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, members of the subcommittee, thank you for the opportunity to come here today to talk to you regarding Operating Rules for Eligibility and Claim Status.

My responsibility for Allina is to implement HIPAA regulations and process improvements for our clinics, hospitals, pharmacies, labs and other related specialty health care services to achieve administrative savings. I have experience working for health plans, a small provider group, and a clearinghouse.

I plan to cover the highlights of my testimony with the slide presentation. The detail below is more information that can supplement my verbal testimony.

Why do we need rules

- Standards are not really standard. It has been proven through multiple studies that the HIPAA X12 standards are not really that standard. Even with the newer version of 5010 we still have confusion on how to use the standards, how to use the codes, and how to pair codes to create meaningful messages to recipients of transactions. In addition standards have introduced a lot of complexity as data requirements have been added. There is an obvious lack of simplification when you go from a claim form with 33 fields to a standard that is over 450 pages.

- The standards body does not have the right people at the table. It is too costly for providers to attend three meetings a year, and the representation is heavy on vendors or non-users of the data.

- The standards process is too slow. The standards process is too restrictive to allow innovation or quick interpretation to keep us moving towards reducing costs. MN found major issues with 5010 in that the concept of patient did not carry from eligibility, to claims to remittance.

- The standards process does not create simplification. The industry will be challenged to understand how a subscriber (which can be a dependent in some cases according to new X12 interpretation), a dependent, a patient, and an insured - which might be all the same person - flow across transactions. A definition of one data type such as patient would achieve simplification. Why does a provider have to tell a health plan the status of the person which the health plan should know?

- The standards process is too confusing. As someone who has worked on this since 1995 even I find it hard to navigate. Do I go to X12, the DSMO, the external code committee (which exists on a web site), to NUCC, to NUBC? When I request an interpretation do I ask for a formal interpretation or informal? I just went through this and was told I should change my formal request to informal because a formal request would take up to a year. When asked why they don't publish the expected turn around I was told they are not allowed to make that part public.

What should be in the rules?

- Clarification of ambiguous terms or usage. For example what does it mean to a provider to learn that the patient has eligibility that has a date labeled as "Begin", or "Policy Effective", or "Eligibility Begin"? Why spend time mapping all those codes?
- Rules that use information gleaned from X12 HIPAA Interpretation Requests.
- Code tables that make sense and that clearly map into messages that can prompt automated action.
- Clarification of Medical Codes.
- Business rules around specific claim types e.g. DME, or Transportation.
- Technical instructions including transmission standards, response times, education on how to connect.
- Best Practices which explain other rules which are not formally adopted until they are proven to work.
- Forms should be standardized. (E.g. cover sheet for faxing claim attachments, Trading Partner Agreements, Prescription Drug Prior Auth Request or Prescription Exception Request.)

Timing of rules

- Rules and Health Plan ID should be created before we implement 5010.
    - Otherwise we will waste time, money and resources…..testing and testing and testing again.
- Ongoing Rule Development
    - Frequent Updates at least 1x year

Who should make the rules?

- Organization that is led by the users of the data (providers and health plans).
    - Equal representation
    - The users of the data are the only voting members
    - Request support and input from experts (clearinghouses, vendors, security, etc.)
- Formal organization
    - Mission
    - Guiding Principles
    - Policies
    - Membership Requirements
    - Offer meetings that do not require travel
    - Organized to expedite work but to ensure data users are able to participate
- Liaison with government and standards bodies

Benefit of Rules

- Allows true standardization
- Removes ambiguity
- Prevents adoption of other companion guides related to data requirements
- Involves the users of the data to make decisions
- Facilitates communication from user community to standards bodies
- Simplifies connectivity
- Establishes requirements to achieve simplification

Specific Recommendations about Eligibility and Claim Status

- Eligibility

    - An eligibility inquiry should be based on the data a provider or patient can read from their ID Card. 80% of eligibility verification for medical office visits occurs with patient on the phone or the patient performing on-line scheduling into the provider web-portal, which means there is not a way to use a Smart Card.
    - An eligibility response should answer all provider questions about patient financial obligations and be clear in its intent.
        - A response indicating eligibility is pending requires a follow-up call.
- Claim Status
    - We need the 277Claim Acknowledgment
    - We do not need the 276/277 inquiry and response. If we use acknowledgements and get the data right, why would a provider have to inquire with a 276?

Other Simplification Ideas

- Create certification body to evaluate compliance
- Coordinate with clinical (EHR/Meaningful Use) certification body
- Expand scope of simplification
    - Medical code sets
- Eliminate multiple bodies maintaining code sets and interpretations
    - External code sets (CARC, RARC, TAXONOMY, etc.)
    - NUBC
    - NUCC
- Enable operating rules to define new billing models
    - E.g. Medical Home