The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

July 7, 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** summarized the agenda and the recent activities of the ICAD TF, including an overview of the last meeting when TF members reviewed a draft of a BPM+ process model depicting the automated prior authorization (PA) process between provider and payer. **Hans Buitendijk,** Chair of the Electronic Health Record Association (EHRA) Executive Committee, presented an overview of the current state, challenges, and recommendations for the electronic PA (ePA) process. ICAD TF members discussed the presentation and submitted questions and comments. **Alix Goss** presented the Guiding Principles/Ideal State small workgroup's updated recommendations and facilitated a brainstorming session for TF members. **Sheryl Turney** 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 (BPM+) and Action Plan
03:10 p.m.	EHRA Presentation
03:40 p.m.	Prior Authorization Recommendations Brainstorming
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 July 7, 2020, meeting of the ICAD to order at 3:04 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
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
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic

MEMBERS NOT IN ATTENDANCE

Leslie Lenert, Medical University of South Carolina
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Alex Mugge, Centers for Medicare & Medicaid Services
Abby Sears, OCHIN
Andrew Truscott, Accenture
Denise Webb, Individual

SUMMARY (BPM+) AND ACTION PLAN

Alix Goss, co-chair of the ICAD TF, welcomed members and reviewed the agenda for the current meeting. She provided a brief summary of the last meeting, at which TF members reviewed an impressive draft of a BPM+ process model depicting the automated prior authorization (PA) process between provider and payer. **Alix** voice her appreciation for the efforts of the creator of the process model, **Robert Lario**. TF members submitted questions and comments and engaged in a robust discussion, during which they identified opportunities to further expand upon patient interactions and the ideal/future state for PA automation. **Alix** noted that there will be opportunities to leverage this work as the TF continues to identify other subject matter areas for their final report to the HITAC, which she and **Sheryl Turney,** co-chair of the ICAD TF, are currently preparing.

EHRA PRESENTATION

Alix Goss welcomed and introduced **Hans Buitendijk,** Chair of the Electronic Health Record Association (EHRA) Executive Committee, and Director of Interoperability Strategy at Cerner Corporation and provided background information on the EHRA and an overview of the current state, challenges, and recommendations for the electronic PA (ePA) process.

About the EHRA

Hans provided an introduction to the EHRA and explained that the EHRA's 30 member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using electronic health records (EHRs) across the United States. The EHRA's core objectives focus on collaborative efforts to accelerate health information and technology adoption, advance information exchange between interoperable systems, and improve the quality and efficiency of care through the use of technology. He explained that the EHRA agrees that there is a need to streamline the PA process and noted that EHRA has learned a great deal from their clients about the many challenges in the PA process, which will be defined during the presentation.

Current State and Challenges to ePA

Hans explained that there is a distinction between PA for prescription medications and other kinds of PA and noted that ePA for prescription medications is more widespread, due to integration with payers through CoverMyMeds and Surescripts. The Centers for Medicare & Medicaid Services (CMS) is moving toward adoption of v2017071 of the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard for Part D plans. **Hans** stated that they are pleased with how far they have been able to go with improvements to PA for medications, but ePA for all other medical services has been lagging.

Hans discussed some of the main challenges to ePA, which included:

- The level of detail at which PA is required, e.g. procedures, tests, durable medical equipment (DME), and services,
- A lack of standard data requirements and granularity across payers (federal, state, commercial).
- A lack of efficient data-exchange technology by payers, and
- Ensuring data capture and workflow integration.

ePA and EHRs

EHRs capture much of the relevant data for PA, but the EHRA has identified the following challenges specific to EHRs:

- The need for PA is often not known at the time of order.
- PA often requires additional documentation beyond what is needed for treatment.
- The need for additional documentation is often not known at the time of order.

- Relevant data may be in a different system or format, such as relevant PDF or C-CDA documents.
- There might be potential lags in accessing and exchanging with payer systems.

Hans explained that challenges are frequently projected onto the EHR, rather than on the source, requiring further documentation and for the infrastructure to be in place to facilitate access to information in a timely fashion. He stated that there is no one-size-fits-all solution for interoperability; rather, it is a complex goal that requires many elements to combine with the right balance, the correct technology and standards, and the participation of all necessary parties.

Recommendations for ePA

Hans discussed the EHRA's recommendations for the ICAD TF's consideration, which included:

- Establish authorization at a higher level than procedure/service/test/DME.
- Integrate the ePA process within the EHR workflow and avoid reliance on separate payer/3rd party portals.
- Automate data capture and PA requests
- Adopt technologies and standards better suited to real-time interactions across systems, e.g., clinical decision support (CDS) Hooks, RESTful, HL7® Fast Healthcare Interoperability Resources (FHIR®), and SMART®.

Hans concluded the presentation by restating the need for all parties to work together to figure out how to best integrate the ePA process within the EHR workflow and noted that there might be several paths, which share common characteristics, to achieve the solution. He thanked the ICAD TF for their time and asked TF members to submit questions.

Discussion:

- **Alix Goss** thanked **Hans** for the presentation and noted that she would facilitate the discussion.
- **Alexis Snyder** thanked **Hans** and asked him to elaborate on the move from fee-based care to more value-based care systems and how this would be helpful in establishing authorization at a higher level than the procedure itself.
  - **Hans Buitendijk** responded that authorization is needed on fee-for-services procedures as they are ordered and considered. He discussed two different ways of looking at the issue:
    - Certain services, procedures, tests, and equipment are expected to be part of the specific categories of care that are defined for each patient. Therefore, he suggested that individual PAs should not be required for things that fall within the category of care.
    - Value-based payment programs are risk-based, so there is an incentive on both the payer and provider sides to balance the quality of cost, and this is an incentive for all parties. It results in a reduction of the number of times PA is needed for individual items.
- **Rich Landen** inquired if the current X12 transaction set fits in as another component with the new technologies and standards listed in the fourth recommendation or if the X12 would have to be abandoned completely in favor of the other standards and technologies.

- **Hans Buitendijk** responded that this is a loaded question but that the level of interaction needed to communicate with payers back and forth using data warrants the use of more nimble data. He explained that HL7 FHIR enables this process while ensuring more appropriate security connections and that any technology that is neutral but can quickly and efficiently manage the workflow between the provider and payer will take over.

- **Jocelyn Keegan** thanked him for the presentation and submitted two questions related to ePA:
  - Does he think that the integration of real-time benefits checks will replace some of the weaknesses around the formulary and benefit side?
  - Could he provide more information around the ideas and concepts behind Smart Applications (Smart Apps) and how he thinks they can be used to improve or reduce the need for PA?
  - **Hans Buitendijk** responded that the topic of real-time benefits can be examined in conjunction with PA or without PA. He explained that the questions of what real-time benefit checks would cost and who would cover the cost are related. During the process of PA initiated by the provider, real-time benefits, accommodations for all involved parties to make informed decisions, and the financial applications need to be considered. He explained that real-time benefits checks and price transparency will need to be completed, regardless of PA.
  - **Jocelyn** noted that there is a codependency in the situation he had described. She inquired if there the EHRA has a perspective on the roles of Smart Apps and creating transparency and workflows around patient benefits.
  - **Hans** responded that EHRA does not have an official opinion or value judgment on the topic, but two methods are being explored at this time that both have related benefits and opportunities. There are pros and cons to both methods, so they are both being explored by the community, and they were:
    - Taking the interaction with the payer and deeply embedding it in the existing workflow for the clinician/administrative staff. If a PA and/or additional information are needed, the request goes into a queue for follow-up.
    - Taking an approach where a Smart App is integrated with the workflow and is triggered by request for a PA, using CDS Hooks or another technique. The Smart App coordinates with the interactions with the different payers and can also collect data from the system using a FHIR-based application programming interface is a computing interface (API).

- **Alix Goss** summarized the two approaches. She asked **Hans** to comment on the statement that Smart Apps must be bolted into that infrastructure for doing the PA calls and the back-and-forth queries, and this method is dependent upon the data being captured and stored in the right data element in order for the Smart Apps to properly leverage it.
  - **Hans Buitendijk** confirmed her assessment of the situation and commented that the Smart Apps can take advantage of existing and emerging technologies. Additionally, Smart Apps might have capabilities that might not be needed or deployed initially in the EHR, but they would be available for quick deployment in the future. He explained that there are benefits to both methods, and the parties involved will have to judge each situation in the context of their EHR, the payers, and other factors to determine which method is the best fit.
  - **Alix** submitted one comment and several questions:
    - She responded that it sounds like there are the right tools in existence to allow the market to innovate while determining what method works best and relieves the burden the most.

        - What was the toolkit that Hans referred to in the fourth recommendation, and where does one get it?
        - How does the toolkit help the market to determine which models best meet the workflows and end-users where they are at?
    - **Hans** responded that the term "toolkit" could refer to a variety of things, including:
        - Standards for CDS Hooks are beginning to be included in some EHRs and can help with triggers in the workflow.
        - RESTful is a technology that can enable communication across the internet, so it is useful for web-based apps, which can support it well.
        - HL7 FHIR is a set of building blocks to define data needed for communication.
        - SMART is used to establish authorization and authentication environments for Smart Apps.
    - **Hans** noted that there is no single place where all of these "tools" are available together, but many in the industry are working to embed the tools into the EHR. The Da Vinci Project has been working on implementation guides. All of the capabilities are beginning to come together to be used.
- **Alix Goss** summarized the presentation and discussion by stating that interoperability rules, the patient access from CMS, and the certification rules from ONC will help to put the pieces of the puzzle together with the payer, provider, and vendor organizations. The correct pieces of the puzzle are starting to come together in the technology choices that organizations will be making.
    - **Hans Buitendijk** noted that there will be many opportunities to enable the workflow, to work with the existing process for PAs, and to streamline everything to decrease burdens and increase efficiency.
- **Rich Landen** requested clarity on the concept from the presentation of a specific order for PA and how it works in the EHR.
    - **Hans Buitendijk** discussed a frequently encountered example, PA for a prescription at the time of prescribing, and noted that there is a specific order that is necessary to complete this process. The order of steps in the PA process is related to a series of requests for information and interactions, so Hans noted that any other, more generic term other than "order" that conveys the need to have a series of steps performed in the PA process would work.
    - **Rich** inquired about how this example fits in the recommendations for PA from the presentation, especially with regard to the recommendation to establish authorization at a higher level than a procedure or service.
    - **Hans** responded that when PA is needed, rather than having to invoke the full workflow for each request, there are a variety of ways to not have to keep triggering various PA requests. He discussed several examples.
    - **Rich** thanked **Hans** for his clear response and noted that there would be one order that triggers the whole PA process. He clarified that the PA in the presentation was based on the request of a specific person and not a clinic.
- **Alix Goss** concluded the discussion by thanking **Hans Buitendijk** for the presentation and for answering the ICAD TF's questions.

PRIOR AUTHORIZATION RECOMMENDATIONS BRAINSTORMING

Alix Goss presented the Guiding Principles/Ideal State small workgroup's updated recommendations for the Guiding Principles and Future/Ideal State. The ICAD TF has worked on these items on a shared Google document several times at their previous meetings, so the small workgroup built a framework to

identify categories, policy levers, and orchestration and implementation opportunities related to technology standards and rules. The ICAD TF will build on the work of the small workgroup, and Alix described some of their recent updates. There are four areas that the ICAD TF has not examined, so they will begin to examine and discuss these areas during their current brainstorming session. She noted that **Sheryl Turney** would be helping to facilitate the brainstorming session.

Alix provided an overview of the following categories, and ICAD TF members submitted comments and questions:

Category: Real-Time Data Capture and Workflow Automation

Alix and **Sheryl** provided an overview of existing attributes in this category, which included:

- Routinely collect all or nearly all the data needed during the ordering steps in efficient workflow approaches for providers and their patients.
- Regardless of the venue of care, the prior authorization process mechanically should be similar for both the clinician and their patient regardless of health plan since patients move across the health ecosystem and providers should not be burdened with disparate workflows depending on venue.
- Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, payers and patients.
- Any workflow utilized to support the prior authorization should auto-generate editable content to document in the progress note/visit note the medical necessity so that clinicians don't have to re-document what they just did to justify the DME/Rx/Procedure, etc.
- All insurance coverage will be identified, and related support provided for coordination of benefits. (For example, verification of insurance coverage eligibility (270/271) is completed and supports ongoing COB activities.)
- Information required for recommendations and decision making should be provided one time by the source, whenever possible.
- Automate prior authorization through health IT and focus on what information can be exchanged to make any coverage decision better, faster and more transparent.
- Collect once and reuse, as permitted.
- Increase end-to-end automation for processing prior authorization data request and response using recognized standards and code set values.
- Protect continuity-of-care for patients who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers or prior authorization requirements.
- Workflow practices include triggers for expiring prior authorization to prompt renewal activities, if applicable.
- Greater use of Clinical Decision Support (CDS) tools, accountable care models and consensus-based guidelines to reduce the volume of prior authorization requests while increasing the value of responses and shared treatment decision making.
- Provider and payer systems can supply procedural, pharmacy, or device specific requirements and information needs to complete prior authorization processing.
- Integration of clinical (EHR) and administrative (Practice Management Systems) workflows required for an ideal prior authorization process.

Alix noted that there were also several additional ideas in the document that had not been included under any of the 14 points in the category. The ICAD TF is invited to discuss these topics, and they included:

- Multiple insurances, dual eligible scenarios are addressed in adopted standards. IGs need to meet the reality in today's landscape of casting a wide net to capture insurance coverage and the upfront step of who "covers" a patient at the start of eligibility discovery and patient encounter processes.
- Member ID cards/lack of standardization here
- Normalizing EHR capabilities
- Standards to support normalizing workflow with technology
- Response time norms

Discussion:

- **Sheryl Turney** discussed the suggestion of developing standards for member ID card formatting, which she had originally submitted to the list. Due to differences in the sizes of cards, they are saved in EHRs as an image, and the data have to be transposed into the mechanical or electronic systems, creating opportunities for errors. Standardization would allow for easier digitization, and this would benefit both the provider and the patient.
  - **Alix Goss** noted that there is a standard for health id cards, which may not be used, but is available and could be leveraged. The Workgroup for Electronic Data Interchange (WEDI) did work on this issue. She summarized the suggestion, which was to pursue the adoption/use of standardized member ID cards with an eye towards consumption of content into EHR.
  - **Sheryl** noted that she was not aware of the standard for member ID cards and suggested requiring that vendors adopt them so that ID card data can be captured electronically.
- **Alexis Snyder** commented on points 11 and 12 on the list and suggested adding additional information to point 11 and rewording point 12 for clarity:
  - **Alix Goss** clarified the suggestion to address the renewal process in relation to point 11 and added the following text to the Strawman Recommendations section of the Google document:
    - In lieu of a new PA for a continuing service (i.e., ongoing medications), pursue "renewal" feature as a matter of policy supported by technical capabilities. {need for additional PA process not needed}
  - **Alix** added the following text after point 12:
    - May need to revisit language for clarity; **Sheryl's** summary worked over the bullet content
- **Jocelyn Keegan** discussed aspects of both points that Alexis had identified and submitted several suggestions and comments. Her suggestions were added to the document and included:
  - (INCITS 284-2011INCITS 284-2011Reaffirmed as INCITS 284-2011 (R2016))
  - Consider federal policy lever aspect to incorporate
  - May need more than a member ID recommendation to uniquely identify the product the member/patient has purchased. (payer line of business; unique product level requirements)
  - **Alix Goss** clarified the suggestions and added them to the Google document.
  - **Sheryl Turney** noted that the suggestions were important, especially regarding the formularies that apply to each individual product. She noted that providers had identified the issue that software they use does not go down to the product level.
  - **Jocelyn** discussed the issues of not being able to manage a product for anything other than claims and no having unique identifiers for different versions of the plans.

Category: Information Security and Privacy

Alix Goss provided an overview of edits to existing Guiding Principles in this category and noted that the suggestions from the previous ICAD TF discussion of this section were noted (here in red texts). The Guiding Principles included:

- Task Force recommendations are grounded in foundational security and privacy considerations, which is intended to benefit the subsequent design of processes and technologies (software).
- Task Force recommendations and solutions should meet current health information and patient rights laws and regulations, such as the federal HIPAA Privacy, Security and Breach Notification rules, 42 CFR Part 2 - Confidentiality Of Substance Use Disorder Patient Records, and state requirements, as applicable.
- The solution the Task Force designs should meet the minimum necessary standard when requesting and disclosing information. We note that minimum necessary is often defined differently in provisions such as:
  - HIPAA Privacy Rule – minimum necessary standard plus the anticipated OCR updates
  - State Laws
  - Data use agreements and business associate agreements
- The solution the Task Force recommends empowers the patient to have a role in proactively providing and expediting his or her consent when required to share information necessary for prior authorization decisions. One example discussed was around reversing previous self-pay restrictions. (and carry through the process when requirements for PA could change (**Sheryl Turney** input about tracking - verify its in another section- not P&S.) Whatever the TF ends up recommending it would actually empower patient to have proactive or active steps. (**Alexis Snyder** comment: revamp bullet to better represent the intent) (and be mindful that empowerment is one thing - that also has to come along with the way or method to have a role in the process)

Alix referred the ICAD TF members to the Ideal State section in the document, and it included:

- Prior authorization stakeholders achieve common agreement on implementation of prior authorization minimum necessary protected health information sharing.
- The data elements that constitute minimum necessary for prior authorization are identified and can be compiled efficiently to facilitate the goal of automating as much as possible to improve workflow and reduce burden.
- Patients are empowered and understand their privacy rights and actively manage consent for sharing their data. This includes aspects related to self-pay scenarios.
- Consent format consistency is established for automated collection and use, when required beyond HIPAA treatment, payment, and operation permissions.
- Simplified (consider if simplified is best word…streamlined?) individual consent collection processes are used for sharing individually identifiable information for prior authorization when required by state or federal law by:
  - Automating the process within the prior authorization workflow to the extent possible, reducing manual steps
  - Informing the clinician prior to or close to the time of the submitting order that patient consent may be needed
  - Empower the patient to have a role in facilitating and expediting the collection process
    - Reword "empower" to have capabilities to be active in empowerment role - as noted above
    - Concerns on what this is getting at and how it links to a specific recommendation

- State law variances (inter- and intra-state clarity needed) are addressed through automation. To facilitate goals such as automating collecting necessary consents above, the ideal state will include ubiquitous machine-readable expressions of privacy restrictions (such as when consent is necessary or how minimum necessary is defined) in state laws. This will allow technology to better accommodate state variation in policy without needing human/personal judgement.
  - Consider transparency piece for citizen movement across country and living in different states)
  - Consider - any time we talk about legislation .. say "legislation and regulation" as they are both at play. Whole document edit. **Rich Landen's** and **Alexis Snyder's** comment: Telemedicine might be another implication for "f. State law variances..."
  - Jill DeGraff: Jill DeGraff here, from b.well. And a privacy/infosec/health IT lawyer. "legislation" often refers to lawmaking. "laws" and "regulations" implemented through formal rulemaking have the force of "law, so you might consider introducing "laws and regulations" near the top of the document and then define them collectively thereafter as "laws"

Discussion:

- **Alexis Snyder** discussed the concept of patient empowerment. She requested that the ICAD TF reword the third point based on her suggestions focused on the differences between patient empowerment and transparency and noted that she made them at the earlier ICAD TF when these topics were previously discussed.
  - **Alix Goss** responded that there was a robust discussion around this point at the earlier meeting and described the issue of a patient simply signing a HIPAA form without understanding their rights. She added the following text to the document:
    - Add content related to consumability; clear and transparent - easy to understand
  - **Alexis** stated that the information presented to the patient on the HIPAA form now is not transparent unless the patient requests more clarification. There are variances to the regulations. She emphasized that the process needs to be clearer and more transparent.
  - **Alix** inquired if the ICAD TF could turn this recommendation into some kind of education materials, similar to how the Office of Civil Rights has done by translating HIPAA privacy and security rules into videos and fact sheets. She explained that the two pieces of the strategy, which included:
    - Education: leverage existing resources for key messaging to empower citizen
    - Education: promote distribution vehicles to meet patients where they are at
  - **Alexis** responded that defining "clear and easy to consume" depends on how health literacy or English literacy the consumer of the materials.
  - **Alix** summarized the suggestion that educational materials are needed that the patient/citizen can easily and clearly consume, absorb, and understand.
  - **Alexis** noted that this is part of transparency and needs to be clearly presented to the patient at the point of care.
- **Debra Strickland** described how patients would normally consume this type of information (e.g., they would see the materials in a doctor's waiting room, on the way into a lab, or in a pharmacy). She suggested placing information in short blocks or images with text online, because most people are at home for the majority of their days now.
  - **Alexis Snyder** suggested that the information be extended to telehealth and/or preregistration.

  - **Debra** suggested that the information could be on the page like a banner or ad that the patient could click through for more information.
- **Alix Goss** summarized the feedback and added it to the Google document. She asked the ICAD TF members to pause their conversation to allow for the public comment period.

The operator 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: Theres *[sic]* lot of feedback on line

Gus Geraci, MD: Gus Geraci joining, listen only. Sorry I'm late.

Raj: Q: This is Raj from MCG. When are you planning to support CDS Hooks in Cerner platform?

Raj: Thanks, Hans.

Lauren Richie: Hello Gus

Jim Jirjis: is it just me who lost all audio

Alexis Snyder: I lost audio?

Debra Strickland: whered *[sic]* she go

Debra Strickland: ut *[sic]* oh

Alix Goss: I'm here..

Gus Geraci, MD: Not hearing

Alix Goss: I am dialing back in

Lauren Richie: I'm talking but I don't think folks can hear me either
Alexis Snyder: I heard Lauren, but not Alix

Gus Geraci, MD: I can hear Lauren/Sheryl

Lauren Richie: Please hold while we troubleshoot

Alix Goss: I'm on hold waiting for an operator. Sorry folks. Not sure why my audio failed.

Alix Goss: I'm back on now. Thank you Sheryl for picking up running the list of ideal state concepts for automation.

Rich Landen: We hear Sheryl just fine.

Mary Kay McDaniel: FYI, there is a standard for health id cards. It may not be used, but it is available.

Mary Kay McDaniel: WEDI did one and it followed

Sheryl Turney: thank you for bringing that forwartd *[sic]*

Alexis Snyder: so the reccommendation *[sic]* would then be to ensure it is used

Rich Landen: ID card standard must be approaching 15 - 20 years old now. Mag stripe; chip.

Mary Kay McDaniel: INCITS 284-2011INCITS 284-2011Reaffirmed as INCITS 284-2011 (R2016)

Melanie Combs-Dyer: What is the best way to "ensure that a standard is used"? Does CMS need to mandate its use?

Rachel Foerster: Melanie, CMS has mandated use of standards for decades and for the most part they are not yet in predominate use, e.g., for 80% plus of info exchanage. *[sic]*

Melanie Combs-Dyer: Medicare FFS allows (for some of its PA'd items) the provider to specify a LENGTH OF NEED. For example, if the provider selects "lifetime" length of need, and the CMS contractor approves it, the Medicare FFS is updated to not require further PA for that patient.

Rachel Foerster: So, can that reqirement *[sic]* be applied to all commercial payers as well?

Melanie Combs-Dyer: Rachael, then maybe CMS needs to prohibit Medicare MA plans and Medicaid and Marketplace plans from accepting medical records via fax.... or prohibit fax and web upload...

Melanie Combs-Dyer: thoughts?

Rachel Foerster: I would go to prohibiting fax - we are in the 3rd decade of the 21st century, right :-)

Melanie Combs-Dyer: Rachael, regarding LENGTH OF NEED, I think it would be great if the ICAD could recommend that CMS require all Medicare MA plans, Medicaid plans and Marketplace plan that utilized PA for ongoing items MUST allow the provider the ability to specify a requested LENGTH OF NEED.

Rachel Foerster: Totally agree with that. I would also strongly support requirements to move Medicare/Medicaid/Commercial to using 21st century technologies.

Thompson Boyd: Prior Authorization for Medications is typically given for a set number of months (e.g. 12 months), when a medication is renewed every 30 days.

Melanie Combs-Dyer: Rachael, regarding getting providers to adopt standards, I think it would be great if ICAD could recommend that CMS prohbit *[sic]* all Medicare MA plans, Medicaid plans and Marketplace plans from accepting PA requests via FAX (with one exception: payers may accept PA requests via FAX from providers that lack internet access)

Thompson Boyd: Prior Authorization for a Radiology Study yields a Prior Authorization Number, given by the Payer, when the Prior Authorization is approved by the Payer. The Radiology Setting will not be able to perform the diagnostic test for payment, without a Prior Authorization Number.

Rachel Foerster: Agree

Rachel Foerster: Melanie - just a thought - think about the global use of cell phones - what would be the approach for something similar here.

Thompson Boyd: Radiology Prior Authorization continued: If the Payer feels the Radiology Study is not clinically *[sic]* indicated, or if the Payer feels there is not enough information to approve the Radiology

Study, no Prior Authorization Number will be provided by the Payer. Without a Prior Authorization Number, the study cannot be performed for payment by the Payer.

Rachel Foerster: Melanie - I really am starting to think that we must move very creatively out of the 20th century and move radically forward.

Rachel Foerster: Baby steps are not going to work any more. *[sic]*

Lauren Richie: To members of the public: To make a comment please call: 1-877-407-7192 (once connected, press "*1" to speak)

Thompson Boyd: Reasons and rules to approve a study or to approve a medication differ among plans within a given payer, and differ among payers.

Gus Geraci, MD: Thanks, all!

NEXT STEPS

Sheryl Turney provided an overview of the next steps and indicated that volunteers are needed to complete a draft of the Documenting Gap Analysis for Prior Authorization Work for the ICAD TF to review. The volunteer(s) would review the TF's materials and identify existing gaps. In response to a prompt from **Alix Goss**, **Sheryl** described the way the volunteer(s) would complete the Gap Analysis. Potential steps included reviewing all materials, summarizing the gaps, presenting them to the TF for comments and questions. She noted that several gaps have already been identified, including the fact that some PA processes are not electronics and that documentation requirements have not been defined for all services. Not every recommendation from the TF will have a gap, but the draft Gap Analysis would identify many of them. **Debra Strickland** volunteered, so **Sheryl Turney** offered to send her all of the items she had already documented.

Sheryl Turney indicated that she would not be present, so **Alix Goss** will lead the next meeting in its entirety, and it is scheduled for July 14, 2020. ICAD TF members should plan to finalize the PA Recommendations. **Jim Jirjis** and **Josh Harvey** will provide a final review and wrap-up of the data classes. Longer-term plans for the TF were defined in the timeline and included moving from the PA example to a broader discussion of integration and a deep dive on clinical and administrative data. Finally, the TF will begin writing the final recommendations and report for presentation to the HITAC.

ADJOURN

Sheryl Turney and **Alix Goss** thanked **Hans Buitendijk** for the EHRA presentation and everyone else for their participation in the meeting.

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