Progress Report on the Implementation of SSB 5346

Submitted by:

A program of the Washington Healthcare Forum
Operated by OneHealthPort

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STATE OF WASHINGTON

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November 30, 2009

To the members of the legislature:

It is my pleasure to submit the first progress report on the initiatives undertaken pursuant to 2ndSSB 5346 (2009) – Health Care Uniform Administrative Procedures Development. The report has been prepared by the WorkSmart Institute on behalf of OneHealthPort and the Washington Healthcare Forum, the entities I appointed to be the lead organizations as directed in the bill.

The report discusses the significant progress made in the past year under this state's new public-private administrative simplification partnership.

The initial signs are encouraging – solid progress has been made in each of several key areas:

- data collection for credentialing,
- access to eligibility and benefit coverage information,
- and standardizing of claims coding and pre-authorization processes.

The report also points out that the most challenging work still lies ahead.

To achieve the potential efficiencies and savings possible through the administrative simplification initiatives, thousands of medical providers and clinics are going to have to change their administrative systems and business processes. This will be in addition to changes flowing from federal health information technology and reform legislation and other initiatives in the health care industry. But I believe Washington is well positioned to meet these challenges. In fact, we are recognized on a national level in this area with only two or three states operating at a comparable level of progress.

I hope that you find this report informative and useful. If you have any questions, please feel free to contact me at (360)725-7100.

Sincerely,

Mike Kreidler
Insurance Commissioner

Progress Report on the Implementation of SSB 5346

I. Forward

WorkSMART extends its deep appreciation to the following parties for their efforts on behalf of administrative simplification in Washington State:

- State Senator Karen Keiser, her fellow state senators on the Senate Health and Long Term Care Committee and in the full Senate and their staff, for their leadership and trust in pioneering the unique public/private partnership approach to problem solving embodied in SSB 5346.
- State Representative Eileen Cody, her fellow state representatives on the House Health Care and Wellness Committee and in the full House and their staff, for their contributions to, and support of, SSB 5346.
- Insurance Commissioner Mike Kreidler and his staff for doing an outstanding job of protecting the public interest while enabling their private partners to lead rapid improvement efforts.
- Governor Chris Gregoire, her staff and state health agency leaders for their aggressive pursuit of administrative simplification in the public sector.
- The Board and staff of the Washington Healthcare Forum for their leadership in creating the WorkSMART Institute and their generosity in financing its work.
- The many talented people from practices, hospitals, health plans and public payers who comprise the work groups, for taking the time to share their experience and expertise and create best practices.
- OneHealthPort's Board, founders, staff and contractors for their hard work and dedication in bringing SSB 5346 to life.
- Most of all, to the thousands of practices, hospitals, ancillary providers, health plans and public payers prepared to invest precious resources and take risks who will do the heavy lifting required to implement and adopt best practices.

II. Executive Summary

The Washington State Legislature passed SSB 5346 on April 26, 2009. SSB 5346 is designed to simplify health care administration and identifies sixteen specific solutions to accomplish this objective. The bill establishes the Office of the Insurance Commissioner (OIC) as the public oversight agency and directs the OIC to designate a private sector organization to lead implementation of the bill. Insurance Commissioner Mike Kreidler asked the Washington Healthcare Forum and OneHealthPort to act as lead organizations and implement SSB 5346. The Forum and OneHealthPort accepted the Commissioner's invitation and designated the WorkSMART Institute to undertake the implementation effort.

In launching the 5346 public/private partnership Commissioner Kreidler emphasized a dual approach; protect the public interest and let the private sector lead. To protect the public interest the Commissioner enumerated four core requirements for the lead organization:

1. Execute the work plan – demonstrate rapid progress in delivering the solutions listed in the bill.
2. Be fair, inclusive and transparent – adopt a process where all interested parties can participate.
3. Be accountable – make regular reports to the Commissioner and engage his staff in the work.
4. Drive adoption – demonstrate ongoing success in voluntary adoption by plans and providers.

Within this construct, the lead organization was free to move rapidly and exercise its discretion. To achieve its objectives in this context WorkSMART adopted the Best Practice Recommendation (BPR) model pioneered by the Forum. A *best practice recommendation* is a better way to get things done that is pragmatic and works for everyone. BPRs are developed through a work group process and will serve as the solutions called for in SSB 5346. In the first few months of work significant progress has been made. The Exhibit below illustrates the accomplishments to date on the 16 BPRs identified in the bill:

Task	In Progress	Draft Solution	Solution Final	Implement/ Adopt
1. Electronic credentialing process				
2. Interoperability between credentialing/licensing				
3. Enhanced eligibility (system-to-system)				
4. Enhanced eligibility (browser-based)				
5. Retro eligibility denials				
6. CCI edit policy				
7. Publishing variations from CCI policy				
8. Remark, group, reason codes on remitts				
9. Processing corrected claims				
10. Standard payer reconsideration process re: codes				
11. Next phase of coding standardization work				
12. Extenuating circumstances denials of pre-auths				
13. Timely response on pre-auth requests				
14. Common web site payer pre-service requirements				
15. Payer pre-auth web site				
16. Goals/work plan for med management protocols				

WorkSMART's initial success in BPR development is due largely to the dedicated and enthusiastic efforts of the health plans, practices, hospitals and public payers who participate in the work groups.

While the pace of BPR development is impressive and heartening, the real challenge – adoption – still lies ahead. For payers and providers the hard work begins with implementation and adoption of the BPRs. Initial adoption efforts have focused on payers. While it is still a work in progress, the adoption matrix on page 18 of this report provides a very positive indication of how Washington payers have embraced the spirit of voluntary adoption. The overwhelming response from payers is that they *do* intend to voluntarily adopt the BPRs developed through the SSB 5346 process.

The initial focus on payer adoption should not obscure the crucial importance of provider adoption. Little real benefit can be generated for anyone unless provider organizations implement their portion of the BPR solutions. The nature of the provider community, large numbers of small organizations with very limited change management resources, makes adoption a significant undertaking. Planning is already underway and provider adoption will be a major focus for WorkSMART in 2010.

Early on in the effort to implement SSB 5346 a strong foundation has been put in place, good working relationships established between the public and private sectors and the community has been engaged. Going forward, the primary challenge will be moving ahead with adoption at a time when all industry participants are facing increased financial pressures, the need to improve performance in many areas and looming questions about the impact of federal reform. In this context, all participants engaged in this ambitious effort to simplify health care administration must continue to push aggressively for meaningful results in the short term and take the longer view to fully assess the progress of change before adding new work. This longer view will give stakeholders the opportunity to assess how best to integrate SSB 5346 within a dynamic and evolving health care environment. For its part, WorkSMART will seek to continuously improve its performance as lead organization while engaging constructively with its public and private partners.

III. Introduction

The Washington State Legislature passed SSB 5346 on April 26, 2009. Governor Chris Gregoire signed the bill into law on April 30, 2009. On May 2, 2009, Insurance Commissioner Mike Kreidler asked the Washington Healthcare Forum and OneHealthPort to continue their longstanding public service in the administrative simplification arena and act as lead organizations to implement SSB 5346. The Forum and OneHealthPort accepted the Commissioner's invitation and designated the WorkSMART Institute to undertake the implementation effort. It is in this capacity, as "lead organization" that the WorkSMART Institute respectfully submits this progress report to the Legislature.

This report is not intended as an in-depth study of administrative simplification. Limited background is provided only to establish a context for the work on SSB 5346. Additional information on administrative simplification and the implementation of SSB 5346 can be found on OneHealthPort's web site at: http://www.onehealthport.com/admin_simp/admin_simp_overview.php.

IV. Background

Much has been written about the nature of the health care administrative system. There are varying opinions about how much waste exists, who is responsible for it and how much it costs. However, there is little dispute that:

- There is too much "non-value added" variation in payer business practices and provider work flow.
- The complexity of the administrative system wastes money and increases the stress involved in delivering, receiving and paying for care.
- The nature of the "many-to-many" flow of transactions in the health care system makes it difficult for individual organizations to unilaterally simplify health care administration. A collaborative effort is required.
- A number of improvement opportunities exist in both the public and private sector.

This broad recognition of the administrative side of health care as a collaborative improvement opportunity has spawned a number of efforts over the years both locally and nationally. Selected efforts to streamline health care administration outside of Washington State include:

- At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. While the primary purpose of the act was to facilitate portability of insurance across employers, the Act also included provisions designed to simplify administration by increasing the use of electronic data interchange (EDI). HIPAA mandates development/adoption of EDI standards, universal identifiers and security/privacy provisions related to health care information exchange.

- The Council for Affordable Quality Healthcare (CAQH) has tackled two issues at the national level: common provider credentialing and operating rules for HIPAA transactions. CAQH has deployed the Universal Provider Data Source as a common credentialing solution and Common Operating Rules for Information Exchange (CORE) in an attempt to standardize the business usage of select HIPAA transactions.

- The Workgroup for Electronic Data Interchange (WEDI) operates at the national level to facilitate improved use of EDI. WEDI also sponsors various local collaborative efforts.

- A variety of states have launched administrative simplification initiatives targeted primarily in two areas; common credentialing and local implementations of HIPPA standards. Minnesota and Utah are perhaps the best known for their HIPAA work, while Vermont, Ohio, and others have required standardized approaches to credentialing, at least for health plans.

- The private sector has pursued administrative simplification in a number of ways:
    - In some communities, New England (NEHEN), Utah (UHIN) and Florida (Availity) health care companies collaborated to create networks that streamline the flow of administrative information.

- Major clearinghouse vendors have put in a place an interoperable network that allows electronic claims to be exchanged between payers and providers.
- Most health plans and many providers have worked over the years to improve work flow, and push as much administrative traffic as possible away from paper and the telephone to electronic exchange.
- Thousands of individual vendors have developed and deployed electronic solutions aimed at simplifying the exchange of administrative information.

Administrative Simplification in Washington State

Washington State has also witnessed a robust local effort to simplify health care administration. The WorkSMART Institute is derived from the Forum and OneHealthPort's previous and ongoing work in the areas of administrative simplification and secure information exchange. The Forum's "Admin Simp" program was targeted at simplifying the administrative exchange between health plans and providers. Begun in 2000, the program focused on improvement in three key areas:

- Claims processing
- Referrals and pre-authorizations
- Practitioner credentialing

Over the course of six years, Admin Simp generated 23 different recommended guidelines and policies across the three major problem areas. Admin Simp's Business and Technical Work Group also developed and published local implementation guides for nine major HIPAA transactions.

As a complement to the process improvement work of Admin Simp, the Forum decided to tackle the challenge of secure health information exchange. The Forum recognized that the nature of this work would require an independent business entity capable of bearing risk and managing operations. For this reason, the Forum decided to create a new company to operate the business. OneHealthPort was created as an independent for-profit corporation in 2002 by seven Forum stakeholders that elected to capitalize OneHealthPort and assume an ownership role. The OneHealthPort investors include:

- The Everett Clinic
- First Choice Health
- Group Health Cooperative
- Health Services Northwest (a Swedish Health Services and Providence Health & Services JV)
- Premera Blue Cross
- Regence Blue Shield

OneHealthPort's initial effort was a common security service designed to simplify and protect access to provider portals. Over the course of the last three years, OneHealthPort has complemented the security service with the deployment of additional offerings.

In 2006, the Forum assessed the direction of the Admin Simp program and concluded some course changes were in order. The Forum believed there were synergies that could be realized by blending the work of Admin Simp and OneHealthPort. In early 2007, Admin Simp was integrated with OneHealthPort.

Since Admin Simp and OneHealthPort were founded – exclusive of in-kind contributions, individual enterprise work or fees for services received – the Forum, its constituents and the OneHealthPort principals have invested over $7,000,000 to launch and sustain these two improvement initiatives. In 2008, the Forum and OneHealthPort decided to leverage and expand upon their investment by creating The WorkSMART Institute.

In addition to the Forum and OneHealthPort's efforts, Washington State's Governor, Legislature and Insurance Commissioner were also actively working on administrative simplification. In January of 2007, the Washington State Blue Ribbon Commission on Health Care Costs and Access (BRC) issued its report. Among many other issues, the report dealt with administrative cost. One outcome of the BRC process was passage by the Legislature of SB 5930. This bill directed the Insurance Commissioner to conduct a study of administrative cost and how to address it. The Commissioner contracted with Thomas & Associates to write the study. On November 26, 2007, the final report was delivered to the Legislature. Key recommendations contained in the Commissioner's report were:

- The state should work with one or more private sector venues to host and undertake administrative simplification work.
- The public/private partnership should focus on a discrete set of issues. Priorities included in the study were:
    - Standardizing claim adjudication edits/payment policies and the use of codes
    - Making enhanced eligibility and benefits information available online
    - Improving information and systems to collect the patient's cost share at the point of service
    - Streamlining and standardizing notification requirements for care plans, referrals, and documentation
    - Establishing a single, streamlined online credentialing approach for plans and hospitals
    - Adopting electronic remittance advice, posting, and payment reconciliation
    - Using common forms and a single set of administrative "rules"
- The optimal solution would blend the existing work of the private sector (the Forum and others) with the application of regulatory authority as needed.

The publication of the Commissioner's report stimulated a series of conversations about administrative simplification in 2008 involving the Forum, its constituents, the Insurance Commissioner's Office, the Governor's Office and legislative leaders. While these discussions occurred in a variety of forums and formats and not all parties agreed on all issues, common themes did emerge:

- The problem of administrative complexity requires a collaborative solution across and between private and public sector stakeholders.
- Private sector efforts like the Forum and OneHealthPort's ongoing work should be leveraged, not replaced.
- It is important to accelerate and expand existing private sector efforts.
- Voluntary adoption of administrative reforms is an acceptable initial strategy, but it is important to have regulatory options if voluntary adoption fails.
- There is no single "silver bullet" for reform. The best approach is to concentrate on a few high priority areas.

The primary action step from the private sector was creation of the WorkSMART Institute to expand administrative simplification efforts and provide a platform for a potential public/private partnership. In response to feedback from public sector leaders, the WorkSMART Institute also accelerated the scope and pace of its activity. On the public sector side, Senator Karen Keiser and the Senate Health and Long Term Care Committee took the lead and introduced SSB 5346. This bill, as amended, was broadly supported across the political spectrum and was passed unanimously by both houses of the Legislature.

The core components of SSB 5346 are as follows:

- The Commissioner is assigned the role of appointing a lead private sector organization, overseeing the work of the organization, monitoring the progress of voluntary adoption, promulgating regulations if voluntary adoption is not proving effective and, with the lead organization, reporting results to the Legislature.
- The lead organization is tasked with convening payers and providers to craft solutions called for in the bill, driving voluntary adoption of the solutions and, with the Commissioner, reporting to the Legislature.
- The bill's provisions pertain to all providers, non-federal public payers and private health plans operating in the state.
- There are sixteen solutions called for in the bill, covering areas such as credentialing, claims processing, coding, eligibility and medical management (see a list of solutions in Exhibit A on page 13).
- The solutions called for in the bill are supposed to be broadly deployed by December 31, 2010.

The next section of this report describes progress to date on implementing SSB 5346.

V. Implementation Activities

A key first step in implementing 5346 was to define roles, responsibilities and ground rules for how the public/private partnership would operate. Commissioner Kreidler took the lead in addressing these vital issues by delineating his expectations of the lead organization and how he saw his oversight role relative to WorkSMART's operational leadership. The Commissioner enumerated four core requirements for the lead organization:

1. Execute the work plan – WorkSMART needs to demonstrate rapid progress in delivering the solutions called for in the bill.
2. Be fair, inclusive and transparent – WorkSMART needs to construct and operate a process that allows all interested parties to participate and makes all work products accessible for review and discussion.
3. Be accountable – WorkSMART needs to make regular reports to the Commissioner and facilitate the engagement of his staff in work group deliberations.
4. Drive adoption – WorkSMART needs to demonstrate ongoing success in the voluntary adoption of solutions by plans and providers in the marketplace.

Of equal importance, Commissioner Kreidler also defined how his office needs to conduct itself and he expressed it succinctly – "let the private sector lead". The Commissioner explained that, as long as WorkSMART was complying with the four requirements defined above, it was free to exercise discretion, move decisively and go about its work without micromanagement from his agency. This formulation proved critical to the early success of the implementation effort. By clearly establishing the public sector expectations and allowing the private sector to work freely within that space, the Commissioner enabled the partnership to achieve the best of both worlds – public sector accountability matched with private sector efficiency.

To support accountability and transparency, the Commissioner took two further steps. First, he created an Executive Oversight Group (EOG) composed of providers, payers and public sector officials from across the state (see list of EOG members in the appendix). On a quarterly basis, WorkSMART provides the Commissioner and the EOG with a progress report. The EOG information flow goes both ways – WorkSMART shares updates, and the EOG members can offer suggestions and input. The second step was to assign a senior staff member to participate directly in WorkSMART activities. The Commissioner's representative attends most of the work group meetings, stays on top of the detail, and consults regularly with WorkSMART leadership about issues of interest.

<u>Best Practice Recommendations</u>

For WorkSMART, the task at hand was to establish a process for developing solutions called for in the bill that fit within the requirements established by the Commissioner. WorkSMART elected to adapt the Best Practice Recommendation (BPR) model pioneered by the Forum. A *best practice recommendation* is a better way to get things done that is pragmatic and works for everyone. BPRs:

- Can describe a policy, procedure or a technology
- Move the industry toward best practice as opposed to just simplifying or standardizing current practice
- Leverage national standards where available
- Favor electronic as opposed to paper or manual solutions
- Are voluntary in nature

The BPRs will serve as the solutions delineated in the bill. From a process perspective, WorkSMART structured the BPR methodology specifically to address the requirements for transparency and inclusiveness. The BPR process has the following components:

- Identify strategic priorities – The Forum Board sets the strategic direction within the framework created by the Legislature. In this case, it was to prioritize the implementation of 5346 over other activities.
- Scope the issue – Staff interviews subject matter experts within a given problem space to define the parameters of the problem and potential solutions.
- Set direction – The OneHealthPort Board approves the scope of the problem/solution to be considered based on the staff summary of subject matter expert recommendations.
- Convene work group – A work group consisting of provider and payer subject matter experts is convened to develop draft BPRs for specific issues. Work groups meet face-to-face, usually on a monthly basis and are limited to 20-25 people in order to facilitate rapid progress.
- Review with stakeholders – The draft BPRs developed by the work group are reviewed with the stakeholder group. Stakeholders do their work virtually. As such, there are no limits on the size of the group, and all interested parties can participate.
- Finalize the BPR – Based on stakeholder feedback, the work group finalizes the BPR and it is posted on the OneHealthPort and WorkSMART web sites for public viewing.
- Develop monitoring approach – For each BPR, the work group develops a monitoring/measurement strategy. This may take the form of a formal validation process as in the case of an electronic transaction (e.g., enhanced eligibility), it may be more of a yes/no as with adoption of a policy (e.g., extenuating circumstances for pre-authorization), or it may involve tracking utilization as with the use of a browser for pre-authorizations.
- Study and improve – Consistent with the direction of the Legislature to establish a continuous quality improvement environment, the work group will study results from the implementation of a BPR, identify needed improvements, appropriately modify the BPR and put it back through the review and finalization cycle.

As the work groups develop BPRs, and payers and providers begin to address implementation issues, some provocative questions have been raised about the nature of the process and ultimate goals of the improvement effort. To some degree, these same questions are also playing out in the national reform

debate. The core question is this: should the focus of administrative simplification be a standardization model or a best practice model?

- Standardization – A very precise standard practice is determined. All variation is eliminated; essentially the minimum, the maximum and the standard are the same.
- Best practice – The best practice is identified as the ideal goal the industry should strive for, a minimum level of improvement is set that achieves compliance, and all industry participants are encouraged to move up the ladder toward the best practice. In this model, some variation remains and there are distinctions between the minimum and the maximum.

In crafting its model for the implementation of 5346, the WorkSMART Institute selected the Best Practice approach. While experience to date has raised questions about this decision, on balance WorkSMART believes their choice has been confirmed as the correct one for the following reasons:

- The Legislature explicitly established "continuous quality improvement" as the desired characteristic of the simplification process. The best practice model is more suited to a CQI process. The standardization model presumes one knows in advance what the ideal should be and that the resources to achieve it will be well invested. The best practice model is more tolerant of incremental learning. This fits well with the early experience payers have had. As they attempt to implement BPRs, they have discovered unanticipated questions that need to be resolved by the work groups.
- For better or worse, the current state of the industry is not highly standardized. Variation is present. The best practice model makes it easier for all organizations to make some progress and reduce overall variation at a reasonable cost.
- The BPR concept aligns better with the public/private partnership concept featured in 5346. The minimum supplies the means to measure compliance with the legislatively-mandated solutions. Progress toward the best practice provides a market mechanism to reward continued improvement.

The adoption of the best practice model means that progress toward simplification and continued improvement are the values WorkSMART and its public and private partners will strive to achieve. It also means that measurement of that progress is a critical component of the implementation exercise. While on balance, the adoption of the best practice model appears to be the correct course, it has raised issues, particularly with national constituents.

<u>National vs. Local Interests</u>

There is a longstanding debate over the merits of national vs. local simplification efforts. Local advocates point to their ability to aggregate critical mass, move more rapidly and adapt to the variations in local markets. National advocates point to the difficulty organizations have experienced nationwide in adopting 50 different policies, and the inefficiency inherent in having so many local groups working on the same issue in ways that vary only slightly. WorkSMART has encountered this debate head-on as

national health plans make a good faith effort to adopt the local best practices defined in SSB 5346 while also trying to be respectful of the national reform agenda. A good example of this is the enhanced eligibility transaction. Enhanced eligibility describes an eligibility response sent by a payer to a provider with increased detail about the benefits for a patient being treated. Groups in Minnesota and Utah have implemented the national ANSI X 12 270/271 standards locally to try and address the "last mile" of connectivity. This is widely seen in those states as a progressive step toward simplification. CAQH has promulgated its CORE initiative to also address a progressive objective on a national basis, standardizing business use of the 270/271 transaction. In Washington State, WorkSMART is attempting to tackle both the "last mile," and business usage. All of these efforts are trying to do the "right" thing. However, for national plans like Aetna, CIGNA, United, etc., doing the "right" thing is much more difficult. Do they pick one approach over the other? Do none of the above? Do all? The "right" answer is not obvious.

This debate has not been resolved, and it will impact future simplification efforts in Washington State as these same questions are being pondered at the federal level. The question there is whether to mandate a single national standard or whether to mandate a single national floor and allow the states discretion to go further. In the short term, WorkSMART believes the best approach to take is "reciprocity." Where national "standards," solutions, or broadly-adopted conventions exist, WorkSMART will try to ensure reciprocity. For example, adoption of CORE eligibility conventions by a national plan should suffice as compliance with at least the minimum level of the SSB 5346 best practice. Similarly, the local approach to provider data collection for credentialing should be interoperable with national systems already selected by national health plans. This is an imperfect solution, but one that seems the most realistic in light of the ongoing debate.

SSB 5346 Tasks

Exhibit A lists the sixteen specific solutions in SSB 5346, the section of the bill and the WorkSMART work group charged with developing the solution (work group members are listed in the Appendix).

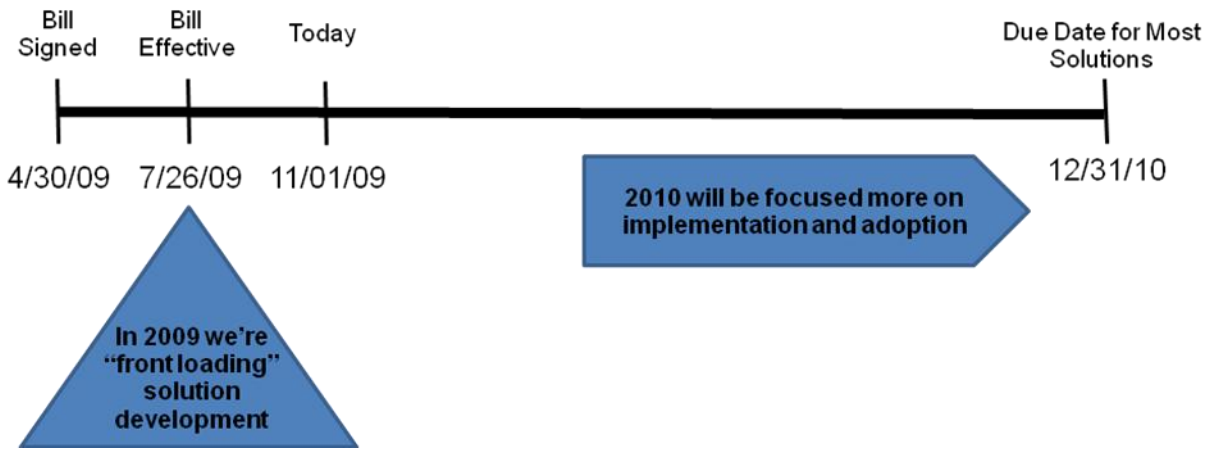
Exhibit A – List of Tasks Set Forth in SSB 5346

#	Task	SSB 5346 Section	WorkSMART Work Group
1.	Develop uniform electronic practitioner credentialing process for hospitals/plans	Sec 6	Credentialing
2.	Work with DOH on interoperability for credentialing system/licensing	Sec 6	Credentialing
3.	Uniform companion document - enhanced eligibility (system-to-system)	Sec 8	Business & Technology
4.	Uniform companion document - enhanced eligibility (browser-based)	Sec 8	Business & Technology
5.	Recommend process to protect plan/provider from retro eligibility denial	Sec 8	TBD
6.	Implementation guideline for CCI edit policy	Sec 9	Code Edit
7.	Implementation guideline for publishing variations from CCI	Sec 9	Code Edit
8.	Implementation guideline - HIPAA remark/group/reason codes on remitts	Sec 9	Business & Technology
9.	Implementation guideline for processing corrected claims	Sec 9	Business & Technology
10.	Implementation guideline for standard payer reconsideration process	Sec 9	Code Edit
11.	By 10/31/10 develop plan for next phase of coding standardization work	Sec 9	Code Edit
12.	Guideline for extenuating circumstances denials of pre-auths	Sec 10	Prior Authorization
13.	Guideline for timely response on pre-auth requests	Sec 10	Prior Authorization
14.	Develop/maintain single common web site for payer pre-service requirements	Sec 10	Prior Authorization
15.	Implementation guideline for payer pre-auth web site	Sec 10	Prior Authorization
16.	By 10/31/10, propose goals/work plan for developing med management protocols	Sec 10	TBD

In assessing how best to sequence the development of the multiple solutions listed in the bill with an implementation process, WorkSMART made two tactical decisions. First, to leverage and adopt relevant BPRs developed by consensus work groups prior to the effective date of SSB 5346. Second, to "front load" development of new solutions in 2009. This meant that the initial priority would be to develop as many of the solutions as possible in 2009. 2010 would then be focused primarily on implementation and adoption. This approach was selected to give payers and providers the maximum period of time to assess, understand and implement the BPRs by the December 31, 2010 deadline.

Exhibit B below illustrates the *front loading* concept.

EXHIBIT B – Front Loading Solution Development in 2009



With this direction, the work groups began an aggressive effort to develop new BPRs and adapt existing BPRs. Numerous individuals from various health plans, public payers, practices and hospitals dug in and worked through an enormous volume of detail in a very compressed timeline. In assessing the progress of the WorkSMART Institute and its constituents on solution creation, it is helpful to consider the following stages of development:

- In Progress – Initial work has begun on this solution
- Draft Solution – A draft BPR has been created by the work group and is under review by stakeholders
- Solution Final – A final BPR has been developed by the work group and posted for the community
- Implementation/Adoption – Payers and providers have begun work to implement and adopt the BPR

Exhibit C below illustrates the status of each of the sixteen solutions called for in SSB 5346, based on the four stages listed above

EXHIBIT C – Tracking Progress on SSB 5346 Solutions

Task	In Progress	Draft Solution	Solution Final	Implement/ Adopt
1. Electronic credentialing process				
2. Interoperability between credentialing/licensing				
3. Enhanced eligibility (system-to-system)				
4. Enhanced eligibility (browser-based)				
5. Retro eligibility denials				
6. CCI edit policy				
7. Publishing variations from CCI policy				
8. Remark, group, reason codes on remitts				
9. Processing corrected claims				
10. Standard payer reconsideration process re: codes				
11. Next phase of coding standardization work				
12. Extenuating circumstances denials of pre-auths				
13. Timely response on pre-auth requests				
14. Common web site payer pre-service requirements				
15. Payer pre-auth web site				
16. Goals/work plan for med management protocols				

With the exception of Task 11, which by its nature is designed to be undertaken in 2010, every other task is underway, most have at least a draft solution in place, and some are already in the implementation phase. The expectation is that, by the end of 2009, a significant majority of the solutions called for in the bill will be in place. This is largely due to the hard work and commitment of the work group leadership, participants and their organizations.

Credentialing

Task 1 on the list above – electronic credentialing process – requires some additional discussion as it is fundamentally different from the other tasks. For all of the other tasks, the role of WorkSMART is to create the solution, and the implementation burden rests on the individual payer and provider enterprises. With credentialing, the only practical way to achieve the objectives outlined in the bill is for WorkSMART to create a service. Because the service requires payment, WorkSMART is effectively creating a business. Because this business is private in nature but partially enabled by legislation, WorkSMART and the Insurance Commissioner's Office (OIC) determined that transparency is particularly important and the nature of the arrangements surrounding the credentialing service should be documented in this report at a more detailed level than other tasks. The approach to credentialing jointly determined by WorkSMART and the OIC is as follows:

- Prior to the passage of SSB 5346, the Commissioner convened a work group of credentialing experts from the public and private sector to assess the costs and benefits of creating a common credentialing solution. The work group concluded it was beneficial to create a common solution, specifically in the area of collecting provider data. This recommendation was

incorporated in SSB 5346. As with the prior BPR work of the Institute, WorkSMART determined that it made sense to leverage the prior work of the Commissioner's group on credentialing rather than starting from scratch. WorkSMART "adopted" the Commissioner's effort and built on that good work going forward.

- WorkSMART determined the preferred course of action was to buy, rather than build, a solution. As such, WorkSMART, with assistance from the work group, developed an RFP and distributed it to three potential candidates: Ingenix, CAQH and Medversant. These candidates were selected because they appeared capable of executing the minimum data collection called for in SSB 5346.
- WorkSMART went through a rigorous vetting process with each of the three vendor responses. Two groups of stakeholder subject matter experts were created; one focused on functional aspects of the responses and one focused on financial aspects of the responses. Each group met independently – though there were a few members who served on both groups – and neither group was shown the other group's information. The two groups were asked to rank the vendor submissions. Both strongly preferred the Medversant response. Medversant's solution was described as "transformative," "superb," and very responsive to the RFP. Medversant's pricing for the data collection service was significantly lower than its competitors. Based on these outstanding recommendations, WorkSMART entered into negotiations with Medversant to execute a letter of intent.
- In order to obtain the best volume pricing and because it could bear business risk, OneHealthPort was designated as the party to contract with Medversant. In this model, OneHealthPort will execute a master agreement with Medversant for the data collection services and then enter into individual agreements with participating payers and hospitals for the same services – the practitioners being credentialed are not charged for the service. Effectively, OneHealthPort will be reselling Medversant's basic service. It was also determined that several payers and hospitals wanted to buy additional services from Medversant beyond the basic service. OneHealthPort negotiated volume discounts for some of these services; however, the contractual relationship for additional services will be directly between Medversant and the participating payer or hospital.
- In addition to being the contracting agent, OneHealthPort will provide authentication services, marketing, tier 1 support, project management and the funds to guarantee the minimum payment due to Medversant for the basic services.
- OneHealthPort worked closely with the OIC to structure the terms of this arrangement. Both agreed that OneHealthPort was entitled to cover its costs and enjoy a modest, limited margin in return for the risk it was taking. Projecting costs, adoption and revenue in this area is challenging due to the absence of relevant data. Therefore, the OIC and OneHealthPort identified what appeared to be a reasonable starting point for pricing to participating plans and hospitals. This allows the business arrangement to be finalized and the service deployed. The OIC and OneHealthPort agreed that, on an annual basis, the costs, revenue, and margin from

the basic credentialing service would be summarized and reviewed with the OIC. Based on that review, OneHealthPort would make any necessary adjustments to pricing for the coming year to ensure that costs were covered, the payers and hospitals received the best possible price, and that OneHealthPort's margins were not excessive.

As of this writing, OneHealthPort and Medversant are continuing their negotiations. A final contract is expected by December 31, 2009. The parties involved to date—the OIC, OneHealthPort and the work group members—are all very enthusiastic about the prospective credentialing service. Practitioners will benefit from only having to enter information once, hospitals and payers will benefit from work flow savings and data quality improvement, and the state as whole will benefit from a significant upgrade to its provider data resources. While not yet implemented, the public/ private approach to provider data collection is off to a promising start.

Payer Implementation and Adoption

While the primary focus of the WorkSMART Institute in 2009 has been on solution development, work has begun in the area of implementation and adoption. Some of the solutions called for in the bill require payers to first put capability in place before providers can begin to adopt it. Other solutions require providers and payers to begin adoption efforts simultaneously. Because it is easier to engage the relatively small number of payers, WorkSMART's initial efforts on adoption focused on payers.

WorkSMART created a payer adoption matrix to track the intent of payers with regard to voluntary adoption of the solutions developed through the work groups. The payer adoption matrix will be posted on the website for public access. The most current version of the matrix, as of the writing of this report, is presented in Exhibit D. The categories of payer responses on the matrix include the following:

- No – the payer does not intend to voluntarily adopt the BPR
- Yes – the payer intends to voluntarily adopt the BPR by the date indicated
- Live – the payer is currently live with the BPR
- Researching – the payer has not yet made a determination

The payer adoption matrix should be viewed with the following considerations in mind:

- It is very early in the process, and payers have had a limited amount of time to digest the BPRs, assess their own environments and determine intent on adoption.
- One of the benefits of the matrix is to create a competitive environment among the payers relative to adoption by their peers. The matrix has not been up long enough to stimulate this type of competitive response.
- The BPRs listed across the top of the matrix do not include all proposed BPRs. The BPRs listed in this initial version include only those BPRs that were finalized early enough for the payers to make a determination. As other BPRs are finalized, they will be added to the matrix.

- There are unusual circumstances that relate to some of the BPRs. For example, the BPR related to timeliness of response on pre-authorization requests is currently in conflict with an existing regulation. The OIC is beginning the process to modify the rule.
- The information is all self-reported. The WorkSMART Institute has not made any effort to independently verify the statements made by the payers. One of the ultimate goals of the monitoring process will be to verify payer adoption of BPRs.

EXHIBIT D – Initial Payer Adoption Matrix

Health Plans	"Eligibility & Benefits (System to System)	Eligibility & Benefits (browser)- Stakeholder Feedback	Pre-Auth & Admission Extenuating Circum.	Notification Timeframes for PreAuth Requests (2)	Browser Capabilities for Pre-Auth	Claim Coding Policy & Edits	Corrections to Professional Claims - Stakeholder Feedback	Corrections to Institutional Claims - Stakeholder Feedback
Aetna	Live with BPR	Live with BPR	Live with BPR	Yes	Live with BPR	Live with BPR (4)	Yes by 12/31/2010	Yes by 12/31/2010
Asuris Northwest Health	Live with BPR	Yes by 12/31/2010	Yes by 12/31/2010	Live with BPR	Yes by 12/31/2010	Live with BPR	Live with BPR	Live with BPR
Cigna	Yes by Q1 2010	Live with BPR	Live with BPR	Live with BPR	Live with BPR	Live with BPR	Live with BPR	Live with BPR
Community Health Plan	Researching (6)	Researching(6)	Researching(6)	Researching(6)	Researching (6)	Researching (6)	Researching(6)	Researching(6)
Group Health Cooperative	Live with BPR	Live with BPR	Yes by 12/31/2009	Live with BPR	Yes by 12/31/2009	Yes by 12/31/2010	Live with BPR	Live with BPR
Kaiser Foundation Health Plan of the Northwest	No (1)	Researching	Researching	Live with BPR	Researching	Live with BPR	Live with BPR	Live with BPR
KPS Health Plans	Yes by TBD	Live with BPR	Yes by 4/30/2010	Yes by 4/30/2010	Live with BPR (5)	Yes by 12/31/2010	Yes by 4/01/2010	Yes by 4/01/2010
LifeWise of Washington	Live with BPR	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010
Molina Health Plans	Researching (3)	Researching (3)	Yes by Final WAC	Yes by Final WAC	Researching	Yes by 12/31/2010	Researching	Researching
PacificCare	Yes by 1/1/2012	Researching	Live with BPR	Live with BPR	Yes by TBD	Live with BPR	Researching	Researching
Premera Blue Cross	Live with BPR	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010	Yes by 12/31/2010
Regence BlueShield	Live with BPR	Yes by 12/31/2010	Live with BPR	Live with BPR	Yes by 12/31/2010	Live with BPR	Live with BPR	Live with BPR
United Healthcare	Yes by 1/1/2012	Researching	Yes by 1/1/2010	Live with BPR	Live with BPR	Live with BPR	Researching	Researching
WA ST DSHS (Medicaid)	Live with BPR	Live with BPR	Live with BPR	Live with BPR (2)	Yes by 7/1/2012	Yes by 12/2009	Live with BPR	Live with BPR
WA ST Dept of Labor and Industries (DLI)	not applicable	Researching	Live with BPR	Researching (7)	Yes by 12/31/2009	Yes by 12/01/2012	Researching	Researching
First Choice Health Administrators	Yes by Q1 2010	Yes by Q4 2009	Live with BPR	Live with BPR	Live with BPR	Yes by Q4 2010	Live with BPR	Live with BPR

Footnotes to table:
(1) Can provide most of the information but accumulators are located in another system and are not available for 270/271 responses
(2) Within constraints of WAC 388
(3) Member Coinsurance/Deductible not present for vast majority of enrolled (Medicaid) population.
(4) Live with Medicare business and Transparency for all business lines. No on CCI edits for commercial business.
(5) Live with submitting auth electronically, YES for BPR by 12/31/2010
(6) In the middle of a major TPA switch, will engage after 1/2010.
(7) Live with URAC, researching other portions.

Even with all of the considerations and constraints, a review of the initial payer matrix provides a very positive indication of how Washington payers have embraced the spirit of voluntary adoption. The overwhelming response from payers is that they *do* intend to voluntarily adopt the BPRs developed through the SSB 5346 process. In fact, a number of plans have made extraordinary arrangements to get at least some of the BPRs live now, well in advance of the December 31, 2010 date established in the bill. WorkSMART has been gratified and impressed by the willingness of public and private payers to invest in change that will simplify health care administration in Washington State for all parties.

Provider Implementation

The initial focus on payer adoption should not obscure the crucial importance of provider adoption. Little real benefit can be generated for anyone unless provider organizations implement their portion of the BPR solutions also being implemented by the payers. SSB 5346 is very clear in calling for changes to be made by both payers and providers. While little work has been done to date by WorkSMART on provider adoption, initial discussions revolve around three provider adoption challenges:

- Thousands of providers – The provider community is far more numerous than the payers. It has been possible to engage in repetitive one-to-one conversations with most payers. This will not be practical in the provider community. How does WorkSMART reach large numbers of providers cost-effectively?
- Getting providers to engage – Most payers have dedicated resources focused on government relations, performance improvement, IT, project management, etc. With payer organizations, the typical communication challenge is trying to find the right person. Few provider organizations have people with this type of dedicated expertise. The vast majority of provider organizations are focused on seeing patients and trying to stay afloat. Among other things, this discrepancy in change management resources between providers and payers makes it much more difficult to engage providers in the BPR development/implementation process. In this environment, how does WorkSMART get someone in the provider organization to care enough about SSB 5346 solutions to engage?
- The number of solutions – Going to market with a single solution poses a number of challenges. Going to market with 16 solutions is much more daunting. In addition, other improvement efforts – quality, HIT, etc. – are also targeting this same population. How does WorkSMART parse the total set of solutions to make it palatable to the provider market?

While WorkSMART has not settled on a given set of outreach strategies and tactics, ideas being discussed include:

- Leveraging the Washington State Medical Association, the Washington State Hospital Association and other professional organizations to reach larger numbers of providers.
- Partnering with other organizations targeting providers with improvement efforts.
- Staggering the roll-out of solutions by featuring limited numbers of offerings over a longer time period.

- Taking a more active and aggressive approach on a few higher value/visibility solutions and taking a more passive and low key approach on others.

In 2010, provider adoption will become a much more prominent part of WorkSMART's effort.

Measurement and Monitoring

As discussed above, most of the effort to date has been on development of solutions. The payer adoption matrix is the only published work that has been done on the measurement and monitoring front. However, below the surface, the work groups have begun to consider how to measure and monitor implementation and adoption. While these efforts are at a very early stage, some conclusions are beginning to form:

- All BPRs are not alike. Validating a complex 270/271 eligibility data standard will require a different approach than validating adoption of a policy like extenuating circumstances for pre-authorization. Work groups have begun to develop initial validation methodologies for some of the BPRs. In most cases, it is still a work in progress
- Validation methodologies will be designed to serve two purposes. A "public" purpose to determine if payers and providers are adopting the SSB 5346 solutions and, a "private" purpose designed to guide the ongoing improvement efforts of the work group and individual enterprise. In some cases the private measurements may be more granular than the public measures.
- Measures may include both quantitative and qualitative indicators. For example, what percentage of pre-authorization requests are submitted through the browser tool that payers have been required to implement versus what percentage still come in by phone and fax? This, in contrast with how providers rate the browser tool offered by Payer A versus that offered by Payer B.
- In many cases, WorkSMART and the OIC will depend on the payers and providers to collect information. The best way to validate payer adoption is through providers who use the service. And, the best way to validate provider adoption is through the payers they interact with.

One particularly thorny measurement challenge being anticipated is the calculation of "savings." The underlying rationale for SSB 5346 is to save money by simplifying administration. Because this effort is at a very early stage of adoption, it is premature to attempt to measure savings related to SSB 5346. However, WorkSMART does have extensive experience in attempting to measure return on investment (ROI) in the private market. Based on this experience, WorkSMART has learned that calculating "savings" from any investment in systematic health care improvement is problematic. Whether in the public or private sectors, whether it's cost control measures, deployment of technology or preventive care, agreeing on metrics, conducting measurements, controlling for all the variables and attributing a given outcome to a specific intervention is very difficult.

WorkSMART believes that solutions called for in SSB 5346 are more accurately viewed as an opportunity for improvement within a given enterprise than as system-wide savings. Each enterprise may capitalize on the improvement opportunity in different ways based on:

- Structural differences between organizations
- Where they started from versus where they ended up
- How effectively they deployed the solution
- How efficient they were at capturing the benefits from the implementation
- How they deployed whatever benefit they captured
- How they measured the benefit captured

Here are two examples:

> 1) Even with simplified administration, a small physician practice with very limited staff may not be in a position to "save" money by reducing headcount because they have minimum staffing levels. However, the opportunity for improvement may allow that practice to see more patients or deliver better service. What are the savings in this case, and how are such savings calculated?
>
> 2) A health plan that is already a top performer may paradoxically generate fewer "savings" from adoption of a best practice than a lower-performing organization because the higher-performing plan had already incorporated the best practice in their operations before the measurement was taken. What's the "right" savings measure in this case, and how is it actionable?

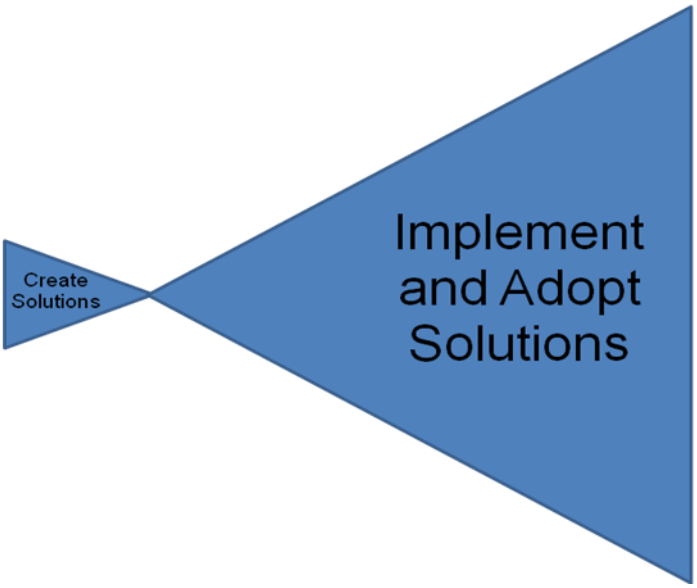
This does not mean measures of success are unimportant or irrelevant – quite the contrary. However, it does mean that expectations should be realistic regarding the ability to measure quantitative monetary savings from specific administrative improvements.

V. Next Steps

On December 1, 2009, SSB 5346 will have been in force for slightly over four months. Progress has been made on a number of fronts:

- A collaborative and cordial partnership has been established between the private sector and the public sector.
- Stakeholders have willingly participated in the work group effort.
- An efficient, fair and transparent process has been put in place to develop solutions.
- Significant progress has been made on creating best practices.
- A rudimentary continuous quality improvement process has been introduced.
- Initial indications are that payers are voluntarily adopting the solutions called for in the bill.

This effort appears to be off to a very good start. While the progress is notable, much of the hardest work lies ahead. The scope and range of the solution set included in SSB 5346 is more extensive than any other state administrative simplification legislation, to the best of WorkSMART's knowledge. It can fairly be said that the Legislature aimed high and hit their target. The advantage of this approach is that there is a greater potential for overall improvement. The drawback is the challenge of implementation. WorkSMART has the easier job: crafting the solutions. The provider and payer enterprises have the harder job: implementing change. The illustration below highlights the relative scope of the two challenges.



The initial adoption matrix testifies to the intent of most payers to work through this challenge. Not to minimize the difficulties facing payers, but the greater concern is with the provider side. Provider organizations tend to be much smaller and most have very limited change management skills and resources. This will pose perplexing choices in designing provider outreach and adoption strategies. It

also has implications for how the Insurance Commissioner and Legislature ultimately determine how successful voluntary adoption has been and what time interval is used to make that assessment.

Conventional wisdom is that implementation of SSB 5346 runs from July 26, 2009 thru December 31, 2010. Based on its initial implementation effort, a longer time horizon may need to be considered. It is reasonable to believe that the solutions called for in SSB 5346 will be translated into best practice recommendations and deployed in the market by December 31, 2010. However, despite the willing participation of providers and payers, it may take considerably longer to drive adoption of all of these changes in the Washington State health care marketplace. In its communication with all types of stakeholder groups, WorkSMART is hearing a common message typified by the illustration below:

Across the industry, there is a shared sense of increasing stress and pressure. Payers and providers are being pushed from a number of directions to do more with less, and do it better — all during difficult economic times. In addition, there is significant tension surrounding national health care reform. Will it happen? If so,when? What will it mean to me? There is no disagreement that the health care industry needs to improve performance, nor is there a belief that reform is unnecessary. However, the theory of change, even the belief in change is not the same thing as executing change on the ground in a complex health care market place comprised largely of small businesses.

All participants engaged in this ambitious effort to simplify health care administration must continue to push aggressively for meaningful results in the short term, and take the longer view to fully assess the progress of change across the spectrum before adding new work. This longer view will give stakeholders the opportunity to assess how best to integrate SSB 5346 with:

- National health care reform
- Changes and consolidation in the local market
- Potential modifications to financing and reimbursement approaches
- Ongoing efforts to improve the health information infrastructure

How some of these emerging trends play out over the next year could significantly impact recommendations WorkSMART would make for future phases of administrative simplification. For its part going forward, the WorkSMART Institute is committed to:

- Assessing and improving its own performance as lead organization. Specifically to increasing its outreach and communication efforts and developing innovative approaches to stimulating adoption of best practices
- Continuing to operate in a fair, inclusive and transparent manner
- Working collaboratively with the OIC to strengthen the existing partnership
- Seeking all opportunities to leverage investments being made by others in work flow improvement, quality management, information technology and standards for the betterment of administrative simplification
- Applying its best professional effort to continue the successful implementation of SSB 5346

WorkSMART appreciates the opportunity to serve as the lead organization for administrative simplification in Washington State.

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Respectfully Submitted:

Richard D. Rubin
President & CEO, OneHealthPort

Appendix

Administrative Simplification Executive Oversight Group - October 2009

Commissioner Mike Kreidler

9 Providers - Organization/Name

Thomas C. VanSweringen	Vancouver Clinic
Patricia Briggs	NW Physicians Network, Tacoma,
Richard Cooper	Everett Clinic
Shaun Koos,	Wenatchee Valley Medical Center
David Page	Physicians Clinic of Spokane
Rodger McCollum	Snoqualmie Valley Hospital
Chrissy Yamada	Evergreen Healthcare, Kirkland
John Fletcher	Providence Health System
Denise Martel	Sound Family Medicine, Puyallup

6 Associations - Organization/Name

Bob Perna	WSMA
Leo Greenawalt	WSHA
Rick Rubin	OneHealthPort
Don Brennan, Abbi Kaplan	WA Healthcare Forum
Sydney Zvara	Assoc. of WA Healthcare Plans
Mary McWilliams	Puget Sound Health Alliance

8 Payers - Organization/Name

Brian Ancell,	Premera
Joel Suelze,	Group Health Cooperative
Laurel Lee,	Molina
Jonathan Hensley	Regence BlueShield
Marilee McGuire	Community Health Plan of WA
MaryAnne Lindeblad	DSHS/HRSA [Medicaid]
John Williams	Health Care Authority
Jonathan Seib	Governor's Executive Policy Office

WorkSMART Workgroup Rosters

Business & Technology Workgroup

Organization	Participants
Chilren's Hospital and Medical Center	Beth Whitney Bill Stout
Clinitech (The Everett Clinic)	Bob Ferguson
Swedish/Providence	Maureen Mann
University of Washington Physicians	Bob Mackay Patrick Harrison
Virginia Mason Medical Center	Kevin Chambers Amy Goldthorpe Stefanie Henderson
Wenatchee Valley Clinic	Cheryl Parkins
FCHA	Ann Emory Don Cooley Cindy Brack
GHC-Provider & Payer	Linda Gilmer Kim Mitchell Gladys Jones Rick Ridgeway
HRSA	Chris Nguyen
Premera	Pam Cottrell Kathy Leahy
Regence	Karyn Corey Jeri Gilstrap
Washington Dental Services	Larry Vandel
OIC	Pete Cutler

Code Edit Workgroup

Organization	Name
Everett Clinic	Karen Franz LaRhonda Durant
Health Services Northwest	Maureen Mann
Multicare	Lynn Herberholz
Northwest Hospital	Sara Blair
Northwest Physicians Network	Phyllis M. Smith
Puget Sound Family Physicians	Fran Daoust
UWP	Patrick Harrison Tonya Alexander
Virginia Mason	Kristi Heussy Kara Cuzzetto
Yakima Urology Associates	Tracey Brooks
FCHA	Evelyn Erdely
GHC	Nancy Lambert
HRSA	Gail Kreiger Cynthia Smith
Molina	Karen Slean Rachele Bridgman
Premera	Dan Richardson Tammy Bowers
Regence	Jeri Gilstrap Kay Etherington
OIC	Pete Culter

Prior - Authorization Workgroup

Organization	Name
Everett Clinic	Karen Franz LaRhonda Durant
Harborview	Phyllis Ochs Cindy Sleighter
Multicare	Lynn Herberholz
Northwest Hospital	Sara Blair
Northwest Physicians Network	Phyllis M. Smith
Physician's Clinic of Spokane	Emilia Keener
Providence-Everett	Sandy Hammer Kelly Kikuchi
Puget Sound Family Physicians	Fran Daoust
Sacred Heart	Lisa Hixson
Swedish Hospital and Physician's Division	Andrea N. Tackett Penny Young
UWP	Patrick Harrison
Virginia Mason	Kristi Heussy Kara Cuzzetto
Yakima Urology Associates	Tracey Brooks
FCHA	Ruth Baker Judy Denny
GHC	Christi Johnson
HRSA	Gail Kreiger Cynthia Smith
Labor & Industries	Nikki D'urso
Molina	Shari Fowler-Koorn
Premera	Laurie McCraney
Regence	Jeri Gilstrap Kay Etherington
OIC	Pete Culter

Retroactive Denied Eligibility Participants

Organization	Name
Children's Hospital & Medical Center	Bill Stout
Everett Clinic	Iwalani Pacquet
Health Services Northwest	Debbie Williams
Multicare	Jason Adams
Northwest Physicians Network	Lori Marceaux
Physician Clinic of Spokane	Emilia Keener
Puget Sound Family Physicians	Fran Daoust Marci Shimada
Sacred Heart	Lisa Hixson
Sound Family Medicine	Denise Martel
UWP	Patrick Harrison
Virginia Mason	Patricia Johnson
Yakima Urology	Tracey Brooks
Cigna	Joyce Reichard
Columbia United Providers	Cindy Lea Orth
First Choice	Sara Kasper
Group Health	Joel Suelzle Debra Moore Ed Madden
HRSA	Carole McRae
Kaiser Permanente	Merlene Converse
KPS	Teresa Haigh Braget
Molina	Laurel Lee
Premera	Loy Suderman
Regence	Jeri Gilstrap
Association of Washington Health Plans	Sydney Zvara
Washington State Medical Association	Bob Perna

Credentialing Workgroup

First Name	Last name	Organization
Bettina	Acosta	UW
Frank	Barrows	Premera Blue Cross
Cindy	Bergley	Premera Blue Cross
Shannon	Beigert	DOH
Georganna	Biggins	Childrens Hospital
Kate	Brown	Multicare - Puyallup
Margaret	Calhoun	GHC
Rick	Cooper	The Everett Clinic
Maura	Craig	Dept of Health
Pete	Cutler	Office of the Insurance Commissioner
Jason	Delasandro	Premera Blue Cross
Marc	Droppert	Graham & Dunn
Joseph	Elder	CHP
Lynda	Evans	Providence
Beth	Fountain	Community Health Plan of Washington
Jean	Gambrielle	Northwest Physicians Network (delegated group) and Puget Sound Health Partners (small Medicare health plan)
Hattie	Good-Clabby	Regence of Washington
Danne	Goodwin	CHPW
Jeff	Goroski	Molina Healthcare
David	Green	UW
Renae	Hamshar	Providence Centralia Hospital
Andi	Hanson	DSHS
Chuck	Hitchings	DLI
Shannon	Howard	Regence
Becky	Johnson	Molina Healthcare
Patricia	Johnson	VMMC
Jim	Kamerer	DLI
Bill	Keller	Premera
Anne	Krepick	Graham & Dunn
Kandi	Long	Franciscan Hospitals
Robin	Lutka	FCHN
Sarah	Marlowe	DOH

Credentialing Workgroup Continued

First Name	Last name	Organization
Sam	Marshall	DOH
Pam	Martin	HCA
Melanie	Maurice	Regence
Rhonda	May	Multicare
Gisela	Mejia	Northwest Credentials Verification Service
Rob	Menaul	WSHA
Sue	Merk	OneHealthPort
Sandy	Mitchell	DSHS
David	Overby	WA ST Dept of Labor and Industries
Elizabeth	Pelley	FCHN
Bob	Perna	WSMA
Rita	Rakestraw	UW
Patti	Rathbun	Dept of Health
Katherine	Reed	Central Washington Hospital
Rick	Rubin	OHP
Pammeal	Schriever	Premera
Evelyn	Sinsel	VMMC
Paula	Thibodeau	GHC
Howard	Thomas	OIC
Paige	Wall	DSHS

Washington Health Care Forum Board of Directors

Scott Armstrong
Group Health Cooperative

H.R. Brereton (Gubby) Barlow
Premera Blue Cross

Don Brennan
Health care executive

Don Brunell
Association of Washington Business

Rick Cooper
The Everett Clinic

Rod Hochman
Swedish Health Services

Gary Kaplan
Virginia Mason

Jonathan Hensley
Regence Blue Shield

Diane Cecchettini
MultiCare

Tom Curry
Washington State Medical Association

Ken Hamm
First Choice Health Network

John V. Fletcher
Providence Health & Services

Leo Greenawalt
Washington State Hospital Association

Michael Wilson
Sacred Heart Medical Center

Sydney Zvara
Association of Washington Health Plans

Abbi Kaplan, Forum Executive Director

OneHealthPort Board of Directors

Brian Ancell
Premera Blue Cross

Florence Chang
MultiCare

Rick Cooper
The Everett Clinic

Jac Davies
Representing the Washington State Hospital Association

Peter Dunbar
Representing the Washington State Medical Association

Ken Hamm
First Choice Health Network

James Hereford
Group Health Cooperative

Vaughn Holbrook
Regence Blue Shield

Steve Schaefer
Virginia Mason

Debbie Williams
Health Services Northwest (Joint venture of Swedish Health Services and Providence Health & Services)