



July 14, 2016

VIA ELECTRONIC MAIL

Dana Safran and Glenn Steele
Chairs
Population Based Payment Group
Health Care Payment Learning and Action Network

Re: Population-Based Payment Work Group's Data Sharing White Paper

Dear Chairs Safran and Steele,

The Health Care Transformation Task Force ("HCTTF" or "Task Force")¹ appreciates the opportunity to comment on the work of the Health Care Payment Learning and Action Network ("LAN") Population-Based Payment Work Group's ("Work Group") draft White Paper titled *Accelerating and Aligning Population-Based Payment Models: Data Sharing* ("White Paper"). As with all LAN projects, the Task Force looks forward to collaborating with the LAN and all of its work groups to help facilitate widespread health care delivery transformation.

The Task Force supports innovative, person-centered, value-based payment models and recognizes the importance of data sharing to drive improvements in cost and quality under these models. We believe the principles put forth in the White Paper are directionally consistent with the data sharing needs we believe are essential for the successful operation of population-based payment models, including an emphasis on transparency, collaboration across the care continuum, and patient-centeredness. Further, we posit that any accountable entity requires a complete, patient identifiable data set to effectively manage triple-aim goals.

While we understand the Work Group's intent to focus on the "who," "what," and "why" of requisite data arrangements, we support the further specification of options and endorsement

¹ The HCTTF is a group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

of meaningful recommendations to address the “how” of each arrangement. Considering the high rates of EHR adoption among hospitals and office-based physicians², we are now at a place where greater specificity is necessary to drive usability and optimize functionality.

In response to the White Paper’s Use Cases and Recommendations, we offer the following comments for consideration related to implementing the recommended data sharing approaches:

Stakeholder communication regarding privacy and security

The Use Cases appropriately describe the potential benefits for purchasers, payers, providers, regulators, researchers, and patients when health care data is made available to support improved health system performance. We have found that some groups may need more targeted and cogent information to gain an appreciation for that benefit.

As noted under Recommendation 3 of the White Paper, “Patients have valid concerns that information in their personal health record will be shared and used in ways that they do not approve of.” Stakeholders should be encouraged to partner with patients and families to develop and communicate information about data sharing practices and goals for delivery system reform generally. Communication pieces should be developed in collaboration with patients and families to ensure language clearly describes, at appropriate literacy levels, why and how their health information will be stored, exchanged, used and protected, the opportunity to opt-out, and other consumer protections. Providers and practice staff should likewise be permitted and encouraged to discuss delivery system goals and the purpose/benefits of data sharing with patients, with recognition that different patients will have different expectations and comfort around data sharing.³

Consent policies

Purely opt-in consent policies have proven prohibitive in reaching the goals discussed in the White Paper. Further, the variation in consent policies and/or regulatory requirements among states, providers, payers, and data types can cause confusion and subsequently low rates of data sharing due to onerous or unnecessary policies. We support the inclusion of consent policy best practices in the next iteration of the White Paper, including an examination of the limitations presented by the 42 CFR Part 2 provisions on the ability for providers to engage in the recommended data sharing approaches and provide high quality treatment and care coordination that address all of a patient’s health needs.

² <http://dashboard.healthit.gov/dashboards/dashboards.php>

³ The recommended framework is rooted in the widely accepted Fair Information Practices (FIPs), a set of policies for privacy and security that form the basis for many laws in the United States and internationally. The Fair Information Practices include transparency about data policies; limiting the collection, use, and disclosure of health information to what is necessary for the particular purpose; protecting the quality, integrity, and security of the information collected; and ensuring accountability through appropriate audit trails and enforcement. These principles operate in tandem with one another: overreliance on one or some principles weakens the greater collective effectiveness of the fair information practices, but utilizing the whole set provides comprehensive privacy and security protection.

Practical considerations

We believe that payers, purchasers and providers must continuously improve access to complete, accurate, reliable, timely data. Yet, the cost and burden for providers to access, aggregate, and exchange clinical information from their certified electronic health records for population health and care coordination purposes – even under a public utility model – can be exorbitant. The White Paper should address the issue of infrastructure cost, both for upfront investments and ongoing maintenance, and endorse approaches to surmount this barrier.

Additionally, the paper does not address regulatory burdens (such as 42 CFR Part 2) which hamper the ability for providers participating in population-based payment models to coordinate care and improve population health.

Transparency

In principle, we support the goal of making population-level data available and transparent among health care stakeholders. We also recognize that health care stakeholders can be differentially mandated to participate in data aggregation or transparency efforts. In light of the Supreme Court’s decision in *Gobeille v. Liberty Mutual*, which excludes ERISA plans from state legislated participation in all-payer claims databases, a specific case must be made for self-insured groups to participate in public-utility data repositories.

In summary, we support continued development of the White Paper to incorporate best practices and lessons learned based on the experience of early population-based payment model participants.

Please contact HCTTF Director of Payment Reform Models, Clare Wrobel, at clare.wrobel@leavittpartners.com or (202) 774-1565 with any questions about this communication.

Sincerely,

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