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Testimony of the

American Hospital Association

before the

National Committee on Vital and Health Statistics'

Subcommittee on Standards

"Hearing on Adopted Transaction Standards, Operating Rules, Code Sets & Identifiers"

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Good morning, distinguished members of the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Standards. I am George Arges, senior director of the health data management group at the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the AHA appreciates the opportunity to testify regarding the adopted Health Insurance Portability and Accountability Act (HIPAA) transaction standards, code sets, identifiers and operating rules.

We are pleased that the committee is taking this opportunity to evaluate the extent to which the HIPAA administrative transactions support claims-related routines. The AHA believes that while the claim submission transaction has clearly experienced widespread adoption and brought benefit, there are significant additional savings to be realized through better use of the other standards, and particularly the remittance standard that outlines the information providers receive back from a payer when a claim is paid. The AHA is prepared to engage with other stakeholders to identify the barriers to widespread use of the administrative transaction standards and craft solutions to accelerate greater use of the electronic administrative transaction standards.

Below, I outline our responses to many of the questions posed by the committee.

DO THE CURRENT HIPAA TRANSACTIONS MEET THE BUSINESS NEEDS OF THE INDUSTRY?

Out of seven named transactions (premium payment, enrollment, eligibility, prior authorization, claim status, claim and remittance) only the claim has reached more than 90 percent utilization. All of the others fall significantly short of this level. However, we can realize greater promise for

business needs if improvements are made to information reported within each of the other standards. Additional efforts with data content committees like the National Uniform Billing Committee, National Uniform Claim Committee and the American Dental Association's Dental Content Committee are needed to build an understanding among providers and health plans on the information or data that are needed to process a claim efficiently.

DO THE STANDARDS, CODE SETS AND IDENTIFIERS ADOPTED FOR EACH TRANSACTION MEET THE CURRENT (AND NEAR-TERM) BUSINESS NEEDS OF THE INDUSTRY?

The AHA recommends enhancing the operating rules to require balancing of the remittance to help alleviate many of the problems providers currently face with the remittance. The standards, code sets and identifiers adopted for each transaction generally can or do meet the business needs of the industry; however, much of the information is not user friendly and requires introduction of additional edit logic for the information to have meaning for computer processing. For example, the remittance standard, which guides the payer's report back to a provider once a claim has been approved for payment, has the ability to convey information about the adjudication of the claim and the type of adjustments that were applied. A remittance advice that balances is one that accounts for all of the adjustments made to the billed amount along with the payment made. However, many health plans fail to submit a remittance advice that balances or they use a default code to force the balance. Failure to balance the remittance requires the provider to undertake additional work to follow-up, generally involving a phone call to health plans to determine exactly what adjustment is missing. Ideally, health plans should take the added step of ensuring that the remittance advice balances before it is sent. Providers do not have much leverage in this process. For example, adding a front-end edit to reject remittance advices that do not balance harms the provider because it would further delay the information about the adjudication of the claim.

Before adoption of the electronic standards, providers generally received paper remittances that balanced and were useful in posting to a patient account. The electronic standard can contain more information about the adjustments made and could be better than the balanced paper remittances. For example, the next version of the remittance standard will list all of the reason codes that apply to an adjustment. Given that the transaction standard for remittance has the ability to carry all of the information needed, health plans should be required to provide a balanced remittance advice. Doing so should not be complicated since many of the adjustment reason codes fall into six general categories – total billed, amount not covered, discounts or allowances, patient deductible, patient co-insurance and amount paid. These categories should provide the appropriate information needed to explain the adjustments within the remittance, and additional adjustments that are lump sum or take backs that are not patient specific should be handled separately.

ARE THERE STUDIES, MEASUREMENTS OR ANALYSIS THAT DOCUMENT THE EXTENT TO WHICH THE TRANSACTIONS AND THEIR CORRESPONDING STANDARDS, CODE SETS, AND IDENTIFIERS AS ADOPTED HAVE IMPROVED THE EFFICIENCY AND EFFECTIVENESS OF THE BUSINESS PROCESS?

The CAQH Index report reliably tracks how the standards are used, where we have seen improvements in the efficiency and effectiveness of the business process, and areas for additional

savings. The CAQH Index report indicates that $8 billion could be saved if the transaction standards were routinely utilized. These savings are substantial and worth pursuing.

The report provides valuable information about the utilization of each transaction standard, including rates of adoption of the standards by health plans and providers, as well as an estimated monetary measure of what can be achieved with greater adoption. According to the report, the cost for manual transactions averaged about $2 per transaction for the six remaining transaction categories; while the costs of electronic transaction ranged from about $0.05 to $0.10 per transaction. The transaction with the highest savings per transaction from use of the electronic standards was prior authorization – nearly $13 per transaction.

The latest CAQH Index report indicates that even with significant savings from a switch to electronic transactions, only the claim standard has widespread adoption. Therefore, additional examination to identify why the electronic percentages are not higher for the six remaining transactions is warranted. Finding a solution that increases the utilization of the transaction standards will require a collective and cooperative approach between health plans and providers to identify and address the barriers and gaps that prevent greater use of the electronic administrative transaction standards.

The CAQH Index report also identifies other mechanisms that are utilized instead of the HIPAA transactions, such as web portals, phone or fax. We must determine why these other mechanisms are used and why the electronic transaction standard is not the first choice so that changes can be made that ease use. For example, if information is missing within the X12 standard, we need to identify the information and include it in the standard. If the transaction standard has the ability to carry the information but essential information is routinely missing when data are exchanged, we may need to educate users on the importance of providing this information and having additional operating rules to foster greater consistency in the reporting of the information within the standard.

More progress must be made to increase the use of all the electronic administrative transactions to at least the level of use as for the claim standard. We recommend that NCVHS investigate barriers that are preventing greater utilization of these standards and identify solutions. Based on input from our member organizations, the AHA believes that possible solutions include:

- adoption of the acknowledgment standard as a HIPAA standard;
- modification of the existing standards to include needed information;
- better operating rules for the standards to ensure all parties are using them in the same way; or
- additional education of users – both covered and non-covered entities – on the importance of the standards and how they work.

By statute, covered entities under HIPAA are required to adhere to the standards; whereas, non-covered entities such as vendors or employers are not. This mismatch in responsibility creates significant challenges for providers, as vendor products may not be able to handle all of the information in a standard and employers may not provide all of the needed data. Contracts between a hospital and vendor can include language that the vendor must have products that

adhere to federal requirements as put forward within the transaction standards and to do so within the compliance date. However, providers cannot always control the contract terms and may need more support on how best to structure contracts or to have reliable resources that score vendor readiness through compliance and certification testing. Although employers are non-covered entities, they need to be made aware of the importance of the transaction standards and understand the importance of their role in providing and maintaining timely enrollment information to health plans**. To increase utilization of the standards, the AHA recommends that the Department of Health and Human Services (HHS) appoint a multi-stakeholder group that can produce additional instructional materials outlining reporting requirements and provide examples. These instructional materials could be included in the transaction guides or as part of frequently asked questions. Additionally, HHS should name an organization that can certify a process to ensure that all entities adhere to the standards and associated operating rules.**

WHAT CHANGES SHOULD BE MADE TO THE CURRENT TRANSACTION STANDARDS OR THE MANDATE TO USE THEM?

Rather than discuss what changes are needed to the transaction standards, we first need to understand why the existing transaction standards do not have greater utilization. We recommend a process that utilizes the CAQH index as a dashboard that annually measures progress. One approach is to target one or two transactions for improvement and work to achieve a certain level of improvement with real progress and meaningful utilization of the standard. **The AHA recommends a collective approach along with development of a tool that can measure compliance with each of these standards and associated operating rules. A certification process that can validate adherence to the standards and utilization of operating rules that define best practices for that standard are needed.**

In addition, we recommend NCVHS designate an entity to create a collaborative multi-stakeholder approach that engages providers, health plans, clearinghouses, vendors and employers. Questions to be answered include:

- What is missing in each standard?
- What procedures or business routines need to change to enhance use of each standard?
- How can we achieve greater utilization of the transaction standards?

CONCLUSION

Over the past several months, the AHA has undertaken an examination of the administrative simplification provisions of HIPAA and the Affordable Care Act. We are working on a paper that will help hospital leaders to better understand the importance of administrative simplification. We solicited help from hospital leaders in the development of this paper, and we have already gained valuable insight into the potential benefit for full adoption. For example, one hospital leader said, "*transactions have value well beyond Administrative Simplification; conglomerated sources of information drive clinical and business decision-making.*" Another hospital leader said, *"Administrative simplification enabled us to shift 15 percent of the revenue cycle workforce to key eligibility verification and collection functions."* These clearly show real world benefits, but more work is needed to remove the barriers and achieve greater utilization of

the other transaction standards. It will require cultural, operational and policy changes. It also will require better working relationships with trading partners to remove barriers and provide greater transparency in the sharing of administrative data, better understanding of the importance of removing redundancy of effort, and work to improve the process flow for sharing timely and accurate administrative information. The CAQH Index should be used to monitor future progress and create a renewed effort to increase the utilization statistics for the transaction standards by improving the standards and establishing meaningful operating rules that increase the utilization of the standards.

Thank you for the opportunity to participate in this panel discussion. The AHA looks forward to working with NCVHS and others to achieve greater utilization of the HIPAA standards.