ACTION REQUESTED: Submit comments to CAQH CORE (core@caqh.org) on this DRAFT Model Letter to HHS on the **Request for Information (RFI) Regarding the Requirements for the Health Plan Identifier (HPID)**. **Response is needed by: Monday, July 20, 2015, 5:00 PM Eastern Time** using the attached template**.**

July 14, 2015

Dear CORE Participants:

CAQH CORE is pleased to request your input on the attached draft model letter in response to the federal government's **Request for Information (RFI) Regarding the Requirements on the Health Plan Identifier (HPID).**[1]

As background, a final rule issued in September 2012 required health plan enumeration and use of the Health Plan Identifier (HPID) in the HIPAA electronic healthcare transactions by November 7, 2016. On October 31, 2014, The U.S. Department of Health and Human Services (HHS) exercised enforcement discretion with the HPID requirements until further notice. It is now seeking information on three key issues:

- HPID enumeration structure, including the use of controlling health plan (CHP), subhealth plan (SHP), and other entity identifier (OEID) concepts.
- Use of the HPID in conjunction with a Payer ID in the HIPAA transactions.
- Whether changes in the healthcare system since the September 2012 HPID final rule have altered perspectives about the function of the HPID.

Attached is a draft model letter. Your input is VITAL to preparing a response to this RFI. Currently CAQH CORE Board is not supportive of the initially proposed HPID enumeration structure for use in the HIPAA transactions, but is supportive of the enumeration of health plans for ***clearly-defined public policy purposes*** and wants to make sure that the enumeration structure meets the proposed purposes and there is a compelling business case for the stated purposes.

The following draft model letter proposes responses to the three key issues presented in the RFI and offers two recommendations. Input is being sought from **CAQH CORE participants** (**via a call on July 15, 2015, 3:00 – 4:00 PM ET**) and via the web through July 20, 2015, 5:00 PM ET.

In order for CAQH CORE to develop a final model letter that organizations can use to submit comments to HHS as you deem appropriate to HHS are:

- Obtain your ***input on the draft model letter by July 20, 2015, 5:00 PM ET.***
- **Finalize and share the final model comment letter by July 21, 2015**.

Final comments must be submitted by organizations to HHS by Tuesday, July 28, 2015, 5:00 PM ET.

Thank you again for the thoughtful contributions that all of you are making to the HPID RFI. Should you have any questions, please contact me at glohse@caqh.org.

Sincerely,
Gwendolyn Lohse
Deputy Director, CAQH and Managing Director, CORE

[1] You can view the RFI on the Federal Register website at: https://www.federalregister.gov/articles/2015/05/29/2015-13047/request-for-information-regarding-the-requirements-for-the-health-plan-identifier

ATTACHMENT: DRAFT MODEL COMMENT LETTER

<Add organization LOGO in Header>

<Date>

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0026-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-0026-NC: *Request for Information Regarding the Requirements for the Health Plan Identifier*

<Name of Organization> is pleased to offer input on the above-referenced Request for Information (RFI) Regarding the Requirements for the Health Plan Identifier (HPID). *In summary, we do not support the use of the HPID in transactions, but do support enumeration of health plans for clearly-defined public policy purposes for which HHS makes a compelling business case.* Following is information with respect to the three topics for which you sought comment, and two recommendations for moving forward with the HIPAA requirement for health plan enumeration. The following are the issues on which you sought input:

- HPID enumeration structure, including the use of controlling health plan (CHP), subhealth plan (SHP), and other entity identifier (OEID) concepts.
- Use of the HPID in conjunction with a Payer ID in the HIPAA transactions.
- Whether changes in the healthcare system since the September 2012 HPID final rule have altered perspectives about the function of the HPID.

Response to HPID RFI Topics

Topic 1: HPID enumeration structure. The structure is causing confusion.

By intent, the HPID regulation afforded flexibility within the respective definitions of CHP, SHP, and OEID. This flexibility is generally appreciated. However, in instances where there is not a clearly defined purpose for the HPID, it is difficult to take advantage of the flexibility.

In the final rule for the HPID, HHS states that the purpose for the HPID is for use in the HIPAA transactions and *"for any other lawful purposes"*[2]. It is industry's understanding that the HPID's use in the transactions was primarily proposed to support routing of the transactions. It is observed by the industry that the routing issues that the 2012 HPID Final Rule intended to address have been largely resolved by the industry using a variety of identifiers and various mapping protocols to direct the transactions to the intended recipient. The identifiers are collectively referred to as Payer IDs and include a range of proprietary Payer IDs as well as other IDs applied as Payer IDs including the National Association of Insurance Commissioners (NAIC) number, the tax identification number (TIN), the employer identification number (EIN), the Health Insurance Oversight System (HIOS) plan and product IDs, and others. These Payer IDs collectively do not cover the full universe of HIPAA-covered health plans; however, covering the full universe may not be a necessary characteristic of an ID used for transactions routing purposes. The Payer ID also includes many non-health plans (see comments under Topic 3).

As noted above, the HPID Final Rule also identified that there could be "any other lawful purpose" for the HPID beyond use in the transactions, and the rule provides some examples – although without clear definitions or compelling business cases for the examples. As there may no longer be a need for use of the HPID in the HIPAA transactions and because other purposes for HPID were not clearly defined in the Final Rule, many in the industry have found it difficult to determine how to appropriately enumerate within the given HPID structure based on the Final Rule. However, as noted in the RFI, the healthcare industry is experiencing sweeping changes. These changes include not only implementation of the Affordable Care Act (ACA) insurance marketplaces, but also significant industry consolidation and various forms of both government and private-sector value-based purchasing, the impact of which as yet cannot be fully anticipated. As such, it can be anticipated that the need for an enumerator of HIPAA covered health plans for public policy purposes, such as for HIPAA Administrative Simplification enforcement, fraud and abuse, and other policy activities, will expand; but HHS must make this need clear so that enumeration is accurate and complete.

The HPID enumeration structure of CHP, SHP, and OEID was intended to describe parent-child relationships within simple and in many cases very complex organizations. That is, the HPID structure was intended to describe a clear chain of command

[2] See 77 FR 54668 and 45 CFR §162.506(b)(2)

from the bottom level (claims) administrator to the controlling health plan ultimately responsible for compliance. This chain of command structure may not be needed for routing so long as the transactions are received by their intended recipients and ultimately the claim is paid.

Knowing the chain of command and maintaining a certain flexibility in HPID enumeration, however, is necessary for there to be a level playing field with respect to HIPAA Administrative Simplification enforcement, fraud and abuse, and other compliance activities and for health plans to manage their risk within this context. In fact, *given that, under ACA, health plans are the only HIPAA covered entities with enforcement penalties via certification*, there also needs to be clarity at what level enforcement penalties could occur. For example, if penalties are only at the CHP level, those that enumerate at the most granular level where the parent-child relationship is clear could be at increased risk simply because they enumerated at a more granular level than those only enumerating CHPs and not SHPs. Without enumeration of SHPs, the chain of command is effectively "broken," and there may not be a way to determine which entity has ultimate responsibility. With any enumeration process, impacted entities should be at a level playing field by having to clearly indicate the entity ultimately responsible for compliance, and have enough information to make informed decisions on how to manage any related risk.

Clarity with regard to the purpose of HPID enumeration, which parties must enumerate, and which parties have ultimate responsibility for compliance is needed as stakeholders responsible for the HIPAA transactions are changing rapidly as a result of industry transformation. For example, many more outsourcing structures are used to achieve economies of scale. Some of the entities to which functions are outsourced are HIPAA covered entities, while others are not. As a result of industry changes and the vast mix of relationships, any given corporate structure may have many CHPs and literally hundreds of SHPs and OEIDs. Moreover, many HIPAA-covered group health plans - which represent a very large number of HIPAA-covered health plans, though a relatively small number of covered lives - almost exclusively outsource their administrative functions to both HIPAA covered and non-covered entities. These HIPAA-covered group health plans are often not clear on their role and responsibilities as HIPAA covered entities, including for enumeration.

Topic 2: Use of the HPID in conjunction with a proprietary Payer ID in the HIPAA transactions may be unnecessary, costly, and disruptive to conducting successful transactions.

"Health plan" and "payer" are distinctly different categories of entities. HHS has defined health plan in the HIPAA regulation; but there is no federal definition of payer or Payer ID. Over the years, industry groups have set forth papers about the differences. Generally a **health plan** as a HIPAA covered entity, is described as the entity that establishes payment policies, assumes financial risk, and is required to be compliant with HIPAA regulations. A **payer** may be a health plan under this definition, but often is an administrator to which transactions are routed and which provides responses within the context of health plan policies, including payment on claims. This administrator is not a HIPAA covered entity, but a business associate; business associates are now accountable directly to the HIPAA Security Rule and parts of the HIPAA Privacy Rule due to recent regulations.

In the past, the healthcare system has experienced routing issues with the transactions. Today it is not known the extent to which routing issued continue. Most health plans, payors and clearinghouses believe they have largely resolved the routing issues through use of various proprietary payer identifiers (Payer IDs). There is concern that there would be disruption and cost if the HPID was required for use in the transactions. This concern stems from a range of reasons. Technically the Payer ID is used on the "outside" of a transaction "envelope" to route to the appropriate payer (which may be a health plan, clearinghouse, or other entity serving as an administrator or other business functionality). If the HPID is to be used in the transactions, it is not clear which of the structural components (CHP, SHP, or OIED) 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 HPID would completely disrupt the current transactions routing process. If the CHP is required for use in the transactions and the CHP is not the payer, the CHP's HPID would likely need to be incorporated somewhere "within" the transaction envelope. If it is placed within the transaction and the Payer ID is retained on the outside (because the CHP is not the payer), the result may be confusion and ultimately disruption of transactions routing as well as internal workflow disruption for health plans and payers, with delays in payments to providers likely. All this said, it should be noted that the Final Rule does state that an HPID is only used if a health plan with an HPID is identified in the transaction. If a payer is identified (that is not a health plan and does not have an HPID), the final rule does not require a health plan needs to be identified in the transaction and thus other IDs are used. There is little understanding of this nuance given the significant concerns regarding sole or dual usage of both HPID and proprietary Payer IDs in the transactions.

Although there are significant concerns for using both the HPID and the proprietary Payer IDs in the transactions, there are also concerns about applying the existing patchwork of proprietary Payer IDs toward HHS's "other legal purposes" because:

- Proprietary Payer IDs collectively aim to capture *the universe of **payers***, but do not collectively identify the *full universe of **HIPAA covered health plans***. As payer functions increasingly are outsourced and health plan

organizational structures grow increasingly complex, it is likely that the full universe of health plans will ultimately be difficult to identify without a unique health plan identifier that is different from what is used for routing transactions to payers. Without knowing the full universe of health plans, bi-directional communications between regulators and HIPAA covered health plans is challenging.

- As new identifiers are created for unique purposes, such as the recently created HIOS for the federal marketplaces (the HIOS are housed in the HPOES database), the variety of proprietary identifiers is increased. In the long term, this may impact transactions routing, especially in coordination of benefits with other payers, or make for a costly routing process. There is no data today on where routing issues may emerge in the future or industry wide ability to report success.
- It is also observed that not all proprietary Payer IDs are publicly accessible. Providers generally must learn about the appropriate Payer ID for routing purposes from payer lists distributed to providers, clearinghouses' individual web sites, the eligibility response, or identification cards held by patients. As health plans may frequently change administrators, these sources may not always be current. It should also be observed that the Health Plan and Other Entity Enumeration System (HPOES) maintained by CMS is not accessible to anyone but CMS and to those entities that register for an HPID.[3]

Topic 3: Changes in the healthcare system since the September 2012 HPID final rule have altered perspectives about the function of the HPID.

Everyone agrees the healthcare industry is changing due to new market entrants, health plan and payer consolidations, and various health reform initiatives such as Accountable Care Organizations (ACOs). Since issuance of the HPID RFI, several organizations have conducted polls about uses of the HPID. For example, in response to one of the CAQH CORE polling questions on a recent public webinar, "Can proprietary Payer IDs and the other identifiers (NAIC, TINs, etc.) meet the needs of HPID *beyond routing*, including public policy uses like enforcement?" roughly 40% of respondents indicated yes, 10% indicated no, and 50% were unsure. There is no industry analysis showing that the complex patchwork of the various proprietary Payer IDs can meet non-routing needs when the purpose of identification is to capture the *full universe of* ***health plans***. Moreover, three year after the HPID Final Rule and nearly 17 years since the original HIPAA legislation, there is no aggregated information on this existing patchwork. The lack of a single, publically accessible identifier that covers the full universe of health plans impacts all aspects of HIPAA Administrative Simplification enforcement, fraud and abuse investigations, and potentially other public policy matters. Such other public policy uses may include understanding the depth and breadth of health plans in the U.S. and the impact of health reform initiatives on one of the most critical players in our healthcare system.

It is generally believed that HHS has not put forth a compelling business case for use of the HPID in the transactions. HHS has formally proposed only one other lawful use for the HPID at this time: HHS health plan certification. A January 2014 HHS notice of proposed rulemaking (NPRM) from HHS proposed that the health plan certification program use the HPID. The need for an HPID in this case made sense, yet industry has been confused with the HPID for use in the transactions and this other lawful purpose. The flexibility in the HPID enumeration structure enables health plans to decide how to manage their risk with respect to the proposed health plan certification. However, there is a lack of awareness that HPID enumeration for health plan certification could be different from enumeration for the HPID use within the HIPAA transactions, who must comply and why flexibility was given. Considerable outreach and awareness is needed about the proposed use of the HPID for *any* purpose, including use of the HPID to enumerate the full universe of covered health plans, and the risk management decisions that a program places in the hands of health plans.

Recommendations on HPID

1. **The HPID enumeration structure for use in HIPAA transactions is not acceptable. However, a universal identifier for HIPAA covered health plans is required to capture the entire universe of HIPAA covered health plans and their administrators and thus allow HHS to oversee HIPAA Administrative Simplification efforts (such as HHS enforcement responsibilities, bi-directional communications between the regulators and covered entities, public reporting, etc.)**. If HHS applies HPID enumeration for "any other legal purposes," HHS must:
   a. Make it very clear that the HPID is not to be used in transactions for routing purposes, given the expected confusion and cost this would cause.
   b. Make very clear the way in which HPID will be used, especially for penalty-based enforcement such as HHS health plan certification, and ensure that the enumeration structure allows enough flexibility for health plans to manage risk and ensures that all health plans are enumerated in a manner that ensures fairness in enforcement administration.

[3] This blog observes that to access the HPOES, users must first register. See: http://smarthr.blogs.thompson.com/2013/04/08/apply-now-for-hipaa-standard-health-plan-identifier/

c. Allow for public comment on any newly proposed "legal purpose" for which the HPID would be required. This statement of purpose should include a compelling business case so that compliance will be pursued by all impacted.
d. Make FOIA-disclosable data in the Health Plan and Other Entity Enumeration System (HPOES) publicly accessible, at least at the level needed to track any component health plan to the parent health plan. This would be consistent with the National Plan and Provider Enumeration System (NPPES) in which providers' NPPES FOIA-disclosable data are publicly accessible.[4]
e. Conduct an education campaign to assure that all covered health plans recognize their obligation to be enumerated for the stated purposes, and that they are subject to HIPAA compliance enforcement. The roles and responsibilities of business associates should be clarified for all who engage business associates for administrative functions.

2. **HHS should support efforts that would allow proprietary Payer IDs used for transactions routing purposes to be made publicly accessible so a foundational baseline is available.** It is unclear if the need for a single database of Payer ID exists, but there is a need for a common approach to basic business practices like proprietary Payer ID enumeration and publication. HHS should state its support for studying the efficacy of propriety Payer IDs on transactions routing so it can then ascertain if short or long-term issues remain that should address. As more changes with health plans, payers, and business associates occur, the status of transactions routing needs to be monitor to report success or challenges. HHS or industry initiatives cannot establish a framework to conduct this monitoring if only a patchwork of proprietary Payer IDs exists.

Thank you for considering our comments. Please let me know if we can provide further clarification.

Sincerely,

<Name of Sender>
<Title>

CC: CAQH CORE

[4] https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do