Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS, AND SECURITY

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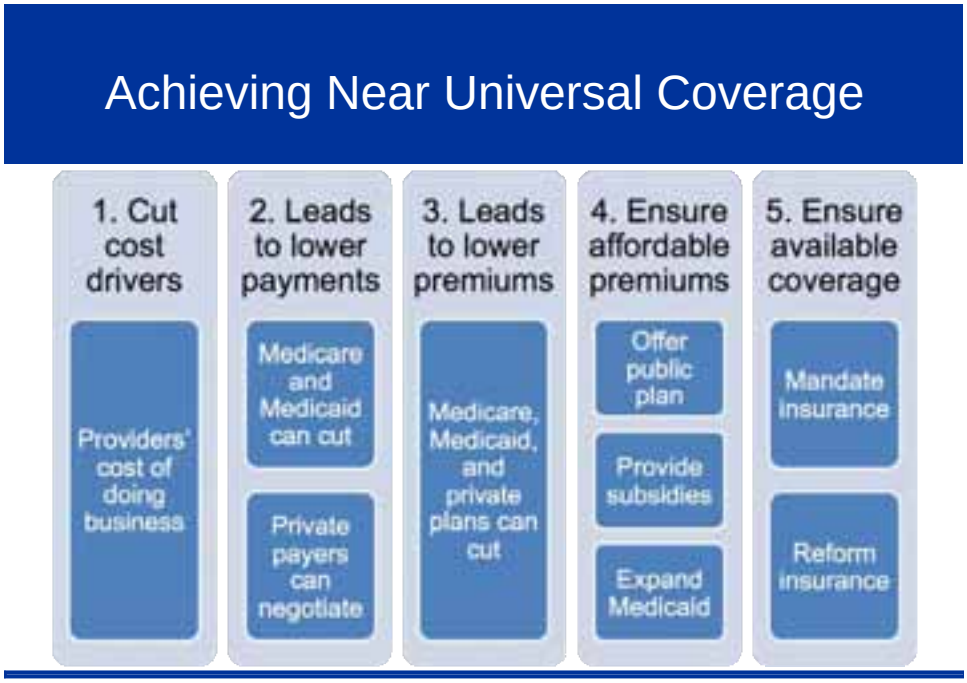
Chairpersons and members of the subcommittee, I am Eric Wallace, Executive Director of Linxus. Linxus is a not-for-profit 501(c)(6) organization, directed equally by its provider and health plan member organizations, whose mission is to simplify and reduce the costs associated with administering health care claim payments. Linxus membership includes seven provider organizations representing 26 hospitals and more than 5,000 individual physicians (including New York Presbyterian Health System, Montefiore Medical Center, Yale New Haven Health System, Memorial Sloan Kettering Cancer Center, Mt. Sinai Medical Center, NYU Langone Medical Center, and North Shore-LIJ Health System), three national health plans (United HealthCare, Wellpoint, and Aetna), and two regional health plans (EmblemHealth and HealthFirst).

Linxus provider and health plan members started meeting in 2004 in a voluntary effort to work collaboratively to reduce administrative costs. This led to the eventual incorporation of Linxus as a member directed and wholly funded not-for-profit Company. Membership in Linxus is open to any health plan or provider organization, and the entity itself is governed equally by a Board of Directors balanced between its health plan and provider participants. This governance structure ensures balanced decision-making, so that the efforts we undertake provide mutual benefits to our health plan and provider members and ensures that no one stakeholder group can direct the priorities over the other. The Greater NY Hospital Association supports and manages these collaborative

activities with the consent of the member organizations through a management contract.

Linxus provider and health plan members recognize the importance of administrative simplification as a national reform priority. Experts predict that by standardizing and automating the way health care claims are processed and reimbursed, we can bend the curve of health care cost inflation in a meaningful way. In fact on June 1st of this year, a coalition[1] of national health care organizations, including America's Health Insurance Plans (AHIP), American Hospital Association (AHA), and American Medical Association (AMA), sent a joint letter to President Obama, estimating that focused efforts on standardization, or administrative simplification, could save $500-$700 billion in national health care expenditures over the next 10 years. Achieving these savings is critical to reducing the costs of health care and expanding coverage to uninsured and underinsured Americans.



Source: GNYHA

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http://www.aha.org/aha/letter/2009/090601-let-health-groups-obama-cost-con.pdf

My comments today on behalf of the Linxus members will touch on three areas:

1. **The critical need to move to Version 5010 transactions and doing so with increased sense of urgency.**

2. **The challenges that exist in implementing HIPAA transactions based on the experience of Linxus members.**

3. **Our recommendations to remove the barriers of transaction adoption, and to meeting the larger goal of administrative simplification.**

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Version 5010: Heightened Urgency Needed

Linxus members are currently focused on increasing adoption of three of the named HIPAA transactions; nationally these three transactions have had less than expected uptake by providers and health plans. Our members identified these as having highest priority and greatest potential to reduce costs if implemented more broadly. They are:

1. The eligibility transaction that confirms a member's enrollment in a health plan and provides detailed information on their covered benefits;

2. The claim status transaction that is used to check status of pended claims in the health plans' adjudication systems (or claims submitted to health plans that do not yet have a finalized payment determination or remittance advice); and

3. The remittance transaction that describes reconciled amounts billed and paid.

Unfortunately, achieving connectivity on these three transactions has been challenging.

A smaller group of our members began meeting in 2004 to address a lack of consistency in health plans' implementation of HIPAA transactions. This lack of consistency significantly complicated implementation work for the providers and resulted in a more costly adoption of HIPAA transactions than was originally anticipated.

Understandably, trade-offs were made at the time the initial HIPAA transactions and code sets were designed. The first version of the standardized transactions, based on the ASC X12 4010A1 Implementation Guides (IG), favored flexibility for the health plans as the marketplace was ramping-up adoption. However, the

understanding in allowing so much flexibility for the health plans was that the Version 4010A1 transactions were only a temporary solution, and that standards would be regularly and frequently updated via changes to the ASC X12 IGs. These updates would reduce the known variability, and in turn reduce the complications for providers in implementing the standards.

Linxus members have frequently referred to this known flexibility in the current IGs as "non-standard, standards." We believe that much of the overall lack of adoption to date of the HIPAA transactions by providers and health plans is the result of complications associated with implementing each transaction according to each health plans' own implementation specifications.

To put it simply – the original HIPAA transaction and code set mandates were a starting point, but administrative simplification remains a destination and is a continuing journey. Linxus envisions a point in time when *every* provider is actively exchanging *all* transactions electronically with *all* of the health plans they do business with. Only when the entire marketplace is participating in information exchange will the full value of administrative simplification be achieved.

Given the barriers to implementing HIPAA transactions that our work group has experienced, we believe there must be a significantly greater sense of urgency than exists today on maintenance and updates to the standards and their associated implementation guides. In fact, further maintenance and updates in the standards will be necessary after the Version 5010 transactions are implemented. Linxus has observed that while 5010 begins to correct variability in the current transactions (and more); it will not solve all problems and should not be considered a panacea. Variability and gaps will remain.

Bigger Picture: Administrative simplification is key part of health reform.

The move to Version 5010 transactions will be a major step towards creating more meaningful savings through administrative simplification. But this step must foster a continued sense of urgency, because we can not afford to delay the process of regular updates to the standards.

As the health reform discussions here in Washington have reminded all of us, significant cuts are looming in provider and health plan Medicare reimbursement rates. Proposals working their way through the Congress now cite the ability of providers to increase their productivity over the next 10 years through such efforts as administrative simplification, and call for Medicare rate cuts to hospitals alone of up to $157B[2] over the next 10 years (with productivity cuts accounting for $111B of the total).

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[2] Source: Congressional Budget Office.

As providers work to manage reduced Medicare reimbursement, health plans will also face increased pressure to reduce costs due to proposed Medicare Advantage premium cuts as well employer and consumer pressure to curb premium inflation. The importance of providers and health plans working collaboratively on strategies to reduce their costs has never been greater.

Collaborating on administrative simplification represents the low hanging fruit for health plans and providers, and only through collaboration can we reduce and eventually eliminate variability in the transaction standards and their associated implementation guides. Eliminating this variability will reduce complications for providers, lead to increased adoption of the basic transactions, and enable a shift in provider and health plan resources to focus on additional transaction types, like claims attachments, where there are additional inefficiencies and opportunities for cost reduction.

Increasing attention and heightened urgency on 5010 will ensure that a concerted work effort begins sooner on additional areas of inefficiencies. We would also advocate after completion of 5010 for putting more focused efforts behind quantifying the costs and understanding the patient safety implications of failures to standardize unique health identifiers for patients (or UPI). Lack of a consensus UPI standard is adding significant cost and unnecessarily complicating the process of patient identification at the delivery system level, and as the comingling of patients' clinical and administrative information becomes increasingly prevalent, lack of a UPI standard not only adds more cost to the system to combine this information, but it also potentially risks patient safety. We strongly urge this subcommittee to revisit UPI standards that were originally discussed as part of the administrative simplification mandates in 1996.

Challenges of Implementing HIPAA Transactions

The challenges of implementing HIPAA transactions should be addressed now, as part of the 5010 mandates, to ensure that we meet the implementation deadline before us, and to create a sustainable process for continuous improvement in the standards that is in all of our longer-term best interests. The first significant challenge is that updating the standards requires a concerted, coordinated and mandatory Federal effort.

Linxus efforts have been predominantly focused on achieving consensus through voluntary efforts of our health plan and provider members to reduce variability in the standards and their associated implementation guides. Our members convene in regular collaborative forums, as many as three times per week, and have published all of our consensus implementation decisions on our public web site (www.linxus.net) Anyone can freely download and utilize these specifications, regardless of their participation status in Linxus.

Our published consensus “implementation specifications” build on the ASC X12 Implementation Guides, and we’ve conducted detailed reviews and analyses of these IGs. Our implementation specifications do not contradict or change the underlying named HIPAA transaction specifications, rather the Linxus specifications constrain and standardize where the IGs do not. Our members are voluntarily building towards these specifications on their own (with the vendors of their choice), and through this participatory leadership, we had hoped to influence others in adopting and eventually endorsing the Linxus specifications.

The voluntary nature of Linxus efforts has been a significant challenge. With so many competing demands on IT staff and resources, both on the provider and health plan side, this year our Board concluded unanimously that stronger Federal mandates are needed to require the maintenance and updating of the standards and their associated implementation guides. Without such mandates, the promise of national cost savings from administrative simplification will be further delayed and remain the priority of a select few volunteers rather than become the imperative of the entire marketplace.

Mandates, such as the conversion to ASC X12 Version 5010 IGs are useful in aligning all the required stakeholders (providers, health plans, and vendors) and orienting them to a common implementation timetable. Attempting this kind of coordinated effort on a purely voluntary basis has proven extremely difficult and challenging. If the 5010 mandates are delayed, this will set-back the entire timetable for the next round of mandates that we already know are necessary. Linxus supports a mandatory, firm schedule for standard updates.

Some states have attempted to legislate standards on their own and require use of State-level specifications for all payers doing business in that State. However, this approach would not be effective in States like New York with a significant penetration of national health plans—e.g., Aetna, United HealthCare and WellPoint— because national plans cannot accommodate 50 different specifications for a single transaction; they need a single, best practice standard.

The most effective approach we believe is to collaboratively reach consensus at the national level on best practice implementation specifications of the standards. This requires a regular mandate to update the standards, so that as feedback from providers and health plans is incorporated into Implementation Guides by the designated Standards Development Organizations (SDO), these updates get promulgated regularly and frequently.

Also, no single stakeholder group or region can drive this process alone; the process must be coordinated at the Federal level through Federal mandates. Linxus believes equal collaboration among providers and health plans is essential for prioritizing these updates.

This brings us to second challenge. To date, there has been an overall lack of enforcement of the adherence to the HIPAA standards. This lack of enforcement in turn has resulted in a tolerance for “soft compliance” to the standards.

To date providers and health plans have been unwilling to use the complaint system set-up under HIPA, to enforce each other’s compliance to the standards. Such complacency in the enforcement of current standards has resulted in “soft compliance” (as opposed to “functional compliance”). Failure to enforce and impose penalties also risks undermining the 5010 implementation efforts, which could further delay expected increase in rates of adoption of the standards.

The third challenge of implementing HIPAA transactions is long delays between the mandates. This has resulted in decreased participation over time in the standards development and maintenance process, and a pull-back from collaborative activities in favor of internally-focused “compliance” projects.

It will be nearly 10 years between standards version 4010A1 and version 5010. Health plans and providers in that time have become conditioned to long delays in the update cycles, and there is already decreasing participation in the national standards development and maintenance process as a result. As mentioned earlier, the need for more collaboration is essential, because 5010 will not solve all problems. Also, Linxus is concerned that participation in standards development organization (SDO) meetings has been declining (particularly among providers) over the past several years. Industry input is essential to the standards maintenance process. SDOs gather industry input on updates needed in the standards and their associated implementation guides. The quality and timeliness of updates SDOs are working on will become increasingly disconnected without broad perspective from health plans AND providers in this process.

The delay between updates has also resulted in the accumulation of many updates for simultaneous implementation, necessitating major overhauls of health plan and provider systems. This is forcing providers and health plans to look internally first, a “silo” mentality, in order to meet their own individual compliance requirements. Providers and health plans instead should be building cross-functional and cross-disciplinary teams, to jointly analyze business impacts, and to identify where continuing gaps in the standards need to be addressed in future updates to IGs. Cross-disciplinary teams, such as Linxus has developed, that are focused on interoperability specification of the provider and health plans systems are essential if intended administrative simplification savings are going to be achieved. It would appear thus far, including in our experience as Linxus that the 5010 implementations are not fostering the necessary level of collaboration and gradual elimination of the “silo” mentality. Instead, internal health plan and provider operations teams are focused on conversion of each discreet transaction and in meeting their own deadlines.

The current economic downturn is a fourth challenge, though hopefully a temporary one. Both health plan and provider organizations are reporting limited ability to hire the appropriate number of operational and technical resources and subject matter experts required to handle all of the mandates and projects on their plates. As a result, their resources are spread thinly on many competing implementation projects, which is restricting them from participating in collaborative activities in favor of internally focused project plans.

Finally, the fifth challenge for implementing HIPAA transactions, which is related to the resource constraints I just mentioned, is the increased focus and attention on implementing clinical systems (i.e. EMRs) and the "meaningful use" of HIT systems with clinical functionalities. This includes the set-up of data exchanges that are predominately focused on moving clinical data rather than both administrative and clinical data. While we strongly support giving increased national focus and attention to converting and meaningfully using clinical information, more focus and attention is also needed on administrative simplification and the meaningful use of administrative data as well. The vendor community today, for example, has greater incentives to implement clinical systems and clinical data exchanges. The incentives and priorities to use clinical and administrative data we feel should be equally prioritized.

Recommendations

In closing, I would like to highlight a number of specific recommendations to the subcommittee, which might remove barriers to adoption and assist the industry in meeting the larger objective of administrative simplification. Our recommendations are premised on the fact that we cannot afford to extend the compliance timeline beyond 1/1/2012 or reduce the scope of implementation work. Instead, we must renew focus successfully implementing 5010 and aggressively pursue additional standards updates beyond 5010.

First, we strongly urge CMS to sound the alarm *now* about the risks associated with missing the mandated 1/1/2012 implementation date. This communication should be targeted to business leaders of all health plan and provider organizations, and it should clearly state the risks associated with non-compliance, including financial penalties and the manner in which these penalties will be enforced. The letter should also provide a rationale behind CMS' current thinking for not granting an extension beyond the 1/1/2012 implementation mandate, reinforcing the heightened sense of urgency that is needed to reduce health care costs, while at the same time acknowledging the need for a sustained and regular maintenance process of the standards and their associated implementation guides after 5010 is implemented.

Second, we would encourage focused national attention on administrative simplification through a training initiative within the next several months, to educate the internal staffs of provider and health plan organizations on the expected benefits (i.e. business and operational) associated with 5010

implementation. This training should be designed from the perspective of the business user and include an overview of best practice implementations that providers and health plans have already adopted under 4010A1 and expected benefits of moving to 5010; tutorials on project managing 5010 implementation work, which involves coordinating multiple stakeholders (i.e. providers, health plans, and vendors) and building cross-disciplinary teams to analyze and understand the impacts of 5010 on different component parts of the organization; and finally, detailed testing instructions encompassing all required hand-offs between providers and health plans to have fully functional 5010 transactions.

Beyond implementing 5010, we also recommend increased focus on the ongoing maintenance of the standards. Our third recommendation is to make funding available to providers and health plans that agree to actively participate in the standards development organizations and processes. The work that SDOs do is vitally important to the adoption of standards, but it requires broadest possible participation from volunteers across the industry -- specifically from providers and health plans. As stated earlier, overall participation in SDO meetings is declining. We would strongly urge more organizations to participate in the process and we recommend that some funding be made available to organizations that are stepping-up to do the work on behalf of all providers and health plans, so at least part of their costs are covered to attend the SDO meetings.

These standards to simplify and reduce costs associated with administering health care claim payments should also be more prominently featured and incorporated into the working definition of “meaningful use” that the HIT Policy Committee under the Office of the National Coordinator is currently considering. So far two of the HIPAA transactions (claim and eligibility) are included in the draft “meaningful use” definition; however, more instruction and detailed description is needed of all administrative data types available and how this data can result in “meaningful” cost reduction for providers. Our fourth recommendation is to more closely link the clinical and administrative data to the policy goal of “meaningful use”, so the greatest possible cost savings through administrative simplification can be achieve. This requires adoption of all HIPAA transactions – not a limited set. As providers engage in the selection and implementation of an electronic health record (EHR) system, they will require training and orientation to more than just the “meaningful use” of clinical data. HIT will transform the entire patient encounter from the registration and determination of the patient’s health plan eligibility all the way through the collection of reimbursement for services provided. Linking administrative and clinical data to the same “meaningful use” policy goal will ensure that providers seeking government funded training assistance for EHR adoption, such as programs provided through regional extension centers, are given appropriate training and orientation to use of administrative data and to exchanging data electronically with their health plans.

I would like to thank you for the opportunity to present testimony on behalf of Linxus, and I look forward to any questions you might have.