Testimony to the National Committee on Vital and Health Statistics Subcommittee on Standards

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CLAIMS OPERATING RULES

Thank you very much for the opportunity to address the Subcommittee on Standards regarding the CORE Phase IV operating rules for the Claim transaction being considered for adoption by HHS. My name is Melissa Moorehead, and I have co-chaired a National Medicaid EDI in Healthcare (NMEH) workgroup called "Operating Standards" since 2012. This group was formed specifically to educate Medicaid stakeholders on the impact that section 1104 of the Affordable Care Act would have on Mechanized Claims Processing Systems, or Medicaid Management Information Systems. NMEH encourages states to work together, along with CMS and other regulatory entities, to ensure that transactions, standards, code sets and operating rules include a Medicaid viewpoint and promote Administrative Simplification in a cost-effective and efficient manner. While every State feels the urgent need for administrative simplification and cost savings, they are subject to multiple, complex regulations at several levels. State Medicaid Agencies are considered Health Plans under the law, but they are not businesses in the same way that insurers are. They also have a special status as payer of last resort, subject to laws requiring special adjudication steps and relationships with both providers and other payers.

While Medicare and Medicaid are very different programs, CMS's payment reform initiative to move payment for health care away from fee-for-service toward value-based payments, has prompted or further enhanced States' efforts to do the same. By 2013, the vast majority of Medicaid Agencies across the nation had already enrolled more than half of their beneficiaries in managed care programs.[1] The transaction standards and operating rules are primarily written for fee-for-service claims processing, envisioned as a unified business process. Regulations requiring their implementation can take focus and investments away from this larger payment reform goal. On the other hand, standardizing elements of claims processing across all payers would have clear benefits for Medicaid providers, and Medicaid as a payer when coordinating benefits and payments. A solution might be for HHS to consider a transaction volume cutoff for the mandate. Payers who are successfully moving out of the fee-for-service arena would not be required to create or redesign systems to accommodate a transaction that has diminishing usefulness.

Thus, the balance between enforcing standards and operating rules that enhance simplification, and simply creating new requirements that don't fill a business need for Medicaid – or even create further confusion – is not yet clear. Part of the issue is the length of the regulatory process, which, combined with the length of the funding process for Medicaid IT systems and political considerations, generally leaves no time for thorough testing. In addition, the variation of State Medicaid programs has made establishing a baseline and conducting evaluations prohibitive. Thanks in part to all of these constraints, State Medicaid Agencies are generally very conservative and reactive on the issue of mandated standards and operating rules. Knowing that mandates are coming can even have a chilling effect on innovation or progress in some areas, as system development lifecycles can make it costly to change direction or to incorporate standards and operating rules that were not foreseen in the design phase.

On open monthly calls, the NMEH Operating Standards subworkgroup has been reviewing progress on the Phase IV operating rules. CAQH-CORE has provided much education and answered questions on the

[1] http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/#map

calls, encouraging states to participate in the rulemaking process. However, in the absence of mandates and implementation deadlines, most states have participating in “listening mode,” unable to devote much time to the development process. The looming threat of massive penalties for noncompliance with section 1104 mandates has also stifled conversations on the open call, and may be more broadly felt as a barrier to working towards compliant, and more uniform, implementations.

It is very welcome that the Phase IV rules do not address data content. Operating rules that specify data content have been the most problematic and costly for states to interpret and implement. The conservative approach to building on the Phase I- III operating rules is also appreciated, although there is evidence that some States are lagging in those implementations, particularly where MMIS modernization or rebids are occurring. It is also worth noting that many states have eligibility systems that are not integrated with claims processing, and payment systems that are not in the same department as claims processing, and thus infrastructure may be on different levels. Implementing claims infrastructure requirements may mean much more work to bring several systems into compliance in these cases of fragmented IT infrastructure. Some states have accommodated these infrastructure changes by creating a separate “CORE connectivity” channel for the transactions already covered by operating rules, but it remains to be seen whether this approach will really provide a bridge to streamlining the transaction across systems.

The timeline specified in section 1104 for this last set of operating rules is past. It is our hope that this does not prompt HHS to act hastily when it comes to adopting these operating rules and setting an implementation deadline. State Medicaid Agencies will need time to understand any needed changes, and to design a compliance strategy in the context of the ongoing systems design and use.

PRIOR AUTHORIZATION OPERATING RULES

The subject of operating rules for the x12 HIPAA5010 278 transaction standard for prior authorizations, and the infrastructure rules that impact it, has come up several times on the NMEH Operating Standards calls. Use of this transaction is very low, although almost all participating states reported having implemented this transaction standard for HIPAA 5010 compliance. It appears that the main reason for the low usage is that the *process* of prior authorization is still very manual, and subject to different laws at the state level, such that standardization is not immediately feasible across States, and an electronic transaction does not enhance efficiency at this time. This is particularly true in the absence of a structured data standard for attachments which are often required for approvals.

The purpose of prior authorizations in the Medicaid context is not closely related to administrative simplification. It is primarily used as a cost control and fraud prevention measure to document a measure of utilization review. Many states have formal processes requiring manual review of prior authorization requests and print confirmations to accommodate providers at many stages of electronic readiness. The prior authorization requirement and its processes may indeed be very expensive, but it is not clear that operating rules for the electronic transaction will address these issues inherent in the process.

While we appreciate the desire to encourage uptake of electronic prior authorizations by mandating operating rules that would assure all participants in the prior authorization process of a uniform implementation, the current landscape is such that it is not clear that the operating rules would be effective for this. Operating rules for the electronic transaction will not have much impact on the efficiency of the processes themselves. Real-time processing of the transaction itself is not feasible in cases where manual review is required. Processing the transaction, or even batch transactions on a different time scale from the process will result in increased transaction volume with less transaction value as the required response would need to be set to “pending,” instead of returning a response only

when it contains actionable information. Implementing these operating rules at this time may lead to further frustration with the transaction instead of enhanced usage.

I would like to acknowledge and second the points made by Debra Strickland of Xerox, particularly regarding paying close attention to the evidence of necessity of business rules before mandated adoption of operating rules. Given the extremely low use of the transaction currently, adopting these rules now is akin to performing an experiment in the hopes that they may increase usage with no guarantees, and with uncertain value. Considering that experiment that will need to be paid for by the public for every Medicaid agency, this may not be a very efficient use of resources.

ATTACHMENT STANDARD

On a recent NMEH Operating Standards Subworkgroup call, the proposed attachment standard was reviewed. As mentioned previously, states are generally compelled to be more reactive than proactive when it comes to developing standards. That said, the time is very ripe to adopt a standard or standards for electronic attachments that would help propel system design to greater efficiency in processing claims, prior authorizations, and other administrative transactions that may require additional information in attachments not supported by current standards.

Adopting a standard would provide momentum to develop processing capacity to handle attachments. Currently there is reluctance to invest much time or resources when there is a risk that a new mandate would necessitate changes to systems in order to accomplish the same goals, but in a different way. The EHR incentive program created by the HITECH Act has created opportunities and incentive to start structuring data in a way that will be helpful for this process at the provider level, but Medicaid Management information systems have not had similar incentives to explore the possibilities of increased health information exchange on Medicaid management. Practice management systems are typically what interact with MMIS, and currently EHRs are not fully integrated in the administrative workflow, so the EHRs are not automatically connected with Medicaid IT. Integrating EHR and HIE activities with MMIS is still quite new, and not necessarily facilitated by the requirement for a special APD funding approach for health information exchange in the Medicaid enterprise.

It is important to note that there is no system in place currently to gauge the length of time necessary for "Medicaid" generally, or even for most states individually, to implement an electronic transaction standard. Electronic transaction standards are all overdue for update, and the possible move to HIPAA 7030 as a baseline in the next four years would further complicate a required implementation of an attachment standard. However, given a standard from which to start meeting business needs for automation is desirable. Especially considering the many reforms and initiatives underway in Medicaid, we would ask that the standard be adopted without a requirement that States implement the capacity by a certain deadline. This would provide the floor for development, with flexibility to accommodate technological advances occurring thanks to the EHR certification and incentive programs.