Intersection of Clinical and Administrative Data (ICAD) Task Force:

Final Recommendations to the HITAC

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The Office of the National Coordinator for Health Information Technology

Agenda

- Task Force Charge
- Task Force Members
- Final Report
  - Industry Comment Submissions
  - Ideal State and Guiding Principles – Updates
  - Recommendation – Updates
- Discussion
- HITAC Vote

ICAD Task Force Charge

Overarching charge: Produce information and considerations related to the merging of clinical and administrative data, its transport structures, rules and protections, for electronic prior authorizations to support work underway, or yet to be initiated, to achieve the vision.

Detailed charge: The ICAD Task Force will:

1. Design and conduct research on emerging industry innovations to:
    - validate and extend landscape analysis and opportunities
    - invite industry to present both established and emerging end-to-end solutions for accomplishing medical and pharmacy prior authorizations that support effective care delivery, reduce burden and promote efficiencies.
2. Identify patient and process-focused solutions that remove roadblocks to efficient medical and pharmacy electronic prior authorization and promote clinical and administrative data and standards convergence.
3. Produce Task Force recommendations and related convergence roadmap considerations for submission to HITAC for their consideration and action. The Task Force will share deliverables with NCVHS to inform its convergence and prior authorization activities.
4. Make public a summary of its findings once Task Force activities are complete, no later than September 2020.

ICAD: List of Task Force Members

Sheryl Turney, Co-Chair - Anthem	Alexandra (Alix) Goss, Co-Chair – Imprado / NCVHS
Steven Brown – VA	Gaspere C. (Gus) Geraci – Individual
Mary Greene/Alexandra Mugge – CMS	Anil K. Jain - IBM Watson Health
Jim Jirjis – HCA	Jocelyn Keegan – Point-of-Care Partners
Richard Landen – Individual / NCVHS	Arien Malec – Change Healthcare
Thomas Mason – ONC	Aaron Miri – University of Texas Austin
Jacki Monson – Sutter Health / NCVHS	Alexis Snyder – Patient Representative
Ram D. Sriram – NIST	Sasha TerMaat – Epic
Debra Strickland – Conduent / NCVHS	Denise Webb - Individual
Andrew Truscott – Accenture	

ICAD Report Outline - Updated

FRONT MATTER:

- Foreword by Co-Chairs
- Vision and Charge
- Task Force Member List
- List of Tables

EXECUTIVE SUMMARY

I. INTRODUCTION

II. ANALYSIS OF THE CURRENT PRIOR AUTHORIZATION LANDSCAPE

III. ICAD TASK FORCE FINDINGS AND RECOMMENDATIONS

IV. SUMMARY AND CONCLUSION:TOWARD FURTHER INTEGRATION OF CLINICAL AND ADMINISTRATIVE DATA

LIST OF APPENDICES

- List of Acronyms
- Glossary
- Presentation Summaries and Key Points
- Compendium of Landscape Artifacts

Final Report Updates

Industry Comment Submissions

- American Hospital Association (AHA)
- American Health Information Management Association (AHIMA)
- American Medical Association (AMA)
- American Psychiatric Association (APA)
- California Public Employees' Retirement System (CalPERS)
- Council for Affordable Quality Healthcare (CAQH)
- CoverMyMeds
- Health Innovation Alliance
- Medical Group Management Association (MGMA)
- National Council for Prescription Drug Programs (NCPDP)

Summary of Material Revisions

Section & Page	Revision
Global	Replaced “electronic” with “digital” (modifying ‘prior authorization’)
Foreword	Inserted Foreword; replaced “other” with “industry”
Vision/Charge	Added specific charges
Member list	Added column for affiliation; corrected 2 names
Exec Summary, p.8	Revised first bullet on what recommendations are designed to do
	Added note about terminology (“electronic” vs. “digital”)
p.9	Revised terminology for guiding principle A
	Expanded introduction to recommendations
p. 10	Revised recommendation 8 as on p. 41
	“This process should continue to include…”
	Revised final paragraph of summary/conclusion
Introduction, p. 15	Added footnote about terminology (as in Exec. Sum., p.8)
Analysis, p. 17	Replaced “The vision… is…” with “The vision… includes…”
p. 27	Added footnote on CAQH CORE
p. 28	Added “The quest for” to “An attachment standard has a long history…”
	Replaced 1 sentence on NCPDP with a new one
Findings & Recs, p. 31	Added “to enhance patient health experiences and outcomes by” to the statement of overarching goal in paragraph 2.
p. 32	In table 7 and text, revised terminology on guiding principle A
	Revised point 1 on ideal state for patient-centered design and focus
p. 38	Expanded introduction to recommendations
p. 39, Rec. 2	Deleted reference to authority
p. 40, Rec. 6	Replaced final sentence with a new one.
p. 41, Rec. 7	Revised recommendation to reflect emphasis on patient-centered design
p. 41, Rec. 8	Revised title and recommendation to clarify focus on member ID card
p. 43, Rec. 13	Revised wording on transparency
p. 43, Rec. 14	Small changes for clarity and consistency with other recommendations
p. 43, Rec. 15	Replaced “Minimum Data Set” with “sufficient data”; added bullet on incentives
Sum./Concl., p. 44	Added “to reduce burden” to the set-up to the list of goals
	Revised first bullet in the list of goals
p. 45	Revised final paragraph

Prior Authorization Process: Ideal State

The ICAD Task Force has heard from various stakeholders on improving the Prior Authorization (PA) process and has re-imagined an ideal state PA process:

- An end-to-end, closed-loop process
- Reduces the burden across all stakeholders
- Accounts for the vast majority of situations
- Leverages existing investments and efforts where appropriate, acknowledging the existing gaps

Achieving the Ideal State: Guiding Principles – Updated

Patient-Centered Design and Focus	Transparency	Design for the Future While Solving Today's Needs
Measureable and Meaningful	Continuous Improvement	Real-Time Data Capture and Workflow Automation
Aligned to National Standards	Information Security and Privacy	Reduce Burden on All Stakeholders

New Recommendations Lead-In

"These recommendations, which are not listed in priority order, outline necessary steps on the path toward clinical and administrative data integration. In other words, they focus on "the what," not "the how," and clarify the areas in which resources and energies must be focused to solidify the details needed to fulfill them.

Using the recommendations as a basis for initiating follow-on activities, industry partners and other stakeholders now need to get involved in translating the "whats" into "hows" and moving forward toward the ideal state. Federal leadership is essential to ensure that this process includes robust interagency coordination, industry and Federal advisory committee engagement, and alignment with other relevant initiatives."

Recommendations

*material updates

1. Prioritize Administrative Efficiency in Relevant Federal Programs
2. Establish a Government-wide Common Standards Advancement Process
3. Converge Healthcare Standards
4. Provide a Clear Roadmap and Timeline for Harmonized Standards
5. Harmonize Code and Value Sets
6. Make Standards (Code Sets, Content, Services) Open to Implement Without Licensing Costs
7. Develop Patient-centered Workflows and Standards*
8. Adopt a Member ID Card Standard*
9. Name an Attachment Standard
10. Establish Regular Review of Prior Authorization Rules
11. Establish Standards for Prior Authorization Workflows
12. Create Extension and Renewal Mechanism for Authorizations
13. Include the Patient in Prior Authorization
14. Establish Patient Authentication and Authorization to Support Consent
15. Establish Test Data Capability to Support Interoperability*

Updated Recommendation 7:

- **Develop Patient-centered Workflows and Standards**

  The Task Force discussed the critical importance of transparency to the patient of key administrative workflows. These workflows define access to and reimbursement for care, and delays in these workflows are a key source of care delays and sub-optimal outcomes within the health care system. Accordingly, "patient-centered design and focus" must be a system-design philosophy and built in from the ground up. Engagement in the workflow should be available to patients at their discretion, and not a requirement of the process. The Task Force believes that administrative workflow information is part of the Designated Record Set (DRS) (as it is patient-specific information used for decision making). If there is uncertainty on the inclusion of administrative workflows in the DRS, the Task Force recommends that ONC work with OCR to clarify the status of administrative workflows under the access provisions of HIPAA and ensure that patients have visibility into bi-directional workflows and exchanges of such data.

  The Task Force recommends that ONC work with other Federal actors and standards development organizations to prioritize and develop administrative standards that are designed for patients' bi-directional digital data exchange. Even "workhorse" administrative standards like eligibility, claiming, and electronic EOB/remittance that are traditionally considered provider-to-payer should allow access through the same API frameworks already supporting API access. Converged clinical and administrative workflows, including prior authorization, should be designed to support API access and patient engagement as a matter of course. As an example, benefits information provided to the provider via eligibility transactions should also be available to the patient via APIs; the content and status of claiming/remittance should be available to the patient not only at the end of the process through the current EOB API, but throughout the process of claiming and adjudication. As another example, the patient should have the ability to bi-directionally share health data (including patient generated data) with providers and other third parties from their applications of choice without special effort.

Updated Recommendation 8:

- **Adopt a Member ID Card Standard**

The Task Force recommends that ONC work with CMS (for Medicare, Medicaid, Medicare Advantage and MAPDs), OPM/FEBP, and DOD/Tricare to adopt a standard for member ID cards (following on INCITS 284-2011; reaffirmed as INCITS 284-2011 [R2016]). Alternatively, a virtual ID card could be permissible provided it complies with the INCITS ID card capability requirements and HIPAA privacy/security requirements. Standard ID cards would reduce burden by supporting patient access, clinical and administrative automation, and transparency between member/patient, provider, and plan. Member ID should be sufficient, along with HIPAA-appropriate levels of assurance, to reference patient-specific plan and product requirements like drug formularies and prior authorization.

Updated Recommendation 15:

Establish Test Data Capability to Support Interoperability

- The Task Force recommends that HHS lead development of a national approach to have test data beds to drive innovation and ensure real-world functionality and interoperability. To accomplish this, the following actions are needed:
  - Review the current administrative transactions and associated value/code sets to ensure that USCDI supports data concepts and elements needed downstream to support clinical and administrative functions.
  - Establish (illustrative) information models, in stages, to align clinical and administrative data for secondary use in stages, based on the highest societal priorities.
  - Establish a sufficient data set for transactions at the intersection of clinical and administrative data that adheres to “minimum necessary” requirements.
  - Advance an appropriately constrained implementation guide as a standard.
  - Offer incentives for stakeholders to pilot and test innovative solutions.

New Final Paragraph

"The Task Force believes that these recommendations will form a solid basis on which to develop the future policies, standards, and enabling technologies that will truly put the patient at the center of an efficient health care information ecosystem. That ecosystem would seamlessly and multi-directionally move appropriate data from the point of initial capture to the point(s) of use without any special effort by those capturing or consuming the data. Those data flows would be protected by robust security practices and privacy policies. Overall burden would be reduced while clinical care, patient experience, and health outcomes would be improved. HHS and industry stakeholders should take these recommendations as a basis for initiating follow-on actions to bring the described ideal state to life."

Discussion

HITAC Vote