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May 16, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets [CMS-0040-P]

Dear Ms. Tavenner:

The American College of Cardiology (ACC) is pleased to offer comments on the proposal to adopt a unique health plan identifier (HPID) and to change the compliance date for ICD-10-CM and ICD-10-PCS code sets as published in the *Federal Register* on April 17, 2012. The College is a 40,000-member nonprofit medical society composed of physicians, nurses, nurse practitioners, physician assistants, pharmacists and practice managers, and bestows credentials upon cardiovascular specialists who meet its stringent qualifications. The ACC is a leader in the formulation of health policy, standards and guidelines, and is a staunch supporter of cardiovascular research. The College provides professional education and operates national registries for the measurement and improvement of quality care. We appreciate the opportunity to respond to the government's proposals.

Identifier Standards

The proposal for a standard HPID has been a long time coming. After all, the National Provider Identifier (NPI) was arguably far more complicated, given the significant number of changes needed to accommodate it and the number of individuals and entities that needed to be enumerated, and it was implemented fully in May 2008. The ACC applauds the Centers for Medicare and Medicaid Services (CMS) for releasing this long-awaited proposed rule. We are also pleased by CMS' proposal to adopt a standard for other entities (OEID). However, the College is concerned by the Agency's failure to require health plans to enumerate to the appropriate level of specificity, as well as the lack of clarity surrounding CMS' plans regarding entities that have already been issued standard identifiers.

HPID

Issuing standard identifiers for health plans will assist cardiologists in ensuring that claims for services rendered are filed with the appropriate health plan. However, the ACC believes that CMS' proposal will not allow them to do this sufficiently to eliminate confusion among a health plan's individual products. The large national

plans offer many different health insurance products that cover different services at different rates. These products frequently have similar names, making it difficult for physician practices and their staffs to differentiate between them. Requiring health plans to enumerate at the product level would help to eliminate some of this confusion. Because of this, the ACC recommends that CMS compel health plans to enumerate at a more granular level, especially if health plans require that level of detail to determine the precise information needed to process a claim for services rendered.

OEID

Given the number of types of entities involved in the submission of claims, establishing a standard OEID is a reasonable proposition. The ACC encourages CMS to consider identifier requirements imposed upon vendors submitting data for its various programs. There appears to be a divergence in the Agency's actions in this area. For entities that may be involved in claims submission or standard transactions, the proposal is to use an intelligence-free, 10-digit identifier. For entities involved in the transmission of data to CMS for its programs, another option has been selected. For instance, entities submitting data to CMS for the Physician Quality Reporting System have been required to obtain a Health Level 7 (HL7) Unique Object Identifier (OID). The ACC recommends that CMS consider the various circumstances in which it interacts with entities other than healthcare providers and requires the use of standard identifiers and the potential for limiting those identifiers to one that has multiple purposes.

UPI

The intention behind the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was to create standard national identifiers for the various parties involved in the health care system. With the finalization of this rule, we will have standard national identifiers for providers, payers and other business entities involved in standard transactions. Once the unique device identifier (UDI) proposed rule is released by the Office of Management and Budget for comment and finalized, that piece of the puzzle will be complete. However, still missing will be a standard identifier for a critical component of the health care system: patients. The ACC understands that CMS is prohibited from expending funds for the purpose of promulgating regulations creating a unique patient identifier (UPI). That said, the College urges CMS to work with Congress to remove this statutory prohibition.

The ACC strongly supports the adoption of a UPI as a way of improving the quality of care patients receive. UPI is integral to maintaining an accurate list of a patient's allergies and current medications. Additionally, a UPI would allow for the improved exchange of health information, contributing to a reduction in medical errors. Current patient identifiers, such as Social Security Numbers, are targets for identity theft. If implemented properly, a UPI could limit susceptibility to medical identity theft. If there is a breach of a patient's record, then the matter could be rectified by reissuing a number. Lastly, a UPI would improve patient care by promoting quality improvement derived from patient data registries. Registries rely on the accuracy and completeness of their data to provide valid analyses to participants. A UPI would provide the capability to link patient information across registries and patient encounters. This capability would not only increase the accuracy and completeness of registry data, it is critical for registry data analysis and would enable a wide array of new scientific analyses. Without a UPI, registries rely on statistical matching logic based on patient identifiers (i.e. name, date of birth, etc.), which suffer from the same errors in statistical matching as cited earlier. For additional information regarding ACC's position on the UPI, visit www.cardiosource.org/healthit.

Proposed Delay of the ICD-10 Compliance Date

The ACC supports CMS's proposal to delay implementation of ICD-10 until October 1, 2014. We appreciate the agency's decision to exhibit the flexibility that will be necessary for a successful transition to ICD-10. While we cannot comment directly on the accuracy of the costs estimates in the Regulatory Impact Analysis (RIA) we agree with CMS that the cost to smaller practices and hospitals could be excessive based on the number of ACC members who experienced difficulty with the HIPAA Version 5010 implementation. Some of our members experienced great financial strain based on the January 1, 2012 compliance date for 5010. We agree that there is a vast potential for health care providers and health plans to be negatively affected by the current compliance date of October 1, 2013. We believe that with a well-executed testing period and compliance date it would greatly increase the likelihood that cardiology practices will be ready for a successful transition to ICD-10 with the suggested delay for ICD-10-CM and ICD-10-PCS of one year. Without the proposed delay in the compliance data, we believe the significant slowdown in payments resulting from manual claims submission by practices not ready for full electronic implementation would be disruptive to patient care.

Alternatives Considered for ICD-10

Option 1: Maintain Compliance Date of October 1, 2013

The proposed rule cites results of a CMS survey in which 25% of physicians surveyed did not think they would be prepared in time for a compliance date of October 1, 2013. We believe that these survey results may well overestimate the percentage of physicians who would be well-prepared to comply with the October 1, 2013 deadline. Although the ACC recognizes that any delay in implementation of ICD-10 will affect providers in different ways, we strongly discourage CMS from maintaining the current compliance date. While we believe that larger hospitals and practices that have been earnestly preparing for ICD-10-CM and ICD-10-PCS may incur the added cost of personnel and maintaining system program upgrades for ICD-9 systems for another year, those costs would most likely be less in comparison to the costs that the smaller practices and hospitals may incur by not being prepared at all. On balance, we do not believe that retaining the current schedule for transition is a viable option.

Option 2: Maintain the October 2013 Compliance Date for ICD-10-PCS and Delay the Compliance Date for ICD-10-CM only

We agree that this option would hold a great potential for confusion among providers and payers and would not help to streamline the implementation of ICD-10. Therefore, we do not support a split transition.

Option 3: Forgo ICD-10 and Wait for ICD-11

The ACC recognizes the appeal of putting off indefinitely the unavoidable cost and disruption of transitioning to a new diagnostic coding system until ICD-11 is ready. However, the disruption and costs of such a major change are highly unlikely to decrease. In addition, failure to implement ICD-10 would mean the loss of any of its benefits. We believe that once ICD-10 is implemented, the future transition to ICD-11 would not be as great a burden. Therefore we agree with your decision not to wait for ICD-11 at this time.

Option 4: Mandate a Uniform Delay in Compliance Date of ICD-10

The College agrees that while a two year delay could be beneficial to some providers, hospitals and payers not yet preparing for ICD-10, a delay beyond October 2014 would be costly and disruptive to those practices and hospitals already maintaining programs and training for ICD-10. The ACC, therefore, supports CMS's proposal to set a new compliance date of October 1, 2014.

Cash flow concerns

During the implementation of HIPAA Version 5010, we saw firsthand the interruption of funds to providers. The problems causing the delay of funds came in various forms: 1) lack of compliance on the part of practices; 2) lack of compliance on the part of clearinghouses; and 3) payers not accepting several formatting issues to name a few. We have heard from practices that they experienced problems even though they had a successful testing session. These reports heighten concern about a compliance date of October 1, 2013 and suggest that physicians should be prepared for similar problems even if CMS finalizes the proposal to delay implementation. While we hope a one year delay in implementation will reduce the likelihood and magnitude of payment disruptions, there is no guarantee that everyone will experience a smooth transition. Thus, the College is concerned about the potential for lengthy delays in cash flow that physician practices may experience and the limited methods they have for remedying the problems caused by those delays.

Education

The healthcare industry has experienced difficulties with the implementation of every new code set and transaction standard. Each transition has required a contingency period to prevent substantial numbers of claims from going unpaid. To limit the need for such a contingency period for either the HPID or ICD-10, the ACC urges CMS to conduct education in a wide-range of formats. The College recommends that CMS create an education plan involving the Medicare contractors, webinars, handouts, podcasts, frequently asked questions, and a variety of other formats. The provider community must be properly educated far enough in advance to allow for the necessary adjustments to workflow, training and systems upgrades to ensure that physician practices are able to treat patients appropriately. The ACC would welcome the opportunity to work with CMS to promote these efforts and encourages CMS to reach out to the provider community for assistance in its education efforts.

Conclusion

The ACC appreciates the effort that CMS has put forth on both the development of standard identifiers and the implementation of ICD-10. The College welcomes the opportunity to provide to CMS further clarification on the comments above, as well as to work with both agencies on future educational programing on these important priorities. Please contact Lisa P. Goldstein at (202) 375-6527 or lgoldstein@acc.org or Debra Mariani at (202) 375-6276 or dmariani@acc.org with any questions or concerns.

Sincerely,

William A. Zoghbi, MD, FACC
President