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Testimony before the NCVHS Subcommittee on Standards
on the Future of the Health Plan Identifier (HPID)

May 3, 2017

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American Health Information Management Association-Public Health Data Standards Council
(AHIMA-PHDSC)

Background on AHIMA-PHDSC and Payer Typology

The American Health Information Management Association (AHIMA) is the not-for-profit membership-based health care association representing over 100,000 health information management (HIM) and informatics professionals who work in more than 40 different types of entities related to our nation's public health and health care industry.

The Public Health Data Standards Consortium (PHDSC, The Consortium) was a national non-profit membership-based organization of federal, state, and local health agencies; professional associations; academia; public and private sector organizations; and individuals. Its goal was to empower the healthcare and public health communities with health information technology (HIT) standards to improve individual and community health.

In 2014, AHIMA and PHDSC merged creating the AHIMA Public Health Data Standards Council (AHIMA-PHDSC, Council). The Council was created on the premise that the value of data increases when used for multiple purposes. The purposes of public health data systems range from providing support for clinical care to assessing the quality of that care and assessing the health status of populations at the state and national level over time. The aim of these systems is to inform sound health policy for the country's population. Because of its diverse purposes, public health needs data from multiple sources to achieve its objectives. The Council believes that it is important to be part of the process creating the data standards necessary for today's health transactions.

PHDSC developed the Source of Payment Typology - a standard for categorizing the different payer types for health transactions. The standard was developed with cross industry cooperation and is currently maintained by the AHIMA-PHDSC. The Source of Payment Typology has been incorporated into X12, HL7, and Uniform Bill standards. Even more significant is the fact that the Source of Payment Typology has been implemented into 7 state public health reporting systems becoming the best solution known for categorizing the types of payers in health care transactions.

The Payer Typology code set, a User Guide and White Paper on the implementation of the code set by states are available on the PHDSC Payer Typology Sub-Committee's website at http://www.phdsc.org/standards/payer-typology.asp. Changes to the Source of Payment Typology are made annually in October. Interested industry representatives can make comments and recommendations for additions or modifications via the PHDSC website.

Response to Questions

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

Current Identifiers include the X12 Claim Filing Indicators, the National Association of Insurance Commissioners ID, and the Source of Payment Typology. The need to differentiate for payer performance extends into Pharmacy, Dental and Vision and should be consistent.

2. **What business needs do you have that are not adequately met with the current scheme in use today?**

The current version of the National HPID registry does not contain any intelligence, such as type of plan. The AHIMA-PHDSC believes that just as each National Provider ID has a Provider Taxonomy code attached to it to differentiate provider types, the National HPID should have a codified typology for use in differentiating plans. This opportunity should not be missed and would facilitate other requirements of recent legislation such as quality and cost measurement. Collection of these data during plan enumeration and its availability to users of the Plan ID registry would allow researchers to answer questions raised by health reform. The following are four examples of these questions:

1. Using hospital discharge data, one could examine the prevalence of specific categories of payer type for various racial, ethnic and linguistic sub-populations. Further investigation could assess how well a particular payer type covers preventive services, ongoing medical treatment for chronic conditions, and long-term care. Disparities among sub-groups could be assessed at national, state and local levels. More specifically, a researcher could examine within payer type the various arrangements that sub-groups are most likely found in, i.e., Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Provider Sponsored Organization (PSO).

2. Using Medicaid claims data, a specific state or group of states could compare utilization of preventive services by Medicaid HMO enrollees with utilization by Medicaid Fee for Service (FFS) enrollees. The results of this type of analysis could inform changes in state policy in regard to either the cost or outcomes associated with the use of preventative services, and whether HMO or FFS models deliver better results. Using payer categories such as those found in the Payer Typology would make this type of research relatively easy to undertake.

3. Researchers at the behest of federal policymakers could assess utilization of specific services in the new Medicare programs, such as Medicare Advantage. Further, researchers could assess whether utilization varies by type of Medicare Advantage Plan, that is, whether it is a HMO, PPO, or PSO. These arrangements could impact individual utilization for specific treatments or services in ways unknown at the time policies were developed.

4. Work underway today by AHIMA-PHDSC members is paving the way to support Semantic Interoperability for Clinical Guidelines across providers. The attached "Source of Payment Typology" sets a foundation to help all providers and patients, informed by public health and clinical informatics research, understand the outcomes provided by Clinical Guidelines as the health sector shifts to value-based and accountable (ACO) care

models. Without a robust Source of Payment Typology, such studies will be limited in scope, to the detriment of essential progress towards the Triple Aim.

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

It does not meet the needs of health services researchers or public health professionals examining differences in care delivery related to type of plan and ownership status. The HPID lacks the built-in intelligence. Adding type of plan detail to the HPID would resolve the problem.

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

See response to Question 2 above.

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

The Source of Payment Typology provides a standardized categorization of payers that will improve the ability of administrative data to support analyses of Federal and other initiatives to which the type of payer may have an impact on cost, quality or access to healthcare. The AHIMA-PHDSC recommends that the Source of Payment Typology be named as the standard vocabulary associated with the national health plan identifier for categorizing payer types for the following reasons:

- We have a unique opportunity for comprehensive categorization of all US payers. We should not reinvent the wheel – no better code set exists today.
- The Typology is recognized by standards development organizations and committees such as HL7 and X12. It is also in the UB-04 standard.
- There is an existing standards consortium which approves additions, changes and deletions to the codes through a transparent public maintenance process.
- The Source of Payment Typology is in use by multiple organizations today.

Thank you for the opportunity to testify.

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Attachments: Source of Payment Typology, Version 7.0, June 2016

Source of Payment Typology
Version 7.0
June 2016



Reference to the User's Guide for Source of Payment Typology can be found at:
http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion7.0_final.pdf

| Code | Description |
|---|---|
| **1** | **MEDICARE** |
| | |
| **11** | **Medicare (Managed Care)** |
| 111 | Medicare HMO |
| 112 | Medicare PPO |
| 113 | Medicare POS |
| 119 | Medicare Managed Care Other |
| | |
| **12** | **Medicare (Non-managed Care)** |
| 121 | Medicare FFS |
| 122 | Medicare Drug Benefit |
| 123 | Medicare Medical Savings Account (MSA) |
| 129 | Medicare Non-managed Care Other |
| **13** | **Medicare Hospice** |
| | |
| **14** | **Dual Eligibility Medicare/Medicaid Organization** |
| | |
| **19** | **Medicare Other** |
| 191 | Medicare Pharmacy Benefit Manager |
| | |
| **2** | **MEDICAID** |
| | |
| **21** | **Medicaid (Managed Care)** |
| 211 | Medicaid HMO |
| 212 | Medicaid PPO |
| 213 | Medicaid PCCM (Primary Care Case Management) |
| 219 | Medicaid Managed Care Other |
| | |
| **22** | **Medicaid (Non-managed Care Plan)** |
| **23** | **Medicaid/SCHIP** |
| **24** | **Medicaid Applicant** |
| **25** | **Medicaid – Out of State** |
| **26** | **Medicaid – Long Term Care** |
| **29** | **Medicaid Other** |
| 291 | Medicaid Pharmacy Benefit Manager |
| 292 | Medicaid - Dental |
| | |
| **3** | **OTHER GOVERNMENT (Federal/State/Local)** |
| | **(excluding Department of Corrections)** |
| | |
| **31** | **Department of Defense** |
| 311 | TRICARE (CHAMPUS) |
| 3111 | TRICARE Prime—HMO |
| 3112 | TRICARE Extra—PPO |
| 3113 | TRICARE Standard - Fee For Service |
| 3114 | TRICARE For Life--Medicare Supplement |
| 3115 | TRICARE Reserve Select |

| Code | Description |
|---|---|
| 3116 | Uniformed Services Family Health Plan (USFHP) -- HMO |
| 3119 | Department of Defense - (other) |
| 312 | Military Treatment Facility |
| 3121 | Enrolled Prime—HMO |
| 3122 | Non-enrolled Space Available |
| 3123 | TRICARE For Life (TFL) |
| 313 | Dental --Stand Alone |
| | |
| **32** | **Department of Veterans Affairs** |
| 321 | Veteran care--Care provided to Veterans |
| 3211 | Direct Care--Care provided in VA facilities |
| 3212 | Indirect Care--Care provided outside VA facilities |
| 32121 | Fee Basis |
| 32122 | Foreign Fee/Foreign Medical Program (FMP) |
| 32123 | Contract Nursing Home/Community Nursing Home |
| 32124 | State Veterans Home |
| 32125 | Sharing Agreements |
| 32126 | Other Federal Agency |
| 32127 | Dental Care |
| 32128 | Vision Care |
| 322 | Non-veteran care |
| 3221 | Civilian Health and Medical Program for the VA (CHAMPVA) |
| 3222 | Spina Bifida Health Care Program (SB) |
| 3223 | Children of Women Vietnam Veterans (CWVV) |
| 3229 | Other non-veteran care |
| | |
| **33** | **Indian Health Service or Tribe** |
| 331 | Indian Health Service – Regular |
| 332 | Indian Health Service – Contract |
| 333 | Indian Health Service - Managed Care |
| 334 | Indian Tribe - Sponsored Coverage |
| | |
| **34** | **HRSA Program** |
| 341 | Title V (MCH Block Grant) |
| 342 | Migrant Health Program |
| 343 | Ryan White Act |
| 349 | Other |
| | |
| **35** | **Black Lung** |
| | |
| **36** | **State Government** |
| 361 | State SCHIP program (codes for individual states) |
| 362 | Specific state programs (list/ local code) |
| 369 | State, not otherwise specified (other state) |
| | |
| **37** | **Local Government** |
| 371 | Local - Managed care |
| 3711 | HMO |
| 3712 | PPO |
| 3713 | POS |
| 372 | FFS/Indemnity |
| 379 | Local, not otherwise specified (other local, county) |
| | |
| **38** | **Other Government (Federal, State, Local not specified)** |
| 381 | Federal, State, Local not specified managed care |
| 3811 | Federal, State, Local not specified - HMO |
| 3812 | Federal, State, Local not specified - PPO |

| Code | Description |
|---|---|
| 3813 | Federal, State, Local not specified - POS |
| 3819 | Federal, State, Local not specified - not specified managed care |
| 382 | Federal, State, Local not specified - FFS |
| 389 | Federal, State, Local not specified - Other |
| | |
| **39** | **Other Federal** |
| 391 | Federal Employee Health Plan – Only to be used when you cannot distinguish plan |
| | |
| **4** | **DEPARTMENTS OF CORRECTIONS** |
| | |
| **41** | **Corrections Federal** |
| **42** | **Corrections State** |
| **43** | **Corrections Local** |
| **44** | **Corrections Unknown Level** |
| | |
| **5** | **PRIVATE HEALTH INSURANCE** |
| | |
| **51** | **Managed Care (Private)** |
| 511 | Commercial Managed Care - HMO |
| 512 | Commercial Managed Care - PPO |
| 513 | Commercial Managed Care - POS |
| 514 | Exclusive Provider Organization |
| 515 | Gatekeeper PPO (GPPO) |
| 516 | Commercial Managed Care - Pharmacy Benefit Manager |
| 517 | Commercial Managed Care - Dental |
| 519 | Managed Care, Other (non HMO) |
| | |
| **52** | **Private Health Insurance - Indemnity** |
| 521 | Commercial Indemnity |
| 522 | Self-insured (ERISA) Administrative Services Only (ASO) plan |
| 523 | Medicare supplemental policy (as second payer) |
| 524 | Indemnity Insurance - Dental |
| 529 | Private health insurance—other commercial Indemnity |
| | |
| **53** | **Managed Care (private) or private health insurance (indemnity), not otherwise specified** |
| **54** | **Organized Delivery System** |
| **55** | **Small Employer Purchasing Group** |
| **56** | **Specialized Stand Alone Plan** |
| 561 | Dental |
| 562 | Vision |
| | **Other Private Insurance** |
| | |
| **6** | **BLUE CROSS/BLUE SHIELD** |
| | |
| **61** | **BC Managed Care** |
| 611 | BC Managed Care – HMO |
| 612 | BC Managed Care – PPO |
| 613 | BC Managed Care – POS |
| 614 | BC Managed Care - Dental |
| 619 | BC Managed Care – Other |
| | |
| **62** | **BC Insurance Indemnity** |
| 621 | BC Indemnity |
| 622 | BC Self-insured (ERISA) Administrative Services Only (ASO)Plan |
| 623 | BC Medicare Supplemental Plan |
| 624 | BC Indemnity - Dental |

| Code | Description |
|---|---|
| | |
| **7** | **MANAGED CARE, UNSPECIFIED (to be used only if one can't distinguish public from private)** |
| | |
| **71** | **HMO** |
| **72** | **PPO** |
| **73** | **POS** |
| **79** | **Other Managed Care** |
| | |
| **8** | **NO PAYMENT from an Organization/Agency/Program/Private Payer Listed** |
| | |
| **81** | **Self-pay** |
| | |
| **82** | **No Charge** |
| 821 | Charity |
| 822 | Professional Courtesy |
| 823 | Research/Clinical Trial |
| | |
| **83** | **Refusal to Pay/Bad Debt** |
| **84** | **Hill Burton Free Care** |
| **85** | **Research/Donor** |
| **89** | **No Payment, Other** |
| | |
| **9** | **MISCELLANEOUS/OTHER** |
| | |
| **91** | **Foreign National** |
| **92** | **Other (Non-government)** |
| **93** | **Disability Insurance** |
| **94** | **Long-term Care Insurance** |
| | |
| **95** | **Worker's Compensation** |
| 951 | Worker's Comp HMO |
| 953 | Worker's Comp Fee-for-Service |
| 954 | Worker's Comp Other Managed Care |
| 959 | Worker's Comp, Other unspecified |
| | |
| **96** | **Auto Insurance (includes no fault)** |
| **97** | **Legal Liability / Liability Insurance** |
| **98** | **Other specified but not otherwise classifiable (includes Hospice - Unspecified plan)** |
| **99** | **No Typology Code available for payment source** |
| | |
| **9999** | **Unavailable / No Payer Specified / Blank** |