

**Testimony of the
American Hospital Association
before the
National Committee on Vital and Health Statistics
Subcommittee on Standards
February 16 – 17, 2016**

**“Hearing on HIPAA and ACA Administrative Simplification Phase IV Operating Rules
and Attachment Standard”**

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 nearly 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 Phase IV Operating Rules for selected HIPAA transactions (enrollment/disenrollment, premium payment, health care claims and prior authorization), as well as the proposed Claim Attachment standards and code sets.

I also wanted to share our recent [TrendWatch](#) report titled “Administrative Simplification Strategies Offer Opportunities to Improve Patient Experience and Reduce Costs.” Since the passage of the Health Insurance Portability and Accountability Act (HIPAA), we have seen widespread of adoption of the claim transaction standard, which has resulted in savings of \$2.3 billion annually since 1996. However, other transaction standards, such as eligibility and benefit verification or prior authorization, have not seen the same level of adoption. We developed this brief to highlight the benefits that would occur if these standards were fully adopted. Greater utilization of the standards can support more information sharing between health plans and providers, a key benefit for organizations participating in emerging care models such as payment bundling and accountable care organizations. Greater dialogue between providers and health plans also can help promote timely sharing of meaningful data, while simultaneously reducing paperwork burden and promoting greater efficiency. These standards also provide tangible benefits for patients, by including real-time insight into an individual’s financial liability in advance of undergoing a potential course of care. In addition, it is estimated that \$8 billion could be saved annually. The need to share administrative health information on a timely basis, while simultaneously working to reduce paperwork burden and promote greater efficiency in the



exchange of information, are goals we should all support. Transaction standards and operating rules working together can move us closer to these goals.

Our responses to some of the many questions posed by the committee follow.

Do The Standards/Operating Rules Meet the Industry’s Business Need/Use/Problem Resolution?

HIPAA introduced administrative simplification as a series of inter-related transaction standards aimed at improving the efficiency and effectiveness of communications between health plans and providers through the adoption of common standards. The value of the transaction standards is that they normalize the collection and report of information around a specific exchange of data. Each of the standards adopted by the Secretary of the Department of Health and Human Services (HHS) is meant to increase the timeliness of data exchange.

Electronic transaction standard type	Who is the information communicated to?
Insurance enrollment	Employer to health plan
Premium payments	Employer to health plan
Patient eligibility and benefit verification	Hospital to health plan; health plan to hospital
Request pre-approval for certain services	Hospital to health plan; health plan to hospital
File claim for services rendered to patient	Hospital to health plan
Request information on claim status	Hospital to health plan; health plan to hospital
Request and supply additional information for claim	Health plan to hospital; hospital to health plan
Receive remittance advice and electronic payment	Health plan to hospital

American Hospital Association. “Administrative Simplification Strategies Offer Opportunities to Improve Patient Experience and Reduce Costs.” January 2016.

To further the utilization of electronic standards, the Affordable Care Act (ACA) mandated the creation and adoption of operating rules for all applicable HIPAA transaction standards by the end of 2016. Operating rules do not change the underlying HIPAA standards, but reduce inconsistency in the data reported and describe specific scenarios for when certain data should be used. The CAQH Committee on Operating Rules for Information Exchange (CORE) has led the effort to establish operating rules through broad stakeholder engagement.

The efforts by CAQH CORE have demonstrated early on that engaging on a particular transaction can lead to improvement. For example, the eligibility transaction originally lacked important information. CAQH CORE encouraged many of the health plans to provide additional information about patient eligibility, including details such as deductibles and co-pay amounts that enhanced the value of the information exchanged. Today 95 percent of health plans support the eligibility inquiry, whereas provider utilization is around 69 percent. Such information is vital not only to providers, but to patients as well. Through the efforts of CAQH CORE, we were able to improve the way the standard should function in terms of information provided and the timeliness of the response. CAQH CORE also has undertaken an examination of the remittance advice and developed operating rules that seek to further a better understanding of the adjustment reason codes that should be reported when the claim is processed. They also spoke of the importance of re-association of the remittance advice to that of the electronic funds transfer (EFT). We need to do more to encourage hospitals and others to understand the significance of the re-association and encourage them to enroll and receive EFTs.

However, as we noted in last year's testimony, only the claim standard has reached more than 90 percent adoption; all of the other six named transactions fall significantly short of this level. Based on the low utilization of the other standards, there is definitely room for improvement. As we stated last year, it would be helpful to prioritize several of these other standards to improve their overall utilization.

Do the Standards/Operating Rules Decrease Cost and/or Administrative Processes?

As noted above, for transaction standards to work as intended, they must be accompanied with a set of operating rules that provide greater understanding about the information that should be consistently reported and to establish performance expectations that allow greater efficiencies in processing this information. Such results do not magically happen – they take provider and health plan engagement. Working together is the key in bringing about a better understanding of the standard and the performance expectations that make it work.

The operating rules have led to some improvements, such as those from the connectivity rule. This operating rule establishes a performance response requirement to ensure timely processing. It also sets additional requirements that further boost the effectiveness of the transaction. As indicated earlier, the operating rules on eligibility provided information about deductibles and co-pays, as well as remaining patient responsibility amounts.

Phase IV refers to the most recent effort by CAQH CORE to establish operating for the remaining transactions. To meet the regulatory requirements, the effort had to focus simply on the connectivity requirements. Connectivity rules are a good starting point; however, more can

be done to improve the understanding and responsibility users must have to each of the remaining standards. To improve utilization of the standards among users, it would be helpful if health plans and providers could work collaboratively to explore how to improve utilization. For instance, it would be helpful to examine whether users of the standards have the ability to work with all of the external code sets referenced in the standard. Doing so would bring about better efficiency in the use of external codes. By way of example, the institutional claim standard relies on external code lists. For instance, Occurrence Codes describe a significant event relating to this bill – such as the “date treatment started for Cardiac Rehabilitation” – or the reporting of Value Codes that provide a monetary, measure, or value necessary to process the claim. Another more familiar external code list is the ICD-10-CM codes used to describe disease or illnesses. **To facilitate electronic exchange, it is important that the users of the claim standard demonstrate that they are up-to-date with the most recent code list for that standard and know how to apply that code when it is reported within the standard.** Otherwise, it slows processing of the claim.

Is the Standard/Operating Rule Flexible/Agile to Meet Changes in Technology and/or Healthcare Delivery Systems?

The existing standards are not as agile as they could be. We know that the process for introducing new changes to accommodate new medical technology and/or changes that reflect new delivery system models can take years before they are incorporated into the standard(s) and then brought forward for consideration as a new HIPAA standard(s). Designing the standard to have greater reliance on external code lists would make the standard more agile in terms of implementing new changes for capturing and reporting new information without having to alter the design of the standard. This would create greater flexibility within the standard to accommodate new approaches to the delivery of medicine, as well as new payment models. New all-inclusive and bundled payment models are rapidly emerging that are designed to simplify the process while establishing tighter controls on the outcome of care at the site of care.

Other Questions Involving the Standard and Operating Rules Regarding Completeness, Efficiency, Complexity, Flexibility, Consistency, Effectiveness and Ambiguity

One major theme throughout the questions has to do with whether the standards are meeting business needs. Meeting the business need of one entity can result in reporting requirements that are costly and burdensome to another. To guard against this, HIPAA named four organizations that “must be consulted with in the development of the standards.” The reason for this requirement is to ensure that the introduction of new reporting requirements are considered by the two groups most affected by the standard – namely providers and health plans. The HIPAA legislation recognized the importance of having checks and balance in the review between provider and health plan representatives. The purpose is to weigh the benefit of a change against the burden.

We must not lose sight of this section of the legislation, which is very clear that consultation should occur in the course of development of new standards. Without safeguards, the standards development process can unduly introduce a new requirement that is so costly to one sector that it would jeopardize administrative simplification.

Viewpoint on the Proposed Standard for Attachments

The time for utilization of the attachment standard is overdue. The attachment standard is designed to provide supplemental medical documentation to support information found on the claim but cannot be accommodated within the format of the claim. It is intended to meet specific informational needs that are unique to a health plan's review or adjudication of the claim. Our concern is that providers are confronted with a variety of different proprietary approaches from health plans for supplying attachment information. Having a claim attachment standard named as a HIPAA standard would alleviate the burden of having to deal with the vast assortment of health plan approaches for supplying additional information.

Additionally, because the attachment standard relies on external code lists to identify the nature of the information being transmitted, it is very agile and capable of adapting to changing technology or new payment models. The claim, as it is presently designed, is not agile.

The attachment also serves as a vehicle to pull information from medical records; the information can be structured or unstructured. Consequently the cost to report supplemental information via the attachment is much lower than trying to modify existing legacy billing systems to report additional "ad-hoc" information on the claim. It should be noted that, when information found in the medical record is identified as one of the meaningful use requirements, it will then meet the HL7 requirements and can be designed to be machine readable, making its use even more efficient.

There are several caveats that should be included with adoption of the claim attachment:

- Instructions for information needed on the claim attachment must be clear so that processing of the claim is not delayed unnecessarily.
- The pre-authorization standard must be fully supported by health plans so that it can serve as basis for identifying any unique reporting needs that could be communicated early on as an attachment submitted at the same time as the claim.
- When a claim is submitted and the health plan notices that more supporting information is needed, the health plan must communicate back in a timely fashion the nature of the supporting information it needs to complete the adjudication and expedite payment.
- The number of attachment requests per claim need to be limited to a reasonable number – perhaps two – and should be done in one request not multiple requests.
- Additionally, a request for additional information using the attachment should never include information that is already reported on the claim standard.

Other than these caveats, the claim attachment has an important purpose and function. **We therefore urge the NCVHS to move forward with a recommendation to adopt the latest version of the claim attachment (ASC X12 275) as a HIPAA standard.**

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