AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Response to NCVHS Recommendations to Modernize Adoption of HIPAA Transaction Standards

Dear Secretary Becerra:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express serious concerns with the recommendations recently submitted to your office by the National Committee on Vital and Health Statistics (NCVHS) regarding electronic transaction standards mandated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[1] The AMA has long advocated for the adoption of electronic transaction and code set standards to reduce administrative burdens for physicians and their staff and promote uniform communication between practices and the many health plans with which they do business. However, we are alarmed that the recent NCVHS recommendations significantly deviate from the original goals of the HIPAA administrative simplification provisions and could lead to increased costs, major inefficiencies, and patient care disruptions if implemented in their current form. The Biden administration has recognized the harm that administrative burden places on health care professionals. The AMA greatly appreciates the efforts the administration is making to reduce burden. If, however, HHS implements the NCVHS recommendations, the AMA strongly believes the policies will severely undermine any progress in this space. **For these reasons, we urge the Secretary to reject the NCVHS recommendations detailed below.**

Adoption and use of more than one standard per business function

In its July 2022 letter, NCVHS directed HHS to "update relevant HIPAA policies to allow the adoption and use of more than one standard per business function." Currently, all HIPAA-covered entities are required to use a single electronic transaction standard for a particular revenue cycle function. While the AMA appreciates the spirit of innovation and flexibility underlying the NCVHS recommendation, **we strongly object to NCVHS' apparent abandonment of the basic tenets underlying HIPAA administrative simplification—namely, that physicians and other health care professionals should be able to interact with all health plans using the same transaction standard and same format and enjoy the cost savings and improved efficiency resulting from this standardization.** Indeed, NCVHS seems to be suggesting a reversion to the pre-HIPAA world, in which every health plan used its own

[1] NCVHS Recommendations to Modernize Adoption of HIPAA Transaction Standards, July 28, 2022. Available at: https://ncvhs.hhs.gov/wp-content/uploads/2022/08/Recommendation-Letter-Modernize-Adoption-of-HIPAA-Transaction-Standards-508.pdf.

proprietary format for revenue cycle functions. The benefits of standardization were cited in the HIPAA administrative simplification final rule and remain relevant today:

> Administrative simplification will promote the accuracy, reliability and usefulness of the information shared. For example, today there are any number of transaction formats in use. There are **over 400 variations of electronic formats for claims transactions alone**. [Emphasis added.] As noted earlier, these variations make it difficult for parties to exchange information electronically. At a minimum, it requires data to be translated from the sender's own format to the different formats specified by each intended receiver. Translation usually requires additional equipment and labor.[2]

Allowing the use of multiple standards would return the industry to our previous "Wild West" environment, where the lack of uniformity necessitated costly translation between formats to conduct business.

In materials prepared for the June 2022 listening session, NCVHS suggested that while health plans would be required to support all adopted standards for a particular business function, providers could choose which one to use. Alarmingly, this leniency is not included in NCVHS' final recommendation letter and suggests that physicians—many of whom are small business owners—would also be required to support multiple standards for a single business purpose. **For small- and medium-sized practices, this is simply an untenable financial proposition, as these organizations do not have the resources to invest in duplicative technology to support multiple formats.**

Even if NCVHS intended to carry forward its initial approach on multiple standards (i.e., allowing providers to choose which standard to support), this presumes a level playing field in contracting relationships between physicians and health plans. While in theory providers could "choose" which standard to use, health plans could force use of a particular standard via network contracting arrangements, particularly for smaller practices with less negotiating power. Physicians could be forced to support one adopted standard for Payer A and another for Payer B due to contracting requirements. **For physicians, this situation would be unworkable, extremely burdensome and costly, and go against the underlying efficiency goals of administration simplification and electronic transaction and code set standards.** To be clear, medical practices often contract with a dozen or more payers. Any future framework that would permit concomitant use of multiple standards would therefore need strict guardrails to prevent health plans from forcing physicians to use a particular standard under a health plan's contract terms.

Please do not misunderstand the AMA's position: we wholeheartedly support adoption of newer technologies to address unmet business needs. However, we believe that allowing the concurrent use of multiple standards would increase costs, confusion, and inefficiency in our health care system. Given the limited resources available to invest in health information technology (health IT), we urge HHS to use the following approach when adopting new or revised standards to ensure sufficient return on investment across stakeholder groups:

- **Recognize successful transaction/code set standards to preserve/enforce (i.e., do not break what is working).** For example, the CAQH Index reports a 97 percent adoption of

[2] 45 CFR Parts 160 and 162, Health Insurance Reform: Standards for Electronic Transactions. Section J - Qualitative Impacts of Administrative Simplification.

the X12 837 for electronic claim submission,[3] suggesting that development dollars could be much better spent on other business functions and transactions.

- **Identify unmet industry business needs.** As noted by NCVHS, the industry is united in calling for a viable, standard approach to automating prior authorization, as adoption of the HIPAA-mandated X12 278 remains low (26 percent per the 2021 CAQH Index).[4]
- **Rigorously evaluate/test any new transaction standards considered for adoption.** A robust piloting program is needed to evaluate standards' maturity, viability in real-world settings across organizations of all sizes, and overall value.
- **Adopt a single transaction standard for a particular business function at a time; new or revised standards should replace previously adopted standards.** This will avoid stepping backward to the pre-HIPAA world of many proprietary formats and costly translation.

Following this approach will ensure that limited health IT resources are invested wisely to address the most urgent unmet business needs and avoid diversion of development time and dollars to duplicative efforts.

Support for one or more versions of adopted standards for business functions

NCVHS also recommends that HHS allow HIPAA-covered entities to support multiple versions of adopted standards for business functions. Again, while the AMA supports the innovative intent of this approach, we maintain that it could be extremely problematic to allow use of multiple versions of the same standard. **Indeed, allowing multiple versions of multiple standards could exponentially compound the issues we have already identified. This approach could lead to a *standards explosion*.** We stress that health IT is not a traditional marketplace, and physicians, particularly those in small practices, do not have the bargaining clout to negotiate for their "standard or version of choice" in payer contracts, meaning that they could end up being required to support multiple versions of multiple standards for a *single business function*. We again reiterate the basic tenets underlying HIPAA administrative simplification—cost savings and improved efficiency resulting from stakeholder uniformity.

Beyond the high costs and burdens involved in supporting multiple standards/versions, we are concerned about the testing and orchestration of several health IT systems that would be required by a medical practice to support such a complex scenario. In today's world, a snag in an upgrade to a single health IT system can bring the entire medical practice to a crawl—leading to care delays. Support for multiple versions would astronomically increase the potential for these sorts of harmful impacts on patient care delivery. These unnecessary disruptions would be compounded in less resourced medical practices such as small, solo, and rural clinics, which often serve marginalized and minoritized communities.

We also strongly caution against viewing clearinghouses or other intermediaries as an easy solution to versioning issues for physician practices. While vendors offering translation services may on the surface appear to solve the problem of practices needing to convert versions in-house, this outsourcing comes at substantial financial and administrative costs to physicians and, indeed, the entire health care system. Moreover, allowing multiple versions could stall the forward momentum of interoperability we are

[3] 2021 CAQH Index. Available at: https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf.
[4] Id.

experiencing today. Without controlling for different versions, health IT systems would receive incompatible software updates, breaking information exchange and creating backward compatibility issues. In fact, NCVHS envisions a future in which a cardiology practice would upgrade to a new version of the electronic claim while another specialty might not. This could lead to interoperability challenges between practices (e.g., preparation of good-faith estimates to meet requirements of the No Surprises Act), to say nothing of problems between different trading partners.

The decision to allow multiple versions should not be taken lightly. Yet, if HHS were to allow multiple versions of the same standard, **only the two most recent versions should be allowed at any one time, and it is essential that these versions be backwards compatible.** This would provide the minimal protection for market stability while also supporting innovation. In addition, there would need to be firm federal control and transition planning to support use of multiple versions. The Office of the National Coordinator for Health IT's Standards Version Advancement Process registry could perhaps serve as a model for version control and transitioning.

Evaluating the overall value and readiness of standards

Lastly, NCVHS recommends that HHS develop guidance to evaluate the readiness, costs, and overall adoption value of standards. Of NCVHS' four recommendations, supporting standards development organizations' (SDO) efforts to evaluate the impact of their standards should be HHS' principal focus. The AMA has long championed the inclusion of clinicians in the development, testing, and implementation of health IT standards. HHS should urge SDOs to create advisory committees comprised of physicians, nurses, office administrators and other frontline professionals. Those committees should be charged with the review and approval of all standards, guides, and work products before publication. Moreover, an implementation feedback loop should be established where "boots-on-the-ground" clinician experiences inform the next standards version. There is a significant gap between SDO work products and real-world medical practice, and one HHS is primed to address. Finally, as HHS considers the adoption of new and revised standards, **HHS should preference those standards that reflect input of frontline professionals who understand the data and workflow needs required by administrative and clinical processes.**

Thank you for considering our comments on the NCVHS recommendations on HIPAA transaction standards. Again, we offer our feedback from a position of supporting innovation to meet unmet business needs while ensuring that the industry does not lose sight of the tremendous value of the original HIPAA administrative simplification provisions. If you have any questions regarding this letter or would like to schedule a follow-up discussion, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD

cc: Chiquita Brooks-LaSure
Mary G. Greene, MD