



**Statement of Jeanette Thornton  
America's Health Insurance Plans  
to the  
National Committee on Vital and Health Statistics'  
Subcommittee on Standards  
Regarding the Health Plan Certification Process  
June 20, 2012**

Overview and Introduction

I am Jeanette Thornton, Vice President Health IT Strategies for America's Health Insurance Plans. I work with our member health plans on the implementation of Section 1104 of the Affordable Care Act (ACA) and am pleased to discuss the issue of health plan certification with you today. AHIP and our member health insurance plans support the administrative simplification reforms that we believe will increase the use of electronic transactions.

As the Subcommittee well knows, the ACA added operating rules for financial and administrative transactions to the existing HIPAA requirements applicable to (1) health plans; (2) health care clearinghouses; and (3) health care providers who transmit any health information using the standard transactions.

While the operating rules will increase efficiencies for all stakeholders – plans, providers and vendors - the ACA added new certification requirements applicable only to health plans that include detailed requirements regarding partner testing, service contracts and compliance documentation. These requirements apply to the previous HIPAA electronic transactions as well as the new operating rules. While health plans are required to certify compliance to the HHS Secretary, the ACA did not require providers or clearinghouses to engage in testing or document their compliance prior to the operating rules' effective dates. This lack of reciprocity poses practical and administrative challenges that may inhibit implementation if not properly addressed.

Recommendations to Make the Certification Process More Effective

In Section 1104(h) health plans are required to provide documentation of compliance that demonstrates the plan:

- Conducts the standards and operating rules in a compliant manner;
- Has completed "end-to-end testing" with their partners (e.g., external entities such as hospitals and physicians); and

- Has ensured that entities that provide services pursuant to a contract are in compliance.

We recommend that the HHS set up an attestation-based approach to certification using the Secretary's broad statutory authority to define the certification requirements for health plans so as to promote testing which reasonably demonstrates compliance.

#### *Definition of Partners and End-to-End Testing*

Health plans are required to provide documentation showing they have completed end-to-end testing with their *partners, such as hospitals and physicians*. CMS should clarify that this reference to *partners* refers to *trading partners*. We recommend CMS develop a high level testing schedule to stress the importance of early planning and testing to meet the certification deadline. Health plans would voluntarily implement the testing schedule through trading partner agreements with their provider partners.

Health plans should have the opportunity to define their own approach to end-to-end testing. Approaches could include testing with a sample of providers and the use of testing modules that simulate provider responses. These approaches are efficient, would demonstrate the plans' readiness and take into account the need for health plan testing prior to the requirement that providers engage in such transactions. To the degree end-to-end testing is not successfully completed because providers are not yet compliant, health plans should be deemed to have satisfied the testing requirement if they notify providers of the new requirement and retain documentation.

The Secretary has the option to designate independent, outside entities to conduct certification. We recommend that voluntary certification by entities such as CAQH CORE is recognized as an option in lieu of individualized testing.

Regarding the requirement that health plans ensure that entities that provide services under a contract with the health plan comply with applicable certification and compliance requirements, we recommend these requirements be limited to those vendors and clearinghouses that are either business associates or covered entities under HIPAA and are conducting HIPAA electronic transactions with or on behalf of a health plan. Furthermore, we recommend that CMS utilize "deemed certification entities" to conduct testing and certification with regard to these entities, as well as trading partners. This approach would be efficient because many health plans contract with the same IT vendors, and it would be administratively burdensome for each health plan to test separately with their IT vendors under service contract(s).

#### *Timing of Certification*

Many health plans have established or are in the process of establishing a testing schedule for the first set of operating rules effective on January 1, 2013; however certification is not due until December 31, 2013. We recommend that the regulations on the certification requirements not disrupt testing that has been completed or is scheduled. Given that the proposed rule for the certification requirements has not yet been released, it is critical that CMS allow for a flexible approach to the certification requirements.

## **Role of Providers and their Vendors in the Certification Process**

As I mentioned earlier, the ACA did not require providers or clearinghouses to engage in testing or document their compliance prior to the effective dates for the operating rules, even though the operating rules apply to standards that are two-way communications between health plans and providers. Providers are the recipients of the standard “messages” from health plans and it will be providers who ultimately benefit from the additional information being received in a more standardized format. Here are potential options to ensure all HIPAA covered entities are in full compliance with these new requirements using existing compliance mechanisms.

### *1. Provide Certification Options for Practice Management Vendors*

Many providers do not conduct standard transactions directly, but use practice management vendors to do so. The HHS Office of the Inspector General (OIG) has recognized the interdependence between providers and practice management vendors when implementing compliance requirements. In some situations, the HHS OIG encourages the incorporation of shared compliance standards and procedures by these entities.<sup>1</sup> It is important to recognize that the practice management vendors may be under direct contract with the providers and not be trading partners of health plans as transactions may pass through additional entities before reaching the health plan. Practice management vendors should be required to demonstrate compliance with the standards and operating rules prior to the effective dates of the operating rules in a manner similar to the health plans.

We recommend that CMS work with the OIG to update this compliance guidance, particularly since the lack of compliance certification requirements for providers and their vendors could place providers in non-compliance with the federal electronic transactions requirements. The OIG could develop guidance recommending that providers use vendors certified by “deemed certification entities” as their practice management system vendors. Such certification could also substitute for health plans’ direct end-to-end testing with the trading partners such as physicians and hospitals that these vendors serve.

### *2. CMS Should Leverage its Relationship to Federal Programs*

The Administrative Simplification Compliance Act (ASCA) amended Section 1862 of the Social Security Act which lists conditions for Medicare participation requirements (i.e., provides parameters through which Medicare payments will be made). The ASCA prohibited payment to Medicare providers for initial health care claims not sent electronically “in an electronic form specified by the Secretary” as of October 16, 2003. The Secretary’s authority to further use Medicare as an avenue to advance administrative simplification goals was expanded in the ACA which added an additional requirement that not later than January 1, 2014, Medicare payments would be prohibited in a method other than the electronic funds transfer (EFT) or an electronic

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<sup>1</sup>Refer to <http://oig.hhs.gov/authorities/docs/physician.pdf> for a specific discussion related to individual and small group practices. Additional compliance information can be found on the OIG website at: <http://oig.hhs.gov/compliance/compliance-guidance/index.asp>.

remittance (ERA) in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.<sup>2</sup>

Both the claims standard and the standard for funds transfer and remittance advance will have associated health care operating rules that are required by the ACA. Therefore, if Medicare providers are already required to implement healthcare transactions standards for electronic claims, EFT and ERA, they should also be required to comply with the corresponding operating rules (in the electronic form specified by the Secretary) which will be necessary to ensure connectivity between health plans, healthcare clearinghouses and providers. Not only is compliance with the operating rules already required, but adding additional guidance in the Medicare Claims Processing Manual that includes operating rule compliance offers providers in the Medicare program additional motivation to comply.

### *3. CMS Should Include Administrative transactions as Part of “Meaningful Use”*

We also recommend that the Medicare and Medicaid Electronic Health Record (EHR) incentive program also be leveraged. EHRs increasingly include administrative transactions as part of their functionality. This provides a unique opportunity for the Office of the National Coordinator for Health IT (ONC) to include standards and operating rules as part of the EHR certification criteria. In such cases, for eligible physicians and hospitals that are “meaningful users,” health plans would not have to provide additional documentation related to end-to-end testing because of their use of a certified EHR or EHR module to conduct administrative transactions with health plans.

Thank you for the opportunity to provide additional input. We appreciate the opportunity to provide our recommendations and we look forward to continued dialog on this important topic

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<sup>2</sup> P.L. 111-148, §1104(d)(3), added this new paragraph (25), effective March 23, 2010.