatory authority would need to be given to the administering/managing state agency beyond what is in current state statute. It is also likely that authority to impose and collect fees would need to be given through statute in order to fully fund and maintain the program beyond implementation.
- New regulations would need to be promulgated to provide carriers and providers with the guidance and framework to comply with the payment and coding requirements of the standardized payment rules and claim edits. This could extend the administering agency's regulatory authority over both carriers and providers, or require coordination of regulatory and enforcement authority by entities with separate jurisdictional purviews. (See below.)

The DOI, upon review of the complexities of this program, and the wide range of expertise and resources that will be required to implement the program, recommend that the implementing agency partner with the U.S. Department of Health and Human Services (HHS) to make this program a federal pilot. Such an approach appears to have many benefits, including access to federal grant funds and expertise, and would put Colorado "out in front" of a potential future federal claims edit standardization program.

Jurisdictional Challenges

Such a program presents many jurisdictional challenges to the implementing and managing state agency. This program will require bringing together the enforcement and regulatory authority of several Divisions within DORA through Memorandums of Understanding or other legal agreements.

Currently, DOI regulates carriers and investigates consumer complaints in the private, commercial health insurance market. The DOI's authority does not extend to third party claim administrators (TPAs) of self-funded health plans. In order to ensure compliance with the standardized payment rules and claim edits, the DOI would need to promulgate rules that would apply to carriers under the rulemaking authority it already possesses as well as specific statutory authority to require the TPAs to comply with the rules. Additional concerns about the DOI's interaction with self-funded plans and TPAs will be addressed later in this document.

Only one party affected by the Medical Clean Claims Task Force recommendations is subject to the direct jurisdiction of the DOI. The DORA Division of Professions and Occupations (DPO) regulates the majority of licensed health care providers operating within the state, while the Department of Public Health and Environment (CDPHE) regulates most of the health care facilities, such as hospitals and ambulatory surgery centers, within the state. The enforcement authority of DPO could be utilized to ensure compliance with the assessment and collection of fees if they were tied to provider licensing. The enforcement authority of CDPHE could be utilized to ensure compliance with the program and the assessment and collection of fees for facilities as well as fees related to providers operating within hospitals, ambulatory surgery centers, and other types of health care facilities. It would require a complex multi-agency coordination and agreement to handle enforcement of the proposed requirements against all parties (providers and carriers). Statutory changes may be necessary for both DPO and CDPHE to

require providers to pay the fees as well as comply with any recommended or needed billing requirements.

The DOI currently is statutorily prohibited from being involved in carrier/provider contracting (network issues) and disputes (see CRS 10-16-121(4), 10-16-705(13)), and lodging this program in the DOI could place it firmly in the middle of many carrier/provider disputes. There is concern that adding authority in the DOI to regulate providers, and/or serving as arbiter of carrier/provider disputes would dilute the consumer focus of the DOI, and erode some of its credibility for consumer protection in the public eye.

Moreover, the DOI cannot transfer its rulemaking or enforcement authority to another agency or entity, which means the CCTF would have to serve in an exclusively advisory role to the Commissioner of Insurance. Final decision-making authority on this program, and any related rulemaking and enforcement would need to remain with the Commissioner of Insurance.

There are also federal implications as ERISA regulates self-funded pension plans, many of which have health benefits. As mentioned previously, the DOI currently does not have the jurisdiction to promulgate and enforce regulations against self-funded plans and their TPAs. It is unlikely that a program under DOI purview could be structured to avoid a federal pre-emption challenge as to employer self-funded plans under ERISA, and potentially even for carriers acting as TPAs for those self-funded plans. Third Party Administrators are not currently licensed or regulated in Colorado.

Statutory Implications/Changes

In order to implement, administer, and manage this program, there are a number of statutory changes that would need to be implemented by the state legislature. The following statutes have been identified as requiring amendments and/or revisions. The statutory changes would need to be made and take effect prior to any implementation rules being promulgated by the DOI.

- § 10-1-108, C.R.S. (Duties of Commissioner) would need to be amended to provide the Commissioner of Insurance general authority to implement this program.
- The Division would require new statutory enforcement authority in order to regulate providers and health care facilities, but only to the extent they would be involved in ensuring compliance by providers.
- New authority in Part 11 of Title 10, Article 3 to provide additional enforcement and rulemaking authority in regulating carriers in relation to this program.
- New authority in Title 10, Article 16 to provide additional enforcement and rulemaking authority regarding health care coverage and health insurance carriers in relation to this program.
- There may be a need to amend Articles 19 and 20 of Title 10 relating to Medicare supplement and long term care insurance as well in order to provide additional needed enforcement and rulemaking authority. Inclusion of Medicare supplement insurance would necessitate working with the Centers for Medicare & Medicaid Services as provider claims are initially billed to Medicare before Medicare supplement policies.

Other statutes would need to be amended to ensure adequate rulemaking and enforcement authority rested with the DOI. Those statutes include, but are not limited to:

- § 10-16-106.3, C.R.S. – Uniform Claims – Billing Codes – Electronic Claims Forms
- § 10-16-106.5, C.R.S. – Prompt Payment of Claims

- § 10-16-121(4), C.R.S. – Required contract provisions in contracts between carriers and providers
- § 10-16-704, C.R.S. – Network Adequacy
- § 10-16-705, C.R.S. – Requirements for carriers and participating providers – in particular, subsection (13)
- § 10-16-709, C.R.S. – Evaluation – nonparticipating health care providers

Costs

It is estimated that a minimum additional 5 FTE would be needed (both complaint-related and project management staff), as would approximately \$500,000 for legal and mediation services. It is also estimated that approximately \$1-1.5 million would be needed to contract with an outside vendor to host the standardized health care claims edits and payment rules database, provide professional services to evaluate and provide future updates to the payment rules and claim edits, and collect fees to help support the program costs. This is an initial cost estimate, and may need to be revised depending on final scope and timeframe of the program

Currently the DOI does not have staff with the necessary medical and billing/coding experience that this program would require, and would need to hire such expertise as the administering agency. The DOI would also need to bring on program management staff to help coordinate and administer this program from its initiation. It is possible that the best approach would be to create a new section within the DOI to oversee and manage this program, if a new Division is not created within DORA, in order to preserve the consumer protection focus of the DOI.

Additional resources needed to provide the legal and complaint/mediation services that this program would require. If the DOI were to be the administrator of this program, it would need to bring on additional staff to process the increased number of complaints it would receive. Those complaints would not be consumer complaints, but complaints filed due to billing and payment disputes between carriers and providers. Such an increase in complaints could easily double the number of complaint analysts currently on staff at the DOI. In addition, there would need to be a significant expansion of the legal services budget for the DOI due to the possibility of billing/payment complaints moving into mediation or litigation as well as issues related to the potential conflict that might arise when new or amended claim edits and payment rules are proposed..

Funding/Fees/Payments

It should be anticipated that this program would not be self-sustaining for the first five years. As such, the General Assembly would need to allocate funding until the program can demonstrate that the fees collected would be sufficient to maintain the program into the future. To this end an annual report would be prepared for the General Assembly identifying fee collection as compared to General Fund appropriation, and how collected fees may be able to offset appropriations in the future. The Division is unable to successfully implement this program without the necessary funding.

Several options have been discussed by the CCTF on how to secure funds for the program, and to continue to fund the Billing Code Edits Database. Those options include: imposing a subscriber/user fee; splitting the fee 50/50 between payers and providers; having a fee assessed via legislation and leaving administration of the fee up to the DOI; and, assessing fees on a “per click” basis to users of the Practice Management System.

Subscriber/User Fee

The first option being considered is that of assessing a subscriber/user fee to each company using the system. The software vendors would assess the fee directly to providers and carriers, and the fee would

be calculated based on the number of lives covered by the carriers. This would place the vendors in charge of collecting the fees, and would make for the most streamlined process, as software is commonly sold via a subscription that requires a fee.

50/50 Split Fees

The second option being considered is that of splitting the costs though a 50% provider licensing fee, and a 50% carrier use fee. The provider licensing fee would be collected during the provider licensing process, and the carrier fee would be based on a per-covered-life calculation and collected by the database administering division. As both the payers and providers are assessed a portion of the fee, it could appear more “fair” than the subscriber/user fee model, and it would be more easily administered and collected.

Legislative Assessment of Fees

The third option being considered is the assessment of the fee via legislation, and then via the DOI’s promulgation of the related regulations. This would create a more transparent and accountable system which may be more easily regulated than a privatized system, and would allow the fee assessment and collection to be aligned with current state practices. DOI would also have the ability to determine how much of the fee assessment and payment system to keep within the Division, and how much could be contracted out to vendors. The challenge to this approach is that such legislation might meet resistance from other legislators and the private sector, and a state-developed and run system may not be as efficient as a system developed in the private sector. This methodology could assess the fees to both payers and providers

“Fee per-click” Basis

The last option being considered is to assess fees on a “per-click” basis. Such an assessment and collection would place the burden on carriers to collect the fees relative to the number of policyholders and the amount of activity on each policyholder account. A per-click fee does not conflict with current Colorado Medical Society or AMA policy, and for each claim submitted, a fee would be assessed and collected. There is some concern that not all providers currently use systems that would be compatible with such a collection regime, and that fees would only be assessed and paid on electronic claims activity, potentially leaving out any paper-based claims. Such a system would be best established on the payer side, as administering such a program on the provider side could be very difficult and very large in scope, and DOI does not have the experience or ability to process claims.

DOI Challenges

Upon review of the scope and breadth of this program, there is concern within DOI that such a program would likely require a reorganization of the DOI within DORA. The DOI, as it is currently structured, focuses on the regulation of the insurance industry, ensuring that consumers are protected from unfair trade practices and illegal business operations. The DOI is currently consumer-facing, and taking on this program would require the DOI to focus more on carriers, other types of payers, and providers. This program has the potential of eroding the consumer focus of the Division, which in turn might erode the credibility of the Division’s consumer protection focus as billing disputes between carriers and providers would become the responsibility of the DOI. The creation of a new section within DOI could potentially alleviate some of this reduction in credibility with consumers.

There is also concern that if the number of provider/payer complaints is substantial as this program comes on-line, it could overwhelm the current capability of DOI staff. Staffing costs would increase significantly as additional complaint-related staff would be needed to administer the program. The hiring of staff specializing in medical billing and coding that would be dedicated to this program would also be

necessary, as DOI would be placed as an intercessor between payers and providers when billing/coding disputes arise. This is a role that DOI has not had in the past, and significant restructuring would be needed as the Division would be placed in the middle of potentially highly-complex dispute resolutions between payers and providers, and would necessitate the DOI be given the enforcement authority to resolve such disputes. This is further complicated by the fact that currently neither the DORA DPO Boards nor CDPHE get involved in billing or financial issues, and this program would place the DOI in the middle of both billing and financial issues.

One possible approach would be to create a new DORA Division with its own Board that could include the Commissioner of Insurance, the Executive Director of DPO, and the Executive Director of CDPHE as Board members.

Pilot Program with National Implications

After internal discussions, it appears that if a decision is made to move forward with the standardized health care claims edits and payment rules database program, the method mostly likely to ensure success would be to request a federal waiver and establish a federal/state partnership pilot program. Such an approach would not only bring in the expertise and funding that CMS/HHS could provide, but would also allow the program to be developed as a potential national model repository that providers and carriers throughout the nation would access and utilize. There appears to be growing momentum at the federal level for a single standardized national claims edit and payment database, and moving forward on this program with federal partners would allow the program to be developed with an eventual national model that could be maintained by Colorado. This would decrease the likelihood of a difficult integration with a national system, and would increase the likelihood that Colorado could serve as the model for that system. A difficult and costly integration with a national system would be exacerbated if a federal/state partnership and pilot is not created. Without federal guidance and assistance, it is likely that many states will begin developing and rolling out their own claims edits systems. The eventual cost of integrating and transitioning these multiple systems will be much greater than if such a program was established initially through a state/federal pilot that is then expanded among the states.

The regulatory enforcement authority provided to the Division through this program would serve as a model for other states to implement as they move to incorporate the Colorado repository into their health care industry. The national uniform standard for claim edits and payment rules of the database would benefit all providers and payers by reducing administrative costs, and would serve as carrier and provider justification for paying the fees required by participation.

Such a federal/state pilot would also require that joint decision-making authority rest in both the Commissioner of Insurance and the involved federal partners, and would require an expansion of the enforcement authority of the DOI in partnership with DPO and CDPHE.

A federal/state partnership pilot of this program would also include Medicare and Medicaid in the program, which would be a key partnership as those two programs and their coding and billing systems will likely serve as any model for a national standardized claims edit system, and as the National Correct Code Initiative is administered through Centers for Medicare& Medicaid Services (CMS). Such a partnership would require a linking of those Medicare and Medicaid payers to the Colorado program in state statute. Such a federal/state pilot would need to be explored in greater depth to see how feasible or likely such a pilot would be, though it appears, at least initially, to be the best option for a successful outcome for a standardized health care claims edits and payment rules database program in Colorado.