AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

October 14, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Attn: CMS-0009-P
P. O. Box 8014
Baltimore, MD 21244-1850

Dear Mr. Weems,

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents over 93,000 physicians and medical students nationwide. Specifically, I am writing to offer our comments on the proposed rule to adopt updated versions of the standards for electronic transactions.

As noted in the proposed rule, this proposal is for modifications to the electronic standards originally adopted in 2000 and modified in 2003. Those standards are envisioned to provide a consistent framework for electronic transactions and to provide for administrative simplification. As also noted in this proposed rule, the benefits of these standards have been limited by operational and technical gaps and the use of "companion guides." In particular, the use of companion guides has effectively allowed individual health plans (perhaps most notably, federal and state programs) to work around the implementation specifications and require non-standard data content. Physicians who were forced to make significant investments in technology and training and, in many cases, have suffered through long delays in the payment of claims, need and deserve to see the administrative simplification promised so long ago.

Unfortunately, physicians have little confidence that they will see gains from the proposed update and have concerns that, like past Health Insurance Portability and Accountability Act (HIPAA)-related rules, this proposed rule will impose significant implementation burdens and yet more unrecoverable costs. Based on this, we urge this administration not to continue under-estimating the impact of this transition and to address the roadblocks that physicians and other healthcare entities have encountered during the transitions to the current standards and the National Provider Identifier (NPI) implementation. Specifically, we note the following concerns:

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- A timeline based not on data but on the Centers for Medicare and Medicaid Services (CMS's) beliefs and desire to speed the International Classification of Diseases, Tenth Revision (ICD-10) conversion
- Disregard for expert testimony and recommendations regarding sequencing and pilot testing
- Dependence of physicians on non-covered entities, including software vendors, to provide system updates
- Understated costs and overstated benefits associated with the transition
- Concurrent CMS initiatives that require extensive resources

The Timeline

We disagree with CMS that the industry experience with implementation issues will enable them to conduct design/build activities and schedule and perform testing within 12 months. This is in direct opposition to testimony heard from the industry and the timeline identified by the Workgroup for Electronic Data Interchange and the North Carolina Healthcare Information and Communications Alliance that included implementation steps through the year 2014. The National Center for Vital and Health Statistics (NCVHS), after considering testimony from the industry, recommended, "*HHS should also take under consideration testifier feedback indicating that for Version 5010, two years will be needed to achieve Level 1 compliance."*

We further disagree that the need for transition to ICD-10 is a reason to rush this transition. The fact that there is a push for the implementation of the ICD-10 code sets does not negate the responsibility of CMS to allow for an orderly transition to the 5010. The compliance deadline of April 1, 2010 for all covered entities is not supported by this argument. Since implementation of ICD-10 depends on implementation of the 5010, the effective date for ICD-10 implementation should depend on the 5010 implementation schedule, not vice versa.

For these reasons, CMS should reconsider the proposed compliance date of April 01, 2010, and instead include in the final rule for the 5010 transactions a compliance date that is 24 months beyond the issue date of that final rule.

Sequencing and Pilot Testing

By offering one compliance date for all entities, CMS ignores the need for sequencing and pilot testing that could reduce the burdens of the transition. Particularly, the single compliance date for all entities creates a situation where physicians find themselves in the undesirable position of dependency on not only their software vendors but on health plans and clearinghouses who must conduct their internal testing prior to allowing physician testing. In past experiences with the 4010 and NPI conversions, this has allowed little time to conduct testing of their transactions before the implementation date and often resulted in delayed payments and substantial administrative overhead costs. Because none of the proposed standards have been tested in a production situation, it is reasonable to allow additional time for such testing as indicated in our request for a full 24 month implementation period.

We acknowledge the concerns of CMS regarding additional burdens of a staggered implementation schedule but also suggest that CMS has the ability to restructure its timeline to accommodate the staggered implementation. CMS suggests that use of dual systems for the duration of the testing period could add to the cost of implementation and that physicians and other health care professionals would incur more costs in managing their own implementation schedule. What is not recognized is that these costs will be necessary either in a planned implementation schedule or in time and productivity lost in dealing with issues resulting from a poorly planned and untested implementation. A well-structured implementation period, as suggested by industry during testimony to the Subcommittee on Standards and Security in July 2007 and recommended by the NCVHS, should be conducted in an effort to avoid delays and permit pilot testing that allows for early identification and resolution of issues. NCVHS noted that staggering compliance dates to bring payers and clearinghouses into compliance one year prior to the compliance date for physicians and other healthcare providers would facilitate end-to-end testing. Again, this supports a two-year implementation period.

Dependence on Vendors

Physicians and other health care professionals must rely upon their software vendors and other trading partners in the transition to the 5010 standards. A physician with a significant investment in a practice management system is placed in the undesirable position of dependency upon the vendor of that system to provide timely and effective system upgrades or, in the absence of these, to purchase yet another system or work-around through a clearinghouse. As software vendors are not covered entities under HIPAA, there is no mandate for them to plan for and provide timely upgrades. While some will have contractual obligations or simply see a need to provide a good client experience, we note that this has not been the case with some vendors in the past. This may be especially true for small physician practices with less sophisticated software.

All software vendors will need time for planning and mapping the new data, reviewing the old mapping for changes, verifying rule changes, and testing. These vendors and the physicians who depend on them as business partners should be given ample time and a structured implementation schedule for these activities as discussed above and noted in testimony from Electronic Data Systems, and the Healthcare Information and Management Systems Society. Vendors also testified that due to past experience with changes that occurred between the proposed and final rules, they will not begin to analyze and code until the final rule is issued. This calls for a time line that begins on the date the final rule is issued and is sufficiently long enough for the required planning and implementation. Again, this is supportive of a two year compliance deadline from the date that the final rule is issued.

We also note that the impact study provided to CMS by Gartner predicts adoption rates for the standards for referral request and response (278), claims status request and response (276/277), and eligibility request and response (270/271) to reach only 20% in the next ten years. Both vendors and physicians have been slow to utilize these transactions because there is a lack of a business case for development of the transactions. The AAFP has participated with CMS and others in activities of the Committee on Operating Rules for Information Exchange (CORE), which has worked to promote the adoption of voluntary rules that encourage standardization of electronic healthcare data and the use of electronic

information exchange before or at the time of patient services. We are unclear as to whether the changes in the 5010 transactions support this effort or have potential to further delay expanded use of the transactions. We ask that CMS investigate the effect of this proposed rule as related to the CORE rules adopted by CORE certified entities and any potential effect on the inclusion of related functions in practice management systems.

Costs and Benefits

CMS's suggestion that the costs of this change will be minimal for physicians shows a lack of understanding of the physician practice environment. As noted recently in the Medical Group Management Association's September 9, 2008, press release[1], the gap between practice operating expenses and revenues swelled to 6.29% for multispecialty primary care practices and is similar for family medicine single specialty practices. In the current financial environment, any increase in overhead costs has a substantial impact on the practice and in turn, the ability to provide health care services. While CMS notes that vendor contracts that include free upgrades may postpone the costs until the time of contract renewal, CMS also notes that the estimated benefits will not be recognized until at least 2012, leaving even those practices whose upgrade costs may be postponed with a potentially unsustainable deficit.

We also note that the benefits of this transition will only be seen if companion guides are not allowed as they have been with the current transaction set. If testing indicates that once again standardization cannot be achieved, there is little value in disrupting an entire industry to achieve yet another system that requires plan-specific work-arounds, and this transition should be postponed until such time as true standardization can be delivered.

Concurrent Initiatives

Perhaps of most concern to physicians and other health care professionals, CMS must not view each of its initiatives and rules within a silo; not recognizing the overlapping effects of each. Physicians today are not only struggling with payment issues but also with implementation of electronic health records and e-prescribing, which are strongly advocated by this administration. In the midst of all of this, physicians continue efforts to participate in quality improvement activities, such as the Physician Quality Reporting Initiative, and with continued NPI delays due to enrollment/crosswalk issues. Physicians also recognize that this proposed rule does not represent an end to the HIPAA-related changes. Indeed, CMS proposes to overlap the implementation timeline of the 5010 with the adoption of ICD-10 code sets. We will provide separate comments on the proposed adoption of the ICD-10 code sets but will take this opportunity to implore CMS to recognize that physician practices have limited resources and staff to manage change and that patient care may ultimately suffer if physicians are not offered adequate time to prepare for and implement change.

In conclusion, we support an orderly and sufficiently long-enough transition to the 5010 and the additional administrative simplification it promises. From our perspective, such a transition would give physicians and vendors at least 24 months after publication of the final rule to conduct the necessary design/build activities and schedule and perform testing before

[1] MGMA e-source: Medical Group Practice Costs Outpace Revenues http://www.mgma.com/article.aspx?id=21926 accessed 09/16/08

compliance is mandatory. It would also permit the sequencing and pilot testing necessary to a smooth transition and to prove that the standards can be adopted without modification. We urge CMS to revise its proposed compliance and effective dates accordingly.

We appreciate the opportunity to provide comments to CMS on this important matter.

Sincerely,

Jim King, M.D.
Board Chair

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