TESTIMONY TO
DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL COMMITTEE
ON VITAL HEALTH STATISTICS SUBCOMMITTEE ON STANDARDS

June 16, 2015

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Members of the Subcommittee, I am Debra Strickland; I am a Client Service Consultant at Xerox Government Healthcare. I would like to thank you for the opportunity to present testimony today on behalf of Employer groups, concerning the matter of Adopted Transaction Standards, Operating Rules, and Code Sets & Identifiers.

GENERAL QUESTIONS TO ALL PANELISTS APPLICABLE TO ALL PANELS

1. VALUE - Overall, does the currently adopted **transactions** meet the current (and near-term) business needs of the industry? Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints

To answer this question one has to review the transactions separately
837 I, P and D – These transactions are functioning in the industry today and have a tremendous amount of uptake in the industry. (72 Million) the fact that these transactions are being used by the largest payers at around 80% of the claim volume speaks to the effectiveness of the transactions and the net result the payment of Healthcare claims.
835 – This transaction as a significant amount of volume (94 Million) although unlike the claim the remittance is plagued with continued issues such as out of balance transactions, COB issues, Reversal correction, PLB etc. There are significant changes that have been requested that will improve the value of this transaction.
270/271 – Eligibility is used widely across the industry and although there is variance to the use across the Payers the business case is solid and is strongly engrained into the business practice of the providers. This is the highest volume transaction processed by Xerox in total at approximately (180 Million). This is a clear indication that the transaction is used in the industry and it is serving a purpose.
276/277 – Claim status has surprisingly low volume which is somewhat surprising however this can be explained by the increase in volumes of ERA transaction. If the providers have elected to receive the ERA transaction they are getting a response to the claim in a timely fashion and therefore do not need to perform a claim status inquiry.

They only need to perform this for situations where they are not receiving payments. This transaction is low in general however more batch then there is real-time when the transaction is performed. Other flavors of the 277 should be adopted such as the 277 P for pended transactions.
834 – The enrollment transaction as Zero volume under the use case of employer to a health plan. The Employers have their own formats for creating lists of their employees to send to the payers for inclusion in a health plan group benefit. They are not covered entities and therefore there is no requirement for them to use this transaction. This transaction should be ***removed from the HIPAA suite****.*
820 – The Premium payment has the same exact situation as the Enrollment and should also be ***removed from the HIPAA Suite****.*
278 – This transaction has very little value across the industry as the transaction failed to provide the payers with the information they required for the authorization which results in them only supplying a response that says "I got this transaction and I am processing it" – there is no additional follow up, then they have to call anyway. This transaction needs to have more industry feedback and work in order to be of value. Recommend that this be ***removed from the HIPAA suite*** *until ROI is proven.*

2. VALUE - Overall, do the **standards, code sets, and identifiers** adopted for each transaction meet the current (and near-term) business needs of the industry? Is the industry achieving the intended benefits from the transactions and their corresponding standards, code sets and identifiers? Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints

   Yes the code sets and identifiers are meeting the industry needs and have appropriate methods to request new values as the industry evolves.

3. VALUE - Have there been any studies, measurement or analysis done that documents the extent to which the transactions and their corresponding standards, code sets and identifiers, as adopted and in use, have improved the efficiency and effectiveness of the business processes? Please provide, as much as possible, information for specific transactions.

   There have been only a few studies but not by impartial organizations. It is recommended that studies by independent agencies be performed to obtain actual results that will measure:
   - *if there is ROI for adoption of standards,*
   - *efficiency that is achieved and*
   - *if changes bring about positive impacts to the healthcare industry.*

   If not, then serious evaluation of the individual changes requested by the industry should be considered for ROI before they are added to the next round of industry standard changes.

4. VOLUME - What is the current volume / percentage / proportion of business transactions being conducted electronically (each transaction) using the adopted standard?

   See Question 1 for volumes.

Claims	Remits	Eligibility	Enrollment HIX	Premium Pay HIX
15.49%	20.11%	42.89%	7.44%	14.06%

5. BARRIERS – Are there any known barriers (business, technical, policy, or otherwise) to using the transactions, standards, or operating rules?

   Enrollment and Premium payment Barriers are that the sending entity is not a covered entity.
   The Prior Authorization transaction has significant gaps in the initial transaction as well as the response transaction.

6. BARRIERS – Is there any perceived or qualified degrees of variability in stakeholders' usage of adopted transactions and operating rules?

   Medicare has in some cases changed their implementation in order to meet the broad population they cover.
   HIX players have increased the use of the 834 with CCIIOO companion guide and 820 HIX –These are no HIPAA rules for this business usage but perhaps there should be – see details in Question 14.
   Many payers support different levels of information and detail on AVR (voice response) web portals, etc even though they are not supposed to support a different level then the HIPAA transaction. However these are very successful because there is a business need – these have evolved due to the long wait for updated standards.

7. BARRIERS – What is the qualified or quantified degree of difficulty in adopting and expanding the usage of the transactions and operating rules

   The adoption of new standards and Operating rules is a large impact to the industry. The next set of ASC X12 Transactions has an enormous number of changes that will be required and some of these changes cross multiple transactions. It would be required that serious consideration is done to determine if a staggered or alternate approach be taken for the next set of HIPAA guides.

8. ALTERNATIVES – Are there any known perceived or qualified availability and acceptance of other methods / approaches in achieving the same goal which the adopted transactions and operating rules intend to deliver

Vendors and clearinghouses provide claim status reports on a daily basis and this could be a reason why the adoption of the 276/277.
Websites supported by the payers support higher level of detail than the transactions.

9. OPPORTUNITIES – Are there any identified areas for improvement of currently adopted transactions and their corresponding standards, code sets and identifiers?

   ASC X12 has received Change requests for all the HIPAA transactions over the many years since the last HIPAA transactions. These requests represent the needs of the industry and the growing need for advancement of the transactions. There is a need for these transactions to advance at a faster pace resulting in fewer net changes. This would make it easier for the industry to adopt the transactions with greater recognizable ROI with less impact to the organization as they transition. With the exception of 834, 820, and 278 the rest of the Transactions should advance to the next ASC X12 recommended versions.
   The industry would be well served to include the TR2 in the HIPAA regulations as the encyclopedia of all available code combinations that are available within the industry. This would resolve issues where the industry thinks that the only usable combinations are those within the 4 scenarios in the CAQH CARC and RARC mapping. This is severely limiting the use of codes and effective transmission of the messages to the provider as we can see from continued reports from providers even after several years with the CAQH CARC and RARC mapping that alone did not resolve the issue.

10. OPPORTUNITIES – What, if any alternatives exist for improving efficiency and effectiveness of the business process for each of the transactions adopted and in use?

   No Comment

11. OPPORTUNITIES – Are there additional efficiency improvement opportunities for administrative and/or clinical processes of these transactions and strategies to measure impact? Would they be addressable via new or different standards?

   277 P adoption would resolve issues with the ERA transaction being used to report pended transactions. This would be a comprehensive list of pended transactions that the provider could then react to.

12. OPPORTUNITIES – What alternatives exist to achieve similar or greater efficiency and effectiveness between trading partners at lower administrative cost?

   No Comments

13. CHANGES – Are there any changes that should be made to the current transaction standards, or the mandate to use them?

Remove the Standard transactions that have very low adoption - allowing the industry to use them voluntarily as they find the benefit to do so. The Claim and eligibility transactions are of the highest volume because these were transactions that were already happening across the industry even before HIPAA mandated them, so they had the voluntary support. The other transactions that are within the HIPAA suite need to find their value. Until they do it is a burden on the payer to have to upgrade transactions with little to no gain for them and very little ROI.

14. What is the usage of enrollment/disenrollment and premium payment transaction standard in health insurance exchanges?

    In the area of Health insurance exchanges the 834 Benefit Enrollment and Maintenance (834) 005010X220 technical report 3 along with the CCIIOO companion guide and the 005010X306 820 Health Insurance Exchange Related Payments is used by the Medicaid's broadly. Millions of these transactions are processed in a payer to payer business process.

    The Enrollment is passed from the State Medicaid as the sponsor to the QHP or MCO to identify which members are in which plan. Then the 820 transaction is used to pay the QHP or MCO so there is a need for these transactions in the industry as part of the Health Insurance Exchanges.

    These 834/820's are not the traditional from employer to the Health plan.

    It would be a good idea to research the value of the 834 HIX which was created by ASC X12 to see if it aligns better with the business use case rather than using the regular 834 with the CCIIOO companion guide.

    Reduce the HIPAA suite by taking the 834 out. This transaction has very little to no adoption for the business use case of Employer to Health plan. This would reduce the amount of work that payers need to do when there is a new HIPAA standard when there is no ROI for that work.

NCVHS Testimony
June 16, 2015

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Xerox Government Health Services

Xerox Supports

- Commercial business
  - Processing **83 Million** Transactions per year
- 9 MMIS State Medicaid's , 4 PBM’s , 2 Other
  - Processing **386 Million** Transactions a year.

Enrollment Transactions

- Commercial business
  - Processing **83 Million** Transactions per year
    - Zero Enrollment transactions
    - Zero Premium Payment Transactions
- 9 MMIS State Medicaid's , 4 PBM’s , 2 Other
  - Processing **386 Million** Transactions a year.
    - 34 Million HIE Enrollment Transactions
    - 51 Million HIE Premium Payment transactions

Traditional Use

- The Enrollment transaction is generally considered an Enrollment from an employer like Xerox for their employees healthcare

- To a payer or supplier of the healthcare to enroll them in a group plan.
- ASC X12 834 Benefit Enrollment and Maintenance (834) 005010X220 Technical report 3
- ASC X12 820 Group Premium payment for Insurance Products 005010X218 Technical Report 3

Health Exchange Boosts 834/820

- HIEs increase the need for State Medicaid's to interact with QHPs and MCOs has created a Payer to Payer business case for the use of these transactions.
- Do they work? Yes and No
- ASC X12 834 Benefit Enrollment and Maintenance (834) 005010X220 Technical report 3 **Plus** the CCIIOO Companion Guide
- ASCX12 820 Health Insurance Exchange Related Payments 005010X306

HIPAA or Not

- These are not HIPAA guides in the true sense
- Support a different business process flow
- FFEs and the Market place selected the guides and companion guides to use at the time.
- Might need to rethink that and adjust as the industry has had time to use these to see if perhaps the 834 HIX guide may be a better choice or if additional changes should be made.

HIPAA Next Suite

- Traditional Enrollment
- Drop out of the HIPAA Suite
  - Primary sender is not a covered entity
- HIX Enrollment and Payments
- Consider adding but evaluate 834 HIX and other necessary changes

QUESTIONS ?