

May 1, 2015

Dr. Karen DeSalvo
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave. SW
Washington, DC 20201

Submitted Via: <http://www.healthit.gov/>

RE: ONC's 2015 Interoperability Standards Advisory

Dear Dr. DeSalvo:

UnitedHealth Group (UHG) is pleased to respond to ONC's specific questions related to the 2015 Interoperability Standards Advisory. We appreciate ONC's leadership in providing the industry with a proposed list of best available standards and implementation specifications to achieve clinical health information interoperability.

UHG 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 183,000 people serves the health care needs of more than 85 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 24 states and the District of Columbia. Recognized as America's most innovative company in our industry by *Fortune* magazine for six years in a row, we bring innovative health care solutions to scale to help create a modern health care system that is more accessible, affordable and personalized for all Americans.

We appreciate ONC's commitment and proposed plan to advance nationwide secure sharing of health information, which is outlined in ONC's Interoperability Roadmap, released on January 30, 2015. We agree that a foundational element to achieving broad health information sharing is the prompt development and widespread adoption of common standards across the health care industry. As articulated in our April 3, 2015 response to the Interoperability Roadmap, UHG believes that defining a consistent meaning of data values embodied in a common administrative data set and a common clinical data set is a critical step towards advancing broad health information sharing to ultimately improve health and health care quality and lower costs.

Although the 2015 Standards Advisory clearly articulates that its focus is limited to the interoperability of clinical health information technology systems, UHG strongly urges ONC to quickly advance a similar advisory for administrative/ payment-oriented interoperability. In order to effectively examine barriers and identify ways to streamline the health care system, the input and export of both administrative and clinical data within each stakeholder's workflow are equally important. For example, administrative revenue cycle workflow has to be examined with medical record exchange, as both impact clinical workflow processes. The industry must begin converging administrative and clinical data by identifying what data is needed for what purpose and perform the required data mapping to pull and push this data between stakeholders' systems. This includes both practice management systems and electronic medical record systems, in an authorized manner.

Additionally, almost all clinical processes start with administrative processes, including plan enrollment, eligibility verification, prior authorization requirements, etc. In order for providers to be more productive and support better care, they require accurate and timely patient-specific health insurance information in an automated, clinically efficient manner within their daily workflow.

In addition to the above recommendation, below please find our responses to the specific questions posed in the 2015 Standards Advisory.

5-1. What other characteristics should be considered for including best available standards and implementation specifications in this list?

- We believe that broad industry adoption of a particular technology standard should be considered to be equivalent to Health Level Seven Draft Standards for Trial Use (HL7 DSTU).

5-2. Besides the four standards categories included in this advisory, are there other overall standards categories that should be included?

- We strongly encourage inclusion of a standard security for transport section, instead of "purposefully" omitting it and depending on HHS advisory on standards for security on internet. The Integrating the Health Care Enterprise (IHE) standards for Patient Identifier Cross Referencing (PIX) and Cross-Enterprise Document Sharing (XDS), used by Health Information Exchange (HIE), are prime example of profiles that are in desperate need of a constrained security profile to promote interoperability of existing technology in the 1-3 year time horizon.

5-3. For sections I through IV, what "purposes" are missing? Please identify the standards or implementation specifications you believe should be identified as the best available for each additional purpose(s) suggested and why.

- We do not see sufficient "purposes" related to the use case of care coordination for a patient. "Care plan" has a recommended standard, but in addition we would like Patient Assessments, Questionnaires, Risk Scores, Goals, Interventions, Task, all of which have HL7 DSTU, to be investigated for standardization.

- 5-4. **For sections I through IV, is a standard or implementation specification missing that should either be included alongside another standard or implementation specification already associated with a purpose?**
- We believe that the industry widely uses Secure File Transfer Protocol (SFTP) to enable data sharing that enables two systems to interoperate together (Section III), and it will be advisable to include that as a standard in combination with the X.509, International Telecommunication Union (ITU) standard for Public Key Infrastructure (PKI) and Privilege Management Infrastructure (PMI) certificates.
- 5-5. **For sections I through IV, should any of the standards or implementation specifications listed thus far be removed from this list as the best available? If so, why?**
- In Section II, Admit Discharge and Transfer (ADT) of the HL7 Version 2.x standard needs to be more specifically adhered to a particular version and implementation guide of HL7 V 2.x standard, and we believe it is HL7 V 2.5.1; otherwise, the standard recommendation should be removed, since interoperability is difficult with a mix of HL7 V 2.x versions.
- 5-6. **Should more detailed value sets for race and ethnicity be identified as a standard or implementation specification?**
- For analytic purposes, race and ethnicity are valuable data sets.
- 5-7. **Should more traditionally considered “administrative” standards (e.g., ICD-10) be removed from this list because of its focus on clinical health information interoperability purposes?**
- No. A number of health care enhancement scenarios, including Healthcare Effectiveness Data and Information Set (HEDIS) and the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System (STARS) measures, utilize International Classification of Diseases (ICD) codes.
- 5-8. **Should “Food allergies” be included as a purpose in this document or is there another approach for allergies that should be represented instead? Are there standards that can be called “best available” for this purpose?**
- Food allergies should be included, as this would be a valuable data set for clinicians. Based on our limited experience, an allergen-based standard is better suited for this purpose.
- 5-9. **Should this purpose category be in this document? Should the International Classification of Functioning, Disability and Health (ICF) be included as a standard? Are there similar standards that should be considered for inclusion?**
- We do not have a recommendation.

5-10. Should the MVX code set be included and listed in tandem with CVX codes?

- Yes, the Manufacturers of Vaccines (MVX) codes should be included and listed in tandem with the Centers for Disease Control and Prevention Vaccine Administered (CVX) codes, as they are currently being used across the industry.

5-11. Public health stakeholders have noted the utility of NDC codes for inventory management as well as public health reporting when such information is known/ recorded during the administration of a vaccine. Should vaccines administered be listed as a separate purpose with NDC as the code set?

- We do not have a recommendation.

5-12. Is there a best available standard to represent industry and occupation that should be considered for inclusion in the 2016 Advisory?

- We do not have a recommendation.

5-13. If a preferred or specific value set exists for a specific purpose and the standard adopted for that purpose, should it be listed in the “implementation specification” column or should a new column be added for value sets?

- The current implementation specification column in Section I has not been utilized, and overloading it with specific-use case driven value sets might be sufficient.

5-14. Several laboratory related standards for results, ordering, and electronic directory of services (eDOS) are presently being updated within HL7 processes. Should they be considered the best available for next year’s 2016 Advisory once finalized?

- We do not have a recommendation.

5-15. Are there best available standards for the purpose of “Patient preference/ consent?” Should the NHIN Access Consent Specification v1.0 and/ or IHE BPPC be considered?

- The National Health Information Network (NHIN) Access Consent Specification v1.0 should be considered as a best available standard for patient preference/ consent.

5-16. For the specific purpose of exchanging behavioral health information protected by 42 CFR Part 2, does an alternative standard exist to the DS4P standard?

- We are not aware of a specific standard for exchanging behavioral health information.

5-17. For the 2015 list, should both Consolidated CDA® Release 1.1 and 2.0 be included for the “summary care record” purpose or just Release 2.0?

- Given the use of Clinical Document Architecture (CDA) 1.1 documents by some industry participants, it would be best to include both.

5-18. Should specific HL7 message types be listed? Or would they be applicable to other purposes as well? If so, which ones and why?

- It will be helpful to be specific about HL7 message types. A good example might be HL7 Observation Result (ORU) message types, used for lab ordering.

Thank you for the opportunity to provide our perspective on the 2015 Interoperability Standards Advisory. Should you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard J. Migliori". The signature is written in a cursive style with a large, sweeping flourish at the end.

Richard J. Migliori, M.D.
Executive Vice President and Chief Medical Officer