STATEMENT TO:

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

REGARDING:

Standards and Operating Rules for Claims Attachments

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SECURE HEALTH INFORMATION EXCHANGE

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We appreciate the invitation to participate in this dialogue around standards and operating rules for claims attachments.

We recognize that this issue is another in a long list of challenges to address in the larger context of developing and transitioning to a more connected and efficient industry.

Our goal in presenting today is to provide some perspective as an experienced industry leader active in the field of ideas in attempting to drive meaningful and valuable change in the area of clinical information exchange.

Introduction

During the past 16 years MEA|NEA has used our patent-pending Information Exchange Engine to store more than 100,000,000 electronic clinical documents and images, exchanging more than 2,000,000 documents and images per month between over 500 health and dental plans and 50,000 providers.

MEA's HIPAA-secure Information Exchange Engine enables payers to electronically request clinical information from providers, who use our *Fast*Attach® application to capture, index and store documents and images from any source (e.g., EHR, paper, PMS, PDF files or mobile images), and then transmits the human-readable documentation back to the appropriate destination via secure Web Services or a web-based portal.

Managed care organizations and vendors to those organizations use the MEA Information Exchange Engine to help address the logistical challenges of medical record requests and reviews for risk adjustment, quality measures, medical management and payment integrity processes, including claim attachments, as well as credentialing and other provider communication exchanges.

Presenting are:

Lindy Benton – **CEO** of MEA|NEA with over 29 years in healthcare delivery space including executive leadership positions with Cerner and Sage Healthcare.

Don Gerdts – **Vice President of Healthcare Information Services** for MEA | NEA has spent over 28 years in managed care administration including roles as Chief Information Officer of two large Medicaid plans and as partner in a management consulting practice.

As we consider the objective of developing operating guidelines to ensure the effective exchange of clinical information, we have found that there are three main areas of significance:

1. *The current state of Clinical information exchange*
2. *The formats and use cases of exchange*
3. *The significant and obtainable benefits of comprehensive exchange*

Current Challenges

The first challenge facing us as we pursue the definition of standards and operating rules is that the managed care industry does not generally exchange clinical information electronically today.

While significant strides are being made in the adoption and meaningful use of electronic health records, the industry is not generally advancing toward sharing clinical information, such as is needed between the point of care and the managed care organizations responsible for payment and outcomes measurements, resulting in dis-integrated business processes and systems.

Standards and operating rules can help provide guidance, but the different systems and nomenclature predominant among the stakeholder groups hinder connectivity.

Another industry challenge for lack of connectivity is that many managed care business processes, like risk adjustment and quality measurement for example, require the exchange of clinical information for which no standards or operating rules exist. Our experience is that more than 95% of these exchanges are accomplished, at least in part, via mail, fax and/or onsite abstraction. The electronic exchanges that do exist occur often in one-off, custom file exchanges between managed care organizations and their BPO vendors for services such as prescription benefit managers, laboratory, dental, and behavioral health management.

The primary reason that our company exists is to solve for the current state of obstacles that face the industry today. Our company has developed a simple, technology-agnostic, end-to-end, electronic solution for the exchange of secure clinical information that is time tested and produces the desired savings and efficiencies

The potential for savings and efficiencies notwithstanding, the current complexities of data collection produce missed opportunities for medical management, which potentially affects care outcomes.

In a study we commissioned in 2012, the extent of inefficiencies found in just the Claims denial process confirmed that despite all of the efforts underway to optimize via electronic medical records, back-office processes remain heavily manual and inefficient. For example:

- Greater than 90% of the processes involved in addressing denials are paper-based, fax and mail-supported steps which require human and time intervention.
- 13%, or an estimated $185M of annual revenue for a mid-sized community hospital is tied up in a complex, manual and often unsuccessful claims denial management process.

Due to the high resource requirements of the status quo, managed care organizations must make choices as to how much clinical information can be reviewed. There is simply not enough capacity to review all medical records to identify medical risk. Even if the capacity existed, the cost to accomplish the evaluations would be prohibitive. CMS Stars bonuses and optimized, risk-adjusted capitation are two examples that depend on efficient and effective clinical information exchange between stakeholders.

Now that we've explored the challenges faced today due to the lack of meaningful clinical information exchange, we would like to explore the applicable use cases and formats of clinical information that we believe should be an integral part of any discussion on standards and operating rules.

Broader definition and use cases needed

Due to the issues that identified above, I believe that the definition of attachments, when applied to standards and operating rules, should be much broader than just claim attachments.

Claim attachments are one practical piece of needed information sharing, but broader medical record information needs drive higher-value processes like medical management, risk adjustment and quality measurement.

In the millions of transactions we process at MEA|NEA, we see nearly as much volume of longitudinal medical record information requested by health and dental plans from providers as we do claim attachments. The requested information may be specific service information for quality measurement or the complete patient record for risk evaluation and the identification of medical management opportunities. To omit these use cases from consideration would be to solve only part of the problem.

In addition to broadening the definition of attachments, I'd like to suggest that human-readable documentation is necessary as we transition to comprehensive exchange of structured clinical data, which is a desirable ideal that we fully support. Human-readable medical documentation will continue to be exchanged for the foreseeable future, even with the advent of standards and operating rules for structured data.

MEA|NEA connects hundreds of trading partners to exchange the types of information we are discussing today. While many of them have plans to adopt standard transactions, only one actually uses X12 transactions for clinical documentation requests and responses and none exchanges clinical messages like HL7 Clinical Document Architecture.

Instead, all of our trading partners exchange electronic requests and responses with human-readable documents and images indexed with structured metadata. Approximately 40% of our clinical information exchange occurs with PDF documents with the other 60% with TIFF and JPEG payloads.

As one of the highest-volume Health Information Handlers for CMS's successful and growing esMD project, we would also highlight that PDF is the document exchange standard for the millions of pages of documentation exchanged between providers and Recovery Audit Contractors (RACs) through the CONNECT gateway.

Benefits

With a broad definition of formats and use cases in mind, I'd like highlight the significant economic, quality and efficiency benefits that can be realized by advancing clinical information exchange

Economic benefits

Electronic exchange of medical documentation measurably reduces hard costs associated with the request and collection of the information.

Using the current predominant methods of request, collection and processing, the average cost of medical record abstraction is approximately $30 per chart (actual contracted amounts by chart review companies in 2012), and the cost of claim attachments nears $5 per attachment (Source: Milliman survey for costs and transaction frequencies from "*Overhauling the US Health care Payment System*," McKinsey Quarterly, June 2007).

Transitioning from current methods to electronic request, acquisition and response of clinical documentation can remove $4-$7 per transaction from administrative healthcare costs. Given the hundreds of millions of claim attachment transactions and tens of millions of medical record reviews, the economic impact is significant and measurable.

Quality benefits

As you know, managed care organizations employ a number of strategies to address the health care needs of their covered members including case management, disease state management and quality measurement.

The last of these strategies highlights a need within the industry for better information to better reflect the actual effectiveness of health care. Years of producing HEDIS measures, for example, show that deficiencies in care quality are often a deficiency in accessible and complete clinical information and not an issue with the effectiveness of actual care delivery.

Electronic exchange of clinical documentation is already helping to bridge the "clinical information gap" between managed care organizations and health care providers. As more complete and accurate clinical data are shared among health care stakeholders, standard quality measurements being used today will more accurately reflect accessibility and effectiveness of care.

Efficiency benefits

In addition to financial efficiencies, our experience in a number of use cases of clinical information exchange shows that significant improvements are achievable in time and human resource efficiency.

One example of possible efficiencies is the use of electronic exchange for payment integrity purposes. The drive by CMS and commercial payers to ensure payment accuracy and appropriateness leaves providers to deal with time-sensitive audit demands, often 30-45 days turnaround, where the mandate is to respond effectively or lose revenue. Since 2009, CMS has recovered over $3B in overpayments through the RAC program, with approximately $2.2B coming in 2012 alone ("

. We believe that this acceleration will continue, driving even more need to end the paper chase.

The growing adoption by providers and vendors of our esMD services as well as similar interest shown by commercial plans and vendors supports this premise. Even without a mandate, providers are using and paying for these services, because they help to achieve improvements in the efficiency and effectiveness of their audit response efforts.

In a similar way, having a standard, electronic means for providers to receive medical record requests for quality measurement and risk adjustment and to respond to such requests from their desktops creates process efficiencies and eliminates the disruptions in patient care and operations that occur when the same review processes are repeated over and again for each of the provider's contracted payer relationships.

The business processes built around the sharing of clinical information in the status quo are substantially improved financially, qualitatively and efficiently with the incorporation of electronic clinical information requests and responses.

Conclusion

As we consider the objective of developing operating guidelines to ensure the effective exchange of clinical information, we have:

1. Explored the challenges that we face in the current state of clinical information exchange,
2. Proposed additional use cases and formats of exchange, and
3. Highlighted the significant and obtainable benefits of comprehensive clinical information exchange.

We sincerely believe that the opportunity lie in front of us to make more incremental improvement to the state of connectivity and information portability in the United States' healthcare enterprise.

Claim attachments are just one of several business process use cases that exist in parallel, and we believe that they can be addressed and the issues solved at the same time. As such, we encourage a broad definition and context for attachment standards and operating rules.

We would like to again thank the committee for inviting us to present on this important topic. For your information we have provided each of you with a supplemental document, which contains our testimony, responses to some of your more technical questions, and a copy of the case study mentioned during our testimony.