The Office of the National Coordinator for Health Information Technology

Transcript

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

May 26, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Alix Goss	Imprado Consulting, a division of DynaVet Solutions	Co-Chair
Sheryl Turney	Anthem, Inc.	Co-Chair
Steven Brown	United States Department of Veterans Affairs	Member
Gaspere C. Geraci	Individual	Member
Mary Greene	Centers for Medicare & Medicaid Services	Member
Alex Mugge	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Thomas Mason	Office of the National Coordinator	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Jacki Monson	Sutter Health/NCVHS	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Ram Sriram	National Institute of Standards and Technology	Member
Debra Strickland	Conduent/NCVHS	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Denise Webb	Individual	Member
Michael Wittie	Office of the National Coordinator	Acting Designated Federal Officer
Josh Harvey	Clinical Services Group of Hospital Corporation of America (HCA)	Presenter

Operator
All lines are now bridged.

Michael Wittie
Good afternoon, everyone. My name is Michael Wittie from ONC. I'm the acting Designated Federal Official today, and welcome to the Intersection of Clinical and Administrative Data, or ICAD, task force. We'll be officially calling the meeting to order now. Let's start with roll call. Do we have…? Well, I know Sheryl is here.

Sheryl Turney
Yes.

Michael Wittie
And, Alix is here. Aaron Miri, are you here? Okay. Abby Sears? Alexis Snyder?

Alexis Snyder
Here.

Michael Wittie
Okay, hi. Andy Truscott? Okay. Anil Jain?

Anil K. Jain
I'm here.

Michael Wittie
Arien Malec?

Arien Malec
I'm here.

Michael Wittie
Great. Debra Strickland? Denise Webb?

Denise Webb
I'm present.

Michael Wittie
Great. Gus Geraci?

Gaspere C. Geraci
I'm here.

Michael Wittie
Hello. Jacki Monson?

Jacki Monson
Here.

Michael Wittie
Great. Jim Jirjis?

Jim Jirjis
I'm here.

Michael Wittie
Great, hello. Jocelyn Keegan?

Jocelyn Keegan
I'm here.

Michael Wittie
Hello. Les Lenert? Okay. Mary Greene?

Alex Mugge
This is Alex Mugge here for Mary Greene.

Michael Wittie
Oh. Hi, Alex. Ram Sriram? Rich Landen?

Rich Landen
I'm here.

Michael Wittie
Hello. Sasha TerMaat?

Sasha TerMaat
Hello.

Michael Wittie
Hello. Steve Brown? Tom Mason?

Thomas Mason
I'm here.

Michael Wittie
Hello. Carolyn Petersen? Okay. Is there anybody I missed? All right, then. Thanks, everybody, for joining, and to the members of the public who are with us. I'm going to turn it over to the co-chairs to begin this meeting agenda. Alix Goss and Sheryl Turney, please take it away.

Alix Goss

Thank you very much, Michael, and for stepping in on behalf of Lauren today. Welcome, everyone, to our pseudo-Monday. It's Tuesday afternoon, and it's time for ICAD. We're going to be picking up where we left off on the ideal state/guiding principle workgroup update to continue reviewing the document that we started last week. We'll then pivot over to a data classes update from Josh and Sheryl, talk about a draft timeline discussion today – I think will be pretty critical to get some feedback on that, so Sheryl and I are looking forward to some feedback on that before going into next steps and, of course, ensuring that we have time for public comment later today. Could we go to the next slide?

We thought it would be good to start out with our usual context-setting. This one is a little bit more far-reaching than just the last week. We thought it would be good to put our arms around the level of work that we've been pursuing since the beginning of March in producing and updating a compendium of historical artifacts, which I think is really foundational to the launch-off point for our vision and charge of addressing the various aspects of prior authorization in the larger conversation of the convergence of clinical and administrative data.

Along the way, we started out with some discussions about use cases and workflow diagrams, and really took a deep dive into examining the wheelchair order process for prior authorization. We've had a variety of small groups doing offline work between our weekly calls around the data classes, categories, and alignment with USCDI. We've been looking at ideal state and guiding principles for our work. That is all captured in our Google spreadsheet. Last week, we kicked off the privacy and security small group. That is a group that's going to take the ideal state and guiding principles more globally that we've been addressing for prior authorization and take a very focused look around privacy and security, and I'm happy to report that group hit the ground running pretty hard last week thanks to the support of Jacki Monson and the others that joined the call – Ram, Sasha, and Denise.

We've also had a number of presentations over the last six weeks, including those from Surescripts, CoverMyMeds, Humana, Cambia, and the American Medical Association, and are currently working on scheduling some additional ones thanks to the industry level of expression in coming to present to us. We also have provided an update to HITAC on our progress, as we reported on last week's call. That paints a picture of the trajectory so far, and we've made a lot of progress, and I'm hoping that with today's work, we can wrap up a few things related to guiding principles and future states as we're looking for some initial feedback on our first summation work, and then, also, after we hear from Josh and Sheryl, I'm thinking the timeline conversation will help us all start to refocus ourselves on the work ahead for the summer. With that context-setting, Sheryl, do you have any additional thoughts or comments?

Sheryl Turney
No, I think you did a great job. Thanks, Alix.

Alix Goss
You're welcome. Okay, what I'd like to do is ask Accel to now start presenting the screenshare that I've offered. Hopefully you'll all see the guiding principles and future state document. Can someone give me a visual clue that you can actually see the Word document?

Sheryl Turney
Yes, we can see it.

Alix Goss
Thank you. All right. So, on last week's call, we started to look at this document. I have updated it to reflect check marks on the items that we actually talked about, and also captured that we've punted on security and privacy pending the small workgroup output, so that means we're going to pick up with the last three categories today. So, first, before I start doing that, are there any general questions from folks on the overview I've just done or on the guiding principles and future state?

Sheryl Turney
I'm not seeing any hands raised, Alix.

Alix Goss
Thank you very much for that. So, we will be picking up with designs for the future while solving the needs of today. I'm just going to walk through these and look for Sheryl to stop me so when we've got questions, we can take those into discussion. Perfection in every scenario is not possible. Let's go for "great enough," covering the vast majority of the cases. Some might think of this as the 80/20 rule, but we do want to make a difference – not only in prior authorization, but in the larger convergence conversation – but we're not going to let perfection be the enemy of the good by going for the majority of the cases.

Our approach should be sensitive to clinician burden to drive adoption and obtain desired results. If a floor is established – meaning related to the standards – no longer a ceiling, ensure corresponding operating rules and regulatory rules allow for rapid standards development and evolution so as to not preclude innovation. The operating rules should continue to raise the foundational level of adoption while encouraging/supporting organizations raising the ceiling capabilities. Those are the four aspects of design for the future. Questions?

Sheryl Turney
Alix, we do have a question if now is a good time to stop. Richard, do you have a question? Go ahead.

Rich Landen
Hi, it's Rich Landen. Question No. 1: I'm concerned with the quantification of "vast majority of the cases." This is a pretty immense field, and I'm not sure that trying to do the vast majority is attainable. I'd like to suggest we limit that language to something more manageable. I agree with the concept – we don't want to boil the ocean, we want to be pragmatic to grow the future – but I don't want to set sights too high, which would preclude us from targeting use cases that are limited in quantity but high in value. Am I making my concern clear?

Alix Goss
Yeah. So, are you thinking that "covering the vast majority of cases" should go, and that we should revamp it with…?

Rich Landen
Yeah. "Vast majority" is my specific concern because to me, that's covering 80% of all prior auth, and that's just way too much. So, I'd choose language that somehow employs the term "significant."

Arien Malec
Why is 80% way too much?

Alix Goss
Hi, Arien. Welcome.

Rich Landen
I think from the discussions and presentations we've had, there's prior auth, and then there's prior auth. There's some simple stuff that I think is attainable, but there are a lot of situations where it's either too complex or, like ordering a wheelchair for discharge after surgery, it's too iterative for the first attempt. So, if we can get 80%, that's great, but I wouldn't – my concern is – I think we need to be a little bit more focused on where we start.

Alix Goss
Arien, did you have any thoughts on that? I heard you pick up there, and I think I see Alexis.

Arien Malec
Yeah. So, I would be an advocate for setting our sights high, and then downgrading in a phased approach. If we set our sights towards automating a small set of cases, then that may be achievable, but not meaningful. I think what we're trying to find is the meaningful portion here. A lot of these things are – do we think that 80% is never achievable, or is this a timeframe question? The other way to address this is to ask if we agree that 80% or 95% is the target, and then we have a timeframe we are seeking to achieve, or do we not think that should be a target at all? I guess that's the way I'd frame my counter-concern. My counter-concern is setting our sights low and achieving them versus – I'd rather our sights high and fall short of the mark than set our sights low and achieve it.

Alix Goss
This is Alix. I want to do just a little bit of housekeeping – all of us should remember to save our names first. The other thing I have from a housekeeping perspective, Sheryl, is that I have figured out how to be able to see the hands raised using two monitors, so I now have the ability to view that. Thank you. I see that Alexis is next in the queue, and then Anil.

Sheryl Turney
And, can we remind people to please raise their hand? When we're done with the hand-raising feature, we'll call for people on the phone that we can't see who are not utilizing Adobe.

Alix Goss
Thank you for remembering that. So, hands raised. Alexis?

Alexis Snyder
I agree with Arien. He pretty much made my point already. I'd just quickly say that if we're making recommendations to the task force for what is supposed to be obtainable for all in the end, I don't think we should be using language like that and try to aim for what works first. It's like we talked about before: What works for the most difficult first may trickle down into everything else getting done for what's easiest, or vice versa, such as maybe saying something more like "We're going to work with simple first as a place to start."

I just don't think we want to start talking about how we're going to help some and not all, and put a figure on that. This would be more meaningful.

Alix Goss
Thank you, Alexis. Anil?

Anil K. Jain
I tend to agree. I think the goal here would be that if we were trying to find something that's more quantitative than qualitative, it's going to be very difficult to do for all the reasons that were discussed. So, given what section this is in, I would recommend finding some general language that supports the intent of what we just discussed and move on. Otherwise, we could get into a semantic issue that could derail us from getting through all the other points that we need to cover, but I think we generally agree with the comments. How do we convert something that we would all want to be able to quantify and say a certain percentage of meaningful PAs would be done in this way? I think this language of – let's just say that it's going to be a majority of those that should be covered by these guidelines because we're not going to get to every single scenario, and I don't think there's any point in trying to quantify something that, as we've discovered, is quite complicated and difficult to quantify in any significant way.

Alix Goss
Got it. So, I'm not seeing any other hands up. I'm going to keep moving to solicit to see if there's any other feedback. Rich, hopefully, you're still okay with all that feedback. What I took away is that we need to tweak that sentence, and we can do that wordsmithing offline so everyone has another bite at the apple downstream. Are there any other comments on No. 1, or more especially on 2, 3, or 4?

Sheryl Turney
It looks like Jocelyn has her hand raised.

Alix Goss
Oh. She's not bubbling to the top.

Jocelyn Keegan
I'm using an app on my phone today, and it's not working really well. So, the only additive thing I would say is I think that there's complexity around the type of prior auths that are done, and I think that there is this – and, I completely agree with all the comments – this desire to say for the things that fit into the 80% bucket, which are the ones that are codifiable or single-use prior auths between two parties, we should set the bar to be able to automate those and reduce their burden as much as possible, but there is this reality that there are more complex episodic multiparty prior authorizations that require data from multiple sources that we should create a path forward to automating, building on what we do to streamline and reduce the burden of the more simplistic one, if that makes sense.

I don't know if simple and complex is the way to phrase it, but I feel like if you have exemplars to say "If you can do this one, then you can do these five other kinds," and then, if you have one that's more complex, then you can make an exemplar to solve for that so the system can learn how to tackle the more complex ones. That was a lot more words than a single sentence, so…

Alix Goss
No, I think I get it. The episodic, multifaceted prior auths versus the less complex scenario aspect needs to be factored in here, and that makes a lot of sense to me, so I think I'm good. I'm seeing a check mark from Rich.

Jocelyn Keegan
Yeah. At the end of the day, there are prior auths that we do that ultimately get approved of 98-99% by payers. Let's figure out how to automate those guys because that would take a huge amount of waste out of the system. But then, there are ones that require the journey of the patient and more information to get exposed as you know more about what needs to be done for those patients, and we should strive toward that, but I think that in Round 1, we're not going to figure out how to fully automate those, but I think we can definitely reduce the burden on them with the tools that we use on the more simplistic ones.

Alix Goss
Got it. I am inferring that you're on audio, but not visual, or are you on both, Jocelyn?

Jocelyn Keegan
I've wandered my way back to my laptop because apparently, using my phone alone wasn't working.

Alix Goss
All right, thank you for that. Are there calls for other questions, comments, or discussion on the four bullets of design for the future?

Sheryl Turney
I don't see anyone else with their hand raised, Alix.

Alix Goss
Oh! Did Alexis just pop up as you were saying that?

Alexis Snyder
Yeah. I don't want to take up any more time. I typed it into the chat box because I forgot to mention the wording for it under No. 2. I just wanted to point that out.

Alix Goss
Okay. So, we are going to want to be more encompassing than "clinician" so we can modify our sensitivity level. Thank you for that clarification. Anybody else?

Sheryl Turney
Alix, this is Sheryl. On that No. 2, I think just to reflect the comment that was made last week, which was that we also need to be sensitive that any recommendations we make don't inadvertently add to the burden. I'm not going to say it's the mission burden, but it's really all-over burden. That was an example that someone made – I didn't capture who it was – that provided a really good example of something that appears to be helpful, but if you look at the long side of it, it then results in significant burden, not only for the physician, but also for the patients.

Alix Goss
So, we should be mindful of unintended burden consequences from our recommendations. I think that seems to be a good principle overall, but I'll capture it here. Thank you for bringing that up, Sheryl. Okay, I'm not seeing any hands raised, so I'm going to move on. Let's talk about aligned national standards. Accelerate industry adoption of national electronic standards for prior auth and approve ongoing transparency of formulary information and coverage restrictions at the point of care and during duration of episode. Our work should inform the coordination and alignment of existing efforts rather than reinvent. Standardized data will align with USCDI, and will be the basis of data exchange for prior auth. If it is not in USCDI, then the ICAD task force will prioritize feedback for consideration in subsequent versions.

Standard format of related policy is adopted at a national level for additional documentation requests and response to provide supplemental information needed to process the prior auth request – meaning we'll have attachment regulations. So, there's an attachment standard with broad ability for payers to receive provider attachment submissions, and without an attachment standard there, clarity will exist on the rules for how providers supply additional information to payers to avoid denials of prior auth because of a lack of information capable of being sent in an initial prior auth request. I'm going to stop with those four and see if there are any questions or comments. Jocelyn?

Jocelyn Keegan
I don't know the exact language at the beginning on No. 1, but I think there's something between formulary information and coverage restrictions that – formulary and benefits does more than just tell you what's on formulary. It tells you what the recommended treatment is for that particular plan, so I don't know if it's as simple as just adding "formulary and benefits" or not making it just "coverage restrictions," but "coverage recommendations and restrictions" – I feel like there's something there that somebody more on the PBM side might have a bigger opinion about than I do, but I just know it's a heck of a lot more than just formulary.

Alix Goss
I have made a few additions. I'm going to move on to Rich Landen.

Rich Landen
Thanks, Alix. On No. 2, besides the coordination of alignments of existing efforts, I think there's another dimension that might prove valuable for this task force to help out those initiatives, and that is working with those initiatives to understand the barriers that they're running into when they're trying to find their solutions, and to see if there's anything we can do at our level to remove or get around those barriers. So, it's not just bringing the groups together, talking about what they're doing and sharing, and trying to get them all following in the same direction, it's seeing what walls they're running into and what we can do about those walls that those groups don't have the power to do by themselves.

Alix Goss
Okay. Sorry, I captured a note there, Rich. I'm hoping that's…

Rich Landen
That has the sense of it, yes. Thank you.

Alix Goss

Thank you very much. Denise?

Denise Webb
Hi, this is Denise. I just have a comment on No. 3. HITAC formed the USCDI task force with a charge to respond to making recommendations relative to the proposed rule, so maybe some of my fellow committee members can weigh in here, but I'm not sure that the task force is a standing task force, and that the idea was that – so, that task force had made recommendations about the process for updating the USCDI, and how stakeholders could introduce new elements and so forth, and what the periodicity of the updates would be, so I think it's more a process that's going to be managed by ONC now, and I welcome my fellow committee members to weigh in, but that's what I recall. I just want to make sure we assign this to the right place.

Sheryl Turney
Denise, this is Sheryl. I think you're right. I think it should be assigned to ONC versus the USCDI task force.

Alix Goss
Thank you very much for catching that, Denise. Jocelyn? Oh, up and down, okay. Any other comments on 1 through 4? Okay. Let's talk about No. 5. There would be a consistent standards advancement process used for administrative and clinical standards adoption. New standards have low additional development and implementation costs relative to the benefits of using the standard. Standards, implementation guides, and operating rules are freely available, and the development activities are funded through private- and public-sector investments and initiatives. Jocelyn? I see your hand up, but I'm not hearing you.

Jocelyn Keegan
I'm talking on mute, sorry. Can you unpack what No. 5 says? I just don't know the background on the point that it's trying to make.

Alix Goss
I'm happy to do so. So, currently today, we have a method for updating HIPAA transactions – ICD codes in particular – that requires vetting through the designated standards maintenance organizations, or DSMOs, to NCVHS that produces recommendations to go to the feds – to the secretary, then ultimately to the Division of National Standards – who will eventually produce a notice of proposed rulemaking that we'll all respond to, and eventually will get a final rule. When we look at the standards advancements process that has recently been promulgated under ONC's interoperability rules, we have a new standards version advancement process, affectionately acronymized as SVAP, which enables us to have a formal rulemaking process, a base standard incorporated by reference through formal rulemaking of the NPRM and final rule processes.

That process is also run in HHS, but on the ONC side of the house. Once the feds adopt that base version, then we can incorporate/update new versions of that standard, which is already promulgated and incorporated by reference. So, we have different processes for how somebody gets an upgrade to administrative and our clinical standards. It would be nice for the industry if we could have a consistent process on how to manage this. That's my two cents. I would ask Arien, Anil, Alexis, or Tom to weigh in on that. It looks like Arien's hand is already up.

Arien Malec
Awesome. First of all, that was very masterful. I give a round of applause to that encyclopedic knowledge. The other thing I'd add to it is what we did around API transactions with the Argonaut project and ONC rulemaking assistance is created intentional room for innovation and standards advancement in advance of formal rulemaking. So, we put in place a process that allows the – this is the "floor and ceiling" approach – we put in place a process that allows the floor to advance at a common level for everybody, but without creating inadvertent disincentives for people to use a new method that raises the ceiling. Right now, with HIPAA transaction standards, you were out of compliance on paper if you adopted, for example, a FHIR-based transaction end to end without going through a 278 or other adopted HIPAA transaction.

So, there are two pieces to this. One is making sure that we have a common standards advancement process across CMS and ONC, second is making sure that we have a more flexible standards advancement process, and third is making sure that we have a standards advancement process that allows for raising the floor and the ceiling at the same time, as opposed to merely raising the floor and ceiling in lockstep. I guess the last piece is that right now, HL7 has moved to making FHIR-based standards freely available, but with a benefit for being an HL7 member, and their business model didn't go away. There's been an ongoing debate over whether selling IP and making standards available only to licensees is the right way to fund a standards development organization. There are models on both sides, but I think from an innovation perspective, it's pretty clear that having the standards implementation guidance be freely available but requiring membership to participate in the process is the approach that drives the greatest adoption and innovation around standards.

Alix Goss
Thank you. I think you were touching upon No. 5, but also No. 6.

Arien Malec
Correct.

Alix Goss
Okay, thank you. I'm not sure if I was supposed to captured something around No. 6, or if it was providing additional color commentary.

Arien Malec
It was providing more color, exactly. I was just providing color commentary around those points.

Alix Goss
I really appreciate that. Thank you so very much. Jocelyn?

Jocelyn Keegan
I was just going to add that I think there's a lot packed into No. 5 that those of us that are living and breathing this stuff really understand the difference for, but if we're writing this for others to read and absorb the full impact of that, I think it would be worth calling out that there are two distinct processes that behave differently, and I don't know if this goes to No. 5 or No. 6, but I do think the concept of allowing for innovation and flexibility is incredibly important to get across.

Alix Goss
Okay, thank you.

Jocelyn Keegan
Thanks.

Alix Goss
You're welcome. Rich Landen?

Rich Landen
Alix, I think you and Arien did a great job. There's one point that I'd like to make for the information of the task force, although I don't think it needs to be added to the language, assuming that we're going to do some unpacking as was just suggested, but that's that the administrative transactions under HIPAA – part of that process does allow for exceptions. So, if a group wants to use something that is not a standard, they have to make application to the secretary of HHS, and there's a whole process for that. It's a little murky on how user-friendly that is – essentially, it has not been used very often, but that is available, and that is something that I think we should keep in the backs of our minds in case we run into something that needs to happen in the short term before this conversation, which is about aligning the two different paths for standards adoption in DNS and ONC, gets completed. Thanks.

Alix Goss
I forgot about the exception process. How could I forget about 162.940? Okay. I see no other hands raised on this, so I think – Sheryl, since I can't see the agenda, do I still have time to go to the last category?

Sheryl Turney
Yes, you do.

Alix Goss
Thank you. So, the last one: Prior authorization processes necessitate a point person to ensure the prior auth is fully resolved – quarterback role, in other words – and related coordination/follow-through is performed. To give a little bit of color commentary, one of the things that we've heard before is that there have been discussions around how we want to try to be that point of care between the provider and the patient, we understand that that's not always realistic, but that often, prior authorization ends up being centralized within provider offices, and that ultimately, it's going to take a point person to make sure the whole process is completed from start to end and renewals are included. So, we felt like it was important to call out that there was this need for a point person. I'm taking questions, comments, and observations on this uncategorized bullet.

Not hearing any, I think people agree as far as a guiding principle or ideal state – I'm not sure which one it falls into yet, but I think at this point now, we've walked through this complete document, and I'll take this back to the team, and we will continue to do our work on it. I think at this point, I am good to go. I think I'm ready to turn it over to Sheryl and Josh. I'll stop sharing.

Sheryl Turney

Okay, great. Thanks, Alix. Josh is going to share his screen and provide an update on the data classes workgroup. I see Josh has already got a preview up there, so…I'll let Josh go in. If you recall, in our last meeting, we indicated it would be helpful to have definitions or descriptions for each of the data classes, and I see that they did update those, so Josh, why don't you go ahead and take that away?

Josh Harvey
Thanks, Sheryl. Can everyone see my screen?

Sheryl Turney
Yes, we can see it.

Josh Harvey
All right. So, to Sheryl's point, our major accomplishment over the last week was just going through and adding some context to each of the data classes that we've been discussing as a group for some time now. I think we've discussed these in terms of data elements that would be useful in the prior auth context. We've also rolled those up to this data class level for ease of reference and discussion points, so one of the things that I think the group was making a point about last time with that was that it gets a little difficult sometimes. We may lose some things in translation when we start talking about these things at a higher level, so the notion of adding a description to each of the data classes was proposed, and I think it's a good one to help make sure we're all speaking the same language.

So, I'll walk through these at a high level. Obviously, they are out there for everyone's detailed reference if you want to go out and take a closer look. Some of these are a little more straightforward than others, so I'll try to focus my comments on some of those that I think are a little more ambiguous at face value. Starting from the top and working our way down, I'm going to skip the patient identity one for a second and come back to that at the end, but the first one I wanted to touch on was patient demographics. Again, this was one of the more straightforward discussion points. Not to belabor it, but we did just want to clarify that the demographic information we're talking about are things that would be in alignment with the patient demographics described in Version 1 of the USCDI data model. So, that is out there for reference.

Getting into more of the nitty gritty related to prior auth, we have a data class around insurance plan information, so the take-home here is that this would be information collected by a provider at the time that a patient presents in a facility or clinic, but about the payer that they are covered by and about the plan they're covered by. So, this would include information about the payer that would also obviously be of necessity for the provider to know, but also what their plan information is so that it could be used at later points in the process.

So, piggybacking on that, the patient benefits coverage data class would be that data class surrounding the information for a patient of what their coverage is under the plan that was obtained in the previous data class. So, this would be in terms of the X-12 context, which would be the kind of information, for example, that we would expect to see in the 270/271 transaction. So, it's specific to an encounter, but it's information about the patient's benefit coverage.

We had some discussion during the last task force meeting about the patient-generated data data class. We've got some comments in here about how this might potentially be leveraged in the future if some

standards can be developed around it and incorporated into the prior auth workflow. There were examples of turnarounds in the past by members of the task force about feedback that a patient may have on a piece of DME in the context of the wheelchair example that we discussed, for instance, about how that wheelchair may fit and different modifications that may need to take place after the initial fitment occurs.

One of the other examples that was thrown out and included here in the interest of comprehensiveness was information from an employer that could contribute to the justification for a particular prior auth. Any questions about that initial stuff? The next four data classes all piggyback on each other, so I can talk about those as a group, but are there any questions or comments on this report?

Sheryl Turney
Josh, if you can take a break, Alexis Snyder has a question.

Alexis Snyder
Hi. In reference to the definition under the patient-generated area, I think the conversation wasn't about information that an employer would provide for further justification. I think we had one sample in the example from somebody in the beginning about employer information, but our conversation was largely about patients themselves or patient caregivers' input about justification for the equipment that may not be seen in the written information from a provider. So, it's more of an extension for the patient.

Josh Harvey
Got it. So, is that a proposal to strike this last example, then?

Alexis Snyder
It's to modify it where it says "employer information required."

Sheryl Turney
I think what we were talking about there – the example given, Alexis, was because of an employment situation, a member or patient needs specific equipment or attachments to their durable equipment in order to perform the duties of their job. So, there may be –

Alexis Snyder
Right, I understand that. Carolyn had brought that up way back in our very first meeting. I'm saying that in addition to that, our discussion last week or perhaps the week before was about patient/caregiver-generated information, about "This is why I really need this" information – a personal statement from a patient or caregiver.

Josh Harvey
Got it, okay. So, it's still about how it needs to be required for the performance of a job duty, but you're just emphasizing that the origin of the information is the patient.

Alexis Snyder
Regardless of employment, even if we're talking about pediatrics. That's why I keep saying "patient and caregiver input." So, it would be like a third bullet or an end. It's not just about employer information, it's about finding a place for a personal statement from either patient or caregiver on the need.

Sheryl Turney
I misunderstood you also because I thought the first statement that was there was what we were talking about. Josh, all of a sudden, it went away.

Alexis Snyder
Oh, it's back.

Sheryl Turney
Now it's back.

Alexis Snyder
No, the first statement is just about fit. That's about after the fact. We're talking about before – for the prior authorization to get the coverage to get the equipment to begin with. I would just further offer – you can leave this, and I think I've mentioned it in the past in the smaller group, but as far as fit – that's automatically in that process already. When the DME provider delivers equipment, the patient needs to sign off, accept, and answer an entire list of pieces about fit and match, et cetera, so there's already a process for that, and if you don't sign it, it gets rejected and it starts all over again.

Sheryl Turney
So, are you happy with the way he modified it now?

Alexis Snyder
Yes, that's fine. The last piece – I was just saying that the fitment on whether you want to keep it or not is already part of the process. It's a standard for DME.

Sheryl Turney
Okay. Are there any other questions or comments before Josh moves on? All right, go ahead, Josh.

Josh Harvey
All right, thanks. The next five data classes are all essentially specific to the lifecycle of a particular prior authorization request. So, the initial data class is – we're calling it the PA request data class. This would be information that the provider submits to a payer specific to the treatment, procedure, service, or product for which prior auth is actually being requested, and this would contain information about the requester specialty and those kinds of considerations as well as the site of service, which I think are all things that have been brought up by task force members to date.

The PA response data class is around coverage rules specific to that request, so this is intended to address the notion that the sooner in the process a provider knows what the rules are for coverage for a particular prior authorization, the sooner they can begin collecting all that information and making it available to the payer for view and approval.

The PA justification data class would then be more of the response to that response data class, sharing all of the documentation or information that would be needed to actually process the request from the payer end. So, this would include things like the medical necessity documentation we've discussed at length in

the past and the history of past treatments that may be necessary, as well as clinical diagnoses that might be used to justify the request.

Then, the follow-up data class is really reserved for those instances when the information submitted with a justification may not be comprehensive enough to actually approve the request initially, so the notion here is that rather than denying a request, a way should be created for that conversation to continue electronically so that the provider could then have an opportunity to add to the information that was requested to ensure that an accurate depiction of the patient's status has been submitted and shared with the payer so it can be reviewed for approval.

Lastly in this section, the PA decision data class is really designed around that final approval or denial event, so I think the emphasis here has just been on making sure that whatever kind of code is returned to signify an approval or a denial is concrete enough that it can be later used in the billing process. So, in the event of an approval, the idea would be that the approval received as part of this process would be sufficient in terms of billing so that ultimately, the billing process can be completed swiftly. In the event of a denial, however, the emphasis is on just making sure that there's sufficient information being transacted between the provider and payer so that the provider can better know the reason for the denial so that the provider can learn from that in the future and ensure that in similar situations, the same kind of denial doesn't happen in the future if it can be prevented. So, those are the five data classes that I would consider to be tied to that feedback loop around the prior auth request itself, so I'll pause there and see if there are any questions or comments specific to those.

Sheryl Turney
We do see one question from Alexis Snyder.

Alexis Snyder
Hi. I would add wording to the PA decision box like "information provided to the provider and transparent to the patient" because you already get a letter with an acceptance or denial in the mail from the payer, and it doesn't always have reasoning there or on an EOB either. You really need that in an appeal process on that side as well.

Josh Harvey
Good callout. I'm adding that exact verbiage in here. Are there any concerns from anyone else about amending this description?

Jim Jirjis
Hi, Josh. This is Jim Jirjis. I'm having trouble with the hand on the computer, sorry.

Sheryl Turney
Go ahead. Who was that?

Jim Jirjis
Jim Jirjis. One question for the group is on that piece about – I view it like two sides of a coin. On the front end, the provider is having enough transparent insight into not just the data needed, but what the rules are, and then, on the back side, when there's a denial, enough granularity about why. I'm just curious if this task

force can get – can we define what level of granularity? Sometimes "not covered" or "didn't" – there's a certain level of granularity that, if we don't address it, will end up being too abstract and not **[inaudible – crosstalk] [00:53:57]** to providers.

Sheryl Turney
Jim, I think you hit a really good point because in the last meeting also, we talked about adding the PA rules to this data grid, and I don't think we did that yet, Josh, so can you add a column for PA rules? And then, we would need to add an item for it.

Jim Jirjis
Is that a column or row?

Sheryl Turney
It's a row. We need to add a row.

Jocelyn Keegan
Yes, I think that's a great point.

Sheryl Turney
Yes, and we did talk about that last week also – adding a row for PA rules.

Josh Harvey
Yeah, I agree. I was trying to address that here in the PA response category, and maybe it's just a naming convention here that's burying it, but I think the idea here was after the initial request is submitted by the provider, the immediate response from the payer would be information about the coverage rules. Are those the kind of rules we're talking about?

Sheryl Turney
Yeah, but I do think it should be its own row.

Josh Harvey
Yeah, it should be overt because it is a very different kind of data, and there may be some reason some constituents may choose not to get granular. I think we talked about calling it last time.

Sheryl Turney
We even talked about adding two rows: One for PA rules, and one for PA data requirements. Those are the notes that I had. They could be different, but maybe if we can't get agreement or collaboration on the rules, then at least we might be able to on the data requirements. That also came up in the CAQH meeting last week as well.

Josh Harvey
I also think there are probably two rows under the response. There's one that's more the 278 – you have the denied…et cetera, but there's another layer of detail about exposing to the patient – thank you, Alexis – as well as the providers what rule was violated that actually led to the denial. I mention that because it's not just so that providers can get trickier about actually getting the approvals – although if it's for the patient's

benefit, that would actually be appropriate – but also so that providers can learn when it's not appropriate and not even an issue to waste everybody's effort. The more transparency there is, the less that occurs as well. So, I think there are two rows on the front end, and on the back end, there's denial – yes or no – versus the appropriate level of detail.

Sheryl Turney
Yeah, I agree with you there. Can I just take a check? Alix, we had said that at 4:00, we were going to pivot to the timeline discussion. It's 4:00 now, and we're not yet done with this discussion.

Alix Goss
Yes, I agree with you. Keep going on this, especially because there's at least one hand up, and I'm debating whether to put my hand up or not. So, I think you keep going, and then how about we make sure that in about 10 minutes – actually, in 15 minutes, we'll make sure to queue people up for public comment.

Sheryl Turney
Okay. And then, if we have to diary over the timeline discussion, we can do that for next time if we don't have time to get to it today. Why don't we move to Jocelyn, who had her hand up, and then we can come back to you, Alix?

Alix Goss
Sure. I'll put my hand up.

Jocelyn Keegan
Okay. I think this is a really important point, and I think calling these out as separate lines is really important. I'll tell a little bit of an anecdotal story. When I worked for NaviNet, we would go out as product managers into the field and do research with providers who were people who had done that manual automation of prior auth. It created centers of excellence around getting PA done. Inevitably, we would hear that they would literally print-screen the affirmation that the prior auth had been approved and store it in their practice management system – the actual screenshot itself – because at the time, they viewed NaviNet as the source of truth that they could use that when their claim was late or denied. I think what's important here is that things happen along the way between when you actually proposed and got approval on a particular event or activity for a patient and there are subtle changes that happen between then and when the claim gets submitted in the future.

I feel like there needs to be more connectedness so that the provider team, or whoever's providing the service for the patient, is alerted to one of those subtle changes that's going to trigger either the need to reauth or the potential for denial when somebody's submitting the claim. So, I think this ability of being able to expose the rules as things that you can interact with and understand will make that easier. To me, when I look at the challenge, it's that there's so much variation between what I'm doing today on May 26th and what will happen when I show up for my surgery on July 27th that inadvertently creates additional wait, and because these processes are really opaque today, it stops the ability for people to warn each other that they've done something that could trigger a denial or no payment. So, I guess that's the first part.

The second part is this idea of being able to say that exposing the rules needs to happen up front because I do think that there is a "What did I submit and what did I get back?" – the PA request and the PA response

– that totally makes sense, but ahead of that, what is that that you're doing to make the rules and the coverage transparent? I'm not sure whether or not rules and coverage need to be completely separate, but I do like the idea of breaking rules out as a separate category.

Sheryl Turney
Yeah, I agree. Josh, what I'll do is after today's meeting, I'll go in and expand out those rows and add a definition to the PA rules and the PA data requirements, but I do think they should be separate. All right. Alix, do you want to chime in?

Alix Goss
Yes. I've been thinking about these rules and data requirements, and then the specificity of the response that gives clarity to the recipient, and I – because I can't manipulate the spreadsheet at the comment, I'm curious where we're handling the remark codes. I know we had a discussion about that last week, and shout out to Mel, who made me aware that if we're using CARC and RARC codes, Medicare created additional codes to provide greater specificity around prior auth responses, so I know this has been an ongoing theme. I just wanted to ask Josh if the specificity of the response code sets is captured in here as something we're going to get at and look at more specifically.

Josh Harvey
Good question. I guess I would pose that to the group to ask if what we've sketched out here is comprehensive enough, but in my mind, the information you're pointing to about the remark codes and things would be things we're looking at in this ultimate decision bucket, unless I'm misinterpreting what you're saying, but I think this is where we're ultimately deriving whether there is an approval or a denial, and if there's a denial, what the reasons behind that denial are and the right level of specificity.

Alix Goss
It looks like it could resonate, but it has to be more than just a denial. It has to do with "append" as well.

Josh Harvey
Okay, good point.

Sheryl Turney
Yeah, that's a really good point. All right, Jim has his hand up, and then Alexis.

Jim Jirjis
I just wanted to be clear that it's one thing to state that the rules need to be exposed, but it's another to have it be in the workflow, and I'm wondering if we need to call something out. The reason I say that is because I know for medical services, if you ask the people at HCA who work those services, they will go to a several-hundred-page PDF where, if you want to, you can go look up what the rules are for any particular situation, but multiply that by the number of payers and multiply that by the variations by which they're updated – some every six months, some even more frequently, some less – it becomes effectively unusable. So, maybe it's in the principles – I don't know if we captured it in the principles document, but is there some information flow in the workflow principle that we could call out so we don't end up with giant tomes of information no one accesses that actually check the box for requirements?

Sheryl Turney
So, that gets to the point that was made previously also about adding burden, where it's great to, say, have predefined rules and data requirements, but again, if you've got hundreds of pages for multiple payers, how does anyone manage that? So, I think that is a balance that we need to speak to in our recommendations related to how this could possibly be done without adding burden, and maybe there is a way to link to some open – and, I'm not going to say "open-source," but open capability within the EMR system that will allow you to access a payer-populated rules engine or something. I don't know. I don't want to design a solution, but at the end of the day, it might require something like that to be able to provide that in a real-time way, which otherwise would result in a lot of burden. So, it's something we need to talk about as maybe an example.

Jim Jirjis
Yeah, because right now, also, every payer has their own portal – "If you just sign on, you get everything you need" – and that does not work.

Sheryl Turney
Right, so again, you're still talking about multiple portals, and I know even our own portal is not going to give you an online rules engine that is going to allow you within a few seconds to know what information requirements are there and what the rules are. Nobody has that right now. But, that's a good point to note, and that's something we have to speak to in our final paper. What really is a reasonable item? All right. Alexis?

Alexis Snyder
Back to the specificity and the transparency of why something was denied, I just wanted to add that I think it also goes beyond a code reason for denial because quite often, it has been my experience that the denial code will be miscellaneous, like a 999 miscellaneous code, which means nothing, and again, just needing that information so that folks know what is missing, why it was denied, and how to proceed to either fix or appeal it – not just a recommendation of the code that comes along with it, but a clear code, not a miscellaneous code.

Sheryl Turney
Yeah. I think that's a fair request, and something we definitely should talk about in, again, our final recommendations, and we'll capture that as part of the description around reason for denial or pend, because it could be for either. Jocelyn?

Jocelyn Keegan
I think that the point around not increasing additional burden is incredibly important here because I think that there's a step between making data known and aware and potentially automating, so from a principles perspective, I think it's really important that we acknowledge that when work needs to be done, there is the ability to not stop somebody in workflow from doing what they need to do, to turn work off – I think workflow is king here in all the conversations that we're having, and I don't know at what level we'll go through describing that, but I can tell you from having rolled out ePA for pharmacy with the assumption that docs were going to stop and do a PA while they were sitting in the room with a patient was a nonstarter, and led to early failures of adoption, and recognizing that there were other parties doing that work, while not a perfect solution, have allowed adoption to happen to remove burden from that workflow, but we should

have a watchword out about the premise that we're going to put one more thing in front of the doc to do while they have a patient in front of them.

Josh Harvey
Can I suggest some wording for the principles? There's an informatics principle that we're really trying to get at here, and that is workflow-friendly information presentation. This concept of an information flow that is built around a workflow is something we should consider because it's an established principle, and it'll avoid people clicking the box, but it not being workflow friendly. That might be good for the principles.

Sheryl Turney
That's a good point.

Alix Goss
I'm capturing it.

Sheryl Turney
Yes, really good point. Jocelyn, do you have another one? All right, I think we're ready to move on, Jim, and we have a couple of minutes before we have to take public comments.

Josh Harvey
All right. So, I have a couple last things to hit on. So, a new data class for this table – I think technically, this is one we've labeled as "service completion," which is really just intended to take into account that ultimately, the goal of a prior auth follows all the way through actual payment of the claim. I don't know if that's something we've specifically discussed in the broader group up to this point, but that's something that is a subgroup that we felt like we wanted to reflect on the table here and make sure we are not omitting the fact that after a prior auth is actually processed, then ultimately, there's another process that kicks off, and there may need to be some interplay between the PA requests and approval itself, and ultimately, payment.

And then, lastly, there's this catchall metadata class that we've discussed in the past, which centers for the most part around information that systems need to interoperate with other systems, as well as the notion that Arien brought up first about the state machine and just being able to make information about the status of a PA request face up for the different constituents – payers, providers, and patients – throughout the lifecycle of a PA request. Any questions or comments on those two before I hop back up to patient identity for a quick moment?

Sheryl Turney
I'm not seeing any.

Jim Jirjis
Can I make a quick comment? It's Jim Jirjis. One of the things we talk about with the state machine – and, Alix, you may have been commenting about this – is the situation changing as time goes on. One of the things we've experienced is if there's an automated system that, once the data is available, just automatically sends it to the insurance company, and then denial occurs. Sometimes it's a timing issue, where information that's not yet available is pending or is about to be ordered the next day, and then there ends up being a denial that's premature that leads to a lot of extra work. So, I don't know if it's part of the

state machine, but I think there needs to be a concept of time before conclusions are drawn that needs to be addressed because first attempts at automation led to some premature denials because of that. I don't know if that's part of the state machine or part of the rules.

Josh Harvey
My two cents is that it may end up being a little bit of both, but I'm curious – I can't recall off the top of my head, Alix, but I think you were about to chime in – there may be something valid here for the guiding principles.

Alix Goss
Yeah, that's exactly where I was going, Josh. I was thinking about this timing aspect, and I think you're calling it a state machine, that things are highly fluid, and things can happen just in time, or can happen too quickly that they're missing a piece, and things have to be redone, so there's a complexity from the timing aspects that we might need to consider, so I'm adding this – along with the workflow-friendly concept – to the document so that we can talk about it in the small working group.

Sheryl Turney
Yeah, I like that. All right. Anyone else with any final questions or comments before we move on to public comment? I think we can go ahead and put up the public comment slide. I don't see anybody's hands raised. Thank you so much, Josh, for doing all this work and presenting, and Jim and the others who have been involved in the data classes workgroup. I will go in and add those definitions to the thing that we talked about today, so we'll at least have those to share for next time.

Michael Wittie
Okay, great. Thank you, Alix and Sheryl. Go ahead.

Sheryl Turney
I was just going to say go ahead with public comment.

Michael Wittie
This is Michael. Thank you, and operator, if we could please open the line for public comment.

Operator
Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 to remove your comment from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. One moment while we poll for comments. There are no comments at this time.

Sheryl Turney
All right, wonderful. Alix, do we want to move into the discussion about our timeline, and then we can check back with public comment?

Alix Goss
I love that idea. Do you want to kick us off on the schedule? You and I didn't really have a chance to talk about the next couple slides and how we were going to cover it, so go for it.

Sheryl Turney
All right. Michael, can you put the PowerPoint back up? So, the next steps for the full HITAC committee review, just so you're aware – we did do our update in May. We have no planned actions for June. We were planning on preventing a draft of our comments and recommendations to the September 9th meeting, and what that means for us is that we will have to have a really good working draft by the end of July, and have enough weeks to review that written draft multiple times before it actually goes to HITAC on the 9th. What will typically happen is on the 9th, HITAC will have a lot of questions and recommendations. We'll have a good amount of time during the meeting to review our recommendations.

What will most likely happen is there will be a PowerPoint as well as a written paper. Comments and questions will come back to both of those. We'll have to rewrite and update those, and then we'll re-present back in the October timeframe, allowing the fact that there are going to be revisions. The hope is that would be the finalization. If we can't finalize it in that October meeting, then we would continue on for one more month, with the final adoption hopefully happening November 10th. Then, the HITAC will have to vote to accept the recommendations and the proposals that we make in our whitepaper, so typically, the PowerPoint will outline what is being recommended in the whitepaper, and then the HITAC members will typically asked to read and review both, and provide comments on a detailed level from both. Any questions?

Alix Goss
I'm going to add to what Sheryl just said in that excellent overview of the HITAC schedule to give some commentary that as we were working offline on our scheduling, we realized that HITAC takes a hiatus, and we had to adjust a bit of our schedule to sync with their schedule. The bonus part of that is it gave us two more weeks of work time, which I think is a welcome addition, and so, let's take questions, as you were going to do on this side, and if there are none on this high-level slide, then we may want to go to Slide 10 and walk through what we think that means to us at a little bit more of a discrete level.

Sheryl Turney
Right. I don't see anyone with their hand raised at this point, but feel free to raise your hands as you need to. So, what does that mean for this group? Again, it means that we will have the updates as we did today. Next week, we are expecting to have some additional presentations. There's the presentation from CMS on the document retrieval that we wanted to review, which is one of the Da Vinci use cases that actually uses a couple of Da Vinci APIs, and then, we had another potential presentation that would occur, which we'll announce as soon as we have it finalized. And then, we'll also review the adjustments that we made to the definitions for the data classes if we have time, based on what we talked about today. Then, moving over to June 9th, we would hopefully be able to look at the process map that another small group is working on, and then, there's the privacy and security deep dive, where the ideal state and goals group has pivoted to. So, we would have updates of those coming into the June timeframe.

And then, sometime in the middle of June, we need to start drafting what our final paper is going to look like so that we have the ability for different stakeholders on this workgroup to split up – divide and conquer, if you will – take a topic, and then actually start exploding out our recommendations and our discussion items that we want to include in that paper. And, just to provide a better picture, that paper usually talked about a current state, and then it will talk about our guiding principles and ideal state, and then it will talk

about our recommendations and enumerate those one after the other with backup information relative to how and why, and then we'll talk about the history of the work task force, the different groups that came to speak, all of the things we did to level-set prior to us actually having the recommendations with the final paper.

So, we need to start formulating that. The hope that Alix and I both have is that we can actually start making assignments in the June timeframe so that the middle and end of July are going to be reviewing different groups of pieces of that document as we start putting it together and it starts formulating a better picture in your mind – what it's going to entail, who's responsible for doing what, and how we're going to review that over the July and August timeframe, knowing that we're going to be losing people here and there for vacations and other things, even with the pandemic that we're dealing with.

The hope is that we will have all of our comments on data classes and ideal states, and then, abstracting up from there to the intersection of clinical and administrative data by the end of June, and again, use all of July and August to iterate a paper, and have our full review and discussion of the initial draft by the beginning of August, as I mentioned before, so we'll have a few weeks to iterate and revise it before it actually goes to HITAC for the September 9th meeting. We would like to have it prepared at least a week in advance of that meeting if possible to give people time to review it and make comments so that in the meeting, they're actually able to provide some substantive input. And then, again, the final recommendations will be in October. Alix, do you want to expound on what I just talked about?

Alix Goss
I think you gave a really great overview, and I'm so appreciative of your experience with the HITAC formal reports. We will be leveraging a template, so we'll start to have a framework of where we started and where we need to get to with that template and start to help build out some assignments. We have been getting notable success with these small working groups and offline efforts, so I think that breaking the task force into portions of work teams will help us with drafting the various sections and then being able to hopefully get some ONC support to just smooth it all out across our work efforts would be helpful.

One additional thing I want to note is that we are looking for a couple of presentations in the middle part of June to help us with not only finishing up prior authorization, but pivoting to the larger conversation, because we are going to need to do a pretty robust effort of abstracting up from prior authorization to the larger convergence issues, so that effort may then inform some agendas for the actual task force meeting so we can kick some tires and get general directions to help the groups. With that said, I think we're about out of time.

Sheryl Turney
Yeah, let me just check back. Operator, did we get anyone else for public comment?

Operator
No, there are no comments.

Sheryl Turney
Okay, perfect. So, we have one final slide, which is this slide for next steps. So, if you have additional input or updates for the workbook, feel free to share them. We'd like to get that effort wrapped up. As we are

starting with those process models, it's going to be very important that we move forward in our conversation to start framing up the components of the paper.

And then, next week, we have the CMS presentation, and moving again from prior authorization to the broader discussion of integration with clinical and administrative data and some of the recommendations that we have around that effort. We just talked about the longer term, but that's recapped on this slide as well. There may be some additional industry presentations in order to provide that pivot for us. Any other questions or comments before we break? Seeing none, I'm going to say thank you very much, and we hope you all have a wonderful week, and we really appreciate your efforts and commitments to this important topic.

Michael Wittie
Okay, thank you so much. With that, as you can see, the next meeting is next Tuesday, June 2nd. Thank you all for joining today. I hope you can join again in the future, and with that, we will adjourn for the day. Thank you all.

Arien Malec
Thanks, all.

Sheryl Turney
Thank you, Michael.