



Testimony by the

Medical Group Management Association

to the

National Committee on Vital and Health
Statistics, Subcommittee on Standards

Re: Health Plan Identifier

on

May 3, 2017

The Medical Group Management Association (MGMA) appreciates the opportunity to provide testimony to the National Committee on Vital and Health Statistics (NCVHS) on issues related to implementation of the Health Plan Identifier (HPID). We supported the 2014 decision by the Centers for Medicare & Medicaid Services (CMS) to delay, until further notice, the enforcement of rules for obtaining and using HPIDs.

We also supported the decision in 2015 by CMS to issue a Request for Information (RFI) regarding the HPID to better understand how implementation of the 2012 final rule would impact stakeholders and identify the appropriate path forward to achieve the administrative simplification requirements of section 1104 of the Patient Protection and Affordable Care Act (ACA). Based on the industry response to the RFI and on testimony received by the industry at this hearing, we contend that NCVHS should issue definitive recommendations to the Secretary of the Department of Health and Human Services (HHS) regarding implementation of this identifier.

As the leading association for medical practice administrators and executives since 1926, MGMA helps create successful medical practices that deliver the highest-quality patient care. Through its national membership and 48 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties, which represent more than 275,000 physicians and more than 46 percent of the healthcare delivered in the United States.

Summary of Comments

- As finalized in the 2012 final rule, the HPID should not be required for use in HIPAA electronic data interchange (EDI) transactions.
- Should it be required in electronic transactions, the HPID would increase physician practice administrative burdens and require costly practice management system software upgrades.
- There could a need for the HPID and associated enumeration process to appropriately identify health plans for purposes of complying with section 1104 of the ACA regarding health plan certification, should existing HPIDs be deemed unsuitable for this task.

Responses to questions posed by NCVHS regarding the current HPID regulation

1. MGMA is aware of current health plan identifiers that include, but are not limited to, National Association of Insurance Commissioners (NAIC) identifier, tax identifier, and Health Insurance Oversight System (HIOS) identifier. It is our understanding that each of these health plan identifiers have a unique purpose in the healthcare environment.
2. MGMA is unacquainted with any unmet business needs with the current use of payer IDs in EDI transactions, with the potential exception of identification in the remittance advice of a health plan not in a contractual relationship with a provider but in a rental agreement with a health plan who does have a contract with the provider.
3. MGMA has reviewed the HPID model established in the final regulation and finds neither a benefit nor a business need for it within the current EDI transactions.

4. MGMA believes the HPID model established in the final regulation could negatively impact current processes that could prove costly for providers to implement and maintain and bring no improvements to EDI transactions.
5. MGMA recommends that the HPID final regulation be rescinded or modified to ensure that the HPID is not required in EDI transactions. CMS, however, should utilize the HPID and HPID enumeration process if no other existing health plan identifier is found to be appropriate for purposes of fulfilling the ACA section 1104 requirement for health plan certification.

MGMA General Comments

HPID Enumeration Structure

The term “health plan” is ambiguous. There appears to be considerable industry confusion regarding the enumeration requirements in terms of which organizations would be required to enumerate and what level of granularity would be required under the provisions of the 2012 final rule. Health plans apparently have varying interpretations of the degree to which they must enumerate individual corporate components. Similarly, physician practices are unsure how these new identifiers will be utilized in the transactions.

HPID Use in Standard Transactions

Requiring the HPID to replace current Payer IDs would essentially trade one number for another with no increase in granularity and thus no positive impact on administrative simplification. Without achieving any administrative benefit, requiring the HPID to be used in transactions would actually increase administrative burden for practices and force practices to incur the expense of practice management and billing software upgrades and replacements. Further, requiring HPID in the transactions would most likely result in significant disruption to current practice workflows.

In addition, technically, the Payer ID is utilized on the “outside” of a transaction “envelope” to route to the appropriate entity responsible for paying the claim. Should the HPID be used in transactions, it is not clear which of the structural components (controlling health plan (CHP), subhealth plan (SHP), or other entity identifier (OEID)) would be required. If the CHP is required, the CHP may not be the payer to whom the transaction needs to be routed, and dependence on the CHP would completely disrupt the current transaction’s routing process. The cost of changing to the HPID for use in the transaction is immense not only for changing the underlying technology to make applicable changes, but in educating all stakeholders and addressing payment issues that will likely arise. Moreover, attempts to use the HPID in combination with the Payer ID would complicate matters further.

A change to using the HPID structure or adding the HPID in addition to the Payer ID would require practices to undertake costly retrofitting of technology and modify existing revenue cycle work flow processes. Further, a long implementation period would be necessary and considerable provider education required. Moving to the HPID structure from the industry-created Payer ID structure could result in disruptions in the use of the transactions, with provider payments at risk.

Recommendation: Do not require the use of HPID in any HIPAA electronic transaction, either alone or in combination with the various Payer IDs in use today.

Changes in the Healthcare Environment Impacting HPID

Previously, without knowing which entity performs each role in the revenue cycle, physician practices experienced difficulties in processing transactions, reconciling claims, and posting payments, which all contributed to patient dissatisfaction and confusion. Practices also faced needless complexity when plans offered many different individual insurance products with their own fee schedules and benefit schedules and engaged in “renting out” plan benefits. These irregularities challenged practices seeking to identify the correct plan product during various steps in the revenue cycle to determine if they were being paid correctly.

In our comments on the HPID proposed rule, we expressed concern that a regulation that permitted a health plan to identify all its products with a single identification number would not yield any significant savings, and would still require providers to implement new or updated practice management system software, at a cost.

Further, significant savings are identified in the 2012 rule, which attributed to a decrease in pended claims. Originally, the Agency projected a 5% to 10% annual reduction of pended claims as attributable to implementation of the HPID. We now assert, however, that the savings attributable to the HPID by CMS were calculated prior to the widespread deployment of operating rules for insurance eligibility verification. With these operating rules in place, we believe the industry has experienced fewer pended claims and eligibility for services is more often established at the time of service.

Use of the HPID in Health Plan Certification Process

Understanding that the HPID should not be used in standard transactions, there may be a different need for the HPID and its associated enumeration infrastructure. As required under section 1104 of the ACA, health plans are mandated to “certify” their compliance with the EDI transactions and supporting operating rules of HIPAA and the ACA.

This health plan certification process is essential if the industry is to achieve a greater level of compliance with the standard transactions and operating rules. With no fines ever having been levied on health plans since the HIPAA transactions went into effect, the threat of enforcement actions has not been a deterrent for health plan non-compliance. Section 1104 of the ACA includes significant potential penalties for non-compliant health plans, yet the certification process has not been initiated. The HPID (or other appropriate identification number) appears to be necessary to move that process forward.

Recommendation: Move forward with health plan certification (as mandated in ACA section 1104) and utilize the HPID and HPID enumeration process only if no other existing health plan identifier is found to be appropriate.

Conclusion

MGMA applauds NCVHS for reaching out to physician practices and other industry stakeholders regarding the HPID issue. Rather than move forward and mandate an identifier that will not result in administrative simplification but rather add unnecessary burden and cost to physician practices, we urge NCVHS to recommend to HHS that the current requirement that the HPID be used in HIPAA transactions be rescinded. At the same time, leveraging the HPID for use in the health plan certification process should be explored. We look forward to working with the government to ensure that the requirements included in HIPAA and the ACA are thoughtfully and efficiently implemented.

We appreciate the opportunity to offer our perspectives on the HPID and related issues. Should you have any questions, please contact Robert Tennant at rtennant@mgma.org or 202-293-3450.