

April 3, 2015

Karen DeSalvo, MD, MPH, MSc  
National Coordinator for Health Information Technology  
Office of the National Coordinator for Health Information Technology  
Office of the Secretary, U.S. Department of Health and Human Services

Re: *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap*

Dear Dr. DeSalvo:

The CAQH CORE Board of Directors is pleased to offer comments on the above-referenced *Interoperability Roadmap*. CAQH CORE brings providers, health plans, healthcare clearinghouses, government agencies, banks, standards development organizations, and vendors together to collaborate on achieving a trusted, simple, and sustainable healthcare data exchange that evolves and aligns with market needs. Its mission focuses on driving development and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, payers, and consumers. CAQH CORE Operating Rules have been adopted as federal requirements for health plans, clearinghouses, and providers.

CAQH CORE supports the vision of the *Interoperability Roadmap* that there needs to be a public-private approach to achieving nationwide interoperability. We agree that there has been “progress in the digitation of the health experience” and that “new technology is allowing for a more accessible, affordable, and innovative approach.” We also agree that “barriers remain to seamless sharing and use of electronic health information,” and the need for motivating the use of standards, and creating a trusted environment for the collection, sharing, and use of electronic health information.

In addressing some of the key questions asked in the *Interoperability Roadmap*, CAQH CORE recommends that the *Interoperability Roadmap* be revised to:

1. **Explicitly state how ONC will work with other HHS agencies to address the “intersection of clinical and administrative electronic health information.”** The *Interoperability Roadmap* describes this intersection as a “critical consideration” but out of scope and deserving of “separate, dedicated attention.” However, one of the key topics in the *Interoperability Roadmap* is “supportive business and clinical environments” and key actions for this area include that CMS will aim to administer 30 percent of all Medicare Payments to providers “through alternative payment models that reward quality and value” by the end of 2016, and 50 percent by the end of 2018. Additionally in the *Interoperability Roadmap* there are six use cases that specifically address the need for clinical and financial data interoperability/administrative simplification, and five more use cases that indirectly relate to such interoperability.

Market need for clinical and administrative electronic health information interoperability is present today. For example, some of the Pioneer accountable care organizations (ACOs) have not succeeded because they could not get quality and cost data together (including from CMS) on a timely enough basis to impact decisions at the point of care – exponentially increasing provider and patient risk. Experience has also shown that addressing such interoperability now is essential to avoiding difficult and costly retrofitting of technology later.

Not addressing the intersection of clinical and administrative electronic health information precludes the ability to achieve and “reward quality and value.” The report should reflect the need to address the intersection in a coordinated manner. This will require ONC to collaborate with CMS, which oversees administrative data needs, other federal agencies and departments, and private sector stakeholders in this effort. CAQH CORE has had clinical and administrative alignment as a key operating rule criteria since its inception. This priority has led CAQH CORE to prioritize requirements for its operating rules to be based on their ability to both meet administrative business needs, and align with efforts in the clinical arena. For example, the operating rules require: real-time eligibility responses for key services for which the delivery of electronic clinical data is occurring, use of common codes to report claim processing issues that are related to clinically-related attachments, and the offering of technical standards like SOAP, which are supported by Meaningful Use. The nation must take advantage of

aligning health information technology (HIT) efforts so that progress can be made more quickly, and that resources are used in the most effective way.

2. **Ensure that rules of engagement and governance apply to all stakeholders.** It is recognized that achieving interoperability is challenging, and that a coordinated governance process may be even more challenging to achieve. Levers such as those identified in the *Interoperability Roadmap* can certainly help bring stakeholders together. However, all stakeholders, including government and the private sector, must share the responsibility for creating the requirements. They must also be held accountable for using the requirements, including standards, or trust and investment will erode. To have the private industry fully resonate with the ONC message on the need for “a single coordinated governance process,” HHS must align its governance approach to demonstrate the power of having a “single coordinated governance process.” By demonstrating this, HHS can help the private sector work towards more quickly achieving a “single coordinated governance process,” including models for how governance and funding can be separate in composition, yet complementary.

As a tactical example, the *Federal Health IT Strategic Plan 2015-2020* recognizes the need for critical building blocks such as common data standards and definitions, security, authentication approaches, and certification. Currently there is a lack of uniformity across different federal departments and within HHS in many of these areas, as well as across clinical and financial domains in the industry at large. In our comments on the *Federal Health IT Strategic Plan*, CAQH CORE highlighted a seemingly simple example of cost and quality issues arising from the lack of precise data definition in the spelling of HbA1c. Commercial labs have testified to the National Committee on Vital and Health Statistics (NCVHS) that there are more than twenty ways to spell or abbreviate this common lab test. The result is added cost to process the data, potential confusion within electronic health record (EHR) systems and in claims adjudication systems, as well as potential negative impacts to audit processes, public health reporting, and research. HHS can align its governance and agency-specific resources to ensure a common approach is taken, thus setting the baseline for collaborative governance.

A strategic example of a federal alignment opportunity that would contribute to achieving clinical and administrative electronic health information interoperability is for ONC to contribute its available resources to support the ACA Review Committee<sup>1</sup> work being overseen by NCVHS. Currently the effort is not well funded, but is very important in creating a nimble maintenance process for administratively focused HIPAA transaction requirements. Such support would help to ensure alignment between electronic clinical information and administrative data needs such as for claims attachments, and ultimately data associated with the claim to support value-based payment models. Uniform and collaborative approaches must be supported across all of HHS or the burden on providers and health plans as well as other stakeholders to reach the larger vision of interoperability, and its related milestones, will be a massive barrier to success.

3. **Work with sustainable business environments to tackle specific tactical and technical areas outlined in the *Interoperability Roadmap* rather than create new and potentially duplicative efforts.** CAQH CORE requests a meeting with ONC to share the current status of our efforts, and lessons learned in creating a collaborative environment between administrative and clinical stakeholders – including where specific metrics of success were outlined and success has been clearly demonstrated. CAQH CORE has created a trusted environment in an arena where lack of trust has been the hallmark. It initially did so on a voluntary basis before there was a Federal mandate, and has made a commitment to focus on voluntary national operating rules when future mandates are not anticipated. This experience is illustrative of approaches that can create impactful change with no incentives other than common mission and vision, and a determination to focus resources to attain systemic improvement.

CAQH CORE has been able to successfully build collaboration among vendors, providers and payers because it has key decision makers as well as implementers at the table. There are a number of tactical goals in the *Interoperability Roadmap* where CAQH CORE can accelerate alignment, add value, and share lessons learned. Examples of the specific technical areas include:

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<sup>1</sup> ACA Sec. (1104(b)(5)(i)) requires HHS to establish a Review Committee no later than January 1, 2014 to advise HHS on evaluation and review of the adopted standards and operating rules. NCVHS was designated the Review Committee in 2015.

- *Secure network infrastructure including standards-based authentication:* Since its inception, CAQH CORE operating rules have included a requirement for entities to offer a method to connect securely using best practices such as digital certificates and recognized connectivity such as SOAP. This “safe harbor” doesn’t require disconnecting other methods; rather it encourages evolution in trading partner offerings that are non-proprietary and best practice.
- *Multi-stakeholder certification and testing:* Achievement of the CORE Seal means that an entity has conducted interactive testing with a recognized external testing body and has submitted an application requiring executive-level engagement and trading partner coordination. Nearly 200 CORE certifications have been awarded, and new approaches for adoption are being promulgated. As an example, providers and health plans are proactively requiring CORE Certification in their vendor contracts.
- *A shared framework for expectations relating to data, definitions, and response time:* Mandated CAQH CORE operating rules are setting expectations in each of these areas such as real-time and batch processing turnaround times, supporting greater use of existing content standards such as remittance codes and meeting basic business needs such as transaction acknowledgements to manage data processing.
- *An integrated education/outreach model that focuses on lessons learned by early adopters:* In 2014 alone, over 15,000 individuals registered for free CAQH CORE education sessions. These individuals and others have also downloaded a host of easy-to-use implementation support tools. Where most other organizations charge for such services, CAQH CORE makes these services available at no charge to the public as a result of the investment made by its participants to drive overall industry adoption.
- *Tracking measures that assure a feedback mechanism to learn what is working and what is not working:* Qualitative and quantitative results are tracked and reported by a wide range of organizations through objective, third-party studies as well as through data submitted by participating entities.

The demonstrated results of CAQH CORE provide concrete examples of how to align organizations, build trust in a competitive environment, and truly promote a learning health system.

CAQH CORE is very supportive of the larger national vision of a learning healthcare system. In such an environment, lessons learned are extremely important, as are guiding principles, metrics for success, and tracking processes that provide feedback mechanisms. Successful cross-industry IT efforts in healthcare and other industries have been predicated on market leaders – often with conflicting perspectives – coming together to address specific, focused business needs. To achieve the interoperability needed for a learning health system, we urge you to incorporate expectations in the *Interoperability Roadmap* for the various HHS owned clinical and administrative health information efforts to align, and then seek federal and private sector collaboration to achieve those expectations.

Sincerely,



George Conklin  
Senior Vice President and Chief Information Officer, CHRISTUS Health  
Chair, CAQH CORE Board



Gwendolyn Lohse  
Managing Director, CAQH CORE  
Deputy Director, CAQH

CC: CAQH CORE Board of Directors