Health Information Technology Advisory Committee (HITAC)

VIRTUAL

Meeting Notes | February 8, 2023, 10 AM – 12:15 PM ET

EXECUTIVE SUMMARY

Micky Tripathi, the National Coordinator for Health IT, Office of National Coordinator (ONC), welcomed everyone to the February 8, 2023, virtual meeting of the HITAC and provided an overview of ONC's recent program updates. The co-chairs of the HITAC, **Medell Briggs-Malonson** and **Aaron Miri**, welcomed members, reviewed the meeting agenda, and presented the minutes from the January 19, 2023, HITAC meeting, which were approved by voice vote. **Medell Briggs-Malonson** and **Aaron Miri** presented the Draft Annual Report for FY22, which was approved by voice vote. **Sarah DeSilvey** and **Naresh Sundar Rajan**, Interoperability Standards Workgroup (IS WG) Co-Chairs, presented an IS WG update. **Alexandra Mugge**, CMS Office of Burden Reduction & Health Informatics (OBRHI), presented the CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule. **Alex Baker**, ONC Office of Policy, presented on HHS Alignment - Pharmacy Standards in Part D NPRM. HITAC members held public discussion sessions following each presentation. There was a robust discussion in the public meeting chat via Zoom.

AGENDA

10:00 AM	Call to Order/Roll Call
10:05 AM	Welcome Remarks
10:15 AM	Opening Remarks, Review of Agenda and January 19, 2023, Meeting Notes – HITAC Vote
10:20 AM	Revised Draft HITAC Annual Report for FY22 – HITAC Vote
10:50 AM	Interoperability Standards Workgroup Update
11:05 AM	CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule
11:45 AM	HHS Alignment – Pharmacy Standards in Part D NPRM
12:00 PM	Public Comment
12:15 PM	Final Remarks and Adjourn

CALL TO ORDER/ROLL CALL

Mike Berry, Designated Federal Officer, ONC, called the February 8, 2023, meeting to order at 10:02 AM and welcomed ONC's executive leadership team.

ROLL CALL

Medell Briggs-Malonson, UCLA Health, Co-Chair
Aaron Miri, Baptist Health, Co-Chair
Shila Blend, North Dakota Health Information Network

Hans Buitendijk, Oracle Health
Sarah DeSilvey, Larner College of Medicine, University of Vermont
Steven (Ike) Eichner, Texas Department of State Health Services
Lisa Frey, St. Elizabeth Healthcare
Hannah Galvin, Cambridge Health Alliance
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Valerie Grey, State University of New York
Steven Hester, Norton Healthcare
Jim Jirjis, HCA Healthcare
Bryant Thomas Karras, Washington State Department of Health
Kensaku Kawamoto, University of Utah Health
Steven Lane, Health Gorilla
Hung S. Luu, Children's Health
Arien Malec, Change Healthcare
Anna McCollister, Individual
Clem McDonald, National Library of Medicine
Deven McGraw, Invitae Corporation
Aaron Neinstein, UCSF Health
Eliel Oliveira, Dell Medical School, University of Texas at Austin
Kikelomo Adedayo Oshunkentan, Pegasystems
Naresh Sundar Rajan, CyncHealth
Alexis Snyder, Individual
Fillipe Southerland, Yardi Systems, Inc.
Sheryl Turney, Elevance Health

HITAC MEMBERS NOT IN ATTENDANCE

Cynthia A. Fisher, PatientRightsAdvocate.org

FEDERAL REPRESENTATIVES

Thomas Cantilina, Military Health System, Department of Defense (DoD) *(Absent)*
Adi V. Gundlapalli, Centers for Disease Control and Prevention (CDC)
Ram Iyer, Food and Drug Administration (FDA) *(Absent)*
Meg Marshall, Department of Veterans Affairs
Alex Mugge, Centers for Medicare and Medicaid Services *(attending on behalf of Michelle Schreiber)*
Ram Sriram, National Institute of Standards and Technology
Nara Um, Federal Electronic Health Record Modernization (FEHRM) Office *(Absent)*

ONC STAFF

Micky Tripathi, National Coordinator for Health Information Technology
Steven Posnack, Deputy National Coordinator for Health Information Technology
Elise Sweeney Anthony, Executive Director, Office of Policy
Avinash Shanbhag, Executive Director, Office of Technology
Mike Berry, Designated Federal Officer
Alex Baker, Federal Policy Branch Chief, Office of Policy

WELCOME REMARKS

Micky Tripathi, the National Coordinator for Health IT, welcomed everyone and thanked HITAC members

and federal representatives for their hard work. **Micky** thanked the IS WG and Annual Report Workgroup (AR WG) members for their work reviewing the Draft United States Core Data for Interoperability Version 4 (USCDI v4) and Annual Report, respectively. The public can submit comments on USCDI v4 through April 17, 2023.

Micky provided an overview of ONC's recent program updates, including:

- 2023 ISA Reference Addition, individuals are welcome to submit feedback for the ISA at any time.
- The Sync for Genes Webinar, in which individuals learn how HL7 FHIR and other standards have been tested throughout the genomics pipeline. This webinar was scheduled for February 28 from 2-3:30 PM ET, but was subsequently postponed until a later date.
- The first joint ONC and CDC Industry Information and Collaboration Day will provide an overview of CDC and ONC's plans to modernize health data and information systems. This event will be held virtually and in person on Feb 27 and 28.
- The ONC Health IT Certification Program Developer Round Table in which ONC will discuss certification updates, deadlines, and developer requirements. This event will be held on March 22 from 12-1:30 PM ET.
- The HHS event recognizing QHIN applicants. This event will recognize the first set of QHIN applicants to proceed with the implementation of TEFCA. This event will be held on February 13 from 11 AM -12:30 PM ET and live streamed on HHS' website.

Opening Remarks, Review of Agenda and January 19, 2023, Meeting Notes – HITAC Vote

Aaron Miri and **Medell Briggs-Malonson**, HITAC co-chairs, welcomed members.

Aaron Miri reviewed the meeting agenda and invited members to examine the minutes from the January 19, 2023, HITAC meeting. **Sarah DeSilvey** made a motion to approve the HITAC meeting minutes. **Hannah Galvin** seconded this motion.

The HITAC approved the January 19, 2023, meeting minutes by voice vote. No members abstained. No members opposed.

Revised Draft HITAC Annual Report for FY22 – HITAC Vote

Aaron Miri and **Medell Briggs-Malonson**, workgroup co-chairs, presented the HITAC Annual Report Workgroup Update. **Aaron** reviewed the AR WG meeting schedule, next steps, and led discussion of the Draft HITAC Annual Report for FY22 and Draft Supplemental Background Research Document.

Medell thanked HITAC members for their review of the Annual Report and **Deven McGraw's** feedback on target areas of privacy, security, and patient access to information. **Aaron** and **Medell** reviewed recent changes to the Annual Report.

Discussion:

- **Anna McCollister** noted she reviewed the Annual Report and Supplemental Background Research Document but did not provide feedback as she is a new HITAC member. **Aaron** explained that the Annual Report includes work completed in 2022 and upcoming prioritization for 2023. **Medell** stated that new HITAC members are welcome to submit feedback as the Annual Report bridges work between the previous and upcoming years.
- **Deven** commented that her recommendations were not incorporated in the Annual Report. **Deven's** recommendations included the issue of data segmentation, clarification of the legal liability for data exchange, and patients' priority. **Medell** explained the process for feedback incorporation, including the robust AR WG member discussion of all comments received. Based on the discussion and consideration of the Annual Report and Supplemental Background Research Document, comments were addressed. Some comments did not result in major edits as they were addressed in other areas of the Annual Report or Supplemental Background Research Document. **Aaron** explained that Annual Report feedback and revisions are available to the public and HITAC members. **Medell** and **Aaron** will develop methods to ensure the Annual Report and Supplemental Document review process is clearer for HITAC members.
- **Hannah Galvin** did view alignment with **Deven's** data segmentation feedback in the Annual Report but noted that components of clinical safety issues were not clearly incorporated. **Medell** explained there is content aligning with **Deven's** feedback in the sensitive patient information area of the Annual Report and Supplemental Background Research Document. **Deven** acknowledged that her feedback was incorporated into the report.
- **Medell** noted that HITAC members can access AR WG meeting materials, deliverables, and recordings.
- **Hans Buitendijk** expressed alignment with Annual Report revisions. **Hans** highlighted that as opportunities are further discussed some long-term opportunities, such as data segmentation, should be viewed as an immediate priority. This is due to tight relations between the data elements.

Hans Buitendijk motioned to approve the Draft HITAC Annual Report for FY22 and Draft Supplemental Background Research Document. **Steven Lane** seconded this motion. **HITAC members approved the HITAC Annual Report for FY22 and Supplemental Background Research Document by voice vote. No members abstained. No members opposed.**

Interoperability Standards Workgroup Update

Sarah DeSilvey and **Naresh Sundar Rajan**, IS WG Co-Chairs, provided an IS WG update, including WG membership, WG charge, and USCDI v4 prioritization criteria.

The IS WG Charge:

- Overarching charge: Review and provide recommendations on the Draft USCDI v4.
- Specific charge:
    - Due to the HITAC by April 12, 2023:
        1. Evaluate Draft USCDI v4 and provide HITAC with recommendations for:
            a. New data classes and elements from Draft USCDI v4.
            b. Level 2 data classes and elements not included in Draft USCDI v4.

Sarah also presented the Draft USCDI v4 schedule of review for the ISWG. This schedule allows for an early review of straightforward elements to develop a familiarity with the process. **Sarah** noted that key stakeholders will be invited to participate in the IS WG's review of specific Draft USCDI v4 data elements. IS WG members aim to complete their review of Draft USCDI v4 by the end of March.

Discussion:

- **Anna McCollister** expressed concern that USCDI v4 prioritization criteria do not consider decreased patient workload and burden. **Sarah** agreed with **Anna's** comment and suggested IS WG members discuss this topic.
- **Kensaku Kawamoto** commented on the importance of USCDI prioritizing items that are not widely implemented but are useful in the ecosystem.
- **Hannah Galvin** explained the public's confusion of perceiving USCDI as a legislatively required data-sharing practice. USCDI is a recommended set of data-sharing standards but not required through legislation. The misinterpretation of data requirements can be addressed by emphasizing the purpose of these data sets, clarifying requirements, and acknowledging the current limitations to data sharing.
- **Steven Lane** agreed with HITAC member comments regarding the public's lack of understanding regarding USCDI.
- **Kensaku** shared feedback he received that USCDI processes are too slow. **Kensaku** suggested that ONC establish a process for prioritizing the development and acceleration of new standards.
- **Anna** raised concerns about the lack of Electronic Health Records (EHR) data relating to vital signs generated by patients outside of the clinic. **Anna** explained the importance of patient-generated vital sign data, referencing her clinical experiences and resulting limited quality measures. There are significant implications if these data elements are not prioritized. **Aaron Miri** agreed with **Anna's** comments.
- **Bryant Karras** agreed with **Kensaku's** comments and noted the need for real-world implementation of data-sharing practices in the public health space.

CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule

Alexandra Mugge, Director of Health Informatics and Interoperability Group (HIIG) and Chief Health Informatics Officer, CMS Office of Burden Reduction & Health Informatics (OBRHI), presented the CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule.

The CMS Office of Burden Reduction & Health Informatics (OBRHI) aims to streamline data exchange. All policies presented link back to ensuring patients and care teams have access to necessary data to determine patient care decisions.

Alexandra explained CMS' process for its Interoperability Proposed Rule and the evolution to its third iteration. **Alexandra** reviewed iteration three of the proposed rule, which focuses on streamlining prior authorization processes and moving the industry towards electronic prior authorization to reduce burden. This rule impacts both payer and provider stakeholders, and five Requests for Information (RFIs) are also incorporated. There is an open comment period for this proposed rule through March 13, 2023.

Alexandra explained that this proposed rule expands patient access APIs, requires maintenance of provider APIs, rescinds payer-to-payer API data exchange specified in CMS-9115-F, improves prior authorization processes, and requires interoperability standards for APIs. The components of this rule are detailed in the presentation slides.

Discussion:

- **Jim Jirjis** suggested that the proposed rule requires granular reasons for denial from providers and payers. **Jim** also suggested a reduction of prior authorization timelines. **Alexandra** explained that prior authorization does take time for review by key stakeholders resulting in the current timeline. In a future state, the timeline could be reduced.
- **Hans Buitendijk** agreed with CMS' recommendation to utilize DaVinci resources as a point of reference tool. **Hans** highlighted that it is challenging to comment on the proposed CMS rule without detailing the accompanying ONC rule.
- **Hung Luu** inquired if the proposed rule intends to streamline provider use of individual vendor portals. **Alexandra** noted there is a discussion of what items of electronic prior authorization, outside of APIs, should remain in use. CMS requests comments from payers and providers on their use of individual vendor portals and available opportunities to reduce their burden via APIs.
- **Anna McCollister** noted there is no mechanism for patients to engage in electronic prior authorization outside of calling payers. The burden on patients to manage processes between the payer and provider is significant and should be acknowledged.
- **Kensaku Kawamoto** inquired if the proposed CMS rule will have guidance on transaction charges and copay estimates. **Alexandra** noted that transaction charges are not included in this rule but are discussed in another policy. Patient cost-sharing in the proposed rule is intended for claims and encounter data. The proposed rule does not discuss cost estimates or coupons.
- **Rajesh Godavarthi** inquired if this rule applies to inpatient divisions and extensions that payers see and approve. **Alexandra** explained this rule includes prior authorizations for medical services being processed through the payer.
- **Rajesh** noted a lack of clarity in the wording of codifying rules.

HHS Alignment – Pharmacy Standards in Part D NPRM

Alex Baker, Federal Policy Branch Chief, Regulatory and Policy Affairs Division, Office of Policy, ONC presented on HHS Alignment to proposed pharmacy standards in part D NPRM.

CMS has released the "Contract Year 2023 Policy and Technical Changes" NPRM, including a proposal for Medicare Advantage (Part C) and the Medicare Prescription Drug Benefit (Part D). ONC and CMS created this proposal to reflect an aligned approach to adopting and updating pharmacy standards for data exchange. The comment period for this rule is open until Feb 13, 2023.

Alex reviewed the CMS/ONC collaborative approach to its standards adoption by which two to four pieces of this proposed rule will be adopted by ONC and cross-referenced by CDC.

Discussion:

- **Clem McDonald** inquired if the discussed standards are available for public review and comment. **Alex** noted the referenced standards were created by the National Council for Prescription Drug Programs (NCPDP). Individuals must participate in the NCPDP to review relevant standards. **Clem** noted that the lack of public access to standards referenced in federal policy is an issue.

PUBLIC COMMENT

Mike Berry opened the meeting for public comments.

QUESTIONS AND COMMENTS RECEIVED VERBALLY

No public comments were received verbally.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Mike Berry (ONC): Thank you for joining the February HITAC meeting. We will be starting soon. Please remember to tag "Everyone" when using Zoom chat if you want all to see your message.

Jim Jirjis: Jim Jirjis here. May be having microphone trouble

Susan Clark: FYI - link for Sync for Genes webinar. I have a personal investment in this one. https://www.healthit.gov/news/events/sink-your-teeth-sync-genes

Seth Pazinski: Please visit the ONC Event site for information on upcoming events, including those that Micky mentioned during his remarks. https://www.healthit.gov/newsroom/events

Hannah K. Galvin: I reviewed Deven's comments and also re-reviewed the report, and agree that I don't see some of the meat of her comments on data segmentation

Hannah K. Galvin: That said, I do very much appreciate the attention to data segmentation in the annual report and all the work by the workgroup.

Hannah K. Galvin: Absolutely agree, Hans.

Sarah DeSilvey: thank you so much for this extensive work.

Eliel Oliveira: When will the report be made public?

Accel Solutions: All meeting materials can be found on today's HITAC meeting page: https://www.healthit.gov/hitac/events/health-it-advisory-committee-53
The report will also be posted on the Recommendations page after transmittal to the National Coordinator: https://www.healthit.gov/topic/federal-advisory-committees/recommendations-national-coordinator-health-it

Eliel Oliveira: Excellent point

Hans Buitendijk: If the USCDI were to describe all of importance we clearly land at covering all EHI. And we cannot do all at once within ~1 year of publication to have all relevant standards/guidance is in place. The prioritization and alignment with what it actually takes to make it happen must occur somewhere. if not through USCDI (thus focus on smaller steps), then where else?

Kensaku Kawamoto: Great point on sensitive Qs. Eg, around domestic violence, illicit substance use, etc

Sarah DeSilvey: Hannah, I just want to echo that this is where, in my mind, the importance of data justice as mentioned in the annual report is critical- the right not only have your data represented, but the right to have it NOT represented as well given the possibility of risk or bias.

Hannah K. Galvin: @Sarah - agree!

Hannah K. Galvin: I think it would be helpful for ONC to better communicate this perspective - perhaps even directly on the USCDI website.

Medell K. Briggs-Malonson: @Sarah and Hannah, this will be a key priority for this upcoming year as well to ensure that these pieces of data justice are understood and incorporated across our standards and recommendations.

Naresh Sundar Rajan: 100% Agree with your comment, Ken. As part of ISWG, and it's scope, we will try our best to accelerate and be comprehensive.

Sarah DeSilvey: Thank you, Medell. I am so grateful for your expertise in stewarding this critical conversation.

Hannah K. Galvin: Agree - looking forward to this conversation, @Medell.

Steven Lane: There is tremendous opportunity to include more "Level2" data elements in the final published USCDI V4. The challenge is that, if we were to include them all, it would likely be impossible for SDOs to provide the supporting implementation guides, for HIT vendors to provide the supporting functionality to their customers, or for clinicians and other exchange participants to incorporate the data and the tools. While we all agree that this process should move forward as quickly as possible, the challenge is to determine what IS possible in the real world. Perhaps the best approach is to progressively turn up the heat on our industry to find out if/when the pan begins to smoke and burn.

Alexis Snyder: Very well said Anna

Rita Torkzadeh: Hopefully Anna's comments and voice will propel elevating Author Provenance in USCDI.

Sarah DeSilvey: Yes, we encourage all to come to the ISWG as we work on these critical concepts. Thank you!

Kensaku Kawamoto: Sure I will comment here. I recommend that ONC also look at the actual speed of pulling USCDI data. Even if data are in USCDI, they are not useful in many cases if they cannot be retrieved with reasonable time. Eg, in at least one of the largest EHRs on the market, pulling any past medications (including, for example, a medication that was discontinued today) can take a very long time. Eg, >30 seconds for a typical geriatric patient. Would recommend that ONC look at adding, at the very least, execution time reporting requirements for typical queries that may be needed. Eg, what medications are the patients currently on, or were on in the past month?

Hans Buitendijk: It is important to recognize the balancing act that USCDI overall is aiming to achieve. It would be helpful to further discuss in the ISWG. Echoing in that regard Steven Lane's comments and recognize the role of Comment, Level 1, and Level 2 that are perhaps underutilized. We also must recognize that from a certification perspective, USCDI sets the scope, and C-CDA and FHIR US Core are used to measure conformance. Thus if it is not yet represented and exercised in those two standards in particular, not withstanding the many other places and formats that the data may already be shared in, must be considered. Argonaut place a role in that, but not exclusively. So does Gravity, Da Vinci, now HELIOS, etc. as that all advance the use of the data using FHIR. But FHIR US Core is the guide that measures conformance to USCDI. So how we get to USCDI covering all EHI and using FHIR guidance beyond FHIR US Core are topics to be explored to help further advance USCDI versions.

Sarah DeSilvey: Thank you all for the comments on USCI and the ISWG. We are reading them and look forward to discussing in the workgroup.

Sarah DeSilvey: USCDI

Jim Jirjis: For USCDI I also wanted to p point out that there is tremendous variation in how much data is being sent per query. Some providers send only data from the last encounter, others send 3 years of datas (VA). It will limit the usefulness of USCDI if there is such variation..the recipient will never know if they are getting

complete information or know how complete the data is. For example. A colonoscopy done last year will not be included in USCDI exchange for those who only send 90 days of information and thus identifying important gaps in case would be difficult. I am curious how we should address this important issue

Hans Buitendijk: @Shelly: Just a clarification that USCDI is already important as it drives the scope of what FHIR US Core and C-CDA is required to support in current regulatory framework.

Susan Clark: I was on a call about this rule yesterday and it was exactly as she said - both extreme comments about implementation date being too soon or not soon enough. Provider side wants tomorrow, payer and state side wants later.

Hans Buitendijk: @Jim: USCDI / FHIR US Core are effectively supersets. What exactly is to be accessed and exchanged very much depends on the use case/question at hand. To data at times (see C-CDA CCD) there has been a tendency to send everything always. With FHIR in particular we can shift to share what is relevant for that use case and get more when needed. Understanding how much is relevant, thus avoiding sending everything always, is a critical next learning step. FHIR US Core is not sufficient to help guide that. But examples in ePA, eCR, and others are starting to work with that.

Steven Lane: There is increasing public discussion of the importance of Data Quality. One dimension of Data Quality is Completeness. In addition to Ken's suggestion regarding the need to measure the time it takes to access/retrieve USCDI data elements, it would be helpful to collect and share real world information regarding what data elements (and for what time frame as per @JimJirjis comment) are actually made available for access and exchange by data sources, e.g., providers' certified EHRs, and the Payer APIs that Alex is discussing.

Hannah K. Galvin: @Ken - I agree with you but wonder about the precedent for ONC setting infrastructure requirements - some of this may depend on the individual organization's network speed, etc. There was discussion in the annual report re: telehealth equity, and some of that depends on patient access to high speed internet. Bandwidth and upload/download speed may be something we want to speak to, especially from an equity by design lens (and provider burden lens as you point out), but wondering on precedent for this.

Jim Jirjis: @Hans. Agree but there is no guideline or approach for the receiver to ensure that they get what is necessary for their use case

Jim Jirjis: @Hans. Thus for example, our executives are less optimistic that this is useful due to this disconnect between the user of the data and the sender

Hans Buitendijk: @Jim: Fully agree there are gaps there. ePA uses Questionnaire and CQL to address that. Attachments is proposing to use LOINC codes for that scope (a bit coarse still). And that needs to be aligned with minimum necessary, critically relevant, etc. So completely agreed that understanding what is needed so the requester/receiver gets what they actually need is not clearly defined yet.

Kensaku Kawamoto: @Hans — agree requirements would not be for any initial consideration. However, reporting seems quite reasonable. Data that takes too long to retrieve would not be able to be used in many important use cases. Eg, e prior auth needing to check prior meds to see if step up therapy requirements have been met — if just pulling past meds takes 50 seconds, it will not be feasible to use in care

Anna McCollister: How does this process facilitate appeals to denials?

Hans Buitendijk: @Ken: Completely agree that purpose and data needs drive appropriateness of queries in-line, pre-population, etc. That is necessary guidance, yet not what C-CDA and FHIR US Core aim to address.

That is for other guidance to address. Thus a need to start to think beyond how to recognize necessary guidance beyond FHIR US Core and C-CDA only.

Kensaku Kawamoto: @hans — good point on where this lands. Us core still is relevant in terms of query parameters. Eg, requiring rather than suggesting the ability to specify lookback period for medication searches could help

Steven Lane: @Hans - +1 to the anticipated value of the coming transition from CDA to more granular/use case specific FHIR-based exchange, as CMS is promoting. In this regard I look forward to the advancement of TEFCA, its FHIR Roadmap, and incentives that encourage engagement in TEFCA exchange.

Jim Jirjis: As for reason for denial…we need to be granular about what that means. I propose that in the initial workflow in addition to what data is needed, there should also be a workflow-friendly transparent communication about the specific rules the payer uses to determine denial or approval. The reason for denial should expose which granular rule(s) were not met. Otherwise we could continue to get (benefit not covered) as a reason for denial, for example

Hans Buitendijk: FHIR US Core is a critical common foundation, but other guides should/are already built on that to apply it to specific use cases where a clinical interaction for similar data as an ePA interaction would possibly yield a different approach to ensure the data is available in time to have impact.

Jim Jirjis: Secondly, why would we keep 7 day (72 hours for expedited) given the benefits of automation that come with this. Why not 72 hours for turnaround with 1 day for expedited. This in the spirit of patients not having unnecessary delays for important medical services or equipment

Kensaku Kawamoto: Prior auth need would depend on specialty, so would need to avoid penalizing providers who do not need to prescribe such meds often

Steven (Ike) Eichner: Jim: would including an administrative field that defined the timeframe covered by data shared in a particular transaction be helpful?

Anna McCollister: Can we also include a provision that requires payers to have an electronic-based process for patient-directed appeals? Currently, they require sending a letter in the mail to a PO Box to an unnamed decision maker.

Jim Jirjis: @Ike. Yes. It would need to work in the information flow of the QHINS and HINS. For example the RLS service in Commonwell would need to embrace this and the sender of the data (EMR's etc) would have to build tools to support this.

Hans Buitendijk: Where ePA is using the exception to communicate all FHIR based, taking a more granular approach is enabled, thus move away from the somewhat coarse and bulky document based approach That experience will yield learnings that can be used in other use cases, clinical, administrative, financial, that can help us right-size data sharing.

Steven (Ike) Eichner: More granular exchange may be more supportive of "minimum necessary," depending upon the particular use case.

Steven Lane: Kudos to CARIN and Da Vinci and their many participants for doing the hard work to develop and advance the Implementation Guides that will make this exchange possible.

Hannah K. Galvin: Proposed PI measure denominator looks like it is only for inpatients. I would encourage CMS to clarify as many PA's are submitted from the ambulatory setting.

Hans Buitendijk: @Ike: Fully agreed, including inclusion/exclusion of sensitive data.

Anna McCollister: Just noting that CMS' graphics/slide template is MUCH better than it used to be! Kudos to the CMS graphics team! (and to Alex!!!) It makes such a difference in readability! :-)

Steven Lane: If a denial is related to the absence of important data in the package received from the provider. Providers will not know just what APIs their system has turned on. Relevant data may be buried in scans, PDFs, or HIT systems other than the EHR. Knowing what PA rules were not satisfied should be supplemented by what data the rule was looking for so providers/patients could respond accordingly.

Jim Jirjis: @Steven. Here here!

Jim Jirjis: @raj. Raj I know you indicated that the technical capability for exposing the rules (including not only the vendor rules, but also the payor specific modifications) exist and are in pilot, so if true, it should be very doable to expose in the workflow the granular rule and thus the reason for denial that is rooted in a rule not being met.

Rajesh Godavarthi: @jim, Yes, it is doable and we have implemented this with payer and provider recently.

Jim Jirjis: @Raj. Can we get a demo?

Rajesh Godavarthi: Absolutely. We can bring the payer and provider too.

Patrice Kuppe: Concern - if the provider has the exception to use FHIR but the health plan does not. Then the provider will have to implement both FHIR and the HIPAA 278.

Pooja Babbrah: +1 Patrice

Anna McCollister: What kind of accountability will there be? If any?

Lorraine Doo: The exception process includes both providers and payers as part of the requirement for that project. You may reach out to Da Vinci to identify the participants.

Pooja Babbrah: Thanks for the clarification Lorraine

Hans Buitendijk: @Lorraine - Is it correct that the payer effectively holds/manages the exception and then includes the providers ready/willing to use that approach?

Micky Tripathi: Thank you Alex and Lorraine!! Great presentation!

Patrice Kuppe: I understand Lorraine (we are a member of Da Vinci). But all payers are not involved in the exception. If they are not covered but provider is, the provider would have to support both methods.

Lorraine Doo: The National Standards Group within OBRHI approves the exception project and the participants. The applicant - in this case Da Vinci, has provided the list of organizations who have agreed to participate, which must include a payer or payers, providers and a vendor.

Hannah K. Galvin: Really appreciative of the work CMS is doing to advance ePA. This is significant burden to providers and health care organizations.

Medell K. Briggs-Malonson: Advancing ePrior Auth with time standards and accountability is critical to providing consistent high quality, equitable accessibility to clinical care. Thank you to CMS for leading this charge.

Accel Solutions: Public comment will immediately follow this final presentation.

Pooja Babbrah: Thank you for this work to coordinate between ONC and CMS related to the eRx standards. It will make things much easier going forward

Sarah DeSilvey: Thank you for an insightful meeting!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

FINAL REMARKS

Mike Berry reminded members that the next meeting of the HITAC will be held on March 9, 2023. All materials and testimony from today's meeting will be made available at https://www.healthit.gov/hitac/events/health-it-advisory-committee-53.

Aaron Miri and **Medell Briggs-Malonson** thanked everyone for their participation, presentations, and discussion.

ADJOURN

The meeting was adjourned at 12:11 PM.