National Committee on Vital and Health Statistics
Subcommittee on Standards

June 20, 2012

WRITTEN TESTIMONY OF THE AMERICAN MEDICAL ASSOCIATION

Administrative Transaction Standards, Code Sets and Operating Rules
Industry Status of Planning, Transitioning, and Implementation

The American Medical Association (AMA) would like to thank the National Committee on Vital and Health Statistics (NCVHS) Standards Subcommittee (Subcommittee) for the opportunity to provide our comments on the industry's experiences and lessons learned with the implementation of the Version 5010 Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards.

AMA Outreach and Education

Following the January 2009 publication of the final rule adopting the Version 5010 transactions, the AMA completed many efforts to outreach to physician practices and educate them about the Version 5010 transactions, the work to implement them, and the compliance deadline. Our efforts included:

- Updated Web content with overview information, educational materials, and resource links;
- Articles in various AMA online and print publications;
- Presentations to various groups;
- Development of written materials, including a fact sheet series on the transactions, a project planning template, and readiness timeline;
- Surveys on awareness and readiness; and
- Collaboration with other industry stakeholders.

The goal of our efforts was to have physician practices implement the Version 5010 transactions in time for the compliance deadline and to have as little disruption in their claims processing and reimbursement. Unfortunately, at the time of transitioning to the Version 5010 transactions, many physician practices experienced implementation issues, which have led us to identify various lessons learned.

5010 Lessons Learned

<u>Communication among Trading Partners</u>
Communication among trading partners encompasses several critical pieces of the implementation process. Practices relied on their vendors, clearinghouses, and payers for information about the installation of upgrades, dates of testing, testing results, readiness for switching to Version 5010, problems with processing Version 5010 transactions, and overall information about the transaction changes. While much of the communication was adequate, room for improvement was identified.

For the vendor component, many practices reported that they had to contact their vendor about their practice management system upgrades. Overall, the vendors should have taken the lead on contacting their customers and alerting them of the need for upgrades. In an informal survey, most practices reported receiving educational materials about the Version 5010 transactions from their vendors, which was very good, since vendors are in the best position to understand the practice's system and transaction changes that will impact them the most.

Clearinghouses were the second most frequent resource for education about Version 5010. Clearinghouses were followed, in descending order, by government resources, professional organizations, and payers. We are aware of good outreach and education efforts that were accomplished by trading partners, including payers, and we see practices' lack of awareness of resources as a gap that needs to be addressed.

We recognize that practices need to be responsible for being aware of changes that will impact the administrative transactions and their revenue cycle, but we also believe that practices' trading partners are a primary source to which they turn to for assistance. We intend to work on raising the awareness of the importance of messages and resources from trading partners to practices.

Installation of Upgrades

The timely installation of practice management system upgrades by vendors was an issue. We had heard that many vendors waited to complete their product upgrades until after the Version 5010 Errata were finalized and adopted through regulation, which happened in October 2010. It was not until 2011 that many vendors began implementing the product upgrades in practices. We heard from many practices that they did not receive their upgrades until after October 2012, which left little time for testing of the transactions before the compliance deadline.

Ultimately, practices are put in the position of being bound by their vendors to provide them with products to make them compliant with the requirements of the transaction standards, but vendors are not accountable to the requirements, since they are not HIPAA covered entities. Not being a HIPAA covered entity means that vendors make business decisions on profitability and not regulatory requirements.

We have been working with the Medical Group Management Association (MGMA) to engage practice management system vendors and work collaboratively to improve products and resources for the physician practice's revenue cycle management. We have also reached out to the Workgroup for Electronic Data Interchange (WEDI) and will be collaborating with them on educational workshops with the goal of challenging providers to improve workflow and vendors to develop more user-friendly and efficient practice management products. Our objective with this work is to improve the vendor development and installation cycle for future administrative simplification regulatory requirements.

Testing

Overall, the industry did a fair job of completing comprehensive, end-to-end testing to ensure that the Version 5010 transactions would process correctly once they were submitted in the "production" mode. Much of the testing that was done was very limited in scope and was done in a testing environment, which did not simulate actual transaction processing. Also, most of the testing was of the claim transaction and little testing was done on the other standard transactions. Many practices completed testing and passed, only to experience problems when submitting their

Version 5010 transactions "live." While the intent of testing was to identify and correct issues before going live, it was ineffective for many.

In addition, there needs to be uniformity in the testing methodologies used in the industry. Uniform testing processes will simplify the burden of following different testing criteria for different vendors, clearinghouses, and payers.

Complete, end-to-end testing where a transaction is submitted, processed, and response returned (e.g., claims – remittance, eligibility request – response, etc.) will ensure that the transactions involved in the revenue cycle are functioning properly. It is not appropriate to risk disruptions in claims processing and payments following the transition due to a lack of proper testing.

Support during the Transition

When physician practices and clearinghouses converted to Version 5010 and began to experience rejections and issues, they attempted to contact their clearinghouses or payers, which resulted in extremely high volumes of calls beginning in early January and continuing into February of 2012. Practices became extremely frustrated by the long wait times, sometimes waiting two to three hours to speak to someone. During this time, practices also experienced finger-pointing between some clearinghouses and payers. The practice would call the clearinghouse, wait an extended period to speak to someone, and be told they needed to contact the payer. Upon calling the payer and waiting to speak to someone, they were told the issues were with their clearinghouse. The lack of coordination and collaboration between clearinghouses and payers added an additional and unnecessary layer of burden to the transition to Version 5010.

During the transition time, our experience working with the Centers for Medicare & Medicaid Services (CMS) staff was very positive. Some issues that practices encountered involved Medicare and Medicaid and they were unable to resolve the issues through their trading partners or Medicare Administrative Contractor (MAC). We raised these issues with CMS and we found CMS staff to be responsive to addressing Version 5010 issues.

Prepare for Payment Disruptions

Because of claims disruptions with some or all payers, many practices did not receive payments for weeks, which put them in precarious financial situations. We heard from practices that were awaiting $100,000 - $500,000 in payments and were having trouble meeting their financial obligations of payroll and rent.

Practices were encouraged to take steps, such as decreasing spending to increase cash reserves or obtaining a line of credit before switching to the Version 5010 transactions to prevent major financial issues if payments were interrupted. In spite of these efforts, many practices still faced significant financial shortfalls. Physician practices will need to take more action in the future when they undergo a HIPAA transition, which experience has shown to be very disruptive to claims processing and reimbursement.

In addition, the AMA has worked hard advocating for a more flexible Medicare advanced payment policy. Medicare has indicated that it is reviewing its advanced payment policy to determine if changes can be made to support physicians in good standing with the program. In particular, Medicare is looking specifically at ways to address the practices that experience egregious cash flow situations stemming from the lack of Medicare reimbursement as a result of a HIPAA transition or other disruptions that can dramatically affect claims processing and reimbursement. If changes are made, they will be greatly beneficial to practices impacted by a lack of Medicare reimbursement.

Recommendations Going Forward

In summary, the AMA makes the following recommendations for the Department of Health and Human Services (HHS) to pursue for future adoptions of HIPAA transactions:

- Conduct more outreach and communication efforts, specifically targeting small practices and rural communities;
- Give more consideration to the impact of Errata, specifically related to vendors' product availability and installation. If Errata are necessary, the compliance deadline should be extended at the time of the adoption of the Errata;
- Create an industry standard for comprehensive, end-to-end testing;
- Raise awareness of the need for more customer support during HIPAA transition periods;
- Provide stronger messaging and support to practices to be prepared for disruptions in payments; and
- Implement a more reasonable Medicare advanced payment policy during HIPAA transitions.

Thank you for considering our experiences on the implementation of the Version 5010 transactions and our recommendations for future implementations. Should you have questions or require additional clarification about this testimony, they may be directed to Nancy Spector, Director, Electronic Medical Records, at 312-464-4059 or nancy.spector@ama-assn.org.