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

Good afternoon, I am Tammy Banks, Director of Practice Management Center and Payment Advocacy at the American Medical Association (AMA). The AMA would like to thank the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Standards for inviting our input on the implementation of operating rules to increase the value of the Health Insurance Portability and Accountability Act (HIPAA) standard transactions.

The AMA strongly supports the administrative simplification provisions in the Affordable Care Act which are designed to fix the problems associated with the transmission of health care information. These problems have significantly hampered the ability of the health care industry to fully automate its activities. The AMA supports the work that X12, the Workgroup for Electronic Data Interchange (WEDI), and the Committee on Operating Rules for Information Exchange (CORE) have undertaken to identify and remedy the hurdles which have been encountered to date, and urges NCVHS to implement the ACA administrative simplification provisions in a fashion that leverages and enhances those efforts.

Implementation/Education

The AMA is gratified by the increasing industry wide commitment to addressing the problems associated with the transmission of health care information, and particularly by the increasing sensitivity of the national commercial health insurers to the automation needs of the physician community. **Administrative simplification is a team sport—it simply cannot be achieved without the coordinated efforts of all the trading partners and all the standard, operating rule and code setting bodies.** The AMA supports, participates in, and appreciates the work which has been and is being done by CORE. Health care is often compared to the banking industry. However, we need to realize one of the main differences between the automation efforts of the banking and health care industries is that the work of creating electronic transactions is distributed among a number of separate entities in health care, while in the banking industry it is consolidated in a single entity, the Electronic Payments Association (NACHA). This undoubtedly reflects, in part, the greater complexity of the health care system, but it also makes the standard setting and operating rule process more complex. Indeed, as between X12 and CORE, the process is iterative, with the potential for each organization to build on the work of the other as operating rules are incorporated in the implementation guide for the subsequent X12 standard, which then creates the opportunity for further refinement in the subsequent operating rule. And, the work of X12 and CORE must also be harmonized with the pharmacy standards created by the National Council for Prescription Drug Programs (NCPDP) and the work of the various code set developers.

The physician practice experience with the implementation of new versions of standards and operating rules should be seamless and incorporated within their daily workflow, using their practice management system. Physician practices look to their practice management systems and clearinghouses to implement and be compliant with the mandated standard transactions and operating rules. **Without practice management system, trading partner, and payer compliance with the standard transactions, we as an industry will not realize the cost savings being touted today.** Physicians simply cannot establish separate workflows for each of the many payers they typically work with. When the electronic standards do not work industry wide, physician practices must drop to paper.

Enforcement

Finally, we must reemphasize the importance of enforcement if we are ever to get to the fully automated health care system envisioned by HIPAA and now mandated by the ACA. Lack of compliance by health plans is slowing the adoption of electronic transactions by the provider community, as the value of these transactions is dramatically reduced to the extent that they cannot be implemented within a physician's practice management system consistently to provide an integrated and automatic single practice workflow across all payers with which a physician or other health care provider does business. It is extremely difficult for organizations, particularly smaller practices, to implement multiple workflows. They will almost certainly not adopt new versions of standards or operating rules if that industry wide functionality will not be forthcoming. Unless all of a practice's trading partners use electronic transactions which meet the practice's needs, the practice will likely find it more efficient to continue to use manual processes which can not be used consistently and effectively.

This is the same issue we messaged out in 2008 and remains equally relevant today. **We must increase enforcement, accuracy, and functionality of existing electronic health care standard transactions, and this should also apply to the upcoming eligibility operating rules and future operating rules.** Fully compliant implementation of all the standard transactions has not been completed by many HIPAA covered entities, let alone third party administrators, practice management systems, and other agents of those covered entities. Moreover, some covered entities using standard transactions have implemented them with variations of interpretation. Thus, true standardization has not yet been obtained, despite the transaction rules.

Functional Compliance and Certification Needed

Even though the industry has experience with the electronic health care standard transactions through both the ASC X12 4010 and 5010 versions of the standards, realizing the full potential of administrative savings has yet to become a reality. The primary barrier to maximizing savings is the gap between syntactical compliance and functional compliance.

Functional compliance, for purposes of this document, is defined as meeting the business requirement that the transaction supports. It is all too common for a transaction to be syntactically correct but fail to meet the business requirements. For instance, the payer has a critical business need to know if a physician who has submitted a claim is in the patient's network or out of the patient's network. The payer may be syntactically correct in selecting a status code of in-network relating to the patient's in-network benefit plan, but the physician may in fact be out-of-the patient's network. The resulting error and rework for one or both parties cancels the expected efficiency of the transaction standard.

The AMA strongly recommends mandated functionality testing of the HIPAA standard transactions and operating rules be conducted by all payers and trading partners, including practice management system vendors. Practice management system vendor certification should also be considered to encourage the increased functionality that will benefit all stakeholders.

Physician Engagement Resources

In addition to our advocacy efforts to improve the value of the electronic transactions for physicians, for the past five years, the AMA has rolled out the national "Heal the Claims Process"™ campaign. The goal of the campaign is to help physician practices achieve administrative simplification and save money by streamlining their practices. This is best done through the use and adoption of electronic health care transactions and operating rules. Physician practices that become more automated will begin to see efficiencies and enhanced workflows that offer not only time savings, but cost savings as well. This year, the campaign will focus on encouraging physician practices to use the HIPAA 5010 transactions and prepare for the upcoming eligibility operating rules.

Practice Management System Software Vendor Directory

The Practice Management System Software (PMSS) directory identifies vendors offering software for physician practices. The directory is the result of the joint efforts of the AMA and the Medical Group Management Association (MGMA), and complements the online resource Selecting a Practice Management System toolkit. Thirty-three vendors currently comprise this vendor database and the majority of the self-reported information was compiled in 2011. Of these practice management system vendors, 23 percent provide the functionality as contained in the Council for Affordable Quality Healthcare (CAQH) CORE Phase 1 and 2 and the certified response of 30 vendors was as follows: 7 percent made the functionality optional; 33 percent were under development; and more concerning, 37 percent did not provide this functionality at all. **The AMA and MGMA will continue to raise vendor awareness of the functionality needs of physician practices and will also continue to educate physician practices on the functionality that they will need to succeed in the 21st century.**

Additionally, the AMA and MGMA are partnering with WEDI to host two vendor and practice engagement conferences to engage practices to improve their workflow and challenge their vendors to develop more user-friendly and efficient practice management products. The first session occurs on July 23, 2012, in Fairfax, Virginia.

Practice efficiency can be improved through the adoption of claims revenue cycle automation solutions, and physician practices must begin to challenge their practice management system vendors to leverage the new standards and operating rules and offer state-of-the art features for the 21st century automated practice. Inefficient health care claims processing, payment and reconciliation carry estimated annual costs of between $21 and $210 billion. In the physician practice, this expense equals, on average, 10-14 percent of practice revenue. Streamlining prior authorization alone could result in over $700 million in cost savings for all size practices.

The AMA is committed to the administrative simplification objective within the physician practice, and is pressing for: point of service pricing through automated, real-time health plan transactions; single integrated workflow for all lines of businesses that will reduce costly manual processes throughout the

physician's claims revenue cycle; and increased transparency and reduced ambiguity during the health insurer claim payment process. The upcoming operating rules that cover eligibility, health claim status, electronic funds transfers (EFT), and others, as well as future mandated standards, specifically attachments and acknowledgements are critical to achieving these goals, but only if they are implemented industry wide.

We look forward to continuing to work collaboratively with NCHVS and respective stakeholders to bring about administrative simplification for physicians and others in the industry. Physicians will adopt additional electronic standard transactions when it makes economic sense for them to do so. The medical profession looks forward to the day it can leave the opaque, paper-based health care process for a fully transparent, fully electronic system. Such a system would dramatically reduce cost and complexity of the business of medical practice, resulting in increased time and resources that physicians can devote to their patients.