

**WEDI**

**National Provider Identifier (NPI) Public Hearing**

**Testimony  
Illinois Hospital Association  
Patricia Merryweather, Senior Vice President**

**April 18, 2006**

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Thank you for the opportunity to present the Illinois perspective on National Provider Identifier issues. I will address not only the here and now issues, but the challenges we must address now if we are to confront more complex issues in exchanging patient level information for RHIOs and the National Health Information Network.

As a representative of approximately 200 Illinois hospitals; chair of the HIPAA Illinois Transaction and Code Set Work Group; NUBC Committee Member; staff for the Illinois Uniform Billing Committee and Illinois RHIO; and Vice Chair of Illinois EHR Task Force. I want to convey the deep concern that the health care community has with the current NPI implementation process. Key areas of health care community concern are:

- Electronic File Exchange Bulk Enumeration Delay
- Access to NPIs for Covered Entities
- Back Up Plan for Impending Implementation Problems

**Electronic File Exchange Bulk Enumeration Delay**

Many providers have yet to apply for their NPI as they anticipated utilizing the bulk enumeration process that was to be implemented in fall 2005. In a letter of communication from CMS in early May 2005, providers were notified that the bulk enumeration was to be available in fall 2005. While CMS has notified providers of delays in implementation of the EFI, there is no solid date yet for this key deliverable.

Many providers anticipated that they would have ample time to submit, implement, and notify all health plans and organizations that rely upon the provider identifier. However, time is slipping by and providers are having increasing concerns that they will not have sufficient time to implement all the health care IT changes and notify all necessary covered entities of the changes. The amount of changes that need to occur and internal provider systems that need to be changed are tremendous – from the complex internal IT systems to billing systems to new prescription forms, and on and on. To put this in perspective as one physician said, it is like losing your wallet and having to contact and secure info on all of your personal information --- only it is far more complex and there are many more trading partners involved that you must contact, document, and receive confirmation that they have implemented the changes.

While it is helpful that CMS revised the EFI Bulk Enumeration process documents on April 4, 2006; providers are most anxious for the bulk enumeration system to be functional. Providers really need a solid date to be provided by CMS for implementation so that they may plan accordingly and have the necessary resources ready. As each day goes by, anxiety increases as the deadline for implementation draws closer.

**Access to NPIs for Covered Entities**

In our discussions with providers, health plans, and clearinghouses in Illinois, there is great concern that the repository of NPIs will not be accessible to providers, health plans, or clearinghouses. Rather, each organization must build its own repository thereby adding significant administrative dollars and resources to administering health care.

It is important to understand the significant role that the NPI repository or National Provider System (NPS) has during both the implementation phase and the ongoing operational phase of NPI.

In the implementation phase, there is much to be gained from utilizing a national repository of NPIs. From a provider perspective, many hospitals utilize the UPIN repository and data bases to verify physician identifiers prior to any billing or coordinated care services for patients. Without the NPI repository access, providers will need to wait for verification from another source, rather than expediting care. Since many providers practice at multiple sites, hospitals are interested in being able to have their systems in place prior to the NPI deadline in May 2007. On an ongoing basis, hospitals and clinics need access to the NPS to obtain and verify NPIs for patient referral cases.

From a health plan perspective, it is essential to have access to the NPS to build and verify their NPI data bases for payment starting using NPI on or before May 2007. As health plans work with countless providers throughout the nation, it is critical that this be an automated, accurate, and timely NPS for access to continuously updated NPIs.

Clearinghouses also need access to the NPS to build and verify the NPIs for HIPAA claims processing. Rather than rely upon countless providers and health plans to build and populate a NPI repository for each clearinghouse, they could also benefit from having access to accurate and timely NPI information.

While we appreciate the confidentiality concerns CMS is having on allowing access to the NPS by covered entities, CMS must remember that providers and health plans are covered under HIPAA privacy provisions and regulations. As health plans and providers are recognized and certified under state and/or federal regulations, it does provide for additional HIPAA protection in allowing their access to NPS. If concern is over control of access to NPS sensitive elements, CMS can institute safeguards and put some remedies for violation in place.

It is perplexing that CMS cannot resolve this issue in light of the ongoing discussions on EHRs, RHIOs, and other CMS supported entities that will exchange much more sensitive information than names and Ids. It is perplexing that extremely confidential information on genetic conditions, HIV, behavioral health, etc. can be exchanged, but a simple id and name among already HIPAA covered entities is insurmountable at this point.

We understand that regulating clearinghouses is more complex as there is no state or federal certification of a clearinghouse; however, a provider (s) or health plan (s) could grant them access if such a permissible access approach was in place.

Additionally, as NPI will replace some existing public provider and health plan data bases and systems at state and national levels, it will be critical that the public continue to have some access to NPI information for purposes of research and ongoing analysis. While not all elements would be available to non-covered entities, there needs to be provisions for access to a limited public data set.

### **Backup Plan for Impending Implementation Plans**

From the covered entity perspective, assuming the two prior issues get resolved soon, the focus will soon shift to implementation. While everyone would like to begin with a phased in approach to the NPI, we know that several providers and health plans will come down to the wire for implementation, especially if the EFI and NPS are not resolved in the very near future.

Due to the complexity of implementing the NPI within covered entity systems and interchanging NPIs with covered entities, back up plans for addressing any shortfalls in the NPS or NPIs must be anticipated. While it may be too early to share plans or approaches with covered entities, it is increasingly being discussed among covered entities to ensure that the health care system does not come to a grinding halt in May 2007.

While we could spend much time looking back and suggesting different approaches, we need to look forward and get the EFI and NPS access issues resolved quickly so that NPI can become a reality next year. Covered entities are waiting for answers to these unresolved issues and cannot wait much longer for them to be resolved with the expectation that they meet a May 2007 deadline.

Thank you for hosting these hearings. We look forward to a quick resolution on these pressing issues.