May 16, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–0044–P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS–0040–P (RIN 0938–AQ13) 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

Dear Administrator Tavenner:

As the nation's principal voice for medical group practices, the Medical Group Management Association (MGMA) is supportive of physician practice adoption of administrative simplification standards and initiatives. However, we are very concerned about the direction proposed by the Centers for Medicare & Medicaid Services (CMS) for the National Health Plan Identifier (HPID) and the protracted adoption of the International Classification of Diseases, Tenth Revision (ICD-10).

We believe that if both proposals are finalized as proposed, the industry could incur significant expense and disruption, with little or no return on investment. Furthermore, if the above entitled rules are not substantially modified, the result could be a failure to meet the statutory goals included in section 1104 of the Patient Protection and Affordable Care Act of 2010 (ACA) and a missed opportunity to achieve significant administrative simplification.

MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices. Since 1926, the Association has delivered networking, professional education and resources, advocacy and certification for medical practice professionals. The Association represents 22,500 members who lead 13,600 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States.

Overview of Key Comments and Recommendations

- While we support extending the compliance date for ICD-10, we remain concerned that CMS has not taken the appropriate steps prior to mandating this new code set.
- The cost for physician practices to adopt ICD-10 will be substantial. As an example, it is estimated that a 10-physician practice will incur more than $285,000 in expenses to implement ICD-10.
- CMS should take the following actions prior to mandating ICD-10:
    - Conduct a comprehensive cost-benefit analysis;
    - Pilot test ICD-10;

  - Fully evaluate alternative approaches;

- Should CMS move forward with mandating ICD-10 for physician practices, we recommend the following steps be incorporated into the implementation process:

  - Stagger implementation dates, requiring health plans and clearinghouses to be ready at least one year in advance of providers;

  - Work with industry stakeholders to develop and mandate one effective ICD-9 to ICD-10 and ICD-10 to ICD-9 crosswalk approach;

  - Institute a certification program for health plans and clearinghouses;

  - Support a private sector practice management system software certification process;

  - Significantly augment education and outreach to providers-especially small and rural providers and those treating underserved populations.

- The HPID, as proposed, will be of limited value to physician practices and will not achieve the level of administrative simplification suggested in the rule.

- The final HPID regulation should require health plan enumeration down to the "product" level.

- The government should take advantage of the significant potential administrative simplification opportunities throughout the claims revenue cycle with a more granular HPID.

- We support the proposed rule provision to include the HPID on a patient ID card.

- We encourage CMS to leverage the HPID and other factors and issue standardized, machine-readable Medicare beneficiary ID cards.

- We support requiring National Provider Identifiers (NPIs) for those providers who are non-covered entities, but need to be identified in the claims revenue cycle and pharmacy process.

- We support the creation of the Other Entity Identifier (OEID) for entities that are not providers, health plans or individuals and need to be identified in the claims revenue cycle.

- The timing of the compliance dates should be modified. An Oct.1, 2014 implementation date for both ICD-10 and HPID, both complex and comprehensive regulations, will place unnecessary administrative burdens on physician practices.

ICD-10 Comments and Recommendations

ICD-10 is expected to be one of the most significant changes the physician practice community has ever undertaken. This new code set will impact not only billing, quality reporting and other administrative transactions, but will also require changes to clinical documentation and workflow processes and necessitate extensive clinician training. The adoption of ICD-10 should not be considered without a revised implementation process in place. Failure to complete these critical steps will divert scarce intellectual, educational and financial resources away from the adoption of HIT and other more critical patient care-focused endeavors.

The industry is currently experiencing a significant challenge transitioning to HIPAA Version 5010. It is clear that migration to ICD-10 will be even more complex and costly. As a consequence, it is critical that the government and industry stakeholders work together to identify and address concerns and agree on a more appropriate implementation approach.

The cost of ICD-10 implementation

In 2008, MGMA and 11 other healthcare organizations commissioned an assessment of the financial impact the proposed ICD-10 rule will have on providers. The report estimated the cost of the ICD-10 mandate for three different sized provider practices:

- A typical "small" practice, comprised of three physicians and two impacted administrative staff
- A typical "medium" practice, comprised of 10 providers, one full-time coder, and six impacted administrative staff
- A typical "large" practice, comprised of 100 providers, with 64 coding staff comprised of 10 full-time coders and 54 impacted medical records staff

Total cost impact of ICD-10 mandate on individual provider practices (see Table 1)

- The estimated cost of ICD-10 for a typical small practice is $83,290.
- The estimated cost of ICD-10 for a typical medium practice is $285,195.
- The estimated cost of ICD-10 for a typical large practice is more than $2.7 million.

Cost impact of ICD-10 mandate in six key practice management areas

Requiring more than five times as many codes as the previous code set, the proposed rule would impact every aspect of business operations for physician practices and clinical laboratories and produce significant added costs in six key areas:

1. *Staff education and training*
   The practice will need to train not only the practice billing staff, but most, if not all, of the clinical staff as well. It will be critical for clinicians to understand the new coding structure and changes to documentation requirements. In addition, adding to the complexity of the process, the clinician may need to know health plan payment policy at the time the patient is being seen in order to accurately document the encounter and assign the correct ICD-10 code.

2. *Business-process analysis*
   Practices will need to perform an analysis of the health plan contracts, coverage determinations and documentation requirements.

3. *Changes to "superbills"*
   Practices will need to update and produce the pre-printed forms used in physician offices with a limited number of commonly-used procedure and diagnosis codes.

4. *IT system changes*
   Practice management system and electronic health record software will need to be upgraded or replaced. In many organizations, these modifications will not be covered under the maintenance contract with the vendor. In addition, significant software upgrades often require hardware upgrades as well. Faster computer and increased storage space will add additional cost for practices moving to ICD-10.

5. *Increased documentation costs*
   Clinicians are expected to significantly increase the level of encounter documentation, thus increasing the time spent per patient encounter. The ICD-10 experience in other nations suggests that there will be a significant decrease in productivity here in the US.

6. *Cash flow disruption*
   With the protracted implementation of the 4010, NPI and 5010 as a guidepost, we are concerned that practices will experience significant cash flow disruption following the ICD-10 compliance date. Particularly vulnerable will be those smaller and rural-based providers, many of whom treat underserved populations. We expect that there will be tremendous uncertainty regarding the assignment of appropriate ICD-10 codes and health plan payment policy. As well, there is a strong likelihood that not all practice trading partners will be ready well in advance of the compliance date, thus not allowing practices to submit test transactions. This could lead to significant cash flow disruption that could have a negative impact on patient access to care.

Table 1

	Typical Small Practice (3)	Typical Medium Practice (10)	Typical Large Practice (100)
Education	$2,405	$4,745	$46,280
Process Analysis	$6,900	$12,000	$48,000
Changes to Superbills	$2,985	$9,950	$99,500
IT Costs	$7,500	$15,000	$100,000
Increased Documentation	$44,000	$178,500	$1,785,000
Cash Flow Disruption	$19,500	$65,000	$650,000
Total	**$83,290**	**$285,195**	**$2,728,780**

Experience in other nations

CMS has asserted that one of the most important reasons for adopting ICD-10 in the United States is that most other developed nations have already adopted ICD-10, and moving to the new code set here, would facilitate seamless data interchange between the United States and these nations. As we will show, the three nations most commonly-cited by CMS in its outreach materials as models for moving to ICD-10, Australia, Canada, and Germany, each implemented ICD-10 with a radically different approach than that proposed by CMS (see Table 2). In addition, the ICD-10 adoption process in these other nations, and even the code set itself, is substantially different.

Table 2

Nation	Size of Code Set	Clinical Setting for Use of Code Set	Funding to Providers for Transition	Pilot Tested?
United States: ICD-10-CM*	Approximately 68,000	Inpatient and outpatient	None	No
Australia: ICD-10-AU**	Approximately 22,000	Inpatient only	Government	Yes
Canada: ICD-10-CA***	Approximately 17,000	Inpatient only	Government	Yes
Germany: ICD-10-GM****	Approximately 13,300	Inpatient and outpatient	Government	Yes

*Final Rule
***National Centre for Classification in Health (Australia)*
**** Canadian Institute for Health Information*
*****In Germany, from 2000 until 2003 outpatient settings used a much less detailed version of ICD-10-GM. After 2003, although ICD-10-GM is used for both inpatient and outpatient coding, it is not nearly as detailed as ICD-10-CM (GM much more dedicated to specific inpatient / DRG problems), thus easier to use. Further, in the German outpatient setting there are a number of exceptions where physicians in Germany may code with less detail-where they are not required to use the extended 5-digit-code (where present). This applies to: primary care physicians; any outpatient physician working in the organized outpatient emergency service; and medical specialists, if they code diagnoses which are not related to their specialty (i.e. cardiologist coding a gynecological disease etc.). Finally, certain non-clinical specialties (ancillary services) can be exempted from coding (i.e. laboratory medicine, pathology etc.). Sources: Prof. Dr. med. Thomas Mansky TU Berlin Fachgebiet Strukturentwicklung und Qualitätsmanagement im Gesundheitswesen / ST 0-1 Steinplatz 2, D 10623 Berlin, and http://www.dimdi.de/static/de/klassi/index.htm

ICD-10 Recommendations

Prior to mandating ICD-10 on physician practices, we strongly urge CMS to leverage the experience of other nations in adopting their versions of ICD-10 and take the following steps to minimize healthcare delivery system disruptions:

1. **Consider alternative options for implementing ICD-10.**
   We recommend the government consider the following alternative options for implementing these complex, new code sets to minimize the disruption to the nation's healthcare delivery system:

   - **Reexamine ICD-9-CM**.
     As an interim step, HHS should fully examine the current ICD-9-CM code development and allocation process and make the necessary changes to permit the full utilization of the current code set and the rapid assignment of necessary codes. While there is currently substantial room for additional codes within ICD-9-CM, we understand that certain

clinical categories require additional space. The current code set could be reviewed to determine if unused or rarely used codes could be retired in these categories, thus making room for the assignment of new codes.

- **Implement adoption of inpatient ICD-10-PCS only.**
  The primary concern in some sectors of the industry is the lack of granular coding for inpatient procedures. Moving first to adopt ICD-10-PCS for the inpatient setting would alleviate that issue and solve a persistent problem vocalized by both hospitals and device manufacturers. Moving to inpatient ICD-10-PCS first would permit HHS and the industry to evaluate the impact on a defined part of the healthcare system and could yield important results regarding implementation challenges and solutions.

- **Implement adoption of both ICD-10-PCS and ICD-10-CM only in inpatient settings.**
  Another alternative approach would be to adopt ICD-10-PCS and ICD-10-CM only in the inpatient setting. This approach would have several advantages. First, it would address the concerns of both hospitals and device manufacturers regarding their continued use of ICD-9 codes. Second, it would mirror the approach taken by many other nations, including the often-cited implementation efforts by Canada and Australia. Third, much of the nation's public health data is captured at inpatient settings. Moving to ICD-10 in the inpatient setting would ensure that public health agencies could receive the majority of their data via their preferred method (ICD-10) and other data captured from outpatient settings could be crosswalked from ICD-9-CM to ICD-10-CM for comparative purposes. Finally, moving to ICD-10-CM in the inpatient setting only would provide the government considerable data regarding the ease or difficulty of that transition—data that could prove extremely useful should the government then decide to move forward with mandating ICD-10-CM in outpatient settings.

- **Implement a smaller "subset" of ICD-10-CM in the outpatient setting and exclude certain providers from detailed coding requirements.**
  Similar to how Germany implemented ICD-10-GM, CMS could develop a smaller subset of ICD-10-CM for use in the outpatient setting and/or exclude certain provider specialties/locations from using the complete ICD-10-CM code set.

2. **Complete a comprehensive cost-benefit analysis.**
   HHS should complete and make public a comprehensive cost-benefit analysis to determine the impact the changes to ICD-10 will have on each healthcare industry sector. This analysis should include consultations with appropriate provider organizations and HHS advisory groups. HHS should issue a report delineating the benefits to physician practices and other care settings.

   This cost-benefit analysis should identify each entity affected by the change to ICD-10 and the degree to which they would be affected. The analysis should, at a minimum:

   - Identify costs associated with the transition, including, but not limited to, information system changes, rate negotiation, recalculation of reimbursement methodologies, training, and changes to forms;
   - Considering the timing of transition, including the impact of timing options on costs and benefits, potential return on investment, and interaction with other major health information investment tasks, including participation in other CMS HIT and quality initiatives; and

- Identify immediate and future costs and benefits on physician practices and others of improved data for, but not limited to, patient safety, outcomes analysis, reimbursement, disease management, utilization review, and health statistics.

3. **Pilot test ICD-10.**
   HHS should conduct comprehensive pilots of ICD-10 and analyze the results before national implementation. These pilots should include a wide range of practice types and sizes, small and large hospitals, providers in both electronic and paper health record settings, and safety net providers.

   We encourage CMS to identify the Workgroup for Electronic Data Interchange (WEDI) to perform several functions before, during and after the pilot. These functions would include identification and coordination of pilot participants, liaising with CMS during the pilot, and working with the agency to disseminate pilot results to the industry. The pilot should also be completed in a production environment to better replicate the transactions being used in the industry. Finally, to expedite the piloting process, we recommend that CMS provide funding for all pilot participants.

4. **Analyze the administrative and financial impact of overlapping CMS initiatives.**
   Existing federal health information technology mandates on physicians such as meaningful use, e-prescribing, and quality reporting as well as the implementation of the 5010 transaction standards and the administrative simplification provisions of section 1104 of the ACA must be evaluated in the context of the enormous burden and cost of ICD-10.

5. **Require certification.**
   For the transition to ICD-10 to occur, provider trading partners must be ready to accept ICD-10 codes. HHS should adopt the approach of Section 1104 of the ACA and require the certification of all health plans to be able to accept ICD-10 codes. As covered entities, clearinghouses should also be certified under the same criteria. Furthermore, we urge HHS to support a private sector certification process for practice management and billing system software.

   Certification of these products would greatly assist physician practices in identifying the software necessary to comply with federal mandates and in taking advantage of the numerous administrative simplification initiatives. Certification can also drive implementation by standardizing software requirements and leveraging market forces to ensure practices can meet federal requirements. The government could partner with one or more existing certification entities (Authorized Testing and Certification Bodies) currently participating in the EHR Incentive Program for this purpose.

Additional ICD-10 Recommendations

Should CMS move forward with requiring adoption of ICD-10 in physician practices, we encourage the agency to take the following steps to minimize claims payment disruption and facilitate a smoother transition to ICD-10:

1. **Identify financial resources to assist physician practices in their migration to the new code sets**.
   It is imperative that HHS recognize the financial impact that this code set transition will have, particularly on small and rural providers already struggling to comply with numerous unfunded mandates.

2. **Stagger implementation dates**.
Should the government decide to mandate ICD-10-CM in the outpatient setting, we recommend adopting an implementation process that includes staggered compliance dates for the different sectors. Clearinghouses and health plans should comply first (a minimum of 24 months after promulgation of the final rule) and then providers would comply with the standard at least 12 months later. Adopting a delineated testing period would allow providers to fully test with trading partners before their compliance date. As a result, all covered entities will not focus on a single compliance date, minimizing disruption to healthcare delivery and the claims payment process.

3. **Review and apply lessons learned from previous HIPAA implementations**.
The industry has implemented several provisions mandated under HIPAA. The two administrative simplification mandates most comparable to ICD-10 are:

    - The 4010 and 5010 versions of the electronic transaction standards. Adoption of these mandates has proven to be protracted and costly—with implementation taking more time than expected and with no financial assistance from the federal government. In addition, HHS permitted health plans to develop proprietary versions of the "standard," forcing many practices to contract with clearinghouses simply to submit claims.

    - The National Provider Identifier (NPI)—despite being, arguably, the "simplest" of all of the HIPAA administrative simplification provisions, implementation of the NPI took from January 2004 to May 2008, with many entities still working to migrate to full NPI compliance for all transactions and for all trading partners.

4. **Recognize the insufficient number of coding professionals.**
Currently, there is a shortage of qualified, professional coders trained in ICD-9. Mandating ICD-10 on an accelerated timeframe will only exacerbate this problem. The lack of qualified professional ICD-10 coders will be particularly acute in rural areas and for medical practices and hospitals providing medical care to the underserved populations. Without professional coders to assist practices populate and submit claims with the appropriate ICD-10-CM codes it is highly likely that the practice will experience high levels of claim rejections. This, in turn, could impact practice cash flow and the organization's ability to continue to treat patients. This shortage of coding professionals and the lack of educational and training resources should be factored into the equation when developing the compliance dates for ICD-10.

5. **Understand that clearinghouses cannot be the provider "safety net" for ICD-10**.
When the industry recently transitioned to the 5010 transactions standards, many medical practices had to rely on clearinghouses to convert their claims to a format that health plans would accept. Practice utilization of clearinghouse solutions resulted in part from payer usage of proprietary "companion guides" (a situation where there were in excess of 1,200 different [4010] formats of a single national "standard" claim form-X12N 837P). With the transition to ICD-10, it is expected that the industry will experience a similar level of proprietary health plan approaches to crosswalks and payment policies. This will add to the administrative burden for providers and force them to rely on vendor and clearinghouse readiness to incorporate ICD-10 into their transactions.

    We are greatly concerned that health plans will develop proprietary approaches to the use of ICD-10-CM codes on claims and other transactions. With so much more coding granularity, we expect health plans to differ substantially in their specific requirements for claims. The difference between this approach and the approach health plans took with the 4010 and 5010 transaction standards, however, is the fact that providers will be unable to rely solely on clearinghouses to convert claims to payer

proprietary formats. The assignment of the most specific ICD-10 codes will occur at the time the clinician is seeing the patient and documenting the encounter. Clearinghouses will not able to retroactively assign more specific ICD-10 codes or add supporting clinical documentation, resulting in significant claim denials. This, in turn, could lead directly to cash flow problem for providers and access issues for patients.

HHS should allow sufficient time for providers to fully train clinical and administrative staff and upgrade billing software in order for claims to be populated with appropriate ICD-10-CM codes and avoid experiencing returned claims from clearinghouses for insufficient documentation or inaccurate ICD-10-CM codes. Failure to provide providers with sufficient time to prepare will likely result in disruption to the claims payment process.

6. Institute vendor outreach programs.

A clear lesson learned from implementation of the 4010 and 5010 transactions and the NPI was that providers and others rely heavily on vendors to meet compliance deadlines. The protracted nature of the implementation of these HIPAA provisions was caused, in part, by the failure to develop and sell software to customers in a timely manner.

Many of our members reported that issues with practice management software upgrades slowed and complicated their practice's 5010 compliance efforts. In particular, some practice management system software vendors did not develop the necessary upgrades, forcing practices to purchase all new software from a different vendor and then train all staff on its use. Others relayed that although their vendor produced the necessary upgrades, they did so only for the latest version of the software. Some practices using older versions of the software were forced to purchase the later version and the upgrade.

Vendors, as non-covered entities, are not required by law to upgrade their software to first process 5010 transactions and later ICD-10 codes. Smaller vendors in particular may be slow to reengineer their software and we expect some of them not to develop 5010 and ICD-10 simultaneously, if at all. We strongly encourage HHS to aggressively educate and monitor this sector of the industry.

7. Monitor industry readiness levels.

The National Committee for Vital and Health Statistics (NCVHS) should reprise its role regarding the implementation of previous HIPAA regulations and closely monitor industry readiness levels throughout the ICD-10 implementation process. As each conversion will be extremely complex, the NCVHS is well-positioned to hold public hearings and develop important recommendations to the Secretary regarding the readiness level of various sectors of the industry and suggest steps to assist implementation.

Further, we encourage the agency to develop a website where Medicare Administrative Contractors (MACs) and state Medicaid agencies would be required to publish regular updates to their ICD-10 readiness status and when they would be ready to accept test transactions from their trading partners. In addition, we urge CMS to work with the WEDI to develop a website where private sector covered entities would publish regular updates to their ICD-10 readiness status and when they would be ready to conduct test transactions.

8. Leverage the current REC infrastructure.

The Office of the National Coordinator for HIT (ONC) has implemented a very effective set of Regional Extension Centers (RECs) in an effort to assist primary care eligible professionals select and become meaningful users of electronic health records. These RECs already have significant provider credibility and in some cases have established relationships with software vendors. We encourage

CMS to work directly with ONC to create and disseminate educational and operational programs, tools and other ICD-10 resources.

9. **Enhance industry outreach.**
ICD-10 is such a complex and invasive change to healthcare that it will require considerable educational and technical assistance. Sufficient education will be critical to ensure minimal implementation delays and cash-flow disruption. We recommend that HHS begin provider and vendor roundtable conference calls as soon as possible after publication of the final rule and continue them on a bimonthly or quarterly basis until at least six months after the compliance date. In addition, HHS should work with appropriate industry organizations to develop and disseminate education and outreach, including face-to-face forums, teleconferences and Web-based tools that are tailored to the various segments of the industry.

Health Plan Identifier Comments and Recommendations

Originally mandated in 1996, the HPID supporting regulations were never released. As a result, Congress included a provision requiring the promulgation of a HPID regulation by Oct. 1, 2012 in the ACA. If properly developed and implemented, incorporating an HPID into the healthcare system is an excellent opportunity to streamline an important part of the claims revenue cycle, defined in medical group practice as the cycle from registration of the patient to the account being paid.

Currently, the term "health plan" is considerably ambiguous. Without knowing which entity performs each role in the revenue cycle, physician practices experience difficulties in processing transactions, reconciling claims, and posting payments, all contributing to patient dissatisfaction and confusion. Practices also face needless complexity when plans offer many different individual insurance products with their own fee schedules and benefit schedules. In addition, health plan "A" may sign a so-called "rental agreement" with health plan "B" to administer a particular benefit such as vision. In some cases, the practice may have a contract with plan "A" but not plan "B", yet receive a remittance from "B." This irregularity can challenge practices seeking to identify the correct plan product during this stage in the revenue cycle to determine if they are being paid correctly.

A standardized and robust HPID process will permit practices to quickly access the full range of HPID numbers online via the National Plan and Provider Enumeration System (NPPES), the system that currently contains the NPIs, which practices are very familiar with today.

HPID granularity

The proposed rule, in permitting a health plan to enumerate itself with just one identification number, fails to understand how the HPID will be utilized in the claims revenue cycle. If finalized as proposed, this regulation will miss out on a significant administrative simplification opportunity and fail to achieve the statutory intent of the HPID.

The more appropriate and reasonable approach is to require health plans to enumerate at a significantly more granular level. We believe that this approach is supported in section 1104 of the ACA, which states that in adopting a plan identifier, the HHS Secretary "shall take into account multiple uses for identifiers…" In addition, the original HIPAA legislation does not refer to routing numbers but rather defines the term "health plan" to cover every party that funds health plan benefits.

Our research confirms the need for significant HPID granularity. Without appropriately identifying the individual health plan insurance products, ambiguity within the claims revenue cycle will persist. Health plan product detail on both the remittance and the eligibility response will be extremely important.

Conversely, this granularity should not be mandated on the front end of the cycle. It is common that patients come into a practice without their health plan card, and generally do not know their HPID number. If a granular product number would be required at this stage of the process it could prevent the practice from conducting a patient eligibility verification transaction.

Rental agreements between health plans further complicate the process. Health plan A may "rent" a benefits package to health plan B for such services as mental health, vision, physical therapy, and others. For many providers, it appears as though the patient is "out of network," but they are actually still in network, just party to a rental agreement. In some cases, even though the provider has an existing contractual relationship with health plan A, it does not with health plan B. The remittance coming back from health plan B is confusing to providers as in many cases they cannot identify the health plan and must manually decipher who the plan is, the contractual agreement between health plan A and health plan B, and any contractual reduction of the claim amount.

We believe that the approach adopted by CMS in the development of the NPI is an example of this granularity. CMS enumerated physicians and other healthcare providers as individual professionals and as organizations. In addition, organizations could have multiple NPIs, depending on the corporate structure and business needs. This is similar to what we suggest for the HPID. We suggest enumerating each of those entities involved in the determination of a patient's financial responsibility, as well as including those numbers that will facilitate automated reconciliation and posting of claim transactions.

Cost savings identified in the proposed rule

The proposed rule states (p. 22952) that "Healthcare providers can expect savings from two indirect consequences of HPID implementation: (1) The cost avoidance of decreased administrative time spent by providers interacting with health plans; and (2) a material cost savings through automation of processes for every transaction that moves from manual to electronic implementation. HPID's anticipated 10-year return on investment for the entire healthcare industry is expected to be between $1 to $4.6 billion."

We have significant concerns regarding these cost savings identified in the proposed rule attributed to implementation of the HPID. We have concerns that the cost data is not reflective of provider reality in terms of efficiency gained and the resulting cost savings. We believe that an HPID that permits a health plan to identify all its products with a single identification number will not yield any significant savings, and will still require providers to implement new or updated practice management system software, at a cost.

Further, significant savings identified in the proposed rule are attributed to "pended claims." As the rule states (p. 22981-2) "We have identified two areas in which health plans will experience savings due to the adoption of HPID: A reduction in the number of pended claims and an increased use of electronic healthcare transactions…Pended claims are claims that necessitate a manual review by the health plan. Pended claims are more expensive than ''clean'' claims, which do not require a manual review or additional information in order to be processed. We are projecting a 5 to 10 percent annual reduction of pended claims as attributable to implementation of the HPID."

We assert that the savings attributable to the HPID by CMS were calculated prior to the development and mandating of operating rules for insurance eligibility verification. With these operating rules in place, we believe the industry will experience fewer pended claims and eligibility for services will be established at the time of service and many of the eligibility issues resolved before submission of the claim.

We also contend that the cost savings in the proposed rule is based on testimony provided by MGMA and others during hearings conducted by the NCVHS in 2010. In those hearings, MGMA and other providers

argued that cost savings would be based on implementation of a HPID that identifies entities down to the health plan product level. With an appropriately granular HPID, consistent cost savings will accrue for providers through a decreased number of claims needing rework and other efficiencies gained throughout the claims revenue cycle.

MGMA Research

In an effort to leverage the expertise of our members on this administrative process, MGMA initiated our Legislative and Executive Advocacy Response Network (LEARN) research in late June and early July 2010. More than 480 practice administrators participated in this research, representing organizations where more than 17,000 physicians practice medicine. Survey respondents were from multiple practice types and sizes, from small 1-5 physician single-specialty organizations to large multi-specialty practices with more than 1,000 physicians.

When asked if the HPID should identify specific entities in the revenue cycle, practice administrators responded definitively, and with several suggestions. As Table 3 indicates, 80.9 percent agreed or strongly agreed that the entity that funds the claim, for example the health plan, employer plan or government health plan, should have a unique plan identifier. 83.7 percent agreed or strongly agreed that entities that receive the claim, for example the primary, secondary or tertiary health plan, or repricer should have a unique plan identifier, 86.3 percent said entities that administer the claim (health plan, pharmacy benefit or other manager) should have a unique plan identifier, or third party administrator and 86.1 percent believe that entities that contract directly with the practice (health plan, rental network or employer) should be identified with a unique HPID.

Table 3

Answer Option	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Funds the claim (i.e., health plan, employer, commercial health plan, government health plan)	8.8%	2%	8.2%	18.9%	62.1%
Receives the claim (i.e., primary, secondary or tertiary health plan, repricer)	9.2%	1.3%	5.8%	14.6%	69.1%
Administers the claim (i.e., health plan, pharmacy benefit or other manager, third party administrator)	8.8%	1%	3.8%	19.7%	66.7%
Contracts directly with the practice (i.e., health plan, rental network, employer)	8.8%	1%	4.2%	15.5%	70.7%

A key concern for practices has been that in some cases the remittance (either the HIPAA 835 electronic or paper) is sent by a health plan insurance product that does not have a contract with the practice. Table 4

suggests that almost 14 percent of respondents stated that this occurs more than 25 percent of the time, with almost 30 percent saying that it happens 11-25 percent of the time. Only 2.6 percent stated that they never received a remittance from a health plan insurance product that did not have a contract with them.

Table 4

Approximately what percentage of your total remittances (i.e. a HIPAA 835 electronic remittance advice or paper remittance) are from a health plan insurance product that you do not contract with (this could include "rental agreements" between health plans)?		
Answer Options	**Response Percent**	**Response Count**
More than 25 percent	13.9%	64
11 to 25 percent	29.0%	133
6 to 10 percent	29.6%	136
1 to 5 percent	24.8%	114
None	2.6%	12

Suggesting that this problem is not improving, Table 5 indicates that fully one-third of respondents stated that over the last year the number of electronic and paper remittances coming from health plan insurance products that did not have a contract with the practice increased, 60.4 percent stated that it stayed the same, and only 6.3 percent stated that the number had decreased.

Table 5

Over the last year, what was the change in the number of electronic or paper remittances coming from health plans that you do not contract with?		
Answer Options	**Response Percent**	**Response Count**
Decreased by more than 25%	1.1%	5
Decreased by 1% to 25%	5.2%	23
Stayed the same	60.4%	268
Increased by 1% to 25%	30.9%	137
Increased by more than 25%	2.5%	11

As Table 6 indicates, 63.8 percent of survey respondents stated that this issue requires additional staff time to process and post the remittance, 63.4 percent stated that it requires additional staff time to identify the health plan insurance product, and 47.3 percent indicated that it requires additional staff time to contact the HPID on the remittance. Just 15.4 percent stated that not having the entity identified on the remittance required no additional work.

Table 6

When you receive a remittance (i.e., a HIPAA 835 electronic remittance advice or paper remittance) from a health plan insurance product that you do not have a contract with (including Medicare fee for service and "rental agreements" between health plans), how does this impact your workflow? Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Requires additional staff time to identify the health plan insurance product	63.4%	268
Requires additional staff time to contact the health plan identified on the remittance	47.3%	200
Requires additional staff time to process and post the remittance	63.8%	270
Requires no additional work (no impact on workflow)	15.4%	65
Are there any other impacts on workflow?	14.4%	61

Not surprisingly, Table 7 indicates that 89.3 percent of survey respondents stated that they would find it very helpful or extremely helpful to have the health plan insurance product identified on the remittance. Only .2 percent indicated that they would not find this helpful. Similarly, 96.1 percent of respondents stated that they would find it very helpful or extremely helpful for the specific health plan insurance product to be accurately identified when receiving patient insurance eligibility verifications (Table 8). 95.1 percent of respondents indicated that it would be very helpful or extremely helpful for specific health plan insurance products to be accurately identified when settling a coordination of benefits (COB) claim (Table 9).

Table 7

How helpful would it be for the specific health plan insurance product to be accurately identified on your remittance (i.e., HIPAA 835 electronic remittance advice or paper remittance)?		
Answer Options	**Response Percent**	**Response Count**
Not helpful	0.2%	1
Somewhat helpful	5.5%	24
Moderately helpful	5.1%	22
Very helpful	33.3%	144
Extremely helpful	55.9%	242

Table 8

How helpful would it be for the specific health plan insurance product to be accurately identified when receiving patient insurance eligibility verifications?		
Answer Options	**Response Percent**	**Response Count**
Not helpful	0.5%	2
Somewhat helpful	1.2%	5
Moderately helpful	2.3%	10
Very helpful	24.3%	105
Extremely helpful	71.8%	310

Table 9

How helpful would it be for specific health plan insurance products to be accurately identified when settling a coordination of benefits (COB) claim?		
Answer Options	**Response Percent**	**Response Count**
Not helpful	0.5%	2
Somewhat helpful	0.7%	3
Moderately helpful	3.7%	16
Very helpful	27.5%	118
Extremely helpful	67.6%	290

Impact of HPID on a standardized machine-readable health identification card

One of the benefits of a HPID will be its application to a standardized, machine-readable patient identification card. MGMA has estimated that industry-wide adoption of this type of patient ID card could result in significant administrative savings that MGMA estimates could be as much as $2.2 billion per year. The card has two critical purposes. First, at the most basic level, a machine-readable card will contain the information that today is currently printed on the card. The value to the practice stems from the ability of the card reader to transfer this information accurately and quickly into the practice management system software. This eliminates errors caused by human transcribing of the information that leads to denial of claims and costly rework and readjudication for the practice and the health plan.

A HPID can add utility to the patient ID card. The identifier can facilitate the ability of the card to be electronically read at the time of service to initiate the 270/271 eligibility transactions. For the purposes of the patient ID card, however, the HPID does not need to identify down to the health plan product level. A number of health plans have already issued machine-readable cards to their customers and the plan identifier included on these cards simply route the card to the correct health plan system. From there, it is our understanding that the health plan utilizes additional information on the card (i.e., beneficiary number) to perform the appropriate transaction.

When asked how helpful would it be for a HPID to be embedded in a machine-readable health insurance identification card to assist in immediately identifying all covered services for the patient, 87.9 percent respondents to our survey stated very helpful or extremely helpful. Only 2.1 percent stated that it would not be helpful to embed a plan identifier into a patient ID card (Table 10).

Table 10

How helpful would it be for a Plan ID to be embedded in a machine-readable health insurance identification card to assist in identifying in near real time all covered services for the patient?		
Answer Options	**Response Percent**	**Response Count**
Not helpful	2.1%	9
Somewhat helpful	3.0%	13
Moderately helpful	7.0%	30
Very helpful	19.0%	82
Extremely helpful	68.9%	297

HPID Composition

There is debate regarding the numeric composition of the HPID number. We assert that there is considerable utility to having the HPID mirror the composition of the NPI. Survey respondents, when asked if the HPID should mirror the current NPI and be an all numeric, 10-digit number to simplify the claims process and online accessibility of HPID numbers, 75.7 percent stated that they agreed or strongly agreed. Only 3.5 percent disagreed or strongly disagreed (Table 11).

Table 11

What is your level of agreement with the following statement? The Plan ID should mirror the current national provider identifier (NPI) and be an all numeric, 10-digit number to simplify the claims process and online accessibility of Plan ID numbers.		
Answer Options	**Response Percent**	**Response Count**
Strongly disagree	1.2%	5
Disagree	2.3%	10
Neutral	20.8%	89
Agree	31.5%	135
Strongly agree	44.2%	189

Although the NPI does not itself contain any intelligence, there would be some value to having the HPID contain some basic intelligence. For example, similar to a credit card's first four digits identifying the issuing bank, the HPID could identify the health plan itself.

HPID Recommendations

MGMA has a number of recommendations that we believe will address some of the critical issues facing the healthcare industry:

- **Granular HPID for all health plans**
  In developing the final rule, we urge CMS to strongly consider the administrative simplification opportunities facilitated by a granular HPID. Practice workflow will be greatly improved by identifying each entity that is responsible for funding, receiving and administering the claim, as well as entities contracting with the provider.

- **HPID granularity not required for providers**
  In order to avoid workflow problems when patients do not have access to their specific HPID at the time of service, identifier granularity should not be required for providers to initiate a patient insurance eligibility transaction.

- **Recalculation of cost-benefit analysis**
  CMS should conduct a comprehensive cost-benefit analysis prior to finalizing the rule. This analysis should include calculations based on data derived from implementation of the related 5010 electronic transactions and the insurance eligibility verification operating rules.

- **HPID should be a 10-digit number with a check digit**
  To keep the HPID numbering system consistent and facilitate an easier industry transition, we recommend that the composition of the number be the same as that of the NPI-a 10-digit number

with a check digit.

- **Conduct a pilot test of the HPID prior to national implementation**
  HPID piloting should involve a wide variety of providers, clearinghouses, health plans, and practice management system software vendors. The first step of this pilot should be the enumeration system, both for the assignment of HPIDs and also of the provider "look up" function. The next stage of the pilot of each of the stakeholders named above and focus on addressing, at a minimum:

  - Whether HPIDs work the way they are intended
  - How claims with the HPIDs are routed during testing (including what happens with lost transactions)
  - Issues relating to routing electronic funds transfers based on Tax ID and HPID testing of not just the transactions but the data content behind each of the transactions
  - Identification of the downstream effects of the HPID on the complete claims revenue cycle (including other transactions utilizing the HPID such as insurance eligibility verification and remittance advice)

  We encourage CMS to identify the WEDI to perform several functions before, during and after the pilot. These functions would include identification and coordination of pilot participants, liaising with CMS during the pilot, and working with CMS to disseminate pilot results to the industry. The pilot should also be completed in a production environment to better replicate the transactions used in the industry. Finally, to expedite the piloting process, we recommend that CMS provide funding for all pilot participants.

- **Work with the industry to develop appropriate timelines**
  Appropriate timelines and milestones need to be developed through industry consensus to assist in reducing implementation challenges. We encourage CMS to work directly with WEDI to establish, disseminate and monitor these timelines and milestones.

- **Modified compliance date**
  The proposed rule identifies Oct. 1, 2014 as the date for providers to be in compliance with both the ICD-10 and the HPID. Each of these mandates will demand significant resources for successful implementation. In particular, practice management system software will need to be replaced or upgraded and we are concerned that these modifications will not be made simultaneously by the vendors. Further, each of these mandates will require significant internal and external testing before providers will be confident that their claims revenue cycle will not be disrupted. Due to these factors, we strongly encourage CMS to space out the compliance dates for these two mandates and ensure that there is also sufficient time between the compliance dates for ICD-10, HPID and other ACA, or HITECH requirements.

- **Require health plans to enumerate prior to the compliance date**
  We believe it will be important to require health plans to enumerate well in advance of the compliance date to ensure that they are able to complete trading partner testing. Should plans be given the option of enumerating up until the compliance date, it is highly likely that providers will experience claims payment disruption.

- **Require MAC call centers to provide adequate support**
  We expect call center requests will significantly increase during implementation of the HPID. We urge CMS to instruct the MACs to adequately staff these call centers in order to avoid the

extremely lengthy waiting times experienced by providers during the HIPAA 5010 implementation process. Similarly, CMS should strongly encourage commercial health plans and all other covered entities to sufficiently staff their call centers to expeditiously handle the expected high call volume.

Other Entity Identification Number

MGMA supports the creation of the OEID as a method to further improve provider management of the claims revenue cycle. Entities not already numerated, such as clearinghouses, should be required to get an identification number. However, it is critical that CMS clarify how the OEID is to be used in the claims revenue cycle. While some uses of the OEID are clear, for example claims and remittance advice, other uses need further clarification. It also should be clear to the provider if the number is identifying a health plan or another entity. We also recommend CMS work with the standards developing organizations, X12 in particular, to evaluate the OEID and its impact on each of the transaction standards.

HPID as a catalyst for a standardized, machine-readable patient ID card

Patient ID cards currently in use have no mandated federal standards to rely on for format or content and most have no machine-readable elements. Healthcare providers must typically photocopy the cards for their records. This process is prone to human error, since employees in a physician office or hospital must physically re-key demographic and insurance information into their practice management computer systems. Many cards are inconsistently designed and feature photos, illustrations and dark backgrounds that make legible photocopying difficult.

Other problems related to patient ID cards and eligibility verification reported by providers include:

- High percentages of patients not bringing their insurance cards with them
- Paper ID cards damaged or aged-thus rendering information on the card illegible
- Not enough useful eligibility information returned by payers (necessitating follow-up phone calls), and difficulty in transferring the electronically returned information into the providers' own electronic health records.
- Not enough magnetic stripe cards in the marketplace to warrant the purchase of a card reader and supporting software

Machine-readable cards, linked to providers' computer systems via a card reader, would lead to automatic, accurate and cost-effective collection of patient information with the simple swipe of a card or scan of a bar code.

Benefits of a standardized, machine-readable patient ID card

We believe that this standardization of information on the ID card is an important first step in reducing administrative waste. There are, however, additional levers to employ that would further augment the functionality of the ID card and lead to further standardization and increased efficiencies. These include additional standardization of the hard-copy ID card and adoption of the industry standard for machine-readable ID cards.

Standardized and simplified information contained on patient ID cards will result in:

- Physicians experiencing more efficient office procedures, faster paid claims, and may see a reduction in the number of administrative full time employees (FTEs)

- Health benefit plans experiencing costs related to managing rejected claims substantially reduced; physicians, employers and members more satisfied; and a decrease in the costs of reprinting member identification cards
- Employers saving administrative costs through reduced differentiation among health plans' ID cards and less employee involvement in the claims payment process
- Employees seeing improved claims payment services, leading to greater satisfaction with employer-sponsored benefits

MGMA's Project SwipeIT

In January 2009, MGMA launched Project SwipeIT, an aggressive, industry-wide effort calling on health plans, vendors and healthcare providers to initiate processes to adopt standardized, machine-readable patient ID cards based on the WEDI Implementation Guide. MGMA publicly invited insurers, vendors and providers to pledge their commitment to helping advance the use of this technology.

Project SwipeIT has received support from a number of practice management system software vendors, health plans including UnitedHealthcare, Humana, and America's Health Insurance Plans (the trade association representing over 1,200 health plans), provider associations such as the New Jersey MGMA, American Medical Association, American Academy of Family Physicians, American College of Physicians, American College of Surgeons, and more than 1,000 medical groups. Visit http://www.mgma.com/SwipeITHome/ for more information.

The SwipeIT savings model

There are significant costs associated with use of a nonstandard, paper patient identification card (see Table 12 in appendix). This chart calculates the waste attributed to additional time required to register the patient with a nonstandard paper ID card at the time of service at the practice and staff time spent to correct errors and resubmit claims that have been rejected due to incorrect patient demographics in practices without card readers. The table identifies potential savings totaling more than $2.2 billion a year.

Time savings estimate model for a typical MGMA practice (2009)

The median MGMA member practice is six FTE physicians. Typically, a family practice physician sees 25 patients per day. The calculations in these tables are for a typical MGMA practice of six physicians. Table 13 shows a conservative estimate where only 10 percent of patients have their insurance cards copied, presumably because of changes in their information. This takes about three minutes per card. Assuming that it takes about 20 minutes to update each patient's record on the practice system as well as the billing system, this takes 300 minutes or five hours for the 10 patients. In addition, when one considers that about 5 percent of claims are denied and need re-processing (assuming 10 minutes to re-file a claim with updated information), seven hours of a given day at a six physician practice may be used up in all the processing revolving around the use of WEDI non-compliant, non-swipe cards. Over the course of a year, this is 1,820 hours.

Table 13

Conservative estimate	Unit	Calculation	Time	
Physicians in practice	6			
Number of patients seen per day	25 / physician	25*6=150		
Proportion of patients whose information needs updating	10%	10% *150=15		
Time to make copies and file in correct spot and give patient copy	3 min	15*3=45	45 min	
Time to update records on patient file **and** billing system (for 30% of patients with new information)	20 min	15*20=300	300	
Overall time taken per day on processing patient information without swipe card		5 hrs 45 min	345 min	
Number of denied claims per day	5%	7.5		
Time to resubmit claims (verify and resubmit) denied because of incorrect info on conventional cards	10 min	7.5*10= 1h 15min	75 min	
Time saved by Swipe Card			**7 hrs/day**	**1820 hrs/yr**

Below in Table 14 is the same analysis for another typical practice but one which is less efficient. This practice, like many practices in the real world, copies the patient's insurance card on each visit. This practice may also have a much larger proportion of patients whose information needs updating. So again, there are six physicians each seeing about 25 patients a day. All the patients have their cards copied by the practice. It takes three minutes to do. Patient information is updated in the practice and the billing system for 30 percent of the patients (or 45 patients) - this takes about 20 minutes per patient for both systems. Overall time taken with just this activity is 22 hours and 30 minutes for the day. Assuming the same proportion of denial rates and resubmission as in the conservative model in Table 13, 23 hours and 45 minutes per day have to be spent on updating patient information with conventional cards. On a yearly basis, this works out to be 6,175 hours.

Table 14

Non-conservative estimate	Unit	Calculation	Time	
Physicians in practice	6			
Number of patients seen per day	25 / physician	25*6=150		
Proportion of patients whose information needs updating	100%	100% *150=150		
Time to make copies and file it in correct spot and give patient copy (estimate)	3 min	150*3=450	450	
Time to update records on patient file **and** billing system (for 30% of patients with new information)	20 min	(30% *150)*20=900	900	
Overall time taken per day on processing patient information without swipe card	22 hours and 30 min	1350 min		
Number of denied claims/day	5%	7.5		
Time to resubmit claims (verify and resubmit) denied because of incorrect information on conventional cards	10 min	7.5*10= 1h 15min	75 min	
Time saved by Swipe Card			**23h45m/day**	**6175 hrs/yr**

Patient ID card standardization efforts

On the national level, while federal law (HIPAA) sets minimum standards for electronic transactions in the health insurance arena, including insurance eligibility verification, there are currently no federally-mandated standards for patient ID cards. (We note that HIPAA did include a requirement to develop a standardized national patient identification number, but regulations were never promulgated). However, Section 1104 of the ACA includes the following provision:

‘‘(4) IMPLEMENTATION.—

‘‘(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.

‘‘(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

‘‘(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013, and may allow for the use of a machine-readable identification card (emphasis added).”

While not a direct mandate on the HHS Secretary to implement a standardized machine-readable patient ID card, it nevertheless is a good indication that federal policymakers see a direct correlation between the ID card issue and a streamlined approach to the electronic insurance eligibility verification transaction.

Workgroup for Electronic Data Interchange

WEDI was established in 1991 at the urging of the HHS Secretary for industry participants to identify practical strategies for reducing administrative costs in healthcare through the implementation of electronic data interchange (EDI). Named in the 1996 HIPAA legislation as an advisor to the HHS Secretary, WEDI is a multi-stakeholder membership organization, comprised of healthcare providers, health plans, vendors, state and federal government and consumer groups. WEDI has become a major advocate in promoting the acceptance and implementation of the standardization of administrative and financial healthcare data.

In November of 2007, WEDI finalized an implementation guide to enable automated and interoperable identification using standardized patient ID cards. This implementation guide standardizes current usage of ID cards and is helping bring uniformity of information, appearance and technology to the more than 100 million cards now issued by healthcare providers, health plans, government programs and others.

The WEDI standards for health insurance ID cards, including requirements for machine-readable elements, are available online in its Implementation Guide (www. wedi. org/snip/public/articles/WEDI-Health-ID-Card-Approved. pdf). Additional information on WEDI is available at www.wedi.org

Patient ID Card Recommendations

We offer the following recommendations regarding the patient ID card:

- Medicare should issue standardized, machine-readable ID cards to all Medicare beneficiaries. It is expected that Medicare will be required to remove the Social Security Number from Medicare beneficiary cards. This presents an excellent opportunity to issue low-cost, machine-readable ID cards using the WEDI standard and significantly increase administrative efficiency.

- Health plans should be required to comply with health ID card standards set forth in the WEDI Health ID Card Implementation Guide, Version 1.0, (November 30, 2007), and the standards referenced in that guide. The standards allow for two types of machine-readable formats: magnetic stripes and bar codes. According to WEDI standards, ID cards act as an access key to data, rather than information storage devices. Reasons for this include the fact that (1) providers usually request or need current, real-time information instead of previously stored, potentially out-dated information; (2) storing personal health data on a card presents more security risks than storing it in a secure database that is password protected; and (3) storing a large amount of information on a card is more expensive in terms of both the cards and the associated card readers.

- While the patient ID card should contain the information necessary to register a patient and initiate an insurance eligibility inquiry, a standardized machine-readable card should act more as a “key” to obtaining secure, real-time information online at the time of service. We do not believe that additional security at the point of service is needed to ensure the identity of the individual receiving services.

Conclusion

In conclusion, although MGMA supports the one-year delay for ICD-10, we remain concerned that CMS has not taken the appropriate steps prior to mandating this new code set. In addition, while MGMA supports identifying all entities involved in the claims revenue cycle, it is critical that the HPID include product level granularity. Should health plans be required only to enumerate at the broadest level, a tremendous opportunity to reduce unnecessary administrative burden and expense on providers and improve patient satisfaction will have been missed. Finally, we urge the agency to move forward with standardized, machine-readable ID cards. It is critical that we leverage standardization and automation of the complete claims revenue cycle as we strive to improve the quality of healthcare and lower the cost of providing it.

We appreciate the opportunity to offer our comments on this important issue. Should you have any questions, please contact Robert Tennant at rtennant@mgma.org or 202-293-3450.

Sincerely,

Susan Turney, MD, MS, FACP, FACMPE
President and CEO

Appendix

Table 12

Cost Savings Attributable to Implementation of an Electronically Readable ID Card

Model Assumptions and Raw Inputs	Values	Data Source
Fraction of practices currently using an electronic reader	0.074	April 2009 MGMA Research
Fraction of patients using electronically readable ID cards, for practices with readers	0.20	April 2009 MGMA Research
Time required to register an established patient who presents an electronically readable ID card in practice that has a reader (minutes)	5.00	April 2009 MGMA Research
Time required to register an established patient who does not present an electronically readable ID card in practice that has a reader (minutes)	10.00	April 2009 MGMA Research
Number of visits to physician offices (that generate a claim for physician professional services) per year	901,954,000	NCHS, 2009. "Health, US, 2008", page 359, 2006 data.
Number of visits to hospital outpatient departments (that generate a claim for physician professional services) per year	102,208,000	NCHS 2009. "Health, US, 2008", page 360, 2006 data.
Number of visits to hospital emergency departments (that generate a claim for physician professional services) per year	119,191,000	NCHS 2009. "Health, US, 2008", page 360, 2006 data.
Number of hospital admissions (that generate a claim for physician professional services) per year	37,189,000	NCHS 2009. "Health, US, 2008", page 391, 2006 data.
Fraction of claims rejected by payers due to incorrect patient demographic information for patients that are registered by using electronically readable ID cards in practices with card readers	0.02	April 2009 MGMA Research
Fraction of claims rejected by payers due to incorrect patient demographic information for patients that are registered by using old-fashioned non-electronically readable ID cards in practices with ID card readers	0.05	April 2009 MGMA Research
Staff time spent to correct the error and resubmit the claim for claims that are rejected due to incorrect patient demographics in practices with card readers (minutes per claim)	15.00	April 2009 MGMA Research

Fraction of claims rejected by a payer due to incorrect patient demographic information in practices without card readers	0.05	April 2009 LEARN Research, question 15, median.
Staff time spent to correct the error and resubmit the claim for claims that are rejected due to incorrect patient demographics in practices without card readers (minutes per claim)	15.00	April 2009 LEARN Research, question 16, median.
Total employed support staff cost per FTE physician (dollars)	165,653	CS07, Multispecialty, page 24, median.
Total employed support staff benefits per FTE physician (dollars)	44,008	CS07, Multispecialty, page 24, median.
Minutes per hour	60	Fact
Staff wage rate in dollars per hour	16.02	See wage assumption worksheet.
Model Intermediate Outputs		
Fraction of claims per year for physician professional services that originate with an electronic registration	0.0148	Calculation
Fraction of claims per year for physician professional services that originate with a non-electronic registration	0.9852	Calculation
Time savings per registration by using electronic card (minutes per registration)	5.00	Calculation, difference of medians
Number of claims per year for physician professional services	1.16 m	Calculation
Number of claims per year for physician professional services that originate with non-electronic registration	1.14 m	Calculation
Ratio of staff benefits to wages	0.2657	Calculation
Staff wage and benefits rate in dollars per hour	20.27	Calculation
Minutes saved per year during registration process by implementing electronic registration	5.71m	Calculation
Hours saved per year during registration process by implementing electronic registration	95,280,498	Calculation
Dollars saved per year during registration process by implementing electronic registration	1.93m	Calculation
Number of claims per year that must be resubmitted due to payer	57,168,299	Calculation

denial due to incorrect patient demographics from non-electronic registration		
Minutes per year to resubmit claims denied due to payer denial due to incorrect patient demographics from non-electronic registration	857,524,484	Calculation
Hours per year to resubmit claims denied due to payer denial due to incorrect patient demographics from non-electronic registration	14,292,075	Calculation
Dollars saved per year by not having to resubmit claims denied due to payer denial due to incorrect patient demographics from non-electronic registration	289,762,993	Calculation
Model Final Output: Benefits of Implementing Electronic Registration		
Total savings due to implementing electronic registration (dollars/year)	**2.22b**	**Calculation**

Notes

- This model does not estimate the one-time cost of implementing an electronic registration process.
- Implementation costs are to be subtracted from implementation benefits to estimate net benefits.
- This model does not estimate many other benefits of electronic registration and does not include paper, toner, and copier depreciation cost of copying patient ID cards during non-electronic registration process.