

OHPR Administrative Simplification Work Group

Tuesday, June 1, 2010

11 am - Noon

OHA Lloyd Satellite Office
1201 NE Lloyd Blvd., Suite 100
Portland, Oregon

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 for Meeting #5	Co-chairs
1:05 pm 5 min	Staff presents pros and cons of alternatives for sequencing of transactions for development of companion guides and going electronic	Staff
1:10 pm 30 min.	Discussion of sequencing	Co-chairs
1:40 pm 15 min.	Other issues anyone wishes to discuss relative to the draft report	Co-chairs
1:55 5 min.	Wrap up	Co-chairs
2:00 pm	Adjourn	Co-chairs

Exhibit Materials:

1. Agenda
2. Meeting #5 Draft Notes
3. Draft Report circulated 5-19-2010
4. Alternative worksheet

**Administrative Simplification Work Group
Meeting #5 Summary**

Tuesday, May 11, 2010
1:00-4:30pm

Work Group Members in Attendance

Laura Etherton, Co-Chair
Dale C. Johnson, Jr., Co-Chair
Rhonda Busek
Tom Chamberlain (by phone)
Alice Cobb
Erick Doolen
Mike Schwab
Tonja Siefarth (by phone)
Dan Stevens
Doug Walta, MD
Joan Kapowich (ex-officio) (by phone)
Teresa D. Miller (ex-officio)

OHPR Staff in Attendance

Sean Kolmer
Lynn-Marie Crider

Work Group Members Not in Attendance

Barney Speight
Nelda Wilson
Todd Bybee
Nancy Franssen
Tyla Kennedy
Mary Kjemperud
Ann O'Connell
Carol Robinson

Meeting Summary (actions in bold)

Meeting Summaries

The work group approved the meeting notes for meetings 1, 2, 3, and 4.

Discussion and refinement of the straw plan

Staff presented straw plan A (revised 5/7/2010). (See item 4 in the meeting materials.)

The revision does three key things:

- (1) It incorporates comments and discussion from the most recent meeting.
- (2) It includes a role for the Health Leadership Task Force (now called the Health Leadership Council) because they have agreed to do the two things the group wanted them to do (a) vet the Minnesota companion guides in the industry and (b) take ongoing leadership in identifying and developing new administrative simplification activities.

(3) It revises the scope of the recommended legislative concept for 2011. After discussion with Teresa Miller, Administrator of the Insurance Division, staff concluded that by requiring insurers to do business electronically using the standard companion guides, DCBS can effectively require providers to use the same standards and methods when dealing with insurers. OHA has similar power to require providers to use the same standards and methods when dealing with DMAP and Medicaid MCOs. Therefore, legislation need not address providers; the only legislation needed is to cover self-insured plans and TPAs.

Dan and Erick reported that in a meeting with the Health Leadership Task Force’s Administrative Simplification Work Group, there was willingness to take on the role of vetting the Minnesota companion guides but some anxiety about the time frames for doing it. They asked that rather than vetting all the companion guides at once—by September 2010, they would propose to vet them sequentially with six months for each guide.

After much discussion, there was agreement that to do the claims guide first, followed by the eligibility transaction, and then the remittance advice.

The group agreed that guides should be done for medical, dental, institutional and pharmacy transactions.

The group agreed that because the proposal allows small providers to use web-based systems, it is reasonable to expect them to comply with the requirement to operate electronically.

The timetable agreed to is as follows:

	Claims submission (837)	Eligibility Inquiry and Response (270/271)	Payment remittance advice (835)	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
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
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	Not applicable
Everyone must to 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)

Contents of the work group report

Lynn-Marie reviewed the savings estimates revised after more information gathering. The group agreed to the target use of each electronic transaction to be used in each estimate.

The group also identified the following issues to address in the report:

- Consideration should be given to forming an administrative simplification consortium with other states
- The report should list some of the topics that should be considered for next steps, including a swipe card, single source for credentialing information, benefit standardization, and payment standardization.

Process

Lynn-Marie will contact Minnesota to get contact information of the chairs of the Minnesota AUC working group co-chairs so that HLTF can liaise with them as the guides are vetted. Lynn-Marie will also see if there are any materials that will be useful.

Lynn-Marie will distribute a draft report May 18th. Comments must be sent to her by May 25th. A one-hour conference call time will be set to be used only if issues come up that require discussion.

**Office for
Oregon Health Policy and Research**



Oregon Administrative Simplification Strategy and Recommendations

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

May 2010

Version for Work Group Review

[Insert Work Group Roster]

DRAFT

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 if not impossible 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—and ultimately purchasers and consumers--\$50-100,000 million in potential savings each year.

The work group recommendations include:

Phase 1: Standardization and automation of insurance transactions.

- The Department of Consumer & Business Services (DCBS) should adopt by administrative rule uniform companion guides for the claims and payment remittance advice transactions in 2011 and require insurers to use them for their electronic transactions beginning in 2012.
- DCBS's rule should require insurers to do the claims (837), payment remittance advice (835), funds transfer, and eligibility inquiry (270/271) transactions electronically on a phased-in basis—setting the dates for each transaction to “go all-electronic” about a year after a uniform companion guide is adopted in Oregon or uniform operating rules has been adopted by the US HHS..

Phase 2: Application of the standardization and automation requirements to all payers.

- The Oregon legislature should 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 to collect data from them to monitor progress and identify future opportunities.
- DCBS should extend the rules adopted in phase 1 to all payers.
- The Oregon Health Authority as a payer should align with the rules established for insurers in phase 1 by DCBS and implement these standards in its contracts with Medicaid managed care organizations, Medicaid providers, and others as applicable.

Phase 3: Standardization of additional payer transactions.

- DCBS's rule should 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 Oregon Health Authority should follow suit for its lines of coverage.

Phase 4: On-going public private collaboration on administrative simplification efforts.

- 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 Our system of insurance administration is itself 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 some transactions and recommending uniform standards for adoption by the Department of Consumer and Business Services.⁶

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 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.”

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 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.

OHPR assembled a diverse work group including two individuals affiliated with commercial health insurers, one affiliated with a Medicaid managed care plan 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 a human resources manager for a large business and another with 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. (A full list of work group members is attached as Exhibit A.)

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 Health Information Technology Oversight Council (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 Council's thoughts on the relationship between health information exchange development and administrative simplification. The Director of HITOC was in addition 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 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. The HLTF leaders sitting on the OHPR work group took the work group's preliminary recommendations to the HLTF Administrative Simplification Work Group for their discussion. They brought feedback to the OHPR work group process.

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.

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 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 coupled with a request to payers to share some baseline data. The provider surveys were conducted by e-mail distribution of an electronic survey. (See Appendix X.) 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.

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.

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 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 health care 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 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 effective in 2003. In 2009, HHS adopted updated transaction standards, known as version 5010, with which all covered entities must comply by January 1, 2012. However, HHS has not adopted standards the Congress directed it to adopt almost 15 years ago. Among the transactions for which no standards have ever been adopted is a standard for "claims attachments," which are clinical documents submitted at the request of the insurer to support a claim, whether sent along with the initial claim or in response to a post-claim request.

Unfortunately, the HHS standards and implementation guides did not accomplish the degree of standardization that might have enabled more widespread automation of health care transactions between providers and payers. This is in part because the HHS standards left many issues open. Consequently, payers have developed unique practices and companion guides to fill gaps in ways that suit individual business needs and systems. While the HIPAA standard transactions have the capacity to 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 not only confirmation of coverage but detailed information about benefits, but it does not require the insurer to provide the detailed information. Consequently, expensive non-electronic communication persists.

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 if not impossible 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 work group developed estimates of the 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.

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, 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 and then setting targets 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 range of savings estimates. 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 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 absorb 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 from Administrative Simplification

	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 going to bank) and payers (cost of printing and mailing check).			
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. 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.⁷

It is critical for the success of this effort that all providers and payers are expected to comply. That means the same uniformity and all-electronic standards must apply to all.

Approximately 16% of Oregonians with healthcare coverage get their coverage through self-insured plans and another 13% are covered through the Medicaid program. Therefore, the success of this effort to reduce administrative costs for providers, payers, employers, and the public will depend on all payers, including Medicaid, complying with the same rules for administrative transactions with providers.

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 widely to result in the desired savings from promising

⁷ Many Medicare and Medicaid providers are eligible for financial incentive payments for achieving meaningful use of health information technology. 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.

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 group proposes to expedite the standardization and automation process by adopting Minnesota's approach and adapting the tools it has developed. 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.

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. The requirements to standardize and go all-electronic took effect simultaneously for each transaction one year after each 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 standards to which a number of national carriers adhere.

Oregon should adopt and use these guides with minimal adjustments to address issues unique to each of the states, confident that they are likely to anticipate any additional standardization that the federal government achieves under the federal reform law. We recommend that the Health Leadership Council 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 by 2014, the greatest savings can be achieved for physicians by 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. Savings for payers will be greatest from increased use of the electronic eligibility inquiry, followed by claims submission, and claims status inquiries. Hospitals will save much less than for physicians or payers because they process fewer claims than physicians and because many are more automated than clinics and practices.

Some experts suggest that very substantial savings could be achieved by replacing faxed claims attachments with electronic ones.⁸ 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.

The detailed proposed timeline for standardizing HIPAA transactions and going electronic are set out below.

For each transaction, the process should begin with a six-month time period for the industry, lead by the Health Leadership Council, to 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 operating rules could stronger consider the Oregon-Minnesota approach for any federal action. In addition, by adhering to the Minnesota guides the state will continue to be able to rely on the expertise of the Minnesota AUC over time.

Immediately following the six-month review period, DCBS should begin an expeditious rule-making process leading to adoption of the companion guide within three months. If for any reason there is no industry recommendations on needed changes to the Minnesota guides after six months, DCBS should adapt the Minnesota guides for its rulemaking process.

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 guides. Then, three to six months later, payers and providers should be required to use the uniform electronic transactions instead of manual methods (phone in the case of inquires and fax or paper for other transactions). In the case of electronic funds transfer and the claims status inquiry, the

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

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

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

	Claims submission (837)	Payment remittance advice (835)	Eligibility Inquiry and Response (270/271)	Claims Status Inquiry (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 to 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 and 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, 2014.⁹

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 very slow, 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.

⁹Patient Protection and Affordability Act, section

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
Claims (837)	1/1/2016 (op rules)	1/1/2012	No requirement (except for Medicare)	7/1/2012
Payment Remittance Advice (835)	1/1/2014 (op rules)	10/1/2012	No requirement (except for Medicare)	1/1/2013
Eligibility Inquiry/Response (270/271)	1/1/2013 (op rules)	7/1/2012	No requirement	1/1/2014
Claims Status Inquiry/Response (276/277)	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

Failure to take these steps would cost the Oregon payers and provider—and ultimately purchasers and consumers—millions in potential savings each year. (For more detail see savings estimates in Appendix A.)

Recommendation #4: Technical assistance to providers will be important to help providers 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 Division of Medical Assistance Programs or the Health Information Technology Oversight Council, do outreach to providers 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.

Recommendation #5: Ongoing public-private partnerships should continue to identify success, challenges and opportunity 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 jointly playing a continued role and should, on an annual basis, carry out each of the following activities:

- 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 health care 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 health care 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 the 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 methodology or clinical management protocols may have potential for reducing both administrative and claims cost and improving the quality of care.

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Appendix A

[Saving projections tables and methodological notes]

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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 electronically by January 1, 2014 and claims attachment and referral and prior authorization 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

[Insert new version of timeline for HIE including state and federal provisions]

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Alternative Sequencing of Companion Guide Development

Option 1 (Agreed to May 17): Claims – Eligibility Inquiry – Remittance Advice

	Claims submission (837)	Eligibility Inquiry and Response (270/271)	Payment remittance advice (835)	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
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
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
Everyone must to 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)

Pros:

1. Taking claims first makes sense because claims transactions are easiest to ask providers to do electronically, present greatest opportunity for savings, and will not be addressed by federal operating rules until 2016. Providers are already required to submit Medicare claims electronically and the vast majority of providers already use electronic systems for submitting claims. In addition, standardizing the claims transaction and making all-electronic by 7/1/2012 will help providers submit 80% of claims electronically to meet the draft meaningful use standard to qualify for maximum Medicare and Medicaid incentives.
2. Taking the eligibility transaction second means giving priority to a transaction that is considered very important for providers and has considerable opportunity for savings for payers as well. The electronic remittance advice, which is left until last, has a great deal of potential value also—but primarily if providers choose to post electronically from it.

Cons:

3. By delaying the Oregon eligibility companion guide's effective date until 10/1/2012 (as compared with the original straw plan date of 1/1/2012), we may have lost the extra value of going ahead of the feds: Federal reform legislation requires use of new federal operating rules for eligibility verification 1/1/2013—just *three* months after the Oregon companion guide would take effect. In addition, this timing for the HLTF-led industry vetting process means that the vetting of the Minnesota guide is supposed to be completed at exactly the same time HHS is supposed to issue rules on eligibility verification; as a consequence, DCBS will either have to handle the comparison of the federal rules and the Minnesota companion guide in the rulemaking process or extend the vetting period beyond the deadline.
4. By delaying the Oregon remittance advice companion guide's effective date until 7/1/2013 (as compared with the original straw plan date of 1/1/2012), we may have lost the extra value of going ahead of the feds: Federal reform legislation requires use of new federal operating rules for the remittance advice 1/1/2014—just *six* months after the Oregon companion guide takes effect. In addition, this timing means that the companion guides are supposed to be adopted by DCBS at exactly the same time HHS is supposed to issue rules on remittance advice and funds transfer; as a consequence, DCBS will probably need to delay rule-making to address the consistency of the federal operating rules and the companion guide recommended by the vetting process.

Option 2 (Suggested by staff in the draft report): Claims – Remittance Advice – Eligibility Inquiry

	Claims submission (837)	Payment remittance advice (835)	Eligibility Inquiry and Response (270/271)	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
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
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
Everyone must to 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)

Pros:

5. Same as Pro #1 above - Taking claims first makes sense because claims transactions are both easiest to ask providers to do electronically and present greatest opportunity for savings. Providers are already required to submit Medicare claims and the vast majority of providers already use electronic systems for submitting claims
6. Taking the remittance advice transaction earlier ensures that Oregon gets a jump on the feds for that transaction: Vetting of the companion guide will be complete *one year before* the federal operating rules are announced and the guide will be in use and the transaction all-electronic *one year before* the federal rules take effect. This means the Oregon companion guide could be a model for the feds, there would be no danger of delay related to re-examining the guides in light of the federal rule, and at least an additional year of savings could be achieved through standardization.
7. Delaying the vetting of the eligibility transaction means the companion guide vetting process takes place after the federal operating rules are announced and can take the federal operating rules into account.

Cons:

8. Delaying implementation of the eligibility companion guide until 7/1/2013 means that the requirement for doing this transaction electronically will not kick in until 10/1/2013 – meaning both that the savings potential will not be realized for several years and that providers that attempt to do electronic eligibility checks on 80% of their patients to satisfy the draft “meaningful use” standards for Medicare and Medicaid incentive payments may be stymied by lack of uniformity.

Option 3 (Suggested by Mike Schwab): Eligibility Inquiry – Claims – Remittance Advice

	Eligibility Inquiry and Response (270/271)	Claim (837)	Remittance Advice (835)	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
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
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
Everyone must to 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)

Pros:

9. Taking eligibility first means a transaction with high savings potential is standardized and made all-electronic early. It also solves the problems identified in Con #3 above: The transaction will be standardized and made all-electronic in time to help providers meet the draft meaningful use requirements for Medicare and Medicaid incentive payments, and the Oregon guide will be in place before federal operating rules are announced thereby avoiding the problem of a vetting period that is complete at the same time the federal rules are announced and increasing the likelihood that the feds will adopt rules compatible with the Oregon guides.
10. Taking claims second means that while some value will be lost over taking it first (compare Pro #1), the transaction will still be standardized by 10/1/2012 so as to assist providers to meet the meaningful use requirements in 2012 as required to maximize incentives available to them under the Medicare program.

Cons:

11. Same as Con #4 above - Taking the remittance advice last means that the scheduled DCBS adoption of the companion guide will occur just as the feds announce their operating rules—thereby creating potential for delay.

**Option 4 (Proposed for consideration by staff to overcome a downside of Option 3):
Eligibility Inquiry – Claims/Remittance Advice**

	Eligibility Inquiry and Response (270/271)	Claim (837)	Remittance Advice (835)	Electronic Funds Transfer
Period for industry review of Minnesota companion guides ends	1/1/2011 (end of Q4 2010)	7/1/2011 (end of Q3 2011)	7/1/2011 (end of Q3 2011)	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)	10/1/2011 (end of Q3 2011)	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)	10/1/2012 (end of Q3 2012)	Not applicable
Everyone must to this transaction electronically	7/1/2012 (end of Q2 2012)	1/1/2013 (end of Q4 2012)	1/1/2013 (end of Q4 2012)	1/1/2014 (end of Q4 2013)

Pros:

11. See Pro #9 above.
12. See Pro #10 above.
13. Scheduling the vetting of the companion guides for the claims and remittance advice transactions simultaneously reduces if not eliminates the potential for inconsistency between the guides for these related transactions.
14. Advancing the timing for vetting and adoption of the companion guide for the remittance advice transaction means the vetting and rulemaking process for the remittance advice will be completed *nine months* before the federal operating rules are adopted for the remittance advice (overcoming Con #11). As a consequence, the problem of likely delay in the rulemaking process for the remittance advice companion guide in order to consider potential inconsistencies with the federal operating rules would be avoided and the likelihood that the feds will adopt rules compatible with the Oregon guides would be increased.

Cons:

15. Advancing the timing for vetting and adoption of the companion guide for the remittance advice transaction puts greater pressure on the industry to vet the Minnesota guides quickly.
16. Advancing the timing for going all-electronic for the remittance advice transaction means providers must accept the electronic remittance advice a year earlier than Medicare will require it. (Note, however, that the all-electronic requirement for the remittance advice could be delayed without undermining the advantages of speeding up adoption of uniform companion guides.)

Option 5 (Co-Chairs' Trial Balloon): Claims – Remittance Advice – Eligibility Inquiry Accelerated

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

Approach: This proposal takes claims first because claims present the greatest opportunity for system savings. It takes the remittance advice transaction second in order to get in front of the federal process—but does so on a slightly accelerated schedule as compared with Option #2. It delays the vetting process for the eligibility transaction three months (as compared with the schedule agreed to May 17) to ensure that the vetting process can address the intersection between new federal operating rules and the companion guides. But, recognizing the importance of standardizing the eligibility transaction, it accelerates the third rulemaking process so that the uniformity will be achieved faster than it would have been achieved under Option #2.

Pros:

17. Same as Pro #1 above - Taking claims first makes sense because claims transactions are both easiest to ask providers to do electronically and present greatest opportunity for savings. Providers are already required to submit Medicare claims and the vast majority of providers already use electronic systems for submitting claims
18. Taking the remittance advice transaction earlier and creating a three-month overlap in the vetting processes for the claims and the remittance advice transactions ensures that Oregon gets a jump on the feds for that transaction: Vetting of the companion guide will be complete *fifteen months before* the federal operating rules are announced and the guide will be in use and the transaction all-electronic *fifteen months before* the federal operating rules take effect. This means the Oregon companion guide could be a model for the feds, there would be no danger of delay related to re-examining the guides in light of the federal rule, and *eighteen months* of additional could be achieved through standardization.
19. By delaying the vetting of the eligibility transaction three months (as compared with Option #1), it becomes possible for the industry vetting process to take account of federal operating rules that will be announced 7/1/2011.

Cons:

20. If the industry needs six months to vet the remittance advice companion guide, it will need to begin the vetting process before the deadline for completing vetting of the claims companion guide.
21. The eligibility transaction will not be fully standardized until 1/1/2013, so providers seeking to do 80% of their inquiries electronically to meet meaningful use requirements in 2012 will need to do them after the Oregon companion guide has been adopted by rule but before payers are required to function under it.