

March 15, 2010

**Submitted Electronically and By Hand**

Charlene Frizzera, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

**Re: Medicare and Medicaid Programs; Electronic Health Record  
Incentive Program; Proposed Rule (CMS-0033-P)**

Dear Acting Administrator Frizzera:

The Council for Affordable Quality Healthcare (CAQH) is a nonprofit alliance of health plans and trade associations and serves as a catalyst for industry collaboration on initiatives that simplify healthcare administration. CAQH solutions promote quality interactions between plans, providers, vendors, and other stakeholders, reduce costs and frustrations associated with healthcare administration, facilitate administrative healthcare information exchange and encourage administrative and clinical data integration. The recommendations put forth in this comment letter have been informed by the experience of CAQH deploying multi-stakeholder, national, health information technology (HIT) initiatives and tracking their impact across a range of stakeholders. Two notable examples include:

- Universal Provider Datasource<sup>®</sup> (UPD) has streamlined the country's provider data collection process associated with credentialing healthcare providers, directory maintenance, claims administration and quality assurance. It is used by over 800,000 providers and over 550 private/public organizations, ranging from state Medicaid plans, large integrated hospitals and private national and regional health plans. UPD has reduced provider administrative costs by over \$92 million per year and has eliminated more than 2.36 million legacy paper applications.
- Committee on Operating Rules for Information Exchange<sup>®</sup> (CORE) has brought together over 115 organizations to implement the exchange of administrative data through a set of phased requirements. CORE is a national, vendor-neutral initiative that makes it possible for any provider to access consistent and reliable insurance coverage and payment information from any health plan electronically, using the technology of the provider's choice. To meet our commitment to quantifying the impact of CORE, a study conducted by IBM Global Services

tracked outcomes affecting over 33 million lives in various provider settings with a range of HIT tools. Results show that providers are saving millions of dollars due to increased efficiency and relying upon CORE-certified vendors to ensure expected benefits occur. Moreover, these providers have increased their adoption of HIT by 33%, a critical indirect benefit.

CAQH commends the significant federal investment in supporting provider adoption of electronic health records (“EHR”) and the thoughtful work of CMS in establishing criteria to define “meaningful use” that will enhance the interoperability, functionality, utility and security of health information exchange (HIE) while also improving health quality and efficiency. CAQH fully supports the phased approach proposed by CMS, in which a range of complementary requirements become more robust over time, and believes this approach to be an effective framework for meeting the long-term policy goals of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Specifically, based on its experience, CAQH strongly supports federal policies that reflect the following three principles:

1. Support for the inclusion of administrative transactions in Stage 1 requirements and acknowledgment of the critical role administrative data plays in realizing the objectives of “meaningful use.”
2. Support for a Stage 1 outcomes reporting process with clear and simple incentive metrics, collection, and reporting processes, as well as incentive requirements that recognize the transformational aspects of Stage 1.
3. Support for staged approach to HIT implementation that signals a trajectory for future meaningful use criteria, thereby encouraging and enabling market readiness for Stage 2 and Stage 3 requirements.

While CAQH recognizes that Stage 1 criteria are aggressive, we believe the proposed requirements also are rational and we applaud the inclusion of metrics tracking that can be used to openly communicate progress toward, and impact on policy goals. We also believe, however, as described more fully in the comments below, that the final rule could be improved with some clarifications and adjustments.

### **Recommendations**

***Recommendation: Maintain electronic verification of insurance eligibility and electronic submission of claims in the Stage 1 requirements, while clarifying that both integrated and outsourced processing methods are valid (Section II.A.2.d of the proposed rule; Proposed 42 C.F.R §§ 495.6(c)(11), (12)).***

Rationale:

**Administrative data are critical to realizing policy priorities of CMS.**

- ***Administrative data are essential to “meaningful use.”*** To create the foundation required for improved quality and efficiency, better care coordination, and increased patient engagement, administrative data interoperability needs to be linked to “meaningful use.” Administrative data provide visibility and transparency into the cost-effectiveness of quality care delivery and are also required to understand the cost of specific treatment modalities and achieve a value-driven system.
- ***Standardized administrative data exchange produces real and tangible return on investment (ROI).*** The 2009 CAQH-sponsored IBM study demonstrated that considerable benefits, potential savings, and ROI result from the adoption of such data. Results showed that such adoption leads to decreased claim denials and faster turnover of accounts receivable for providers. Specifically, the study demonstrated that claim eligibility denials were reduced 10-12% and that providers saved on average \$2.60 per electronic eligibility verification due to reduced time spent on verification. This study tracked data from a wide range of providers including Cedars-Sinai Health System, Duke Health System, Eastern Carolinas University School of Medicine, Montefiore Medical Center, Pinehurst Surgical Clinic and individual providers working with various vendor systems.
- ***Operating rules support data use goals as envisioned by the HITECH Act.*** Those providers and health plans that use the CORE rules will see greater ROI. CORE has brought together over 115 organizations to implement the exchange of administrative data through a set of phased requirements. The CORE rules fill in the gaps not addressed by the HIPAA transaction standards for eligibility verification, with Phase I starting with eligibility and later phases moving to other transactions and adding to eligibility. Health plans that become CORE-certified agree to report additional data, including patient financial responsibility information (e.g., cost-sharing and deductibles), in response to provider queries. The CORE rules also establish standardized infrastructure definitions and business requirements (e.g., timely response, connectivity rules). Interoperability depends on clear definitions of, among other things, the rights and responsibilities of all parties, security, transmission standards and formats, response time standards, liabilities, exceptions processing, and error resolution – and the CORE rules, with each phase, help to support the move to this process and are aligned with national efforts such as HITSP. As you are aware, the Office of the National Coordinator for Health Information Technology (ONC), in its Standards and Certification Criteria Interim Final Rule with Comment (IFR), recommended adoption of the CORE Phase I operating rules as the implementation specification for eligibility transactions.

- ***Stimulus dollars alone will not cover the cost of realizing meaningful use.*** Until clinical data become more readily available, robust and easily exchanged administrative data remain a key source of information with which to evaluate the quality of care and care delivery processes. This ongoing ROI is needed to support the success of the EHR Incentive Programs. As captured in the IBM study, administrative simplification allows providers to reduce the time spent on registration and billing activities, thereby leaving them more time to focus on the quality of care delivery. In the near- and medium-terms, the use of administrative data represents an essential and available migration path to the eventual marriage of clinical and administrative data to realize the vision of a value-driven healthcare system.
- ***The integration of administrative and clinical data has significant implications for patient engagement.*** These data can allow consumers to more thoroughly understand their healthcare and more effectively participate in self-management regimens, provide feedback on care experience, and ultimately assist patients in evaluating information on the cost and quality of care provided by physicians, hospitals, or other providers. This range of information is essential to a value-driven healthcare system.

#### **Administrative data platforms vary widely throughout the industry.**

- ***Administrative data are often collected and managed outside an integrated EHR.*** A variety of tools currently exist for eligible professionals (EPs) and hospitals to electronically conduct the two proposed meaningful use administrative transaction requirements. While there are many examples of integrated EHRs currently deployed, a number of EHRs are not designed to manage administrative data and few have addressed the necessary role of enabling exchange with practice management systems (PMS). This lack of focus on PMS integration has been and will continue to be a key concern of providers. For example, the American Society for Quality recently began leading a project with representatives of CAQH, the American Medical Association (AMA), and the Medical Group Management Association (MGMA) to focus on the need to engage vendors in changing this area, even though vendors are not covered entities under HIPAA. HIPAA does not regulate PMS tools or integration; therefore the vendor systems used to electronically conduct administrative transactions are not standardized and span a spectrum of integration levels: some providers use EHRs that directly carry out these transactions; other providers use systems that interface to the financial system given the business value of coordinated data activities such as validating billing codes with provider documentation or identifying referral networks/participants; and many EPs and hospitals outsource electronic claims and eligibility transactions to third-party clearinghouses. This integration is not unique to administrative transactions. For example, some e-prescribing systems are integrated, while others are not.

***Upgrading technology applications is costly and takes time.*** CAQH frequently receives requests from providers (e.g, University of Miami, University of Maryland, smaller provider practices) seeking assistance on how to encourage their vendors to

become CORE-certified. These vendor systems typically will not give the provider a timeline for the change or provide an understanding of the potential charge for the upgrade that would include CORE-required data fields, such as in/out of network variances in patient financial responsibility, which are or will be provided in less than a year for over 85% of the commercially insured population and many of the state Medicaid programs that are managed by private insurers. Transactions conducted by and interacting with the EHR all need a set of definitive based requirements so that efficiencies and data analysis can occur in a more streamlined manner.

#### Detailed Recommendations:

- CAQH recommends that CMS clarify in the final rule that under the incentive program, electronic verification of insurance eligibility and submission of claims can occur through the use of an integrated module of a certified EHR, a financial/billing system with an interface to a certified EHR, or via an agent with whom an EP or eligible hospital has contracted with for outsourced claims processing services. Other stand-alone systems such as e-prescribing may also have similar transformational challenges that require milestone-driven change and, certainly, adjustments to address current provider contracts.
- Given that Stage 1 is a transformative period for many providers, the rule should reflect that some providers will continue to use clearinghouses throughout Stage 1, and ensure that Stage 1 incentives are not impacted for these providers as long as any integrated, interfaced, or outsourced solution a provider relies upon complies with data interchange standards and implementation requirements set forth in the ONC's standards IFR. Further, such clarification will encourage vendors to offer solutions to providers that integrate vendor modules.

***Recommendation: Require providers to report to CMS performance against functionality measures, but lower thresholds given Stage 1 is a transformational period aimed to move the industry towards meaningful use. Also reduce administrative burden of metrics tracking and reporting given Stage 1 will have many lessons learned regarding how best to collect and then publicly post provider performance information (Sections II.A.2.d and II.A.5 of the proposed rule).***

#### Rationale:

**The story of successes and failures of Stage 1 will inform future debate.**

- ***Measurable objectives are essential to assessing progress and planning for the future.*** CAQH supports the CMS proposal to establish clear thresholds for the meaningful use measures and to require providers to report their performance against the HIT functionality measures. This will allow HHS to use these data to generate

insights into best practices and providers' progress toward meeting the overarching policy goals of the HITECH Act.

- ***Transparency and public reporting are critical to program success and shared learning.*** Efforts around public reporting of healthcare costs and quality to date has helped providers improve by enabling them to benchmark their performance against other providers, encourage private insurers and public programs to reward quality and efficiency, and help patients make informed choices about their care. Public reporting also helps inform sounder public policy. In order to foster true transformation, data – and public access to that data – is essential. As hospitals and EPs will be receiving federal monies to support EHR adoption, we urge CMS to build processes that ensure timely and transparent reporting of provider attestations so that the stakeholder community can collectively analyze and debate the successes and challenges of the programs and open a public dialogue on best practices to move forward. Such reporting would also allow necessary transparency regarding lessons learned in how to track and report on the impact of the EHR Incentive Program, including which metrics to apply and best practices for data collection processes; and will demonstrate the qualitative and quantitative benefits of EHR use in a way that will enable industry support and consequent system transformation.

**The proposed Stage 1 criteria may result in unintended barriers to success.**

- ***“All or Nothing” may equal nothing.*** We are concerned that the high bar for achieving “meaningful use” and the number of requirements included in the proposed rule will severely limit healthcare providers’ ability to access the critical resources allocated by HITECH for the more widespread adoption of health information technologies. With the program beginning in less than a year, very few providers – as they must rely on their vendors and then changing their work flow - will be able to meet the proposed “all-or-nothing” approach, even if they have adopted or are adopting EHR systems. Further, many providers have not been able to start an EHR implementation project because they have not had access to funding or necessary personnel.
- ***Providers need time to effectively prepare for meaningful use.*** Through its CORE initiative, CAQH is quite familiar with the realities of the amount of time it will take providers of all sizes – from the smallest practice to the largest hospital – to efficiently prepare to prove “meaningful use” and the challenges they will face in meeting the proposed measure threshold requirements. Vendors must first adjust their systems and roll them out to providers, and providers must then undertake the arduous and complex task of integrating these new tools into their daily workflow processes. Based on our experience with CORE, this process would take, on average, a minimum cycle of 10 months, and would be greatly impacted by the unique contractual adjustments for adding new functionality between the provider and vendors. Moreover, the proposed meaningful use requirements touch upon different

aspects of the overall provider office/station workflow, further complicating this task. In addition, many of the metrics will need to be reported via an attestation method that requires human resources, placing a resource intense burden on EPs and hospitals – and this will hold true until metric reporting can be fully automated via agreed upon standards and processes.

- ***Threshold requirements are overly aggressive - providers will face operational and market challenges with HIT adoption – as expected exceptions will be uncovered.*** While we are highly supportive of tracking performance against specific measures to reach broader objectives, we are concerned that many of the thresholds proposed in the NPRM are too high to be realistically achieved for Stage 1 and, as such, may have the opposite effect of that intended and discourage adoption. The thresholds proposed overestimate the ability of current systems to support providers as they seek to integrate ambitious new EHR capabilities into their clinical routines and daily workflows and do not take into account the operational and market realities of information technologies.

As with any major IT implementation, an EHR system implementation requires a significant time and resource investment in planning, technology acquisition, installing, testing, training and workflow redesign. It will be extremely difficult, if not impossible, for providers to go from “zero to 60%” out of the gate (or in the case of many measure “zero to 80 %”).

It is inevitable that providers will face operational and technical challenges outside of the provider’s control, such as power outages, bugs or viruses in the system, system upgrade quirks, and maintenance needs that require the system to be offline. The thresholds need to be structured in a way that allows some flexibility and does not penalize providers for operational problems.

Further, while the EHR incentives promise to significantly impact hospital and physician EHR adoption in a very positive way, the healthcare industry at-large is not beholden to the meaningful use criteria. This said, as providers move toward greater connectivity and use of standard metrics due to meaningful use, the market will undoubtedly begin to respond – but that will take time on all sides and thresholds should acknowledge this. For example, clinical transactions may be impacted by current vendor contracts, and or self-insured employed programs related to quality metrics. Another example, administrative transactions are not fully carried out electronically in some market segments, e.g. worker’s compensation, given the unique aspects of certain market segments. Adding additional complexity, many states have their own laws restricting what types of health information can be reported. The meaningful use measures and their associated thresholds should focus on furthering the goal of broader EHR adoption, yet be sensitive to market-limiting factors, some of which will be uncovered during Stage 1 roll-out.

In combination, these operational and market challenges are likely to make use of an EHR impossible in more than 20% of a provider's patient encounters – thus making unrealistic achievement of the 80% thresholds CMS has proposed for many of the Stage 1 measures.

**Attestation and reporting may present technical challenges.**

- ***Data collection capabilities are varied.*** Based on the CAQH experience with tracking ROI, there are extremely varied capabilities in the market with regard to data collection, especially given that the majority of EHR vendor systems do not currently have the functionality to assist with metrics tracking and, if and where this functionality does exist, it may not meet meaningful use definitions that still have to be interpreted by the market, and interpretations will vary. Additionally, skill sets to achieve this type of tracking are very limited, and this limitation is even more extensive in the provider setting.

**CMS should recognize those that are ahead of the curve.**

- ***Recognition is a key factor for program success.*** While we support an overall lowering of threshold requirements in order to incentivize a broader group of providers, CAQH believes in recognizing achievement and fostering advancement. Organizations such as the National Committee for Quality Assurance (NCQA), the Leapfrog Group, the Magnet Recognition Program of the American Nurses Credentialing Center's (ANCC), the Health Information Management and Systems Society (HIMSS) Analytics EHR Adoption Model, and the Baldrige National Quality Program among many others, have demonstrated that public recognition of outstanding achievement promotes innovation and provides a platform for shared-learning of best practice. CMS has an opportunity to raise the bar through recognition.

**Detailed Recommendations:**

- CAQH recommends that CMS adopt its proposal to require providers to report their performance against the HIT functionality measures.
- CAQH recommends that CMS develop a transparent, web-based system for timely public reporting of measures and overall results.
- CAQH urges CMS to re-evaluate the “all-or-none” payment approach included in the proposed rule and allow EPs and hospitals to qualify for the incentives if they prove they have achieved a sufficient component of the requirements versus all of the requirements.



- CAQH recommends that CMS consider lowering the thresholds for meeting meaningful use measures.
- CAQH recommends that CMS establish programs for training providers with respect to attestation and reporting and enable providers to make test submissions prior to their EHR reporting periods.
- CAQH recommends that CMS consider creating a public recognition program for advanced achievement in meaningful use of EHR technologies.

***Recommendation: Maintain staged approach to meaningful use requirements while providing more specific rationale for how Stage 1 requirements support improved health outcomes and encourage market readiness for future stages by outlining more detailed trajectory for Stage 2 and Stage 3 requirements (Section II.A.2.d of the proposed rule).***

Rationale:

***Greater insight will promote better planning.***

- ***Stakeholders would benefit from understanding the direct linkage between Stage 1 objectives and the overall vision.*** CAQH appreciates the vision of requirements scaling up over time with emphasis on data aggregation, population health, care coordination and patient and family engagement. We strongly support the concept that a foundation is needed, and that Stage 1 is the place to set the foundation. The overall transformation envisioned by the EHR Incentive Programs can happen only if the stages of meaningful use are ambitious enough to bring about tangible change to the marketplace. However, market leaders have expressed a desire to understand and prepare for future stages of meaningful use, and the undefined objectives for Stages 2 and 3 make it difficult for EPs and hospitals to plan their IT adoption activities. In turn, it is also challenging for vendors and other stakeholders to plan their development cycles and support programs. As much as possible, it would be helpful for CMS to provide greater specificity and more detailed guidance regarding future requirements.
  - Stakeholders would have a better sense of the types of objectives and measures that might be required in future Stages if CMS were to outline how the Stage 1 measures directly support improved care delivery – entities need to understand without Stage 1 foundation, later stages aren't achievable.
  - In addition, although it may be impossible for CMS to commit in the final rule to specific objectives and measures for Stages 2 and 3, a long-term strategic plan – included in the final rule or in a separate public release prior to the Stage 2 rule-making process - that outlines each future draft stage would be invaluable to future planning activities.

Greater insight will better guide EPs and hospitals as they purchase HIT and devote substantial time on planning and projects in order to satisfy future meaningful use regulations and program requirements.

- ***Articulate the clear role administrative data plays in achieving HITECH goals.*** Considering the important role administrative data plays in realizing the policy priorities of CMS, CAQH also believes it is critical that in the final rule CMS more clearly articulate the key role that administrative data plays in achieving improved patient health outcomes and a value-driven healthcare system. All stakeholders impacted by meaningful use need to have a clear understanding of how these data relate to clinical data in achieving improved quality and efficiency, care coordination and increased patient engagement.

Detailed Recommendations:

- CAQH requests that CMS, in the preamble to the final rule, provide greater clarity to the extent possible around the underlying rationale for Stage 1 requirements, including how collected data will be used to benefit individual health outcomes and how requirements will impact the initial policy goals of HITECH.

We appreciate the opportunity to provide comments on the proposed rule and thank you for your consideration of the CAQH recommendations. Should you have questions or require additional information, please contact Gwendolyn Lohse, Deputy Director, at (202) 778-1142.

Sincerely,



Robin Thomashauer  
Executive Director

cc: David Blumenthal, PhD  
National Coordinator  
Office of the National Coordinator for Health Information Technology