

SUBMISSION REFERENCE No.: 1jz-8k8j-m14v

July 28, 2015

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*

CAQH CORE is a non-profit, multi-stakeholder collaboration representing healthcare providers, health plans, clearinghouses, vendors, government agencies, and standards setting organizations. Under the Affordable Care Act (ACA) it was named by the Secretary of the U.S. Department of Health and Human Services (HHS) as the authoring entity for the operating rules that support the HIPAA transactions standards, accelerate interoperability, and help align administrative and clinical activities. The CAQH CORE Board of Directors 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. When there is a clearly defined other lawful purpose to identify the full universe of HIPAA-covered health plans, HHS must make a compelling business case and meet other necessary characteristics as discussed herein when proposing an enumeration structure.* The comment letter is presented in two sections:

- **Section I** outlines three specific recommendations.
- **Section II** has comments on each of the three topics identified in the RFI.

Section I: Recommendations

HHS should:

1. **Not require the use of HPID in HIPAA transactions, either alone or in combination with the various Payer IDs in use today.** The HPID is not acceptable to the industry for use in the transactions. To enable transactions routing today, the industry applies various identifiers (some with other intended purposes, such as the NAIC, TIN, EIN, and HIOS, and some that are proprietary; collectively referred to as Payer IDs) and mapping strategies. The majority of the industry believes that these Payer IDs and mapping strategies are working (although no data are available on the extent to which routing is successful industry wide, or where there may be issues.). A change to using the HPID structure or adding the HPID in addition to the Payer ID would require costly retrofitting of technology and processes. A period of transition would be necessary and require considerable industry education. Changing to the HPID structure from the industry-created Payer ID structure could result in disruptions in the use of the transactions, with provider payments at risk.
2. **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.** It is unclear if there is a need for a single database of Payer IDs, but there is a need for a common approach to basic business practices, such as Payer ID enumeration and publication. Not all Payer IDs today are publicly accessible. Providers generally learn about the appropriate Payer ID for routing transactions from payer lists distributed to providers, clearinghouse web sites, response to an eligibility inquiry, and/or identification cards held by patients. As health plans may frequently change contracted payers, these sources may not always be current.* HHS should state its support for industry studying the efficacy of the system of Payer IDs on transactions routing. As more changes in health plan structures, payers, and other business associates occur, the potential for routing issues could arise. The status of transactions routing needs to be monitored to ensure and report on continued performance and to identify any challenges. **CAQH CORE is ready to work collaboratively with the industry – especially health plans and clearinghouses – to establish such an approach. CAQH CORE collaboration could help provide more concrete data on the status of successful routing, and establish a framework to monitor any future issues as more changes in health plans and contracted payers occur.**

* 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. The following 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/>

3. **Clearly identify the lawful purposes for which a HIPAA-covered health plan enumeration structure is necessary. Ensure whatever enumeration structure is proposed, that it meets the following characteristics:**
- a. **Very clearly stated lawful purpose and compelling business case.**
 - b. **Very clear enumeration structure**, including the structures application for HIPAA-covered health plans that outsource their transaction work.
 - c. **Publication of a notice of proposed rulemaking** with sufficient comment opportunity from the public.
 - d. **Ability for HIPAA-covered health plans to manage their compliance risk**, especially since HIPAA-covered providers are not required to be in compliance with the transactions (except for filing Medicare claims).
 - e. **Assurance of publicly accessible FOIA-disclosable data** in the Health Plan and Other Entity Enumeration System (HPOES). Such public accessibility would be consistent with the National Plan and Provider Enumeration System (NPPES) in which providers' NPPES FOIA-disclosable data are publicly accessible.* HHS needs to ensure the industry understands the specified lawful purpose of the enumeration is not for use in the transactions so that such transparency does not result in confusion.
 - f. **An education campaign** to assure that all HIPAA-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; this clarification is critical as many HIPAA-covered health plans outsource their administrative functions to contracted payers.

Section II: Comments on HPID RFI Topics

Topic 1: The HPID enumeration structure is causing confusion.

In the final rule for the HPID, HHS states that the purpose of the HPID is for use in the HIPAA transactions and “*for any other lawful purpose*”.[†] The industry believes that the HPID’s use in the transactions is unnecessary today because the routing issues that the 2012 HPID Final Rule intended to address have been largely resolved (see also Topic 2). Furthermore, many believe that the HPID’s use in transactions will cause significant confusion. In many cases, the Payer ID and HPID are not identifying the same entity because health plans are often not payers, and payers are often not health plans.

Beyond the question of whether the HPID is useful in the transactions, the HPID enumeration structure has been confusing to some in the industry when HHS applied the HPID to other lawful purposes, albeit HHS was clear in the final rule for HPID that it had the right to pursue other such purposes. One factor causing this confusion is that how health plans would enumerate themselves in the transactions, which has been the industry’s main focus of HPID since the Final Rule issuance in 2012, is different than how health plans might enumerate themselves for other lawful purposes.^{‡§} For the transactions, the focus is “who is the payer” (see Topic #2); while for other lawful purposes the focus is “who is the HIPAA-covered health plan.”

Additionally, by intent, the HPID regulation afforded flexibility within the respective definitions of controlling health plan (CHP), subhealth plan (SHP), and other entity identifier (OEID) and the requirements for enumeration by each of these types. The flexibility is generally appreciated when the industry understands that it can be used to manage risk. For example, some health plans decided to enumerate themselves with multiple CHPs when anticipating the HPID for the proposed health plan certification.** They did this to manage their penalty risk; yet such flexibility in the three types of identifiers is not a factor needed when the HPID is used for identification in the federally-facilitated marketplaces.^{††}

The HPID enumeration requirements for CHP, SHP, and OEID can allow the industry to establish a parent-child relationship between entities. That is, the HPID structure describes a clear chain of command from the bottom level contracted payer to the CHP ultimately responsible for compliance. However when compliance is not the purpose, the HPID at only the CHP level can be used. Knowing the chain of command and maintaining flexibility in HPID enumeration are both useful purposes when considering HIPAA Administrative Simplification enforcement, fraud and abuse, and other compliance activities where health

* <https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>

† See: <http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf>

‡ See: <https://federalregister.gov/a/2013-31318>

§ See: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf

** See: <https://federalregister.gov/a/2013-31318>

†† See: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf

plans must manage their risk. Further to this point, *given that, under ACA, health plans are the only HIPAA-covered entities with enforcement penalties via certification and the penalties are significant*, these impacted entities should be able to make informed decisions on how to manage any related risk that the entity ultimately responsible for compliance will need to bear.

Education by HHS should highlight the parties that must enumerate, and which parties have ultimate responsibility for compliance. 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 contracted payers and not HIPAA-covered entities. As a result of industry changes, the vast mix of relationships, and the frequency with which these relationships can change, any given HIPAA-covered health plan 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 payer functions to both HIPAA-covered and non-covered entities. These HIPAA-covered group health plans are often not even clear on the fact that they are HIPAA-covered entities and are responsible for HIPAA compliance, including for HPID enumeration. They must understand that they are ultimately responsible for their compliance, even if they have contracted relationships that cover their operations and costs of any potential penalties.

Topic 2: 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.

The final HPID rule does not address the distinction between “health plan” and “payer,” which may be very different types 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** is described as the entity that establishes payment policies, assumes financial risk, and is required to be compliant with HIPAA regulations. Over 10,000 HIPAA-covered health plans already have registered for an HPID. A **payer** may be a health plan under this definition, but often is a contracted entity to which transactions are routed and which provides responses to transaction inquiries within the context of health plan policies, including payment on claims. This contracted payer is not a HIPAA-covered entity, but a business associate.

In the past, the healthcare system has experienced routing issues with the transactions. Today it is not known the extent to which routing issues continue. Most health plans, payers, and clearinghouses believe they have largely resolved the routing issues through a system of identifiers, collectively referred to as Payer IDs. These identifiers include a range of proprietary Payer IDs as well as identifiers that were not intended to be healthcare payer identifiers, 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. This may not be a necessary characteristic of an identifier used for transactions routing purposes, though it is necessary for other legal purposes, including public policy purposes in which the full universe of health plans needs to be determined.

While a patchwork system of Payer IDs and related mapping strategies may not have been the ideal choice for routing of transactions, the system is in place today and the majority of the industry has indicated it is working. As a result, there is considerable concern that there would be significant disruption and cost if the HPID was required for use in the routing of transactions. 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 contracted payer). If the HPID is to be used in the transactions, it is not clear which of the structural components (CHP, SHP, or OEID) 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 CHP would completely disrupt the current transactions routing process. The cost of changing to the HPID for use in the transaction is immense not only for changing the underlying technology to make applicable changes, but in educating all stakeholders and addressing payment issues that will likely arise. Moreover, attempts to use the HPID in combination with the Payer ID would complicate matters further.

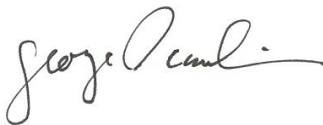
Topic 3: Changes in the healthcare system since the September 2012 HPID final rule have altered perspectives about the function of the HPID.

New market entrants, health plan and payer consolidations, technology improvements, and various health reform initiatives, such as ACA Insurance Marketplaces and Accountable Care Organizations (ACOs), have brought to light the difference between enumeration for the full universe of health plans and the role of the existing patchwork of proprietary Payer IDs for routing transactions to payers, which may include non-HIPAA-covered health plans:

- Proprietary Payer IDs collectively aim to capture *the universe of payers*, but do not collectively identify the *full universe of HIPAA-covered health plans*. Payer functions increasingly are outsourced. Health plan organizational structures are growing increasingly complex. Market consolidations and new product entrants are occurring simultaneously. As a result, the full universe of health plans will ultimately become even more difficult to identify without a universal health plan identifier that is different from what is used for routing transactions to payers. This gap in identification creates challenges for bi-directional communications between regulators and HIPAA-covered health plans as well as for other lawful purposes, such as compliance enforcement, certification, and public reporting.
- As new identifiers are created for unique purposes, such as the recently created HIOS identifiers for the federally-facilitated marketplaces, the variety of proprietary identifiers is increasing. In the long term, this may impact transactions routing, especially in coordination of benefits with other payers, or increasingly require mapping strategies that may increase the cost of the routing process. There is no ability today to report on what routing issues may currently remain since the Payer ID has been in widespread use, or what issues may emerge in the future. There is also no ability to report on the efficacy of the current routing process, which is important. Providers need transparency in understanding routing issues for their contracting purposes, and data to appreciate existing successes within what is a complex system.
- Three years after the HPID Final Rule and nearly 17 years since the original HIPAA legislation, there is no aggregated data about the existing patchwork of Payer IDs, which the industry acknowledges also requires mapping strategies to work. Additionally, there is no evidence showing that the complex patchwork of the various types of Payer IDs can meet the non-routing purposes identified to date by HHS. The lack of a publicly accessible identifier that covers the full universe of health plans impacts all aspects of HIPAA Administrative Simplification enforcement, fraud and abuse investigations, and public policy reporting needs. 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 our healthcare system.

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

Sincerely,



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CC: CAQH CORE Board of Directors