March 18, 2020

Don Rucker, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
Mary E. Switzer Building, Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Re: ONC Draft 2020-2025 Federal Health IT Strategic Plan

Dear Dr. Rucker,

On behalf of Providence St. Joseph Health we thank you for the opportunity to provide feedback in response to the Office of the National Coordinator for Health Information Technology (ONC)

At Providence St. Joseph Health we are committed to providing for the needs of the communities we serve, with a special focus on those who are poor and vulnerable. We are dedicated to high-quality, compassionate health care for everyone - regardless of coverage or ability to pay. Together, we share a singular commitment to improve the health of our communities through digital innovation, population health and clinical quality strategies, mental health, specialty institutes, research and education. Our diverse family of organizations employ 119,000 people who serve in 51 hospitals, 1,085 clinics, a health plan, senior services and housing, and many other health and educational services across seven western states. Each year we work to provide care and services where they are needed most, including investments in community benefit that in 2018 totaled $1.6 billion.

Providence St. Joseph Health appreciates the opportunity to provide comments on ONC's Draft 2020-2025 Federal Health IT Strategic Plan. We commend ONC on its well thought out Strategic Plan and would like to highlight four priority areas for ONC's consideration:

- Patient Identification
- Data Access and Exchange Standardization
- Social Determinants of Health (SDoH) Capture & Opportunity
- Harmonization of Privacy Rules Across Agencies

Patient Identification

A prerequisites to value based care information exchange is the ability to precisely identify the providers and attributed beneficiaries to a VBC program. From a technical perspective, prior to the exchange of information is knowing the answer to the following questions:

1. Which patients/members are in the request list for resources?

2. How do we identify and verify eligibility of the requestor's need to access this data for all these patients/members?
    - One of the biggest challenges faced when managing populations – especially those under risk payment models is "to precisely identify" who the covered beneficiaries are from a month to month basis. Unless the payer-provider or the two business entities reach an agreement about synchronizing these populations, the request (either single or bulk data transaction) may be perceived as a compliance and privacy risk.
    - The focus needs to be on enabling monthly communications around the administrative side of population health agreements – such as member rosters (provider and attributed members by VBC program). Requiring the dissemination of timely accurate reports to VBP's identifying the above information should be a pre-condition to single or bulk data transaction exchange through FHIR API's.

These prerequisites are essential for information exchange whether it is between a payer and a provider's EMR or a payer and a provider's designated repository.

Providence St. Joseph Health in its effort to promote secure exchange of patient data, within and outside its borders, strongly supports continued efforts to establish a Universal Patient Identifier leading to increased accurate Patient Matching.

- Without a UPI it makes it very difficult to ever achieve true interoperability. Technically a UPI would solve patient matching issues, however the political and cultural settings are at risk for security reasons, such as "who would control access, etc." Patient matching is an issue and if there was an established standard today that the industry could adopt and support, Providence St. Joseph Health would use as well.
- Inaccurate patient matching is a quality of care and patient safety issue. Accurately identifying patients and matching them to their data is essential to coordination of care.

Data Access and Exchange Standardization

Providence St. Joseph Health has over 109 value based care agreements with government and commercial payers that cover over 1.5 million lives under risk arrangements, each with varying data collection and reporting requirements.   Prioritizing and harmonizing these requirements across Medicare and Private Sector Alternative Payment Models would reduce the current operational complexity of complying with the Alternative Payment Model (APM) requirements, including beneficiary identification, performance monitoring, reporting and population management.

As Value Based Care programs continues to evolve and grow through complex programs with multiple payers, Health IT is a crucial underpinning to exchanging meaningful data to manage APM financial benchmarks and productivity expectations between payers and providers.

Providence St. Joseph Health strongly agrees with ONC that *"Healthcare provider success in value-based payment models is contingent upon access to robust data that allows them to better understand the needs of their patients, stratify their patients by risk, engage in additional patient outreach and track improvement over time. Further, health plans require new types of data at the population level to define and measure outcomes and assure improved health for Americans."* These new types of data include the convergence of both claim-level claims and EHR data. This data needs to be sent in near-real-time

(e.g. ADT) via a standard API format to meet provider's clinical, operational, and quality improvement business needs. This data provided in a standard API format is necessary for "scalability" of Value Based Care.

Providence St. Joseph Health current experience with Value Based Care contracts is that:

- Only 20-30% provide usable member eligibility data;
- Less than 10% of contracts provide member claim-line detail; and,
- Between 25 and 35% of contracts provide usable contract performance summaries.

These data types, expanded below are typically, not received or received in a non-standard format with imprecise data that require manual review and entry and are crucial to the success of value based care programs.

Eligibility data - Accurate member-level enrollment data to identify which members are included in the contract. This information is essential for clinical care and for accurately measuring contract performance (e.g. membership projections).

Member PCP relationships – Understanding the payer's perspective of how a member is assigned to a product and which PCP and/or Tax ID Number and/or medical group the member belongs to allows the determination of who is responsible for managing each member's care.

Contract performance reports – Monthly payer-generated performance reports are crucial because payers are generally the arbiters in determining financial performance on risk contracts with health systems. Payers have information on Per Member per Month (PMPM) spend, contractual terms, regional or historical trends, and other financial information that health systems need to track and manage performance on those contracts. Claims data alone is usually insufficient to understand risk contract performance. These reports allow validation of the enrollment and claims data provided by the payer and to evaluate contract performance. This includes identifying up-to-date membership counts as well as information on financial performance for the current and previous plan years (or going back to beginning of contract), including target estimates, medical loss ratio.

Plan benefit summaries – Annual benefit summaries are commonly used to identify spend and utilization management opportunities as well as to determine performance benchmarks for populations. These summaries include major policy terms for the most common plan designs associated with the contract, including member deductibles, copays, coinsurances, benefit maximums as well as descriptions on how to identify each member's benefit in the enrollment data.

Member care/documentation gap reports (quality measures) – Monthly gap reports identify care opportunities for individual members and aggregate results to better understand and manage contract performance for the quality metrics specified in the contract.

Capitation payment reports – Monthly file details the payments and adjustments for a given period for all members included in a capitated contract. Capitation revenue data is necessary to validate capitated payments and to evaluate contract performance.

Post-acute care/Skilled nursing facility (SNF) information & bi-directional interoperability - Post-acute care operational and performance tracking require access to near real-time quality and cost/utilization

claim-line level data via standard API that includes ALL claims-data generated outside of the organization to identify areas for process improvement.

This data and the associated reports need to be sent timely, contain complete information and be in a standard format that provides the ability to parse and make the data useable and actionable across all value based care programs, both commercial and government that include managing total cost of care. In addition, providing aggregate data does not deliver the level of data to meet business needs. As stated above, less than 10% of contracts provide member claim-line detail. Claim-level data is required to make the data useable and actionable, as described below.

Claim-line level data

This data must be provided in Claim-line level data to measure and manage contract performance, to identify high-risk members, and to provide clinical care. Processing claim line level detail allows comparison of strategically important risk arrangements on an apples-to-apples basis. Claim line detail can be used to understand performance and utilization at a detailed level, to risk stratify member populations and for clinical care (i.e. accurate coding initiatives, care management, clinical pathways, etc.). A written description of data is also required that is de-identified or excluded from the claims, as well as control totals (i.e. total records) with each deliverable for data validation purposes.

We encourage ONC and CMS to prioritize the development of and incorporate implementation of standards to support VBC APM as part of rulemaking that would require complete, accurate and timely information to be sent by all participating stakeholders in VBC arrangements, including Commercial and Governmental Payers, Institutional and independent Providers, Diagnostic Services, Pharmacy, SNF/Post-acute Care.

Core HIT providers need to support these standards at no additional administrative/utilization costs.

Social Determinants of Health (SDoH) Capture & Opportunity

We encourage ONC to go further in its strategic plan, since the collection of SDoH during a patient visit, isn't enough. Access to reliable SDoH data from community-based organizations that resides outside of the EMR would allow an early alert system to detect unmet chronic and mental healthcare needs. This information should be protected to ensure it is not utilized to enable a new revenue stream for 3rd parties. Since community-based organizations are not covered entities under HIPAA TPO, which results in privacy challenges, we recommend regulation be revised to allow collection of specific SDoH data that provides patient protections, but allows early detection of unmet healthcare needs through a consumer opt out selection.

Further, we would like to call to your attention that there is wide degree of variability in format, structure and accuracy of directory of community services compiled by private and public agencies. We would recommend consideration of an industry wide standard for construction and communication of a directory of community services that address social determinants needs. Such a directory standard would facilitate interoperability between systems and allow updates to be available at the point of referral so that patients are presented with the latest community resource options available to meet their social determinants needs.

We support the expansion of telehealth to home sites to increase the opportunity to reach attributed populations that do not typically come into the office for a visit to perform Medicare Wellness or other E/M visits, recognizing telehealth should not replace onsite visits when preferred by patients. We encourage HHS to accept the telehealth mode of healthcare delivery as a viable option to capture accurate HCC's and SDoH to ensure preventive medicine can be deployed to a patient population that typically doesn't take advantage of annual visits.

Harmonization of Privacy Rules across Agencies

Monitoring and tracking privacy rules across agencies, for example FERBA (education regulations) and HIPAA is labor intensive. The harmonization of privacy rules across agencies would strengthen protections and reduce current administrative burdens to maintain compliance with varying regulatory requirements.

Thank you for your consideration of our comments concerning the prioritization of Patient Identification, Data Access and Exchange Standardization, Social Determinants of Health (SDoH) Capture & Opportunity and the Harmonization of Privacy Rules across Agencies. We hope that you find our input informative. For more information, please contact Sarabeth Zemel, manager, federal regulatory affairs and engagement, at (425) 525-3228 or via email at Sarabeth.Zemel@providence.org .

Sincerely,

Rod Hochman, MD
President and CEO
Providence St. Joseph Health