# Written Statement
# on
# "Meaningful Use" of Health Information Technology

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## I. Introduction

America's Health Insurance Plans (AHIP) appreciates the opportunity to share its member companies' perspectives on the potential criteria for "meaningful use" of certified EHR technology beginning in FY 2011. AHIP is the national trade association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace – including health, long-term care, dental, disability, and supplemental coverage – and also have a long history of participation in public programs.

We recommend the defintion of meaningful use supports the following key principles:

- Improve health care quality and affordability for all patients;
- Stimulate innovation - consider traditional electronic health records (EHRs) and internet-enabled technologies to exchange information;
- Focus on improving patient outcomes and limit the focus on the installation of software or hardware that includes certain features;
- Requirements should be obtainable with technology currently available in the marketplace;
- Recognize the link between administrative and clinical information, leveraging administrative data where available; and
- Provide solutions for a wide-range of providers, including those who are just investing and those who have installed EHRs.

## II. Meaningful Use of Certified EHR Technology

AHIP supports the phasing in of more advanced requirements for meaningful use over three to five years. In the initial FY 2011 – FY 2012 criteria we suggest that providers must:

- Demonstrate the use of clinically relevant patient electronic information to improve medication management and coordination of care;
- Regular use of e-prescribing, including access of medication history and alerts, leveraging the recently implemented Medicare e-prescribing incentives;
- Use of a "registry function" (practice-focused registry) to manage patients and coordinate care (e.g., use of a condition specific list to manage patients with a chronic condition);
- Access recent laboratory test results and images (where available); and
- Conduct insurance eligibility verification electronically utilizing consistent rules developed by the Committee on Operating Rules for Information Exchange (CORE).

Beginning in FY 2012 we suggest an expanded defintion that includes the following requirements for providers:

- Expanded requirements for data access and exchange including integration with available networks and health information exchanges;
- Electronic exchange of data with public health and specialty society registries (if available) and use of advanced internal registry functions; and
- Implementation of electronic processes for eligibility verification, claims submission, claims status, claims payment, and claims remittance.[1]

[1] Concurrently, health insurance plans will support advanced electronic capabilities and data exchange.

## III. Information Exchange & Quality Improvement

We support a phasing in of more advanced requirements for information exchange and quality improvement. In the initial FY 2011 – FY 2012 criteria we suggest that providers must:

- Implement medication management that includes the exchange of medication history and alerts and coordinate care using available electronic data (e.g., laboratory test results);
- Commit to being accountable for improving clinical outcomes and patient experience, appropriate utilization of health care services, and ensuring transparency of reliable clinician performance data; and
- Support alternative mechanisms (e.g. use of administrative data) to determine improvements in healthcare quality until data can be generated by EHRs (since many of the EHR systems that currently exist do not have the capability to collect and aggregate performance measurement information).

Beginning in FY 2012 we suggest an expanded defintion that includes support for advanced information exchange between health care settings and demonstrable improvement in patient outcomes.

## IV. Quality Reporting

The requirements for quality reporting must account for the variability of system capabilities. Quality outcomes should be measured over time including overall clinical quality, cost effectiveness and patient and physician experience. In the initial FY 2011 – FY 2012 criteria for quality reporting we suggest that providers must:

- Support quality reporting using National Quality Forum endorsed measures and utilize other consensus-based measures on a provisional basis where gaps exist (e.g., outcome based measures).
- Consider adding intermediate outcomes measures (i.e. measures that include laboratory and prescription data) such as those that are being evaluated by the NQF's Clinically Enriched Administrative Data project.
- Support submission of quality information directly from EHRs and qualified registries (where the infrastructure already exists to receive information). The requirements should also permit reporting via other electronic means.

Beginning in FY 2012 we suggest expanded requirements for quality reporting, including EHRs as the primary data source for clinical and performance information. This will require an education and outreach initiative that would encourage physicians to use electronic data for quality improvement and performance measurement.

## V. Role of Health Plans

AHIP and our member companies stand ready to work with providers as they take steps to implement the new EHR incentive programs. We will ensure that quality improvement initiatives such as disease management, care coordination, quality measurement and administrative processes are complementary with the Medicare incentives. We also stand ready to work with providers to leverage existing data sources (e.g., claims and personal health records) and support the portability of data in PHRs to aid the transition to the meaningful use of EHRs.