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Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-0040-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Proposed Rule for 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 ICD-10 (RIN 0938-AQ13)

Dear Sir or Madam:

On behalf of the members of America's Health Insurance Plans (AHIP), we offer comments in response to the proposed regulations regarding administrative simplification that were issued in the *Federal Register* on April 17, 2012 (77 Fed. Reg. 22950).

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

Below we offer detailed comments on the three topics included in the proposed rule: 1) the adoption of a standard for a unique health plan identifier (HPID); the change to the ICD-10 compliance date; and 3) changes to the national provider identifier requirements.

Adoption of a Standard for a Unique Health Plan Identifier (HPID)

Definitions of entities to be enumerated under the HPID (§162.103) and Proposed Enumeration Requirements and Options for CHPs and SHPs (§162.512)

We support the approach outlined for enumeration and the definitions of Controlling Health Plan (CHP) and Subhealth Plan (SHP) and recommend they are retained in the Final Rule. It is critical that the approach used to enumerate health plans does not add any unnecessary confusion to the marketplace, thus we appreciate that HHS chose to have little "meaning" embedded with the number itself except for the first number which indicates whether the number is associated with a health plan, provider or "other entity".

Further, we support the rationale presented in the Proposed Rule for why a more granular level enumeration scheme (e.g., product and plan) is not needed for health plan entities. The same type of information can be provided using other data fields in the standard transactions. For example, operating rules could be used to provide information on product or plan type in the electronic transactions. Operating rules have the potential to identify the health plan paying the claim and could in the future identify the claim payer and routing instructions for all entities involved in the claim process.

A more granular approach would add significant administrative costs to the implementation of HPID and would require the creation of a clearinghouse to maintain a myriad of separate identifiers with little gain for providers, vendors and health plans. We recommend that in the future, HHS work with the Operating Rule Development Entity for the applicable transactions if additional information is needed. We strongly agree with the decision not to require separate HPIDs because 1) the current proposal ensures a standard enumeration structure in a non-proprietary format and 2) and additional layers of enumeration would add costs, delays and administrative burden and not provide any new information. We also appreciate flexibility in those cases where there are multiple owners of a plan, in that the plan should decide how to implement.

> ***Recommendation*: *We support the approach outlined for enumeration and the definitions of a CHP and SHP and recommend they are retained in the Final Rule.***
>
> ***Recommendation*: *We support the options provided for the enumeration of SHPs based on a CHP's organizational structure and business needs.***

Applicability to self-insured group health plans (Preamble at p. 229578)
Currently, self-insured group health plans are included in the definition of a health plan and thus required to obtain a HPID if they meet the definition of a controlling health plan (CHP) at §162.103. The rationale provided is that there is a "potential need" for them to be identified in the standard transactions; however the preamble includes a discussion that in most cases the third-party administrator (TPA) would be identified in the HPID field not the plan sponsor, because the TPA is the entity actually processing the transactions.

We are not aware of any business need that would require self-insured group health plans that are not conducting electronic transactions to be enumerated. Thus, we recommend that this requirement is removed in the Final Rule. We note that it is very rare that a self-insured plan conducts electronic transactions directly, instead employing the services of a TPA, who handles all activities that include, but are not limited to claims processing, billing, and customer service. In the future, if business needs are identified for self-insured group health plans, several options could be considered including future changes to the ASC X12 mandated standards, thru the use of a CORE operating rule or a combination of both.

The existing approach creates additional operational challenges for health plans that are acting as TPAs. If the proposed approach is retained in the Final Rule, health plan entities serving in this role will need to enumerate on behalf of their plan sponsors which may create complications if the plan sponsor moves their business elsewhere. Today, health plans have a variety of products and services that will likely be enumerated with an HPID even though they are acting in the role of an "other entity" if a CHP does business as a TPA. This raises several questions, as it would not easily be discernible which identifier should be used in the transactions and how the proposed enumeration database would be structured to ensure transparency.

Recommendation: Self-insured group health plans that are <u>not</u> conducting electronic transactions directly should not be required to be enumerated.

Use of the HPID in Electronic Transactions (Implementation Specifications: Covered Entities §162.510 and Implementation Specifications: Health Plans §162.512)
We note that the regulation focuses very little on the use of the HPID in the electronic transactions, only indicating that covered entities must use the HPID to identify a health plan where a covered entity identifies a health plan in the electronic transactions adopted by the HHS Secretary.

Additional clarity is needed regarding the use of HPID in more complex situations where it could be appropriate to reference several different health plans in the HPID field. For example, one health plan may be adjudicating the claim and a separate health plan may hold the actual contract with the provider. The Final Rule should include additional information on potential scenarios on how the HPID should be used in each case. However, it is critical that the CHP or SHP should have the sole authority to assign the HPID structure, and to determine which HPID is used with electronic transactions. No other entity should be able to request or assign a particular HPID. We are particularly concerned about the potential for future mandates that would require certain entities within health plans to obtain and use a unique HPID and this should be expressly prohibited.

Following implementation, we recommend that the Department work with the National Committee on Vital and Health Statistics (NCVHS) to determine if operating rules regarding the use of the HPID in the electronic transactions are necessary to clarify various implementation issues once all stakeholders gain additional experience.

Recommendation: The Final Rule should include additional information on the various business models and how the HPID should be used in each case.

Recommendation: The Department should work with the NCVHS to determine if operating rules regarding the use case for HPID are necessary to clarify any implementation issues raised following HPID implementation.

The preamble at page 22958 includes several examples of permitted uses beyond the electronic transactions for the HPID including use on a health plan's identification card and use as a cross-

reference in health care fraud and abuse files. We recommend that health plans have the flexibility to determine other uses based on their business needs. Further, we recommend that the Department clearly state that the use of an HPID on a member ID card is optional given the understanding that the use of the HPID is limited to specifically identified electronic healthcare transactions.

> ***Recommendation: The Department should stress that all uses of the HPID beyond the electronic transactions are optional and specifically indicate that the use of an HPID on a member ID card is not required, unless required by state law.***

The preamble at 22958 seeks comments on whether a SHP should be responsible for submitting updates to its own data if a CHP obtained the HPID on its behalf. We recommend that update responsibilities be left up to the CHP and SHP to work out. This would allow a certain degree of flexibility which the parties can use to make business decisions consistent with their own business practices.

> ***Recommendation: The responsibility for updating information associated with the HPID should be left up the CHP and SHP to determine based on their business practices.***

New proposed OEID and entities eligible for enumeration as an OEID (§162.514)
The proposed rule includes a creation of an "other entity identifier" that would be used for entities that are not health plans, health care providers or individuals, yet they need to be identified in a standard transaction. However, if the OEID is obtained it is required to be disclosed upon request to entities that need to identify such entities for covered transactions. While obtaining an OEID is optional, if obtained the regulation sets up unclear expectations regarding the requirements for the use of the OEID in standard transactions.

The preamble at page 22963 lists several examples of entities that health plans use to provide services on their behalf including rental networks, benefit managers, third party administrators, health care clearinghouses, repricers, and other third parties that perform functions similar to, or on behalf of, health plans. In many cases these entities are already being identified in the same fields and using the same type of identifiers currently used by health plans today. They may also be the actual recipients of eligibility queries or claims on behalf of the health insurer or the entity ultimately responsible for payment.

The establishment of the OEID raises several operational challenges for health plans, especially since there is no current place for them in the adopted electronic transaction standards, raising questions about the ultimate use of the OEID. Therefore, we recommend that further study takes place prior to implementation. As you conduct this review, we offer recommendations on the use of the OEID for third party administrators and healthcare clearinghouses for consideration:

Third Party Administrators - We agree that in the case of self-insured group health plans that are using the services of a TPA, the TPA would be identified in the HPID field not the plan sponsor,

because the TPA is the entity actually processing the transactions. However, under the proposed definition, TPAs that are subsidiaries to CHPs would obtain a HPID (either as a CHP or SHP) given that the OEID is only available to those entities that are "not eligible to obtain an HPID." This sets up a dual approach for TPAs, depending how they are structured, which will lead to a dual routing and identification system whereby everyone in the system would need to track which entities have taken what approach.

Healthcare clearinghouses - We are unclear as to the business cases for healthcare clearinghouses to obtain an OEID. Health plan responsibilities are to adjudicate and pay claims; enroll members; and provide eligibility information. We are unaware of healthcare clearinghouses who perform these functions unless they are a complete surrogate for a health plan's function, such as when they hold a health plan's eligibility file, in which case they should use the health plan's HPID. Only those entities that perform the functions of a health plan (while not actually being a health plan) should be eligible to receive an OEID. Clearinghouses act like surrogates and should use the HPID of the entity they are replacing. We also note that the only place a clearinghouse could be defined independently in existing transactions is on the ISA envelope and that element (Information receiver or sender, ISA07 and ISA05 respectively) does not allow HPID as a valid option.

The creation of an OEID does address certain issues today with certain entities who do not have a Payer ID or NPI but are conducting transactions. The regulation at §162.514(c) provides unclear guidance on the actual usage of the OEID in the standard transactions as there is not currently a data field to support the OEID. Section 162.514(c) indicates that these other entities may use the OEID it obtained from the Enumeration System to identify itself or have itself identified on all covered transactions in which it needs to be identified. However, as currently proposed health plans as well as other covered entities that process transactions would need to maintain a massive list of which entities have taken what approach to determine if transactions are correctly formatted.

Recommendation: The Department should conduct further study to determine the appropriate entities to receive an OEID and work with the appropriate standard development entities to (1) determine where the OEID should be included in the standard electronic transactions and (2) and minimize the costs associated with the implementation of the OEID.

Recommendation: We support the use of the OEID for TPAs, however, we note that in the cases of TPAs that are owned by health plans, it will be more likely they will be using their applicable HPID.

Recommendation: We recommend that the language in section 162.514(c) be reworded to say that if an OEID is obtained it must be used in the transactions:

- *Proposed new language: "an other entity* ***must*** *use the OEID it obtained from the Enumeration System to identify itself or have itself identified on all covered transactions in which it needs to be identified"*

Proposed Enumeration System (§162.508) and Information Collection Requirements (ICR)
The Department proposes to create an Enumeration System that would assign unique HPIDs and OEIDs. It would serve as a comprehensive system, which would collect and maintain certain identifying and administrative information about CHPs, SHPs and other entities. It would also disseminate information publicly through a database or through downloadable files.

It is critical that a minimally necessary set of information is collected in a non burdensome way. However, we are unable to provide detailed comments on the information collection and record keeping requirements associated with HPID until CMS provides additional information about the system and what mandatory and optional data will be collected from health plans as part of the enumeration process. These data elements should not include confidential business information. We do understand that the Department is considering the development of a module for the existing Health Insurance Oversight System, which we do support as a potential way to reduce the information collection burden on health plans.

> ***Recommendation: The Department should release for public comment a detailed list of the data elements (including both mandatory and optional data elements) to be collected from health plans during the HPID enumeration process as soon as possible.***

> ***Recommendation: The Enumeration System should only collect a "minimally necessary" set of information and steps should be taken to ensure the protection of confidential data.***

Since many industry stakeholders will have business needs for HPID data or the ability to verify HPIDs, it would be useful to have the capability to download files to enable an efficient way to satisfy those needs. Clearinghouses and providers, for example, may need to build crosswalks from identifiers currently in use to the HPID. If stakeholders are required to obtain HIPD data from the database for one HPID at a time, it will be a very inefficient process. The Enumeration System should include a file download capability to facilitate automated solutions for HPID verification.

> ***Recommendation: The Enumeration System should include a download function to allow for access to HPID information in an efficient way (i.e., not one at a time).***

Effective and Compliance Dates (§162.504)
The Proposed Rule provides little guidance and clarity around the testing and implementation process for the HPID and OEID. While entities could obtain HPIDs beginning on October 1, 2012, there is unclear expectation as to whether covered entities should use their HPID in transactions or wait until the implementation date (either October 1, 2014 or in the case of small health plans October 1, 2015). When entities switch from their proprietary ID to the HPID, all of their trading partners require notification in order to include the HPID in the appropriate transaction fields. Unless there is a specified implementation date from Payer ID to HPID, the industry will have to code for dual usage during the interim period. It may be prudent for the Department to work with the

NCVHS to determine if an implementation project plan should be developed that could include an optional milestone for when health plans should obtain their HPID in advance of the implementation date. This would allow health plans the time to notify their trading partners of the new HPID and allow for all parties to update their systems accordingly.

The planned phased-in implementation for large and small health plans will essentially create a period of dual use where all covered entities will have to track which health plans and other entities have implemented the HPID, and which entities continue to use their existing legacy number. Not all transactions can accommodate HPID and Payer ID simultaneously, meaning covered entities will have to build systems that accept both the proprietary Payer ID in some transactions and the standard HPID in production at the same time. It is critical that the implementation schedule is well thought out and all of these issues are addressed to ensure a successful HPID implementation. We are especially concerned given that HPID and ICD-10 implementation will be taking place concurrently.

The implementation of the OEID brings additional complexity. Because the OEID use is optional, the industry has to include placeholders for IDs used today and the new OEID for the foreseeable future to track which entities will continue to use the legacy ID (either a Payer ID or Taxpayer Identification Number) and which entities will be using their new OEID to identify themselves (either a HPID or OEID).

> ***Recommendation: HHS should work with the NCVHS to address issues regarding the staged implementation dates for health plans given that small health plans have an additional year and the issues surrounding the optional nature of the OEID.***
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> ***Recommendation: HHS should work with NCVHS, in partnership with all stakeholders to develop a meaningful testing and transition plan for HPID and OEID implementation. This plan should include an examination of whether an optional milestone should be established for when health plans should obtain their HPID in advance of the implementation date to allow time for the notification of trading partners and the necessary system updates.***

Changes to the ICD-10 Effective Date

We understand the rationale for proposing to change the compliance date from October 1, 2013 to October 1, 2014 for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding. We appreciate the numerous options that the Department considered when making the change and agree that a 2 year delay would create too large of a financial burden for those entities that would have been otherwise ready on October 1, 2013.

However, any change to the compliance date must recognize that without undertaking the following steps, further compliance efforts may also result in significant costs to AHIP's member health insurance plans:

We recommend that the Department comprehensively review upcoming administrative simplification deadlines. The implementation of Section 1104 of the Affordable Care Act (ACA) along with ICD-10 requires significant changes to health plans IT infrastructure and impacts almost every facet of a health plan's operations. Given the proposed delay, we believe it is prudent for the Department to work with the NCVHS to determine if the forthcoming compliance dates for operating rules related to the electronic remittance advice, electronic funds transfer and future operating rules related to enrollment, authorizations and referrals and claims should be adjusted. This review should also include a holistic review of all forthcoming implementation dates related to the ACA, administrative simplification, and other regulatory and statutory requirements with significant business and information technology impact on the industry.

We can currently support concurrent implementation of HPID and ICD-10, so long as the HPID approach described in the Proposed Rule is retained in the Final Rule. Significant changes to the HPID implementation approach will require reconsideration of the HPID compliance date occurring concurrently with ICD-10 implementation.

The Department should work with the NCVHS to develop a detailed ICD-10 testing and implementation plan. To keep the implementation momentum, we recommend that the Department work with the NCVHS to develop a testing program that would allow for covered entities to begin testing around October 1, 2013 and continue until the revised implementation date. This program should also include milestones and metrics that would be monitored to better understand the state of the industry.

In tandem, the Department, working with the NCVHS should consider other non-monetary incentives to ensure all stakeholders can meet the new deadline. One approach would be to leverage the momentum towards achieving "meaningful use" by ensuring that certified EHR vendors are required to comply with ICD-10 as well as SNOMED CT. We understand that there are available tools to help with the crosswalk between the two coding systems.[1]

We understand that the small provider community will need a place to go to get answers to questions concerning the clinical documentation needed to determine the correct or most appropriate diagnoses code. While large institutions and provider practices may not need such assistance, the small provider community will need assistance to determine if their current documentation practices will enable the selection of an appropriate ICD-10 code. In addition a main frame version of the DRG

[1] See March 3, 2012 Letter from the NCVHS to the Honorable Kathleen Sebelius, available at: http://ncvhs.hhs.gov/120302lt4.pdf

grouper should be available to the industry for testing purposes should be made available as soon as possible. Finally, we recommend that the code freeze be extended until October 1, 2015.

We are pleased to see that the NCVHS Subcommittee on Standards is planning a June hearing on strategies and recommended milestones to achieve a successful transition and we look forward to providing additional input on this topic at that time.

The Department must commit to not moving the implementation date again. The continued uncertainty regarding the enforcement deadline for 5010 over the first 6 months of 2012 have demonstrated the high costs associated with constantly moving deadlines that are often extended at the last minute. Further changes in the compliance date throughout 2013 and 2014 prior to the October 1, 2014 deadline would cause significant costs for health plans and ultimately for their customers at a time when the industry will be preparing for the implementation of Health Insurance Exchanges and all of the other ACA-mandated changes. This is because systems naturally evolve for a number of reasons over time and an extended delay will require an extension of testing activities and prolonged maintenance of the testing environment. We stand ready to ensure that member plans will be able to meet the October 1, 2014 deadline and thus strongly encourage HHS to not make any further changes to the implementation date.

In meeting its commitment to 2014 implementation, we strongly recommend against any dual implementation periods for ICD-10 as some stakeholders have suggested. We have heard recommendations for either different implementation dates for health plans and providers; while others have suggested phasing in the implementation of ICD-10 procedure codes and diagnostic codes. Both of these approaches would be nearly impossible to implement from an operational perspective and would cause great challenges both in the development of health plan and provider contracts as well as the implementation of quality improvement strategy reporting, which depends on ICD-10 diagnostic and procedure codes. It would also add significant costs and marketplace confusion to the implementation of ICD-10.

The Department should provide allowances in the Medical Loss Ratio (MLR) Final Rule to account for impact of ICD-10 delay. In the MLR Final Rule published in the *Federal Register* on December 7, 2011 the Department recognized that ICD-10 conversion implementation costs are quality improvement activities. However, the rule proposed to limit the amount of ICD-10 conversion costs to only those incurred in 2012 and 2013.

We ask that HHS provide allowances to account for the recent proposed delay since the MLR Final Rule was issued; taking into account the implementation costs that will now be incurred after 2013 into 2014. We recommend that companies should be able to track and include their ICD-10 implementation costs on later year MLR Reports. This is a reasonable consideration, since health insurers would incur additional implementation costs to bridge and maintain dual processing modes and reporting in such a scenario. To be penalized for timely implementation by being prohibited from reporting additional costs (incurred from delays due to other health care systems) would be

both unreasonable and unfair. Should there be any unforeseen delays beyond October 1, 2014 the regulatory approach should afford the Department with the flexibility to synch up the accounting of ICD-10 implementation costs with the ICD-10 implementation date, consistent with the current regulatory and compliance requirements.

Recommendation: HHS should allow the MLR final rule's treatment of ICD-10 to:

- ***Adjust the 0.3% cap on ICD-10 costs to reflect the proposed changes' costs; and***
- ***Extend the ability to take costs into account beyond 2013 into 2014. This change takes into account the implementation delay period and the additional costs incurred given the current rule limits treatment of ICD-10 as quality cost only for 2012 and 2013.***

National Provider Identifier Changes

The Department proposes an additional requirement for organization covered health care providers that have as a member, employ, or contract with, an individual health care provider who is not a covered entity and is a prescriber. We understand that these changes will impact largely hospital-based providers who staff clinics and emergency departments, or otherwise provide on-site medical services, such as medical residents and interns. We support the implementation of these changes and believe that a compliance date of April 7, 2013 is appropriate.

Recommendation: The changes to the NPI requirements should be retained in the Final Rule.

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Thank you for the opportunity to provide comments. Please do not hesitate to contact Jeanette at 202-861-1491 or jthornton@ahip.org if you have questions.

Sincerely,

Jeanette Thornton
Vice President
Health IT Strategies
America's Health Insurance Plans