Statement of the

HIPAA Implementation Working Group

to the

National Committee on Vital and Health Statistics

Subcommittee on Standards and Security

on

Implementation of the HIPAA Electronic Transactions and Code Sets Standards

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Presented by

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American Hospital Association

American Medical Association

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AFECHT

Rational Migration to Achieve HIPAA Administrative Simplification: A Call for HHS Leadership

Good morning. My name is Jack Emery and I'm Assistant Director of Federal Affairs and Outreach at the American Medical Association (AMA). I am presenting testimony today on behalf of the HIPAA Implementation Working Group (Working Group), a health care provider and vendor coalition. The Working Group is pleased to have this opportunity to share our recommendations on implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Electronic Transactions and Code Sets Standards. The Working Group includes the American Medical Association, the American Hospital Association, Laboratory Corporation of America Holdings, WebMD and AFECHT and collectively represents many of the nation's physicians, hospitals, health systems, one of the nation's largest clinical laboratories, other health care providers, clearinghouses and vendors. The Working Group was formed to help providers and vendors better understand the standards modification process and to increase provider and vendor representation. We offer the suggestions below to further the objectives of reducing costs and increasing efficiency in health care administration. Any questions about the Working Group testimony may be directed to Jack Emery at jack_emery@ama-assn.org or (202) 789-7414 or to Lawrence Hughes of the American Hospital Association at lhughes@aha.org or (312) 422-3328.

HHS MUST ACT IF ADMINISTRATIVE SIMPLIFICATION IS TO ACHIEVE ITS GOAL OF REDUCING HEALTH CARE COSTS.

The HIPAA statute requires that standards "be consistent with the objective of reducing the administrative costs of providing and paying for health care." The current haphazard migration process has increased transaction costs and continues to present a risk of disrupting

health care payments and therefore health care services. AFECHT, AMA, AHA and WebMD have met with Medicare and the Office of HIPAA Standards about the obstacles to HIPAA compliance faced by providers and vendors. WEDI, through its hearing process, has identified many of the barriers to current transition efforts. Without HHS leadership, the standardization process will falter. The Working Group recommends a strategy of rational migration and offers the following specific suggestions for implementing Administrative Simplification.

HIPAA PRINCIPLES

HHS actions with regard to implementing Administrative Simplification should be guided by the following principles. First, in order to comport with the intent of Administrative Simplification under HIPAA, including cost containment and increased efficiency, (a) payment of claims should not be disrupted during the transition, and (b) claims should not be rejected because they are missing data that payers do not need to process the claims. Second, standards should impose proportional burdens on the payer and provider communities with regard to data collection. Third, the standards change process must be made more efficient, effective and fair to the provider and vendor communities.

MODIFICATION OF THE CMS CONTINGENCY PLAN

The recent modification of the CMS contingency plan delays payment for providers that do not submit claims in the HIPAA standard format. However, there is no indication or representation that all CMS carriers and fiscal intermediaries will be able to accept HIPAA formatted transactions by the July 1, 2004 deadline. The modification is unfair in that it imposes penalties exclusively on providers, and fails to require payers to offer standard ERA, eligibility and claim status transactions prior to terminating their contingency plans for claims.

WE URGE CMS TO TAKE THE FOLLOWING STEPS IMMEDIATELY

1. Continue Contingency Period

Continued use of contingency plans is vital to maintaining provider cash flow. Widespread use of contingency plans has prevented the administrative train wreck predicted in the fall and CMS should not jeopardize the progress made to date by terminating the contingency period under which providers are submitting and clearinghouses and payers are accepting claims. Before considering contingency plan termination, it is essential that HHS develop an accurate understanding of the health field's readiness. Medicare's experience with the readiness of trading partners is not representative of the field as a whole because submitters have typically focused migration efforts on their largest payer.

CMS, as the largest health care payer in the country, should demonstrate leadership in preventing disruption of cash flow by maintaining the Medicare contingency plan and urging other payers to do the same. To these ends, CMS should specify that the recent modification to its contingency plan scheduled to take affect in July applies only to submitters not actively testing or requesting to test with CMS. Providers must not be penalized where CMS carriers or Fiscal Intermediaries are not able to accept HIPAA formatted transactions or accommodate submitter requests to test. Furthermore, CMS should make clear to commercial payers that modification of the CMS contingency plan is an example of the need for staged implementation and significant advanced notification of trading partners prior to implementation of any change in HIPAA contingency practices.

We request that CMS, as the agency responsible for HIPAA enforcement, issue guidance that payers must not end the use of their contingency plans until they are conducting HIPAA

standard ERA, eligibility, and claim status transactions. This will assure that the benefits and burdens of administrative simplification are more fairly distributed.

2. Coordinate a Rational Migration

CMS should coordinate the development and implementation of a rational, system-wide migration plan. It was unrealistic to expect that the complex system that grew over two decades could be turned around in a short period. Realizing the promise of administrative simplification will require the cooperation of government, payers, clearinghouses, POMIS vendors and providers acting under a rational transition plan. The DSMO process is too slow to serve as an effective mechanism for identifying and eliminating barriers to system-wide migration to the HIPAA standards.

Practical Implementation Specifications. CMS should adopt practical implementation specifications in two phases. The current specifications are rigid, overly complex, impossible to satisfy and costly. HHS should immediately adopt a modification to current implementation specifications to specify that payers should not reject or delay claims because data that is not needed for adjudication is missing. Subsequently, substantive modifications to the implementation specifications, including changes approved through the DSMO process if appropriate, should be adopted to make the specifications consistent with the HIPAA principles of cost containment, increased efficiency and balanced data collection burdens.

Sequence implementation. Implementation of the HIPAA standards should be sequenced, rather than attempting everywhere-all-at-once compliance. HHS should prioritize implementation efforts. The health field should focus first on universal adoption of the HIPAA standard claim format. After achieving system-wide implementation of the HIPAA format for claims, prioritize implementation of the transactions that will provide the greatest system-wide

efficiencies. HHS should phase in compliance by covered entities based upon their role in the system (first payers, then clearinghouses/vendors, and finally providers) and ability to achieve compliance (large and then small entities). Finally, advanced implementation efforts should build on initial success. HHS has acknowledged that compliance is an evolutionary process, not a one-time event. Enforcement efforts should focus on achieving a base level of system-wide compliance upon which further standardization can be built over time rather than require perfection from the start.

3. Promote Uniformity

HHS should establish or identify a mechanism for resolving differences of interpretation of standards and implementation specifications in order to achieve real uniformity and thus administrative simplification. Currently there are hundreds of companion documents, each with a different set of specifications for conducting "standard" transactions. The divergent requirements and definitions of what makes up a standard transaction threatens to defeat the goal of administrative simplification.

PROVIDER AND VENDOR ACCESS TO THE MODIFICATION PROCESS MUST BE INCREASED

Many transition issues can be attributed, in part, to the lack of meaningful provider and vendor representation in the standard setting process. All sectors of the health care field are not equal in their capacity to participate. Effective participation requires a sophisticated understanding of electronic communications, substantial personnel and financial resources dedicated to participation, a vested interest in the outcome and sector-wide awareness of that interest. The perspectives of the provider and vendor communities have not been and will not

be heard in the standards setting process until the means by which each health sector may participate are changed. We urge CMS to support/lead a rigorous analysis of the standards change process to identify and help correct any imbalance in the sector representation.

Summary of Recommended HHS Action:

1. Contingency Plans
    a. Continue the contingency period (CMS enforcement)
    b. Maintain the CMS contingency plan (CMS payer)
    c. Urge other payers to continue contingency plans
    d. Specify that recent modification to CMS contingency applies only to submitters not actively testing or requesting to test with CMS
    e. Announce that the CMS modification is an example of the need for staged migration and significant prior-notification of changes to contingency plans
    f. Issue guidance that payers must not end their contingency plans until they are conducting HIPAA standard ERA, eligibility and claim status transactions.
2. Coordinate a Rational Migration
    a. Immediately adopt modified implementation specifications to clarify that payers may not reject or delay claims because data that is not needed for adjudication is missing.
    b. Adopt substantively modified implementation specifications consistent with the HIPAA principles.
    c. Prioritize implementation of transactions one at a time, based on system-wide benefit. Begin with achieving implementation of HIPAA claim format.
    d. Phase-in compliance. First payers, then clearinghouses and vendors and finally providers should be required to achieve standardization. Within each category, efforts should be focused first on the largest participants.
3. Promote uniformity by identifying a mechanism for resolving differences of interpretation of standards and implementation specifications.
4. Lead or support an analysis of the standards change process to correct the imbalance in sector representation.