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Co-Chairs, National Committee on Vital and Health Statistics (NCVHS), Subcommittee on Standards
3311 Toledo Road
Hyattsville, MD 20782-2002

Re: Request for Comment

Submitted electronically to: NCVHSmail@cdc.gov

Dear Mr. Landen and Ms. Love:

Thank you for the opportunity to provide input to the National Committee on Vital and Health Statistics (NCVHS), Subcommittee on Standards Request for Public Comment on Healthcare Standards Development, Adoption, and Implementation.

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.

AHIMA applauds the Subcommittee's intention to understand the extent to which current and emerging standards for exchanging electronic health-related data under the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal legislation and regulatory processes are meeting the business needs of the healthcare system.

AHIMA offers the following comments regarding the request for public comments.

Opportunities to Improve Data Sharing (Question 1)

This section of AHIMA's comments is focused on the area of enhancing the exchange of clinical and administrative data, and particularly the exchange of clinical data in support of administrative activities. As noted in the background section of the Request for Comment, "Administrative and clinical data flows are frequently co-mingled and used in both the same and different systems or by the same entities; data can no longer be considered separate and distinct, or in silos." However, administrative transactions that require the sharing of clinical information often includes time-consuming and costly processes that involves a considerable amount of manual work and use of multiple portals, phone calls, and faxes.

AHIMA members experience numerous challenges exchanging health information between providers and payers on a routine basis. Last year, AHIMA convened a group of members to examine what is happening on the ground when providers share clinical data with payers, including various prior

authorization processes, concurrent reviews, and post-discharge processes. Our members' experiences confirm that exchanges of all sorts suffer from variability, lack of clarity about the documentation that is needed, changes in rules over time and without notice, and the need for multiple formats for sharing information, even for a single patient stay or encounter.

AHIMA believes there are a number of things that could be done to improve data sharing between different actors including advancement of a number of recommendations made to the Office of the National Coordinator for Health IT by the Health Information Advisory Committee (HITAC) in 2020. Key recommendations that AHIMA believes should be advanced include:

- **Convergence of Healthcare Standards:** Harmonizing standards to create a consistent set of standards for code sets, content, and services must evolve together to address clinical and administrative workflows. Such harmonization must include content and classification standards to enable more automated transactions. Additionally, such efforts should allow for all stakeholders to participate in the process to allow for input from frontline professionals that understand the data and workflow needs required by administrative and clinical processes. Consistent with the HITAC's recommendations, the principle of minimum necessary must also apply to limit unnecessary or inappropriate access to and disclosure of protected health information. Given the considerable expertise the NCVHS brings, the Committee could make significant contributions in this area.

- **Harmonized Code and Value Sets:** Integration of clinical and administrative data will only be successful if code and value sets used to encode clinical data are linked to the code and value sets used to determine administrative authorization for payment for the orderable, procedure, or referral. Having a detailed and transparent understanding of how code sets are used for administrative and clinical purposes is critical to successful integration of these two distinct data streams, particularly when different code sets are used for the same data element (e.g., SNOMED-CT versus ICD/CPT). The Committee could make significant contributions in this area by recommending the National Library of Medicine (NLM) examine how code sets are used for administrative and clinical purposes, and share such findings with relevant stakeholders.

- **Clear Roadmap and Timeline for Harmonized Standards:** A clear roadmap and timeline are necessary to ensure the successful convergence of clinical and administrative data streams. This roadmap must include reasonable timelines that reflect the operational realities of the providers and payers that will be expected to use the harmonized standards. This means recognizing workforce development needs, including shifts in needed capabilities and training on new standards or new versions of existing standards, vocabularies, technologies, and processes.

- **Develop Patient-centered Workflows and Standards:** "Patients at the center" must include a systems-design philosophy and be built in from the ground up. Patients and caregivers need to be at the center of administrative workflows. Administrative standards should be developed and prioritized to enable patients to engage as key actors. Application programming interfaces and modern technical standards also should be leveraged to facilitate the development of administrative standards designed for digital access and engagement.

- **Adopt a Member ID Card Standard:** A standard ID card would enhance patient identification, thereby reducing burdens for patient, providers, and payers and enhancing clinical and administrative automation and transparency between the member/patient, provider, and plan.

- **Name an Attachment Standard:** The naming of a HIPAA attachment standard would be a positive step forward in helping to establish a national approach to exchanging clinical data to support clinical information exchange, whether for care delivery or for administrative processes.

- **Include the Patient in Prior Authorization:** Prior authorization systems must be designed with patient engagement as a critical design goal to ensure that patients and/or caregivers have the opportunity to participate and engage throughout the process.

- **Establish Patient Authentication and Authorization to Support Consent:** Standards should be created to enable patients and caregivers to authorize the sharing of their data with a tool of their choice to interface with their corresponding provider and payer systems. This includes the establishment of a standard for third-party authorization that allows patients to access and bi-directionally share their data across the landscape. Consideration must be given to the security implications associated with third-party authentication. Additionally, consideration must be given to the operational impact of sharing bi-directionally data between provider and payer systems at the patient's request, including the need for robust data integrity and data quality practices.

- **Establish Test Data Capability to Support Interoperability:** Establishing a national approach to testing capabilities is necessary to drive innovation and ensure real-world functionality and interoperability. Additionally, such capability is foundational to ensuring the success of many of the recommendations put forth by the HITAC ICAD Task Force.

In addition to the HITAC recommendations cited above, AHIMA believes that a number of recommendations proposed by this Committee as part of its Predictability Roadmap in 2019 to improve the adoption of national standards for the healthcare industry should be advanced, including modernization of the existing HIPAA transaction standard and operating rule process to one that is industry-driven and supports the use of updated transaction standards and operating rules when updates to the named standards become available. Furthermore, the promotion and facilitation of voluntary testing and use of new and/or updated transaction standards and operating rules prior to their adoption through sub-regulatory guidance should also be advanced to improve data sharing. That said, the use of updated transaction standards and operating rules should be voluntary. Positive incentives should also be deployed to encourage the adoption and use of transaction standards and operating rules. Key findings also should be disseminated and shared when new and/or updated transaction standards and operating rules are tested or used to identify challenges, improve processes, and encourage adoption of the transaction standards and operating rules by other stakeholders.

Barriers to Improving Data Sharing (Question 1)

There are a number of challenges associated with improving data sharing among patients, providers, payers, public health systems, and other actors in healthcare that must be addressed**.** These include:

- **Lack of Standardization for Business Processes:** As noted above, existing prior authorizations and authorizations for inpatient care are characterized by variability in the data requested to make a determination—both across payers and across plans offered by a given payer. Greater predictability is needed by providers and payers should provide notice to providers if their criteria changes. Opportunities for providers and payers to work together to create more standardization and predictability, such as CAQH CORE's creation of operating rules for administrative transactions, might be one pathway to further standardize business processes.

- **Operational Issues:** New approaches to enhancing data sharing must take into account existing workflows and operations to better understand how future roles and technologies will need to evolve. Furthermore, administrative transactions currently flow through a significant existing infrastructure. As policymakers contemplate changes to the existing system, consideration should be given to "what works today" to avoid disruption to the revenue cycle.

- **Technical Issues:** New approaches will require a deeper understanding of the shift in information technology needs, as well as investment and deployment of appropriate systems which could impose a significant cost burden on providers. Additional challenges may include the timing and scale of deployment. Expectations must be clear as to whether all plans will be required to shift to more automated approaches or whether there will be a mixed model where providers are expected to send data to different places in different formats.

- **Workforce Implications:** New approaches to data sharing may require a different skill mix, including shifts in needed capabilities, training on new technologies and processes, and the potential for significant workforce re-alignment.

- **Alignment and Accuracy of Vocabulary Standards:** Data interoperability enables providers and payers to coordinate care among organizations and act based on comprehensive and current information. The scope of data interoperability has expanded to encompass social and behavioral services, public health, cost and quality assessment, and research, in addition to administrative uses. Terminology standards, therefore, must be multifaceted and meet the needs of the industry. They must be credible, comprehensive, and developed using rigorous and evidence-based processes.

  ICD-10-CM, ICD-10-PCS, and CPT® are terminologies that are foundational for describing medical services and procedures. They are universally trusted by the health care system, evidence-based, timely, and reflect current clinical practice in a common medical language. They are also embedded into today's operations of coordinating patient care in a manner that cannot be simply replaced.

  The maintenance bodies for these terminologies continually demonstrate successful coordination in the development, adoption, implementation, and conformity of the standards across disparate health-related data systems. The code sets will continue to play a critical role in data sharing among providers, patients, payers, public health systems, and other actors in healthcare. These reliable and trusted terminologies must continue to be supported.

  Today, clinical and administrative data may rely on different standards for similar data elements (such as SNOMED/HL7 versus ICD/CPT for problems and diagnoses). Currently, we lack a consensus-based map to accurately and consistently link the different standards. While many

electronic health record (EHR) vendors include mappings, they are generally unique and proprietary. A single, transparent, national mapping effort led by the NLM could possibly address this issue, but would need to be accompanied by an external validation process, including experts in the codes sets being mapped to ensure widespread acceptance and use. Similarly, the Secretary of the US Department of Health and Human Services (HHS) should approve the *Criteria for Adoption and Implementation of Health Terminology and Vocabulary Standards* and the *Guidelines for Curation and Dissemination of Health Terminology and Vocabulary Standards* to guide current and future health terminology and vocabulary initiatives and to assist with further alignment, curation, and dissemination. Given the considerable work the NCVHS has done in developing these criteria and guidelines, the Committee could provide significant insight in this area.

- **Data Integrity**: Data integrity is a particular challenge today and limits the ability for semantic interoperability. In addition, given the lack of a solution to the patient matching problem, high duplicate error and/or overlays can lead to patient safety issues. Additional work is needed to advance a national strategy to address patient identification and matching, which could improve data integrity.

- **Privacy and Security**: Ensuring the privacy, security, and confidentiality of a patient's health information is an obligation that providers take seriously. Increased sharing of health information across payers and providers requires careful consideration of privacy issues, including ensuring that only the minimum necessary information is shared and uses beyond the specific transaction are limited. With respect to security, challenges with authorizing and authenticating data recipients before exchange represents a particular challenge. The lack of a national approach to accurately identify patients further complicates this issue.

- **Trust and Representation:** Trust among individuals, payers, and providers is key to improving data sharing. Should clinical data be re-used for other purposes outside of the specific transaction in question (e.g., underwriting, setting premiums, or benefits design), it could have a profound impact on individuals. Similarly, such information could be used for other purposes such as contract negotiations between providers and payers. In both instances, trust may be easily eroded. Participation by all parties is critical to ensure that operational and trust considerations are addressed.

Considerations to Support Interoperability, Burden Reduction and Administrative Simplification (Question 2)

We applaud the Subcommittee for recognizing in the background section of the Request for Comment the need to improve "coordination of standards development, adoption, implementation, and conformity across disparate health-related data systems." As the NCVHS examines new standards or use cases for recommendation to HHS in support of interoperability, burden reduction and administrative simplification, multi-stakeholder collaboration and coordination are a critical aspect of this effort. This includes establishing clear roles and responsibilities of stakeholders and agencies involved in the process. Such collaboration and coordination is necessary when considering the roles and responsibilities the advisory committees, such as this Committee and the HITAC, have to play as well as federal agencies such as CMS, ONC, NLM, and others with respect to the convergence of clinical and administrative data. Without strong coordination, stakeholders may be left with inconsistent or

incomplete direction, or find themselves in a situation where systems are still not able to communicate efficiently and effectively even after adoption of new standards.

Along these lines, we believe that the NCVHS has a unique role to play in aligning standards and ensuring that as data are exchanged, they are semantically interoperable to ensure the integrity and fidelity of the data itself. This means leveraging the NCVHS' unique expertise to promote the development of code sets, terminologies, and value sets that support semantic interoperability.

Ensuring that all stakeholders "move together" to create more certainty and consistency for providers and payers when adopting new standards is also a key consideration in supporting interoperability, burden reduction, and administrative simplification. This includes having a clear and comprehensive understanding of the impact of the standard and related implications. For example, as the US begins to contemplate a transition from ICD-10 to ICD-11, there are still considerations related to ICD-11 that must be taken into account, including whether ICD-11 provides significant opportunity to reduce provider burden and increase interoperability of electronic health information. Research and evaluation of ICD-11 are needed to estimate the costs, benefits, and opportunities of moving to ICD-11, as well as to evaluate the impact of alternative transition timelines. However, as ICD-11 evaluation activities and development of a transition strategy move forward, there remains an opportunity to more fully realize the benefits of ICD-10 and further demonstrate ICD-10's return on investment in the interim. Since ICD-10 was implemented in the US for morbidity use just six years ago, the growing amount of high-quality ICD-10 data offers opportunities to further leverage the increased specificity and level of detail in ICD-10-CM and ICD-10-PCS and begin to realize some of the longer-term benefits of ICD-10.

Role of NCVHS (Question 4)

As an advisory body to HHS, the NCVHS has a crucial role to play given its knowledge of terminologies, use of standards, and the importance of such standards to be specific and communicated to healthcare stakeholders at-large on a transparent timeline that takes into account both standards adoption and implementation. This includes the Committee's knowledge and understanding of the operating rules and how new standards may be used and implemented, consistent with the operating rules, or with similar types of guidance if the standards do not support specific HIPAA transactions. Given the depth of the Committee's expertise, the NCVHS can play a critical role with the detailed-level coordination needed to advance this critical work.

We appreciate the opportunity to respond to the Subcommittee's request for public comment. Should you or your staff have any additional questions or comments, please contact Sue Bowman, Senior Director, Coding Policy and Compliance at sue.bowman@ahima.org or Lauren Riplinger, Vice President of Policy & Government Affairs, at lauren.riplinger@ahima.org.

Sincerely,

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