



Response to “Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets” NPRM (RIN 0938-AQ13)

Submitted via Federal eRulemaking Portal

May 16, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-0040-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Secretary Sebelius:

The North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA) is a nationally recognized, nonprofit consortium that serves as an open, effective, and neutral forum for health information technology and policy initiatives that improve health and care. NCHICA is comprised of over 230 member organizations representing the many sectors of the healthcare industry, including covered entities, as well as government agencies, business associates, research organizations, application vendors, consultants, and attorneys.

NCHICA would like to take this opportunity to respond to the Department of Health and Human Services’ request for comments on the above referenced notice NPRM concerning the federal adoption of a standard for a unique health plan identifier and the proposed delay in the ICD-10-CM and ICD-10-PCS compliance date. NCHICA’s comments on this NPRM are the result of a collaborative effort from NCHICA’s various member organizations representing a diverse cross section of healthcare stakeholders including vendor, clearinghouse, provider, and payer input.

It is NCHICA’s stated mission to assist in accelerating the transformation of the U.S. healthcare system, through the effective use of information technology, informatics and analytics. NCHICA is a strong supporter of the Patient Protection and Affordable Care Act and the Secretary’s work thus far in implementing the administrative simplification

provisions under section 1104 of the Act. Our membership believes strongly in the potential of administrative simplification to increase safety and quality of care while reducing costs. We believe the best way to achieve these goals is by maximizing the return on investment for these mandates thereby providing incentive for increased use of the transactions for which the Secretary has adopted a standard.

NCHICA supports an extended compliance date of no more than one year for the adoption of the ICD-10-CM and ICD-10-PCS code sets. We appreciate CMS' decision to maintain the same compliance date for ICD-10-CM and ICD-10-PCS. NCHICA agrees in principle with creating both a health plan identifier (HPID) and an other entity identifier (OEID). Furthermore, we support the enumeration of health plans at both the controlling health plan (CHP) and subhealth plan (SHP) levels. We also agree that the HPID is not necessary for commercial pharmacy purposes as the Bank Identification Number (BIN)/ Issue Identification Number (BIN/IIN) and Processor Control Number (PCN) are sufficient in current transactions.

However, we have several concerns about the HPID and OEID rule as proposed. We are concerned that the rule:

- needs additional clarification on the intent, purpose, and use of the HPID and especially the OEID including the expected business process for use in the transactions and the qualifications for enumeration;
- may introduce an additional level of complexity if steps are not taken to eliminate duplication of enumerated entities and enumeration of the OEID remains voluntary as proposed;
- may be interpreted to endorse the use of the HPID or OEID immediately upon enumeration by the health plan or other entity creating a period of dual use that is not currently supported by all of the ASC X12 v5010 standards and may not be adequately proportioned to allow time for external testing; and
- will hinder ICD-10 implementation due to a lack of adequate industry resources.

NCHICA would like to propose the following recommendations:

1. INTENT, PURPOSE AND USE OF THE HPID AND OEID

In reviewing the proposed rule for comment with various stakeholders, it has become clear that further clarification is needed in the usage of the HPID and OEID as envisioned by the Secretary. The National Committee for Vital and Health Statistics (NCVHS) held hearings from a broad pool of stakeholders on July 19-21, 2010 in preparation for its recommendation to the Secretary. At that meeting, various stakeholders presented on the desired granularity of the plan ID to solve for various business needs in the market. While various proposals were presented, a dichotomy was formed between simply replacing the proprietary identifiers currently used in standard transactions and a desire for greater granularity to satisfy business needs of the provider community not directly related to the transaction. The proposed rule presented by the Secretary appears to have had the unintended consequence of confusing many as to the granularity of the identifier system.

In addition, many aspects of the business use of the HPID and OEID remain unclear. For example, as HHS has illustrated, the usage of an HPID and OEID, if widely adopted, could provide for a higher level of automation for the ASC X12 271 and the 835 transactions. It is unclear in practice however how the OEID would be used in the transactions themselves. The proposed usage of the OEID in particular suggests that the identifier could be used in segments by other entities acting as an “information source” where a payer identifier would be used in that same transaction today. Some have questioned whether the rule as written permits the OEID to be used as a submitter and receiver identifier in the envelope of a standard transaction in place of the electronic transmitter identification number. This is particularly true in clearinghouse exchanges where these identifiers tend to be proprietary numbers assigned by trading partner agreements at the time of initial connection to the plan’s transaction gateway.

Recommendation:

NCHICA recommends that the Secretary further clarify that the specific purpose of enumeration in the usage of the HPID and OEID in standard transactions. We ask the Secretary to further clarify the intent and purpose of the HPID and OEID in the final rule. We also ask to include more specific and real-world examples of the use of the HPID and OEID in various transactions and other business processes to provide further clarity on this point.

2. ENUMERATION OF SELF-INSURED GROUP HEALTH PLANS

The Secretary has stated in considering the purpose of the HPID, “...*the primary purpose of the HPID is for use in standard transactions in order to identify health plans in the appropriate loops and segments and to provide a consistent standard identifier so a health plan no longer uses multiple identifiers in the HIPAA covered transactions.*” However, in application of the examples of enumerated entities, the rule as written is still unclear as to whether the HPID and OEID is solely meant to replace proprietary and other identifiers as currently used in standard transactions. The Secretary seems to also indicate that the identifier has a secondary purpose meant to identify additional health plans and other entities that would not receive a standard transaction, but are enumerated for identification purposes beyond the scope of the standard transactions leading to the aforementioned confusion.

For example, the Secretary proposes to require that Self-Insured Group Health Plans be enumerated with an HPID if they meet the definition of a CHP. As correctly pointed out, some Self-Insured Group Health Plans utilize third party administrators (TPAs) to adjudicate claims and process electronic transactions. The Secretary has proposed that the Self-Insured Group Health Plan would be required to obtain an HPID, while the TPA would have the *option* of obtaining an OEID. In filing health care claims for benefits of the Self-Insured Group Health Plan, one would expect to use the OEID of the TPA to route claims to the appropriate adjudication system. In such cases, the HPID of the Self-Insured Group Health Plan becomes redundant and a potential source of confusion in conducting transactions. This situation could potentially cause some providers to incorrectly select the HPID when an OEID or other identifier is required, leading to misrouted or failed claims as a result. The proposed voluntary enumeration

process for the OEID only serves to make the correct identifier choice more challenging for billing staff.

Recommendation:

NCHICA does not support the HPID enumeration requirements for Self-Insured Group Health Plans as proposed. For the reasons stated above, we believe that an entity should be required to obtain an HPID or OEID if they are conducting electronic transactions directly and would require identification in the transactions for transaction processing purposes.

3. HEALTH PLAN IDENTIFIER ENUMERATION PROCESS

In the proposed rule, we interpret the Secretary to mean that all CHPs would be required to obtain one HPID per CHP. Furthermore, the CHP would have the option of obtaining an HPID on behalf of their SHPs or direct their SHPs to obtain HPIDs directly from the Enumeration System.

We recognize and support the need for both a CHP and SHP identifier to properly enumerate covered health plans and simplify the exchange of electronic transactions. However, it is our belief that the rule as currently proposed will lead to duplicative IDs caused by dual requests at both the SHP and the CHP levels. To attain administrative simplification and ensure the validity of the HPID enumeration process, we believe making the CHP responsible for all health plan enumeration requirements will resolve this issue.

Recommendations

NCHICA recommends that the Secretary consider a modification to the rule and define a responsible party for both the HPID application process and the HPID maintenance process. This will ensure there is a clearly defined owner for the information housed within the enumeration system.

4. MANDATORY USE OF THE OEID

The Secretary has asked for comment on whether the OEID should be voluntary as proposed, or made mandatory through trading partner agreements or other instruments. As proposed, the OEID will facilitate administrative transactions in circumstances where the “information source” is not a health plan. There are many situations where standard transactions are conducted by entities that do not meet the definition of health plan as defined by HIPAA. Therefore, NCHICA supports the enumeration of entities that are not currently defined as health plans in order to achieve uniformity.

However, it is NCHICA’s belief that the OEID requirements must match the requirements of the HPID to limit system requirement variability in order for the OEID to achieve the intended administrative simplification and return on investment (ROI) from a technical perspective. A voluntary OEID will only serve to require additional changes to existing connections as some entities replace their current identifiers and thus introduce another level of complexity without a discernible benefit to the industry. It is also our

belief that making the OEID mandatory will strengthen the intended purpose of the enumeration system and protect the validity of its data.

Recommendation:

NCHICA encourages the Secretary to make the OEID mandatory. We ask the Secretary to clarify that entities which trade electronic transactions for which the Secretary has adopted a standard must be enumerated. We believe this may be accomplished as the Secretary has suggested by making it mandatory that all covered entities require any trading partners that would qualify for an OEID be enumerated by contract, trading partner agreement, or business associate agreement as necessary and use that identifier accordingly in standard transactions.

5. ENUMERATION PERIOD

As stated in the proposed rule, *“Health plans would be able to begin to apply for an HPID on or after the effective date of the final rule, which we expect to be October 1, 2012, and must use it in standard transactions by the compliance date of the final rule.”* It has been observed that this language does not clearly prohibit a health plan from immediately using an HPID upon enumeration.

The Secretary correctly points out that the industry currently uses multiple identifiers that differ in length and format. Some enumerated health plans and other entities may seek to accept the new identifier to replace these legacy identifiers before the required compliance date for providers and clearinghouses. The transition to a universal standard will require time and resources to redesign systems to handle the conversion to a common format. As many providers and clearinghouses will require the full implementation time to prepare to use the HPID and OEID in transactions, this has led many to speculate that the Secretary means to implement a phased “dual use” approach much like the dual usage period allowed for ASC X12 v5010.

It is critical that HPID and OEID be implemented in such a fashion that the current TR3s may handle the identifier for all business uses. Not all of the ASC X12 v5010 TR3s support multiple payer identifiers; therefore a potential unintended consequence of early adoption of the HPID and OEID may be that ASC X12 is required to introduce another round of errata to some of the current TR3s to permit dual usage. Another round of errata must be avoided at the risk of vastly increasing implementation costs.

Recommendation:

NCHICA supports October 1, 2012 as the first date on which an entity may apply for enumeration. We recommend that the Secretary adopt the implementation date for all covered entities as a hard cutover date and permit the use of the HPID and OEID identifiers only for testing purposes prior to that date. We also ask that the final rule clarify that all enumerating entities must continue to accept legacy identifiers in a production environment prior to the compliance date for all covered entities (except small health plans) to provide a safe harbor for standard transactions and prohibit costly rejections and delays.

6. IMPLEMENTATION TIMELINE

One of the lessons learned from adoption of the ASC X12 v5010 standards was that adequate advanced testing was the key to a successful implementation. Unfortunately, due to many factors, a significant portion of trading partners were not ready to perform external testing in sufficient time to thoroughly discover issues prior to the January 1, 2012 deadline, leading to costly delays.

It is crucial that the industry understand and anticipate unintended consequences of changing identifiers used to route these transactions and work through these issues outside of the production environment. For instance, in addition to the possible impact of errors in cross-walking legacy identifiers to an HPID or OEID, the potential exists for legacy identifiers to continue to be used in reporting systems and acknowledgment transactions. Until the adoption of the standard acknowledgment transactions as recommended to the Secretary in the September 22, 2011 letter from NCVHS, the use of legacy IDs is still possible in proprietary acknowledgment transactions.

Correct use of the unique identifier in all transactions is crucial not only to the smooth operation of information exchange and billing as previously discussed, but in some cases necessary to protect against a potential breach of protected health information. The threat of misrouting a transaction due to an incorrect choice in identifier is a significant concern to the industry. Therefore, regardless of the method of implementation prior to the effective date, it is the belief of NCHICA that testing will be required prior to adoption of the new unique identifiers to avoid these potential issues. In order to provide adequate time to complete testing, we believe that the Secretary must set an interim milestone by which a Health Plan or Other Entity must obtain an HPID.

Recommendation:

NCHICA recommends the Secretary set a date for completion of enumeration of all applicable health plans and other entities at least one year prior to the compliance date to allow for adequate testing of the transactions.

6. COMPLIANCE DATE

In the proposed rule, the Secretary requests comments on the proposed compliance dates for the HPID and OEID. The dates proposed for all covered entities to use an HPID in a standard transaction, provided the final rule is adopted as intended on October 1, 2012, would be October 1, 2014 (except for small health plans, which would be required to use the HPID in standard transactions by October 1, 2015). We note that this NPRM also proposes to delay implementation of ICD-10-CM and ICD-10-PCS for all covered entities from October 1, 2013 to October 1, 2014, as we will comment on separately below.

As NCVHS observed in their September 30, 2010 letter to the Secretary on the health plan identifier, "*Timing associated with industry compliance of the ASC X12 v5010 and NCPDP D.0 financial and administrative transactions was also identified as troublesome. Along with modifications to accommodate v5010 and D.0 of the HIPAA*

standards, adoption of the HPID will have an impact on systems. Plan and provider information systems will require updating including expansion of data fields to accommodate the HPID, and crosswalks between existing proprietary identifiers and the HPID. Clearinghouses and vendors will need to update their systems and create crosswalk identifiers. Health plans will need to retool their systems to accommodate the new HPID, determine entities to be enumerated, communicate their HPIDs to trading partners, and accept the new HPIDs as valid on the transactions they receive. The HPID will also impact information systems that involve HL7 standard protocols.” In addition to these, we would point out that business processes will also need to be evaluated, contracts updated to ensure enumeration of other entities, and testing will be required to avoid breaches and potential disruptions in revenue chains. While ASC X12 v5010 supports both the HPID and ICD-10 in the standard transactions, a significant amount of work remains to be done to implement them within processing systems. In addition, the impact of the OEID must be evaluated.

It is NCHICA’s belief that the proposed rule timeframes for implementation will place an unnecessary burden on the industry to implement both the HPID, OEID, and ICD-10 system changes at the same time. This convergence of initiatives will require an additional burden on the same technical resources that will be implementing changes needed to handle ICD-10 implementation in standard transactions, such as testing prior to and monitoring after the effective date, and could endanger the success of both initiatives.

Recommendation:

We propose that HHS move the October 1, 2014 mandatory compliance date for the HPID and OEID to a minimum of 90 days following implementation of ICD-10-CM and ICD-10-PCS. If ICD-10 implementation should be delayed further, we believe the compliance date for the HPID and OEID mandate must be adjusted accordingly.

7. ICD-10 ONE YEAR DELAY

The proposed rule states, “A 1-year delay would enable the industry as a whole to test more robustly...” NCHICA supports a delay of no more than one year. The additional time will allow for not only additional testing but outreach, education and time for industry tools such as computer assisted coding to mature. A longer delay would run the risk of new, unanticipated regulatory requirements once again hampering ICD-10 implementation efforts. We agree a one year delay imposes additional costs for the industry and any further delay beyond one year would exacerbate costs by requiring re-assessment, re-education, and project team re-formation.

Recommendation:

NCHICA recommends not extending the delay further than one year and that CMS clearly communicate its intent to enforce ICD-10 compliance on October 1, 2014. Please consider establishing milestones to propel the industry towards compliance. Payers and vendors should be educated and encouraged to accelerate their plans to reach compliance in their systems and products so testing may begin within the industry by the original October 1, 2013 date. Early internal and external testing will avoid much

of the confusion and early issues that the industry experienced with the 5010 implementation. The existence of milestones would enable the industry to communicate and measure their trading partners' progress toward implementation.

8. COST OF ICD-10 DELAY

The proposed rule states, "...we estimate it will cost health plans up to an additional 30 percent of their current ICD-10 implementation budgets for a 1-year delay. We can assume, therefore, that a 2-year delay would be at least double the cost; that is, a 2-year delay would cost at least \$13 billion for all commercial and government health plans."

The one year delay brings about additional challenges to not only health plans but all entities implementing ICD-10. The expectation is ICD-10 will undergo additional testing. The industry at the same time will be testing Meaningful Use and the HPID; therefore, additional testing for ICD-10 may be an unrealistic expectation. Each of these industry initiatives requires substantial internal testing environments. Additional cost may be incurred in order to meet the compliance dates for testing all three projects simultaneously let alone the additional robust testing for ICD-10. The additional cost for the ICD-10 implementation delay will vary by entity from 10% to 30%.

Recommendation

NCHICA believes additional costs will be incurred without the benefits of a pilot test to identify gaps, robust end-to-end testing, and education. Please consider allowing several early adopters to participate in a pilot. Lessons learned from a pilot test in production will help socialize the scope of the code set conversion as well as the end-to-end testing concept.

9. EDUCATION AND TRAINING FOR ICD-10

NCHICA applauds the tools and resources for ICD-10 that CMS has made available to the healthcare community to date. It is likely that as of October 1, 2014 some providers will still be unable or unwilling to provide ICD-10 codes to their trading partners. There may be additional opportunities for collaboration in outreach, education and training through existing portals already integrated into the provider community such as RECs, and the use of the Medicare PECOS. PECOS has captured provider information for a large portion of the provider community and could assist the RECs to identify and target the industry population most in danger of non-compliance of the new proposed implementation date.

Recommendation:

Please consider leveraging the success that CMS has had with the Quality Improvement Organizations (QIOs) to provide extensive outreach and education to the small provider practices, Medicaid agencies, and other entities at risk for not meeting the ICD-10 compliance date. The Office of the National Coordinator for HIT should work with the QIOs to ensure that the Regional Extension Centers be trained and funded to assist in the implementation of the ICD-10 code sets (as required). Also, please consider utilizing the provider information housed in the PECOS system to identify and

target additional outreach, educational material, and resources necessary to achieve full ICD-10 compliance.

10. CURRENT STATE OF INDUSTRY READINESS

The proposed rule states, *“It is crucial that all segments of the health care industry transition to ICD-10 at the same time because of the failure to any one industry segment to successfully implement ICD-10 has the potential to affect all other industry segments.”*

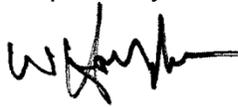
If all segments of the healthcare industry do not convert to the ICD-10 code sets at the same time, the cost of the project will skyrocket. Phasing a compliance deadline across different sectors of the health care industry will lead to confusion and challenging complexities within information systems. Organizations would be required to re-assess, re-educate, and re-formulate teams to accommodate a split implementation.

Recommendation:

NCHICA agrees with CMS and recommends that all segments should be required to comply at the same time.

In summary, we thank CMS for the opportunity to share our perspective and welcome the opportunity to work with HHS to ensure that the goals of administrative simplification are fully achieved.

Respectfully submitted,



W. Holt Anderson
Executive Director