AHA
Advancing Health in America

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May 19, 2003

Ms. Jared Adair
Director
Office of HIPAA Standards
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C5-24-04
Baltimore, MD 21244

Dear Jared:

We are pleased that the Office of HIPAA Standards under your leadership has been willing to listen and respond to hospitals' concerns related to implementation of the electronic transactions and code sets (TCS) standards. The trip that you and Karen Trudel made to D.C. on a snowy morning to meet with the American Hospital Association's (AHA) HIPAA Advisory Group was a clear demonstration of that commitment. Our members found your overview of the CMS Office of HIPAA Standards very informative. They appreciated the opportunity to raise with you directly a number of remaining concerns about TCS implementation.

Without a doubt, the greatest concern that hospitals raised at the meeting — and continue to express concerns about — is the potential for disruption in the current claim submission and payment cycles that might result from poor, improper or incomplete implementation of the transactions standards. Maintaining proper cash flow is critical for all hospitals to ensure that essential operations and the delivery of quality patient care are not compromised. Even a slight decrease in claims processing volumes or lengthening of the payment cycle could negatively affect hospitals' ability to care for their patients. To address this concern, we propose development of a system-wide implementation plan that clearly outlines remedial actions that every health plan must take to ensure that an adequate level of cash flow to hospitals is maintained as the field transitions to HIPAA standardized claims.

In addition, we believe that successful implementation of the transactions and code sets standards will require that health plans complete end-to-end testing of the transactions with providers well before the October 16th compliance date and communicate timely information to providers about the specific deficiencies in any claims submitted for processing.

We outline below some recommendations that we believe will help to ensure a smoother transition to the HIPAA claims processing environment.

Adopting a System-wide Implementation Plan

Hospitals sincerely hope that the transition to HIPAA standardized claims occurs smoothly and are doing their part to ensure that smooth transition. The AHA, however, urges the Office of HIPAA Standards to adopt a comprehensive system-wide implementation plan to ensure that hospitals continue to have an adequate cash flow in the event that there are system slowdowns or failures during the initial compliance period. The AHA has developed a set of principles to help guide the development of any such system-wide implementation plan and we provide details on these guiding principles in an attachment to this letter.

Under these principles, the Office of HIPAA Standards would require all health plans to take specific actions to maintain current claims processing volumes and cash flow cycles for each hospital with which the health plan does business. Today, health plans know the amount of time it takes to receive, process and pay a claim as well as the typical monthly transaction volume and payment total. We would expect and anticipate no slowdown after October 16th.

End-to-end Testing of the Transactions

Full end-to-end testing of the transactions standards in advance of the October 16 compliance deadline also would help alleviate providers' concerns about operational and payment disruptions that may occur as a result of implementing the transactions standards. Many hospitals are using testing and certification software to validate their ability to properly prepare the transaction standards. They, however, must also conduct end-to-end testing with real world examples to ensure that they have properly interpreted the reporting requirements of the standard transactions and that they are capable of exchanging the standardized information electronically with the health plans. Advance testing would give providers time to identify and correct reporting and formatting deficiencies that might result in the rejection of transactions that a provider currently believes are HIPAA compliant.

Currently, many hospitals are having difficulty getting health plans to commit to conducting complete end-to-end testing in a timely fashion. This lack of progress in completing end-to-end testing raises serious doubts for providers about how ready they and the health plans they do business with will be to meet the October compliance deadline.

Today there are no procedural requirements for any covered entities to demonstrate that they have successfully concluded testing before October. When Congress passed ASCA, it allowed the health care industry an opportunity to make progress toward the adoption of the standards. But in exchange for the additional implementation time, Congress required that testing of the transactions begin no later than April 2003. As a result, we believe that Congress likely anticipated that the conclusion of testing would be within a few months of the April date and well before the October compliance date.

At your meeting with the AHA's HIPAA Advisory Group, you described the responsibilities of the CMS Office of HIPAA Standards, and we believe that your office has the authority to issue guidance around the testing process through outreach efforts, as well as forewarning compliance efforts now and in the future. Based on previous discussions with your office, we understand that CMS is planning to issue a testing schedule for its contractors that will require them to

communicate testing plans directly with providers. We urge you to use your authority to ensure that a rigorous communication schedule about CMS's contractor testing plans will soon begin and that it will include end-to-end testing directly with providers.

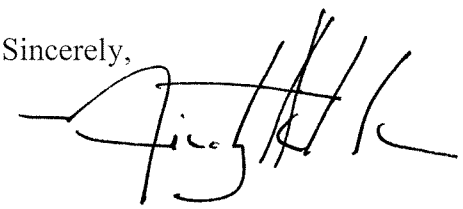
Identification of Claims Deficiencies

Health plan communication and collaboration with providers is key to the successful implementation of the transaction standards, not only during the testing phase, but also after October 2003. Confirming the receipt of a transaction and specifically identifying any deficiencies that might exist is important information that a health plan must communicate to a provider as part of the overall efficiency of standardized transactions. We, therefore, urge CMS to recommend the routine use of various X12 acknowledgement transactions as an adjunct to the submission of a standardized transaction.

In addition, we have heard from some providers concerned that their fiscal intermediaries have indicated that, for batched transactions where a single claim within the batch contains an error, the entire transaction batch will be returned without processing rather than just the individual deficient claim. Processing claims in such a way is inefficient and costly and only guarantees significant disruptions in the claims processing and payment cycles. Returning only deficient claims, while processing the rest of the transaction that are part of the batch is the more efficient and less disruptive approach. We urge CMS to adopt that approach and require its fiscal intermediaries to proceed with processing the remaining batched transactions that do not contain deficiencies or errors. Finally, we urge CMS to instruct its contractors to identify specifically any deficiencies in the rejected transactions within the batch so that providers may make the necessary corrections and resubmit the claim in a timely manner.

We look forward to continuing the dialog with the Office of HIPAA Standards to cooperatively resolve these and other implementation issues and concerns that may arise. As we have indicated in our various discussions with your office, the AHA stands ready to assist CMS in its efforts to get critical implementation information out to the field, by using our various communication vehicles. Please contact me at (202) 626-2336, George Arges, senior director, Health Data Management, at (312) 422-3398, or Lawrence Hughes, regulatory counsel and director, Member Relations at (312) 422-3328.

Sincerely,



Melinda Reid Hatton
Vice President and Chief Washington Counsel

Attachment

cc: Karen Trudel, Deputy Director, Office of HIPAA Standards, CMS
Gary Kavanagh, Director, Business Standards and Systems Operations Group, CMS
Cathy Carter, Deputy Director, Business Standards and Systems Operations Group, CMS
Janis Nero-Phillips, Director, Division of Data Interchange Standards, Business Standards and Systems Operations Group, CMS
Maria Friedman, Senior Advisory, Office of HIPAA Standards, CMS

Attachment

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TRANSACTIONS AND CODE SETS COMPLIANCE:
A PROPOSAL TO PREVENT IMPLEMENTATION FAILURE

The Problem

Improved efficiency of health care transactions was Congress' stated purpose in enacting the administrative simplification provisions of HIPAA. Thus, initial implementation of the transaction and code set standards could be judged a failure if it created risks to patients because of administrative delay in verifying coverage (resulting from a failure to process eligibility inquiries), or jeopardized the financial viability of providers because of failure to process and pay claims for payment.

This is not an argument for delaying the October 16, 2003 compliance date or modifying the transaction and code set standards (TCS). Rather, this is sound reasoning for establishing a system-wide implementation plan to ensure that these unintended effects do not cause implementation failure.

Implementation specifications for the TCS are highly specific regarding the data elements that must be included in each unique transaction. However, it will be virtually impossible for a covered entity to be certain that it's submission includes each of the required and situational elements that need to be present in every transaction it sends. This problem largely results from the ambiguity of "situational" data and how they are applied by various health plans. Frequently, the reporting of the situational defined data is specific to the type of service, the category of provider, and the different health plan benefit coverage requirements, just a few of the items that influence reporting variations. Almost inevitably data elements will be missing for many of the individual transactions. This is true even if every health plan and provider is prepared to process the standard *form* of each transaction (or use a clearinghouse to provide the translation to a 4010 or other applicable format), *and* to use only the standard code sets required by the regulation. More importantly, it seems quite likely that health plans' HIPAA compliant systems may reject such transmissions as "non-compliant." In fact, some systems reportedly will reject an entire batch of claims as "non-compliant" if one of the included claims is missing elements. The receipt of significant volumes of such rejection messages will inevitably cause the claims payment system to collapse.

The problem for both the submitter and the health plan is that the *content* requirements established in the implementation specifications for each of the standard transactions in many, if not all cases, requires more data elements than is required to actually adjudicate the transactions. As such, even a covered entity that has passed general testing and validation requirements almost certainly will not be able to assure, for example, that a specific claim for a specific patient with a specific health plan includes all of the data elements required by the implementation specifications. Only actual experience in processing live claims for different types of services, by different categories of providers, with varying patient indications, and with differing health

plan coverage requirements, will enable systems to identify what data elements are missing so that systems can be reprogrammed or clearinghouses can be engaged to insert all of the necessary elements the next time around.

At the October compliance date and for some time thereafter, the potential for implementation failure becomes extraordinarily high. The consequences of such failure, however, are different for each of the covered entities. Health plans may find themselves buried in paper claims, or find that each claim is submitted as a unique electronic transaction rather than as a batch. Either of these developments will increase the cost to health plan operations.

Providers, on the other hand, may find that the submission of a claim believed to be in HIPAA standard format is rejected by the health plan for non-compliance because the provider's interpretation about whether to report a situational element is different from the payer's interpretation. It will be extremely costly to figure out which data element is missing if the plan does not provide detailed feedback. Moreover, such delays will increase the potential for a disastrous impact on the provider's cash flow; consequently many providers will have little choice but to drop a resubmission to paper. Relying on paper claims, whether as a fallback for failed claims or for all claims, will have the net effect of delaying payment to the provider and will increase both the provider and the health plan's administrative costs. In short, implementation failure will create significant disincentives to use electronic claims submission. All of these results are precisely the opposite of Congress' intent in enacting the administrative provisions of HIPAA.

In the long run, it may be defensible and desirable to include the excess content required by the implementation specifications in standard transactions. Certainly, it will allow health plans' coverage criteria to be more detailed than currently is possible. Over time, as systems are refined, programming corrected and clearinghouses engaged, there might be relatively few claims for which this problem occurs. In the near term, however, it is not desirable — or defensible — to jeopardize the financial viability of providers, or to increase the administrative costs of transaction processing, simply because payment and eligibility verification systems on October 16 begin to spit out rejection notices based on an unspecified HIPAA defect in application.

To date, HHS has focused on specific standard and specific covered entities' compliance efforts. However, HHS must take a broader view. Otherwise, it would be naïve to think that the switch can be successfully flipped on October 16 and expect that all of the covered entities' separate compliance efforts will result in a smoothly operating system. The absence of any system-wide implementation plan makes this seem to be the operating assumption. Only HHS is in a position to provide the necessary leadership for a system-wide implementation plan. In our view, its failure to do so will likely lead to a catastrophic implementation failure for the TCS roll out.

Purpose of a System-wide Implementation Plan

A system-wide implementation plan serves as a "safety net" that is at the ready with respect to each provider-payer relationship if and when the adverse impact of the unintended consequences reaches a critical stage. *It does not delay compliance obligations*, but instead provides the

information needed to achieve compliance while preventing cash flow disruption and saving the administrative costs of any interim switch to paper claims. Because the most critical unintended consequence is the disruption to the existing payment cycle between providers and health plans, and the resulting increase in administrative costs if claims submitters choose to use paper claims, we have focused our proposed system-wide implementation plan to protect existing cash flow payment cycles.

Elements of a System-wide Implementation Plan

I) Claims Processing Baseline. Each health plan establishes for each submitter an average number of processed claims per day for the year prior to the TCS compliance deadline. Each health plan also establishes for each submitter the average daily dollar amount paid for claims in the year prior to the TCS compliance deadline.

Total Number of Claims Processed for the Year/365 = Average Daily Volume

Total Amount Paid for Claims for the Year/365 = Average Daily Payment

II) Contingency Triggering Event. A provider would be eligible to receive a contingency payment if at any time the submitter's daily volume of claims processed ***or*** the daily payment received falls more than 5% below the baseline.

III) Contingency Payment. For any period triggering a contingency payment, the health plan adjudicates the claims based on the actual data submitted provided that:

1. The claim was submitted electronically in 4010A.1 format and using the standard code sets;
2. The claim includes the data elements necessary to process and adjudicate the claim;
3. The health plan sends the submitter a statement identifying the missing or non-material data element errors.

IV) Transaction Correction. Any submitter is eligible to receive payment under the contingency plan only so long as it takes action to use the data provided by the health plan in above III.3 to implement a submission correction mechanism, whether by use of a clearinghouse or by systems reprogramming.

A System-wide Implementation Plan is not a Delay. The proposed implementation plan does not help entities – providers or health plans – that are unprepared to generate a standard transaction. Rather, it is an attempt to ensure that those covered entities that are in substantial compliance are not inadvertently penalized for their efforts by damage to their cash flow.

The System-wide Implementation Plan Should Include a Timetable. With respect to covered entities that are prepared to use TCS as of the compliance date, HHS should require use of contingency payments with respect to every submitter and health plan for the first six months after the compliance date. Thereafter, HHS should use its enforcement discretion to ensure that any individual health plan or provider that continues to have regular contingency triggering events is addressing deficiencies. Additionally, health plans that receive claims that contain

material deficiencies should, as a matter of improving the application of future electronic transactions, communicate to the provider the specific problems in need of correction.