TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

On

Operating Rules for Eligibility and Claim Status – Preparing for Implementation

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BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

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Good afternoon. My name is Janet Jackson. I am the Director of Document Operations and Electronic Solutions at Blue Cross and Blue Shield of North Carolina (BCBSNC), where my responsibility includes 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 Preparing for Implementation of Operating Rules for Eligibility and Claim Status.

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. Members of our management teams actively collaborated with the other health plans, providers, vendors, clearinghouses, and standard setting bodies (SDOs) in the creation of the CORE Phases I and II operating rules, which are now the PPACA Section 1104 Administrative Simplification Operating Rules for Eligibility and Claim Status. We also actively participated with CAQH CORE on the proposed HIPAA 835 Remittances and Electronic Funds Transfer Operating Rules. We believe the existing CAQH CORE process meets industry needs and should serve as an effective framework for the remaining sets of Operating Rules.

BCBSNC voluntarily adopted the CORE Phase I operating rules and some of the then draft CORE Phase II Eligibility rules in May 2007. We became CORE Phase I certified to demonstrate our compliance at the completion of the project. Our project costs exceeded $2M. At the time of our implementation, we were receiving 100K inquiries per month. We now receive 2.8M real-time eligibility transactions per month from our trading partners, which represents a 300% increase in the past two years. Providers are not only seeing benefit in the enhanced content of the Eligibility transactions, but many are also executing the transaction as a demographic check prior to submitting a claim and have built this into their claims submission workflow. This helps to reduce the number of invalid member ID and member

ID/name/date of birth claim error rejections, which streamlines the claims submission process and helps to reduce providers' Accounts Receivable Days. Additionally, the system we constructed for this effort is now leveraged throughout our enterprise for almost all applications performing member validation checks or returning member benefits. As a result of being able to leverage this work into other applications, we have realized significant cost savings. Therefore, the value has been and continues to be spread across the enterprise.

Our experience with CORE Phase I has been extremely beneficial in the transition to the new mandated Operating Rules. There were enough of us still around with the experience from the 2007 project that we knew we needed to begin work early on the Operating Rules project. We gained project approval in July 2011. Our project budget is $2.8M. For ease of implementation, we broke the project down into three manageable work streams. We implemented the necessary Eligibility changes this month for one of our adjudication systems. Development is underway for the remainder of our project and is on-track for a November implementation. From an enterprise perspective, timely completion of this project is critical because we have a very full plate, including ICD10, product enhancements necessary for the health benefit exchange, implementing new adjudication systems, additional Operating Rules and Health Plan ID.

BCBSNC currently has two EDI front-ends, as a result of a merger several years ago. To alleviate this redundancy, we have taken the opportunity in our Operating Rules project design to streamline the support of the HIPAA 270 and 276 transactions and receive/respond through a single front-end. This will simplify the EDI interaction for our trading partners, as well as reduce our administrative costs for these transactions. We also took the opportunity to start the transition to new EDI translation software as we are currently on a version that is going to be unsupported in 2017. This allows us to maximize our cost savings opportunities through architecture simplification.

BCBSNC does not currently offer real-time 276/277 capability. Therefore, the Claim Status changes represent new functionality for our local trading partners and will enhance our ability to meet our providers' business need. Clearinghouse or practice management vendor interfaces will be able to automate 'on demand' claim status inquiries and reduce customer service phone calls.

From a technical perspective for the real-time 276/277, we will leverage the connectivity channels built for our real-time 270/271 and the web services used for our batch 276/277 to streamline support and maintenance costs for this capability. One of our lessons learned with the implementation and subsequent growth of our real-time eligibility experience, is to utilize a governing device for real-time transactions that ensures system availability for all trading partners and does not allow one trading partner to consume all available system resources. Our internal goal is to have highly available systems that can be leveraged in our service-oriented architecture to reduce implementation costs for these capabilities in other applications, including provider and member portals, VRU, customer service, etc.

Regarding technical challenges, we are most challenged by the 86% availability requirement. This is because our claims adjudication systems are the source system for the eligibility and claim status data and the systems are not designed to be highly available. They are designed for batch processing with more loosely defined availability service levels and have traditionally operated in an 'online' mode during the day and a batch mode at night. To address the needs of the Operating Rules, we needed to build surrounding systems and services that enable 86% availability compliance, which has been challenging and resource intensive. We have worked closely with our technical teams on the system

design and more robust support processes to ensure our solutions support both the Operating Rule availability requirement, while continuing to support our enterprise needs for batch processing.

As we begin this transition to Operating Rules, it is important that we, as an industry, adhere to published compliance dates for Eligibility and Claim Status Operating Rules. Our mandate plates are overflowing. Any change of compliance dates only creates a domino effect, increases the cost of each project along the way, and damages our internal credibility when we are negotiating for over allocated resources—think of the little boy who cried wolf. We have already begun our project initiation process for HIPAA 835 and EFT Operating Rules, so if HHS is going to make a change to future Operating Rules compliance dates, we recommend that they make them at least one year in advance of the Compliance date.

We support the current CAQH CORE process for authoring Operating Rules. CAQH CORE conducts outreach to all industry stakeholders to encourage participation in establishing the rules. All stakeholders are encouraged to collaborate in the creation of Operating Rules that will further functional use of the transactions. If more than one entity is responsible for authoring the Operating Rules, we are concerned about the additional requirement of stakeholder resources that will be needed to ensure that we are actively participating in driving change.

While we are implementing our solution for Eligibility and Claim Status Operating Rules in 2012, we do not yet know what will be required for certification by 12/31/13. We participated in the development of the multi-stakeholder approach to CAQH CORE certification and believe that it is valuable. We have encouraged our trading partners to get CORE certified over the last five years and have been exchanging CORE Phase I compliant transactions for five years. We would like to encourage CMS to recognize CORE certification as being sufficient for certifying Operating Rules compliance for the Administrative Simplification certification requirement.

As an industry, we need to continue our education and outreach efforts to include all stakeholders. BCBSNC actively works with CAQH CORE and other industry groups to share our experience with implementing CORE Phase I. We will continue outreach with our trading partners and providers to ensure they understand our plans for meeting the mandated Operating Rules, what tools we have available, and that we understand their growth patterns to ensure that our systems will support the additional transaction volume.

We see demonstrated value and firm ROI from the current sets of Operating Rules. We recommend continued thoughtful evaluation of future operating rule opportunities. Our commitment to partner with all stakeholders in this process remains firm. We encourage all providers to expand their use of electronic transactions beyond claims and for clearinghouses/practice management vendors to expand the interfaces between their applications and the transactions to allow for seamless integration and use of the information. Otherwise, we will simply add costs and complexity to an already overburdened system and those costs are ultimately passed onto the consumers of healthcare.

Thank you for the opportunity to testify and I am happy to answer any questions.