TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

On

Operating Rules

Presented by: Janet Jackson, Director, Electronic Solutions

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

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Good afternoon. My name is Janet Jackson. I am the Director of Electronic Solutions at Blue Cross and Blue Shield of North Carolina, where I am responsible for implementing, enhancing, and supporting our HIPAA solution for providers. I am speaking on behalf of our Plan, an independent licensee of the Blue Cross and Blue Shield Association. We are a leader in delivering innovative health care products, services, and information to more than 3.7 million members, including approximately 900,000 members served on behalf of other Blue Plans. We provide healthcare coverage for nearly one in three North Carolinians. We appreciate the opportunity to offer our comments on the Operating Rules.

Blue Cross and Blue Shield of North Carolina has a history of participation in CAQH and its Committee on Operating Rules for Information Exchange or CORE. Our CEO, Brad Wilson, currently serves on the CAQH Board, and members of our Senior Leadership team previously served as Chairman of the CAQH Board and Chair of CORE. Members of our Management teams have actively collaborated with the other health plans, providers, vendors, clearinghouses and standard setting bodies (SDOs), all of whom make up the CORE membership, in the creation of the CORE operating rules. We are in support of the industry's collaboratively defined and voluntarily adopted CORE Phases I, II and draft Phase III operating rules.

The Patient Protection and Affordable Care Act's administrative simplification provisions related to new or existing standard transactions and operating rules are very broad. The overall resource requirements, front-loaded costs, changes to business processes, and implementation of new technology, all of which will be necessary for health plans to implement federal mandates within the next 5-7 years will be significant for health plans of all sizes.

To reduce overall administrative costs, simplify the interaction between health plans and providers, and obtain a return on investment, it is critical that the operating rules are limited to those that have demonstrable business and financial value, while understanding that the cost and benefits of implementation may vary greatly from one organization to the next. For those transactions for which

CORE operating rules currently exist and of which many in the industry are already adopting, it is important that we not spend additional time and resources creating new and different operating rules.

All stakeholders must partner together in this process—health plans implementing the standards and operating rules; providers expanding their use of electronic transactions and working with their software vendors to integrate the resulting information into their systems. Otherwise, we will simply add costs and complexity to an already overburdened system, with no assurance of a return on that investment or realization of the potential reduction in the administrative cost that health plans and providers share, which is ultimately passed on to the consumers of healthcare.

It is helpful to think of operating rules as documented 'best practices', gleaned from many sources--including business, standards, and technical subject matter experts, and health plan Companion Guides. Existing operating rules are useful because they go beyond the standards and address data content usage—what types of data to use in certain common business scenarios. They also address performance requirements and connectivity and security methods, none of which are addressed in the current HIPAA standards. Under the status quo (sans operating rules), connectivity and security methods are generally addressed individually in health plans' Companion Guides; therefore, they do not offer the cross-organizational uniformity of operating rules. It is important that operating rules be seen as a minimum level of what a health plan may return on a transaction, versus setting an absolute level of what a health plan can return.

With the existing implementation of CORE operating rules, providers and software vendors have a level of certainty of how information is being processed and returned to them. Therefore, they are able to set up rules based processes to map responses from all CORE certified entities in a unified manner into the provider's patient accounting or practice management systems. This allows for the information obtained in the Eligibility response to be used in other transactions, for example, ensuring that the member ID and demographic information is correct on the original claim; thus reducing the number of claims that reject for invalid member information. This increases the provider's claims first pass rate, which helps to shorten the accounts receivable days related to an episode of care for the provider. It also reduces the number of calls to the health plan for assistance with the rejections, and reprocessing of the previously submitted claim.

Additionally, with the implementation of operating rules, trading partners are not dependent on individual health plan's Companion Guides to give them the information they need on what connectivity or security protocol to use, or to map information differently for each health plan. This increased uniformity encourages higher levels of adoption, thus improving the timely return on investment for each of us.

The main reason that I travelled here to testify is to share Blue Cross and Blue Shield of North Carolina's experience with implementing operating rules. I believe that our story is a compelling one with regard to the potential value of operating rules. From a business perspective, our providers needed and were demanding more detailed benefit and financial information at the point of patient care. We knew that a real-time robust eligibility response would meet their business need. At project initiation, although we found it difficult to attribute direct return on investment based on a quantifiable decrease in call volume or an increase in claims first pass rate, our Senior Leadership was forward thinking and committed to advancing interoperability via CORE Phase I adoption.

Prior to implementing our Eligibility project in 2007, we offered a basic HIPAA 271 eligibility response. This included member demographics, the effective dates of the member's coverage, and general coverage information related to deductible and coinsurance. We did not have real-time 270/271 capability, could not meet the CORE connectivity, availability, and response time metrics required for certification, and needed to add more data content regarding benefits and patient financials. In other words, we had much work to do!

As part of the project, we significantly enhanced our HIPAA 271 Eligibility response using the CORE Phase I and most of the then draft Phase II operating rules related to eligibility for data content, performance, connectivity, and security. Our technical solution provided near 24x7 real-time availability and standard connectivity requirements for our local trading partners. The implementation costs for this work exceeded $2M.

During the first six months following our implementation, we processed 1.2M real-time eligibility transactions. By contrast, the first six months of this year, we have processed over 6M transactions. We forecast that we will increase our monthly volume to 2.5-3M transactions per month by the end of this year. Our organic transaction growth over the last three years proves that the information is valuable to our providers.

Our experience of increased transaction growth is a direct result of implementing real-time capability using the CORE operating rules—a delivery of more robust content, one connectivity method, standard hours of availability, and expected response time. All the rules work together to allow clearinghouses and patient accounting or practice management vendors to build the capability into their applications so that an eligibility inquiry is automatically 'kicked off' each time a provider registers a patient, or even the night before using the provider's scheduler. The information that is returned in the eligibility response is then mapped into the provider's claims system. This results in claims being submitted with correct member information (ID number, name, date of birth) and faster claims processing and payment, which ultimately leads to higher member and provider satisfaction.

Do we believe that this success story will occur for us on every transaction? No, we do not, unless a measurable return on investment and business process improvement based justification is used during the operating rules development and vetting process. We believe that there are some transactions in which operating rules will have significant positive impact and show a return on investment. The operating rules requirements for 2013 include eligibility and claim status, which will benefit from the current CORE Phase I, II and draft Phase III data content and usage rules, real-time availability and performance standards. The operating rules requirements for 2014 include remittances, which will benefit from data content and usage rules; for example, consistent mapping of health plan proprietary denial codes to claim adjustment reason and remittance remark codes.

Some of the transactions identified for 2016, authorizations and premium payment, will not show a return on investment for our health plan. Both of these transactions have low or no volume within our health plan, so achieving any return on investment will be difficult at best. We currently receive 94% of our claims electronically; therefore, operating rules for claims would not drive significant transaction growth for us. However, if the operating rules were to include the 277CA as the standard acknowledgement for claims, then the clearinghouses, vendors, and providers would have one version of 'error reporting' for claims that fail Implementation Guide or payer specific business edits, instead of the many different proprietary versions that exist today. Thus we will achieve industry-wide administrative simplification of this error reporting.

In summary, Blue Cross and Blue Shield of North Carolina supports the existing CORE operating rules, development process, and voluntary implementation. From an interoperability perspective, we believe it is important that a single entity, knowledgeable and experienced with business processes, be responsible for defining the operating rules and that CAQH CORE is well-positioned to serve in that role.

It is important that the rate of adoption of standards and operating rules be structured so that the entire healthcare ecosystem can absorb and adjust to the changes. If all impacted stakeholders—especially health plans and providers—work together to carefully consider improved business processes and expected return on investment early in the opportunity selection process, and commit to increased exchange of information electronically, there will be significant opportunities to move the industry towards the interoperable capabilities that will prove to be one of the cornerstones of administrative simplification and cost reduction.

Thank you for the opportunity to testify.