TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

On

Healthcare Attachments

Presented by:

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BLUE CROSS AND BLUE SHIELD ASSOCIATION

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Good morning. My name is Gail Kocher and I am the Director of Industry Standards & eHealth for the Blue Cross and Blue Shield Association. BCBSA is a national federation of 38 independent, community-based and locally-operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for 100 million members – one-in-three – Americans.

On behalf of BCBSA and its member Plans, I would like to thank you for the opportunity to respond to the Subcommittee's questions and provide our perspective on healthcare attachments. While current operations for attachments vary somewhat from Plan to Plan, our comments provided below in response to your questions reflect a representative view of all Blue Plans.

Before going through each question, I would like to emphasize the following general issues that we believe are critical.

First and foremost, we believe strongly in the value of standardization. Rules for attachments that automate today's largely manual processes have the potential to generate significant savings. Further, we believe that the rules should apply not only to claims transactions, but also to referral and prior authorization, through a staggered implementation approach.

However, to realize the potential, we recommend:

(1) Building in flexibility to allow trading partners to mutually agree to alternative methods to exchange healthcare attachments.

(2) Putting limits on unsolicited attachments to avoid unnecessary work to manage and control unwanted and unnecessary documents.

(3) Planning extensive outreach to providers to encourage participation that will enable the realization of the full potential value.

(3) Sequencing the implementation of operating rules so that finalization of operating rules is sequential to and after finalizations of the transaction standards.

(4) Staggering the implementation of attachments for the referral and prior authorization (278) transaction and other business purposes after claims to limit operational overload.

These last two recommendations are emblematic of a larger issue, the huge volume of systems-related mandates bearing down on Plans, not only HIPAA but also the profusion of other requirements related to the Affordable Care Act (ACA). Therefore, we see the need for a strategic roadmap to balance all the coming mandates and ensure a smooth and successful implementation.

RESPONSES TO NCVHS QUESTIONS

What is the current state of industry with respect to the exchange of standard clinical information to support administrative or financial transactions?

The most common methods of requesting additional information are via letter, email or facsimile with the predominate method being letter. The most common way Plans receive attachment information is via hard copy reports or images, e.g.; x-rays, through the mail or other courier. In some instances, Plans receive reports or images via facsimile. A few Plans can accept attachments uploaded via internet portals as PDF documents. There is also limited use today of electronic transactions to transmit reports and images as JPEGs, within the ASC X12N *Additional Information to Support a Health Care Claim or Encounter* (275).

What problems or repercussions occur because of the current state? How would these be addressed if this process was standardized?

The issues most frequently mentioned by Plans are that the process of requesting and exchanging attachment information is labor intensive, takes too much time, and is difficult to manage. The handling requirements for hard copy documents are prone to error and often result in the need to request or prepare responses more than once. Even when there are no errors, the number of days required to complete the process results in payment delays, which in turn can increase the volume of service calls by both providers and members.

For this transaction, can we predict the technological state of the industry so that we adopt standard(s) that provide consistency, yet are flexible enough to take advantage of emerging systems and technologies?

To some degree we know that current standards and infrastructure will support electronic exchange of clinical information between payers and providers. What we know with less certainty are the alternatives that may be in place and easily adopted with respect to such exchange in 2016 and future years. Both technology and standards are rapidly changing and any rules promulgated for healthcare attachments should allow for flexibility in the use of new transport methods and document types. As long as trading partners mutually agree to alternative methods and remain compliant with base standards, those alternatives should be permissible under the rules (for example, agreeing to use of LOINC Codes as an external code set for healthcare attachments).

With regard to claims attachments or attachments in general, what is the role of operating rules in relation to the transactions, i.e. what problems could they solve? What problems do they create? How can the process of development be improved?

Operating rules should both promote wider adoption through greater uniformity among all trading partners and greater consistency in operations once they are implemented. While certain rules can be based on those adopted for other transactions such as base line “safe harbor” connectivity, system availability, response time and performance in general; other rules may need to be specific to the transaction such as unique requirements for unsolicited attachments. We support the development of a unique set of healthcare attachment operating rules through an industry-wide collaborative process. However, in our view, in order to avoid potential conflicts a final set of standards needs to be adopted prior to completion of a complete set of operating rules for healthcare attachments.

Overall, what would you say are the most significant benefits we should expect to see (i.e. efficiency, quality, safety, economic, other) that we can rely on to monitor progress and measure success? Where do you think would benefit realization be most challenging?

Success metrics could be based on the elimination or reduction of known issues or improvement in existing performance measures. If for example, a certain percentage of attachment types require more than one request we would expect that percentage to go down with greater automation and this is something that is measurable. The length of time to complete or finalize claims that require additional information would be another meaningful measure of success. Accuracy based on statistical sampling could also be used to monitor progress.

What are your current costs (estimate) associated with the exchange of clinical information to support financial and administrative transactions?

While we do not have specific absolute or unit costs available to report to you, we know that Plans realize significant costs in several areas. Labor costs associated with manual requests and document handling for both request and receipt of attachments generates a high percentage of current operational costs. Other than labor, costs are incurred for postage or courier services.

If clinical information in support of administrative transactions was exchanged electronically, what are the estimated costs and savings? In what areas, would you realize these costs and savings?

Costs savings can be achieved through greater automation and standardization through either cost reductions or cost avoidance. However, the level of such savings for payers will be largely dependent on the level of participation by the provider community. We would expect cost reductions for labor and postage and costs avoidance through the reduction of both service calls and redundant work due to lost or misplaced documents. In addition we would anticipate that improved customer relations, whether provider or member, due to timelier processing might also be a valuable consequence of greater automation based on standard document types.

How would use of existing infrastructure or planned infrastructure that will be in place by 2016 impact costs and savings?

We would categorize the use of existing infrastructure as cost avoidance as opposed to cost savings. If providers and payers could use the same basic infrastructure to exchange healthcare attachments as they use for claims and other mandated transactions, there would be no need to expend additional resources to implement a new infrastructure for healthcare attachments. Whatever combination of standards are adopted for healthcare attachments should be implementable within our current infrastructure, but should not preclude other methods for those trading partners that choose and mutually agree to develop and implement alternative methods.

With respect to operating rules, what areas related to attachment transactions do you see are most important to address through the creation of operating rules?

As we indicated in response to the previous operating rule question, operating rules can address important issues such as connectivity, system availability and performance measures such as timing of responses from request to delivery. The need for other rules specific to the transaction type such as unsolicited, items that may require more than one request and others should become more evident once final standards have been specified for adoption. An operating rule for document quality and readability for unstructured documents might also prove valuable.

Are the current set of standards (and operating rules) you have heard about applicable only to claims attachments, or will they be applicable also to other types of attachments?

Healthcare attachment standards that either currently exist or are close to SDO approval could be used for additional requirements for transactions other than claims. Within the current suite of transactions required under Administrative Simplification provisions, additional information required in order to respond to a prior authorization request would seem to be supported by a combination of ASC X12 and HL7 standards. However, while we support the development and use of such standards for multiple purposes, we would caution against having use of such standards for multiple purposes mandated at the same time as claims attachments. The ACA mandates that Plans implement claims attachments by January 1, 2016. Any requirement to implement attachments for other transactions should be staggered one or more years later.

What are some of the most important business and technical issues surrounding attachments for providers, health plans and vendors, and how would you recommend addressing them?

Attachment standards and operating rules introduce the use of clinical document formats and code sets that are new to most payers. Attachments also introduce a variety of concepts around the exchange of clinical and administrative data, among them: structured and unstructured data, multiple uses for clinical information beyond support for claim payment envelope and transport delivery options and greater automation surrounding unsolicited attachments.

The last issue, unsolicited attachments, warrants particular attention because allowing unsolicited attachments outside of trading partner agreements would unnecessarily impose additional administrative burden on payers. Payers would need to develop new administrative procedures to receive, store, protect or dispose of potentially large volumes of PHI/PII for which they have no need. Payers also would face challenges marrying the unsolicited attachment, a separate transaction, with the appropriate claim in the adjudication system. For example, if the inbound claim is rejected prior to entering the adjudication system, the unsolicited attachment data would have nothing to match it back to. These are additional concerns that must be addressed in any implementation of unsolicited attachments and are unique to the unsolicited process.

Providers who send unsolicited attachments outside of trading partner agreements would bear a greater burden to document compliance with minimum necessary standards than if sending unsolicited attachments as part of a trading partner agreement. Trading partner agreements outlining when unsolicited attachments are appropriate would give providers guidelines to justify disclosing the protected health information to a health plan for payment.

Getting started with basic requirements that show immediate positive results will be a key first step. As evidenced by the 2005 CMS Electronic Claims Attachments Pilot, immediate cost and performance improvements were realized using a very basic approach for requesting and receiving claims attachments. Once there is wide adoption of the basic standards within the industry, we will be better positioned to take greater advantage of the standards through enhanced automation made possible by structured documents. This approach should not preclude immediate adoption and implementation of greater automation for those that are willing and capable to do so immediately. Also, as we have previously stated in prior comment letters and testimony, we believe the use of unsolicited attachments should be based on mutual trading partner agreement and not mandated by rule.

CONCLUSION

BCBSA supports the adoption of standards and operating rules for healthcare attachments. We recognize the potential value of their use with respect to reduced costs, greater quality and improved customer satisfaction. However, we caution against rulemaking that would require the adoption of more than claims attachments as specified in the ACA. We see the need for a basic set of requirements that will promote adoption, but at the same time permit other uses and more sophisticated automation. Also, while some concurrent development of standards and operating rules seems reasonable, we would recommend the finalization of operating rules should be sequential to and after finalizations of the transaction standards and that implementation time lines be adjusted accordingly. BCBSA recommends that the implementation of all federal mandates, including claims attachments, be approached in phases to address these many aspects.

Given the number of mandates with an implementation date of 2016, we encourage CMS to consult the National Committee on Vital and Health Statistics to develop a strategic road map for Administrative Simplification provision implementations. This road map should balance all mandates from the ACA, not just Administrative Simplification provisions, along with other ARRA/HITECH mandates to work towards avoiding bottlenecks and overlapping resource commitments. We would also request that the NCVHS work with industry stakeholders in developing this road map.

We appreciate the opportunity to testify and I would be happy to answer any questions.