NaviNet Comments re: *"Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap"*

Frank Ingari
April 3, 2015

I am writing these comments as NaviNet's CEO and as a citizen. The comments represent both NaviNet's corporate view and my own opinions. My personal views have been shaped by experiences as NaviNet's CEO, as the former CEO of Essence Healthcare (a 4.5 STAR MA plan substantially owned by primary care providers), and as the co-founder of Lumeris (a population health management solutions company).

First, thanks to all at the ONC who clearly worked so hard to develop this important document. We are particularly grateful for the clear technical directions suggested, which we endorse strongly.

However, we believe that the Roadmap suffers from serious flaw. While recognizing and appreciating ONC's recognition of the fact that it does not have executive, legislative, or regulatory power to mandate behavior or enforce policy, we believe that a conscious decision cited in the document underutilizes critically the very power that the Roadmap seeks to apply -- the power that derives from deep understanding, wise counsel, and the gravitas of the ONC's role in the national health reform dialogue.

On its face, the ONC Roadmap seems to adhere to the long-standing position of many theoreticians that reform depends largely on what happens to "purely clinical" information that passes among providers. Despite the assertion that the ONC vision "significantly expands the types of information, information sources and information users well beyond clinical information derived from electronic health records (EHRs)," the Roadmap defers consideration of the payer's role: "The intersection of clinical and administrative electronic health information is a critical consideration, but is out of scope for the Roadmap at this particular time."

In our view, this decision to defer "the intersection of clinical and administrative electronic health information" from the ONC's suggested industry engagement in the associated effort -- and, by direct implication and effect, the engagement of payers in any substantive manner -- may well have tragic effects on the fragile momentum of sustainable healthcare reform in the nation.

Of course, health care thinkers have always split on whether payers can play a productive role in reform.

Some imagine a world in which clinical integration among EMRs and providers will provide all the insight necessary to achieve the Triple Aim, reducing the payer to a kind of generic TPA focused on stripped-down administrative tasks in support of risk-bearing delivery systems.

Others see the enlightened payer working in close collaboration with a heterogeneous clinical community, functioning as the best-equipped supplier of evidence-based guidance and a central participant in value-based coordinated care.

In our opinion, the answer to this question will shape the pace and scale of successful reform. From NaviNet's perspective, we see payers making tremendous investment ***today*** in funding, developing, and evolving clinical connectivity as a part of redefining the relationship between what is "administrative" and what is "clinical" in value-based care. Perhaps more importantly, we see providers adopting

population health and clinical programs funded and enabled by their contracted payers, broadly and at an accelerating pace. We are already working with several major payers who plan to connect their own self-funded regional HIE investments to the NaviNet collaboration network to ensure, for example, that the referral ***approval*** process is integrated with the clinician-to-clinician ***information exchange*** process.

What's more, a growing number of IDNs are integrating quintessential payer functions into their core competency set, and discovering that connecting reimbursement-related processes to care coordination processes is essential to provider adoption of evidence-based care.

Perhaps the ONC understands how important the integration of reimbursement-oriented processes will be to achieving truly fluid clinical information flow, but chose to focus the Roadmap on what it sees as the central and blocking task -- getting EMR vendors to play nicely by providing a combination of pressure and a potent new technology asset in FHIR. This could work, although the pressure may be blunted significantly if MU3 is not potent.

On the other hand, given the lengthy timeframes of the Roadmap, is it really sensible to defer the question of administrative/clinical integration for three, five, or even ten years?

Evidence suggests that such delay may avoid use of the most potent tools of all. Payers already have amassed significant stores of claims, PBM, and lab data -- and invested in the big data systems, tools, and informatics staff to manage and harvest them. As payers increasingly integrate EMR, HIE, and consumer data into these massive warehouses, who will be better equipped to provide the best population health guidance, tailored to the specific patient and connected to reimbursement incentives based on the Triple Aim?

Connecting clinical workflows to eligibility, benefit, and patient financial responsibility detail; to referral and authorization processes; and to the emerging class of population health campaign and value-based incentive management software will likely emerge as the most effective vehicle of all for moving the interoperability dial.

There is one payer in particular who could play a defining role in an accelerated and successful shift to the interoperable learning system envisioned by the roadmap: CMS. While understanding that the ONC has no authority to direct the activities of HHS, the Roadmap might contemplate in its recommendations the enormous power CMS has demonstrated repeatedly to affect the behavior of all participants in the healthcare ecosystem.

We urge the ONC to consider the example of Medicare Advantage and the STARS Rating system. If CMS were to include interoperability requirements in the STARS Ratings system on a graduated multi-year basis, payers would include these requirements in their most important provider contracts and we would see results. In our view, CMS' recent announcement of its commitment to majority-share VBR for Medicare cannot succeed without the foundation of the ONC's interoperability vision being solidly in place. MA plans could be measured, for example, on the degree to which referral communications in their networks employ the sharing of electronic clinical support documentation.

Laying the interoperability foundation will cost a lot of money. As someone who has been involved in the development and adoption of interoperability and network technology in many market segments for 35 years, it is my personal view that the question "who pays?" is the most important question of all.

In healthcare, the answer must be: the payer pays. The ultimate payers, of course, are Federal and State governments, employers, and consumers. Commercial insurance companies function as their intermediary payers and managers of risk. Engaging all of these entities in the noble effort is essential. The Roadmap attempts to achieve this engagement with a combination of wise advice and the use of the verb "should."

Is there a reason the Roadmap cannot apply a "should" to an urgent focus on the connection of administrative, reimbursement-related processes and clinical information flow? Is there a reason ONC cannot offer the opinion that CMS "should" include an escalating set of interoperability measures into STAR Ratings?

In our view, if these questions are not addressed in a substantive redraft of the Roadmap, the sad result may well be yet another decade of time, energy, and money spent on "purely clinical" interoperability efforts that are not sustainable because they ignore the realities of economic incentive and fail to address the honest linkage of funding and care delivery methodologies which is, after all, at the very heart of value-based care.