

**MHS Testimony to NCVHS Subcommittee on Standards
on the Topic of Common Operating Rules
-- July 20, 2010 --**

BEGINNING OF REMARKS

Good day and hello. My name is Nancy Orvis and I'm pleased to present testimony today regarding the Military Healthcare System's (MHS') current perspectives on the topic of Common Operating Rules for named HIPAA electronic data interchange standards, as identified for implementation in the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148).

The Military Health System (MHS) is a global medical network within the Department of Defense that provides cutting-edge health care to U.S. military personnel worldwide. Equipped with 59 hospitals, 364 health clinics, numerous shipboard medical facilities and mobile medical care facilities in theater, MHS delivers high quality health care worldwide to a beneficiary population of more than 9.6 million Service members, retirees, and family members through both military medical treatment facility (MTF) clinics and hospitals as well as civilian network of providers. The MHS is both a payer and provider. As a managed care health program with associated plans, MHS provides a health maintenance organization (HMO) like plan called TRICARE Prime, a Preferred Provider Organization (PPO) like plan called TRICARE Extra, and a fee-for-service plan called TRICARE Standard. As a payer, the MHS contracts with managed care support contractors and their fiscal intermediary sub-contractors to administer purchased care and adjudicate TRICARE purchased care claims. And finally, as a provider, the MHS delivers direct patient care in our MTF hospitals, clinics, and in austere environments

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such as the battlefield and onboard ships. Yet, the MHS is more than a large health program and network of health care providers; it is an elegant synergy of Army, Navy, and Air Force capabilities that serve, protect and treat the service members who defend our country, and their families.

At MHS, we understand the concept, the intent, and the potential benefits of identifying and employing common industry-wide operating rules. Our managed care component understands that the common operating rules are intended to provide standardized and commonly applied constraints that are expected to reduce reliance on organizational, entity-specific, HIPAA administrative transaction companion guides. In addition, we understand that common operating rules, which provide external constraints to the HIPAA Technical Reports (implementation guides), may be much more flexible in terms of frequency of updates that may be applied against the transactions.

We understand too that the common operating rules are only constraints (restrictions) to broader allowances that exist in the HIPAA X12 transaction Technical Reports and NCPDP (Pharmacy) implementation guides. Just as lower levels of management may tighten but not loosen higher level implementation guidance or policy; the common operating rules may tighten tolerances and place limits on available options while not loosening or going against what is in the higher level guidance. I'm saying this because there may be some who believe they can use common operating rules to make interim and pseudo-fixes to HIPAA X12 implementation guides, since the implementation guides

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will probably be on a slower and more stringent version release cycle – and that belief is an incorrect belief. However, we can see where approved and ongoing use of common operating rules for transactions may drive future changes to HIPAA X12 and NCPDP transaction implementation guidance. After all, why keep unused options in HIPAA X12 or NCPDP implementation guides if it's certain that operating rule constraints to the guides will be permanent.

We expect that implementation of common operating rules may eventually provide benefits to the MHS and to the broader U.S. healthcare industry; though being at both an operational and technical cost. One benefit, of course, should be more standardized and common application of named HIPAA EDI standard implementation guidance. As I mentioned earlier, this should reduce reliance on organizational companion guides and also reduce variability that has to be programmed into software to account for so many differences in what payers or plans specify for their uniquely acceptable transaction content.

Implementation costs of common operating rules will likely be incurred across the spectrum of entities that use HIPAA transactions. Software used by providers has to be modified for initial implementation compliance, and potentially on an ongoing basis as new common operating rules are released and mandated. Changes to software used at the provider level may also drive operational user interface changes as allowed data input choices may change. From a payer/plan perspective, the very function of applying

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common operating rule constraints may limit the flexibility that entities may have counted on for their transaction processing and data collection. In fact, there are provisions of the current CORE Phase-1 operating rules for eligibility response that, if applied by the MHS, would require the MHS to reply with coverage information for service types that are very rarely used by DoD's managed care component, TRICARE. Modifying eligibility system software in this case would be costly, and benefits to the MHS and military personnel would be limited due to unused payload.

Because the MHS (TRICARE) is a Federal health program with a unique operating environment, and due to what is expected to be little or no benefit from employing industry common operating rules in communications that are solely between MHS Covered Entities, we'd like NCVHS to consider exempting the requirement for compliance with common operating rules for HIPAA standard transactions that are exchanged between two Covered Entities within a corporate entity. This exemption would relieve the MHS and possibly other entities from incurring costs, but offer little benefit for employing common operating rules for either enrollment transactions that are performed by MHS entities in communication with a DoD enrollment database or eligibility transactions from MHS military clinics and hospitals.

Please consider too, as an industry-wide cautionary note, that once Common Operating Rules become the normal and ongoing process, there will be a need to carefully control and manage updates. Expectations are that HIPAA transaction implementation guide

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versions will be updated and released more frequently, when compared to the time between the compliance date for HIPAA version 4010A1 and HIPAA version 5010. Common Operating Rules will have to stay in synch and be timely. In addition, there needs to be serious awareness and consideration given to budget and implementation impacts on Federal healthcare entities and the broader industry when making decisions about when and how many Common Operating Rule updates are promulgated, if any, between version implementations of the standardized transactions.

Finally, I'd like to emphasize as well that the MHS and the industry currently have no baseline industry common operating rules with which to compare or to use as insight when budgeting or planning for operating rule costs associated with claims-related transactions (837-Institutional, 837-Professional, NCPDP for Pharmacy, 276/277 Claims Status, and 835 Remittance Advice). Given this current lack of information, neither MHS nor industry can plan for how much impact to expect (bigger than a breadbox but smaller than a boxcar?) and we're not able to provide any specifics about compliance implications because most of the HIPAA EDI transactions (the claims-related transactions) have no existing basis from which to draw conclusions. We're familiar with the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase-1 Operating Rules that exist for HIPAA eligibility EDI transactions, but we don't see that we can extrapolate from the operating rules for eligibility transactions to project the magnitude of operating rules implications in HIPAA claims, or other, transactions.

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We see the CORE Phase-1 eligibility and response transaction operating rules, as written; applying to transactions from providers to plans; but the MHS also uses HIPAA eligibility transactions for an annual Medicaid and DoD eligibility reconciliation which is Plan-to-Plan. We recommend that NCVHS look into excluding operating rules that are intended for provider-to-plan/payer transactions from payer-to-payer transactions.

To summarize; the MHS understands and appreciates the projected benefits of common operating rules, while we are aware of initial and ongoing operational and technical costs. There are also some unknowns, such as there being no current HHS-directed industry-wide common operating rules in place for the HIPAA transactions, which makes us somewhat concerned about how big a change this might be in our fiscally constrained environments. And, finally, we have two requests: 1) That NCVHS consider a specific MHS exception to operating rules when transactions are between MHS program areas such as between DoD provider entities and the DoD Personnel system, and 2) that when the NCVHS adopts common eligibility transaction operating rules that the common operating rules not apply in Federal-to-Federal or State-to-Federal payer-to-payer transactions.

The MHS is, and remains, committed to being compliant with HIPAA transactions, code sets, and identifiers. We're not asking for relief from HIPAA requirements, but we do

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ask that you consider the MHS perspective as you make recommendations on operating rules.

Thank you for your time today. Do you have any questions for me? If not; it's been a pleasure.

END OF REMARKS