**SUBJECT: BCBSA COMMENTS ON DEFINING "MEANINGFUL USE"**

Date: April 30, 2009

To: Marietta Squire and NCVHS

The Blue Cross and Blue Shield Association (BCBSA) – a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for 102 million (one in three) Americans – appreciates the opportunity to offer comments to NCVHS on defining meaningful use.

First and foremost, we commend Dr. David Blumenthal for his view that health IT is important for its ability to improve the health system and that, therefore, we must focus on health IT's impact on the daily lives of providers and patients, as well as on the efficiency of health care services. It is imperative that the definition of meaningful use reflect this point of view.

Our comments follow the structure of the statutory language in the HITECH Act and cover (1) Technology requirements; (2) Certification; (3) Demonstrating meaningful use; (4) Demonstrating more stringent measures over time; and (5) Demonstrating connectivity.

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## Technology Requirements

The HITECH Act requires that meaningful users use "certified EHR technology," and lists certain attributes that an EHR should include.

We recommend that the Secretary take into account the need for continual upgrades, by including in the eligibility rules for incentive payments (and avoidance of penalties later) a requirement that EHR vendor contracts have provisions to ensure follow-up maintenance and upgrades that insure EHR systems remain compliant as the tiered criteria becomes more rigorous.

- There is always the risk for providers that system upgrades to meet ever higher criteria requirements will not be available from the EHR vendor after the initial EHR purchase. Most importantly this will include a commitment by vendors to the upgrades of EHR systems as the nation converts from an ICD-9 based health care reporting system to one based on ICD-10 and future coding changes, without a second major capital investment.

## Certification

- The Secretary should recognize use in 2010 of CCHIT-certified EHRs for 2011 incentives.
- During 2010, HHS should pilot test (with CCHIT or other independent entities) new approaches to certification, which could include multiple certification entities, and apply that certification process to determining eligibility for incentives after 2011.

## Demonstrating Meaningful Use

The ultimate goal should be to demonstrate meaningful improvement in health care outcomes, but the approach should be phased or tiered.

- In keeping with a tiered approach to setting measures of meaningful use (see below), we recommend a phased-in approach that builds toward a comprehensive and combined method of multiple proofs of meaningful use. These multiple methods could include: attestation; provider or vendor reporting of use of certified/qualified products and systems; provider/vendor reporting of quality measures and data reports; and steps to include meaningful use as part of provider credentialing.
- We would note that attestations can be somewhat cumbersome, and it is difficult to ensure accuracy with regard to which EHR a provider is using (e.g. version), and whether it is certified (as those definitions are changing). Therefore, we recommend periods audits to maintain accuracy.

- To complement attestations by providers, vendors could report to CMS which providers are using their certified products (since they have their NPIs). For example, in one state where a BCBS Plan provides incentives for HIT products, a vendor (Allscripts) lets the Plan know which providers are using which products.

**Demonstrating Over Time**

HITECH directs the Secretary to require more stringent measures of meaningful use over time.

- We recommend using a tiered approach to evaluating meaningful use of an EHR by physicians and hospitals. For example, a recent article in the *NEJM* identified 24 functions that should be present in all major clinical units of a hospital to conclude that it had a comprehensive EHR and identified eight of those 24 as necessary for a basic EHR. A tiered meaningful use criteria process could determine that meaningful use was met in the first year if the provider was both using an EHR that contained these basic EHR functions and using the data output for the related quality measures. Additional functions could be added in succeeding years until all functions were in place and comprehensive quality measures were reported.
- The tiered approach should also require capability functions at a different pace for large and small, and rural and non-rural physician practices; in other words, a small physician practice should be allowed more time to achieve a certain performance capability than a large group practice.
- In the initial tiers, to the extent practicable model criteria on existing programs with which many physicians are already familiar. For example, using the NCQA standard for achieving medical home status to assess meaningful use (specifically Level 2 certification) would drive effective and appropriate use by clinicians.

**Demonstrating connectivity**

- At this time, we recommend against requiring linkages to administrative data. Plans and providers are going through massive IT systems changes because of the transition to version 5010 of the HIPAA standard transactions and ICD-10. Requiring linkage to administrative data would unnecessarily complicate and add a heavy resource burden to adopting EHRs and using them in a meaningful way.
- In keeping with a tiered approach, allow graded levels of exchange, for example:
  1. Grade One: Capability to accept medication history from an outside source
  2. Grade Two: Capability to accept laboratory results
  3. Grade Three: Capability to import or export EHR in CCD format
  4. Grade Four: Capability to interoperate with other EHR systems or a PHR.
- We would strongly urge against requiring participation in a Health Information Exchange (HIE) as part of the definition of meaningful use, at least for the first three or four years. Currently, many HIEs are not sustainable because incentives are misaligned and, perhaps more important, current EHR products lack the capability to collect comprehensive data on a patient, organize it in a meaningful way for the provider and the patient, and then help the provider make better decisions based on algorithms running on these comprehensive data (i.e., interoperable health care, not simply interoperability). Over time, as Medicare and the private sector test and refine alternative payment structures, and vendors develop EHRs that support interoperable health care, the market should naturally gravitate to providing sustainable business model for HIEs.
- Finally, allow for levels of optionality, not an all or nothing approach. Criteria for demonstration in actual production implementations of EHR technology should not require daunting efforts in interoperability. Users will have initial implementation challenges including training and process workflow changes to overcome.

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