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Advancing Health in America

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June 25, 2003

The Honorable Tommy G. Thompson
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

We appreciate the leadership the Department of Health and Human Services (HHS) demonstrated in implementing the medical privacy standards required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We welcome the department's strong leadership in ensuring a smooth implementation of the electronic transactions and code set standards (TCS) on October 16.

As the TCS implementation date approaches, hospitals are growing increasingly concerned about the potential for disruption in the current claims submission and payment cycles that might result from poor, improper or incomplete implementation of the HIPAA standard transactions. 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, the AHA proposes development of a system-wide implementation plan that clearly outlines remedial actions HHS would take – and set an example that others could be encouraged to follow – to ensure that an adequate level of cash flow to hospitals is maintained as the field transitions to HIPAA standardized claims. We also suggest certain other steps, such as testing and identifying deficiencies in the standard claims a provider submits, that will help to ensure proper progress and improvements in 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 transactions 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 it jeopardized the financial viability of providers because claims were not processed and paid in a timely manner.

Let us be clear, this is not an argument for delaying the October 16 compliance date or modifying the transaction and code set standards. Rather, this is sound reasoning for establishing a system-wide implementation plan for the Medicare, Medicaid and other federal programs that will ensure that these unintended effects do not cause total implementation failure. We believe that if HHS adopts such a plan for government payers, private payers can and will be strongly encouraged to do the same.

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 its submission includes each of the required and situational elements that need to be present in every transaction it sends. This problem largely stems 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 – these are just a few of the items that influence reporting variations. 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 4010A.1 or other applicable format) and 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 batched claims is missing elements. Significant volumes of such rejection messages inevitably will cause the claims payment system to grind to a halt.

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 are required to actually adjudicate the transactions. As such, even a covered entity that has passed general testing and validation requirements almost certainly will be unable to ensure, 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 the field 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 development will increase the cost to health plan operations.

Hospitals, 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 differs 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 an

adverse 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 delay payment to the provider and 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 run contrary to Congress' intent in enacting the HIPAA administrative simplification provisions.

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. However, in the near term, it is not desirable – or defensible – to jeopardize patient care or 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 standards 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 implies that this is 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 likely will lead to implementation failure for the TCS roll out.

Purpose of a System-wide Implementation Plan

A system-wide implementation plan serves as a "safety net" to prevent or substantially ameliorate implementation failures. *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.

Elements of a System-wide Implementation Plan

1) Implementation Guidance. HHS should provide guidance with respect to the standard claims transaction that all covered entities meet the applicable requirements of the statute by:

   - submitting each claim electronically in the 4010 format (as amended) and using standard code sets;
   - including the data elements necessary for the specific payer to adjudicate the claim; and
   - requiring that the health plan send to the submitter a statement identifying the missing or non-material data element errors.

2) Claims Processing Baseline. Each government payer establishes for each submitter an average number of processed claims per day for the year prior to the TCS compliance deadline. Each payer 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

3) Contingency Triggering Event. A provider is 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 percent below the baseline.

4) Contingency Payment. For any period triggering a contingency payment, the government payer adjudicates the claims based on the actual data submitted provided in accordance with the requirements of the guidance described under "Implementation Guidance."

5) 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 payer to implement a submission correction mechanism, whether by use of a clearinghouse or by systems reprogramming.

We would like to emphasize the following points about a system-wide implementation plan:

- **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.

- **A system-wide implementation plan should include guidance.** Congress instructed that the standards adopted be consistent with the objective of reducing the administrative costs of providing and paying for health care. This instruction will mean little if the complexity of the data content requirements – when used simultaneously for the first time by millions of entities in processing live claims – results in a breakdown of the health care claims payment system. Congress also recognized that the standards are quite complex and that the retrofitting of electronic information systems requires an "implementation strategy for achieving compliance" and "a time frame for testing that begins not later than April 16, 2003." A system-wide implementation plan premised on a continuation of a more robust "live" testing of the standards could continue for a reasonable period of time after the October 16 implementation date.

- **A 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 for the first six months after the compliance date. 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 containing 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.

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 transactions standards. They, however, also must 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 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 prior to October 16. When Congress passed the Administrative Simplification Compliance Act, it gave the health care field an opportunity to make progress toward adopting the standards. 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 testing would conclude within a few months of the April date and well before the October compliance date.

We believe that HHS 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 the Office of HIPAA Standards, we understand that the Centers for Medicare & Medicaid Services (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' contractor testing plans will begin soon and that it will include end-to-end testing directly with providers.

Identification of Claims Deficiencies

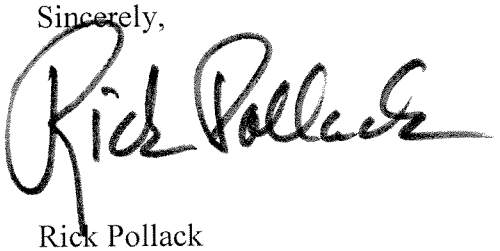
Health plan communication and collaboration with hospitals is essential to successfully implementing the transactions standards not only during the testing phase, but also after October 2003. It is important that health plans confirm the receipt of a transaction and specifically identify any deficiencies that might exist as part of the overall efficiency of standardized transactions. Therefore, we 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 hospitals 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 transactions that are part of the batch is a 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 specifically identify 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 to work with HHS to resolve these and other implementation issues and concerns that may arise in the coming months. If you have any questions about our proposals, or if the AHA can be of further assistance, please contact Melinda Hatton, vice president and chief Washington counsel, at (202) 626-2336.

Sincerely,



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