The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

May 5, 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 their recent work on a shared Google document that is being used to determine how to improve the PA workflow process. She noted that, at the previous meeting, Surescripts and CoverMyMeds shared presentations covering electronic PA (ePA) approaches and processes from a pharmacy perspective.

Presenters from Humana gave an overview of the HL7 Da Vinci Project as well as a presentation on the topic of prior authorization (PA) optimization and current, related initiatives taking place at Humana.

Presenters from Regence gave a presentation on accelerating the PA process using fast healthcare interoperability resources (FHIR) based technologies and presented a video demonstration of their PA process.

There was one public comment submitted by phone, and a discussion took place between presenters from both groups and ICAD TF members in response to the public comment. There were several comments from ICAD TF members and members of the public 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.	HL7 Da Vinci Project Overview
03:20 p.m.	Humana Demonstration
03:50 p.m.	Regence Demonstration
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 5, 2020, meeting of the ICAD to order at 3:06 p.m. ET.

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
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
Jacki Monson, Sutter Health/NCVHS
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

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
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 presenters would give the ICAD TF a brief introduction to the HL7 Da Vinci Project. Then, presenters from Humana and Regence would discuss medical prior authorizations (PA), especially with regard to how the Da Vinci use case implementation guides could advance medical PA.

She summarized the ICAD TF's previous meeting, during which they reviewed recent progress on the shared Google document that is being used to determine how to improve the PA workflow process. She thanked the two smaller TF subgroups that have advanced work on the data categories and classes section of the Google document, as well as the Guiding Principles and Ideal State section. Also, she thanked **Sheryl Turney**, ICAD TF co-chair, who added historical content from prior meetings of the HITAC, including presentations from third parties given over the past year and considerations and recommendations applicable to the TF's scope of work. She encouraged TF members to continue to engage with the workbook, which will form a foundation for the work that will be done on their final recommendation deliverable for the HITAC.

She noted that, at the previous meeting, Surescripts and CoverMyMeds shared presentations covering electronic PA (ePA) approaches and processes from a pharmacy perspective. ICAD TF members had robust discussions around the topics of real-time benefit checks, multiple payer scenarios, insurance coverage for patients, and coordination of benefits.

Alix Goss introduced the presenters from Humana and noted that they would give an overview of the HL7 Da Vinci Project as part of their presentation.

HL7 DA VINCI PROJECT OVERVIEW AND HUMANA DEMONSTRATION

Patrick Murta, Principal Solutions Architect and Chief Interoperability Architect, and **Phil Britt**, Director of Business Improvement, both of Humana, presented on the topic of PA optimization. They introduced themselves and gave an overview of their roles in the organization and experience in the industry. **Patrick Murta** noted that he works with **Alix Goss** on several initiatives, including the Da Vinci Project, where he is on the coordinating committee with **Jocelyn Keegan. Phil Britt** noted that his area of focus relates to Humana's utilization management of clinical technology, end-to end. **Patrick Murta** noted that he would lead the conversation and would ask Phil to contribute additional commentary. In this way, they would be able to share perspectives from both architecture and integration/interoperability perspectives, while making sure to discuss business enablers, the impact of business, and operations.

Patrick Murta gave an overview on the Da Vinci Project, which was one of the original HL7 Fast Healthcare Interoperability Resources (FHIR) Accelerators; the FHIR Accelerators were projects run under the auspices of HL7 which take advantage of capabilities made available in FHIR and adjacent technologies to solve business needs, provide enablers, remove abrasions, and make data available at the right time, with the right clinician, and in the right workflow. The Da Vinci Project focuses on payer to provider integration. They began meeting several years ago to discuss a new model in value-based care in which sharing information was emphasized as critical for the success of physicians, providers, and payers and for better patient outcomes. He noted that the industry recognized the need to agree on a set of use cases and the appropriate implementations of those use cases, so that they could build once for all

payers and all electronic health record (EHR) vendors and have only one on-ramp for each of the use cases, as opposed to the classic proprietary model. He explained that they would walk the ICAD TF through some of the contemporary technologies and industry-standard use cases that the Da Vinci Project is using to provide a framework for the industry to follow. He noted that they would focus on PA in their presentation, but the Da Vinci Project is also running use cases for cost transparency, provider data exchange or payer data exchange, clinical data exchange, PA support, coverage requirements discovery, document template and rules, and more. The Da Vinci Project initiative is to facilitate the development and implementation of use cases, including their associated implementation guides and reference architectures, that allow payers and providers to solve real world use cases using contemporary technology.

Then, he described the framework for Humana's approach to the medical PA process and noted that they recognize that there are issues with PA, including unnecessary abrasions and inefficiencies that need to be solved. They are looking at their work through the lens of a Da Vinci perspective. For example, he noted that in Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12N 278 (278), the standard transaction to electronically submit authorization and referral requests, is their PA standard; however, through their work with Da Vinci, they have come to realize that this is not true for other organizations. Additionally, Humana's response is real-time, regardless of the mode of submission. They have a business rules engine that processes PA transactions and renders a response in seconds. He shared the following statistics:

- 35,000 278s are processed per day
- About 80% of transactions are automated approvals
- About 70% of transactions are real-time electronic, coming from business-to-business (B2B) connections or a portal

He noted that PA has been a focus for Humana for over 20 years, but the use of PA and ePA across provider groups varies. He and **Phil Britt** compiled a great deal of research on the state of PA in the industry between 2017 and 2019, so he gave an overview of their findings. The administrative PA processes have been estimated to contribute as much as $25 billion annually to the cost of healthcare and have been linked to negative effects on patient care and provider performance. Although Humana has supported the real-time 278 standard for many years, this is not true across the industry. While ePA emphasis has attempted to reduce burden, adoption across the industry continues to be low with only 12% use of form 278 in 2018. Industry barriers mentioned include lack of operating rules, ubiquity of payer web portals, a myriad of state laws, and some components of the workflow which occur outside the scope of the electronic standard. He noted that while ePA is progressive, it is not transformative. Payers have levers to reduce inefficient communications and increase data exchange efficiency with providers.

Phil Britt noted that Humana's process has focused on streamlining PA and detailed examples of current initiatives, including:

- Da Vinci PA Support (PAS), including Coverage Requirements Discovery (CRD) and Documentation Templates and Rules (DTR)
- EHR specific optimization
- Authorization Questionnaires
- Automation BOTs
- Analytics at point of submission
- Natural language processing (NLP)/optical character recognition (OCR) for medical necessity documentation
- Fax automation with NLP
- Watson AI for interactive voice response (IVR)

Patrick Murta described how Da Vinci PAS works at a high level and provided workflow documentation instead of showing a live demonstration. The workflow he described depicted how the EHR/Provider

back-office systems are connected to the payer's process through clinical decision support (CDS) Hooks, the clinical language query (CQL)/Questionnaire, and the X12 278 and X12 275 (if required) standards. Examples of the CRD, the DTR, and the PA response were shown, and he described how they would function as parts of Humana's PA process. In this particular workflow, he noted that the PA transaction is going from the EHR system over a transformation layer, which is a clearinghouse or intermediary; he explained that the clearinghouse takes the all of the information, including FHIR messages, the FHIR claim, and the FHIR bundle. The clearinghouse converts those into a HIPAA X12 278 and possibly a HIPPA X12 275, if there are medical attachments. Then, the PA is submitted to the payer using existing modalities. In this model, because the PA support transfers through an intermediary, it goes from FHIR to a 278 and then to the payer using existing 278 channels. Then, Humana, the payer, responds in real-time, because that is how their PA engine works. **Phil Britt** noted that the goal of their end-to-end process is to be able to streamline decisions and allow providers to work in their native workflow.

Patrick Murta described the broader perspectives of Humana, their model, and their work and research in the industry. These included:

- Many FHIR initiatives, of which PA is one of the most critical (FAST, Da Vinci, Argonaut, CARIN)
- FHIR provides mechanisms which complement the X12 baseline. Adjacent integrations, such as coverage requirements discovery and documentation template and rules, streamline the overall process. He noted that this may be a Humana bias given that they use 278 as their standard.
- Payer agnosticism is a key consideration. Payer rules may be different, but the workflow experience does not have to be.

Discussion:

- **Jim Jirjis** noted that it is impressive that they are using so many live technologies to adjudicate in real-time. He submitted two questions:
  - How many and which EHR platforms are able to participate?
  - Did they test the ability of a variety of electronic medical record (EMR) systems to work in their processes?
    - **Patrick Murta** responded that the current technology initiatives that **Phil Britt** discussed earlier are completely EHR agnostic, and they operate on the Humana side or in the cloud between transactions. The Da Vinci-specific use case that was detailed is being tested in a sandbox environment, not production, with Epic. He noted some other healthcare groups that are also doing prototype testing.
- **Arien Malec** submitted several questions:
  - To what extent does the workflow anticipate or require an eligibility check on the front end before it goes into coverage discovery?
  - To what extent is the eligibility transaction built into coverage discovery?
  - What are the pre-requirements?
  - What are the pre-requirements for a payer to quasi-adjudicate some of the EPA work?
    - **Patrick Murta** responded that it is a given in the model that the 270 (the transaction set is used to transmit health care eligibility benefit inquiries) or the 271 (the transaction set that is the appropriate response mechanism for health care eligibility benefit inquiries) are already a part of the workflow because they are captured before the clinical work is done. The assumption is that the covered Humana member has already done a beneficiary ID secondary check and confirmation of eligibility is assumed.
  - **Arien Malec** conjectured that some of the assumptions are the ability to run these workflows in real-time and the infrastructure that Humana has built would be a pre-condition for building functionality and capability.

        - **Patrick Murta** confirmed this and noted that other payers would need the technical capacity and infrastructure to be able to execute in real-time.
    - **Arien Malec** inquired about the response time Humana is targeting for their production environment and if there is a specific interactive response time required by physicians in the ePA workflow.
        - **Patrick Murta** responded that the target response time is based on an H12 perspective. The target response time for a 270, 271 is 1.5 seconds to the clearinghouse, to Humana, and back. They are aiming for the 2-3 second range, round trip, for CRD. The same range is the target for the document template in rules. He noted that some of their work in production is taking a little longer, but they are keeping the range from 2-5 seconds. The 278 decisioning is broader, but it runs through the rules engine in production fairly quickly (average of 3-4 seconds), though some take 7-8 seconds. Their internal utilization management system is working on improving this performance. Ultimately, it needs to be less than 10 seconds, but he noted that they want it to run much faster.

Alix Goss requested that ICAD TF members hold the rest of their questions for the presenters from Humana until later in the meeting, due to time constraints.

REGENCE DEMONSTRATION

Sheryl Turney introduced the presenters from Regence (also known as Cambia Health Solutions, which includes their insurance business, Regence Blue Cross Blue Shield): **Kirk Anderson**, Vice President and Chief Technology Officer, **Julie Lindberg**, Vice President Clinical Services, **Dave Degandi**, Manager Technology Strategy at Cambia Health Solutions, and **Heidi Kriz,** Manager of Medical Policy at Cambia Regence.

Kirk Anderson gave a brief overview of the goals for their presentation. **Heidi Kriz** continued by introducing herself, and described how their organization has prioritized transforming the PA process from the member experience to the provider experience. She described the benefits of PA to the health care consumer, which included:

- Benefits to health care consumer
- Quality and safety of care (evidence-based decision making)
- Assurance of coverage (avoidance of balance billing)
- Prevention of overtreatment (medical necessity review)
- Minimization of cost-shares (appropriate level of intensity/quantity)
- Reduction in healthcare costs associated with fraud, waste and abuse

Kirk Anderson presented the history of the PA process at Regence and described how they transformed it from one with significant pain points that relied on manual process to an automated process that provides real-time responses. The project and strategic initiative at Regence were launched four years ago and was called eAuth (also called autoAuth). He gave a high-level overview of how Humana handled the project and noted that it primarily involved extending automation to providers via a portal. While this was an improvement, there were issues that needed to be solved, so Regence identified the need to work with the Da Vinci Project to bring the automation and real-time latency that they sought to fruition.

Heidi Kriz provided more details about Regence's eAuth functionality. She noted that the goal was to create greater transparency for providers, and they worked to achieve this by focusing on the PA check part of the process, to give providers real-time information about what does and does not require PA. Some of the improvements of eAuth included:

- Reduced wasted: 65% of electronic authorization requests don't require authorization
- Shortened cycle time:
  - 87% of the authorization requests are completed ≤ 5 calendar days (vs. 69% at baseline)
  - If all clinical info received at time of request: 85% ≤ 2 days, 98% in ≤ 5 days
- Auto-Approval feature creates transparency, returns instant approvals if clinical criteria satisfied

Then, she described some of the limitations of Regence's PA process, which included:

- Requires submission through separate portal
- Auto-Authorization process adds time to providers
  - Low adoption rates, low auto-approval rates
- Still requires attachment and review of clinical records

Julie Lindberg noted that eAuth was an improvement for Regence, but it was not enough, as it did not improve the provider experience other than they did not have to submit an authorization that was required. Many burdens remained in the process for providers and their support staff. Providers continued to work in the EHR and still had to submit records separately. Then, their clinical staff still had to go through all the records to look for the salient clinical points to make decisions with regard to medical necessity. As a result, Regence moved on to the next generation of PA: the FHIR standards. She noted that FHIR standards have removed the barrier and allow providers to submit PA without leaving EHR. She detailed the FHIR acceleration of PA at Regence.

Kirk Anderson described how Regence complies with current clinical data standards. He detailed their process for using the Da Vinci Project's use cases and implementation guides to support their bridging between FHIR endpoints to existing HIPAA administrative standards. Then, **David DeGandi** launched a recorded demo video of the eAuth process within the Epic workflow. He described the steps as they occurred. He noted that the majority of the data fields are pre-filled, and he drew the ICAD TF's attention to the point in the demo in which it was determined that PA was needed.

Following the Regence presentation, **Sheryl Turney** opened the meeting up for questions for all presenters from both groups.

Discussion:

- **Ram Sriram** submitted two questions for Humana:
  - He inquired about the role of CoverMyMeds in the Da Vinci PA Support workflow that was shown.
  - He asked about the role of artificial intelligence on both the payer and provider sides.
    - **Patrick Murta** responded that Humana tests integration with CoverMyMeds, since they are part of their pharmacy offering, but nothing that was shown in their demo page was part of the CoverMyMeds implementation. He noted that they are testing support for CoverMyMeds, KARIN real-time benefit check (RTBC), and the Carolina implementation type guide in their development sandbox. However, the experience that they demonstrated was only on the member app.
    - **Phil Britt** explained how Humana is using AI in their PA process. He noted that the current implementation they have with Watson involves Watson actually talking to providers and support staff as they call into Humana and providing real-time PA information. They do not have any further goals to make it part of the Da Vinci integration stack or their FHIR technology at this point.

Jocelyn Keegan thanked the presenters from both groups for their time. **Sheryl Turney** thanked everyone for their participation in the meeting and noted that the work would help to inform the ICAD TF

as they begin to build the recommendations and considerations in their final deliverable. She recognized that every stakeholder in the healthcare landscape is dealing with some amount of burden, and she noted the importance of understanding the wide variety of issues, levers, and incentives so the ICAD TF can work toward making their recommendations more meaningful.

Lauren Richie opened the meeting for public comments.

PUBLIC COMMENT

There was one public comment via the phone:

Heather McComas, from the American Medical Association (AMA): I have a question and it's probably for both speakers on today, maybe Humana first and then everyone. The presentations were hugely helpful and thank you all for your time.

There were a lot of references to auto-adjudication during both presentations. This is great, because it indicates that care would not be delayed in those cases and it's something obviously important to all of us. I was wondering if both Humana and Regence/Cambia could talk a little bit about if that model requires an attestation system, versus an actual review of clinical data. I know the Humana example template showed some boxes to check, and one of the examples was a patient who has abnormal electrolytes. That obviously is kind of a yes/no thing which could be processed as machine, versus actually the clinical data showing abnormal potassium values or sodium values that someone would have to review and approve. I guess more for the Cambia Regents side, it sounded like when there's auto-attestation, that can involve a retrospective review and submission of clinical data that might, in some cases, involve the clinical criteria not being met and the claim possibly being retroactively denied. I was wondering if you can talk a little bit about the whole auto-adjudication process and what model you need to make that work. Thank you.

Responses:

- **Phil Britt** responded that, at Humana, there are several different ways to extract the PA information and process it appropriately in the auto-adjudication process. From a systems perspective, he noted that they have several different capabilities that they use make that happen.
  - **Patrick Murta** added that the app they showed during their presentation was a prototype, so the auto-adjudication was approved in the sandbox. He explained that the auto-approval initiatives other than Da Vinci, like the ones that typically exist in today's world, usually must be approved via the rules engine based upon the content of the 278 or based upon data that is readily available inside of the organization without attachments. They do use some NLP and other types of OCR, but for the most part, it is an auto approval. He explained that the 20% of cases that are not auto approved go into a pending status in which a human has to work on the clinical documentation and recommendation. **Phil Britt** added that they are working on decreasing that percentage.
  - **Heather McComas** responded that it sounds like the kind of auto approval model is for something that does not require clinical attachments or documentation review on the plan side. **Patrick Murta** confirmed that this is an accurate generalization.
- **Heidi Kriz** responded on behalf of Regence/Cambia, and she noted that they have built out their auto-auth tool around clinical criteria. She explained how they would use it to select relevant patient data, including information in the background that is hidden from the provider. She described the process of the attestation statement from a provider's perspective. She noted that they are auditing a subset of those auto-approvals and detailed this process. Though it is a detail-oriented process that requires them to work with providers, she stated that their experience with it has been very positive. The providers have taken that collaboration to heart and have tried to make it work because they see the benefits when they

get quick auto-approvals. She noted that they have not been in a situation yet where a denial has been retroactively reversed or has required recouping money. She attributed their success to choosing policies for auto-approval that had significantly higher approval ratings, historically.

Other Discussion:

- **Ram Sriram** inquired about the percentage of the PAs that are rejected after getting through the entirety of the PA processes described by the presenters.
  - **Patrick Murta** and **Phil Britt** responded that they did not have the exact numbers but the cases that go to a pending status at Humana are around 20%. Then, these are reviewed, and very few are actually rejected or denied (perhaps in the low single digits).
  - **Ram Sriram** inquired about the cost-benefit analysis and savings in this process.
    - **Alix Goss** encouraged him to submit any other comments or questions in writing.
    - **Julie Lindberg** responded that Regence is excited about the FHIR standards and doing the PA use case with Da Vinci because their eAuth and autoAuth systems are not really performing as well as they would like, though there have been improvements. She encouraged the ICAD TF to continue their work and to clear technology and standard barriers, because that is very helpful.

Questions and Comments Received via Adobe Connect

Jim Jirjis: Jim Jirjis Checking In

Ed Glynn: Hey

Rich Landen: Listening to the music.

Gus Geraci, MD: I hear music on the webapp, but am listening to the conversation you're having.

Gus Geraci, MD: I dialed in, not using the webapp for voice.

Rich Landen: I'm not hearing any conversation???

Alix Goss: We are currently gathering.. sorry for the delay folks!

Lauren Richie: Hi All, we will be starting shortly

David DeGandi: Kirk has continued to have audio problems

Katherine Campanale: Hi David, please have Kirk dial back in. His line has dropped.

David DeGandi: he is dialing

Kirk Anderson: I am dialing back in.

Kirk Anderson: I'm back in.

Jim Jirjis: how many and which emr's?

Ram D. Sriram: @Humana: What is the role of CoverMyMeds in Slide 6?

Nicole Wilson: I can't really hear the speaker

Gus Geraci, MD: Ram: key question....

Gus Geraci, MD: In My experience is between 5-20% of requested auths get denied (after all appeals and pends.)

CLOSING REMARKS AND ADJOURN

Sheryl Turney thanked the presenters from Humana and Regence and ICAD TF members for their participation. She briefly detailed the next steps, including a demonstration of CMS DRLS work and a presentation from the AMA. Also, she encouraged members to continue working on the shared Google document with a specific focus on the “Other Considerations” and “Recommendations” sections.

She noted that the next meeting will be held on Tuesday, May 12, 2020.

In the longer term, the ICAD TF will look at additional use cases (pharmacy, medical service, hospital service, and specialty) and will plan for May 19 meeting.

The meeting was adjourned at 4:33 p.m. ET.