National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards

Hearing on Predictability Roadmap
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Testimony from the American Medical Association

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The American Medical Association (AMA) thanks the National Committee on Vital and Health Statistics (NCVHS) for the opportunity to provide our written comments on the Draft Recommendations for the Predictability Roadmap.

The AMA is a long-time champion and supporter of administrative simplification and recognizes the important role that reduction in manual burdens and processes can play in achieving the Quadruple Aim of improved patient experience of care, improved health of populations, reduced per capita health care costs, and improved clinician experience. We applaud the significant progress that the health care industry has made in reducing administrative costs through the implementation of the Health Insurance Portability and Accountability Act (HIPAA)-mandated transactions. We believe, however, that the current standards development, adoption, and implementation processes need further refinement and improvement.

Physicians have a unique and valuable perspective from which to offer recommendations on administrative transactions. **While payment-related functions comprise the primary business of most other stakeholders in the health care industry (e.g., health plans, clearinghouses, and vendors), revenue cycle transactions play an auxiliary, supporting role for physicians and other health care professionals, whose principal responsibility is providing patient care.** As a result of this unique viewpoint, we urge the Standards Committee to consider our comments while determining the appropriate course of action.

Comments and Concerns

After adoption of the initial Version 4010 electronic standard transactions, it took more than 10 years for the finalization and adoption of the Version 5010 transaction set. Since this 2012 mandate requiring the transition to Version 5010, the industry has released no updated versions of the standards, with the proposed Version 7030 transaction set presumably several years away from being named in regulation and subsequently mandated. The more than 10-year cycle for transaction updates fails to keep pace with the needs of the industry and to account for changing payer-provider relationships. Because of this inflexibility, providers are often forced to comply with individualized patches to meet the ever-changing needs of health plans. Such patchwork erodes the ability of the standards to promote administrative

simplification. For these reasons, the AMA commends NCVHS for initiating the Predictability Roadmap to help ensure that the standard transactions can work more efficiently.

The AMA believes that the potential impact on physician workload and patient care should be carefully considered before updating the standards development processes. After reviewing the proposed recommendations through this lens, we have the following broad areas of concern regarding the Predictability Roadmap:

- Variation in standards via trading partner agreement;
- Elimination of the Designated Standards Maintenance Organization;
- Increased costs associated with more frequent changes to transaction standards;
- Improved compliance and enforcement; and
- Provider representation in standards development.

Variation in Standards via Trading Partner Agreement

The slow pace of standards adoption coupled with the frequent industry needs for additional functionality creates inefficiencies in administrative workflows. To solve this problem, many in the industry push to allow payers to innovate beyond the standard and create specific solutions to meet their business needs. In furtherance of this ideology, the draft recommendations support establishing a basic "floor" for standards and operating rules, with industry participants allowed to advance beyond this standard "floor" via willing trading partner agreement.

While the AMA supports innovation to meet industry participants' needs, we are concerned about accomplishing this goal via trading partner agreement, as the discrepancy between health insurer and provider bargaining positions may limit a provider's ability to willingly participate (or not participate) in nonstandard electronic data interchange (EDI) usage agreements. Specifically, in many states and markets, physicians' financial viability is entirely dependent on participation in particular health insurer networks. This dependency could force physicians to agree to an insurer's terms of participation that they might otherwise oppose, including usage of idiosyncratic EDI interchange rules.

Fostering payer-specific EDI transactions—particularly without adequate provider freedom of choice—would compromise some of the intended efficiencies of the HIPAA standards. As HHS expressed when proposing the original HIPAA standards, "Standard EDI format allows data interchange using a common interchange structure, thus eliminating the need for users to reprogram their data processing systems for multiple formats."[1] As the regulation astutely predicted, the benefit of the transactions for providers is the efficiency of performing revenue cycle processes consistently across payers. By creating the ability for payers to tailor information exchange beyond the standard baseline to meet their needs, the proposed recommendations could re-introduce inefficiencies associated with payer-to-payer variations. In order to ensure that the necessary innovations can be made and tested, **NCVHS should develop and enact a pilot program for standards advancements that adequately protects physician autonomy, such**

[1] FEDERAL REGISTER: MAY 7, 1998 (VOLUME 63, NUMBER 88) PAGE 25271-25320

as a requirement of CMS oversight or approval of pilots prior to implementation.

Elimination of the Designated Standard Maintenance Organization

The HIPAA Administrative Simplification regulations established the Designated Standards Maintenance Organizations (DSMO) with the charge of maintaining standards for health care transactions adopted by the Secretary and receiving and processing requests for adopting new standards or modifying an adopted standard. While the DSMO continues to receive requests to adopt new standards and modify adopted standards, it receives very few initial change requests. Although the function of the DSMO has changed, the AMA recognizes the continued need to foster collaboration, consistency, and support amongst the standards development organizations (SDOs) and data content committees (DCCs) when considering changes to the HIPAA standards and ongoing development of varying solutions to meet the industry needs. For example, such cross-SDO coordination and cooperation would be valuable in any forthcoming rule related to electronic attachments, as standards from several SDOs are involved in the exchange of supporting clinical documentation. The question is if this work can be done by the DSMO or if another organization should be formed. At this time, **the AMA recommends that NCVHS further research and evaluate the specific roles and responsibilities of this envisioned cross-SDO/DCC organization and then determine which entity will best facilitate the work. We also recommend that NCVHS conduct a cost-benefit analysis before reaching a final recommendation on this matter, as there should be a clear return on investment associated with any new entity created to replace the DSMO.**

Increased Costs Associated with More Frequent Changes to Transaction Standards

The AMA supports necessary changes to the transactional standards to meet industry needs without the delays associated with the current 10-year release cycle. We believe, however, that the potential financial impact of more frequent version changes and the associated system updates must be carefully considered and addressed before moving forward with any new standards release schedule. In order to transition to new standards, all stakeholders are required to make significant software and workflow updates, which can be extremely costly and time-consuming. For example, CMS reported in a 2015 letter to Senator Elizabeth Warren that it spent approximately $700 million and 5 years updating Medicare systems from Version 4010 to Version 5010.[2]

A regulatory framework requiring industry participants to more frequently absorb such costs without clear and significant benefit would not only eliminate potential administrative savings, it may create a greater reluctance to participate in EDI transactions altogether. With figures and concerns such as these in mind, **the AMA recommends that, prior to any recommended update, NCVHS conduct an appropriate return-on-investment (ROI) analysis across each stakeholder group (e.g. providers, payers, etc.) to ensure that the update will be worth the related costs for all industry segments.**

[2] http://assets.fiercemarkets.net/public/Warren%20Final%20Signed.pdf

Improved Compliance and Enforcement

The administrative transactions increase efficiency and reduce business costs industrywide, making adherence with the standards generally in a health plan's best interest. Nonetheless, ensuring health plan compliance is essential to achieving EDI uniformity across the revenue cycle and the intended benefits of the HIPAA transactions. Until the information being conveyed electronically eliminates the need for follow-up phone calls and other manual processing, administrative simplification will remain an unfulfilled promise. Moreover, the information in the standard transactions must be at least as robust as the information provided via a payer portal or other manual process.

Although the HIPAA legislation and regulations include plans for health insurer audits and compliance certification, enforcement of the HIPAA transaction standards is still entirely dependent on a provider complaint system. Currently, physicians must file a formal complaint against a noncompliant health plan with the Administrative Simplification Enforcement and Testing Tool (ASETT), which is then researched and arbitrated by the CMS Division of National Standards. The AMA commends NCVHS for urging increased transparency and additional physician education surrounding the complaint process in its draft recommendations; however, we are concerned that the recommendations fail to offer any additional enforcement mechanisms or penalties for noncompliance.

The October 2017 withdrawal of the "Administrative Simplification: Certification of Compliance for Health Plans" proposed rule eliminated the prospect of having an external oversight body ensure health plan transactional compliance, leaving initiation of enforcement action solely in the hands of providers. Providers are often apprehensive about filing a complaint against health plans due to their dependence on insurer claims revenue and fear of plan retaliation. Additionally, the ASETT complaint system requires a significant amount of physician time and resources to pursue, as the process requires registration, the filing of a formal complaint, subsequent fact-finding, and potential in-depth analysis. Amidst this concern, the AMA is unaware of a single instance in which CMS has fined or otherwise penalized health plans for noncompliance through the ASETT complaint system. To effectively deter noncompliant behavior, an enforcement system must sufficiently penalize entities in violation of the HIPAA standards. Appropriate enforcement of HIPAA standards violations would send a strong message and undoubtedly lead to widespread improvements in transactional compliance across the industry—and would reduce the reliance on the provider complaint system alone. As a result, **the AMA encourages NCVHS to recommend enhancements in transactional compliance enforcement to protect provider rights, including (1) increased transparency and visibility of enforcement activities; (2) a multifaceted, enforcement program, to include audits, certification, corrective action plans, and provider complaints; and (3) appropriate penalties for health plan noncompliance.**

We also urge NCVHS to suggest areas for enforcement priority based on the potential impact of improved compliance. For example, there is nearly universal agreement across the health care industry on the need for greater efficiency and automation in the prior authorization process. Prioritizing compliance with the HIPAA-mandated transaction for medical services prior authorization (X12 278) would significantly reduce administrative costs for both providers and health plans and—more

importantly—minimize patient care delays. NCVHS could also use testimonies from previous hearings to determine other transactions that should be prioritized for enforcement activities.

Provider Representation in Standards Development

The AMA appreciates the NCVHS efforts to improve the standards oversight and development processes within the draft recommendations, including the call for increased provider education, the development and release of best practices, and greater transparency. These recommendations create an important framework within which standards could effectively and efficiently be crafted. For these improvements to facilitate meaningful change, the industry needs to ensure that the standards truly reflect the collaborative work and agreement amongst the various industry participants. Although health plans, clearinghouses, vendors, and providers are all represented within existing SDOs, provider participation is significantly limited. The AMA supports NCVHS's goal of additional outreach to encourage physicians and other health care professionals to participate in SDOs, as increased provider input would benefit the standards. It must, however, be acknowledged that participation in SDOs, which requires significant technical knowledge and resources, is frequently impractical for physicians. Physicians, particularly those in smaller practices, often do not have the resources to expend on developing future administrative functionalities and must instead devote their limited resources to addressing the immediate demands of clinical practice and patient care. As a result, providers are unlikely to ever truly have representation in SDOs that is reflective of their usage of standards. In acknowledgment of this, **NCVHS recommendations should include additional protections to ensure a more proportionate provider voice during the development of standards.**

The AMA enthusiastically supports NCVHS's efforts to improve the administrative simplification transactions development processes, and we thank you again for the opportunity to provide our feedback on the Predictability Roadmap draft recommendations. We urge you to consider the comments outlined above and in our oral testimony, as we believe that they will help protect the amount of physician time and resources available for direct patient care. We look forward to continuing to work with the Committee and all industry stakeholders to identify and implement innovative ways to improve the efficiency of health care in our country. If you have any questions, feel free to contact Nancy Spector, Coding and HIT Advocacy Director, at nancy.spector@ama-assn.org.