



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

On

Health Care Attachments Transaction Standard

Presented by:

Gail S. Kocher, Director, National Programs

BLUE CROSS BLUE SHIELD ASSOCIATION

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Good morning. My name is Gail Kocher and I am a Director, National Programs for the Blue Cross Blue Shield Association. BCBSA is a national federation of 37 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 Subcommittee questions and provide our perspective on attachments. While attachments are ultimately a local Plan business decision, our comments provided below in response to your questions reflect a representative view of all Blue Plans.

As we have testified before the Subcommittee previously on attachments, today I would like to summarize a few key points and then focus on one question in particular. First and foremost, we continue to strongly support standardization, which brings value to all stakeholders within our industry. Rules for attachments that automate today's largely manual processes have the potential to generate significant savings for all stakeholders. Further, we support the rules being applied not only to claims transactions, but also to referral and prior authorization, through a staggered implementation approach.

Our recommendations to enable the realization of these goals remain largely the same:

- (1) Build in flexibility that allows mutually agreeing trading partners to use alternative methods to exchange healthcare attachments.
- (2) Standards, protocols and rules for health data exchange should be fully open and supportive of data portability and interoperability.
- (3) Put limits on unsolicited attachments which avoids unnecessary work in the management and control of unwanted and unnecessary documents.
- (4) Plan for extensive outreach to providers which encourages participation to enable the realization of the full potential value.
- (5) Sequence the implementation of operating rules so that finalization of operating rules is after finalization of the transaction standards.
- (6) Stagger the implementation of attachments for all other uses after the claim, i.e. the referral and prior authorization (278) transaction and other business purposes, to limit operational overload.

The larger issue is the huge volume of systems-related mandates and the profusion of other requirements, as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Affordable Care Act (ACA), bearing down on not only Plans but providers and other trading partners as well. Therefore, we continue to see the need for a strategic roadmap to balance all the coming mandates and ensure a smooth and successful implementation.

Our industry is at a point where the exchange of both administrative and clinical data is critical to driving towards quality and cost improvement. As part of this, the industry is moving towards different provider relationships where everything is patient-centric and the provider needs more data to manage care and engage the patient. As part of reaching this goal, the exchanging of administrative and clinical data is new to most payers and introduces a variety of concepts around this data exchange, which is key to successful implementation of quality and cost improvement programs. It is important to consider the administrative impacts and burdens of data exchange to both payers and providers. The need for data must balance the requirements under HIPAA for minimum necessary documentation and privacy and security.

Examples of newer, innovative programs are coordinated care models such as Patient-Centered Medical Homes (PCMHs) or Accountable Care Organizations (ACOs) which protect our members through a safe, affordable and quality-driven care program. Data exchange between our Plans and the PCMHs and ACOs is at the core of these models, enabling physicians and hospitals in a wide range of capabilities including medication management, identifying gaps in care, clinical decision support, disease registries and reminder systems. Clinical data such as pre-service, admissions, discharge notifications along with case management and disease management notifications, is needed by the provider to whom a member is attributed when other providers are involved, in order for the provider to coordinate the member's total care. Care coordination member data includes information standard to the exchange of pre-service, admission and discharge notifications, such as member demographic data, diagnostic and procedure data, care date(s) and authorization information when applicable. This exchange of data enables a member's PCMH or ACO to continue to better coordinate care when the member receives services outside of their attributed arrangement.

PCMH models rely on a team coordinated by a primary care physician (PCP) that takes collective responsibility for patient care, and when appropriate, arranges for care with other qualified physicians as defined within the health plan's program. The patient has an ongoing relationship with the PCP. This offers patients accessible, continuous, coordinated and comprehensive patient-centered care. An ACO is a group of healthcare providers that agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their patient populations. ACOs are typically, but not universally, hospital based. These models rely on the exchange of patient data, both administrative (member and claim) and clinical data. BCBSA member Plans support these models by enabling clinical data exchange of relevant member personal and health data information. The information is made accessible at the times and places where clinical decisions will be or are likely to be made. This timely exchange helps clinicians, patients and payers make the best possible clinical and administrative decisions. By supporting providers with a meaningful exchange of data, all stakeholders become more accountable stewards for the quality and safety and bring greater value to the healthcare system.

## **CONCLUSION**

BCBSA supports the adoption of standards and operating rules for healthcare attachments. We recognize their value in achieving the overall goal of quality and affordable healthcare. Affordability and quality necessitates the exchange of patient information. It enables providers to have a 360-degree patient view and allows our Plans to conduct predictive modeling and identify gaps in care. This data exchange is a value to our industry but collectively we need to proceed with care and caution to the end goal of improving population health. The barriers should not prevent forward movement towards the ultimate goal.

Given the number of mandates with an implementation date of 2016, we continue to 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 such a road map.

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