TACKLING ADMINISTRATIVE BURDEN IN OHIO'S MANAGED CARE PROGRAM

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The COVID-19 public health crisis has impacted nearly every state and Federal program. For Medicaid in particular, rising unemployment resulting from the pandemic is increasing enrollment and straining staff and budgets. In Ohio, as of August, Medicaid enrollments have increased 7.6 percent compared to the same time last year.[1]

Even before these events, however, the Ohio Department of Medicaid (ODM) has been working to transform the program by introducing a seamless service delivery system and improving service to beneficiaries. Today, that effort is more critical than ever. But, for it to be successful, the state must reduce administrative burdens and improve efficiency throughout the system.

In Medicaid programs across the nation, inefficient administrative processes are time-consuming, costly and frustrating to plans, providers and beneficiaries. Rectifying them requires a thoughtful approach to business process automation, standardization and collaboration.

In particular, ODM is examining these significant areas:

- Centralizing credentialing
- Improving prior authorization
- Combatting Medicaid waste

CENTRALIZED CREDENTIALING

The credentialing process can be cumbersome for both healthcare providers and Medicaid plans. Over the years, a number of solutions have been developed to alleviate the burdens associated with this workflow. But, while advances have been made in automating credentialing, in some cases, plans and providers are using different platforms.

A recent survey conducted by CAQH determined that providers may contract with 20 or more health plans, using a variety of credentialing platforms.[2] This can create an administrative nightmare for hospitals and practices. However, the survey also showed that when large numbers of providers and plans coalesce around a single automated platform, costs and complications are minimized for all parties involved.

According to the survey, physician practices that use multiple methods for credentialing spend $2,068.00 per month on this workflow.[3] Those that used a single platform spent only $1,249.86 per month. On average, moving to one credentialing platform could save physician practices $818.14 per month, or $9,818 annually--a savings of 40 percent.

The research by CAQH also revealed that today's fragmented credentialing system has a disproportionate impact on practices in rural areas.[4] According to the survey, physician practices in urban areas could save 39 percent while physician practices in rural areas could save 75 percent on credentialing costs by moving to a single data exchange platform.

While there are a number of factors that contribute to this, one stands out: practices in rural areas manage a higher number of contracts, 26 on average, compared to 18 for urban health practices. This results in rural providers having more platforms to navigate.

Adopting a single platform to manage provider credentialing has a significant upside for plans as well, such as a faster process, lower costs, increased accuracy and reduced provider abrasion. Plans are likely to obtain higher quality data in a consistent format, which could reduce the time and resources allocated for provider outreach and follow up.

ODM's planned implementation of a centralized model for credentialing providers is expected to reduce administrative burden and redundancies, and provide access to higher quality, aggregated and standardized data.

IMPROVING PRIOR AUTHORIZATIONS

Health insurers use prior authorization as a check on the safety, quality, necessity and cost of medical services. However, many healthcare providers view it as a confusing, labor-intensive process that often delays patient care.

Although an electronic standard for prior authorization has been in place since the early 2000s, industry adoption remains low relative to other federally mandated electronic transactions. According to the 2019 CAQH Index®, an annual study of U.S. industry adoption of standard electronic healthcare transactions, only 13 percent of reported transactions were completed fully electronically.[5] The remaining 87 percent of transactions were conducted through an inefficient, partially or entirely manual process–often by phone or fax.

Each manual prior authorization costs the industry $14.24 on average, but when fully-electronic processes are employed the cost falls to $1.93 per transaction.[6] Across healthcare, automating the prior authorization process could save over half a billion dollars annually.

Automated processes also significantly decrease the amount of time necessary to complete these transactions. The CAQH Index found that manual prior authorizations require 21 minutes of provider staff time on average, while electronic prior authorization transactions require only four. Fully electronic prior authorizations also reduce the amount of time spent by both payers and providers on outreach and follow up.

There are now calls among public and private sector stakeholders to address the challenges associated with prior authorizations. Some of these initiatives include:

- The introduction of the Improving Seniors' Timely Access to Care Act (H.R. 3107) in Congress. This bipartisan legislation would establish requirements for use of prior authorization under Medicare Advantage.[7]

- CMS launched the pilot Documentation Requirement Lookup Service Initiative.[8]

- CAQH CORE created two Operating Rules for prior authorizations to encourage widespread adoption of automated processes.[9]

- Leading healthcare organizations released a Consensus Statement on Improving the Prior Authorization Process.[10]

By adopting fully automated prior authorization processes, Medicaid programs can alleviate significant burdens on their staff, as well as their provider network, while providing a better experience for members.

COMBATTING MEDICAID WASTE

By law, Medicaid is the payer of last resort. As such, Medicaid programs must take all reasonable steps to identify and recover payment from third parties liable for a beneficiary's care. However, appropriately paying or recovering claims can become difficult when a significant number of Medicaid beneficiaries are also eligible for or enrolled in additional coverage.

The complexity of claims procedures has led to the development of an industry of billing services, claims clearinghouses, practice management solution providers and other vendors that format and route eligibility and claims transactions between providers and health plans. When claims are incorrectly routed, payers often use vendors to identify and recover overpayments.

In short, what has evolved over the past two decades is a patchwork of rules, vendors, technologies and practices to identify third party liability and recover overpayments. The most widely used method to coordinate benefits -- pay and chase -- is costly and only marginally effective.

Solving this problem is now more important than ever. As a result of the COVID-19 pandemic, Medicaid enrollment rose 8.4 percent nationwide from February to July 2020.[11] It is anticipated that this number will continue to grow as the full impact of job losses becomes more widely known.

By adopting a prospective approach to coordination of benefits (COB), where responsibility is established before claim is paid, health plans can streamline workflows, improve accuracy and significantly reduce recovery costs, or eliminate them entirely. It also significantly reduces the need to contact beneficiaries and alleviates the burden on providers.

There are a number of benefits that stem from an industry-wide adoption of a prospective approach to COB, including:

- Increased medical cost savings
- Reduced claim rework
- Reduced vendor fees
- Improved member and provider experience

THE PATH FORWARD

Administrative inefficiencies put an unnecessary strain on critical resources across Ohio Medicaid. And, as the full impact of the COVID-19 pandemic on our health system is still unknown, it has never been more important to streamline these processes--and provide administrative teams, providers and beneficiaries with much needed relief.

However, the full benefits of streamlined administrative processes cannot be achieved without widespread collaboration and adoption of these changes. That's why Medicaid programs, health plans and providers from across the nation have turned to CAQH--a non-profit alliance that is leading the industry in creating shared initiatives to streamline the business of healthcare.

CAQH ProView, the organization's flagship solution, connects more than 1.6 million providers and 1,000 participating plans and other healthcare organizations to share credentialing and other practice information. COB Smart is a registry of eligibility data from plans representing more than 180 million covered lives that enables payers to identify overlapping coverage before claims are paid. And CAQH CORE is leading the charge on behalf of the industry to automate and streamline prior authorizations and other key administrative transactions.

The business of healthcare is changing. And for ODM to successfully deliver on its goal to serve beneficiaries, better administrative processes need to be in place for its plans and providers.

Endnotes:

1. "Enrolled Population for the Month of August 2020." Ohio Department of Medicaid, Analytics.das.ohio.gov.

2. "The Hidden Causes of Inaccurate Provider Directories." CAQH, 2019, https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf?token=kx9rkgqJ

3. "Credentialing - All for One." CAQH, 2020

4. The US Census Bureau defines urban areas as a continuously built-up area with a population of 50,000 or more. It comprises one or more places—central place(s)—and the adjacent densely settled surrounding area—urban fringe—consisting of other places and nonplace territory.

   Territory, population, and housing units that the Census Bureau does not classify as urban are classified as rural. For instance, a rural place is any incorporated place or CDP with fewer than 2,500 inhabitants that is located outside of an urban area. A place is either entirely urban or entirely rural, except for those designated as an extended city.

5. "2019 CAQH INDEX®: Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed." CAQH, 2019, https://www.caqh.org/sites/default/files/explorations/index/report/2019-caqh-index.pdf.

6. "2019 CAQH INDEX®: Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed." CAQH, 2019, https://www.caqh.org/sites/default/files/explorations/index/report/2019-caqh-index.pdf.

7. DelBene, Suzan K. "Text - H.R.3107 - 116th Congress (2019-2020): Improving Seniors' Timely Access to Care Act of 2019." Congress.gov, 6 June 2019, www.congress.gov/bill/116th-congress/house-bill/3107/text.

8. "Documentation Requirement Lookup Service Initiative." CMS, www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/LookupServiceInitiative.

9. "Prior Authorization." CAQH CORE, www.caqh.org/core/prior-authorization.

10. Consensus Statement on Improving the Prior Authorization Process , www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

11. "Medicaid Enrollment Continues to Rise." Center on Budget and Policy Priorities, 9 Sept. 2020, www.cbpp.org/blog/medicaid-enrollment-continues-to-rise.