

OHPR Administrative Simplification Work Group

Wednesday, April 7, 2010

1:00-5:00 pm

Room 218

Clackamas Community College

Wilsonville Campus Training Center

29353 Town Center Loop East, Wilsonville, OR

Time	Item	Lead
1:00 pm	Call to Order	Laura Etherton and Dale Johnson, co-chairs
1:00 20 min.	Debrief presentations by Dave Haugen (Minnesota) and Pete Cutler (Washington)	Co-chairs
1:20 pm 10 min.	Quick review of key materials from March 30: <ul style="list-style-type: none">• Principles• Federal reform summary• Calendar of HIT/Administrative Simplification activity	Co-chairs
1:30 30 min	Another look at savings potential of increasing use of electronic transactions <ul style="list-style-type: none">• Global estimates based on surveys and the literature• Provider and payer survey results continued – Opinion on what changes offer promise for savings	Lynn-Marie Crider
2:00 45 min.	Barriers to increasing use of electronic transactions <ul style="list-style-type: none">• Barriers identified in surveys• Local payer efforts to encourage increased use of electronic systems	Lynn-Marie Crider and discussion
2:45	BREAK (will be taken at discretion of the chairs)	
3:00 90 min	DISCUSSION: Priorities for simplification – what types of uniformity should happen most urgently, when can they happen The state's role	Co-chairs
4:30 30 min.	SUMMING UP: Is the group ready to make any tentative decisions for staff to draft?	Co-chairs
5:00	Adjourn	Co-chairs

Next Meeting: April 20, 2010, 1-5 pm, Wilsonville Training Center Room 115.

Exhibit Materials:

1. Agenda
2. Calendar of Health Information Technology and Administrative Simplification Activity (11x17 format)
3. Draft estimates of potential savings from selected administrative simplification activities in Oregon
4. Provider/payer feedback on potential savings from administrative simplification activities

02. Electronic Health Information Exchange Calendar (3/24/2010)

	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 planning		Strategic plan due August												
HIE meaningful use		Stage 1 includes 80% patients eligibility checked electronically (not web?), 80% claims submitted electronically, 75% e-prescribe												
HIE Medicaid incentives (eligibility limited to hospitals w/ 10% & professionals w/30% w/ some exceptions)				For 2011 subsidy show MU July 1 (hospitals), Oct 1 (phys)					Show MU to get any subsidy for stage 1 (phys)					Show MU to get any subsidy (phys)
HIE Medicare incentives (all providers are eligible with maximum payments depending on multiple factors)				For 2011 subsidy show MU July 1 (hospitals), Oct 1 (phys)		Show MU to get maximum total subsidy (phys)		Show MU to get maximum total subsidy (hospital)				Payment reductions begin if no MU by July 1 (hospitals), Oct 1		
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)	
TO BE DETERMINED: OREGON UNIFORM STANDARDS														

03. DRAFT OREGON ADMINISTRATIVE SIMPLIFICATION SAVINGS ESTIMATES

	Estimated transactions (AMA prorated by Oregon share of total health care spending)	Ratio other transactions to claims	Per transaction savings for physicians (electronic v. manual)	Oregon payer estimates of per transaction savings for payers (electronic v. manual)	AMA estimates of per transaction savings for payers (electronic v. manual)	Total per transaction savings (AMA)	Per transaction savings for payers (electronic v. manual) (Oregon where we have the data, otherwise AMA)	Oregon estimates total per transaction savings (electronic v. manual)	% now done electronically (Oregon)	Total Oregon savings potential (2009)
Claims submission	9,943,000	1.00	\$3.76	\$2.32	\$0.60	\$4.36	\$2.32	\$6.08	80%	\$12,090,688
Payment posting	6,960,000	0.70	\$1.48	\$0.00	\$0.00	\$1.48	\$0.00	\$1.48	20%	\$8,240,640
Claims status inquiry	994,000	0.10	\$3.33	\$3.75	\$0.90	\$4.23	\$3.75	\$7.08	50%	\$3,518,760
Referrals	1,604,000	0.16	\$6.23	unknown	unknown	\$6.23	unknown	\$6.23	50%	\$4,996,460
Pre-authorization	160,000	0.02	\$8.71	unknown	\$0.75	\$9.46	\$0.75	\$9.46	30%	\$1,059,520
Eligibility and benefits	2,005,000	0.20	\$2.96	\$3.75	\$1.40	\$4.36	\$3.75	\$6.71	50%	\$6,726,775
Total										\$36,632,843

Sources: AMA, "Standardization of the Claims Process: Administrative Simplification White Paper," Appendix D (June 2009) relying on studies by the Milliman Group and the National Healthcare Exchange Service for per transaction savings potential for physicians and payers and number of transactions; Oregon payer and provider survey for percentage of transactions done via HIPAA compliant electronic transaction (either web or batch) and estimates of payer per transaction savings potential for electronic versus paper or telephone.

DRAFT Payor Interviews: Feedback on changes to the system and their impact on administrative costs*

	will greatly reduce costs	will significantly reduce costs	may slightly reduce costs	will not have any impact	will increase costs	do not know		ready now	within 2 years	more than 2 years
A central repository where Clinics and plans go to get information for physician credentialing		2	1	2		1		2		3
A system for electronic exchange of both clinical and administrative health information		1	2			2			1	2
A web portal where providers can access eligibility and claims information for all plans	1		3	1	1			5		
Standardizing the content and format of eligibility and claims information health plans put on the web	1		2	1	1	1		1	3	1
Standardizing the content and format on the insurance card			2		4			1	2	
Standardizing information health plans provide on the payment remittance advice including specific standard reason codes	1		1	1		2		2	1	
Requiring plans to provide more comprehensive benefits information in response to a HIPAA 270		1	3		1	1		2	1	1
Requiring plans to provide a HIPAA 277 electronic claims status response explaining why a claim has not been immediately adjudicated			3		1	2		2	1	
Replacing the companion guides used by individual health plans with standard companion guides for the HIPAA electronic transactions			2	1		2			3	
Require all providers to submit claims electronically**	2	2	2					5		
Require plans to accept electronically submitted claims and send an electronic payment remittance advice**		2	1	2				5		
Replacing the companion guides used by individual health plans with standard companion guides for the HIPAA electronic transactions			2	1		2			3	
Standardizing the information health plans can require for prior authorization	1	1			1	2		1	1	1
Standardizing payment methods while leaving actual rates to be negotiated between the provider and the plan (for example, all plans pay a negotiated percentage of Medicare rates)			2			2				1

Other suggestions: Electronic swipe care, required electronic funds transfer, electronic provider contracts, electronic COB, solve attachment problem, move to payand pursue, eliminate COB estimation.

*Payers participating in the interviews included Aetna, DMAP, HealthNet, ODS, PacificSource, Providence, Regence. Aetna did not provide written responses that could be tally-ed. (LIPA has scheduled an interview. Lifewise and CareOregon have not participated.)

** These two innovations were combined on the provider survey.