Meeting Notes

INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE (ICAD TF)

March 3, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

During its inaugural meeting, members of the Intersection of Clinical and Administrative Data Task Force (ICAD TF) introduced themselves to the task force. Co-chairs **Sheryl Turney** and **Alix Goss** reviewed the task force's charge, timeline, and procedures. Members discussed the task force's approach to workstreams and potential subtopics of importance. There were no public comments, but there were several comments written in the public meeting chat via Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call
03:05 p.m.	Welcome & Introductions
03:20 p.m.	Overview of Task Force Charge and Timeline
03:35 p.m.	Review of Task Force Procedures
03:45 p.m.	Discussion of Task Force Approach to Work Streams
04:20 p.m.	Public Comment
04:30 p.m.	Adjourn

CALL TO ORDER

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the March 3, 2020, meeting of the ICAD to order at 3:02 p.m.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Steven Brown, United States Department of Veterans Affairs
Gaspere C. Geraci, Individual
Mary Greene, Centers for Medicare & Medicaid Services
Anil Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point of Care Partners
Leslie Lenert, Medical University of South Carolina
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Abby Sears, OCHIN
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic
Andrew Truscott, Accenture
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Rich Landen, Individual/NCVHS
James Pantelas, Individual/Patient Rep

WELCOME & INTRODUCTIONS

Before turning the meeting over to the co-chairs, **Lauren Richie** reviewed some of the features of Adobe Connect, the program used to conduct the virtual meeting, and she reminded task force members a public comment period would be held towards the end of the meeting. Also, she noted that there is a chat feature in which members may use to weigh in, but she reminded everyone that those comments would be captured as part of the official record of the meeting.

The co-chairs of the task force, **Sheryl Turney** and **Alix Goss**, welcomed members to the first meeting of the ICAD TF. **Sheryl Turney** stated that the efforts of the task force will serve the needs for more detailed information for both the Health Information Technology Advisory Committee (HITAC) and the National Committee on Vital and Health Statistics (NCVHS), as both are focused on the topic at this time. She asked members, as an introduction, to state their name, a little bit about themselves, their organization, and their title.

Introductions:

- **Sheryl Turney** is from Anthem, Inc. Her title there is Senior Director of Data Enablement & Quality Management.
- **Alix Goss** is from Imprado, which is the consulting division of DynaVet Solutions. In addition to her private sector consulting role, she sits on the NCVHS, where she is the co-chair of the Standards and Review subcommittees. She said that NCVHS is charged with providing guidance to HHS on HIPAA related transactions and privacy and security matters.
- **Anil Jain** is a VP at IBM Watson Health. He serves as the Chief Information Officer and has a variety of responsibilities, including setting the tone and direction on data efforts on areas including the use of clinical EMR data and administrative data that comes from a variety of different sources. He is a member of the HITAC, as well. Finally, he is a part-time practicing primary care physician at the Cleveland Clinic.
- **Arien Malec** is VP of R&D at Change Healthcare, where he runs large administrative processing networks, as well as clinical networks. He said that they process eligibility and claiming volumes, clinical attachments into claims transactions, and they are the service provider for Commonwell. He is excited about this task force because he thinks there is a lot of untapped promise for better efficiency and better quality of the US health care system sitting at the intersection of clinical and administrative inoperability and administrative data for administrative efficiency.
- **Andy Truscott** is Managing Director for Health and Public Service at Accenture, a health and public service business, and he works with clients in North America and around the world to help them embrace health information and technologies to make the jobs that they do faster, better, cheaper, higher quality, better patient outcomes, and more. Also, he co-chaired the Information Blocking Task Force of the HITAC.
- **Leslie Lenert** is a Professor and Assistant Provost at the Medical University of South Carolina, and he works on learning health systems and population health systems. He represents the public health perspective on the HITAC as a voting member, and he said that he is particularly excited about the idea of being able to streamline prior authorizations.
- **Ram Sriram** is a program manager for the National Institute of Standards and Technology (NIST) Health IT Program, which is deeply involved in developing tools for the testing infrastructure. He is also involved with the Networking Information Technology Research and Development (NITRD), which includes many federal agencies working together under an umbrella organization. He said that there is a health IT working group there, with which he is closely involved. It works on medical device interoperability and the National Academy of Medicine report on procuring interoperability, that came out last year. His primary expertise is in computer science with a four-decade focus on artificial intelligence.
- **Sasha TerMaat** is with Epic, an electronic health record company, and she also works with many developers of electronic health records in the Electronic Health Record Association, where she is a current member of the executive committee.

- **Abby Sears** is the CEO of OCHIN, and she is on the HITAC, as well. OCHIN hosts electronic health records all across the country for safety net healthcare organizations, so they have the largest database of under-insured or Medicaid patients around the country. Also, she said they are huge advocates for the movement of data.

- **Jim Jirjis** is the Chief Health Officer for HCA Healthcare. Because they have interoperability coming, he said that his primary interest is in the burden on providers and the interference with the patient's continuity of care due to delays. He said that there is endless frustration between the provider, the patient, and the insurance company, and, because they have 185 hospitals, he is interested in scalable solutions that take out some of the frustration. Also, he is a member of the broader HITAC committee.

- **Denise Webb** has 20 years of experience in health IT. The first part of her health career was at the Department of Health Services in Wisconsin, and she worked primarily on the policy end of health IT. Then, most recently, she was at Marshfield Clinic Health System as their CIO. She has been on the HITAC committee since its inception, and she is interested in making progress in the area of clinical and administrative data integration, particularly around reducing provider burden and making things better for the patient so they can get care right away around prior authorization.

- **Debra Strickland** is a program manager at Conduent Services, and she serves as a member of NCVHS. She worked as a volunteer on X12, co-chaired the Admittance Advice workgroup for over 15 years, and helped several leadership positions in the Standards community.

- **Jacki Monson** is the Vice President, Chief Privacy and Information Security Officer at Sutter Health, and she serves on NCVHS. She said that her expertise is in privacy and security.

- **Gaspere C. Geraci** said that he spent the last 20-25 years on the insurance side. He is a family physician and an ER doctor by background, has done prior authorization for about 25 years, and he has practiced medicine through most of his career. He said he could not list his current employer for various reasons, but he is a Chief Medical Officer for a large Medicaid insurance plan in Pennsylvania and has served at the state and national levels in similar roles in the past. He had an interest in IT for many years, with a special interest in health IT. He has worked with **Alix Goss** in the past, trying to implement an HIE in Pennsylvania. He said that he can speak to both sides of the issues, with regards to prior authorization.

- **Jocelyn Keegan** works for Point-of-Care Partners, which is a small consultancy focused on where standards and industry match up. She is the Payer Practice Lead, and she works on care and strategy on the pharmacy and medical side, and she focuses on specialty medications, specifically how to improve their workflows and automate them. Additionally, she spends half of her time as the program manager for the Da Vinci Project. She is a Task Group lead of Pharmacy ePA at NCPDP, former Task Group lead of Specialty Pharmacy Benefit Identification at NCPDP and leads POCP's team in support of ONC FAST (FHIR at Scale Task force).

- **Aaron Miri** is the Chief Information Officer at the University of Texas at Austin. He is a current member of the HITAC and a prior member of the health IT policy committee. He co-chaired the Annual report workgroup and works with many individuals on the ICAD on several different task forces. His passion is around privacy and security, as well as research, data, big data and how to leverage data into artificial intelligence in the near future.

- **Steven Brown** is the Director of Knowledge-Based Systems (KBS), program office within the Veteran Health Administration (VHA)'s Office of Informatics and Informatics Governance (OIIG), Health Informatics (HI) Component. The KBS Office is responsible for Standards, Terminology, Clinical Decision Support, and Informatics Architecture. He runs an office of knowledge-based systems. He said that his office has been doing standards for bodies like this at the federal level since the days of the consolidated health informatics initiative and the first contests in the early ops.

- **Alexis Snyder** is an independent family advisor and engagement specialist. She works with several researchers to ensure the caregiver voice is present and represented across many areas of health care, such as process improvement and patient center outcomes. She joined the HITAC in January, representing patients and caregivers, and is very excited about being able to represent the patients' and caregivers' voices on the ICAD task force.

OVERVIEW OF TASK FORCE CHARGE AND TIMELINE

Sheryl Turney gave an overview of the new task force's charge. She said that its vision is to support the convergence of clinical and administrative data to improve data interoperability to support clinical care, reduce burden and improve efficiency— furthering the implementation of "record once and reuse." She noted that its overarching charge is to produce information and considerations related to the merging of clinical and administrative data, its transport structures, rules and protections, for electronic prior authorizations to support work underway, or yet to be initiated, to achieve the vision. She emphasized that the task force should leverage existing information and work from HITAC and NCVHS prior authorization hearings, and other sources, to inform the task force's information acquisition and analysis efforts. She listed the specific charges, which are as follows:

- Design and conduct research on emerging industry innovations to:
    - o Validate and extend landscape analysis and opportunities, and
    - o Invite industry to present both established and emerging end-to-end solutions for accomplishing medical and pharmacy prior authorizations that support effective care delivery reduce burden and promote efficiencies.
- Identify patient and process-focused solutions that remove roadblocks to efficient medical and pharmacy electronic prior authorization and promotes clinical and administrative data and standards convergence.
- Produce Task Force recommendations and related convergence roadmap considerations for submission to HITAC for their consideration and action. The Task Force will share deliverables with NCVHS to inform its convergence and PA activities.
- Make public a summary of its findings once task force activities are complete, no later than September 2020.

Sheryl Turney directed members of the task force to the part of the presentation with the timeline and noted that it will be adjusted. Roughly, the timeline states that the March-April period will be used to establish work streams and task force subgroups, if needed, and for landscape analysis. Work plans for the May-June and July- August periods have yet to be determined. The final recommendations will be submitted in September 2020. She suggested that the task force might choose to break up into smaller teams. The goal will be to come up with combined recommendations, similar to how workgroups and task forces have done for the HITAC in the past. She noted that the Information Blocking Task Force of the HITAC used an effective method; they had preliminary recommendations and presented those to HITAC to get input. Then, they updated their work based on the input they received, leading to final recommendations. She emphasized that, because she understands the nature of how this works, she believes the task forces needs to have some preliminary recommendations fairly well developed in the July timeframe to meet the final September date.

REVIEW OF TASK FORCE PROCEDURES

Lauren Richie reminded task force members that all of the calls are open to the public, and each meeting will include a public comment period at the end. She said that they try to honor that time period, so if they get off schedule, they will take a break as per the agenda to see if there are public comments

on the phone, and, then if there is remaining time, they will come back to the discussion. Also, she reminded members that the task force does not provide recommendations directly to ONC. They are submitted to the full HITAC for final vote and approval, and then they go from the HITAC to the National Coordinator for consideration for ONC policy or programs. In this case, those recommendations will then advance to the NCVHS Subcommittee on Standards for consideration. Finally, once everything is approved and transmitted to the respective agencies, they become final recommendations and are posted on healthIT.gov. For their convenience, she listed the other ONC and Accel Solutions staff who might contact the task force in the future.

DISCUSSION OF TASK FORCE APPROACH TO WORK STREAMS

Alix Goss began the discussion of the task force's approach to work streams by giving an overview of the current landscape. She noted that previous ONC and NCVHS work has described numerous challenges for payers, providers, and patients when conducting prior authorization related activities and tasks. She gave some examples of disparate requirements and opportunities for improvement and action, which included:

- HIPAA-mandated use of the X12 278 Version 5010 rather than the NCPDP SCRIPT transaction standard for medication authorization requests.
- Limited adoption of or support for the mandated HIPAA transaction standard X12 278 for medical services.
- Outdated and complex workflows.

She noted that ONC is compiling a list of key artifacts outlining the current landscape of standards and mechanisms for exchanging clinical and administrative data, with a focus on prior authorization, which will be shared with the task force to inform its work. She said that the task force has a good opportunity to advance past work and to improve the day-to-day lives of administrative staff supporting the clinical delivery, including inefficient faxes, portals, phone calls, etc., and to achieve better outcomes for patients.

Alix Goss said to accomplish the timeline that **Sheryl Turney** described, which is to advance weekly to the point where a draft recommendation is ready in the July timeframe, several steps need to be undertaken. The first step is to examine the landscape holistically to identify:

- Specific gaps and opportunities to fully enabling the electronic flow of information needed at the point of care within the electronic health record workflow.
- Availability and use of appropriate, harmonized standards (transport and business rules) to support desired flow.
- Data protections risks, gaps and best practices.
- Barriers to existing regulations to achieve care delivery and system efficiencies.
- Considerations for converging clinical and administrative data frameworks.

She said that step 2 will build on the findings of step 1 and may suggest that different solution approaches will be needed across medical services, pharmacy, devices, and specialty prior authorization processes. As previously mentioned, she noted the task force could divide into subgroups to examine each of these areas, applying lessons learned along the journey. Then, she invited task force members to share questions and comments.

Discussion:

- **Sheryl Turney** said the work is difficult because it is conceptual and said she likes to think in terms of what would her desired end goal be for the effort in question. She gave an example of an ideal patient experience to illustrate her point. She said that gaps in the EMR system and lack of data connections to all payers were an issue and posed several related questions to spur discussion.
- **Arien Malec** proposed that the task force should start with critical metrics and definitions of delight for

each of the actors (patient, provider, payer) and use this information to make strategies to bring down to the total cost of care. He stated that the task force could consider the key actors and ask questions like, "What information do they have?" and, "What workflow drives the end customer benefits?"

- **Les Lenert** emphasized laying up a good foundation for going forward. In the current system, he said, there is a lack of transparency from the patients' and the providers' perspectives. He proposed that the task force should come to some agreement as to what the gold standard is, and that gold standard should be the consensus of experienced physicians. He emphasized that prior authorization rules must be considered in terms of their impact on health outcomes. Secondly, discussed the problem of physicians and patients not being on the same side and noted that it is important that decisions be shared so patients have a way to explore what is and is not authorized. This should be done by a company independent of the physician. He said that a patient's autonomy should always be preserved in this situation, in case a physician has made a recommendation that favors themselves and not the patient. He urged the task force to consider how to move ahead with newer technologies, such as AI, to a much better vision of what prior authorization could be, rational, cost-efficient and providing equally to patients and insurers.

- **Jim Jirjis** inquired how much work the task force intends to do in the area of insurance companies that are, intentionally, trying to keep costs down and margins high and may have instituted delays. He said it seems like the task force would want to start with mapping out the workflows and starting with a platform where the data, information, and content rules are exposed, and, at a later time, CMS and others could decide to regulate what the requirements are for the insurance companies. He asked if the charge of the task force is to define the process and what kinds of API's timeliness rules and what types of automation need to be included, as well, or is the job of ONC to solve the evidence-based medicine versus the insurance companies' misaligned goals? Which is it that the task force is supposed to deliver in September?

  - o **Sheryl Turney** responded that the focus of the task force is to look at what recommendations can be made to clear some of the hurdles to what is required to submit a prior authorization and which procedures or medications require prior authorization, including which supporting documents are needed. When it comes to AI and decision making, she noted that she assumes the task force can make recommendations related to using evidence-based, but it should be cautious in that regard because there is no standard for AI decision making, what is the patient's right of access and knowledge regarding what decisions are made with AI, and whether the AI data is direct (can show evidence) or circumstantial (like a social determinant of health, something made using assumptions, self-reported data).

  - o **Dr. Thomas Mason**, Chief Medical Officer at ONC, responded they should be thinking about areas where the task force can make an impact in the regulatory process. He said that it is important to initially focus on recommendations that will go to the National Coordinator, which will also be relevant for NCVHS.

  - o **Mary Greene** of CMS said that they have been focused on the process itself and how to make it more efficient, more transparent, and standardized. She said they have been shying away from addressing anything that is in the purview of making decisions about how prior authorization should be used, although they have a lot of information about it. She said they are not focusing on that right now, though the issue does come up for clinicians often. She raised the issue of formulary changes triggering the need for more prior authorizations. **Alix Goss** responded that, in her mind, none of the topics are off the table, and the task force should consider dividing into smaller groups to examine all of the topics.

- **Jocelyn Keegan** noted that it is the lack of clarity, the variability, and the lack of clear information and sources of truth for provider organizations that make prior authorization so painful. She loves the theme of transparency. She challenged the task force to think of their goals as more submitting a form and getting a workflow; rather, she pressed the task force to consider what workflow is involved and to try to understand a patient-specific benefit at the point in time of care. She said that if they look at it from a workflow perspective, then they will be able to show the best practices that tie together existing

standards and where they can experiment so they can unleash the data to make real progress.

- **Gus Geraci** responded to **Mary Greene's** comments about formulary changes and prior authorizations, and he said that sometimes they change because the manufacturers make changes to discounts or rebates, and it has nothing to do with efficacy and quality. He said that before they talk about prior authorization and define the basis for it, they have to define what is meant by "medically necessity" and the concept of trying to provide some kind of definition of quality, because, he said, the definitions of the two are intertwined. He would like the task force to address the idea of quality.

- **Arien Malec** thinks the members of the task force should proceed with the notion that they assume good intent, assume there is an issue with inappropriate utilization, and assume that there is a reasonable interest in putting safeguards in place. They should assume there is an interest in getting the patient the most appropriate care and there is an interest in spending as little time, energy, and effort in getting the patient to the highest quality of care at the most appropriate.

- **Jim Jirjis** described possible scenarios for workflows related to the need for prior authorization and inquired if the authority the task force could include examining preexisting workflows, stripping out what good looks like from a transparency perspective, determining priorities, and defining what the standards would be to reduce the burden between the care and the provider that a patient gets caught in. He asked if anyone would confirm how far ONC's authority extends.
  - o **Lauren Richie** said that the charge and outline of the committee were very specific. She said that the task force will advise the HITAC, which is authorized to provide health IT recommendations to ONC. NCVHS is a separate and distinct advisory Committee, yet because the topic at hand involves both interoperability and standards, we anticipate that the work of the Task Force will also inform NCVHS in its work to develop standards-related recommendations, which are submitted to the HHS Secretary.
  - o **Sheryl Turney** responded that a one-page document on the division of authority between ONC and NCVHS could be created and distributed at the next meeting.

PUBLIC COMMENT

There were no public comments.

Questions and Comments Received via Adobe Connect

Adi Gundlapalli, MD: Adi Gundlapalli MD from CDC here

Jim Jirjis: Jim JIrjis Present also

Lauren Richie: Hello Jim

Aaron Miri: Aaron Miri also present

Lauren Richie: Hi Aaron!

Aaron Miri: Howdy from Texas :-)

Leslie A Lenert: AI should be used to summarize and replicate and scale human judgment

Jim Jirjis: Seems like we need the chassy before the horse...standardizing the process and some level of rules around the process

Jim Jirjis: The guidelines often have grey area

Jim Jirjis: So the insurance company has wiggle room

Gus Geraci, MD: There is a great deal of controversy in the PA process about offering alternatives to what is being denied. Some rule making or guidance about that may be helpful. Transparency is a good key theme.

CLOSING REMARKS AND ADJOURN

Sheryl Turney and **Alix Goss** thanked members for their thoughtful participation and feedback. **Alix Goss** summarized the main themes from the meeting: transparency, understanding workflows, getting to work on a wide range of activities, critical metrics of "delight"/knowing what "great" looks like, conversations around the medical necessity and quality aspects. She said that the co-chairs would work with ONC on the materials and determining a structure for the next meeting. **Sheryl Turney** noted the conversations that occurred around workflows. She said it would be helpful if they define the information requirements related to each actor, how they might be different, and then talk about what happens when prior authorizations are denied. The task force could consider some techniques and alternatives or standards that could be put in place.

Alix Goss thanked the members of the ICAD Task Force for their participation and feedback, and she reminded them that the March 10 meeting had been canceled. The next meeting will be held on March 17. The ICAD will continue meeting, weekly, until September. **Lauren Richie** thanked everyone and reminded them all that the notes and materials from this meeting would be provided to them soon.

The meeting was adjourned at 4:24 p.m. ET.