The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

September 22, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Sheryl Turney and **Alix Goss,** co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Alix** reviewed the agenda for the current meeting and provided an overview of the activities of the previous meeting. Then, **Alix** facilitated the ICAD TF's discussion of the broader intersection of clinical and administrative data, and TF members held a robust discussion. Finally, the co-chairs briefly reviewed the TF's plans for moving forward and the next steps. There were no public comments submitted by phone. There were several comments submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Broader Intersection of Clinical and Administrative Data
03:20 p.m.	Review Draft Document and Comments
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 September 22, 2020, meeting of the ICAD to order at 3:02 p.m. ET.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Gus Geraci, Individual
Mary Greene, Centers for Medicare & Medicaid Services
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point-of-Care Partners
Thomas Mason, Office of the National Coordinator
Rich Landen, Individual/NCVHS
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

Steven Brown, U.S. Department of Veterans Affairs
Arien Malec, Change Healthcare
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
Andrew Truscott, Accenture

SUMMARY AND ACTION PLAN

Sheryl Turney and **Alix Goss,** co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Alix** reviewed the agenda for the current meeting, which will include a continuation of the TF's discussion of the broader intersection of clinical and administrative data and a review of comments on the synthesized draft report, which will be delivered to the HITAC on October 21, 2020.

Then, **Alix** provided an overview of the activities of the previous meeting, during which **Sheryl Turney** led the TF in a review and discussion of the feedback from the full HITAC, including questions of public input protocol and discussion themes. The group discussed operating rules, the desire for an open process, and takeaways from the HITAC members' comments. At the previous meeting, **Alix Goss** led the TF to discuss the broader intersection of clinical and administrative data and how to integrate these new ideas into the draft paper. Particular topics included patient and caregiver involvement, use of data across the continuum (including public and population health) without adding burden, supporting specialty care, and including stakeholders at different levels of technical advancement.

BROADER INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA

Alix Goss lead a continuation of the ICAD TF's discussion from the prior meeting of the broader intersection of clinical and administrative data. She described the approach the TF would take at the current meeting, noting that the TF would build on the September 8 and 15 discussion results and would focus on the following topics:

- Synthetic Data for Testing
- Price Transparency
- Patient at the Center
- Other Topics and Concept Areas

Alix explained that she and **Sheryl Turney** would capture additional principles and notes to produce report content and inform the development of the TF's Recommendations. Synthesis of these notes will occur offline by the co-chairs, ONC staff/**Michael Wittie**, and Susan, the editor, who will weave this work into the report. The timeline for the delivery of the draft work is October 14, 2020, and, as previously noted, the report will be presented to the HITAC at their meeting on October 21, 2020.

Alix displayed and described a document that listed the major themes from the ICAD TF's previous conversation on the broader intersection of clinical and administrative data and noted that the TF would discuss the new topic areas during their current meeting.

Topic Area: Synthetic Data and Testing

- Add administrative and transaction data to Synthea, for example, or to AEGIS testing mechanisms.
- Create a recommendation for the HITAC, which should include an ecosystem to make sure it all works properly that has built-in players, synthetic data, and testers.
  - Discuss the suggestion, submitted by **Ram Sriram**, to use test protocols, use cases, end to end testing, and other mechanisms needed.
  - Consider the commercial market aspects to meet the need for minimum testing rigor, and this will in tie in to the have/have not conversation the TF had. The federal government can help create the floor.
  - Consider Fast Healthcare Interoperability Resources (FHIR) ecosystem advancements to facilitate piloting/testing. The FHIR at Scale Taskforce (*FAST*), specifically, is looking at

this, but not with the focus on the intersection of administrative and clinical data.

Discussion:

- **Sheryl Turney** suggested that the point that whatever ecosystem is put in place gives app developers the ability to test against a synthetic database should be added to the TF's Guiding Principles, Ideal State, and/or Recommendations. She discussed her experiences with interoperability from a payer perspective and noted that third parties are looking for test accounts to be set up for them to use in the ecosystem, which is a time consuming and possibly risky endeavor. She noted that the opportunity to access a synthetic dataset/test bed for testing is better, in terms of creating a more robust, consistent experience, than having every participant create their own data test bed in the ecosystem. This should lead to smoother and easier piloting/testing and more rapid adoption.
  - **Ram Sriram** voiced his agreement.
  - **Alexis Snyder** also noted her agreement and discussed her experiences with providers pushing tests is difficult. She suggested that the topic be added to all three parts of the report.
  - **Denise Webb** noted her agreement.
  - **Rich Landen** suggested that having national test beds would be a common service instead of allowing individual actors to create their own limited test data beds.
  - **Alix Goss** summarized that this topic has to be woven into all three sections of the document and added the following comments to the shared topics document, noting that **Michael Wittie** would be working on synthesizing the comments in preparation for the editor, who will add them to the document for the HITAC:
    - Guiding Principle: Synthetic ecosystem test bed to aid initial validation, then it can support piloting objectives.
    - Recommendation: A national approach to have test data beds; the infrastructure must be invested in and supported as a public good.

Topic Area: Link to Price Transparency

- This is the biggest issue for the patient, whether it is prior authorization (PA) or retrospective.
- Examples of challenges submitted included:
  - Lab test occurs before PA possible
  - 'Named' service does not cover all aspects of costs, such as lab/pathology in colonoscopy example
  - Multiple providers involved in rendering one service and they offer different coverage – e.g. anesthesiologist is out-of-network though surgeon is in-network
  - Coverage was verified but the facility billing unit causes a different portion of the patient's coverage to be engaged

Discussion:

- **Alix Goss** summarized the topic and noted that, in the intersection where clinical and administrative data is becoming more integrated, several questions should be considered:
  - How can the price transparency objectives be supported?
  - What other things should the ICAD TF include in its report?
  - How should the TF recommend tackling the challenges listed above?
- **Sheryl Turney** highlighted the comment a HITAC member made that it should be as easy to shop for healthcare services (whether a PA or a contracted provider) to compare prices on any other consumer good (blouse example). She suggested that the TF should highlight the challenge of creating an ecosystem where people can shop for their services, regardless of their "plan"/network. She discussed her personal experiences with having two recent surgeries and not knowing in advance all of the items that would be included/billed.
- **Rich Landen** suggested having a patient-oriented "safe harbor" for the patient if a network is involved, in which the patient would be assured that all the adjutant services of their process/procedure would be covered in-network if the provider who is the first step of care/coordinating the patient's care is in-network. If other services are not available in-network, the financial burden rests on the contract between the health plan and the initial provider, not on the patient.
  - **Alexis Snyder** thanked him for his comment and stated that the TF was there to push the envelope.
- **Alexis Snyder** voiced her agreement with all of the earlier points, especially the example of shopping for a blouse, and noted that the healthcare industry is the only industry where the buyer/patient goes in unknowingly and is charged unknowingly. She described an example of buying a card and not knowing all of the hidden costs until after the check-out process began and emphasized that this process is not fair to the patient, linking this issue to the TF's transparency Guiding Principle. Also, she discussed the hidden costs related to ancillary service charges and agreed that changes to this process need to begin with the payer being as clear and transparent as possible. Testing and collecting data should be made easier and embedded in the process, as other TF members discussed, and everything should be set in the beginning, as if in a contract. If anything, there is a gap in details or a mistake is made, the payer and providers must reach a solution and not place additional burden on the patient. Finally, she highlighted issues that occur when the delivery of electronic information to the patient and provider is different in almost every situation, due to the lack of national healthcare and different contracts between providers and health facilities; there should be more consistency related to technology in this process for the sake of removing burden on the patient.
  - **Alix Goss** thanked **Alexis** for her comment and noted that it was entered into the documentation.
- **Gus Geraci** voiced his agreement with all of the previous comments but stated that, because the ICAD TF's charge is to facilitate the PA process, the Guiding Principle of Transparency could be difficult to implement and could get in the way of advancing PA. He discussed the examples of buying a blouse or card, noting that these processes are not covered by insurance, and nobody signs a contract when making these purchases, so there is a delicate situation with a third party (the insurance company) involved. He discussed the complexities highlighted in the example of having an echocardiogram read at either a hospital or a private cardiologist, noting that the determining "who is responsible" can sometimes be difficult to pinpoint, and cautioned the TF against saying anything stronger than transparency should be a goal. He noted that this is a complex topic, warranting caution on how the TF proceeds.
- **Jocelyn Keegan** noted that this is a large topic with a great deal of real-world work

being performed and echoed the point made by another TF member in the meeting chat that price shopping is a necessity for some patients, determining whether a procedure is done or not. She discussed her experiences working on a use case for price transparency with the Da Vinci Group over the past two years, noting that the American College of Surgeons at Brandeis and others in the FHIR/DV community have contributed a great deal of early discovery work and would be able to present useful information on the topic to the TF. The project has focused on getting to patient-specific information, which has been a major challenge in the workflows. She discussed the patient, provider, and payer parts of the equation that goes into the patient's choice and the many of the challenges around the patient's experiences with unknowns and costs connected to diagnosis, site of service, coordinating or bundling types of services, plan coverage/design, and other factors. She suggested that the TF set up an exemplar on Patient Cost Transparency like they did with PA.

  - **Alix Goss** summarized **Jocelyn's** points, noting that a recommendation another exemplar/discovery process should be set up by the HITAC on Patient Cost Transparency.

- **Anil Jain** discussed value transparency for consumers concerning price transparency as another level of the process. The question he highlighted is, "What is the patient getting for what they are spending, and how can a consumer get the data to reflect value more than just cost? He explained that by bringing together the two silos of data, the outcome for the patient is quality beyond price point.
  - **Alexis Snyder** noted her support for some of **Anil's** comments but suggested that value is not the patient's main concern. Consumer need varies widely based on each patient's situation, if they need specialty care, and where care can be received. She stated that transparency is the most important piece for consumers and that having the transparency of cost and information involved at the point of care informs choices made by the patient and provider. She discussed the example of all of the complications related to getting an MRI scheduled, performed, and read.
  - **Anil** clarified his statement that value in the equation has many factors and varies by patient and noted that being able to bring data to the front to help provider/patient is key to allow for the comparison factor that is not available now.
  - **Alexis** responded that she agreed with clarifications but asserted the need to keep the patient centered Guiding Principle in focus to enhance the patient's decision-making process.
  - **Anil** responded that a provider-centric approach would increase transparency and would allow providers to make referrals based on more and better information. In response to a statement from **Alexis**, he rephrased the statement that enabling the provider would enhance the shared decision-making process.
  - **Alexis** reiterated her comparisons between shopping for consumer goods and healthcare, noting that for a consumer who makes $10,000 and pays $500 per month in health insurance (for example), the cost of a procedure makes a difference. The process should be simpler from the patient's perspective.
- **Jim Jirjis** commented in support of the shared decision-making comment. There is value in the provider/patient relationship based on the provider's experience, and, if there is a trust between patient/provider, making data more transparent will aid in shared decision-making. He discussed statistics around consumers making procedures based purely on cost.
- **Anil Jain** noted that services should be differentiated from objective things like prescription drugs and medical devices. He discussed the example of a colonoscopy and noted that it is easier for objective things like services to cause a different price point outcome because new details can be discovered during the procedure.

  - **Alix Goss** discussed the colonoscopy example, noting that there were details in the insurance plan that said that even though the colonoscopy was supposed to be a covered, preventative service, the discovery of a polyp and resulting pathology would not be covered. This issue should have been revealed to the patient prior to the service because it was coded into the plan, but it was not revealed.
  - **Anil** noted that this is a common issue that occurs when, due to a discovery, a screening turns into a diagnostic event. He cautioned the TF against equating everything that happens in healthcare with consumer shopping, noting that most things in healthcare are not as tangible as buying a sweater, for example. The dynamic of preventive services becoming diagnostic services, which turns into financial impact or surprise fee scenario, needs to be avoided. He noted that transparency is need on the clinical and administrative sides, and **Alix** responded that the situation comes down to not surprising patients with costs.
- **Jocelyn Keegan** commented on difficulties created by the current complexity of plan designs, especially of high deductible plans, and noted that this creates variability and challenges for patients, which is connected with the TF's transparency Guiding Principle. She voiced her agreement with **Anil Jain's** points, noting that determining prices based on services (preventative, diagnostic) are very challenging aspects for providers/payers and that it warrants taking thoughtful steps to improve the issue incrementally. She suggested creating a price sheet for what could be charged based on what results are found in the service/diagnostic.
- **Alexis Snyder** voiced her support for **Jocelyn's** points and suggested using a different analogy for discussing the issue. She stated that it is not about the cost/price and comparison upfront to inform choice; rather, it is about patients not being surprised by many costs after the point of service. This is the only industry where this happens, and she noted that there should be the ability to forecast what could happen in service/diagnostic, inform the patient of potential costs before the service, and then avoid surprise. She suggested that nobody would agree to a bundled cost for veterinary services, for example, and then would agree to a higher cost after the procedure.
- **Sheryl Turney** responded that **Alexis'** analogy of the vet bill was good and discussed the topic of patients receiving bills related to waste calculators, which were not related to the PA scenario, but rather were a medical necessity determination made during claims processing (after the service was rendered). She discussed her family's experience of receiving a large bill after having blood work done that had been covered by insurance in the past but was deemed no longer medically necessary. The patient had no idea that the procedure would no longer be covered at the time of service.
- **Alix Goss** responded that it is not in the ICAD TF's scope to continue the deep dive into price transparency. In sum, she stated that this is a broad topic/issue that warrants a separate task force. The ICAD TF will bolster its transparency Guiding Principle content to reflect this discussion, and the resulting recommendation will call for another group take the deeper dive to tackle the complexities of the topic of price transparency.
  - Other TF members voiced their agreement.
  - **Alexis Snyder** agreed that price transparency is a separate issue. She suggested that patients armed with more data about cost transparency could benefit the patient out of pocket, as well as the payer coverage/premium dollar usage.

- **Sheryl Turney** thanked all commenters for sharing their viewpoints and noted that the ICAD TF gathered enough information to add to the TF's Guiding Principle for Transparency and to put together a Recommendation for the creation of a separate group to focus on the topic of price transparency.

Additional Topics or Consideration Areas

Alix Goss placed a final call for comments on the broader intersection of clinical and administrative data.

Discussion:

- **Jocelyn Keegan** suggested examining if there are policy and regulatory elements that are in place that could act as barriers or that could help advance the intersection of clinical and administrative data frameworks.
  - In response to a question from **Sheryl Turney, Alix Goss** noted that the ICAD TF started to look at opportunities on this topic for ONC leadership in the past but suggested that the TF discuss it again.
  - **Jocelyn Keegan** noted that the ask could include a broader focus on burden reduction and suggested that ONC, as well as the Office of Burden Reduction, would be able to move that work forward.
  - **Alix** discussed the various authorities that the ICAD TF will engage, following the completion of their report. Leadership at ONC and CMS could be engaged to work together.
- **Sheryl Turney** asked if a recommendation is needed related to patient third-party credentials to access their data. She discussed the gap in industry guidance and noted that this kind of recommendation could make things easier for patients who want to use centralized credentialing for things like the Apple Health app.
  - **Alix Goss** and **Sheryl** discussed how this would supply greater assurances to entities in knowing "Citizen Suzy-Q" is truly her identity across the industry and how patient at center design could lead to the creation of something like a hub for citizen credentials. Then, they discussed how this concept trips into app consent and revocation options by citizen/patient. For example, deleting an app does not really revoke consent based on the fine print.
  - **Alexis Snyder** emphasized maintaining the patient-centered aspect of such a design, which would make it more secure. She discussed the scenario, which was mentioned at a previous HITAC meeting, of "hospital A" and "hospital B," in which the patient does not necessarily want to share information with "hospital B" to prevent providing details, noting that today's loophole with a shared patient dynamic results in patient data sharing, even when a patient did not consent or may have opted out to prevent sharing. She noted that the shared patient scenario is a loophole.
  - **Alix** responded that she captured the feedback and would follow up on this example with **Alexis.**

Alix Goss thanked everyone for their comments and noted that out of consideration for the meeting time, the review of the draft document and comments would be moved to a future meeting.

Lauren Richie opened the meeting for public comment.

PUBLIC COMMENT

There were no public comments via the phone.

Questions and Comments Received via Adobe Connect

Mary Greene: Mary Greene is on

Deb Strickland: Deb S is on

Lauren Richie: Hello Deb

Alexis Snyder: agree with national approach

Alexis Snyder: yes yes yes and yes :)

Rich Landen: Great examples, Alix!

Jim Jirjis 2: what proportion of patients do we think would actually do such shopping versus trusting their pcp or being overwhelmed.

Jocelyn Keegan: hi, this is a massive topic, with lots of real world work being performed here. i can share what we are tackling on DV, but i think we should set up another exemplar like PA on Patient Cost Transparency

Anil Jain: Hi Anil Jain is on now...

Alexis Snyder: YES

Rich Landen: Another way to frame the concept is that the responsibility within the system must rest on the professionals (who are the SMEs and deal with the processes day after day) instead of resting with the non-professional, i.e., patient.

Alexis Snyder: transparency shoud *[sic]* not be a goal its already a guiding principle

Alexis Snyder: its not help to get a PA but not know how much the service costs

Jocelyn Keegan: Understanding actual cost for patient is critical. Alexis is right.

Alexis Snyder: its not about making a decision based on price, its about knowing up front what you are paying without surprise fees after.

Jim Jirjis: Lipitor is like a sweater. Heart surgery or colonoscopy is not

Alexis Snyder: Yes Alix thank you

Alexis Snyder: Exctly-thank you Joclyn *[sic]*

Jocelyn Keegan: heart surgery is like building a house, or more like a home renovation :) i think everyone should have to watch The Money Pit, before we come back together ;)

Jocelyn Keegan: The ability to take the "leap" of unknown today is the purview of people with access to capital.

Jocelyn Keegan: Many Americans don't have the priviledge *[sic]*

Alexis Snyder: yes-MOST do not

Gus Geraci, MD: I do not disagree that price transparency is important. I question the role of this panel to do more than say it is important, which we have done. Trying to solve that issue of pricing transparency is not within our scope, IMHO.

Jocelyn Keegan: I'm with Gus on focus. And Alexis, I typed MOST and retyped to many :|

Gus Geraci, MD: Agree, Alix.

Rich Landen: Agreed: we can put forth the principle/concept that there should be price transparency, but recommend someone else pursue further.

Alexis Snyder: I'm with you Joclyn :) *[sic]*

Mary Greene: I agree

Jocelyn Keegan: :)

Alix Goss: Rich - are you and Arien all set with purple text cleanup in google doc?

Rich Landen: I need to double check with Arien.

Alix Goss: thank you

NEXT STEPS

Sheryl Turney provided an overview of the next steps and explained that, at their next meeting, the ICAD TF will reconcile all final TF comments and will continue to focus on the broader intersection conversation. She described the offline work, during which all TF members are encouraged to review the contents of the document and submit comments by the end of the day on September 28. The editor will continue to work on the document, which will be discussed at the next TF meeting. Comments on the shared Google documents are now closed. Finally, the co-chairs will deliver the final recommendations and report to the HITAC on October 21, 2020.

Alix Goss noted that she would check with **Rich Landen** and **Arien Malec** to ensure that they have finished their synthesizing work, as the editing team transitions the document to a more traditional report format.

ADJOURN

Sheryl Turney and **Alix Goss** thanked everyone for their participation. **Lauren Richie** reminded members that the next meeting of the ICAD TF was scheduled for 3:00 p.m. ET on September 29, 2020.

The meeting was adjourned at 4:30 p.m. ET.