Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS, AND SECURITY

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Chairpersons and members of the sub-committee, I am Patrice Kuppe, Director Administrative Simplification – Allina Health System. My responsibility for Allina is to implement HIPAA regulations and process improvements for our clinics, hospitals, pharmacies, labs and other related specialty health care services to achieve administrative savings.

I would like to thank you for the opportunity to present testimony concerning implementation strategies and challenges for 5010 and ICD10 compliance on behalf of Allina. My comments will also reflect findings from the MN HIPAA Collaborative, and the MN Administrative Uniformity Committee (AUC).

First I would like to provide you some history about our work in MN. Our state has been a long time supporter of EDI transactions and we believe that if we can increase the rates of adoption we can reduce administrative waste in health care. In the early-90s the health care community in MN created the AUC. The goal of the AUC is to reduce administrative costs through the creation of standards and best practices. The AUC is a *voluntary* broad-based group representing 43 Minnesota and national health care public and private payers, health care providers and state agencies. The AUC is named as an advisor to the Minnesota Department of Health in state law. The AUC and other community members participated in the 1993 WEDI report which explained the value that standards and EDI can bring to healthcare. In 1995 the state formed a public-private partnership and created the MN Center for Healthcare EDI (MCHE). This center was formed to promote EDI and provide education about EDI standards. MN adopted health care EDI standards in 1996 using ANSI X12 version 3051.

The MN HIPAA Collaborative was formed in 2000 to help Minnesota providers and health plans achieve timely and cost-effective implementation of the HIPAA transactions, codes, and identifier standards (not privacy and security). The Collaborative provides education, implementation tools, and a free testing site which we continue to support today.

After much work promoting and implementing standards we found that the adoption of non-claims transactions (for instance, eligibility inquiries) was severely lacking. In early 2000 a study was conducted by the Minnesota Hospital Association, Minnesota Medical Association, and the Minnesota Council of Health Plans to determine why the adoption rates were so low. The study revealed that the main cause of the low adoption was the variability in data content and processing rules.

Based on this study, MN passed a law in 2007 that requires all health care payers and providers to exchange eligibility, claims, and remittances electronically in 2009, using a single, uniform, standard data content and format (companion guide). The AUC created companion guides for eligibility, all four types of claims (professional, dental, institutional and pharmacy), and remittances. The eligibility and claims standards have already been implemented.

In addition to companion guide development the AUC has also created medical coding rules for the use of HCPCS, revenue and ICD-9 codes, created rules on how to map the remittance advice claim adjustment reason codes and remark codes, created over 18 Best Practices, developed a claims compliance check-list, and provided best practices that support electronic secondary (coordination of benefits) claims. We found that it's not just the transaction format or data content alone that eases implementation. It's also the processing rules – how standard code sets are used – that really help to achieve standardization.

Implementation Activities for 5010:
The AUC has been conducting outreach and education, including: EDI and X12 high level educational training for AUC members, presentations at industry educational forums, issuance of newsletters, FAQs, and surveys to gauge readiness.

The AUC is in the process of reviewing the 5010 guides to create rules for state companion guides for eligibility, claims, and remittances. Our review of the 5010 transactions has led us to request new codes from various coding committees, and has led us to submit numerous X12 interpretation requests. We have a tight schedule to complete 5010 work in early 2010 so that our community can begin adoption.

The MN HIPAA Collaborative is preparing to add the MN 5010 companion guides, once completed, to our free testing site so that all health care entities can begin testing.

Transaction Key Risk Areas for 5010:
The AUC has participated in all 5010 NPRM comments. A few of the issues and recommendations we identified in the 5010 transactions still exist. Our concern is that there is not a process to quickly make changes to transactions for flaws we may find now or in testing, and thus the industry is left to implement processes that create confusion and payment delays.

Critical Issue Across X12 Transactions: We are very concerned with the fact that the terms subscriber, dependent, patient, and insured are not defined and used consistently within a single guide (i.e., 271), or across all guides (i.e., 271 and 837s and 835). We believe the same information that is indicated on a 271 should be indicated an 837 and on an 835. We believe the

current inconsistent use of terminology and definitions creates a critical flaw in the 005010 transactions that, if not corrected, will result in an ineffective application of the transactions under some patient/ subscriber/dependent models, create major disruptions for payers and providers when dealing with patients that are dependents and have unique identifiers, and have a significant negative impact in the industry overall. The AUC has spent considerable hours working with X12 and creating tools for our community. To date we feel that this issue has not been resolved.

Critical Issue to Ease Implementation: We believe that one of the most important lessons learned with the adoption of the previous HIPAA standards (004010A1, NPI) was that there CANNOT be a SINGLE DEADLINE for the entire industry and for all transaction standards. In our NPRM comments and in previous NCVHS testimony the industry has recommended that we should phase-in the testing, transition and full compliance with each transaction, taking into account 1) the order in which transactions need to be introduced; 2) the order in which entities need to become ready and comply with each transaction; and 3) the start-date for beginning the transition and the end-date for achieving full compliance. Our concern with the HIPAA rule is that guidance has said trading partners can agree to use any version during the transition, thus we are not able to publish a MN rule that would mandate the adoption of these in an orderly process. We are concerned that our implementation of the 5010 standard transactions in MN will not go as smoothly because we are not able to phase it in for 5010 as it was for 4010.

Critical Issue to Ease Implementation:
The ability to test is limited. Some trading partners do not allow testing or refuse to first validate their transactions against a free testing site. We recommend all trading partners be required to validate their transactions prior to implementation.

Critical Issue to Ease Implementation:
We recommend implementing a clear public forum for all to submit issues and receive interpretation. Current methods under the Work Group for Electronic Data Interchange are not public, and the X12 interpretation portal is difficult to use, nor is it widely known.

Transaction Barriers Not Related to the Version:
In our efforts to implement 100% eligibility, claims, and remittances we have identified other challenges with HIPAA transactions that are not related to the version. We believe these barriers will impede adoption of any new versions.

- There are no connectivity/EDI “yellow pages”. A provider or patient does not have enough information on a health care ID card to adequately inform how to connect to trading partners for sending transactions. In addition, EDI requires an agreement between trading partners and these agreements vary greatly by transaction and by trading partner.

- Without a national health plan identifier secondary (COB) claims are a challenge.

- HIPAA standard (implementation guides/TR3s) are not free. We have found the cost of guides limits our ability to have all of our community participate in our work on our state companion guides.

- Without guarantee that a transaction is compliant the receiver of the transaction will have to invest unnecessary resources to implement. A national testing site or certification tool would eliminate many testing challenges.

- The industry needs standard acknowledgement transactions that inform the receiver of transaction status. The current X12 versions of acknowledgements is not clear on which acknowledgement to use for what purpose, the codes are ambiguous, and the transactions are not mandated.

- The industry needs adequate representation at the standards table. The X12 process is not inclusive of the provider community. The standards also contain code sets that are maintained by small groups that are not vetted across the industry nor are they ANSI accredited.

- The standards development process is cumbersome, confusing and unknown by a vast segment of the industry: We continue to be concerned with the fact that the standard development and maintenance process is unknown by a very large segment of the health care industry across the board, but particularly within the health care provider community. As an example, there are close to 5,000 hospitals in the country, more than 230,000 small, medium and large medical clinics, and close to 4,000 health plans. Yet only a very small fraction is engaged and participates in the standards development process.

- Education across the industry is critical. Perhaps the HITECH extension centers could provide education around EDI whether that is for clinical or administrative data exchange.

ICD10 barriers – challenges:

Our major challenge is that we have not had time to explore ICD10 strategies, or barriers. In Minnesota we have been implementing our MN 4010 companion guides, creating MN 5010 companion guides and now are focused on meeting our eHealth mandates for ePrescribing and electronic health records along with some other unique health reform initiatives. The MN HIPAA Collaborative is meeting in January to assess our readiness to begin collaboration on ICD10

In conclusion, I would like to state that we have no lack of will to implement comprehensive standards in a timely manner. We need your help to make the necessary changes to the infrastructure of the standards setting process, to help correct the connectivity and transaction challenges due to lack of health plan ID, to provide an EDI connectivity road map, and to provide education. With your help we will be able to increase the adoption of standards so that we can achieve the ultimate goal of saving health care dollars.

Thank you for your thoughtful consideration of these comments.