NCVHS Hearing on Meaningful Use
April 29, 2009
Testimony on behalf of Payer Stakeholders: John Kelly, Harvard Pilgrim Health Care
Panel #8

Good Morning. I want to thank the committee for the opportunity to speak here today on behalf of the Payer Community. My name is John Kelly and I'm the Director for eBusiness Architecture for Harvard Pilgrim Health Care in Wellesley Massachusetts. eBusiness Architecture-- That means that I'm the person responsible for getting machines to talk to machines. I do this so that those whose primary responsibility is to improve the general health and well being of a large number of people, can do so as effectively and efficiently as possible.

In truth, I've spent the past ten years with Harvard Pilgrim and the payer/provider community in New England dealing with the question of meaningful use and technology. In addition to my role at Harvard Pilgrim, I sit on the governing boards of NEHEN (New England Healthcare EDI Network) and MaShare, a subsidiary of the Massachusetts Health Data Consortium. In essence, MaShare is a Health Information Exchange. The first important thing to understand about the relationship between these organizations is that they use the same train tracks to deliver two different kinds of cargo- the network that delivers HIPAA transactions also handles discharge summaries, medication histories and plan formularies. The provider and payer members of these collaborative organizations have jointly developed standards, software and processes that meaningfully improved healthcare delivery in our region. The second important thing to understand about these organizations and meaningful use is that the tools and methods we used in New England can be replicated and scaled nationally.

Harvard Pilgrim Health Care has been named for the fourth consecutive year by US News and World Reports and NCQA as the Number One commercial health plan in America. Now, beyond just shameless self promotion, I mention this because the capabilities we have developed, and the culture we have sustained which helped us achieve that recognition has very much to do with the information exchange relationships we have established between Harvard Pilgrim and our network of Providers. Most of those exchanges are electronic, some are still paper based, but our lesson learned is that we continue to strive, as a process community, to electronically share more and better information from all of our systems in order that we can get better outcomes for our members and patients.

Meaningful use.
Health Care is a Process Community; Providers, members, patients, plans, DME vendors, facilities, etc. As the delivery and financing of care has become increasingly complex, so has the web of interactions that take place between all the participants. It's been said that "what makes a community is that you have to need each other", willingly or otherwise. The parties in our community certainly meet that criterion despite public perceptions to the contrary. And what we need most from each other is information exchange.

Though payers as a group have, and will continue to work steadily on Administrative Simplification, Delivery System simplification is a much more challenging task. Can HIT really "simplify" the delivery system? The Federal Reserve might call it de-complexification. What I can say from my experience with technology is that even if I can't make a complex problem simple, I can use smart systems to mitigate risk at potential points of failure. From the payer point of view, this is meaningful use. It's a cliché in other industries but "right information, right place, right time" is how smart systems improve outcomes. In health care the stakes might be higher but the principle is the same from a patient's point of view.

To a payer, meaningful use has to be about outcomes. The validity of using "claims data" to measure quality is challenged on a regular basis. There are two reasons usually cited:

1. Claims data is not a true representation of what happened in the exam room since the codes are chosen for billing purposes
2. Claims data can really only be used to measure process, not outcomes.

I don't disagree with either of these assertions but I will add my voice to others, and say that right now it's the best data we have. I further add that a lot of good has come from smart people using claims data to develop programs that improved the lives of literally millions of Americans both sick and well. In addition, those programs have clearly shown that the meaning of quality differs very much depending on whether you are generally well or chronically ill. Claims data delivers fairly good process measures about whether or not healthy people are receiving the procedures that demonstrate and benchmark the best standards of care. For the chronically ill however, claims data at best determine only that the patient probably needs more attention than they are receiving.

Meaningful use of an EHR's should necessarily lead to the combining of data from multiple sources so that the quality and value of delivered care can be measured in a way that can be accepted as valid by all constituencies.

With all that HIT money right around the corner, one might take the position that it's time to thank the Payers very much for all their good work on disease management, health and wellness programs, centers of excellence development, discharge coordination programs, etc. Maybe between EHR's and the Medical Home, providers will be ready, willing and able to reclaim the role of "end to end" caretaker. Maybe meaningful use will mean that Payers aren't needed anymore and are therefore no longer part of the process community.

I was at a recent HIMSS event in Chicago where Dr Wesley Wong, Regional Vice President and National Medical Director for Anthem Blue Cross Blue Shield, was speaking on a panel with two physicians advocating for a diminished role for Payers once EHR's are broadly adopted. Dr. Wong observed that "size matters". Payers can leverage economies of scale, capital investment in data analysis systems and access to large repositories of data to partner with providers in the best interest of the patient. Payers can also put together programs that cover patients across spectrums of care that are beyond the span of control of all but the largest integrated delivery systems. I agree with Dr. Wong and believe that Payers do have an important role to play in a future process community saturated with electronic medical records.

What our regional experience in New England has shown is that not only are Payers important suppliers to, and consumers of, a merged clinical and administrative data stream, but payers and large delivery systems provide critical leadership in efforts to put together communication networks that will form the basis of regional health information exchanges. Without the thought leadership and capital investment resulting from the collaboration of Payers and large Provider Systems, the build-out of the communication grids necessary to support meaningful use will be difficult to sustain.

If you accept that Payers do indeed have a role, then with regard to meaningful use, Payers need to be considered when determining the baseline certification standards established for EHR data exchange capabilities. EHR's must be capable of exchanging data with everybody in the process community. I strongly support making CAQH CORE level I and II a vendor certification a requirement for subsidy consideration.

As example, if you buy a PC today there is a baseline assumption that you get Outlook loaded at the factory. Without it you couldn't do email. Vendor EHR systems should have such a requirement. The CAQH CORE standards have been developed on a national basis in a fashion similar to the work done in New England within NEHEN and MaSHARE. Though the current data content standards address only eligibility and claims status transactions, they will rapidly evolve with the goal of automating the entire Payer/Provider revenue cycle. What we've proven at Harvard Pilgrim however, is that we can use the current CORE connectivity protocols to deliver any payload that two trading partners agree to exchange. Using the CORE II web service standard I could, with equal ease, exchange a HIPAA 270/271, a CCR document, medication history or even a "Joke of the Day". With such capability broadly available, the forces of market innovation will quickly yield the desktop workflows that will create real value in the health care delivery system. I can confidently assert this because it's a phenomenon we've seen repeated over and over when any industry fully embraces the internet. John Wookey, formerly of ORACLE and now with SAP once said, "The internet is all about connectivity, collaboration and self-service". That internet effect begins the minute lots of "point A's" can connect with lots of "point B's". The important work being done by HITSP, IHE and others to harmonize standards for semantic interoperability will be greatly accelerated if every machine comes ready to talk to each other.

I know that to some degree, this committee is faced with refereeing a food fight between those that recommend setting the meaningful use bar low, so as to mitigate the risk of adoption failure; and those that want the bar set high so as to insure the realization of the ultimate goals of increased quality, lower costs and overall value for every healthcare dollar spent. I also have grown to believe over time that the fundamental principle of management science is to measure what's easy, not necessarily what's important. Increasing quality, lowering costs, insuring value are all functions of our ability to assess the collective outcomes of a series of complex processes. This is true in any industry.

Within our regional healthcare community, as payers and providers we have begun to view our interactions and efforts as a supply chain integration challenge. We question the notion that everything we do is proprietary; that sharing information reduces our competitive advantage. We have found that the more we know about each other's interactions, internal and external, the better we can integrate our activities to jointly create an improved product for the customer we all share, the patient.

As I understand the scope of this hearing, the committee is gathering input to support the requirement under the HIT stimulus program to define the term "meaningful use". Payers, as stakeholders in this discussion believe that the standards should be established such that they strike a balance between aggressive support of outcomes management and broad based provider adoption. We also support progressively higher standards being promulgated beyond the timeline of the recovery package. We believe strongly that there will be an inevitable convergence of clinical and administrative data in support of both quality and efficiency, and as the PMS and EHR vendors consolidate their product offerings.

The national Payer community will support the CAQH CORE efforts to supply better and more information that can be integrated with provider systems to automate manual processes, increase reliability of information and drive down the friction costs associated with the coordination of responsibilities between Payers and Providers. We look forward to the provider community reciprocating our commitment to information integration under a wisely crafted definition of meaningful use.

As an active member of AHIP, Harvard Pilgrim and other member Plans stand ready to work with providers as they take steps to take advantage of the new EHR incentive programs. We will ensure that our quality improvement initiatives such as disease management, care coordination, quality measurement, value based purchasing and streamlined administrative processes are complementary to the Medicare incentives. We also stand ready to work with providers to leverage existing data sources (e.g., claims and personal health records) to aid the transition to the meaningful use of EHRs.

Again I want to thank the Committee for its time, and as well for this valuable opportunity and I welcome any questions.