National Committee on Vital and Health Statistics
Subcommittee on Standards and Security Hearing
On
Implementation of the National Provider Identifier

April 6, 2005

Presented by
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My name is George Arges and I am here today on behalf of the American Hospital Association's (AHA's) 4,700 member hospitals and health care systems and 31,000 individual members. The AHA appreciates the opportunity to comment on the upcoming implementation of the National Provider Identifier (NPI). The AHA is very concerned about the process for enumeration and implementation of the NPI.

Hospitals remain confused about exactly how and when the NPI will be implemented and one especially confusing issue is the subpart identifier. We are witnessing the same level of confusion that providers experienced from the adoption of the HIPAA transaction standards. Without additional guidance, the implementation of the NPI will result in significant additional costs that could have been otherwise avoided if we had clearer guidance especially on subpart enumeration and a better deployment process.

Currently, there are many unanswered questions on NPI implementation and providers (and others) have a desperate need for additional outreach and educational material. To effectively orchestrate the much needed guidance, there must be a central authority that can effectively respond to questions and concerns raised about the NPI. This central authority should be the source for clear and authoritative responses about general NPI issues and questions, subpart guidance (especially in relationship to federal programs), bulk enumeration procedures, and enumeration progress reports. In addition, it is essential to encourage additional coordination and collaborative outreach initiatives in order to ensure that independently developed information and material is consistent with the NPI regulations and instructions.

One area that especially deserves more attention is subpart enumeration. There is insufficient guidance on what criteria providers should consider as they determine whether to apply for a subpart identifier. The final rule, and in particular the preamble, states that the provider generally will make the decision to apply for subpart identifier. Hospitals have indicated that there is insufficient guidance on how they should approach this decision and they are fearful of making the wrong the decision. Consequently, we are seeing wide variation among providers in how they are approaching subpart

identifiers. Wide variations in the approach to subpart enumeration will defeat the purpose of administrative simplification and is likely to increase the cost for both providers and health plans.

Providers also are concerned that they may be coerced into filing for a subpart identifier in order to accommodate a particular health plan's need. Many providers, for example, currently are being asked by health plans to apply for a subpart identifier based on the location of a particular unit within the campus of the hospital. While location deserves some consideration in making the decision, it should not be the sole factor that drives the decision to enumerate an organizational subpart. Other more important elements, other than location, should factor into this decision; for instance governance, senior management team, strategic budgeting, and operational oversight are components that are more important in defining an operation than is location. These components are instrumental in determining how the provider's operation functions. In addition to these operational elements, there are other organizational elements that should be considered, especially specialized units that require or meet unique certification and/or special licensure requirements. Until we see guidance to clarify this issue, we cannot move ahead to mandate the routine use of the NPI.

- A staged implementation approach for the NPI is extremely important and the AHA is collectively working with other organizations to develop a set of recommendations related to the deployment approach.
- Without a clear path that has well defined readiness stages, implementation of the NPI is likely to proceed in a confusing and increasingly costly way for all. Our members seem to prefer a "step-up" approach that has clearly defined readiness stages much like the following:
    - <u>May 23, 2005 through May 22, 2006</u>
        - Declare the first year as simply the period for acquiring an NPI
        - Recommend against use of the NPI during this period
        - Enumerator runs periodic progress reports by each type of provider category

        - Encourage collaborative outreach programs to increase provider awareness
        - Establish NPI web board that contains FAQs and can serve as central point of contact for asking questions throughout this transition period
        - Fast track bulk enumeration readiness by the NPI contractor; 4th quarter 2005 is unacceptable
    - May 23, 2006 through December 2006
        - This timeframe should be a period of testing between trading partners – allowing providers and health plans with sufficient opportunity to examine whether appropriate identification and processing of the claim can be derived from the NPI information supplied or whether other information supplied on the claim should be used in combination with the NPI. This would allow health plans an opportunity to modify the edit logic of their claim processing systems.
    - January 2007 through May 22, 2007
        - This third stage would allow routine sending of both NPI and legacy ID – this would allow health plans to utilize this information as a crosswalk that can validate the NPI against previous legacy IDs
    - May 23, 2007 Forward
        - From this point forward all eligible providers should report only the NPI.

The two initial phases of the staged approach are critical and require constant monitoring and reporting to ensure that appropriate progress is being made and that testing is occurring among trading partners. Monitoring enumeration progress is essential and will help to identify whether and what types of additional outreach measures are needed. This is especially important for hospitals who not only must report their own NPI but also that of the attending, operating, or other physician or caregiver involved in the care of the patient. Hospitals are concerned about the timing required for all these care givers to obtain their NPI and share this information with the hospital.

An adequate period of testing is essential to ensure that all of the NPI receivers are ready and capable of handling the submitted NPI. As part of the staged approach, HHS should make clear that routine use of the NPI should not begin any sooner that 1st quarter 2007. Providers don't want to be forced into using the NPI earlier for one health plan while other health plans are not ready. They want a NPI start date where significantly large numbers of receivers are ready to accept and successfully utilize the submitted NPI.

Finally, in the spirit of creating a collaborative approach to education and outreach to ensure that providers receive additional clarification about a number of key concerns, especially the enumeration of organizational subparts and the bulk enumeration process, the AHA offers to use its numerous communication vehicles to ensure that all critical information reaches the hospital community. Again thank you for the opportunity to comment on this issue.