The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

May 12, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Co-chairs **Alix Goss** and **Sheryl Turney** welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Alix Goss** summarized the agenda and the recent activities of the ICAD TF.

Presenters from the American Medical Association (AMA) presented on the state of PA from the perspective of physicians. ICAD TF members discussed the presentation and submitted questions for the presenters.

Sheryl Turney noted that she and **Alix Goss** will present an update on the ICAD TF's work to the Health Information Technology Advisory Committee (HITAC) at their May 13 meeting. She outlined the items that they will present, including the task force charge, vision, approach, and a list of questions. The ICAD TF discussed the wording of specific questions and how to reframe them for clarity.

The Data Classes Workgroup Update and State/Guiding Principles Workgroup Update were moved from the agenda to a future meeting.

There were no public comments submitted by phone. There were several comments submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	American Medical Association Presentation and Discussion
03:40 p.m.	HITAC Update Discussion
03:50 p.m.	Data Classes Workgroup Update
04:05 p.m.	Ideal State/Guiding Principles Workgroup Update
04:20 p.m.	Public Comment
04:30 p.m.	Adjourn

CALL TO ORDER/ ROLL CALL AND WELCOME

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the May 12, 2020, meeting of the ICAD TF to order at 3:02 p.m. ET.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Gaspere C. Geraci, Individual
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Anil K. Jain, IBM Watson Health
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator
Alex Mugge, Centers for Medicare & Medicaid Services
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Sasha TerMaat, Epic
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Steven Brown, United States Department of Veterans Affairs
Mary Greene, Centers for Medicare & Medicaid Services
Leslie Lenert, Medical University of South Carolina
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Abby Sears, OCHIN
Debra Strickland, Conduent/NCVHS
Andrew Truscott, Accenture

SUMMARY AND ACTION PLAN

Alix Goss, co-chair of the ICAD TF, reviewed the agenda for the current meeting. She noted that the ICAD TF has heard presentations over the past several meetings that were meant to help expand their understanding of the current landscape and emerging standards, and she summarized these presentations. The ICAD TF heard an overview of the HL7 Da Vinci Project, including its history, goals, use cases, and timelines. They saw demonstrations of electronic prior authorization (ePA) approaches and processes from Humana and Regence. These presentations focused on medical ePA, from the payer perspective, and how they have used existing X12 and emerging FHIR-based standards (Da Vinci). The ICAD TF discussed needs and opportunities for process streamlining, real-time benefit information, automated approval, and cost benefits.

She noted that at today's meeting presenters from the American Medical Association (AMA) would share the state of PA from the perspective of physicians.

AMERICAN MEDICAL ASSOCIATION (AMA) PRESENTATION AND DISCUSSION

Heather McComas, PharmD Director and Director of Administrative Simplification Initiatives, introduced herself and the other presenters from the AMA, including **Laura Hoffman**, Assistant Director of Federal Affairs, and **Matt Reid,** Sr. Health Care IT Consultant.

Heather McComas presented an overview of the agenda for the meeting, which included the following topics:

- Current state of prior authorization (PA): not too delightful
  - 2018 AMA PA physician survey data
  - The human face of PA
- Where are we on PA reform?
  - Consensus Statement on Improving the Prior Authorization Process
  - Status of PA reform efforts
- Observations: we've been listening to the ICAD TF
- Suggestions for path forward & questions

She discussed care delays and the increase in treatment abandonment associated with PA. She noted that, in December of 2018, the AMA fielded a survey of 1,000 practicing physicians to capture the impact of PA on both patients and physicians. One question from the survey asked about the frequency of delays in access to necessary care for patients whose treatment required PA, and the results indicated that 91% of the surveyed physicians said PA could delay access to necessary care. Also, she noted that three-quarters of physicians surveyed indicated that PA could lead to treatment abandonment. Then, she explained the way in which these factors combine to impact clinical outcomes. She highlighted the issue of patient harm and shared that 28% of physicians report that PA has led to a serious adverse event for a

patient in their care. She explained that there are human and financial costs, and she provided statistics that illuminated the burden placed on physician practices, and she noted that 88% of physician practices have reported that PA burdens have increased over the past five years.

She emphasized that the statistics illustrated a troubling picture. The AMA captured numerous physician and patient stories about PA on their PA website, and she detailed the example of how delays in the PA process might have contributed to the recovery challenges and subsequent death of a patient suffering from metastatic melanoma.

She noted that the AMA partnered with other organizations to prioritize addressing issues surrounding PA. The 2018 Consensus Statement on Improving the PA Process (Consensus Statement) was released in January 2018 by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. The five broad areas of reform addressed in the Consensus Statement were:

- Selective application of PA
- PA program review and volume adjustment
- Transparency and communication regarding PA
- Continuity of patient care
- Automation to improve transparency and efficiency

The goal of the Consensus Statement was to promote safe, timely, and affordable access to evidence-based care for patients; enhance efficiency, and reduce administrative burdens. She noted that, following the Consensus Statement, progress has been sluggish, and she shared the following statistics:

- 86% of physicians report that the number of medical service PAs required has increased over the last five years.
- Only 8% of physicians report contracting with health plans that offer programs that exempt providers from PA.
- 69% of physicians report that it is difficult to determine whether a prescription or medical service requires PA.
- 85% of physicians report that PA interferes with continuity of care.
- Only 21% of physicians report that their electronic health record (EHR) system offers electronic PA for prescription medications; phone and fax are still the most common methods.

She noted that the AMA has been listening to the ICAD TF over the past several months, and she thanked them for their work. She noted that they have heard that the ICAD TF is taking a broad, "sky's the limit" approach, but, while the AMA appreciated the ambitious nature of the TF's work, she voiced her concern that the TF would not be able to accomplish all of its goals before the September deadline. She noted that the ICAD TF mentioned allowing multiple standards to automate the same process (floor/ceiling), and she stated the AMA's concern that requiring physician practices to use different standards for the same process would be very cumbersome and expensive.

She summarized information the AMA gathered while listening to the recent presentations given to the ICAD TF on the prescription drug PA process and landscape. She noted that an established standard exists, and it is the NCPDP SCRIPT standard for electronic PA (ePA). However, the presentations indicated that its implementation is variable across EHRs and payers. Also, she noted that, even with automation, ePA vendors' recommended practices have a "centralized PA team" to complete the ePA question set. She stated that this is concerning and indicates a burden. She noted the exploration of real-time pharmacy benefit (RTPB) technology but indicated that the current solutions that were discussed are proprietary. She noted that the AMA was interested in the medical PA presentations that were given to the ICAD TF at their previous meeting. The AMA heard throughout the TF discussions that the Health

Insurance Portability and Accountability Act of 1996 (HIPAA) mandated X12 278 (278) adoption (the transaction to electronically submit authorization and referral requests) is weak, and there is no mandated standard for exchange of supporting clinical data (attachments). She noted that the AMA heard the ICAD TF and presenters expressing a strong interest in advancing technology, but she noted that the projects described in the presentations were in the prototype/" sandbox" environment. She questioned if these are solutions that could be widely scaled across the industry and would be available to physician practices within a reasonable period of time.

She phrased the AMA's recommended ingredients for success using the metaphor of a cake, and the "layers" of recommendations included:

- Bottom layer: Standard technology should be integrated into the EHR, ordering workflow that providers use to determine PA requirements across all health plans at the point of care.
- Top layer: Standard electronic transaction should be integrated into the EHR workflow that supports a payer-agnostic automated PA workflow and minimizes provider burden.
- Icing: Support for the top and bottom layers is necessary to hold the whole cake together, including tools to improve adoption of standards.
- Recipe: Data are needed to inform choices in standard selection before they start mixing the batter, including metrics to establish baseline and measure progress.
- Scalability: Multiplication of recipe is necessary to serve many guests, including baking time for a huge "PA cake."
- Toppings: Extra goodies (e.g., patient communications, cost information, coordination of benefits) could be added after they are sure the cake is stable.

Then she gave a brief overview of recommendations and work related to both the prescription drug PA process and the medical services PA process that could be used when the ICAD TF creates its deliverable for the HITAC in September. These recommendations were detailed in the presentation slides and were divided by the metaphorical cake layer categories. She noted that many of these concepts came from the recent ONC Burden Report and explained examples.

She listed some final thoughts and considerations, which included:

- Need for PA reform is urgent to prevent patient harm and reduce provider burdens
- What concrete, immediately actionable recommendations can Task Force make?
- If there is an existing, viable standard:
  - Recommend adoption and actions to ensure vendor/payer support
  - Recommend enhanced implementation to further reduce practice burdens
- If there is not a viable standard:
  - Research PA data needs to ensure any solution will work across payers (e.g., models requiring attestation vs. actual clinical data)
  - Initiate cross-payer pilot to test a single PA workflow for a small range of services
  - Evaluate the time/costs to implement solution across current volume of services requiring PA
- Establish baseline metrics to track progress (e.g., PA volume, approval/denial rates, processing time)
- Consider how USCDI can be leveraged/expanded to improve PA and other types of data exchange
- Set timelines for all actions
- Beware the seductive siren call of flexibility
  - Multiple technology options across payers is not a standard

- Without uniform process across payers, there are no efficiency gains for providers
- Keep needs of small physician practices in mind – especially in these challenging times

In closing, she provided her contact information and a link to AMA's online resources.

Discussion:

- **Alix Goss** thanked **Heather McComas** for the presentation and noted that the final slides, which contained the AMA's recommendations, would be valuable to the ICAD TF as they continue their work.
- **Gus Geraci** submitted several comments:
  - He noted that, early in their meetings, the ICAD TF determined that the process PA does have to exist. Additionally, he emphasized that not all PA requests should be approved. He stated that, given his background as a former family doctor, clinician, and a former CMO for managed care organizations, he has been part of a team that has appropriately denied unnecessary surgeries, diagnostic testing, and radiology testing.
  - He addressed the topic of physicians receiving a high volume of PA denials and questioned whether it is part of the ICAD TF's charge. He stated that it might partly be due to physicians practicing what might be out-of-date medicine and that they should flag these providers to the insurance companies. He noted that the role of the AMA in deciding what to do with physicians who exceed the norm in denials should be part of the AMA's charge, but he suggested that it might not be part of the ICAD TF's charge.
  - **Heather McComas** submitted several responses:
    - She noted that the AMA is not calling for a complete elimination of PA, but, rather, they are asking for PA to be reformed and right-sized to ensure that patients are not harmed and that unnecessary costs are not introduced into the health care system.
    - She drew the ICAD TF's attention back to the presentation slide that referenced the Consensus Statement and noted that addressed his concerns about physicians not following guidelines and having their PAs denied. She stated that the AMA's approach is to get rid of some of the volume through flagging physicians with many denials while working to reduce some of the burdens of the system for the majority of physicians that are following guidelines and getting their PAs approved.
    - She stated that any solution to the PA volume issue would include a great deal of programming in the EHR and payer communities, and the AMA is concerned that the issue will not be addressed in a timely fashion.
  - **Gus Geraci** detailed the ways in which his experiences as a doctor and as a CMO have shaped his opinions, and he called for a system of flagging physicians that have gotten frequent denials and instituting a practice of "gold-carding," in which practices that have no or very low denials are exempt from PA. He discussed his personal experiences with small practices and PA, and he noted that a universal database of all insurers would help with this process.
  - **Heather McComas** responded that the AMA would be interested in continuing the discussion about operationalizing gold-carding. She noted that the AMA views gold-carding as beneficial for all involved and an effective way to cut down on costs and time needed for the process.
  - **Gus Geraci** voiced his agreement and noted that they could target the high-denial doctors with a correction plan.
- **Arien Malec** submitted several pieces of feedback:

- He commented that the thought process behind the concept of "floors and ceilings" that was mentioned came from their historical work on PA, and he noted that the ways in which standards are researched and released leads to large-scale EHR certification rollouts. He discussed the notion that the goal is to gradually raise the floor for standards and to provide regulatory flexibility for organizations that want to pilot, implement, and rollout advanced capabilities and to acknowledge interoperability.
- He discussed the history of the rollout of e-prescribing and how developments in that process drove workflow improvements.
- He asked AMA to speak to the concept of floors and ceilings and inquired about the roles of incentives, payment policies, and coordinated work between CMS and commercial insurers in terms of providing mandates and incentives, relative to ePA.
- **Heather McComas** acknowledged his comments and provided responses:
  - She noted the floor should be available and suggested that the ceiling is something that practices and systems with more resources can explore with payers. She noted that the AMA is concerned that the contract negotiation power is often not on the side of providers. Also, there is a concern that the floor has to be a workable option that offers enough capability to transmit the clinical data needed to support medical service PAs; she noted that the most basic option should not require practices to go through a portal or to use a phone or fax to complete the process.
  - She discussed incentives and the need to make sure that technology is available. She noted the issue of cost concerns, especially in the wake of the COVID-19 crisis; she noted that practices would be hesitant to spend extra money on additional technology to comply with a mandate.
  - She noted that awareness is also an issue and shared that AMA has a short ePA educational video series for physicians on their website.
- **Laura Hoffman** responded that many providers feel the need to constantly update to keep up with the evolution of technology, and because there has not been a specific standard named and established, people are not sure in which one they should invest. She highlighted the AMA's call for decisions and guidance on these standards and noted the need for pilots.
- **Arien Malec** highlighted the tension in the conversation around rollouts and mandates and noted the AMA's desire to see the ICAD TF solve some of the PA workflow issues. He discussed the potential tradeoffs in the process in regard to requiring a mandate or not and to network adoption. He noted that there could be an optimal approach in which the requirements imposed actually drive significant workflow improvements.
- **Laura Hoffman** responded that the AMA would be very supportive of a singular standard. She noted that they have not seen good uptake on the 278, despite the mandate. She recognized the need for a concerted effort to make people use the standard, but she noted that this might be a separate discussion.
- **Heather McComas** referenced a study conducted by the Agency for Healthcare Research and Quality (AHRQ) on e-prescribing that included ePA for prescription drugs. It came to the conclusion that the 278 was not the right path for prescription drug PA, which is why the National Council for Prescription Drug Programs (NCPDP) developed a different standard that worked through e-prescribing and fit into a physician's workflow.
  - She inquired if the ICAD TF would feel comfortable issuing a formal report on these topics.
  - She noted that the recommendation could be research, as a first step,

then pilots, and then a timeline to decision.

- **Rich Landen** noted his appreciation for the presentation, and he highlighted the themes from the AMA presentation of uniformity across all payers, scalability, and information technology, as the primary ingredient. He asked how an IT-driven solution would be scaled down to work for small practices, as they typically have greater challenges making investments in IT.
  - **Heather McComas** responded that the ICAD TF might look into recommending pilots including providers with small, medium, and large practices. This would allow them to discover if having a centralized PA team is a possibility for smaller practices, as this process could impose an administrative burden. She praised the Da Vinci Project's work but encouraged pilots to include smaller providers. She noted that evaluating the costs across the practice sizes would guide the decision-making process and ensure that no practice is left out.
  - **Matt Reid** shared two points:
    - He noted that he has a background in working in a medium-sized practice but shared his experiences with smaller practices. He explained that within practices of these sizes, there is an expectation that when an EHR is purchased, it should be able to do everything the physicians need to manage patient care and facilitate payer-provider interactions. He stated that they need to think about how to ensure that the core component of the EHR can manage everything without add-ons, which can be costly. He noted that they are thinking the United States Core Data for Interoperability (USCDI) standard and ONC's certification process when considering how to leverage EHRs in the short and longer terms.
    - He emphasized the need for uniformity and a process that is widely applicable for the entire health IT community. He highlighted difficulties faced by small practices when trying to manage many one-off customizations to the EHR. He noted that they prioritized leveraging technology that was already in place.
- **Jocelyn Keegan** thanked the AMA presenters and submitted several pieces of feedback:
  - She emphasized that the solution that is chosen should be all-payer, meaning that the small and mid-sized practices should have the same advantages and should work as the large systems do. She noted that the shift towards application program interfaces (APIs) and having everything happen in the EHR is important.
  - She inquired about how the perfect pilot would be structured, in their opinion. She asked for the presenters' opinions on how and where it should live, and she noted that experimentation will be critical as they move out of the current state of PA.
  - She discussed her experience with the Da Vinci Project and rolling out ePA across the provider landscape. She emphasized thinking about ecosystems when considering providers, and she inquired if the PA issue needs to be solved across all ecosystems or if just specific ones (like certain disease states or treatment areas) could be targeted.
  - She noted that gold-carding has to be a clearly defined system in which providers know for certain that they are "gold-carded" and can skip PA.
  - She emphasized that the new system has to be attractive to providers and easy for them to adopt. The investment in new technology must be worth the cost and burden.
  - **Heather McComas** responded the ideal pilot would involve all the major payers and would address a narrow set of services. They must consider scalability

issues, and there must be standardization in the PA data element request. She identified the need to agree on which data points are needed. She suggested including a mix of EHR vendors in with the various sizes of practices. They would need to have a set metrics for measurement defined before beginning the pilot. She emphasized the need to have whatever is built be able to accommodate all payers.

- **Laura Hoffman** reiterated **Heather McComas'** suggestion about the importance of knowing that certain services could receive the data elements required and that simplifying the process for physicians to know what data are needed ahead of time is important. She noted that the AMA clearly sees the value and promise of the work that Da Vinci is doing, but they have also heard from physician practices that worry that they will not be able to adopt these newer technologies. She raised the question of functionality and knowing if the standards support the exchange of the necessary data in a usable format. She emphasized the importance of minimizing the work and any additional steps for physicians and noted that they must consider the outcomes, impact, cost, and the time for the solution. She suggested developing a pilot, similar to the ones that AHRQ did for e-prescribing, in which they compare the 278 plus attachment standards track and a FHIR-enabled prior authorization track across different services. She suggested that they focus on a few different payers, different practice sizes, and gather data to determine the balance. She concluded by stating that the AMA would support a pilot that would help the industry make a decision about the direction in which it needs to head.

Sheryl Turney thanked the presenters from the AMA and noted that the ICAD TF would use the presentation as a reference for their work going forward. She asked that any additional questions be submitted offline.

HITAC UPDATE DISCUSSION

Sheryl Turney noted that she and **Alix Goss** will be presenting an update on the ICAD TF's work to the HITAC at their May 13 meeting. She outlined the items that they will present, including the task force charge, vision, and approach. They will share the ICAD TF's meeting schedule and progress to date with the HITAC, including their next steps. Then, she invited TF members to review and discuss the questions for the full HITAC, along with the workbook in their shared Google document, to create the whitepaper/deliverable that they will submit in September.

She presented a general overview of the list of potential questions for the HITAC and noted that the idea for the questions is to generate discussion at a future meeting of the ICAD TF.

Questions for the HITAC:

- As we move from PA focus to broader intersection of clinical and administrative data, what specific goal areas should be covered, or questions should be answered?
- What are key considerations for the task force to keep in mind?
  - Coordination of benefits
  - Cost transparency
- What should we say about timeliness of Prior Approvals across the spectrum?
- What about the standards and adoption of attachment requirements?
- What other topic areas should we include in the conversation of clinical and administrative?
- What are the barriers and changes EMR systems need to make to support the intersection of clinical and administrative data?

- Is there a way to standardize the data requests across payers which clinical decisions are based upon, even if the prior authorization decisions differ by payer, plan and product? And how would the USCDI fit into this model?

Due to time constraints, the discussion of questions for the HITAC was paused, and **Lauren Richie** opened the meeting for public comments.

PUBLIC COMMENT

There were no public comments via phone.

Questions and Comments Received via Adobe Connect

Alexis Snyder: Alexis Snyder is here

Alexis Snyder: Sorry couldn't [*sic*] unmute quick enough :)

Ram D. Sriram: Ram D. Sriram from NIST here

Lauren Richie: hi Alexis and Ram, noted

Rich Landen: I see the AMA slides are copyrighted. Can we get permission to share them outside ICAD?

Lauren Richie: hi Rich, we can ask AMA

Alexis Snyder 2: very good analogy :)

Jocelyn Keegan: Nice job here Healther [*sic*]. As I'm still stuck in my kitchen, recipe analogies, I love your cake layers :).

Alix Goss: Thank you AMA Team!

Heather McComas: Thanks all --appreciate your work! Heather

Laura Hoffman (AMA): Thank you all for having us today.

Lauren Richie: To the member of the public: please dial 1-877-407-7192 if you would like to provide comment

Lauren Richie: once connected, press "*1" to speak

Matt Reid: Agreed, thank you all.

Rich Landen: I suspect that the question on barriers and charges to EMR is premature: until we propose some sort of solution that describes the role of the EHR, how could barriers be identified?

Laura Hoffman (AMA): Good question to evaluate in a pilot! :)

Jocelyn Keegan: with utmost respect and deference to my wise colleague Rich Landen :)

Following the public comment period, **Sheryl Turney** opened the meeting up for discussion on the topic of the upcoming presentation to the HITAC.

Discussion:

- **Jocelyn Keegan** requested that the third bullet point be reworded for clarity. She inquired if the question was meant to reference time delays caused by PA or the ability to do PAs prospectively instead of retrospectively.
  - **Sheryl Turney** responded that the point was meant to address that not everything could be done in real-time and also raise questions of the amount of time steps in the PA process should take.
  - **Jocelyn Keegan** suggested the idea of rewording the point to address removing uncertainty about the processing of PAs. She noted that the characteristics **Sheryl Turney** described (for example: not knowing where the PA is, when it is being processed, who will give an update about it, if more data will be shared) all deal with the uncertainty part of the PA process.
- **Rich Landen** voiced his concern for how actionable the answers to the question about barriers and changes to EMR systems. He agreed with the idea of tying their work into the role of EMR systems, but he questioned the value of this question now when they do not know what the role for EMRs will be.
  - **Jocelyn Keegan** noted that it would be good to understand that the PA process does happen outside of the EHR and that they should have an awareness that patients' benefits coverage is not happening in the workflow. She suggested that they raise the issue of where that information should be surfaced in the workflow and what barriers might exist.
  - **Arien Malec** noted that the work on the "happy path" that the TF has done has shown that they should drive PA as far up the workflow as possible; the ideal would be at the time of referral or the order. He noted that, given that goal, they should inquire about how to best achieve this in the workflow by working with the EHR, instead of against them.
  - **Sheryl Turney** noted that the question would be reframed.

CLOSING REMARKS AND ADJOURN

Sheryl Turney thanked everyone for their participation in the meeting. Due to time constraints, she noted that the following items would be moved from the current agenda and would be discussed at an upcoming meeting:

- Data Classes Workgroup Update
- Ideal State/Guiding Principles Workgroup Update

She noted that other next steps would include members or groups continuing to add feedback on the Google document workbook, further consideration of the questions for the HITAC, and moving from the PA example to a broader discussion of integration. She noted that there is a possibility that another presentation would be scheduled. In the longer term, the ICAD TF could examine additional use cases, including pharmacy, medical service, hospital service, and specialty. She emphasized the need to begin working on the framework for the whitepaper/deliverable for the HITAC.

Alix Goss noted that the ICAD TF would form a group focused on privacy and security as the next step of work beyond what has been completed by the Guiding Principles/Ideal State workgroup. She stated that **Jacki Monson** has agreed to work with her in a small group to advance privacy and security-specific considerations beyond the high-level concepts they have captured so far.

She noted that the next meeting will be held on Tuesday, May 19, 2020. The meeting was adjourned at 4:31 p.m. ET.