

Testimony before the NCVHS Subcommittee on Standards  
on the Future of the Health Plan Identifier (HPID)

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American Health Information Management Association-Public Health Data Standards Council  
(AHIMA-PHDSC)

Background on AHIMA-PHDSC and Payer Typology

The American Health Information Management Association (AHIMA) is the not-for-profit membership-based health care association representing over 100,000 health information management (HIM) and informatics professionals who work in more than 40 different types of entities related to our nation's public health and health care industry.

The Public Health Data Standards Consortium (PHDSC, The Consortium) was a national non-profit membership-based organization of federal, state, and local health agencies; professional associations; academia; public and private sector organizations; and individuals. Its goal was to empower the healthcare and public health communities with health information technology (HIT) standards to improve individual and community health.

In 2014, AHIMA and PHDSC merged creating the AHIMA Public Health Data Standards Council (AHIMA-PHDSC, Council). The Council was created on the premise that the value of data increases when used for multiple purposes. The purposes of public health data systems range from providing support for clinical care to assessing the quality of that care and assessing the health status of populations at the state and national level over time. The aim of these systems is to inform sound health policy for the country's population. Because of its diverse purposes, public health needs data from multiple sources to achieve its objectives. The Council believes that it is important to be part of the process creating the data standards necessary for today's health transactions.

PHDSC developed the Source of Payment Typology - a standard for categorizing the different payer types for health transactions. The standard was developed with cross industry cooperation and is currently maintained by the AHIMA-PHDSC. The Source of Payment Typology has been incorporated into X12, HL7, and Uniform Bill standards. Even more significant is the fact that the Source of Payment Typology has been implemented into 7 state public health reporting systems becoming the best solution known for categorizing the types of payers in health care transactions.

The Payer Typology code set, a User Guide and White Paper on the implementation of the code set by states are available on the PHDSC Payer Typology Sub-Committee's website at <http://www.phdsc.org/standards/payer-typology.asp>. Changes to the Source of Payment Typology are made annually in October. Interested industry representatives can make comments and recommendations for additions or modifications via the PHDSC website.

## Response to Questions

### **1. What health plan identifiers are used today and for what purpose?**

Current Identifiers include the X12 Claim Filing Indicators, the National Association of Insurance Commissioners ID, and the Source of Payment Typology. The need to differentiate for payer performance extends into Pharmacy, Dental and Vision and should be consistent.

### **2. What business needs do you have that are not adequately met with the current scheme in use today?**

The current version of the National HPID registry does not contain any intelligence, such as type of plan. The AHIMA-PHDSC believes that just as each National Provider ID has a Provider Taxonomy code attached to it to differentiate provider types, the National HPID should have a codified typology for use in differentiating plans. This opportunity should not be missed and would facilitate other requirements of recent legislation such as quality and cost measurement. Collection of these data during plan enumeration and its availability to users of the Plan ID registry would allow researchers to answer questions raised by health reform. The following are four examples of these questions:

1. Using hospital discharge data, one could examine the prevalence of specific categories of payer type for various racial, ethnic and linguistic sub-populations. Further investigation could assess how well a particular payer type covers preventive services, ongoing medical treatment for chronic conditions, and long-term care. Disparities among sub-groups could be assessed at national, state and local levels. More specifically, a researcher could examine within payer type the various arrangements that sub-groups are most likely found in, i.e., Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Provider Sponsored Organization (PSO).
2. Using Medicaid claims data, a specific state or group of states could compare utilization of preventive services by Medicaid HMO enrollees with utilization by Medicaid Fee for Service (FFS) enrollees. The results of this type of analysis could inform changes in state policy in regard to either the cost or outcomes associated with the use of preventative services, and whether HMO or FFS models deliver better results. Using payer categories such as those found in the Payer Typology would make this type of research relatively easy to undertake.
3. Researchers at the behest of federal policymakers could assess utilization of specific services in the new Medicare programs, such as Medicare Advantage. Further, researchers could assess whether utilization varies by type of Medicare Advantage Plan, that is, whether it is a HMO, PPO, or PSO. These arrangements could impact individual utilization for specific treatments or services in ways unknown at the time policies were developed.
4. Work underway today by AHIMA-PHDSC members is paving the way to support Semantic Interoperability for Clinical Guidelines across providers. The attached "Source of Payment Typology" sets a foundation to help all providers and patients, informed by public health and clinical informatics research, understand the outcomes provided by Clinical Guidelines as the health sector shifts to value-based and accountable (ACO) care

models. Without a robust Source of Payment Typology, such studies will be limited in scope, to the detriment of essential progress towards the Triple Aim.

**3. What benefits do you see the current HPID model established by the HHS regulation provide? Does the model established in the final HPID rule meet your business needs?**

It does not meet the needs of health services researchers or public health professionals examining differences in care delivery related to type of plan and ownership status. The HPID lacks the built-in intelligence. Adding type of plan detail to the HPID would resolve the problem.

**4. What challenges do you see with the current HPID model established by HHS?**

See response to Question 2 above.

**5. What recommendations do you have going forward regarding health plan identifiers and an HPID final rule published by HHS?**

The Source of Payment Typology provides a standardized categorization of payers that will improve the ability of administrative data to support analyses of Federal and other initiatives to which the type of payer may have an impact on cost, quality or access to healthcare. The AHIMA-PHDSC recommends that the Source of Payment Typology be named as the standard vocabulary associated with the national health plan identifier for categorizing payer types for the following reasons:

- We have a unique opportunity for comprehensive categorization of all US payers. We should not reinvent the wheel – no better code set exists today.
- The Typology is recognized by standards development organizations and committees such as HL7 and X12. It is also in the UB-04 standard.
- There is an existing standards consortium which approves additions, changes and deletions to the codes through a transparent public maintenance process.
- The Source of Payment Typology is in use by multiple organizations today.

Thank you for the opportunity to testify.

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## Source of Payment Typology

Version 7.0

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Reference to the User's Guide for Source of Payment Typology can be found at:

[http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion7.0\\_final.pdf](http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion7.0_final.pdf)

<b>Code</b>	<b>Description</b>
<b>1</b>	<b>MEDICARE</b>
<b>11</b>	<b>Medicare (Managed Care)</b>
111	Medicare HMO
112	Medicare PPO
113	Medicare POS
119	Medicare Managed Care Other
<b>12</b>	<b>Medicare (Non-managed Care)</b>
121	Medicare FFS
122	Medicare Drug Benefit
123	Medicare Medical Savings Account (MSA)
129	Medicare Non-managed Care Other
<b>13</b>	<b>Medicare Hospice</b>
<b>14</b>	<b>Dual Eligibility Medicare/Medicaid Organization</b>
<b>19</b>	<b>Medicare Other</b>
191	Medicare Pharmacy Benefit Manager
<b>2</b>	<b>MEDICAID</b>
<b>21</b>	<b>Medicaid (Managed Care)</b>
211	Medicaid HMO
212	Medicaid PPO
213	Medicaid PCCM (Primary Care Case Management)
219	Medicaid Managed Care Other
<b>22</b>	<b>Medicaid (Non-managed Care Plan)</b>
<b>23</b>	<b>Medicaid/SCHIP</b>
<b>24</b>	<b>Medicaid Applicant</b>
<b>25</b>	<b>Medicaid – Out of State</b>
<b>26</b>	<b>Medicaid – Long Term Care</b>
<b>29</b>	<b>Medicaid Other</b>
291	Medicaid Pharmacy Benefit Manager
292	Medicaid - Dental
<b>3</b>	<b>OTHER GOVERNMENT (Federal/State/Local)</b> <b>(excluding Department of Corrections)</b>
<b>31</b>	<b>Department of Defense</b>
311	TRICARE (CHAMPUS)
3111	TRICARE Prime—HMO
3112	TRICARE Extra—PPO
3113	TRICARE Standard - Fee For Service
3114	TRICARE For Life--Medicare Supplement
3115	TRICARE Reserve Select

<b>Code</b>	<b>Description</b>
3116	Uniformed Services Family Health Plan (USFHP) -- HMO
3119	Department of Defense - (other)
312	Military Treatment Facility
3121	Enrolled Prime—HMO
3122	Non-enrolled Space Available
3123	TRICARE For Life (TFL)
313	Dental --Stand Alone
<b>32</b>	<b>Department of Veterans Affairs</b>
321	Veteran care--Care provided to Veterans
3211	Direct Care--Care provided in VA facilities
3212	Indirect Care--Care provided outside VA facilities
32121	Fee Basis
32122	Foreign Fee/Foreign Medical Program (FMP)
32123	Contract Nursing Home/Community Nursing Home
32124	State Veterans Home
32125	Sharing Agreements
32126	Other Federal Agency
32127	Dental Care
32128	Vision Care
322	Non-veteran care
3221	Civilian Health and Medical Program for the VA (CHAMPVA)
3222	Spina Bifida Health Care Program (SB)
3223	Children of Women Vietnam Veterans (CWVV)
3229	Other non-veteran care
<b>33</b>	<b>Indian Health Service or Tribe</b>
331	Indian Health Service – Regular
332	Indian Health Service – Contract
333	Indian Health Service - Managed Care
334	Indian Tribe - Sponsored Coverage
<b>34</b>	<b>HRSA Program</b>
341	Title V (MCH Block Grant)
342	Migrant Health Program
343	Ryan White Act
349	Other
<b>35</b>	<b>Black Lung</b>
<b>36</b>	<b>State Government</b>
361	State SCHIP program (codes for individual states)
362	Specific state programs (list/ local code)
369	State, not otherwise specified (other state)
<b>37</b>	<b>Local Government</b>
371	Local - Managed care
3711	HMO
3712	PPO
3713	POS
372	FFS/Indemnity
379	Local, not otherwise specified (other local, county)
<b>38</b>	<b>Other Government (Federal, State, Local not specified)</b>
381	Federal, State, Local not specified managed care
3811	Federal, State, Local not specified - HMO
3812	Federal, State, Local not specified - PPO

<b>Code</b>	<b>Description</b>
3813	Federal, State, Local not specified - POS
3819	Federal, State, Local not specified - not specified managed care
382	Federal, State, Local not specified - FFS
389	Federal, State, Local not specified - Other
<b>39</b>	<b>Other Federal</b>
391	Federal Employee Health Plan – Only to be used when you cannot distinguish plan
<b>4</b>	<b>DEPARTMENTS OF CORRECTIONS</b>
<b>41</b>	<b>Corrections Federal</b>
<b>42</b>	<b>Corrections State</b>
<b>43</b>	<b>Corrections Local</b>
<b>44</b>	<b>Corrections Unknown Level</b>
<b>5</b>	<b>PRIVATE HEALTH INSURANCE</b>
<b>51</b>	<b>Managed Care (Private)</b>
511	Commercial Managed Care - HMO
512	Commercial Managed Care - PPO
513	Commercial Managed Care - POS
514	Exclusive Provider Organization
515	Gatekeeper PPO (GPPO)
516	Commercial Managed Care - Pharmacy Benefit Manager
517	Commercial Managed Care - Dental
519	Managed Care, Other (non HMO)
<b>52</b>	<b>Private Health Insurance - Indemnity</b>
521	Commercial Indemnity
522	Self-insured (ERISA) Administrative Services Only (ASO) plan
523	Medicare supplemental policy (as second payer)
524	Indemnity Insurance - Dental
529	Private health insurance—other commercial Indemnity
<b>53</b>	<b>Managed Care (private) or private health insurance (indemnity), not otherwise specified</b>
<b>54</b>	<b>Organized Delivery System</b>
<b>55</b>	<b>Small Employer Purchasing Group</b>
<b>56</b>	<b>Specialized Stand Alone Plan</b>
561	Dental
562	Vision
	<b>Other Private Insurance</b>
<b>6</b>	<b>BLUE CROSS/BLUE SHIELD</b>
<b>61</b>	<b>BC Managed Care</b>
611	BC Managed Care – HMO
612	BC Managed Care – PPO
613	BC Managed Care – POS
614	BC Managed Care - Dental
619	BC Managed Care – Other
<b>62</b>	<b>BC Insurance Indemnity</b>
621	BC Indemnity
622	BC Self-insured (ERISA) Administrative Services Only (ASO)Plan
623	BC Medicare Supplemental Plan
624	BC Indemnity - Dental

<b>Code</b>	<b>Description</b>
<b>7</b>	<b>MANAGED CARE, UNSPECIFIED (to be used only if one can't distinguish public from private)</b>
<b>71</b>	<b>HMO</b>
<b>72</b>	<b>PPO</b>
<b>73</b>	<b>POS</b>
<b>79</b>	<b>Other Managed Care</b>
<b>8</b>	<b>NO PAYMENT from an Organization/Agency/Program/Private Payer Listed</b>
<b>81</b>	<b>Self-pay</b>
<b>82</b>	<b>No Charge</b>
821	Charity
822	Professional Courtesy
823	Research/Clinical Trial
<b>83</b>	<b>Refusal to Pay/Bad Debt</b>
<b>84</b>	<b>Hill Burton Free Care</b>
<b>85</b>	<b>Research/Donor</b>
<b>89</b>	<b>No Payment, Other</b>
<b>9</b>	<b>MISCELLANEOUS/OTHER</b>
<b>91</b>	<b>Foreign National</b>
<b>92</b>	<b>Other (Non-government)</b>
<b>93</b>	<b>Disability Insurance</b>
<b>94</b>	<b>Long-term Care Insurance</b>
<b>95</b>	<b>Worker's Compensation</b>
951	Worker's Comp HMO
953	Worker's Comp Fee-for-Service
954	Worker's Comp Other Managed Care
959	Worker's Comp, Other unspecified
<b>96</b>	<b>Auto Insurance (includes no fault)</b>
<b>97</b>	<b>Legal Liability / Liability Insurance</b>
<b>98</b>	<b>Other specified but not otherwise classifiable (includes Hospice - Unspecified plan)</b>
<b>99</b>	<b>No Typology Code available for payment source</b>
<b>9999</b>	<b>Unavailable / No Payer Specified / Blank</b>