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Testimony
of the
American Hospital Association
before the
Standards Subcommittee
of the
National Committee on Vital and Health Statistics

"Industry implementation of updated and new HIPAA Standards and Code Sets
X12 Version 5010, NCPDP Version D.0, NCPDP Version 3.0 and ICD-10"

June 17, 2011

Good morning. I am George Arges, senior director of the health data management group at the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the AHA thanks you for the opportunity to participate in today's National Committee on Vital and Health Statistics (NCVHS) hearing on the implementation progress for the updated HIPAA Standards version 5010 and the new code set ICD-10.

The AHA has engaged a cross-section of our member hospitals to obtain input on the progress and implementation issues surrounding the transition to the newer HIPAA standards, as well as the adoption of ICD-10. Our member discussions have included hospitals ranging in size from small Critical Access Hospitals to large multi-site and multi-state hospitals. The following observations stem from multiple conference calls and e-mail correspondence with members.

OVERLAPPING IT INITIATIVES

One of the more important themes to emerge from our member discussions, but not directly addressed by the NCVHS questions, is the overwhelming number of overlapping federal information technology (IT) initiatives impacting providers. Overlapping IT initiatives, such as Stage 1 and the pending Stage 2 of the Medicare and Medicaid electronic health record (EHR)

programs, along with health reform initiatives such as value-based purchasing, accountable care organizations, bundled payments and readmissions, as well as upcoming operating rules, are making it difficult for hospitals to find the necessary resources to complete them. Capital and qualified IT staff already are in short supply, and when these IT initiatives are stacked on top of ICD-10 implementation, it makes the task enormously difficult. Our members are seeking breathing room as well as leadership that can provide a thoughtful coordinated pathway to help them manage all of these important IT initiatives. (Enclosed is a graphic depicting these overlapping IT initiatives.)

Our members support the adoption of ICD-10, but recognize that it is no easy task that becomes more complicated as other overlapping IT initiatives are introduced. There is a lack of coordination among the competing IT initiatives, which results in the dilution of already scarce resources and further complicates efforts to properly implement ICD-10. As a first step, we suggest delaying the start of Stage 2 of "meaningful use" for the EHR programs to no sooner than fiscal year 2014, and only after at least 75 percent of all eligible hospitals and physicians/ professionals have successfully achieved Stage I and not before ICD-10.

NECESSARY RESOURCES AND TESTING

While many hospitals indicated that they have completed their ICD-10 assessment, they also mentioned that the cost for doing so was much larger than they had anticipated. The added costs associated with the assessment phase placed a further strain on their ability to find the necessary funds to carry out the remaining work. But more importantly, they foresee manpower shortages to carry out the essential system changes, training and testing associated with the implementation phase.

Most hospitals mentioned that their own transition effort to the HIPAA version 5010 is on track. They are, however, concerned that the testing phase is unfolding more slowly than they expected. The testing phase for 5010 is at least six months behind the original timeline. Testing delays have the affect of encroaching on the next phase of ICD-10 implementation – namely installation of system changes. Many indicated that they were encouraged by the Centers for Medicare & Medicaid Services' (CMS) national day of testing and hope that commercial plans, as well as Medicaid plans, also would provide similar testing days.

A growing area of concern is the state Medicaid programs. We understand that some programs – such as California, Illinois, New York, and Pennsylvania – will not be ready to handle the newer version of 5010 by January 2012, or even use the ICD-10 codes by October 1, 2013. This is particularly troublesome because it would result in dual reporting of ICD-9 and ICD-10. Such delays are unacceptable and add significant operational costs and administrative burden to an already costly undertaking. CMS could potentially facilitate our understanding of Medicaid readiness status by surveying states to gauge their readiness for 5010 and their ICD-10 progress as well as undertaking a national day of testing for state Medicaid programs.

PROCEED CAUTIOUSLY

The combined effect of limited staff, costly conversion, overlapping IT initiatives, delays in 5010 testing, as well as delays among the Medicaid programs, have caused our members to question whether they can meet the October 1, 2013 start dates for ICD-10. Unless there is an orderly transition to 5010 by January 2012, then a one year extension for ICD-10 must be considered to provide the least disruptive and costly pathway. Staying with the scheduled October 1, 2013 date could prove calamitous if there are not sufficient resources, adequate education and testing with trading partners.

Preparations for establishing a contingency plan will be needed to prevent payment disruptions. But if there are gaps in ICD-10 readiness, a contingency plan by itself will not likely include the added administrative costs for dual processing of ICD-9 and ICD-10. While some have suggested a strategy to utilize the General Equivalence Mappings (GEMs) as a tool to convert an ICD-9 to an ICD-10, or vice versa, it is important to note that the GEMs were not designed for this purpose: they were intended as an aid to help users translate their internal system logic to handle ICD-10 codes. The GEMs were not designed as a plug-in module to crosswalk or convert codes. While the GEMs identify 90 percent of the matching codes, 10 percent do not have a corresponding code. That is precisely why more time was given for the adoption of ICD-10 in the final rule – to allow the user community time to prepare and make their system logic and contract changes.

Again, if version 5010 requires additional time to test, or correct problems, it will take away from the remaining time needed to prepare for ICD-10 implementation. The issue of finding the necessary resources to carry out ICD-10 remains critical. Many hospitals are now being asked to reach out to the physician community to help educate them on ICD-10 changes.

The AHA is actively engaged in providing a variety of ICD-10 educational programs to inform our members about the upcoming changes and challenges. In 2009, the AHA sent to each hospital CEO an Executive Briefing – *HIPAA Code Set Rule: ICD-10 Implementation*. Since 2009, we have had a series of ongoing audio and onsite programs along with member advisories and articles. In our CEO briefing, we described various implementation stages and the importance of creating a cross-functional team to manage the implementation effort. At this point, our members have indicated that they have completed the assessment of information system changes that are needed. While many have completed this phase, few of our members have moved onto the next phase – the implementation of system changes.

When asked the reasons for the delay, we heard once again about overlapping IT initiatives and the competing resource needs to tackle each IT change. Some indicated that once they completed their assessment of the ICD-10 changes needed, they could not evaluate whether the vendor solution or product was available since many of the vendor solutions also seem to be behind. This may be a signal that many vendors also are struggling with the resource issues associated with overlapping IT initiatives. It is not unusual for hospitals to have more than 50 different vendor products, all of which must be tested for their ICD-10 solution prior to installation.

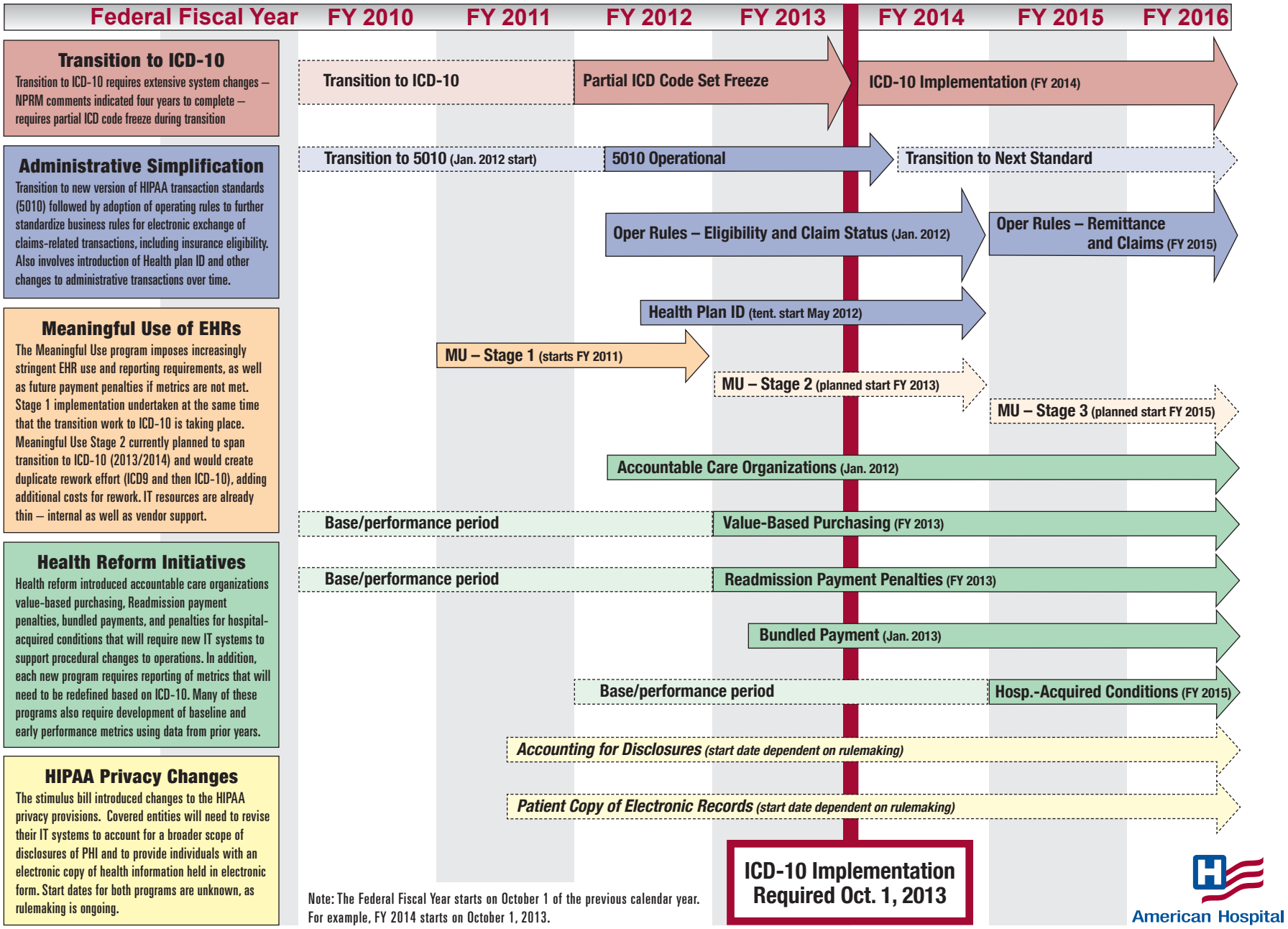
SUMMARY

The AHA supports adoption of the ICD-10 code set and sees it as an important first step in a series of IT changes geared toward improving our understanding of the quality and performance of patient care. The AHA recommends:

- That the Secretary of Health and Human Services (HHS) and the Office of E-Health Standards and Services (OESS) work with the provider community to coordinate the overlapping IT initiatives to create a manageable timeline that is sensitive to the resources needed by the hospital community, as well as others, to move forward.
- Support for the HIT Policy Committee's recommended one-year delay so that Stage 2 meaningful use begins no sooner than fiscal year 2014, and only when at least 75 percent of all eligible hospitals and physicians/professionals have successfully achieved Stage 1 and no earlier than ICD-10 implementation.
- That NCVHS and CMS OESS closely monitor the outcome of version 5010 testing and to urge the Medicaid plans, as well as commercial plans, to begin a similar day(s) of testing.
- That NCVHS and CMS OESS conduct a survey to gauge the readiness of the different sectors of health care – the providers, government plans and commercial plans, as well as the vendor community, to determine where they are in relation to ICD-10 implementation.
    - To avoid dual-processing of ICD-9 and ICD-10; and
    - Map out a strategy for a possible one-year extension on the implementation of ICD-10 – in lieu of dual processing or a long-term contingency plan.

Thank you for the opportunity to share our member's thoughts and insights on how we can collectively move forward with these IT initiatives, especially the 5010 and ICD-10 implementation.

Overlapping Timelines of ICD-10, Meaningful Use of EHRs, and Health Reform Initiatives



Note: The Federal Fiscal Year starts on October 1 of the previous calendar year. For example, FY 2014 starts on October 1, 2013.

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