
Oregon Health Authority
Office for
Oregon Health Policy and Research



**Oregon Administrative
Simplification Strategy and
Recommendations**

**Final Report of the
Administrative Simplification Work Group**

June 2010

Table of Contents

	<u>Page</u>
Administrative Simplification Work Group Membership	ii
Executive Summary	1
Background.....	3
An Oregon Strategy for Administrative Simplification.....	5
Oregon Administrative Simplification Recommendations.....	9
Next Steps	15
Appendix A – Administrative Simplification Savings Projections	17
Appendix B – Recommended Outline for Administrative Rules	22
Appendix C – Health Information Exchange Timeline	23
Appendix D – Glossary.....	24
Appendix E – Provider and Payer Survey on Administrative Transactions:	26
A Report to the Health Policy Board	

Administrative Simplification Work Group Membership

Co-Chairs

Laura Etherton
OSPIRG

Dale C. Johnson, Jr.,
Blount International

Members:

Rhonda Busek
Lane IPA

Todd Bybee
Tuality Hospital

Tom Chamberlain
Oregon AFL-CIO

Alice Cobb
Division of Medical Assistance Programs

Erick Doolen
Pacific Source Health Plans

Nancy Franssen
Corvallis Clinic

Tyla Kennedy
NW Human Services

Mary Kjemperud
Legacy Health System

Ann O'Connell
OHSU

Carol Robinson
Health Information Technology Oversight
Council

Mike Schwab
Portland Clinic

Tonja Siefarth
West Valley Hospital

Barney Speight
Oregon Health Authority

Dan Stevens
Providence Health Plans

Doug Walta, MD
Providence Health and Services

Nelda Wilson
Int. Union of Operating Engineers, Local
701

Ex Officio:

Teresa D. Miller
Insurance Division

Joan Kapowich
Public Employees Benefits Board

Staff:

Sean Kolmer, Deputy Administrator
Oregon Health Policy and Research

Lynn-Marie Crider, Policy Analyst
Oregon Health Policy and Research

Executive Summary

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

The keys to simplification are elimination, standardization, and automation of processes. In Oregon, many transactions that would be automated in other industries are still performed manually by most providers and many payers. The healthcare industry is unlikely to take major strides toward automated processes until there is greater standardization of the methods for conducting the transactions electronically. Standardization has proven difficult for the industry to achieve on a voluntary basis. Standardization requires each individual business to make upfront investment in changing systems and work processes. Such investments are rational only if all, or nearly all, providers and payers with which they deal are making similar investments at the same time. Therefore, the state has a central role in enabling the industry to move forward together to greater simplification and automation of administrative processes.

The state's role in administrative simplification should be to identify and adopt standardized and automated ways to do business and to require payers and providers of healthcare to use those standard, automated processes. In addition, the state should work with the healthcare industry to monitor progress toward adoption of the standardized and automated ways of doing business, identify opportunities for additional standardization, and set priorities, goals, and benchmarks for additional standardization.

The work group recognized that the federal reform legislation enacted this year addresses administrative simplification issues. The legislation requires the U.S. Department of Health and Human Services to periodically revise its standards for HIPAA electronic transactions and sets deadlines for issuing "uniform operating rules" for each of the HIPAA transactions. The workgroup concluded that the federal reform law should inform Oregon's efforts but does not eliminate the need for state-level action.

The work group estimates that failure to take these steps outlined in this report would cost Oregon payers and providers nearly \$100 million in administrative savings each year.

The work group makes the following recommendations:

Recommendation #1: Oregon should adopt the Minnesota approach to standardization and automation.

Recommendation #2: Oregon requirements for standardization and automation should be phased-in. This means that providers and payers should be given time to adjust to the changes.

Recommendation #3: Oregon should lead. Oregon should not wait for the federal government to standardize HIPAA transactions.

Recommendation #4: Technical assistance to providers will be important to help providers adjust to and take full advantage of administrative simplification opportunities.

Recommendation #5: There is need for on-going public-private partnerships to identify successes, challenges, and opportunities for future administrative simplification.

To carry out these recommendations, the following steps will need to be taken:

- The Department of Consumer & Business Services (DCBS) must adopt by rule uniform companion guides for eligibility verification, claims, and payment remittance advice by adapting the Minnesota uniform companion guides. The rules should require insurers and the providers that do business with them to conduct the transactions electronically about a year after adoption of each uniform companion guide.
- The Legislature must enact legislation in 2011 giving DCBS authority to establish uniform standards for healthcare administrative transactions to all payers (including third party administrators and self-insured plans) and clearinghouses and to collect data from them to monitor progress and identify future opportunities.
- The Oregon Health Authority as a payer should follow the DCBS rules and require Medicaid managed care organizations, Medicaid providers, and others with which it deals to do so as well.
- DCBS must require insurers and other payers to perform additional transactions electronically on a phased-in basis between 2014 and 2016—setting the dates for each transaction to go “all-electronic” no later than one year after a HIPAA standard and uniform companion guide or uniform operating rules have been adopted by the U.S. Department of Human Services.
- The industry should bring forward its recommendation to develop a single sign-on to health plan web portals and a single source for information used in physician credentialing. In addition, the industry should identify and develop additional opportunities for standardization.
- The Insurance Commissioner and the Director of the Oregon Health Authority should take joint responsibility for continued progress toward greater administrative simplification. They should carry out these responsibilities in collaboration with providers and payers, collecting data to evaluate progress; establishing priorities, goals, benchmarks, and timelines; and using rulemaking authority as necessary.

Background

The health care delivery system in the United States is unquestionably the most expensive in the world.¹

Administration of insurance in the United States is less efficient than insurance administration in the rest of the developed world.² In Oregon, the major insurance carriers spend about 10-15% of premium on health insurance administration—including marketing, underwriting, medical management, claims administration, and profit.³ A recent study of the California market suggested that the portion of insurer administrative cost that goes for dealings with healthcare providers was 8.1% of premium. But insurers are not the only healthcare actors that have insurance-related costs.

Hospitals, physicians, and other providers also incur costs for insurance administration. While there is no public reporting of those administrative costs, recent analyses suggest that health insurance-related activities consume 7-10% of hospital revenues and 10-15% of physician revenues.⁴ It is unlikely that this level of administrative cost is inherent in the private insurance system. A recent case study of a large physician practice led one group of experts to conclude that more than 12% of physician revenue could be saved if some specific steps were taken, including much expanded use of standard electronic transactions, elimination of referral requirements and other medical management processes, and standardization of payment methods and rules.⁵

While there is dispute over the magnitude of waste from administrative complexity, there is unquestionably room for very significant savings from simplification.

Developing an Oregon Solution

HB 2009 tasked the Office for Oregon Health Policy and Research (OHPR) with convening a work group to take on the issue of standardizing transactions and recommending uniform standards for adoption by the Department of Consumer and Business Services.⁶ The

¹ “Healthcare Costs: A primer,” Kaiser Family Foundation (2009), page 4.

² “Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008 (citing Organization for Economic Cooperation and Development Health Data 2007).

³ Oregon’s seven largest health insurers (omitting Kaiser Permanente, which operates differently) spent an average of 12-17% of premiums over the last five years for non-claims costs. See “Health Insurance in Oregon,” Department of Consumer and Business Services (January 2010), page 25.

⁴ See e.g., Merlis, Mark, “Simplifying Administration of Health Insurance” (released by the National Academy of Social Insurance, National Academy of Public Administration, and the Robert Wood Johnson Foundation 2009) at pages 5-9. Kahn, James G. et al., “The Cost of Health Insurance Administration In California: Estimates For Insurers, Physicians, and Hospitals,” *Health Affairs*, vol. 24, no. 6 (November/December 2005).

⁵ Blanchfield, Bonnie B., et al, “Saving Billions of Dollars—And Physicians’ Time—By Streamlining Billing Practices” (*Health Affairs Web First*, June 2010).

⁶ The language reads, in its entirety, as follows: “SECTION 1192. The Director of the Department of Consumer and Business Services may establish by rule uniform standards applicable to health insurers licensed by the Department of Consumer and Business Services that incorporate the standards developed by the Office for Oregon Health Policy and Research pursuant to section 1193 of this 2009 Act. “SECTION 1193. (1) The

legislature specifically required the work group to develop uniform standards for claims (that is, provider bills to insurers), remittance advice (insurer explanation of payments made to providers), and eligibility verification (provider requests for information about a patient's health plan enrollment, plan benefits, and patient cost-sharing responsibility).⁷

The Oregon Health Policy Board (the Board) asked the work group to develop a broad strategy for administrative simplification, including specifying the appropriate role for the state. The Board also asked the group to estimate the potential for cost savings achievable through administrative simplification.

OHPR assembled a diverse work group including two individuals affiliated with commercial health insurers, one affiliated with a Medicaid managed care organization (Medicaid MCO) that is not a licensed insurer, three affiliated with hospitals, four affiliated with physician practices (including the OHSU clinic system and an ambulatory surgery center), two affiliated with health care purchasers (one human resources manager for a large business and the other a trustee for a Taft-Hartley Trust), one affiliated with an organization of consumers, one physician, one affiliated with organized labor, and the Director of the Health Information Technology Oversight Council (HITOC). The Administrator of the Public Employee Benefits Board and the Oregon Educators Benefits Board and the Administrator of the Insurance Division participated also.

In addition to the work group members, two other important stakeholder groups were engaged throughout the development of these recommendations. The work group sought information from the HITOC concerning the preparation of the state's strategic plan for health information exchange, Medicare and Medicaid incentive payments available to physicians and hospitals for developing and implementing health information exchange capacities, the meaningful use requirements for accessing the incentive payments, and the HITOC's thoughts on the relationship between health information exchange development and administrative simplification. The Director of HITOC was a member of the workgroup to ensure effective coordination between recommendations from this workgroup with the work of HITOC.

There were two members of the Health Leadership Council (HLC) on the OHPR work group to ensure coordination and opportunities for collaboration between the legislative intent of the workgroup and the industry led efforts currently underway.⁸ The HLC leaders sitting on the OHPR work group took the work group's preliminary recommendations to the HLC Administrative Simplification Work Group for their discussion. They brought feedback to the OHPR work group process.

Before convening the work group, OHPR surveyed providers and payers to accomplish three objectives: (1) To get a baseline measure of Oregon's progress toward adopting efficient

Office for Oregon Health Policy and Research shall convene a stakeholder workgroup to develop uniform standards for health insurers licensed in this state, including but not limited to standards for: (a) Eligibility verification. (b) Health care claims processes. (c) Payment and remittance advice.”

⁷ For a glossary of terms used in this report, see Appendix E.

⁸ The Health Leadership Council is the successor to the Health Leadership Task Force.

methods for conducting business transactions between providers and payers, (2) to learn from providers and payers about the barriers to adopting more efficient methods of doing business, and (3) to offer providers and payers an opportunity to tell the work group what they thought would be most helpful in reducing administrative burden.

The payer survey was conducted using a structured interview of health plan staff coupled with a request to plans to share some baseline data. The provider surveys were conducted by e-mail distribution of an electronic survey. (See Appendix E.) The group reviewed the results of the payer and provider surveys to better understand the concerns and opinions of providers and payers not directly involved in the work group process.

In addition, the group reviewed studies of the potential for savings from moving from manual to electronic methods for doing a variety of transactions.

The group heard reports from leaders in Washington, Minnesota, and Utah to consider whether to adopt the approach taken in any of these states or to recommend adoption of any products developed in those states. The group found that the three states had taken very different paths, determined in large part by when they began work on administrative simplification and the relative capacity of the state's private industry bodies to provide leadership. The three paths were distilled into alternative models for the state's role in administrative simplification and considered by the work group. Finally, when the federal health reform bills were enacted, the group reviewed the administrative simplification activities and timelines set by Congress.

The work group identified guiding principles for its work that included:

- Use what's already built. Don't re-invent the wheel and coordinate with other states where possible, but make sure that whatever we borrow is appropriate to Oregon.
- Take advantage of time-sensitive opportunities.
- Take on projects that won't be done otherwise.
- Don't bite off too much.
- Do things with opportunity for return on investment.
- Prioritize activities that reduce cost or improve service for patients.
- Make any requirements that are developed applicable to everyone—payers and providers alike.

An Oregon Strategy for Administrative Simplification

The goal of administrative simplification is to reduce total system costs and reduce the amount of resources that must be devoted to administrative transactions between providers of care and payers by simplifying these activities.

The primary objective of the work group process was to advance Oregon's efforts on the third prong of the Triple Aim for healthcare improvement—that is, the reduction or control of the per capita cost of healthcare. The work group believes, however, that administrative simplification can also advance efforts to improve the patient experience of care by making it

easier for physicians to provide timely information to patients about the cost of health services under their health benefit plans and by facilitating collection of accurate electronic administrative data to support clinical decision-making by providers and improve measurement of the quality of care provided to patients.

Standardization and automation are the keys to realizing savings on administrative transactions.

The keys to reducing administrative costs through simplification are elimination, standardization, and automation of insurance administrative processes. To date, the federal government and the industry have been unable to standardize administrative processes sufficiently to achieve dramatic system-wide cost savings. That inability has created an opportunity for the state to play a role in realizing the potential for standardizing and automating insurance transactions. Therefore, the centerpiece of the state's administrative simplification strategy must be state-led standardization and automation.

International standard-setting organizations long ago developed electronic methods for doing the basic healthcare administrative transactions. In 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required providers and payers performing health care administrative and financial transactions electronically and the clearinghouses that are intermediaries for many of these transactions to conform to uniform standards and code sets that the legislation directed the U.S. Department of Health and Human Services (HHS) to adopt. Years later, HHS adopted standards developed by the American National Standards Institute-accredited committees for most but not all of these transactions. Compliance was required in 2003. In 2009, HHS adopted updated transaction standards, known as version 5010. Compliance with the new standards is required by January 1, 2012. HHS never adopted standards for several of the transactions the 1996 law sought to standardize. Among the transactions for which no standards has been adopted is a standard for "claims attachments," which are clinical or administrative documents submitted to support a claim, whether sent with the initial claim or in response to a post-claim request by the payer.

Unfortunately, the HHS standards and implementation guides did not accomplish the degree of standardization that might have facilitated more widespread automation of health care transactions between providers and payers. This is in part because the HHS standards left many issues unresolved. Consequently, payers have developed unique practices and companion guides to fill gaps in ways that suit individual business needs and systems. In addition, while the HIPAA standard transactions can be used to solve certain problems, the HHS rules do not require their full utilization. For example, the standard eligibility verification transaction allows the payer to provide both confirmation of coverage and detailed information about benefits, but it does not require the insurer to provide the detailed information. Consequently, expensive non-electronic communication persists.

In Oregon, most providers and many payers still perform many transactions manually that are automated in other industries. The healthcare industry is unlikely to take major strides toward automated processes until there is greater standardization of the methods for conducting the transactions electronically. Standardization has proven difficult for the

industry to achieve on a voluntary basis. Standardization requires each individual business to make upfront investments in changing systems and work processes. Such investments are rational only if all, or nearly all, payers and providers make similar investments at the same time. Therefore, the state has a central role in enabling the industry to move forward together to greater simplification and automation of administrative processes.

Standardization and automation will significantly reduce healthcare administrative expenses of providers and plans.

The work group estimated savings to physicians, hospitals, and payers from increased automation of the transactions discussed above. Although the standardization requirements would apply to other healthcare professionals and facilities, there was insufficient information from which to generate savings calculations for them.

The estimates do not deduct expenses incurred to transition from manual to electronic because we believe that physician practice transition expenses will be recouped in the first year.

The estimates were developed by first estimating the volume of each transaction performed annually, the cost differential for payers and providers doing the transaction electronically versus manually, and the degree to which the transaction is currently being done electronically or manually. Then targets were set for compliance with electronic requirements and take-up of voluntary electronic processes, such as automatic posting from an electronic payment remittance advice. Because credible estimates varied greatly for transaction volume, per transaction savings from going electronic, and the degree to which transactions are currently automated, the group developed ranges for estimated savings. The detailed methodology and calculations are in Appendix A.

The savings estimates range from \$92 million to \$202 million a year beginning in 2014, after rules take effect requiring the first five transactions to be done electronically. Savings potential is greatest for physicians, especially those who do a high volume of office visits. Payers also have much to save. Hospitals probably have the least to save because they have lower transaction volumes relative to net patient revenue and because most are currently more highly automated than physician practices.

The chart below summarizes the low-end savings estimates. Assuming personal healthcare spending in Oregon will be about \$32 billion a year by 2014, the annual savings from the administrative simplification activities recommended in this report could reduce healthcare spending from .3-.6% by 2014.

Estimated Annual Savings

	Hospital	Physician	Payer	Total
Claim Submission	\$746,000	\$23,499,000	\$4,270,500	\$28,515,500
Remittance Advice, including posting	\$625,800	\$23,728,250	unknown	\$24,354,050
Eligibility Verification	\$3,587,680	\$13,018,600	\$2,195,856	\$18,802,136
Claims Payment (i.e., funds transfer)	Insufficient information to estimate the number of transactions. There are some savings for both providers (cost of trips to the bank) and payers (cost of printing and mailing checks).			
Claims Status Inquiry and Response	\$1,480,640	\$13,633,760	\$6,010,368	\$21,124,768
All transactions to be electronic by 2014	\$6,440,120	\$73,879,610	\$12,476,724	\$92,796,454

The state has a central role to play in enabling standardization and automation of administrative transactions.

The state’s role in administrative simplification should be to identify and adopt standardized and automated ways to do business and to require payers and providers of healthcare services to use those standard, automated processes. The state should develop a provider outreach plan. The plan should spell out an effort to assist providers by providing technical assistance and tools to use as they make the transition to automated processes. In addition, the state should collaborate with the healthcare industry to monitor progress, identify opportunities for additional standardization, and set priorities, goals, and benchmarks for additional standardization.

The phased-in requirements to go “all-electronic” should be timed so as to further several objectives:

- The timing should maximize savings for providers, payer, and purchasers in the short-term by moving as quickly as practicable.
- The timing should allow providers, payers, and clearinghouses to retool their systems to comply with state-adopted standards while they are retooling to comply with the 5010 version of the HHS rules, which providers must follow beginning January 1, 2012.
- The timing should expect providers and payers to function electronically for commercial insurance and Medicaid transactions as soon as they must do so for Medicare transactions. Medicare has required providers to file claims electronically for many years and will require providers to accept an electronic payment remittance advice and electronic payment by January 1, 2014.
- The timing should ensure that physicians and hospitals that comply with Oregon’s all-electronic requirements will be well positioned for Medicaid and

Medicare incentive payments under the American Recovery and Reinvestment Act of 2009 for “meaningful use” of health information technology.⁹

It is critical for the success of this effort that all providers and payers use the standard automated processes. That means the same uniformity and all-electronic standards must apply to all. Standards applicable only to state licensed insurers would fail to address plans that provide healthcare coverage to 16% of Oregonians through self-insured plans and 13% of Oregonians through the Medicaid program. Therefore, the success of this effort to reduce administrative costs will depend on third party administrators, the Division of Medical Assistance Programs, and Medicaid MCOs following the same rules for administrative transactions with providers that DCBS adopts for insurers.

Administrative simplification must not end with standardization and automation of the transactions addressed by HIPAA.

In addition to standardizing and automating the transactions covered by HIPAA, the state should encourage and support private sector innovation in other areas of administrative simplification. The state’s primary role should be to ensure that efforts to reduce administrative costs continue and are effective. It should involve monitoring what is being done, looking for opportunities to partner with industry, and setting priorities and expectations in a collaborative way. From time to time, if it appears that uniform processes will not be adopted sufficiently to result in the desired savings from promising standardization opportunities, it may also involve adoption of uniform standards via the rule-making authority of the Department of Consumer and Business Services.

Oregon Administrative Simplification Recommendations

Recommendation #1: Oregon should adopt the Minnesota approach to standardization and automation.

The path to standardization and automation has been paved by the state of Minnesota. The work group proposes to expedite the standardization and automation process by adopting Minnesota’s approach and adapting the tools it has developed, tested and fine-tuned.

In 2007, the Minnesota legislature required all providers and all group purchasers (including health insurers and third party administrators, self-insured health plans, workers’ compensation and property and casualty insurers) to conduct eligibility verification, claims, and payment remittance advice transactions electronically and to do so in accordance with standard companion guides established through a Minnesota process, rather than in accordance with individual insurer-published companion guides.

⁹ Many Medicare and Medicaid providers are eligible for financial incentive payments for achieving meaningful use of certified electronic health record systems. To get the maximum payments available under the Medicare program, physicians must achieve meaningful use by 2012 and hospitals must achieve it by 2013. The draft meaningful use standard, phase 1, requires providers to file 80% of their claims electronically and to electronically verify eligibility of 80% of their patients.

Minnesota's Department of Health developed the uniform companion guides by the end of 2008, relying for much of the work on its Administrative Uniformity Committee (AUC). The AUC is a multi-stakeholder body that has worked together for more than 20 years under the aegis of the state to standardize administrative processes in healthcare. Minnesota's requirements to standardize and go all-electronic took effect simultaneously for each transaction one year after the uniform companion guide was formally adopted by administrative rule. The guides, which were prepared to standardize the federal HIPAA 4010 standards, have been in place since 2008 and have been in use since 2009. Minnesota has just revised its guides for all three transactions so that they comply with the HIPAA 5010 standards, which go into effect January 1, 2012.

In developing the guides, Minnesota paid careful attention to emerging thinking nationally, including compatibility with the CORE standards, a set of industry standards to which a number of national carriers adhere.¹⁰

Oregon should adopt and use these guides with minimal adjustments to address issues unique to Oregon and eliminate those unique to Minnesota, confident that they are likely to anticipate any additional standardization that the federal government achieves under the federal reform law. The workgroup recommends that the HLC be asked to invite a wide range of provider and payer technical experts—including individuals from the Medicaid managed care organizations, independent third party administrators, and the Division of Medical Assistance Programs as well as providers of all sorts—to assist in reviewing the Minnesota guides and to recommend to the Department of Consumer and Business Services any changes that need to be made before applying them in Oregon.

Recommendation #2: Oregon requirements for standardization and automation should be phased-in.

The work group's recommended timelines for adoption of the standard companion guides give top priority to transactions where the savings will be substantial for going electronic and for which Minnesota has developed guides—eligibility inquiry, claims, and payment remittance advice. Other transactions would become all-electronic as soon as standardization has been achieved by federal action.

Study of current work processes and Oregon provider costs and the academic literature on savings from automation suggests that in the near term the greatest savings can be achieved for the system as a whole from automation of claims. Very significant savings can also be achieved from automating eligibility and claims status inquiries and the payment remittance advice.

The work group recommends beginning by standardizing the eligibility transaction. First, improved eligibility verification processes are most important to providers. A standard transaction that requires payers to provide more information will have value both to them and

¹⁰ CORE standards are agreed to by the Committee on Operating Rules for Information Exchange, a voluntary organization of providers and payers.

to their patients. By beginning with that transaction, Oregon will signal to providers that the move to automated transactions is designed to have value for them. In addition, an improved eligibility process will result in the denial of fewer claims and reduce the number of re-submitted claims. Finally, although automating claims may generate greater system savings in the short term, going electronic for verifying eligibility will truly transform business processes.

For physicians, greatest savings will come from automating posting from an electronic payment remittance advice, followed by verification of eligibility, claims submission, and claims status inquiries; savings from electronic funds transfer may be significant, but the amounts are not known. For payers, greatest savings will come from automating the claims status inquiry, followed by claims submission, and eligibility verification. Hospitals will save much less than physicians and payers because they process fewer claims than physicians and because many are more automated than clinics and physician practices.

Some experts suggest that very substantial savings could be achieved by replacing faxed claims attachments with electronic ones.¹¹ Because HHS has not adopted a standard for such a transaction, however, the work group has concluded the state should not attempt to create one on its own. Rather, Oregon should seek to standardize the way attachments are linked to electronic claims—as Minnesota has done in its companion guide for claims.

The detailed proposed timeline for standardizing HIPAA transactions and going electronic are set out at the end of this section.

For each transaction, the transition process should begin with a period for industry vetting of the guide. The vetting process should be led by the HLC. The industry should examine the Minnesota companion guides and identify any changes necessary to tailor the guides to Oregon. It is important, however, that the guides ultimately adopted by DCBS be as close as possible to the Minnesota guides. By maintaining a tight relationship with Minnesota, Oregon will maximize the likelihood that federal rules and standards will follow the model Oregon has put in place. In addition, by adhering to the Minnesota guides the state will be able to rely on the expertise of the Minnesota AUC in the future.

Immediately following the six-month review period, DCBS should begin an expeditious rule-making process leading to adoption of a companion guide within three months. If for any reason no industry recommendation has been developed by the end of the industry review period, DCBS should adapt the Minnesota guide as necessary and complete the rulemaking process on schedule.

Following adoption of the companion guide, providers and payers should be given a nine to twelve months to adjust their systems to comply with the new guide. Then, three to six months later, payers and providers should be required to use the uniform electronic transaction instead of manual methods. In the case of electronic funds transfer and the claims

¹¹ See e.g., Center for Information Technology Leadership, "The Value of Healthcare Information Exchange and Interoperability," Chapter 8 (2004).

status inquiry, the DCBS rule should time the all-electronic requirement to follow federal adoption of applicable uniform operating rules.

The work group recommends that the HLC complete the vetting processes for the remittance advice more quickly than called for in the chart below so that Oregon’s companion guides may be adopted before HHS adopts operating rules for that transaction. By doing so, the HLC will increase the likelihood that HHS writes rules that work for Oregon as well as making the most of this opportunity for savings.

Recommended Oregon timeline for standardizing HIPAA electronic transactions and going all-electronic

	Eligibility Inquiry and Response (270/271)	Claim (837)	Remittance Advice (835)	Claims Status Inquiry and Response (276/277)	Electronic Funds Transfer
Period for industry review of Minnesota companion guides ends	1/1/2011 (end of Q4 2010)	7/1/2011 (end of Q2 2011)	1/1/2012 (end of Q4 2011)	Not applicable	Not applicable
DCBS rule-making to adopt uniform companion guide completed	4/1/2011 (end of Q1 2011)	10/1/2011 (end of Q3 2011)	7/1/2012 (end of Q2 2012)	Not applicable	Not applicable
Everyone doing the electronic transaction must follow the uniform guide	1/1/2012 (end of Q4 2011)	10/1/2012 (end of Q3 2012)	7/1/2013 (end of Q2 2013)	Not applicable	Not applicable
Everyone must do this transaction electronically	7/1/2012 (end of Q2 2012)	1/1/2013 (end of Q4 2012)	10/1/2013 (end of Q3 2013)	1/1/2014 (end of Q4 2013)	1/1/2014 (end of Q4 2013)

Recommendation #3: Oregon should lead. Oregon should not wait for the federal government to standardize HIPAA transactions.

The federal reform legislation enacted this year addresses administrative simplification issues, albeit in a fashion that is in some regards more limited than the proposed approach. Oregon should take advantage of what the federal government will do by way of standardization but should take additional steps at the state level.

The federal legislation takes the following steps:

- It requires the U.S. Department of Health and Human Services (HHS) to periodically revise its standards for HIPAA electronic transactions.
- It requires HHS to issue rules by mid-2014 setting standards for claims attachments and other transactions for which the agency has never promulgated the rules required by HIPAA.
- It sets deadlines for issuing “uniform operating rules” for each of the HIPAA transactions for which HHS has already adopted.
- It requires providers to accept electronic payment remittance advice and electronic funds transfer from Medicare starting January 1, 2014.¹²

¹²Patient Protection and Affordability Act, section 1104.

The federal legislation has the potential for pushing HHS to take some critical next steps toward standardization. However, HHS has not traditionally moved quickly with regard to administrative simplification, and the deadlines set in the bill are far in the future, phased in over many years. In addition, it is not clear whether or not the operating rules that HHS must adopt will actually eliminate the proprietary companion guides that make doing business electronically so complex for providers. Therefore, Oregon should adopt the Minnesota companion guides to achieve standardization as soon as possible.

In addition, the federal law does not require use of electronic transactions except insofar as it requires providers to accept electronic funds transfer and electronic payment remittance advice from Medicare. If savings are to be achieved from automation of transactions in the Medicaid program and other forms of coverage, state action is required. Therefore, the state should require providers and payers to use uniform electronic transactions.

The chart below compares the time when the standardization and all-electronic rules that are necessary for achieving major savings will be in place if the state leaves administrative simplification to the federal government to the time the rules will be in place if the work group’s recommendations are carried out:

Timelines for Standardization and Automation with and without State Action

	Standardization with no state action	Standardization: Oregon	Automation with no state action	Automation: Oregon all-electronic
Eligibility Inquiry/Response (270/271)	Uncertain (1/1/2013 op rules)	1/1/2012	No requirement	7/1/2012
Claims (837)	Uncertain (1/1/2016 op rules)	10/1/2012	No requirement (except for Medicare)	1/1/2013
Payment Remittance Advice (835)	Uncertain (1/1/2014 op rules)	7/1/2013	No requirement (except for Medicare)	10/1/2013
Claims Status Inquiry/Response (276/277)	Uncertain (1/1/2013 op rules)	Same as federal	No requirement	1/1/2014
Electronic Funds Transfer	1/1/2014 (HIPAA standard & op rules)	Same as federal	No requirement (except for Medicare)	1/1/2014

Recommendation #4: Technical assistance to providers will be important to help providers adjust and take full advantage of administrative simplification opportunities.

Some providers and payers have been slow to automate insurance transactions because they do not have in-house capacity to reorganize work processes and business systems to take advantage of savings opportunities.

The federal government, through the Medicare and Medicaid programs, is offering providers financial incentives for using health information technology—including electronic claims and eligibility inquiries. These incentives should help them invest in these systems.

We recommend that the Oregon Health Authority, through either the DMAP, HITOC, or Oregon’s Regional Extension Center for health information exchange, take the lead in

developing a program to do outreach to providers and small plans to educate them about the state's administrative simplification strategy, what will be expected of them, and how to get help in making the necessary transitions. The program might develop tools such as web-based claim submission systems that comply with the uniform companion guides. The means of delivering these services should leverage any federal dollars that may be available.

Recommendation #5: There is need for ongoing public-private partnerships to identify successes, challenges and opportunities for future administrative simplification.

The state's ongoing role in administrative simplification should be carried out systematically. Therefore, the Oregon Health Authority and the Insurance Division of the Department of Consumer and Business Services should collaborate to carry out each of the following activities annually:

- Collect data from payers and providers necessary to measure rates of adoption of both the uniform standards and all-electronic requirements and any voluntary standards that have promise for reducing administrative cost;
- Evaluate the state's success in achieving compliance with the requirements of administrative simplification rules and the effectiveness of the rules in producing savings in healthcare administrative cost;
- Assess progress against plans, benchmarks, and timelines—and make any necessary adjustments;
- Solicit input from providers and payers, including broadly representative groups of industry stakeholders; consumers; and purchasers of healthcare regarding ways to reduce expenses related to healthcare administration;
- Familiarize themselves with innovative thinking and examine what is being done in other states and in the private sector and what is being done in development of health information technology infrastructure, to inform state-level planning;
- Identify opportunities for collaboration and for aligning with other states to increase Oregon's leadership role nationally in reducing healthcare costs;
- Establish priorities, goals, benchmarks, and timelines for development and adoption of uniform methods for conducting healthcare administrative transactions and assign responsibility to broadly inclusive industry organizations for developing and seeking industry adoption of those methods; and
- Evaluate industry performance relative to established goals, benchmarks, and timelines.

The healthcare industry should collaborate and partner with the state to identify opportunities and develop and seek adoption of uniform methods for doing business. The work group

encourages the industry to complete work on the effort to designate a single entity to collect information used by hospitals and insurers to credential physicians and to put in place a single sign-on system for providers to use to access health plan websites.

The work group addressed itself primarily to standardization and automation of purely administrative or financial processes—leaving more complex proposals to future work. The work group does not intend to suggest that proposals to standardize or eliminate additional processes are inappropriate. The group particularly urges the state, in collaboration with the industry, to consider whether standardization of plan design, payment methodologies or clinical management protocols may have potential for reducing both administrative and claims cost and improving the quality of care.

Next Steps

In order to carry forward the strategy and recommendations described in this report, the following steps will need to be taken:

- The Department of Consumer & Business Services (DCBS) must adopt by rule uniform companion guides for eligibility verification, claims, and payment remittance advice by adapting the Minnesota uniform companion guides. The rules should require insurers and the providers that do business with them to conduct the transactions electronically about a year after adoption of each uniform companion guide. (The recommended content of the rules is outlined in Appendix C.)
- The Legislature must enact legislation in 2011 giving DCBS authority to establish uniform standards for healthcare administrative transactions to all payers (including third party administrators and self-insured plans) and clearinghouses and to collect data from them to monitor progress and identify future opportunities. DCBS currently has broad authority to set standards for insurers but not for third party administrators, self-insured plans, Medicaid MCOs that are not Oregon licensed insurers, or clearinghouses.
- The Oregon Health Authority as a payer should follow the DCBS rules and require Medicaid managed care organizations, Medicaid providers, and others with which it deals to do so as well. This means DMAP must prepare to comply with the rules governing payers in the fee-for-service Medicaid program. In addition, DMAP should adopt rules and amend contracts so that providers follow the uniform processes when dealing with Medicaid as a payer and Medicaid MCOs follow the uniform processes in their dealings with providers.
- DCBS must require insurers and other payers to perform additional transactions electronically on a phased-in basis between 2014 and 2016—setting the dates for each transaction to go “all-electronic” no later than one year after a HIPAA standard and uniform companion guide or uniform operating rules have been adopted by the U.S. Department of Human Services. (See Appendix B.)
- The industry should bring forward its recommendation to develop a single sign-on to health plan web portals and a single source for information used in physician credentialing. In addition, the industry should identify and develop additional opportunities for standardization.

- The Insurance Commissioner and the Director of the Oregon Health Authority should take joint responsibility for continued progress toward greater administrative simplification. They should carry out these responsibilities in collaboration with providers and payers, collecting data to evaluate progress; establishing priorities, goals, benchmarks, and timelines; and using rulemaking authority as necessary.

Appendix A

Administrative Simplification Savings Projections

Transaction	Entity			Annual Savings by 2014
	Hospital	Physician	Payer	Total
Claim Submission				
High volume estimate (rounded to nearest million)	5,000,000	51,000,000	56,000,000	
Low volume estimate (nearest million)	4,000,000	35,000,000	39,000,000	
High est per tran savings from manual to electronic (USHEI for provider, Oregon payer average for payer)	3.73	3.73	2.51	
Low est per trans savings from manual to electronic (USHEI)	3.73	3.73	0.73	
Estimated current % electronic (based on Oregon provider and payer survey)	90%	77%	80%	
Goal % electronic	95%	95%	95%	
High savings est	\$932,500	\$34,241,400	\$21,084,000	\$56,257,900
Low savings est	\$746,000	\$23,499,000	\$4,270,500	\$28,515,500
Remittance Advice, incl posting				
High volume (.99 per claim from one Oregon hospital)	4,950,000	50,490,000	55,440,000	
Low volume (.7 per claim from several Oregon providers and Milliman study)	2,800,000	24,500,000	27,300,000	
Estimated per tran savings from manual to electronic (USHEI)	1.49	1.49	\$.60 per page	
Estimated current % electronic (posting for providers, sending of RA for payers--Or provider and payer survey)	80%	20%	15%	
Goal % electronic	95%	85%	100%	
High savings est	\$1,106,325	\$48,899,565	unknown	\$50,005,890
Low savings est	\$625,800	\$23,728,250	unknown	\$24,354,050
Eligibility Verification				
High volume (1.12 average per claim for Oregon providers on the workgroup)	5,600,000	57,120,000	62,720,000	
Low volume (.68 lowest per claim for Oregon providers on the workgroup)	2,720,000	23,800,000	26,520,000	

Appendix A (continued)

High est per tran savings from manual to electronic (USHEI for providers, Oregon payer survey for payers)	2.95	2.95	3.75	
Low est per trans savings from manual to electronic (Oregon work group member av time estimate x OHSU average cost per minute for providers, USHEI for payers)	2.46	2.46	1.38	
Estimated per trans savings from web to electronic (Oregon work groupmember av time estimate x OHSU average cost per minute for providers)	0.89	0.89	0	
Estimated current % electronic	40%	10%	71%	
Estimated current % web	40%	60%	see electronic	
Estimated current % phone	20%	30%	29%	
Goal % electronic (with balance phone)	90%	75%	77%	
High savings est	\$4,144,000	\$41,326,320	\$14,112,000	\$59,582,320
Low savings est	\$3,587,680	\$13,018,600	\$2,195,856	\$18,802,136
Claims Payment (eg, funds transfer)				
	Hospital	Physician	Payer	Total
Transaction volume	Unknown - payment is often weekly or biweekly, unknown av claims per payment	Unknown - payment is often weekly or biweekly, unknown av claims per payment	Unknown - payment is often weekly or biweekly, unknown av claims per payment	Unknown
Per transaction savings from check to electronic funds transfer	Savings for depositing check	Savings for depositing check	Savings for printing and mailing check	Unknown
Savings estimate	Insufficient information to estimate the number of transactions. There are some savings for both providers (cost of going to bank) and payers (cost of printing and mailing check).			
Claims Status Inquiry and Response				
	Hospital	Physician	Payer	Total
Hi volume (0.14 average per claim frequency for Oregon providers on the workgroup)	700,000	7,140,000	7,840,000	
Low volume (.14 average per claim frequency for Oregon providers on the workgroup)	560,000	4,900,000	5,460,000	

Appendix A (continued)

High est per tran savings from manual to electronic (Oregon work group member av time estimate x OHSU average cost per minute for providers, USHEI web and phone cost estimate for providers, Oregon payer survey estimate for cost of eligibility inquiry for payers)	4.14	4.14	3.75	
Low est per trans savings from manual to electronic (USHEI electronic savings over phone and web)	3.33	3.33	2.56	
Estimate per trans savings from web to electronic (Oregon work group member av web time estimate x OHSU average cost per minute for providers)	3.29	3.29	0	
Estimated current % electronic (providers are not using HIPAA electronic inquiries but because many transactions are now on the web, we are treating these as electronic from payer perspective)	0%	0%	37%	
Estimated current % web	50%	33%	see electronic	
Estimated current % phone	50%	67%	63%	
Goal % electronic (with balance phone)	80%	70%	72%	
High savings est	\$2,020,900	\$21,644,910	\$12,642,000	\$36,307,810
Low savings est	\$1,480,640	\$13,633,760	\$6,010,368	\$21,124,768
All transactions to be electronic by 2014				
	Hospital	Physician	Payer	Total
High savings est - all transactions	\$8,203,725	\$146,112,195	\$47,838,000	\$202,153,920
Low savings est - all transactions	\$6,440,120	\$73,879,610	\$12,476,724	\$92,796,454

Methodological notes:

1. Claims volume

Estimates of claims volume were computed in two ways.

A high estimate of physician claims was computed based on Oregon’s pro rata share of national estimates for Medicare and commercial claims reported in the AMA Administrative simplification white paper (2009), which cited the National Healthcare Exchange Service’s “2006 Physician Characteristics”(2007), assuming Oregon’s share of the totals are the same as Oregon’s share of personal health care spending in 2004 (the most recent date state-level

Appendix A (continued)

data is reported by CMS, Office of the Actuary). The estimate then assumed that the number of enrollees per claim is the same for Medicaid and self-insured plans as it is for commercial plans.

A low estimate of physician claims was computed based on the sum of: (a) the Oregon's pro rata share of national estimates for Medicare claims reported in the AMA Administrative simplification white paper (2009), which cited the National Healthcare Exchange Service's "2006 Physician Characteristics" (2007) assuming Oregon's share of total claims is the same as Oregon's share of personal health care spending in 2004 (the most recent date state-level data is reported by CMS, Office of the Actuary) and (b) the average number of claims per enrollee reported by Oregon payers in the OHP provider survey, assuming it is typical of all types of coverage except Medicare and assuming 85% of the reported claims are physician claims (as is true for PacificSource).

A high estimate of hospital claims was computed based on the number of claims reported by Legacy Health System (attributing a % of the five-hospital total to Legacy's Oregon hospitals based on their share of net patient revenue, according to the system financial statement filed with OHP) and estimating a number for all Oregon hospitals assuming Legacy has the same share of all hospital claims as it has of all net patient revenue for Oregon hospitals.

A low estimate of hospital claims was computed based on the average number of claims per enrollee reported by Oregon payers in the OHP provider survey, assuming it is typical of all types of coverage (commercial, Medicare, Medicaid, and self-insured) and assuming 9% are hospital claims (as is true for PacificSource).

2. Volume of other transactions

Estimates of volume of other transactions were based on the volume of claims and on estimates of the number of each other transaction done per 100 claims. Estimates were made by provider members of the work group (OHSU clinics, Portland Clinic, Corvallis Clinic, NW Human Services, and Legacy Health System hospitals).

High estimates were calculated using the high estimate for claims volume and, where ratio estimates were widely varied among the work group, the high estimate.

Low estimates were calculated using the low estimate for claims volume and, where ratio estimates were widely varied among the work group, the low estimate.

3. Per transaction savings

Estimates of savings were drawn from two sources.

Where available, a first estimate was drawn from "US Healthcare Efficiency Index: National Progress Report on Healthcare Efficiency 2010" (April 2010). The USHEI based its estimates on the best available studies of cost from a variety of sources.

Appendix A (continued)

Where available, a second estimate of provider savings was based on the average number of minutes for doing transactions by phone, on the web, and using a HIPAA electronic transaction estimated by provider members of the work group. A \$.70 per minute conversion factor was used, based on an OHSU estimate of salary, benefit, and overhead costs.

Where available, a second estimate of payer savings was based on the average savings reported for electronic versus manual transactions by DMAP and Providence Health Plans. In the case of savings for electronic claims, the savings represents savings in preparing a claim for adjudication. It does not include savings for adjudicating a claim electronically rather than manually. We excluded savings for adjudicating electronic versus manual claims for two reasons: First, the preparation cost is designed to convert manual to electronic claims; hence, to add the two savings figure would overstate savings. Second, by excluding the savings on the adjudication side, we exclude adjudication-related savings that will be realized only when elimination of paper or faxed claims attachments allows elimination of attachment-related manual adjudication. This savings will be substantial but can only be realized after methods are adopted for electronic coding information that is currently supplied by an attachment such as an explanation of benefits or a chart note.

For each transaction, a high and a low were reported.

No savings is estimated for payers related to doing an electronic payment remittance advice. One payer estimates the savings is 60 cents per page. However, we have no basis for estimating the number of pages of remittance advice or the ratio of pages to claims.

No savings is estimated for payers or providers for electronic funds transfer because we have no information from which to estimate the volume of paper checks, the cost to payers of making deposits on the payer side or the cost of preparing and mailing checks for payers.

4. Current utilization of electronic, web, and phone or paper methods

The baseline utilization of electronic, web, and phone and paper methods of accomplishing each business transaction are best estimates based on results on the OHPR payer survey and the OHPR provider survey and feedback from members of the work group.

5. Projected 2014 utilization of electronic, web, and phone or paper methods

The projected 2014 utilization levels are best estimates of the work group.

The degree to which projected savings are achieved or exceeded (particularly for the inquiry transactions) will be largely dependent on the completeness of information supplied by payers in response to the electronic inquiry. The degree to which projected savings are achieved or exceeded for the remittance advice transactions will be largely dependent on the choice of the providers to post automatically from the electronic remittance advice rather than to print it and continue to manually post.

Appendix B

Recommended Outline for Administrative Rules

DCBC Rules

- Licensed health insurers must conduct business in accordance with uniform standards. (Note: The effect would be to place the same requirements on insurers and providers accepting payment from insurers.)
- The 5010 version of the Minnesota companion guides for claims (837), payment remittance advice (835) and eligibility inquiry and response (270/271) transactions (with any modifications for Oregon) are adopted as uniform guides for Oregon.
- Insurers must use the companion guides adopted by DCBS starting on specified dates.
- Insurers must configure web browser and direct data entry systems consistent with the data content component of the applicable companion guide.
- Licensed insurers must conduct claims, eligibility inquiry/response, and payment remittance advice, and funds transfer transactions electronically by specified dates.
- Licensed insurers must conduct the claims status inquiry/response transaction (276/277) electronically by January 1, 2014 and claims attachment (275) and referral and prior authorization (278) transactions electronically beginning July 1, 2016 (after HHS adopts standards and operating rules for those transactions).
- After legislation passes to authorize DCBS to prescribe uniform standards for administrative transactions applicable to all healthcare payers and clearinghouses, TPAs, self-insured health plans, and clearinghouses must follow the same rules.

OHA Rules

- DMAP as payer must conform its practices to the DCBS rules and by contract or rule Medicaid managed care organizations must follow the DCBS rules.

Appendix C

Oregon Health Information Exchange Timeline																				
	1/1/2010	7/1/2010	10/1/2010	1/1/2011	4/1/2011	7/1/2011	10/1/2011	1/1/2012	4/1/2012	7/1/2012	10/1/2012	1/1/2013	4/1/2013	7/1/2013	10/1/2013	1/1/2014	1/1/2015	1/1/2016	7/1/2016	
FEDERAL REQUIREMENTS																				
ICD-10 code																				Mandatory (Oct 1)
5010 HIPAA transaction rules				Testing begins				Mandatory												
HIE meaningful use requirement (proposed)	Stage 1 includes 80% patients eligibility checked electronically, 80% claims submitted electronically, 75% e-prescribe										Stage 2 includes COPE (including transmission), lab results submitted in code					Stage 3 includes?				
HIE Medicaid incentives (eligibility limited to hospitals w/ 10% & professionals w/30% w/ some exceptions)						For 2011 Medicaid subsidy show MU July 1 (hospitals), Oct 1 (phys)														Show MU to get maximum Medicaid subsidy (phys)
HIE Medicare incentives (all providers are eligible with maximum payments depending on multiple factors)						For 2011 Medicare subsidy show MU July 1 (hospitals), Oct 1 (phys)				Show MU to get maximum total Medicare subsidy (phys)									Show MU to get maximum total Medicare subsidy (hospital)	
Federal health reform law requirements												Eligibility inquiry and claims status uniform operating rules take effect (rules issued by 7/1/2011)							Certification and auditing of payer systems begin	EFT and remittance advice uniform op rules take effect (rules issued by 7/1/2012) Medicare requires electronic funds transfer and remittance advice. Payer noncompliance penalties begin.
OREGON UNIFORM STANDARDS																				
Industry work on standardization and automation		HLC reviews MN companion guides for eligibility verification		HLC reviews MN companion guides for claims.		HLC vets MN companion guides for remittance advice.														
State statutory changes and rulemaking on standardization and automation				DCBS adopts rule requiring all electronic claims, eligibility, RA, EFT, claims status by specified dates and adopts guides for eligibility verification.		Legislature authorizes DCBS to adopt standards applying to payers not licensed as insurers and clearinghouses.		DCBS adopts rule applying all-electronic and companion guide rules to all payers and clearinghouses and adopts guides for claims.			DCBS adopts guides for remittance advice.									Providers and payers must do referral/authorization and claims attachment transactions electronically.
State standardization and automation requirements for payers and providers							Providers and payers must use uniform guides for eligibility verification.		Providers do eligibility verification electronically.	Providers and payers must use uniform guides for claims.	Providers and payers must send/accept claims electronically.		Providers and payers must use uniform guides for remittance advice.	Providers and payers must send/receive remittance advice electronically.	Providers and payers must do funds transfer and claims status inquiry electronically.					
Ongoing industry work	ONGOING INDUSTRY SIMPLIFICATION WORK STARTING WITH COMMON WEB PORTAL, COMMON SITE FOR CREDENTIALING INFORMATION																			
Ongoing OHA/DCBS work				Annually: OHA/DCBS do data call to evaluate progress	Annually: OHA/DCBS assessment of progress, needs, and priorities in collaboration with the industry		Annually: OHA/DCBS do data call to evaluate progress	Annually: OHA/DCBS assessment of progress, needs, and priorities in collaboration with the industry			Annually: OHA/DCBS do data call to evaluate progress	Annually: OHA/DCBS assessment of progress, needs, and priorities in collaboration with the industry		Annually: OHA/DCBS do data call to evaluate progress	Annually: OHA/DCBS assessment of progress, needs, and priorities in collaboration with the industry	Annually: OHA/DCBS data call and collaborative assessment of progress, needs, and priorities in collaboration with the industry	Annually: OHA/DCBS data call and collaborative assessment of progress, needs, and priorities in collaboration with the industry	Annually: OHA/DCBS data call and collaborative assessment of progress, needs, and priorities in collaboration with the industry	Annually: OHA/DCBS data call and collaborative assessment of progress, needs, and priorities in collaboration with the industry	

Appendix D

Glossary

Administrative Simplification – The process of simplifying and reducing the cost of health insurance administration, primarily by bringing uniformity to paper forms, electronic communications, and a variety of insurance processes.

Claim – A request for payment.

Claims attachment – A document sent by a provider to a plan in support of a claim, such as a chart note, discharge summary, or a remittance advice or explanation of benefits from the health plan that is the primary payer on a claim.

Companion Guides – Documents that specify how the standards and implementation guides for each HIPAA electronic transaction will be used between particular trading partners—generally a healthcare provider and a health plan. Where implementation guides provide options, the companion guides provide direction. Generally, companion guides are issued by plans. Providers are contractually required to comply with a different companion guide for each plan.

Department of Consumer and Business Services (DCBS) – The agency that regulates insurance as well as many other businesses in Oregon. The director of the department is the Insurance Commissioner. The Administrator of the Insurance Division of DCBS oversees the insurance functions of the agency.

Encounter information – A report of services rendered that is not a claim for payment. For example, the Division of Medical Assistance Programs (DMAP) requires Medicaid Managed Care Organizations (MCOs) to submit encounter information on services rendered to Medicaid enrollees even though DMAP pays MCOs on a capitation basis, not a fee-for-service basis.

HHS – US Department of Health & Human Services, the federal agency that administers Medicare and Medicaid, as well as many other federal programs.

Health Information Technology Oversight Council – The state council in the Oregon Health Authority that coordinates Oregon's public and private statewide efforts in electronic health records adoption and the eventual development of a statewide system for electronic health information exchange.

Health Insurance Portability and Accountability Act – Federal statute enacted in 1996 requiring, among other things, the Secretary of the US Department of Health & Human Services to adopt standards for transactions, to enable health financial and administrative information to be exchanged electronically and requiring those that transmit information electronically to conform to the standards. 42 USC §1320d-2.

Appendix D (continued)

HIPAA – See *Health Insurance Portability and Accountability Act*.

HIPAA standards – Rules adopted by the US Department of Health & Human Services pursuant to authority granted in the Health Insurance Portability and Accountability Act adopting technical standards for electronic health financial and administrative transactions, including detailed standardized code sets.

HIPAA transactions – The transactions for which HIPAA requires HHS to develop standards for electronic information exchange. The transactions addressed by the 1996 statute were claims (or encounter information), claims attachments, remittance advice, eligibility inquiry and response, prior authorization and referral, claims status inquiry and response, health plan enrollment/disenrollment, health plan premium payments, and first report of injury (worker’s compensation).

Health Leadership Council (HLC) – A private, non-profit organization formed as a successor to the Health Leadership Task Force by various participants in the Oregon healthcare industry.

Health Leadership Task Force – An Oregon healthcare industry group established with the encouragement of several Oregon business organizations and funded by Oregon health insurers and health systems with a mission to find ways to reduce healthcare costs.

Implementation Guides – Documents adopted by international standards development organizations to provide detail on the use of each transaction adopted by HHS under HIPAA.

Insurance Commissioner – The director of the Department of Consumer and Business Services.

Office for Oregon Health Policy and Research (OHPR) – The agency, within the Oregon Health Authority, that collects and analyzes data regarding the health system; provides information and advice to the legislature, the governor, and the Authority; and staffs a wide variety of statutory and advisory bodies.

Remittance Advice – A communication sent explaining to the provider the payments made by the plan for a particular period of time. It will list the claims that are being paid and uses a coded format to explain how and why the payment amounts differ from the amount billed.

U.S. Department of Health & Human Services - The agency that administers Medicare and Medicaid, as well as many other federal programs.

**Office for Oregon Health
Policy and Research**



***Provider and Payer Survey on
Administrative Transactions:
A Report to the Health Policy Board***

June 2010

***Provider and Payer Survey on
Administrative Transactions:
A Report to the Health Policy Board***

Prepared By:
Office for Oregon Health Policy and Research

Jeanene Smith MD MPH
Administrator

Sean Kolmer, MPH
Deputy Administrator

Satenik Hackenbruck
Research Analyst

Lynn-Marie Crider
Policy Analyst

For additional copies or an alternate format of this report, please call (503) 373-1598

[THIS PAGE INTENTIONALLY LEFT BLANK]

Table of Contents

Survey Purpose and Methods.....1

Payer Survey.....2

Provider Survey.....4

Appendix A: Administrative Simplification Survey - Clinics

Appendix B: Administrative Simplification Survey - Hospitals

Appendix C: Providers' Perspectives on Possible Changes

[THIS PAGE INTENTIONALLY LEFT BLANK]

Survey Purpose and Methods

In early 2010, the Office for Oregon Health Policy and Research (OHPR) conducted surveys of ambulatory health clinics (including ambulatory surgery centers), hospitals, and health plans to inform the deliberations of the Administrative Simplification Work Group. The work group was formed by direction of the legislature to assist OHPR in formulating uniform standards for insurers. OHPR would recommend standards for adoption by the Department of Consumer and Business Services.¹ In addition to developing uniform standards, OHPR will offer strategic direction to the Health Policy Board's efforts to simplify health plans' administrative processes in order to reduce the administrative expense component of health care.

The three primary purposes of these surveys were (1) to provide a rough baseline measure of Oregon's progress toward adopting efficient methods for conducting business transactions between providers and payers, (2) to learn from providers and payers about the barriers to adopting more efficient methods of doing business, and (3) to offer providers and payers an opportunity to tell the work group what they think would be most helpful in reducing administrative burden.

The payer survey was conducted using a structured interview of health plan staff. Most agreed to participate. Some of the plans provided almost all of the cost and volume data we requested, but others did not—either because they did not collect the data or chose to treat it as proprietary.

The ambulatory health clinic and hospital surveys were conducted electronically.² The surveys were distributed by OHPR, Oregon Association of Ambulatory Surgery Centers, Oregon Association of Hospitals and Health Systems, Healthcare Financial Management Association, Oregon Medical Association, Medical Group Management Association and, Division of Medical Assistance Program. Results were tabulated after eliminating duplicates.

Thirty-two hospitals (55% of the state's acute care hospitals) and 225 ambulatory clinics submitted completed surveys in time to be tabulated.³ While the rate of participation by ambulatory clinics cannot be calculated owing to the method used for distributing the survey, we know that the rate of participation by ambulatory facilities was much lower than for hospitals.

¹ See HB 2009, sections 1192 and 1193 (2009).

² Copies of the surveys are included as Appendix A and Appendix B to this report.

³ We received a number of incomplete or duplicate surveys. Incomplete surveys were tabulated for the questions answered unless a more complete survey was received from the same facility. Duplicates were eliminated. About 15 surveys were submitted after the date of tabulation; the numbers were not re-run to include them.

Payer Survey

OHPR staff met with one or more staff from eight participating plans—the Division of Medical Assistance Programs (which operates the Medicaid fee-for-service program), one Medicaid managed care organization, and six commercial insurers. OHPR conducted structured interviews of staff identified by the plans. Most of the plans also submitted written materials before or after the meetings. All provided some baseline data. The data has been used to help develop savings projections.

Utilization and cost savings from substituting electronic for manual transactions

Over 30 million health care claims are submitted by Oregon providers annually.⁴ Plans realize savings when claims are submitted electronically rather than on paper because of both reduced costs to prepare a claim for adjudication and to adjudicate it: The average reported plan savings for preparing an electronic claim for adjudication as compared with a paper claim was \$2.38 per claim.

Of the surveyed plans, DMAP is furthest along in moving to electronic claims filing, with 90% of its claims received electronically. The commercial plans receive between 76-81% of their claims electronically. DMAP and the commercial plans have invested in systems allowing them to convert paper claims to electronic ones in order to run them through auto-adjudication systems. Auto-adjudication rates are widely variable, ranging from 52-73% on the commercial side to only 18% for a Medicaid managed care organization. One of the plans estimates that auto-adjudicating a claim costs \$3.15 less than manually adjudicating it.

Six of the plans offer providers the option to receive an electronic payment remittance advice. A seventh plan is preparing to offer electronic remittance advices this year, the eighth in 2011. A payment remittance advice explains any variation between the amount billed and the amount paid on a claim. There is some savings to payers from eliminating printing and mailing costs. The greater potential for savings may be to providers who should be able to post from the electronic remittance advice, rather than manually posting.

Most of the plans offer electronic funds transfer as well, but the take-up so far ranges from 5-20% of total payments. Two of the plans do not yet offer electronic funds transfer. One expects to do so this year.

Oregon plans receive an average of one provider call per enrollee per year.⁵ That means over 3 million Oregon provider phone calls per year. One plan estimated that provider

⁴ The estimated number of claims was arrived at in two ways. Claims were estimated based on the number of claims per enrollee received by the payers in our survey and the total number of Oregonians with some kind of health plan coverage. Claims were also estimated based on the number of claims filed nationally each year and Oregon's share of national health care spending. The estimation methods each suggested an Oregon total between 30 and 35 million a year.

⁵ Plan estimates of the number of provider calls per enrollee per year varied from 3 calls for every 10 patients to 15 calls for every 10 patients.

calls cost the plan about \$1.22 per member per month. If the figure is typical of other plans, then plans spend about \$43 million each year to field provider calls. Plans were unable to report their provider call volume by issue. However, one plan was able to say that call volume was highest for benefits inquiries, followed by eligibility inquiries, prior authorization requests, claims status inquiries, and processing issues. Plan representatives are persuaded that savings would be achieved if providers accessed plan information using HIPAA-compliant electronic inquiries or plan websites.

Payer feedback on proposed strategies for achieving administrative savings

OHPR asked both payers and providers to rate the potential for reducing the cost of administration for their organizations by implementing various administrative simplification proposals and to tell us how quickly they believed their organizations could be ready to implement each.⁶

Payers anticipated the greatest savings from requiring providers to submit claims electronically. Four out of seven projected great or significant savings from the requirement. Only one payer saw great savings potential from implementing any of the other proposed changes.⁷ On the other hand, several payers anticipated increases in their costs from standardizing the insurance card, requiring plans to provide more information in response to eligibility inquiries, and requiring an electronic claim's status message explaining the reason the claim had not been immediately adjudicated.

When asked an open-ended question about how to reduce administrative costs in their organizations, payers suggested increasing utilization of electronic transactions of all types, requiring electronic claims and payments, developing an electronic method for doing coordination of benefits transactions, developing a swipe card system for accessing electronic eligibility and benefits information, implementing electronic provider contracts, extending the prompt pay period, and making other changes to the coordination of benefits payment system.

Payer feedback on the state's role

The state's commercial payers did not answer questions about the appropriate role for the state. They offered support for standardization, a desire to work collaboratively to take steps to save administrative cost for both providers and payers, and a view that the appropriate role for the state should be assessed in relation to each opportunity for savings. The national plans that participated in the interviews were less enthusiastic than the others about state-driven standardization because it may require them to develop expensive work-arounds to comply with state requirements.

⁶ The proposals are listed in question 21 of the clinic survey, which is Appendix A to this report.

⁷ One payer saw great savings potential from standardizing reason codes on the payment remittance advice, creating a single log-in to payer websites, standardizing the content and format of information on payer websites, and standardizing the information that could be sought for prior authorization. Some plans also saw potential for significant administrative savings from requiring plans to send electronic payment remittance advices, from a health information exchange systems, and from a central repository for credentialing information.

Provider Survey

OHPR analyzed responses of 225 clinics and 32 hospitals to gain an understanding of the methods they are using to conduct the most common business transactions with insurers, to identify barriers to increased use of electronic methods, and to gather input about what administrative changes would help reduce costs and time spent conducting insurance transactions.

Participation

A good mix of survey responses was received from both hospitals and clinics. (See Table 1 and Table 2.) Overall, 58 percent of Type A hospitals (7 out of 12), 40 percent of Type B hospitals (8 out of 20), and 65 percent of DRG hospitals (17 out of 26) responded to the survey.

Table 1. Hospitals that responded to the survey

Size	Responded to survey	Percent of total responses
Fewer than 50 beds	15	46.9%
50-99 beds	3	9.4%
100-249 beds	6	18.8%
250 or more	8	25.0%
Total responded	32	100.0%

Half of the responding clinics were single-specialty clinics, 27 percent were primary care clinics, and the remaining 23 percent were multi-specialty clinics.

Table 2. Clinics that responded to survey

Size	Responded to survey	Percent of total responses
Solo	51	22.7%
2-4 clinicians	48	21.3%
5-9 clinicians	57	25.3%
10-19 clinicians	30	13.3%
20-49 clinicians	29	12.9%
50 or more clinicians	10	4.4%
Total responded	225	100.0%

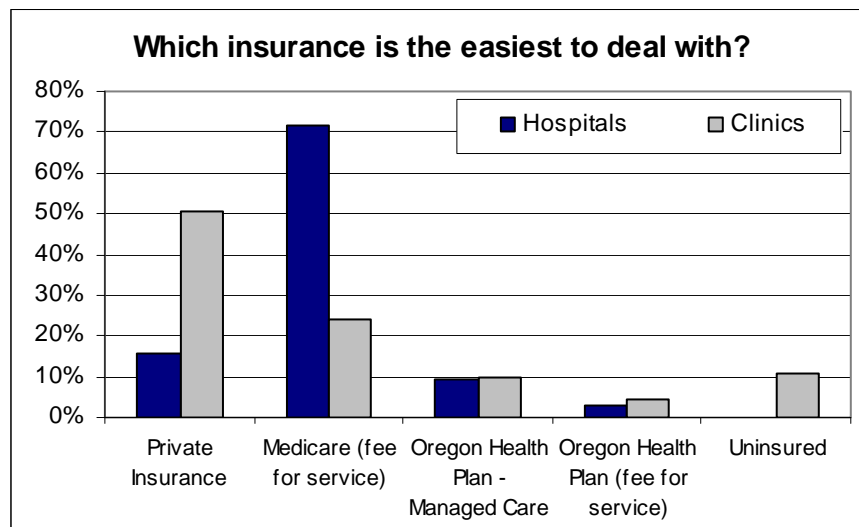
Provider opinion about ease of dealing with health plans

To get some sense of the administrative issues that matter most to providers, OHPR asked which payers are the easiest and which payers are the hardest to deal with from an administrative standpoint and why. Respondents could choose private insurance, Medicare fee-for-service, Oregon Health Plan (OHP) fee-for-service, OHP - managed care, or uninsured individuals. Some clear patterns emerged.

The most salient administrative issue for both hospitals and clinics was the speed of claims payment, but hospitals and clinics find different plan types best in this regard. Seventy-two percent of hospitals said Medicare fee-for-service was the easiest to deal with. (See Figure 1.) Of those hospitals that said Medicare fee-for-service is the easiest to deal with the top three reasons were: clean claims are paid quickly (96%), the payment remittance advice is useful and easy to understand (91%), and the insurance card has good content and is easy to read (83%).

Clinic responders were less uniform in their responses, but slightly more than half said private insurance plans were the easiest to deal with; a number, however, commented that there was a wide variation among the private insurers and the OHP - managed care plans on administrative issues. Of those clinics that said private plans were the easiest to deal with the top three reasons were: clean claims are paid quickly (79%), insurance card has good content and is easy to read (68%), and payment remittance advice is useful and easy to understand (64%).

Figure 1

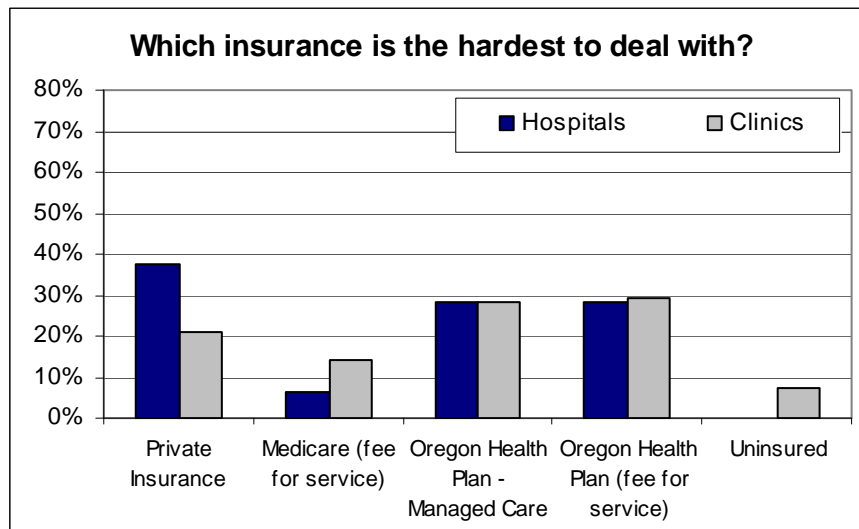


The picture was somewhat less clear in regards to which type of coverage is the hardest to deal with from an administrative standpoint for both hospitals and clinics. (See Figure 2.) Thirty-eight percent of hospitals said private insurance was the hardest to deal with. Of those hospitals that said private insurance coverage is the hardest to deal with the top

three reasons were: the insurance card is confusing or lacks information (100%), websites do not provide complete information (92%), and the payment remittance advice is confusing or inconsistent with paper explanation of benefits (83%).

Combined 58 percent of clinics said that either OHP fee-for-service or OHP - managed care plans were the hardest to deal with. Of those clinics that said OHP fee-for-service or OHP - managed care were the hardest to deal with the top three reasons were: call centers are slow or unhelpful (61%), insurance card is confusing or lacks information we need (60%), and many claims are denied for technical reasons (60%).

Figure 2



Provider use of information systems to conduct insurance transactions

Most hospitals and clinics responding to the survey are currently using systems that enable them to deal electronically with payers. Ninety-four percent of hospitals and 86 percent of clinics use clearinghouses, the third party intermediaries that assist providers and payers to transmit electronic messages to one another in formats that comply with the Health Insurance Portability and Accountability Act (HIPAA). Eighty-three percent of clinics reported that they use electronic practice management systems, which are often used to communicate with the clearinghouses.

Submission of claims

We asked providers to indicate all the methods that they currently use for submitting bills. We also asked what percentage of their claims is submitted electronically. More than three-quarters of both hospitals and clinics reported that they submit 75% or more of their claims electronically. (See Figure 3.)

Indeed, one of the methods of submitting bills utilized by 94% of hospitals and 87% of clinics is electronic billing through a clearinghouse. (See Figure 4.) In addition about half of the hospitals and 20 percent of the clinics also utilize direct billing either using a HIPAA compliant electronic transaction or through health plan’s electronic system. No hospitals and only 3% of clinics reported that they are submitting no claims electronically. However, despite the high penetration of electronic claims submission systems, 72% of hospitals and 68% of clinics are still occasionally sending paper bills due to some common barriers to electronic bill submission.

Figure 3

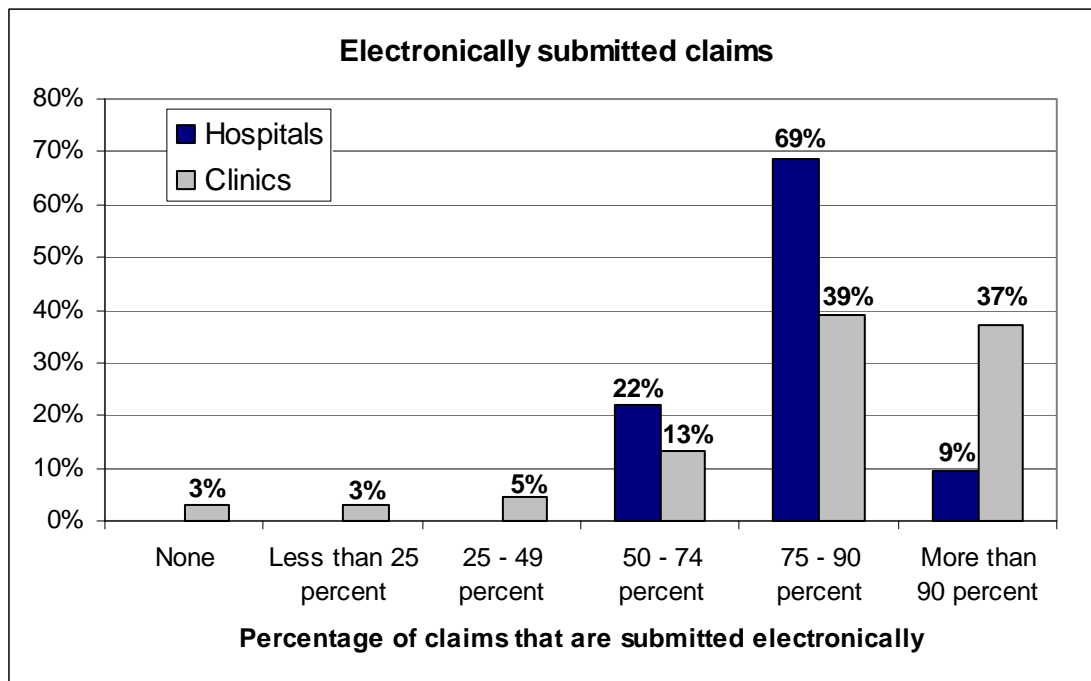
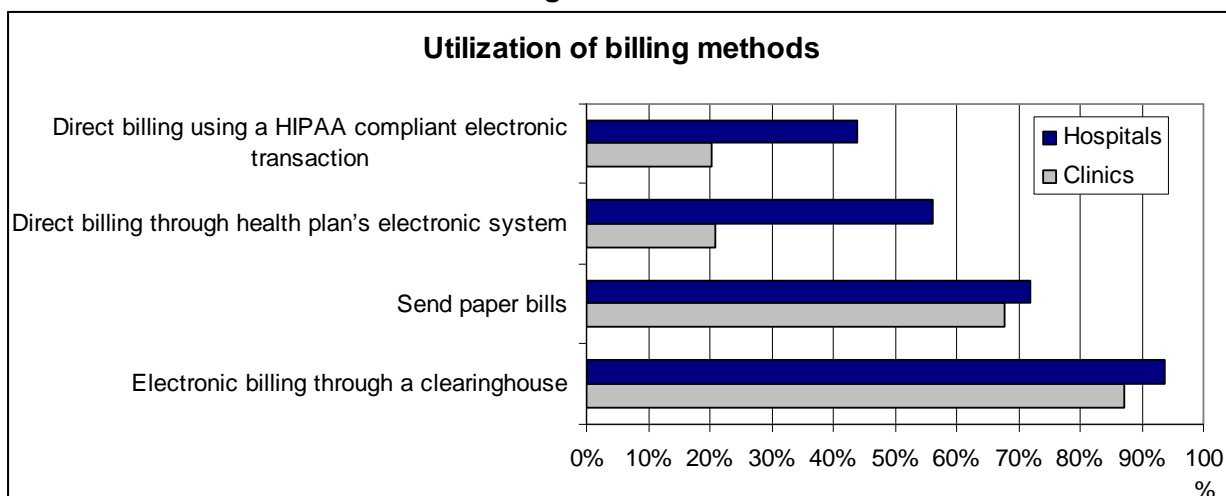


Figure 4



Providers were asked to identify the most common barriers to electronic claims submission from a list based on provider interviews.⁸ The barriers are enumerated below, from most to least frequently selected:

- Some claims require attachments which cannot be submitted with an electronic claim (97 percent of hospitals and 75 percent of clinics)
- Some health plans do not accept electronic claims (72 percent of hospitals and 56 percent of clinics)
- Clearinghouse has problems with certain plans or claim types (25 percent of hospitals and 34 percent of clinics)
- Practice management software problems (3 percent of hospitals and 11 percent of clinics)
- Paper is easier or better (0 percent of hospitals and 5 percent of clinics).

Non-claims transactions

Although providers are accustomed to submitting claims electronically, only a minority use HIPAA batch transactions to conduct any other business with insurers. Moreover, most do not make use of electronic payment remittance advices to move from manual to automatic posting of payments.

Many providers check insurance eligibility, coverage, and cost-sharing for their patients when an appointment is made or a patient presents at the provider’s facility. Providers do this in order to know where to submit the bill and how much of it the patient will be responsible to pay. The most common method used by both hospitals and clinics to make what is known as the eligibility inquiry is checking plans’ websites. (See Figure 5.) The second most commonly used method for clinics is telephone inquiry and for hospitals it is electronic inquiry.

⁸ A few informal interviews with providers were conducted prior to designing the survey tool.

Providers were asked to identify the most important barriers to using electronic or web eligibility inquiries in place of telephone or fax inquiries. They were asked to choose from a list based on provider interviews. For both, the plans' failure to provide complete information was a key barrier to greater use of web and electronic inquiry methods.

The barriers to greater use of electronic inquiries are enumerated below, from most to least frequently selected:

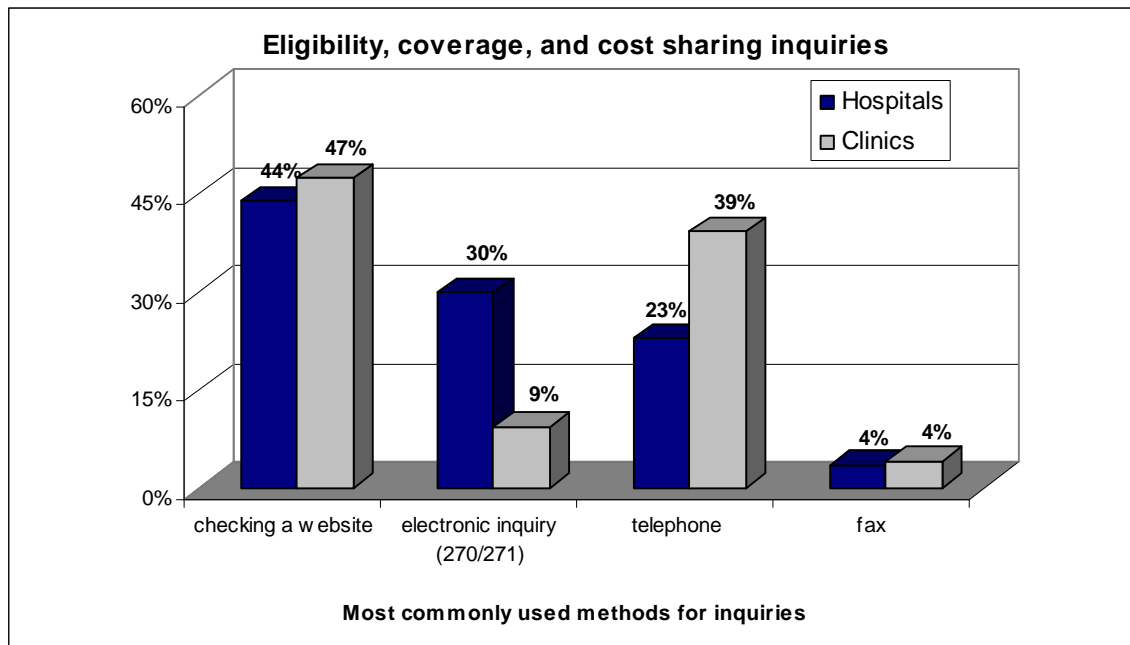
- Insurers do not provide enough information in response to this type of inquiry (87 percent of hospitals and 60 percent of clinics)
- Clearinghouse problems (48 percent of hospitals and 16 percent of clinics)
- Practice management or other practice software or internet problems (36 percent of hospitals and 28 percent of clinics)
- Prefer to use a web look-up system (19 percent of hospitals and 40 percent of clinics)
- Insurers do not provide fast enough responses (16 percent of hospitals and 20 percent of clinics)
- Prefer to talk with a plan representative (13 percent of hospitals and 36 percent of clinics).

The barriers to the increased usage of web look-up technology are listed below, again from most to least frequently selected:

- Some insurers do not have web systems or their web systems are not easily accessible (81 percent of hospitals and 71 percent of clinics)
- Some insurers do not provide enough information on their web systems (72 percent of hospitals and 78 percent of clinics)
- Practice management or other practice software or internet problems (26 percent of hospitals and 16 percent of clinics)
- Prefer to talk with a plan representative (7 percent of hospitals and 25 percent of clinics)

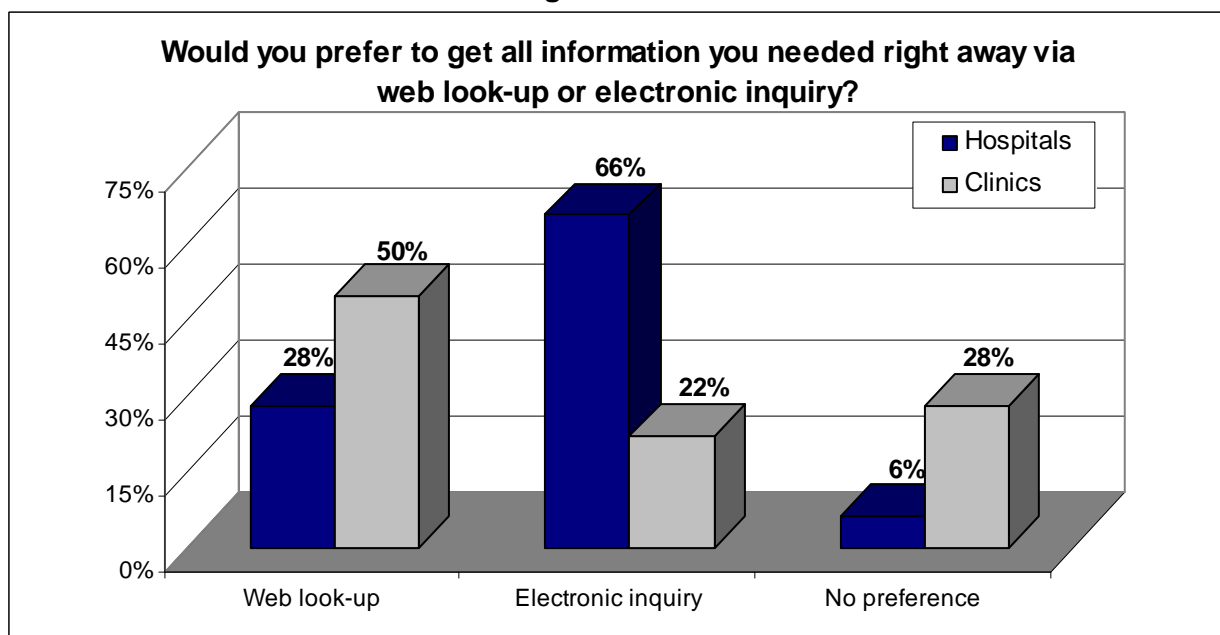
In addition to the barriers pre-listed in the survey, in their comments some clinic responders indicated lack of training and extra costs as important barriers for increased use of electronic inquiries and user limitations, difficulty managing numerous web logons and passwords, unfriendliness of some websites, and lack of uniformity as important barriers for increased usage of web look-up technology.

Figure 5



Although the majority of hospitals are using web look-up systems as their primary method of getting eligibility, coverage, and cost sharing information, they would prefer to use electronic inquiries if they could get all the information they needed right away. Clinics, on the other hand, reported a preference for web look up systems – although many were indifferent as between the two technologies. (See Figure 6).

Figure 6



Many plans offer hospitals and clinics the option to receive an electronic rather than a paper payment remittance advice. Providers can post payments from the electronic remittance advice automatically, saving the cost of manual posting. As noted in payer survey section of this report, payers report that few providers have availed themselves of this option. Figure 7 shows what methods of posting payments are currently used by hospitals and clinics and Figure 8 shows what form of remittance advice hospitals and clinics prefer.

The majority of clinics (79%) are currently manually posting their payments; on the whole, they prefer receiving paper remittance advices or both paper and electronic documents. On the other hand, a majority of the hospitals (77%) automatically post their payments; they prefer receiving electronic remittance advices. Ninety-seven percent of hospitals and 60 percent of clinics want to receive an electronic remittance advice. Of the clinics that prefer to receive only a paper remittance advice, 85 percent are small clinics, with fewer than 10 clinicians. (See Figure 8).

Figure 7

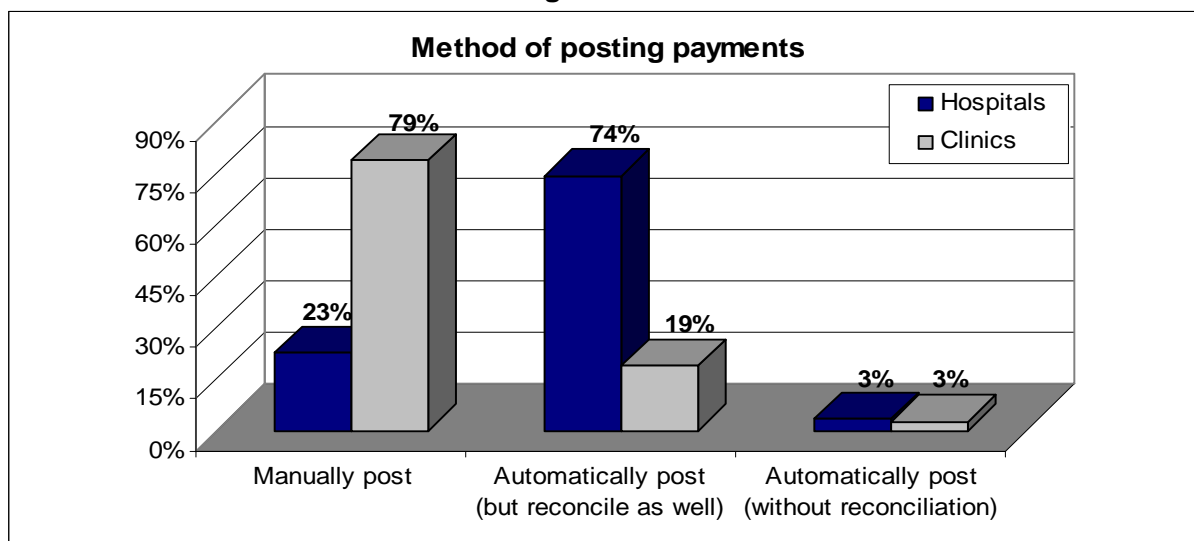
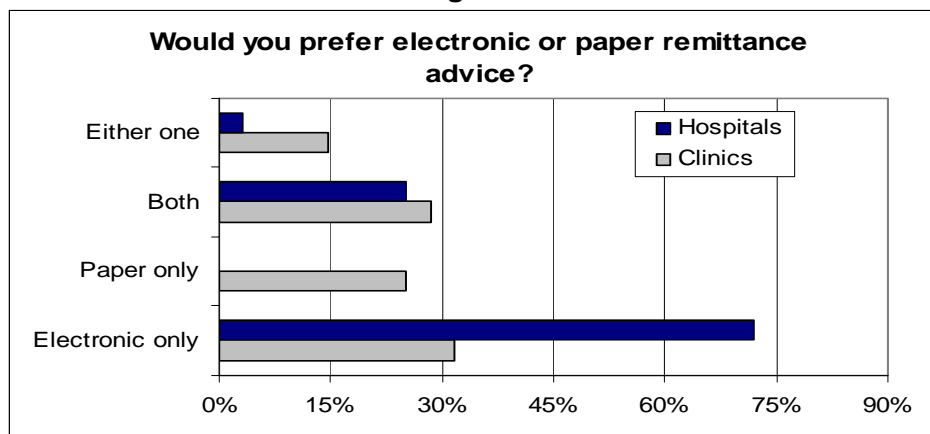


Figure 8



Interest in making greater use of HIPAA electronic transactions

For several activities, OHPR asked questions designed to elicit how many are currently using electronic methods based on the HIPAA electronic transactions and assess their interest in increasing their use of the electronic methods.⁹ Vast majority of the hospitals use the electronic claims, eligibility inquiry, and payment remittance advice transactions and post from the electronic remittance advice. It is difficult to determine how many clinics use the standard transactions because many answered that they were unsure. What is clear from the responses, however, is that many providers would start using the transactions or use them more if insurers followed uniform practices. Very few indicated that they would use it only if required to do so. (See Table 3.)

Table 3. Utilization of HIPAA Transactions

HIPAA Transaction	Provider Category	We use today OR We use today but would use more often if insurers followed uniform practices	We do not use today but would if insurers followed uniform practices	We do not use today and will not unless it is required	Unsure
837 for claim to primary insurer	Hospitals	94%	6%	0%	0%
	Clinics	50%	8%	13%	29%
837 for claim to secondary insurer	Hospitals	78%	16%	3%	3%
	Clinics	37%	17%	18%	28%
270/271 to make eligibility inquiry	Hospitals	84%	16%	0%	0%
	Clinics	31%	29%	14%	26%
276/277 to request claim status	Hospitals	44%	50%	0%	6%
	Clinics	25%	25%	17%	33%
278 to request prior authorization or referral	Hospitals	9%	63%	6%	22%
	Clinics	20%	28%	17%	34%
835 remittance advice to post payments automatically	Hospitals	78%	16%	6%	0%
	Clinics	29%	17%	27%	27%

⁹ For each transaction, the survey asked “where your organization is at,” choosing from the following options:

- We use today
- We use today and would use more often if insurers followed uniform practices
- We do not use today but would if insurers followed uniform practices
- We don’t plan to use unless insurers require it
- Unsure.

Provider feedback on proposed strategies for achieving savings through administrative simplification

Like payers, OHPR asked providers to rate the potential for reducing the cost of administration for their organizations by implementing various administrative simplification proposals and how quickly they believed their organizations could be ready to implement each. Provider responses to the proposals are set out in detail in Appendix C.

Providers were more enthusiastic than payers about the potential for realizing savings from the administrative simplification proposals described in the survey. For example, more than 70% of hospital and 40% of clinic respondents said that standardizing the information plans provide on the payment remittance advice (including specific standard reason codes) would greatly reduce their administrative costs, most payers said it would either cost them money or would be cost-neutral. The greater provider enthusiasm for proposals such as this one is fueled by the reality that the proposals require insurers to standardize their practices whereas providers are not required to do much. Nevertheless, provider enthusiasm for administrative simplification is not limited to proposals that require nothing of them.

Providers predicted that their administrative costs would be reduced greatly or moderately by implementation of three administrative simplification proposals that will require their organizations to make significant financial investment and substantially change their business systems and/or work processes:

- Implementing a system for electronic exchange of both clinical and administrative health information,
- Requiring providers to submit electronic rather than paper claims and plans to send an electronic rather than a paper payment remittance advice, and
- Standardizing payment methods while leaving rates to be negotiated between provider and plan.

What is more, 96% of hospitals and 93% of clinics said they are ready now or could be ready within two years to implement a system for electronic information exchange. Similarly, 100% of hospitals and 96% of clinics said they are ready now or could be ready within two years to submit claims electronically and receive remittance advices electronically. About seventy percent of both hospitals and clinics said they could be ready to implement standardized payment systems now or within two years as well. (See Figures 9, 10 and 11 below.)

Figure 9. Implementing a system for electronic exchange of both clinical and administrative health information

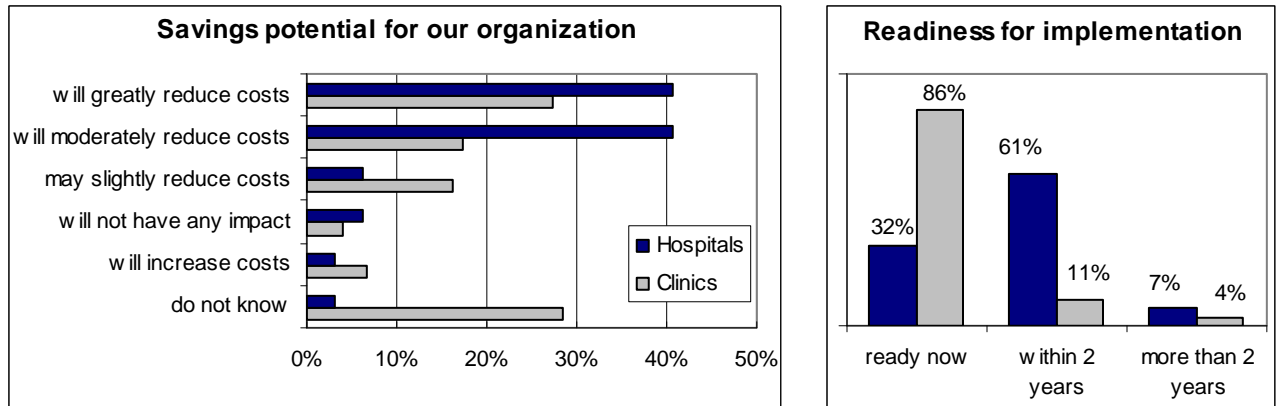


Figure 10. Requiring providers to submit electronic rather than paper claims and plans to send an electronic rather than a paper payment remittance advice

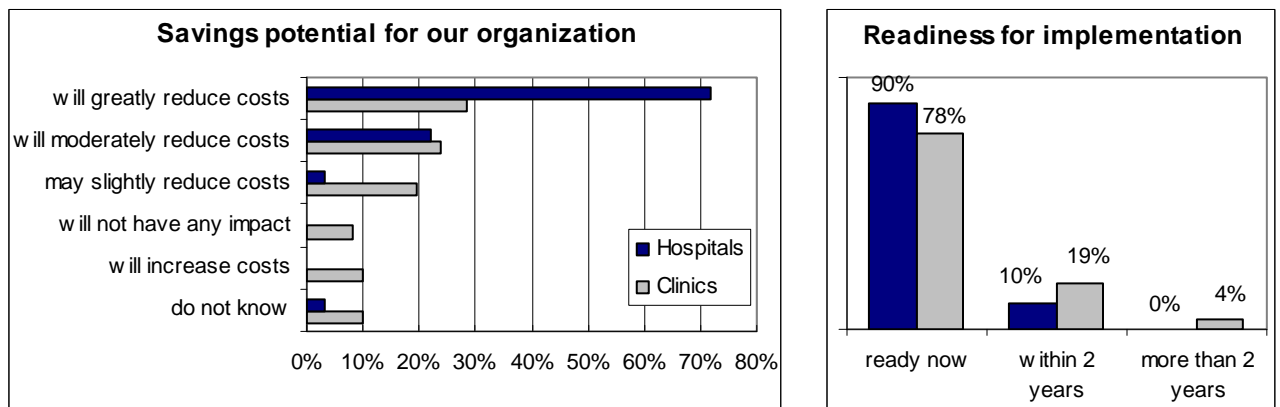
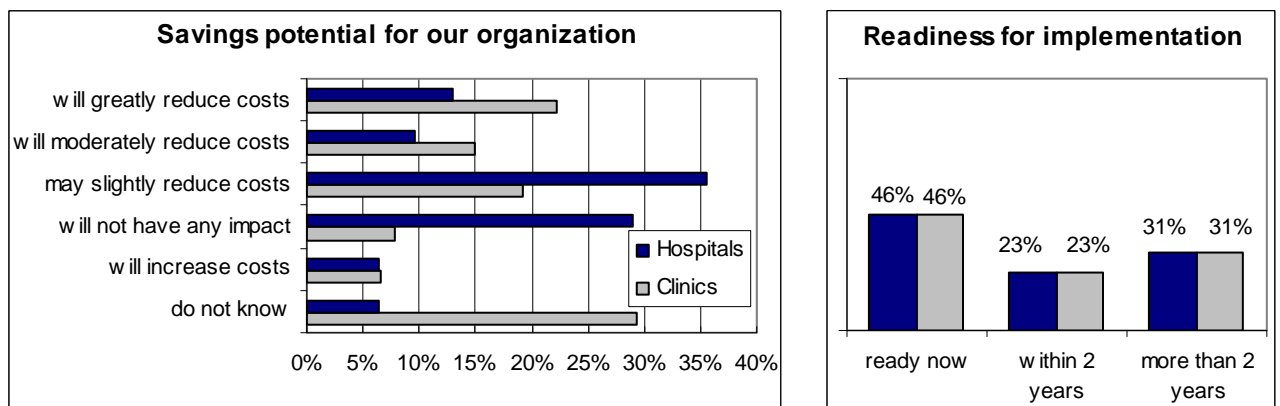


Figure 11. Standardizing payment methods while leaving actual rates to be negotiated between the provider and the plan (for example, all plans pay a negotiated percentage of Medicare rates)



APPENDIX A:

Administrative Simplification Survey- Clinics

Introduction

A survey of Oregon hospitals regarding insurance transactions is being conducted by the Office of Oregon Health Policy and Research. The purpose of the survey is to help determine what policies should be implemented to reduce administrative burden.

It is very important to get responses from hospitals of all types and sizes, so every response is valuable. Your opinions will help us shape the state's effort to bring uniformity to insurer practices. The survey should take about 10-15 minutes to complete.

Please designate one person to complete this survey for your hospital's inpatient and hospital-based outpatient programs. (Separate surveys will be sent to hospital-owned ambulatory facilities.) You must provide the name of your hospital so that we can avoid duplicate responses, but the name of the responder is optional. We greatly appreciate your time and input.

1. Please provide the following information (required):

Clinic name:	
Street address:	
City:	
Zip code:	

2. How many practicing clinicians are in your practice or clinic?

Choose one.

- Solo
- 2-4
- 5-9
- 10-19
- 20-49
- 50 or more

3. How is your practice organized? Check all that apply.

- Stand alone clinic
 - Hospital-associated clinic
 - Federally qualified health center
 - Stand alone diagnostic facility
 - Hospital-associated diagnostic facility
 - Stand alone ambulatory surgery center
 - Hospital-associated ambulatory surgery center
- Other (please specify)

--

4. What are your practice specialties? Choose one.

- Primary care specialties (including pediatrics) only
- Single specialty (not primary care)
- Multi-specialty

5. What share of the services your practice provides are paid for by private insurance?

- 0-5%
- 6-25%
- 26-50%
- 51-75%
- 76-100%

6. Please rank the following health plans by volume of services provided in your practice, with 1 being the highest volume type and 5 the lowest.

	1	2	3	4	5
Private insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicare (fee-for-service)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oregon Health Plan – Managed Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oregon Health Plan (fee-for service)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uninsured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. From administrative standpoint which one of the following insurance coverages is the easiest to deal with? Choose one.

- Private Insurance
- Medicare (fee-for-service)
- Oregon Health Plan - Managed Care
- Oregon Health Plan (fee-for-service, open card)
- Uninsured

What makes it the easiest to deal with? Check all that apply.

- Insurance card has good content and is easy to read
 - Website provides complete information
 - Responses to electronic inquiries are complete
 - Payment remittance advice is useful and easy to understand
 - Call centers are quick and helpful
 - Clean claims are paid quickly
 - Fewer denials of claims for technical reasons
 - Better coordination of claim benefits
 - Direct billing system is easy to use
 - Fewer prior authorization requirements
- Other (please specify)

8. From administrative standpoint which one of the following insurance coverages is the hardest to deal with? Choose one.

- Private Insurance
- Medicare (fee-for-service)
- Oregon Health Plan - Managed Care
- Oregon Health Plan (fee-for-service)
- Uninsured

What makes it the hardest to deal with? Check all that apply.

- Insurance card is confusing or lacks information we need
- Website does not provide complete information
- Responses to electronic inquiries are incomplete
- Does not accept electronic claims
- Payment remittance advice is confusing or inconsistent with paper explanation of benefits
- Call centers are slow or unhelpful
- Clean claims are not paid quickly
- Many claims are denied for technical reasons
- Coordination of benefits claims are hard to process

- Direct billing system does not work well
- Many prior authorization requirements
- Other (please specify)

9. Do you use an electronic practice management system?

Choose one.

- Yes
- No

10. Do you use one or more clearinghouses for any electronic transactions? Choose one.

- Yes
- No

11. What share of your eligibility, coverage, and cost sharing inquiries are currently made by

	most	about half	not many
checking a website?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
electronic inquiry (270/271)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
telephone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
fax?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. What are the most important barriers to increased use of electronic inquiries (HIPAA 270/271 transactions) for getting eligibility and benefit information? Check as many as you feel are very important barriers.

- Practice management or other practice software or internet problems
- Clearinghouse problems
- Some insurers don't provide enough information in response to this type of inquiry
- We cannot get fast enough response to an electronic inquiry
- We prefer to use a web look-up system
- We prefer to talk with a plan representative
- Other (please specify)

13. What are the most important barriers to increased use of web look-up technology for getting eligibility and benefit information? Check as many as you feel are very important barriers.

- Practice management or other practice software or internet problems
- Some insurers don't have web systems or some web systems are not easily accessible
- Some insurers don't provide enough information on their web systems
- We prefer to talk with a plan representative
- Other (please specify)

14. How do you submit bills? Check all that apply.

- Direct billing through health plan's electronic system
- Direct billing using a HIPAA compliant electronic transaction
- Electronic billing through a clearinghouse
- Send paper bills

15. What percentage of your claims do you currently submit electronically? Check one.

- None
- Less than 25%
- 25-49%
- 50-74%
- 75-90%
- More than 90%

16. What are the most common barriers to submitting a claim electronically? Check as many as you feel are very important barriers.

- Some health plans do not accept electronic claims
- Clearinghouse has problems with certain plans or claim types
- Practice management software problems
- Paper is easier or better
- Some claims require attachments which cannot be submitted with an electronic claim
- Other (please specify)

17. If you had a choice, would you prefer to receive an electronic or a paper payment remittance advice? Check one.

- Electronic only
- Paper only
- Both
- No preference

18. Do you manually post payments or does your practice system automatically post payments from the electronic remittance? Choose one.

- Manually post
- Automatically post (without reconciliation)
- Automatically post (but reconcile as well)

19. If you could get all the information you needed right away via either a web look-up or electronic inquiry, which would you prefer to use? Choose one.

- Web look up
- Electronic inquiry
- No preference

20. On the following HIPAA Transactions, where your organization is at (checking one box on each transaction):

	We use today	We use today and would use more often if insurers followed uniform practices	We do not use today but would if insurers followed uniform practices	We don't plan to use unless insurers require it	Unsure
Check eligibility, benefits, co-pays & deductibles via 270/271	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submit claim to primary insurer via 837	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submit claim to secondary insurer via 837	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Check claim status via 276/277	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Request referral or authorization via 278	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Post payments automatically from 835	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. For each of the following items (a-I) please provide your input regarding i) how the change would impact your organization's administrative costs and ii) how quickly could your organization adapt to the change.

a. A central repository where hospitals and plans go to get information for physician credentialing.

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

b. A system for electronic exchange of both clinical and administrative health information.

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

c. A web portal where providers can access eligibility and claims information for all plans.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

d. Standardizing the content and format of eligibility and claims information health plans put on the web.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

e. Standardizing the content and format on the insurance card.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

f. Standardizing information health plans provide on the payment remittance advice including specific standard reason codes.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

g. Requiring plans to provide more comprehensive benefits information in response to a HIPAA 270 electronic eligibility inquiry.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

h. Requiring plans to provide a HIPAA 277 electronic claims status response explaining why a claim has not been immediately adjudicated.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

i. Replacing the companion guides used by individual health plans with standard companion guides for the HIPAA electronic transactions.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

j. Require all providers to submit claims electronically and plans to accept electronically submitted claims and send an electronic payment remittance advice.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

k. Standardizing the information health plans can require for prior authorization.

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

l. Standardizing payment methods while leaving actual rates to be negotiated between the provider and the plan (for example, all plans pay a negotiated percentage of Medicare rates).

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

22. Are there other changes you would propose to reduce your organization's costs for dealing with health plans?

23. In order to follow-up with any questions regarding your responses, please provide the following contact information.

Name:	
Title:	
Phone:	
Email address:	

Thank you for your time!

APPENDIX B:

Administrative Simplification Survey- Hospitals

Introduction

A survey of Oregon hospitals regarding insurance transactions is being conducted by the Office of Oregon Health Policy and Research. The purpose of the survey is to help determine what policies should be implemented to reduce administrative burden.

It is very important to get responses from hospitals of all types and sizes, so every response is valuable. Your opinions will help us shape the state's effort to bring uniformity to insurer practices. The survey should take about 10-15 minutes to complete.

Please designate one person to complete this survey for your hospital's inpatient and hospital-based outpatient programs. (Separate surveys will be sent to hospital-owned ambulatory facilities.) You must provide the name of your hospital so that we can avoid duplicate responses, but the name of the responder is optional. We greatly appreciate your time and input.

1. Please provide the following information (required):

Hospital name:	
Street address:	
City:	
Zip code:	

2. How many staffed beds does your hospital operate? Choose one.

- Fewer than 50
- 50-99
- 100-249
- 250 or more

3. From administrative standpoint which one of the following insurance coverages is the easiest to deal with? Choose one.

- Private Insurance
- Medicare (fee-for-service)
- Oregon Health Plan - Managed Care
- Oregon Health Plan (fee-for-service, open card)
- Uninsured

What makes it the easiest to deal with? Check all that apply.

- Insurance card has good content and is easy to read
- Website provides complete information
- Responses to electronic inquiries are complete
- Payment remittance advice is useful and easy to understand
- Call centers are quick and helpful
- Clean claims are paid quickly
- Fewer denials of claims for technical reasons
- Better coordination of claim benefits
- Direct billing system is easy to use
- Fewer prior authorization requirements

Other (please specify)

--

4. From administrative standpoint which one of the following insurance coverages is the hardest to deal with? Choose one.

- Private Insurance
- Medicare (fee-for-service)
- Oregon Health Plan - Managed Care
- Oregon Health Plan (fee-for-service)
- Uninsured

What makes it the hardest to deal with? Check all that apply.

- Insurance card is confusing or lacks information we need
- Website does not provide complete information
- Responses to electronic inquiries are incomplete
- Does not accept electronic claims
- Payment remittance advice is confusing or inconsistent with paper explanation of benefits
- Call centers are slow or unhelpful
- Clean claims are not paid quickly
- Many claims are denied for technical reasons
- Coordination of benefits claims are hard to process
- Direct billing system does not work well
- Many prior authorization requirements
- Other (please specify)

5. Do you use one or more clearinghouses for any electronic transactions?

Choose one.

- Yes
- No

6. What share of your eligibility, coverage, and cost sharing inquiries are currently made by

	most	about half	not many
checking a website?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
electronic inquiry (270/271)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
telephone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
fax?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. What are the most important barriers to increased use of electronic inquiries (HIPAA 270/271 transactions) for getting eligibility and benefit information? Check as many as you feel are very important barriers.

- Practice management or other practice software or internet problems
- Clearinghouse problems
- Some insurers don't provide enough information in response to this type of inquiry
- We cannot get fast enough response to an electronic inquiry
- We prefer to use a web look-up system
- We prefer to talk with a plan representative
- Other (please specify)

8. What are the most important barriers to increased use of web look-up technology for getting eligibility and benefit information? Check as many as you feel are very important barriers.

- Practice management or other practice software or internet problems
- Some insurers don't have web systems or some web systems are not easily accessible
- Some insurers don't provide enough information on their web systems
- We prefer to talk with a plan representative
- Other (please specify)

9. How do you submit bills? Check all that apply.

- Direct billing through health plan's electronic system
- Direct billing using a HIPAA compliant electronic transaction
- Electronic billing through a clearinghouse
- Send paper bills

10. What percentage of your claims do you currently submit electronically? Check one.

- None
- Less than 25%
- 25-49%
- 50-74%
- 75-90%
- More than 90%

11. What are the most common barriers to submitting a claim electronically? Check as many as you feel are very important barriers.

- Some health plans do not accept electronic claims
- Clearinghouse has problems with certain plans or claim types
- Practice management software problems
- Paper is easier or better
- Some claims require attachments which cannot be submitted with an electronic claim
- Other (please specify)

12. If you had a choice, would you prefer to receive an electronic or a paper payment remittance advice? Check one.

- Electronic only
- Paper only
- Both
- No preference

13. Do you manually post payments or does your practice system automatically post payments from the electronic remittance? Choose one.

- Manually post
- Automatically post (without reconciliation)
- Automatically post (but reconcile as well)

14. If you could get all the information you needed right away via either a web look-up or electronic inquiry, which would you prefer to use? Choose one.

- Web look up
- Electronic inquiry
- No preference

15. On the following HIPAA Transactions, where your organization is at (checking one box on each transaction):

	We use today	We use today and would use more often if insurers followed uniform practices	We do not use today but would if insurers followed uniform practices	We don't plan to use unless insurers require it	Unsure
Check eligibility, benefits, co-pays & deductibles via 270/271	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submit claim to primary insurer via 837	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submit claim to secondary insurer via 837	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Check claim status via 276/277	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Request referral or authorization via 278	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Post payments automatically from 835	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. For each of the following items (a-i) please provide your input regarding i) how the change would impact your organization's administrative costs and ii) how quickly could your organization adapt to the change.

a. A central repository where hospitals and plans go to get information for physician credentialing.

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

b. A system for electronic exchange of both clinical and administrative health information.

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

c. A web portal where providers can access eligibility and claims information for all plans.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

d. Standardizing the content and format of eligibility and claims information health plans put on the web.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

e. Standardizing the content and format on the insurance card.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

f. Standardizing information health plans provide on the payment remittance advice including specific standard reason codes.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

g. Requiring plans to provide more comprehensive benefits information in response to a HIPAA 270 electronic eligibility inquiry.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

h. Requiring plans to provide a HIPAA 277 electronic claims status response explaining why a claim has not been immediately adjudicated.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

i. Replacing the companion guides used by individual health plans with standard companion guides for the HIPAA electronic transactions.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

j. Require all providers to submit claims electronically and plans to accept electronically submitted claims and send an electronic payment remittance advice.

How would this change impact your organization's administrative costs?

- | | |
|---|--|
| <input type="radio"/> will greatly reduce administrative costs | <input type="radio"/> won't have any impact |
| <input type="radio"/> will moderately reduce administrative costs | <input type="radio"/> will increase administrative costs |
| <input type="radio"/> may slightly reduce administrative costs | <input type="radio"/> don't know |

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

k. Standardizing the information health plans can require for prior authorization.

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

l. Standardizing payment methods while leaving actual rates to be negotiated between the provider and the plan (for example, all plans pay a negotiated percentage of Medicare rates).

How would this change impact your organization's administrative costs?

- will greatly reduce administrative costs
- will moderately reduce administrative costs
- may slightly reduce administrative costs
- won't have any impact
- will increase administrative costs
- don't know

How quickly could your organization adapt to the change?

- we are ready now
- within 2 years
- more than 2 years

17. Are there other changes you would propose to reduce your organization's costs for dealing with health plans?

18. In order to follow-up with any questions regarding your responses, please provide the following contact information.

Name:	
Title:	
Phone:	
Email address:	

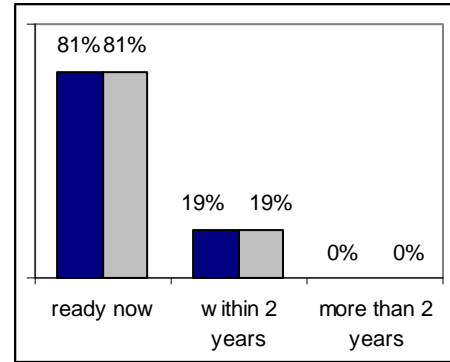
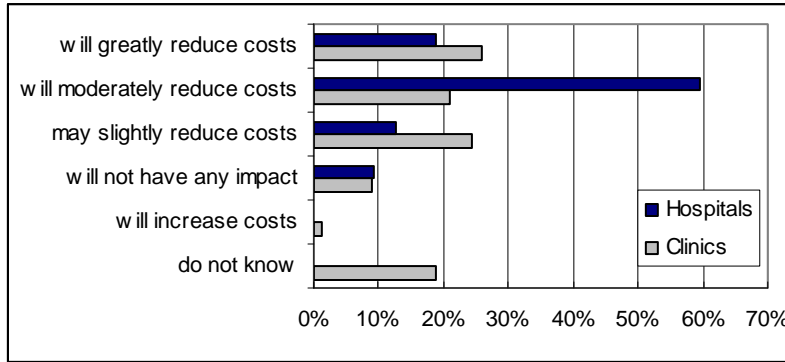
Thank you for your time!

APPENDIX C:

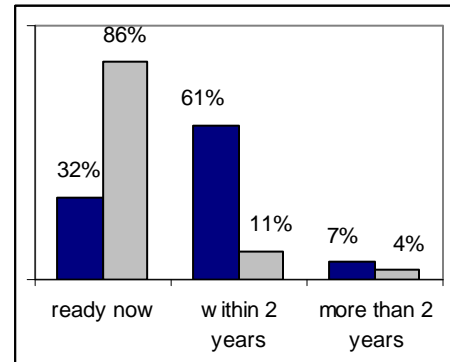
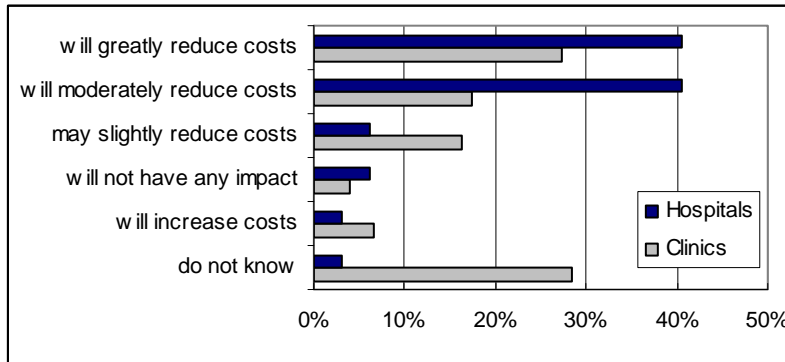
Providers' Perspective on Possible Changes

Providers' perspectives on some of the possible changes

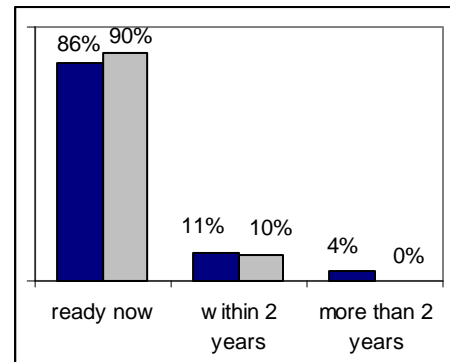
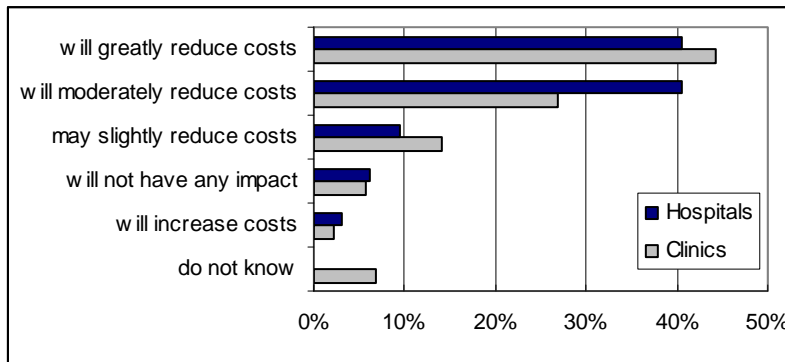
- A central repository where hospitals and plans go to get information for physician credentialing



- A system for electronic exchange of both clinical and administrative health information

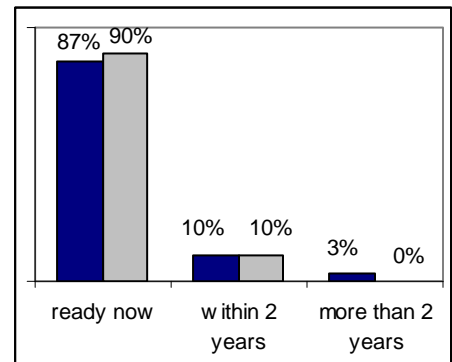
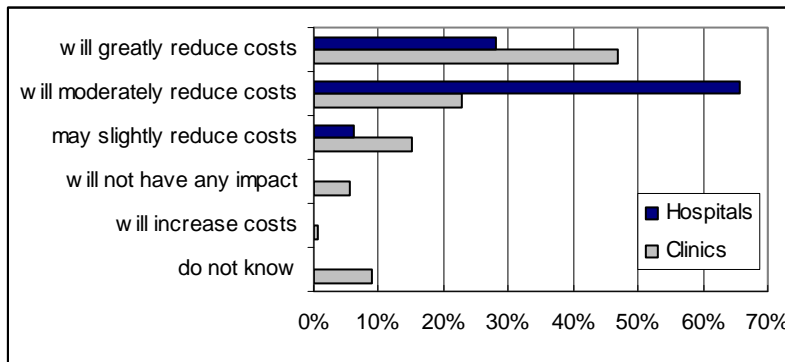


- A web portal where providers can access eligibility and claims information for all plans

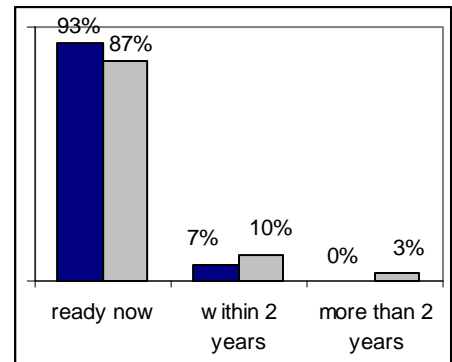
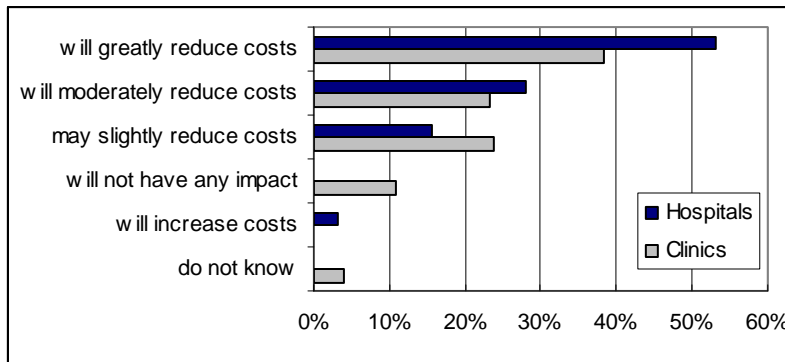


Appendix E (continued)

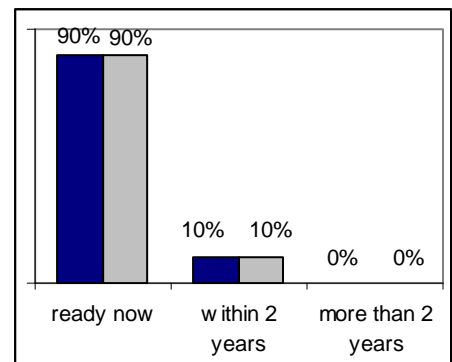
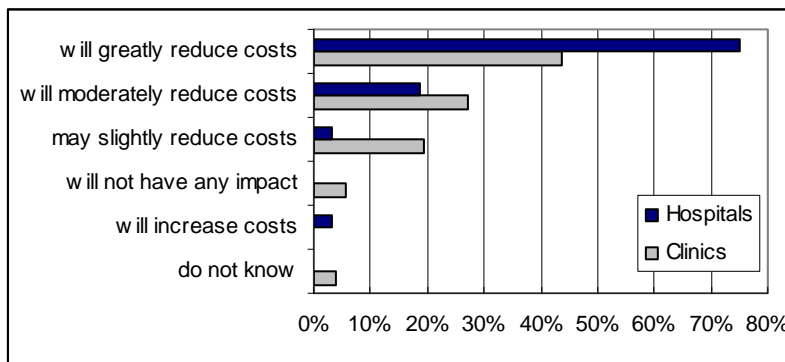
- Standardizing the content and format of eligibility and claims information health plans put on the web



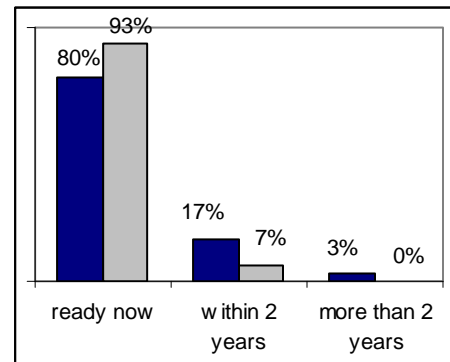
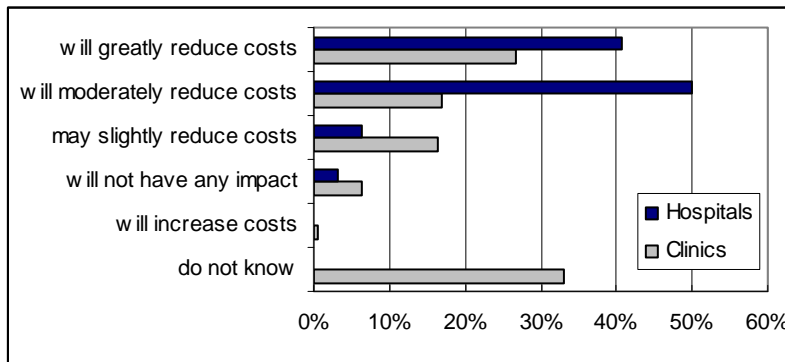
- Standardizing the content and format on the insurance card



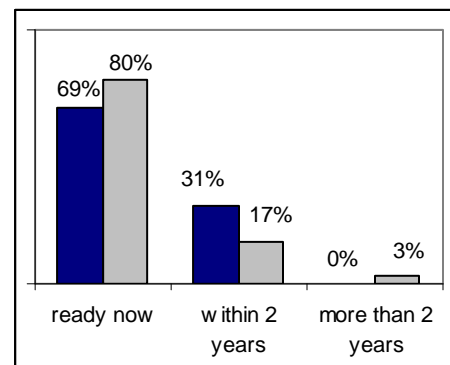
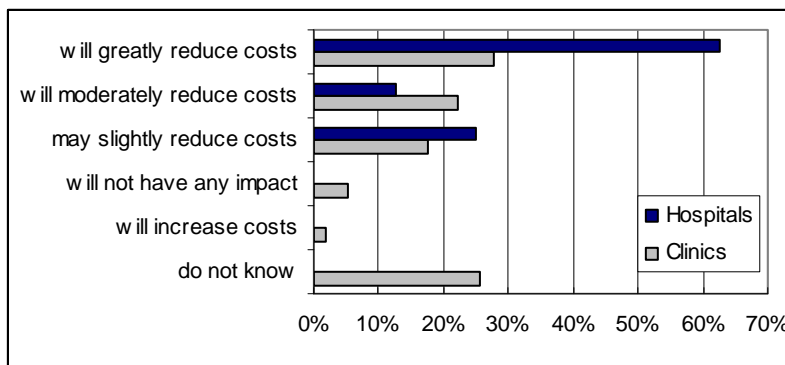
- Standardizing information health plans provide on the payment remittance advice including specific standard reason codes



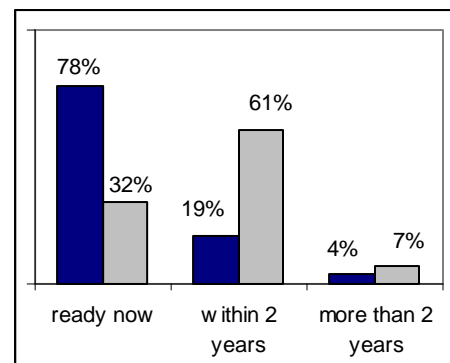
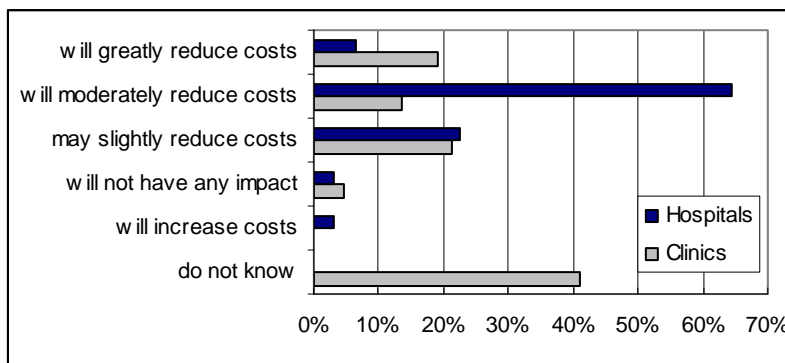
- Requiring plans to provide more comprehensive benefits information in response to a HIPAA 270 electronic eligibility inquiry



- Requiring plans to provide a HIPAA 277 electronic claims status response explaining why a claim has not been immediately adjudicated

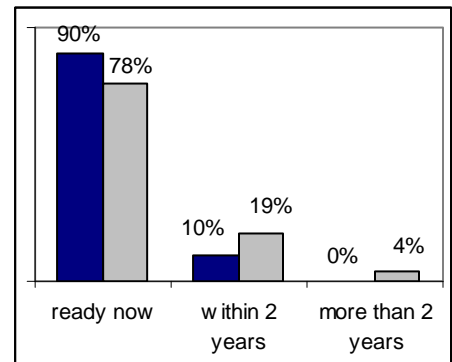
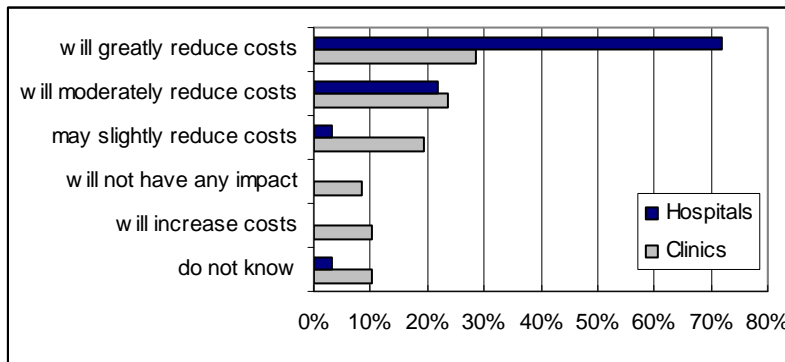


- Replacing the companion guides used by individual health plans with standard companion guides for the HIPAA electronic transactions

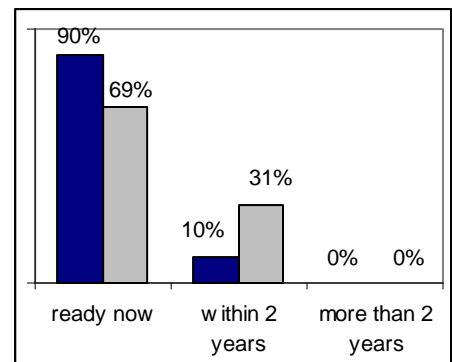
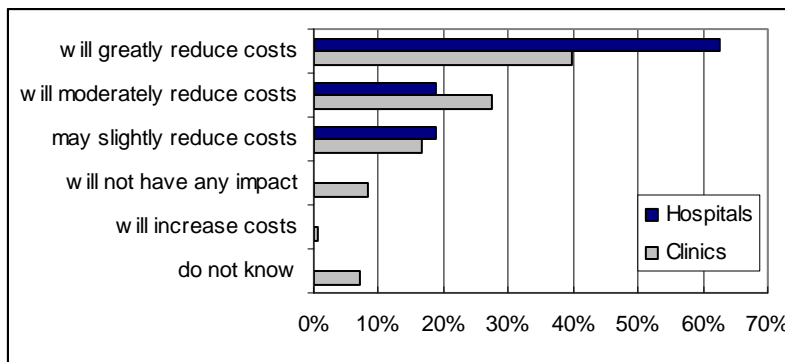


Appendix E (continued)

- Require all providers to submit claims electronically and plans to accept electronically submitted claims and send an electronic payment remittance advice



- Standardizing the information health plans can require for prior authorization



- Standardizing payment methods while leaving actual rates to be negotiated between the provider and the plan (for example, all plans pay a negotiated percentage of Medicare rates)

