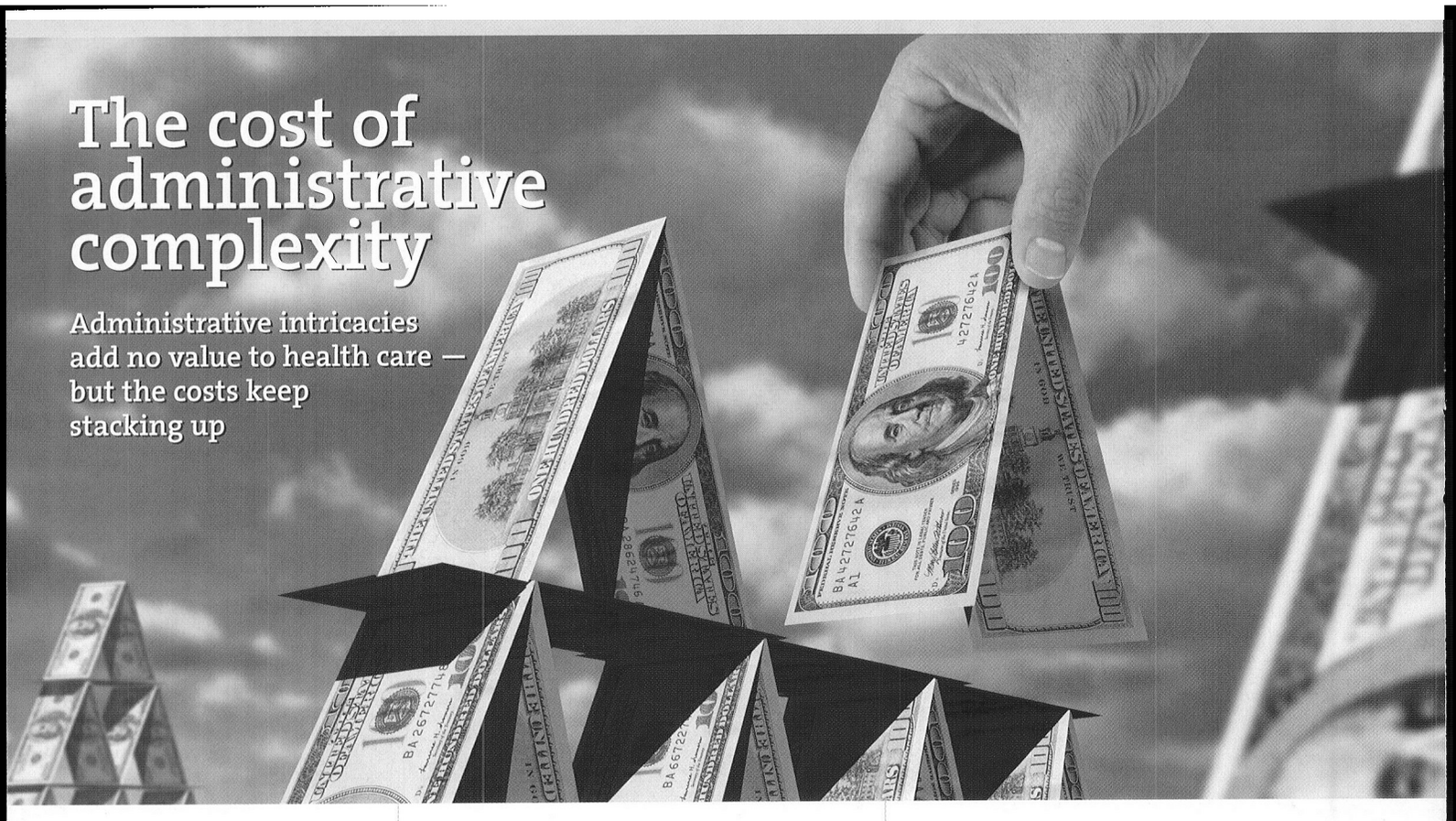

The cost of administrative complexity

Administrative intricacies add no value to health care — but the costs keep stacking up

By Christina Pope

about the author

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reader take-away

- Learn how hard unnecessary administrative complexity is hitting the health care system — including medical group practices — in the pocketbook
- Learn about the administrative simplification initiatives that states and MGMA members around the country are launching and how you can, too

If you've just filled out yet another physician credentialing application or finished negotiating yet another insurance contract, you know that redundant administrative complexity costs your practice time and money. But how much?

The Group Practice Research Network (GPRN), established by the Medical Group Management Association (MGMA) Center for Research, asked its network of medical groups to ascertain how much they spend on several aspects of administration (see box page 37).

The figures are stunning.

The practices reported that for each physician in their group their staffs verify insurance information on as many as 25 patients per day, answer up to 50 calls per day from pharmacies and spend up to three hours a day on each credentialing application.

The estimated annual cost of the handful of wasteful administrative tasks listed in the box on p. 37 for a 10-physician medical group: almost $250,000. It's not hard to see why simplifying our health care system's administration could reduce annual health care costs by almost $300 billion.[1,2]

MGMA urges more public debate and discussion of these concepts, and asks health care industry stakeholders to spread the word. To provide a road map for this issue, six important areas of administrative complexity in health care are outlined below, and details are given on how a simplified payment system might operate.

Simplify insurance product design

The problem: The GPRN research found that practices on average verify insurance information for 4.88 patients per physician each day and spend almost 13 minutes on each patient's verification. Yearly cost for a 10-physician group: $38,761. Not only is verification expensive, it's also a hassle. Of those visitors to the MGMA Web site who voted in a recent "Pulse Check" survey, the greatest number — 39 percent — indicated that "multiple coverage policies and billing requirements" was their most troublesome form of administrative complexity.

More than 1,000 companies offer health insurance products in the United States, and each offers multiple products, varying in copayments, deductibles, and services covered and excluded. So, during each patient encounter, providers must verify each patient's eligibility, coverage and any copayment or deductible provisions each time the patient seeks care. Insurers' verification processes vary wildly, and there is no standard content, format or response time.

How to simplify insurance:

- Limit the number of policy forms. Four or five standard policy forms — ranging from a relatively low-cost, high-deductible catastrophic policy to a full-coverage health maintenance option — should be sufficient. State legislation would be required for this change.
- Require employer self-insured plans to conform to this same limited set of policy forms. Employer programs are exempt from state insurance regulation under the Employee Retirement Income Security Act (ERISA), so this change would require federal legislation.
- Standardize insurer processes for verification of insurance coverage. All insurers should adopt a single, common electronic inquiry and response system for verifying patient insurance coverage.

Simplify payer and provider contracting

The problem: The GPRN research found that practices contract with an average of 20.5 different health plans per year, renew 14 of those each year and that administrators spend 5.5 hours negotiating each insurance contract. Yearly cost for a 10-physician group: $33,800.

Many medical groups have 100 or more separate contracts with third-party payers; each one is negotiated separately, usually annually. The cost incurred by medical groups alone in negotiating these contracts is at least $700 million per year[3].

How to simplify payer and provider contracting:

- Standardize the basic terms of provider/payer contracts. Use a single contract form for contracting between health plan payers and each type of provider organization. Since state law generally governs these contracts, the form — with an antitrust exemption — would need to be state-specific. Payer and provider groups would collectively determine the terms of these agreements.
- Separate provider payment terms from the balance of the payer/provider contract to achieve agreement more easily between payers and each provider class on the remainder of the terms governing their contractual relationships.
- Standardize the effective date and term of provider/payer contracts. To further minimize confusion and costs associated with

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Waste costs big money, honey, and a lot of time

Just how financially wasteful is unnecessary administrative complexity for a typical physician practice? The Group Practice Research Network (GPRN)* recently surveyed 94 practices to determine real outlays and found that unnecessary administrative complexity costs a 10-physician practice $247,594 per year in physician and staff labor. That's calculated from 7,872 hours in a 10-physician practice per year, or 151 hours per week — the equivalent of almost four staff positions. Below are the costs in dollars and cents.

10-physician practice calculated cost/year	
Support staff time verifying patient coverage/copayments/deductibles	$38,761
Administrator time negotiating insurance contracts	$27,573
Physician time negotiating insurance contracts	$6,227
Support staff time resubmitting denied claims	$9,248
Support staff time submitting credentialing applications	$4,264
Physician time submitting credentialing applications	$3,354
Nonphysician providers' time submitting credentialing applications	$467
Support staff time on the phone with pharmacies regarding Rx refills	$19,291
Support staff time on the phone with pharmacies regarding other issues	$3,904
Support staff time on the phone with pharmacies regarding formulary issues	$3,746
Support staff time on the phone with pharmacies regarding Rx substitutions (generic)	$3,443
Physician time on the phone with pharmacies regarding Rx refills	$80,833
Physician time on the phone with pharmacies regarding other issues	$16,360
Physician time on the phone with pharmacies regarding formulary issues	$15,698
Physician time on the phone with pharmacies regarding Rx substitutions (generic)	$14,425
Total cost per year	**$247,594**

Total costs were calculated based on compensation, staff and physician minutes spent, and the number of administrative tasks conducted each year.

*The Group Practice Research Network (GPRN) is a collaboration of leading medical group practices across the United States interested in the development and implementation of research and practice improvement initiatives. Funded by a contract from the Agency for Healthcare Research and Quality (AHRQ), GPRN was established by the Medical Group Management Association Center for Research. GPRN comprises a large, nationally representative network of medical group practices to advance the health care industry by participating in cutting-edge research. The "Administrative Complexity in Medical Practices" research was conducted in September 2004 as an online questionnaire with a 45 percent response rate.

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- On the home page, select the link to the Simplified Payment System concept
- For more information about the Group Practice Research Network and its "Administrative Complexity in Medical Practices research," enter GPRN in the *Search* box
- For more information about the Patient Friendly Billing project, go to the *Interactive* tools section in the member area

annual contract revisions, all payer contracts should become effective on the same date each year.

Simplify billing and payment processes

The problem: The GPRN research found that an average of 4.60 claims per FTE physician are denied each week because of lack of information about the insurer's requirements, that 73 percent of denied claims are ultimately paid at least in part and that support staff spends an average of 16 minutes per resubmission. Yearly cost for a 10-physician group: $9,248.

Almost no standardization of billing and payment processes exists among the more than 1,000 health insurers in the United States. Although the Centers for Medicare & Medicaid Services 1500 form and the Health Insurance Portability and Accountability Act's coding and transaction standards have made some required billing elements uniform, other associated billing processes vary tremendously, from patient eligibility verification procedures to formats for explanations of benefits (EOBs).

How to simplify billing and payment processes:

- Standardize the form and content of patient bills. Medical practices, hospitals and other providers should adopt standard patient billing forms in each state based on the principles established by the Patient Friendly Billing project, of which MGMA is a partner.
- Develop and implement a standard Web-based system through which providers can verify patient eligibility and insurance coverage. The technology is available; insurers need to agree on standards for data content and format, and make current information on their insured customers available electronically.
- Develop standard rules for claims submission. Insurers should develop and adopt standards specifying the documentation required for any specific CPT* codes and agree to common coding policies, including bundling and use of modifiers.
- Standardize the format and content of EOBs and provide the standard EOB to practices electronically and to patients either in hard copy or online.

Simplify credentials verification

The problem: The GPRN research found that practices submit 17.86 credentialing applications per physician each year on average, with each requiring an average of 69 minutes of support staff time and 11.27 minutes of physician time. Yearly cost for a 10-physician group: $7,618.

Every health plan, hospital, ambulatory surgery facility or other organization in which a physician practice must verify that physician's credentials before permitting him/her to work and must reverify the accuracy of the information every two years. Compounding the redundancy, each health

Simplification, state by state

A year ago, the Medical Group Management Association (MGMA) publicly proposed ideas to simplify the health care payment system and has received more than 200 responses to date. Some suggested that the proposals are far-fetched; most supported discussion and identified common ground to start — such as what several states have done.

In Kansas, the Governor's Office of Health Planning and Finance has worked with the national and Kansas MGMA to conduct an online health care administrative issues survey to understand and assess the scope of the administrative requirements on medical practices in its state.

In Louisiana, the Credentialing Process Simplification Act is now law, thanks in large part to the Louisiana MGMA. It mandates use of either the state's standardized credentialing application form or the Council for Affordable Quality Healthcare form. It also has provisions for the use of electronic submissions of the data, allowing Louisiana providers to move toward a centralized credentialing verification organization concept.

And in Massachusetts, the state's providers and payers implemented a standardized process this spring for physician credentialing by health plans and hospitals. This effort streamlines and simplifies the credentialing process, featuring a uniform application for physicians to complete, copy and submit to each health plan and hospital with which they seek affiliation.

MGMA continues to move the simplification payment system concept forward. MGMA President and CEO William F. Jessee, MD, FACMPE, is helping the health policy professional society Academy Health and other key stakeholders in the payment system explore strategies to assess and alleviate the current burden of administrative costs on the health care system through funding from The Commonwealth Fund. Several professional associations, including the American Health Information Management Association and the National Council for Prescription Drug Programs, have formally endorsed the simplified payment concept.

plan and other organization independently contacts primary sources such as state licensing agencies and hospitals at which privileges are held to verify the information provided by the physician.

How to simplify the credentials verification process:

- Develop a state-specific standardized application form and data set. Require that organizations such as health plans, hospitals, nursing homes and ambulatory surgery centers use it for physician credentialing.
- Authorize a single "public utility" organization to conduct verification of the credentials of all health care providers seeking to practice in facilities or health plans in each state. Users of the verified credentials data should support this central credentials verification organization through fees. Any organization that credentials health care professionals in the state should be required to use the verified data provided by the credentialing organization.

Simplify health care fees

The problem: The amounts insurers pay to providers have little or no relation to charges. For a particular CPT code, a practice may receive several different fees from different insurers, and even different fees from the same insurer, based on different products or contracts administered by that insurer. Practices and other providers waste resources on reconciling widely varying payments received against the widely varying amounts contractually owed by insurers.

How to simplify health care fees:

- Establish a standard physician fee schedule (and similar uniform fees for services provided by hospitals and other

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e-mail us

What is your organization or state doing to help simplify health care administration? Let us know at simplify@mgma.com

providers) with uniform base fees paid for a particular CPT code for all insurers. Such a single-fee schedule would not, however, mean that every practice would be paid the same or that practices would not have the opportunity to differentiate themselves from their competitors. A statewide organization could negotiate a single base-fee schedule with all payers in the state and agree on a standard set of additions to the base fees to reward groups that meet patient needs. This would eliminate the patchwork of base rates and incentives, varying by payer, that we currently face.

- Standardize "pay for performance" incentives, so that all insurers would make higher payments to practices meeting a common set of performance incentive measures.

Simplify clinical care management

The problem: Health plans attempt to control health care costs and improve clinical outcomes by managing clinical care. However, differences in care management programs for each patient are based solely on a patient's insurance company rather than any difference in a patient's clinical condition.

How to simplify care management:

- Standardize clinical guidelines for common conditions. Plans and local practitioners in a geographic region could collaboratively develop and maintain guidelines, and plans in each market could collaboratively finance the effort.
- Standardize disease management protocols and processes within practices. If plans cannot agree on a condition's disease management approach, each primary care practice should be allowed to choose which approach to apply to its patients, regardless of a patient's insurer.

- Eliminate prior approval except where proven effective, and standardize remaining requirements among all payers.
- Standardize drug formularies.
- Standardize use of hospitalists. Primary care practices should have the option to decline hospitalists for patients. If insurers develop evidence that hospitalist care is superior to that provided by the primary care practice, the practice may be subject to a fee reduction if it continues to opt out.

*Current procedural terminology

notes

1. Heffler S, Smith S, Keehan S, Clemens MK, Won G, Zezza M. Health spending projections for 2002-2012. Health Affairs Web Exclusives, Feb. 7, 2003. http://content.healthaffairs.org/webexclusives/index.dtl?year=2003.
2. Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of the U.S. health care system. N Engl J Med 1991;324:1253-1258.
3. Jessee WF. Administrative complexity in medical practice: Its impact on costs, practice operations and patient care. ACMPE paper 2003;32.

Where MGMA stands

"Simplifying the health care payment system" — The position statement of the MGMA Board of Directors, Adopted Oct. 10, 2003

"The MGMA Board of Directors believes that administrative redundancy and unnecessary complexity in our public and private health care financing programs is a major source of waste. This complexity diverts billions of dollars each year from the provision of health care services into non-value-added administrative busywork. It has severe adverse effects on patients, employers, payers, physicians and health care administrators.

"We do not believe that the current financing and payment system can long be sustained. Similarly, we do not believe that a government-run, single-payer national health system is a viable solution to this problem.

"In the interest of stimulating further public debate, and of stimulating creative thought about alternatives, we encourage public discussion of the concept of a 'simplified payment system.' We welcome comments on and criticism of this concept, and hope that it can contribute to the rapid identification of solutions to this immense problem. By putting forth this concept for discussion, we declare our intent to play a leadership role in working with policymakers and with all sectors of the health care industry to seek constructive improvements in our system for financing and delivering health care services to all our citizens."