National Committee on Vital and Health Statistics
Subcommittee on Standards
Regarding National Health Plan Identifier

Reactor Testimony:
John Kelly, Harvard Pilgrim Health Care and AHIP

- My name is John Kelly, Director of eBusiness Architecture for Harvard Pilgrim Health Care. With headquarters in Wellesley, Massachusetts, Harvard Pilgrim offers health care products and services to over 1 million members in New England throughout the United States. In addition, my experience is informed by ten years tenure as a board member of the New England Healthcare Exchange Network (NEHEN). An organization formed in anticipation of HIPAA and specifically chartered to facilitate collaborative activity among payers and providers in the interest of increasing the quality and efficiency of healthcare revenue cycle processes. In full disclosure I am also a member of the AHIP Operating Committee. I want to thank the committee for the opportunity today to react to this morning's presentations.

- Today I'm speaking on behalf of America's Health Insurance Plans. In general, AHIP and Harvard Pilgrim support the proposal detailed by Jim Daley of Blue Cross Blue Shield of South Carolina.

- Within the spirit of today's NCVHS' process, my remarks are as a "reactor" and I will therefore respond to this morning's proceedings in that capacity and within my role as industry representative.

As a statement of principle,

- Harvard Pilgrim supports the concept that steps need to be taken to simplify the submission and payment of claims and steps should be taken to ensure consistent identification of the healthcare entities involved in the processing and payment of claims.

- In my opinion, the best way to address this is by not adding additional complexity in the development of this regulatory proposal.

Display Revenue cycle graphic

- I'd like to start by citing an example of a HIPAA implementation that I consider to be a great success.
  [Give example of NEHEN eligibility-
  - Lessons learned:
    1. Collaboration
    2. Leverage the existing transactions
    3. Integrate with vendors in a B2B, machine understandable format

- The industry will achieve the most benefit by first ensuring that all of the fields in the 5010 standards are being used to their maximum potential and committing to take steps to make enhancements where needed – either through future versions of the standards or operating rules.

- I'd like to Echo x.12 comments about the various and specific roles attributed to parties in the transactions and how some might be served by the Payer ID and others by different standard codes and identifiers. This model was well thought out and processed over a decade.

- It is also important to look for guidance to the original HIPAA definition of Payer. To the degree that we don't have to rewrite this, we can avoid further time spent achieving concensus. If we establish the original definition as a baseline. It will help make clear the path forward. Much input and controversy went into that definition and in the interest of expediency, let's use what the "original framers" gave us.

- Many have cited the problems with the implementation of 4010 and although 5010 has addressed many of the issues cited, I would argue that it was the inconsistent and bare bones implementation of the standards by the industry that has caused most of the problems, not the limitations of the transaction.

- We don't need to wait for the 6020. Operating rules could address the majority, if not all of any issues identified within 5010

- For example, "Product" is, and always has been available as a discrete field. Unfortunately it's use and definition was poorly defined and consequently, PM systems never incorporated into desktop workflow.

- On the issue of granularity:

- With reference to a number of statements made this morning with regard to all the possible sub-flavors of the National Payer ID, let me provide and analogy to the NPI implementation [Specific comment on the AMA?]

- Specifically, the AMA proposal references fee schedules but during the question and answer session, the term "allowed amount for a CPT code" was used. These are not interchangeable terms and the assumption that they are leads to significant problems. Fee schedules are baseline agreements to which +/- multipliers are applied as mutually agreed to terms for specific services. Allowed amount, further, can take into account a number of factors like risk arrangements, situation and location specific case rates, pay for performance criteria and "carve outs". Consequently, until a claim is actually being adjudicated, the "allowed amount" frequently is not available on a prospective basis.

- Also, as providers independently contract with multiple third parties other than a health plan, and the payer frequently is not aware of these arrangements, rather than keep track of all the changing arrangements between providers and third parties, at time of adjudication, payers investigate which fee contract can be applied for the specific service, for the specific provider, for the specific service or geographical location. This situation results from providers entering into these many contracts, not from payer business practices.

- Consider for an instant, the complexity that would be ensue from an attempt to specify fee schedule information within the health plan identifier. Many payers negotiate fees separately with hospitals. Each of these fee schedules would result in a separate identifier. For even a small state there could be fifty to a hundred hospitals which participate in one or more networks each. Taking a simple example of fifty hospitals each participating in two networks would result in one hundred health plan identifiers for one health plan. Additional identifiers would be needed for schedules associated with physicians and group practices. These fee schedules often change whenever physicians change affiliations, when groups merge, or when negotiated rates change. Maintenance of this information embedded in a health plan identifier would have to be updated in real time as claims are being processed continuously. With multiple sources of truth for the same information, this task would be impossible cumbersome and counter to the goals of administrative simplification.

- Let me just point out that the an obvious analogy to payer implementation of NPI

- Embedding "meaning" in numbers is dangerous. I agree with every issue identified by AMA but I think the proposed fix will not really solve the problem. It's not "file cabinets" used for revenue managment, It's practice management and hospital information systems that track and reconcile accounts receivable. These systems would have to be constantly updated with new information as it is generated. Are these systems ready to store and make sense of these ultimately thousands of Payer ID's? Or would this complexity all be outsourced to billing agencies and other intermediaries that will charge transaction fees and percent of billables to make sense of it all?

- Importantly, most, if not all of the information needed to address the problems cited here today is or could be available in real time by promulgating robust Operating Rules for the 271, 277 and 835 transactions. Our current conundrum results from the fact that most payer and provider interactions do not take advantage of the various loops, codes and fields available in 4010, nevermind 5010.

- The other thing that seems not to be well understood is that in many cases, the network, fee schedule and benefits are frequently not “fixed” for a patient based solely upon a patient and a date of service. In many cases, the “network” and contract/fee schedule are not determined until all data on a claim are submitted. There are many factors that contribute to the determination, specifically resulting from the fact that the providers enter into and withdraw from numerous contracts with numerous parties in the interest of being part of many networks. Plans who contract with these various networks cannot maintain the network affiliations of all the contracts with whom every provider enters into an agreement and therefore, to reduce upward pressure on the cost of care, we identify these contracts upon receipt of claim. Thus we cannot identify with any certainty prospectively what network and fee schedule will apply. That said, if providers incorporated all of their contracts and terms into their a/r systems, they would be in a much better place to predict accurate recievables.

- Lastly, regarding product, we will need to settle on what constitutes a product as well as how it is to be used. Is a product what’s filed with regulators, which may have hundreds of variations with regard to actual covered benefits and patient responsibility. That information is highly volatile information that was specifically addressed as belonging to real time information available in the 271 response. In addition to what’s filed, there’s what’s marketed, what’s contracted for, etc.

- Finally, on granularity,

  With all due respect to my payer colleagues, the wisdom of enumerating all plan lines of business simply because of very complex internal business processes should be viewed with skepticism relative to administrative simplification. At its heart, the National Payer ID conversation is a small part of the broader conversation of supply chain integration in health care. As such, it requires process redesign on the part of all stakeholders in order to leverage the promise of standardized transactions within an eCommerce mindset.

On urgency:

- The AMA and others have mentioned that a decade has passed since the 4010 standards were mandated and many problems that could have been solved remain a huge issue for both payers and providers. It is my belief that with good intent, some are seizing the activity of moving forward with a National Payer ID as an opportunity to address some critical issues in the healthcare process community. I wholeheartedly agree that payers and providers need to collaborate to fix these problems but I respectfully suggest that encumbering the Payer ID with all this functionality is not just bad design but a solution that will add significant complexity to an already overly complex system and will, in my experience, certainly fail to achieve its objective.

- I say embrace the hard fought and won achievements of the original legislation. The notion that the National Payer ID is our best and only chance to deal with multiple issues runs contrary to the model suggested today by this committee that this is the first of many frequent leaps.

- One thing not emphasized today is that we must address the systems that providers are using in their offices to conduct these transactions. Many of these systems have not been updated in many years and are not capable of supporting the robust processes that are needed to eliminate paper in the administration of an office practice. There would be great value in bringing together heath plans, providers and vendors (EHRs, PMs) to discuss ways to raise the level of performance and capability – so that health plan's investments under PPACA are not lost because providers haven't made the necessary steps to automate. I suggest further hearings are warranted in these areas.

- On the issue of "if it aint broke..."

- Grandfathering of existing enumeration schemes, where feasible and reasonable to meet the goals ease, speed and efficiency of adoption does make some sense but we must beware the trap of assuming something is working now relative to the possiblility of the future.

- If by working you mean claims are moving from point A to point B, then yes it's working; but if your barometer for working is a system that leverages a well conceived enumeration plan for payers along side a web services based, electronically discoverable internet registry, then I believe one might draw the conclusion that very little of today's inconsistent, proprietary payer enumeration scheme is working to serve any of the stakeholders in service to a public good.

- In general, good system design is based upon a simple principle: Form follows function.

- As an example, spending money needlessly is not good form, on the other hand, implementing a sub-optimal design in order to avoid some ID card churn is not good policy.

- Regarding a registry

- In his remarks, Jim mentioned the importance of a registry. In my experience, a registry is about "connectivity", not product and contract information- 271,277 and 835 are the appropriate place for that information.

- AHIP is evaluating the feasibility of a payer sponsored registry to fill what is certainly an important need in payer to provider transaction exchange. To advance secure messaging nationally, a routing registry would create a library of health plan internet connection information (e.g., routing addresses, connection protocols, “trust community” association, public keys, etc.) and help transactions find their desired endpoint. The use of this technology will significantly open up the connectivity options available to health care providers, promote market competition between practice management systems and web portal vendors and, reduce administrative costs for both health plans and providers. Placing the burden of being a content repository for rich text would run counter to its core purpose.

- In conclusion, AHIP and Harvard Pilgrim wholeheartedly support the efforts of this committee to achieve real improvements via use of the National Payer ID. My own small hope though is that Harvard Pilgrim’s payer ID doesn’t look something like super califragilisticexpialidocious.

- Thank you.