

November 20, 2017

Dr. Donald Rucker  
National Coordinator for Health Information Technology  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Suite 729D  
200 Independence Ave. S.W.  
Washington, D.C. 20201

**RE: Office of the National Coordinator for Health Information Technology (ONC); 2017 ISA Updated Interoperability Standard Advisory (ISA) questions for the Review and Comment Period**

Dr. Rucker:

UnitedHealth Group is pleased to respond to ONC's Updated Interoperability Standards Advisory objectives to achieve widespread exchange of health information through the use of certified Electronic Health Records (EHRs) by December 31, 2018.

UnitedHealth Group is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 270,000 people serves the health care needs of more than 139 million people worldwide, funding and arranging health care on behalf of individuals, employers, and government. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, but we are also the nation's largest Medicare health plan – serving nearly one in five seniors nationwide – and one of the largest Medicaid health plans, supporting underserved communities in 27 states and the District of Columbia. Recognized as America's most innovative company in our industry by *Fortune* magazine for seven years in a row, we bring innovative health care solutions to help create a modern health care system that is more accessible, affordable, and personalized for all Americans.

We appreciate ONC's leadership in facilitating broad and secure health information sharing nationwide, and the commitment to identifying future areas of improvement in the Standards Advisory. We believe ONC and UnitedHealth Group share the same goals of implementing real-world interoperability and achieving the seamless and bi-directional use of information technology in the health care system. This will improve the quality of health care; develop technologies to deliver innovative solutions; advance health information exchange for administrative, clinical, and patient-reported data; and reduce costs and administrative inefficiency, all of which allow us to achieve the Triple Aim of better health care delivery and access, optimized patient outcomes, and lower per capita costs.

In furtherance of these goals, we are providing and creating innovative technologies to solve multiple stakeholder interoperability business needs through our many capabilities. We have a variety of products that enable communication between technology, processes, and people. These products facilitate health care portability, and remove the boundaries that currently impede administrative and clinical information exchange. We are also sharing clinical and administrative claims data everyday with our providers and others who manage our members' care. We have developed innovative and cost efficient tools for our providers to advance interoperability and make data-sharing a part of the daily care routine.

Consistent with our letters in response to ONC’s previous Interoperability Standard Advisories, we offer the following comments in the spirit of achieving our mutual goals and to accomplish a shared outcome – a technology-enabled, integrated, and coordinated approach to patient-centered care through population health management and in support of the Triple Aim—i.e., to improve population health outcomes, improve consumers’ experience with health care, and to reduce per capita health care costs.

## **General Comments**

UnitedHealth Group applauds the ONC’s establishment of the ISA process to coordinate the identification, assessment, and determination of the “best available” interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. We recognize that the purpose of the ISA is to: a) provide a single, public list of standards and implementation specifications; b) provide feedback from public comments, surveys, workgroups, and consensus reporting when more than one standard is identified as best available; and c) document known limitations, constraints, dependencies for the best available referenced standards and implementation specifications.

To further enhance the value of the ISA, UnitedHealth Group recommends that the ONC consider expanding the purpose of the ISA to include healthcare business relevance by way of aggregated (industry captured) Value-Based Use Cases, that have a high dependency on clinical health IT interoperability. Ideally, the Use Cases (e.g. Medication Reconciliation) would list the ‘best available’ standards that best meet the interoperability needs of the Use Case. In addition to the ‘best available’ standards, we recommend that the particular Use Case includes a list of viable reference architectures that may be applicable. For example, the electronic Prior Authorization Use Case would list SureScripts as viable reference architecture for electronic Rx PA’s.

## **Specific Comments**

### **Additional Features or Functionalities to Enhance the ISA Experience**

Also, a function for subscriber-based ‘alerts’ could provide timely notifications on any updates.

UnitedHealth Group appreciates the added functionality with the 2017 ISA Reference Edition. We agree that transition from a stand-alone document to a web-based resource offers a more interactive experience while also providing enhanced transparency to the process of updating the ISA. We recommend that similar to ‘product release notes’ any changes or improvements are captured in a “Release Notes” section of the ISA documentation that will be easy to digest.

Also, we recommend that the ISA includes examples of the standard being used or referenced. For example, if you reference *Section II – Content/Structure Standards and Implementation Specifications*, then *II-A Admission and Discharge Transfer*, while the standard for “Sending a Notification of a Patient’s Admission, Discharge and/or Transfer Status to Other Providers” is provided, what would be more helpful and useful is to see not just the HL7 & Clinical Domain, but an example of the actual ADT message with sample patient data.

For the new material under review we would appreciate the ability to print out a complete PDF and have the option to print sections for easier review, as well as, provide a function for subscriber based ‘alerts’ based on timely notifications of any updates. As the ISA continues to grow, these new functionalities will be necessary in order for the document to be a more useful resource.

### **Educational and Informational Resources to Consider for Appendix II**

Open standardized APIs provide better functionality and experience for the user. We urge ONC to require the use of standardized open APIs that allow for bi-directional information exchange, in order to broadly drive adoption of interoperable technology capabilities beyond “meaningful EHR” users. APIs should be freely available at no additional costs beyond reasonable expenses for building and maintaining the API. The impact of open, standardized APIs would help consumers better understand their own health and make more informed choices.

There are a number of active Taskforce workgroups that are addressing interoperability. It would be helpful to have a search tool to find out more about these initiatives in one centralized place.

Additionally, adding information resource regarding Blockchain capabilities would be of benefit to raising the level of industry understanding on future interoperable methods. If Blockchain is included in the 2017 reference guide it should be added in the security section Appendix I. Moving forward, this appendix should include other educational standard setting organizations like WEDI, eHi, and HL7.

Finally, UnitedHealth Group recommends that ISA provide an Interoperability Matrix for EMR Vendors. This will provide insight into what interoperability capabilities are out of the box versus what interoperability capabilities are only available with specific modules, and if these require additional licensing. This also must provide insight into the deployment architecture of the EMR, for example, Cloud Hosted.

### **Specific Sociodemographic, Psychological, Behavioral or Environmental Domains**

ONC could consider the inclusion of factors such as, air pollution, water quality, social determinants of health, and clinical genomic standards. In addition, UnitedHealth Group recommends that the ISA include and promote telehealth/telemedicine and remote patient monitoring programs that are becoming more common and used more frequently by our membership. It would make sense and follow the lead of the Federal government that uses telehealth and remote patient monitoring in various Federal health care programs; it would be valuable for all stakeholders to see the outcome of these ONC created Use Cases and Interoperability Standards being used today, that can then be documented in the ISA.

### **Public Health Reporting: Birth Defects to Public Health Agencies**

It would be useful to have standards that interact with state health department requirements for reporting, as well as state registries that contain important clinical data for care coordination and HEDIS. ONC can specify standard approaches and transactions that allow for seamless data flow. Standard transactions should be defined to allow for better transmission and connectivity of data from agencies and their registries.

### **Consumer Access to and Exchange of Health Information**

We appreciate the addition of this section, which is critical to support patient communication and eliminate gaps in care. This section should be expanded to include information that can be exchanged between the patient, provider, health plan, and other entities with clinical systems that support care coordination and quality measures. In addition, specific standards related to patient communication would be useful for subscription based alerting to allow for automatic notifications to the individuals/patients or their designated family or caregivers. Other entities that may have consumer information might include, but are not limited to pharmacies, labs and imaging, and ambulatory care centers.

### **Listing Models and Profiles**

ONC could add additional attributes like HL7 Data Analysis Models (DAMs) and Quality Improvement (QI) Core Profiles for FHIR.

### **Administrative Standards and Implementation Specifications**

UnitedHealth Group stresses two EDI business needs that need to be considered across this section:

- Increased payer and provider communication

Payers, in an effort to increase payment and patient specific benefit plan transparency, are sending proactive provider notifications when a claim triggers an actionable alert based on their agreement with a health plan and/or patient's benefit plan. This prompt notification prior to adjudication speeds up claims reconciliation and provides for the notification of gaps in a patient's care and other payer benefit requirements. Quicker claims reconciliation and patient care alerts activated by a submitted procedure or diagnosis code assists providers in complying with

the emerging value based payment requirements and related regulations. UnitedHealth Group encourages ONC to include the above use cases within this document. The ASC X12 277CA – with trading partner agreement – has the ability to meet these use cases and provide the needed enhanced communication between payer and providers within the EDI workflow. This increased communication is crucial for the success of value based payment contracts/incentives and other emerging arrangements.

- Administrative and Clinical Transactions Harmonization (i.e., attachments)

One example of the required harmonization is the exchange of information through attachments within an organization (practice management systems and electronic medical records), across organizations (electronic medical record to electronic medical record); across stakeholder enterprises (provider to provider) and across industry (payer and provider). It would be useful to understand where X12, HL7 and CAQH CORE are collaborating to solve for attachments to assist in defining an industry best practice roadmap. Managing a member's care requires data to be exchanged on both X12 and HL7 standard transactions. The addition of use cases that require harmonization across standard transactions would assist in focusing the industry direction and speed up real-world interoperability. ONC should add these questions through the use cases: 1) what transactions from X12 and HL7 solve a specific use case? 2) What is the recommended format/versions from X12 and HL7 that work together? Should the focus be on clinical attachments with the X12 275, HL7 CDA, or is HL7 FHIR becoming the best practice?

### **Additional Administrative-Related Interoperability Needs**

The following administrative-related interoperability needs may be considered for this section:

- V-A HealthCare Claims and Coordination of Benefits
  - ADD - ASC X12 277CA
  - ADD - ASC X12 277 Request for Additional Information
  - ADD - ASC X12 275 Additional Information to Support a Health Care Claim or Encounter
  - ADD - Acknowledgments – 999, etc.
- V-C Administrative Transactions to Financial Exchanges
  - ADD - X12 835 Health Care Claim Payment and contractual adjustments
  - ADD V–X Administrative Transactions – Provider Information
  - ADD - X12 274 Healthcare Provider Information
  - ADD - X12 EDI 834 Benefit Enrollment and Maintenance
- V-D Administrative Transactions to Support Clinical Care – Exchange of Patient Information
  - ADD - ASC X12 277CA
  - ADD - ASC X12 277 Request for Additional Information
  - ADD - ASC X12 275 Additional Information to Support a Health Care Claim or Encounter
  - ADD SECTION V–X Administrative Transactions – Provider Information
  - ADD - X12 274 Healthcare Provider Information
  - ADD - X12 EDI 834 Benefit Enrollment and Maintenance
- FHIR for Value Based Care/Care Plan

### **Health Care Claims or Equivalent Encounter Information for Institutional Claims**

We suggest the creation of an open-sourced, agile delivery of standard transactions, with more frequent and smaller changes to meet today's business needs. ONC rules could set standard transactions as a floor and allow partners to use a non-standard version as long as content meets provided requirements.

Additionally, a common data dictionary is needed across all standard transactions. Consistent usage of data terminology across all standard transactions is critical for interoperability across stakeholder systems. We urge ONC to outline requirements for a mandatory minimum set of common data standards in order to facilitate harmonized and consistent data exchange. Without this level of uniformity, health care stakeholders will continue to have difficulty accessing, sharing, and interpreting data, which adds unnecessary costs to the health care system and undermines clinical quality and patient outcomes.

**Health Care Payment and Remittance Advice**

The value of electronic remittance advice (ERA) would increase substantially if, in addition to the Claims Adjustment Reason Codes (CARCs) and Remark Adjustment Reason Codes (RARCs), additional clarifying information could be conveyed. The CARCs and RARCs external code sets are helpful for identifying the issue through the reported codes, but are not clear enough to provide next-step action to resolve a denial. Denials require manual intervention. Allowing a payer to explain a specific policy and provide next-step action directly within the provider workflow would create a more efficient process.

Should you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,



Eric Murphy  
Chief Executive Officer  
OptumInsight



Sam Ho, M.D.  
Executive Vice President and  
Chief Medical Officer  
UnitedHealthcare