



AHIMA Policy Statement on Integrating Clinical and Administrative Health Data

AHIMA's Position:

AHIMA supports the use of policy and other tools to realize the benefits of greater integration of clinical and administrative data, including improved patient experience, decreased administrative costs, reduced provider burden, and improved quality of care and outcomes. Health information (HI) professionals have considerable knowledge and relevant experience to contribute in developing policy. To ensure the best outcome for individuals, AHIMA believes that policy must:

- 1. Improve processes for patients and providers.** Policy approaches must be evaluated to ensure that they remove unnecessary steps and complications for patients, while decreasing administrative burdens for providers.
- 2. Address factors beyond automation.** Policy must take a holistic approach that looks at business processes, representation from stakeholders, and other factors that will create trust across providers and payers.
- 3. Maintain stability of the revenue cycle.** New approaches to administrative processes must be adopted in a way that supports all parties and does not disrupt or slow down the numerous steps from checking patient eligibility through claims processing and payment.
- 4. Consider operations and the role of HI professionals.** New standards and approaches must reflect how information flows through the health care system, the technical systems that are needed, and the crucial role HI professionals play in translating across clinical and administrative domains.
- 5. Address coding accuracy.** Integration will only be successful if it builds from a detailed understanding of how code sets are used for administrative and clinical purposes and addresses mapping issues, particularly when different codes sets are used for the same underlying concept (such as SNOMED/HL7 versus ICD/CPT/HCPCS for problems and diagnoses). Otherwise, data may not hold the same meaning for those who generate it and those who use it in other contexts (semantic interoperability).
- 6. Account for workforce training needs,** including shifts in needed capabilities, training on new standards, vocabularies, technologies and processes, and the potential for workforce realignment. Successful automation also will require greater collaboration across the range of professionals engaged in creating, curating, sharing and using both clinical and administrative data.
- 7. Prioritize privacy and security.** Increased sharing of health information across payers and providers requires careful consideration of privacy issues, including ensuring that only the minimum necessary information is shared, and uses beyond the specific transaction are limited. One element of building privacy in by design is addressing the problem of patient matching. Addressing privacy and security successfully involves both

technical and operational solutions that support clear policies that are consistent across all actors.

Background:

Through a combination of public and private sector efforts, the health information underlying our healthcare system has undergone digital transformation, leading to great promise for better informed and safer care, increased individual engagement in health, and improved efficiency. However, significant work remains to bring healthcare fully into the digital economy to support changing health models that put the consumer in the center, reward value over volume, and harness tools such as clinical decision support and machine learning. Improved interoperability and attention to data integrity will be key to making progress.

According to the 2019 CAQH Index,¹ providers electronically submit 3.4 billion claims per year, which amounts to 9.3 million claims per day. And according to federal data, virtually all hospitals (96 percent) and most physicians (80 percent) have adopted electronic health records (EHRs) certified through a federal program run by the Office of the National Coordinator for Health Information Technology (ONC).²

However, processes that require the exchange of clinical data to support administrative processes generally involve a considerable amount of manual work, including phone calls, use of payer portals, and faxes. Inpatient authorizations, medical necessity reviews and prior authorizations for tests, procedures, and medications all impose significant burdens on providers and patients and raise administrative costs. In some cases, they delay treatment and negatively impact patient outcomes.

Better integrating administrative and clinical health data, including tools for automation, could bring significant benefits for improved patient experience and decreased provider burden. However, significant barriers beyond the technical approaches, such as standardizing business processes and privacy concerns, will need to be overcome. As policymakers consider the best path forward, AHIMA members provide a crucial on-the-ground perspective.

Key Points:

Improving the ability to share and combine clinical and administrative data could result in considerable benefits, including:

- Improved patient experience, satisfaction, understanding of financial obligations, and possible improved outcomes;
- Improved care planning and management;
- Reduced provider burden;

¹ <https://www.caqh.org/sites/default/files/explorations/index/report/2019-caqh-index.pdf>

² <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php> and <https://dashboard.healthit.gov/quickstats/pages/certified-electronic-health-record-technology-in-hospitals.php>

- More timely and relevant data for value-based purchasing and population health management; and
- More efficient payer operations.

However, realizing the benefits of greater integration of clinical and administrative data will require addressing barriers. These include:

- **Lack of standardization for business processes.** Prior authorization and authorization for inpatient care currently are characterized by variability in the data requested to make a determination – both across payers and across plans offered by a given payer.
- **Operational issues.** New approaches will need to be mapped across existing operations to understand how roles and technology will need to change.
- **Implications for workforce.** New approaches may require a different skill mix, leading to a need for training and other workforce considerations.
- **Alignment and accuracy of vocabulary standards themselves.** Today, clinical and administrative data often rely on different standards for similar concepts (such as SNOMED/HL7 versus ICD/CPT/HCPCS for problems and diagnoses). Currently, we lack a consensus-based map to accurately and consistently translate across them.
- **Data integrity,** particularly given the lack of accurate patient matching, and in light of high duplicate record error rates that can lead to patient safety issues.
- **Protecting privacy and ensuring data security.** Providers want to be good stewards of patient information and ensure that data sharing is supportive of patient privacy. Security, such as authorizing and authenticating data recipients before exchange, must also be assured.

Current Situation:

A major contributor to the current challenge is that these two main streams of health data – administrative and clinical – have developed on separate trajectories, use different technical standards, and are subject to different regulatory authorities. In general, the Centers for Medicare & Medicaid Services (CMS) regulate the administrative transactions standards promulgated under the Health Insurance Protection and Portability Act of 1996 (HIPAA). Meanwhile, ONC regulates clinical standards such as those used in EHRs. In addition, the National Committee on Vital and Health Statistics (NCVHS) advises the federal government on the HIPAA administrative transaction standards, while the Health Information Technology Advisory Committee (HITAC) offers advice on interoperability, including clinical standards.

Policy attention to integrating clinical and administrative health data is accelerating, with CMS, ONC, NCVHS, and HITAC all undertaking efforts. These include:

- Support for modern technical approaches, including application programming interfaces (APIs) in recent final rules on interoperability from both ONC and CMS.

- A CMS pilot to support prior authorization in Medicare for oxygen and continuous positive airway pressure (CPAP) devices.³
- Recommendations for further integration of administrative and clinical data in a recent report from ONC and CMS on reducing burden related to the use of health IT.⁴
- A joint NCVHS/HITAC Task Force on the Intersection of Clinical and Administrative Data that expects to make recommendations in September.
- Engagement in and support for the HL7 DaVinci Project, which is focused on “using modern standards to support and integrate value-based care (VBC) data exchange across communities,” and particularly across payers and providers.

Today, these efforts are mostly focused on automating administrative processes such as prior authorization. Discussion of this topic to date has had limited input from providers, including HI professionals. AHIMA stands ready to bring its experience and expertise to the table.

³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/LookupServiceInitiative>

⁴ Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. February 2020. <https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs>