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

October 13, 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
Gus 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
Arien Malec	Change Healthcare	Member
Thomas Mason	Office of the National Coordinator for Health Information Technology	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Jacki Monson	Sutter Health/NCVHS	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
Lauren Richie	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Michael Wittie	Office of the National Coordinator for Health Information Technology	Staff Lead

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome to our ICAD task force meeting this week. Of our task force members, we have our two co-chairs, Sheryl Turney and Alix Goss. We also have Alexis Snyder, Andy Truscott, Anil Jain, Denise Webb, Gus Geraci, Jacki Monson, Ram Sriram, and Rich Landen. Are there any other members that are on the phone that haven't been announced? Okay. Hopefully, others will be able to join us here soon. I will turn it over to Alix and Sheryl to get us started.

Summary and Action Plan (00:00:42)

Sheryl Turney
Thank you very much, Lauren. This is Sheryl. What we have on the agenda today is a review of our draft report. Of course, we'll review what we did last meeting, and then, we're going to go over all the comments that have come in from the task force members on the draft report that was put out to the Google Drive last week. Thank you to all those who did participate in providing comments. We're going to discuss briefly the pathway to the report submission, which is expected for next week within HITAC, both the report and a presentation on the report, and then we have time for public comment. So, can we go to the next slide?

So, in the last meeting, we had a very robust discussion regarding the synthesis that had been completed on the broader intersection of clinical and administrative data. We discussed with the task force how we wove that in to both the information regarding the guiding principles and the ideal state, which ended with our addition of an additional guiding principle focusing on reducing burden on all stakeholders within the transaction point, and then, we also added, as a result of that discussion, two additional recommendations. One focused on establishing patient authentication and authorization to support consent, and another to establish test data capability to support interoperability.

In addition to that, we reviewed many other areas in total within the draft report that we had not been able to get to previously, and then, after the session that we had, Alix and I met with the report writers in ONC and Accel staff to further massage the report, and I believe now, we actually have all the components for that complete draft in place. So, without further ado, I'm going to turn it over to Alix, who's going to review the final comments that we have that we would like to discuss within the draft report. Alix?

Draft Report: Review Incorporation of Task Force Feedback (00:03:09)

Alix Goss
Sheryl, thank you so very much for that really thoughtful and well-orchestrated overview from where we've come, where we're headed, and more especially, what we did on our last call because it really enabled us, as you noted, to work with the editor in advancing a clean version for everyone to see as of late day Friday, and that today, we will be walking through the document so that we can produce that final draft to submit to HITAC this week so that we can present to them next week and start to have a dialogue with them to get their feedback.

As such, hopefully you're all able to see the draft document. What I'm planning to do today is that we have about 15 comments that we need to walk through, and my goal is to get through all of these items during our call today so that we will be – Sheryl and I will be on firm ground in finalizing the content for the draft submission, which we're trying to get to HITAC as quickly as possible this week.

So, without further ado, the first comment that we had in the document is in the introduction section. Dr. Gus Geraci emailed the co-chairs with what he felt was somewhat of a substantive comment, and he was following – we thank you, Gus, for emailing us, as we had suggested to folks that if something was of particular concern to please reach out to us so we could make sure to handle it, and I think you are on the call today, Gus. I'm hoping that you're here.

Gus Geraci
I am.

Alix Goss
Awesome, thank you. So, there was – the email that you sent in really wanted to help us present a whole picture, I believe, of the good, the bad, and the ugly, so to speak, of prior authorization in some of our opening remarks, and as such, you were proposing that the second sentence of the second paragraph, which I currently have highlighted, would be modified to read, "Prior authorization, when done ethically and good clinical rules, stops unnecessary care, reduces cost, and improves quality," and that would be the lead-in to the next sentence, which really gets at the darker side – the challenge side – with prior authorization. So, we wanted to – I hope I framed that correctly. Please let us know.

Gus Geraci
From my point of view, yes. Thank you.

Alix Goss
You're welcome, Gus. And so, we wanted to put it out there clearly at the beginning of the call, at the beginning of the document, to let folks know that this is a proposed change that we received and open up for any discussions related to Gus's suggestion.'

Sheryl Turney
This is Sheryl. I would just like to say I liked Gus's suggestion, and I would like to see us retain it.

Alix Goss
I see Arien's hand up.

Arien Malec
I think we started early on by pre-assuming that there are some categories of prior authorization that are necessary and proper, and that our goal was to streamline the pathway, so I think noting that when used properly, prior authorization is a useful practice and that it's our goal to streamline the process and make it less painful for patients is a useful preamble.

Alix Goss

I'm going to say that we have – thank you for that comment, Arien, as well as Alexis's chat box note. I think there's agreement to make that change, and as such, I'm going to move on to the next item. Thank you. So, there was a suggestion here from our editor that we may want to modify the title – the first sub-head title – to essentially, if I interpreted this correctly, to remove the broad context to just talk about clinical and administrative data integration issues. I'm going to call for any concerns with making that change.

Sheryl Turney
I see no hands raised.

Alix Goss
Thank you for that. Okay, two down out of 15. We're rocking and rolling. All right. I'm scrolling down. Hopefully, I'm not making everybody dizzy. We're just coming out of the setup portion of the report where we've set the context. We're coming into establishing the task force, moving into our process, and when we got into the position of discussing the… Before we went into the analysis of the current landscape that we did, it was observed by our editor that we hadn't really talked about standards until almost the end of the first portion where we're introducing the overall issue, and she posed the question of the fact that the landscape analysis focused on relevant standards possibly warrants a few words in the previous paragraph or in an earlier section, since so much of what we're doing is really to try to fix standards, and standards can really be policy or technical-type standards.

It seems like a good catch to me, and I wanted to see how that was landing for other folks and whether we should just go ahead and make the change or if there was a concern. Okay, I'm seeing chat box comments that say, "Good idea, good catch, no concerns." We're going to take that one and keep going. Thank you, Susan, our editor, for catching that. Some of these are easier than others, so I'm glad we're getting our mojo going with the easier ones here today.

The next comment comes in regard to the beginning of the analysis of the current prior authorization landscape, also known as Section 2. In this section, there's a list of topics that does not seem to accurately represent the topics covered in the landscape analysis, specifically related to these guiding principles, ideal states, and recommendations, which are covered in the next large section – Section 3 – of the report, and this section is really only about the landscape, so we're proposing – she's proposing – that we delete this highlighted content and end the introductory section with the previous sentence. So, in essence, I believe we would just take off the section from here forward, meaning we're just ending the introduction with saying what we did in our analysis, and then we would just clean up any flow to pop us right into the findings. On the surface, this appears to make sense to me. Are there any concerns? I see Jocelyn's hand raised.

Jocelyn Keegan
Hi, Alix. Just from a readability perspective, would it make sense to actually take those couple sentences and lift them into the end of the previous section to just set the reader up to say, "This is what you're going to see in the remainder of the document" versus just removing it? I think that now that we've put all the parts together and are wordsmithing, I think setting the stage for what the remainder of the document is going to say for the reader so they're not pre-guessing what they're going to be reading would be helpful.

Alix Goss

And, if we didn't do it, we need to make sure we did do it, so perhaps consider moving this section to the end of the prior section when cleaning up the intro to Part 2.

Sheryl Turney

I agree. I think that makes sense. Originally, that's why we put it in here, and we've added a lot since, so a position in the document might have actually changed slightly.

Alix Goss

Yeah, I noticed we were doing a lot of that shifting. Good point there, Sheryl. So, now, I'm going to scroll down to the next comment. So, this section needs clarification by straightening out the punctuation – dashes, parentheses, and brackets – and adding a verb or two. She also suggests breaking it into two sentences. So, for everybody to have context, what we're really talking about here in this section are the roles and the stakeholder roles, and the paragraph is talking about or setting up the stakeholders involved in Table 1. Just to give you orientation, Table 1 is this idea of prior authorization and who it's impacting. And so, we're describing that table, and we have a very robust sentence flow here that needs to be broken down into parts, and so, I think we're just looking to make sure no one's going to have a concern that we want to clean this sentence up, and possibly, she's looking at going all – using this first part as a sentence, and then using the remaining part as a secondary sentence.

Sheryl Turney

Jim had his hand up. There we go. It's back up.

Alix Goss

Thank you.

Jim Jirjis

Hey, there. It's Jim Jirjis. It is hard to read, and I agree that keeping the meaning but deconstructing it so it's more readable makes sense. Can you guys hear me?

Alix Goss

Yes. Sorry, I was typing.

Jim Jirjis

Hey, my words magically appear on the screen!

Alix Goss

Yes! Ask, and you shall receive. So, here we are. All right. Moving our way through the document, I know some of this may seem pretty simple, but we're in the home stretch, and we don't want to misstep here in the final editing writes that we have because as I noted earlier, we really want to get it out the door to HITAC. I'm continuing to scroll down now. We're passing through Section 2 with all the work on the landscape, looking very clean here, and we are moving our way a little more quickly now. Hopefully, no one's getting dizzy. We are very clean in this portion. We've done a lot of work. Thanks to Jim and

Jocelyn for getting a lot of stuff done at crunch time last week, and now, we are in Section 3, "ICAD Findings and Recommendations."

And, there is a – I'm just checking off my box to make sure I'm not missing any of our comments. There is a reference in this opening Section 3 paragraph, where we use use cases, and there's a question from the editor of whether or not that's synonymous with situations or an example of them, and it has to do with the correct follow-on example citation. So, in this opening portion, where we're talking about the task force articulating the ideal state, offering a sample workflow, and that it depicts the ideal state end-to-end closed-loop process, that reduces the burden across all stakeholders, accounting for the vast majority of situations. I'm looking for guidance.

Sheryl Turney
I don't think use cases in this context are examples of a situation. I think the use cases we were referring to were all of the different situations that we had discussed, like durable medical equipment, hospital stay, and all of that, and the term "use cases" was describing them in general, so maybe we need to define "use cases" in our appendix in this instance. I think that's what we were talking about.

Alix Goss
Yeah, or we might be able to – I see Jocelyn's hand up. Sorry there, Sheryl, but it may also be simple enough that I think "the majority of situations" is pretty clear. We may just be able to delete the term. Jocelyn, your thoughts?

Jocelyn Keegan
I just added a comment. I would use the term "scenarios" as opposed to "situations," and from a product development perspective, I think in product development circles and the FHIR community, we're using "scenarios" or "exemplars" as a subset of a particular use case. We need to automate prior authorization. That's the use case you're trying to automate, and those exemplars or scenarios of how you would do it for DME or med/surg become different exemplars or scenarios to see what the variation is across those particular use cases.

Sheryl Turney
Yeah, I vote for that word also. I like "scenarios."

Alix Goss
Yeah, I think we're getting agreement to go to "scenarios" and delete the parentheses. Okay, that is the direction I'm seeing from what I'm hearing and reading on the chat box. So, thank you all for weighing in there. Moving along – this is good because we have one or two juicy topics we're going to need maximum time for, so thank you for everybody's effective use of chat boxes and raising hands today.

Scrolling down, Ms. Keegan, I'm glad you're here. So, we are in the guiding principle section now. We are in the measurable and meaningful guiding principle, where we've talked about "The process of reforming and improving prior should be measurable so that the progress can be tracked," and in order for the reform process to be measurable and meaningful, the ideal state was first talking about the characteristic of being driven by patient safety, evidence-based medicine, and the goal of reducing burden.

The second one was that the end of the phase-in process described below, where we talked about this 95% end goal that we have to incrementally get to – we had a comment from Jocelyn on the third subpoint that we felt needed to be discussed, so, as we're looking at this progression toward the 95% of PAs having decision and related determination specifics, there was a comment about "Surveys by groups representing the various stakeholders are used to assess 'satisfaction' and the impacts of the ideal state." So, Jocelyn, in your comment – I hope you're off mute – that "Given prior research here, we must be cautious in what we demand here. It is critical to capture avoided/abandoned prior auth if we're going to do these metrics." Do you want to start to elaborate a little bit and see what you're possibly asking us to do?

Jocelyn Keegan
Yeah. I'll let folks chime in from a public commentary perspective later on if they think I'm horribly wrong here, but when we brought ePA live as a draft standard, and then, later on, as it moved toward standardization within the NCPDP side of world on the pharmacy world, what we found was that there's this concept that I affectionately refer to as a soft denial, and that is that the provider or provider team member – the MA or the nurse that's doing the actual PA work – pulls the criteria down – the question set down – for a particular drug for a particular patient based on the patient-specific information, and they see what the criteria are, and they understand that the patient isn't going to meet criteria.

And, in some cases, because the provider thinks it's the right drug – and, this happens more with specialists than with PCP – they will actually go through the work to document why they think the patient needs to be on this specific drug for this specific purpose, but a lot of times, the provider easily sees that there's a similar drug that's on benefit that's going to have a much lower copay for the patient, and they review that with the patient, and they switch drugs, which is a desired outcome in some ways. How do we make sure that we can get the patient on something that's medically adherent and fits their existing benefit profile? So, if you only capture actual processed PAs, you miss that population of prior authorizations that look abandoned. You wouldn't really know that you got the desired behavior. So, I just think that with any kind of metrics, you need to look carefully at what it is they're asking for to make sure that you're not biasing your data collection toward missing or non-actors in the transaction set.

Alix Goss
So, is there a specific modification you're requesting here? Because I think the point is that satisfaction can be scored in a bunch of different ways, and we want to be careful not to introduce unintended consequences through lack of specificity in our meaning.

Jocelyn Keegan
I hadn't really gotten that far along in my comment because I was hammering through the latest version of the document. I don't know that there's a specific warning here other than the fact that I just think you have to be careful what you ask for because you may get data back that's misleading or biased toward the negative if you're not capturing, so if I were doing this and setting it up, I think I'd need to capture the patient getting on medication for their – or, the patient getting the service or medication that they're looking for, not necessarily the turnaround time of the PA, because sometimes, it's not about the PA, it's about avoiding the PA to get the patient on the right regimen faster, more efficiently, in a way that they're going to be able to sustain and stay adherent with whatever –

Alix Goss

So, it's really to assess outcomes and process satisfaction.

Jocelyn Keegan

Right. I think that's a good way to put it.

Alix Goss

"Assess outcomes/process satisfaction, and…"

Jocelyn Keegan

And, I think I heard the Ghost of Christmas Future because I've already been on a couple of these projects where you don't necessarily end up measuring the right thing.

Sheryl Turney

Yeah, and that was a good point because it has generated some questions.

Alix Goss

Okay, cool. So, what we will – I guess Rich is up next.

Rich Landen

Yeah. The previous bullet talks about tracking and analyzing metrics. This bullet is more about surveys, which is a different critter, and I agree that surveys should be used to measure satisfaction. I'm having some difficulty using surveys to measure outcomes or to – I really don't understand the last phrase of that sentence "…and impacts of the ideal state." So, I'm good with using **[inaudible] [00:24:12]** to metrics in the bullet before, but I'd be cautious not to use surveys as data-driven metrics, and I'm not sure what an impact of the ideal state would be.

Alix Goss

Thank you. Alexis?

Alexis Snyder

Yeah. I had just typed it in the chat box too. I was on the same – you hit half of it on the head already when you said "outcomes." I was going to say it was really about measuring outcomes. But then, as far as the satisfaction piece and to what Gus was just saying, I think maybe it's measuring more experience as it relates to outcomes rather than satisfaction.

Alix Goss

I think that was Rich, but I see what you're referring to. Yes, I'm going to stop editing in the document –

Alexis Snyder

Sorry, I'm staring at the chat box and listening to Gus's name, but listening to Rich talk. You're correct.

Alix Goss

Okay, cool beans. All right, so, I'm going to be capturing some notes. "Also, it's about measuring experience. Surveys are qualitative, not quantitative." Okay. I don't want to miss Rich's comment, and I hope I'm getting that right, and I think Anil is up next.

Anil K. Jain
I just wanted to add something that I heard earlier, but maybe it got dropped. That was the unintended consequences, and perhaps this is the place to put it. The surveys could be helpful in capturing what the industry is feeling.

Alix Goss
Okay. Oh, I think it was "Ideal states ending can be eliminated." I think that was the other part of Rich's comment. So, what I'm thinking is that we've got input knowing that we need to tweak this one, and I'm feeling pretty comfortable that Sheryl and I can work with the editor tomorrow and clean that sentence up.

Sheryl Turney
I usually – go ahead.

Jocelyn Keegan
Sorry for speaking out of turn. I do want to point out – and, I think Gus got what I was saying – my comment was really around this whole section, not just the last bullet, so I really think this idea of unintended consequences is around the percentage goals and targets more than the survey piece. I just don't know how to use the little box that well.

Alix Goss
Oh, okay. Thank you for Gus and – that was really important. "…and is at the crux of…"

Sheryl Turney
All right, homework.

Alix Goss
"…and is at the crux of Jocelyn's comment; thus, relates to section, not just last bullet." That works.

Sheryl Turney
I think Andy asked in the chat if we could look at the whole section again versus just the last comment.

Alix Goss
Okay, Andy. Can you talk with us, or are you just in the chat box? Do you want me to do it now? Because I still have about a half-dozen comments to get through.

Andrew Truscott
Go toward the end. Get the job done, and then we can quickly come back to the beginning. It's just a phrasing thing. That's all. Nothing major.

Alix Goss

Okay, will do. Thank you, Andy. So, let me go down to the next one. Oh, we've got a verb missing here, and we have some extra words here. I don't think these are as critical, so I'm going to come back to these, and also to address Andy's wordsmithing, so I'm going to come back to those in a moment. Let me scroll down to get to our next part. There was a slight heading change to our new guiding principle. "Burden reduction for all stakeholders at transaction points" is the suggested revised title, and there was a question about whether it should also say "at all" or just be "at transaction points." Anyone have an opinion about that? Alexis?

Sheryl Turney
Hopefully, someone does.

Alix Goss
Alexis, I think you were…

Alexis Snyder
Yeah. I don't know. I don't like the term "transaction points." It just doesn't hit me. When I look at "burden reductions for all stakeholders at transaction points" kind of leaves the reader who hasn't been involved in this wondering what that means, and I definitely think it's bigger than "at," like you were asking about. It's definitely throughout the trajectory of all the transaction points.

Alix Goss
But, do we even need "at transaction points"? I'm just wondering if we can just make it "burden reduction for all stakeholders."

Alexis Snyder
How about "burden reduction for all stakeholders throughout the process" or something like that? If the editor really thinks it needs something, it seems to be throughout – I don't know. Just "at transaction points" doesn't sound right to me. I don't know what others might be thinking.

Alix Goss
I see a chat going on. "Across workflow," "across transactions," "across entire process." What did Gus say? "Not sure 'all' adds anything."

Alexis Snyder
I like "process."

Michael Wittie
This is Michael Wittie, just to jump in. I think I'm the one who wrote the "transaction points" thing, which was really just me trying to get at the intersection of clinical and administrative data, so that's the transaction point that I was trying to get to, and if that doesn't work – and, that's why I did – when you say "across the entire process," then you're going back down to the prior authorization level and not broadening to the broader intersection, but that can work out later.

Alix Goss

Okay. We have people who are in wordsmithing mode today, so you've given us lots of options. In consideration of time, we can come back and look at that. I've tried to capture all of your various points. As options, "throughout process," "in workflow across transactions," "entire process," "each step in workflow," "transaction burden reduction for stakeholders across friction points." Is there anything you would like – anything I missed that people wanted – "throughout the entire process." That was the other one that Alexis just put in.

Sheryl Turney
How about "across the clinical and administrative ecosystem"?

Alix Goss
Say that again.

Sheryl Turney
I said "across the clinical and administrative ecosystem." What do folks think about that?

Alix Goss
"Burden reduction across the clinical and administrative ecosystem" is what Sheryl is proposing. Yes, "administrative ecosystem" might leave out the patient, so what I'm going to suggest – you've given us a lot of good ideas. We're going to tweak this accordingly and come up with a new, pithy title for all of this. So, in the same section, there was a new point that Alexis had added, and we just wanted to make sure that folks were aware of this because we really hadn't discussed it before. So, when we're looking at this really pithy guiding principle title that we'll have, one of the subpoints in the ideal state was "Reducing or eliminating demand on the patient/caregiver is the driving force for pushing the prior authorization process forward. The goal is to allow the patient/caregiver to be just that, rather than having to act in an administrative role that could have a negative impact on outcomes."

Alexis Snyder
Just to be clear, I think there's a typo there when it got translating. Should it be "reducing or eliminating demand on the patient or caregiver to be the driving force" or "demand on the patient" – I don't know how I originally wrote it, but whatever has been put in there is not making sense when it says "is the driving force for pushing." It's more like "eliminating the demand to be the driving force," "the driving force that pushes the PA process forward," or "to push the PA process forward."

Alix Goss
"…becomes a" – oh, "is the driving force." I think it's "reducing or eliminating demand on them is a driving force."

Alexis Snyder
Yeah, but that's not what I was saying when I put in the comment to be added. It was about reducing the demand of the patient or the caregiver to be the driving force, reducing the demand for the patient to act that way. The patient and the caregiver should not be the driving force. So, I think it was "Reducing or eliminating demand on the patient or caregiver should be the driving force to push the PA process forward."

Alix Goss

Okay. I didn't get that all captured if you were trying to give me a new wordsmith, and I see that Andy, Jocelyn, and Anil are all in the queue. So, instead of me trying to catch up to you, Alexis, let's see what others in the queue have, and then we'll come back. Is that all right?

Alexis Snyder

Yes.

Alix Goss

Andy?

Andrew Truscott

Sure. I'm rereading, and I think I understand what we're trying to say in the sentence, more because I understand the subject matter than the words. The words are clunky. I would suggest we write Paragraph No. 2 from scratch again because we'll probably get to the goal more quickly.

Alix Goss

Okay, I think we're getting at what is intended, so that may help us with wordsmithing it, so, thank you for that, Andy. I agree. Jocelyn?

Jocelyn Keegan

I like the comment that Sheryl made while I was waiting to speak. I agree with Andy. I think we need to flip the situation because what we want to say is we want to get the patient and caregiver out of the business of having to drive the PA process, which is currently where it often lies or lands, so I was simply wordsmithing "reducing or eliminating demand on the patient/caregiver is the driving force," and I just say "to reduce, remove, or automate the PA process going forward," but I like the idea of flipping it around so that it's a positive statement, like "reducing, removing, or automating the PA process will remove hardship and burden on the patient, who often ends up driving this process," or something to that effect. But, if Anil's behind me, I'm sure he's going to say it better than me.

Anil K. Jain

I doubt that. I was just going to say that whatever we write here – and, I like the idea of blowing it up and rewriting it to capture Alexis's and Jocelyn's points – the main thing is that we don't want to lose sight of the fact that we are making this a patient-centric process. So, while we want to make it patient-centric, we don't want the administrative burden to fall on the patient or the caregiver, and somehow, we need to be able to settle that. You want the patient to ultimately be in the middle – not in the middle, sorry – should be aware of everything that's going on, but shouldn't be burdened with the administrative aspects and, at the same time, should not be disintermediated.

Sheryl Turney

Exactly. I think you've got that point. Anil, the way you've said it is helpful.

Alix Goss

Okay. What I'm hearing is a kumbaya. Ooh, did I just see – okay, someone's typing here. So, folks, you are rapidly iterating in the chat box. I need somebody to give me a final on that because I'm going to keep moving, and you can tell – give me one sentence because I can't track all that. Yes, Alexis?

Alexis Snyder
I had just written in the chat box that we had added – given the same comment in the summary, and that got added to the summary, and it's worded slightly differently, which is probably clearer there. So, I'm suggesting we use the same wording, so when you get to the bottom of it, people will see it, but maybe make a note to grab the wording about –

Alix Goss
Oh, you mean the conclusion.

Alexis Snyder
Yeah, the patient not being an administrator.

Alix Goss
The conclusion section – well, thank you, because I worked on what you and Sheryl offered and wrote that section, so, thank you. "…as the language is likely usable." Okay. I don't know – Accel Solutions – are we able to get the chat box threads if we want to get –

Sheryl Turney
I copied those, Alix. I have the chat box. I'll bring it to you tomorrow.

Alix Goss
Perfect. I appreciate that. So, I'm not seeing any hands up, so I am moving on. We've left guiding principles, and we're now in the recommendations section. So, we open up with some discussion about levers, et cetera, and who might be able to assist with transformation efforts, and then we start to get into the specific recommendations. In Recommendation 1, there was a suggestion from Rich that we wanted to bring forward, and when we're talking about the prioritized administrative efficiency and relevant federal programs, the closing paragraph that was added was "To accomplish this, the task force suggest that federal payment programs provide targeted incentives." Since this was new, I just wanted to open it up, and although you've clearly all read the draft that we released on Friday, I just want to make sure that we have our due process here.

Oh, and Rich further underscores that this was a purple text that we had previously captured in our discussions, but missed in an initial draft; thus, that would probably explain why nobody is commenting, so I'm going to say it's okay, and that means I also get to check the box, and that comment is resolved. One fewer thing for us to do tomorrow. Thank you.

Moving on now, we're going to move down to the next item, which is in Recommendation 7, "Develop patient-centered workflows and standards." In this, Sheryl suggests adding a point that patients should have the ability to receive paperwork from their providers to support their patient care journey – for example, surgery preparation documents, discharge summaries, and operating notes. I believe this was incorporated somewhere in this portion.

Sheryl Turney
Anil has his hand up.

Alix Goss
Thank you. Anil?

Anil K. Jain
Yeah, I just want to make sure I understand this because aren't we already required to produce after-visit summaries as part of promoting interoperability now, formerly known as "meaningful use"? What am I missing here?

Sheryl Turney
So, what's missing here, Anil, is that what is included in that is currently different for every provider, and the paperwork is not given digitally. It's basically a paper. And so, in talking to groups of patients with chronic illnesses, this is actually one of the things that came out of some of those discussions I've had, where they are individuals that are not paper-centric and would rather be able to have their prep documents in the digital process, have their discharge summaries digitally, and it's especially helpful if they're going to coordinate care between two professionals that are dealing with situations with an individual that are similar, but not the same. Often, they want to see operating notes and things like that, which are not included in the patient summary, and they're not included currently in the EMR systems that are visible to the patient, and that's why I specifically brought them up here.

Anil K. Jain
Okay.

Alix Goss
Okay, so, I – go ahead, Anil.

Anil K. Jain
I agree with the comments that are being written in the chat box. I think this is a broader issue. Sheryl, you're making a good point that there might be other mechanisms outside of the PA process where this would also be incredibly relevant and helpful, and maybe to expand the types of documents that are covered under the disclosure of the patient's preferred route of communication, for example, but there might be other ways for us to make that recommendation and just to add those types of documents to the existing mandates.

Alix Goss
Yeah, that's a good way to put it. Alexis also had her hand raised, and I think she had some notes in the chat on this topic.

Alexis Snyder
Yeah, I didn't want to take up time, so I was just typing while Anil was talking. I'm just confused because, like Anil was pointing out from the comments, it's broader than the task force for PA. It feels more to me like we're talking about an open-notes task force now, and as far as getting those electronically,

depending upon who actually has open notes available or not, you can request those electronically, so that is something that already exists today.

Sheryl Turney
Right, but this isn't a prior authorization task force. This is the intersection of clinical and administrative data, so it's broader than –

Alexis Snyder
But, we've been basing our examples on prior authorization, so I guess that's where I'm confused, but I guess what I'm also trying to point out to you is that that already exists today. That information is available electronically if requested electronically versus paper. It's just an issue on how to get it and an issue of transparency. And, I just want to quickly –

Sheryl Turney
I don't agree because it's come up in multiple meetings that I've been in with groups of patients, and they've brought it up in multiple meetings, both –

Alexis Snyder
So, it depends on the healthcare system that you're in and how open the notes are or not, but all of that information is available to you, and you can request that, and it must be given to you, and most of the systems today – as part of the law in getting your records that things that are already in the system electronically need to be available electronically to patients as well, so unless it was never entered into the EHR and it's only been handwritten and therefore can't be given to a patient electronically because it doesn't exist, where the EHR has the information electronically, by law, it must be passed on if requested electronically.

So, I think it's just more about the patient or consumer not being aware of how to actually get it, and that's probably a different issue than what we're doing in this task force because it is available. That's what I was saying. The chat box got moved down, so I can't see who said it now, but I think Rich said it, about taking a final look at the comments we just talked about earlier about not burdening patients with being in between, but then, it sounds like folks are now saying, "Oh, but patients want the information." It's both. There's a place for both, and I think we already have that in the document in both places. It's about reducing the burden to have to be involved and push things forward, but at the same time, you should have that information available to you if you want it to be able to help push things forward. You shouldn't have to, but it should still be transparent, and in my opinion, I think we do capture both those in two different sections.

Alix Goss
I think we have some cleanup work to do, but I also see that Jocelyn's hand is raised.

Jocelyn Keegan
The only point I was going to share, to Alexis's point, is that I think that with both regs coming out of CMS and the movement forward with USCDI, we're seeing more and more clarity to the clinical data both on the provider's side and the payer's side to be expected to be available and portable to patients. So, I think we're seeing that sentiment way beyond this task force, and if I go back to where we started these

conversations, where folks were sharing personal testimonies and experiences around prior authorization, that patient has a view into an episode of care, and what the patient or the caregiver's patient is going to need through the whole process has a unique seat at the table, so, being able to have that transparency is critically important because often, the patient or the patient's proxy is going to catch something that's missing, stopped, or stuck in a way that our current disparate healthcare system isn't going to catch. So, giving people a place to monitor, check, nudge, or share missing information is critically important.

Alix Goss

Thank you for that. Anil is next in the queue.

Anil K. Jain

I was just going to quickly add that I think the broader issue – let's assume that we are living in an ideal world and all these documents are freely available to all the stakeholders. The problem that the patient and caregivers have is that there's an asymmetry. Often, the documents are in medical speak, and so, if anything, one of the recommendations or comments we should be making is that if we're going to make the patient a part of this, give them access to these documents, and have them be part of the process, then there needs to be some medical literacy component to these documents. And so, I don't know how to put that in the recommendation, but one of the challenges is that even in an open-notes environment or in document sharing, you can't just start reading it and make sense of it immediately. So, if anything, I think it's really going to be about just having access, but the ability to actually comprehend what it is that's being done to you or to your loved one as a caregiver.

Alix Goss

Okay, I'm just making an edit.

Anil K. Jain

It's sort of like the lay-friendly language that needs to be –

Alix Goss

"…ensuring they can comprehend notes and documents beyond the transparency aspect that all agree to." Okay, cool. So, that is helpful. I think we've got enough to work with. I'm going to suggest that we move on. Sheryl, I think your Adobe is reconnected and you're all set, but I just want to make sure you're good to go before I move on to the next item, which is attachments. Maybe she's lost audio as well. She's typing.

Sheryl Turney

No, I'm back. I have everything back. Thank you, Alix.

Alix Goss

Okay. So, moving on to the next topic, this is the juicy one that I was referring to in that in Recommendation 9, we suggest that we name an attachment standard, and what was captured as the attachment standard was to build on the existing HIPAA version of the X12 standards that are in existence today, and so, it was captured previously as being the 275 Version 5010 that we were suggesting in here, and what we've noticed is that that does not comport with other industry

recommendations that have been advanced by NCVHS in that four years ago, we suggested that we would go to Version 6020 of an EDI standard, and so, I think that there's not only that disconnect, but there's also been task force discussion about the haves and the have-nots, and from our presentations, we've seen organizations advance different kinds of solutions for exchanging clinical data, and so, we thought we should open it up for discussion today about what we should be asking for in an attachment standard.

Is it that we know enough to ask a specific version today, or is there a proposed rule that we want to have advanced, knowing that we've asked for rulemaking since HIPAA, Affordable Care Act, and numerous NCVHS letters? What is it that folks might like to suggest here to help with clarity on next steps? I see Rich Landen's hand up.

Rich Landen

As I recollect, in our task force discussion of this a few meetings back, we had some good reasons for 5010 specifically, as that is pretty much the common version that's implemented. But, Alix raises a good concern. NCVHS has recommended the 6020, and over the last month, NCVHS has held hearings on some operating rules, which, in and of themselves, are not germane to this task force, but the discussion around the operating rules adoption did get into this need for an attachment, and I would like to suggest that we stay fairly generic, and I'm thinking of either just totally saying generic and just making a recommendation that the attachment standard be adopted or we do something like adopt the 5010, the 6020, or a future version that is appropriate at the time.

Part of the necessary background to understand this is that the rules adoption process is essentially a four-year process, so whatever it's recommending as best for today may no longer be best four years down the road. So, I think we need to stay open-ended. I think it's a critical point that we should recommend an attachment standard be adopted, but we need to give a lot of flexibility to the process of rule adoption for determining exactly which version of the standard or standards that might be.

Alix Goss

Thank you, Rich. I'm seeing some chat box feedback, and I'm going to call out some folks because they're not raising their hands because they're busy typing. I'm going to call on Andy Truscott.

Andrew Truscott

Hang on.

Alix Goss

Hi, Andy. Would you like to share what your question?

Andrew Truscott

I couldn't figure out if I was on mute or not. So, the point I was going to make was yeah, sure, I get the EDI standards, but shouldn't we be recommending creation and alignment of and moving to something that's FHIR-based?

Alix Goss

Okay. So, Andy, what I think I just heard you say is sure, we've got X12, but why not have something that's tracking more with FHIR as a viable option as well?

Andrew Truscott
If we're going to develop and enhance, then we should absolutely be moving to modernized standards to do that. That's my belief. And, if we're not, then we should be creating something in parallel that uses modernized standards.

Alix Goss
Jocelyn, I see your hand is up.

Jocelyn Keegan
I think it's not necessarily an "or," I think it's an "and," and we deal with this in the work we're doing in prior authorization with Da Vinci today. We're doing all the predecessor tasks up to the actual submission of the 278, and then we crosswalk and are doing the mappings between the two standards, and at its core, the 278 is a container that allows you to put whatever you want as a blob of data inside of it, so there's nothing to say that that blob of data couldn't be a FHIR packet that is well-defined and coming out as structured content from an EHR, but I do want to emphasize that I agree with Andy and Arien here. We've invested a tremendous amount of money to get that data at rest into a format via API that can be available and used in real-time workflows with FHIR in the work that all the EHRs and our provider organizations should do, so I think we need to look at that as a viable solution to free that clinical data to flow.

Alix Goss
Okay, thank you. Arien, I see you've been actively chatting there. I tried to capture what I think was your final suggestion, so I'm going to call you out and ask if you can get on audio. Oh, you're having phone issues. Thank you for letting me know that. So, I think I captured "Agree with adopt a standard and align to the future direction." I'm not sure how we would craft "align to the future direction." I think it's "align to" – ah, Andy, your hand is up. Are you speaking to Arien?

Andrew Truscott
Yeah, I was going to add a bit more to that. I think we're actually saying – well, at least I'm saying rather than going with EDI, as a recommendation, we should say that any new development around prior authorization or any of the other things we're talking about with ICAD should be done through the medium of FHIR.

Alix Goss
So, what I just heard you say is we should be advancing FHIR as a good solution to help with bridging broader intersection of clinical and administrative data.

Andrew Truscott
Including prior auth, yes. I think our go-to should always be FHIR, and by exception, we should do other things as well.

Alix Goss

Okay. "Recommend FHIR" –

Andrew Truscott
That's a pregnant pause of unhappiness, isn't it?

Alix Goss
It was me trying to capture your note while noticing that Arien is still typing and Jocelyn's got her hand up. So, Arien, I think you just gave this to me, which is "Further clarified by Arien – 'align to future direction' means 'align to harmonize'" –

Andrew Truscott
We're not saying to shoot EDI. Far from it. We're just saying that new developments should be preferentially upon FHIR, and then, if we still need to support other standards as well, we should bring those up as well.

Alix Goss
So, what you're saying is we should be promoting things in the FHIR sphere, but because we know they can work with and build on EDI investments.

Andrew Truscott
Correct, but Arien is saying something slightly different because Arien is saying we should go with whichever approach is quicker, and then fast follow with the other things that will be useful too, and I must confess I'm probably not in the same thought space as Arien is on this one because I think it would be beneficial if we promoted and preferentially pushed FHIR, but, that said, by exception, we might need to make that base for EDI too. I'm not really being that helpful, so I'll stop talking and let Jocelyn jump in.

Alix Goss
Okay, but before she does, I'm going to interrupt and say Andy, what I think I'm hearing from this discussion is we are not going to easily garner consensus on what the nit and the nat should be when we come back to Rich's suggestion that says to get high enough in our recommendation that's going to produce an attachment to proposed reg coming out the door and let the industry weigh in. That's what I think I heard, and where I suggest we go.

Andrew Truscott
We may not be unanimous. We might be able to come to consensus if everyone else says, "We disagree with you, Andy," but I don't think we're going to be unanimous.

Alix Goss
I didn't quite follow everything –

Andrew Truscott
[Inaudible] [01:00:32], so you could tell us.

Alix Goss
Jocelyn?

Jocelyn Keegan

I do think that Andy's last point there, that consensus doesn't mean we're unanimous, is important, and I think that I would want to get the point across that I think Andy is attempting to make, which is that where we can, we should use FHIR as an accelerator for the industry and take advantage of the power and breadth of access to the clinical data and the workflow that we get out of FHIR, but having worked with payers over the last decade, I appreciate the investment and the existing impact of what we do on the 278 front today.

So, one of the things that I often speak about, both in my consulting world and the work I get to do in Da Vinci, is that one of the amazing powers of FHIR is that ability to act as a bridge to meet different participants in the industry where they're at, and where folks can jump over a bar and do everything with FHIR, I think we should give them permission to do that, but there needs to be some base level of minimum that the market needs to be able to support. Today, that minimum current state is basically the ability to submit and give an answer – a determination with a 278. That's state of the art. Can somebody accept a 278? Can somebody get data back with the determination of a 278? Any sort of maturity varies wildly based on current implementations across the payer community today.

The ability to accelerate the ability for that submission determination process to happen in real time with the right clinical data in workflow is a great example of where the power of FHIR can be unleashed between payers and providers, and so, I guess I'm of the mindset as I look at these updated comments or the way that things are written today is that it's not clear to me that for prior auths – maybe for other X12 transactions – that the mandatory adoption of the 275 is necessary at this point in time. I think there being some floor of support to free clinical data through a number of different ways so that the industry can evolve and move beyond older technologies would be desirable, but I defer to other folks on the phone. When we're on the precipice of rolling out FHIR and APIs across the industry, I don't understand why this would be the time that we would drop a mandatory 275 rule for prior authorization because I think we are seeing so much promise in FHIR-based payloads for prior authorization.

Alix Goss

So, to that point, Jocelyn, if we're going to recommend a minimum baseline be adopted for an attachment policy statement, we've got an install in 5010, but we've also got an emerging install in FHIR, so is it that we need the ability to – we've been talking about managing – trying to advance recommendations that respect the investments of the past, so is there a need, in this case, to actually provide the "and" situation and let the industry weigh in a rulemaking because this has got a lot of sea legs?

Andrew Truscott

I'll be potentially getting over prescriptions when we start talking about attachments in this way. Should we just purely be talking about information being supported by EDI standards as of **[inaudible] [01:04:30]** and FHIR?

Alix Goss

Can you say that –

Jocelyn Keegan

And, Alix, in my comments, I think that what Andy's getting at is a really important point. I feel like our recommendation is that clinical data needs to flow.

Andrew Truscott
Yeah.

Jocelyn Keegan
I don't think that we need to say in this document that it should be this transaction set versus another transaction set. I think we should acknowledgement that there is significant investment in existing technology and that whatever we do needs to bridge, but clearly sell out that there's promise of fielded clinical data that can be automated because if you just require the 275 and I've got a PDF inside of it, I don't get to automation. I don't get to that real-time answer. If the 275 has a FHIR payload or some sort of structured information in it, it means my chance of getting automation is better, and that's what we're really after here. How do we actually reduce the burden? If we're taking the data and the data format out of the EHR and getting it over to the payer and we want to keep it fielded so it can be automated, I think that's what the focus needs to be in our commentary.

Alix Goss
Okay. We need a minimum baseline attachment capability adopted, and one that –

Jocelyn Keegan
Alix, I don't know why we're calling it an attachment capability because to me, it's about clinical data. The reason the 278 doesn't work today is because the clinical data that you need for determination is missing, and it's about making the clinical data portable. Sorry, I didn't mean to cut you off.

Alix Goss
Right, but Jocelyn, you're getting at the crux that we have a terminology within our healthcare system that talks about attachments as the data that is not already available in a mandated transaction, so the point is that an attachment – it's very important that we don't let people open up the door to say, "I'm going to ask you whatever I want." The attachment was only ever intended to bridge the gap when the data element couldn't be exchanged or wasn't already in the existing part of the mandated transaction. So, I think that you get at this aspect of an attachment. We've talked about it historically as a claims attachment, but we've evolved past that to just be the attachment; thus, what we don't already have our fingertips on or can get at through our mandated transactions.

So, if we want to focus this on the clinical data needs being exchanged, that makes sense to me, and I'm trying to manage how we want to position this and get consensus on that in this call so that we can reword this tomorrow and get it out the door, and as my co-chair is nudging me on, we still have other comments to get through here today, and this is a very robust topic. I've been hearing from about three of you, and so, I'm looking for somebody to help give me a proposal so we can call the question and move on. The proposal could also be what the text is you want us to write or a proposal that you volunteer to craft something for all of us to look at because we've got 24 hours to figure out the revised text. Jocelyn, your hand is up.

Alexis Snyder

Sorry, I just typed my answer. I agree with what Andy's saying in the chat box, Alix, which is that I think we are set on this concept of an attachment, and if we're really talking about moving the ball forward, we need to move beyond the concept of an attachment, and we really need to focus on the missing clinical data, and we do this today with script. There are tons of transactions that have data missing, but if there are other folks who feel strongly that we need to keep the "attachment" word, I'd love to hear from them.

Alix Goss
Next in the queue is Andy.

Andrew Truscott
I agree with what Andy was saying in the chat box too. My suggestion would be we discuss information and information exchange, and then we probably say – to Rich's point – an example of this would be the inclusion of an attachment in the EDI standards because Rich is right. FHIR isn't a national attachment standard, but it's a vehicle by which similar – if not the same – information could potentially be exchanged. And, Arien's right. Right now, it's all about EDI, so we should just – I think we can probably move on, talk about information, and then give an example of EDI attachments.

Alix Goss
Thank you. Anil?

Anil K. Jain
I don't know whether this is – when we put this language together, it was really about any information that's not going to be able to be packaged up in the current terminology and standards that we have, and it was supposed to be used in a minimal way, but you guys convinced me that we needed an attachment standard. Maybe we don't specify an attachment standard, but it should be suddenly used; there are going to be cases where additional information needs to be presented that is not going to be captured in the traditional ways in even electronic systems. So, we absolutely need that. I think the examples that you provided me that convinced me were PDFs that might need to be transmitted along. So, I think we do need something, but we don't need to specify exactly what it is. Maybe we punt that to another group and just basically say that a standard must be agreed upon.

Alix Goss
I thought this might be a hot topic today, but this is one of the most active conversations you guys have all been weighing in on. I'm kind of surprised you didn't weigh in in the comments when you were reviewing the document because I'm not sure if the version issue created a new lens on this. Anil, your hand is still up. Are you good? Okay, it's down. So, at this point, I'm going to say you guys have given a lot of thought to this. I have to move on in consideration of the other things. I'm not sure what we're going to do about it, so stay tuned. We might come back to it, along with the other items I've punted on today. Jocelyn, I don't know that we can talk about the new idea that you threw out there last week, which was if we should require support for electronic appeals. I don't know that we can talk about that today, so I'm going to put on a hold for future discussion because it was a new topic, and depending upon what we get back from ICAD, we may need to come back to this document extensively anyway.

So, the next comment – because I know I'm six minutes away or so from public comment period – Recommendation 14. We wanted to confirm with everyone that you were all good to go with this

recommendation. This has really come out of the last five weeks of discussion on the broader intersection of clinical and administrative data. Recommendation 14 is now titled "Establish patient authentication and authorization to support consent." We talked about this in the last meeting. I wanted to really just make sure that everybody was good on that section because it had been massaged heavily at the last call. Rich is making a comment in the chat box. "We've tied this in the future state section. I'm fine with adding Recommendation 14. I do believe that from a guiding principles perspective that it would have been in the prior state section." I think we're fine. I think we have done that, but I will make a note.

Sheryl Turney
It is tied in to the guiding principles and future state, Alix. That's really where this came from.

Alix Goss
Okay, thank you. It's done, then. Okay, I'm not seeing any hands up or any further chat boxes, so I'm going to move on to the Recommendation 15 comments. We have revised the recommendation header and new bullets, so Recommendation 15 was to establish test data capability to support interoperability, and that we want to have HHS lead development of a national approach, and we then had some new bullets related to the review of current transactions and code sets aligned with USCDI. Establish illustrated information models and support for secondary uses. Establish minimum data set for transactions to adhere to minimum necessary and advance an appropriately constrained IG as a standard.

Sheryl Turney
No hands.

Alix Goss
Okay. So, I think we're okay on this. I'm not seeing any comments on it. Since I got through that, I can now say that we have gotten through the comments. The only one remaining is if we choose to do a crosswalk, so with four minutes left before public comment period, that permits me to return to our earlier sections, so that means that I'm going to need to scroll back up because we had – let me see. I knew Andy had something, so let me come back up here to Page 26. I left off there, and I said I needed to come back to…ah, okay.

So, in the real-time data capture and workflow automation guiding principles, our editor noted that when we are describing the real-time data capture, the ideal state characteristics No. 4 seems to be missing a verb, and we're looking for how people want to frame this about "Any workflow utilized to support prior authorization auto-generate editable content to document the medical necessity and the progress visit note so that clinicians do not need to redocument or rejustify the prior authorization request." So, we were looking to have this potentially tweaked a bit if there was something missing. I don't know if Susan is able to come off – hi, Denise. I see your hand is up.

Denise Webb
Isn't the verb "auto-generate" and it's just missing an S? "Any workflow auto-generates" if you cut out the "any workflow," and I would say "used" instead of "utilized." "Utilized" is an overused word. "Any workflow used to support prior authorization auto-generates editable content."

Alix Goss

Got it. I think you're right, that that would probably – we'll take a look at that. The next one from Susan was in No. 5, "All insurance coverage is identified and verified on or before the point of service. Related supports are provided for ongoing coordination of benefits that allows for efficient and comprehensive coverage as allowed." It gets a little bit unclear for her when we get into the next sentence, which says, "For example, verification of insurance coverage eligibility is completed and supports ongoing coordination of benefit activities, or the provider and the patient have full transparency into coverage requirements, medical evidence required by the insurance for the proposed treatment plan."

I think this example is actually two examples. It's either that they've gotten everything through the coordination of benefits or they already had full transparency. I think that's what might have been meant. I don't know if anybody has any thoughts on that – how we might make this a little bit clearer.

Sheryl Turney

Right. So, I think the difficulty here was Alexis's point how the patient should understand how coordination of benefits works before they actually get the service instead of having to find out later because I think there are some missed understandings where the focus of one policy might be **[inaudible] [01:18:49]** limits and another policy, other limits, but basically, don't start at zero and then go to the next thing. So, if the underlying policy covers up to $1,200.00 and the secondary policy covers up to $1,400.00, the only thing that second policy is going to cover is the additional $200.00, and perhaps some patients think it's going to be the next $1,400.00, and that's not how it works. Alexis, I don't know if that's what you're talking about here, but if that's what this point is trying to go after – and, she has her hand raised, too.

Alix Goss

Yes, and we've also just been notified that it is 4:20 for public comment period, so I'm going to have to ask Alexis to pause for a moment in responding and turn it over to Lauren.

Public Comment (01:19:49)

Lauren Richie

Sure. Thanks, Alix. We'll ask the operator to open the line.

Operator

Thank you. If you would like to make a public 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 line 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.

Alix Goss

Thank you. Alexis, the floor is yours.

Alexis Snyder

Unless I'm getting dizzy with the scrolling up and down about which section it is – we might have to go back and look at it again – I don't think that's the section that I commented on last week, and I was asked during the edit process to go and fix that paragraph that I was referring to about coordination of benefits, and I did, and it was accepted and explains it better, so I think this was trying to say something else that

I'm not sure about, but my overarching comment is that that's the comment from last week, and the section where I did correct it as asked was, again, not about a patient understanding how that works. It was about the actual coordination of the benefits aligning because sometimes, the second plan will not cover something the first one did, and the first won't cover the alternative that the second is suggesting, and somehow, those two need to be aligned so that the benefits work together, as they should, to have it covered. But, without scrolling through the whole document, I can't really tell you where that other section is. It was earlier.

Alix Goss
Okay. So, it may have cleaner text –

Alexis Snyder
And, it may **[inaudible – crosstalk] [01:22:00]** it's trying to talk about something else, which is what I thought it was.

Alix Goss
Thank you. So, Rich made a comment about getting at that "Patient has full visibility into coverage requirements and benefits across all the patient's coverage plans," and that's sort of what we're getting at there. I think we can take a look at that and try to pull those pieces together with your additional clarifications. If we remain struggling on that, we know where to find you, Alexis, and we can reach out and possibly ask you for a double-check. Andy, you had a comment about some wordsmithing or lead-in section. Do you remember where that was?

Sheryl Turney
I thought it was the first comment.

Andrew Truscott
Yeah, the very first one we looked at. It wasn't a problem, but just a bit of grammar.

Alix Goss
I know it was just an hour ago, but it feels a lot longer than that.

Andrew Truscott
[Inaudible – crosstalk] [01:23:22]

Alix Goss
Okay. No, it wasn't a heading. I think it was a scenarios one. I think it was a standards…

Andrew Truscott
No.

Alix Goss
Okay, maybe you can take a –

Sheryl Turney

[Inaudible – crosstalk] was that it was an edit where we got some clarification or rewording from Gus, so that's the note I had made when he made that comment, but I think that's the one that we already accepted.

Alix Goss
Right, it's up here.

Andrew Truscott
Yeah, I remember it. It was – I just thought the word "stop…" It felt a little bit clunky. My authorization –

Sheryl Turney
Yeah, replacing the word "stop" with "inhibit," "delay," or something like that.

Andrew Truscott
Yeah. "Stop" is an absolute, "potential" is a non-absolute, so maybe "prevent," "inhibit," something like that.

Sheryl Turney
That's a good point.

Andrew Truscott
And, the way the sentence is structured, prior authorization permits this, so it's either a delay in prior authorization or a non-prior authorization – that's bad language, but do you get what I'm saying? Prior authorization is a permissive statement. The permissive statement does not have the potential to prevent unnecessary care. It's the lack of prior authorization that does.

Gus Geraci
This is Gus. I'm sorry to interrupt. The sentence that's on the screen right now has been amended.

Andrew Truscott
I know. I wasn't comfortable with the amendment; I just didn't say anything at the time.

Alix Goss
Oh, okay. So, you weren't okay with it, and we accepted that. You're looking at this – this is what's being revised. This is what it says now; this is what we agreed to change it to an hour ago.

Sheryl Turney
Maybe the one –

Alix Goss
And, "stops" –

Sheryl Turney
Instead of stops –

Andrew Truscott

Yeah, but I would say that when you say "stops unnecessary care" – no, we can provide unnecessary care with or without prior authorization.

Sheryl Turney

How about "prevents unnecessary care"?

Andrew Truscott

"Can prevent unnecessary care."

Gus Geraci

I like reduces because you're right, it doesn't stop everything because not everything is prior authorized, but it does reduce unnecessary care.

Andrew Truscott

"Can reduce" or "does reduce…" I like "can prevent." The point is that we can absolutely do poor care with or without prior authorization.

Alix Goss

Okay, "can prevent."

Andrew Truscott

Anyway, I wanted to get back to it. Thank you.

Alix Goss

You're welcome. We have two minutes left, and actually, I wanted to go back to the appeals issue from Jocelyn. I think we're going to have to punt that one out a little bit further until our next iteration of opportunity, and I think that – oh, Rich is proposing "poorer" as an option, but I'm sure we'll have more wordsmithing opportunities. I believe we now need to pivot back to our wrap-up for today, so that would mean we'd stop sharing my screen, and we'll go to the next slide if we can advance in the deck.

Okay, so, where we're at, folks, is Sheryl and I are going to take your feedback from today, we're going to work with the editor in a several-hour work session tomorrow so that we can update the draft report, and we can get it ready to go to HITAC Thursday, and that means that next week, we're going to have a meeting, and we'll be able to fine-tune some of our maturing of the report, executive summary, appendices, et cetera, and then, the following week – I'm sorry, following next week's Tuesday session, we will meet with HITAC on Wednesday to present the draft, which they will have hopefully had a chance to review. All of you HITAC members have a leg up on your colleagues in that you've already read this, but we will hopefully be able to have a very robust discussion on the 21st with all of HITAC, enabling us to come back here on the 27th to discuss that feedback and figure out what's next, including report revisions and assignments, so that we can get to a final report submission, and I believe we are at the end of our time. Sheryl?

Andrew Truscott

I just want to say you've done a really good job on this. It's a really good document. Thank you.

Path to Report Submission (01:28:49)

<u>Sheryl Turney</u>
Thank you for that, Andy. We really appreciate it. So, here's the report timeline. We do have another meeting next week on the 20th for any final discussion. Certainly, we're going to submit the report to HITAC. We do fully expect to get some comments back from them, so if there are some final editorial changes that you want to make, let's be aware of those, and we can discuss them next week. Do we have any final action items for the team? Alix, do we want to do anything between now and then?

<u>Alix Goss</u>
Stay tuned. Watch your email. We'll let you know.

<u>Sheryl Turney</u>
Thanks.

<u>Andrew Truscott</u>
Take care. Bye, all.

<u>Alix Goss</u>
Thanks for all your help, guys. It's really important.

<u>Lauren Richie</u>
Thanks.

<u>Sheryl Turney</u>
Thank you.

Adjourn (01:29:41)