The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

June 9, 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. **Sheryl Turney** summarized the agenda and the recent activities of the ICAD TF.

Presenters from America's Health Insurance Plans (AHIP) and Premier presented on the topic of automating prior authorization (PA). ICAD TF members discussed the two presentations and submitted questions for the presenters.

Alix Goss provided an update on work completed by the Privacy and Security small workgroup and the Ideal State and Guiding Principles small workgroup. She shared the new Guiding Principles and Future Ideal State document and asked ICAD TF members to review it in preparation for a longer discussion session at a future TF meeting. Then, she presented the draft timeline and discussed the next steps for the TF.

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.	America's Health Insurance Plans (AHIP) Presentation and Discussion
03:40 p.m.	Premier Presentation and Discussion
04:10 p.m.	Privacy and Security Ideal State and Guiding Principles Introduction and Next Steps
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 June 9, 2020, meeting of the ICAD to order at 3:05 p.m. ET. She welcomed the presenters from Premier and America's Health Insurance Plans (AHIP).

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
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
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
Alex Mugge, Centers for Medicare & Medicaid Services
Jacki Monson, Sutter Health/NCVHS
Abby Sears, OCHIN
Andrew Truscott, Accenture

SUMMARY AND ACTION PLAN

Sheryl Turney, co-chair of the ICAD TF, welcomed members and gave a brief summary of the presentation from the Centers for Medicare & Medicaid Services (CMS) on the Document Requirement Lookup Service (DRLS) from the previous ICAD TF meeting. She explained that the CMS presentation provided an excellent knowledge base for the TF. Then, she provided an overview of other work completed by the TF at its previous meeting, including: a discussion on Guiding Principles and Ideal State work – which focused on design for future state work and a discussion about how to focus on the highest value areas to "create a pathway to automation" for prior authorization (PA); a review of updates to the Data Classes; and, a review of next steps and the updated timeline.

She reviewed the agenda for the current meeting and noted that America's Health Insurance Plans (AHIP) would give a presentation on their work to reduce prior authorization (PA) burdens. Following AHIP's presentation and a discussion by ICAD TF members, she explained that Premier would give a presentation on providing automated solutions for PA, followed by another discussion. Finally, she stated that **Alix Goss** would present the Privacy and Security Ideal State and Guiding Principles Introduction and Next Steps.

AMERICA'S HEALTH INSURANCE PLANS (AHIP) PRESENTATION AND DISCUSSION

Kate Berry, Senior Vice President, Clinical Affairs and Strategic Partnerships, AHIP, presented a briefing on the AHIP's work on PA. She began by providing a brief overview of AHIP as an organization, including their work and mission statement.

She presented an overview of AHIP's multi-pronged strategy on PA. AHIP has been working on identifying areas of common interests and opportunity for improvements with providers. She explained that they have also done the following work as part of their strategy while noting that her presentation to the ICAD TF would focus on the Fast PATH project and the landscape survey:

- AHIP Demonstration Project on Prior Authorization Automation – Fast PATH
- AHIP Prior Authorization Landscape Survey
- Data-Driven Collaboration to Promote Evidence-Based Care
- Communications, Messaging, and Advocacy
  - Federal and State Advocacy
  - Message Guide
  - Resources and Talking Points
  - Op-Ed
  - Statement of Commitment

She explained that ICAD TF members had received additional materials before their current meeting, including the survey results and related infographics. She provided an overview of the survey of commercial health insurance plans, which was conducted between September and December 2010, and its methodology and key findings. She stated that the report found that health plans use multiple sources of evidence-based studies, guidelines, and federal standards in designing their PA programs. Also, she noted that PA is used sparingly; most commercial enrollees are in plans that make only a few medical

services and prescription medications subject to PA. She noted that the majority of commercial insurers use input from doctors in developing their PA programs, and the majority of plans report the positive impact of these PA programs on the areas of quality of care, affordability, and patient safety. She explained that the survey found that PA is often part of a broader medical management strategy that includes offering providers evidence-based resources, comparisons to their peers, and incentives to provide value-based care.

She provided an overview of the Fast PATH PA Technology Highway Project (Fast PATH Project), which AHIP is using as a demonstration project to automate aspects of the PA process and to evaluate that impact. She discussed the launch and development of the Fast PATH Project and the entities that have come together to coordinate and support the project, including AHIP's Board of Directors, technology companies, eight health plans and their provider partners, and consultants. She described the process by which AHIP selected and worked with the two vendors; she noted that Surescripts was selected for prescription medications use cases, and Availity was selected for medical/surgical procedure use cases.

She stated that AHIP is working with RTI, a global non-profit research organization, to evaluate PA by focusing on two major research questions. She discussed these questions, which included:

- Question 1: How does automating aspects of prior auth process change the experience and administration burden on health care providers?
  - The % of PAs that are approved
  - The volume of PA transactions
  - The volume of PA-related phone calls and faxes
  - The transparency of the PA-related information and process
  - How often providers change from prescribing a medication that requires PA to one that does not?
- Question 2: How does automating aspects of the prior auth process change the patient experience?
  - The time it takes between submitting PA request to receiving decision
  - Perceived timeliness to recommended treatment
  - How often do providers change from prescribing a medication that is more expensive to one that is less expensive for the patient?
  - How often do patients who have a prescription for the first time fill their prescription?

She described the sources for the data used to support the evaluation and the timeline for the project, which was adjusted due to the COVID-19 response efforts. Also, she noted that, in light of COVID-19, AHIP has found that PA has been waived more often. She stated that project outcomes will be used to inform stakeholders, including federal and state-level policy makers, providers, health plans, and technology companies, and to streamline the PA process. She explained that AHIP would release their findings but that they would not make recommendations for a specific approach, vendor solution, or type of platform. However, they will adhere to the principles that AHIP started with, which included: technology solutions to improve PA should be standards-based, scalable, payer neutral, and as integrated as possible with the provider workflow.

Discussion:

- **Alexis Snyder** thanked **Kate Berry** for the presentation and inquired about how AHIP drafted their research questions. She asked if patients and/or caregivers were involved in the process of creating the research questions because neither question reflected a patient-centered approach.
  - **Kate Berry** responded that there were several draft versions of the questions before AHIP created the final questions, and she explained that AHIP and RTI worked with technology partners and health plans. She stated that they did not engage with caregivers, specifically and noted that it would be a good idea to do

so in the future.
    - **Alexis Snyder** encouraged AHIP to engage with patients and/or caregivers in the future to better understand the burden of the PA process.
- **Sheryl Turney** inquired about the timeline for the full Fast PATH Project.
    - **Kate Berry** responded that the project was delayed due to COVID-19, but AHIP hopes to complete it by the end of 2020. AHIP's goal is to release the summary report of findings in late 2020 or early 2021.
- **Alix Goss** submitted several pieces of feedback:
    - She thanked AHIP for the statistics submitted to the ICAD TF via a supplemental PDF and noted that the statistics would be helpful as the TF prepares the Current State section of their final report to the HITAC.
    - She inquired about challenges between more straightforward types of PA versus the complex types. She asked if complexities related to medical or prescription drug PA factored into the design of the pilot program.
    - **Kate Berry** responded that the release of the survey results was held due to the COVID-19 crisis so that they were first released on the day of the current ICAD TF meeting. The survey results were included in the materials sent to ICAD TF members.
    - **Kate Berry** noted that the prescription medicine PA process side has a more mature infrastructure and mature standards, which have often been leveraged to do real-time benefits checks and electronic PA (ePA). Also, because she noted that CMS would require ePA for Medicare Part B by early 2021, she surmised that the prescription medicine PA process side would move forward faster. She explained that the medical/surgical side of PA would move forward more slowly, due to complexities in the process.
    - **Alix Goss** discussed the PDF with the statistics and noted that 100% of prescription medicine respondents and 95% of medical/surgical respondents stated that they reviewed their PA lists yearly. She tied these statistics to the work the ICAD TF is doing on their guiding principles.
    - **Kate Berry** confirmed the statistics and thanked **Alix Goss** for the reminder to discuss the topic.
    - **Alix Goss** noted that the statistics spoke to the fluidity of the PA ecosystem and added another layer of consideration for the ICAD TF's work to promote transparency and better patient care.
    - **Kate Berry** responded that AHIP's goal is to make the PA process smoother.

Sheryl Turney thanked the presenters from the AHIP and noted that more information was included in the ICAD TF's materials.

PREMIER PRESENTATION AND DISCUSSION

Meryl Bloomrosen, Senior Director, Federal Affairs, Premier Inc., **Scott Weingarten,** MD, CEO Stanson Health, and **Alex Tatiyants,** VP, CTO Stanson Health, presented on the topic of automating PA.

Scott Weingarten began the presentation by providing an overview of Premier, and he noted that the provider of its underlying prior authorization automated technology, Stanson Health, was acquired by Premier a year and a half previously. He explained that Premier is a health system-driven IT and supply chain company, while Stanson is a provider-led, driven, and owned clinical platform company started at Cedars-Sinai in Los Angeles. He explained the background of Stanson and noted that its clinical decision support (CDS) tools are integrated directly into the provider's EHR workflow, providing real-time, patient-specific best practices at the point of care. He explained how Stanson repurposed its clinical platform to be payer agnostic, scalable, and standards-based to implement PA following an evaluation by Aetna four

years ago. He explained that **Meryl Bloomrosen** would provide an overview of the key lessons Stanson/Premier learned over the past four years.

Meryl Bloomrosen noted that discussion topics during the Premier presentation would include the following: Stanson/Premier's experience automating PA for providers within the EHR and also for payers in their utilization management systems, key lessons learned, and recommendations to the ICAD TF. She discussed the main reasons to automate PA, which included:

- For patients: less time spent waiting for approval; reduced delays and interruptions in care; and improved patient satisfaction.
- For providers: streamlined workflows with fewer phone calls, faxes, and portals; reduced administrative costs; and reduced administrative and reporting burdens.
- For payors: improved provider satisfaction; lower costs related to utilization management; and better consistency in adjudication decisions.

She provided an overview of the overarching PA issues and challenges identified, which included:

- Labor-intensive source of administrative burden for providers and health plans
- Unintended consequences for patients, plans, and providers
- Clinical and administrative workflow disruptions and inefficiencies
- Clinician administrative and reporting burdens
- Need for real-time access to data within workflow and at point-of-care
- Lack of standards adoption and implementation
- Cumbersome and diverse PA requirements and processes
- Lack of robust, end-to-end automation
- Requires exchange and sharing of data among several stakeholders

Then, she noted that some of the key themes already identified by the ICAD TF in their work would be explored in the rest of the presentation, including the need for interoperability between clinical and administrative systems.

Alex Tatiyants discussed the meaning of "automated PA" with regard to Premier's work on the subject. He explained that Premier has taken a provider-centric approach to automation in order to create a solution that is readily accepted and adopted by providers. He noted that Premier focused on one of the areas they deemed the most difficult parts of the PA process: medical necessity adjudication in real-time using chart data; he described the workflow for this illustrated in Premier's presentation slides. He explained that for the ideal workflow to be possible, Premier identified a set of "table stakes," or ground rules, which included:

- No portals:
  - Must be embedded into provider workflow
  - Must be triggered automatically
  - Must be at the point of decision making
- No double documentation:
  - Must use what's already on the chart (both structured and free-text)
- No waiting:
  - Must be done in real-time (both adjudication and approval)

He emphasized that medical necessity adjudication is hard, and he posed the statement that it is the most difficult part of PA. He asserted that the factors at play are the guidelines, which can be complex, ambiguous, and incomplete, and the data, which are often noisy, incomplete, and unstructured. He stated that these combine to create difficult situations. Then, he described two approaches to auto adjudications:

- Probabilistic Model ("Black Box")
  - Uses statistical model
  - Requires training data of PAs
  - Output: likelihood of approval (with 87% chance)
- Deterministic Model ("Show Your Work")
  - Uses rules
  - Requires clinicians to build rules (decision trees)
  - Output: approval + provenance (or exactly why the approval was made)

He noted that both systems have pros and cons, but, in the experience of Premier, he stated that the Deterministic Model is easy to make work and is more legally defensible. As a result, it is the one Premier uses.

He explained that Premier has found guideline codification to be complex and time-consuming but necessary. He stated that, because EHR data often has complexities and issues, documentation patterns vary. He noted that data are often incomplete (e.g., outcomes are frequently missing), patient records are fragmented, data entry errors are common, and the timeliness or currency of the data can be difficult to establish. Also, he stated that providers do not always document before signing orders. He explained that structured data is limited. In a recent survey of U.S. hospitals equipped with advanced EHRs, only about 35% of the hospitals' clinical data were captured in a structured format, while 65% was in unstructured text. He discussed the ways in which Premier put effort into making sense of the large amounts of unstructured text using natural language processing and machine learning. He explained that provider interaction can be necessary, so Premier built an interactive app that pops up in the EHR to assist providers in completing the adjudication process.

He stated that standards can be helpful in automating PA, and he discussed the ways in which two standards, Clinical Decision Support (CDS) Hooks and Fast Healthcare Interoperability Resources (FHIR), are useful in the adjudication process. He noted that CDS Hooks helped integrate into the provider workflow, and FHIR helps get patient data. Then, **Meryl Bloomrosen** continued the discussion of helpful standards by providing an overview of what is standardized by ONC's Final Rules and CMS's recognition of ONC's Rules. She discussed the usefulness of standards-based API and API certification criteria and the U.S. Core Data for Interoperability (USCDI), which is a standardized set of health data classes and data elements and the Standards Version Advancement Process.

Alex Tatiyants provided an overview of surprises and lessons learned during Premier's work, which included:

- Payors
  - Amount of human interpretation involved in manual adjudication
  - Duplicative guidelines, lack of clarity about which guidelines should apply
  - Amount of similarity between guidelines from various sources
    - For example: 90%+ similar in some cases
  - Complications caused by assumptions inherent to existing PA process
    - For example: furnishing facility is known when the case is submitted for approval
- Providers
  - Variability in provider prior authorization management processes
  - Lengths providers are willing to go in order to streamline prior authorization
    - For example: One health system maintains list of questions they have collected over time about what payors might want to know about.
  - Unexpected data gaps
    - For example: missing payor info
  - EHR workflow limitations

- For example: Scheduled vs. ordered procedures

He noted that a final interesting development is that some EHRs have created their own app stores where third-party vendors place apps that are specific to the EHR. However, he argued that many app stores do not give developers enough tools to properly develop, debug, and test their solutions, but most EHRs do not give third parties access. He discussed related issues and limitations.

He discussed whether automating PA is the preferred end state, and he asserted that it should not be. Rather, he stated that PA is a means to an end for managing appropriate utilization, and it is an important next step in the process. He argued that there is another way to do this: CDS, which would eliminate the administrative hassle and expense related to PA. He asserted that paired with analytics, CDS still gives health systems a way to manage utilization, but at a lower cost.

Meryl Bloomrosen presented Premier's recommendations, which included:

- Advance efforts to align and optimize existing and emerging standards and technologies
- Address interoperability between administrative and clinical data and systems
- Accelerate and expand development and adoption of open data and interoperability standards (APIs; CDS hooks; USCDI; FHIR)
- Ensure providers and clinicians can connect and use any third-party applications of their choosing
- Facilitate real-time data access for clinicians at point of care and within workflow
- Harmonize requirements across agencies (CMS and ONC) and programs (HIPAA; CEHRT; PI)
- Incentivize uses of health IT that reduce burdens and provide value to clinicians
- Recognize nuances of PA (surgeries, tests, procedures, medications)

Then, she concluded the presentation by asking ICAD TF members to provide feedback on the recommendations and other items covered by the presenters from Premier.

Discussion:

- **Jocelyn Keegan** thanked the presenters and submitted several questions:
  - She inquired if Premier's customer base is looking into how to utilize services as part of contracting, in light of the comment made that PA is a next step and not an end goal.
    - **Scott Weingarten** responded that to be successful in risk-based contracting, information on appropriateness and whether providers are following evidence-based appropriateness guidelines is needed and helpful, especially as risk shifts from payors to providers. He stated that the ability to track it longitudinally over time for providers is also helpful.
  - She asked if there is a level of the importance (or not) to picking certain apps to plug into the workflow based multi-payer or all-payer involvement.
    - **Scott Weingarten** responded that multi-payer involvement is needed, which is why Premier has focused on being payer agnostic and scalable in order to be a good fit for all situations.
  - She inquired how widely the capabilities that the presenters discussed are currently available in production and are being used in the market.
    - **Alex Tatiyants** explained that Premier is currently running multiple pilots for their technology live in production, but they do not have widespread availability yet.
- **Sheryl Turney** inquired about what kind of effort it takes to implement a system like the one the presenters described. She also asked if it would work with any EMR system.

  - **Alex Tatiyants** responded that the effort depends on the EMR system and discussed capabilities the EMR would need to have. He added that, while many EMRs would be able to implement, many smaller ones would not. He explained that there was a government effort around introducing CDS into advanced imaging with a mandate that any imaging order that must be submitted to CMS has to be consulted with a mechanism that has been approved for that purpose.
- **Arien Malec** inquired if the capability that the presenters referenced is the full FHIR profiles and CDS Hooks supporting a variety of hook actions and triggers.
  - **Alex Tatiyants** responded that Premier's existing implementations use what is available. He explained that if EHRs fully or partially support CDS Hooks and FHIR, Premier uses them; if EHRs use a proprietary solution, Premier uses that.
  - **Arien Malec** asked if there were a standards-based platform where every EHR supported the full FHIR profiles and CDS Hooks with a variety of order-based trigger conditions, it would be kind of the platform that Premier would use to build out their capabilities.
  - **Alex Tatiyants** that this type of platform would lower costs for app developers to leverage capability with multiple EHRs, and it would be useful.
  - **Arien Malec** inquired if there are data elements, triggers, or other capabilities that currently do not exist across EHRs that Premier feels are necessary and appropriate.
  - **Alex Tatiyants** responded that there were many, so he explained that he would focus on the two most notable, which included the distinction in the workflow between organized and scheduling: as an example, he discussed how some actions, like ordering an advanced imaging test, trigger and present a provider with an interaction and recommendation very easily. He noted that others, like scheduling a provider, are a different workflow and do not often present triggers. He explained that there are workarounds, but they are not an inherent capability of the EHR. He also discussed the issues related to the process for providers creating and signing their notes at different times of the day and noted that a solution could be for EHRs to support unsigned notes.
  - **Arien Malec** summarized the discussion.

Alix Goss noted that the discussion would have to be concluded due to time and further agenda items, but she thanked everyone for the presentations and the robust discussions. She asked that any other questions for presenters from either group be submitted offline.

PRIVACY AND SECURITY IDEAL STATE AND GUIDING PRINCIPLES INTRODUCTION AND NEXT STEPS

Due to time constraints, **Alix Goss** noted that the public comment period would be moved back by five minutes to 4:25 p.m., and then she continued with an update on work completed by the small workgroups that have focused on Privacy and Security and the Ideal State and Guiding Principles. She shared the new Guiding Principles and Future Ideal State document, which was dated as of June 8th and was distributed to ICAD TF members. She explained that it was created by combining input from the newer Privacy and Security small workgroup and a reconciliation of TF input. She explained that this work was important and would be instrumental in creating recommendations and policy levers.

She noted that the summary at the top of the page of the categories of Guiding Principles was modified to include "Information Security and Policy." Then, she directed the ICAD TF to the fourth page of the document, where the new information was presented. She asked TF members to review that section of the document and to formulate comments, questions, and feedback. She suggested moving the TF's discussion of the new section of the document to the next meeting of the ICAD TF when she and the other members of the small workgroup would be prepared to answer questions and lead a discussion.

She provided background information on the experts and resources that the small workgroup utilized to create the new section of the document, and she provided some insight into the formatting of the new sections.

Then, she presented the draft timeline, which included several additional presentations to be given to the ICAD TF. She discussed the next steps and noted that, by July, the TF should develop draft recommendations and a report outline for review at the August 4, 2020, meeting of the ICAD TF. Then, the draft recommendations will be presented to the HITAC for review at their September 9, 2020, meeting, and the recommendations and report will be finalized at the October 21, 2020, HITAC meeting.

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

Anil Jain: I'm having audio issues and will call back in.

Gus Geraci, MD: Apologies for being late. I'm here.

Anil Jain: Anil here - I'm back on...

Arien Malec: Arien here now.

Lauren Richie: Hello Gus and Arien

Gus Geraci, MD: :-)

Alexis Snyder: Are the slides changing?

Katherine Campanale: Hi Alexis, not currently

Alexis Snyder: ok thanks wanted to make sure it wasn't my end :)

Jocelyn Keegan: Can Kate share the stats she shared with the group. That is great data to reference as we move forward.

Alix Goss: Would be good to know if all those stats are contained in the materials provided by AHIP. They would be great to use in the current state writeup for the Task Force report.

Rich Landen: Rich Landen joining by Web. No phone yet. Sorry I'm late.

Denise Webb: These are good guiding principles.

Jocelyn Keegan: can you help us understand what's in tech stack? all proprietary API? FHIR? transaction/messaging?

Jocelyn Keegan: perfect.

Lauren Richie: To members of the public, we will hold public comment at approx 4:25. To make a comment please call: 1-877-407-7192(once connected, press “*1” to speak)

CLOSING REMARKS AND ADJOURN

Sheryl Turney and **Alix Goss** thanked everyone for their participation in the meeting and wished them good health.

The next meeting will be held on Tuesday, June 16, 2020. The meeting was adjourned at 4:29 p.m. ET.