



# TRENDWATCH

## Redundant, Inconsistent and Excessive: Administrative Demands Overburden Hospitals

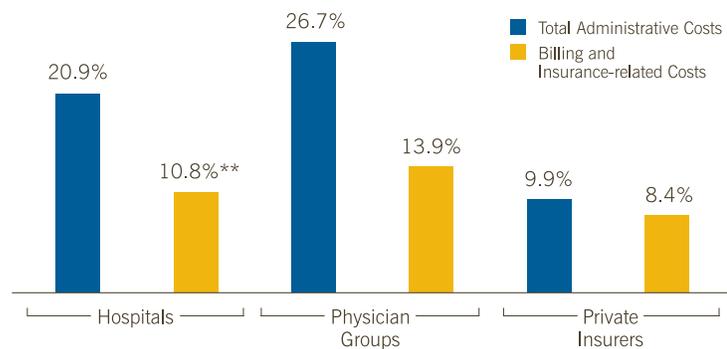
Hospital managers strive to run high-performance health care organizations that deliver the best quality care to their patients. Beyond the mission of providing quality care, hospitals also must comply with government regulators', payers' and other stakeholders' ever-growing administrative requirements. Such activities are increasingly diverting precious resources away from patient care and contributing to making health care less affordable.

Administrative costs stem from functions that are necessary to operate a health care organization but that are not directly associated with the "hands on" delivery of patient care. Some activities are purely administrative, such as those for claims processing, billing, data reporting, and complying with regulations at the national, state and local levels. Other administrative work is linked to patient care, such as admissions and discharge processes, clinical record keeping, utilization review and quality improvement programs. While these administrative functions are essential to providing high quality care, when they become redundant or excessive administrative tasks impose undue burden on health care organizations.

Given the breadth of activities considered administrative and the many layers of costs, few studies have

### Administrative costs are a big part of health care spending.

Chart 1: Percent of Revenue Spent on Total Administrative Costs and Billing and Insurance-related\* Costs by Entity

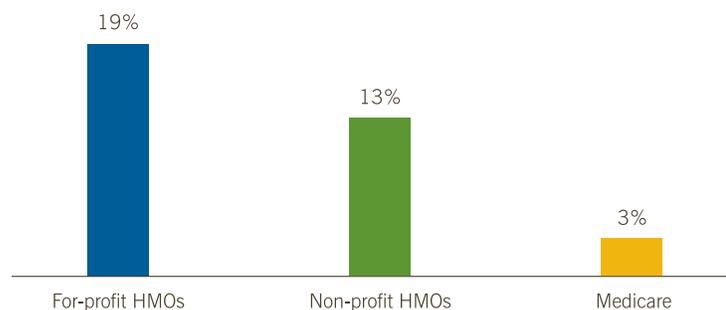


Source: Kahn, J.G., et al. (2005). The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals. *Health Affairs*, 24(6), 1629-1639.

\* Billing and insurance-related figures represent a portion of total administrative spending.  
\*\* 10.8% is the high estimate of the range; figure could be as low as 6.6%.

### Private managed care organizations have higher administrative costs than Medicare.

Chart 2: Percent of Revenues Spent on Administrative Costs by Type of Insurer, 1999



Source: Woolhandler, S., & Himmelstein, D. (2004). The High Costs of For-profit Care. *Canadian Medical Association Journal*, 170(12), 1814-1815.

estimated health care administrative costs in their totality. A 2007 Congressional Research Service report estimated that the U.S. spent \$465 per capita on health administration.<sup>1</sup> This report included spending by insurers not attributable to medical costs, plus administrative spending by government programs and philanthropies, but it did not include downstream administrative spending of hospitals and caregivers. Other studies have estimated that approximately one quarter of hospital spending is for administration.<sup>2</sup> Physicians' offices may spend as much as 27 percent of their revenue on administration, including 14 percent for billing and insurance-related functions.<sup>3</sup>

Administrative activities of insurers – claims administration, premium billing, underwriting, marketing and the like – account for a considerable share of the cost of health insurance. It is estimated that administrative processes consume 10 percent of insurance premiums for large employer group plans, and as much as 40 percent of individual insurance plan premiums.<sup>4</sup> In the first quarter of 2008, major health insurers Humana, United, WellPoint and Aetna reported spending 80 to 87 percent of premium revenue on medical benefits, retaining 13 to 20 percent of the premium for administrative activities and profit.<sup>5</sup>

Private insurers' administrative costs are estimated to be two-and-a-half times those of public programs such as Medicare and Medicaid, largely due to tasks that public insurers do not perform, such as those related to

marketing and compliance with state and federal regulations.<sup>6</sup> Public programs do, however, incur administrative costs, such as those associated with enrollment and claims processing. For example, in one city researchers found that it takes \$280 to enroll one child in Medicaid.<sup>7</sup>

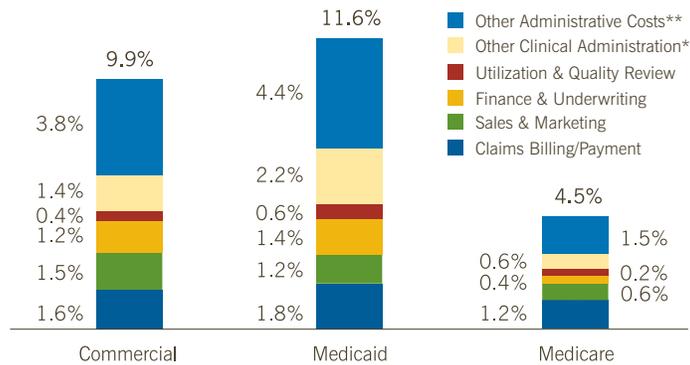
Aside from the significant financial costs, administrative activities can have a direct and important effect on patient care. For example, administrative duties

consume time of nurses and other clinical personnel that could be spent caring for patients. One study found that paperwork adds at least 30 minutes to every hour of patient care.<sup>8</sup>

Many administrative tasks are duplicative, overlapping or even conflicting. Streamlining or reducing administrative requirements offers a prime opportunity to lower health care spending without sacrificing the quality of patient care.

### A number of components drive health plan administrative spending.

Chart 3: Percent of Health Plan Costs by Administrative Function, 1996-2000

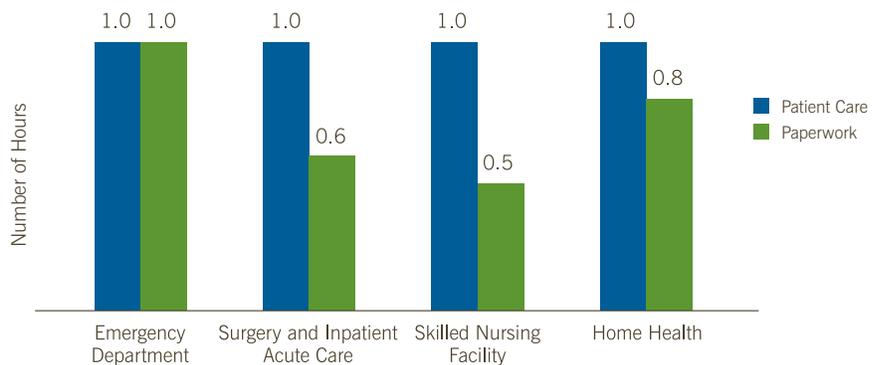


Source: Kahn, J.G., et al. (2005). The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals. *Health Affairs*, 24(6), 1629-1639.

\* Other clinical administration includes case management, medical director costs and other health care related services.  
 \*\* Other administrative costs include membership and billing, customer service, provider services and credentialing, information systems and general administrative costs.

### Paperwork demands take time away from patient care.

Chart 4: Time Spent on Patient Care vs. Time Spent on Paperwork,\* by Setting



Source: American Hospital Association and PricewaterhouseCoopers. (2001). *Patients or Paperwork? The Regulatory Burden Facing America's Hospitals*.

\* Figures for paperwork show time spent on paperwork for each hour spent on patient care.

**\$465**  
per capita  
U.S. spending on health administration

## Myriad Payers Place Administrative Burden on Hospitals

To ensure that the resources exist to deliver high-quality patient care, hospitals must perform financial and operational functions such as coding and billing of claims, utilization review and determining patient insurance eligibility and benefit structure. The growing complexity of the U.S. health care financing system adds to the effort required to perform these functions. For example, there are more than 1,000 private insurance companies, plus many more employers who self-insure for employees' health care, in addition to

public payers such as Medicare, Medicaid and the Department of Defense.

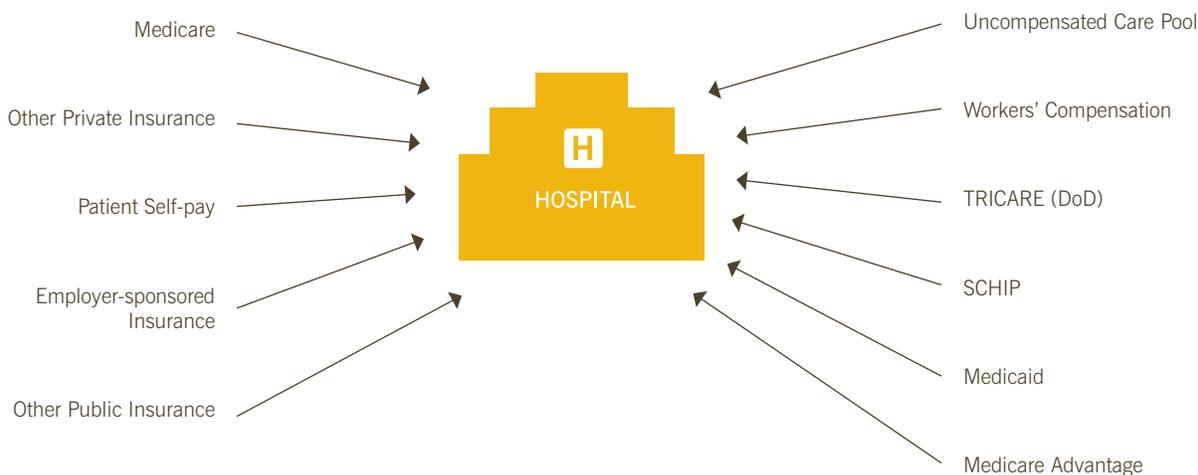
Each of these payers offers a range of insurance products – types of health plans – and each product can have different combinations and permutations of covered and excluded services, patient cost-sharing, payment schemes and rules.<sup>9</sup> Hospitals must comply with payers' requirements for preauthorization and admission notification, as well as utilization review and reporting requirements.

Unfortunately, there is no standard set of requirements that hospitals must

follow; each insurer can set its own requirements as well as change those requirements at any time without consultation with the hospitals that must comply with them. For example, a large national insurer recently announced a change in policy requiring hospitals to notify the insurer of all inpatient admissions within 24 hours (rather than the more common practice of "next business day") in order to receive full reimbursement for the admission.<sup>10</sup> Hospitals, which have had to employ weekend and holiday administrative staff

### Hospitals receive payments from a variety of public and private payers...

Chart 5: Hospital Payer Types



Source: The Center for Health Affairs. (2007). *Hospital Finance 101*. Cleveland, OH.

“ ”  
*from the field*

“ A greater focus on quality measurement and improvement is always welcome, but the current plethora of measures and diverse requirements for providers without an underlying framework and phase-in approach leads to confusion, diversion of resources from direct patient care or other quality and safety improvement efforts, and in the long run will hamper rather than enhance the quality movements.” <sup>41</sup>

Gregg Meyer, MD, Senior Vice President for Quality and Safety, Massachusetts General Hospital

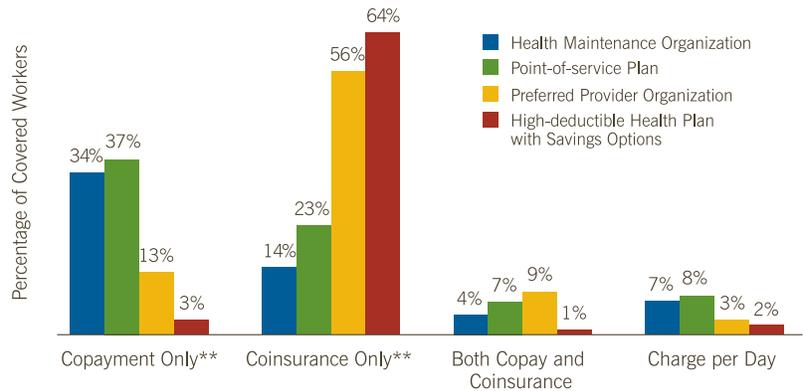
to comply, have expressed a number of concerns regarding the new policy, including the insurer's failure to engage the hospital community in its development. And while this insurer recently provided more transition time and eased the requirements for critical access hospitals, this new area of variation still raises hospital administrative costs.

Further, as payers change patient cost-sharing arrangements – introducing high-deductible health plans, health savings accounts, multi-tiered coinsurance tied to provider rankings – hospitals are devoting more administrative resources to billing activities, making changes to their claims processing systems, and helping patients understand their coverage. These functions add to the administrative costs that hospitals incur. Thus, it is not surprising that U.S. spending on administrative health care costs is greater than that of other countries.<sup>11</sup>

Likewise, hospitals must comply with thousands of pages of Medicare regulations and guidance issued yearly through the hospital inpatient and outpatient prospective payment system rules, as well as regulations governing psychiatric hospitals, long-term acute-care hospitals, and skilled nursing facilities. These rules set payment rates, establish standards for claims submission, communicate coverage decisions, explain what services can be done in which care settings and set reporting requirements. Hospitals must employ many people just to

**...and must navigate the complex and variable payment structures of health plans.**

Chart 6: Percent of Workers with Health Insurance Who Must Pay Cost-sharing\* for a Hospital Admission, by Plan Type, 2007



Source: Kaiser Family Foundation & Health Research and Educational Trust. (2007). *Employer Health Benefits 2007 Annual Survey*. Washington, DC: Kaiser Family Foundation.

\* In addition to any deductible.  
 \*\* A copayment is a fixed dollar amount required by a health insurer to be paid by the insured at the time a service is rendered; coinsurance is a set percentage of the charge or fee for services to be paid for by the insured.

implement these policies and to ensure that their systems and processes are in compliance.

In addition to these national rules, hospitals also must be cognizant of local rules for coverage of treatment and therapies. The Centers for Medicare & Medicaid Services (CMS) is replacing the current claims payment contractors – Fiscal Intermediaries for Part A and Carriers for Part B – with new contractors called Medicare Administrative Contractors (MACs). Each MAC will make coverage decisions

for the specific region(s) it oversees.<sup>12</sup> This will result in regional differences in coverage.<sup>13</sup> By 2009, there will be 15 MACs across the country that will process Medicare Part A and Part B claims and create local coverage policies.<sup>14</sup> This patchwork approach, while using fewer total contractors than today's system, will continue to pose major challenges for providers – particularly multi-state health systems – that may have to contend with different rules and processes within the Medicare program itself.<sup>15</sup>

“ ”  
*from the field*

“Like many other observers, I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as a staggeringly complex public system with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird.”<sup>16</sup>

Henry Aaron, PhD, Senior Fellow, Brookings Institution

## Streamlining Public Program Oversight Could Yield Administrative Savings

The federal government devotes significant effort to make certain that the Medicare and Medicaid programs pay providers accurately and avoid fraud and abuse. Annual funding for CMS oversight exceeds \$700 million for the Medicare Integrity Program<sup>17</sup> and is currently \$50 million for the Medicaid Integrity Program.<sup>18</sup> These programs have overlapping objectives, offering an opportunity to streamline their efforts without diminishing their results.

CMS hires private contractors to carry out these oversight programs. In theory, each contractor has an individual assignment, but in practice there is duplication across the work of the contractors. For example, at least

two different contractors review the adequacy and accuracy of Medicare payments, review claims to determine if procedures are medically necessary and conduct audits. At least four different contractors identify and investigate fraud and abuse.<sup>19</sup> To abide by CMS rules, hospitals and other institutional providers must work with these contractors and CMS by submitting cost reports and medical records, complying with audits and participating in administrative hearings and appeals. Managing interactions with multiple contractors adds complexity and costs to these activities.

According to the Government Accountability Office, CMS has not

actively assessed the comparative effectiveness of these multiple programs, nor does it know whether the programs yield benefits commensurate with their cost to both CMS and providers.<sup>20</sup>

Health care organizations also must ensure that they meet Medicare program participation requirements. For example, hospitals must comply with approximately 500 standards of practice that make up the Conditions of Participation for Medicare,<sup>21</sup> as well as 307 pages of interpretive guidelines governing hospitals.<sup>22</sup> These conditions govern everything from staffing and records management to food services and the physical environment of a hospital.<sup>23</sup>

### Multiple Medicare contractors perform the same oversight activities...

Chart 7: Medicare Oversight Activities by Type of Medicare Contractor

| Activity  | FIs* | Carriers | MACs** | PSCs*** | COB Contractor* | NSC* | DAC Contractor* |
|---|------|----------|--------|---------|-----------------|------|-----------------|
| <b>Audit</b> – Reviewing cost reports for institutional providers   | ✓    |          | ✓      | ✓       |                 |      |                 |
| <b>Medical Review</b> – Reviewing claims to determine whether services provided are medically reasonable and necessary        | ✓    | ✓        | ✓      | ✓       |                 |      |                 |
| <b>Secondary Payer</b> – Identifying primary sources of payment   | ✓    | ✓        | ✓      |         | ✓               |      |                 |
| <b>Benefit Integrity</b> – Identifying and investigating fraud and abuse and referring cases to law enforcement agencies      |      |          |        | ✓       |                 | ✓    | ✓               |
| <b>Provider Education</b> – Communicating Medicare coverage policies, billing practices and issues related to fraud and abuse | ✓    | ✓        | ✓      | ✓       |                 |      |                 |

Source: Avalere Health analysis and adaptation of Government Accountability Office. (September 2006). *Medicare Integrity Program: Agency Approach for Allocating Funds Should Be Revised*. Washington, DC.

\* FI = Fiscal Intermediary; MAC = Medicare Administrative Contractor; PSC = Program Safeguard Contractor; COB = coordination of benefits; NSC = National Supplier Clearinghouse; DAC = data analysis and coding.

\*\* By 2009, MACs will replace FIs and Carriers, which are being phased out of Medicare.

\*\*\* Per the Medicare Modernization Act of 2003, PSCs will be replaced by Zone Program Integrity Contractors (ZPICs).

The federal government’s own estimates of the burden placed on hospitals and other providers is significant. For fiscal year (FY) 2006, the Office of Management and Budget predicted that new regulations and statutes overseen by

the Department of Health and Human Services would add approximately 70 million hours to the 368 million hours required in 2005, representing a 20 percent increase in providers’ and related organizations’ administrative

time burden. And more recently, CMS estimated that new requirements for how hospitals must notify Medicare beneficiaries prior to discharging them from the hospital would consume 3.25 million hours annually.<sup>24</sup>

### Recovery Audit Contractors

CMS uses many types of contractors to oversee the Medicare Program. CMS’ newest, Recovery Audit Contractors (RACs), are paid a contingency fee for identifying and collecting both overpayments and underpayments made to providers participating in Medicare Parts A and B.<sup>25</sup> Authorized under the *Medicare Modernization Act of 2003*, the RAC program began in 2005 as a three-year demonstration project in the states with the largest Medicare populations: New York, California and Florida; it expanded to South Carolina and Massachusetts in fall 2007. *The Tax Relief and Health Care Act of 2006* codified the RACs as a permanent program and mandated expansion to all 50 states by 2010.<sup>26</sup>

There are several areas of overlap between RACs and the functions of other existing oversight mechanisms, including the Fiscal Intermediaries/Medicare Administrative Contractors, the Comprehensive Error Rate Testing program and others. RACs, as well as several other contractors, are charged with reducing improper Medicare payments and working with providers to prevent future improper payments.<sup>27</sup> These overlapping duties create confusion for providers. In addition, a contingency fee payment incentivizes RACs to find problems even where they may not exist.

### ...and the new Recovery Audit Contractors add further redundancy.

Chart 8: Overlap Between Recovery Audit Contractors (RACs) and Other Contractors

|  | Incorrectly Billed Claims | Processing Errors | Medical Necessity | Incorrect Payment Amounts | Non-covered Services | Incorrectly Coded Services | Duplicate Services |
|--|---------------------------|-------------------|-------------------|---------------------------|----------------------|----------------------------|--------------------|
| Recovery Audit Contractors (RACs)                | ✓                         | ✓                 | ✓                 | ✓                         | ✓                    | ✓                          | ✓                  |
| Medicare Administrative Contractors (MACs)       | ✓                         | ✓                 | ✓                 | ✓                         | ✓                    | ✓                          | ✓                  |
| Program Safeguard Contractors (PSCs)             |                           |                   | ✓                 | ✓                         | ✓                    | ✓                          | ✓                  |
| Comprehensive Error Rate Testing Program (CERT)* |                           |                   |                   | ✓                         | ✓                    | ✓                          | ✓                  |
| Hospital Payment Monitoring Program (HPMP)**     |                           |                   | ✓                 | ✓                         | ✓                    | ✓                          | ✓                  |
| Office of Audit Services Audits                  |                           |                   |                   | ✓                         | ✓                    | ✓                          | ✓                  |
| Annual Work Plan Projects                        |                           |                   | ✓                 | ✓                         | ✓                    | ✓                          | ✓                  |

Sources: Centers for Medicare & Medicaid Services. CERT Overview. <http://www.cms.hhs.gov/cert>; Hospital Payment Monitoring Program. <http://www.hce.org/medicare/mcareHPMP.html>; Government Accountability Office. (September 2006). *Medicare Integrity Program: Agency Approach for Allocating Funds Should Be Revised*. Washington, DC; Fedor, F. (2005). Recovery Audit Contractors “RAC” Up Another Challenge for Providers. *Healthcare Financial Management*, 59(9), 52-56; Stockdale, H. (October 2007). *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*. Washington, DC: Congressional Research Service; Office of the Inspector General. <http://oig.hhs.gov/oas/oas/cms.html> and [http://www.oig.hhs.gov/publications/docs/workplan/2008/Work\\_Plan\\_FY\\_2008.pdf](http://www.oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf).

\* CERT contractors will have new responsibility for medical review of inpatient hospital payments once CMS completes its transition to its new system for review of inpatient hospital prospective payment system claims.

\*\* The QIOs will no longer have responsibility for the functions previously included in the HPMP once CMS completes its transition to its new system for review of inpatient hospital prospective payment system claims.

## Regulation and Licensure Imposed by Multiple Entities, Sometimes with Inconsistent Requirements

Hospital regulation and licensure help ensure safe, high-quality patient care, but the lack of a coordinated system for oversight imposes duplicate and sometimes inconsistent regulatory demands. Many agencies exert regulatory oversight of hospitals, including The Joint Commission, the Medicare and Medicaid programs, and federal, state and local government agencies. At the federal level alone, hospitals are regulated by more than 30 different agencies. For example, the Environmental Protection Agency sets hospital regulations on air emissions

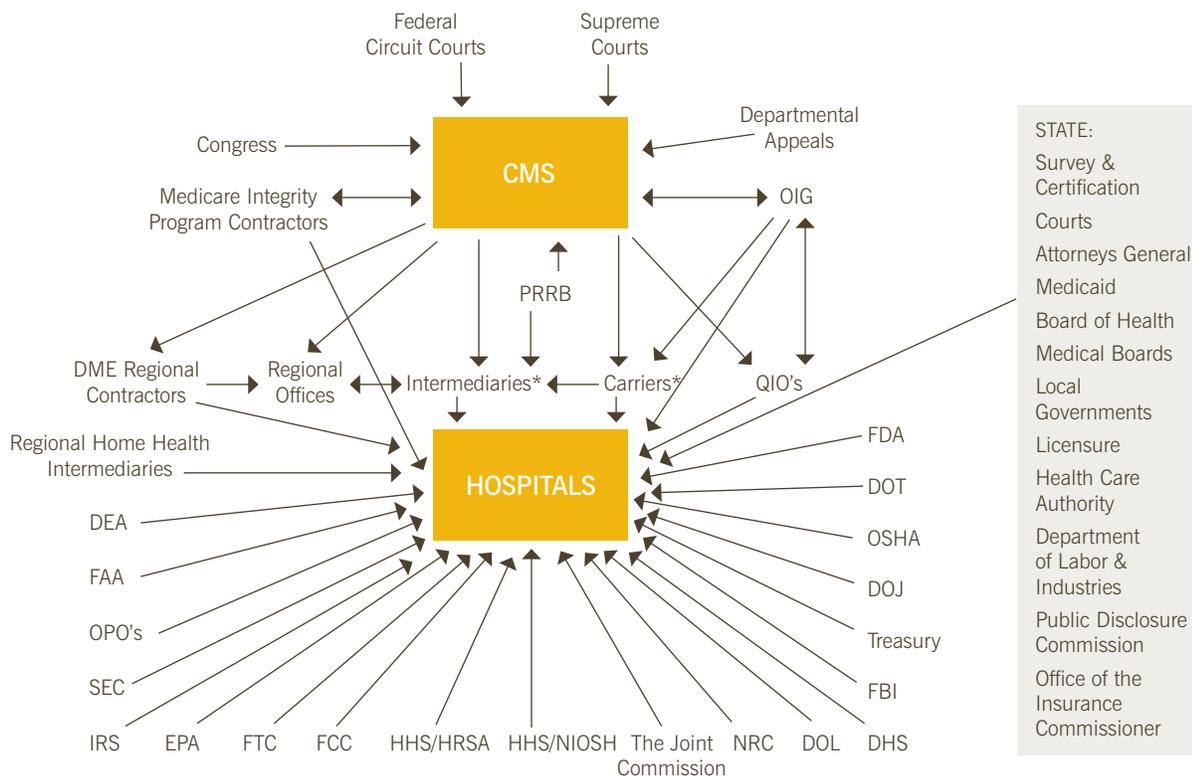
from medical waste incinerators; hospitals must report suspected drug, biologic or medical device-related deaths or serious injury to the Food and Drug Administration; and the Nuclear Regulatory Commission oversees administration of radiopharmaceuticals.

There also is overlapping oversight between the federal and state levels. To receive Medicare payment, hospitals must be surveyed by The Joint Commission, American Osteopathic Association or a state survey agency.<sup>28</sup> In addition, states require that hospitals have state licensure and accreditation.

Each state has its own set of requirements, many of which duplicate or add to federal requirements. For example, both the federal Centers for Disease Control and Prevention (CDC) and the Pennsylvania Health Care Cost Containment Council (PHC4) require that hospitals report data on hospital-acquired infections. However, only the CDC collects data on readmissions due to infections.<sup>29</sup> Because of this, some Pennsylvania hospitals have had to maintain separate records for CDC and PHC4 reporting.

### Hospitals are regulated by a multitude of state and federal agencies.

Chart 9: Sample of Agencies Regulating Hospitals at the State and Federal Levels



Source: Adapted from Washington State Hospital Association. (2001). *How Regulations Are Overwhelming Washington Hospitals*. Available at: <http://www.wsha.org/files/62/RegReform.pdf> and American Hospital Association and PricewaterhouseCoopers. (2001). *Patients or Paperwork? The Regulatory Burden Facing America's Hospitals*.

\* By 2009, MACs will replace FIs and Carriers, which are being phased out of Medicare.

## Quality Measurement and Reporting Efforts, While Valuable, Are Numerous and Overlapping

The proliferation of quality improvement and patient safety initiatives, as well as the recent introduction of pay-for-performance (P4P) programs, have heightened the focus on health care quality but also have increased data collection and reporting requirements for hospitals. Because each program or payer has instituted its own quality reporting requirements, each with a distinct set of metrics, hospitals typically have more than 300 external measures to report.<sup>30</sup>

While the measures reported to each program may be focused on the same conditions or care processes, the measures themselves vary. For example, hospitals choosing to participate in the American Heart Association's *Get With The Guidelines* program report on cardiac measures that are different from, and not simply a subset of, those reported to The Joint Commission and CMS.<sup>31</sup> Though this program and others like it may be voluntary, hospitals feel pressure to participate because the results are publicly reported or their participation is publicly recognized; not participating could reflect poorly on the hospital.

Reporting these data also can be quite costly. For example, hospitals spend between 50 and 90 hours each month to collect data for The Joint Commission measures for acute myocardial infarction, heart failure and pneumonia, at an annual cost of \$77,000 - \$100,000 per hospital.<sup>32</sup>

If payers agreed upon and used a common set of measures it would help alleviate the burden created by these myriad programs. However, that would require the cooperation of multiple health plans, many of which institute their P4P programs to gain a competitive advantage.<sup>33</sup>

### Pay-for-performance programs each have their own reporting requirements.

Chart 10: Overview of Several Private Plans' Pay-for-performance Programs

| Plan/Program   | Description   |
|--|---|
| WellPoint/Quality-in-sights Hospital Incentive Program (Q-HIP) | Rewards hospitals based on patient safety, clinical processes and outcomes and patient experience.  |
| The Leapfrog Group/Hospital Rewards Program (HRP)              | Rewards hospitals based on quality and cost-effectiveness.  |
| BlueCross BlueShield/Highmark QualityBLUE                      | Rewards hospitals in their efforts to prevent, reduce and eliminate hospital-acquired and central line-associated bloodstream infections. |

Source: Roble, D.T. (2006). Pay-for-performance Programs in the Private Sector. *Journal of Oncology Practice*, 2(2), 70-71. Reuters. (2008). *Blue Cross of California Introduces Pay-for-performance Hospital Program*. Available at: <http://www.reuters.com/article/pressRelease/idUS175344+19-Mar-2008+PRN20080319>. BlueCross BlueShield Association. (2007). *Highmark's Hospital Pay-for-performance Program Demonstrates Impressive Results*. BlueCross BlueShield Association Press Release.

Quality reporting and quality improvement programs have been instituted by public and private payers, as well as states and employer groups. For FY 2009, the Medicare program will require hospitals to report on 30 measures in order to get the full Annual Payment Update (APU). Hospitals that do not comply face a 2 percentage point reduction in their APU. In addition, CMS has proposed 43 new quality measures for FY 2010, which would more than double the number of measures on which hospitals must report. In the near future, hospitals' payments may be linked to their actual performance on these clinical measures.

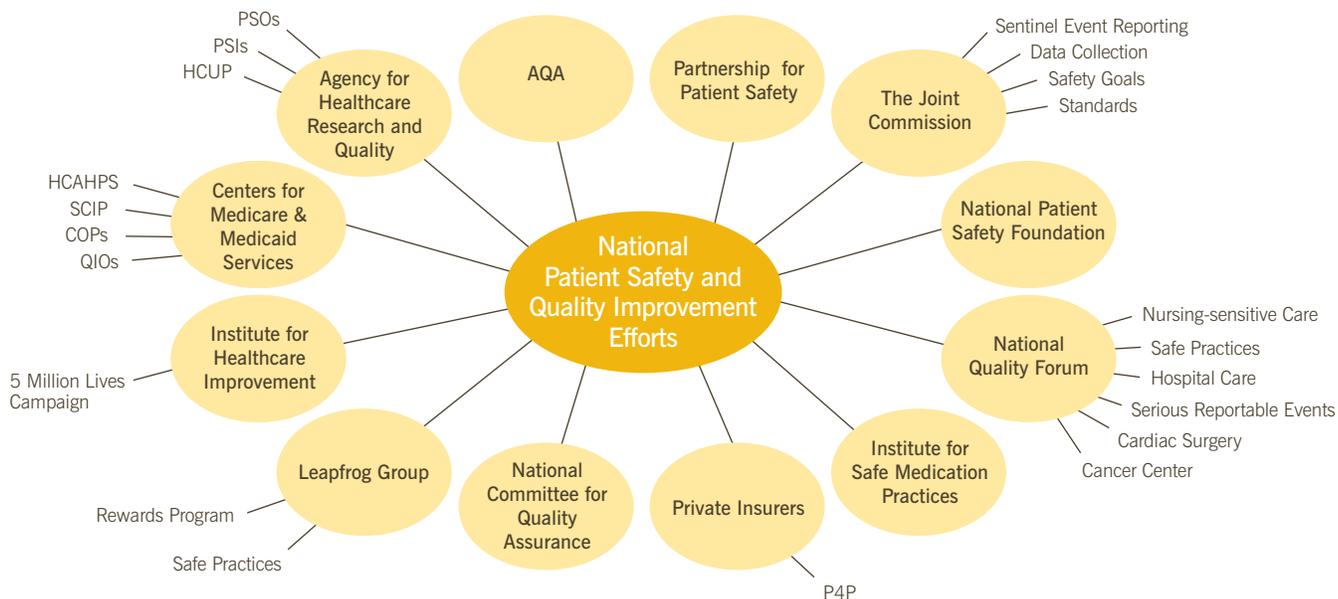
State Medicaid programs also have started to implement P4P programs; most target health plans and physicians, though a few states are exploring hospital-based P4P programs.

Many private payers also have their own quality reporting or P4P programs. These programs do give consumers useful information, but they may create additional data collection requirements for participating providers.

Significant hospital resources are consumed by quality measurement and reporting. To comply with these demands, hospitals must facilitate data collection, recruit and train staff, process and analyze data, and devote staff time for interpreting data, providing feedback, and using the findings for improvement activities.<sup>34</sup> For instance, while the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) is an effort supported by hospitals, collectively hospitals spend an estimated 285,200 additional hours on the required data collection and reporting.<sup>35</sup>

Hospitals participate in a multitude of mandatory and voluntary quality programs...

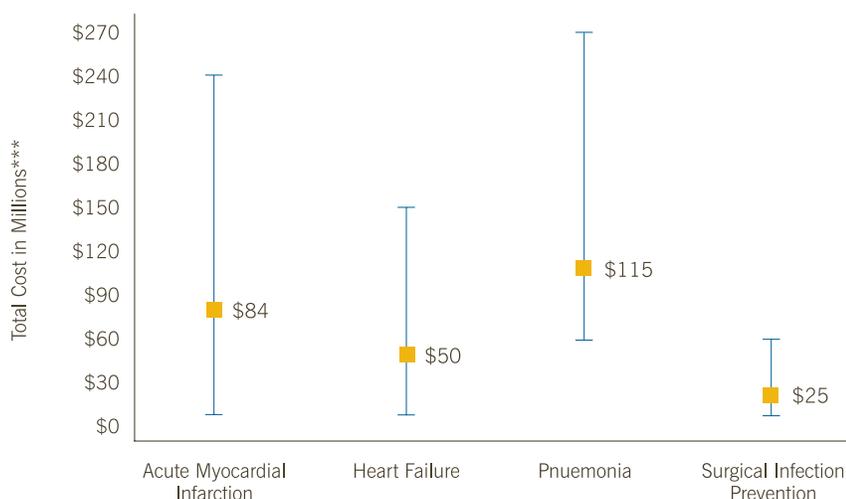
Chart 11: Sample of National Hospital Quality Improvement and Patient Safety Programs



Source: Analysis by Avalere Health and American Hospital Association.

...each requiring additional hospital resources for data collection and transmission.

Chart 12: Estimated National Costs\* for Hospitals to Collect and Transmit Quality Reporting Data for Four Hospital Compare Measure Sets\*\* (in Millions)



**\$77,000-  
\$100,000**

Annual cost per hospital to collect data for three Joint Commission measure sets

Source: Booz Allen Hamilton. (2006). *Hospital Quality Reporting in the United States: A Cost Analysis for the Hospital Quality Alliance*. Washington, DC: The Hospital Quality Alliance.

\* Figures only represent the cost to report process measures to Hospital Compare, a Web site created through the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS) and Hospital Quality Alliance (HQA) that publicly reports 26 measures voluntarily reported by hospitals.

\*\* Measures are process of care measures that indicate how often hospitals provide recommended care for each condition.

\*\*\* Yellow squares represent national estimates based on an average hospital cost while endpoints represent estimates based on minimum and maximum costs.

## Administrative Requirements Consume Valuable Resources; Options Exist to Alleviate Burden

Payers and regulators have options to help hospitals and other health care providers minimize the burden of excessive and duplicative administrative requirements and rules. For example, accrediting and licensure requirements could be streamlined to help eliminate the duplicative and sometimes inconsistent nature of the processes. States and CMS should make an effort to align their requirements.

Attempts to streamline data reporting can be observed in the implementation of *Health Insurance Portability and Accountability Act* (HIPAA) transaction standards. HIPAA requires providers that submit certain electronic transactions – such as eligibility verification or claims – to do so in standard electronic formats, using standardized medical data codes as opposed to local and/or proprietary codes.<sup>36</sup> Transaction standards have helped reduce paperwork and facilitate data collection for hospitals by simplifying processes; however, more could be done to further refine these standards

and adopt common business practices that allow for the smooth and consistent implementation of such standards. For example, CMS could adopt standards that would make consistent the way in which payers acknowledge receipt of claims submitted by hospitals.

Hospitals' billing and collections burden could be eased by the collaboration of public and private payers to develop and implement simplified and standardized benefit packages, claims processing procedures and business practices. A single database could provide access to enrollment data, cost-sharing requirements and status and benefits for multiple plans in a community. For example, OneHealthPort provides a single access point for eligibility, benefits and claims information for 13 health plans in the Seattle area.<sup>37</sup> Payers also could work to reduce or eliminate paperwork and redundant oversight procedures.

Quality reporting measures that are consistent across payers could help hospitals use valuable resources more

appropriately. Some researchers have called for a single national core set of measures across all providers,<sup>38</sup> while others suggest that, at minimum, a common set of measures and methods should be implemented for each provider type.<sup>39</sup>

Some groups are trying to create more uniform quality measures. The Hospital Quality Alliance (HQA), a public-private collaboration, developed Hospital Compare, a Web site that publicly reports the measures voluntarily reported by hospitals. Ultimately, HQA hopes to identify a set of quality measures that would be reported by all hospitals, and accepted by all purchasers, oversight and accrediting entities, payers and providers. As of April 2008, 4,231 hospitals were participating.<sup>40</sup>

CMS might reduce the number of types of contractors performing Medicare and Medicaid oversight, and better define the assignment of each contractor so that each performs a unique set of tasks.

### POLICY QUESTIONS

- Where do opportunities exist to streamline administrative tasks or programs while ensuring a high-quality health care system?
- What savings could be attained by eliminating redundancy in the oversight of the health care system, and where might those dollars be reallocated?
- How could the need for quality measure data collection be balanced with appropriate resource allocation?
- How could existing programs or processes be reengineered to meet all objectives without duplication, at a lower cost to federal and state governments and hospitals and other providers?
- How much staff time could be redirected from administrative tasks to patient care if administrative burdens were streamlined?

## ENDNOTES

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- 2 Woolhandler, S., & Himmelstein, D.U. (1997). Costs of Care and Administration at For-profit and Other Hospitals in the United States. *New England Journal of Medicine*, 336(11), 769-774, and Woolhandler, S., et al. (2003). Costs of Health Care Administration in the United States and Canada. *New England Journal of Medicine*, 349(8), 768-775.
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- 5 Goldstein, A. (2008). Humana's Profit Rises 13% on Health Plans for Elderly. *Bloomberg News*. Accessed April 28, 2008, from [http://www.bloomberg.com/apps/news?pid=newsarchive&sid=a1qgm\\_JRDSLc](http://www.bloomberg.com/apps/news?pid=newsarchive&sid=a1qgm_JRDSLc).
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- 7 Fairbrother, G., et al. (2004). Costs of Enrolling Children in Medicaid and SCHIP. *Health Affairs*, 23(1), 237-243.
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