Author Full Name : Frank McStay **Received Date :** 02/22/2021 04:01 PM

Comments Received :

Ms. Sherrette A. Funn,
Paperwork Reduction Act Reports Clearance Officer, Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: 0990–New–30D| Agency Information Collection Request; 30-Day Public Comment Request: HHS Teletracking COVID–19 Portal (U.S. Healthcare COVID–19 Portal)

Dear Ms. Funn,

We appreciate this opportunity to provide feedback to the Office of the Secretary regarding the hospital reporting burden associated with the collection of data for assorted disease monitoring and resource allocation purposes during the COVID-19 pandemic.

Baylor Scott and White Health (BSWH) is the largest not-for-profit healthcare system in Texas and one of the largest in the United States (US) with over 1,100 access points. Our organization employs more than 48,000 and affiliates with more than 7,500 physicians, attending to more than 7 million patient encounters annually. As a fully-integrated delivery system, our accountable care organization (ACO) and Scott and White Health Plan cover over 900,000 lives through both public and commercial contracts. In 2018 and 2019, BSWH received an exceptional performance adjustment in the Quality Payment Program (QPP). It is our ambition to be a trusted leader, educator, and innovator in value-based care delivery.

The pandemic has laid bare some underlying deficiencies in the infrastructure and process to gather data. Reporting requirements and systems have been instituted by diverse health care authorities at the local, state, and federal levels, applying inconsistent definitions for key variables, such as what counts as a “COVID-19 case” or a “COVID-19” death, and differing practices for reporting (for example, whether a new case is counted towards the date on which it is reported or the date on which the sample was drawn). Additionally, even when the definitions and reporting practices align, there may be substantial differences in testing patterns between jurisdictions – or even in the same jurisdiction over time, driven by availability of supplies as well as variable priorities for testing (for example, setting out to capture a random sample of the community vs targeting high risk settings such as nursing homes or prisons) that invalidate comparisons, if data elements such as age are not captured to enable risk adjustment.

We provide further details on these issues in our attached response. We appreciate this opportunity to provide feedback to HHS regarding data reporting requirements and the associated burdens. BSWH values the partnership the federal government has built with providers and would be happy to answer any questions that may arise from our comments here.

Sincerely,

Kristi Sherrill

Cc: Frank McStay, Senior Policy Advisor