HIT Standards Committee
FINAL
Summary of the July 17, 2013 Meeting

ATTENDANCE

The following members attended the meeting:

- Dixie Baker
- Kevin Brady for Charles Romine
- Steve Brown
- Anne Castro
- Jeremy Delinsky
- Lorraine Doo
- Tim Cromwell
- Jeremy Delinsky
- Floyd Eisenberg
- Jamie Ferguson
- Keith Figlioli
- Lisa Gallagher
- John Halamka
- Leslie Kelly Hall
- Stanley Huff
- Elizabeth Johnson
- Rebecca Kush
- Anne LeMaistre
- David McCallie, Jr.
- Kim Nolen
- Jonathan Perlin
- Wes Rishel
- Eric Rose
- Christopher Ross
- Andrew Wiesenthal

The following members were absent:

- John Derr
- C. Martin Harris
- Arien Malec
- Nancy Orvis
- Sharon Terry

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 49th meeting of the Health Information Technology Standards Committee (HITSC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting with two opportunities for public comment, and that a transcript will be posted on the ONC website. She instructed members to identify themselves for the transcript before speaking. She asked members to introduce themselves with their affiliations.

Remarks

David Muntz, Principal Deputy National Coordinator, thanked MacKenzie Robertson for her work with ONC and the FACAs. He introduced Michelle Consolazio as the new FACA Lead. He referred to the good press recently enjoyed by ONC. Farzad Mostashari was interviewed on NPR. That day's *USA Today* money page contained an article on health IT (HIT). Mostashari and Patrick Conway testified today before the Senate Finance Committee.

Review of the Agenda

Chairperson John Perlin declared that the great story of HIT was reflected in the agenda items. He thanked everyone; much has been accomplished. Many milestones have been met. He thanked Robertson for her support. The purpose of the FACA is to provide transparent feedback. He welcomed new members. He inquired about objections, corrections, modifications, improvements, amendments, or additions to the meeting summary distributed with the meeting materials and, hearing none, announced the acceptance of the summary of the June 2013 meeting as distributed.

Action item #1: The summary of the June 2013 HITSC meeting was approved as circulated.

Comments

Vice Chairperson John Halamka commented on the challenging times. With ICD 10, new cost control and reimbursement models, and Stage 2 creating pressures in members' organizations, it is difficult to sustain the momentum for FACA volunteer work. He mentioned each of the agenda items. Each contains important issues, such as non-repudiation.

Clinical Operations Workgroup (COWG) Update

Halamka, who is also co-chair of the workgroup, announced the presentation of a report on formulary and benefit. Workgroup Chairperson Jamie Ferguson explained the need to separate administrative transactions and the clinical utility of the information, including drawing parameters between the two. He expected the discussion to result in definition of boundaries. The formulary and benefit item was a follow-up to a report by Kim Nolan and John Klimek at the June meeting. Nolan reminded the members that questions asked at the June presentation guided the current presentation. She noted that e-prescribing is intended to assist clinical decision making. She mentioned a study on the use of medication and non-adherence that found that 24 percent of prescriptions were not filled and picked up by patients. 80 percent of prescriptions not covered by benefits were not picked up.

The core measure is to generate and transmit permissible prescriptions electronically (eRx). In Stage 1, more than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. In Stage 2, more than 50 percent of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology. The sender is responsible for: maintaining updated formulary and benefits information; publishing the information regularly to keep recipients up-to-date; and providing a means for linking a patient to a formulary, either through a cross-reference list or through an eligibility transaction. The intermediary is responsible for: facilitating the distribution of formulary and benefits information between the formulary publishers and retrievers; documenting and communicating the data load specifications, processing, and usage guidelines particular to the service; and validating transmitted files against the standard specification (optional). The technology vendor is responsible for: accepting or retrieving the formulary information from the sender (directly or via an intermediary) and integrating it into the point-of-care application; associating formulary and benefits information to the patient or group, as appropriate, using the cross-reference list or an eligibility transaction; and in the context of a prescribing system, presenting the formulary and benefits information to the physician during the prescribing process, enabling him/her to make the most appropriate drug choice for the patient.

She showed a slide and described challenges with data quality, data availability, system design, and data usefulness. They then answered the questions asked in June:

- Is RxNorm a replacement for NDC or in addition? RxNorm is in addition to because some products do not have RxNorm codes. Pharmacies need the NDC for inventory, recalls and reimbursement.
- Where is PCN/BIN/Group exchanged or seen? It can be seen via a match. But today providers do not see this information. They need to have a more accurate formulary at the point of care.
- Is formula and benefit data direction or actual? They are directional.
- What version of F&B is needed for ePA? The transaction standard recently balloted under the script standard is moving forward.
- How feasible is a real-time transaction? Some private entities have tested the transaction. It is possible in incremental steps; but it is difficult when trying to obtain co-pay structure information due to the time gap between the information generated and presentation for payment at the pharmacy.
- Is this in alignment with Medicare part D? The new fee schedule is in the comment period. V3.0 was recommended by NCPDP and it aligns with part D.

Klimek presented the revised commendations:

> Short term: NCPDP Formulary & Benefit Standard Version v3.0 (Current standard – batch files) should be supported in CEHRT for F&B transmission to EHRs. F&B transmission with NCPDP 3.0 should be required to use RxNorm in addition to NDC to facilitate accurate exchange of data and to reduce file size. Certified EHR Technology should have the functionality to match the patients not only to their medical benefits but also to their pharmacy benefits utilizing PCN/BIN/Group. Certified EHR Technology should be required to support acceptance of automatic updates or push functionality to update F&B data at the provider level to minimize latency in information at the point of care. F&B data presented at the point of care should, at minimum, represent the patient's group pharmacy benefit.
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> Long term: Certified EHRs should develop the functionality to run patient level formulary checks against the patient's actual drug benefit for a specific drug and dose in a timely manner. A new standard or transaction is required.

Discussion

Kelly Hall spoke about harmonization with other efforts, in particular, shared decision making with patients. Patients want providers to be kept up to date with their benefits. It should not be assumed that problems can be resolved at the pharmacy. She expressed concern that the recommendations were biased toward reduction of large files. The recommendations are too narrow. Klimek agreed that the recommendations were just scratching the surface. Nevertheless they give providers a tool to get some useable information. The standards work. It is better for patients to know that some of the information used by the provider is correct even though the information is not 100 percent complete. Halamka said that in conjunction with Health eDecisions, these recommendations would standardize current practice as a first step. Kelly Hall continued to express opposition, saying that this was the first opportunity to take cost into account in shared decision making and should not be a missed opportunity.

Eric Rose reported on his use of the technology in his clinical practice. It provides many opportunities for efficiency and better patient care, but usability of the data is an issue. Although the technology can handle complex formulary information, pharmacies use a less precise categorization scheme, which is not useful at the point of care. The patient needs to have the same information at the point of care as when she presents at the pharmacy. It should be possible to inform the patient about a range of possible costs and let

the patient make decisions based on that information although the information may not be exact. Klimek acknowledged that although it might be possible to get to a range, it is not possible to state the actual cost. Patients could be informed of the actual cost "if you fill it right now" before other prescriptions are entered or before benefits change. Perlin summarized that several principles had been described: inefficiencies in the download of large files, data at the point of care, and the challenge of rational standards applied to an irrational world. He said that they should be realistic yet aspirational.

McCallie urged fixing the problem prior to the application of this incremental approach. He agreed with Rose and Kelly Hall that the more fundamental issue should first be addressed. Halamka wanted a statement from the HITSC on aspiration. Are the goals articulated by the members' comments on NCPDP's roadmap? Klimek repeated his argument for an incremental approach. Because of the complexity of the standards, one cannot predict when a more complete approach will be available. Observing that an aspiration is not the same as specifying a trajectory, Perlin asked Nolan and Klimek to work with the committee on a trajectory.

Doug Fridsma, ONC, observed that the recommendation is to move from NDC to RxNorm. The discussion suggests a need for another content standard that allows for granularity. There may be a need to get to RESTful. Work on content and transport standards is needed. Consistency on vocabulary is needed. Halamka summarized that the members seemed to favor moving to RxNorm for vocabulary and moving away from batch to a real time query approach. He defined the choice before the committee as improving the current setting versus asking the workgroup to delineate and move on a trajectory.

Comments continued. Wes Rishel observed that NDC may not have the appropriate membership to represent EP users. There is room for harmonization and taking the physician workflow into account. He wants EPs to be able to look at therapeutic alternatives. ONC should examine the available policy levers to improve the uptake once the standards are in place.

Andy Wiesenthal noted that ACOs need real time information. Integrated systems deliver this information to the point of care.

Halamka declared consensus that the status quo is not sufficient. Real time information on formulary benefits is needed by physicians and patients at the point of care. The recommendations are acceptable for setting direction only. For Stage 3, real time information will be required.

Clinical Operations Workgroup (COWG) Update Continued

Halamka reported on image exchange. The workgroup considered three use cases: provider to provider, provider to patient (patient mediated provider to provider exchange), and group sharing. In order to gather information, the workgroup heard on June 28 a presentation on RSNA image sharing by David Mendelson from Mount Sinai and Keith Dreyer from Mass General. Several members of the Consumer Technology Workgroup attended. Mendelson and Dreyer emphasized the flexibility of the RSNA solution set for a zero footprint consumer to enable both her own use of her images as well as sharing of complete DICOM with other radiologists and clinicians. As a result of the presentation, members realized the need to more narrowly target any recommendations. Mendelson and Dreyer said that the current cost of the sharing facility is about $1 per GB or 50 cents per CT, and about 1 of every 8 images has been shared (100k of 800k at Mass General), a higher proportion than was anticipated. There were mixed views on solutions for ACOs depending on the HIE capabilities in place. Some were just adding on images to existing XDS infrastructure; others needed to use Direct image sharing because they lacked infrastructure. The RSNA specs enable all modes. Testimony from cloud-hosted image exchange vendors is scheduled for July 19.

Discussion

McCallie wondered about the reasons for moving to an edge server. Halamka responded that providers did not want images pulled through their fire walls. Alternatives are being investigated. Kelly Hall noted the cost issue and RSNA being more scalable. McCallie opined that publishing the URL should be simple.

Implementation Workgroup Update

Chairperson Liz Johnson announced that the HITSC Implementation Workgroup, the HITPC Meaningful Use Workgroup, and the Certification and Adoption Workgroup will sponsor a joint hearing on implementation and usability on July 23, 2013 from 9:30 a.m. to 4:30 p.m. Four panels are planned consisting of: EPs, EHs, HIE and interoperability, and usability. The latter will include a presentation on the application of human factors research. The hearing is an opportunity to affect the Stage 3 objectives. Specific questions have been addressed to each panel. The questions, which Co-Chairperson Cris Ross reviewed, were listed on the presentation slides. The three workgroups will meet jointly on the day followed the hearing.

Discussion

Wiesenthal inquired about plans for interpreting the testimony, much of which will likely be negative. He asked what was expected from asking vendors for scientific evidence on usability. Johnson responded that the members will take the issues and work with the testifiers on defining various solutions. They may come up with innovations. They will help identify those objectives not working as intended. Ross talked about the role of the FACA being to raise issue for ONC's attention. Should ONC develop standards for usability? Can usability be regulated? What levers can ONC apply to supplement regulation? He advocated keeping the eyes on the prize. Johnson said that the human factors research indicates vendor commitment.

Lisa Gallagher reported that CMS had convened a hearing on usability. She wondered whether the workgroup members were aware of CMS efforts. There may be overlap.

Stan Huff talked about his experience at Intermountain concerns. The meaningful use criteria had unexpected results. He described an example with immunizations. Although his employer uses an integrated state provided application to add data to the registry, certification required sending immunization data via HL7 message to the state. Intermountain staff had to create something that was never used. Regarding electronic orders, he wondered whether physicians are always the best ones to enter orders. And is it really good for one specialist to reconcile meds for other specialists? Over regulation has reduced innovation and usability. He suggested a bigger discussion on interoperability of information exchange rather than focusing on these process measures. Perlin said that HITPC issues may be involved. He will take them up with Paul Tang.

Baker pointed out that the questions were health system focused. What about patient generated data and outside the box solutions? Mobile apps and home care devices must be considered. Did the workgroup members think about asking about information coming from outside systems? Johnson indicated that she will take those questions under consideration. Perlin referred Johnson and Ross to information from a hearing on patient generated data.

Muntz suggested asking the deeming questions to both EPs and EHs. Workflow and patient life flow issues should be considered. He advocated broadening usability to pragmatism: What are the pragmatic implications? Also, culturally competent care is part of usability. How data are requested and presented have cultural implications.

Fridsma spoke about where in the process incentives for usability can be applied. FDA uses both pre and post marketing. Whatever the solutions, they must be actionable. Action involves cost.

Another member reported on his 20 years of experience with usability. What worked was to let customers write and rewrite their own documentation. Innovation is essential for usability. Customers must be able to innovate on top of long term contracts. Perlin noted that it was too bad committee members were not invited to testify. It is challenging to find the sweet spot between over-prescriptive regulation and maintaining an environment conducive for innovation.

Public Comment

Consolazio announced the three-minute limit on comments.

Tom Bizzaro, a pharmacist employed at First Data Bank and President, NCPDP Board of Trustees, commented that formularies are not built at the NDC level. He endorsed smaller files and giving doctors as much formulary information as possible. EHR vendors would have to integrate the formularies. Another concern is the cost of the transaction fee and the physician's time.

Gary Dickerson related a personal experience with a prescription filled by a U.S. pharmacy. The cost without his pharmacy benefit was $220, which was reduced to $50 once his benefit kicked in. While traveling in China, he took his brand name med to a hospital pharmacy where he received his medication for a charge of $3. Doctors need to review options with the patient at the point of care in order to maximize their leverage over cost factors.

Following the lunch break, Consolazio announced that Anne Castro and Keith Figlioli had joined the meeting. She announced a change in the order of the remaining agenda items.

ONC Updates

Fridsma reported that 2,700 individuals have participated in the wiki. Sixteen-hundred workgroup meetings have been held. He noted the current status of each item on the portfolio slide. For instance, Health eDecisions has developed three use cases. The Knowledge Artifact Sharing Model, Schema and implementation guide was approved by HL7. One pilot is complete. The CDS Guidance Service achieved consensus. Standards were identified and vMR was aligned with C-CDA. QRDA is working on the HL7 ballot for the second use case. For Blue Button Plus, additional functions for clinical and financial data, and images are being built. RESTful is being considered for transport. RESTful is not restricted to Blue Button; it could be used to pull to receive updates, for instance, to subscribe to and receive formulary benefit updates. Regarding structured data capture, work is underway to identify a standard for granular data and a container. Collaboration with UK and other European countries was recently initiated on an internationally recognized Blue Button standard to enable global alignment. The Data Access project was announced July 16 to give providers access into their own records for small analytics. It will begin to support targeted queries and eventually merge with Query Health, a mechanism for access.

Fridsma referred to a map that showed the entire country covered with ONC projects. Referencing the standards readiness slide, he said that the HITSC could identify next steps. The Standards Implementation and Testing Environment (SITE) now includes an issue tracker. ONC is working with CMS and others on quality measures. Sometimes policy issues are involved. The tracker allows for triage. ONC staff is working with HL 7 and other standards bodies. They have developed a sandbox for the use of C-CDA. Functionalities will be built out. For more information, visit: http://wiki.siframework.org/.

Q&A

Jeremy Delinsky said that provider disclosure requirements may create barriers to the use of many of the efforts. Fridsma responded that he had learned from Query Health and Direct to engage the HITPC Privacy and Security Tiger Team early on and prior to the pilots.

Acknowledging that the SITE is promising, McCallie pointed out that the HITSC should have a procedure and check points for reviewing the projects. Which use cases require the most advanced notice

to vendors? Which are priorities? Vendors want to know where ONC is headed. He suggested that the HITSC review the use cases. Fridsma recognized the idea as a good one. He will give a more detailed report in the future in order to elicit feedback. Staff has contacted Commonwell and other organizations and HL7 to identify appropriate use cases. He announced that a meeting on the data access framework will take place next week. McCallie went on to say that the unification of Blue Button and another standard would allow vendors to use one technology on several applications.

ONC Updates Continued

Jodi Daniel, ONC, showed slides and talked about the HIT Patient Safety Action and Surveillance Plan, which was released July 2. Preliminary work was done by IOM. IOM recommended a safety plan. ONC staff worked with HHS sister agencies. Staff considered input from the HITPC as well as public comments on an earlier draft, which was released in December 2012. The plan considers potential benefits and potential risks. The Safety Plan seeks to use HIT to make care safer; while continuously improving the safety of HIT, and to promote a culture of safety. On July 2, 2013, ONC issued guidance to its Authorized Certification Bodies (ONC-ACBs) explaining their responsibilities for conducting live surveillance of certified EHR technology. The ONC-ACBs will perform live surveillance of certain safety-related capabilities (CPOE, drug-drug and drug-allergy interaction checking, and medication reconciliation). The results will provide insight into how these capabilities perform in actual clinical environments, and will help staff understand and mitigate the risks associated with these capabilities. They will also examine developers' processes for receiving and responding to user complaints related to the safety of developers' HIT products. ONC is strongly encouraging ONC-ACBs to make the results of their surveillance publicly available. This will promote transparency and provide users and customers with better comparative information when selecting HIT products and services.

Daniel reported that collaboration with The Joint Commission involves a 1-year contract with option year. Performance began June 3, 2013 to: investigate HIT-related sentinel events in hospitals and ambulatory practices; conduct research on a large national database of HIT-related sentinel events; and provide ONC with de-identified reports on actual investigations, including findings and recommendations; and examine and provide recommendations on the role of external oversight bodies in ensuring HIT patient safety.

Regarding certification, on July 10 ONC announced that a mark will appear on EHR products that have been certified by ONC-ACBs. The mark indicates that the product meets the 2014 Edition Standards and Certification Criteria. More information is at: http://www.healthit.gov/policy-researchers-implementers/onc-hit-certification-program. The Update on the Adoption of Health Information Technology and Related Efforts to Facilitate the Electronic Use and Exchange of Information report to Congress covers the period January 1, 2012 to April 30, 2013. It describes CMS' and ONC's efforts to facilitate the nationwide adoption and exchange of electronic health information and identifies and discusses barriers to the adoption and exchange of electronic clinical data, and how HHS programs are helping to address those barriers. Available at: http://www.healthit.gov/sites/default/files/rtc_adoption_of_healthit_and_relatedefforts.pdf

Discussion

Baker asked Fridsma about the level at which standards for regulation are expected. Last month's presentation on Blue Button Plus indicated that it could be a standard itself. What does ONC consider a standard? What does readiness on slide 7 mean? Fridsma responded that Joy Pritts leads the data segmentation efforts, which are closely linked to policy. Nevertheless, he is trying to get technical work done in advance of policy. A better match is needed to prepare for regulation. HITECH authorizes the HITSC to recommend standards. ONC also produces implementation guides. Sometimes several standards are combined into an implementation guide. Some of the implementation guides have been balloted, which makes them a standard.

Observing the many federal agencies mentioned in Daniel's report, McCallie asked what she was doing to avoid a regulatory thicket of many agencies. Daniel replied that PSOs, CMS, and FDA preceded the establishment of ONC. The Safety Plan attempted to take advantage of existing structures and to incorporate safety into existing programs. Collaboration across agencies has increased. An interagency coordinating committee is being organized. The FDASIA Workgroup is addressing duplication in regulation. An open comment period is now in effect.

Gallagher inquired about the rationale for the selection of the AHRQ report form, which does not match the forms used by other agencies. Daniel replied that AHRQ and FDA are coordinating reporting procedures. They focused on the common format because of the role of the ecosystem. The common format is used by EHs. She offered to talk with Gallagher offline.

esMD and Digital Signature Presentation

Melanie Combs-Dyer, CMS, reported that the Office of Financial Management estimates that each year the Medicare FFS program issues more than $28.8 billion in improper payments (error rate 2011= 8.6 percent) and the Medicaid FFS program issues more than $21.9 billion in improper payments (3-year rolling error rate = 8.1 percent). There are 4.8 million claims daily. CMS is mandated to pay claims in 14 days. Little money is allocated by Congress for enforcement. These factors contribute to the high error rate. Most improper payments can only be detected by a human comparing a claim to the medical documentation. Medicare and Medicaid issue billions of dollars in improper payments every year. These are not fraudulent situations, but rather cases in which the health care provider unintentionally fails to comply with the coverage and coding rules. CMS hires review contractors to help find improper payments. Nurses and other clinicians look for these improper payments by comparing the claim to the medical documentation created by the provider at the time of service. Hospitals, physician offices, and other providers receive many requests for patients' medical records every year from review contractors. Health care payers frequently request that providers submit additional medical documentation to support specific claims. Until recently, this has been an entirely paper process and has proven to be burdensome due to the time, resources, and cost to support a paper system.

The ONC S&I Framework Electronic Submission of Medical Documentation (esMD) initiative is developing solutions to support an entirely electronic documentation request. The goals are to: reduce administrative burden; reduce improper payment; and move from "post-payment audit" to prior-authorization or pre-payment review. Requirements are to: move from paper to electronic communication; replace "wet signatures" with digital signatures; and migrate to structured data from unstructured data.

Combs-Dyer went on to explain that the validity of the end user must be determined. There are standards for signing credentials. A mechanism for sending medical documents is now in place. FISMA requires that the end recipient is known. Therefore, a provider will have to register and to update the registration annually.

Bob Dieterle described the work flow. All participants will have a digital identity. They will submit a digitally signed certificate with NPI. The certificate and NPI will be validated with a provider directory. All actors will obtain and maintain a non-repudiation digital identity. The provider registers for esMD. The payer requests documentation. The provider submits a digitally signed document (bundled) to address the request by the payer. The payer validates the digital credentials, signature artifacts and, where appropriate, delegation of rights. If the documents are digitally signed, then the payer validates the document digital signature artifacts esMD AoR Level 2. The project involves three phases. HL7 balloting is expected in September.

According to Dieterle, esMD is based on best practice for: establishing the identity of providers; identity proofing of all participants (individual and organizations); Digital Credential Lifecycle management,

including access to private keys, Digital Signatures Standards, and Delegation of Rights Standards; and addressing Author of Record requirements; and defining requirements for structured documentation that includes digital signatures for proof of provenance.

Q&A

Halamka noted that the presentation required digestion of 27 slides in an abbreviated time period. He observed that the scheduled time for adjournment had passed. He requested a change in the order of the agenda items to allow public comment before extending the scheduled time for Q & A.

Public Comment

None

Q & A Continued

Rishel observed that esMD pays no attention to the overlap with the burden of authentication with DEA. Perhaps ONC can take up the topic. esMD can also be used to deal with the problem of passing information via the patient's PHR for providers that are concerned about modification of the data.

Baker announced that the Privacy and Security Workgroup will schedule a meeting to review esMD. She said that esMD incorporates several internal responsibilities such as assigning contributions. Delegation of rights is typically considered a local responsibility. Also, she said that she understands there is no federal-wide requirement for the federal bridge on acceptance of digital certificates. Combs-Dyer acknowledged that it is the provider's internal responsibility to manage digital certificates, but to approve Medicare coverage an order by a physician is required. Baker wondered why CMS does not believe the provider. Combs-Dyer informed her that 28 billion claims did not meet the requirement last year. OIG oversight and reporting of improver payments are required. Dieterle said that delegation of the right is assigned by an individual or organization. The organization says who can sign on its behalf. CMS wants a non-repudiation assignment of rights. Baker wondered why it could not be done as part of the original identity proofing. Dieterle responded that delegation to whom and for what transaction is required. Halamka asked that the Privacy and Security Workgroup draft a formal response to the presentation; he implied that the process may be overly complex for the expected benefits. Baker replied that many of the issues are policy issues.

Delinsky suggested that the annual enrollment requirement be changed to a one time until changed requirement. Signatures are applied many times in the EHR workflow. It may be reasonable to require a signature at the conclusion of a session, but signature at the sub-session level is not reasonable. Requiring a signature in the EHR before a claim is generated is a problem. Combs-Dyer said that it is required for paper claims; otherwise, the claim is not paid.

McCallie declared that he had seen these slides many times for other use cases. One solution across federal use cases is needed. The DEA work should be leveraged. He asked that CMS coordinate with other agencies. What is the evidence on what percent of fraud would be eliminated by this approach? Combs-Dyer replied that the vision is the burden will be reduced with electronic signatures. If everything from EHRs came in as structured data, CMS could develop computer programs to monitor for improper payments. The esMD approach will be optional. Providers can continue to submit claims by fax, paper, or PDF.

Wiesenthal was adamant that the process will not be used by providers. The SSA disability request process is less complicated and it works. What about the SSA's FISMA requirement? Dieterle reminded him that CMS receives many more claims than SSA does. Furthermore, SSA is not a covered entity. Its approach is not that different. By structured data, the same as the CDA is intended.

Kelly Hall said that consumers and families need to be recognized by authors.

Perlin acknowledged that the meeting did not adhere to the allocated timeframe. He asked that the record show that the HITSC thanked Robertson for her work on its behalf.

SUMMARY OF ACTION ITEMS:

Action item #1: The summary of the June 2013 HITSC meeting was approved as circulated.

Meeting Materials

Agenda
Summary of June 2013 meeting
Meeting presentation slides and reports