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Department of Health and Human Services

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

Subcommittee on Standards
April 27, 2011

Administration Simplification under the Patient Protection and Affordable Care Act

The Acknowledgment Transaction Standard and Maintenance and Modifications to Standards and Operating Rules (the Present and the Future)

Marriott Washington Hotel
1221 22nd Street, NW, Washington, D.C. 20001

The National Committee on Vital and Health Statistics Subcommittee on Standards was convened on April 27, 2011 in Washington, D.C. The meeting was open to the public and was broadcast live on the Internet. A link to the live broadcast is available on the NCVHS homepage.

Present:
Committee Members
Walter G. Suarez, M.D., M.P.H., Co-Chair
Judith Warren, Ph.D., R.N., Co-Chair
Justine M. Carr, M.D.
Raj Chanderraj, M.D., F.A.C.C. (via telephone)
William J. Scanlon, Ph.D.

Absent
J. Marc Overhage, M.D., Ph.D.

Staff and Liaisons
Denise Buenning, CMS, Lead Staff
J. Michael Fitzmaurice, Ph.D., AHRQ
Marjorie Greenberg, NCHS/CDC, Executive Secretary
Debbie Jackson, NCHS
Jim Sorace, M.D., ASPE
Marietta Squire, NCHS
Michelle Williamson, NCHS
Nicole Wilson, VA

Presenters
Tammy Banks, AMA
J. Robert Barbour, AMA (in collaboration with MGMA)
Don Bechtel, WEDI
Stacey Barber, DSMO (via telephone)
Denise Buenning, CMS
Doug Bilbrey, SSI Group
Michael Cabral (written)
Peter Cutler, Washington State (via telephone)
Laurie Darst, MN AUC
Richard Donoghue, NYUMC/Linxus (via telephone)
Gregory M. Fisher, UnitedHealth Group
Annette Gabel, NCPDP
Chris Gayhead, CMS
Lynne Gilbertson, NCPDP
John Kelly, NaviNet
Gwen Lohse, CAQH CORE
Barbara Mayerick, VA (provider)
Lisa Miller, X12
Randy Miller, NMEH (written)
Noam Nahary, Montefiore Hospital (via telephone)
Susanne Powell, Emdeon (via telephone)
John Quinn, HL7
Shelagh Kalland, MN AUC (via telephone)
Peter Walker, WEDI
Margaret Weiker, X12
Jim Whicker, WEDI

Others Present:
Matthew Albright, CMS
Bill Alfano, BlueCross BlueShield Assn.
Michele Davidson, Walgreens
Rachel Foerster, CAQH
Maria Friedman, Brookside Consulting Group
Kari Gaare, CMS
Priscilla Holland, NACHA
Sean Kilpatrick, Availity
John S. Klimek, NCPDP
Gail S. Kocher, BlueCross BlueShield Assn.
Catherine Kajubi, Kaiser Permanente
Steven S. Lazarus, BIG
Matt Scantland, Covermymeds
James A. Schuping, WEDI
Robert M. Tennant, MGMA
Robin J. Thomashauer, CAQH
Jeannette Thornton, AHIP
Allison Viola, AHIMA
Peter Walker, Aetna
Gladys Wheeler, CMS
Shannon Whetzel, CMS

EXECUTIVE SUMMARY
Wednesday, April 27, 2011

ACTIONS

- All testifiers were asked by Ms. Buenning to submit written information about acknowledgments costs and benefits, noting technical and business changes. The Subcommittee will receive information derived from a major CAQH Core ROI study and from WEDI that will inform a costs and benefits analysis.

- With regard to acknowledgments, a letter of observations and process improvement recommendations will be sent by the Subcommittee to the Committee for approval and then to the Secretary. The intention is to prepare a draft letter for discussion in the June Subcommittee meeting (taking place just prior to the full Committee meeting, June 15-16, 2011).

CALL TO ORDER, WELCOME, INTRODUCTIONS, AGENDA REVIEW
Walter G. Suarez, M.D., M.P.H., Co-Chair; Judith Warren, Co-Chair; Denise Buenning, CMS

PART I Standard Transactions for Acknowledgments

Session 1.1 Overview of Acknowledgments (in plain language) and Perspectives from Standards Organizations and Operating Rule Authoring Entities

General Overview — **Margaret Weiker, X12**
History of Acknowledgments — **Michael Cabral, CMS (written)**
Standards Organizations — **Lisa Miller, X12; Annette Gabel, NCPDP**
Operating Rule Use of Acknowledgments — **Gwen Lohse, CAQH, CORE**

Discussion

Topics about acknowledgments included: overload; the need for acknowledgements to communicate error; when acknowledgments are needed (examples given); a phased-in approach to implementing acknowledgments by transaction; and who most benefits from acknowledgments (partly depends upon response time). Further study of the business case and cost benefits of sending acknowledgments is being conducted in response to a rapidly changing industry. While all transactions should have acknowledgments, some believe in choice about whether to receive them (especially those with associated costs) while others believe that the decision should rest upon operating rules and what is best for the system (which must mature in order to determine what is best).

How should NCVHS respond to the acknowledgments debate? One suggestion was to separate business from technical considerations. The TAI is the only transaction instigated by the sender or trading partner. In part, the value of acknowledgments lies within their movement through the whole system (e.g., providers, venders, health plans). An industry-wide opportunity is available to determine what business rules are needed to drive HIPAA-adopted standards (noting deadlines). A concern was raised about the impact of removing acknowledgments from the operating rules on other parts of the infrastructure.

Session 1.2 Provider, Payer and General Industry Perspectives of Acknowledgments

J. Robert Barbour, AMA (in collaboration with MGMA); Noam Nahary, Montefiore (via telephone); Barbara Mayerick, VA Provider (written); Greg Fisher, United Health Group; Peter Walker, Aetna; Jim Whicker, WEDI

Discussion

The number of claims processed without human intervention was discussed (noting a 2009 AHIP claims processing survey). For the majority of claims, acknowledgments are automatically generated and flow through the system untouched, notwithstanding identified problem areas (e.g. work queues). The value of acknowledgments paid within a reasonably short time was emphasized, noting a need to identify and work with exceptions quickly. Whether providers submit claims directly or through intermediaries, it is imperative that they receive robust standardized electronic information. The need for trust and timeliness between entities should be addressed within the operating rules. Two types of acknowledgments were described: point-to-point that are returned to submitters (TAI-999); and the 277 claim acknowledgment, which returns through the chain to the original source.

Within Medicare's acknowledgments process, clear communication with payers is needed with regard to COB claim submissions (i.e., when a claim is sent to a secondary payer and the provider doesn't know where it is being handled). When referring to multiple hops, it is important to understand EDI mechanics, noting that the current implementation structure makes the acknowledgment process more difficult. The functionality of 277 was mentioned. Payers described companion guides in relation to acknowledgments (generally, acknowledgments are addressed but not in separate guides); and their experience with the application of acknowledgments in pharmacy transactions. One participant noted that pharmacies lack the ability to provide initial 999 acknowledgments that indicate receipt of the 835; and another noted an additional acknowledgments transaction for prescriptions as opposed to medical claims.

Session 1.3 Other Perspectives of Acknowledgments

Suzanne Powell, Emdeon (via telephone); Doug Bilbrey, SSI Group; John Kelly, NoviNet; Shelagh Kalland, MN AUC

Discussion

Lack of vendor information about transactions (and how they work) was identified as a common theme. Participants supported the idea that practice management systems be certified in the same way as EHRs. With regard to the Fed Ex metaphor, one participant thought that the issue was about context of usage for particular transactions rather than about overload.

The morning's sessions were summarized: acknowledgments (i.e., TAI; 999; 277CA) provide valuable information within EDI transactions. Other considerations included: how quickly a standardized system could be implemented; and acknowledgment triggers (when they should be expected and how they work), noting real time and batch transactions differences. A 5010 is the expected minimum. Questions were raised about when and to what extent 835s should have acknowledgments; and differences in acknowledgments applicability for pharmacy transactions were noted. The need to transition and phase in an acknowledgments process was recognized and the industry's cost concerns were raised.

PART II MAINTENANCE AND MODIFICATION FOR STANDARDS AND OPERATING RULES

Session 2.1 Overview of Statutory and Regulatory Requirements for Maintenance and Modifications of Standards, Implementation Specifications and Operating Rules
Denise Buenning, CMS

No Discussion Note that most discussion on the four sections of Part II took place following the 2.4 presentation.

Session 2.2 Overview of Current Process for Requesting, Processing and Communicating Change Requests to Standards
Stacey Barber, DSMO (by telephone); Margaret Weiker, X12; Lynne Gilbertson, NCPDP; John Quinn, HL7

Discussion

Discussion followed about to how merge an object-oriented CDA document with an EDI transaction; and how to coordinate vocabulary to ensure usage of the same terms by NCPDP, X12 and HL7.

Session 2.3 Overview of Current Maintenance and Modification Process for Operating Rules Gwen Lohse, CAQH CORE

Discussion

Discussion began with a question about how to ensure that receivers understand payload at many different levels, especially with electronic records now the norm (e.g., clinicians; clearinghouses; payers). Another consideration is how to coordinate and address difficulties across X12, HL7, NCPDP and other standards and code set maintainers. The industry's corporate side is prioritizing administrative items that match up with clinical activity, which can function as a guide to improve coordination and alignment. HIPAA code sets (e.g., SNOMED, ICD-10, CPT and RxNorm) were originally NCVHS recommendations that are working their way through the system. Attachment payloads provide strong incentive to align with payers, providers, ONC and CMS. The value of standards, implementation specifications and operating rules are unquestionable; now the question is how to harmonize them all to work best for the industry.

Other questions were: how can operating rules help leverage the standards; and when will the next version of standards be available? What happens when new approved versions, which are immediately beneficial, are not slated to go into effect for several more years? Putting new rules or requirements into operating rules is not doable because implementation must still occur according to the original operating rules until the new input has been integrated into regulation. According to the legislation, operating rules cannot change the standards or implementation specifications; and an operating rule is not an interim implementation specification. If an industry needs something outside of existing operating rules, there are ways to deal with exceptions to the rules. Generally, the existing process must be followed in order to avoid chaos.

From an X12 perspective, one can expect a review of operating rules and implementation guides every two years after the first adoption. Business rules and dated standards content should go into implementation guides rather than operating rules. The DSMO position is that operating rules should not be used as stopgap measures for implementation guide problems. Operating rules are tools to help achieve industry goals. Further discussion followed about whether active operating rule elements could be moved into standards (example given). SDOs, driven by business requirements, must have their own areas. Operating rules that relate to SDOs should be driven into SDO areas, which will increase adoption of the standards.

How can participants provide feedback on 5010 changes to go into 6020 and 6010 when these transactions have not yet been implemented? To date, there is very limited experience with 5010. An NCPDP representative suggested removing the regulatory process (recognizing that this is not an "appropriate" response but also acknowledging how the business process has been stifled due to these timing challenges). Moving forward is held up by necessary processes such as testing and public comment periods. The challenge of obtaining meaningful public commentary from people who have not yet used the product was reiterated. A forum that brings operating rules and SDOs together and recommends collaborative structures is needed.

Session 2.4 Panel on Process Improvement
John Kelley, NoviNet; Laurie Darst, MN AUC; Pete Cutler, Washington State (via telephone); Greg Fisher, UnitedHealth Group; Tammy Banks, AMA; Don Bechtel, WEDI; Randy Miller, NMEH (written); Richard Donoghue, NYUMC/Linxus (via telephone)

Discussion

Certification for the Core Operating Rules (which apply to health plans, provider- and payer-facing vendors and large providers with home-grown systems) was discussed with regard to business rules, parameters and testing of required activities. An RFP issued by CORE asked vendors to create business models for testing (the return was two usable responses of three, especially EdFX). Once certified for Core Phase I, maintenance is required; and another certification process is needed for the following rules phase. The certification process can go quickly or can take from four to six months, depending upon organizational planning. Gap analysis tools are available. Public webinars have been offered and letters about meaningful use highlight lessons learned about the Core certification process. Certified payers represent approximately 130 million lives (two thirds of commercially insured lives). Certified providers include large hospitals like the Mayo Clinic; the VA (federal); Montefiore Hospital (almost certified); and Wake Forest Hospital (a current list exists).

Questions were posed about piloting standards. Can the industry form a work group to address the complexities of pilot programs? Two WEDI claim attachment pilots were successful. The difficulty of finding vendors to participate in pilots was noted and a test tool (such as the IHE model) was suggested as a more practical approach. The industry is not looking for a more streamlined, efficient way to develop and adopt standards (i.e., standards; implementations; specifications; and operating rules). A set of guiding principles for a new approach to standards development and the adoption process is needed in order to have a more organized and defined process into the future. In particular, processes should be harmonized externally between all SBOs, operating rule authorizing organizations and data content and code maintenance organizations. There is also a need to delineate differences and relationships between operating rules and standards; and to educate the industry. Also necessary is a place where all groups (DSMO members; operating rules; authorizing and vocabulary maintenance organizations; and others) convene to agree upon a sequential and orderly process. The new

process would establish steps; delineate roles and responsibilities; and create an inviolate timeline for the adoption of new requirements. Work is currently being done to establish a two-year cycle.

Business decisions will determine what moves to the next version. Making use of a learning laboratory that ensures continuous quality improvement was encouraged to meet business needs (NY E-Health Collaborative is interested in financing such a lab). A learning lab should include end-to-end testing and cost documentation to determine ROI. A question was posed about how essential is doing a sweep of the same version; and are there benefits of different transactions at different version levels? Such activity was not okay years ago in relation to 5010 and 4050, that is, use of the same version was preferred. Currently, the only entity that can be implemented is 4050 and 5010 during the transition year (not 6010; 6020; or 6050 until there are new rules). The ACA bill allows for interim rulemaking, which speeds up the standards process. A brief discussion about control structures ensued.

Concluding Comments and Next Steps

Today's testimony has elevated the Subcommittee's challenge to develop an approach that improves the process for developing new versions of the standards and operating rules, noting that the current process is confusing, complex and costly. With regard to acknowledgments, a letter of observations and process improvement recommendations will be sent by the Subcommittee to the Committee for approval and then to the Secretary. The intention is to prepare a draft letter for discussion in the June Subcommittee meeting (taking place just prior to the full Committee meeting, June 15-16, 2011).

Dr. Warren adjourned the meeting at 5:00 p.m.

To the best of my knowledge, the foregoing summary of minutes is accurate and complete.

Judith Warren, Ph.D., R.N. DATE
Co-Chairman

Walter G. Suarez, M.D., M.P.H. DATE
Co-Chairman