Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) e-PRIOR AUTHORIZATION REQUEST FOR INFORMATION TASK FORCE 2022

January 27, 2022, 10:00 a.m. – 11:30 a.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Tammy Banks	**Individual**	**Co-Chair**
Sheryl Turney	**Anthem, Inc.**	**Co-Chair**
Hans Buitendijk	Cerner	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Jim Jirjis	HCA Healthcare	Member
Rich Landen	Individual/NCVHS	Member
Aaron Miri	Baptist Health	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Alexis Snyder	Individual	Member
Debra Strickland	Conduent/NCVHS	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Michael Wittie	Office of the National Coordinator for Health Information Technology	ONC Staff Lead
Alex Baker	Office of the National Coordinator for Health Information Technology	ONC Staff Lead

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

Michael Berry
Good morning, everyone, and thank you for joining the kickoff of the Electronic Prior Authorization RFI Task Force. I am Mike Berry with ONC, and we are very pleased that you could join us today. We would like to thank our cochairs, Sheryl Turney and Tammy Banks, for serving as cochairs of this Task Force and all the Task Force members for lending their time and expertise. As a reminder, your feedback is almost welcome, which can be typed in the chat feature to everyone throughout the meeting or communicated verbally during the public comment period that is scheduled at approximately 11:20 this morning. So, let's get started with our meeting. I will now call the meeting to order and begin roll call of our Task Force members. So, when I call your name, please indicate you are present. Let's start with our cochairs. Sheryl Turney? Okay, Sheryl is still connecting, so let's go to Tammy Banks. Okay, Hans Buitendijk?

Tammy Banks
Here. Sorry, I am on Slack. Sorry, Michael, I got your other task.

Hans Buitendijk
I think you called me. I am present.

Michael Berry
Okay. Raj Godavarthi?

Rajesh Godavarthi
I am here.

Michael Berry
Jim Jirjis?

Jim Jirjis
Present.

Michael Berry
Rich Landen?

Rich Landen
Rich Landen is here.

Michael Berry
Aaron Miri? Eliel Oliveira?

Eliel Oliveira
I am here.

Michael Berry
Michelle Schreiber? Alexis Snyder?

Alexis Snyder
Good morning.

Michael Berry
And, Debra Strickland?

Debra Strickland
I am here.

Michael Berry
Great, thank you, everyone. So, now, please join me in welcoming Sheryl and Tammy for their opening remarks. Sheryl, Tammy?

Sheryl Turney
Can you hear me?

Michael Berry
We can, thank you, Sheryl.

Task Force Introductions (00:01:59)

Sheryl Turney
Okay, well, I do not know why I could not get the panelists' link this morning. So, I want to thank everybody who volunteered to participate in this forum, a very important activity, and I am really looking forward to working with all of you. I think we have a quite aggressive agenda, as you will see in the presentation, and so, we are going to be asking folks to put in their homework, if you will, but looking for lively discussions, and hopefully we will set those off in very few minutes. So, thank you all very much, and I am looking forward to the discussion.

Tammy Banks
I also would like to welcome the committee, and I look forward to catching up to the great work that was done before this work over at ICAD, and also thank NCVHS and ONC for the opportunity to cochair this meeting, and look forward to collaborating with all of you on this very important issue, which I think we all know is a priority item that needs to be resolved. So, again, I look forward to the discussions and the great output that we are going to get to finalize through this work, so thank you. Sheryl, did you want to go through the agenda, or would you like me to go through it?

Sheryl Turney
Sure, go ahead.

Tammy Banks
Okay. We got a jam-packed meeting today, a lot of briefing just to get up to speed. We will start with introductions, go through the charge workgroup, planning, Alex and Michael will go through the electronic prior authorization RFI that was published last week, and then we would really like to jump right into the discussion and begin to flesh out where we want to go. Again, because of the shortened timeframe, it is

going to be very important that we continue the conversations between meetings and during meetings. Then the public comment, and then we will head into next steps and what type of homework to be prepared for the next meeting.

Sheryl Turney
All right, we can go to the next slide. Okay, this is the list of volunteers. We are very happy to have you all participating. I will say that we may have a couple of additional individuals who may join our group where we have had invites outreach to them, so if they are not here today, hopefully they will be here in a future meeting. I do think we have a good representation across the board. And so, let's take a moment for the folks who are on. We can see the organizations that you represent, I think from the perspective of the group, just so we can match up your name and your organization. You just take 30 seconds to tell us a little bit about yourself. I will start. I am Sheryl Turney from Anthem, I lead the interoperability work for Anthem and data use and data sharing, and I am also a representative from HITAC, and really looking forward to this work. Tammy?

Tammy Banks
Thank you, Sheryl. I sit on the NCVHS full committee and the subcommittee of standards, and I am working on the SOGI work. I am an individual. I come at this more from the provider perspective due to my background with organized medicine, and basically looking at operationalization solutions.

Sheryl Turney
Thank you. Hans?

Hans Buitendijk
My name is Hans Buitendijk. I am Director of Interoperability Strategies with Cerner, focusing on our industry engagement around topics like this, actively involved in a number of industry activities, but specifically in this context, I am currently chair of the EHRA where EHR vendors come together, HL7, Da Vinci, Argonaut, Care Quality, CommonWell, so, a number of different organizations that touch on these topics.

Sheryl Turney
Wonderful. Rajesh? Is that the right way to say it?

Rajesh Godavarthi
Yeah, sure. You can call me Raj. This is Raj from MCG Health. I am AVP of Technology and Interoperability, primarily leading the interoperability initiatives. My background over the last few years is in the HL7/Da Vinci space dealing with several interoperability initiatives, and my expertise is the clinical decision support. Primarily, this is the bread and butter of what I have been living and dealing with the last few years in the electronic prior authorization and burden reduction, actually even implementing with patient providers, participated in the RLS Committee, collating the HL7/Da Vinci efforts on these implementation guides, so I am very much looking forward to work with all of you.

Sheryl Turney
Wonderful. Jim?

Jim Jirjis

I am Jim Jirjis, an internist from HCA Healthcare. I am the Chief Health Information Officer. I was on the original ICAD meeting, so we are so excited to see this follow-up. Man, from a provider standpoint, there is so much waste involved in the manual human effort that this is a noble and worthy, impactful program, so I am very excited to participate.

Sheryl Turney
Thank you, Jim. Rich?

Rich Landen
Good morning. Rich Landen. I am a retired individual. I am also cochair of the National Committee on Vital and Health Statistics subcommittee on standards. My background includes hospital administration, payer trade associations of X12, CAQH Core, and, like a few others, I am a veteran of ICAD. Thanks.

Sheryl Turney
Wonderful. Aaron? Okay, let's go to…is it Eli?

Eliel Oliveira
It would be Eliel.

Sheryl Turney
Eliel.

Eliel Oliveira
Thank you, Sheryl. Good morning, everyone. My name is Eliel Oliveira. I am the Director of Research and Innovation at Dell Medical School here in Austin, and I have quite a few years in healthcare IT. I was previously the Chief Information Officer for the Louisiana Public Health Institute, where I managed Greater New Orleans Health Information Exchange and PCORnet data network. Previously, I was in cancer research for about 10 years, and I also support our HIE in central Texas. I am currently lead technical for two ONC-funded projects under the LEAP Project, and I have also worked with ONC closely in the past in several FHIR standards development areas, for PRO extraction from electronic medical records and pediatric consent in clinical trials. Thank you.

Sheryl Turney
Wonderful. Next we have Michelle. Or, do we have someone else on from CMS?

Michael Berry
I do not see anyone from CMS as an alternate, Sheryl.

Sheryl Turney
Okay. How about Alexis? All right. And, what about Debra?

Debra Strickland
Yes, I am here. Hi, my name is Debra Strickland. I am a member of NCVHS full committee as well as the standards subcommittee. I have been in standards development, X12, WEDI, and the like for 20-plus years, and I was also part of the ICAD workgroup.

Sheryl Turney
All right, wonderful. I thought someone else said they were here, but now I am not seeing the note. All right, I guess we can go to the next slide. Welcome, everybody, and again, I think we have a great group that will hopefully work together to provide the best input for this RFI to advise ONC with our recommendations. So, next we are going to go over the charge for the Task Force. I think we can advance it to the next slide. All right, do you want to go over this, Tammy, or do you want me to?

Tammy Banks
Go ahead.

Task Force Charge, Workgroup Planning (00:11:34)

Sheryl Turney
Wonderful. So, the charge that we have been provided from ONC, which is what frames our scope of work, is that ONC has issued a request for information that is seeking input on electronic prior authorization. So, what we are looking to do is to provide comments and recommendations as a result of that RFI that hopefully all of you have received and had the opportunity to review, and these comments will be used by the ONC to help inform the work that they are going to be doing on the health IT certification program as well as incorporated into standards and certification criteria and, potentially, future notices of public rulemaking.

So, our Task Force specifically is to provide input and recommendations in response to the RFI on the electronic prior authorization to inform future rulemaking and other actions in this area. We have a very limited time period, and it is March 10th, 2022, and so, as a result, we do have a fairly aggressive schedule, but I think this will be a little bit easier than the ICAD work, for those of you who were part of that with me, because we are starting with an artifact, and we are going to get right into it a little bit later, after we go over the overview of the RFI. And so, now I am going to turn it over to Alex Baker, who is going to review the elements of the RFI.

Oh, sorry, I skipped ahead. This is the draft work plan, and in this work plan, as you can see, today is the 27th. We will have some homework. Excel has created a Google doc for us to capture comments and input, so we will be able to start each meeting with a little bit more of a structure. Today, we are going to talk a little bit more about the functions and capabilities that need to be present in an electronic prior auth, and then we are going to build from there with our recommendations and response to the questions that were included in the RFI.

And so, as you can see, we have weekly meetings at this time that are going to run through March 3rd, when we hopefully will have a final discussion and edits of our proposals and recommendations and paper that is going to go to HITAC, and then, that will go to HITAC in the March 10th meeting. And, we really cannot slip from this schedule because as you know, the RFI has a very specific time period where comments have to be accepted, and that time period ends also in March, so this is a schedule that we are going to need to try to adhere to. And so, the more input we can get sooner on the questions that were asked and the capabilities that we are going to be talk about are going to help us all in our discussions. Any questions on the work plan?

Tammy Banks
Sheryl, Rich has his hand up.

Rich Landen
Sheryl or Tammy, I think the charge is clear, but my question is why the Task Force? What is the expectation, either from HITAC or ONC, for input from this group that would be different from all of us responding to the RFI individually?

Sheryl Turney
In my experience, and I will answer this from what I have done, and then I will let Michael Berry speak on it as well, whenever ONC has done a notice of public rulemaking or an RFI since HITAC has been established and I have been part of it, there has been a Task Force that has been raised to provide additional comments. And again, it is, just from my view, another way to get as many comments as possible because I do believe the outcome is to try to have the best opportunity to gather all the information in a very short period of time. And then, Michael Berry, I do not know if you want to add anything to that.

Michael Berry
That is exactly right, Sheryl. Because this is a multiweek opportunity for discussion not only amongst the Task Force members, and, of course, the public can provide their comments through the chat or through the public comment period, it is a live conversation back and forth, and I think a lot of good ideas and conversations will come out of this discussion, this Task Force, as opposed to just submitting something online through the public comment process that is established for the RFI, so that is how I would view it, as more robust and different opinions coming in from the various people from the Task Force.

Tammy Banks
Does that answer your question, Rich?

Rich Landen
Yes, thank you.

Rajesh Godavarthi
Can I ask one more question, Sheryl?

Sheryl Turney
Yes.

Rajesh Godavarthi
In addition to our own comments and discussions in this timeframe, are we also responding to public comments?

Sheryl Turney
I am sorry, I did not hear your question. Can you say that again?

Rajesh Godavarthi

In addition to the Task Force discussing all the RFI stuff, in this timeframe, are we also responding to the public comments?

Sheryl Turney
My experience is we have not in the past. If there are comments that come through the chat, we will talk about those, but we do not necessarily respond to all of those. We do try to provide, when needed, qualifications around the comments that we do make so that if we are stating a particular recommendation or direction, often, we will provide some background as to why we believe that is needed or necessary, but it is not always possible for us to respond to every public comment, so we are not going to be out to the website and looking at every comment during this period. We are going to focus on the discussions and the information that is raised in this forum.

Rajesh Godavarthi
Thanks, Sheryl.

Michael Berry
Let me just add, Raj, that this forum is meant for the HITAC's recommendations to the national coordinator. It is a consolidated recommendation that is voted upon formally at the March 10th HITAC meeting and will be transmitted to Micky for consideration.

Rajesh Godavarthi
Thanks.

Tammy Banks
Can I just add one more thing? These types of forums are great, and I have worked with many of you before, in really looking at this from all the different stakeholder perspectives and coming out with recommendations that meet the overall industry needs versus coming from individual stakeholder needs, which both are important, and so, this helps balance the recommendations that come out. And, nice presentation, Raj, on the Da Vinci forum yesterday. Anybody who is interested in implementation of the prior auth, take a look at that recording because you and your colleagues did a nice job.

Rajesh Godavarthi
Thanks.

Tammy Banks
I think Jim has his hand up.

Jim Jirjis
Hey, quick question. So, is this Task Force tasked with looking at the RFI and responding to all the questions? Is that the charge, or is there a separate set of ONC questions they want us to focus on?

Sheryl Turney
The set of questions we have is the same one that exists in the RFI.

Tammy Banks

So, we are going to get an overview, again, of the RFI questions, and then, really drive in functional capabilities. What is that minimum set that is needed in order to truly ensure prior authorization works and is used by the stakeholders? And then, diving into what is the status of the IGs and other things that were recommended? 2020 was quite a while ago. And so, we are going to gain that expert advice and also get our own experience on how has time evolved since that last regulation that was dropped.

Jim Jirjis
Just being on the prior ICAD Task Force, we landed with identifying what the datasets were that we thought were necessary, and then we also did a crosswalk to where are there standards that simply have been adopted by the industry, have not been adopted, but standards exist, or there were quite a few areas where there was not a standard. So, is the expectation after the RFI that then, once the data sets and transport mechanisms, etc. are recommended, that then, Vital Statistics and others create terminology sets where they do not exist? Because that seemed like one of the biggest gaps.

Sheryl Turney
So, if that would be a gap, then that would definitely be a capability or a function that we would indicate needs to be created in order to support electronic prior authorization, so I think that is exactly the kind of area that we are looking to bring forward to identify where there are current gaps.

Tammy Banks
Yeah, and I will just add onto what Sheryl said. The ICAD work has to be incorporated within this work as a building block, right? And then, we have the areas of recommendations, which I think you are alluding to what type of recommendations may make sense, so please do not lose those because we are going to want to get that recaptured.

Sheryl Turney
Right, absolutely. I cannot see the hand raise function, so are there any more?

Tammy Banks
I think that is it. That is all we have so far. I will keep letting you know.

Sheryl Turney
All right, thank you. I think we can then go ahead to the next slide. I will turn it over to Alex now.

Alex Baker
Hi, everybody. Can folks hear me?

Sheryl Turney
Yes, we can.

Electronic Prior Authorization RFI (00:23:00)

Alex Baker
Okay, great. This is Alex Baker. I am the Branch Chief for the federal policy branch of ONC's Regulatory and Policy Affairs Division under our Office of Policy, and really just want to give a quick overview of what is in the RFI that ONC released last week. I have not included everything in these slides, just for space

reasons, so I definitely encourage folks to look at the actual document, and I am going to run through these fairly quickly, but certainly, as Sheryl and Tammy get into the discussion, I can turn back to any of these slides as needed.

So, as folks who have had a chance to look at the RFI, it starts out with some sort of general background about prior authorization processes, about burden issues that have been identified with prior authorization activities in various fora, including ONC's strategy on reducing EHR-related burden that came out in 2020 for the final report, and then, it turns to some of the key background to inform what is here. So, first, we talk a little bit about the certification program, which is really the focus of this RFI in terms of what updates could be made to the certification program to address these issues. It talks about previous activity on prior authorization.

So, as folks may know, in the 21st Century CURES Act final rule, where ONC adopted NCPDP 2017-071 for the electronic prescribing criterion, ONC identified the prior authorization transactions in that standard as optional for certification. The certification program does not currently address prior authorization for other items and services that beneficiaries may wish to obtain, and that is really the focus of this RFI. And then, also talks about the standards-based API criterion that ONC also finalized in the CURES Act final rule based on FHIR Release 4 and other specifications, and talks about how, while the initial iteration of that criterion is focused on patient access, ONC really sees this capability as supporting a wide variety of use cases in the future, including use cases related to healthcare operations. Next slide.

So then, we provide a little bit of the background around HIPAA requirements for electronic prior authorization transaction standards, noting that HHS has currently adopted two standards for referral certification and authorization transactions under HIPAA, and then, also noting that HHS adopts operating rules under HIPAA, which the operating rules that have already been adopted for that, which do not include specific prior authorization items yet. Next slide.

So then, we talk about just a couple of recent activities that are really informing this RFI and the 2019 HITAC work, which identified prior authorization as part of the interoperability standards priority target areas, of course, the ICAD Task Force final report in 2020, which provided a very in-depth look at this area and look at available standards that could be used to support these activities, and then talks about the NPRMs that was released in December 2020.

The NPRMs are plural, so, CMS released the interoperability prior authorization NPRM, and then, in the same notice of proposed rulemaking, ONC released a rider, as we call it informally, in which ONC proposed to adopt the implementation guides that CMS had identified for payer API requirements for APIs that certain payers would be required to establish to support prior authorization. Notes that neither of these have been finalized at this time, and also that as part of CMS's rulemaking, they were really focused on requirements for payers and did not touch on the requirements for providers or health IT systems used by providers, and talked about how they were sort of looking at how health IT developers and healthcare providers would be expected to voluntarily update their systems to interact with the APIs the payers were required to establish. Next slide.

So then, we get into really the meat of the RFI with the specific areas of background where ONC is really looking for comment, and so, I will touch on the background areas and then the questions which come at

the end of the document, just to match those up. So, first, there is a section sort of taking a high-level view of what are the core set of capabilities that commenters believe should be included in a certified health IT module or modules to support prior authorization, lists a total of seven capabilities here for consideration, so, these cover identifying when prior authorization is applicable for an item or service, querying the pair for those authorization requirements for each item and service, and identifying the rules and documentation requirements, being able to collect the documentation needed to complete the prior authorization documentation from the health IT system, being able to electronically submit that completed documentation to a payer's API. Next slide.

Then, receiving a response from a payer regarding the approval or denial and a reason for that denial or a need for more information, a capability to be able to query a payer system for updates on pending requests, and then, capabilities around being able to meet some of the administrative requirements that payers may have around documentation for those transactions. Next slide.

And so, some of the questions about these functional capabilities get into do commenters see all these capabilities as necessary for certified health IT modules to be able to really successfully support these processes, are there additional capabilities that are not mentioned in this list that should be included here as the fundamental roadmap for what certification criteria should include, should any of the capabilities that are in this list not be included in certified health IT modules, or should ONC, in terms of the certification program, be thinking about a more limited set of functional capabilities than what has been described in that list? And then, talks about the intersection between these capabilities and the HIPAA-compliant workflows that are needed to do a complete submission of the prior authorization transaction, and sort of thinking about certification criteria and whether that should cover the complete HIPAA-compliant workflow and any translation that may be necessary, or if ONC should look at more a part of that that maybe does not include that translation piece.

And then, it talks a little bit about how commoners believe those functions should potentially be structured within the certification program, so ONC has choices as they structure certification criteria, which may influence how health IT developers approach certifying their products in the market that may be influenced by whether ONC chooses to do this, and different criteria and different developers that may be focused on different parts of the process versus whether there should be a single criteria, so this last question really gets at this kind of structural piece. Next slide.

So then, the RFI drills down specifically on the three implementation guides that were proposed by ONC as a part of that December 2020 NPRM: The coverage requirements discovery IG, the documentation templates and coverage rules, IG, and the prior authorization support IG. Next slide. And, the questions here specifically focus on these three IGs in the context of the certification program. Obviously, they were previously proposed by ONC in the context of CMS's proposal for payer API requirements, and the focus here for this RFI is the appropriateness of adopting these IGs as part of the certification program in order to support certification criteria.

So, these questions really get to the readiness of these three IGs for adoption as part of certification criteria, ask about what would be a feasible timeline for use of these IGs in production for transactions, asks about whether there are additional changes that are needed to the current versions of these implementation guides prior to adoption as part of the certification program. There is a question about alternatives. So, if

the commenters believe the existing IGs are not ready for adoption, should ONC still consider certification criteria? For instance, should ONC consider criteria that may require the use of FHIR but do not require use of the specific implementation specifications until a later date if there are readiness concerns? And also, they talk about whether these commenters believe the current IGs affect and fully support some of those compliance requirements around clinical documentation mentioned earlier in the functional capabilities. Next slide.

We have a couple more questions about alternative approaches. So, generally focusing on are there alternative approaches that ONC should explore that would meet the same needs but are not based on the three Da Vinci IGs that we have described, are there simplified approaches to the workflows described in those IGs that ONC should consider as alternative ways to support electronic prior authorization through the certification program, and then, are there any additional specifications that are needed in addition to the specifications that we have described in order to fully meet the needs of these workflows? Next slide.

So then, there is a section that is about a specific portion of the prior authorization workflow, and that is healthcare attachments, which has certainly been the focus of other HHS work in the past, and the RFI specifically talks about two approaches for consideration that would build on standards that have already been adopted in the certification program, so, using the C-CDA in order to support attachments and the implementation guide that is available for using the C-CDA for healthcare attachments, including prior authorization, and then, also talks about FHIR documents as a potential approach to supporting healthcare attachments, and then, asks besides these two approaches that the RFI describes, are there other approaches that commenters want to put forward that are specific to healthcare attachments for prior authorization for consideration. Next slide.

Then, the questions on this section get to the effectiveness of either of the approaches that we have put forward for consideration, the use of the C-CDA and the use of associated attachments IG for exchange, as well as FHIR documents, questions about given limited testing of use of these for the specific prior authorization use case today, what would be a feasible timeline for either of these approaches. Next slide. We have some questions about the strategy of whether commenters believe ONC should consider adopting one or the other of these four certification criteria or whether ONC should explore use of both within certified health IT, a question related to the previous section about the Da Vinci IGs and other approaches that might support the complete prior authorization workflow, do commenters believe that ONC should focus on healthcare attachments alone versus more comprehensive approaches at this time, and then, questions about those approaches are used in other administrative or operations transactions, and whether any of those considerations should inform ONC's next steps with either of these approaches. Next slide.

So then, the last couple topic areas are really focused on impact for different stakeholders, so, first, are asking about potential impact on patients of these changes to the certification program, do commenters believe the kinds of changes contemplated in this RFI would have the ability to positively impact healthcare consumers, positively impact different areas of concern around prior authorization processes and their impact on patients, and then, questions about whether there are other areas not discussed in this RFI that commenters believe would be particularly impactful for patients in the context of prior authorization. Next slide.

Then, we focus on providers and thinking about the kinds of changes contemplated in this RFI. Do commenters believe those would be likely to reduce burden for healthcare providers as they engage in prior authorization activities, to what degree would these kinds of capabilities in certified health IT really be useful to healthcare providers across all of the patients that they serve, to what degree would additional incentives or requirements outside of what is in the certification program and ONC's authority be necessary to ensure providers are effectively using these capabilities, would other support documentation be needed to ensure that the kinds of capabilities contemplated in the RFI are effectively implemented and effectively improve workflows, and then, any estimates that providers might want to share with ONC about the potential burden, time, and cost associated with implementing new processes around electronic prior authorization? Next slide.

And then, we turn to health IT developers, ask for any information health IT developers want to provide about the burden that would be entailed in updating their products to incorporate this new functionality, developing new certified health IT modules that would incorporate this functionality, asks specifically for any information about specific burden associated with the Da Vinci IGs that have been described in the RFI, and then, go back to that alternative scenario that was discussed in the Da Vinci section about what the relative burden might be if developers were to focus on functionality that was only focused on the use of the base FHIR standard and did not have the specific implementation guides as requirements. Next slide.

And then, the last section here is around payers and implications for them of changes to the certification program, and particularly what ONC should consider in terms of designing certification criteria with the needs of healthcare payers in mind. So, to what degree certification criteria…how they may need to take into account payer workflows as part of developing those requirements, but then, also, questions for payers about whether those certified health IT modules would reduce burden for them, and if certified health IT modules were available, to what extent payers might look to certification for their own systems if those were available and what ONC might want to consider if they were making certification criteria available that are targeted for payers as well. So, that is the end of the questions, and I will turn it back to Sheryl and Tammy, and happy to go back to any of these as necessary.

Discussion (00:44:08)

Sheryl Turney
Thank you so much, Alex. Would we be able to go back to Slide 14? Because where we would like to start the discussion today is basically to talk about the functional capabilities. So, hopefully, again, you have all had a chance to look at the details in the RFI, which this deck has highlighted, but essentially, there are about seven things in the deck, this goes on to Page 15 as well, to identify functional capabilities, and I think to start with, we want to make sure we understand what these capabilities are as they are outlined, and it is a complete list.

I know the RFI speaks to attachments and it also speaks to patient access, but I think both Tammy and I have agreed that we need to add for functionality the ability to exchange attachments in a standard way as well as add a functional requirement capability where the patient has the ability to get updated status. That was a key component for the intersection of clinical and administrative data, and again, although there is a section here that speaks about the patient, it does not really outline that as a capability, and we see that as a core capability because in the end of the day, although there is burden by the providers as well as the

payers, when a prior authorization does not get approved, the burden falls on the patient to coordinate both parties, and that is not where the responsibility should really lie.

So, we want to make sure the patient has the ability through their patient access API to get updated status on their electronic prior authorization and know whose bucket it is in. Is the payer waiting on additional information, or is the payer considering that they got all the information, and then they are providing the liberation for the updated determination, or has the prior authorization been approved or denied? And again, if it is denied, then what is the denial reason? So, I would like to start the discussion there, and then I am going to open it to the other members and panelists if you would like to weigh in. Tammy, is there anything you would like to add?

Tammy Banks
No, excellent. I appreciate those additions. Hans has his hand up.

Sheryl Turney
All right. Again, I cannot see the hand raise, so, Tammy, if you could do the hand raise, that would be great.

Tammy Banks
Go ahead, Hans.

Rajesh Godavarthi
You are on mute, Hans.

Hans Buitendijk
Is this better?

Tammy Banks
You got it.

Hans Buitendijk
Got it, okay. You never know how many buttons you need to push for that. But, I really appreciate the opportunity to participate with this group and go through these questions. I think they are great questions that help us highlight what do we have, what do we not have, what do we need to focus on. Initial reaction on this list, so, holding opportunity for further refinement on that, but overall, I believe that the list really covers a lot of the steps that are needed, and I agree with Sheryl there are a couple of clear ones that need to be considered and added as well, a status update by a consumer, how do we get the data actually across claims attachment, what format do we need to do that.

There is one other one that I would like to offer as well in particular, and that is there may be some assumptions behind this list, and when you particularly look at the Da Vinci implementation guides, the interaction always would be between the provider-based system and the payer directly, and I think there are a couple of variants in there that have already been demonstrated in early work to date that are in play as well that would have to recognize some other elements as well. One is that on the provider side, it is not necessarily one system that covers all aspects of the prior authorization workflow. There is a clinical element

to it. I need possibly prior authorization to start in a clinical environment, but then I have follow-up for additional data that may or may not be automatically retrievable. I need to tie it into other systems.

So, I think we need to recognize it may not be all coming from one environment. That means that there are going to be configurations out there that might use smart apps/intermediaries to achieve this, and we already see examples out there with this happening and beginning to happen, but also, that means they need to get the data. They need to get the retrieval of the data, and that is more than the three interactions and the ones that are listed in here. I need to go out and see, to the extent I can, obtain that information automatically. That is where we see right now an interesting alignment on FHIR/US CORE to gather the data where that is feasible.

So, I think we need to recognize that extra step of how can I get consistently, no matter what the system is, access to the data, not just understanding what the data is telling me to get, but to actually get it. I believe that is the most important one at this point in time that jumps out, but then also is the general construct of we need to not just think of this as everything is done by one system. There are different components, depending on the progression where we are at, that it could be a combination of different IT that is going to make this happen.

Tammy Banks
Hans, do you have specific functional capability? How would you word that so you make sure that it encompasses everything that you are envisioning?

Hans Buitendijk
The main one I would say that I am highlighting that would be added is the automated retrieval, if you will. That might be a shorthand right now that we can flesh out, but it is the actual obtainment of the data that I cannot do automatically.

Tammy Banks
Perfect, thank you. Rich?

Rich Landen
Thanks. My one comment at this point is I think we need to be explicit that what we are looking for is coverage determinations or prior authorization that is specific for this patient, and that is in contrast to a general rule of thumb, that we need a definitive answer for this patient, so we need to make that very explicit. The other thought is more of a question to the payer-knowledgeable members of the Task Force. Would it also be important to be very explicit and specific about what provider, or in other words, will prior authorization responses differ depending on what provider will be providing the service or item?

Tammy Banks
Can I ask one question on your first, the coverage determined specific for a patient? So, we are assuming real-time or near-real-time back-and-forth. Is bulk also important to consider in this functional capability? Do we need both?

Rich Landen
By “bulk,” do you mean multiple patients?

Tammy Banks
Yes.

Rich Landen
Ooh, I see that as a very different question. A good question, but very different from mine.

Tammy Banks
Okay, we will table that. And then, does anybody want to respond to his question about provider info being submitted, and if that would make a difference on response, and if that is something that should be incorporated in the final capability? And, I see Jim with his hand raised and his physical hand raised.

Jim Jirjis
Yes, I think it sort of necessary that whoever the provider is, information would be passed. I would think so. I also wanted to bring up one other point, if I could, and that is that when we are automating, it is easy to talk about defining a data set and transport mechanisms, etc., but we have to make sure that we incorporate very vividly time. For example, if you automate this process and some information has not yet been populated in the EMR, you could experience the unfortunate additional burden of denials going up that have to be then appealed because information came in that actually met authorization requirements.

So, at some point, understanding the workflow around the information flow is going to be really key, or untoward consequences could occur. The only other point I wanted to make is we keep talking about prior auth, but remember, a lot of hospital admissions are not prior, they are concurrent auth, and I know it is probably just an imprecise term, but to me, what we are really talking about authorizations, the majority of which are prior, but many are not, and there is a different set of workflows around those concurrent. If someone gets admitted through the ER to a hospital, for example, that is more of a concurrent than a planned prior auth.

Tammy Banks
Jim, good point. Can we table that part and come back to that? Because I think that is really important, but just stay focused on the prior auth workflow at this point, recognizing there are similarities to keep it simple. In regards to the timing, I just want to capture what you are saying. Are you saying that there needs to be timeframe around it, like you need to respond within X amount of time? Is that where you are going with time?

Jim Jirjis
I think it is important that there be time, not waiting weeks for an authorization. I am talking about the other direction. It needs to be designed where the provider can decide when it is time to submit for authorization instead of an automated process. For example, if there was an automated trigger, like the patient was in the hospital or something, and then it was all automated, and it looked in the EMR, and there was not the data it was looking for yet, and a denial occurred, but an hour later, that data came in that would have justified it, now it gets relegated to an appeal process that is highly manual and could make us take several steps backwards because timing has created erroneous denials based on incomplete info where it was overautomated. So, there have to be some controls for those who are working denials on the provider side

to make sure that there is not a premature submission sent that would create that additional burden, which would be highly ironic and unfortunate.

Tammy Banks
That is what I noticed, too. We are looking at it in the workflow, that it is going to happen right when the patient is there, when in fact, in some workflows, you are going to have to role-base it out to those who are actually handling authorizations, so that would be the same type of capabilities, different timing. Do I get you, Jim?

Jim Jirjis
Absolutely, and I think in our response somewhere, we need to emphasize that the system should be designed in such a way to avoid that untoward consequence.

Sheryl Turney
Good point.

Tammy Banks
I am sorry, I do not know if Raj or Deb was next. Can I go with Raj, just because you are first on my screen?

Rajesh Godavarthi
Sure. So, a couple of observations looking at the scope of the Task Force. It seems like we are taking a lot on the plate in terms of looking and defining in two months, which is doable, but I just want to state that. No. 2, when we look at this use case, how much payer can support is critical for the success of what we recommend to ONC as a Task Force because if that other hand does not clap, it is not going to work at all. So, if it is the previous task force or collaboration with CMS, we are requiring a payer API for prior authorization requirements, and if that is not in place, then how do we support that? Unlike patient access API and provider access API, this is really multiple systems coming together to make this happen, so that is one observation I have, to see how we can bring support and collaboration from CMS.

The second one I would like to comment is the provider workflow. When we say this is going to reduce the burden on providers, the provider is sitting with the patient and looking at what payers say about MRI and what kind of requirements they are asking. That is not really going to work for providers. It is going to create additional fatigue. So, we have to really think to do the workflow in terms of how the provider has a back-office workflow, and how do we implement this thing so that we are not adding more burden to the providers in the workflows? We have to look at the workflow aspect very critically.

Tammy Banks
Good points, Raj. When I was looking at this, I was doing the same thing. You want this to work, so you look at the end in mind. I think for right now, that is where we have to go. Right now, we just have to think about it from the EHR criteria perspective. What is the minimum functional capabilities that will need to be built, and then we will move to that point. And so, the question is what is minimum and what is the complete Cadillac version, which is kind of a hard conversation, and how do we then figure out what are the levers to incent payers, providers? Where is the reduction in the burden that is going to make people want to do this?

So, I think this is going to be Part 2, if you guys agree, in that approach to narrow down the scope, and agree with the payer workflow. Prior authorizations already have to be done. There are already criteria that are requested. So, I do not think we are asking that point, but I think there are some pain points in regards to what was asked, and I think that is what was being brought up, so I think that is another thing to put on the table to have a conversation, and I think Jim wants to speak to it, and then we will get over to Deb.

Jim Jirjis
Sorry, I was both physically and electronically raising my hand again.

Tammy Banks
I know, you are pretty hyper. I was like, "I better get to you." Sorry, Deb. We owe Deb an apology.

Jim Jirjis
Go ahead, Deb. I am sorry.

Debra Strickland
So, I was just going to go back to Rich's original question about what has to be part of this, and I think it is that patient-specific benefit, perhaps the data service as we are talking maybe now, current prior auth, as well as in future, and certainly, the provider is going to need to be part of that because if you are saying my PCP is going to do the surgery, no, your surgeon is going to do the surgery, and that is when that would be acceptable. So, I think those are all pieces and parts that have to be part of the request, and I understand workflows, as I think Jim said. I think Jim was more on the EHR side. I think this is going to be a big pull for the provider. I really do. I really think we have to look into the impacts of what this is all going to entail as far as what the burden is going to be on the provider and understand that very, very clearly because this is supposed to help them, not hurt them, so we want to make sure we are doing right by them.

Tammy Banks
Good point, Deb. Jim?

Jim Jirjis
I have not worked my way through the full RFI yet, but I think there are a couple things. One is the patient identity, then there is the coverage, what are the patient's benefits, and then the specifics about the procedure and what data is needed, and I can see we are automating that. That will really be an improvement. But, I also want to make sure that it is part of our charge to talk about the rules themselves because in the last ICAD meeting and in the draft rule from the Trump administration before the administration changed, we wanted to be pretty vivid about making sure that the requester and the patient understand what the rules are that lead to a denial or an approval, and I know that is challenging because there may not be a data construct to represent that, but is that part of what our comments will be, the data and the rules, so it is transparent and clear to everybody what is required for authorizations? Because now, it is a little bit of a black box. There is a denial.

Tammy Banks
No, I hear you. I will give you my perspective, and then I want other people to jump in. But, the way I look at it, since we are looking at the functional capabilities for the EMR, we are going to have to have functional capability that that information can be received, inputted, and displayed. Now, I think what you are asking

is if we want to make a recommendation that health plans are able to be transparent in what those underlying decision criteria are in order to do the yes, no, or whatever. I think for what we are asking right now, that is out of scope, but that definitely is in scope for the final work product in my mind. Does anybody have any different opinion?

Sheryl Turney
Tammy, I do not think he is asking about the rules for the decision-making. I think what he is really talking about is No. 2 that is in this list, which is really what are the requirements for documentation and support of the prior authorization, and that being fully transparent.

Tammy Banks
Oh, the other side.

Sheryl Turney
Yeah. The rule behind it…ICAD chose to not go there, and that is not in this RFI either, unless people want it to be brought up, but specifically, Jim, what you are talking about is really No. 2 here, and that is what are the documentation requirements, what is this reporting information, and what needs to be submitted all at once so that that prior auth decision can be made without a long time on the payer's part to get a decision made.

Jim Jirjis
Yeah, and just to let you know how it works right now, a patient will come in, that data will be transmitted, and there will be an authorization number, but then, what comes back is just a denial without any granular explanation of why. That is what leads to an additional burden of all these appeals, so that is why I am saying for provider adoption in the final product, we have to have that be addressed. Otherwise, it is asymmetric. It is just a black box.

Tammy Banks
Is there any wording change for that functional capability you would recommend? Thank you, Viat mentioned that these rules are already represented in the Da Vinci implementation guide, so when we review that, we are going to need to look at that closely from that lens, and Hans makes a good point again that with e-prior auth, this is just a wonderful use case because we are looking at it both from an administrative and clinical perspective, which may pull information out of the practice management system and EHR, and Hans, I hope you keep us honest in that regard as we look at that complete workflow. So, as we move forward, if there is any change to the wording there to be more clear, let me know. Otherwise, let's really take a look at those IGs from that perspective to make sure that that is captured. Great point.

Sheryl Turney
And, one of the capabilities, Capability 5 on Page 15, if we can move forward one slide, speaks specifically, Jim, to the denial, and that a reason must be included in the denial.

Jim Jirjis
I think what I am trying to say is in Part 2. Part 1 is on the front end, knowing the rules. Part 2 is the reason, and for the reason that comes back, "reason" needs to be defined better because the reason can be that it

did not meet requirement, so I think to enhance transparency, we need to really focus on what we mean by reason, what granular level.

Tammy Banks
And, I would love to change it to include a specific reason and next-step action.

Jim Jirjis
Yeah, if there is. If somebody is just willy-nilly ordering a PET scan that they should not be, the next step should be to not order it, but I hear what you are saying. I think that is important, or we will end up with opacity.

Tammy Banks
Well, they have to be able to respond and comply with that information and not have to ask for more information through a phone call or any other type of medium.

Jim Jirjis
Correct, and also, the appeal process is so burdensome, and what happens, then, is providers begin to learn what they did wrong and quit repeating it, so the ability to actually learn means being exposed to the transparency about the rules as well as the reasons, and I think that will help reduce burden because it allows people to understand why it was denied with more granularity.

Sheryl Turney
So, what I captured, Jim, from what you just said was include a detailed reason that allows the requester to know what the next action they need to pursue in order to continue pursuing the prior auth.

Jim Jirjis
Well, possibly. I think before that would be letting know with enough granularity, which is, I think, what this task force should weigh in on, to have understandable and actionable reasons. Even if that means that for that patient, I am not going to pursue it, “Oh, that is why, because the rules require this, and the specific reason for the denial is that.” There we go.

Tammy Banks
Can we add that specific patient, Rich’s point about being very clear that it is for a specific patient, which I think is inferred, but just being clear? Hans, I think, is next.

Hans Buitendijk
Yeah, this is more a procedural question as we go through. I am hearing a lot of great ideas, and other ones are being spun off. At some point in time, let’s really discuss how, in between meetings as follow-ups, whatever format it is, that there is a collaboration place where we can enter thoughts and ideas, and what is the format in which we are going to do that, because I am hearing a lot of great ideas that spin out already, and I am not sure where to start to put them at some point in time, in between and as we go forward.

Sheryl Turney
So, let m e take that one, and I apologize if I did not talk about this in a robust enough manner, but we are going to have a Google doc that has hopefully already been created which will have all these capabilities

and the questions as part of it to frame our response to ONC. So, initially, Tammy and I are going to capture what we discuss today along with the transcript and help seed some of that information into that document. In addition, we are going to be asking all of you, and you are going to hear this again when we go over homework in a few minutes, but we are going to be asking all of you to go in and add comments, both to capabilities section as well as to the questions, and we are going to utilize that information and actually, in future meetings, use that Google doc to go through and expand the comments, inform the discussion, and capture, hopefully, some collaborative responses that we can all agree on.

The way we have done this before is we have gathered all the inputs without scoping things out in the beginning, so what probably will be best for the discussion is we capture all the ideas, and then we will go back and review those ideas as we go through so that we are not eliminating something in a first meeting and then it keeps getting brought up. If we are going to not include it, we will know why we are not including it. So, we try to at least be open in the beginning to all the ideas, and then we will review them continue to review them in each meeting until we have edited it to the degree that we are all happy. And then, Tammy, did you want to add anything to that?

Tammy Banks
No, I think that is great. Thank you, Sheryl.

Sheryl Turney
Okay. So, you will get a link to the Google doc, and if you use an alternate address than the one that you have used for this meeting, you need to give them that as well so they can open it up to that email.

Tammy Banks
Sheryl, I will add, though, we are on a short timeframe, so, Hans, great question, and please, everybody, when you are thinking about this, send in your thoughts to any question, and we will make sure that we can expedite the discussion, so to speak. Rich, I think you were next.

Rich Landen
No, I took my hand down, thanks.

Tammy Banks
Okay, sorry. Raj?

Rajesh Godavarthi
Do we have time for a question?

Tammy Banks
Yes.

Rajesh Godavarthi
So, the question I was thinking, as we are going to recommend looking at the functional capabilities and the certification criteria, the standards between USCDI, US CORE, and what we specify there, and then, the FHIR CORE, what we are specifying from the FHIR side and how the Da Vinci guides align with that, I know because I am part of that committee working on it as well. We need to make sure that is part of the

work we are doing here so that whatever we say in the end is consistent with the standards that is USCDI Version 3 or whatever is coming next. Otherwise, we impose something in the standards and do not help following that. We will have a conflict.

Tammy Banks
Good point. All right, I am not seeing any other hands. Does anyone else have any final comments? We do have public comment coming up in two minutes, so we have time for one or two more questions or comments before that.

Rajesh Godavarthi
The one other comment I will make on the denial reasons… I am not sure if you can go back to the NPRM that was frozen. There was a pretty good amount of discussion on the denial reasons and turnaround times. I believe that is well articulated in that NPRM and the final rule as well. There is enough information that overlaps between the previous CMS rule and the documentation we are reading, so, some more discussions could be potentially there with some answers, like how, from the CMS point of view, they thought **[inaudible] [01:13:16]** the denial reasons and turnaround times should be improved and how they should be articulated to the provider side, so it is a good read if you have time.

Sheryl Turney
I did want to make one other comment, too. That is a good point, and you might have brought it up, Jim or Rich, I cannot remember which one of you, about making sure that we are able to match on the member. One of the things that was brought up in the ICAD forum as a result of that member match was the ability to have a digital ID card that was standard because of the fact that a lot of providers were still scanning those documents in, and now, that is even harder because of the fact that a lot of the payers have moved to digital ID cards, and there is no standard for that. And so, I do not know if that needs to be at least noted as part of what we are doing, but if we want to aid the member match, a lot of the providers indicated that certainly would go a long way because now they are still having to transpose the information to get it into their system, and there are always errors associated to that. So, that may be one thing we want to at least note because it was brought up again in the prior forum. So, we are at time now to go to public comment, so I am going to turn it over to…Michael, is that you?

Public Comment (01:15:02)

Michael Berry
Yes, that is me. So, we are going to open up our meeting today for public comments, so if you are on Zoom and would like to make a comment, please use the hand-raise function, which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, you would press *9 to raise your hand, and then, once called upon, you would press *6 to mute and unmute your line. And, we do limit public comments to three minutes, so if any of the members of the public would like to make a comment, please raise your hand or, if you are on the phone, press *9. We will pause a minute to see if anyone would like to make a public comment. And, I see no hands raised, so we can move on, and I will turn it back to Sheryl and Tammy.

Next Steps (01:15:56)

Sheryl Turney

All right. So, let's go to the next slide, or actually, you do not need to. Leave this up in case anybody wants the instructions. I will just speak to the next steps, and then we can move the slide forward in a moment. So, regarding next steps, you are going to get a few homework assignments. What we would like people to do is review the RFI, obviously, if you have not. It might also be beneficial if you reviewed some of the Da Vinci documents, the implementation guides for document templates and payer roles, as well as coverage requirements discovery and the prior authorization support.

Again, there is a lot of material out there. Nobody is expecting anyone to be an expert, but we all have different levels of background in those efforts, and so, it would be good to inform the discussion if you had at least reviewed those implementation guides. And then, we will send a link with the Google doc to the panelists. Please provide any alternative email address, for instance, in myself, I cannot get in there from my Anthem address, so I have to use my personal one, and then we will ask you to make comments in the document, and then, hopefully associate your name to those comments, so as we will bring those forward to the next meeting, what we would like to do in the next meeting is review the comments that have been made on the functions and capabilities that we talked about today, and then really start digging into the questions.

Tammy and I will work offline to see how many of the questions we can get through. We are not expecting we are going to get through every question in every meeting, so we will take it in sections and go that way, so, primarily, I would ask you to focus your comments on the capabilities section, the functions, as well as the first maybe five questions, and then we can build from there because that is maybe all we will be able to get through in the next meeting. Certainly, if you have comments to other questions, please put those in. Again, if you would at least note your name, that will help us so if there are follow-up questions regarding those comments, we will know who we can reach out to during the meeting.

Also, consider if there are any external SMEs who you think might be helpful for discussions. Obviously, a lot of these questions have to do with certification requirements. There are some of us here that are more knowledgeable about those than others. I know I asked that a couple of people be pulled in who I thought would be helpful to this discussion. I also notice, Alix Goss, you were participating today, and I know you have a lot to bring forward as well, but if there are particular folks we would like to hear from, let us know that ASAP because we do not have a lot of time, but if there is someone you would like us to bring in, we can have them come and provide some framing, or some conversation, or some additional input if that is needed. Our next meeting is next week. They are going to be Thursdays from 10:00 a.m. to 11:30 Eastern Time, and then, we will use a similar format to this, although primarily, all of next meeting will be discussing the comments that people have populated out in the Google doc, hopefully. Any questions about our next steps and homework? All right, anybody who has raised their hand for public comment?

Rajesh Godavarthi
Sorry, Sheryl, if I can make one comment. If anybody would like any help going through the implementation guides, please ping me. I am happy to walk you through this. It is probably a crash course you rather than having to read the whole thing.

Sheryl Turney
That would be wonderful, Raj, absolutely, because they are sometimes a little hard to get through if you have not been part of the collaboration team. Someone actually suggested already in the chat maybe it

would be good for the next meeting to have someone come and step through those implementation guides, and maybe we can work that out for first thing in the next meeting if we are able to get someone to do that for us.

Rajesh Godavarthi
Happy to help.

Tammy Banks
And so, it will be really important if you do have additional considerations for those functional capabilities, again, for the EHR criteria, that you get those in the Google docs this week because then, obviously, we can add that task of matching them up with the implementation guide, so that will just further us a little bit quicker.

Sheryl Turney
Right, and then, for anyone that is on the public, the Google doc is only available to the panelists, but if there is something that you would like added, please add it to the chat, or you can send it directly to any of the panelists, and we can provide that as input as well. All right, any other questions or comments before we break? I am not seeing any other hands raised. I did just take a look through. All right, I guess then we will give you a couple minutes back in your day, and we will look forward to your input. Hopefully, that link to the Google doc will go out by tomorrow.

Rajesh Godavarthi
Thank you.

Tammy Banks
Thank you, everybody.

Sheryl Turney
Thank you for a great first meeting.

Adjourn (01:21:42)