

OHPR Administrative Simplification Work Group

Tuesday, May 11, 2010

1:00-5:00 pm

Room 104

Meridian Park Hospital Education Center

19300 SW 65th Avenue, Tualatin, OR

Time	Item	Lead
1:00 pm	Call to Order and Agenda Review	Laura Etherton and Dale Johnson, co-chairs
1:00 pm	Acceptance of Meeting Notes	Co-chairs
1:40 pm 15 min.	Revised Straw Plan – Staff Presentation	Lynn-Marie Crider Sean Kolmer
1:55 pm 2 hours	Revised Straw Plan - DISCUSSION	Co-chairs
3:55 pm 20 min.	Report Contents and Process for Review of Draft Report - DISCUSSION	Co-chairs
4:15 pm 15 min.	Public Comment	Co-chairs
4:30 pm	Adjourn	Co-chairs

Materials:

1. Agenda
2. Meeting #4 Draft Notes
3. Straw Proposal A (revised 5-7-2010)
4. Straw Proposal A Summary (revised 5-7-2010, summary)
5. HIE calendar, including Straw Proposal A (large format)
6. Draft estimate of savings potential from administrative simplification (revised 5/10/10)
7. Draft outline of report and recommendations

**Administrative Simplification Work Group
Meeting #4 Summary**

Wednesday, April 20, 2010
1:00-5:00pm

Work Group Members in Attendance

Laura Etherton, Co-Chair
Dale C. Johnson, Jr., Co-Chair (by phone)
Rhonda Busek
Todd Bybee (by phone)
Alice Cobb
Erick Doolen
Nancy Franssen
Tyla Kennedy
Mary Kjemperud (by phone)
Ann O'Connell (by phone)
Carol Robinson
Mike Schwab (by phone)
Tonja Siefarth
Dan Stevens

OHPR Staff in Attendance

Sean Kolmer
Lynn-Marie Crider

Work Group Members Not in Attendance

Tom Chamberlain
Joan Kapowich (ex-officio)
Teresa D. Miller (ex-officio)
Barney Speight
Doug Walta, MD
Nelda Wilson

Meeting Summary (actions in bold)

Presentation by Jan Root, Utah Health Information Network (UHIN)

Jan Root, Executive Director of the Utah Health Information Network, described the roles of the state and UHIN, a private nonprofit business created by the health care industry, in administrative simplification. She explained that UHIN is a hub service; it does not reformat claims like a clearinghouse but it began standardizing transactions even before passage of HIPAA. Medicaid program has been a participant and has required providers to transact business through UHIN. Some standards developed and adopted by UHIN participants have been adopted by the state insurance commissioner to apply to all insurers.

UHIN historically was a hub for administrative but is now developing the capacity to transmit clinical information.

Almost all claims are electronic in Utah. The exception is claims requiring attachments, the most common of which is a secondary claim with an attached EOB.

Debrief of UHIN presentation

Comments from the work group included these:

- It is not clear what savings Utah has achieved because they don't seem to have tried to measure savings.
- The Utah hub model made sense in Utah 20 years ago, but it may not make sense in Oregon today. They were able to avoid the need for clearinghouses, but we are now dependent on them and a central hub could amount to an added layer of cost.

Discussion of straw plans

Staff presented two straw proposals. Straw A was dubbed the "Modified Minnesota Model." Straw B was the "Let the feds go first model." (See attached summary, which was distributed during the meeting.)

Discussion addressed the following points:

- Pluses and minuses of waiting for the feds
- Uncertainty of what feds will do to standardize
- Cost/difficulty of adjusting systems to accommodate any inconsistency between state uniform standards and what the feds ultimately do
- Need to standardize by going electronic in order to realize savings
- Barriers to providers going electronic, particularly for small providers
- Need for technical assistance and possibility that regional extension centers for HITEC can support providers to adopt, implement, and upgrade systems to do administrative transactions as well as clinic information exchange
- If we build this into the state Medicaid plan, maybe we can get federal match to help with the transition for Medicaid providers.

Conclusions:

- It is not a good idea to wait for the feds.
- Oregon should build a collaborative relationship with Minnesota and others to continue this work.
- The industry has had some difficulty finding broad enough consensus to implement some of the solutions they have built for administrative issues. The state can play a useful role in blessing solutions developed by the industry so that everyone can invest together in innovations that only have value if everyone participates.
- Solutions must be bilateral—requiring both providers and payers to change.
- Both providers and payers in the group feel straw A is the way to go.
- Straw A calls for industry vetting of the Minnesota companion guides before DCBS adopts them to see if any Oregon-specific changes should be recommended. The Health Leadership Task Force should be asked to convene a broad group of industry players to play that role. Erick and Dan will take the issue to the Task Force and report back.
- There is a need to further define Track 4.

The final Committee meeting is scheduled for:

Tuesday, May 11 (#5 – Final Meeting)

1:00 - 5:00 pm

Meridian Park Hospital

Education Center - Room 104

19300 S.W. 65th Avenue

Tualatin, OR 97062

**Straw Plan A
Revised 5/7/2010**

Goal: Reduce system costs and provider resources devoted to administrative transactions between payers and providers of care.

Strategy:

- **Standardize electronic transactions by administrative rule, using multi-stakeholder developed products that are being used elsewhere already and are likely to be consistent with an emerging national standard.** (*Rationale: There is significant risk in waiting for federal operating rules because they are phased in over a very long time period and it is unclear the federal operating rules will achieve the simplification necessary to reduce cost*)
- **Phase in requirements for both providers and payers to do business electronically.** (*Rationale: Experience in the Medicare program suggests this can be done by providers when tools are provided and change required.*)
- **Time the transition to fully electronic transactions to**
 - **Realize savings for providers, payers and purchasers in the short term**
 - **Coordinate with provider, payer, and clearinghouse work to retool systems to comply with the 5010 rules**
 - **Coincide with the timing of Medicare requirements to go all-electronic**
 - **Ensure that by complying with Oregon requirements, providers will increase opportunities for Medicare and Medicaid incentives for achieving meaning use of health information technology.**
- **Encourage and support private sector collaborative innovation** in other areas of administrative simplification.
- **Provide for an ongoing public sector role** to ensure that efforts to reduce administrative costs continue and are effective.

Timeline: See page 5.

Phases:

Phase 1 – Require licensed health insurers and providers (A) to use standard companion guides for electronic transactions named in HB 2009—claims (837), payment remittance advice (835), and eligibility inquiries and responses (270/271) and (B) to conduct certain provider-payer administrative transactions electronically. (Phased implementation beginning Jan. 1, 2012)

(A) Standard Companion Guides➤ **Content of the rule:**

- 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 January 1, 2012.
- Insurers must configure web browser and direct data entry systems consistent with the data content component of the applicable companion guide starting January 1, 2012.

➤ **Process:**

- **Stakeholder engagement process:** The Health Leadership Council will engage providers and payers to review the Minnesota 5010 companion guides for the 837, 835, and 270/271 transactions, so that industry participants have an opportunity to suggest modifications to the Minnesota guides and to reach general agreement on modified guides. (Completed and delivered to DCBS by September 1, 2010.)
- **Rules advisory committee process:** DCBS convenes a rules advisory committee to provide feedback as the agency drafts a proposed rule to standardize use of electronic claims, remittance advice, and eligibility inquiry transactions according to the Minnesota guides (with any modifications with Oregon industry support) and (B) to phase in requirements for licensed health insurers to conduct the three standardized transactions electronically. (Completed by October 1, 2010.)
- **Formal rule-making process regarding licensed health insurers:** DCBS conducts formal rulemaking and adopts rules applicable to licensed health insurers. (Completed by December 31, 2010.)
- **Process to apply rules to Medicaid:** DMAP as payer conforms its practices to the DCBS rules and amends contracts with Medicaid managed care organizations to align with DCBS rules.

(B) All-electronic conduct of standardized transactions (phased in).➤ **Content of the rule:**

- 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.)
- Licensed insurers must conduct claims and eligibility inquiry/response transactions electronically beginning July 1, 2012.
- Licensed insurers must provide payment remittance advice and funds transfer electronically beginning January 1, 2014 (when Medicare requires these transactions to be done electronically).

➤ **Process:**

- **Rules advisory committee process:** Same as above.

- **Formal rule-making process regarding licensed health insurers:** Same as above.
- **Process to apply rules to Medicaid:** Same as above.

Key questions:

How much lead time is necessary from adoption of rules to their effective date?

How should the rules handle smaller provider groups? Should there be any kind of accommodation of small providers—either by exempting them or imposing the requirements at a later date than for others? (Note: Medicare exempts providers employing 25 or fewer employees if they bill through a fiscal intermediary and 10 or fewer employees if they bill a carrier; Minnesota law does not exempt small providers.)

Phase 2 - Extend the applicability of uniform standards to all payers, regardless of the form of health care coverage

- Amend HB 2009 to extend DCBS authority to establish uniform standards for administrative transactions to all payers, including TPAs, other non-insurance payers, and clearinghouses and to collect data to monitor progress.
- Formal rule-making process regarding other payers: DCBS conducts formal rulemaking and amends rules already in place for licensed health insurers to apply to other payers. (Completed by September 2011.)

Note: After consultation, staff has concluded that DCBS has the authority to write rules that effectively require both insurers and providers to do business using uniform electronic transactions and that no additional statutory authority is necessary accomplish reciprocal requirements.

Key questions:

What payers should be subject? TPAs? Self-insured employers?

Phase 3 – State requires use of electronic methods for additional business transactions between payers and providers as additional uniform standards are adopted by the U.S. Department of Health and Human Services or by other states using multi-stakeholder development processes. (Phased in as standards become available.)

- DCBS adopts rules requiring additional transactions be conducted electronically as uniform operating rules and HIPAA standards are adopted by HHS:
 - Claims status inquiry/response by January 1, 2014.
 - Claims attachments and prior authorization/referral by January 1, 2016.
- DMAP as payer conforms its practices to the DCBS rules and amends contracts with Medicaid managed care organizations to align with DCBS rules.

Key questions:

Should this track be limited to federal standardization?

Phase 4 – Industry leads administrative simplification activity with state setting goals and monitoring achievement beginning 2011 and continuing indefinitely.

- The Insurance Commissioner and the Director of the Oregon Health Authority are jointly responsible for continued progress on an administrative simplification strategy that reduces cost. They should carry out these responsibilities in collaboration with providers and payers.
- Each spring, the Insurance Commissioner and OHA will
- Each spring, the Insurance Commission and the Director will:
 - Solicit input from a broadly representative group of industry stakeholders, consumers, and purchasers of healthcare regarding ways to reduce expenses related to health care administrative transactions;
 - Collect data from providers and payers to assess progress on administrative simplification, including rates of adoption of both mandatory and voluntary uniform standards;
 - 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 health care administrative cost;
 - Establish priorities, goals, benchmarks, and timelines for development and adoption of uniform methods for conducting health care administrative transactions and assign responsibility to broadly inclusive industry organizations for developing and seeking industry adoption of those methods;
 - Evaluate industry performance relative to the established priorities, goals, benchmarks and timelines.
- Implement, if necessary, additional uniform standards for health care administrative transactions via administrative rules applicable to both payers and providers.

Key questions:

Should more specific priorities be defined by the work group now?

Should a specific industry organization be named?

When should this process begin?

Summary Straw A (rev. 5/7/2010)

Phase	Components	Straw A
I	Standardize HIPAA electronic transactions and set dates to go electronic for four transactions	<p><i>DCBS rulemaking:</i></p> <p>(a) Standardize HIPAA electronic transactions with a uniform companion guide based on Minnesota guides (after making any necessary changes to adapt for Oregon) and</p> <p>(b) Set dates by which the following transactions must be electronic:</p> <p>Claims (July 2012, six months after 5010 rules take effect)</p> <p>Eligibility Inquiry/Response (July 2012, six months after 5010 rules take effect)</p> <p>Remittance advice and EFT (January 2014, when Medicare requires it)</p> <p><i>DHS changes its processes</i> to comply with DCBS rules and incorporates the same requirements into its contracts with providers and managed care plans.</p>
II	Apply Phase I rules to all health plans, including those not licensed insurers	<p><i>Legislature authorizes</i> DCBS to adopt rules for administrative processes applicable to TPAs</p> <p><i>DCBS modifies the rules</i> to apply to TPAs</p>
III	Set dates to go electronic for additional transactions	<p><i>DCBS rulemaking:</i> Require electronic conduct of additional transactions as federal or other uniform standards and operating rules are in place:</p> <p>(a) Claims Status Inquiry (January 2014)</p> <p>(b) Claims Attachments (January 2016)</p> <p>(c) Prior authorization/referral (January 2016)</p>
IV	Industry-led simplification work	<p><i>Providers and payers take the lead</i> in identifying and carrying out new initiatives for administrative simplification.</p> <p><i>OHA and DCBS monitor progress</i> and set new goals and priorities in collaboration with the industry.</p>

Electronic Health Information Exchange Calendar (5/7/2010)														
	1/1/2010	7/1/2010	1/1/2011	7/1/2011	1/1/2012	7/1/2012	1/1/2013	7/1/2013	1/1/2014	7/1/2014	1/1/2015	7/1/2015	1/1/2016	7/1/2016
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 (not web?), 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)				Medicare 3% payment reductions begin if no MU by July 1 (hospitals), Oct 1 (physicians)		
DMAP MMIS and electronic transformation goals					DMAP goal: 95% electronic claims, 100% electronic RA & EFT Sept 2011									
Washington soft deadlines			Eligibility inquiry and companion guide developed											
Federal Requirements (HB 3950 as amended by the reconciliation bill)							Eligibility inquiry and claims status uniform operating rules take effect (rules issued by 7/1/2011)	Certification and auditing of payer systems begin		Medicare goes all-electronic for funds transfer and Payment Remittance Advice EFT and Payment Remittance Advice uniform op rules take effect (rules issued by 7/1/2012) Payer noncompliance penalties begin			Claims attachment standard and claims attachment and referral/authorization uniform op rules take effect (rules issued by 7/1/2014)	
STRAW A: OREGON UNIFORM STANDARDS			DCBS adopts rules prescribing uniform companion guides for claims, eligibility and payment remittance advice and requiring electronic business transactions (phased). Legislature authorizes adoption of uniform standards applicable to payers not licensed as insurers. Providers and payers must follow uniform companion guides for claims, eligibility inquiry and payment remittance advice. Providers and payers must do eligibility inquiry and claims transactions electronically. Providers and payers must do remittance advice, funds transfer, and claims status inquiry electronically. Providers and payers must do referral/authorization and claims attachment transactions electronically.											

DRAFT Administrative Simplification Savings Projections				
Phases 1,2, and 3				
Transaction	Entity			Annual Savings by 2014
Claim Submission	Hospital	Physician	Payer	Total
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	Hospital	Physician	Payer	Total
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	100%	90%	100%	
High savings est	\$1,475,100	\$52,661,070	unknown	\$54,136,170
Low savings est	\$834,400	\$25,553,500	unknown	\$26,387,900

DRAFT Administrative Simplification Savings Projections				
Phases 1,2, and 3				
Transaction	Entity			Annual Savings by 2014
Eligibility Verification	Hospital	Physician	Payer	Total
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	
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%	80%	82%	
High savings est	\$4,144,000	\$43,868,160	\$25,872,000	\$73,884,160
Low savings est	\$3,587,680	\$15,946,000	\$4,025,736	\$23,559,416
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).			

DRAFT Administrative Simplification Savings Projections				
Phases 1,2, and 3				
Transaction	Entity			Annual Savings by 2014
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	
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%	80%	80%	
High savings est	\$2,020,900	\$21,644,910	\$12,642,000	\$36,307,810
Low savings est	\$1,480,640	\$15,245,860	\$6,010,368	\$22,736,868
All transactions to be electronic by 2014				
High savings est - all transactions	\$8,572,500	\$152,415,540	\$59,598,000	\$220,586,040
Low savings est - all transactions	\$6,648,720	\$80,244,360	\$14,306,604	\$101,199,684

5/11/2010

DRAFT 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 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.

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 estimates are a best guess based on the OHPR payer survey and the OHPR provider survey.

5. For purposes of this draft, the goal was set by staff. The degree to which goals can be met (particularly for the inquiry transactions) will be largely dependent on the completeness of information supplied by payers in response to the electronic inquiry.

DRAFT OUTLINE FOR WORK GROUP REPORT

The problem

The work group process

- Composition of the workgroup
- Mandate
- Principles
- Information-gathering

The recommendation

- State's role:
 - To assist all parties to reduce administrative expense when doing so requires investment that is rational only if all providers and payers do so or doing so requires standardization that cannot be achieved through voluntary efforts.
 - To monitor progress toward administrative simplification and, in collaboration with the industry, set goals and benchmarks that push the work forward.
- Industry role:
 - Share expertise on priority projects
 - Develop new initiatives and take them as far as possible
 - Help set priorities, goals and benchmarks
 - Let the state know when state action is necessary for success
- Specific recommendations:
 - Strategy
 - Phased activity
 - Need for legislative action
 - Need for a technical assistance plan to help transition to electronic processes
 - Need for further work to reduce administrative cost (identify key opportunities group has identified)

Supporting rationale

- The need for state action:
 - The feds are going too slow and are not requiring either providers or payers to go electronic
 - Voluntary efforts cannot standardize
 - Voluntary efforts cannot bring about shift to electronic beyond current level
- Recommendation brings Medicare practice to the rest of the market
- Recommendation means providers will do what is necessary on the administrative side to qualify for Medicare and Medicaid incentive payments
- Recommendation will save a lot of money