Written Statement of Rhonda Starkey
On Behalf of Harvard Pilgrim Health Plan and America's Health Insurance Plans
to the
ACA Review Committee
Regarding Health Care Claim Status
June 17, 2015

Introduction

Good afternoon. I am Rhonda Starkey, Director of eBusiness Services at Harvard Pilgrim Health Care, Boston, Massachusetts. The eBusiness Services team manages all provider self-service connectivity and transactions including the provider web portal and all EDI transactions for eligibility, claims status, claim submission, remittance advice and referral, authorization and notification. We are CORE I and II certified.

Harvard Pilgrim Health Care is one of the nation's leading not-for-profit health services companies, providing a variety of benefit options and funding arrangements to more than one million members in Massachusetts, Maine, New Hampshire and Connecticut. Harvard Pilgrim's mission is to improve the quality and value of health care for the people and communities we serve.

Today I am providing testimony on behalf of Harvard Pilgrim Health Plan in coordination with America's Health Insurance Plans (AHIP). AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our industry processes millions of claims, eligibility requests, payments and other administrative and clinical transactions on a daily basis.

Overview

Harvard Pilgrim has supported the use of the 276 claims status transaction for 15 years. We observed a marked shift in claims status use beginning in 2009 with the plan's CORE I and II certification. Prior to certification, our provider web portal use represented 82% of all claims status inquiries, with a slowly declining use rate beginning in 2003. By 2009, 68% of claims status inquires were portal-based, 24.5% of inquiries used the 276 claims status transaction, and paper, phone and fax requests accounted for 7.5% of inquiries. During the first two years under CORE certification, portal use rate fell from 68% to 57% of inquiries with a corresponding increase in the rate of 276 claim status use from 24.5% to 38% of inquiries. As of year-end 2014, portal transactions have further reduced to 49%, 276 claims status use rate has increased to 46.5%, and paper, phone and fax are 4.5% of inquiries. Our volume of 276 claims status transactions is 2.2 million annually. The increase in use rate of the 276 claims status we experienced was driven entirely by the volume increase of the transactions. Portal, paper, phone and fax volume has remained relatively constant. The ability of the health plan to sustain

increases in transactional service growth with no corresponding increase in resources underscores the administrative cost effectiveness for the plan.

Harvard Pilgrim consistently seeks to maximize the use of administrative transactions and their standards with external partners as well as within plan operations. Internally, we have found value in the use of the claims status code sets. All claims status responses, whether through the web portal, the 277 claims status response, or phone inquiry, utilize the claims status transaction's category and group codes. This provides consistent responses across all methods of inquiry and reduces administrative maintenance requirements. It also reduces the need for users to utilize multiple routes of inquiry and requesting assistance to resolve differences in status results.

Efficiencies in Onboarding Trading Partners

A tangible benefit of operating rule implementation has been efficiencies gained in on-boarding trading partners to conduct eligibility and claims status transactions with Harvard Pilgrim. Prior to use of operating rule standards, connectivity with trading partners was largely through point-to-point, virtual private networks and on-boarding with trading partners averaged 50 business days. In our first experience on-boarding a CORE-certified vendor using defined connectivity standards, the implementation time was a record 15 business days – a reduction to less than one-third the time previously experienced. On an ongoing basis, we have sustained an on-boarding time at below half of the plan's historical time of 50 business days and we experience fewer documented issues with connectivity and connectivity maintenance than with other connectivity methods.

Use by Providers and Third Party Vendors

Harvard Pilgrim has experienced varying degrees of uptake of the claims status and eligibility inquiry transactions across providers and third party vendors. Vendor use of the claim status inquiry has increased from one third party entity, which performed less than 1% of our claims status inquiries, to five third party entities representing 67% of all of Harvard Pilgrim's claims status inquires. For eligibility inquiries, we began with five initial third-party vendors who performed less than 1% of claims status inquiries. As of 2015, we now have 17 third party vendors performing eligibility inquiries, representing 40% of our eligibility inquiries; the remaining 60% are performed by providers.

Our health plan has realized administrative value in using the claims status transaction; however, we see strong evidence that health care providers are still working to find value from the transaction. First, we have not seen any marginal or significant change in volume of portal, paper, phone and fax inquiries. In discussions with our provider phone service center, they do not find any differences in the content of claim status calls now compared to historical calls that might explain the consistent volume. Second, while all entities that perform claims status inquiries with Harvard Pilgrim also conduct eligibility inquiries, not all entities that perform eligibility inquiries also engage in claims status inquiries. All 17 entities that perform eligibility inquiry with our plan have the capability to perform claims status inquiry, yet only five entities

do. Despite these gaps, because these entities already have the capability to support the claims status transaction, we anticipate that we will see continued growth in its use. Finally, we reviewed call center records for one third party entity as well as for two provider entities who submit weekly or bi-weekly batch claim status inquiries on outstanding claims. In all cases we found the entities continue to use the provider call center for claims status in parallel with the electronic claims status inquiry.

Challenges Impacting Adoption

We have observed several challenges impacting adoption of the 276 claims status transaction:

- Our business users have raised concerns about the differences in the adjudication reason results reported in the claim status transaction compared to the electronic remittance advice. The differences in code sets causes confusion with users in many accounts receivable groups with whom we work when different codes are used describe the same issue across different standard transactions (276 vs. 835).

- Business users have misperceptions regarding to what information is communicated in the claims status response. Providers have looked to the claims status response transaction to post claim adjudication items communicated in the 835 electronic remittance advice. In particular, we receive requests for items communicated in the provider level adjustment (PLB) segment, which are not components of the claims status response. We also receive frequent questions as to why patient responsibilities are not included in the claim status response. Better education and alignment across these two standards may be needed.

- Providers or third party entities fail to fully utilize claim receipt acknowledgement information, regardless of whether claim receipt information is in a proprietary format or the 277 claim acknowledgement. Claim acknowledgement information from the payer does not always reach the provider who submitted the claim when an intermediary is used. As a result, providers subsequently submit a second claim status inquiry related to claims for which a response with a rejection status, and the reason for rejection, has already been communicated. A more effective and efficient process would be for payer acknowledgements to be fully shared with and acknowledged by the provider so that swifter action can be taken to address any claim submission issues, rather than delay until a claims status inquiry is performed some time after claim submission.

Recommendations

We have identified several opportunities for improvements in the business processes, including:

1. Adopt the 277 Health Care Claim Pending status information transaction. Many states mandate that pended claim information be provided, including requirements that information occur through written communication. However, with the increase in use of 835 electronic remittance advice and electronic fund transfer, reporting pended claim information is a vestige of paper-based activity still remaining in the claims cycle.

Adopting the pended claim transaction would further reduce administrative costs through timely notification to providers of pended claims while reducing paper management costs of printing, mailing, and filing.

2. Implement operating rules for content of the claims status response. We have observed a reduction in code maintenance efforts for the electronic remittance advice with the defined code combinations for the transaction. We anticipate that adopting defined code combinations for the claim status transaction would result in similar benefits and also address business user questions on valid code use in the claim status transaction.

3. We would support industry efforts to increase the business understanding of the claim status inquiry and response standards, their purpose and role; however, it may be more productive to focus efforts on the other critical activities in the service and claims cycle to ensure they are functioning efficiently before focusing on the claims status transactions. Our recommendations include:

    - Effective use of the eligibility inquiry reduces the volume of pended or rejected claim;
    - Moving referral, authorization and notification services from paper to automated transactions will reduce claim adjudication issues;
    - The submitted claim acknowledgement, when fully consumed, would allow the provider to quickly address any claim rejection issues.
    - Implementing the outbound pending claim status would keep providers effectively informed instead of relying on the 276/277.
    - And robust understanding and consumption of the electronic remittance advice reduces need for claim follow-up including claim status inquiry.

Additional Industry Perspective

AHIP recently conducted a survey of its member plans to solicit broad industry perspective on the status of adopted standards and operating rules being evaluated by the ACA Review Committee. Twenty plans responded to the survey, representing major medical carriers (18), dental carriers (10), Medicare payers (10), Medicaid health plans (9), as well as plans offering long term care, behavioral health, or vision benefits (7). Most of the responding health plans (13) offer coverage in multiple states and estimated their number of covered lives ranging from under 100,000 to over 10 million (20% estimated their covered lives between 100,000 to 1 million, 20% between 3 million to 5 million, and 30% over 10 million). A summary of the responses related to prior authorization.

AHIP's survey found that most health plans do not think that the current 276/277 standards meet their business needs – with 56% indicating it only somewhat meets their needs and 11% indicating it doesn't meet their needs at all. Plan responses specifically focused on the need for additional specificity in the standard and the existence of other electronic alternatives that are more robust as barriers to broader adoption.

Twenty percent of plans who responded to AHIP's survey cited lack of specificity as one of the primary barriers for the standard. Currently, stakeholders use and interpret claim status responses differently, especially in real-time (e.g., in provider portals). Plans specifically noted that the transaction does not indicate to providers when the claim will be paid if it is in a pended status, resulting in phone calls when the expected response is not received. Code sets need to be developed to allow more specific status reasons and additional clarification in responses. Plans recommend that use of the standard would increase if operating rules were developed with guidance and business scenarios to standardize code uses on the response (similar to HIPAA 835 CARC/RARCs), including the combination use of X12 277 Claim Status Category Code and Claim Status Code to provide consistent detailed information back to the provider/submitter.

Because of lack of specificity in the response, plans indicated that stakeholders are trending toward alternate options, both manual (phone, fax) and electronic. Survey respondents commented that existing payer-specific tools offer more search options and proprietary information on why a claim is pended, serving as more robust and efficient alternatives to meet current business needs.

Closing

Harvard Pilgrim Health Plan has experienced benefits of claims status transaction use and of operating rule connectivity standards. Progress in meeting business use is growing and has further potential for growth. We strongly recommend the Subcommittee focus its recommendations on the need for new operating rules on claims status inquiry content and to implement the health care claim pending status transaction.

We thank the Subcommittee for the opportunity to submit this testimony for the record.