



Division of Financial Responsibility (DOFR)

Overview

As part of its Administrative Simplification project, the Integrated Healthcare Association (IHA) assembled a group of stakeholders to develop a coded Division of Financial Responsibility (DOFR) template for use in contracts between hospitals, physician organizations, and health plans. The DOFR provides a framework for plans and providers to use when allocating financial responsibilities for services.

The coded DOFR has benefits for all healthcare stakeholders. Although it does not assign risk, it gives plans and providers a uniform starting point for capitated payment negotiations. The implementation of a coded DOFR providing a standard set of service categories with associated codes should help manage any redefinition of the DOFR, commonly called “DOFR creep.” This should help to reduce payment ambiguities between parties and claims re-direction from organization to organization that drive up administrative costs and can lead to consumer frustration with health plans and providers. Providers – both hospitals and physician organizations – will benefit from reductions in both administrative burdens associated with managing multiple risk relationships and in the costs associated with misdirected claims that can result from ill-defined lines of responsibility. Consumers will also ultimately benefit from fewer misdirected claims, which can negatively impact their experience of care. Under the Affordable Care Act, health plans are required to keep administrative expenses at or below 20% of premiums in the individual and small group markets, and 15% of premiums in the large group market. Having a standardized template for determining the assignment of risk should help California health plans to meet these requirements.

Background

The need for a coded DOFR was spurred by frustration on the part of healthcare stakeholders about the lack of consistent formats across plans, and insufficient service descriptions within contracts to identify who is financially responsible for specific services under different circumstances. For example, does the financial responsibility for the services of an anesthesiologist rendered in an inpatient hospital setting come out of the physician organization’s capitation payment, or is it the responsibility of the health plan? Often, the spheres of financial responsibility are not sufficiently spelled out in capitated contracts, which can lead to confusion in billing departments, misdirected claims, and frustration on the part of consumers.

Previous attempts by California healthcare stakeholders to create a coded DOFR were unsuccessful, but interest has never waned. This most recent effort grew out of IHA’s attempt to create an all-payer portal for administrative transactions between hospitals, physician groups, and health plans. Although the original project failed to attract sufficient interest, stakeholders identified three priorities for administrative simplification: a coded DOFR; standardized eligibility format; and standardized benefit information, and consensus emerged that the DOFR was the most pressing of these three issues. In early 2011, a DOFR workgroup comprised of representatives from health plans, physician organizations, hospitals, and others was formed by IHA.

Goals and Scope of DOFR Project

The goal of the DOFR project was to develop and implement a coded DOFR framework for commercial HMO/POS and Medicare Advantage populations in California. The workgroup first decided on a framework, using a draft developed by a group of physician organizations. It then developed and populated 104 service rows with the help of a certified coding consultant. Currently, the DOFR includes almost 10,000 billing and revenue codes. The group also developed ten guidelines for DOFR use and identified areas to be addressed in subsequent stages of the project.

DOFR Release Plan and Stakeholder Comment Period

The initial DOFR Release 1.0 was launched in September 2011 followed by a 60-day public comment period. Individuals must register and accept the terms of the End User Agreement on the IHA website (www.iha.org) in order to download the DOFR.

The stakeholder comment period for registered users began on the initial launch date and closed after two months. All comments were tracked by IHA and reviewed and vetted by the DOFR workgroup. Changes accepted by the workgroup have been incorporated into the DOFR Release 1.1 and a formal response to submitted comments was posted on the IHA website in January 2012.

DOFR Release	Release Date
Release 1.0	September 2011 followed by 60-day comment period
Release 1.1	January 2012
Release 2.0	TBD 2012

The DOFR was specifically developed for use in the California delegated environment and is therefore available to all California stakeholders that register to download the DOFR and accept the End User Agreement. Individuals from organizations located outside of California should contact Cindy Ernst at IHA (cernst@iha.org) for more information on the DOFR.

DOFR Workgroup

A multi-stakeholder workgroup comprised of representatives from physician organizations, health plans, hospitals, consultants and other representatives developed the initial DOFR and continue to review changes incorporated into subsequent releases. DOFR stakeholder organizations include:

- Providers: Brown & Toland, Cedars-Sinai, MCS/Gemcare, Sharp HealthCare
- Health Plans: Aetna, Anthem/Blue Cross, Blue Shield of CA, CIGNA, Health Net, UnitedHealthcare
- Other: HFMA Southern CA Chapter Members from US Bank and Receivable Optimization, Inc., Hazlewood Consulting, Sinaiko Healthcare Consulting