Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

National Unique Health Plan Identifier

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Thank you to the co-chairs, members, and staff of the Subcommittee for the opportunity to present today. I am Jim Whicker, Principal Technology Consultant, Health I.T. Strategy and Policy with Kaiser Permanente. Until recently, I was employed at Intermountain Healthcare as Director of EDI within the Revenue Cycle Organization. However, I am here today representing the American Association of Healthcare Administrative Management as their National EDI Liaison. AAHAM is a provider organization of individuals involved mostly in the business side of hospitals and clinics. The following testimony is offered on behalf of AAHAM and does not represent the positions of either my current employer or that of my previous employer.

The PPACA legislation directs HHS to move forward with a new National Unique Health Plan Identifier stating that “The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.”

The referenced section of the HIPAA 1996 legislation states:

(b) UNIQUE HEALTH IDENTIFIERS
(1) IN GENERAL- The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.
(2) USE OF IDENTIFIERS- The standards adopted under paragraph (1) shall specify the purposes for which a unique health identifier may be used.”

As we consider implementing another key piece of administrative simplification, we must remember one of our main goals should be to reduce the cost of health care and simplify the administration of the business side of health care. Related to the identifier under discussion today, the key phrase, as we try to understand the intent of congress

for the National Health Plan Identifier, would be to take into account the “multiple uses” of the identifier.

When the National Provider Identifier rules were determined, we allowed for certain distinctions between “types” of providers, and allowed certain entities to enumerate in a way that made sense for their business needs. Our recommendation would be that all payers who meet the definition of a Health Plan under HIPAA would be required to enumerate their Organization and obtain a NHPI for their health plan. We also recommend that payers not covered under the HIPAA regulations be allowed to obtain a NHPI identifier – i.e. Workers Compensation, Auto Insurers, and other Property and Casualty payers who process and pay healthcare related claims. Health Plans should be allowed to implement internal processes for handling transactions and payment processing that takes into consideration existing system capabilities and internal payer processing to meet business needs. Payers will also need to take into consideration state regulations as they may relate to enumeration.

A second recommendation would be to then allow payers to enroll additional entities or subparts and obtain an NHPI when it met a business need. In addition, allow other related entities – such as re-pricers, TPA’s, etc. to enroll as a subpart entity and obtain a NHPI as needed.

This recommendation would allow the usage of the NHPI to include the following concepts when business needs dictate:

- Identify the line of business or product line within the plan/payer in which the patient is enrolled (i.e., XYZ Commercial Payer, XYZ Commercial Payer HMO, XYZ Commercial Payer PPO, XYZ Commercial Payer Medicare Advantage, Medicaid of XX, Medicaid XX HMO 1, Medicare Part A, Medicare Part B, etc.),
- Identifying the “network” (i.e. Beech Street, PPO USA, etc) the payer/plan is using through which the provider accesses the payer;
- Identifying the entity within the plan that is paying the claim;
- Ensure at the time of registration/patient encounter that the appropriate entity for plan administration of the encounter from a payer perspective is determined so that any expectations of the payer/provider relationship can be handled appropriately (referrals, authorizations, notifications, etc.),
- Identify self insured employers, TPAs, and Re-Pricing Networks, and
- Identify Workers Compensation carriers, Auto Insurers, and other property and casualty payers.
- NHPI’s for additional entities (TPA’s, re-pricers, etc.) are to be maintained by the organization requesting them – not by the health plan that uses them or to maintain systems that might track the health plans relationship to them.

Elements to consider that are NOT in scope for the new identifier should include:

- Plan-specific contracts or fee schedules that drive to a provider specific level of detail
- Plan-specific adjudication office locations – internal routing should be handled by the payer

While allowing for a more granular NHPI than just for routing, we do believe we need to be just as cautious on the other side - and not get too detailed in NHPI assignment and overwhelm the industry with too many identifiers at too great of detail.

In regards to network determination – often the determination of network status for pricing is dependent on dynamic factors such as referral status. When this level of granularity (pricing network) is involved as determined by the payer, it is recommended that the pricing network be communicated in the 835 when payment is sent, or at the time of eligibility if the payer is able to determine that information at the time of inquiry.

There has been a lot of debate and discussion about the purpose and use of the identifier. If the only purpose is to simply use it to route transactions, then this recommendation covers that need. If, however, there are "purposes and uses" above and beyond routing that are directly applicable to multiple HIPAA transactions, business processes, workflows, health ID cards, and other possible uses, then our challenge is to define the NHPI so that it reflects those additional purposes, and allowing the additional enrollments as appropriate would meets those needs.

In an effort to make a case for allowing a subpart identifier when needed, let me offer the following. In my previous employment, I spent many years working with the electronic transactions. I felt that one of the greatest benefits to a provider under HIPAA was to automate the eligibility/insurance verification process as well as automate the process of payment posting and EFT. We were able to achieve over 90 percent adoption of these transactions, but it took a lot of effort and coordination with payers to make it happen.

From an eligibility (270/271) and posting (835/EFT) perspective – the single biggest issue was to ensure that not only did I know who the “payer” was, but what entity within the payer (line of business) or pricing network/third party administrator was involved.

If you look at many non-standardized health insurance ID cards today it can be difficult to figure out what you really are being told as there are multiple logo’s and messages on the card. Providers frequently must resort to phone call follow-ups to figure it all out. As a result, the cost of a simple health care service just became much more expensive. Patients don’t understand the involvement of TPAs, re-pricers, etc. in the claims administration world and don’t communicate that information correctly to the registrar. Quite often the patient fails to bring in their card, and the provider is left only with what they can receive electronically, or must resort to a phone call to clarify.

Was the patient covered by state traditional Medicaid, or Medicaid HMO 1, HMO 3, or HMO 14? Are they covered by Blue Cross, or was it really Blue Cross PPO 1 or Blue Cross Medicare Advantage? Is there a “suitcase” in the bottom right hand corner of the card – does the suitcase contain a “+” or not? As stated before – routing the transaction is not the biggest issue. It was more an issue of who is administering the benefits for the patient, and what contractual relationship do I have as a provider that is being used to pay me by the payer? On the routing topic, the most common problem is the need to identify the Third Party Administrator and/or Pricing Network that is being used for the transaction – both of which could be identified utilizing an NHPI within the appropriate transaction.

There is an important note to remember when considering the need for “line of business” indication within a 271 transaction. The HIPAA transaction has an indicator for “In/Out of Network”. The Y/N indication does not reference if the provider is in or out of network for the health plan. It only indicates if the benefits quoted in that EB segment APPLY to an in or out of network provider. It’s up to the provider to determine if they are “in” or “out” of the network – and often need more information from the payer to make that determination than they receive today in the 271.

Another benefit to the provider with a more granular identifier would be the ability to more correctly match encounter information with expected reimbursement. In a hospital setting – there’s a lot of activity involved in predicting reimbursement for discount accrual purposes and for contract monitoring to ensure that appropriate discounts have been applied.

Allowing payers to enroll those lines of business/product lines in the NHPI and reporting them in transactions would bring a significant amount of standardization to those transactions that bring ROI to the provider. If a provider is NOT contracted with a particular plan, the more detailed information would also assist them in re-directing the patient when appropriate to ensure a good financial outcome for both patient and provider.

Identifying the Line of Business offers another advantage. Once a provider has the defined line of business within a health plan that a patient is enrolled in, the provider can access the plan’s line of business requirements and limitations directly from the payer, if necessary, to supplement the information contained in a 271. Information for that business product could be made readily available to the provider to eliminate the need to search around for that information within a payer’s resources.

The comments above only scratch the surface of the "use/purpose" of a standard identifier within the transactions beyond routing. When you consider benefits in automated COB reporting, attachment requests and responses, referrals and authorizations, state data reporting requirements, IRS reporting, etc - going beyond just routing transactions may provide the additional benefits some payers and providers may need – depending on the particular circumstances of the payer. Some entities may benefit from using the subpart capability, others may not.

Another discussion has been that of having a more detailed requirement for the identifier would cause problems for providers in 'getting it right' on outbound claims and the ability to route would be compromised due to multiple numbers. I would expect that a clearing house could route the few instances of an NHPI's that a payer might need to enroll to point to a single endpoint within the network - i.e. many to one mapping for routing (and editing) purposes. However – having a more granular number would allow a clearinghouse or other software vendor to provide more specific claim edits and improve data quality sent and received.

We do not recommend that there be any intelligence built into the number. While the "NAIC" number may be familiar today for some plans and providers, trying to build "intelligence" of any sort into the number is setting the stage for confusion in the future. Any numbers issued as a plan ID should be issued incrementally as applications are submitted without any attempt to "select" or apply meaning of any kind to a number.

Additionally, we recommend that the identifier follow national and international standards, be consistent with current enumeration of providers, and be consistent with the next versions of the HIPAA transactions, to be implemented January 1, 2012. We recommend that the groups responsible for development of standards, implementation guides, instructions, white papers, and operating rules work together to ensure a clear understanding exists of what is expected with transactions in production today, and appropriate enhancements are made in the next round of updates, regardless of the final form and requirements of the NHPI.

Thank you for this opportunity to speak.