

March 21, 2016

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

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

RE: ONC's Final 2016 Interoperability Standards Advisory

Dear Dr. DeSalvo:

UnitedHealth Group is pleased to respond to your request for comments on the Office of the National Coordinator for Health Information Technology's (ONC's) 2016 Final Interoperability Standards Advisory in preparation for next year's iteration of this work.

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 225,000 people serves the health care needs of more than 125 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 five 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 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 for the use of information technology in the health care system which are to: improve the quality of health care; develop technologies to deliver innovative solutions; advance interoperability and 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.

Furthering these goals, UHG is providing technology to solve multiple stakeholder interoperability business needs through our many capabilities. One example is Optum Link -- a cloud-based, interoperable, multi-payer platform, used to support and connect end-to-end workflow processes to help stakeholders leverage the value of standardized data exchange. As a powerful integration tool, Link enables communication between technology, processes, and people. This facilitates health care portability and removes the boundaries that currently impede administrative and clinical information exchange. Other examples of our capabilities include sharing data and analytics related to transactional and analytical reports, Admit, Discharge, and Transfer (ADT) information, prior authorization, requests for eligibility and longitudinal patient records and registries.

Consistent with our letters in response to ONC's 2015 Interoperability Standard Advisory and the Interoperability Roadmap, 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 the Triple Aim.

Comment 1: Require uniform application and adoption of interoperability standards.

Enhanced interoperability can resolve business needs by enabling the sharing of actionable data or information, at the right time, to the right stakeholder, and in a standard format.

Use Case Example: A primary care provider (PCP) creates a patient's care plan with the relevant patient assessments within an electronic medical record (EMR) using a defined standard. The PCP shares the care plan with patient's cardiologist and endocrinologist in anticipation of the patient's upcoming scheduled visits. Each provider is located in different practices with separate EMR systems, however interoperability allows each care provider to see the comprehensive care plan and act upon it. This provides a more complete and informed view of a patient, and facilitates better communication amongst all providers involved in the patient's care for a more patient-centered and coordinated approach. Moreover, since the care plan is in a standard format it also can be shared with the payers to support quality improvement and care management.

Ensuring the data and information are readily available using standards and interoperability formats connects the provider, patient, and payer in a three-way network of care that maximizes population health outcomes, care coordination activities, and quality initiatives.

Comment 2: Adopt a consistent list of standards and implementation specifications that can be used to fulfill interoperable clinical data exchange.

UnitedHealth Group recommends that ONC publish a list of standards and implementation specifications identified as appropriate for specific use cases. We encourage ONC to list one standard per use case, and where multiple standards are relevant, to clearly expand upon the specific use case that each standard is intended to solve (i.e., pharmacy, specific

specialty, specific audience). It is our experience that the existence of a multitude of standards for the same use case that targets the same audience or clinical context contradicts the efforts of the Standard Advisory to promote interoperability.

Further, ONC is encouraged to provide a clear definition of what adoption of a standard means, which audience has adopted each standard, and identify the source of the rating for each standard. For example, the Consolidated-Clinical Document Architecture (C-CDA) standard is fully adopted by certified EMRs, but that may not be the same as the adoption of exchanging C-CDAs for all use cases, such as C-CDAs between payers and providers. ONC should consider funding pilots on specific use cases to drive interoperability and uniform adoption.

Comment 3: Adopt standards that support quality initiatives and reporting.

As the industry moves provider reimbursement away from volume to value, it is critical to accurately, and in a timely manner, evaluate provider performance for fair comparison. To do this, clinical data is one of the lynchpins for the complete measurement of a provider's performance. Currently, there is a proliferation of measures across federal agencies, state government, private payers, purchasers, and provider specialty societies. The measures recommended vary across organizations depending on what type of data they have readily accessible. Providers tend to recommend clinical measures as they have direct access to clinical data, while others tend to recommend more process measures due to a lack of readily accessible clinical data. As a result, measures are misaligned across the industry, especially at state level. We applaud AHIP and CMS efforts to work with multiple stakeholders to develop a core measure set around population health and six specialty areas. Many of these measures require clinical data and uniform vocabulary, format, and transmission standards for the appropriate use of this data. The most recent example of potential standardization is the CMMI-sponsored SIM grant awards, in which each state seems to be developing its own set of performance metrics.

Further, UnitedHealth Group recommends that ONC adopt more interoperability standards around disease stage, including for example, cancer stage, polyp size, and patient outcomes – such as blood pressure measurement, laboratory results, body mass index, radiology results, and previous treatment history of mastectomy, hysterectomy, and colonoscopy screening. The availability of clinical data to various stakeholders makes it possible to measure cost-effectiveness of providers in managing and treating patient conditions. Also, it allows the industry to develop a consensus on parsimoniously set measures on providers that are pertinent to their practice specialty and care setting.

We encourage ONC to examine transactions that would support the exchange of quality information between payers, providers, and patients, such as the Quality Reporting Document Architecture. UnitedHealth Group also recommends the inclusion of quality reporting to government agencies, but requests the following additions to Section III – Interoperability Need for Services:

- Supporting exchange of gaps in care between payer and provider,

- Supporting a gap in care closure from provider to payer
- Supporting exchange of gaps in care information to patients, and
- Supporting exchange of public health information.

Comment 4: Appropriate standardization and synchronization of care plan data.

There is a growing need to support care coordination for patients across and between clinical teams and providers. We applaud the listing of the mandated standard and of HL7 Clinical Data Architecture (CDA®) Release 2.0, Final Edition supporting the interoperability need: Documenting patient care plans and the associated implementation specification. Though widely available and mandated, in our experience the CDA is not used consistently, and sections including the care plan summary are not appropriately or completely populated, which makes it difficult to obtain consistent and reliable information and data. To ensure the ability to share care plans that are reflective of all needs, we recommend that ONC call for the consistent use of content and format, and require deployment of all sections of the care plan: Goals Section, Health Concerns Section, Health Status Evaluations, the Outcomes Section, and Interventions Section. This framework provides a structured format for data exchange.

Further, in addition to the document structure, it would be helpful if ONC promoted better mechanisms and standards for the exchange and synchronization of care plans and associated assessments. We encourage ONC to provide a framework and standards that will allow synchronization of care plans between provider EHRs and across provider EHRs and health systems, facilitating interoperability of care coordination activities.

Where appropriate, ONC should also encourage the enhancement of discrete data element content standards for care plans. Today, these are primarily included as large text fields, which require either Natural Language Processing or extraction into an appropriate vocabulary that links commonly selected aspects of the plan to specific codes. This method is prone to error and there is not a standard process for linking elements together (e.g., Dietary Restrictions and Activity) and applying codes behind the scenes on the EHR. This data is not available via a claim.

Though standards exist for the transmission of care plans and assessments, they are not widely or uniformly adopted. As a result, these are documents handled using suboptimal methods (e.g., embedding a PDF Assessment into an HL7 V2 Medical Document Management message). UnitedHealth Group believes ONC has an opportunity to mandate a transmission standard to support sharing of care plans and assessments.

Comment 5: Implement a better tracking process for prescribing and medication usage across EMRs, electronic prescriptions (eRx), pharmacy dispensing software and claim systems.

Standards and implementation guidance are needed to support the tracking of a prescription throughout its lifecycle. The ability to correctly follow a specific prescription

across systems will facilitate improvements in population health management and care delivery by providing a more complete view a patient's medication history. For example, ICD-10 diagnosis and National Drug Codes (NDC) should be reconciled to ensure appropriate medication adherence for health outcomes, reduction in the risk of mismatched treatments, and lower discretionary pharmacy medication costs. It is imperative for ONC to require the tracking of NDC and ICD-10 data from provider EMRs so we can contribute to better management of drug tracking and avoidable complications. An improvement in medication reconciliation is another benefit, as is the ability of a pharmacist to provide a more informed consult when dispensing new medications. Current ONC standards and guidance do not allow for this full lifecycle view of individual prescriptions.

Comment 6: Address data blocking across health care system stakeholders.

Our recommendations are meant to further the work that the industry has done over the last 20 years. We have seen significant improvements (e.g., vocabularies, transmission standards, content formats) but we have a long way to go. In furtherance of the need to drive improvements, we encourage ONC to lead the way in addressing data-blocking activities though meaningful enforcement with particular attention to not only technology and data standards, but also onerous, anti-competitive business practices and contractual terms. Accordingly, in the 2017 Standards Advisory ONC should prioritize measures to evaluate the health of interoperability across health care system stakeholders to identify entities that hinder the sharing of data necessary to improve health outcomes. This will inform solutions and corrective actions to ensure seamless exchange of information across the health care system. In addition, ONC should continue efforts, like stakeholder working group meetings, to convene leaders from government and the private sector to define the key mechanisms of data-blocking, provisions of data access and sharing agreements, and distinctions between data and intellectual property. This should result in the development of an actionable plan with initiatives and incentives that address these serious issues.

Finally, UnitedHealth Group recognizes that patients, providers, payers and policymakers are all eager to realize the full value of interoperable health care data through connected systems that improve population health, quality, care delivery, and result in lower costs. We look forward to continuing our partnership with ONC to discuss data standards, and create a modern and connected health care system that maximizes the potential of health care data and innovative health care technology. Should you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,



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