October 28, 2020

Ms. Carolyn Petersen
Dr. Robert Wah
Co-chairs, Health Information Technology Advisory Committee (HITAC)
US Department of Health and Human Services
330 C Street, SW
Washington, DC 20201

Dear Ms. Petersen and Dr. Wah:

On behalf of the American Health Information Management Association, I would like to take this opportunity to offer feedback on the Intersection of Clinical and Administrative Data (ICAD) Task Force's draft recommendations on the convergence of clinical and administrative data, which the Health Information Technology Advisory Committee (HITAC) is currently considering for approval and submission to the National Coordinator for Health Information Technology.

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

Overall, the Task Force has produced a thoughtful analysis of how integrating clinical and administrative data can improve the patient experience, enhance efficiency, and reduce burden for providers and payers. Processes today that require the exchange of clinical data to support administrative processes generally involve a considerable amount of work, including phone calls, use of payer portals, and faxes. Inpatient authorizations, medical necessity reviews, and prior authorizations for tests, procedures, and medications all impose significant burdens on providers and patients and raise administrative costs. In some cases, they can also delay treatment and negatively impact patient outcomes.[1]

That said, some of the recommendations made by the Task Force are ambitious and would have a wide-ranging impact, but lack specificity regarding how they can be achieved. We offer the following comments regarding certain recommendations from the Task Force for your consideration.

Recommendation 1: Prioritize Administrative Efficiency in Relevant Federal Programs

The Task Force recommends that ONC work with CMS and other federal agencies to incorporate aligned administrative efficiency objectives into relevant payment programs (e.g., HEDIS, MA/MADP STAR ratings, MIPS, MSSP, Promoting Interoperability, etc., and private payers contracting through Tricare and FEHP), and that ONC and CMS jointly establish relevant certification criteria associated with the

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[1] Available at: https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf.

health information technology used to further administrative efficiency, reduce clinician burden, and improve the patient experience.

AHIMA is concerned that this recommendation may be premature given that the standards, processes, and real-world implementation considerations associated with integrating clinical and administrative data must be addressed before aligned administrative efficiency objectives are incorporated into relevant federal payment programs. In other words, we believe that additional work is needed to understand "how" these two distinct data streams may be converged before federal programs adopt incentives for using new approaches. For example, further understanding is needed as to how data is captured for clinical purposes using SNOMED but then used for administrative processes that are conducted using ICD or CPT. This includes consideration of the implications of mapping the different code sets and the impact on semantic interoperability. Consideration must also be given as to how providers and payer organizations may have to account for changes to their IT systems and workflows to accommodate new approaches. These include system upgrades and workforce training and realignment to account for shifts in needed capabilities, including the implementation of new standards, technologies, and processes.

We also suggest, under Recommendation 1, the Task Force consider recommending only positive targeted incentives be deployed to address challenges of small practices in implementing the new standards versus penalizing smaller practices for failure to implement new standards.

Recommendation 2: Establish a Government-wide Common Standards Advancement Process

The Task Force recommends that ONC, in collaboration with CMS and other federal agencies, establish a single consistent process for standards advancement for relevant standards for healthcare interoperability, including transactions, code sets, terminologies/vocabularies, and privacy and security used for conducting the business of healthcare, irrespective of whether that business is clinical or administrative. The Task Force also recommends that the standards advancement process incorporate multiple rounds of development testing and production pilot use prior to adoption as national standards.

AHIMA is concerned that Recommendation 2 in its current form lacks specificity. In other words, Recommendation 2 does not appear to map out a clear path to get from our existing, bifurcated approach of setting administrative and clinical standards to the ideal state laid out in the draft report. For example, it is unclear whether Recommendation 2 suggests changing either the existing regulatory process for the HIPAA Administrative Simplification standards or the existing ONC Interoperability Standards Advisory and its related process for the advancement of clinical standards, or both. We support the harmonization of these two distinct data streams. However, there are certain aspects of the HIPAA transaction standards process that should not be cast aside, including: (1) establishment of clear roles and responsibilities of stakeholders involved in the process, (2) consideration of operating rules and how new standards are to be used and implemented (versus simply the development of the standards themselves), and (3) the principle that all stakeholders "move together," which creates more certainty and consistency for providers and payers when adopting new standards.

Furthermore, this recommendation makes no mention of involving stakeholders outside of the federal government in developing this new standards process, although all stakeholders, and particularly payers and providers, would presumably need to use the standards that are subsequently adopted.

Recommendation 3: Converge Health Care Standards

The Task Force recommends that ONC, working in concert with CMS, the National Library of Medicine, voluntary consensus standards organizations, and other relevant federal agencies harmonize standards to create a consistent set of standards for Code Sets, Content and Services that evolve together to address multiple clinical and administrative workflows. The Task Force also recommends that ONC, working with standards development organizations, establish domains of expertise around common standards. The Task Force also clarifies that its recommendation to harmonize standards does not imply that legitimate users of the data shall have unfettered access to the complete clinical or administrative record and that the principle of minimum necessary must still apply.

AHIMA agrees with the Task Force's recommendation to harmonize standards to create a consistent set of standards for Code Sets, Content and Services that evolve together to address clinical and administrative workflows. However, we are concerned this recommendation lacks specificity. For example, the recommendation only provides an example of how to harmonize exchange standards (e.g.—FHIR, X12, NCPDP). Content and classification standards are equally important to achieve the goal of more automated transactions, particularly for prior authorization. However, Recommendation 3 does not specifically address how to harmonize content standards. This is a particularly challenging area, as clinical and administrative systems may use different code sets for the same concept (such as SNOMED for problems and ICD-10-CM for diagnoses). For example, it is unclear whether Recommendation 3 would result in a policy that requires all diagnoses for every purpose be captured using only one code set (e.g.—either SNOMED or ICD-10-CM must be selected for all diagnosis data elements) or whether a diagnosis data element that is part of a pre-authorization data set should be coded in a single, standard code set.

It is also unclear whether all stakeholders will have an opportunity to participate in this convergence process. As written, the recommendation only refers to a range of federal agencies and "voluntary consensus standards organizations." However, successful standards adoption will likely be enhanced by input from those with frontline experience who understand the data and workflow needs required by clinical and administrative processes.

AHIMA also agrees with the Task Force's recommendation under Recommendation 3 that the principle of minimum necessary must apply, however, it is unclear whether Recommendation 3 contemplates the need to limit secondary uses of information as well. Addressing secondary use will be key to establish trust.

Recommendation 4: Provide a Clear Roadmap and Timeline for Harmonized Standards

The Task Force recommends that ONC, working with other organizations, establish a clear roadmap and timeline for harmonized standards, following the standards advancement process, including adequate pilot and production usage, to raise the national floor.

AHIMA agrees with the Task Force's recommendation to establish a clear roadmap and timeline for harmonized standards. We recommend that the roadmap incorporate reasonable timeframes that consider the operational realities of the providers and payers expected to use the harmonized standards.

Recommendation 5: Harmonize Code and Value Sets

The Task Force recommends that ONC work with CMS, NLM, and relevant value set authorities to harmonize code and value sets to serve clinical and administrative needs.

AHIMA supports the harmonization code and value sets to serve clinical and administrative needs. Integration of clinical and administrative data will only be successful if code and value sets used to encode clinical data are mappable to the code and value sets used to determine administrative authorization for payment for the orderable, procedure or referral. To do so, there needs to be a detailed and transparent understanding of how code sets are used for administrative and clinical purposes, particularly when different code sets are used for the same underlying concept (such as SNOMED versus ICD/CPT for problems and diagnoses). AHIMA members have considerable expertise in understanding and using code sets. We welcome the opportunity to assist in these efforts.

Recommendation 7: Develop Patient-centered Workflows and Standards

The Task Force recommends that if there is uncertainty on the inclusion of administrative workflows of the designated record set (DRS), that ONC work with OCR to clarify the status of administrative workflows under the HIPAA right of access to ensure that patients have digital access to such data. The Task Force also recommends that ONC work with other federal actors and standards development organizations to prioritize and develop administrative standards that are designed for patients' digital access and engagement.

AHIMA agrees with the Task Force that "Patient at the Center" must be a system design philosophy and built in from the ground up. Patients and caregivers need to be at the center of administrative workflows and administrative standards should be developed and prioritized to enable patients to engage as a key actor. HI professionals play a pivotal role when individuals seek access to their health information, as they are often the frontline professionals involved in helping to facilitate such requests. Since the HIPAA Privacy Rule's inception, HI professionals have led efforts within their institutions to define the DRS. We agree with the Task Force's belief that administrative workflows should be a part of the DRS; should uncertainty arise as to whether such workflows should be included in the DRS, we welcome the opportunity to work with ONC and OCR to ensure that patients have electronic access to such information under the HIPAA right of access.

AHIMA also supports the leveraging of APIs and modern technical standards to facilitate the development of administrative standards designed for digital access and engagement.

Recommendation 8: Create a Standardized Member ID

The Task Force recommends that ONC work with CMS to create and incorporate standards for member ID cards.

AHIMA supports the Task Force's recommendation that ONC work with CMS to create and incorporate standards for member ID cards. As a founding member of the [Patient ID Now Coalition](#), we support the accurate identification of patients to reduce burden for patients, providers and payers. We believe that a nationwide patient identification strategy should be adopted, and we encourage the development of a public-private sector framework that identifies opportunities to enhance patient identification. Along these lines, the creation and adoption of a standardized member ID is an important step in this

direction. However, consideration should be given to CMS' prior work with the development and deployment of the Medicare Beneficiary Identifier to ensure that any creation of standards for member ID cards is not duplicative.

Recommendation 9: Name an Attachment Standard

The Task Force recommends that ONC work with CMS and other federal actors to establish a national approach to exchanging clinical data needed to support clinical information exchange, whether for care delivery or for administrative processes.

AHIMA supports the Task Force's recommendation that ONC work with CMS and other federal actors to establish a national approach to exchanging clinical data needed to support clinical information exchange, whether for care delivery or for administrative processes. The naming of a HIPAA attachment standard would be a positive step forward.

Recommendation 10: Establish Regular Review of Prior Authorization Rules

The Task Force recommends that ONC work with CMS and other federal actors to establish consistent processes and guidelines for prior authorization rulesets to apply to CMS, MA, FEHP, and other federally controlled or contracted plans. The Task Force also recommends that ONC work with CMS and other federal actors to establish transparency in the prior authorization process via published metrics on authorization and denial rates, rates of appeal, and metrics on appeals.

AHIMA is concerned that providers are not included in the establishment of a regular review of prior authorization rules under Recommendation 10. If the intention of the process is to simplify and remove rules that have high burden, it is important for providers to be a part of this review process given that the prior authorization rules apply to them. It is also unclear whether Recommendation 10 intends to suggest that CMS and other federal agencies referenced will establish requirements or other incentives to ensure that plans engage in regular review of prior authorization rules and take steps to simplify them.

Recommendation 11: Establish Standards for Prior Authorization Workflows

The Task Force recommends that ONC work with CMS, other federal actors, and standards development organizations to develop programmatic (API) specifications to create an authorization (electronic prior authorization or related determinations such as medical necessity), such that the authorization and related documentation can be triggered in workflow in the relevant workflow system where the triggering event for the authorization is created. The Task Force also recommends that ONC work with CMS and other federal actors overseeing benefit plans to establish policy mechanisms to provide or incent increased benefit transparency and automated electronic prior authorization.

AHIMA suggests that any development of automated approaches cited in Recommendation 11 must be accompanied by an evaluation of workflows, technical needs and workforce implications for providers. In addition, it is unclear how the HITAC would recommend that ONC work with CMS and other federal actors to support the transition to increased benefit transparency and automated electronic prior authorization. Changes of this scale generally require coordination across parties to avoid a "mixed model" where providers will be obligated to follow different approaches for different payers.

Recommendation 12: Create Extension and Renewal Mechanism for Authorizations

The Task Force recommends that ONC work with other federal actors and standards development organizations to develop programmatic (API) specifications to renew or extend an authorization where prior authorization applies to services that have long durations.

AHIMA supports the Task Force's recommendation that ONC work with other federal actors and standards development organizations to develop API specifications to renew or extend an authorization where prior authorization applies to services that have long durations.

Recommendation 13: Include the Patient in Prior Authorization

The Task Force recommends that ONC work with CMS and other federal actors administering health benefits (e.g., FEHP, Tricare, VHA) to ensure that prior authorization systems be designed with patient engagement as a critical design goal, such that the patient is included throughout the process.

AHIMA agrees with the Task Force's recommendation that prior authorization systems be designed with patient engagement as a critical design goal, as to include the patient and/or their caregiver throughout the process. However, it is unclear as to how ONC, CMS, and other federal actors charged with administering health benefits will implement this laudable goal.

Recommendation 14: Establish Patient Authentication and Authorization to Support Consent

The Task Force recommends the creation of standards that will enable patients and caregivers to authorize the sharing of their data with the tool of their choice to interface with their corresponding provider and payer systems.

AHIMA agrees with the creation of standards that will enable both patients and caregivers to authorize the sharing of their data with the tool of their choice to interface with their corresponding provider and payer systems. AHIMA also supports the establishment of a standard for third party authorization that allows patients to access and bidirectionally share their data across the landscape. However, consideration must be given to the security implications associated with third-party authentication. Consideration should also be given to the operational impact of bidirectionally sharing of data between provider and payer systems at the patient's request, including the need to maintain data integrity and data quality.

Recommendation 15: Establish Test Data Capability to Support Interoperability

AHIMA supports the Task Force's recommendation that HHS develop a national approach to have test data beds to drive innovation and ensure real-world functionality and interoperability. However, we believe that Recommendation 15 is foundational to the success of many of the other recommendations that have been proposed in the draft report. We recommend that the HITAC and the Task Force consider including this recommendation at the beginning of the recommendations to underscore its foundational importance vis à vis the other recommendations.

We appreciate the opportunity to offer comments on the Task Force's draft recommendations on the convergence of clinical and administrative data. We hope that you will continue to engage extensively with stakeholders on these critically important recommendations and we look forward to working with

you to ensure the successful implementation of these recommendations. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Vice President, Policy & Government Affairs, at lauren.riplinger@ahima.org and (202) 839-1218.

Sincerely,

Dr. Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer
AHIMA

Cc: Dr. Thomas Mason, Chief Medical Officer, Office of the National Coordinator for Health IT
    Alix Goss, Co-chair, ICAD Taskforce
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