The Office of the National Coordinator for Health Information Technology

Meeting Notes

INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE (ICAD TF)

April 14, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Co-chairs **Alix Goss** and **Sheryl Turney** welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting.

Sheryl Turney and **Josh Harvey** reviewed a shared Google document created to capture the prior authorization (PA) workflow process. A new spreadsheet, "Data Classes and Elements," was created for the Google document, and the ICAD TF members reviewed and discussed it. The new spreadsheet will be added as a tab to the existing shared Google document.

ICAD TF members from the smaller group formed to focus on identifying guiding principles and an ideal future state for PA discussed their contributions to the existing Google document and responded to questions.

There were two public comments submitted by phone, and there were several comments from ICAD TF members and members of the public submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Review and Discuss Prior Authorization (PA) Info Table
03:40 p.m.	Review and Discuss Ideal State and Guiding Principles Table
04:15 p.m.	Next Steps
04:20 p.m.	Public Comment
04:30 p.m.	Adjourn

CALL TO ORDER/ ROLL CALL AND WELCOME

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the April 14, 2020, meeting of the ICAD to order at 3:00 p.m.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Steven Brown, United States Department of Veterans Affairs
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Gaspere C. Geraci, Individual
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator
Jacki Monson, Sutter Health/NCVHS
Alex Mugge, Centers for Medicare & Medicaid Services
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Mary Greene, Centers for Medicare & Medicaid Services
Leslie Lenert, Medical University of South Carolina
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
James Pantelas, Individual/Patient Rep
Abby Sears, OCHIN
Andrew Truscott, Accenture

SUMMARY AND ACTION PLAN

Alix Goss, co-chair of the ICAD TF, reviewed the agenda and summarized their recent work on developing the details of the PA process. At their last several meetings, the ICAD TF reviewed and refined a shared Google document that has been used to determine how to improve the PA workflow process. Part of the conversation at the previous meeting had centered on keeping their work at the correct level of detail, and she thanked ICAD TF members for their feedback, which will help to guide and focus their work.

At the previous meeting, members discussed guiding principles, which they split into a separate table (tab) in the workbook. Members volunteered to work in smaller groups on different aspects of the tabs:

- Info Table Group: Jim Jirjis, Josh Harvey, Jocelyn Keegan, Ram Sriram, Sheryl Turney
- Happy Path Group: Arien Malec, Alexis Snyder, Anil Jain, Alix Goss

Both of these groups will be presenting the work they completed between the meetings to the full ICAD TF.

She explained that the two subgroups would review their progress on the tabs as a way to facilitate a group discussion on updates, needed revisions, and options for moving forward. She reminded members that a “parking lot” tab was added to the document to capture ideas and create a framework for future work.

Also, she mentioned the possibility of inviting guest speakers to do “show-and-tell” presentations of current state and ongoing projects to help the ICAD TF better understand the current affairs and bolster their written compendium.

Sheryl Turney explained the process by which she reviewed and added ICAD TF members’ comments from the previous meetings and offline work. The Google document and “parking lot” comments tab will be used as a source when the ICAD TF crafts their final whitepaper, which will be presented as a recommendation to the HITAC in September.

REVIEW AND DISCUSS PRIOR AUTHORIZATION (PA) INFO TABLE

Sheryl Turney explained that a new tab, “Data Classes and Elements,” was created for the Google document, and it would be incorporated into the document following the ICAD TF’s review.

Josh Harvey displayed the new tab in the Abode online meeting client and gave an overview of work he and **Jim Jirjis** completed to incorporate the comments and feedback submitted at the last meeting. As a result of discussions with the co-chairs, he restructured the existing document to organize and separate the higher-level concepts from more granular data element types. This work directly addresses many of the discussions that occurred at the previous meetings, and the new framework is based on work already completed by ONC, which overlaps with the United States Core Data for Interoperability (USCDI). This

previous work should make it easier for the ICAD TF to fill out the rest of the spreadsheet (once they agree on a new framework).

At this point, the data classes were broken down into five categories, and he explained the rationale used to make the divisions. He noted the important classes are those related to PA requests, and the information exchanged between the requestor and approver of the request. He briefly described the patient demographics data class, which has a foundation in ONC's version of the USCDI. The idea is that related data elements can now be tied to a broader data class and used in a more modular way. He highlighted the new data class categories, which are:

- Patient Identity
- Patient demographics
- Insurance Plan (Primary, Secondary, Tertiary)
- Patient-Generated
- PA Request
- PA Response
- PA Justification
- PA Follow-Up
- PA Decision
- Metadata

He noted that this new method might result in some redundancies in the associated data elements, which he also highlighted in the new tab. Because this is an initial draft, he encouraged ICAD TF members to give feedback on the new framework in the Google document's comments section.

Discussion:

- **Jocelyn Keegan** voiced her support for the restructured spreadsheet. She submitted two pieces of feedback:
  - Consider adding a data class related to the concept of coverage and all of the potential variables connected to it, including but not limited to the service(s) requested, the provider(s) involved, locational constraints, payment obligations,/copays, etc. She explained that the data could be taken from an ASC X12 271, which is the eligibility and benefit verification request transaction.
  - Include a separate class of supporting clinical data, which would contain all clinical information beyond notes like lab results or images. She stated that a certain "payload of proof" of clinical information is often required to justify a PA decision.
- In response to a question submitted in the public chat, **Jocelyn Keegan** discussed the three PA use cases that Da Vinci is using to create transparency around benefits and to automate the population of the data required to do an ASC X12 278 transaction (a 278), which is the PA and referral request. They are Coverage Requirements Discovery, Document Templates & Rules, and PA Support. She noted that Da Vinci had done recent work to support its members with different application programming interfaces for exchanging electronic health records (EHR), so they can automate the process of getting a PA determination. Their work on automating the transferring of information between disparate systems reduces many of the complexities in the PA workflows. She is working on setting up a presentation for the ICAD TF by an early adopter, who will share their progress.
  - **Sheryl Turney** responded that the presentation would occur during a future meeting.
- **Arien Malec** shared several comments, including:
  - He supported the reorganization of the framework and thanked those who worked on it.
  - He encouraged them to think about the current state of the authorization. In his previous

work on complex, multi-stakeholder, orchestrated transactions, expressing the current state of a PA request is useful.
    - He noted that some of the items that the new spreadsheet captured might need to be recategorized.
- **Alexis Snyder** commented that she would expand on previous comments with suggestions for the new Google document spreadsheet.
    - There should be different processes shown in the spreadsheet for patients with single-payer insurance and patients with secondary and/or tertiary insurances.
    - There should be a way to capture who is responsible for collecting, translating, and submitting all of the PA-related information in a situation with multiple providers to make sure that nothing in the process goes awry.
    - **Sheryl Turney** responded that, the request for the data elements of secondary and/or tertiary insurance had been captured in this and previous documentation.
- **Gus Geraci** commented that it might be difficult to include "cost to patient" in this scenario because this might not be known until the end of the PA process. In his experience, some insurers are not willing to reveal the cost to patients except for in the explanation of benefits statement (EOB). Also, DME suppliers know what they will be paid but have not wanted providers to access that level of information.
    - **Sheryl Turney** responded that, while that has been a concern in the past, the upcoming Interoperability Final Rule will have a requirement that gives patients the ability to see more cost information during the PA process. The ICAD TF should not leave this part out of the process because it will become important in the future.
    - **Gus Geraci** responded that, while he supports giving the patient as much up-front, cost-related information as possible, insurers will not necessarily do so until legislation is passed.
- **Jocelyn Keegan** agreed with Gus's point that the concept of "cost/price to patient" has been challenging, but she noted that Da Vinci has made some positive progress on this workflow. She discussed the example of giving the patient choices in pharmacy and care provider options as a way to allow them to have a role in determining the cost of treatment. She encouraged them to keep this information in the workflow as a way to get to a fully automated PA process.
- **Arien Malec** commented that although there may be business considerations that prevent the flow of information (e.g., cost of care to a patient), the ICAD TF should focus on modeling the "happy path" end state (in which a patient would have full and transparent pricing information for specific classes of care services).
- **Alexis Snyder** commented on the process of a durable medical equipment (DME) PA request. She noted that because the specific cost cannot be determined until the patient gets partway through the process of meeting the DME provider and determining the specifics of the DME, a cost range of covered DME options with insurance coverage details (copay, deductible, etc.) should be shared instead. She agreed that the "cost to patient" element must stay in the spreadsheet.

REVIEW AND DISCUSS IDEAL STATE AND GUIDING PRINCIPLES TABLE

Alix Goss directed ICAD TF members to shift their focus to the guiding principles and ideal state section of the primary Google document spreadsheet, used at previous meetings. She noted the importance of assessing where they are now (with regard to the PA process) to best articulate an ideal state for PA in the future.

She asked **Josh Harvey** to update the document with a new guiding principle that reflects **Rich Landen's** comment that the patient cost data field and the basic ability to capture that information should be built into the process from the beginning. Whether this information is populated by a payer, when it gets populated by the payer, and whether it is binding or an estimate can all be determined later.

Then, she asked ICAD TF members to explain the comments and work they submitted to the Google document in between meetings. They began with the guiding principles section.

Discussion:

- **Anil Jain** described the items he added under the "guiding principles" section of the document, including:
  - Perfection in every scenario is not possible – go for great enough covering the vast majority of cases.
  - The approach should be sensitive to clinician-burden to drive adoption and obtain desired results.
  - The work should inform the coordination and alignment of existing efforts rather than re-invent.
  - The work should not sacrifice privacy/security in the efforts to make the process more efficient.
  - The ICAD TF should focus on HIT/Informatics aspects rather than thornier issues of dynamic decisions of what is covered and why/why not and broader health policy. Instead, the focus should be on what information can be exchanged to make any coverage decision better/faster/more transparent, etc.
  - **Alix Goss** and other members thanked him for these additions to the section and voiced their agreement in the chat and verbally.
- **Alix Goss** suggested adding the concept that price transparency will be built in from the beginning of the list of guiding principles.
  - **Anil Jain** commented that, as a clinician, he supports adding this as a guiding principle but is concerned that requiring this from the beginning might impede their work, due to several factors related to prohibitive pricing or pricing not available until after the procedure is completed.
  - **Rich Landen** commented that the first guiding principle listed, putting the patient at the center, encompasses the concept of price transparency. He discussed the reasons why the price might change throughout treatment. He emphasized that the responsibility of the ICAD TF is to enable the patient to get clear information and understand decisions being made in their care process. Still, the ICAD TF should not to attempt to influence if a treatment is covered or not, based on personal interpretations.
  - **Jocelyn Keegan** commented that she is in favor of leaving the concept in the list of guiding principles as a placeholder, due to its important role in making the process more transparent. She discussed solutions in pharmacy PA that allow the patient to have pricing information while meeting with their doctor or care provider.
  - **Anil Jain** responded that the guiding principle should be built in from the beginning but the ICAD TF should recognize that some types of PA lend themselves to very clear pricing structures while the pricing for other types of PA only becomes apparent based on the procedure done, the results of the procedure, and recommendations made for the patient's care. They should differentiate between these two scenarios.
- **Alexis Snyder** submitted two edits to the first guiding principle ("patient at the center") and an additional area of focus:
  - Add the phrase "reduce the burden on patient to be the go-between or driver for information needed for the PA."
  - Add the phrase "cost transparency/price range, to the extent possible." Numbers of dollar

signs could note these ranges. Then, she discussed several applicable examples.
    - Also, she emphasized the need for the ICAD TF to focus on ensuring a seamless and transparent information exchange. In response to a question from **Alix Goss**, **Alexis Snyder** clarified that this should be an area of focus and not a specific guiding principle.
- **Jim Jirjis** commented on **Alexis Snyder**'s suggestion to add dollar signs to denote cost ranges instead of stating the exact copay. He noted that patients and care providers have different sets of needs related to managing costs and methods of care. The concept of the difference between provider-facing and patient-facing costs to the plan/patient should be added under the patient at the center guiding principle.
    - **Jocelyn Keegan** agreed that this is an important nuance that was previously identified in work on price transparency. Patient obligation is the first step, but the ICAD TF cannot forget all of the components and stakeholders in the PA process.
    - **Anil Jain** agreed with **Jim Jirjis'** comments. He emphasized that the dollar signs/cost range concept would be instrumental on the provider side by allowing them to choose between treatment methods with equivalent levels of success but different costs. He discussed the example of ordering imaging studies. The "dollar sign cost range" concept is a clinical decision support aid that is not currently part of the electronic PA process, and it should be incorporated into the clinical workflow.
    - **Jocelyn Keegan** emphasized the need to connect the disparate sets of information on PA transactions in the future ideal state model. This connection will allow them to transform the PA process and offer better care outcomes to patients.

Alix Goss directed the ICAD TF to move their focus to the ideal state section of the Google document. Several ICAD TF members added new content to this section, so they presented their work.

Discussion:

- **Alexis Snyder** submitted a flow chart of the ideal state for steps taken from a patient/caregiver perspective detailing the PA process in three situations: patient visit (seeking care/DME), patient visit to ER, pharmacy PA request. She discussed details added to each of the steps.
- **Alix Goss** submitted several comments, denoted with her initials, on the ideal state of PA and related policies. She extracted these directly from industry materials and the recent Workgroup for Electronic Data Interchange (WEDI) whitepaper, which was based on a consensus paper from January 2018 created by a coalition. She noted that these comments were only slightly modified from theiroriginal sources. ICAD TF members should be familiar with these concepts.
- **Anil Jain** summarized his comments to the ideal state section, which were:
    - PA efforts should be behind the scenes, i.e., the rules should always be attempted (based on known data) by fully automated adjudication when possible before invoking or interrupting the patient-doctor workflow (including ballpark cost information as early in the process as possible).
        - **Rich Landen** requested that a footnote be added to this item to capture the point made earlier that the physician/provider should be able to use the process to estimate the range for a patient's out-of-pocket costs of alternative treatments (e.g., different medical imaging options) ahead of the patient's visit. Then, the provider can discuss options because they have an informed basis of costs for alternative treatments.
        - Members discussed the implications and challenges related to this item. **Rich Landen** clarified his statement that the care provider does not have to be the specific staff person who obtains the cost range, as long as it is offered to the patient.

- Regardless of the venue of care, the PA process mechanically should be similar for both the clinician and their patient regardless of the health plan since patients move across the health ecosystem, and providers should not be burdened with disparate workflows depending on the venue.
- A full audit trail should be available to both patient (e.g., through a patient portal) and clinician (e.g., through the EHR) so that there is a common source of truth about the status of any PA.
- Any workflow utilized to support the PA should auto-generated editable content to document in the progress note/visit note, etc. the medical necessity so that clinicians don't have re-document what they just did to justify the DME/Rx/Procedure, etc.

- **Jocelyn Keegan** highlighted the differences between the ideal state of PA and what happens during the current process. Because a variety of actors, from various levels of care providers to office staff to pharmacy, support the PA process, the focus should be on developing tools to automate the process of moving information between them all. A seamless process will help put the patient at the center.

PUBLIC COMMENT

There were two public comments.

Heather McComas, American Medical Association (AMA): Thanks so much. I want to express our appreciation for the task force efforts thus far. Unfortunately, I think during our public health emergency, the importance of your work is highlighted to reduce the administrative burden for clinicians so they can focus on patient care. As I am sure you are aware, the AMA places a high priority on reforming prior authorization. We have done extensive research on how the process can impact both patients and physician practices. Alix, as you referenced a few weeks ago, we partnered with other national healthcare professional organizations and health insurance trade organizations in early 2018 to release a consensus statement that outlines key PA improvements. We participate in standards development organizations that are involved in creating transactions for electronic prior authorizations. We first would like to offer our assistance to the group at any time. That is a standing offer. This is a huge priority for us, so please consider that. We will be there to help out.

I have two basic comments. My first comment is an observation, and the second is a suggestion. We observed that the task force has been using the term “delight” throughout the discussion today. We appreciate your optimism, but I have to stress that in its current state, prior authorization is anything but delightful for patients and physicians. In our 2019 prior authorization physician survey, over a quarter of the physicians indicated that prior authorizations led to a serious avarice event for patients and their care. I think of stories of on our website, and one comes to mind: “I am a patient who was diagnosed with Crohn's disease, but medication by doctor prescribed lead to a long wait for prior authorization. While waiting for the appeal, my colon perforated. I received the PA after having the emergency surgery to remove my colon.” Our survey data highlighted the magnitude of the current problem and the urgency of moving the industry towards viable solutions. So, we encourage the task force to review our survey results and to identify how your efforts will resolve the direct impact on patients and clinicians.

Also, we noticed that the task force identified many important issues to tackle, and we appreciate the fact that you have taken the sky is the limit approach to your work. However, we have to note that if you have a deadline of September unless that has been changed. Because of that looming deadline, we encourage you to think about limiting the scope of your work so you will have meaningful, actionable recommendations in that timeframe. Here are some things to think about, in terms of scope:

Where is the standards guidance for prior authorizations most needed? There is a standard for prescription drug authorizations and ePA transactions. That transaction is accepted in the industry. It was named in the NPRM last year. However, in contrast as you have discussed, the 278 transaction has low

adoption, and there is currently not a standard to exchange clinical data. So, perhaps focusing on medical services prior authorization might be something to consider.

We also ask you to think about if you are thinking about issues and trying to think outside out PA, we noticed there is discussion about price transparency and patient cost. We agree that these are critical issues and that they can very much impact the patient's ability to access care. However, we would argue that they may involve different processes or transactions, such as real-time adjudications or predeterminations, that might be outside of prior authorizations workflows and processes.

And then, this came up a couple of minutes ago, but think about the information that is already done in the industry. Things like the 2018 consensus statement that represents the agreement between providers and health plans on key prior authorizations reforms. Also, think about the Da Vinci Clinical Advisory Council guiding principles that were developed. They address the privacy and security concerns that the task force addressed, and we encourage you to take a look at those and incorporate those in your work.

There are many things we don't know right now. For example, could the 278 transaction work with an attachment mandate? What are the costs and benefits of the standard approaches (X12, 278, FHIR)? Do we need pilots, seems like these are important data points for you and things that on the groups have not done to date.

Alix Goss responded that this is an important input, and she wanted to capture all of these thoughts. They do have another commenter in the queue, with only two minutes left in the meeting. She asked to have a written copy of these thoughtful and detailed points submitted to the ICAD TF. She inquired if they could correspond on the topics of guiding principles and other actionable things the task force might want to consider. **Heather McComas** will send a written comment to the task force.

Kim Boyd, Cover My Meds: Thank you so much task force committee for opening up a dialogue with the public around the initiatives that you are addressing as a task force committee. We are interested in how the details from this committee will playout for the bulk of the health information technology world, especially associated with prior authorization. I am Kim Boyd with Cover My Meds, which is one of the fastest-growing healthcare companies and has been recognized as one of the best places to work. Not only are we industry professionals, but we are also patients, ourselves. We are keenly aware that patients are challenged every day to obtain their medications. As a health IT company, our mission is to get patients and medications they need to live happy lives. I wanted to reference our concurrence with a lot of the comments made by the task force committee members around prior authorization and the need to continue to evaluate how to automate and codify that process.

Cover My Meds has been very involved in creating those technology solutions in the medication prescription benefits space to automate that process. We have taken what was an arduous facts process, taking three to five days to complete and get access to the patient, down to near real-time (around eight seconds) by using standards are available in the industry today. There is still room for improvement. We are glad the task force is looking at ways to improve that by using other things like FHIR and API technology.

But I do want to concur with task force members who talk about price transparency and real time benefit tools. As task force member Jocelyn Keegan noted, these tools have been on the market for about a year now, and we do have one of the private tools on the market. I can tell you that these tools are creating great opportunities to actually mitigate the need for a prior authorization all together. The tools will reference that transparency information that patients and providers need to make a thoughtful decision support around the prescription therapy for that patient. Many times, we are finding that the physicians, in dialogue with their patients, are choosing medications that don't require a PA. So, they see a PA is needed and that the patient is able to afford it based on the transparency structure. And then many times,

they are going, “No, we are going to the alternative because it doesn't require PA because it has efficacy for the patient.” I would encourage task force committee members to still consider that there are ways to help mitigate requiring the PA all together such as real-time benefits tools, and please continue how to evaluate how to codify and merge the clinical and administrative functions more thoroughly. As one of the leaders in the industry, we are happy to be a reference or resource for this committee and to provide mutual details to what is working in the prior authorization space as we see it today, where it needs to evolve, and around price transparency. Thank you so much.

Questions and Comments Received via Adobe Connect

Adele Allison: What is the difference between highlighted and non-highlighted?

Denise Webb: I like this format as it sets us up to more easily make data class and data element recommendations on needed updates to the USCDI to support PA uses cases.

Alix Goss: We've been using highlighting to show new content from last time we met.

Adele Allison: ty

Jocelyn Keegan: I think this is great. two areas/classes i'd blow out. . .under insurance plan/after it concept of coverage.

Jocelyn Keegan: and a separate class of supporting clinical data, "payload of proof" often required.

Sheryl Turney: we will take questions as soon as Josh is done with the overview

Raj: How does this fit in with Da Vinci PA use case specs?

Raj: Jocelyn can you answer

Alix Goss: Three Da Vinci Use cases Jocelyn describing: Coverage Requirements Discovery - Document Templates & Rules - Prior Auth Support

Jocelyn Keegan: i love this point. we have rolled out "communication" transactions in ePA SCRIPT because knowing "who's on first" between multiparty is critical!!!

Alexis Snyder: yes-part of what I wanted to mention is the multiple players

Jocelyn Keegan: especially as service goes from fuzzy (i need knee surgery) to more concrete (X procedure code, at this location with this practice)

Jocelyn Keegan: there is sooooo much waste of people re"auth" the same procedure over and over

Jocelyn Keegan: Building on Alexis point, there is a lifecycle that is short for simple and long and looping for complex. . .one time script vs. knee surgery or oncology

Jocelyn Keegan: this would be a good visual for white paper, and why "state" is important

Gus Geraci, MD: I will submit that it might be difficult to get costs from the insurer to display/reveal on this, except for member/patient responsibility, which may be disclosed to the member/patient in the EOB. Not to other parties. Obviously, the supplier knows what they get or expect.

Jim Jirjis: I also want to point out that we need to figure out how to depict the the variety of providers and entities (hospitals) that all have to get separate authorization for a service.

Adele Allison: Seems like this is playing into the transparency rules coming out of CMS

Alexis Snyder: cost will not be available until DME figures out what will be ordered.... but priliminary info could be provided on range of cost, deductible, and any co-insurance

Richard Landen: Having the patient cost field is important to build in. Whether it is populated by a payer and when it gets populated by the payer and whether it is binding or an estimate can be worked out later. But the basic ability to capture and transport should be built in frrom the get-go.

Jocelyn Keegan: Agree Richard. A worse scenario isn't a patient getting EOB that surprises them, its the patient not moving forward with a planned procedure, drug treatment or care plan because of sticker shock with no loop back to close it. . .so we do all the work to get auth approved and service//product

Jim Jirjis: Is there a nee dto adress research costs when treatments combine services some of which are insurance covered and some grant covered

Jim Jirjis: HOw to separate those? I know in academic centers or other hospitals have to deal with that bifurcation

Raj: we can see

Gus Geraci, MD: Grants/other sources of payment are considered "other insurers/payers."

Jim Jirjis: My screen is black

Richard Landen: Out-of-pockets are dynamic: how much of the patient's dedcutible remains will change over the course or treatment, depending on when the claims reach the payer, get processed and paid. Just FYI.

Alexis Snyder: I added under ideal state but it is not yellow

Jim Jirjis: Thanks Gus

Gus Geraci, MD: :-)

Alexis Snyder: forgot to intial-thought it was tracked

Jocelyn Keegan: jim, we've focused both on RTBC and DV side on patient cost. . .all the other imputs are part of "formula" if that makes sense

Alix Goss: Thanks for clarifying Alexis. Once Anil is done, we can run through your additions.

Jim Jirjis: here here

Jocelyn Keegan: i agree not show stopper. . .i think understanding that there is a data class around price/copay information ala CRD and RTBC. . .

Alexis Snyder: I would add under patient centered to lessen the burden on the patient to be the go-between trying to get all the pieces needed for PA and be the communication between providers

Jocelyn Keegan: agreed.

Jocelyn Keegan: Yes!

Alexis Snyder: knowing your co-insurnace is only helpful when you have a relative idea of how much the product will cost-again a range of min-max

Jocelyn Keegan: we see it as a funnel, more info, better/tighter actual estimates are. . .there's a Cambia team Healthspark doing some great work here.

Jim Jirjis: thanks Stated much better than I did

Richard Landen: Row 48: can it be footnoted to capture the point made earlier that the physician/provider should be able to use this proces to ballpark the patient out-of-pocket costs of alternative treatments (e.g., XRay vs. MRI) ahead of the patient visit, so that the provider can discuss options already having an informed basis of cost of alternative treatments?

Jocelyn Keegan: THis is key.

Jocelyn Keegan: https://confluence.hl7.org/download/attachments/66940155/Guiding%20Principles%20for%20Da%20Vinci%20Implementation%20Guides.pdf?version=1&modificationDate=1579736721996&api=v2

Jocelyn Keegan: https://confluence.hl7.org/display/DVP/Da+Vinci+Clinical+Advisory+Council+Members

Jocelyn Keegan: Links to the CAC and the guiding principals for ensuring privacy constraints are included in all work to move towards APIs

Meryl Bloomrosen 2: We would urge the work group to look toward additional technologies and tools, including the use of machine learning and artificial intelligence to glean information directy from the EHRs as part of the prior auth process. We urge that the automation of Prior Auth be able to provide data to the clinician at the point of care and within work flow. Thank you.

NEXT STEPS AND LOGISTICS

Alix Goss thanked the public for their comments and the ICAD TF members for remaining on the call several minutes after the scheduled time of adjournment. As a result of the time, she asked **Sheryl Turney** to summarize the next steps for the ICAD TF quickly.

Sheryl Turney noted that **Josh Harvey** would be updating the first page of the Google document, and she encouraged all ICAD TF members to resolve any access issues and to continue to share comments in the document. She noted that the next meeting of the ICAD TF would begin with a recap of their work.

CLOSING REMARKS AND ADJOURN

The co-chairs thanked ICAD TF members for their participation.

Lauren Richie noted that they would pick up with the topic of the next steps for their work at the next meeting, which will be held on Tuesday, April 21, 2020.

The meeting was adjourned at 4:34 p.m. ET.