HIT for Health Plans 101: What Emerging Changes Mean for You

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October 22, 2004

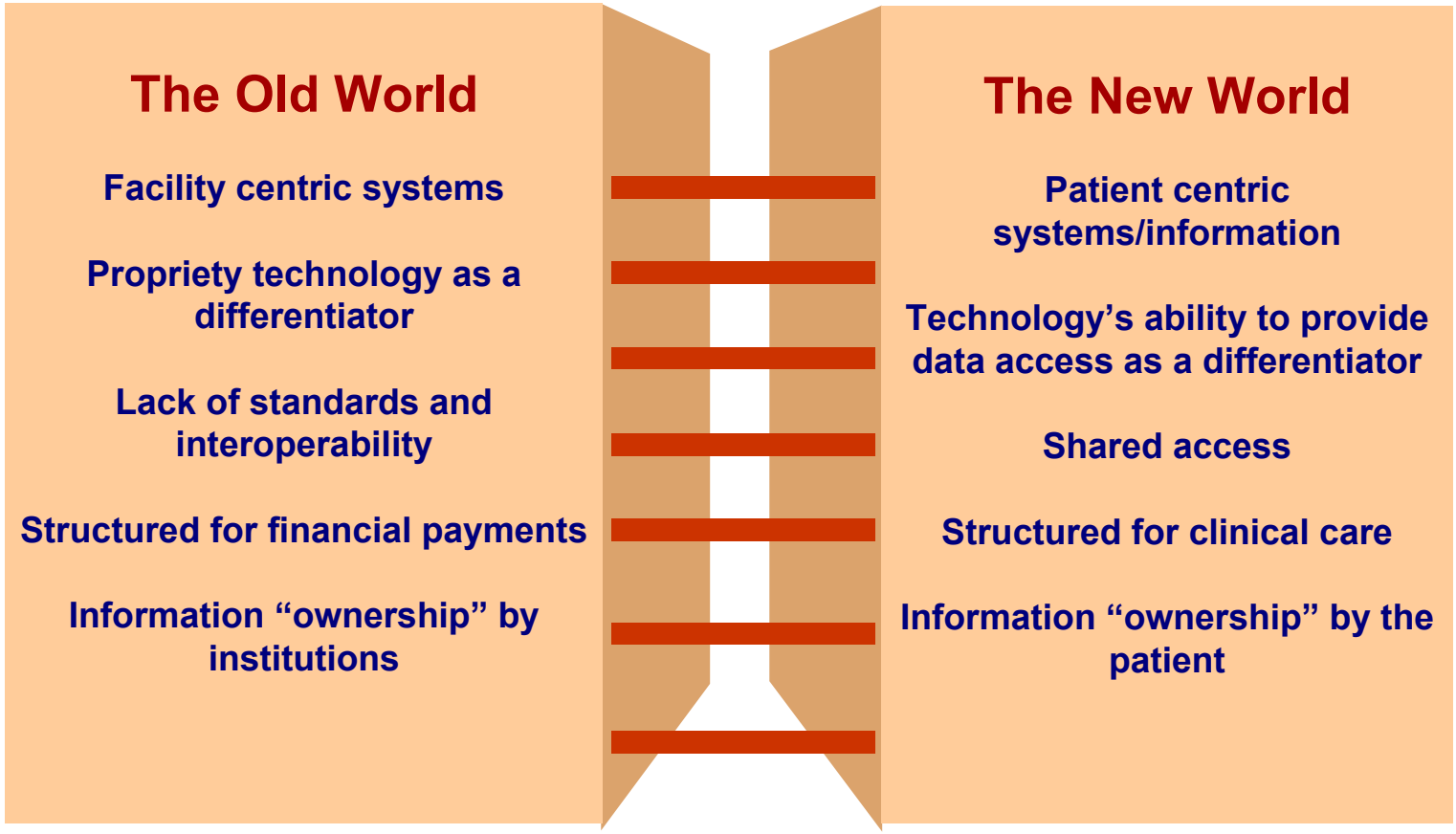
CAQH COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE

a catalyst for positive change

Agenda

- The Changing Healthcare Paradigm
- Examples of CAQH Technology Initiatives
  - Universal Credentialing DataSource
  - Simplified Prescribing
  - Online Eligibility and Benefits Inquiry
- What We've Learned
- Considerations for Health Plans

Technology and Change



New World technology will be patient focused

Impact on Health Plans

- Patients need to have easy access to accurate and understandable information
- Members and providers recognize the value of and want access to comprehensive patient information (history of care and administrative data)
- Patient-specific information needs to be collected and made available in new ways
- Technology strategies need to focus on providing information that aids in decision making
- External forces shaping health plan engagement
  - Federal and state initiatives
  - Accreditation bodies: National Committee for Quality Assurance voluntary program (likely to become mandatory component in 2007) recognizes plans for robust Internet tools that help consumers
- Health plans need to reconsider the role of technology as a market differentiator

CAQH Initiatives:

Helping Health Plans Benefit from Health Information Technology

An Introduction to CAQH

The Council for Affordable Quality Healthcare (CAQH) is a not-for-profit alliance of health plans and networks that promotes collaborative initiatives to:

- Make healthcare more affordable
- Share knowledge to improve quality of care
- Make administration easier for physicians and their patients

Two areas of focus:

- Administrative Simplification: Making administration easier for physicians and consumers
- Quality of Care and Patient Safety: Working with professional organizations to improve overall healthcare quality through national initiatives to educate physicians and the public

Universal Credentialing DataSource: Overview

- Online application to submit all of the data required to satisfy the credentialing requirements of multiple health plans
- Eliminates need for providers to submit recredentialing applications
- Allows health plans to access reliable provider information for network quality assurance and a variety of member support services, such as directories, referrals and claims processing.
- Developed in consultation with
  - Health plans
  - Medical specialty organizations such as the American College of Physicians and the American Academy of Family Physicians
  - Industry accreditation bodies (e.g., NCQA, JCAHO, and URAC)

Progress To Date

- More than 85,000 providers have successfully completed the CAQH application
- Providers who have used the Universal Credentialing DataSource thus far have relationships with an average of 4 participating health plans
  - Equivalent of ~340,000 legacy applications have been eliminated
- More than 125,000 providers have registered with system in launched markets
- Forty-seven healthcare organizations participating
- Once complete, providers no longer need to submit additional credentialing paperwork as new organizations join initiative
- Endorsed by the American Academy of Family Physicians (AAFP); formally supported from American College of Physicians (ACP)

Simplified Prescribing: Overview

- Facilitate vendor access to formulary data
  - In March 2004, partnered with RxHub® to launch the nation's largest centralized formulary database
  - Providers now have access to a single source of formulary data for a majority of insured Americans
- Encourage adoption of e-prescribing technology, including formulary check
  - Actively participate in regional and national e-prescribing initiatives (e.g., CAQH-DrFirst-MedStar e-prescribing pilot in Washington, DC)

Online Eligibility and Benefits Inquiry: Vision

Give providers access to information before or at the time of service...

- Providers will send an on-line inquiry and know:
  - Which health plan covers the patient *
  - Whether the service to be rendered is a covered benefit (including copays, coinsurance levels and base deductible levels as defined in member contract)
  - What amount the patient owes for the service**
  - What amount the health plan will pay for authorized services**

*Only HIPAA mandated data element; other elements are part of HIPAA, but not mandated

** These components are not proposed for Phase I.

Online Eligibility and Benefits Inquiry: Vision

… Using any system for any patient or health plan

- As with credit card transactions, the provider will be able to submit these inquiries and receive a real-time response*:
  - From a single point of entry
  - Using an electronic system of their choice
- For any patient
- For any participating health plan

*CAQH initiative will initially support batch and real-time.

Industry Operating Rules Are The Key

- What are operating rules?
  - Agreed upon business rules for utilizing and processing transactions
  - Encourages the marketplace to achieve a desired outcome – interoperable network governing specific electronic transactions
- Key components
  - Rights and responsibilities of all parties
  - Transmission standards and formats
  - Response timing standards
  - Liabilities
  - Exception processing
  - Error resolution
  - Security
- CAQH to serve as facilitator of cross-industry operating rules development

Lessons Learned

Lessons Learned: The Need for Interoperability

- The effective and efficient exchange of information between and among all stakeholders is the only way to keep up with the evolution of the healthcare system
- Significant administrative and clinical benefits can be achieved through technology and automation
- Some level of standardization is required to develop effective HIT solutions
  - Administrative data elements
  - Clinical data elements
  - Outcomes and measures
  - Business specifications
- Adoption is hindered by a lack of consistent approaches
  - Each stakeholder at a different point in the life cycle
  - Lack of comprehensive solutions; stakeholders operating in “silos”
  - Without standards, no market for vendors to build solutions

Lessons Learned: Driving Provider Adoption

- Confusion in the marketplace
  - Many solutions, lack of uniformity
  - Providers unsure about investing in ever-changing technology
- Need to incorporate HIT into workflow
  - View as benefit rather than burden
  - Facilitates understanding of the benefits
- Significant investment required by providers
  - Human capital (e.g., training)
  - Financial capital (e.g., hardware, software)
  - Return on investment to providers is often unclear
- Recognize learning curve
  - Lack of technical knowledge and experience
  - Technical “glitches” create frustration and reduce motivation
- Health plans can be a powerful force in motivating providers to adopt technology solutions
  - Incentives
  - Promotion and/or requirements

Lessons Learned: Quality of Care

- HIT delivers information that aids providers in decision making
  - Access to guidelines
  - Patient-specific administrative information
  - Patient-specific clinical information
  - Cost-effective treatment options are more easily explored
- Patient safety can be enhanced by having health and drug information available
  - Drug interaction and allergy warnings
  - Identification of adherence issues
  - Identification of contraindications
- Interoperability allows for aggregation of data among multiple health plans; more meaningful conclusions from larger sample sizes
- Difficult to assign return on investment to clinical benefits and avoidance of adverse outcomes

Lessons Learned: Health Plan Engagement

- Think big: to achieve greatest returns requires enterprise-wide view of operations
  - Example: automated data obtained through the credentialing process can also improve claims processing, maintain more accurate provider directories
- Even the seemingly simplest of projects are complex
- Technology adoption requires internal change (workflows and strategies)
- Resistance often based on issues of proprietary processes and perceived competitive advantage
- ROI often difficult to determine
  - Lack of agreed-upon measures
  - Inconsistent communication between all parties

Considerations for Health Plans

- How can using health information technology become a point of differentiation realizing the need for all-payer solutions?
- How can we illustrate the importance of health plan involvement *beyond* financing needed technology for physicians and medical groups?
- What types of internal changes are necessary to achieve the benefits of technology?
- How do we balance the allocation of resources for internal business priorities with the resources needed for industry-wide HIT evolution?

Questions