The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

August 18, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Alix Goss and **Sheryl Turney**, co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Sheryl Turney** and **Michael Wittie** walked through a draft of the document and related artifacts for presentation to the HITAC, including a gaps document, remaining strawman recommendations, and a compendium of themes and suggestions from the third-party presentations that were given to the TF. After each recommendation and section, TF members submitted questions and comments. Before the conclusion of the meeting, **Alix Goss** briefly reviewed the TF's plans for moving forward and the next steps. 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.	Review Draft Paper and Comments
04:10 p.m.	Plans Moving Forward
04:20 p.m.	Public Comment
04:25 p.m.	Next Steps
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 August 18, 2020, meeting of the ICAD to order at 3:02 p.m. ET.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Steven Brown, U.S. Department of Veterans Affairs
Gus Geraci, Individual
Mary Greene, Centers for Medicare & Medicaid Services
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point-of-Care Partners
Arien Malec, Change Healthcare
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Andrew Truscott, Accenture
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Rich Landen, Individual/NCVHS
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
Alex Mugge, Centers for Medicare & Medicaid Services
Sasha TerMaat, Epic

SUMMARY AND ACTION PLAN

Alix Goss, co-chair of the ICAD TF, welcomed members and reviewed the agenda for the current meeting while noting her thanks to **Alexis Snyder** for the work she contributed offline. **Alix** noted that her co-chair, **Sheryl Turney,** and **Michael Wittie** would be walking through a draft of the document and related artifacts for presentation to the HITAC. **Alix** also provided a summary of the previous meeting, at which **Rich Landen** described the process he and **Arien Malec** took to synthesize recommendations from the ICAD TF strawman work and other materials and presented the draft recommendations section of the document. TF members provided feedback and discussion on the draft, including notes on the need to streamline and reduce repetitive content.

REVIEW DRAFT PAPER AND COMMENTS

Sheryl Turney opened the presentation of the ICAD TF's draft recommendations documents by explaining that **Michael Wittie** would share the work completed on each of the ICAD TF's documents via the Adobe meeting client.

Sheryl Turney presented the draft Guiding Principles and Ideal State Gaps documents (Gaps document) and cross-referenced the related sections of the revised Recommendations document. She summarized each of the recommendations that she and **Debra Strickland** identified during their offline work for the gaps and related priority target areas, which included:

Priority Target Area: Patient Access to Personal Health Information

- Gaps:
  - Ability to check on the status of a Prior Authorization (PA) electronically by patient does not exist today. In today's world the patient has to call both the provider and payer to check on the status and find out why it is stuck.
  - Patients don't know who to contact if they have issues with a PA approval. Patients need to know who to contact within both the payer and provider ecosystem who can support the PA approval.
- Related Recommendation: #7 – Develop Patient-centered Workflows and Standards
  - **Sheryl Turney** noted that this is connected to the second part of the recommendation, related to the "workhorse" administrative standards needed to be examined and suggested that the wording might not be detailed enough. Also, she highlighted the need to standardize wording across the ICAD TF's documents related to the explanation of benefits (EOB) API and the patient access API.
    - **Arien Malec** voiced his agreement with the intent of the recommendation and then discussed how the wording could be changed to communicate better the intent that all administrative standards are designed for patient access and involvement, which is inclusive of workhorse administrative standards.
    - **Sheryl** noted the comment and that the wording would be updated for clarity and harmonization across TF documents.

Priority Target Area: Interoperability

- Gaps:
  - Code sets exist but the application of the code sets to specific electronic health data that is exchanged is not consistent in the same data class. There are also market forces that impact the code sets since some are proprietary and costly to utilize.

- Attachment standards have not been adopted and as a result many providers are sending Consolidated Clinical Document Architecture (CCDA) which requires the recipient to have to mine the information required rather than having specific data exchanged based on what is required to support the PA.
- Image standards need to be adopted to enable the exchange of images in a standard digital format.

- Related Recommendations: #5 – Harmonize Code and Value Sets, and #6 – Make Standards (Code Sets, Content, Services) Open to Implement Without Licensing Costs
  - **Sheryl Turney** discussed the two possible related recommendations and inquired if, together, they accurately expressed the ICAD TF's recommendations focused on the convergence of standards and code sets and definitions of terminology. She suggested that they could be modified to included defining industry-related terminology consistently so APIs or programmatic interfaces could eventually be based on common terms.
    - **Arien Malec** suggested adding a new recommendation that focuses on standardizing the terminology for administrative workflows to make sure that all actors are using common terms to communicate requirements consistently.
    - **Sheryl** inquired if this should be added a new recommendation.
    - **Arien** responded that it could be added as either a new recommendation or a recommendation detail.
    - **Sheryl** thanked him for the feedback, and **Michael Wittie** incorporated it into the document as a placeholder for future work.

Guiding Principle: Design for the Future While Solving Needs Today

Next, **Sheryl Turney** reviewed some of the strawman recommendations related to the Guiding Principle of Design for the Future While Solving Needs Today. These strawman recommendations and related gaps were previously identified by ICAD TF members but have not yet been folded into the draft paper for the HITAC or recommendations.

- Strawman Recommendation: Establish a light weight and feasible exception process to achieve the spirit of 162.940.
- Gap: Might this cause a high level of experimentation in the industry, thus increasing burden on partners?
  - Partners would be willing participants
  - Only well-vetted options should be considered after amount of internal and external successful testing with partners. Personal interview by the ISA team so they can vet the success.

Discussion:

- **Sheryl** provided an overview of the suggested recommendation and inquired if any TF members could elaborate on it, especially concerning the two comments listed under the gap.
- **Debra Strickland** explained that she submitted the strawman recommendation to draw awareness to the existence of the piloting process, to help users understand piloting, and to make the process less cumbersome to bring more success to piloting.
- **Alix Goss** directed ICAD TF members to the ICAD TF's Recommendation #2 and noted that a new challenge and recommendation were identified.

- **Sheryl** added a comment to the recommendation to add an exception to the exception standards to link the Health Insurance Portability and Accountability Act of 1996 (HIPAA) world to ONC's Standards Version Advancement Process (SVAP).

Sheryl Turney asked the ICAD TF to consider whether the following strawman recommendation and gap should be called out within an existing recommendation or if there were too many complexities with a national pilot. She noted that there is a formal pilot process within HL7.

- Strawman Recommendation: Promote/develop/implement a national piloting process?
- Gap: Creating and funding pilots is a challenge.
  - Would need:
    - Hard and fast requirements on what a pilot must cover
    - Success criteria / Entity to certify the successful pilot
    - Willing partners who will build a new potential standard before it is mandated / regulated this is expensive.

Discussion:

- **Alix Goss** distinguished between the testing done at HL7 in the form of the Connectathon and the concept of true piloting that gets qualitative and quantitative feedback on a standard in a more representative environment.
- **Arien Malec** noted his agreement and suggested adding this information to Recommendation #2.
- **Alix Goss** asked to discuss the matter further and suggested that adding the concept as a new recommendation would prevent the ICAD TF's message from being diluted.
  - **Arien Malec** agreed and suggested that a new, separate recommendation could be added for both testing and piloting. **Alix** agreed that those could be added together.
  - **Sheryl Turney** suggested adding the new recommendation after Recommendation #6.
  - **Arien** responded that he would do an editing pass and add the information offline.
- **Jocelyn Keegan** agreed that testing and piloting should be a separate issue and noted that the current ability for someone to innovate is very burdensome. She discussed the ways which to reduce the burdens around creating architecture, the agreement to get an exception, and the burden and cost of piloting to scale. **Arien** noted that he would incorporate her suggestions.
- **Sheryl Turney** discussed her personal involvement as a payer in several piloting opportunities and suggested that standard terms and operations for piloting would be helpful and would reduce burdens related to data sharing and use agreement. In response to a question from **Alix Goss, Sheryl** noted that getting a data use agreement in place to do piloting is challenging with some provider partners.
  - **Jocelyn Keegan** added that this is a chicken and the egg type of issue.
  - **Sheryl** explained that setting up the data use agreement is burdensome due to the time needed and lawyer fees and suggested that having a standard data use agreement would reduce the burden and encourage the adoption of piloting.
  - **Debra Strickland** noted that on the standard side, including X12, there was an issue related to a lack of requirements related to success and what pilots must cover. As a result, there has not been a lot of motivation to build an end-to-end system that mimics production.
  - **Sheryl** discussed the benefits that could be gained if there was a utility network set up to enforce the adherence to and participation in common agreements for all partners in the piloting program.

Guiding Principle: Real-Time Data Capture and Workflow Automation

Sheryl Turney asked the ICAD TF to review some of the strawman recommendations and gaps related to the Guiding Principle of Real-Time Data Capture and Workflow Automation and to consider whether they should be included.

- Strawman Recommendation: Routinely collect all or nearly all the data needed during the ordering steps in efficient workflow approaches for providers and their patients.
- Gap: There is no consistency across all payers as to what "all the required data" is. Develop a consistent template for each illness type in effort to create consistency across Payers.

Discussion:

- **Sheryl Turney** summarized the strawman recommendation and suggested that it could be added to Recommendation #7 -- Develop Patient-centered Workflows and Standards. She asked the ICAD TF to examine the language to determine if it included the concept that required that the list of procedures that require prior authorization be communicated and, for that list of procedures/services, all the data requirements are defined commonly.
  - **Arien Malec** voiced his agreement with the concept and noted that he would examine the offline work to find out if there is a written record of the concept.
  - **Debra Strickland** noted that the past discussion of this concept was related to the example of the wheelchair durable medical equipment (DME) request and collecting all related data.
  - **Sheryl** and **Arien** noted their agreement that the concept should be included and discussed, which under which recommendation it should be added. **Sheryl** suggested Recommendation #7, and **Arien** suggested #11.
- **Alix Goss** asked that the recommendation be split into two separate pieces.
- **Arien Malec** suggested that, upon further review of the Recommendations document, the two could be broken apart and added under #11.
  - **Shery Turney** noted her agreement.
  - **Arien Malec** asked that the following points be added to the master document and noted that he would refine them during offline work:
    - Need to break the points under Recommendation #11 up into severable recommendations.
    - Ensure that we have specific recommendations for making, (a) list of orderables that require PA available, and (b) that the requirements for authorizing each of those procedures/orderables are available and standardized (e.g., weight and height of patient for a wheelchair order).
    - **Michael Wittie** confirmed that they were added to the document, and **Sheryl** noted that she would also share her notes.

Sheryl Turney noted that there were other items identified within the Gaps document. Still, they have been addressed within the draft of the Recommendations document that the ICAD TF reviewed at their previous meeting.

Presentation Compendium Review and Discussion

Sheryl Turney explained that supporting staff from ONC developed a compendium with the recommendations from all of the third-party vendors, agencies, representatives, and stakeholders that presented to the ICAD TF. The document included comparisons between what the presenters recommended and the recommendations the TF members developed themselves. She suggested that the TF review the items in the compendium.

First, **Sheryl** presented an overview of the themes provided in the meeting materials, including the tenants of the Ideal State workflow, steps to make the Ideal State electronic PA a reality for providers, and recommendations to help drive the industry closer to a fully-automated PA workflow from

CoverMyMeds' presentation. **Sheryl** asked TF members to provide input on whether additional recommendations should be added to encourage the adoption of real-time electronic processes. In response to an inquiry from **Alix Goss**, she noted that many of the recommendations from the various presenters were related to the theme of requiring real-time responses for things like benefits checks and the status of deductibles.

Discussion:

- **Jocelyn Keegan** submitted two comments:
  - She highlighted the importance of the concept of getting to real-time processes but also emphasized that the ICAD TF should focus on improving the steps before the actual transaction. She noted that this goes beyond automating an existing PA and includes getting better data and information to avoid the PA potentially. She discussed how automation fits into the process for the provider and the patient.
  - Because there is currently great penetration with the PA workflows, the real-time benefit checks, and the National Council for Prescription Drug Programs' (NCPDP) work, the ICAD TF should augment that work and should also focus on order entry, either inside or outside the facility that requires PA. Be careful that the search for real-time does not mask the underlying steps towards automation.
  - **Sheryl Turney** noted her agreement with **Jocelyn** and discussed how the example of patients receiving false-positive COVID-19 test results ties into the intersection of clinical and administrative data. She stated that some patients had noted that they were told that their providers' offices were reimbursed more for positive tests and suggested that the process could become self-auditing if both the payers and providers received the test results. She explained that having data where it is needed and when decisions were being made would be helpful, but it does not necessarily have to be in real-time.
  - **Debra Strickland** asked **Jocelyn** to clarify if she was referring to the need for a pre-conversation, with the aid of real-time, about what information is needed to create a solid PA before it is submitted, to have the best chance of approval.
  - **Jocelyn** responded that, while steps in the PA process should be as automated and real-time as possible, the focus should be on transparency, understanding the steps in the process like benefits and where they are in the plan, and having a complete patient/medical record. If PA is needed, then the process should have clear rules and happen in real-time, but the ultimate goal is to reduce the number of PAs that are submitted.
- **Alix Goss** noted that the comments were captured in the document's notes. She noted that she and **Sheryl** would like to make sure that the ICAD TF has clear recommendations, especially about how important real-time is to the process.
- **Arien Malec** noted that, as a TF member, he would like to propose two recommendations, tempered with an additional comment:
  - Recommendation 1: there is a need for eligibility checks to increase precision and the availability of data in order to better inform downstream information on workflows.
  - Recommendation 2: add an industry standard (like the real-time benefits check standards or the NCPDP standard for benefit discovery) to the pharmacy workflow.
  - However, he commented that as an editor of the document, there are adequate recommendations of intent, even if they are not fully captured, in the text to drive automation and workflow. He is happy to take another editing pass to ensure that the wording is completely clear.
  - **Alix Goss** responded that she understood that **Arien** had not completed all of the editing work on the recommendation and implementation sections of the document.
    - **Michael Wittie** captured all of the feedback within the margins of the draft document.
  - **Arien** agreed, and **Alix** noted that a footnote would be added.

- **Sheryl Turney** suggested that having consistent processes to get lab or hospital data entered into the electronic medical record (EMR) system should be added as a recommendation because this topic was a common theme throughout many of the presentations given to the ICAD TF.
- **Anil Jain** noted that, as a clinician, he would stress the danger of having multiple copies of test results sent to the provider and the payer, because then the patient might seek opinions from both. He cautioned against using the intersection of clinical and administrative data to confuse further the patient about how clinical decisions are made. He emphasized his support for the automation of administering workflows. Still, He cautioned that this should be the purview of the clinician/provider and not the payer, who might only have part of the data.
  - **Sheryl** noted that all TF members would agree.
- **Jim Jirjis** mentioned **Jocelyn's** comment about making sure that there was enough time for completeness of data before the decision is rendered and discussed his experience with premature denials of PA that lead to appeals. There is a timing and completeness factor that needs to be spoken to in the document.
  - **Sheryl Turney** noted that this was an important consideration, and **Alix Goss** summarized **Jocelyn Keegan's** comment from the chat via Adobe that the most important concept is not necessarily real-time data but the right data/information, at the right time.
- **Alexis Snyder** noted that she was confused by **Anil's** point and asked for further clarification around the point that the relationship between the clinician and the patient could be jeopardized because the patient has too much information.
  - **Anil Jain** responded that there was a misunderstanding and noted that he meant to note that the patient could be confused if the payer also receives results, as discussed in the example with the COVID-19 test results.
  - **Sheryl Turney** explained that there was a misunderstanding and noted that she meant that the providers could not overreport positive COVID-19 results if the payers also receive the results information. She did not suggest that the payer would engage with the patient about their test results, in this case. Sharing the test result information would simply preclude an audit and would allow the payer to know that they overpaid on the reimbursement for the patient, due to a misreported result from the provider.
  - **Alexis** stated that the payer should not know information about a patient's diagnosis unless it comes up as a red flag during an audit. She asked **Anil** to confirm that they were all, indeed, speaking to different topics and points.
  - **Anil** clarified that the ICAD TF does not want to disrupt the patient-provider relationship. Secondly, physicians might have more information about why certain results of tests, as discussed in the COVID-19 test results example, might not tell the same diagnosis story. If the payer has only one piece of the data, they might make the wrong decision, and there might be unintended consequences of getting the wrong information, at the wrong time, and in the wrong context. The ICAD TF should be cautious about inadvertently creating unintended consequences during work on the intersection of clinical and administrative data.
  - **Jim Jirjis** asked to piggyback on **Anil's** comment and noted that there are grey areas where the logic rules set by the payer do not work. He noted that, for example, tests for tuberculosis might not have been returned as positive, but the physician has had to proceed with therapies for treatment. There might be inappropriate denials due to a lack of specific data in the EMR to make a definitive authorization decision.

- **Anil** responded that the payer does not have the same relationship with the patient as the physician. Therefore, if the payer has all of the data in advance, the patient might be confused about who is making the clinical decision. He does not want this to become the case.
- **Sheryl Turney** noted that these are important points and emphasized that the ICAD TF's recommendations should not disturb the patient-provider relationship, which is related to the TF's Ideal State characteristic of reducing burden and confusion.

Sheryl referenced the themes (as provided in the meeting materials) from Premier's presentation to the ICAD TF and asked TF members to provide input on whether there should be incentives for using health IT that reduces burden and provides value to clinicians. She noted that the TF did not include recommendations related to incentives in any of their documents.

Discussion:

- **Arien Malec** noted that this recommendation is there but was not couched in the right terms. He suggested that the language around CMS programs and certification criteria be reworded in the recommendations to be more explicit. A note was added to the draft document.
  - **Sheryl Turney** agreed and noted that EMR systems, like Premier's and one that Epic has for the portal, are expensive for both providers and payers. Smaller providers might not have the opportunity to utilize these systems without an incentive, due to the burden of cost.

Sheryl presented an overview of the themes provided in the EHRA presentation and the related questions they posed. She noted that the ICAD TF did not address in their recommendations that many payers are eliminating the need for many kinds of PA when the providers take on risk and noted that pilots have been done on this topic. She suggested that the TF could recommend expanding the value-based payment models to enable the expansion of eliminating PAs and inquired if more piloting should be done.

Discussion:

- **Arien Malec** noted that this area was discussed by the ICAD TF at a meeting and needs to be added to the Recommendations document. To the extent that it is possible, PA should be eliminated in cases where incentives are appropriately aligned. The TF can also make recommendations relative to including incentives in value-based programs that reduce the need for PA.
  - **Sheryl Turney** agreed.
  - **Alix Goss** noted that this is not a piloting aspect but, rather, a policy framework that could be tied into part of the TF's recommendation on transparency with a sub- or related recommendation on value-based care to enable providers to make determinations on what services are needed for PA.
  - **Arien** noted his agreement, but **Sheryl** suggested adding a more explicit statement to the recommendations.
  - **Alix Goss** noted that if any TF members disagreed, they should provide additional feedback.
- **Anil Jain** stated that there is no further incentive to have PA whenever a physician or clinician takes on the risk, and **Alix Goss** questioned why there would even be a PA in this case.
  - **Sheryl Turney** stated that, as it is a value-based arrangement, there would be fewer PAs; that is the incentive.

- **Anil** inquired that if the ICAD TF is advocating that PAs are not needed in the setting where the physician takes the risk with value-based care, what is the purpose of the PA? He asked if it is to reduce unnecessary expenses when they are in a fee-for-service arrangement.
- **Alix Goss** referenced the previous conversation about not undermining the patient-provider relationship but noted that there are also situations in which providers recommend outdated treatments. This would provide a safety valve on behalf of the patient in this situation, as someone else would consider the treatment from an evidence-based perspective.
- **Anil** noted that this needs to be coupled with strong clinical decision support that providers take on, as the risk has been shifted to the clinician. There is a risk that this process will become less patient-centric, so he suggested that in the event where the clinician is taking on a risk, is performing the evaluation, and is utilizing clinical decision support tools that provide guidelines, then the PA is unnecessary.
- **Jim Jirjis** responded that all value-based programs are very different in terms of what is incentivized and how incentivization works. Stating that PA is not necessary is the Ideal State but is not currently realistic. He noted that providers that have a value-based care program might be behaving appropriately but still might require a PA. He discussed the example of ordering a CAT scan versus an MRI. He seconded **Alix's** point about how the PA process alerts payers that physicians have prescribed outdated treatments and noted that these cases make up a large portion of PA denials.
- **Alexis Snyder** noted that the payer often ends up being the safety net for the patient, but without full transparency to the decision process, the patient cannot intervene or correct any issues. She discussed her recent personal experience with this process and noted that she was able to correct an incorrect diagnosis entered into the medical record due to the transparency of the PA denial. Also, she referenced **Anil's** point about protecting the patient-provider relationship when a clinical decision is made.
  - **Sheryl** thanked her for the point.

- **Jim Jirjis** responded to **Anil's** question about why a PA would be needed. He discussed the example of risk shifting to a provider's practice when they started doing Medicare Advantage work and explained that, though the PA did not come from the payer, the infrastructure of the PA was useful to the practice. **Jim** described an example of PA under Medicare Advantage and noted that reducing the number of inappropriate referrals to specialists is a major piece that the practices go after themselves, instead of the insurance company. In this way, a PA process would be desirable to and driven by the practice.

Sheryl Turney thanked ICAD TF members for their feedback. She raised the additional question of calling out workflows and automation, which were already included within the TF's Recommendations document, in light of the comment submitted during a presentation. The presenter noted that many payers push providers to use portals. **Sheryl** asked if the TF would like to recommend integrating the electronic PA process within the EHR workflow to reduce reliance on separate payer/third-party portals.

Discussion:

- **Arien Malec** noted that the intent is to reduce or eliminate specific portals.
  - **Sheryl Turney** noted that she would add this to the Recommendations document.
  - **Alix Goss** noted that the TF would continue to discuss this specific recommendation following the Public Comment period. She noted that real-time capacity or clinical conversation capacity might not be what is promulgated today.

Lauren Richie opened the meeting for public comments.

PUBLIC COMMENT

There were no public comments via the phone.

Questions and Comments Received via Adobe Connect

Jocelyn Keegan: Lauren, I'll be stuck on listen only mode for start of the call :)

Lauren Richie: hi Jocelyn, np

Arien Malec: im heee *[sic]*

Arien Malec: here

Lauren Richie: hi Arien

Jocelyn Keegan: can michael make his font size larger for all of us old people :)

Alexis Snyder: This is very diffacult *[sic]* to follow without seeing it

Jocelyn Keegan: Agreed.

Alix Goss: Andrew has developed a summary of all presentations and built a side document of their recommendations which Sheryl has reviewed and is bringing to our call today for discussion.

Alexis Snyder: that's Denise

Alix Goss: or is it Debra Strickland?

Alexis Snyder: y

Jocelyn Keegan: Thanks Deb! Sorry!

Jocelyn Keegan: Yes.

Jocelyn Keegan: We can/should pull this from the HUmana *[sic]* presentation as well Michael.

Alexis Snyder: We also talked about coordination of benefits and being able to see both and requirements for both

Jocelyn Keegan: Yes, on RTBT as well. . . this is key

Jocelyn Keegan: I agree with everything Arien says, would add the idea of exposing criteria and rules, not just eligible, but what the bar is, so data and knowledge is equal among all parties (patient, provider, payer and service deliverer (provider, pharmacy, DME))

Jocelyn Keegan: not real time, but at right time, with right information

Jim Jirjis: here here

Gus Geraci, MD: I agree. Insurers are payers, not providers of care.

Jim Jirjis: interestingly put. Imagine a world where the payer has all of the data clinical adn *[sic]* admin and is tempted to make decisions, but the clinician has metadata and information not in the record

Gus Geraci, MD: The clinician knows the patient.

Gus Geraci, MD: The insurer has data.

Jim Jirjis: the insurer has the data captured in the EMR. There are lots of other data points

Gus Geraci, MD: Respectfully, usually the insurer has billing data, not necessarily EMR data. Occasionally, lab and radiology and sometimes EMR through direct feeds or an HIE, CCD's.

Meryl Bloomrosen: Meryl Bloomrosen here- would be happy to followup *[sic]* with the Task Force and continue to discuss more about CMS and incentives for health IT adoption

Jim Jirjis: Gus, I meant in the new world of the future when the payer has access to both clinical and administrative data

Jim Jirjis: THe *[sic]* provider group may still want a PA process, but not driven by the payer

Jim Jirjis: Driven by the practice

Jim Jirjis: not all value-based care is about signific ant *[sic]* risk shifting

Anil Jain: You need peer review internal to the medical group...

Gus Geraci, MD: In an ACO environment, the providers often create an internal PA review process.

Anil Jain: Exactly

Alexis Snyder: agree with Jim

Lauren Richie: Public Comment coming soon: To make a comment please call: 1-877-407-7192 (once connected, press "*1" to speak)

Alexis Snyder: universal platform for PA regardless of payer

Alexis Snyder: I think we talked about the opposite

Following the public comment period, the ICAD TF continued their discussion.

Discussion:

- **Alix Goss** noted that the bulk of the recommended discussion points had been discussed by the TF but noted that she would like to address several other topics before the conclusion of the meeting, which included:
  - Would the TF like to discuss **Alexis Snyder's** comment from the Adobe chat about universal platforms for the PA process, regardless of the payer?

- TF should discuss the topic of the Da Vinci Project's work, concerning portals and the objective of having integration with EHRs, so that the clinician at the point of care and their support team, who would be working in a specific tool, would need to have different kinds of integration. She discussed how the 278 X12 transaction (the transaction for PA) has not been fully integrated into the EHR system and inquired if the TF would change their recommendation to something that says that the 278 would be promulgated today. However, there is no exception process (162.940 reference) that has proven the ability to give the fodder to national standards groups to make a different standard available to do the PA function. She asked if the TF would like to address these topics in their recommendations.
- **Sheryl Turney** asked if any TF members had any feedback and noted that she had envisioned something similar to **Alexis'** suggestion that there is some sort of open source solution where there is a payer portal that can be integrated into any EMR system to exchange data. The data would be readily available for the EMR system to be able to use it because it would be predefined to a standard.

- **Alexis Snyder** noted that **Sheryl** was correct. However, she shared several ideas within the Adobe chat about **Alix's** comments and noted that the opposite idea was captured within the Ideal State following a previous discussion of the TF. That discussion centered around creating standards but also assuring that the TF did not accidentally set up a monopoly that would benefit one group over another. She asked if the TF should change their work to reference a national standard.
  - **Alix Goss** noted that **Alexis** brought up a good point and explained that the TF might be doing too much wordsmithing, at the risk of losing their original points. The purpose of the current meeting was to weave a thread from previous presentations through the TF's recommendations, and the TF will have the opportunity to review the master document and add comments.

PLANS MOVING FORWARD

Alix Goss discussed the ICAD TF's plans, moving forward, and thanked all TF members for their contributions. She specifically thanked **Alexis Snyder** and **Gus Geraci** for adding comments to the master document, **Sheryl Turney**, along with **Michael Wittie's** assistance, for performing a deep dive to tie up loose threads, and **Arien Malec** and **Rich Landen** for the work they completed and will continue to do soon. **Alix** stated that it will be a balancing act to move the industry forward with a better approach to PA through the TF's recommendations but also to consider if the TF has gone far enough to create some notable changes.

Alix noted that she would not be able to attend the next meeting of the full ICAD TF and that some other TF members would also be absent during the meeting time and not available for offline work. She explained that Sheryl would walk the TF through a review of the report document. To help resolve comments, the TF has instituted a weekly small group meeting to touch base and review comments, wordsmith sections, provide edits, and make sure the points are philosophically sound.

NEXT STEPS

Alix Goss provided an overview of the next steps and explained that, at their next meeting, the ICAD TF will review the Report Comments and Resolution documents, and a discussion of the broader Intersection will be held. Offline work will include report comments from all ICAD TF members and refining a draft of the presentation for the HITAC. On September 9, 2020, the ICAD TF will present the draft report and recommendations to the full HITAC. Following the HITAC meeting, the TF review the HITAC feedback and revise the report as necessary. Then, the TF will deliver the final recommendations and report to the HITAC on October 21, 2020.

Sheryl Turney noted that the documents will be updated with new comments and then will be reviewed by the TF. **Alix** asked that comments be submitted within the next week and reminded TF members that they have access to the report in Google Docs. If TF members do not have access, they should contact **Sheryl** and ONC.

ADJOURN

Alix Goss and **Sheryl Turney** thanked everyone for their participation and reminded them that the next meeting was scheduled for 3:00 p.m. ET on August 25, 2020.

The meeting was adjourned at 4:31 p.m. ET.