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Testimony of the

American Hospital Association

before the

National Committee on Vital and Health Statistics

Subcommittee on Standards

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"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 to 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.

AMERICAN HOSPITAL ASSOCIATION
JANUARY 2016

TRENDWATCH

Administrative Simplification Strategies Offer Opportunities to Improve Patient Experience and Reduce Costs

The health care system suffers from an overabundance of paper work. Hospitals and health systems can realize improvements and significant savings by increasing the volume of electronic data exchange called for under the Health Insurance Portability and Accountability Act's (HIPAA) administrative simplification provisions. HIPAA adopted a series of administrative transactions standards that enable hospitals and health plans to communicate with one another electronically. These standards specify what key information, such as a patient's eligibility for benefits or the amount that remains on a patient's annual deductible, should be included in a specific transaction type.

These standards 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. 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 (ACOs). 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. While significant savings have been already achieved, it is estimated that an additional $8 billion annually could be saved if health care organizations fully implement these standards. Providers stand to gain the greatest savings, according to the Council of Affordable Quality Healthcare (CAQH), with $7.2 billion of the savings accruing primarily to them.[1]

The benefits of administrative simplification fall primarily into three major categories:

- Quality
- Timeliness
- Cost reduction

Administrative Simplification

- Reduces the paperwork burden for providers and patients
- Prepares the field for health reform changes in reimbursement by better integrating financial and clinical data
- Helps patients learn about their financial obligations up front

Quality

Quality efforts are supported by improvements in standardization of terminology and data accuracy. Claims data is becoming more standardized with an emphasis on clinical components; it also is increasingly being used to evaluate health care quality and make risk-based decisions in value-based purchasing. For these reasons, more accurate and complete data are critical. Business routines that improve on the policies and procedures for transactions around coverage, billing and payment also ensure greater accuracy in the transactions to achieve cleaner claims, resulting in less rework.

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Timeliness

Timeliness benefits result from data that move quickly from source to destination, often for real-time answers to questions about patient insurance benefits and the status of a claim sent to a health plan. The data is properly formatted and structured to allow it to be utilized in decision making, such as coverage considerations or meeting medical necessity criteria. The operating rules provide standard denial reason codes that enable providers to efficiently determine which denied claims to rework. Such processes avoid errors that often delay processing and payment functions.

Cost Reduction

Cost benefits largely derive from gains in efficiency. Clerical savings accrue by allowing information to automatically post and applying edit logic to enable proper processing and resolution of claims, verification of patient eligibility for insurance benefits, and other needed steps. For example, remittance information from an insurer allows a provider to correctly post and handle payment for a claim, and to do so automatically. It is estimated that the U.S. health care delivery system spends 15 to 32 percent of each health care dollar on the types of administrative costs that would be streamlined through the adoption of the HIPAA transactions standards and operating rules processes.[2] The Center for Medicare and Medicaid Services' (CMS) latest figures from the National Health Expenditures report (2009) reveal that such costs are split evenly between providers and health plans.[3]

The health care system stands to save significantly by fully embracing electronic transmissions. Much has been done to simplify the administrative processes and provide common standards; however, much more needs to be done to increase the routine use of the standards across the system and improve the reported information. Hospital administrators, regulatory bodies and policy makers should actively seek opportunities to improve and simplify the transactions.

The Importance of Administrative Simplification for Patients

Increasingly, patients are bearing a larger portion of the cost of their health care, due to the increasing prevalence of high-deductible health plans and rising copayments and/or coinsurance obligations. Because of the increasing level of cost sharing, patients are more price-sensitive and often find estimates of their out-of-pocket costs more useful than any other kind of health care price information.[i] However, it can be difficult for patients to get a complete picture of their cost-sharing responsibilities in advance of treatment, as the process to procure information regarding coverage and patient liability prior to the advent of operating rules typically consisted of a paper-based, manual process that involved continual hospital staff intervention, including calling health plans for verification of benefits.

Converting these types of interactions with health plans from paper to electronic methods streamlines the eligibility verification process and enables rapid communication of benefit information to ensure providers and patients have the right data at, or prior to, the point of care. Having this information allows for fully-informed decision-making. Patients want accurate and timely information about their financial liability, which reduces the risk of "sticker shock" upon receiving a post-service invoice. Providers would like to offer that transparency, but must rely on health plans to convey timely and accurate benefit information. Full use of electronic transaction standards simplifies this process, to the benefit of patients and providers.

from the field

"Standards and operating rules for the HIPAA transactions have value well beyond administrative simplification; conglomerated sources of information drive clinical and business decision-making."

– George S. Conklin, Senior Vice President and Chief Information Officer, CHRISTUS Health, Irving, Tex.

Administrative Simplification Transaction Types

HIPAA required the Department of Health and Human Services (HHS) to develop and implement a consistent framework for electronic health care transactions, code sets, identifiers and other administrative aspects related to the delivery and coverage of health care services. Over 17 years, the field has developed a common set of standards for the submission of claims, eligibility and claim status inquiries, and other transactions.

Transactions include:

- Payment of premiums
- Eligibility and benefit verification
- Electronic claims
- Claims status inquiry and response (allows the provider to check on the status of a submitted claim; e.g., received, being processed for payment, claim denied, missing information, etc.)
- Electronic remittance and electronic funds transfer (EFT)
- Prior authorization
- Electronic attachment (not currently a HIPAA transaction, but used to supply additional information, such as surgical notes)
- Acknowledgements (not included under HIPAA, but used to indicate receipt of a transaction)

What is Administrative Simplification?

HIPAA introduced administrative simplification as a series of interrelated *transaction standards* aimed at improving the efficiency and effectiveness of communications between health plans and providers through the adoption of common standards. It also set forth protection requirements (including privacy and security requirements) for the electronic exchange of patient information contained within the standards.

The value of the transaction standards is that they normalize the collection and reporting of information around a specific exchange of data. Each of the standards adopted by the HHS Secretary seeks to increase the timeliness of data exchange. These efforts impact the provider's management of their finances (see Figure 2) and provide data that benefit the operational strategies of providers.

For each electronic transaction, data is transferred from or to an external organization to the hospital.

Figure 1. Types of Transaction Standards

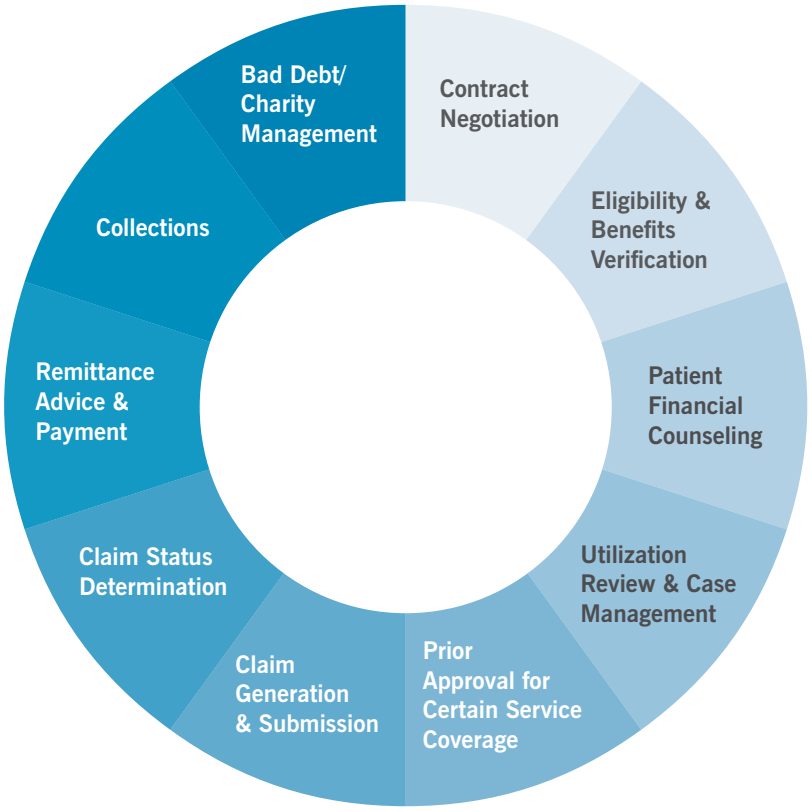
Electronic transaction standard type	Who is the information communicated to?
Insurance enrollment	Employer to health plan
Premium payments	Employer to health plan
Patient eligibility and benefit verification	Hospital to health plan; health plan to hospital
Request pre-approval for certain services	Hospital 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

For example:

- Counseling with respect to patients' financial responsibility is made easier by verifying eligibility and benefits up front.
- Utilization review and case management require eligibility and benefits information to quickly obtain prior approval when needed.
- Integrated financial and clinical data help providers and patients make informed decisions at the point of care.
- The ability to check a claim's receipt and adjudication status supports following up on lost claims, claims pended for additional information and denied claims.
- Reconciling remittance advice to payment receipts improves management of accounts receivable.
- Use of acknowledgement transactions assures that claims and other transactions are received by the intended party and not lost in the transmission process.
- Comprehensive and standardized information can support contract negotiations for reimbursement with health plans.

Streamlining collection and reporting of data helps to remove extra steps and accelerate the process for handling claims for reimbursement.

Figure 2. Finance Management Steps



from the field

"We were early adopters of CAQH Committee on Operating Rules for Information Exchange (CORE) operating rules because of the opportunities CORE provided to collaborate with payers to reduce the paperwork burden for our physicians and improve transparency for our patients. Administrative simplification enabled us to shift 15 percent of the revenue cycle workforce to key eligibility verification and collections functions."

– Joel Perlman, Executive Vice President and Chief Financial Officer, Montefiore Health System, Bronx, N.Y.

Complexity of Legislating and Implementing Administrative Simplification

Moving forward on administrative simplification has not been easy. More than 40 years were spent in creating, legislating and implementing standardization to support greater use of information systems aimed at streamlining administrative processes, reducing paperwork burden, achieving greater cost savings, and improving patient and provider satisfaction.

Prior to the passage of HIPAA, the exchange of data was based on each health plan's proprietary data formats. Consequently, providers spent an inordinate amount of time and resources customizing claims information for each different health plan according to the plan's unique requirements. In the mid-1970s, the American Hospital Association (AHA) called for the creation of a National Uniform Billing Committee (NUBC). The NUBC included major health plans, including government programs, as well as providers—its task was to develop and agree on a data set that could be used in a uniform bill (UB). In 1982, the NUBC ultimately adopted the UB-82 Data Specifications Manual and Form that would be utilized by Medicare and state insurance commissions for the purpose of submitting and processing hospital claims. Since that time, the UB has been updated several times and the UB data set is an integral part of the HIPAA claim transaction standard for institutional providers.

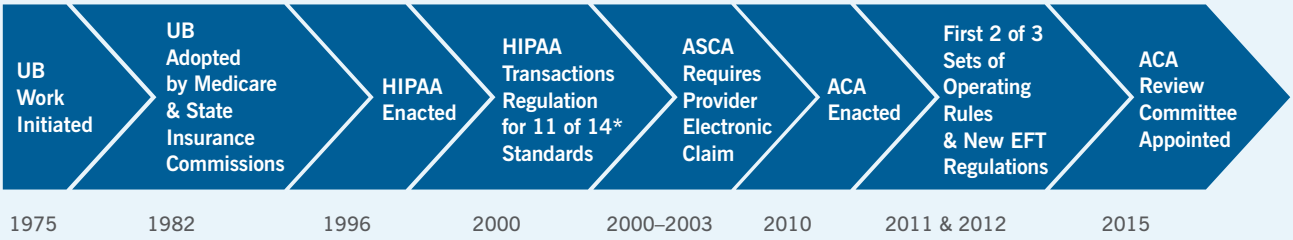
The passage of HIPAA in 1996 began the process of standardization of administrative transactions for adoption by providers and health plans. Final regulations issued in 2000 detailed the requirements under HIPAA. In order to encourage utilization of the HIPAA transactions, the Administrative Simplification Compliance Act (ASCA) was enacted in 2000. It required providers to use the HIPAA standard electronic claim for submission to Medicare by 2003. This resulted in a major increase in the use of the standard claim transaction for both Medicare and commercial plans, but did not significantly impact use of the other transactions such as enrollment, premium payment, eligibility and benefits, claims status, electronic remittance advice and payment.

To further the utilization of electronic standards, the Affordable Care Act (ACA) mandated the creation and adoption of operating rules for all applicable HIPAA transactions standards by the end of 2016.[4] The field also is awaiting finalization of a standard transaction or transactions that would support exchange of additional information (referred to as attachments) for prior approval and claim adjudication.

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. Operating rules also provide for a minimum level of security for transmission and other business-related requirements such as system availability and turnaround time. In 2005, a group of major health plans recognized that lack of adherence to standards was precluding effective use of information systems and ultimately costing the industry. They formed the CAQH Committee on Operating Rules for Information Exchange (CORE) to include representation from all stakeholders to the HIPAA transactions. CAQH CORE also developed a process where health plans, providers and others can obtain voluntary certification of compliance with the standards and operating rules.

The process of advancing administrative simplification and standardization has been underway for more than 40 years.

Figure 3: Administrative Simplification Timeline



* Transactions not yet mandated include request for additional information, supplying additional information, and first report of injury.

Progress to Date and Areas for Improvement

Despite the many challenges, there has been modest progress in administrative simplification, especially with the adoption of operating rules. Figure 4 summarizes the benefits for each of the transaction types that are currently applicable to providers (excluded are the transactions for enrollment in a health plan and premium payment, which have a marginal impact on providers). These benefits are further described below.

1. Eligibility and benefits inquiry and response transactions

"It is estimated that as much as 30 percent to 50 percent of bad debt can be reduced by eligibility and benefits verification prior to service to enable alternative arrangements to be made, such as charity, Medicaid, health insurance exchanges, disability, third-party coverage, prompt-pay or self-pay discounts, or extended payment arrangements." *National Association of Healthcare Access Management* [5]

Patients want to know what a service will cost and whether it is covered by their insurance. Essential to a hospital's ability to provide accurate price information are communications with health plans that verify eligibility and coverage for a given treatment. With that information at hand, hospitals can, when needed, work with patients to find alternative payment or coverage arrangements. Patients can benefit from better financial management. Hospitals can benefit from reduced bad debt.

2. Electronic claims

Currently, 92 percent of all claims are submitted electronically to health plans, resulting in significantly shorter turnaround times for payment.[10]

Providers can experience tangible benefits by adopting the operating rules that cover HIPAA transactions.

Figure 4. Summary of HIPAA Transactions Benefits Applicable to Providers

HIPAA Transaction	Benefits
1. Eligibility and benefits inquiry and response transactions	• Inform patients • Collect payment promptly • Reduce bad debt
2. Claim submission transaction	• Reduce discharged not final billed (DNFB) days • Speed payment • Reduce errors
3. Claims status inquiry and response transactions	• Reduce time on telephone • Address issues sooner
4. Electronic remittance advice and funds transfer transactions	• Match payments to remittance advice to streamline processes and more quickly flag for problems • Make funds available sooner
5. Request and response for prior approval transactions	• Reduce labor costs • Inform patient sooner
6. Request and response for additional information (attachments) transactions	• Support auto-adjudication of claims • Reduce labor costs
7. Acknowledgements transaction (not mandated by HIPAA)	• Confirm receipt of transaction • Provide electronic log to determine timeliness

Many of these represent "clean" claims (i.e., claims without errors or missing data). The remaining claims that not filed electronically create significant costs and delays. Although a relatively small amount of these claims come from providers who do not file electronically, most of these claims involve coordination of benefits (COB) requirements, when patients have coverage under more than one health plan or when claims need additional information to be supplied for their adjudication.

Provider Success

Dignity Health, a health system based in San Francisco, Calif., has reduced the number of days to submit a claim to a health plan to two or three days, and expects to reduce this to one day by using electronic processes to ensure accuracy and completeness.[11]

Operating rules have yet to be adopted for the claim transaction. However, by standardizing data content, future operating rules could provide additional benefits such as automated COB.

3. Claim status inquiry

Claim status inquiries allow providers to follow-up on the status of a submitted claim. It is estimated that as much as 40 percent of billing staff time is spent on telephone calls to check the status of submitted claims. This staff time could be drastically reduced through use of the electronic claim status transaction standard along with the adoption of operating rules.[6]

4. Electronic remittance advice and electronic funds transfer

The electronic remittance advice (ERA) is the report that shows the contractual adjustments, the amount disallowed, the amount that is the patient's responsibility and the amount that will be paid by the health plan. The ERA is increasing in popularity, with 68 percent of providers (see Figure 5) taking advantage of CORE operating rules adopted in 2013 to more fully automate the remittance processing function, though this process is still in need of improvement. Together with the utilization of the health care-specific electronic funds transfer (EFT) standard, which contains the payment instructions to the provider's banking institution, and adoption of operating rules (which have increased by 150 percent since being mandated by ACA), providers are finding it much easier to reconcile their claims with payments received.[7]

5. Prior authorization

Patients and physicians need to quickly know if a health plan will pay for medical care. The prior authorization transaction standard is used by the provider to obtain health plan approval for the medical care that will be provided to the patient, including authorization for coverage of certain procedures and referrals. Currently, less than 1 percent of health plans use this transaction standard to respond electronically. In large measure, health plans have established web portals rather than use this HIPAA-mandated transaction.

The operating rules for this transaction standard were approved by CAQH CORE in September 2015 but have not yet been federally mandated for adoption. Standardizing and automating electronic prior authorization would reduce staff time in making telephone calls or having staff enter data on the health plan's website and deliver information to patients more quickly. For example, efficient prior authorization provides information sooner to providers about approval for services, reduces patient anxiety and time for services to be performed from two or three weeks to three to five days.[9]

6. Electronic attachments

While the electronic attachment transaction has not been named as a HIPAA standard, it is currently used by some providers and health plans. Electronic attachments transactions enable a provider to supply additional information in support of a request for prior authorization or additional information needed by the health plan for the adjudication of the claim. Because it is not a HIPAA-mandated transaction standard, there are no adopted operating rules.

Today, this transaction is conducted electronically by a very small percentage of providers. Attachment information is submitted to health plans utilizing paper documents, scanned images of paper, or other, non-standard electronic formats or via web portal access.[12] Attachments for prior authorization and claims would benefit from transparency that could be manifested through operating rules that would support submission of additional information in conjunction with the claim or prior authorization request.

7. Acknowledgements

Acknowledgements serve to confirm receipt of a transaction. This can be especially important for transactions such as claim submission and claim status, where uncertainty about receipt can lead to provider and health plan staff time being spent on follow up calls. They also enable stakeholders to document timeliness in compliance with prompt payment requirements. Acknowledgements are widely used among willing trading partners and are included in the CAQH CORE Certification program, but have not been adopted as a standard by the federal government.

Provider Successes

Emory Healthcare in Atlanta, Ga., has streamlined collections and reduced costs through use of electronic remittance data on a case-by-case basis. The hospital also has been able to pair the remittance data with insurance claims data to create models that help predict denials and allow the hospital to proactively address potential issues.

HCA, a health system based in Nashville, Tenn., experiences a 70 percent reduction in processing costs with EFTs when compared to paper checks.[8]

Barriers to Full Utilization of the HIPAA Transactions

The legislative efforts have led to modest improvement in the utilization of the HIPAA transactions. Figure 5 estimates the current percent of providers that use each transaction. In many areas, there is substantial room for greater adoption. However, there are barriers to use that merit consideration by stakeholders.

While the adoption rate for HIPAA transactions has improved, there is still substantial opportunity for many providers to realize additional savings.

Figure 5. Adoption Rate of Transactions Used by Providers

	Total Number of Transactions (millions)	Electronic (percent)	Manual (percent)
Claim Submission	11.6	92%	8%
Eligibility and Benefit Verification	8.9	63%	37%
Prior Authorization	0.6	*	99%
Claim Status Inquiry	10.0	21%	79%
Claim Payment	3.5	85%	15%
Remittance Advice	4.3	68%	32%
Claim Attachments	0.8	1%	99%
Prior Authorization Attachments	0.2	2%	98%

Sources: Council for Affordable Quality Healthcare. *CAQH 2014 Index*. http://www.caqh.org/sites/default/files/explorations/index/report/2014Index.pdf *Less than 1 percent.

Not All Stakeholders are Required to Follow Standards

HIPAA defines covered entities who must comply with administrative simplification, but not all stakeholders in administrative simplification are required under HIPAA to use them:

- **Health plans** are required by HIPAA to conduct standard transactions when any person desires to conduct such a transaction. They may not refuse or delay conducting a standard transaction.
- **Providers** are only required to adhere to HIPAA transaction standards if they choose to conduct any of the transactions electronically. However, ASCA required providers to file claims electronically with Medicare; as a result, adoption has spread to commercial health plan claims as well. Yet, many providers do not conduct other types of HIPAA transactions electronically.
- **Health care clearinghouses** must follow HIPAA transaction standards. The role of the clearinghouse to rearrange data from legacy systems to the transaction standard layout. This function is necessary in situations when health plans and providers have not updated their internal systems to the HIPAA standard layout.
- **Information systems vendors** are not covered entities under HIPAA; the federal government does not have a certification process for the vendors of information systems to support administrative transactions. This gives providers less leverage with their vendors (other than contractual) to ensure the ability to conduct electronic transactions.

Lack of Support to Keep Standards Up-to-date and Compliant

A lack of federal support for continued development of standards, prioritization of prompt adoption and enforcing adherence is an important barrier to wider use of transaction standards. Regulations mandating standards do not always support prompt implementation, as strategies for meeting the new expectations are not supplied. Education and technical assistance on standards have generally not been provided until just before compliance is at risk. As such, the field counts on health care clearinghouses[13] and deadline extensions to fulfill selected administrative simplification requirements. One recently implemented change that will help to maintain guidelines is a bi-annual review of the HIPAA standards and operating rules, as mandated by the ACA. The National Committee on Vital and Health Statistics (NCVHS) was named in 2015 as the ACA Review Committee. NCVHS is a federal advisory committee

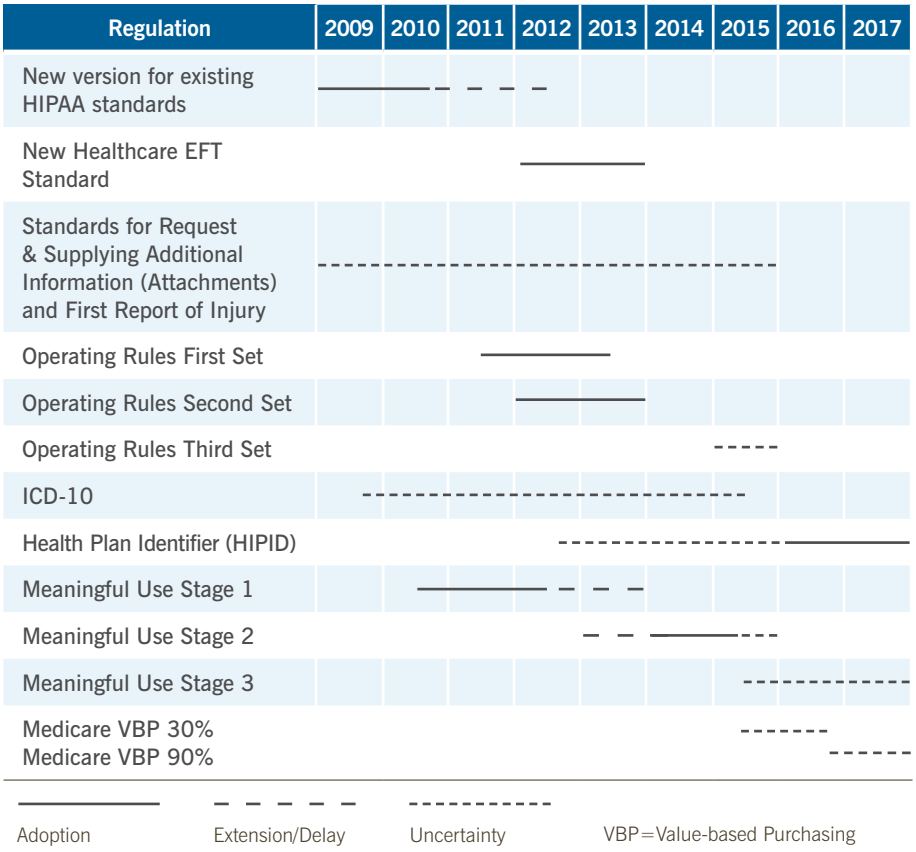
from the field

"Closing the remaining gaps may require a different approach. Small provider offices account for the majority of remaining manual claim [submissions], and they face an entirely different set of barriers to submitting claims electronically. Therefore, health plans may need alternative—and innovative—solutions."

– CAQH CORE 2013 U.S. Healthcare Efficiency Index

The proliferation of other mandatory programs and demands has created difficulties in planning for and implementing the operating rules for HIPAA transactions.

Figure 6. Competing Demands and Timelines to Date



A large percentage of the estimated savings created by simplifying each type of transaction would accrue to health care providers.

Figure 7. Projected Annual Savings Opportunity (from 2013 data)

	Industry Savings Opportunity (in millions)	Providers' Savings Opportunity (in millions)	Percent of Savings Opportunity for Providers
Claim Submission	$670	$540	81%
Eligibility and Benefit Verification	$4,000	$3,520	88%
Prior Authorization	$530	$450	85%
Claim Status Inquiry	$830	$450	54%
Claim Payment	$740	$710	96%
Remittance Advice	$1,540	$1,500	97%
Total	$8,310	$7,170	86%

Sources: *2014 CAQH Index*. Reprinted with permission.

to the HHS Secretary and has responsibility under HIPAA for "study[ing] the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information."[14]

Many Competing Demands

The combination of many overlapping mandates (as can be seen in Figure 6) in rapid succession and shifting deadlines make it difficult to perform long-range planning and management of HIPAA standards. For example, HIPAA-covered entities in 2010 were required to adopt a new version of the standard claim in order to accommodate future International Classification of Disease, 10th Edition (ICD-10) reporting. Although the final rule on ICD-10 was published in January 2009, it would take nearly six years for ICD-10 adoption to begin on Oct.1, 2015. During the same time period, providers were charged with meeting meaningful use requirements tied to electronic health records (EHR) utilization. Meeting meaningful use standards includes changes that fundamentally alter hospital staff workflows and require very significant ongoing financial investment. Providers face unique challenges surrounding the need for interoperability. Each stage of meaningful use requires increased connectivity and data sharing both internally between clinical and financial systems and externally with patients and public health departments, as applicable.

In summary, the potential benefits of full adoption of administrative simplification transaction standards and operating rules are sizable. The *2014 CAQH Index* estimates of how these benefits translate into cost savings is provided in Figure 7. The benefits to patients and potential cost savings present an important opportunity. However, barriers must be addressed in order to take advantage of the benefits administrative simplification offers.[15]

Steps to Further Simplify Administrative Transactions

Administrative simplification is not just about implementing standards and operating rules or technology; it is about each stakeholder doing their part to address fundamental cultural, operational and policy issues that can make a difference in health care quality, cost and experience of care. There are some specific steps that hospital executives and policymakers can take to bend the adoption curve for administrative simplification.

Hospital Executives

Cultural change is often necessary to fully embrace administrative simplification. A number of providers are embarking on changes that require a common commitment to standard best practices.[16] Some of these changes could include:

- *Consolidate administrative processes to achieve economies of scale.*
  Administrative processes are not as unique as individual patients; there are economies of scale in centralizing functions, as many hospitals are learning from consolidation and/or the adoption of standards to improve administrative and clinical operations across each of their organizational sites.[17]
- *Recognize the steps in financial management as a set of interrelated processes.*
  These interrelated processes start at the point of patient access and continue until the total amount due is reconciled.[18]
- *Address the interrelatedness of clinical and financial data.*
  It is important to understand the cost component and work with patients to help make value-based decisions; however, such information will only be available if providers and health plans agree on the data that are needed and how the data will be collected, shared and used.[19]
- *Cultivate a relationship of trust between providers and health plans.*
  Trust requires transparency as well as talented leaders who are willing to embrace a shared need for greater coordination and improvement. This may require contractual arrangements with health plans that not only define shared savings or shared risk, but shared responsibilities and accountabilities.[20]

Hospital executives can make operational changes to seize the opportunities that administrative simplification provides. Some operational changes include:

- *Move fully to electronic processes.*
  When providers utilize the transaction standards and operating rules to establish automated routines for the handling and posting of data, they can benefit from better and more timely data, reduced operating costs and improved patient satisfaction.
- *Eliminate redundancy in financial process to eliminate redundant manual paper and phone-based legacy processes with health plans and replace these with automated routines.*
  Currently, providers often have to undertake duplicate processing for eligibility verification, such as sending an electronic transaction to request information and also checking the health plan's website to learn about deductible and co-pay amounts not supplied in the electronic transaction to respond to patient questions about coverage and care options.
- *Change what you can.*
  - Engage actively in the finance system of the hospital to ensure processes support efficiency gains and greater transparency for patients.
  - Create and/or participate in a community that has a "say."[21] Although large provider organizations tend to have more leverage to seek standardization from health plans, small organizations may consider using their local or regional health information exchange organization, local professional associations and medical societies to create a collective voice to achieve shared administrative simplification with plans.
  - Establish expectations with vendors to ensure that they keep pace with system changes and ensure that

from the field

"Administrative simplification is a key ingredient in sustainability under health reform, especially for our small hospitals where managing revenue cycle processes as well as the ever changing payer and regulatory requirements might have bankrupted them."

– Scott Hawig, Senior Vice President of Finance and Chief Financial Officer, Froedtert Health, Milwaukee, Wisc.

systems are upgraded to accommodate standards and operating rules. HIPAA does not require vendors to be in compliance with the transaction standards and operating rules. To support HIPAA standards and operating rules in a timely manner, customers must demand that vendors implement changes. Examine your vendor contracts to ensure they include language requiring timely updates and demonstrated compliance with standards and operating rules. Vendors can demonstrate support for compliance through voluntary certification of their products through CAQH CORE.

- *Work collectively to promote administrative simplification.*
  More than ever before, providers need to engage and work with health plans and others to ensure the standards are feasible for everyone. Providers that have engaged with CAQH CORE have found that it is an excellent opportunity for them to have their voice heard. Participation in CAQH CORE is a forum that builds consensus on business process improvements and seeks to foster greater trust among all participants. Benefits go far beyond the technical operating rules to address business needs that historically have posed challenges for providers and health plans.

Policymakers

Administrative simplification can create savings and increase efficiency within the health care system. Policymakers can take the following steps to support administrative simplification:

- *Expand certification efforts for plans and extend requirements to vendors.*
  The ACA mandates that health plans be compliant with transaction standards, but certification of compliance under the ACA is not yet active. Providers, vendors and clearinghouses can demonstrate that they fully support transaction standards and operating rules by seeking voluntary certification under CAQH CORE. Policymakers should reclassify vendors as covered entities so that they, too, must comply with administrative simplification efforts. Through regulation, HHS also should require a product certification that ensures that financial management information systems meet the HIPAA transactions standards and operating rules.
- *Coordinate and align efforts to address health care information vocabulary standards.*
  A common vocabulary is critical to any communication; however, standardization of terms is still a work in progress. Today there are multiple efforts, including those by HHS, to define key vocabulary for use in health IT. However, these efforts currently are not fully aligned. Without working together, there may be multiple definitions for a given concept, which undermines efforts for parties to communicate clearly.
- *Prioritize high-value transaction standards and promote increased volume/utilization.*
  For instance, focus efforts to increase use of one or two selected transactions between providers and health plans. The goal is to reduce costs and improve the efficiency for both providers and health plans.
- *Provide predictable schedules along with adequate educational and technical assistance well in advance of regulatory deadlines.*
  Recognize that many providers depend on vendor products to ensure compliance with the standards. Adequate lead time and a predictable schedule are critical in supporting providers and health plans in meeting the compliance requirements of the standards and operating rules.

Conclusion

Administrative simplification facilitates the smart use of information technology to reduce costs and increase efficiency. Achieving these goals will require cultural, operational and policy changes. It also offers opportunities to work collaboratively across the field to achieve mutual benefits for all stakeholders—providers, health plans, vendors and patients. However, administrative simplification's promised benefits for providers and the larger health care system have been hampered by limited focus on a technical, largely unseen—yet critical—set of functions. The AHA's past president and chief executive officer, Rich Umbdenstock, noted, "Hospital engagement in the operating rule development process offers the opportunity for providers to voice their needs for simplification and cost reductions so that the ensuing guidelines are truly beneficial to all in a way that will positively impact the entire health care field."

The additional benefits of enhanced price and coverage information for patients support the need for renewed focus from providers, health plans, vendors and policymakers on facilitating adoption of operating rules and administrative simplification initiatives.

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