simplifying healthcare administration

CAQH

Health Plan Identifier (HPID) Request for Information: Initial Stakeholder Input July 1, 2015

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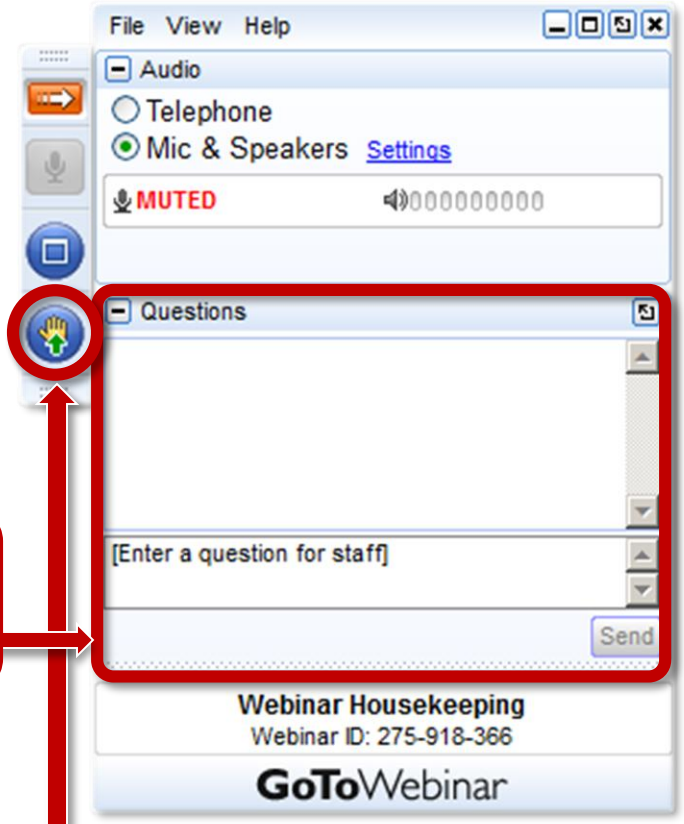

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Call Overview

Topic	Time
Foundational framework in which HPID resides – What HIPAA Requires • HIPAA covered health plans • HPID – What is a (proprietary) Payer ID? – The RFI on HPID – HPID Database	3-3:10pm ET
Issue 1: Enumeration	3:10-3:25 ET
Issue 2: HPID and (proprietary) Payer IDs	3:25-3:40 ET
Issue 3: Changes in the Healthcare System Since 2012 Affecting HPID	3:40-3:55 ET
Next Steps	3:55-4pm ET

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Foundational Framework: What HIPAA Requires

- HIPAA called for creation of a health plan ID (HPID) to identify health plans (HIPAA covered entities) to facilitate HIPAA transactions and for other legal purposes[1].
- The definition of "HIPAA covered health plan" per HIPAA regulations is an individual or group plan that provides, or pays the cost of, medical care.
  - ERISA plans are HIPAA covered health plans unless they are a self-funded group plan with fewer than 50 participants.
- The term "payer" is not defined by HHS regulations; however, industry uses it to refer to entities responsible for: final claim processing and the return of the remittance advice; final processing of the inquiry (eligibility, services review or claim status) to return the response (eligibility, services review or claim status); or final processing of the member enrollment or premium payment.
  - A health plan often be a payer AND not all payers are HIPAA covered health plans.
  - A vast majority of the health plans (given ERISA health plans are included in total) outsource their claims processing of HIPAA transactions to a payer and/or third party administrator.

1 Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets. Federal Register, vol. 77, no. 172, September 12, 2012, available at http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf

Foundational Framework: What is a Payer ID?

- There is no codified federal definition of a payer ID or federal government process around the use of a payer ID.
- It is a proprietary, undefined term used by various entities that work in the HIPAA transactions arena.
  - Unlike the HPID, which has a specific number of numerical digits and a federally recognized definition, (proprietary) payer IDs are defined by whoever assigns the ID.
  - Currently, "payers" are identified in the transactions via (proprietary) payer IDs and/or other industry-recognized identifiers, such as NAIC numbers, in the HIPAA-mandated X12 standards (TR3), which require payers to identify themselves (as they choose).
    - NAIC numbers (and their associated payer type code) are assigned by the National Association of Insurance Commissioners (NAIC). NAIC uses these codes to identify insurance companies when they are licensed to sell or offer health insurance in a particular state. NAIC numbers do not include many of the HIPAA-covered health plans, e.g., ERISA plans do not sell insurance, Medicare-contractors do not get NAIC codes. Thus, any use of NAIC codes as a federal requirement for HPID would mean some HIPAA covered health plans would be excluded from the HPID regulation unless NAIC made a change to its code set. *Sometimes NAIC codes are referred to as Payer IDs but their formal term is NAIC numbers.*
    - There is no recognized statistic on the total number of health plans or (proprietary) Payer IDs. A percentage of HIPAA-covered health plans are in scope for identifiers such as NAIC. As payer IDs are proprietary, total number of these (proprietary) Payer IDs vary. Other codes like TIN (tax identification number) also don't cover the same universe of entities as HPID.

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Foundation Framework: HPID Final Rule

A final HHS rule was issued in 2012 that has two requirements for HPIDs

1. HPID Enumeration: All Controlling Health Plans (CHPs) must obtain a health plan identifier (HPID)

- A CHP is defined as a HIPAA covered health plan that "controls its own business activities, actions, or policies or is controlled by an entity that is NOT a health plan".
- The CHP definition was intended to invoke the idea of "a parent health plan." Although not required by regulation, a CHP can have sub-health plans (SHPs) that have the option of obtaining HPIDs as well.
- "Other Entity Identifier," or OEID, was offered as a voluntary identifier for health care organizations that are not health plans.
- The HPID regulation does NOT require a health plan to enumerate at a certain level, e.g. product or line of business. The regulations allows health plans to determine the level of enumeration, thus health plans' HPIDSs in the HHS Health Plan and Other Entity Enumeration System (HPOES) may not be at the same level.

2. HPID Use: The HPID must be used in the standard HIPAA transactions to identify a health plan that has an HPID when a HIPAA covered entity identifies a health plan in a transaction. Does not apply to retail pharmacy transactions.

- An HPID must be used only if the health plan that is being identified in the transaction has an HPID. If the health plan is a sub-health plan without an HPID or other health plan organizational construct that does not have an HPID unique to itself, then it does not need to be identified with an HPID.
- An HPID must be used only if a health plan is being identified. If a clearinghouse or other agent of the health plan is being identified in the transaction, then an HPID need not be used.

CMS has delayed enforcement indefinitely and issued a RFI.

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Foundational Framework: Is There a HPID Database/Directory?

- The HHS Health Plan and Other Entity Enumeration System (HPOES) is the system created by HHS where health plans can obtain an HPID.
- Other than HPOES, which is housed at CMS, there is currently no nationally recognized database whose purpose is to identify all HIPAA-covered health plans.
  - Over 10,000 health plans have obtained HPIDs through HPOES and are listed in the HPOES database. Brokers or TPAs for health plans may act on behalf of a health plan to register with HPOES.
- There are nationally recognized databases/directories of identifiers which are used at times to identify a portion of the HIPAA covered health plans,
  - NIAC, TINs, etc. (some in industry may call these Payer IDs)
- There are also market-based databases/directories of (proprietary) Payer IDs.
  - These databases/directories are owned by various stakeholders and are used by the market for various reasons, including to help route claims to the correct payer. Per stakeholders, many such relationships are working well; some are not.

Foundational Framework: Alternative Uses for HPID

Additional uses have been identified for a single national standard HPID and associated database/directory:

- **Public policy support.** HIPAA has been used to regulate health plans since the late 1990's. There is little understanding of the universe of "health plans." In order to develop effective policy approaches, the universe of health plans and the policy makers must have bi-directional communication.
- **Enforcement and auditing.** HPID could serve as a tool for trading partners to track which health plans meet functional HIPAA transaction compliance.
  - There is ***no relationship outlined*** in the HPID Final Rule between health plan use of the HPID enumeration and the ACA-mandated HHS Health Plan Certification of Compliance requirements. To further this point, in the HHS NPRM on Health Plan Certification, *it states* ***health plans do not need*** **to use the same enumeration approach as they may use in the transactions**. Some have stated that this may be that the clearest purpose for the HPID; yet, health plans are the only entities for which audits are proposed and identifiers exist of other HIPAA covered entities.
- **Other uses.** The regulation preamble references a range of other uses such as pubic health data reporting purposes.

Foundational Framework: HPID Request for Information (RFI)

- HHS issued an RFI on the HPID on May 29, 2015.
  - Comments are due by COB on July 28, 2015
- The RFI asks for comments on three issues:
  - The HPID enumeration structure outlined in the HPID final rule, including the use of the CHP/SHP and OEID concepts.
  - The use of the HPID in HIPAA transactions in conjunction with the Payer ID.
  - Whether changes to the nation's health care system, since the issuance of the HPID final rule published September 5, 2012, have altered your perspectives about the function of the HPID.

First Polling Question

- Is the complexity of HPID's foundational framework causing confusion around the purpose and implementation of the HPID?
  - Yes
  - No
  - I am not sure

Issue 1: Enumeration

There are still many issues with enumeration. Beyond cost…

- Many health plans still have questions about whether they need an HPID, despite guidance from HHS.
- Some organizations find the regulatory definitions unclear as to what constitutes a controlling health plan (CHP), sub-health plan (SHP), and other entity, which would need an other entity identification number (OEID).
- It is confusing to some as to why enumeration down to the product or line of business is optional; others see the ability to decide how to enumerate as appropriate.
  - The flexibility in what can be enumerated has caused implementation challenges when putting the HPID in the transaction as the HPID can refer to different levels of the health plan business. Some say National Provider ID (NPI) is more uniform.
  - Such flexibility also may hinder research studies that are looking to evaluate trends or outcomes at a specific level or reviewing outcomes for pay-for-performance purposes.
- Determining the “right”/”needed” level of enumeration for the US healthcare system is situational, depending on use (e.g., research vs transaction routing vs enforcement/audit)

Issue 1:
Examples of Enumeration Issues

- Some employer group health plans are uncertain whether they meet the definition of a “controlling health plan” or a “sub-health plan.”
  - The total number of group health plans in the US is unclear and is changing due to the ACA insurance exchanges and employer business needs.
- An ERISA health plan (fully insured or self-insured) is a HIPAA covered health plan and would need to be enumerated per the HHS regulation.
  - Yet an ERISA health plan rarely would be identified as the “payer” in the transactions because its billing and payment would be contracted out to other organizations – such as third-party administrators (TPAs) and insurance issuers – that would use their own payer identifiers.
  - Self-funded plans don’t understand the purpose of the HPID or understand why they would have to secure one when they don’t use it themselves. In contrast, “agents” of ERISA health plans that conduct the transactions for them, such as third-party administrators (TPAs), are not acting as HIPAA-covered entities but serving as business associates. However, they may be referred to as “payers” and may be referenced with a (proprietary) “payer ID” in the transaction.
- In cases when outsourcing does occur by a HIPAA covered health plan, many health plan’s business associate contracts don’t address risk sharing or roles if/when compliance issues arise.

Issue 1:
Share your Thoughts

a) Is the confusion over HPID enumeration an educational issue?

- If so, how should it be addressed (e.g., CMS or outreach to certain groups?)

b) For what public policy efforts is HPID needed? Are there transaction needs?

c) Is enumeration of HIPAA covered health plans via the HHS enumeration system necessary? Why and/or why not?

- *Maintain HPID*: Need transparency for reasons stated in HPID regulation. Are more precise definitions needed for the HPID's component parts (i.e., CHP, SHP, OEID)? Should the SHP and OEID designations be required instead of optional?
- *Pursue only some of the enumeration needs outlined in the regulation*: Identify which ones are critical and enumerate accordingly.
- *HHS enumeration unnecessary:* Address needs other ways, e.g., call upon the market to have a national definition for (proprietary) Payer IDs, explaining what it is and what it does?

d) What else is needed?

- For example, is there more transparency needed regarding the underlying health plan in light of all the new products coming into the system? (see slide 16)

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Second Polling Question

- Is enumeration of HIPAA covered health plans via the HHS enumeration system necessary?
  - Maintain HPID
  - Pursue only some enumeration needs
  - Enumeration unnecessary
  - I do not know

Issue 2:
Use of the HPID with the Payer ID

Health plans conducting HPAA standard transactions use various identifiers with different sources and a variety of formats. Examples include NAIC codes, tax identification number (TIN), employer identification number (EIN), (proprietary) payer ID.

- Multiple clearinghouses may identify the same health plan using different (proprietary) Payer ID in different covered transactions.
- There is no common digit or level approach with the (proprietary) Payer IDs. Additionally, some of the industry-recognized codes (non-proprietary) are alphanumeric while other identifiers are only numeric and of varying lengths, including:
  - NAIC codes are 5 digits, EIN is 9 digits, HPID is 10 digits
- As a result, it is unclear if short-term having both (proprietary payer) IDs and HPID in the transactions would be useful other than for learning information such as how the two enumerations different in reference, how frequently proprietary codes change or new codes are added. If appears there is little aggregated information on such informative data points.

Issue 2 (continued): Use of the HPID with the Payer ID

- How an entity views the use of HPID vs (proprietary) Payer IDs may be based on their specific role with the transactions. Creation, maintenance and use of (proprietary) payer IDs are integral to the business models of many entities, so changes could create hardships. For example:
  - There is significant investment (direct and indirect) in these (proprietary) Payer IDs
  - Clearinghouses have built (proprietary) payer ID directories that are key parts of their products
  - Providers have learned the various (proprietary) Payer IDs, some health plans assign Payer IDs so provider learns (proprietary IDs or relies on system to do so unless issues arise), providers rely on these (proprietary) approaches to help with routing claims and thus revenue cycle management. When mergers and acquisitions occur, many times Payer IDs change and thus manual intervention is needed.
  - Any transition to a CMS HPID may challenge the above and other business models, either short-term or long-term, and directly or indirectly.
- There are significant costs involved from transitioning from (proprietary) payer IDs to the HPID; the 2015-2016 period is an especially intense time for this transition.
  - Health plans and providers are transitioning to ICD-10 and addressing new products from the ACA marketplace; reimbursement issues may arise from both.

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Issue 2:
Share your Thoughts

a) **What routing issues have been identified currently when the market is relying upon a mix of (proprietary) Payer IDs and other nationally recognized identifiers such as NAIC codes?**
   - Have related costs been estimated?
   - Is a pilot needed to better understand the business case for using the HPID in conjunction with and/or in place of (proprietary) payer IDs?

b) **Can the (proprietary) Payer IDs and the other national identifiers like NAIC and TINs meet the stated needs of HPID beyond routing, including public policy uses like enforcement?**

c) **If the market was relying on HPIDs, how could only secure access to the HPOES database be ensured?**

d) **Should the HPID implementation deadlines be moved back?**
   - If so, why and to what date?

e) **Should HIPAA covered health plans that outsource their claims processing be responsible for ensuring their outsourcer is compliant?**
   - How can such a requirement be incorporated in HPID regulatory guidance?

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Third Polling Question

- Can the (proprietary) Payer IDs and the other national identifiers like NAIC and TINs meet the stated needs of HPID beyond routing, including public policy uses like enforcement?
  - Yes
  - No
  - I am not sure

Issue 3:
How do changes in healthcare since 2012 affect use of HPID?

New health plans entering the market. The insurance market has significantly changed because of the ACA. Before the ACA, a few health plans dominated the individual health insurance market in most states.(1) Some of the major plans hung back, waiting to see how that would play out. New entrants arrived — some 56 as of June 2014, according to one estimate.(2) The result is an increasing number of players. As an example, Texas had roughly 5-30 offerings for each Bronze, Silver and Gold health plans in 2014, according to one study of the impact of the ACA in 6 states.(3)

Due to the insurance exchanges, a plethora of new business associates will be coming on board. This will create challenges in identifying who the underlying health plan is and who is (payers) providing claims routing, payment and data exchange within and across the care continuum.

Finally, health plans on the ACA Federal insurance exchange have "Plan IDs" assigned by HHS(4) .

1 Commonwealth Fund. How insurers competed in the ACA's first year. 2015, June. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2015/jun/insurers-aca-first-year?
2 Abelson, R. Has the healthcare industry been helped or hurt by the law? New York Times, October 26, 2014. http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?_r=1#/
3 Commonwealth Fund, *op. cit.*
4 https://www.healthcare.gov/glossary/plan-id/

Issue 3:
How do changes in healthcare since 2012 affect use of HPID?

More complex payer arrangements and new entrants. Payer arrangements have become more varied and complex since 2012. New delivery forms - such as accountable care organizations (ACOs) - were created recently in response to the move toward value-based care by Medicare and other payers. There now are 585 ACOs as of January 2015: 426 Medicare ACOs and159 other types of ACOs.(1) This complexity, coupled with the various identifiers that might be employed, creates challenges for transaction routing and payment.

Although such organizations share common goals, they vary widely in terms of organization, level of development and integration of health information technology. This creates challenges in correctly identifying payers outside of network borders and exchanging information within and across organizations that can be used to obtain shared savings and quality-related payments.

1 Oliver Wynn. ACOs: A Slower Pace of Growth. April 2015. http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/insights/health-life-sciences/2015/ACO-Update-2015-v2.pdf

Issue 3 (continued)

- **Compliance for all parts of HIPPA.** Compliance is taking on heightened importance.
  - The discussion around the NPRM on HHS health plan certification has demonstrated many HIPAA covered health plans do not know they are covered entities and thus must comply with HIPAA requirements; similarly, many business associates do not know they must support their HIPAA covered trading partner with their compliance.
  - The enforcement/audit processes are moving from being complaint-driven to proactive
    - If the processes are audit driven, how are health plans being selected? Every HIPAA covered health plan should have same risk for audit and therefore any enumeration system needs to account for all HIPAA covered health plans.
    - The final regulation gives health plans some flexibility on enumeration, which is useful to the health plans giving they have to (unlike other HIPAA covered entities) manage risk and potential penalties. However, some health plans do not want that flexibility and want CMS to tell them specifically how to enumerate.
- **Business case**. There is an ever growing understanding of the significant cost (indirect and indirect) associated with any health IT related project, especially when it is a long-term vision-focused proposition. *The cost of not doing HPD isn't clear.*
- **Evolving technology.** The ability for technology to solve sophisticated issues such as identification is growing and will continue to do so.

Issue 3:
Share your Thoughts

a) **Can technology solve the needs related to health plan identification? Is a national HPID managed by HHS still needed?**

b) **What needs exist for identifying payers in**
   - Federal and state health information exchanges?
   - Health information exchanges?
   - ACOs and other value-based purchasing initiatives?

c) **Does any HPID solution need to be more granular—such as getting down to the product or line of business—to take into account the rapidly expanding number of insurers and payer types, and offerings available on the federal and state exchanges?**

d) **Is more education needed for HIPAA-covered entities about who they are and their responsibilities in complying with HIPAA ?**

e) **Should HPID enforcement move forward while other aspects of HPID are delayed until more clarity is achieved?**

Next Steps

- **Comments on the issued raised on today's call**
  - Please share your thoughts on the issues discussed on today's to core@caqh.org by July 10th. Information received from stakeholders will be used to draft a model comment letter.
- **Draft Model Comment Letter**
  - CAQH CORE will host a CORE participant call to discuss the draft model letter. **The call will be held July 15, 2015, from 3-4 pm ET**. The draft model letter will be posted prior to the call on CAQH CORE website.
  - Should you have a position or draft letter you would like to share, please send to core@caqh.org by July 10th.
- **Final Model Comment Letter**
  - The final model letter will be posted on the CAQH CORE website by July 21st and shared via email.
- **Final CAQH CORE Letter**
  - The CAQH CORE Board will be submitting a final CAQH CORE letter by HHS due date of July 28th.

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