

July 31, 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

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

RE: Office of the National Coordinator for Health Information Technology (ONC); Proposed Interoperability Standards Measurement Framework Open for Public Comment

Dear Dr. Rucker:

UnitedHealth Group is pleased to respond to ONC's Proposed Interoperability Standards Measurement Framework 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 works 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.

In furtherance of these goals, UnitedHealth Group is providing technology to solve multiple stakeholder interoperability business needs through our many capabilities. Optum has 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.

Consistent with our letters in response to ONC's 2015 and 2016 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 in support of the Triple Aim.

Comment 1: Is a voluntary, industry-based measure reporting system the best means to implement this framework? What barriers might exist to a voluntary, industry-based measure reporting system, and what mechanisms or approaches could be considered to maximize this system's value to stakeholders?

- UnitedHealth Group believes that a voluntary reporting system is an appropriate approach to capture how industry stakeholders are advancing in the electronic exchange of health information. However, ONC should confirm who is submitting and reporting and provide clear instructions on how to report to certify the data is aggregate so there is no duplicative messages and documents.
- A valuable reporting system means the establishment by ONC of minimum standards that provide a consumable format for easy clinical data integration. There must be a framework in place that focuses on value and/or outcomes of patients. Further, ONC code sets and standards need to be aligned between the government and industry practices while protecting the identity of the vendors when standards are reported. The lack of minimum standards is further complicated by decisions EMR and other developers make about how standards are deployed or customized, which then increase barriers to tracking and employing basic standard functionalities of interoperability and interoperability standards. Given the tremendous expense in effort, time, and resources in both acquiring and facilitating data exchange, ONC can and should implement minimum standards around IT language, data transmission and basic functionalities so we can all support and prevail from a successful framework.
- UnitedHealth Group requests that the ONC should not report specific vendor information. This information should be private to protect proprietary practices.

Comment 2: What other alternative mechanisms to reporting on the measurement framework should be considered (for example, ONC partnering with industry on an annual survey)?

If ONC wishes to use a survey tool to measure interoperable data exchange and health information, UnitedHealth Group highly recommends the adoption of the survey tool and process used by the eHealth Initiative and its Interoperability Executive Workgroup. This Workgroup focuses on:

- Establishing a baseline understanding of the meaning of interoperability in technical and operational terms, and specific criteria to be collected for collective measurement of interoperable data.

- Connecting with other interoperability efforts – and fill in the gaps.
- Disseminating information to the eHealth Initiative community and beyond.
- Continuing to contribute to the Online Interoperability Resource Center, a collection of interoperability success stories.

ONC could leverage or collaborate with eHealth Initiative’s effort on interoperability measurement.

Comment 3: Does the proposed measurement framework include the correct set of objectives, goals, and measurement areas to inform progress on whether the technical requirements are in place to support interoperability?

UnitedHealth Group requests the ONC provide more specific standards because industry stakeholders may have different opinions of what the determinations are from the ONC. For example, Health Level Seven International (HL7 v2) is a widely used standard and works well for messaging information such as vaccination data and lab results. However, it is highly flexible and invites extensive variability around definitions for data elements. EMRs tend to impose high costs and complex processes, such as point-to-point VPN tunnels, to share HL7 transactions.

The HL7 Clinical Document Architecture (CDA) standard is not complete or simple to use. Additional conformance details have improved the standard, yet there remains no overall conformance across vendors and providers on how to generate CDA documents. There has been limited success with pushing HL7 CDA data back into Electronic Medical Records (EMRs). In addition, clinical data from EMR vendors must be trusted as a standard data source. In some cases, Continuity of Care Document (CCDs) generated from EMR vendors directly are considered non-standard. We encourage ONC to work with healthcare stakeholders to resolve this.

The HL7 Fast Healthcare Interoperability Resources (FHIR) standard does offer a more common language, data set, and timely queries in support of true interoperability between disparate systems. FHIR has the potential to streamline data exchange and create a standardized framework for requesting data. However, the FHIR standard remains immature, evolving slowly, and not widely adopted. The first normalized version is not expected to be released until late 2018.

UHG Recommends the development and implementation of FHIR as a common and streamlined set of Federal health data standards without delay. In addition:

- Require a CCD with every claim and assign a standard to ensure the same data always arrives in the same format.
- For point-of-care data capture, identify a single clinical vocabulary that meets the needs of quality measurement and real-time clinical decision support for each data type.
- Require as part of health IT certification: batch exchange and triggers; an import standard for EMRs to pull in structured data; automated health event monitoring; and HHS Clinician and Groups Survey data exchange.
- Promote standards for batch data exchange capabilities with EMR vendors, versus sharing one encounter at a time.

We ask ONC to address the lack of interoperability content standards with, for example, HL7 v2 and v3. The lack of content standards has become a detractor for data exchange because data is simply

unreliable to use. This is further complicated by decisions developers make about how standards are deployed or customized, which will no doubt increase barriers to tracking interoperability standards. Given the tremendous expense in effort, time, and resources in both acquiring and facilitating data exchange, ONC can and should implement the use of existing standards, where appropriate, and if there are gaps ONC should develop, with stakeholder input, appropriate standards. Today, vendors like labs still use non-standard codes in lieu of Logical Observation Identifiers Names and Codes (LOINC). And, the very same member/patient can be coded differently by different vendors but for the same purposes. ONC can help tremendously by building upon the standards currently under development that provide a consumable format for easy integration. Having a framework in place that focuses on value and/or outcome would encourage this moving forward in the marketplace. Further the ONC code sets and standards need to be aligned between the government and industry practices while protecting the identity of the vendors when standards are reported.

Comment 4: What, if any gaps, exist in the proposed measurement framework?

UnitedHealth Group believes challenges remain in the exchange of complete data sets and the need to include both clinical and administrative data - X12 and HL7 are not in alignment and there needs to be consistency among measures. 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. ONC should look to emerging technologies standards like these which are consistent with the ONC Roadmap as data is being exchanged.

UHG Recommends ONC accelerates the development and implementation of FHIR as a common and streamlined set of Federal health data standards without delay.

- Require a CCD with every claim and assign a standard to ensure the same data always arrives in the same format.
- For point-of-care data capture, identify a single clinical vocabulary that meets the needs of quality measurement and real-time clinical decision support for each data type.
- Require as part of health IT certification: batch exchange and triggers; an import standard for EMRs to pull in structured data; automated health event monitoring; and HHS Clinician and Groups Survey data exchange.
- Promote standards for batch data exchange capabilities with EMR vendors, versus sharing one encounter at a time.

Comment 5: Are the appropriate stakeholders identified who can support collection of needed data? If not, who should be added?

UnitedHealth Group recommends that ONC expand the focus of measurement beyond “meaningful EMR” users, and that additional priority stakeholders for measurement be specified that include eligible interoperating stakeholders, such as, all health care providers; health plans/payers; disease and population health managers; health information exchange (HIE) entities; and consumers. In addition, health care providers should not be limited to those who have contact with CMS related to the Medicare Fee for Service member population. Limiting the measurement focus only to the population

of certified Meaningful Use users greatly underestimates actual information exchange activities in a given community. These additional and important secondary uses will continue to expand with the additional focus in the marketplace on analytics-based activities to support population health management and value-based payment models.

UnitedHealth Group recommends ONC convene a multi-stakeholder expert panel to report on what metrics of what “widespread” means based on how successfully the data support the defined prioritized list of use cases. As a beginning question and process, ONC should ask the expert panel, for each ONC prioritized use case, to discuss/pick at least “more likely than not” for each example of high value data exchange, which would be the minimum floor for defining “widespread”. This will help to develop a concrete and quantifiable definition across interoperable measures of data exchange.

We believe the aim of this activity (to measure interoperable health information) is to support Congress and its intent to promote widespread interoperability of health information to achieve the Triple Aim; and then look to ONC to implement a results-oriented interoperable plan that will result in value and outcomes through good data exchange measurement. Overall, we strongly believe that while interoperability is necessary to achieve the Triple Aim, it is not sufficient and we encourage ONC to ensure that the exchange of data results in improvement in outcomes for patients. We encourage ONC to keep focused on the fact that interoperability is a means toward the end of better patient care, better outcomes, and more efficient resource use.

Private-sector led organizations are working diligently to establish data standards and common frameworks for sharing health information. Organizations such as HL7, Integrating the Healthcare Enterprise (IHE), the Argonaut Project, Cooperative Exchange, Clearinghouse Quality Review organizations and eHealth Exchange are developing and testing standards and processes to enhance connectivity.

Connect-a-thon events have also advanced health data standards through low-cost real-world testing scenarios. These events facilitate the integration and testing of capabilities across platforms in ways that are otherwise difficult to reproduce by a single organization.

Additionally, the HIMSS Interoperability Showcase provided an opportunity to experience scenarios of health data-sharing between disparate systems. This resulted in key learnings that are now being leveraged by multiple industry stakeholders to advance product designs.

Comment 6: Would health IT developers, exchange networks, or other organizations that are data holders be able to monitor the implementation and use of measures outlined in the report? If not, what challenges might they face in developing and reporting on these measures?

Private-sector initiatives have yet to achieve the scale and pace to rapidly accelerate adoption of common data standards to achieve widespread interoperability in health care. UnitedHealth Group believes that details are very high level so it is hard for data holders to understand exactly what the ONC is requesting. Flexibility is good but the ONC must identify all stakeholders and specify what stakeholders ONC intends to reach out to make sure they are not missing key players.

UnitedHealth Group recommends:

- Launch public-private partnerships that scale-up the testing of standards and accelerate use case development to rapidly disseminate new intelligence to the industry.

- Host a series of public-sector led events to convene and enhance coordination across standards-setting industry organizations, instead of these groups working on disparate efforts.
- Coordinate with other ONC workgroups.

Comment 7: Ideally, the implementation and use of interoperability standards could be reported on an annual basis in order to inform the Interoperability Standards Advisory (ISA), which publishes a reference edition annually. Is reporting on the implementation and/or use of interoperability standards on an annual basis feasible? If not, what potential challenges exist to reporting annually? What would be a more viable frequency of measurement given these considerations?

UnitedHealth Group believes annual reporting is sufficient however the ONC should consider aligning reporting of the Interoperability Standards Advisory (ISA) with the Health IT Certification Program rules. It would be helpful to industry stakeholders if both are updated consistently and simultaneously on annual bases so they can be on the same track and aligned.

Comment 8: Given that it will likely not be possible to apply the measurement framework to all available standards, what processes should be put in place to determine the standards that should be monitored?

UnitedHealth Group believes that much of the current measurement of data exchange has focused primarily on the number of transactions, or connections. Instead, we believe the value of the data/information being exchanged must also be taken into account. This is best accomplished by the definition of specific data domains or use cases in which data exchange can be measured and simultaneously assigned a weight based upon its value in supporting that particular use case or the derived outcome. For example, in a Care Coordination use case, the exchange of Care plans is of much higher value than the exchange of miscellaneous, non-indexed notes, such as PDFs. Without a framework for assigning value to the exchange, the note would be counted equally to the Care plan, which is misrepresentative and therefore much less effective.

In addition, interoperability ensures that as patients move from one provider to another their data are complete and actionable so handoffs are smooth, readmissions are prevented, and effective care is delivered in every setting. As such, measuring interoperability “by provider” or “by transaction” separates the means from the ends. We would suggest, therefore, looking directly at the goal of interoperability and counting how often data was or was not shared that could have prevented a specific event, e.g., a 30-day readmission. Specifically, we would suggest sampling a set of patients who readmitted within 30-days, reviewing the inpatient, ambulatory, primary care records, and any involved post-acute records to determine when, whether and how data was or was not shared. This would give a clear sense of how much is being shared, with whom, and whether the data were used effectively. We would suggest that the current chart abstraction methods used to collect the Joint Commission measures could be leveraged to accomplish this kind of in depth measurement. It would give a qualitative as well as quantitative view on how well the system is functioning for those who obviously needed it.

Comment 9: How should ONC work with data holders to collaborate on the measures and address such questions as: How will standards be selected for measurement? How will measures be specified so that there is a common definition used by all data holders for consistent reporting?

ONC should leverage a variety of data sources to reflect the widest possible view of actual interoperable data exchange in the marketplace, and not limit data exchange to just certified EMR

exchange supported by the Meaningful Use Program. Further, interoperability measures should reflect a number of different data domains and represent prioritized use cases beyond transitions of care and encounters. Population health and analytics uses now constitute a significant part of data exchange efforts in the marketplace and these uses need to be accounted for in any interoperable measures developed by ONC.

ONC should consider the wide multiplicity of data types that are available and necessary for the management of care, resource utilization, and the cost of care. We encourage ONC to focus on the exchange and measurement of laboratory results, admission, discharge, and transfer (ADT) data, radiology and pathology results, medication data, biometrics, immunization data from a variety of sources using the appropriate standards to ensure the availability of a complete history of a patient's care. In addition, we recommend ONC should focus where applicable on ensuring that data are made available from multiple sources. In our experience no one source provides 100% of the required data, for example, we have found that obtaining laboratory results from providers EMRs *and* laboratory facilities is imperative for us to collect laboratory results data for all of our members for quality reporting. Similarly, medication-prescribing data are available from inpatient and outpatient EMRs; however, the pharmacy and the PBM data sources provide additional information including the medication fill history, the exchange of both the medication prescribed and the medication fill data is essential to ensure patients are receiving and compliant with appropriate care.

Comment 10: What measures should be used to track the level of “conformance” with or customization of standards after implementation in the field?

There are a number of tools like the ONC Consolidated Clinical Document Architecture (C-CDA) score card and FHIR that can be used measure conformance with standard and drive consistency in enforcement of common streamlined data standards and implementation specifications to avoid significant manual rework and expense downstream.

UnitedHealth Group recommends:

- Ensure HIE trust policies and practices allow for analysis of all available data around specific health episodes to determine when and how data was or was not shared in order to improve clinical outcomes, close gaps in care, and reduce preventable health issues.
- Focus on the value and not the number of data transactions by prioritizing domains and use cases that improve quality and health outcomes such as readmission prevention, timely access to acute care, and care coordination for patients with chronic conditions.
- Support adoption of automated patient matching algorithms.
- Require hospitals to exchange Admission, Discharge and Transfer (ADT) and discharge summary data.
- ONC must do more to address the fact that Facsimile continues to be the method of communications (between members, providers and health plans), and it is very costly and outdated. Secure email must become the primary form of communication and standard adopted by ONC.
- Require providers to implement EMR bi-directional data exchange to send and consume clinical data through their EMR's so they can actually accept data back into their systems.

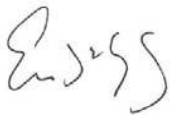
- Support a complete history of a patient’s care by including the exchange and measurement of lab results, Admission, Discharge, and Transfer (ADT) data, radiology and pathology results, medication data, biometrics, and immunization data from a variety of sources.

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,



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



Eric Murphy
Chief Executive Officer, OptumInsight