



# Call on NCVHS Testimony for Health Plan Identifier

**FOR CORE PARTICIPANTS  
ONLY**

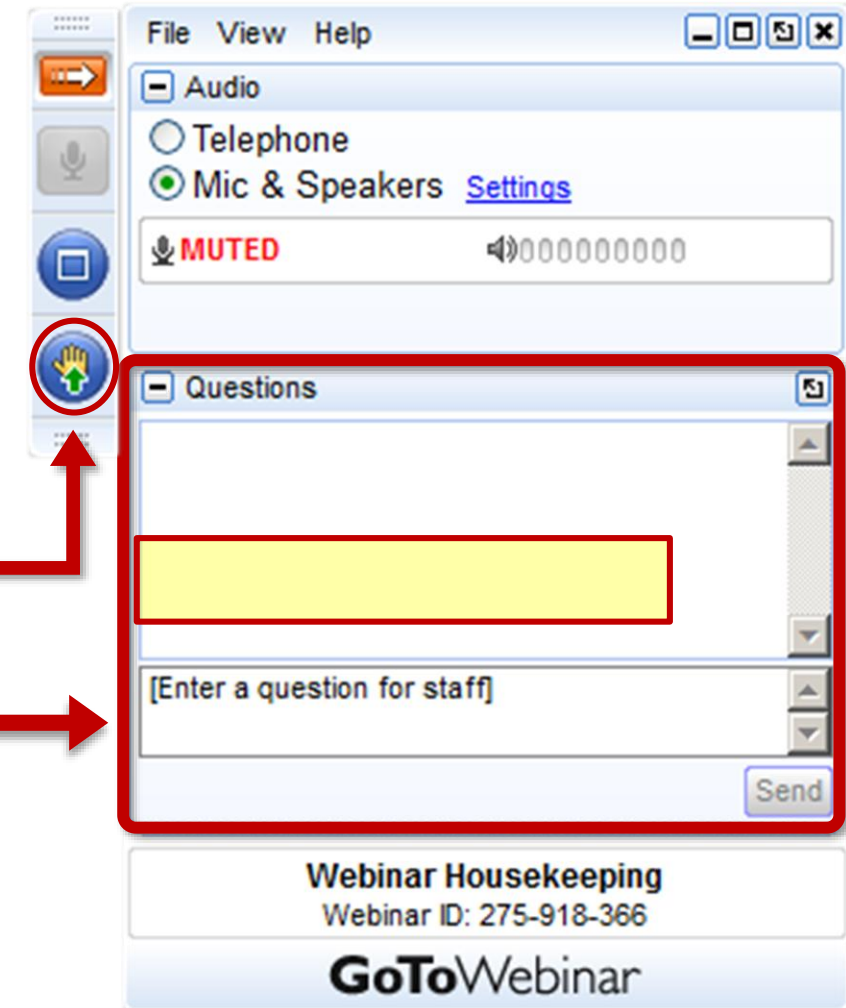
April 18, 2017

2:00 – 3:00 PM ET

# Logistics

## *Presentation Slides & How to Participate in Today's Session*

- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
- The phones will be muted upon entry and during the presentation portion of the session.
- During the dialogue, we will ask for feedback to specific polling questions. After each polling question, we will open the lines for a 3-minute discussion. Attendees can submit questions/comments during the discussion periods one of two ways:
  - To submit audio questions/comments, press the “**Raise Hand**” icon on the **GoToWebinar dashboard** and we will open your line.
  - Submit written questions/comments on-line by entering them into the **Questions panel on the right-hand side of the GoToWebinar dashboard.**
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# Session Outline

- Health Plan Identifier Level-set
- CAQH CORE HPID Activities to Date
- Current Charge: May 2017 NCVHS Hearing
- Polling and Dialogue on HPID
- Next Steps

# Health Plan Identifier Level-set

**Denise M. Buenning, MsM**  
CAQH CORE Director

# Primer on Identifiers



There is no codified, federal definition of a payer identification number or process around its use.



HIPAA called for the creation of a Health Plan ID (HPID) to identify health plans (HIPAA covered entities) to facilitate HIPAA transactions and for other legal purposes<sup>1</sup>.



Currently, Payer IDs are proprietary undefined terms used by various entities that work with HIPAA transactions. (Proprietary) Payer IDs are defined by whoever assigns the ID; they do not have a specific number of numerical digits or a federally recognized definition.



Other common industry-recognized identifiers are Tax Identification Numbers (TINs) and National Association of Insurance Commissioners (NAIC) numbers which may be used when payers are required to identify themselves.

<sup>1</sup>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>



# Overview of HPID Timeline of Events

**September  
2012**

[HHS final rule](#) issued requiring health plan enumeration and use of the Health Plan Identifier in the HIPAA electronic healthcare transactions by November 5, 2014 (small plans until November 5, 2015). Beginning in 2012, health plans could apply for an HPID through the Health Plan and Other Entity Enumeration System (HPOES); over 10,000 health plans enumerated from 2012 through 2014.

**October  
2014**

CMS [delayed enforcement](#) of HHS requirement for obtaining and using HPIDs.

**NOTE:** The CMS enforcement delay is still in effect.

**May  
2015**

HHS released a [Request for Information \(RFI\)](#) to solicit feedback from the industry on HPID.

**July  
2015**

CAQH CORE held calls to obtain industry feedback on RFI; feedback was used to develop model comment letter entities could use to submit comments to HHS. CAQH CORE Board also submitted comment letter to HHS in response to RFI.

**May  
2017**

Given delay in enforcement and time since HHS RFI, NCVHS will hold a hearing on May 3<sup>rd</sup> to collect updated industry input to inform next steps for HHS enforcement action on the HPID.

# 2012 HHS Final Rule

## Requirements

**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”.
- Regulation does not require a health plan to enumerate at a certain level, e.g. product or line of business; health plans allowed to determine the level of enumeration.

**HPID Use:** An 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\*.

- 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.

**OEID:** The HPID final rule also established an Other Entity Identifier (OEID), a voluntary identifier for entities that are not health plans, providers, or individuals but need to identify themselves in the HIPAA standard transactions.

**\*NOTE:** Requirement does not apply to retail pharmacy transactions.

# 2012 HHS Final Rule

## HPID Enumeration

### **Must obtain an HPID.**

May obtain an HPID for its SHPs  
OR May direct its SHPs to obtain  
HPIDs.

### **Controlling Health Plan (CHP)**

A health plan that controls its own business activities, actions or policies **OR** is controlled by an entity that is not a health plan.

### **Not required to obtain an HPID.**

May obtain an HPID at the discretion of its CHP OR on its own initiative.

### **Sub Health Plan (SHP) #1**

A health plan whose business activities, actions, or policies are directed by a CHP.

### **Sub Health Plan (SHP) #2**

A health plan whose business activities, actions, or policies are directed by a CHP.

**NOTE:** Effective October 31, 2014, Centers for Medicare & Medicaid Services (CMS) announced a delay in enforcement of the HHS Final Rule requirements for health plan enumeration and use of the HPID. The enforcement delay applied to all HIPAA covered entities, including healthcare providers, health plans, and healthcare clearinghouses.



# CAQH CORE HPID Activities To Date

**Robert Bowman**  
CAQH CORE Associate Director

- On May 29, 2015, HHS released an Request for Information (RFI) to solicit feedback from the industry about the HPID; RFI asked for comments on three issues:
  1. The HPID enumeration structure outlined in the HPID final rule, including the use of the CHP/SHP and OEID concepts.
  2. Use of the HPID in HIPAA transactions in conjunction with the Payer ID.
  3. Whether changes to the nation's health care system since the issuance of the HPID final rule had altered perspectives about the function of the HPID.
- In response to the RFI:
  - CAQH CORE held an [industry-wide call](#) and [CORE Participant only call](#) to collect feedback on the HPID.
  - Using the feedback, CORE developed a [model letter](#) entities could use to respond to the RFI.
  - CORE Board issued its own [public comment letter](#) to HHS.

# CORE Response to HHS RFI

## *July 2015 Industry Perspectives*

**Attendees to the July 2015 CORE HPID calls could provide feedback via polling questions, emails, and discussion periods; some key themes were identified:**

- Agreement that the HPID is not needed in the HIPAA transactions because health plans and clearinghouses have already resolved routing issues through proprietary Payer IDs and mapping strategies.
  - Attendees believed existing Payer IDs meet the transactional needs the HPID is intended to address.
- Strong agreement that utilization of the HPID would be burdensome and not meet the goals of improved transaction routing.
  - Most attendees did not believe the HPID should be maintained for use in the HIPAA transactions.
- Strong agreement that the HHS Final Rule requirements for enumeration and use of the HPID were too complex.
  - Attendees believed the complexity of the HPID's foundational framework was causing industry confusion on how and when to use the HPID.
  - Attendees believed that the enumeration of HIPAA covered health plans via the HHS system is unnecessary.
  - Attendees felt that the HPID enumeration structure as outlined in the HHS Final Rule is not acceptable.

# CORE Response to HHS RFI

*July 2015 CORE Board Comment Letter*

The CAQH CORE Board elected to submit its own [public comment letter](#) to HHS on the RFI; the letter outlined a set of recommendations to HHS and specific comments in response to the topics identified in the RFI:

## Board recommendations to HHS:

- Do not require the use of HPID in HIPAA transactions, either alone or in combination with the various Payer IDs in use today.
- Support efforts that would allow the various types of Payer IDs currently used for transactions routing purposes to be made publicly accessible to enable monitoring.
- Clearly identify the lawful purposes for which a HIPAA covered health plan enumeration structure is necessary.

## Board responses to topics in the RFI:

- The HPID enumeration structure is causing confusion.
- Use of the HPID alone or in conjunction with a proprietary Payer ID in the HIPAA transactions is currently unnecessary, costly, and disruptive to conducting successful transactions.
- Changes in the healthcare system since the HPID final rule have altered perspectives about the function of the HPID.

# **Current Charge: May 2017 NCVHS Hearing**

**Robert Bowman**  
CAQH CORE Associate Director

# 2017 NCVHS Hearing

- Given almost two-year timeframe since the HHS RFI, NCVHS is seeking updated industry input to inform next steps for HHS enforcement action on the HPID.
- Testifying entities are asked to address the following questions:

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

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

**What business needs exist that are not adequately met with the current scheme in use today?**

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

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



# Industry Evolution Since 2015

Industry Initiatives	Summary & Potential Implications for HPID
<b>All Payer Claims Databases (APCDs)</b>	<ul style="list-style-type: none"> <li>Number of states implementing APCDs has been steadily increasing since 2007.</li> <li>In 2011, APCD Council released a <a href="#">proposed set of data elements</a> for data submissions which includes National Plan ID; APCD Council currently working with states, their vendors, and the payer community to draft a Common Data Layout for State APCDs.</li> </ul>
<b>Blockchain</b>	<ul style="list-style-type: none"> <li>Blockchain technologies will likely improve connection to patient data with Uniform Patient Identifiers; implication for Health Plan IDs is uncertain.</li> </ul>
<b>Attachments Standard</b>	<ul style="list-style-type: none"> <li>ACA Section 1104 requires adoption of transaction standards and operating rules for Attachments, but HHS has not yet issued a regulation.</li> <li>In July 2016, NCVHS issued a recommendation to HHS to adopt the ASC X12N 275 to support attachment routing (and other X12 transactions to support attachments workflow); role/opportunity for HPID utilization to be determined.</li> </ul>
<b>Potential Conversion to ASC X12N v6020 &amp; v7030</b>	<ul style="list-style-type: none"> <li>ASC X12 Insurance Subcommittee has proposed HHS adoption of the approved X12N v6020 and draft X12N v7030 transaction standards.</li> <li>There is and will be need for health plan and payer identifiers in all X12 transactions.</li> </ul>
<b>Value-based Payment Models (e.g., ACOs, PCMHs, etc.)</b>	<ul style="list-style-type: none"> <li>Public and private payers moving from Fee for Service to value-based payment models; Medicare goal to have 90% of payments tied to quality by 2018. Potential for use of HPID to:               <ul style="list-style-type: none"> <li>Assist in posting Accounts Receivable to the correct “at risk” services in the provider’s billing system, and identify at risk accounts (for bonus or downward adjustments) in financial statements and revenue allocation.</li> <li>Support patient/provider assignment for the purpose of managing bonus or at risk payment for the patient’s care for a contracted scope of services.</li> </ul> </li> </ul>

# Polling and Dialogue on HPID

**GOAL:** Collect CORE Participant feedback to ensure CAQH CORE testimony reflects current industry business needs and perspectives.

**Drew Voytal**  
Facilitator

**Denise M. Buenning, MsM**  
CAQH CORE Director

**Robert Bowman**  
CAQH CORE Associate Director

## **PROVIDERS & PROVIDER-FACING VENDORS/CLEARINGHOUSES:**

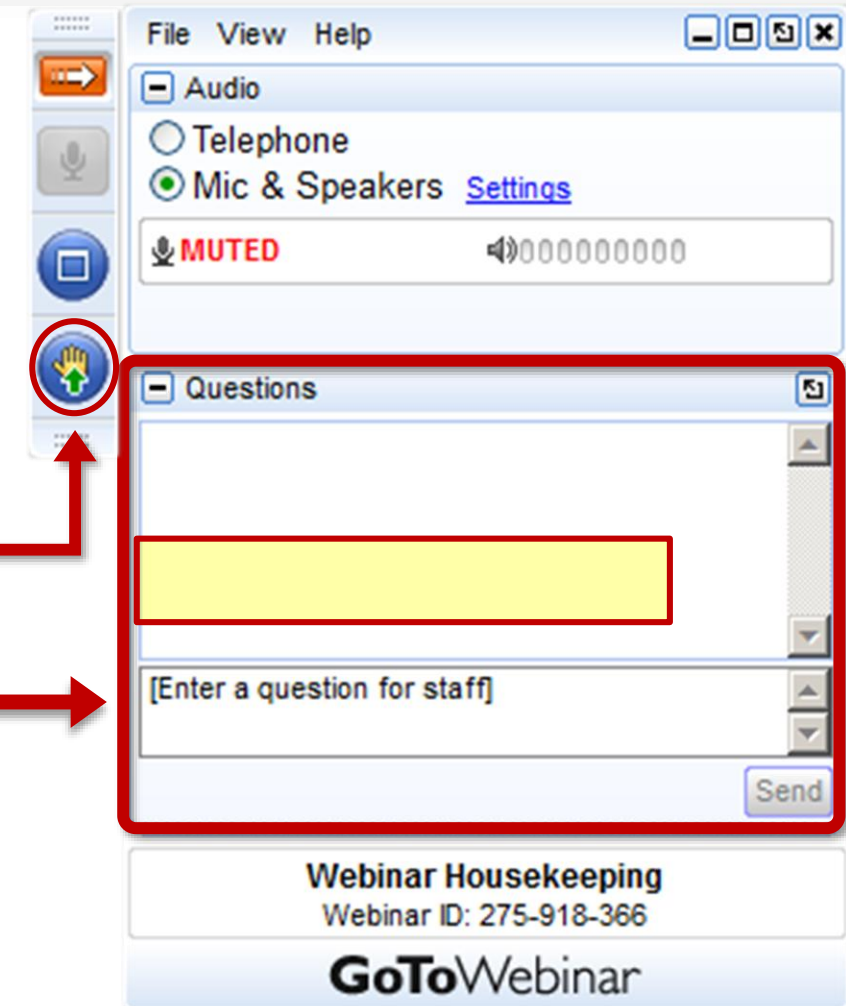
**What health plan identifiers are you using today? (Select all that apply)**

- **Federal Taxpayer Identification Number/Employer's Identification Number**
- **Electronic Transmitter Identification Number (ETIN)**
- **National Association of Insurance Commissioners (NAIC) ID**
- **CMS HPID/OEID**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

- **Please submit your questions and comments:**
  - **Raise Your Hand to be Unmuted:** To submit audio questions/comments, press the “**Raise Hand**” icon on the **GoToWebinar dashboard** and we will open your line.
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### HEALTH PLANS:

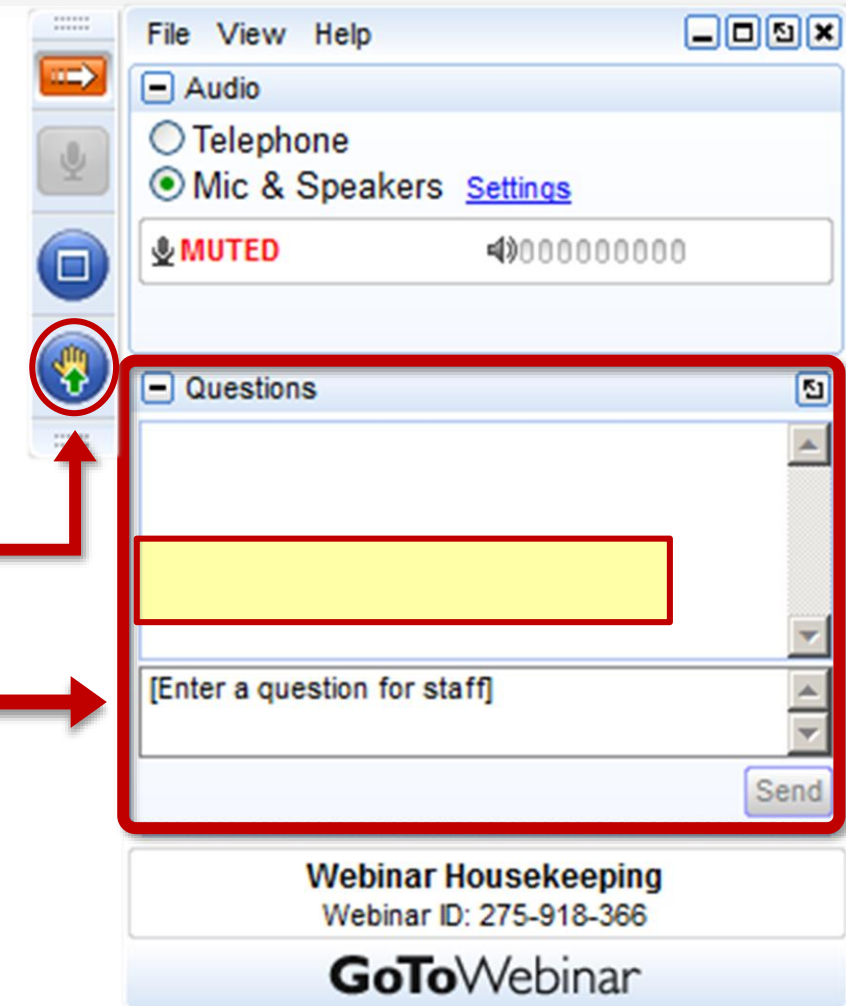
**What health plan identifiers are you using today? (Select all that apply)**

- **Federal Taxpayer Identification Number/Employer's Identification Number**
- **Electronic Transmitter Identification Number (ETIN)**
- **National Association of Insurance Commissioners (NAIC) ID**
- **CMS HPID/OEID**
- **Other (*Please describe via Questions panel*)**

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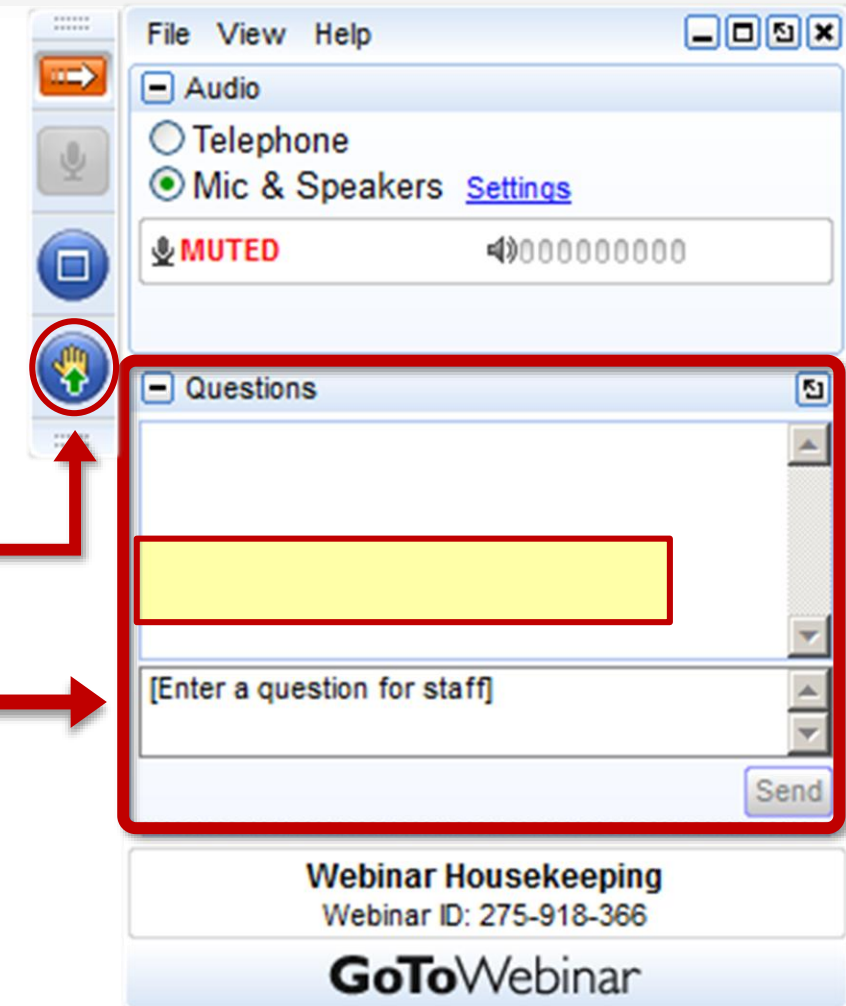
**How do you obtain health plan identifiers today? (Select all that apply)**

- **Patient health plan identifier card**
- **Health plan/clearinghouse companion guide**
- **Clearinghouse**
- **Vendor**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

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## Audience Poll #4

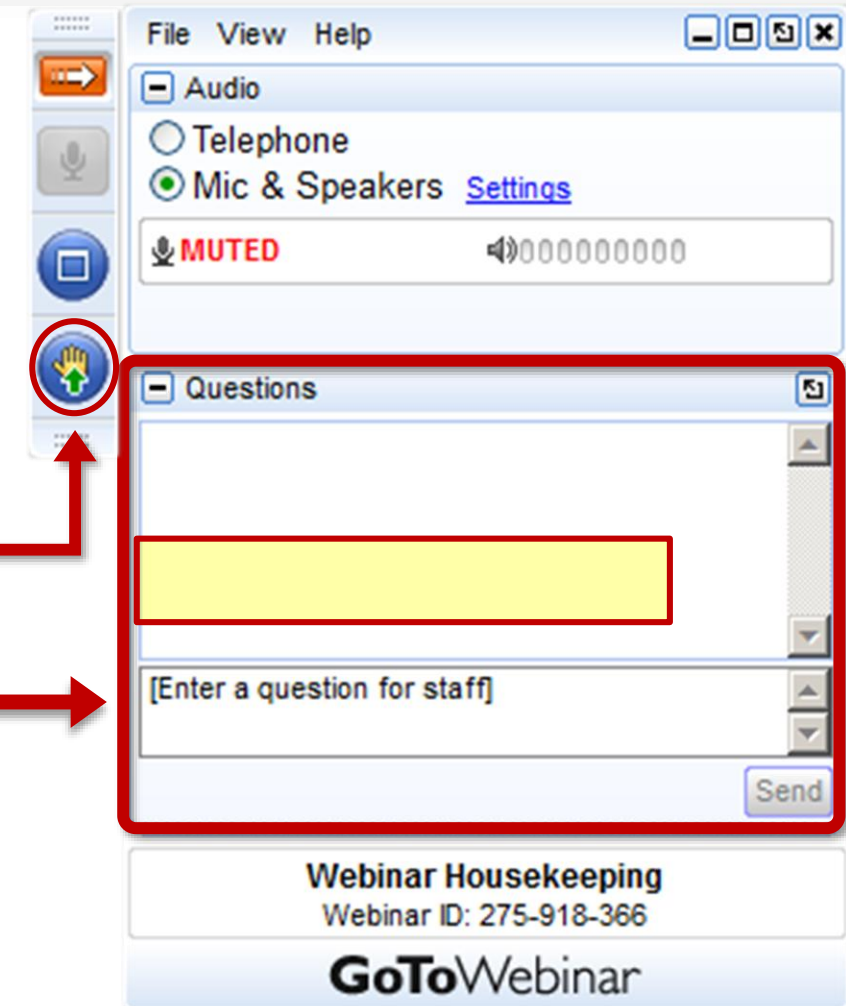
**When/how do you use health plan identifiers today? (Select all that apply)**

- **In HIPAA EDI and/or other standard transactions**
- **Providers contacting payers/health plans via telephone/fax**
- **On paper claims**
- **On health plan and vendor web portals**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

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## Audience Poll #5

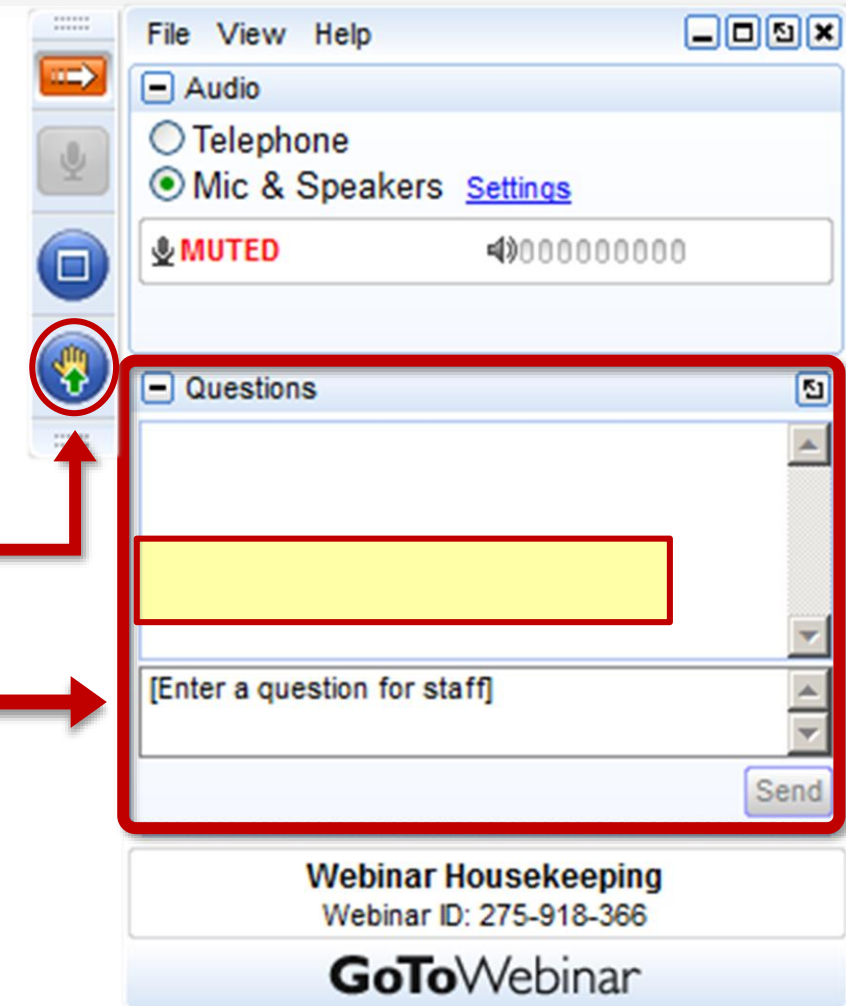
**Are there business needs that are NOT met by the payer identifiers and processes in use today? (Select all that apply)**

- **Provider value-based payment needs (e.g., treating/referring a patient) OR Health plan value-based payment needs (e.g., communicating VBP participation to providers)**
- **Provider administrative/clinical processes**
- **Provider ability to determine if patient is covered by a health plan provider contract**
- **Health plan need for use of OEID for payers and other intermediaries**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

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## Audience Poll #6

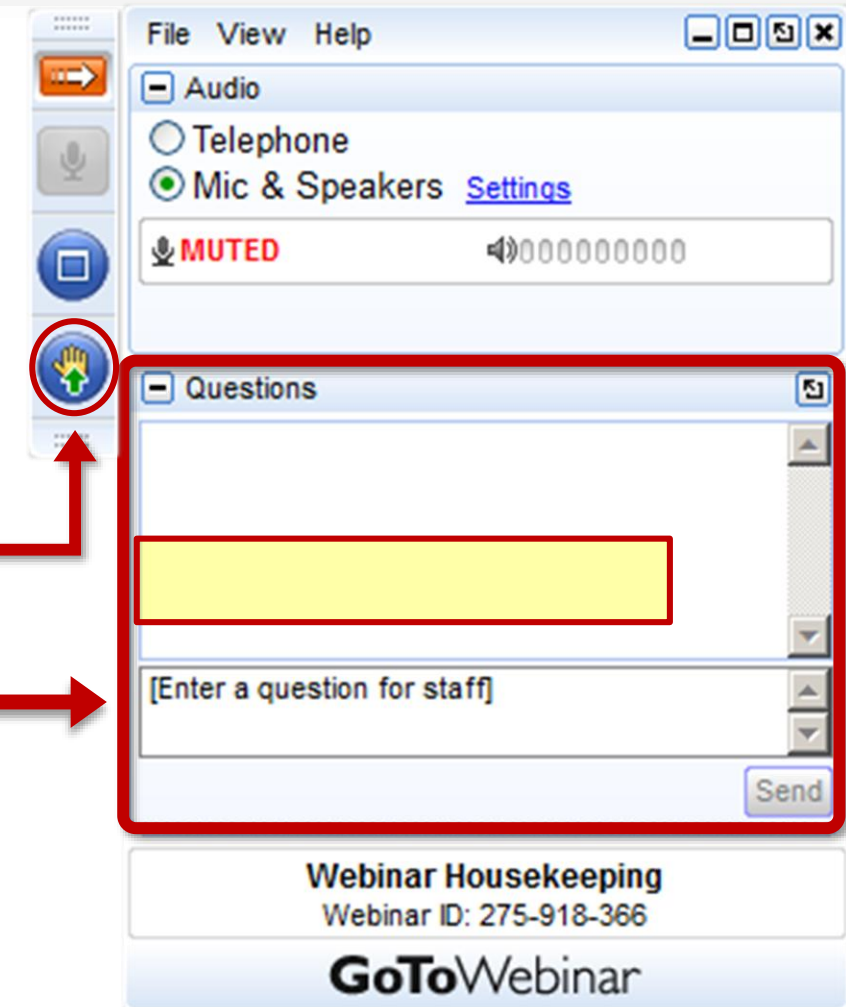
**Which benefits for regulating/assigning a unique health plan identifier do you see in the current HPID model established by HHS? (Select all that apply)**

- **Needed for ACA Section 1104 Health Plan Certification of Compliance**
- **Needed to meet aspects of value-based payment**
- **No clear purpose for a regulated identifier in standard transactions**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

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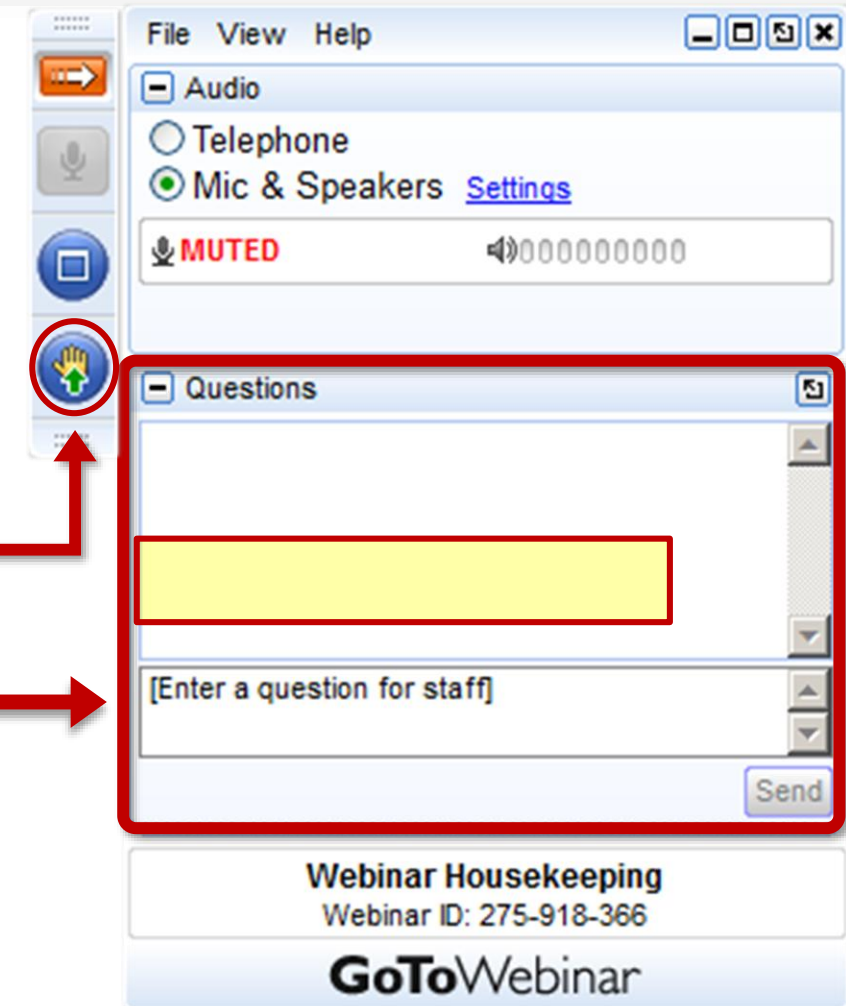
**Does the current HPID model established by HHS fit industry's business needs?**

- **Yes**
- **No**
- **Unsure**

# Comments & Questions

Three Minutes

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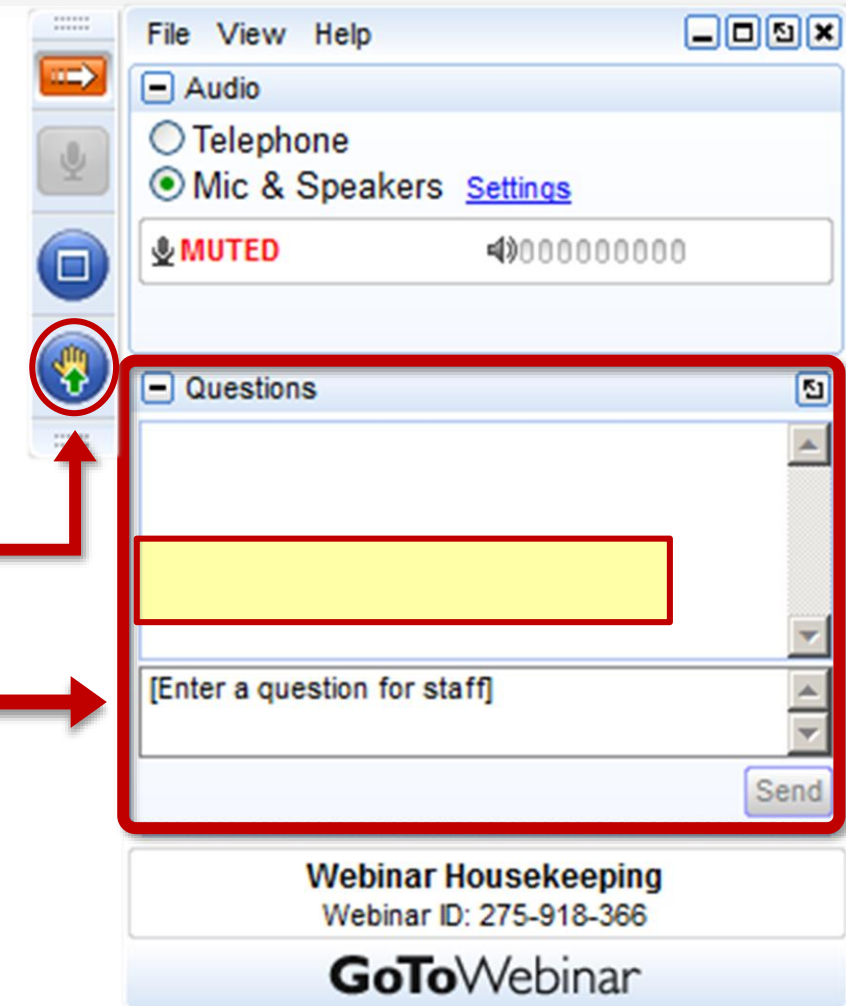
**What challenges is your organization facing with the current HPID model established by HHS? (Select all that apply)**

- **Confusion about enumeration process/requirements**
- **No publicly available searchable database**
- **No distinction between a health plan or payer (e.g., a TPA, ASO)**
- **No challenges/No opinion**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

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# Audience Poll #9

July 2015 CORE Board Comment Letter	
Recommendations for HHS	Responses to RFI Comment Issues
<ul style="list-style-type: none"><li>• HHS should not require the use of HPID in HIPAA transactions, either alone or in combination with the various Payer IDs in use today.</li><li>• HHS should support efforts that would allow the various types of Payer IDs currently used for transactions routing purposes to be made publicly accessible to enable monitoring.</li><li>• HHS should clearly identify the lawful purposes for which a HIPAA-covered health plan enumeration structure is necessary.</li></ul>	<ul style="list-style-type: none"><li>• The HPID enumeration structure is causing confusion.</li><li>• Use of the HPID alone or in conjunction with a proprietary Payer ID in the HIPAA transactions is currently unnecessary, costly, and disruptive to conducting successful transactions.</li><li>• Changes in the healthcare system since the HPID final rule have altered perspectives about the function of the HPID.</li></ul>

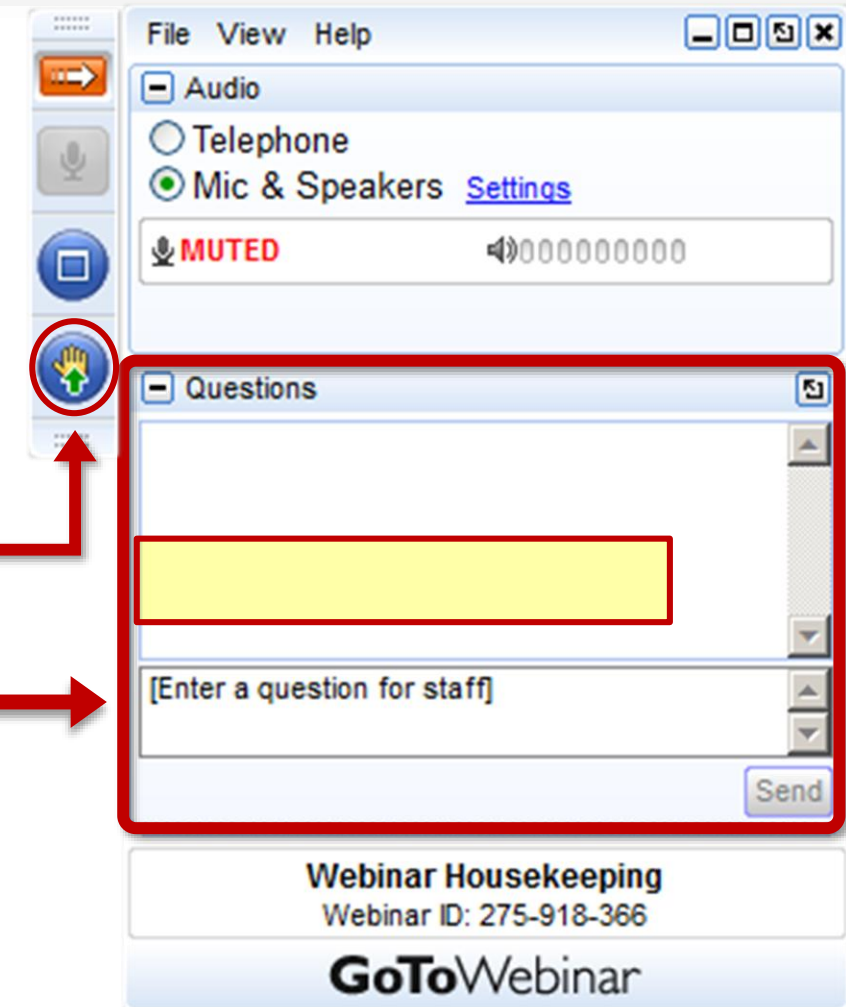
**Do you continue to agree with the above July 2015 CORE Board position regarding the HPID?**

- **Yes, position should not be changed**
- **Yes, with modifications**
- **No, do not agree**
- **Unsure**
- **Other (*Please describe via Questions panel*)**

# Comments & Questions

Three Minutes

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# Next Steps

- **Application of CORE Participant Feedback**

- If you have any additional thoughts/comments, please submit them by **5 PM ET TODAY, April 18<sup>th</sup>** by e-mailing [core@caqh.org](mailto:core@caqh.org).
- CAQH CORE will utilize all feedback received to develop updated testimony for the NCVHS hearing.

- **CAQH CORE Testimony to NCVHS**

- The CAQH CORE testimony to NCVHS will be published to the [CAQH CORE website](#) by Thursday, May 4<sup>th</sup>.

# Thank you for joining us!



Website: [www.CAQH.org/CORE](http://www.CAQH.org/CORE)

Email: [CORE@CAQH.org](mailto:CORE@CAQH.org)

## **The CAQH CORE Mission**

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, payers and consumers.