July 27, 2015

Mr. Andy Slavitt  
Acting Administrator  
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

Dear Mr. Slavitt:

The North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA) is a nationally-recognized, nonprofit consortium that serves as an open, effective and neutral forum for health information technology and policy initiatives that improve health and care. Our mission is to assist in accelerating the transformation of the U.S. healthcare system through the effective use of information technology, informatics and analytics.

We are responding to your Request for Information on the following topics:

- 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
- Our perspective on the function of the HPID

We would like to take this opportunity to thank you for seeking input from the industry before proceeding with the implementation of this controversial mandate. Our response represents the views of a diverse cross section of healthcare stakeholders, including vendor, clearinghouse, provider and payer input.

The HPID Enumeration Structure Outlined in the HPID Final Rule, including the Use of the CHP/SHP and OEID Concepts

The flexibility in interpretation of the final rule presents a number of challenges to the industry:

- Enumeration strategies are producing a complex system of numbers used for different purposes from health plan to health plan, which is counter to the goals of administrative simplification.
- Enumeration strategies built around corporate structures are not effective for streamlining standard transactions.

The Use of the HPID in HIPAA Transactions in Conjunction with the Payer ID

NCHICA does not support the use of the HPID in HIPAA transactions in conjunction with the Payer ID for the following reasons:

- The original intent of the HPID was to facilitate the movement of transactions. The health care industry has solved the problem through the use of the Payer ID; therefore, there is no clear business case nor a clear return on investment for use of the HPID or OEID in transactions.
- The HPID is poorly understood and will be implemented unevenly across the industry resulting in disruption and producing no real benefit in terms of productivity to either health care payers or providers. Today, changes in the ratio of routing identifiers to a payer, whether consolidating to one Payer ID or splitting transactions to different Payer IDs, requires trading partner system changes, practice management system changes, coordination of transaction submission and receipt, possible re-enrollment of existing trading
partners, system down times, and occasionally, new trading partner agreements. Introduction of the HPID into this system will be highly disruptive to the industry and require enormous work by EDI trading partners to implement.

- The lack of a publicly accessible database of HPIDs maintained in real time creates an incredibly challenging environment for payers, covered entities and business associates. It is likely that communication failures regarding when and how to use the HPID in transactions will lead to increased rejections, rework and the heightened potential for unauthorized HIPAA disclosures as the industry remedies systems, processes and workflows.
- The required Type 1 Errata to version 5010 to accommodate the HPID and OUID in transactions raises the potential for increased rejections due to the version change which must be accommodated by both sender and receiver to trade transactions.
- Lack of uniformity in the usage and purpose of the new identifier greatly reduces the benefits that can be achieved through automation of systems and processes.

Our Perspective on the Function of the HPID

With the creation of new payment models it is not always a health plan that is responsible for payment of claims. For example, in Accountable Care Organizations, it may be a provider paying a provider. In this case the use of a Payer ID is appropriate to help route claims to the appropriate location. The interchangeable use of Payer IDs and HPIDs could be difficult to manage. Again, the goal of improving electronic exchange of data through the use of standard formats, code sets and stakeholder identifiers cannot be achieved by using an identifier for two different purposes: identification in standards and health plan certification.

The industry testified before NCVHS in June of 2014 that routing issues in standard transactions caused by the current system of Payer IDs have been resolved by the industry, and that the implementation of the HPID and OUID either as a replacement for the Payer ID or in conjunction with the Payer ID would be extremely disruptive to current solutions, costly to implement, and provide virtually no improvement in routing or reduction in rejections. The NCVHS recommended to the Department in their letter dated September 23, 20141 that, “HHS should rectify in rulemaking that all covered entities (current and future health plans, providers and clearinghouses, and their business associates) will not use HPID in administrative transaction [sic], and that the current payer ID will not be replaced with HPID.”

NCHICA wholeheartedly agrees and endorses this recommendation and fully hopes the Secretary will accept this recommendation and take the necessary actions to remove this requirement.

Sincerely,

Jennifer Anderson, MHSA, PMP
Executive Director
NCHICA

1Available at http://www.ncvhs.hhs.gov/wp-content/uploads/2014/10/140923lt5.pdf