The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE MEETING

June 23, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Alix Goss	Imprado Consulting	Co-Chair
Sheryl Turney	Anthem, Inc.	Co-Chair
Steven Brown	United States Department of Veterans Affairs	Member
Gaspere C. Geraci	Individual	Member
Mary Greene	Centers for Medicare & Medicaid Services	Member
Alex Mugge	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Thomas Mason	Office of the National Coordinator	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Jacki Monson	Sutter Health/NCVHS	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Ram Sriram	National Institute of Standards and Technology	Member
Debra Strickland	Conduent/NCVHS	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Denise Webb	Individual	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Lauren Riplinger	AHIMA	Presenter
Alison Nicklas	Trinity Health of New England	Presenter
Chantal Worzala	Alazro Consulting	Presenter
April Todd	CAQH CORE & Explorations	Presenter

Call to Order/Roll Call and Welcome (00:00:00)

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome to the ICAD task force. Before we get started, I will do a quick roll call. Sheryl Turney?

Sheryl Turney
Sheryl is here.

Lauren Richie
Alix Goss?

Alix Goss
Present.

Lauren Richie
Aaron Miri? Abby Sears? Alexis Snyder?

Alexis Snyder
Hello.

Lauren Richie
Andy Truscott? Anil Jain?

Anil Jain
I am here.

Lauren Richie
Arien Malec? Deb Strickland? Denise Webb?

Denise Webb
Present.

Lauren Richie
And Gus Geraci?

Gus Geraci
I am here.

Lauren Richie
Jacki Monson? No Jacki? Okay. Jim Jirjis? Jocelyn Keegan? Les Lenert? Either Mary Greene or Alex Mugge? Ram Sriram? Rich Landen?

Rich Landen
I am here.

Lauren Richie
Sasha TerMaat?

Sasha TerMaat
Hello.

Lauren Richie
Steve Brown?

Steve Brown
Here.

Lauren Richie
All right. And Dr. Mason indicated he would be absent today. So, I will turn it over to our co-chairs.

Ram Sriram
Again, this is Ram Sriram. I do not know whether you heard it or not. I was on mute. So, I am here.

Lauren Richie
I got you, thank you, Ram.

Ram Sriram
Okay.

Summary and Action Plan (00:01:45)

Alix Goss
Well, thank you, Lauren. I think we can go ahead and advance to the next slide. Thanks for already completing the roll call. Welcome. This is Alix Goss, and I am going to do a little bit of summary and action plan update before we turn it over to our two presenters today. We have AHIMA, as well as CAQH CORE. Sheryl and I will be tag teaming on handling the questions and answers between those sessions. Before she wraps us up with our next steps overall, obviously, we will take time for public comment, as well.
With that set up on today's agenda, we have got a lot of exciting presentations today to help us advance our further thinking around our intersection of clinical administrative data. But first let us talk about what happened on our last call – if you go to the next slide. Thank you.

Last week – it was only a week ago – Cathy Sheppard, the executive director of X12, delivered a very robust presentation that helped us understand X12 as a standards development body of multi-industry focus that they have had for over 40 years. And their standards are in use billions of times a day with transactions that are exchanged across the multiple verticals that use the EDI standards. They also shared that there is more than just electronic data interchange they use. They have other JSON, XML, and crosswalks vocabularies that will help them exchange information across multiple syntax.

As a part of that work, it was really exciting to understand the bifurcated approach that X12 has for their accredited standards committee. Many of us know their work from the HIPAA transactions that were promulgated. But they have also created a registered standards committee, which really helps out with that vocabulary aspect. They produce technical reports, including implementation specifications, and that has been on an as-ready-to-publish approach. Cathy Sheppard talked about their new ARC, annual release cycle. It was a very exciting development for us to learn that X12 has been really developing an approach to more of an annual activity updating of implementation guides and technical reports to be more responsive to the industry sector.

With that sort of framing, she led us into some discussions around the prior authorization with the HIPAA implementation guide and their iterative work based upon the business asks within the community, and talked about their perch of disconnects in the 278 world and some questions we might be asking ourselves as we look to better meet the efficiency opportunities within the healthcare ecosystem. She also spoke a little bit to their work in the community working with Da Vinci in trying to improve their overall code lists for clarity, which are several items that we have talked about within the task force arena over the last several months.

In addition to Cathy's presentation and the robust Q&A we had, there was a privacy and security guiding principles and ideal state presentation, bringing back the work from that small group, rounding out the prior work that we had done in regards to the overarching ideal state and guiding principles.

We wrapped up the session with a discussion around timing and updates that will be forthcoming from some of our small working groups. We have some on data classes and business process modeling. We wrapped up the guiding principles and ideal state work, and that has pivoted into our recommendations discussion. We also talked about the report that we are queueing up to work on over the summer to make our Labor Day delivery to HITAC. So, we have a lot of timelines and goals over the July and August time frame to get there. So, we are going to be wrapping up this week with a couple more presentations, and then we will continue down the path of wrapping up prior authorization before we get into the intersection, more global conversation, and what that means for our report.

So, it was a pretty action-packed meeting, and I want to thank everybody for their involvement in those presentations and discussions. I hope you will do so again today as we now pivot to our first presentation from AHIMA. I think we are about ready to invite Lauren and her team to come into the fold and share their presentation. And then I will facilitate their Q&A before we wrap and move to the next presentation. Sheryl, with that setup, is there anything else you would like to add?

Sheryl Turney
No, I think you said it all. Thanks, Alix.

Alix Goss
You are welcome, Sheryl. So, if we are ready to turn it over to Lauren, I think we can pivot to her slide deck. I am really excited to hear from AHIMA, so thank you, Lauren. Why don't you take it away?

AHIMA Presentation and Discussion (00:07:08)

Lauren Riplinger
Excellent. Thank you, Alix. And thank you all for this opportunity to present to you all today. Next slide, please.

So, Alix mentioned, first of all, I am the vice president of Policy and Government Affairs for the American Health Information Management Association. And today what we really wanted to present to you all was first to provide an overview of AHIMA itself. And then I will ask Alison Nicklas, who has joined us today and is also an AHIMA member, to talk a little bit about and provide an overview of Trinity Health, and then in coordination with Chantal Worzala, also provide really the operational picture, the meat of this presentation. The next slide, please.

As many of you all may or may not know, AHIMA is a global organization that represents health information and professionals that work with health data for more than a billion patients a year. Our mission is to empower people to impact health. And our vision is a world where trusted information transforms health and healthcare by connecting people, systems, and ideas. Next slide, please.

One of the core tenants of our organization and as a profession is that we believe that health information is human information. In other words, what that means is that AHIMA certified professionals hold an intimate relationship with health information. And even though patients may not always necessarily see us, we see many patients in ways that no other health professional necessarily does. And what that means is we see that person connected to the data, and we need to ensure that that health information stays human, because when the information stays human, it stays relevant. Next slide, please.

I am not sure. On my end, it is a little slow. So, has the slide deck advanced for other folks?

Alix Goss
Yes, I am seeing AHIMA's role in coding.

Lauren Riplinger
Perfect. Okay, then we can keep going.

One of the things we are most well-known for is really our role in coding. As many of you all know, we are one of the designated cooperating parties for ICD-10 coding guidance. We share that responsibility with CMS as well as the National Center for Health Statistics and the American Hospital Association.

But beyond that, we participate in a variety of coding usage and standardization activities not only in the US but overseas and internationally, as well. We also serve as the preeminent source of coding education and professional education. And this is a responsibility that we really take seriously. And so, for that reason, we are an organization that has developed the standards of ethical coding that we ask our members to abide by, because we believe so strongly in our role in this coding world.

One of the things, I think for purposes of this discussion today, that I often share with folks is that what is interesting about AHIMA and its members is that we sit at this intersection of clinical and administrative

data in that many of our members' role is to translate that clinical data for standardized administrative data transactions. And our core focus is really to ensure the correctness of those claims and to keep them flowing to really sustain the revenue cycle. And it is really because of this expertise being at this intersection that we are really happy to serve as a resource to you all in this area.

So, I am going to turn it over to Alison to talk a little about Trinity Health and what she sees on the ground perspective in regards to this issue.

Alison Nicklas
Thanks, Lauren. So, if you would go to the next slide. I have mentioned my name is Alison Nicklas. I am the regional director of HIM Services for Trinity Health of New England and am part of Trinity Health as a system.

As you can see on the slide, Trinity Health is a national Catholic health system. There are 92 hospitals in 22 states. Our region has four of two care hospitals, two rehabs, and two psych units along with multiple physician practices, and continuing care locations. Some of my background that I am sharing here is to help you understand where I am coming from when I discuss the next oncoming slides. So, if you could go to the next slide.

Our mission as a faith-based organization is to serve together in the spirit of the Gospel as a compassionate and transforming, healing presence within our community. We are daily reminded as employees of the importance of living our core values, which include reverence, justice, commitment to those who are poor, stewardship, safety, and integrity. And all of these values, I feel, are really important to be considered when we are working with the current environment, where our health models are constantly changing. So, if you could go to the next slide.

As outlined on this slide, we are in a time of continued change. We see customers, consumers, patients who are actively accessing and interacting with their own personal health information, while we as providers, insurers, or payers, are moving from a fee-for-service to a value- and outcome-based reimbursement model. AHIMA believes that health information is the most powerful currency for change in this healthcare ecosystem – information that will require combining our revenue cycle or reimbursement models with quality data. And we rely heavily on the use of clinical decision support within each of our organizations, along with machine learning, to navigate through these changing times. You can go to the next slide.

What is really important for you to understand, AHIMA is very focused on clinical documentation integrity. We see the clinical documentation as a fundamental core of every one of our patient encounters. The information has to be documented completely, it has to be accurate, and it really has to be timely to reflect the full scope of services that we provide to ensure that all parties involved in the healthcare arena – from the patient, to the provider, to the payer – are able to make the best decisions with regard to the service provided and the appropriate reimbursement for those services. This information is shared in both a textual and a coded format, which is what Lauren was sharing before about the use of codes – the ICD-10 coding system. The textual is so that the providers and the patients are able to communicate in a way that everybody understands. But the coded information has to be accurate, as well, so everyone across the continuum, and across the country, is speaking the same language. So, if you could go to the next slide.

So, the full scope of information gathering and use is broad, as noted earlier. On this slide, what we are trying to show is that there are three major touchpoints in which there is sharing of clinical data and administrative data with the payers. We will call them three swim lanes.

The first swim lane, or touchpoint, is before we even provide a service. And I heard earlier there was a discussion about prior authorizations. This is where that step comes in – prior to doing a service. Payer rules and employer plans will require providers to be aware of when a prior authorization is required, and to notify the payer of any planned encounter to ensure that the service and the level of care being considered are covered by the plan, and to make sure it is in the right location. Is it appropriate to do the service as an outpatient or an inpatient? Should it be an observation status? In addition, we do prior authorizations at the point of discharge, because it is prior to services that may be needed after the patient leaves that provider or facility. It could be rehab, it could be home health, it could be any number of different areas that would need to continue care with the patient.

The second swim lane that we are looking at here, where we are sharing information, is known as the concurrent review process. At this stage – and generally, this is for inpatient services – there is a communication between the payer and the provider to ensure that the patient is being cared for in the most appropriate setting. And we call that utilization review services. So, we have a team of people that review records concurrently and discuss the information with the payers to make sure the patient really should be at the level of care they are at. In addition, the provider is helping to prepare the patient for their continued self or assisted care post discharge. And we have a team at that point – they are case managers – that work with external organizations to evaluate the level of care that is required for these patients. And they have to do that by determining the acuity of illness that they have.

And then the third lane, or swim lane, is the post discharge process. And this is where we see a large amount of information being shared back and forth between providers and third parties. Payers in quality organizations are reviewing data for many reasons. They confirm that the documentation supported the service that was actually authorized, that the care was appropriate, and determined the quality of services.

At this step, they are also looking for information to support the coding and the reimbursement that is being provided for that service. It can involve requests for specific documents from a single patient encounter. They could also request an entire record for a single encounter. But on top of that, what we will also see is requests from third parties, where they are asking for many records – sometimes as many as 200 or 300 at a time – looking at a large number of patients, requesting records to determine whether or not the payment is appropriate. This is for risk adjustment or HEDIS measures. And on occasion, they even request records if there is a patient complaint or they need to review something specific.

What underlies all of these reviews is that all parties involved have to be aware of the ethical obligations in managing the patient's personal health information. Are we following HIPAA requirements while simultaneously ensuring that there is ease of access? From a privacy and security perspective, we need, as a provider, to ensure that the request and the requester are allowed to have the access that they are looking for. From an accuracy perspective, we have to make sure that the documentation that we are sending out is complete and accurately reflects the services that were provided. For accessibility, we have

to make sure that the data is accessible in the form and the format that is being requested by that third party.

We also have to ensure that the integrity of the provision of that information is there. If it is being sent in multiple formats, we need to make sure that the data is secure. And then we also have to make sure that the disclosure is appropriate. So, is the information limited to what is minimally necessary for the purpose of the request? So, the next slide.

The dilemma that we find we are facing is how to best manage the sharing of the data for the various clinical and administrative purposes that rely on the information. I have been doing this for over 40 years, where I was really looking forward to an electronic health record. In the paper environment, it was very easy to provide the information that was being requested, because the paper clearly identifies what specific document and clearly identifies the author of every entry. In the electronic health records system, the data is actually collected as data elements. While a provider is documenting, the provider sees a screen that looks like a form you might see in a paper record. But to reproduce that documentation requires the development of reports by IT to pull the specific data elements into a format that can be read easily by the recipient. And that is going to be based on the specific information that is being requested by that third party.

For certain types of requests, the electronic record system has templating support. So, we could say that any time a provider is looking for just a discharge summary and a history and physical, we can very quickly provide that through that template. But many of the requests that are received are for special reports that have to be designed to ensure that the data that is being requested or required to perform the functions that the requester is trying to get done is included. And that can create difficulty. The content is generally payer or requester driven, and it can depend on the event that triggered the request. It is required to support a service that will often change when the coverage rules change, or for other reasons, often without notice to those that are reproducing the information. And because of that, as the requests come in, we may find ourselves having to scramble to write a report to send specifically what that requester is asking for.

The providers must also be prepared to produce the data in the form and format requested. We ask third parties that ask for paper, they ask for information to be backed electronically or by paper. They may ask for a CD, they may ask for a thumb drive, they may have a portal that we upload the data to, and some are asking for direct access into our electronic systems. Each of the methods that they are requesting access through require different equipment or technology and can create barriers for that ease of access and responding within required time frames. So, it has helped models continue to change. And the requests for information are increasing in both frequency and scope. They all need to be considered as the healthcare system is moving forward. So, I will turn the presentation over now to Chantal.

Chantal Worzala
Great, thanks so much, Alison. My name is Chantal Worzala, and I am a consultant working with AHIMA. As Alison so eloquently shared, the data flows with supporting administrative transactions are really just one piece of the picture. If we think about automating prior auth, that is super important, but there are a lot of other issues to be addressed if we really want to be taking friction out of the system for patients, for providers, and for payers.

If you go two slides – I forgot to say "next slide" – here are some of the other aspects that can pose some barriers to greater integration of clinical and administrative health data and may point to some of the policy considerations for the task force recommendations. First, is that lack of standardization for business processes. Is there a way to harmonize plan rules for the data that is being asked for and when it is being asked for? There is tremendous variability, as Alison was speaking to, and there really needs to be a little more predictability and definitely notice if criteria change.

From a policy perspective, wondering if there is a way for providers and payers to work together on a process that might lead to better standardization and predictability. I know you are hearing from CAQH CORE today, so we have in the past seen policy support for creation of operating rules. So, that is one thought.

Then there are, obviously, the operational issues. If we think about having a new automation, how would that fit into today's workflow? And if you think about just the case of authorizations, how will that affect what happens on the clinician's side for the physicians and the nurses at the point of care? And what will the impact be for back office functions, such as those many AHIMA members take care of? And then how do the systems that are being used today change? This is really an area where AHIMA members are on the ground and can potentially serve as a resource.

In addition, of course, administrative transactions are flowing through a significant existing infrastructure. We have got the whole revenue cycle to think about. And as we contemplate changes, it really will be important to minimize disruption to the revenue cycle. And I think Alix might have said in her introductory remarks, we have more than 3 billion claims that are filed and adjudicated electronically each year. So, that is a lot to think about.

Then on technical issues, of course, there will be shifting IT needs and investments that will need to be made. And so, we need to think about whether providers will actually have affordable solutions that work in the real world. There is also that challenge of the time and scale of deployment. So, if you are a provider working with multiple health plans, is everyone shifting to more automated approaches at the same time? Or are you going to end up with this mixed model still of sending data to different places in different formats? So, some consideration to timing and scale of transformation might be interesting.

And then we have implications for the workforce. As we really move forward here, there may be shifts in needed capabilities. Folks may need training on new standards, on new technologies, and new processes. And over time, there may, indeed, be significant workforce realignment. So, this may be an area where policymakers should support greater understanding of potential impacts.

Then this question of the alignment and the accuracy of the vocabulary standards themselves. It is a little bit geeky, but this is a geeky crowd. So, if you think about your clinical systems and your administrative systems, they actually rely on different vocabulary standards for the same concept. So, think about the difference of SNOMED being embedded in the HR and ICD-10 being the basis of, at least, inpatient claims and outpatient diagnoses.

So, right now, we do lack a consensus-based map to go between and translate across these standards. There are mappings embedded in a lot of products, but they are generally unique and can be proprietary.

We do not know a whole lot about them, which raises the question of whether we need a single national mapping, for example.

Some of the other issues here – data integrity, and how does the lack of a patient matching solution lend itself or create issues for data integrity? Know you are taking on privacy and security, which are clearly big issues. Providers take their responsibility to protect the confidentiality of sensitive information very seriously. And think long and hard about that issue of limiting sharing of information to that which is the minimum necessary for a given purpose such as adjudicating payment. And, of course, we have the security challenges and trust.

I would just end here on trust. Data moves at the speed of trust, as they say. And there are concerns that clinical data shared for one purpose could potentially be reused for other purposes that negatively affect individuals or impact the relationship between providers and payers. And so, ensuring that we are moving forward in a way that there is trust among all parties will be very important. And really, one way to build trust is participation. So, if we can make sure that all parties are part of this conversation, that really will help to ensure that the operational and trust issues are addressed. And to that end, I have got to say, I really appreciate the broad representation on this task force and the wide net you have cast in seeking input. So, let me stop there, so that we have some time for Q&A.

Alix Goss
Thank you, Chantal. This is Alix Goss. Terrific presentation by the team here today. I would like to call upon our members to raise their hand should they want to get in the queue to ask questions of our presenters. I will look to see if any are coming up. While I wait to see those hands raised, I do want to ask you a little bit more about the vocabulary issue. When you talked about on Slide 19, maybe we can go back to that. Because I think it is an interesting list, having worked with the recommendations team just a couple of hours ago. It was feeling like AHIMA may have been cued in on some of the threads we were having. And one aspect we were talking about was the data capture and how that works.

I think about this vocabulary aspect that you mentioned on this slide with the mapping. And so, I guess I have a two-pronged question to the AHIMA team. I would like to hear a little bit more of your thoughts about this one single national mapping of vocabularies. And the other part I would like to hear, related to that, is how does that work with the boots on the ground data capture in the electronic health records in a national mapping? I am curious about the challenges clinicians have with putting data into their EHR, and what that means to you as you are moving forward and actually getting a health information request that you need to fulfill, and ultimately trying to get to that end-state mapping that somebody can actually not only have the medium in which they can consume the export you give them but also to interpret it correctly?

Chantal Worzala
Lauren, this is Chantal, do you want me to take that?

Lauren Riplinger
Yeah, that would be great, Chantal.

Chantal Worzala

Yeah. So, I think the challenge here is we have had our EHR systems growing up through one set of standards and our administrative systems growing up through another set of standards. The prominence of ICD-10 versus SNOMED is an interesting aspect of this. And if we start to think about just pulling stuff from the electronic health record to populate something that might be used for an administrative purpose, we have this question of how those vocabularies are working together. And I think this is something that will require some investigation. In really answering some of your questions, I do not think we have all the answers, but it is a place where we see there is a lot of expertise built up in the world of ICD-10, and how you look at a full medical record to understand what the best code to assign is versus thinking about moving toward an automation where you would map it.

I think there are a lot of questions there. And also, honestly, I do not know how much we know about your question, which is when a physician is developing a problem list and picking among SNOMED codes, what is that process? And how do we know really the fidelity of the SNOMED codes that are in EHR today?

Alix Goss
I really appreciate the focus around ICD-10 as something we should get our arms around, especially as we think about the fact that ICD-11 is in the works and on the horizon in the next 5 to 10 years. It is something for us to thinking about. The national mapping, I know there has been a lot of work. The NCVHS recently did an environmental scan of terminologies and vocabularies. And there is some really great work available on the NCVHS website related to that. And there has been a lot of investment in years gone by with the United States Health Information Knowledgebase, or USHIK. So, I think that there is something for us to think about as we explore our data classes and data categories discussion, which I think we are going to be diving into more on next week's call. So, I appreciate elevating that awareness and our thinking.

I am not seeing any other hands up. I know we are slated to pivot here in a minute to our next presenter. But I am curious as to this trigger event conversation and if there are any other thoughts you might like to add about that. The triggers are really critical. I think that was back on Slide 16. If we could roll back to that slide, I would appreciate that. It would be three slides back.

This is a really interesting slide. I like the way the swim lanes approach; I think Alison was describing this. There is a lot of different business processes, or specific threads, that are being handled in all of these swim lanes with probably a pretty common set of data, one uber set of data, used as applicable with each one of these threads. Do you have any commentary about the data aspect and the triggers that maybe we should be thinking about as we move forward with how to make it better from a provider burden perspective?

Alison Nicklas
Yeah, this is Alison; if I could speak to that, Chantal and Lauren. It is one of the things we deal with every single day. As I mentioned, the payers have different rules. And the knowledge base, I think Chantal touched on that, is how do we have staff that know exactly what each of the payers need and each point in this swim lane process.

So, for prior authorizations, you will see a certain group that are looking for very key information to approve **[inaudible] [00:37:05]** that is happening. During the concurrent review process, there are different people touching from both the provider side and the payer side. They are looking for a different set of information that could overlap with that prior authorization. And then on the discharge side, again, you have a different

set of people from both the provider and the payer base. And there are times – I have to say from a personal perspective – I just think we should just give all payers all the records, so they can get all the information they need in one place, and they are not asking for information at different stages of the game that might look different.

So, triggers are not just these prior authorizations, concurrent review, and post discharge, but also the internal workings of both the provider and the payer in terms of communicating information for services that are being provided. So, I do not know if that answers your question, but am hoping that it did.

Alix Goss
It did. It actually gave me something to think about, which is not only that inter exchange, but the intra processes that have to go into play. It is something we need to be thinking about in our global thinking around the business process model.

So, very good response. Thank you for that very much. Terrific presentation. A lot of good content for us to think about. We will be adding, hopefully, your presentation to our compendium. And it will help us, as I said, advance our body of work. It already helped crystallize a few things we were talking about earlier today in some small working group meetings. So, thanks again. At this point, I think I am going to turn it over, probably, to Sheryl and April.

CAQH CORE Presentation and Discussion (00:39:04)

Sheryl Turney
Thank you, Alix. So, yes, what we have next is CAQH CORE and April Todd, who is going to be providing a presentation. And I will help facilitate the questions at the end. So, April, I will turn it over to you.

April Todd
Great. Thank you, Sheryl. Thank you all for having us here today. We have a lot of information to share with you. And I have also included some resources in the back in the appendix, as well – particularly a few white papers that we have written on the topics we will talk about today that provide some more detail as well as some specifics on some of the operating rules that we have recently passed and submitted to NCVHS – the actual detailed language itself, if you are interested in reading that.

But before we do that and start in to talking about some of the things we have been working on, I wanted to give this group just a brief background on what CAQH CORE is and what we do. So, if we could move to the next slide, please. CAQH CORE, we are very proud to be an industry-led, multi-stakeholder organization. Our participants include providers, health plans, vendors, government entities, associations, standards-setting organizations, and really represent the vast majority of the industry that we are working with.

And what we do with these participating organizations is to create operating rules, which are, essentially, those business rules that support use of the standards. And what I mean by "support use of the standards" is support a consistent, standardized common expectation of how standards will be used. And when we talk about standards, we are standards agnostic. These are business rules that should support the broad use of standards and the intersection and connection of standards that we see as being more necessary, as there is a need to connect clinical and administrative data more now than has been in the past.

Based on the work we have done in the past, we are designated by the Department of Health and Human Services as the national operating rule author for the HIPAA transactions. And I will go over which ones those cover – that we have worked on and are currently working on. And as I mentioned before, we work on these operating rules through a process working with our stakeholders across the industry to develop those rule sets that can be brought to NCVHS first and then HHS for consideration for a federal mandate.

On the next slide, I just wanted to provide a very brief understanding, or brief description, of what an operating rule is. An operating rule, as I mentioned before, is the business rule that helps with the exchange of electronic information. In health care, for example, I think one of the most common transactions that is exchanged today is the 270/271 eligibility request and response. Through surveys that we do through the index, that is by far the highest volume transaction that exists.

When that transaction first started to be used by the industry, there was a lot of variation in how it was used. And providers were needing to engage with the plans on that transaction in multiple different ways. There were different ways that the plans were using that. And the industry came together and asked us to help work to standardize that. So, one of the first operating rules that we put together was an operating rule that when you use the eligibility transaction, it specified what financial information needed to come back about the patient, including the co-pay and deductible, and then it would come back in real time. So, that is one of the things that helped to standardize the transaction. And since that operating rule is in effect, the volume of that transaction has gone up significantly over time.

The use of business rules is not just specific to healthcare. It has been used in the financial services industry for a long time. And think about, for example, one of the organizations we work with closely, NACHA, which has developed operating rules, for example, that help with the use of electronic payments. Operating rules also make it possible for people to use their cash card all across the world in similar ways across various different banks. So, business rules are one of the things that really help to standardize the use of electronic systems.

One of the things I want to specify, though, that operating rules do not do, that I know this task force has talked about a bit, is operating rules are not designed to specify whether or how a payer or provider structures a business process. For example, operating rules would not specify when or how a prior authorization was used by a health plan. But if a prior authorization was used, what the operating rules specify is how that information is electronically exchanged. So, I just wanted to make that very clear point there.

If we can go to the next slide, this is a high-level overview of CORE's operating rules. We have them structured by different business processes. The operating rules themselves include things related to infrastructure. These are things like system availability, use of acknowledgments, companion guides, and response times. It also includes information about data content. Within the standards, there is often a lot of flexibility and the ability to communicate various different types of data content. What the operating rules do is specify what must be communicated and how it is communicated, so that there is a common expectation of that baseline that plans and providers can expect.

There are also operating rules that we do in other areas. We have done rules, for example, related to web portals to help them become more standardized related to prior authorization, even though that is not something that our participating organizations recommend as a long-term solution. It is something that can help in the near-term.

And then we also have rules around connectivity, which I will talk about a little later. And those rules around connectivity have to do with security, authentication, metadata, and message envelopes for how information can be communicated. And then, specifically a little later on, I will describe how we are currently working on updating those rules to help with the exchange of clinical administrative data and the need to interact between some existing and emerging standards.

Now going specifically into prior authorization – if you can go to the next slide – one of the things that CAQH does is an index report every year, where we survey plans and providers to gauge the adoption of electronic transactions across the industry. And for a number of years, prior authorization has been very low in terms of the adoption of the electronic standard. And we have had definitely more use of portals and manual submission, as well.

And I will describe – if we can go on to the next slide – is what we have learned to why that exists. What are the barriers to adoption of electronic prior authorization? And there are a number of them that we have heard in a variety of the work products that we have worked on. One of them, and kind of the key one that drove our board to want to focus on data content rules for the 278, is that there is a lot of inconsistency in the use of the data content across the industry when communicating the 278, and a lack of understanding of how it could be used. And so, what had happened in the industry is that health plans, when they got a request for a prior authorization, were just immediately pending it and not much else happened after that. So, it required a provider to call in to figure out, what do I do next? What do I need to send you? So, there is a lot of manual work that came after that.

Another barrier that we hear very frequently is that the lack of a federally mandated attachment standard to communicate the clinical information that needs to go with prior authorization is a big reason for why the 278 is not adopted and why it is very manual.

Also, the lack of integration between clinical and administrative systems – they do not talk to each other very easily. There is a very limited availability of vendor products that support the 278. We had done a survey previously through the index that showed that only 12% of vendors were offering that, as opposed to between 74% and 91% offering the other transactions. So, there is just lack of availability there.

Often for providers, it is offered as an add-on, and it is an expensive add-on to include that. Also, in the research that we have done and heard from some of our participants, there are state requirements for manual intervention. And what I mean for that related to prior authorization is that a number of states require that if there is going to be a denial of a prior authorization, that the health plan needs to send a letter to the provider – needs to send a letter to the patient. There is also a number of states that require a peer-to-peer phone conversation to occur if there would be an adverse determination or recommendation for a different type of care alternative that exists. So, there are things there that are just requirements that exist.

Errors, also a lack of understanding of the 278, in general, and in particular, by providers and providers not knowing that it is the mandated standard and that if they ask for it, the plans need to be able to conduct that transaction. And then just various levels of maturity along the standards and adoption curve related to prior authorization. There are some organizations that are way ahead of the curve and are doing a lot in this space, and there are others that everything is manual. So, there is a wide variability in the industry on that.

If we can go to the next slide, I wanted to highlight a few things to talk about in this presentation. And there is probably more content here than I will go through, but also wanted for you all to have it as reference. The five different things that we are doing right now related to prior authorization that I think have a strong connection to the work that you guys are doing around administrative and clinical data.

One is the data content related to prior authorization. I will talk about that briefly. Second is once we have established consistent data content, we have rules that establish consistent infrastructure and time frames for communicating that information. We also have rules around connectivity, modes of data exchange, and creating some consistency there. And, as I mentioned before, we have a baseline set of rules that we have submitted to NCVHS. We are in the process of updating those specifically to help with communication of clinical information. Fourth, we are also working on operating rules related to attachments and exchange of clinical information. That work will be starting in our workgroups this summer. And then, lastly, we have also been working on pilots for the work that we are doing. And we are doing pilots for a couple of different reasons. One is to test some of the new operating rules, how they are working, what is the ROI, but also to test and evaluate additional areas that we could be working on and where there may be a need for additional operating rules in the future.

But to go through these five areas very briefly. First, is related to the data content related to prior authorization. These are the operating rules that we have recently passed and submitted to NCVHS. So, our data content rules require a number of things to help address one of the most significant problem areas for prior authorization, and this is where the provider submits a request and the plan sends back append and there is no additional information. The provider needs to get on the phone. Usually what happens – what we hear – is that the provider gets on the phone, calls, and says, hey, I submitted this request, did you get it? What do I need to give you; what do I need to do next? Or they will download the entire patient's record and fax it to the health plan, so that the health plan has everything they need they think to make a determination.

What the data content rules do to help address that are the following – a few key things. One, to create consistent patient identification and verification requirements. The second is to require a return of specific error codes and action codes when a specific error is detected on the request from the provider. This is a very frequent reason why a prior authorization is denied; it is just because there are errors and omissions in the submission. There is also a requirement for return of specific healthcare decision reason codes to provide an explanation to the provider as to what needs to happen next and what the status is. We have also required use of specific codes, including blank codes, to provide clearer direction both on the status and what is needed. So, it will say, you need to send us a lab result, for example. And then there is also a requirement to display the code descriptions to reduce the burden of interpretation from the provider, as well.

And in terms of future opportunities, how we have set up these operating rules is to make sure that the data content that underlies them is something that is evergreen. Regardless of whether the version of the X12 standard increases, or whether there could be a change in use of standards, that underlying data content, there is a common expectation of what it is that should be communicated back and forth.

We can go to the next slide. This is the second set of rules that we worked on after data content. And the purpose of this rule was to create common expectations around the time frames to be communicating this data content between plans and providers. This, I would say, is one of the most challenging operating rules we have done as an organization. In the research that we did leading up to this, across the states, there are 30 different states that have requirements for response times for prior authorization, and they range from two days to 15 days. And there is a lot of variability on the applicability of the time frames, when the clock starts ticking. But in general, the most common thing we found was two or three business days.

We worked with our participating organizations to come up with these specific response time rules, which includes the following. One, is that when a provider submits a request, the plan would need to respond within two business days to describe the status, to either approve it or to ask for additional documentation. Once the plan has received that, any additional documentation that they need back, they have an additional two days to provide a final determination to that provider for that request.

There is also the optional closeout that a plan can close out the request if they do not receive information back from the provider within 15 business days. They do not need to use that, but they can. And one of the requirements is that 90% of the time that these maximum response times be complied with.

So, those are the components of those rules. And one of the things that I wanted to comment here – I know there has been a lot of discussion – a focus on real-time prior authorizations. And we have had those conversations in our groups, as well. I think there is a number of reasons why we have heard this is challenging for the industry to do right now.

One of them is around system interactions. So, when a request comes into a plan, they are not just looking at that request alone. They are looking at it in combination with eligibility information, provider network information, and their claims. And claims are often not done in real time, so they are checking that information for, is this something that we should approve based on the benefit plan, based on the clinical needs of that.

There is also the documentation submission. The documentation submission, or access to that without an attachment standard, much of that is very manual. And so, they are taking the time to do that. Also, even if the information is coming in quickly, oftentimes there is a need for clinical review. So, they have clinicians that are reviewing that information, and at times would be communicating back care alternatives that may be more cost effective, for example.

So, there are a variety of things that we have heard why real time is challenging at the moment. But in terms of future opportunities, as we can get in these baseline standards on data content and on response times, we hope to improve those over time, particularly as we have rules and standards that can help with the exchange of clinical information or attachment.

We can go to the next slide. Another area that we have submitted operating rules to NCVHS for review is also for our connectivity operating rules. These are things that specify how data can be exchanged. They establish consistent message envelope, security, authentication standards that are there. And the rules that we have submitted are the most up-to-date that our participants have worked on. However, we are working on an update to these connectivity rules that would help to support the exchange of clinical information and the intersection with clinical and administrative information.

And in particular, we are working on operating rules for the use of REST and APIs, and also working on real-time and batch message interaction to support attachments as well as authorization standards using OAuth. And I would just highlight that we will be holding a webinar on July 22nd with Bob Bowman from CORE and one of our co-chairs, Patrick Murta from Humana, that will be going through more detail on these requirements and what the group is working on. We can go to the next slide. Actually, if we could go to Slide 12. Slide 11 is more background for you all. We can save time there and go to Slide 12.

For Slide 12, this describes the work that we are starting to do around attachments. And, specifically, we have a group that is starting in July that will be working on rules to support the exchange of clinical information. We will be starting with prior authorization and then moving on to claims. And our initial focus is going to be looking at how to help support the complete adjudication of a prior authorization using either the 275 or the HL7 C-CDA.

There are a number of requirements that could be included in here, including reassociation requirements between the request and the documentation that has been sent, use of specific code sets to enable the conversation that goes back and forth related to prior authorization, specifically with the use of blank codes, as well as aligning with some of the work that ONC has been doing around the USCDI. So, there are a number of things that we are doing in this space, as well, that can help support that work and, hopefully, tie into an attachment standard that we hear is forthcoming out of CMS.

Then one of the last things I wanted to cover on the next slide, if we can go to that, is the work we are doing around our pilots. Late last year, we started to work to identify partners within the industry, plans, providers, vendors, to start to test some of the new operating rules that had been passed as well as to test some need for additional operating rules to support the entire workflow for prior authorization. And we had been making some great progress with that. And then COVID-19 hit, and we are in a bit of a pause on that at the moment. Just because there are a very limited number of prior authorizations that are actually occurring in the market today.

But we are looking forward to being able to share some initial pilot results in August based on some quantitative data that was collected before the start of COVID-19 as well as some qualitative provider experience. And what you can see on this slide are some of the metrics that we are working with, with those organizations to help collect information on some of the ROI and the benefits associated with different operating roles that are there.

Lastly, I think I will close up probably with Slide 14 and 15 here, if you can go on to the next slide, and just talk a bit about how the rules that we pass today will help improve automation of prior authorization. If we think about the workflow process of what exists here, you think about a provider populating or sending in the 278 requests to a health plan. Previously, they would send that and just get append.

Now how it will work with the operating rules is that the provider has specific information requirements to send in information about the patient, about the provider, and the service that is being requested. And they know that there will be system availability and connectivity requirements to get that request there. The providers will also know that once the plan receives that, they need to respond within a specific amount of time back to the provider, not just telling them they got it, but what additional information is needed and if there are any errors they need to correct.

The health plan, when they respond back, are going to respond back with very specific information on what is needed, what codes are communicated to send in that specific information that will come back to the provider. Once the provider receives that information back, they will have more detailed information on the requirements, the display of those codes, to understand what they mean so they can then respond back more quickly with that information. And then the provider also knows when they send that information back that has been specifically requested, there is a specific time frame with which they will get a response back. So, that is just on a very high level how the rules will help streamline a process that has been very manual to date.

Then I will just close up with the last slide here that just gives a visual as to the different things that we have been working on over time. Hopefully, you will see how all of these things build upon each other. And we are looking to take a step-wise approach to get the industry to start to adopt some of these requirements and build on those to over time build the automation of the prior authorization process. So, with that, I will stop for any questions.

Sheryl Turney
Thank you, April. I do see a couple of hands raised. So, we will start the questions with Rich Landen.

Rich Landen
April, thanks for the presentation. I have got a couple of comments and then a question. The first comment you have mentioned, but I want to just specifically call out that the NCVHS subcommittee on standards is holding a hearing this August 25th and 26th for the purpose of hearing from CAQH CORE and from the industry on the value of making the prior auth and connectivity rules – the version specified in your slides – as a national mandate through the CMS regulatory process under HIPAA and ACA. Another comment on that: in today's *Federal Register*, the notice of that hearing was published. For those who want to see the details, today's *Federal Register* has it.

The second comment is just to make sure that the task force members have it clear that in her slides today, April was talking about a couple of different versions of the prior auth. There is one version that is up for NCVHS consideration for recommendation for adoption as a national mandate. Then her slide went on to say there are further developments going on toward a future version. I want to make sure that distinction is clear. They were clearly labeled on the slide, but I wanted to call that out.

Now the question, April, in all work that CORE and its members have done on this, are you seeing any areas of prior auth that are either more conducive for automating given the state of the art, or areas of prior auth that are less conducive for an automated solution at this point in time?

April Todd
That is a great question. What I can say is that in the conversations that we have had with our participating organizations that are interested in working with us on the pilot, is that there is a lot of interest, in particular, on imaging. There is a feeling, I think, in two directions. One is that that is something people are readily interested in doing that can maybe be more easily done and that we could see a quick return in terms of the ROI.

In terms of things that may be a bit more challenging – this is maybe just a more broad comment – based on some of the comments from the working groups, is that whenever there is a substantial amount of clinical documentation that needs to be submitted that is not something that can be easily codified, or something that needs to be reviewed, those are the things where it would be more challenging and where there is, I think, a lot of interest in trying to find a way to create some level of standardization, at least, in terms of how that information is communicated.

Sheryl Turney
Thank you very much. We also have a question from Jocelyn Keegan. Jocelyn?

Jocelyn Keegan
Hi, Jocelyn here. Thank you so much. April, this is great. I really like the way you lay out all of the complications in a clean way, so I appreciate that you guys are working hard to do that.

I think my question overall was I did not realize you were doing piloting, and I would love to understand if the people that are participating in the pilots are public. I think it would be really interesting to get feedback from folks mid pilot, or if there are any interim findings that are happening from the piloting work – having lived and breathed 278 implementation in my past life.

April Todd
Yes, so we are working on that as we speak. We are hoping to have that to be able to share in August, by the time of the hearing.

Jocelyn Keegan
Awesome, thanks.

Sheryl Turney
Thank you. And I do not see any other hands raised, but I do have a question. And maybe this is going to show my ignorance. But I do know that there was some work going on between Da Vinci and the… I thought it was your group wrapping the 278 in a transaction. Are you guys involved directly in that, or is that more focused from the HL7 perspective?

April Todd
I think you are probably referring to something that Cathy had mentioned last week around the mapping that had been occurring between Da Vinci and X12 around some of the data elements between the two standards.

Sheryl Turney

Yes.

April Todd
Yeah, we have been, I would say, consulted on that at a distance, but not heavily involved in that effort.

Sheryl Turney
Okay. All right. Thank you. Because I did not see it in your deck, and so that is why I was wondering. I thought maybe you guys were more involved in that.

Okay. Any other questions from the group? I do not see any more hands raised at this moment. I really thank you for your presentation. It was very helpful, and especially, I think, as others pointed out, the diagrams were very, very helpful in terms of understanding exactly what was in the rule. I did spend the weekend reviewing the proposed rules, and these figures that you have are very helpful.

April Todd
Thank you.

Sheryl Turney
Well, if we have no more questions, I guess what we are going to move to now is we will do a little bit of an early open of the line for public comment, and then we can always come back and see if we get further questions.

Public Comment (01:11:47)

Lauren Richie
Great. Thanks, Sheryl. We are just pulling up the phone number now, and we will ask the operator to open the public line.

Operator
Thank you. If you would like to make a public comment, please press star 1 on your telephone key pad. A confirmation tone will indicate your line is in the queue. You may press star 2 to remove your line from the queue. And for participants using speaker equipment, it may be necessary to pick up your headset before pressing the star keys. One moment while we poll for comments. We have no comments at this time.

Next Steps (01:12:32)

Sheryl Turney
Okay, wonderful. I do not see any more hands raised while we are waiting. It is a lot of material that both groups went over today, so there is a potential that people will have questions after, but hopefully, we will be able to follow up, as we do have the contact information. Why don't we put up the next slide and we will do a little recap and give people a few minutes back in their day?

For this group, just so you understand, there are small team workings going on, working on the recommendations that we are going to be presenting in the next couple weeks and also the process model. So, next week we are looking to have a presentation from the process model group, as well as at least an introduction to the recommendations. And then also the topic that I know we only brought up briefly before,

but it has, I think, come to the surface from a variety of ways in that potentially one of the recommendations might center around having an integrated model, a federal data model, that integrates clinical administrative data to help drive the work of the USCDI as well as what we are looking to accomplish.

The whole goal, when we look at the broader topic, is to capture data once and reuse it everywhere that it needs to be. And in order to really do that, right now we are focusing on prior auths, because that has been the current challenge. It is very burden intensive, but there could be a completely different way of operating here. And largely, we have not been able to really explore that, because EMR systems are focused on what the providers need to provide clinical services and claims administrative services are focused on payment.

So, maybe if we turn everything on its axis and say what do we need if we need an integrated capability, and the data that is needed can be available in some integrated way from day one, what would that drive? And what would that data model look like? And maybe that is what we should be operating under. So, we are going to try to explore some of those topics next week. And then, further, we have a couple of other presentations coming up, one from EHRA, and then the schedule for the remainder of the summer is on this slide. I am not going to go over every single thing. You have heard it numerous times before.

But the most important thing – let us go to the next slide – will be for members to really continue looking at the Google Documents and provide some input, feedback, and notes. Please, do not change what is there, but you can certainly add to it and add comments. And if you have trouble getting access to the Google Docs, please let the support team know, and we will make that available. The recommendations workgroup is going to continue working as well as the process model for that work to come back next week. And then the longer term that we just talked about.

And we particularly, today, want to thank the representatives that we had both from AHIMA and CAQH CORE. AHIMA's presentation really focused on their ability to look at how to improve the quality of health records through the sharing of clinical data as they are looking at it. And really trying to come up with what are the triggers and then how we can fix this problem beyond automation. Whereas the CAQH CORE really focuses on their role as an industry standards group and, really, the recommendations that they are making available right now for adoption in the current hearing that we have coming up and the current standards commitment. And then the pilot work that they are doing, their new road map, uses a steps approach in order to adopt some additional improvements and changes.

And so, all of these things will be very helpful to us as we are trying to build our current landscape and then recommendations and take into consideration all of the material that has been brought forward to us through these important industry groups.

We do have a few more minutes, so I am going to ask if anyone else has any additional questions or comments that they would like to share. Please, raise your hand now. Not seeing any. Alix, would you like to offer any final comments?

Alix Goss
I encourage all the members to take a look at the Google Docs and get engaged. We will be looking forward to your active support in the writing exercise this summer.

Sheryl Turney
Yes, we will. I second that. All right, seeing no hands raised, anything more from public comment?

Operator
There are no public comments.

Sheryl Turney
All right. I think that is a wrap. I think we can give you guys back a few more minutes in your day. Thank you very much.

Lauren Richie
Thanks, everyone.

Female Speaker
Thank you.

Female Speaker
Thank you.

Male Speaker
Thanks, bye.

Female Speaker
Thank you. Bye-bye.

Adjourn (01:18:18)