March 23, 2020

The Honorable Don Rucker, M.D.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street, S.W.
Washington, DC 20201

Submitted electronically via https://www.healthit.gov/topic/2020-2025-federal-health-it-strategic-plan

RE: 2020–2025 Federal Health IT Strategic Plan

Dear Dr. Rucker:

The National Association of ACOs (NAACOS) is pleased to submit comments in response to the Department of Health and Human Services' (HHS) draft 2020–2025 Federal Health IT Strategic Plan. Led by the Office of the National Coordinator for Health Information Technology (ONC), this plan is intended to guide federal health information technology (IT) activities. ONC's goal to build a truly interoperable health system has been shared by every administration since President George W. Bush.

NAACOS members are acutely aware of the value of data and patient-record exchange. Our ACO members serve more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid and commercial insurance. To properly manage and coordinate care, ACOs need to be able to easily exchange data among hospitals, physician offices, and other community providers. Without such information, it's impossible to coordinate care, manage illness, and improve overall quality and outcomes. Simply put: The bipartisan goal of shifting to a value-based payment system won't be possible without improving the flow of health information among patients, providers, and payers.

NAACOS would like to take the opportunity to highlight a few pressing issues from our members, who are on the frontlines of helping shift this country's payment system to one that's based more on value and outcomes. We are an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and healthcare efficiency.

Providers operating in alternative payment models (APMs) have unique interests and needs in health IT that ONC should help address. Advancing value-based care has been a priority of HHS Secretary Alex Azar. If HHS's goal is moving all Medicare payments into APMs by 2025 — the same year ONC's strategic plan runs through — then it is imperative HHS listen to the needs of providers in ACOs and other value-based payment models.

Reprioritize provider-to-provider data exchange

An HHS Inspector General report from May 2019 highlighted several problems ACOs face with health IT. ACOs often use methods external of electronic health records (EHRs) to share data among providers, including through phone calls and faxes. The report notes that health information exchanges contain little or incomplete data, making it difficult to coordinate care with outside providers. ACOs must either invest in a single EHR system — which is expensive and impractical given the multitude of providers they must work with —or use other, non-IT means to share patient data.

The HHS Inspector General concluded "the full potential of health IT has not been realized," which is a disappointing statement given the important role IT systems play in our delivery system and illustrates the need for meaningful action to deliver on this potential. NAACOS urges ONC to prioritize provider-to-provider data exchange. Sadly, ACOs have had to develop costly workarounds to data exchange that both increase burden and slow efficiencies in health care that IT was supposed to bring. NAACOS submitted comments in June 2019 to ONC in response to its proposed interoperability rules and was supportive of efforts to help spur the flow of medical records. We are appreciative of many of the changes included in that rule, and while those policies won't fully solve our nation's interoperability challenges, they will provide a number of positive benefits.

ONC should help providers better use technology and ingest data, rather than focusing so much on getting information out of technology and the people who use it. We need to help providers more easily access relevant clinical data from disparate IT systems when needed. While important, much of ONC's focus in recent years has shifted to enabling payor-to-payor exchange or provider-to-payor exchange, which diverts needed attention from getting the necessary patient data into doctors' hands. ONC should use its convening power and bully pulpit to further advance the need for improved provider-to-provider data exchange. Unfortunately, the Da Vinci Project, which bills itself as representing "value-based care stakeholders," has been spread too thin to appropriately focus on this issue, with 17 different ongoing projects and use cases it's trying to tackle.

Interoperability and data liquidity are more than just getting data into the hands of patients. Patients should not be the conduit for interoperability. Instead, interoperability should enable patients to access their records for their needs and uses, and it should allow providers to share records with each other to provide high-quality, well-coordinated care. We can't expect patients' access to their own records to fully solve our interoperability problems.

Keep a focus on burden reduction

ONC recently published its "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs," and NAACOS values its findings and recommendations. The four areas it addresses — clinical documentation, usability, federal EHR reporting requirements, and public health reporting requirements — are all necessary to reduce the burden of EHR use. NAACOS has and will continue to offer comments on specific reporting requirements, which often come from the Centers for Medicare & Medicaid Services (CMS), but we wanted to offer ONC a few guiding principles as well.

Federal mandates, whether they are intended to be placed on providers or the IT systems they use, still require time and manpower to implement. ONC and its federal partners should always consider the clinician and other affected parties in the health ecosystem when creating new requirements and be mindful of the burden they might cause. It's important to note that they don't always make clinical

workflows easier, and it's critical to consider the cost of implementing federal mandates or policy changes and impact on clinical workflow.

Earlier this year, the Health IT Advisory Committee developed a new task force whose goal is to reduce clinician burden and improve efficiency. But the focus of the Intersection of Administrative and Clinical Data Task Force has zeroed in on prior authorization. Burden reduction is an area that goes beyond prior authorization, and we hope ONC's work in this area focuses on bigger picture issues.

Integrate social determinants and health data

NAACOS members are increasingly working to address patients' social needs, recognizing that much of clinical spending is influenced by, or dependent on, social factors. As such, we need a broader federal effort to connect social data sets from non-HHS agencies (including housing, transportation and labor) with clinical and claims data we already possess. Together, social needs and health data could help unleash knowledge to address patients' needs in non-clinical settings. ONC should help standardize the collection of social needs data among different providers, payers, and community organizations. Unless we act now when resources and attention are flowing into the field, data risk being stuck in silos for years to come, and we will face the same problems we have now.

ONC can use its convening power to help advance the Gravity Project, an initiative undertaken by Health Level Seven International (HL7) to identify and harmonize social risk factor data for interoperable electronic health information exchange. The Gravity Project is working to identify and code elements representing social determinants in EHRs, focusing on three areas: food insecurity, housing instability and quality, and transportation access. This is potentially valuable work ONC can help promote.

Population-Level Transfer of Health Data

NAACOS was very appreciative of Application Program Interface (API) certification criteria in ONC's proposed interoperability rule to support the data exchange of multiple patients, and we are glad to see it finalized. This data could include a specific provider's patient panel and a group of patients cared for through an APM. As stated in the final rule, APIs that focus on multiple patients would enable providers to better manage patient populations as well as external services such as quality improvement support, population health management, and cost accountability.

ACOs face challenges in trying to extract data from multiple EHR systems to pool into a single source to access patient records, analyze data, and generally manage the care and quality of their assigned patient populations. If successful, wider use of APIs and easier access to data through APIs will help ACOs who today must deal with disparate EHR systems and deploy costly techniques to access, exchange and use data. While NAACOS appreciates ONC's mentioning of population-level transfer of data in its strategic plan, it would be a missed opportunity to not recognize its use in APMs.

Connect data across the care continuum

NAACOS appreciates ONC's previous efforts to support IT use and adoption in healthcare settings that were ineligible for meaningful use incentives, including long-term care, post-acute care (PAC) and behavioral health. To successfully manage patients' needs, we need data across all sites of service, not just traditional doctors' offices and hospitals. Since ACOs must work across care settings, they are hampered by poor care transitions.

Prioritizing care transitions goes beyond using IT systems and involves systems' ability to receive data from disparate systems. Unfortunately, providers struggle with workflow issues and are forced to manually enter or lookup patient information. Policy must focus more intently on data importation to better support interoperability, rather than giving exclusive attention to sending records.

As outlined in our June 2019 response to CMS's interoperability rule, there are several strategies federal policymakers can employ to improve information exchange across care settings. CMS could consider a pilot to test the ability of PAC vendors to better consume data from the acute setting to improve care handoffs, efficiency, and outcomes. The agency should consider ways to financially support PAC providers in joining health information exchanges and health information networks. When it comes to specific data points needing to be exchanged between acute and post-acute providers, policymakers should start with elements with board applicability, including functional status, medical conditions, and comorbidities.

Conclusion

Health IT should be an enabler, not a burden, for ACOs and others in value-based care models. It is possible that technology can be both a tool to offer better patient care and at the same time make office work simpler. Thankfully, ONC has several efforts underway in the areas we address above. But we want to ensure that you weigh the considerations of providers focused on APMs into your work. Advancing value-based care is a secretarial priority, so it should influence ONC's work. APMs have unique interests and needs in this space that must not be ignored and addressing those specific needs will improve patient care and quality while reducing costs in the long-term. With those positive outcomes in mind, we hope you consider the needs of those working in population-health payment models, including ACOs, as you continue your valuable work. If you have any questions, please contact David Pittman, Health Policy and Communications Advisor, at dpittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS