May 7, 2012

Department of Health and Human Services,
Office of the National Coordinator for Health Information Technology,
Attention: 2014 Edition
EHR Standards and Certification Criteria Proposed Rule,
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave., SW., Washington, DC 20201

Reference: RIN 0991-AB82

Dear Sir/Madam:

I am writing on behalf of the Software and Technology Vendors Association (SATVA) to offer comments regarding the advance notice of proposed rulemaking on the Electronic Health Record Incentive Program. SATVA members provide software and services to support the operation of a large percentage of the country's mental health and addiction treatment programs.

Our specific comments about the proposed EHR Certification Program are as follows.

1. **ICD-9 versus ICD-10.**

   Given the delay in adoption of ICD-10, SATVA believes that many EHRs will not be enhanced to support ICD-10 by the time certification will be required for Stage 2 certified EHRs. EHRs will then not be able to support Problem reconciliation absent that support. SATVA recommends acceptance of only ICD-9 or of either ICD-9 or ICD-10 for diagnoses until such a time as the adoption of ICD-10 has, in fact, been accomplished.

2. **Proposed User Centered Design testing**

   SATVA members recognize the value of EHRs to both improve adoption and to reduce errors but we voice the strong objection to the proposed usability testing methodology. SATVA believes that there is no mechanism to introduce a professional unfamiliar with psychiatric treatment, unfamiliar with other mental health treatment or unfamiliar with substance use treatment to an EHR designed to be familiar to and supportive of those specialists and for them to objectively test the results. A doctor or nurse whose only EHR experience was in a general practice or in a hospital setting could not be expected to evaluate a specialty EHR and vice versa.

   Software professionals also recognize that the vast majority of professionals who use an EHR are only familiar with a single EHR and, if asked to evaluate any other EHR, will evaluate it largely on how much it looks and feels like the EHR they are familiar with, not with how usable it would be to a trained user. The test results of these users would obviously be biased even if objectively evaluated due to the fact that they would be able to more readily use an EHR that had a familiar look and feel

regardless of the fact that it could be much more usable than the EHR the professional is familiar with once the user was trained. The unintended consequence of adopting this testing procedure could well be the stifling of innovation as EHR vendors would hesitate to introduce innovative approaches that were unfamiliar to the current user base.

SATVA believes that it would be a very poor practice to introduce any user to a specialized software application in any industry absent training and ask for the user's feedback on its usability. To improve test scores EHR vendors would be motivated to reduce the available functionality to that which a total novice could intuitively absorb. SATVA recognizes that a professional will use the same EHR for many years and that advanced and sophisticated EHR support whose mastering can be best be done through specialized training is to the advantage of the professional. Use of such advanced capabilities over the tenure of the professional at the agency using the EHR would result in considerable savings in time and effort to that professional and in improved treatment and would inure to the benefit of the professional, their agency, and to the consumers over use of an EHR whose entire suite of capabilities could be absorbed in a few short minutes absent any training.

To have a fair usability test result, SATVA believes that the testers would need to be selected to be professionals that are already familiar with more than one EHR of the same specialty as the vendor's from a pool of professionals that specialize in the same treatment as the EHR vendor and that are not already familiar with the vendor's EHR or with any of its major components such as its ePrescribing system. The vendor should then be allowed to train that professional using the same level of training they recommend in their standard proposal. Once that training was accomplished, the professional could test the software in a similar fashion to that described. SATVA believes that it will be some time before EHR adoption and use is to the level such that a pool of testing specialty professionals is available for making these determinations and that this measure be deferred until such a time as that pool of testers is available.

3. Proposed EP Clinical Quality Measures - Alternative Data Capture Certification Options

The customers of SATVA vendors primarily provide mental health and substance use treatment and would not be able to report EP clinical quality measures for each of the six domains as currently defined measures exist in either Table 6 or Table 8 of the EHR Incentive Program APRM. It is an unnecessary burden and additional cost to mental health and substance use EHR vendors to develop capabilities which will not be used by our members' customers and the cost of doing so must be absorbed in some fashion by those customers.

SATVA therefore recommends that Option 1a of the EHR Incentive Program APRM be adopted as modified to include reporting of 12 clinical quality measures from Table 8 that apply to the domains of the customers of specialty EHR vendors. The ONC Rules for Certification Criteria should be similarly modified such that only the data elements of the CQMs supported by that specialty EHR need be recorded and only those CQMs reported.

Of the options available for defining QDM data elements, SATVA recommends the "Explicit Data Capture List" approach with the further distinction of identifying for each data element the CQMs that depend on each data element such that, if SATVA's recommendation that only the subset of the QDMs needed for the CQMs selected for a specialty EHR is accommodated, that subset of the QDM could be easily selected.

4. Data Export of QDM data for Complete EHRs

EHRs that are certified to perform the calculation of CQM results would now appear to also need to be able to export that data to a generic module designed to perform CQM calculation and reporting. This is an unnecessary overhead cost to the vendors of Complete EHRs and must ultimately be borne by the vendors' customers in some fashion. SATVA recommends that EHRs be required to either support the calculation of CQMs or to export QDM data in this manner, but not both.

5. Certification and Certification Criteria for Other Health Care Settings

SATVA recommends that ONC identify and adopt certification criteria for behavioral health settings. These criteria would differ from the ambulatory setting criteria by removing criteria not needed for the typical mental health and substance use EP. The CCHIT BH certification program includes a number of certification criteria that, while admirable, are not required by the HITECH Act. ONC should limit the certification criteria to those criteria that do not unnecessarily increase the cost of development and certification for behavioral health software vendors, and therefore do not increase the cost of EHRs for EPs.

6. Data Portability

The SATVA vendors recognize that the information in the Consolidated CDA could be valuable for supporting an EP's conversion from one EHR to another but in no way sufficient to significantly impact that process, especially for behavioral health EHRs and likely for other specialties. The diagnosis information is not sufficient to support five axis diagnoses as required for behavioral health nor is it adequate to support many states' requirements for Medicaid billing. The encounter information is not adequate to address programmatic level admission and discharge information as normally maintained by BH EHRs. The payer information is not detailed enough to support many state's Medicaid requirements. The demographic information does not reflect state level definitions that apply to BH EPs and is not extensive enough to address the full panoply of data that is required to be maintained by BH EHRs. The encounter information is not adequate to support service or intervention level historical documentation. Medicaid requirements for BH claims are such that specialized formats are required in a number of states and a Consolidated CDA would not adequately address this. Claims data alone is not adequate if data conversion of current receivables would be an expectation. In addition to claims there would need to be data formats for every EOB, appeal, denial, rebilling, void and replace, partial payment, crossover of balance from one payer to another (dual Medicare and Medicaid or dual private insurance and Medicare), et al.

For an incremental approach towards data portability to work in Behavioral Health, ONC would need to incrementally define common Medicaid reimbursement and state level reporting requirements and get all 50 states to modify their billing and reporting requirements to match those standards. SATVA recommends that any attempt to enable Data Portability be performed very cautiously, incrementally and as optional certification criteria.

7. EHR Technology Price Transparency

EHR pricing for behavioral health EHR vendors cannot readily be reduced to a bumper sticker level appropriate for inclusion in all marketing materials. The intended results of ONC requiring EHR vendors to do so would also not be accomplished. For example, virtually all BH EHR vendors consider the practice management capabilities of claiming, revenue management, specialized state reporting, other administrative reporting, etc. to be part of their normal offering. But, a Complete EHR requires none of those capabilities, so a vendor attempting to demonstrate a low cost would include only the

costs of the Complete EHR in their advertising knowing full well that the customer would always pay more.

An EHR vendor can also reasonably have different pricing, either on an enterprise license or a per user basis, for an organization with two professionals versus an organization with one-hundred professionals and may often target larger agencies that have at least several professionals. Behavioral health agencies generally have professional levels of approximately 4% of their total staff. BH EHR vendors generally have different per user pricing for professionals versus other level s of users. Treatment providers that focus on different aspects of behavioral health have significantly different proportions of professional users to non-professionals so there is no realistic basis for behavioral health EHR pricing based upon only the number of professionals.

A single vendor may offer pricing on a per user license, per professional user license, SaaS, enterprise or other pricing options based upon the needs of particular agencies. A single price sheet could then span many pages of documentation and is not appropriate for inclusion in a typical advertisement.

The SATVA vendors agree that price transparency is important but believe that this can be best accomplished by ONC requiring that the costs for a Complete EHR be clearly identified in all responses to RFPs. The RFP itself can provide the information the vendor requires to make their pricing offer and the response allows for providing the detailed level of pricing information as well as to provide detail of various pricing and purchase options.

Thank you for consideration of these comments.

Sincerely,

John Leipold

Chair
Software and Technology Vendors' Association

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