WELLPOINT

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Via e-mail: marietta.squire@cdc.hhs.gov

April 30, 2009

Harry L. Reynolds, Jr.
Chair
National Committee on Vital and Health Statistics
Hubert Humphrey Building
200 Independence Avenue SW
Washington, DC

RE: NCVHS Executive Subcommittee Hearing Defining "Meaningful Use"
Dr. Charles Kennedy Submission on behalf of WellPoint, Inc.

Dear Mr. Reynolds:

On behalf of WellPoint, Inc., thank you for the opportunity to provide testimony for the National Committee on Vital and Health Statistics (NCVHS) Executive Subcommittee public meeting to help define and clarify the term "Meaningful Use," a term used in the HITECH Act (part of the American Recovery and Reinvention Act [ARRA]).

WellPoint, Inc. is the largest health benefits company in terms of medical membership in the United States, with medical enrollment of almost 35 million members. Through its nationwide networks, the company delivers a number of leading health benefit plan solutions, along with a wide range of specialty insurance products and services including life and disability, pharmacy benefit management, dental, vision, behavioral health, long term care and flexible spending accounts. Headquartered in Indianapolis, Indiana, WellPoint is an independent licensee of the Blue Cross and Blue Shield Association and serves its members as the Blue Cross licensee in California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan and surrounding counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin; and also serves members across the country through UniCare.

WellPoint believes Health I.T. can facilitate comprehensive management of medical information through an exchange of information between health care consumers, providers and payers. Health I.T. has become an increasingly important public policy issue at both the state and federal levels, as policymakers struggle to identify means to lower healthcare costs and increase efficiency. In an era of continually rising health care costs coupled with ever-tightening budgets, Health I.T. holds the promise of both lowering long-term healthcare costs and improving healthcare quality, while increasing efficiencies in the health care system and empowering patients. WellPoint supports the widespread adoption of interoperable Health I.T. solutions WellPoint supports the HITECH Act in part because the Act's objectives align well with WellPoint's health care value maximization strategies, however we have had, and continue to have, concerns that the privacy and security provisions provide a disincentive to health care technology adoption. The testimony we are submitting contains comments that are based on WellPoint's experience in deploying Health I.T. to date.

We appreciate the opportunity to comment on these important issues, and we hope that our testimony will assist the National Committee on Vital and Health Statistics and the Office of the National Coordinator in defining and clarifying the term "Meaningful Use" in the hope that it will lead to the widespread adoption of Health I.T. that will

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improve quality and ultimately decrease the cost of health care for everyone in the nation. Please contact me by phone at (202) 628-7844 or by email at elizabeth.hall@wellpoint.com with any questions.

Sincerely,

Elizabeth P. Hall
Vice President for Public Policy

**Date:** APRIL 30, 2009

**Subject:** Dr. CHARLES KENNEDY TESTIMONY, ON BEHALF OF WELLPOINT, INC., TO NCVHS ON DEFINING "MEANINGFUL USE"

**To:** NATIONAL COMMITTEE ON VITAL HEALTH STATISTICS (NCVHS)

WellPoint and its health plan subsidiaries serve over 10% of Americans, constituting the largest health benefits company in the United States. It is a major component of the current health care system. WellPoint supports the HITECH Act in part because the Act's objectives align well with WellPoint's health care value maximization strategies, however we have had, and continue to have, concerns that the privacy and security provisions provide a disincentive to health care technology adoption. The comments below are based on WellPoint's experience in deploying Health I.T. to date.

**Defining a Qualified E.H.R.:**

In order to define the term "meaningful use" it is important to first determine what use is meaningful to our health care system. To be meaningful, an E.H.R. must support the maximization of health care value through successful completion of the requirements of the HITECH Act. Many of the HITECH Act requirements are available from a wide variety of vendors in today's market. However, several requirements are not. Key capabilities that are less commonly found in the industry, but defined in statute, include the capacity (i) to provide clinical decision support, (ii) to support physician order entry, (iii) to capture and query information related to health care quality, and (iv) to exchange electronic health information with, and integrate such information from external sources.

**Clinical decision support**

In today's paper environment, clinicians expend tremendous effort locating and understanding patient specific information to relate to their medical knowledge. The result of this interaction is a care management decision and strategy. It is this process of patient specific information interacting with a physician's general medical knowledge that must be addressed by qualifying systems to improve decision making. Qualifying systems should provide patient centered cognitive support consistent with the National Research Council (NRC) report.[1] Patient centered does not mean the decision support is generalized guidelines applicable to any patient with a given disease. This type of static guideline presentation is consistent with the 2007 ambulatory E-HR requirements established by CCHIT. Rather, a qualifying clinical decision support capability should synthesize data from multiple sources and apply disease specific algorithms derived from the evidence base for personalized decisions unique to each patient. This process should support the physicians own general medical knowledge and clinical judgment. In this way, decisions can be improved, care management strategies optimized, and improved health care value realized. WellPoint has experience in this type of approach. Our Resolution Health subsidiary routinely analyzes claim data and identifies gaps in care. Despite the limitations of claims data and the use of paper letters as a vehicle to communicate the results of these analyses, we have routinely seen increases in health care value as measured by improvements in benefit use and trend reduction (See appendix 1). We are confident that the creation of a health information network, which would make these processes more timely, more effective through the use of claim data, and more actionable through electronic communications with patients and physicians, will take an already valuable program to a transformational one. Although there are significant technical and data architectural challenges to be overcome, the expected quality and efficiency improvements as called for in the HITECH Act cannot be realized without such personalized approaches in mind.

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[1] Willam W. Stead and Herbert S. Lin, editors; Committee on Engaging the Computer Science Research Community in Health Care Informatics; National Research Council. *Computational Technology for Effective Health Care: Immediate Steps and Strategic Directions.* 2009. http://www.nap.edu/catalog.php?record_id=12572

**Capture and Query Health Care Quality Information**

Qualifying electronic health records must lead to higher quality care in order to achieve maximal health care value and meet the objectives of the HITECH Act. Key to improving quality is the ability to define and actively track quality metrics. Quality information within qualifying systems should have as their primary use an active application of these measures as care is occurring for the individual patient. The expectation to use quality information as care is occurring will have fundamentally different architectures than systems designed for reporting physician performance (e.g. Pay for Performance). CMS interpretation and implementation of this standard will send an important signal to the technical community. Systems that capture and query this information in a patient centric or personalized way in the provision of direct care services will influence overall system design and will become an important guide post as to how this technology should be deployed on a regional basis. For instance, an approach to real time quality capture and query will require a substantial integration of data from a variety of sources outside of the physician's office as it will be critical to make sure only the right interventions are performed for a particular patient. If another physician performed the test or intervention, this information is fundamental to advising the treating physician correctly. Systems designed to measure the quality of care delivered by the physician as part of a quality measurement approach might not be so concerned with care delivered outside of the physician's office nor whether the intervention was completed more than once. WellPoint has experience with this type of approach. Our collaboration with Kettering Medical Center in Dayton, Ohio has been operational for two years. We have not only seen reductions in medical cost trends but, more importantly, 10-40% improvements in HEDIS measures—a nationally accepted set of quality measures (See appendix 2). Improvements in health care quality and safety through effective use of information technology require technology which has as its primary purpose support of the patient's entire health care team through a single, comprehensive, focused, algorithm supported patient record.

**Data Integration**

Systems which integrate data across organizational, departmental, and relational silos are fundamental to maximizing health care value through Health I.T. However, integration can take on a variety of meanings. For instance, transmission of a static report which is stored as an image in the receiving EMR system might be suggested as a solution for data integration. However, this image based approach to data integration is unlikely to improve care quality or efficiency. The main result from an image based approach is to transform today's fax into tomorrow's electronic transmission. These types of transmission routes include the Continuity of Care Document (CCD) data standard. This approach cannot provide maximal health care value because it is the inappropriate data foundation to provide cognitive decision support rules. Without cognitive decision support that result in better care management decisions, health care value cannot be maximized.

**Meaningful Use**

Use of a system can certainly be categorized and measured. There is tremendous experience in the industry in assessing, measuring, and reporting on system use. A variety of metrics – from web hits to number of sessions, to number of pages viewed to number of patient records created – can all become components of rigorous use measurement approaches. The challenge is to define meaningful. Meaningful in WellPoint's view should be the degree to which use of a Health I.T. system maximizes health care value. This approach dictates use of measures related to quality such as outcomes measures, process measures, or health status measures. This more rigorous approach, where the definition of meaningful is less closely tied to simply using any qualified system, is more likely to result in more sophisticated, and effective, systems being deployed. However, the paucity of systems that can meet that objective may risk a backlash from physicians who might become frustrated at their lack of choice. Further, existing systems already deployed would be unlikely to qualify in many installations. A middle ground might be to set the bar a bit closer to use of existing qualified systems such as CCHIT certified systems and then raise the bar substantially over the upcoming three years. This approach was used by CCHIT successfully in its certification process development.

**Appendix 1**

## Financial Results

| Continuous Enrolled Study Cohort | | | |
|---|---|---|---|
| **Health IT Non-Users** | | | |
| | **2007** | **2008** | **Variance** |
| Allowed Cost | $ 9,077,150 | $ 11,661,058 | 28.5% |
| Mbrs | 4126 | 4126 | 0.0% |
| MM | 37134 | 37134 | 0.0% |
| Cost PMPM | $ 244.44 | $ 314.03 | 28.5% |
| Avg DXCG | | 2.13 | |
| | | | |
| **Health I.T. Users** | | | |
| | **2007** | **2008** | **Variance** |
| Allowed Cost | $ 1,839,258 | $ 2,226,974 | 21.1% |
| Mbrs | 666 | 666 | 0.0% |
| MM | 5994 | 5994 | 0.0% |
| Cost per Pt | $ 2,762 | $ 3,344 | 21.1% |
| Cost PMPM | $ 306.85 | $ 371.53 | 21.1% |
| Avg DXCG | | 2.72 | |

7.5% trend reduction

.60 higher risk score

**Appendix 2**

# Quality Results

| Measure | IHR User | IHR Non User | Difference |
|---|---|---|---|
| Colonoscopy | 41.50% | 25.60% | 15.90% |
| Mammogram | 10.50% | -11.20% | 21.70% |
| Pap Smear | 12.70% | 0.80% | 11.90% |
| PSA | 62.50% | 24.40% | 38.10% |
| LdL Test | 21.70% | 1.10% | 20.60% |
| Hemoglobin A1C | 13.90% | 2.30% | 11.60% |
| | | | |
| | | | |
| Measured in year over year change | | | |