



Health Information Technology Advisory Committee

Electronic Prior Authorization RFI Task Force 2022 Virtual Meeting

Meeting Notes | February 16, 2022, 10:00 a.m. – 11:30 a.m. ET

Executive Summary

The focus of the Electronic Prior Authorization RFI Task Force 2022 (ePA RFI TF 2022) was to continue the work of the task force. The TF reviewed its work plan and the [Request for Information \(RFI\) on Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria](#) published by ONC on January 24, 2022. On behalf of the Workgroup for Electronic Data Interchange (WEDI), John Kelly presented an overview of the current state of attachments. Members reviewed comments on a working document and provided feedback.

There was one public comment submitted by phone, and there were several comments submitted via the chat feature in Zoom Webinar.

Agenda

10:00 a.m.	Call to Order/Roll Call
10:05 a.m.	Welcome Remarks, Review of Plan
10:15 a.m.	Attachments: C-CDA and FHIR
10:35 a.m.	Working Document Review and Discussion
11:20 a.m.	Public Comment
11:25 a.m.	Homework and Next Steps
11:30 a.m.	Adjourn

Call to Order

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:01 a.m. and welcomed members to the meeting of the ePA RFI TF 2022.

Roll Call

MEMBERS IN ATTENDANCE

Sheryl Turney, Anthem, Inc., Co-Chair

Tammy Banks, Individual, Co-Chair

Hans Buitendijk, Cerner

Dave DeGandi, Cambia Health Solutions

Rajesh Godavathi, MCG Health

Jim Jirjis, HCA Healthcare

Rich Landen, NCVHS

Heather McComas, AMA

Eliel Oliveira, Dell Medical School, University of Texas at Austin

Debra Strickland, NCVHS



MEMBERS NOT IN ATTENDANCE

Aaron Miri, Baptist Health
Patrick Murta, Humana

ONC STAFF

Mike Berry, Designated Federal Officer
Alex Baker, Federal Policy Branch Chief
Michael Wittie, Policy Analyst

Key Specific Points of Discussion

TOPIC: WELCOME REMARKS, REVIEW OF PLAN

Sheryl Turney and Tammy Banks, ePA RFI TF co-chairs, welcomed everyone and thanked TF members for their hard work between meetings. Sheryl reviewed the agenda for the meeting and the TF workplan and explained that the co-chairs would present a progress report to the HITAC at its February 17, 2022, meeting. She explained that an additional work session might be added, pending members' approval, to review the final ePA RFI TF work product prior to the final presentation to the HITAC. Tammy thanked everyone for attending and welcomed the presenter.

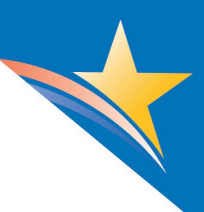
TOPIC: ATTACHMENTS: C-CDA AND FHIR

John Kelly, Principal Business Advisor at Edifecs and Vice Chair, Programs & Education, Workgroup for Electronic Data Interchange (WEDI) Board of Directors, presented an overview of the current state of attachments and briefly shared background information on WEDI. He described prior authorization (PA) end-to-end (E2E) automation and explained how attachments must be considered in terms of what actions are occurring (beyond the standards). He discussed how the process must address administrative metadata, transport and process mediation, and clinical presentation. Across these three areas, he described supporting E2E automation, the PA process, and the current state of standards maturity for the X12 attachment standards, the Da Vinci Project implementation guides based on Fast Healthcare Interoperability Resources (FHIR), and the Consolidated Clinical Document Architecture (C-CDA) standard. This information was detailed in [the WEDI presentation slides](#). John shared several specific use cases as examples and listed the applicable standards and guidelines when describing how to match the message to the medium for attachment solutions and standards.

John discussed how the term "translation" has been used in the context of PA and explained how it is a misnomer. He stated that maturity does matter in the workflow; however, that means ruling options in instead of out. This information was detailed in the presentation slides. Then, he described the fundamentals of reducing burden, noting that data must be structured to be of value in automating E2E processes, and listed ways to build on existing capabilities and standards. He emphasized the need to learn from successful process automation and described the three key processes that improved outcomes for all stakeholders (claims, eligibility, e-prescribing), noting that they were successful transactions not because of mature standards but due to the commitment made to develop their workflows.

John referenced a conversation TF members had at a previous meeting when he described how crossing business units to support an E2E process for PA is a workflow issue – not technology. He stated that mandating standard processes and technology certifications drives the evolution of the workflow and that actors need to plug into a common process rather than designing a process that plugs into all the actors. He discussed how successful burden reduction is predicated on being sensitive to contexts and stated that the attachments process should be considered part of the broader request for information and must be supported by common workflows, tooling, and communication patterns. He explained how the Da Vinci Project's implementation guides (IGs) address the E2E issues and how X12, FHIR, and C-CDA processes can and should coexist.

John shared a summary of WEDI's eight recommendations, which were all detailed in the presentation slides,



along with an appendix.

Tammy shared a list of questions TF members shared in the Zoom chat, and John responded to them.

DISCUSSION:

- Heather McComas asked about the use of C-CDA/the Additional Information to Support a Health Care Services Review (275 transaction, which is used to send attachments related to a health care services review or review notification) for prior authorization (PA).
 - John stated that a payer can articulate a request using a standard C-CDA and X12 process using a LOINC code, but if the standard has not been widely adopted, the provider side of the process will lack granularity/specificity. He discussed differences between how information is shared via the general Clinical Document Architecture (CDA), C-CDA, and FHIR and explained that the healthcare industry often adopts a one-size-fits-all approach that results in sparse, unstructured documentation, though querying using FHIR resources can result in a highly granular, specific, and articulated response. He stated that the three Da Vinci IGs provide for a best-case scenario with properly articulated requests for whether PA is needed and targeted specific responses. However, in practice, he noted, accommodations in the HL7 standards and the 275 standard allow for flexibility within the standards and the certifications, which is successful as long as there is a minimum bar so that everybody can create a structured payload. WEDI's opinion is that progress will be made in the healthcare industry if the standards support the minimum requirements (to support HL7, FHIR and X12), which 99% of payers, providers, and stakeholders can support, and then it mandates the process flow.
- Eliel Oliveira asked how to best inform patients on what is taking place in the PA and how to present this information. Patients are too often uninformed about the costs of medical services and if they are authorized/covered or not.
 - John described progress made under the 21st Century Cures Act (the Cures Act) and emphasized that if standards that convey structured information are adopted and made available through APIs, interfaces can be created for every actor in the system. He explained how the use of common standards in the PA process could allow anyone to create useful apps and user interfaces (UIs) to better inform patients. The standards ensure that the data will be formatted and structured to be useful and, with the proper permissions to establish identity, can be exposed.
- Tammy shared a question from a TF member asking for clarification around the eighth WEDI recommendation that the CMS Rule scope must address the business and care workflows of providers, payers, and consumers. How does this differ from the previous regulatory language?
 - John explained that previous rules mandated a standard and basic business processes, while the CMS Rule wrote a standard that sets a bar for performance and for patient access to data. He described the confusion created by aspirational standards that were set uniformly across all stakeholders. A workflow for PA must be built before the standards can be fully matured.
- Hans Buitendijk asked if data for a Request for Additional Information (RFAI) can be a collection of granular data, document(s), is it necessary to (re-)organize and structure that into a C-CDA or FHIR Document, rather than just a collection as gathered? Are you suggesting starting in the PAS space and then build from there into support for the other IGs?
 - John stated that though the IGs are not needed, an established standard for the process creates rules for asking for information. He described the examples of how SMART on FHIR apps, Clinical Quality Language (CQL), FHIR Resources, and the PAS guides are used in the workflow. He explained that the ecosystem needs to agree on how the CQL to FHIR translation will take place, but this is a maturity of process issue, not technology.
 - Hans and John discussed the challenge of having too many SMART on FHIR apps under one vendor. Hans described ways in which CQL is translated in different configurations and agreed that a defined path must be created for the process. However, he stated that



requiring all these capabilities for certification might be putting too much rigidity into the environment. He asked John to comment on how to find a balance.

- John responded that the original draft certifications for Meaningful Use had a higher level of rigor than where they ended up in the final version. He explained that there could be such a thing as too much certification and too much granularity but that building a new process requires core capabilities. He used the analogy of building on-ramps for a highway system to describe the need for minimum capabilities necessary for payers, EHRs, providers, and other stakeholders. He stated that many payers will have to retool their rules so that they do not lose data and that implementation must give a slow path to providers through vendors investing across the whole industry to capitalize on the minimum capabilities in their technologies. He shared some specific examples and highlighted the need to ensure a specific level of certification for all actors involved in the workflow.

TOPIC: WORKING DOCUMENT REVIEW AND DISCUSSION

Tammy reviewed the most recent ePA RFI TF member comments from the TF's shared Google working document and described updates to the document. She invited members to share any missing comments, caveats, or information and to provide any necessary corrections to the text. TF members discussed the comments.

DISCUSSION:

- Tammy stated that, prior to John's presentation, the ePA RFI TF had two different positions in response to the following question:
 - Would the specifications within the CDA Attachments IG, if adopted as part of a certification criterion, support a more effective exchange of healthcare attachments for PA? Would any changes to the IG be needed, or would additional functionalities or standards be required for effective implementation of the CDA Attachments IG in certified health IT?
 - Tammy explained that NSG is working on this effort, and she invited TF members to change their submitted comments or to provide additional feedback because the capability is already in certification via and Meaningful Use.
 - Hans stated that support for C-CDA need not mean supporting the C-CDA template for all attachments. He asked if the aim of the task is to collect as much data electronically (rather than via human intervention) to support an attachment/authorization, what is the value of translating everything into a CDA-formatted document rather than a FHIR document? What is the value of doing this in a document format? He cautioned against adding steps in a specific format that might not be necessary for the future.
 - Tammy stated that FHIR is straining functionality across the board and described the two types of PAs across the workflow (triggering for the 278 and the gap of how additional/attachment information is returned). She stated that the TF should also consider the vision of a future ideal state and asked if the TF would support a phased-in approach that will not require retooling in the future and uses the capabilities that are required under the Cures Act and Meaningful Use. She inquired how vendors are investing in this work.
 - Hans responded that not all vendors have made the investments to use CDA attachments in EHRs. He asked if a document in the correct required format (C-CDA, FHIR) or if the collection of data to support the authorization request is more relevant?
 - Heather McComas highlighted concerns around the potential burdens and delays in providing care due to the time needed for payers to process documents. She asked if payers could fully support both the document-based and more granular approaches at the same time and asked TF members to consider the associated costs for doing both.
 - Raj described two examples of his recent experiences with implementation and explained



that key learning was that both the attachments and granular data collection were needed. He stated that the TF should stay at the process level and not advocate for C-CDA or FHIR specifically (the industry is not mature enough to define the criteria now). He added that the IGs are sufficient for implementers at this stage. He suggested supporting the TF's recommendation with the future vision of adding criteria to support the capabilities within PAS and leaving any specifics around documents collection to how the market currently works today.

- Dave DeGandi commented that the TF should support the use of structured (over unstructured) documents to encourage automation.
 - Raj and Hans agreed, and Hans described the balancing act between how the data are currently being made available (structured versus unstructured). He drew parallels to work on electronic quality measures that is underway at CMS. Hans voiced his support for more data capture that avoids the need to transform the original format, with documents as a part of the collection of relevant information. Hans asked to remain neutral in his comments in the way Raj described previously.
 - Tammy captured the following neutral comment: "Leverage investment currently made to give room for stakeholder to make decision how to reduce the current burden. PAS articulates how to bundle collection of data using existing investment. We can make recommendations as PAS becomes more mature. Focus in on collection of data, rather than document exchange format, and provide flexibility of data being asked down the road."
 - TF members suggested changing the way the questions, themselves, would be asked.
 - Raj explained how the Da Vinci Connectathons have tested mappings to X12 278 and examined broader solutions (than FHIR). Denial reasons are in place due to testing and will continue to be leveraged.
- Heather commented that the questions only refer to C-CDA attachments and documents, which is only one part of the process (clinical documentation). For the TF's comments on the question to remain neutral, there would need to be a full equivalent for this method to get the documentation requirements to the provider. She suggested several options.
 - Hans asked if the TF's current conversation was solely focused on the transmission of the documents for supporting the clinical information for authorization. If the recommendations go beyond that process, they could result in varied implementations that do not connect.
- Tammy reviewed comments that TF members submitted previously on the 3.1 questions, which were split evenly between "Support" and "Remain neutral," with no members suggesting "Do not support." She encouraged TF members to choose an option in its recommendations, adding that the current discussion seemed to be "Remain neutral." She stated that her opinion would be to support the adoption of an attachment standard to support claims and PAs, as investments have been made, it helps other types of functionalities, and it is an option for the smaller payers and providers.
 - Raj asked for more time for consideration, but Tammy suggested that they could leverage what they have in the short term with a phased approach (instead of not acting/remaining neutral). She described the history of this work and urged the TF to make a recommendation that would reduce burden to the industry.
 - Eliel commented that the item that was missing from the recommendations is a systematic approach/plan for how to pilot the phased approach to implementations in real settings. What are the low-hanging fruit that can be solved now? He laid out several possible phases with examples.
 - Tammy informed TF members that she would write a recommendation that was neutral and would invite members to review it within the shared Google document.



- Tammy reviewed comments TF members submitted on the 3.2 questions around the use and adoption of FHIR Documents as part of a certification criterion to support a more effective exchange of healthcare attachments. She invited TF members to share any additional comments.
 - Hans stated that the issue with this item is like the topics the TF discussed regarding 3.1: whether FHIR or CD documents are used, the issue is formatting. Is it necessary to create a document as a wrapper or just a data pull? FHIR is moving toward data exchange, as compared to document exchange. He asked TF members to consider the value behind reformatting data as a document and suggested that the TF's recommendation could be like the one for question 3.1 (Remain Neutral).
 - Raj commented that, unlike 3.1, in 3.2, documents support other administrative use cases beyond PA, like claims processing. The TF should ensure that whatever the criteria the payers use for the claims processing transactions that are in place today are preserved.
- Tammy reviewed comments TF members submitted on the 3.3 questions around the timeline for the use of the CDA Attachments IG or FHIR Documents in production for PA transactions.
 - Tammy suggested that previous TF discussions around leveraging what already exists to move in a phased approach toward an ideal state would also apply to these questions.
 - Sheryl Turney commented that the TF could include a recommendation around the development of a proving ground for the maturity of all IGs and the ability to go from document to structured data. Several TF members agreed.
- Tammy reviewed comments TF members submitted on the 3.4 questions around approaches that would best accommodate improvements over time to meet payer and provider needs. Should ONC consider adopting certification criteria referencing one approach over another or support both within certified health IT?
 - Previously, TF members agreed via their submitted comments to move toward supporting a finite number of options (towards data over documents and leveraging technology). No TF members spoke in support of both.
- Tammy reviewed comments TF members submitted on the 3.5 questions around whether ONC should propose certification criteria to support healthcare attachments transactions for PA alone if the Da Vinci IGs are not ready.
 - Previously, TF members agreed via their submitted comments that an iterative plan should be developed to make incremental steps towards a fully functional PA process. What would the value be in focusing only on attachments? There was a consensus on the recommendation.
- Tammy reviewed comments TF members submitted on the 3.6 questions around the healthcare attachments used for a wide range of operations and administrative workflows beyond PA.
 - Previously, TF members reached a consensus that an iterative plan should be developed that allows for adoption and maturity. Tammy reviewed the agreed-upon comments.
- Tammy stated that there were no comments from TF members on the 3.7 questions around other additional areas to consider in supporting the exchange of healthcare attachments in PA workflows and on the potential intersection with other administrative and operations processes.
 - Hans agreed that the same general approach the TF has used in response to the other questions applies here. He asked what is used in the current workflow when there is a need for a payer to request additional information that is not part of the additional authorization request. He suggested that which IG/standard supports specific interactions to ensure consistency by stakeholders should be clarified.
 - Dave responded that the Da Vinci Clinical Data Exchange (CDex) IG is an option, but the functionality is being built out and needs to be more completely defined.
 - Hans stated that this clarification should be added, as this workflow cuts across different actors with different interpretations, making alignment and expectations difficult for developers.



- Eliel stated the analysis of the burden on developers and providers has been discussed, but the TF should also add a recommendation perform a return on investment to streamline workflows and capabilities.
- Tammy described the next tasks the TF will undertake, and Sheryl suggested the TF continue the discussion around patient needs and communications at the next meeting. Comments from TF members and the public that were added to the Zoom chat will be saved and included in the next discussion.

Action Items and Next Steps

The ePA RFI TF co-chair captured comments and suggestions submitted by ePA RFI TF members in a Google document, which was then shared with TF members to capture their thoughts and recommendations between meetings to better inform the TF's recommendations and streamline conversations. Members should share a Google email address with ONC's logistics contractor at onc-hitac@accelsolutionsllc.com to be set up with access to the document.

Before next week's meeting, ePA RFI TF members were asked to:

- Heed the last call to add or revise comments on the RFI questions in the Google document
- Prepare to shift focus from the collected comments to the TF's final recommendations document.
- Focus in on the functional capabilities in your priority topic areas to create consensus comments for all TF members to react to in the document
 - Topic 1: Certified Health IT Functionality – ALL,
 - Topic 2: Implementation Specifications for Prior Authorization - All
 - Topic 3: Healthcare Attachment Standards – SME's Identified
 - Topic 4: Impact on Patients, Heather McComas, ALL
 - Topic 5: Impact on Providers - Jim Jirjis, Aaron Miri, Eliel Oliveira, Heather McComas
 - Topic 6: Impact on Developers - Hans Buitendijk, Rajesh Godavarthi, Deb Strickland
 - Topic 7: Payer Implementation – Patrick Murta
- Make sure that any previous comments in the notes are properly reflected, or add clarifications if necessary. TF members will discuss the comments at the next meeting and begin formulating them into recommendations.
- If you have additional supporting information (e.g., costs and burden of PA), please send it to the co-chairs and onc-hitac@accelsolutionsllc.com so it can be added to the discussion.

Public Comment

QUESTIONS AND COMMENTS RECEIVED VIA PHONE

There was one public comment received via phone:

Steve Kim: My name is Doctor Steve Kim. I am a practicing physician, and I have been focused on prior authorization for the better part of a decade. What I would say from the practical perspective of implementation is that these standards are definitely desirable to have a common highway, but it goes back to the point that Jim made from WEDI. The fact that one of the biggest challenges will always be the workflow and the processes, and that needs to be addressed in terms of the complexities and how do we find a way to make that meaningful in taking these standards and making the clinical document exchange to be one that is very useful. Whereas the ability to translate the standards into practical, implementable, end workflow results is I think where there should be some additional focus and attention and discussion around. I was the one who made the comment around patient engagement, I'm very glad that was listed. One of the things that is a frustration from a day-to-day provider perspective is patients deserve to know what the processes are, in terms of prior authorization and the delays that can be experienced around that. I think there are ways to do



that, and we are working and actually doing things around that aspect that do incorporate the ability to use the existing standards that are put out there and translate them. With that, I would definitely like to emphasize and also consider the challenges around the workflow process implementation, from both the practical perspective, as well as from a cost of implementation perspective. Thank you.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR

Michael Berry: Good morning, everyone. Please remember to change your chat setting to "Everyone" if you want everyone to see your comments. Thanks!

Jocelyn Keegan: +1 to ruling in options , not ruling them out, we're discussing daily FHIR is AND, not OR in work to solve these hard challenges.

Heather McComas: Can you speak specifically to use of C-CDA/275 for prior authorization? NGS use is claims/operating reports, I believe. Have payers mapped their PA criteria/data points to C-CDA documents to ensure that C-CDA captures all the necessary data? e.g., does the C-CDA have all the data points requested in a FHIR questionnaire?

Eliel Oliveira: How would we be able to best inform patients on what is taking place from a PA standing point? Would a patient presentation capability be best delivered by EHR vendors, PMS vendors, some other way? We as patients are generally in the dark about what any medical services will cost and when/if something is authorized/covered or not.

Jocelyn Keegan: I think it would be helpful to keep the recommendations up during discussion.

Hans Buitendijk: If data for an RFAI can be a collection of granular data, document(s), is it necessary to (re)organize and structure that into a C-CDA or FHIR Document, rather than just a collection as gathered?

Hans Buitendijk: Are you suggesting to start in the PAS space and then build from there into support for the other IGs?

Steve Kim: As a provider, patient, and someone who's been working at the practical PA workflow level for years, the ability inform patients of PA activity (submitted, approved, denied, etc) is a big component of patient engagement, particularly since they are increasingly on the hook for non-covered services financially. Also, PAs are a frustrating component related to delays in patient access (time to service) which would benefit from real-time status as transparency and accountability. We are providing real-time status updates for a provider on PA and referrals through a client's SMS text patient engagement platform.

Hans Buitendijk: Or are *[sic]* you suggesting that FHIR US Core API support with SMART App, plus that part of PAS that addresses the format/structure supporting information for an authorization?

Heather McComas: Could you please speak to FHIR documents? This is a question in the RFI and the Task Force wanted more info on this.

John Travis: The minimal capability for the EHR enabled through certification still likely needs to allow for progression over time and a variety of approaches to interop with payers

John Travis: Individual certification criterion cannot be overspecified *[sic]* to over assume what should be certified together that boxes out approaches or locks in approaches

Hans Buitendijk: Agreed with Raj that the PAS approach that does not require a singular document, but a collection of data that could include documents (or not) provides for opportunities to minimize transformations of data.

Jocelyn Keegan: Given history and experience with prospective/retrospective PA on NCPDP side of the house, getting to data, resources specific data exchange, and reduce the number of "attachments" is critical



to get provider adoption. Evolution is important concept here, but realize workflows to support staff completing PA submission vs provider in workflow IS critical for success. *[sic]* Any recommendations would need path/expectation towards full automation or fielded data, or you bog down with simply digitizing existing "forms" in an electronic format and offline/not real time adjudication AND not reap benefit of real time PA if "PROOF" is required.

Hans Buitendijk: From a provider HIT perspective, when one looks at the non-financial systems starting with X12 would introduce an extra, big step. Additionally, if the prior-auth requires two data points (whether test A and B were performed in last 2 months), is it necessary to create a full C-CDA or FHIR Document for that?

Heather McComas: Hans, that all makes sense to me . . . there needs to be value in putting in a document format. I'm not clear what that value is. Seems like would be more digestible by payers is not in document.

Hans Buitendijk: AGreed *[sic]* with the importance of the meta data, but that indeed need not be in document format. @John: Do you believe that the PAS profile in this regard has captured the necessary meta data sufficiently from a payer perspective?

Heather McComas: Most recent 2021 AMA PA physician survey results: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

Heather McComas: AMA survey results show patient, practice, and employer impact of prior auth.

Sheryl Turney: thank you all for the great comments.

Tammy Banks: Thank you, John and WEDI, for

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

[ePA RFI Webpage](#)

[ePA RFI – February 16, 2022 Meeting Webpage](#)

[ePA RFI – February 16, 2022 Meeting Agenda](#)

[ePA RFI – February 16, 2022 Meeting Slides](#)

[HITAC Calendar Webpage](#)

Meeting Schedule and Adjournment

Sheryl and Tammy thanked everyone for their participation and stated that an additional meeting will be added to the TF schedule on March 7, 2022, during the same time period as the previous meetings.

The co-chairs thanked John and WEDI for the presentation and described the schedule for the next meeting, which will be held on February 24, 2022, and will include a presentation from Hans and a discussion around the remaining modules/questions.

The meeting was adjourned at 11:30 a.m. E.T.