May 2, 2017

National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards
c/o National Center for Health Statistics
3311 Toledo Road
Hyattsville, Maryland 20782

Re: May 3, 2017 Testimony to the NCVHS - Health Plan Identifier

Dear Subcommittee Co-Chairs Coussoule and Goss:

Thank you to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards for the opportunity to testify in response to the Subcommittee's questions on the Health Plan Identifier, or HPID. CAQH CORE is a non-profit, multi-stakeholder collaboration of more than 130 organizations representing healthcare providers, health plans, clearinghouses, vendors, government agencies and standard setting organizations. Our health plan participants cover 75 percent of the nation's commercially insured. In 2012, CAQH CORE was named by the Secretary of Health and Human Services (HHS) as the authoring entity for the operating rules that support the Health Insurance Portability and Accountability Act (HIPAA) transaction standards, accelerate interoperability and help align administrative and clinical activities. This more detailed written testimony reflects our brief oral remarks presented to the Subcommittee.

Based upon recent feedback, we are reiterating the two key positions from the CAQH CORE Board July 28, 2015 letter[1]to the Centers for Medicare and Medicaid Services (CMS) in response to the CMS 2015 Request for Information Regarding the Requirements for HPID, and providing new detail on the growing need for our recommendations on monitoring:

1. Regarding use of the HPID to route HIPAA transactions, HHS should:
    *   Not require the use of the HPID in the HIPAA transactions, either alone or in combination with the various payer[2] identifiers (IDs) in use today.
    *   Support efforts that would allow the various types of IDs currently used for transaction routing purposes to be made publicly accessible to enable monitoring.
        o   The industry uses a patchwork of proprietary IDs for routing transactions; some of the entities with payer IDs are not HIPAA covered health plans. There is no aggregated data on and thus understanding of the industry's successes, challenges or cost of this ID patchwork. Additionally, there is no collective industry understanding of how this ID patchwork would apply to emerging routing needs such as processing value-based contracts. As noted in detail in this letter, this lack of understanding is a growing concern to some CAQH CORE Participants when they consider routing needs.
2. Regarding other lawful purposes for an HPID that are separate from transaction routing:
    *   Other lawful purposes may include public policy needs or HIPAA compliance enforcement.

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[1] See: https://www.caqh.org/sites/default/files/core/testimony/caqh_core_board_letter_on_hpid_rfi.pdf.
[2] There is no definition of "payer" in HIPAA or other federal statute. *A health plan* is defined and regulated in HIPAA as "an individual or group plan that provides or pays the cost of medical care". Health plan business operations include defining the benefits offered by the plan, determining who is eligible for the plan, and funding the benefits and administrative costs of the plan. There is no public list of US-based HIPAA covered health plans. The term *payer* refers to entities that make payments to providers and beneficiaries as directed by health plans which contract for these services. As a health plan may perform these functions itself, health plans may be payers; however, not all payers are health plans.

- Clearly define the lawful purpose for which an HPID enumeration structure is necessary for all potential HIPAA covered health plans and ensure this purpose meets the following key characteristics:
  - A compelling business case.
  - A clear enumeration structure.
  - Publication of a notice of proposed rulemaking.
  - Ability of HIPAA covered health plans to manage their compliance risk.
  - Assurance of publicly accessible Freedom of Information Act disclosable data (similar to the National Plan and Provider Enumeration System, or NPPES).
  - An education campaign.

RESPONSES TO SPECIFIC QUESTIONS RAISED BY THE NCVHS

To ensure that our HPID position reflected current views and experiences, on April 18, 2017, CAQH CORE convened a CAQH CORE Participant call to collect feedback on the concepts raised by the Subcommittee's questions.[3] Over 40 organizations were in attendance. Approximately 40 percent of the attendees represented payer organizations including health plans and state Medicaid agencies. The remaining attendees represented providers, vendors, clearinghouses, federal agencies and associations/standard setting organizations.

During the call, attendees were encouraged to provide feedback on the Subcommittee questions through online polling and/or submission of written and verbal comments or data. Over 90 percent of the attending organizations participated in the polling and/or submitted comments. In addition to addressing the concepts raised by the NCVHS, attendees were asked if the 2015 CAQH CORE Board position still reflected their organization's thinking on the HPID or if the position needed to be revised or overturned.

The following summarizes the CAQH CORE Participants' responses. Additional research that would prove useful to inform the questions posed by the NCVHS, such as comparing the scope/size of the various identifiers listed below, documenting several real-world claim routing issues or outlining business needs that exist for a listing of HIPAA covered health plans, could not be completed within the timeframe provided by the NCVHS. To provide such deliverables would require time, a targeted project plan and associated resources.

1. **What Health Plan Identifiers are Used Today and for What Purpose?**

Responses on the health plan identifiers currently in use included:

- Most frequently used/referenced:
  - Federal Tax Identification Number (TIN)
  - Federal Employer Identification Number (EIN)
  - Electronic Transmitter Identification Number (ETIN)
  - Proprietary Payer IDs
- Other identifiers referenced:
  - National Association of Insurance Commissioners (NAIC) Number
  - CMS Health Plan ID (HPID) and Other Entity ID (OEID)
  - CMS Health Insurance Oversight System identifiers (HIOS)
  - Payer Typology Codes[4]

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[3] See: https://www.caqh.org/core/list-participating-organizations for a list of CAQH CORE Participating Organizations.
[4] These codes are developed and maintained by the Public Health Data Standards Consortium and allow consistent reporting of payer data to public health agencies for health care services and research. These codes are accepted by

A few entities suggested the NAIC Number be adopted to fulfill the requirements for the Affordable Care Act (ACA) mandated health plan certification of compliance program. Execution of the federal health plan certification of compliance is an intended, non-transaction routing, use of the HPID. Notably, other entities have previously highlighted the limitations of using the NAIC Number to enumerate HIPAA covered entities (key to this limitation is whether the health plan conducts the transactions or outsources such work to another entity/payer).

Overall, the Subcommittee's questions on health plan identifiers and their purposes initiated a robust discussion regarding industry use of the term *HPID* versus *Payer ID*. It was evident from the attendee dialogue that, despite HHS' efforts to educate stakeholders on the concept of a "HIPAA covered health plan" versus a "payer", further education on these terms is needed. Specific business or policy needs must be designed to target the appropriate universe – whether it is potential HIPAA covered health plans and/or payers – and the industry should be able to understand the required traits/functions of the targeted universe and the need being addressed.

Obtaining Health Plan Identifiers

Providers and provider-facing vendor/clearinghouse attendees were asked how they obtain health plan identifiers today. Respondents indicated that the industry obtains these identifiers from a variety of sources:

- The most common sources reported were *health plan and clearinghouse companion guides* and *health plan lists provided by clearinghouses*. *Member identification cards* were also identified as a key source. One state Medicaid agency noted that, because there is no automated means for accessing health plan identifiers, states must obtain appropriate identifiers by creating a proprietary payer ID, asking their vendor or clearinghouse to create a proprietary identifier or reviewing companion guides, if they are available.
- Site visits to large health systems conducted by CAQH CORE in March 2017 supported the view that, for many providers, the most common sources for health plan identifiers are companion guides, clearinghouse lists and member cards. The need to obtain identifiers from a myriad of sources requires significant manual work by provider staff. Providers (or their contractors) have implemented processes to periodically update their identifier listings to incorporate changes from these varied source documents. However, such manual efforts invite a range of challenges that can impact claims routing, in addition to consuming unnecessary staff resources.

While it is unclear whether a strong industry need exists for a single database of health plan or payer identifiers, we reiterate that HHS should support in-depth industry study of the business need for and any potential benefits of such a database. CAQH CORE would welcome the opportunity to work collaboratively with industry stakeholders to help establish such an approach.

Current Business Uses for Health Plan Identifiers

The overwhelming majority of respondents used health plan identifiers in the HIPAA electronic transaction standards. Other key uses were on paper claims, in health plan and vendor web portals and in providers' telephone and/or fax communications with health plans. Respondents

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ASC X12, Health Level Seven International (HL7) and other standard setting organizations. Their proliferation in current provider systems is unknown.

identified a few additional uses for the identifiers including to differentiate between plan products, in proprietary claim and remittance reports, and in payer-to-payer provider network rental agreements.

Regarding the HPID, some health plans noted that they had enumerated and obtained HPIDs, per the Final Rule requirement, but had not implemented their use given CMS' enforcement discretion. Most respondents did not provide a specific number when discussing the average number of HPIDs each health plan had obtained. One private health plan stated that they had obtained seven HPIDs, however, other plans have previously stated many multiples of this. Additionally, one health plan anecdotally noted that their HPID enumeration had resulted in their organization having many more HPIDs than they currently have proprietary payer IDs.

2. What Business Needs Do You Have That Are Not Being Adequately Met with the Current Scheme in Use Today?

Many attendees did not provide a response to this question, potentially because their needs are being met or they are still determining a position. A few health plans and their associations stated that their needs were met by the current network of payer identifiers. The key business need reported as not being met was providers' ability to determine *patient-specific coverage*. Issues with provider transaction processes that require both administrative and clinical information (for example, attachments) were also noted. Additionally, a few respondents noted the lack of a standard source(s) for easily or electronically obtaining health plan identifiers. Related to the lack of a source(s) was the inability to use current identifiers to meet policy requirements such as the ACA-mandated health plan certification of compliance.

Notably, provider and health plan value-based contract needs were also reported as not being met by the health plan identifiers currently in use. While this may indicate a demonstrated need in value-based models to understand/access individual health plan contract terms, more study is needed. One industry expert shared, after the call, that value-based payment volumes are currently low for most providers, so spreadsheets and customized health plan/payer identifier systems are used to track these specific contracts. However, this expert also noted that once value-based payments exceed 15-20 percent of a providers' revenue, this manual management of identifiers is costly, burdensome and prone to error.

3. What Benefits Do You See the Current HPID Model Established by the HHS Regulation Provides? Does the Model Established in the Final HPID Rule Meet Your Business Needs?

For transaction routing purposes, nearly 80 percent of respondents (including 94 percent of all health plan respondents) indicated that they saw *no clear purpose for a regulated HPID in the standard transactions*. Additionally, almost 70 percent of respondents indicated that the HPID model established in the Final Rule does not fit their business needs. Several respondents commented that use of HPIDs or OEIDs in conjunction with a Payer ID was unnecessary and would cause confusion, disruption and additional expense without any offsetting benefits. A few respondents did note the need for the HPID to track HIPAA compliance such as for the ACA mandated health plan certification of compliance, for which a regulation has not yet been finalized.

4. What Challenges Do You See with the Current HPID Model Established by HHS?

The following challenges were noted:

- Defining what constitutes a HIPAA covered health plan versus a payer – and HHS clarity on which of the entity types HHS is attempting to identify and why.
  - As a regulator, HHS must be able to communicate that it understands many HIPAA covered health plans outsource claims processing (to payers); however, HHS must also communicate that, even with such outsourcing, the responsibility remains with the HIPAA covered entity to meet its HIPAA obligations - however that may be done – and, hopefully, to help resolve industry confusion such as is being seen with identifiers.
- No publicly available, searchable database of HPIDs.
  - Such a database could help with understanding the identifier universe and enumeration strategies, or help support innovative and new identifier business applications.
- The HPID enumeration process and requirements:
  - Respondents noted that the HHS HPID Final Rule did not clarify how CMS enforcement would be applied.
  - Health plans have the flexibility to enumerate however they wish, which was viewed as having both benefits and challenges. A significant challenge is that health plans determine their own enumeration strategy. This can result in differing levels of enumeration, variety in the number of HPIDs obtained by health plans and a lack of transparency in the business rationale for each health plans' enumeration approach.

5. Previous July 2015 CAQH CORE Board Recommendation

Finally, when asked if they still agreed with the July 2015 CAQH CORE Board recommendation to not use the HPID in the transactions and for HHS to clearly outline other lawful purposes for an HPID, the majority (almost 70 percent) of the responding stakeholders concurred that the Board's position should not change, as noted in the beginning of this written testimony. Some respondents were unsure and a few wanted some modifications to the Board recommendations, however, CAQH CORE has not received any suggested modifications.

CAQH CORE would welcome the opportunity to collaborate with HHS and/or the NCVHS to identify any actions that can provide more direction on the critical industry topic of health plan identifiers. Should you have questions for CAQH CORE, please contact me at glohse@caqh.org or 202-517-0404.

Regards,

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Managing Director, CAQH CORE

Cc: Members of the NCVHS Subcommittee on Standards
        CAQH CORE Participants
        Lorraine Doo, CMS