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January 28, 2019

Donald Rucker, National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology (ONC)
U.S. Department of Health and Human Services
330 C ST SW Floor 7
Washington, DC 20201

Seema Verma, Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health Information Technology (HIT) and Electronic Health Records (EHRs)

Dear Dr. Rucker and Administrator Verma:

This letter is in response to the ONC and CMS draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. We appreciate this opportunity to provide feedback and are greatly encouraged by the draft report.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. As one of the nation's top contractors for Medicare Advantage (MA) with approximately 3.1 million members and Medicare Prescription Drug Plans (PDPs) with approximately 5.1 million members, we are distinguished by an over 30-year, long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend on the Medicare Advantage program as their safety net and many in underserved areas – receive integrated, coordinated, quality, and affordable care through our plans.

For the purposes of these comments, we draw not only on our extensive experience as a MA organization, but also as a Management Services Organization (MSO) providing population health services supporting over 1,500 clinicians in understanding, managing, and administering

health care coverage for their populations through integrated population health analytics and value-based models of care.

Humana strongly supports the recommendations included in the draft Strategy and we urge ONC and CMS to make the program changes necessary to fully implement the agencies' vision. In addition, we have outlined below additional recommendations which we believe would further reduce provider burden.

As always, we value this opportunity to provide comments, and are pleased to answer any questions you may have with respect to the comments below.

Sincerely,

A handwritten signature in blue ink, appearing to read "Mark A. Newsom".

Mark A. Newsom
Vice President, Public Policy
mnewsom@humana.com

Section 4001 of the 21st Century Cures Act (Cures Act) requires the Department of Health and Human Services (HHS) to articulate a plan of action to reduce regulatory administrative burden relating the use of health IT and EHRs. Specifically, the Cures Act directs HHS to: 1) establish a goal for burden reduction relating to the use of EHRs; and 2) develop a strategy for meeting that goal; and 3) develop recommendations to meet the goal.

Leverage Federal Health Programs to Incentivize Interoperability

We commend CMS and ONC for recommending that federal programs “incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.”¹ We also strongly concur with ONC that the current health IT marketplace “is not always self-motivated to move toward a more standardized electronic health landscape with readily available data exchange among multiple systems.”² While digital technology is ubiquitous in the world of health care, establishing interoperability between various technologies remains a challenge for many health systems, providers, and plans. A recent study by the American Hospital Association (AHA) found that although EHRs are employed by 75 percent of hospitals, interoperability between disparate EHR vendors remains a challenge. The AHA further found that only 23 percent of clinicians are able to access and use EHR data from other providers in a functional way that supports care coordination and collaboration.

In 2017, Humana subsidiary Transcend Insights commissioned an online survey to gauge patient attitudes and expectations related to their clinical experiences, and to determine whether patients are aware of interoperability issues.³ 78 percent of participants felt that it was important for any health institution, regardless of type or location, to have access to their full medical history. 87 percent of respondents said that it is extremely or very important for their primary care physicians to have access to their full medical history.⁴ We encourage HHS to leverage all public health programs and agencies under its jurisdiction to incentivize the interoperable exchange of electronic health information.

Encourage EHR Vendors to Support Interoperable Transaction Standards

We concur with ONC and CMS that while standards currently exist to support electronic prior authorization transactions, such as the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version D, Release 0 (Version D.0) for retail pharmacy and the ASC X12N 278 Healthcare Service Review Request for Review and Response transactions for medical services benefits, EHR developers have not widely implemented these standards. We urge ONC and CMS to prioritize the deployment of interoperable transaction standards, such as HL7 Fast Healthcare Interoperability Resources

¹ Office of the National Coordinator for Health IT, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, Draft for Public Comment, November 2018, p. 20.

² Ibid, p. 37.

³ Online market research company Research Now conducted the survey over a one-week span in January 2017 and reached a total of 2,597 U.S. adults of diverse ages, genders, and geographical backgrounds who visited a doctor within the previous year.

⁴ Complete survey results are available online at:

https://www.transcendinsights.com/assets/pdf/DigitalHealthSurvey_Interoperability_6_22_17_V4_FINAL.pdf

(FHIR), so that IT vendors, providers, patients, and plans can work more collaboratively to finally begin realizing the transformational potential of health IT. Some of this work is already underway. As highlighted in the report, the private sector led DaVinci Project, of which Humana is a founding member, is working to implement FHIR-based solutions to common administrative burdens faced by payers, providers and patients, including prior authorization.⁵

Improve Alignment of CMS Quality Measurement and Reporting Systems

CMS must prioritize the alignment of the Healthcare Effectiveness Data and Information Set (HEDIS) and MA/Part D Stars with other CMS quality systems. As we have commented before, we believe that the U.S. healthcare system places a tremendous measurement burden on providers that likely adds unnecessary administrative costs and diverts attention away from clinical practice. Indeed, a recent study published in *Health Affairs* found that physician practices in four common specialties spend 785 hours per physician and \$15.4 billion in aggregate dealing with the reporting of quality measures.⁶ Moreover, recent surveys conducted by the Medical Group Management Association (MGMA) and KPMG with the American Medical Association (AMA), have found that the majority of providers find CMS quality systems, like the Merit-Based Incentive Payment System (MIPS) to be burdensome.⁷

To alleviate the reporting burden on providers, Humana strongly urges CMS to more closely align MA and Part D Stars measures with other quality systems. While some Stars measures are specific to the administration of plans (e.g., member complaints), the majority of Stars measures are determined based on provider performance. An analysis conducted by the actuarial firm Milliman found that approximately 65% of the Stars quality measures relating to physician performance have a similar corollary measure in the MIPS.⁸ Ideally, the percentage of overlap would be much higher, and it is important to note that this overlap often is limited to the measurement concept or domain level. In other words, even when both traditional Medicare and MA measure the same concept (e.g., All-Cause Readmissions) there can be important technical distinctions in how data are pulled, from whom, and how risk or case mix adjustments are performed between the two systems. Functionally, this means that providers must support multiple measurement processes, thus increasing their burden. We therefore encourage CMS to seek ways to limit the differences between MA/Part D Stars and other CMS quality systems like MIPS. CMS should also seek to reduce the total number of quality metrics.

⁵ http://www.hl7.org/documentcenter/public_temp_3F78DD74-1C23-BA17-0C961FD7C52C2EBA/pressreleases/HL7_PRESS_20180905.pdf

⁶ Casalino, Lawrence P., et al. "US physician practices spend more than \$15.4 billion annually to report quality measures." *Health Affairs* 35.3 (2016): 401-406.

⁷ MGMA 2017 Regulatory Burden Survey Report [http://www.mgma.com/getattachment/Government-Affairs/Advocacy/Advocacy-\(1\)/MGMA-2017-Regulatory-Relief-Survey/MGMA-Regulatory-Relief-Survey-Results.pdf](http://www.mgma.com/getattachment/Government-Affairs/Advocacy/Advocacy-(1)/MGMA-2017-Regulatory-Relief-Survey/MGMA-Regulatory-Relief-Survey-Results.pdf) and KPMG, "Physicians Found to be Unprepared for Quality Reporting: Survey," available online at <https://home.kpmg.com/us/en/home/media/press-releases/2017/06/physicians-found-to-be-unprepared-for-quality-reporting-survey.html>

⁸ <http://www.milliman.com/insight/2017/MACRA-and-Medicare-Advantage-plans-Synergies-and-potential-opportunities/>

We also concur with the American Academy of Family Physicians (AAFP)⁹ that CMS should align the agency’s measurement systems more closely with core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative, in which CMS played a key role.¹⁰

Transition from Process-Based Measures to Outcomes-Based Measurement

In a press release announcing the launch of the CMS’ Meaningful Measures Initiative, Administrator Seema Verma committed to “focus on outcome-based measures going forward, as opposed to trying to micromanage the process.”¹¹ We strongly concur with the Administrator’s remarks and encourage CMS to accelerate the transition from process- and administrative-based measures to true outcomes-based measures.

Seek to Adopt Measures that Leverage EHRs and Other Electronic Data Sources

The CMS Quality Measures Inventory contains over 1,058 measures currently applicable to providers.¹² While this is down considerably from the staggering 2,189 measures in 2017,¹³ we encourage CMS to help alleviate the burden of measure reporting by seeking to leverage EHRs and other electronic reporting mechanisms where possible. Today, only 380 of the 1,058 measures in the CMS Quality Measures Inventory leverage EHRs or other electronic sources.¹⁴ Moving forward, we encourage CMS to partner with EHR vendors, providers, and plans to identify additional opportunities to automate measurement data collection and reporting.

Eliminate Unnecessary MA Risk Adjustment Reporting

Under current rules and auditing practices for the MA risk adjustment program, CMS requires medical records with a date of service within the MA risk adjustment data collection period.¹⁵ This effectively means that plans must request medical record information on a patient every year that the individual is an enrollee, even if there is no change in the enrollee’s clinical status. This policy is burdensome for providers and makes little sense when applied to conditions that are irreversible or incurable. For example, under current rules, physicians must document annually that an amputee continues to have an amputated limb. This is not an efficient use of time and resources for already overburdened providers. We encourage CMS to work with physician organizations and MA plan chief medical officers to develop a list of incurable diseases/conditions that would be exempt from the annual documentation policy.

⁹ <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-CMS-ONC-AdminSimplification-020718.pdf>

¹⁰ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>

¹¹ <https://www.cms.gov/newsroom/press-releases/cms-administrator-verma-announces-new-meaningful-measures-initiative-and-addresses-regulatory-reform>

¹² CMS Quality Measures Inventory available online at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html>

¹³ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMSMeasuresInventory20171103.xlsx>

¹⁴ Based on our analysis of data from the CMS Quality Measures Inventory Tool as of January 22, 2019: <https://cmit.cms.gov/>

¹⁵ CMS, Contract-Level RADV Medical Record Reviewer Guidance,09/27/2017 and CMS Medicare Managed Care Manual Chapter 7 – Risk Adjustment.