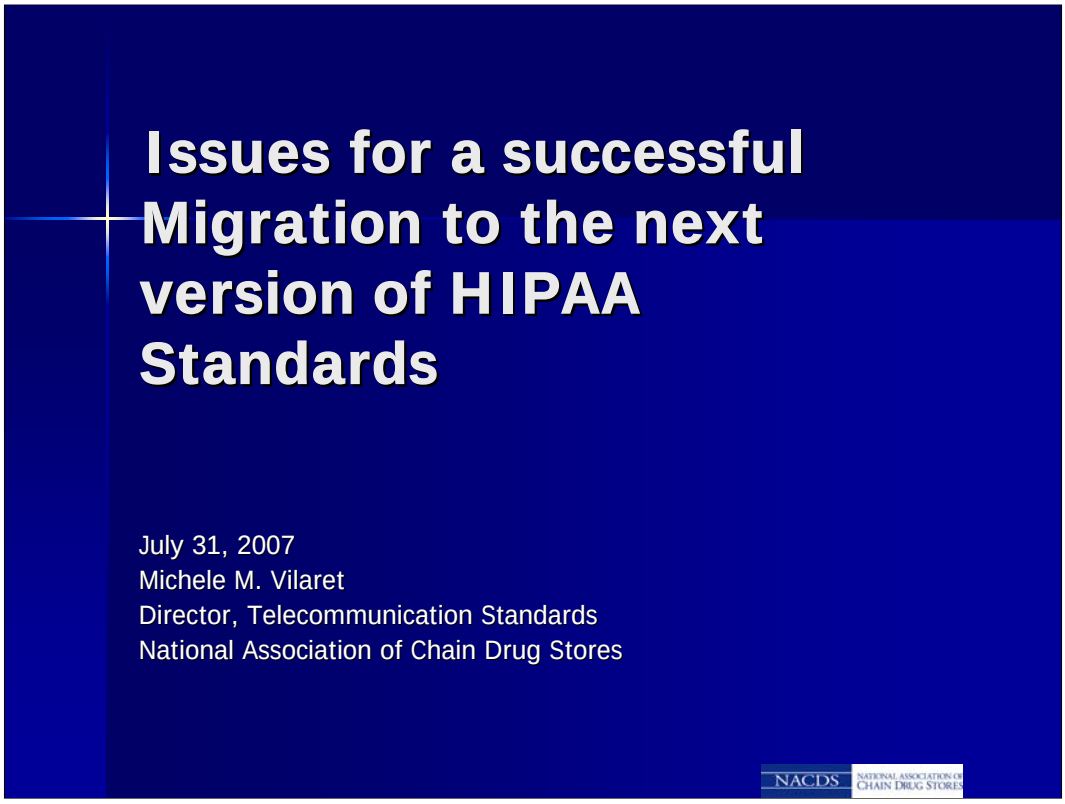
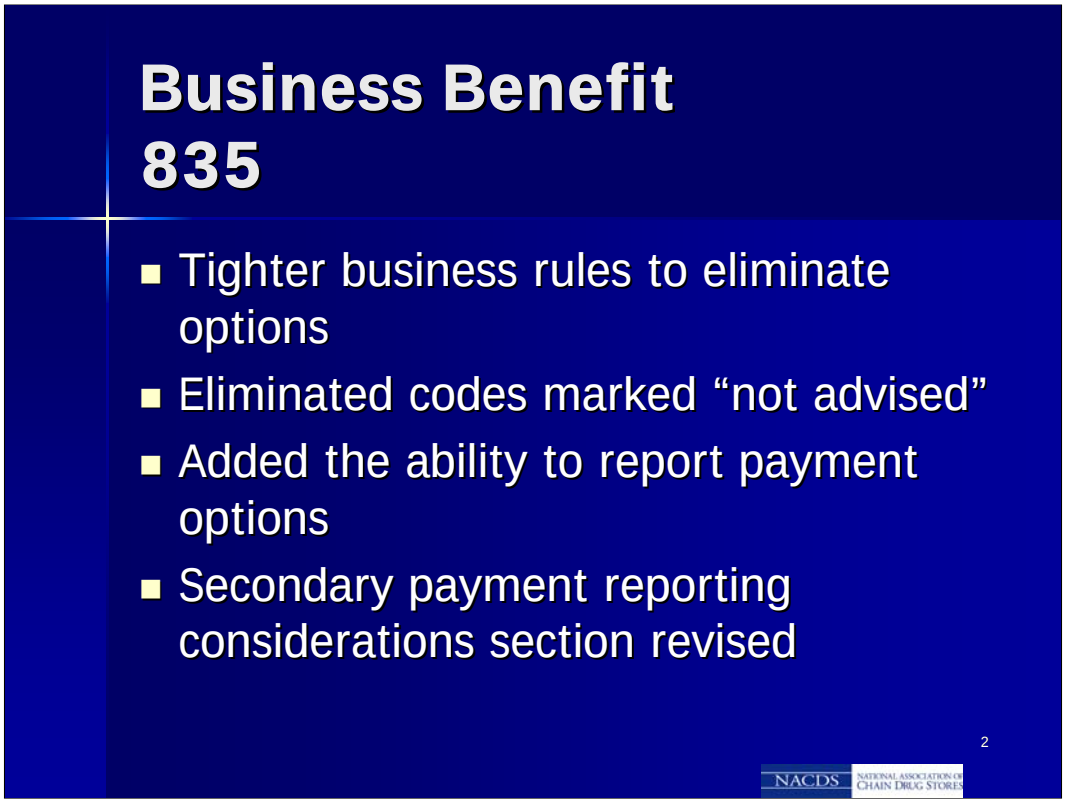


My name is Michele Vilaret, I am the Director of Telecommunications Standards with the National Association of Chain Drug Stores. I would like to thank you for the opportunity to comment on this important topic today.

NACDS represents the nation's leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. Chain pharmacies operate more than 38,000 pharmacies, employ 114,000 pharmacists, fill more than 2.3 billion prescriptions yearly, and have annual sales of nearly $700 billion.



During this presentation I am going to attempt to answer most of the questions asked by the panel. For this presentation I polled our members to obtain their options on these issues.

The first question dealt with the Business benefits of the various HIPAA standards

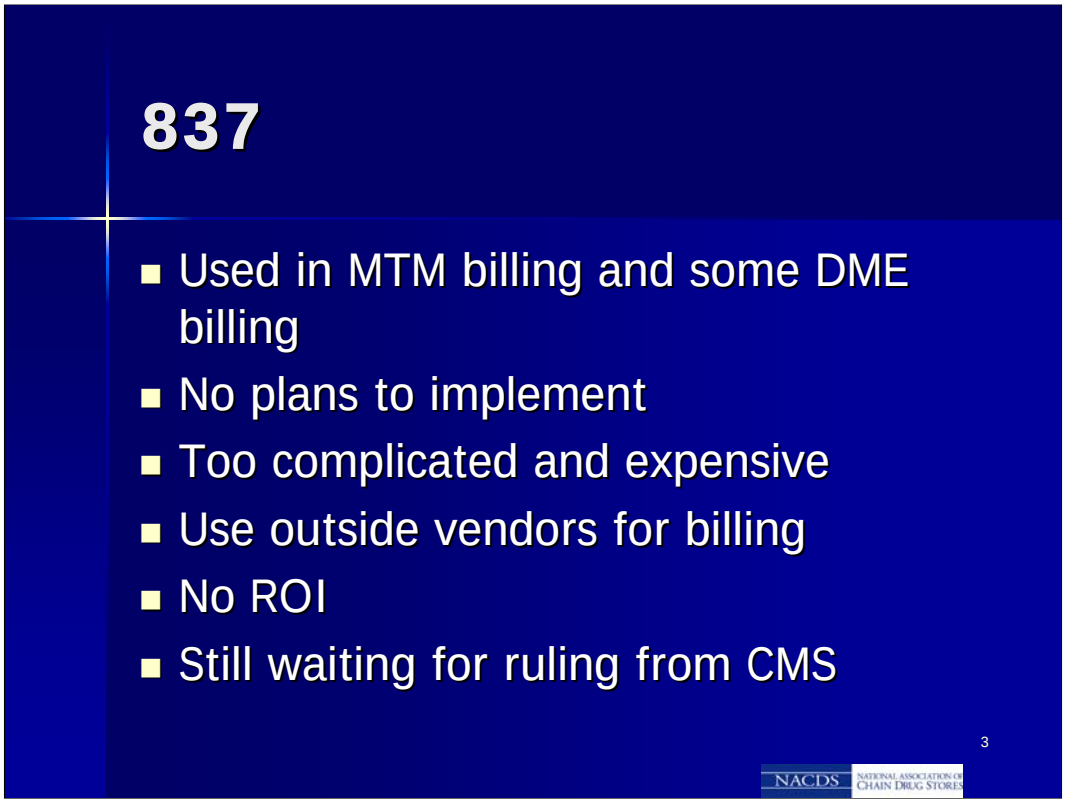
The 835, Remittance Advice is essential to pharmacy to ensure payment.

Tighter business rules to eliminate options is badly needed with the 835. Most of the problems that we deal with today are due to the various interpretations of the 835. If the business rules are tightened and better defined then there should be less room for “interpretation”.

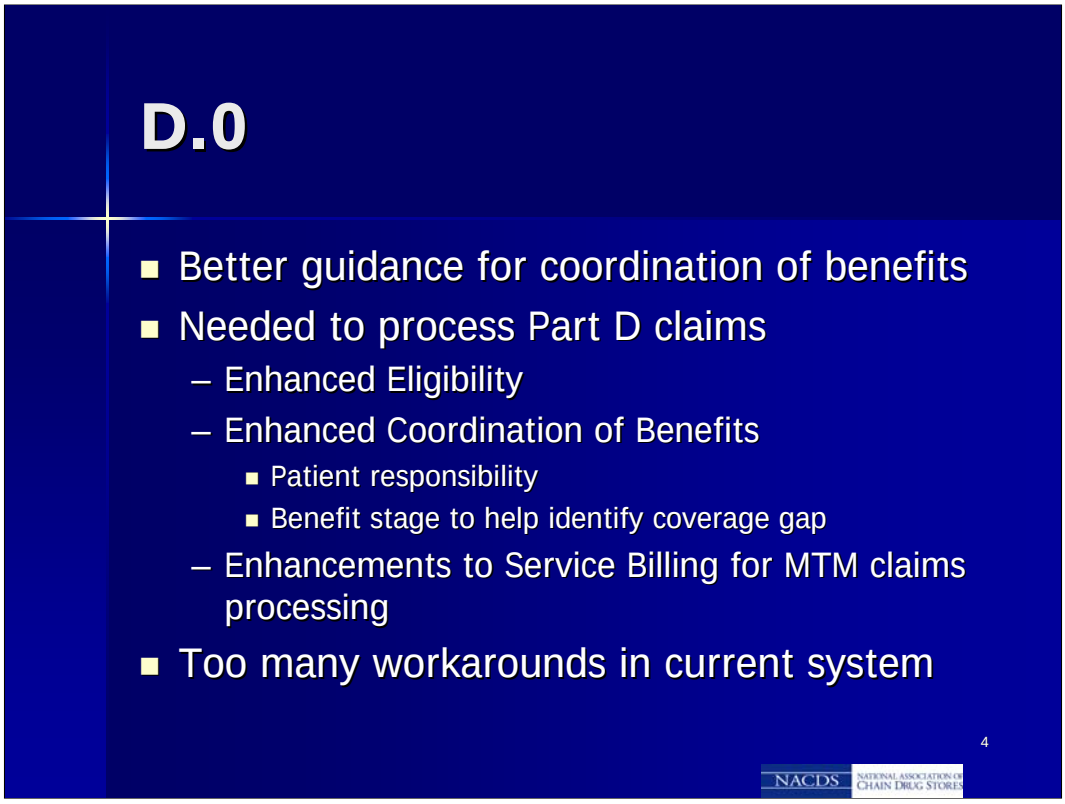
It is very helpful that the several of the codes have been eliminated. We are in the process of reviewing the list of eliminated codes and so far there has been only one that we have found that we needed as an industry which we were able to prove as useful and get returned to the list. It has been very helpful to keep the NCPDP work group involved in this process. It is always good to eliminate codes that are no longer used to keep code lists to a minimum.

Reporting of payment options is not as important to pharmacy as to other entities. Pharmacy prefers EFT.

Secondary payment reporting is extremely important to pharmacy. This section results in a lot of errors and a lot of time spent manually reconciling claims. The changes made in this area are essential to our business.



Although the 837 is used in MTM and service billing as well as by some state Medicaid plans for DME claims chains pharmacies do not plan to implement this transaction. Implementation is just too complicated and expensive. Instead pharmacies plan to use outside vendors in the billing process. There is just no Return on Investment to the provider if they invest the time and money to code for the 837 (it is estimated that it takes well over 1 year to code for the 837) – it is not a good investment when the transaction is not widely used by pharmacy. We are still waiting for a ruling from CMS on whether NCPDP 5.1 can be used in conjunction with the 837 for MTM and/or service billing.



Pharmacy needs D.0 to provide better guidance in coordination of benefit situations. Currently, most of the problems that we have with NCPDP 5.1 deal with misinterpretation of “coordination of benefits”. NCPDP went to great lengths to redefine the “other coverage codes” and to provide claim examples in COB situations in order to eliminate future confusion.

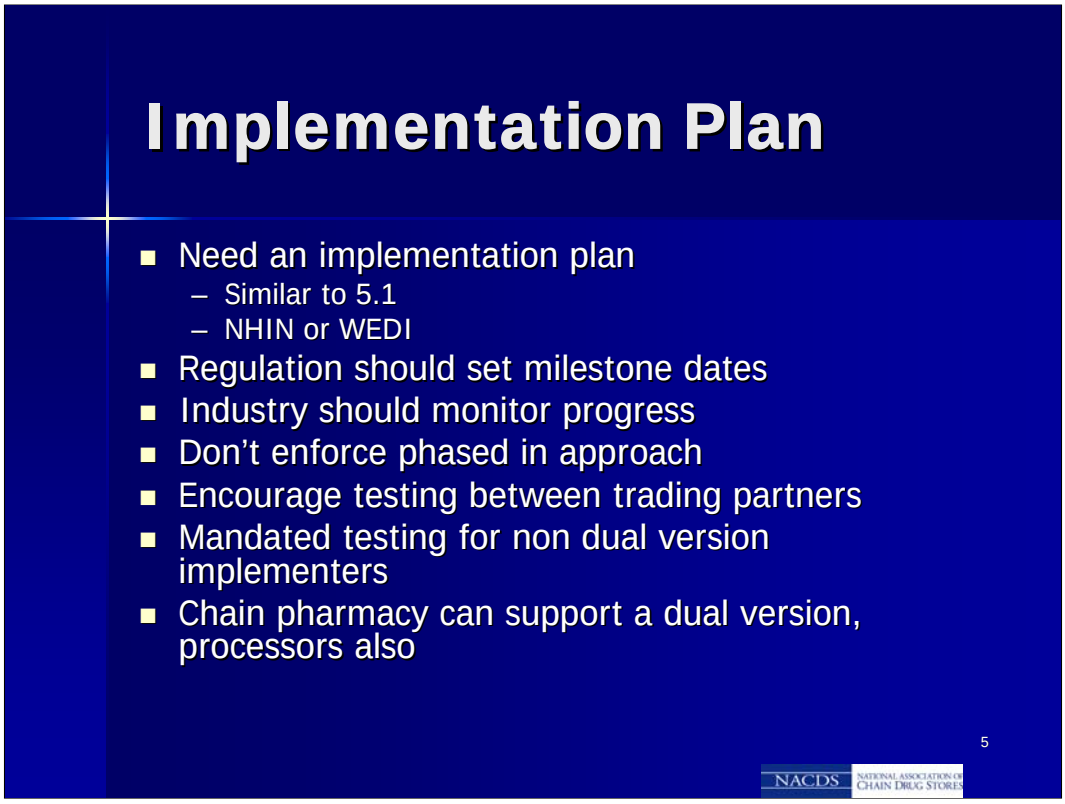
Pharmacies also need D.0 to process Medicare Part D claims due to all of the enhancements that NCPDP and CMS have added to D.0 for processing of Part D claims including –

Enhanced eligibility check

Enhanced “coordination of benefits” section which now identifies “patient responsibility” and “benefit stage” to help identify the coverage gap on secondary claims.

Several enhancements have also been added to the “service billing” for MTM claims processing in hopes that CMS will rule that D.0 may be used to process MTM claims especially for Medicare Part D claims.

We currently have too many workarounds in pharmacy systems due to the short comings of NCPDP Version 5.1 especially when it comes to processing “coordination of benefits” claims. D.0 is badly needed with its redefined pricing segments and robust “coordination of benefits”, as well as streamlined compound claims processing.



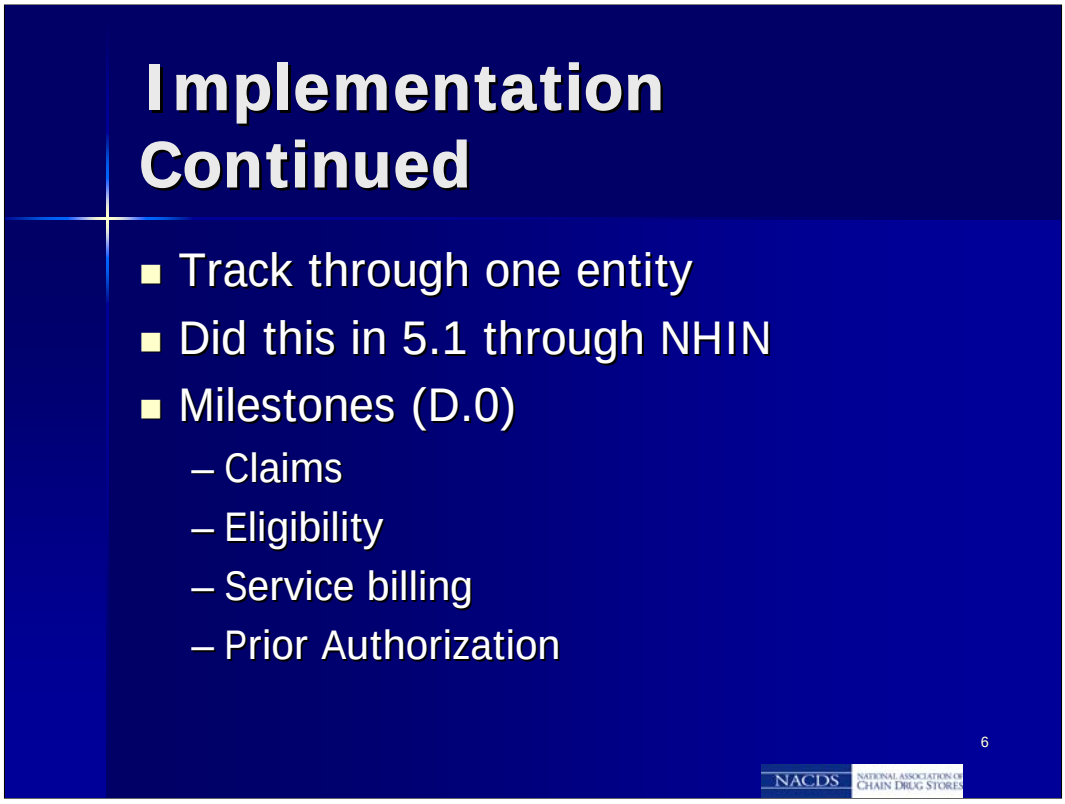
We need an implementation plan similar to 5.1. We found that working through NHIN (the National Health Information Network) for version 5.1 was very successful. For Version D.0 we may want to use WEDI if NHIN is not available.

It would be a good idea for the regulation to set milestone dates. This will help to keep the industry on track, but let the industry monitor its own progress through NHIN or WEDI.

Some pharmacies will implement D.0 as a phased in approach but others will not. Because of this we would not support a mandatory phased in approach.

Testing between some trading partners will be necessary but not mandatory for all. Testing will need to be mandated for plans or payers that are not going to implement a D.0/ 5.1 dual version strategy. Therefore we cannot support mandatory testing for all, only for those who will not implement a dual version strategy.

We surveyed our members and all of chain pharmacy can support a dual version of translations for the phased in periods and beyond. This includes processors. If there are pharmacies that may have difficulties with the dual version approach, there are vendors that are capable of assisting them through the transition.

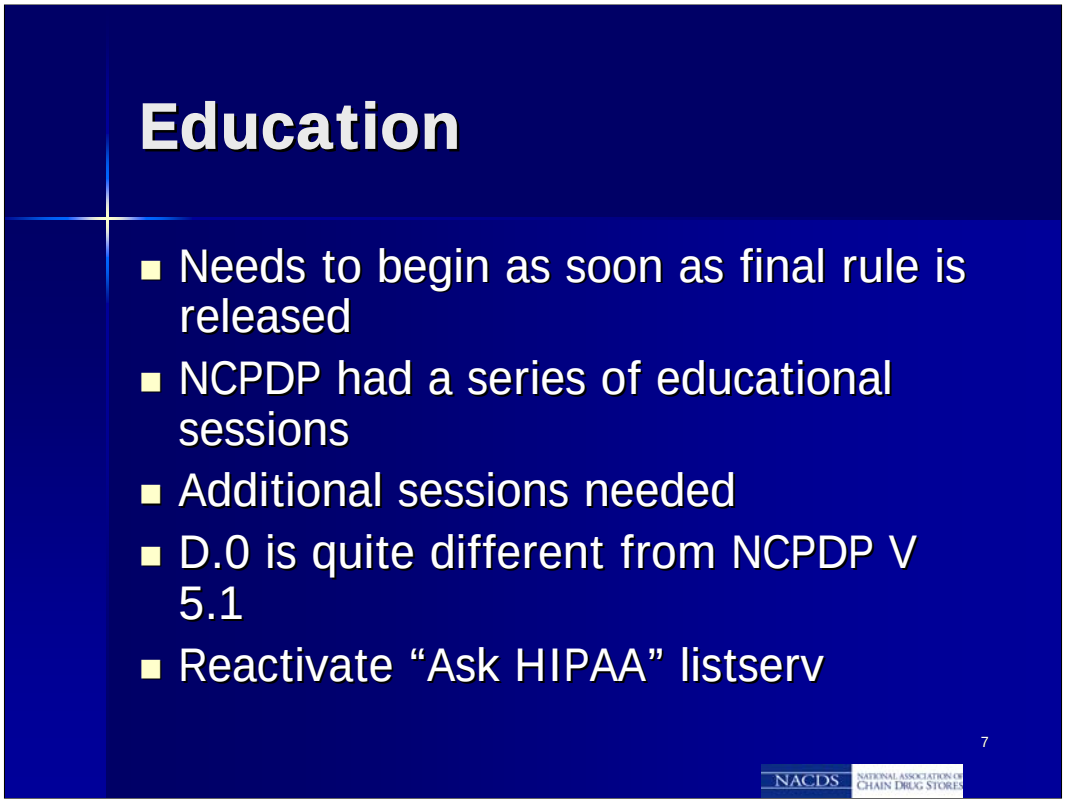


The Implementation process should be tracked through one entity as we did in 5.1 through NHIN. Pharmacies may not code for all segments depending on companion guides from the various payers.

Suggested milestones for pharmacy providers D.0 would be:

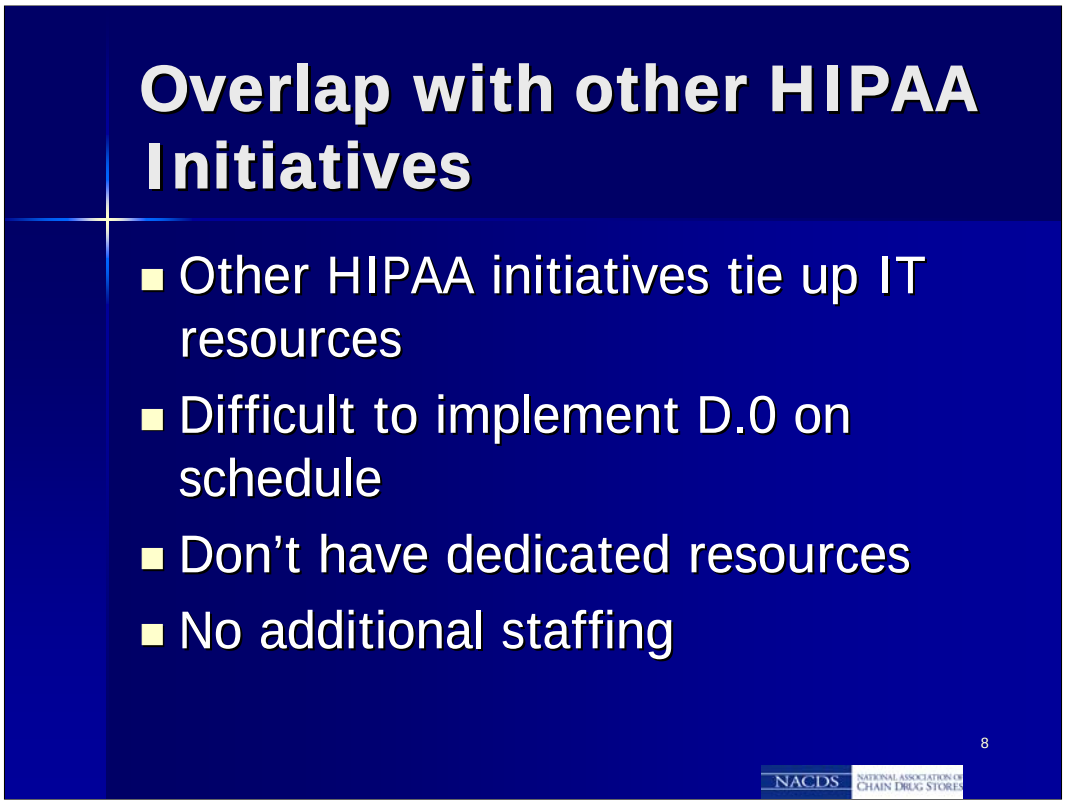
- Claims
- Eligibility
- Service billing (only if approved by CMS for use in MTM)
- Prior authorization

Milestones would differ for different providers

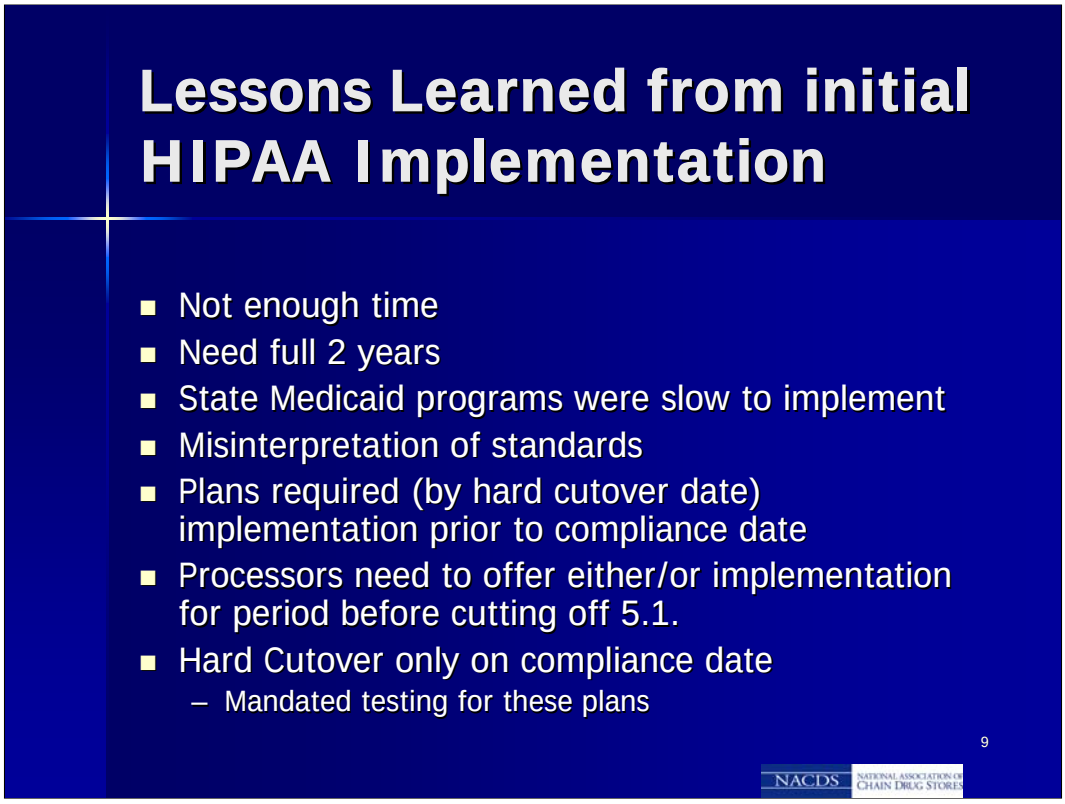


Education to the providers, payers and software vendors needs to begin as soon as the final rule is released.

NCPDP has already had a series of educational sessions. Additional educational sessions will definitely be needed since D.0 is quite different from NCPDP version 5.1 . Previously CMS provided the “Ask HIPAA” listserv which was quite valuable. We recommend the reactivation of this service. Providers found this to be very helpful during the implementation of 5.1.



Pharmacies have limited resources, other HIPAA initiatives such as ICD-10 would tie up these limited resources that are already dedicated to priority projects such as D.0. This makes it very difficult to keep to an implementation schedule since pharmacies don't always have dedicated resources for these types of project. We ask that you not have overlapping compliance dates for HIPAA requirements.



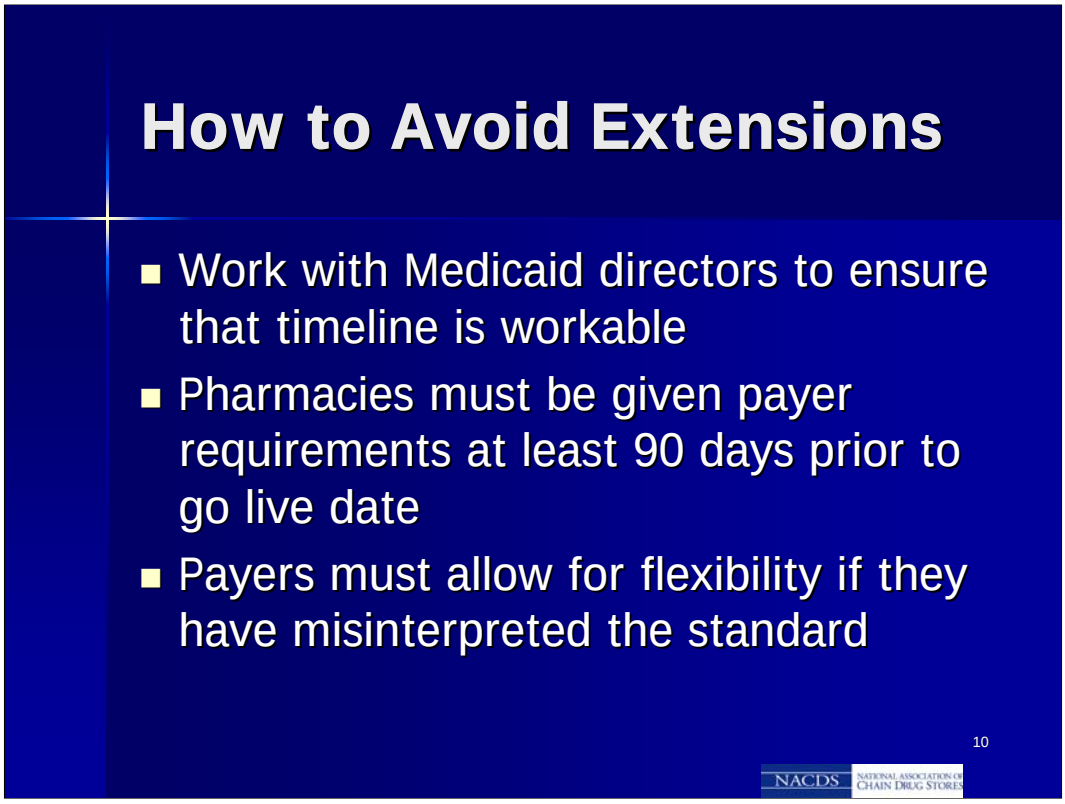
What lessons did we learn from our previous HIPAA implementation?

Last time we did not have enough time to implement …we need a full 2 years to properly implement D.0. The state Medicaid programs were especially slow to implement the initial HIPAA standard. We must make sure they are on the same page this time.

We also need to make sure that payers are flexible. We spent a lot of time last time dealing with plans that had misinterpreted the standards. This can waste a lot of everyone's valuable time. We may need assistance from CMS or NCPDP in enforcing and interpreting the standards.

We can not have all plans implementing on the compliance date. Plans should be required to implement D.0 prior to the compliance date with an either/or strategy. They can eliminate the use of 5.1 on the compliance date.

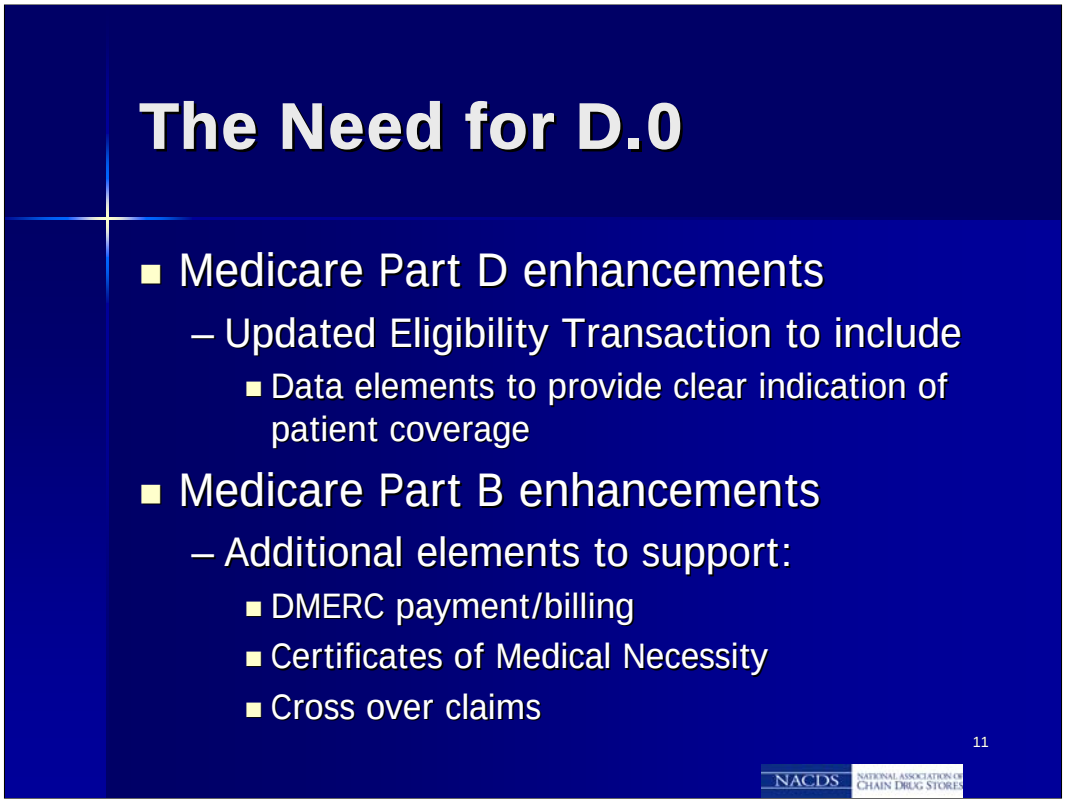
We also need to make sure that we don't have any early implementers. That was also a problem last time. IF a plan wants to mandate D.0 only they can only do so on the compliance date, not before. Prior to the compliance date they must implement with the dual version strategy. If plans are going to implement with a hard cutover to D.0 then testing must be mandated. There is no other way to ensure a seamless implementation than without mandated testing.



How do we avoid extensions? We have to work with the slow adopters from the previous version of HIPAA. Make sure that the Medicaid directors are on board and ensure that the timeline is workable.

Also, make sure that pharmacies receive the payer sheets or companion guides at least 90 days prior to go live date of the plan. This should be mandated in the rule.

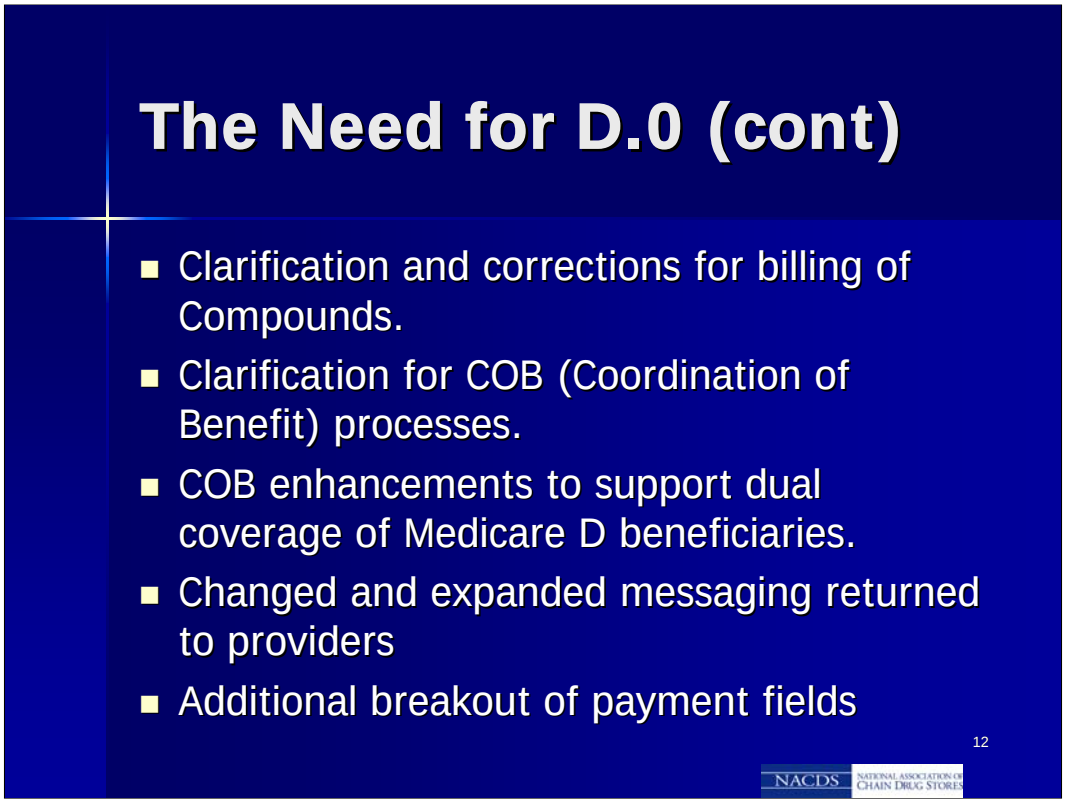
Based on experiences with 5.1 it is VERY important that payers allow for flexibility especially in areas where they (the payers) have misinterpreted the standard and are asking pharmacies to provide inappropriate information especially when this causes a HIPAA violation.



There are many difference between 5.1 and D.0 that were requested by the industry to improve claims processing.

In order to provide patient eligibility information for Medicare Part D and also other insurance information coverage, wide scale changes to the “eligibility transaction” were required. Changes include the addition of three segments along with new data elements and rejection codes and the shifting of data elements from one segment to a new segment. Additionally, long term care pharmacy claims processing required new data element and new rejection messaging codes in order to appropriately identify and process Medicare Part D Claims.

For Part B - Three segments were added to facilitate the processing of Medicare certificates of medical necessity. New data elements were identified and added to allow the items needed to process Medicare Part B transactions and assist the crossover of claims from Medicare to Medicaid.

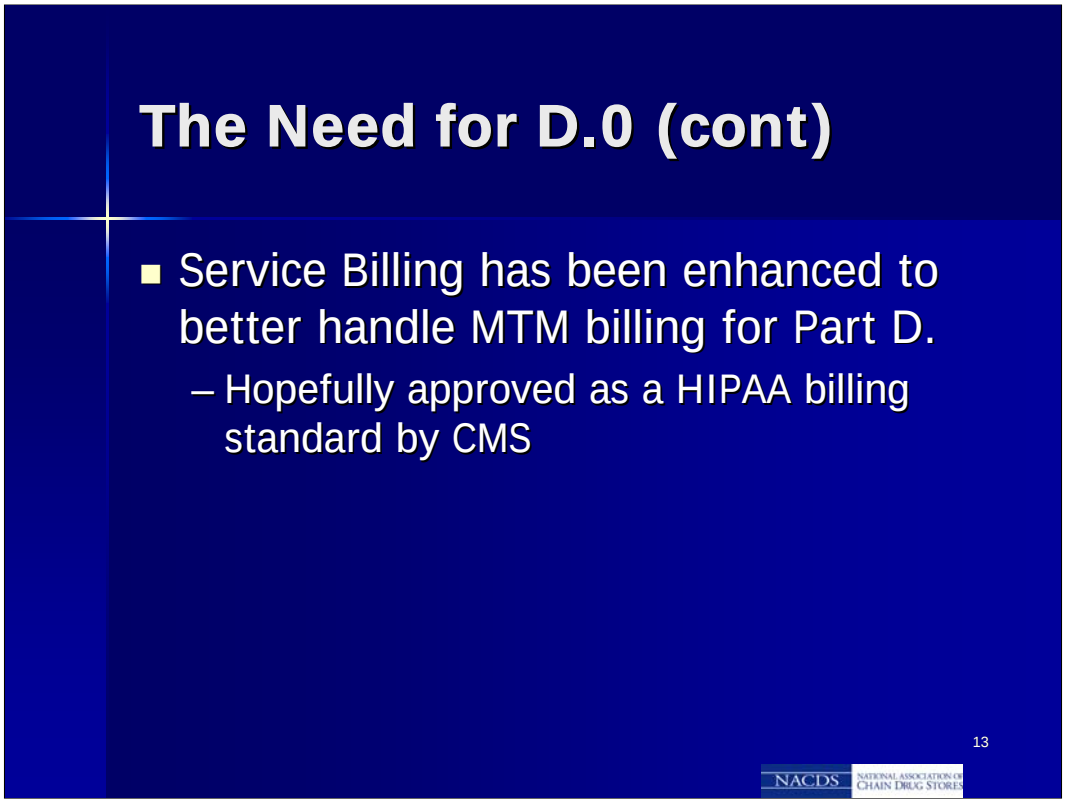


In version D.0, the only method for billing of compounds has been clarified. The two alternatives supported in previous versions for compounded claim processing were removed.

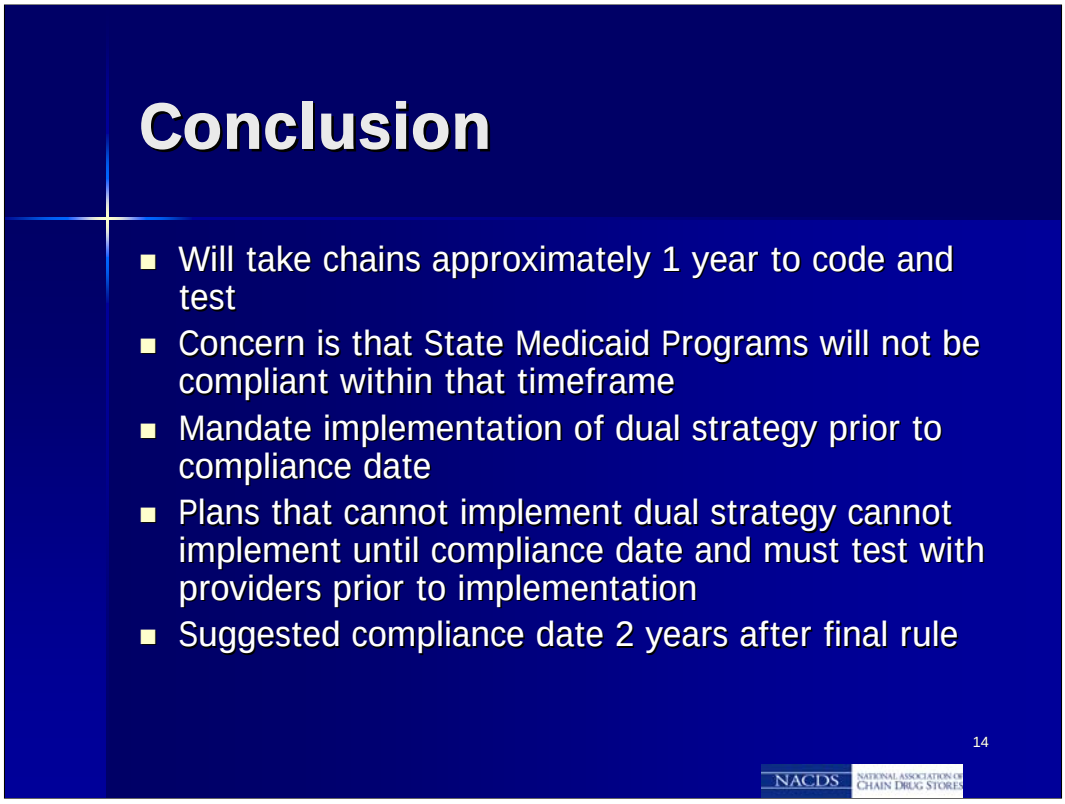
Extensive clarification was made for “coordination of benefits” processing as COB is more complicated with more complex rules than in the past. New data elements have been created for helping to identify various stages of the coverage gap during Part D claim processing. These include “patient responsibility” and “benefit stage”. Also the “other coverage codes” were redefined to help ease confusion during secondary claims processing.

The messages returned on rejected claims were changed and expanded in D.0 to help better communicate reject codes to the pharmacists and pharmacy staff.

And the additional breakout of payment fields allows pharmacies to convey the proper financial details of a claim to the processor.



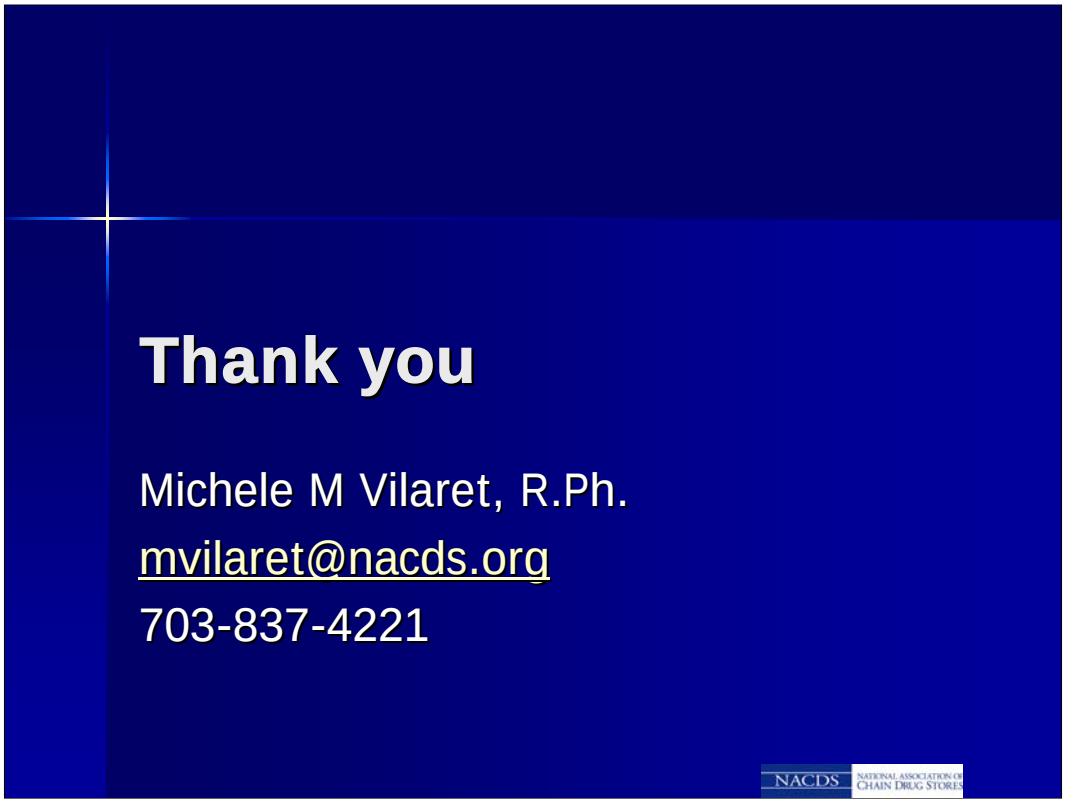
"Service billing" has been enhanced to better handle MTM billing from Part D and now has it own transaction code. Hopefully "service billing" will be approved as a HIPAA billing standard by CMS and will be able to be used in future transactions in place of the 837.



Given the complexity of D.0 chain pharmacy is going to need a full 1 year to implement this standard – It will take them about 1 year to code and test. Our concern is that the state Medicaid programs will not be compliant even within this timeframe. There is also concern that some plans may try to implement the standard early before systems are compliant.

Therefore, we ask that the rule mandate that plans cannot implement prior to the compliance date with D.0 only. We prefer that plans implement prior to the compliance date and allow the use of either 5.1 or D.0. If a plan can only implement using D.0 then the plan must test with providers and cannot implement using this strategy until the compliance date.

Our suggested final compliance date would be 2 years after the final rule. At that time all entities should be able to process claims accordingly using all aspects of D.0.



Thank you for the opportunity to present to you today.
Feel free to contact me if you have any additional questions.

Questions?