

# Oregon Administrative Simplification Strategy and Recommendations

Final Report of the Administrative Simplification Work Group

*Health Policy Board*

*June 8, 2010*

## What administrative simplification is and is not

- “Administrative simplification” refers to efforts to reduce the complexity of health insurance administrative and financial transactions between payers and providers.
- It addresses issues like claims submission and processing; provider credentialing and contracting; provider payment; exchange of information between providers and payers; prior authorization, referral, and other utilization review processes.
- It does not address other components of insurance administrative cost such as marketing, underwriting, and profit.

## Goals of Administrative Simplification

- Reduce insurance administrative costs by standardizing, eliminating, or automating health insurance administrative and financial transactions.
- Improve the patient experience of care by helping providers give patients information about their costs for various care options

## Health care administrative costs for financial and administrative transactions are high

- Health plans = 2-4% of premium (directly)
- Health plans = 13-19% of premium (indirectly)-- reported as claims cost because
  - Physicians spend 10-15% of revenue
  - Hospitals spend 7-11% of revenue

## The federal government took the lead on standardizing and automating health insurance

- HIPAA (1996)
  - Directed HHS to develop uniform standards for doing key transactions electronically, including codes and methods
  - Required anyone who did the transaction electronically to follow the HIPAA standards adopted by HHS
- Administrative Simplification Extension Act (2001)
  - Required most Medicare providers to submit claims electronically

## HIPAA did not result in the expected degree of automation in the health insurance industry

- HIPAA did not require anyone to do business electronically.
- Providers and payers could and did continue to use manual processes.

## The HIPPA shortfall was predictable

- The standards did not achieve anticipated levels of uniformity
  - HIPPA standards adopted by HHS left much to the choice of “trading partners” (i.e., plans and providers)
  - Each plan developed its own companion guides, requiring providers to do the “standard” transactions in many different ways

## The HIPPA shortfall was predictable

- The industry did not use the transactions effectively
  - Although the “standard” transactions *made it possible for* plans to give providers very detailed information in the electronic remittance advice and in response to inquiries, the standard did not *require* plans to give detailed information
  - Many providers, finding the electronic transactions did not resolve the issues that faced them, declined to use them
  - And payers, finding that providers were not using the electronic transactions, declined to invest in making the transactions more useful to providers.

# Potential Opportunity for Savings from Administrative Simplification

## Who stands to gain?

- Clinics
  - Those with higher visit volumes may experience greatest savings
- Insurers
- Hospitals
  - Lesser gains due to lower claims volume
  - Lesser gains due to increased automation already
- Purchasers and consumers could gain if insurance premiums go down

## Potential for savings from increased administrative simplification

About \$100 million per year in Oregon for standardizing and automating five transactions

- Claims submissions
- Remittance advice
- Eligibility verification
- Claims payment
- Claims status inquiry

## Estimated annual savings in Oregon (millions)

	Hospital	Physician	Payer	Total
Claim Submission	\$1	\$23	\$4	<b>\$29</b>
Remittance Advice	\$1	\$24	Unknown	<b>\$25</b>
Eligibility Verification	\$4	\$13	\$2	<b>\$19</b>
Claims Payment	Insufficient information to estimate. Savings to providers (cost of banking) and payers (cost of printing and mailing checks).			
Claims Status Inquiry	\$1	\$14	\$6	<b>\$21</b>
<b>Total</b>	<b>\$6</b>	<b>\$74</b>	<b>\$12</b>	<b>\$93</b>

# Oregon's Process to Address Administrative Simplification

## Legislative and Policy Directions

- HB 2009
  - Directed OHPR to convene a work group to develop uniform standards for insurers – including eligibility verification, claims processes, and payment and remittance advice.
  - Authorized DCBS to establish uniform standards for insurers that incorporate the standards developed by the work group.
- Health Policy Board
  - Recommend priorities for administrative simplification work – i.e., a state administrative simplification strategy

# Work Group Membership and Process

## Work Group Membership

- Purchasers of healthcare – one co-chair is an employer HR director
- Consumers of healthcare – one co-chair is a consumer advocate
- Commercial insurers
  - Health Leadership Council Co-Chairs of Administrative Simplification Work Group
- Medicaid MCOs
- Physician practices and clinic systems
- Ambulatory surgery centers
- Hospitals
- DMAP
- HITOC
- Organized labor
- Taft-Hartley plans
- PEBB and OEBC
- Insurance Division

## Work Group Process

Tools used by the work group:

- OHPR background materials
- Results of payer and provider surveys
- Analysis of federal reform legislation
- Communication and reports from HITOC
- Communication with Health Leadership Council
- Presentations regarding state-level initiatives in Washington, Minnesota, and Utah

## The sequence of the group's deliberations

- Agreeing on principles
- Estimating potential for savings
- Concluding that administrative simplification requires state action and involvement
- Describing the roles of the state and the industry
- Assign priority among transactions
- Reaching consensus recommendations

## Work Group Principles

- Don't reinvent the wheel
- Don't bite off too much
- Take advantage of time-sensitive opportunities
- Take on projects that won't be done otherwise
- Do things with opportunity for return on investment
- Prioritize activities that reduce cost or improve service for patients
- Apply the same requirements to everyone

## The industry's inability to automate has become entrenched

- The industry is caught in a vicious circle:
  - Providers don't automate because they have to comply with too many different companion guides and the transactions aren't always as useful to them as manual processes
  - Plans resist investing in uniformity or improved transactions because they have no confidence that providers will give up high-cost manual processes

# Work Group Recommendations

## Recommendation #1

Oregon should adopt the Minnesota approach to administrative simplification because it will break the significant barrier that interferes with automation of healthcare administration.

Step 1: Standardize electronic processes by replacing the plans' companion guides with a single uniform companion guide for three key transactions

Step 2: Require all plans, providers, and clearinghouses to do the three key transactions electronically

## The Minnesota approach...

- At the direction of the **state legislature**, uniform companion guides were adopted for claims, remittance advice, and eligibility inquiry transactions.
- A **state-convened industry work group**, which had been engaged in simplification activity for 20 years, developed the three companion guides.
- **Expert leadership** for the work groups made sure the guides complied with the HIPAA standards and with emerging voluntary industry standards.
- The state **Department of Health** adopted the guides by administrative rule.

## The Minnesota approach

- A year after each guide was adopted **everyone** was required to give up manual processes and do the transaction electronically, following the uniform guide; this included all payers, all providers, and all clearinghouses.
- **Minnesota has updated each of the original guides** to comply with the version of the HIPAA standards that takes effect January 1, 2012.
- **Results:** 95% of claims are now submitted electronically.

## How do we get to an “Oregon Guide”?

- Oregon should use an industry-led process to review the Minnesota guides to identify and develop modifications addressing issues unique to Oregon.
- Adopting the Minnesota guides with the minimum necessary modifications is important.
  - Oregon should not reinvent the wheel
  - Oregon should adopt companion guides that were developed using a multi-stakeholder process and have stood the test of actual use
  - Oregon, by aligning with Minnesota, will increase the likelihood that any revisions to the federal HIPAA standards will not require changes to the Oregon companion guides

## Recommendation #2

Oregon requirements for standardization and automation should be phased in.

## Recommended phase-in method

- Standardize the first three transactions using the Minnesota guide as the template, one transaction every six months.
- Leave standardization of additional HIPAA transactions to federal rule-making.
- For each transaction, standardize and then go all-electronic, giving ample time for providers and payers to modify their systems and processes new companion guides .
- The first five transactions all-electronic by January 1, 2014

## How did the group chose the order?

Priorities were set based on

- Value to patients,
- Value to providers seeking to establish “meaningful use” to access Medicare and Medicaid payment incentives,
- System cost savings, and
- Availability of a uniform standard that Oregon can adopt

## How fast can Oregon move to all-electronic transactions?

- Transactions should be standardized and go all-electronic:
  - Eligibility verification (all electronic 7/1/2012)
  - Claims (1/1/2013)
  - Remittance Advice (10/1/2013)
  - Claims Status Inquiry (1/1/2014)
  - Electronic Funds Transfer (1/1/2014)

## The Health Leadership Council should lead the industry review process for the companion guides

- Industry review of the Minnesota guides will enable the state to harness needed expertise.
- Industry review will facilitate involvement of DMAP, Medicaid MCOs, self-insured plans, TPAs, clearinghouses and others that should follow the guides but will not be subject to DCBS rule-making authority when the process begins.
- Industry review will expedite rule-making.

## Recommendation #3

Oregon should lead and not wait for the federal government to standardize the HIPAA transactions.

## Why should Oregon lead?

- Federal law moves too slowly toward standardization.
- No federal law requires providers and plans to use electronic transactions
- The win-win approach brokered in the Minnesota where payers invest in uniformity and providers invest in going electronic is missing in the federal approach, so the success of the simplification project is jeopardized.

## How does the Oregon approach connect with federal reform?

- **The Patient Protection and Affordable Care Act (PPACA)** sets deadlines for HHS to adopt standards for electronic funds transfer, claims attachments, and first notice of injury
  - These new standards will be phased in from 1/1/2014 to 1/1/2016
  - The new standards will probably permit less variation than standards adopted pre-PPACA
  - Oregon should not adopt Oregon uniform companion guides for these transactions
  - Oregon should require use of the electronic transactions once the federal standards are in place

- PPACA sets deadlines for HHS to adopt operating rules for HIPAA transactions
  - Operating rules for eligibility, remittance advice, and claims will be phased in from 1/1/2013 to 1/1/2016
  - Operating rules will probably address business practices rather than the variation created by the proliferation of companion guides
  - Oregon should adopt uniform companion guides for these transactions to capture additional savings by standardizing more quickly
- PPACA requires providers dealing with Medicare to accept electronic funds transfer and electronic payment remittance advice, but the requirement does not apply to commercial insurance and Medicaid
  - Oregon should require everyone to do business electronically

## Recommendation #4

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

## The Oregon Health Authority should take the lead in supporting the transition process

- The OHA should consider designating one of the following agencies to coordinate an outreach, education, and technical support program—DMAP, HITOC, or Oregon's Regional Extension Center
- Criteria should include capacity and access to federal matching funds

## Recommendation #5

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

## Recommended OHA-DCBS work

- Collect data
- Evaluate compliance with administrative rules
- Assess progress against plans, benchmarks, and timelines
- Solicit input
- Stay on top of innovative thinking
- Identify opportunities for collaboration with other states
- Set priorities, goals, benchmarks and timelines in collaboration with the industry
- Evaluate industry performance

## Recommended private sector work

- Partner with the state to identify opportunities and set priorities, benchmarks, and timelines
- As first tasks
  - Lead the process for reviewing the Minnesota companion guides
  - Make a recommendation on the effort to designate a single entity to collect information for use in credentialing physicians
  - Complete work on effort to establish a single web portal for accessing plan web sites

# Implementation Steps

## Schedule of activities

- HLC reviews Minnesota companion guides (completed in three phases 1/1/2011-1/1/2012)
- DCBS adopts administrative rules applying to insurers (and providers that do business with them) in three phases (4/1/2011-7/1/2012)
- Legislature empowers DCBS to apply rules to self-insured plans, TPAs, and clearinghouses (7/1/2011)
- OHA applies the rules in the Medicaid program (phased as each DCBS rule is adopted)
- Industry brings forward recommendations on credentialing and single web portal (as soon as possible)
- DCBS and OHA begin developing assessment tools to evaluate progress and take leadership in establishing priorities, goals, benchmarks, and timelines (7/1/2010)

# Vocabulary

- **Eligibility Inquiry:** Request from a provider to a plan seeking to know if a patient is enrolled in a plan and if so, the plan's benefits and cost-sharing rules.
- **Claim:** A request for reimbursement (or bill) sent by a provider to a plan.
- **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.
- **Electronic Funds Transfer:** Payment of claims by funds transfer.
- **Claim Status Inquiry:** Request from a provider to a plan seeking to know whether a claim has been accepted for payment and if not, what's going on.

- **HIPAA transaction:** A transaction for which HIPAA required HHS to develop standards for electronic information exchange: 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).
- **HIPAA standard:** An HHS rule adopting a technical standard for electronic health financial and administrative transactions, including detailed standardized code sets.
- **Implementation Guide:** Part of each HIPAA standard that provides detailed instructions and explains the choices the standard leaves to trading partners.

- **Companion Guides:** Documents specifying how the standards and implementation guides for each HIPAA transaction will be used between particular trading partners. Generally, companion guides are issued by plans. Providers must comply with a different guide when doing business with each plan.
- **Operating Rules:** A new term, introduced by the 2010 federal reform law, defined as “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications .”