HBMA Testimony to NCVHS Standards Subcommittee on Proposed Revisions to Electronic Transaction Standards

January 18, 2023

Presented on behalf of HBMA by Arthur Roosa

Thank you for inviting the Healthcare Business Management Association (HBMA) to testify at today's NCVHS Standards Subcommittee meeting to discuss X12's request that the Subcommittee adopt the 008020 version of the 835 and 837 electronic transaction standards. HBMA is grateful for the opportunity to share the perspective of our members and our industry.

The Healthcare Business Management Association (HBMA), a non-profit professional trade association, is a major voice in the revenue cycle management industry in the United States. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

Arthur Roosa is the founder and former CEO of SyMed Corporation, a healthcare revenue cycle management company. He currently serves as its Chief Business and Technology Strategist helping to guide the annual submission of over one million insurance claims for physicians, outpatient clinics and behavioral health providers. The company additionally develops software for other RCM businesses. He has been a longtime advocate for integrity in the Medicare and Medicaid programs, receiving an award from the California Department of General Services for identifying Medicaid fraud which saved California several million dollars.

The RCM industry heavily relies on the 835 and 837 electronic transaction standards. These transaction standards allow us to better serve our clients' revenue cycle management needs. HBMA is generally supportive of the proposed revisions outlined in X12's letter to the Subcommittee. These revisions will bring needed modernization and improved capabilities which will reduce administrative burdens on RCM companies and providers.

For example, we are particularly supportive of the proposal to expand the Provider's Assigned Claim Identifier (CLM01) to 35 characters. This will greatly improve our ability to reassociate remittance advice with specific items on a claim, particularly in an environment such as RCM companies where multiple providers and multiple legal entities may be reported within a single 835 envelope.

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We also support how the revisions attempt to improve the utility of RARC and CARC codes. Payers inconsistently use RARC and CARC code combinations. These codes will be more useful if they are used more uniformly across the entire payer landscape.

While we are generally supportive of these revisions, we believe some additional clarifications are needed for certain proposals. For example, we support the concept behind more detailed source of payment codes. X12's letter did not provide specific information about what additional information will be included under these changes. We believe it is important for these codes to provide clear information about the payment source, especially when paper checks may be involved.

We agree with X12's description of the "challenges of a lengthy Federal Rule-making process that doesn't always operate at an expected cadence and the standards development organizations' continuously evolving standards." We support transitioning to the 8020 version of all electronic transaction standards. However, we caution that this transition must be gradual and predictable. Transitioning too aggressively will be too burdensome on RCM companies and other stakeholders. We suggest that X12 works with the Subcommittee to provide a more detailed plan to stakeholders on expected upgrades to other transactions so that the industry can prepare accordingly.

Lastly, and most importantly, standards are only as effective as the enforcement behind them. Our members have long been frustrated by noncompliance with these standards on the part of health plans. We have also found that the Centers for Medicare and Medicaid Services (CMS) enforcement process is often ineffective. It can take years between a complaint being filed and a health plan taking the necessary corrective action. What's more is that these corrective action plans do not always result in the health plan correcting the cause of the complaint.

We recognize that NCVHS does not have the responsibility to enforce standards. However, we encourage NCVHS to work with CMS to ensure these standards are strongly enforced.

Thank you again for the opportunity to provide our input on these important revisions. We agree with the need to modernize electronic transaction standards to improve their capabilities and maximize their ability to reduce burdens on providers. The technical standards discussed in this hearing are only the beginning of the conversation. We hope to see a robust enforcement framework accompany the adoption of these revised standards.

Please do not hesitate to contact Arthur or HBMA Executive Director Brad Lund (brad@hbma.org) if you wish to discuss HBMA's suggestions in more detail.