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

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

VIRTUAL

# Speakers

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

**Operator**
All lines are now bridged.

**Lauren Richie**
Thank you, and good afternoon, everyone. Welcome to another edition of our ICAD task force. A quick roll call, and we'll get started. Sheryl Turney?

**Sheryl Turney**
Here.

**Lauren Richie**
Alix Goss?

**Alix Goss**
Present.

**Lauren Richie**
Aaron Miri? Okay. Abby Sears? Not here? Okay. Alexis Snyder?

**Alexis Snyder**
Here.

**Lauren Richie**
Andy Truscott? Anil Jain?

**Anil Jain**
I'm here.

**Lauren Richie**
Arien Malec? Deb Strickland?

**Debra Strickland**
I'm here.

**Lauren Richie**
I believe we have Denise Webb.

**Denise Webb**
Yup, I'm here.

**Lauren Richie**
Gus Geraci?

**Gaspere Geraci**
Here.

**Lauren Richie**
Jacki Monson?

**Jacki Monson**
Here.

**Lauren Richie**
Great. James Pantelas will be absent today. Jim Jirjis? Jocelyn Keegan?

**Jocelyn Keegan**
Here.

**Lauren Richie**
Great. Les Lenert? Mary Greene? Ram Sriram?

**Ram Sriram**
I'm here.

**Lauren Richie**
Rich Landen? Sasha TerMaat?

**Sasha TerMaat**
Hello.

**Lauren Richie**
Steve Brown?

**Steven Brown**
Yeah.

**Lauren Richie**
Great. Tom Mason?

**Thomas Mason**
I'm here.

**Lauren Richie**
And Carolyn Petersen? Okay. I'm handing it over to Alix and Sheryl.

**Alix Goss**
Well, thank you so very much for doing that roll call today. We did get a separate note indicating that Mary Greene will not likely be here today, but I think her backup, Alex Mugge, will be joining us shortly. We're also seeing a request as the call has been opened up to the public, and I think, staff support, the answer is yes, but they're not hearing our audio, so I'm hesitant to start with the call until…

**Lauren Richie**
Let me just double-check with the operator that the lines have been bridged.

**Operator**
Yes, all lines are bridged.

**Alix Goss**
All right. So, Lauren Wu, who can't hear me, but might be able to read my words – I suggest she try to dial back in because everything is bridged and we're getting confirmation from other participants that they can hear us. Thank you. So, good afternoon. This is Alix Goss. I'm going to kick us off with a bit of agenda review and give us some level-setting on the summary and action plans from the last meeting before turning it over to Sheryl to walk us through the data categories, along with Josh Harvey, who's been very helpful in capturing a lot of our thoughts and advancing work between meetings, and who may showcase some additional thinking evolved from your thoughtful contributions at our last session.

After talking about the data categories for a little bit, I'm going to jump into the "guiding principles and ideal state" tab. I may ask Alexis Snyder if she's willing to help me co-facilitate that section, as she added some very thoughtful comments into that tab today. And then, we'll want to confirm our next steps and level-set our thinking on where we want to head before we go to public comment and then ultimately adjourn today. With that overview, I'm going to go ahead and jump into the summary and action plan, thank you.

So, it's always good to start with a reflection of where we came from, and even though it's only been a week, I don't know about you, but it's been a long week. A lot has been going on, a lot of holidays for folks, religious celebrations, and a lot of other activities pulling us away – unfortunately, due to COVID. But, we were able to accomplish a number of things at the last meeting, including refining the data categories table. It really helped us to level-set our thinking at the concept level and be mindful of not wanting to go too far into the weeds. One of the things I thought was particularly helpful in the last call was right-sizing our expectations – and, Sheryl and I spent some time talking about that after the call, and we were really very appreciative of the mind meld we heard come from the task force message about staying at the right level.

We also started to discuss some guiding principles, so we broke those into a separate table for us to start working, and we also added some additional tables to help us capture where we want to head in the end with a potential report, so we've got one space in Google Docs for the task force members to collaborate. I understand that some folks are still having challenges with getting into Google Docs, so please correspond with the ONC HITAC support, and they will be able to guide you through reconciling any access issues you may be encountering.

In addition to our work on the table, we really got some volunteers to raise their hands, to advance the information or data categories table, as well as what we're affectionately referring to as the "happy path" group that reflects our guiding principles and ideal state bookends, so we'll talk a little bit more about those today because we've had some content added. I really want to do a shout-out to the comments that were captured in the last meeting and thank the team that got those comments translated from the last meeting into an "other considerations" tab, almost like a parking lot so we don't lose those great thoughts. This really

starts to give us a robust framework for us to capture thoughts, and then advance them iteratively week by week either between meetings or more specially during our 90 minutes together every Tuesday.

In addition to that great work that we accomplished, we are also looking ahead and thinking about the show and tell of the current state, and more specially, the projects that are happening in the landscape today that can help to meet the guiding principles and ideal state considerations that will be evolving, so we put that on the plate of consideration, but realized we needed to do a little bit more work, but I think we wanted to talk about trying to do some advanced scheduling, so I think we'll get to that at the end of today's call. If we could go to the next slide, please.

So, the approach to today is to hear back from the very informal subgroups that have been nibbling away at the data categories and the "guiding principles and ideal state" tabs in particular. Time permitting, we can start to look at the "other considerations" tab. But, as we discuss things today, we're going to rely upon Josh to give us some support in capturing the details to the best of our ability, and then ask folks to continue – regardless of whether you volunteered in the past as task force members, we encourage all of you to update the workbook and considerations between meetings. After we do some of the tab reviews, we really want to talk about our next phase to continue to advance our efforts. Sheryl, would you like to add anything to the last meeting or to today's meeting setup?

**Sheryl Turney**
I think you did a great job, Alix, in explaining it. I know I was a little bit challenged when I put in most of the comments that were made in the last meeting to the "other considerations" so we didn't lose those. I did not highlight them in yellow, though, because it wasn't new information in between the meeting that we would necessarily want to review because all of that data was shared in the last meeting, and it's also in our meeting notes, but again, Alix and I did not want us to lose that because this way, we can use the workbook as our source as we're trying to draft our final paper rather than having to hunt through all of the comments people have made along the way.

But, as we – Josh is going to open the document in a few minutes, and we're going to start looking at the "data considerations" tab, and then you can see how people have been making updates. Again, as Alix just said, please be sure to go out there. If you have any trouble opening it, it's probably because you don't have a Gmail account linked to your work email address, and they can basically either open it, give you permission with a Gmail account address that you might have, or add your work email address to it. So, if we could get that resolved this week, that would be really good, but also, thank you to everybody who did participate from the last meeting because we do have a lot of updates, which are going to be wonderful.

**Alix Goss**
I think that's a perfect segue to the next slide, Sheryl, for you and Josh to take us into the table.

**[Crosstalk]**

**Sheryl Turney**
Okay, thank you. I don't know, I think that was background conversation somebody had. All right, so, Josh, if you could – all right, he's doing his screen share, so we'll just take a moment, and this is not yet in the Google update table because Josh and Jocelyn, I believe, did review it. So, Josh is going to speak to it, but

this is such a big change that we really wanted you guys to be able to see it before we make this change in the table, and this is based on the suggestions that folks had to further define the terms and also help to reorganize them because it might help people assimilate better what the data flow is that's going to help us drive some of the recommendations that we need to include in our paper. I'll let you take it from there, Josh.

**Josh Harvey**
Sounds good, thank you. After last week's call, Dr. Jirjis and I were spending some time catching up, and we bounced around some ideas about how to try to incorporate a lot of the common themes we were hearing on the call last week and trying to kill as many birds with as few stones as possible. So, I reached out to Sheryl and Alix in between meetings to say, "Hey, this is a little bit different, but I think I have a way to restructure the foremost parts of this – the inventorying of the data and helping to clarify what data we're talking about before we dive into the more granular part – so, help us find the right balance between the higher-level concepts and the more granular information we need in order to identify the current-state and ideal-state standards for each of the data requirements we have. So, fundamentally, the idea was essentially to piggyback off the great work that ONC has done on version 1 of the USCDI and use this notion of data classes and data elements to help organize and separate those higher-level concepts from those more granular data element types of information.

So, a lot of this has a direct overlap with the USCDI, making it pretty easy to fill out the remainder of the spreadsheet, assuming we have agreement on that being the best approach forward. Some things may be a little more difficult, but if we have a framework for how to capture it, then that's where we can expend calories between meetings. So, I'll just briefly go over this and then open it up for feedback because for the most part, this is really just reorganization of information we've talked about before to hopefully make it a little more digestible and scalable as we go through and do the future steps.

So, just as a pretty basic example, the first data class that has risen to the surface and is a little easier to digest than some others is patient demographics. There's already a great foundation for that in ONC's version 1 of the USCDI. The idea here would be to describe demographics as a concept or data class supported by several different, more granular data elements, which I think everybody follows from previous experience in other applications. Now, expanding it beyond a more basic example than that, taking a stab at organizing the other pieces of information in the classes and elements, one of those being those things related to an insurance plan. So, we've discussed payer plan and benefits information all as important data elements that would be associated with a payer and a beneficiary – some combination of the two, the idea being that those things are interrelated. We can tie them to a data class and organize them that way so they could be then used in a more modular way, but we've described them as one broader concept.

There are also several different outstanding questions that have started accumulating after going through this, where there may be some redundancies and some level of clarification we might need in order to tie it to a particular standard, so I envision those as saying that we can continue to add week to week in some of the comment sections of the working document that we have.

I don't want to spend too much time going through this, but I do want to point out the classes that I've listed out. So, I mentioned the payer information, but I think some really important ones are these ones related to the prior authorization request and the information going back and forth between the requester and the approver of the request. So, those have been broken out into what are effectively five classes, but I would

classify this as a pretty rough idea that I think we're going to want a lot of feedback on. So, the initial idea would be that there's a request and some basic information that has to be transmitted as part of that request, much of which are things we've already discussed. There would be different information that would be included in the response from the payer back to the provider submitting the request, so that would be where things like coverage termination and/or requirements to actually satisfy the request – documentation needs and things like that – could be transmitted.

And then, a further class would include all the information that would be included in a response back to the payer to support the request initially made once the requirements have been defined. The notion of a follow-up – so a request for additional information if there was something beyond what we've already included and the justification was necessary – and then, ultimately, a decision. So, an approval or denial, and then, all those things we talked about around covered alternatives and cost of plan, cost of patient.

Lastly, there is a class broadly described as metadata, which – I think you could make the argument that each of these classes has its own metadata associated with it, or all of the metadata could be separated out in its own data class, so I think those are things that would continue to be up for discussion, but I'll stop there and see – first, I know Jocelyn had an opportunity to review it a little bit ahead of time. Jocelyn, do you have any feedback or input you want to share? Before we open things up to the rest of the group, I want to make sure you have an opportunity to do that.

**Jocelyn Keegan**
Thanks, Josh, and sorry I didn't get back to you. As Alix said, it's been a crazy couple of weeks. I really like those structures, and I think the way that you've simplified the concept of classes is a really good way to look at this. When I look at it – and, I put a couple notes in the tab, but when I look at it… We have a visual we use that talks about the steps to get through a prior authorization that's way more than just actually submitting a prior auth, so I think that bucket around insurance plan is actually more complicated than just who your insurer is. There's a class of content that is around coverage, and coverage cuts across the service you're asking for, who the providers are, what the different rules are around particular groups of providers based on your contract, whether there are any constraints about locations and where you can go based on the contract you have for that particular member, with that particular payer, and with that particular provider, and then, a concept around copays – patient obligations.

I think it's separate from just who the insurer is, because that is complicated in and of itself because of who has dual coverage, but I think this concept of coverage itself and coverage detail – in the pharmacy world, it would be formulary benefits. In the work that we're doing on the Da Vinci side, it would be the concept around coverage requirements discovery and documentation templates in the rules that would really answer those questions. In some places, based on our conversation we had last week, there are vendors and payers who do a really great job with having really rich, robust 271s, so that data can come out of a 271 today as well.

And then, the second area I would say as I was looking at the classes is really this concept of – part of the challenge I think we have with existing PA standards is this concept of the payload of the clinical data itself that's often used to justify the decision, so that's in the PA justification area, but I almost think there's a truth of clinical information that may be beyond what's just in clinical notes. That could be lab results or images

– just this concept of what that clinical record is. I don't know if this just blows out justification more or if it's its own class of data. Those are my immediate reactions from looking at the structure, but I really like it.

**Sheryl Turney**
Thank you, Jocelyn. That was very helpful. We do have –

**Jocelyn Keegan**
And, I'm looking at Raj's comment. Do you want me to talk a little bit about the Da Vinci use cases and how they fit in together, or Raj, did that get at what your question is?

**Sheryl Turney**
Raj, I think Jocelyn was responding to your question in the chat.

**Jocelyn Keegan**
Yeah, he's typing.

**Sheryl Turney**
Oh, okay. I see it now.

**Jocelyn Keegan**
I can't share my screen, can I? So, there are three use cases in the Da Vinci world that we're working on that are really around creating transparency around benefits and, if you need to, being able to automate the population of the data required to do the 278s from the back end. So, there's coverage requirements discovery, which is the ability, leveraging CDS Hooks, to put a trigger in the workflow to basically say, "Based on this thing I want to do for this particular patient at a given point in time, can I do this? Are there any blockers, things I need to do, or boxes I need to check?" We typically describe it as "Is prior auth required?" – really being able to answer that question definitively for the caregiver.

And then, if and when there's something that needs to be done, the next trigger or the next smart app or call that could be triggered in workflow for a care team would be an implementation guide that we call "document templates and coverage rules," and that was, "If I need to do something, actually tell me what the rules are. Tell me when I need to document, tell me what needs to be in the physical record to make sure I'm going to get paid for the service I'm performing, and then tell me what the rules are so I can know whether or not I meet necessity, or tell me other information about these alternatives and information like that that would be available. And then, if and when, as a caregiver, I decide I actually want to do the thing and it requires some additional permission like a prior authorization, how do I do that prior authorization in as automated a way as possible?"

So, we have a third implementation guide called "prior auth support," which we've worked to essentially extract and collect the data using FHIR resources from the EHR, and working with HL7 and X12 members – so, members of Da Vinci who are members of both HL7 and X12 – we've actually done a crosswalk between the FHIR resources and the X12 278 standards so that we could potentially automate end to end, and we've had some members who have started demonstration projects doing this being able to go from EHR, to FHIR, to 278 to get a determination that then comes back to FHIR to fully automate the prior auth as part of workflow.

And, what I would say from an adoption standpoint is – and, we're talking about having one of the early adopters come in and share their progress and the decisions they've gone through. I've been talking to Alix and Sheryl about that in the background. But, what we're seeing is that typically, people are chomping on doing the CRD use case first, just really getting better information in front of the physician or physician team about whether or not they need to do anything, and that itself just has a huge benefit from reducing complexities and unknowns in workflow for provider teams. Thanks, Alix.

**Sheryl Turney**
That was really helpful, and we'll look to see if Raj has a follow-up question, but we definitely had discussed having that presented in a future meeting so people would be aware of it.

**Jocelyn Keegan**
Yeah, that was totally mountaintop, sorry.

**Sheryl Turney**
That's okay. We also have a couple other questions. Arien is first, and then Alexis Snyder. I don't know if they're particularly for you, Jocelyn, or for the greater table, so Josh, if you could show the table, that would be helpful as people ask their questions. Arien, why don't you go first?

**Arien Malec**
Thank you. First of all, I just want to comment that I've got two sets of issues related to getting access to the document that I need to work through. One is that my data loss prevention framework around change healthcare hasn't allowed me to get access, but Google documents – I have to do it from my own computer, and secondly, I've got the work email – personal email, so I'm working through some of that stuff so I can actually comment on the table directly, but I send my apologies for not getting there yet.

I really like the organization and framework, so first of all, kudos to doing the hard work of reorganizing the table. Secondly – and, I'm not sure if this has been an area that Da Vinci has explored, but in previous work that I've done around complex, multi-stakeholder-orchestrated transactions, the notion of expressing the current state of workflow is really important, and if you get super fancy, you can actually express some of these things as state machines – so, what state can I transition to given that I'm in this state? – but, at a very simple level, allowing someone to query the current state of a prior authorization or authorization request is a really useful lens, and some of the stuff that you've encapsulated as request/response, additional information, et cetera may be better captured as opening a prior authorization, and then getting the current state and responding to the current state with appropriate information. In some cases, you go directly from request to approval.

In many cases, you go from request to additional information needed, and then, in some of the edge cases, you get to denial, denial appeals, and those kinds of things. So, if you start to think about these things as the current state of your authorization, that may be a useful unifying comment. Again, once I get access, I will go through and try to add some of this stuff on the table itself. Thank you.

**Sheryl Turney**

Thank you, Arien, and I think that's a very appropriate comment about the statuses because we definitely need to be sure that we're providing those in the table. All right, why don't we then go to Alex Snyder? Alexis, I'm sorry.

**Alexis Snyder**
That's okay. I'm going to piggyback onto what was just said and maybe expand upon it a little bit. So, usually, if you're dealing with a complex patient – and, I mentioned this on another call – you're dealing with multiple insurance as well, and usually, that second insurance is going to need a denial, partial approval, or any of the approval before they will make their final decision about costs, so I can't see the table live now, but some part of that decision box probably needs to break it down into primary and secondary insurance because it's going to be a different process for someone with single-payer insurance.

And then, piggybacking on what was just said, the multiple providers in complex care that are usually involved in something like durable medical equipment – more specifically, a wheelchair or other apparatus – it's kind of a place on the table where that PA process started, reflecting who's running the show, basically – who is collecting all the information when there's multiple players bringing pieces to the PA process so that they don't get lost, and who's going to ultimately submit and translate it. So, I'm not quite sure at the moment how we necessarily capture that easily in those boxes, but it's still something to remember. Just as an example, you may go to your physical therapist, who is saying, "Yes, you're going to need a wheelchair or crutches, but we need a prescription from your primary."

Somebody has to start the PA process, it goes back to the PT to then write up there why it's needed and the functional status, et cetera, and things can get lost in the shuffle. And then, there's your DME provider, who is collecting it all as well. So, usually, there are at least three people with hands in it, and that's usually where things go wrong. I don't know how we reflect multiple providers and multiple insurance, but it is important to the process because that's where a lot goes wrong, and it creates a lot of extra work for the providers, too, when people might be doing things twice, as well.

**Sheryl Turney**
Yeah. I know in the original table, we had the secondary insurer, and probably would need tertiary in some cases because at most, people seem to have three, but right now, I think Josh has locked access to the Adobe meeting, so we can't show his table because it's offline; it's not in the Google doc, so I apologize for that, but we will take that comment back and make sure that it is in there, but it was in the original. I'm looking at the original right now, and secondary was definitely out there.

**Alexis Snyder**
It wasn't in the original. We added it when I mentioned it on the call a couple of weeks back, but it's important because you might get that first approval, and then it's useless if you don't have it for the second.

**Sheryl Turney**
No, I mean it was in there last week. That's what I meant.

**Alexis Snyder**
Yes.

**Sheryl Turney**
The original one that Josh was working from – it's in there. Okay, any other questions or comments?

**Alix Goss**
Hey Sheryl, let's just check and see if Josh is back.

**Josh Harvey**
I am here, and I've been capturing those comments, completely unaware that I was not still connected, so I apologize for that, but I've been capturing the comments as I go, and I'm currently rejoining.

**Alix Goss**
That's awesome. Thank you. I don't see any hands up, but I'm wondering – Gus Geraci is making some comments, and I also saw Jocelyn make some comments in the chat box which may or may not have gotten captured in that interesting conversation from Alexis building on Arien's feedback.

**Sheryl Turney**
All right. So, would either of you like to speak?

**Gaspere Geraci**
This is Gus. I just think there are some barriers to putting cost to plan and cost to patient in this kind of scenario, only because that may not be known until everything is done, and even so, I'm not sure they would – I can't necessarily speak for the insurer, but I've played with enough of them. They may not be willing to reveal that except in the EOB to the member, and then, obviously, knows what they're going to get paid, but I don't know that they would want the providers and all the folks – that gets to how granularly this information is shared as well.

**Sheryl Turney**
Yeah. I do know that that has been a concern that payers and others have had, but even with the upcoming interoperability rule – when that's finalized – giving patients the ability to see what their costs are going to be with as much information as you have at that point in time is going to be a requirement, so I think it's something that we don't want to leave out of this process.

**Gaspere Geraci**
I agree, and ultimately, the patient/member should know ahead of time, but ultimately, they always find out on the EOB. It's just that until that legislation, guidance, or whatever is passed, it may be challenging for some insurers.

**Sheryl Turney**
Exactly. That's a very good point, Gus. All right, I think there were a couple other people that made comments in the chat window. I do see Jocelyn has her hand up, so Jocelyn, why don't you go first?

**Jocelyn Keegan**
Just on the concept of price and cost, we've spent some time at the Da Vinci project on price/cost transparency, and also, with my Point-of-Care Partners hat on, there's actually been positive progress around the concept of real-time benefit check at the transaction on the pharmacy side, and I think there are

probably two ways I would frame this because I completely agree with Gus's point that today, it's challenging. I think if we think in terms of cost and it not being a specific dollar amount, but as the patient gets further through the journey and more becomes known, you move through the initial, which is an answer to say "This person has a copay of X amount, this person has a cost-sharing of 20%, this person has a high-deductible plan" – that high-level first pass of this patient's particular situation so there can be a conversation around what the options are for that patient for their plan with their care team at the very first step.

And then, as things become more known – which procedure, which location, which doctor – you can get to more fine-grained reality around what a specific cost would be, but all of those steps get you to better information that's not just about what the options are with the unknown – "Someday, I'm going to get an EOB to tell me how much I'm paying for something," which is how we all operate today, but being able to make informed decisions and give the patient choices as they start to look for care providers and be able to – I hate to use the word "shop," but be able to make decisions about what their options are based on their actual health plan benefits. So, I guess I look at – part of this workflow needs to be including that information leading up to being able to get to a fully automated prior authorization.

**Sheryl Turney**
Yeah, those are all really good points, and I think there were a couple additional points being made while you were talking, Jocelyn, in the chat window as well, and I don't know if those folks want to speak up, but let's go to Arien first, as he rose his hand.

**Arien Malec**
Thank you. I definitely appreciate the point that there are sometimes business considerations that prevent the flow of information or there are considerations where you just don't have enough information to appropriately price. I think one of the benefits of modeling the happy path and modeling the end state is that we can model a state where it's not that everybody gets access to everybody's price sheets, but the patient has prospective pricing information for the specific class of service that's being rendered, and I really appreciate the point that sometimes that may need to be progressive as more information is supplied.

But, one of the benefits here is that as we model a happy path and an end state, we can model from the perspective that the patient is getting to full and transparent pricing information, recognizing that in the – as we get there, we need to solve for cases where that may not be fully known or, in some cases, not fully shared for business reasons, and the patient only finds out how much their responsibility is after the fact on an EOB, which is unfortunately the current state for many of us. Thank you.

**Sheryl Turney**
Thank you, Arien. That's very helpful. All right, hold on. I'm trying to see. Alexis?

**Alexis Snyder**
I was just going to reiterate the piece about cost that I had been seeing in the chat while Jocelyn was talking. She said a lot of what I was going to say. But, when we're talking about something like durable medical equipment, until you meet with the DME provider, pick out specifics, and get ready to process something, there's no way to determine the cost, but I think it's important to preliminarily know pieces like the range of cost. It's easy to say to someone, "Well, this manual wheelchair might cost you anywhere between

$3,000.00 and $5,000.00, and there's this deductible, and your insurance is going to pay 70%, and you have to pay 30%."

Going in with that preliminary information makes a huge difference up front just to know what's going to be covered, what's not going to be covered, and what your responsibility of it is. You don't need the exact number, but you need to know those pieces because then, even offline, patients actually can be sometimes looking up pieces of equipment that they want, cost of medication, et cetera, and then be more aware of what that end cost is going to be, and then, the final end cost back in there after a medication has gone through or they've met with a DME provider, et cetera, but I think that's definitely something that needs to stay there and start giving those preliminaries, especially for those patients who aren't as savvy as knowing what their benefits are so they do know if they've met the deductible or not; if not, how much it is first, what their coinsurance is going to be, et cetera.

It makes a big difference, and if you hear, "Oh, it's going to be covered 100% if you want to keep moving forward, or we should find an alternate route to get equipment or a different medication, or you're going to have a $3,000.00 deductible first, and then you're going to pay 20% of it, and the cost is approximately…" Then, you'll do some math and figure out whether that's going to work for you or not, so I think that definitely is a piece that needs to stay.

**Sheryl Turney**
Yeah, I definitely agree, and Josh, I don't know because I hadn't seen it before today, but with the list that you're showing us right now, do you have cost still on there, or was it TBD for after this week? Oh, you still have it there. You have cost to plan, cost to patient, and I think originally, we had cost to first plan, cost to second plan, cost to patient, so we need to definitely expand that based on what we're hearing in the meeting today to allow for multiple plan costs because there will be some in the event of secondary and tertiary. So, I think that's something to bring back. I think I saw a few other comments in the chat, but they're all revolving around the cost aspect. Was there any other comment that people wanted to make on any other type of data class?

**Alix Goss**
This is Alix. One of the things I'm thinking is that Rich Landen gave us a comment about patient cost field, and that's kind of a nice segue into the guiding principles discussion, but I also realize that folks have been having technical issues with accessing the Google doc, and on top of it, we're changing the Google doc, so maybe since we're slated to pivot at 3:40, we can go ahead and make that shift over to the primary spreadsheet, knowing that Josh will upload this revised approach, which is really getting some fabulous feedback today, and we can then start to get people to comment on that. All task force members are invited to do so, especially if we can get their access issues resolved. If we can't, then I think we're going to have to think about a way to download it and maybe send offline to help those who cannot work through their technical issues.

So, one of the things that Rich Landen noted was that the patient cost field is important to build in, and matching along with the lines of the discussion, it's a complex issue. We need to think about where we're at today and where we can get to tomorrow. The point that I really like about Rich's comment was that it was that the basic ability to capture and transport should be built in from the get-go, and that felt very much to me like a guiding principle. Since we only have stuff in Column A, maybe we can make this a little bit

bigger, and Alexis Snyder, are you still out there? I know you did a lot of additions today that you put in yellow under the guiding principles, and all the other ones above your AKJ – I think that was…

**Anil Jain**
It's me, Anil.

**Alix Goss**
Anil did it! Okay, I'm confusing initials. I'm like, "Wait a minute, 'AS' is not 'AKJ.'" So, Anil, would you like to talk about the ones that you added today? I apologize for mixing that up.

**Anil Jain**
I'm happy to. I don't know if it's just me, but I don't see anything on the screen. It's all black. I can pull up the Google docs on a separate browser and read off that.

**Alix Goss**
I can actually see – he's displaying the guiding principles now.

**Anil Jain**
Okay, it's probably me, so I will pull up the spreadsheet on my computer – the live version of it – and I put a few things under the guiding principles, and I'll just read them out, and you guys tell me if you want more detail. Most of them – so, when I thought about guiding principles, one of the things I was thinking through is what do we want to make sure that whatever we recommend as a committee or task force, we live with those principles as a way to inform the level of depth and the amount of guardrails that we use in our recommendation. So, I started with establishing something we've said in our meetings all along: Perfection in every scenario is not possible, so let's go for being good enough or great enough to cover the vast majority of use cases. I think that's really important. Even if you look at e-prescribing, there are exceptions to e-prescribing that I deal with as a clinician when it's not appropriate, so even though we will recommend an ideal state or a happy path for the vast majority, we need to have some wiggle room so that we don't need to be perfect.

The second one I put on here is that the approach that we recommend as a task force should be sensitive to the clinician burden so that we drive adoption and obtain the desired results. We could have a very patient-centric mechanism that's heavily automated, but if it adds any level or significantly more complexity to the clinical workflow or to the clinician's team, then you're likely not going to get adoption, and therefore not going to get the results that we want. I'll pause after I read them all, and we can go back to them. I still can't see the document – oh, I see it now.

The third one is that our work should inform the coordination and alignment of existing efforts in the industry rather than reinvent them, and again, one of the things we don't want to do is have this task force come up with a whole bunch of recommendations for things that are already in flight. Rather, we may want to recommend how they could be aligned with disparate efforts or perhaps not necessarily vote for or advocate for, but call out efforts that might be further along than others. Obviously, we've talked about a lot of those in these task force meetings already.

The fourth one is something that I heard in a prior meeting, and I may have misunderstood, but we do need to make sure that the patient-centric view around privacy and security is not compromised in the hopes of making the PA process more efficient. We don't want to share more information with somebody than what is absolutely minimally necessary, and that's really difficult to do, but we need to make sure we don't sacrifice the privacy and security aspects because it's simpler to send a packet of data, or the data classes are filled, and we send them to everyone that needs to – that it goes to, but really, we need to think about what is the minimum needed for that to work, not what is the easiest for that to work.

The final one I put under "guiding principles" is that there's a lot that goes into PA, and as a physician, I will tell you that I don't agree with a lot of the decisions that come back or the principles on which the folks may decide that my clinical opinion is not worth more than a set of guidelines that are adopted from five or 10 years ago, but our work in this committee or this task force should be focused on HIT and informatics aspects, standards aspects, messaging aspects, interoperability aspects, rather than the thornier issues of trying to figure out why something is covered or not.

Using anecdotes to guide our discussion is fine, but using them to decide where we're going to carve out and carve in various policy implications is way out of scope, and our goal should really be to say we're going to make – whatever our society creates, we're going to make it more efficient, fast, and transparent through interoperable standards and through HIT than try to reinvent why I have to fill out a form every time I order X, Y, and Z. So, I'll pause there. I hope those made sense, but what I was trying to do was to ask what we should be thinking about whenever we put something forth without going into the details about each and every aspect of work because I think that's the goal for the first tab or the first sheet in terms of how we're looking at data. Does that make sense?

**Alix Goss**
Anil, that's a really great recap. It does. I read the commentary before – or, entries 9 through 13 before – but the way you described it really brought it all home, and you got a "Hear, hear" in the chat box from Jim, so it seems to be resonating with folks. Just from a process perspective, what I'm hoping we can do is have people talk about what they're adding to the table. If folks have concerns, tweaks, or commentary, then please raise your hand or add a chat box. I'm not seeing any raised hands, so I'm taking that as – no raised hands and no comments other than "Hear, hear" is endorsement for what you've added, and I certainly want to solicit people to raise their hand, add comments, or come in and update the table later, but these are all really good additions. From a guiding principles perspective, Anil, I want to see if Alexis had anything here because I don't want to go down to the "ideal state" section until we cover the guiding principles, if that's okay.

**Anil Jain**
Yeah.

**Alexis Snyder**
I don't have anything to add there. I would ditto everything that he said, and kudos for worrying about the privacy piece.

**Alix Goss**

And so, the only thing that I would – I'm wondering if we need to add, Rich Landen, the concept of the guiding principle is price transparency that will be built in from the beginning. Is that one that we want to add to this? If you're talking, you're on mute.

**Anil Jain**
This is Anil. I think you should add it, and I'll let others weigh in, but as a clinician I will say that price transparency at the time of discussing with a patient on what needs to be done is a double-edged sword in many ways because sometimes, knowing the price may prohibit a patient from doing something about it, so until we get to a level of an ideal state when it comes to transparency of price, I find it very difficult to have a conversation with a patient, and the folks on the call who might have more patient care than I do these days may want to comment. So, oftentimes, a dollar sign, two dollar signs, and three dollar signs are much more effective than specific amounts that may or may not change after the results come in and after the procedure is done. I think we should add something about price transparency, but I think because that's a moving target, waiting for that to be there from the beginning would mean that we would never get started until that all happens, and that may not be possible.

**Alix Goss**
Rich?

**Rich Landen**
Yeah, I think our guiding principle No. 1 is putting the patient at the center. To me, that encompasses the concept of price transparency because obviously, the patient needs the best information available when making decisions for himself or herself. That being said, for reasons we've gone over, it's not always possible to know the exact price, and depending on other things that are dynamically happening – other medical expenses incurred, unforeseen situations – it can change over time, but it has to be built in, it has to be acknowledged, and it has to be a commitment to the patient.

We have to set this model up to make sure business is done, but we have to do it in a fashion that absolutely enables the patient to get the information and understand that decisions are being made, and by whom, but it also is very clear – I like what somebody said earlier. It is not our role to shape those decisions. That's up to whatever the process in place is and who owns that accountability and responsibility. That's not ours. We provide the information necessary for the actors to make the decision, but we don't influence – we don't attempt to influence whether something's covered or not based on our own personal interpretations of what is right and just. Thanks.

**Alix Goss**
Thank you for that. Jocelyn?

**Jocelyn Keegan**
I think it might be helpful to understand the impact of what – real-time benefit check has been in the market for about a year and a half or so across some proprietary solutions, so I think when we have people come in to talk to us about ePA – the pharmacy prior auth automation – it would be helpful to understand the impact that data has had in proving the quality of that data over existing formulary and benefits data around prescribing decisions and adherent to formulary because what we've found from a research perspective is just getting better data allows that conversation to happen. A member is actually in front of – the patient is

in front of their doc; they can have a dialogue about what their options are that changes it versus it happening asynchronously when the patient shows up at the pharmacy and gets sticker shock.

So, to me, having the placeholder for it and knowing that that's an important part of that transparency information at care is important, but I agree: We want to figure out what the steps are and how we're sewing these things together based on current state to move in the right direction. I don't think it should be a blocker for us by any means.

**Alix Goss**
Thank you. Anil? Anil, I'm not able to hear you.

**Anil Jain**
I'm so sorry. Sorry about that. I was saying that I think the principles ought to be built in right from the beginning, as Rich and Alexis said, but I do want to make sure we differentiate between what I think is – it's a great service to know how much a patient might be paying for a specific drug, and it's generally very close in the ballpark when they actually go pick it up, but something that is commonly done at a colonoscopy – I might know what an approximate cost would be, but the charge for that colonoscopy will vary significantly after the colonoscopy is done based on what is found and what might happen with the patient.

So, we do have to differentiate between the different types of things that might be done to a patient and accept a certain degree of price transparency differently for different types of services, and as long as we do that, I think it makes a lot of sense to create the capabilities up front, not let it slow us down, but make sure that we educate our consumer/patient, have them come along on the journey with us because it is sometimes as nebulous for the clinicians as it is for the patient. Sometimes it's because we don't know until after the results are in if a biopsy was taken, not taken, et cetera. So, I just want to put that out there that yes, but this might take a little while for us to get comfortable and the goal that we're trying to achieve around transparency.

**Alix Goss**
Thank you for that. Alexis, I noticed you had a chat box, but unfortunately, when Josh is sharing his screen, he can't see any of the chat boxes. So, I'm not sure if you're still going to propose that idea, but I would like to read it to Josh to make sure he captures it or make sure it gets captured in support of whatever other comments you may have.

**Alexis Snyder**
Sure. I had raised my hand, so you don't have to read it. If you want, I'll just go through it with what I was thinking.

**Alix Goss**
Exactly, thank you.

**Alexis Snyder**
No problem. So, the first piece I would say in reference to the comment that Josh can't see was I was saying under the "patient at the center" piece, probably besides the price transparency or cost transparency, a piece about lessening the patient burden and the go-between for the patient, the patient being the

communicator between multiple providers and trying to gather the pieces needed and check on where it is in the process to make sure things are moving along because that's very burdensome, and I think that's a very important piece we shouldn't lose sight of. There's definitely a lot of patient/caregiver burden in this entire process.

The other piece that I wanted to mention – and, not to go on and on too much with the price transparency, but I think – I'm not sure if someone else mentioned this point of not having the actual cost, but perhaps putting one, two, or three dollar signs – I don't think something like that works because what is that? What is that range of cost? Every patient is different. There are different socioeconomic classes, and what might be two dollar signs for somebody might be five for somebody else. I don't think that is transparent enough, but again, I think it goes back to the point that I and others had made before about gathering as much as we can up front about deductibles, coinsurance, and a range of prices, and just for a quick couple of examples that I had thought of and jotted down while I was listening, in reference to drugs, there's a difference between finding out what the cost is for 30 days versus 90 days and **[inaudible] [00:58:48]** versus picking it up at the pharmacy.

There's so much variable that goes into it, so as much information up front makes a difference in the end. Something else – another example I have thought of – something like getting an MRI – where you get it is a big difference, so you do need transparency, knowing that up front, it may cost you way more versus at an outpatient MRI center, or you can call the MRI center because your insurance won't cover it there. So, there are definitely those pieces there to be fair and up front – again, not the actual end cost.

And then, the other piece that I wanted to add to the conversation about where our recommendations should be and what we should focus on – absolutely, we're not here to try to change the way the insurance companies are setting guidelines for how they're denying or approving things, but I want to make sure that we do not lose sight that part of the work that we are doing with the IT piece is to make sure that things get done seamlessly and that things don't get lost, and that's where I think we have an important piece to play here in making sure that the information is captured up front and delivered to the insurance company at the right point and the right information that they're looking for. That might make the difference in the end between an approval and a denial because just missing one little step or one piece of information they're looking for might just generate an automatic denial, and then that's just more work for the providers all over again. So, I just wanted to make sure we didn't lose sight of that. I think those were all my comments in this area.

**Alix Goss**
Okay. So, for that third – so, I think I was tracking with all three of those, and I think we've captured the concepts, except I don't know that we got the third concept, which was the seamless and transparent information exchange and not letting it get lost, leading to a denial unintentionally. Do you feel like it's captured –

**Alexis Snyder**
It didn't necessarily need to be captured there. It's more of a piggyback comment on the larger conversation that folks were having about making sure we stay focused in a certain area, and I was just saying that of course, we're not going to focus on fixing the insurance guidelines, but we do need to fix this process so that we don't end up with a denial in the end because we missed a piece of it.

**Alix Goss**
Thank you for clarifying that for me. So, I see that we've got Jim and Anil with their hands up.

**Jim Jirjis**
Hey, it's Jim. I just have an important point to clarify about the discussions about the one versus two or three dollar signs versus what the actual copay is. One thing to consider is that you're really solving two different problems. One is when the provider, with the patient in front of them or not, is trying to decide between two relative costs for the plan interventions – the cost of a cardiac MRI versus echo, for example. Having directional information about relative costs that the dollar signs are meant to depict is valuable. The patients, however, may have a completely different set of needs, wanting to know exactly how much out of pocket, and I would say that it wouldn't be an either/or, but both of them have value to managing the cost, and both of them fit into transparency, but for different purposes.

**Alix Goss**
Okay. I'm adding that in there. Do you want us to capture something else, or is that just a commentary?

**Jim Jirjis**
Well, there was a discussion someone brought up earlier about having relative cost, and then, somebody else – I think it was Jocelyn – who just said, "Well, that's not helpful. What people really want is out-of-pocket." So, just in that cost piece, I think there are different costs, and both approaches are valid, not just the relative cost that the dollar signs present to the doctor being as valuable as the actual copay to the patient. I'm just making the point that cost should be depicted based on different decisions: The patient wanting to know copay versus the doctor making decisions about general courses of treatment.

**Jocelyn Keegan**
I think that's important. So, in our pre working sessions we've done conceptually around price/cost transparency, we have definitely got into that nuance, and I think as you shift into at-risk contracting, that cost to the provider organization actually becomes a really important information that the provider team is going to want to understand. I think that at the grosgrain level, understanding patient obligation is definitely the first step, but I completely agree that understanding the different components of what is essentially a formula is important as all of the stakeholders get better arms around moving into at-risk contracting and value-based care contracting, and we're all headed there.

**Alix Goss**
Anil?

**Anil Jain**
Jim said exactly what I'm trying to say. When I mentioned the dollar signs – yes, it means a different thing to every patient at different points. The dollar signs are for the clinicians who are having to make clinical-supported decisions based on two, say, bioequivalent – or, two equivalent imaging studies in the example that Jim gave. This happens all the time, and oftentimes, clinicians are making decisions without really understanding the full impact, so the dollar sign is a clinical decision support aid, and that can actually lead to a much more meaningful conversation with a patient so that you can even get to the point where you can start wondering what the copay is for the ultrasound of a kidney instead of, say, a CT scan of the kidney looking for a stone.

So, I think Jim said it well. The dollar sign is a clinical decision support aid. If that's not part of the ePA process and we have a divorced system between ePA and clinical decision support, we'll have other problems, so there ought to be some way of linking the two. If we have information about relative costs of equivalent testing, then there's no reason why that can't be incorporated into the clinical workflow at the same time. Otherwise, you could end up having some very strange decisions where the patient will know exactly how expensive their MRI is, but not realize the clinician could have ordered a simple x-ray instead.

**Alix Goss**
Thank you, that's helpful. Jocelyn?

**Jocelyn Keegan**
I'd like to double down on this point. I think it's really important that what we need to do from a focus perspective is bring together these different transaction sets – the HIPAA world to the clinical world – and that has to be part of our focus: Bringing those two disparate sets of information together and merging them because it's critical in order for us to be – Alix gets to listen to me talk about this on the Da Vinci front all the time – it's critical that we bring back together administrative and critical transactions in order for providers, patients, and payers to be successful in transforming how we care for people, so we can really focus on better outcomes. I know that it's future state, but I think keeping that in mind as we move forward is critically important because it's a world that's been divorced for the last 30 or 40 years, and we need to bring it back together.

**Alix Goss**
Perfect segue! Thank you, Jocelyn. Let's go down to the next portion of this tab. It's called "ideal state," and if Josh could scroll down, I would be gratefully appreciative, and we'll have an ability to – I want to say to Alexis – if you had content you added, do you want to talk to that? I know I put mine in yellow highlighting with my initials, and I think Anil did as well, so maybe if you can kick us off to talk about a few of the ideal state contents.

**Alexis Snyder**
Well, I would if I could see it. I lost my connection, and I keep trying to log back in, but I do know the gist of what I put in there. What I tried to do under the – and, you can read off some of the specifics that I can't see –

**Alix Goss**
Do you know if you added it below mine? Let me see if he can scroll down because I can see the screen.

**Alexis Snyder**
I added it – well, mine's not in yellow, and I added it right under "ideal state" where it said "patient," so I made a list of –

**Alix Goss**
Yeah, so actually, you are at the top of the page.

**Alexis Snyder**

Yeah, I made a flowchart, more of a list of steps that ideally, from a patient/caregiver perspective, would need to happen regardless of what's going on behind the scenes from our side and the coordination that needs to go into it – what happens walking into the office, getting a recommendation, finding out if a PA is needed, once the PA is needed, et cetera – so, if you could see the list there and if you have questions I could specifically answer.

And then, what I did a little further down was put in – I think you had started a tab that said "patient visits – ER," and there wasn't anything under it, so I wasn't sure if you were looking for patient/caregiver perspective on what happens and the happy path for the patient when they're in the ER, so the only piece I added there was very minimally that I hope it's an expedited process and you just get what you need while you're there. And then, I added a tab or a line for pharmacy, and I can answer any questions that are there, but the basics, again, from the patient/caregiver side of what your happy path is to getting the drug that requires a prior authorization. So, again, I can't read it because I can't log in, so just ask questions.

**Alix Goss**
Yeah, we seem to be having a number of issues with Adobe today, and it's kind of sporadic, but what we do show on the screen –

**Alexis Snyder**
Of course, I had no problem in the first half of the call until you asked me to look at it.

**Alix Goss**
Yeah. Well, I appreciate that you took the time to add "patient visit," "ER visit," and "pharmacy" – some high-level workflow steps of how it should it work. I think that's a really great setup, and knowing that we are about eight minutes away from public comment, I'd ask if Josh could scroll down to row 36 because what I wanted – so, if you bring 36 to the top of the screen, what you're going to find is several rows – so 36 to 45 – I have extracted items – I was looking at the compendium of materials and thinking about the fact that industry has done a tremendous amount of work already on prior authorization, and I specifically went through the weedy whitepaper and captured a variety of ideal state policies – concepts – and either took them lock, stock, and barrel or tweaked them to fit into the spreadsheet so that we could have this foundation of work from the industry because the weedy whitepaper also built on the coalition of the AMA, AHA, BCBSA, AHIP, I think, and MGMA – there was a consensus paper that came out with positions in January of 2018, which were also included in the weedy whitepaper, and I thought those were really good, and I didn't want to lose that basis of historical hard work by the industry.

And so, I'm going to cut it short on going through those since many of us have seen this before, and I'm hoping that we'll take a deeper dive into some work on this tab, but there is additional content below, starting on row 46 if you could scroll down to that. Anil, I'd like to ask you if you'd be willing to talk through 46 through 49, which were new content that you added in and had been prior artifacts that people would be aware of, and I want to spend the last few minutes that we have going through those. Thank you.

**Anil Jain**
Sure. I'll go through them fairly quickly and see if there are any questions or concerns. I think the first one on row 46 is to simply say that, in the vast majority of cases, if we can have everything automatically adjudicated so that the workflow and the relationship between the patient and their physician is – that whole

process is not interrupted for the vast majority of cases, that would be great. Oftentimes, what I've seen in the EMR world is that even workflows that can be fully automated still require a bunch of things to happen, and it just gets in the way for really low-value work that gets added to the process. So, in the ideal state, we should try to automate with complete adjudication as much as we can, knowing that there are obviously going to be situations where more information is needed.

And then, row 47 – regardless of the venue of care, the PA process that we're going to recommend should look mechanically similar no matter where you are, whether you're an ER doc, whether you happen to be seeing patients in urgent clinic that day, whether you're a surgeon or anesthesiologist. If you're a rehab doc or primary care doc, it should look very similar because the roles change and the patients travel to various places in the health ecosystem, and we don't want multiple ways of doing the same thing just because different people worked on it from their specialty vantage point.

In an ideal state – row 48 – a full audit trail should be available to both the patient and the clinician with some lay-friendly language for the patient, obviously, so that we have a common source of truth. Oftentimes, what I've seen – at least, both as a clinician but also in my own personal care whenever I've been dealing with this – often, the material I get as a patient is not aligned to the material that my physician will get and vice versa, and that just creates more friction, confusion, and mistrust that we don't need in the industry.

The final one is that any workflow that's utilized to support the PA should auto-generate content that can be edited by the clinicians to document what it is that they just did. Oftentimes, what I've seen in the electronic health record, whether it's a smoking cessation widget, for example, or something that is mandated as part of my interactions with the patient, is that I'll do everything that the EMR has created, and I'll go through all the steps, but I still have to now do a separate documentation of it when I just did all that, and the system can generate that content for me and say, "Okay, you just ordered a wheelchair because this patient has X, Y, and Z, and you've documented that they need it for at least 90 days," and it spits it out, and I simply have to attest that that's the right information. We need to make things easier for the patient and the provider, not create more and more places where documentation is needed. So, the ideal state should be automatically generated content. I'll pause there. Again, this may not make sense to everyone, but I was trying to come up with some things that we should be considering.

**Alix Goss**
This is great. I'm really appreciative, and you've gotten a comment from Rich Landen for row 48. "Can it be footnoted to capture the point made earlier that the physician provider should be able to use this process to ballpark the patient out-of-pocket costs of alternative treatments – like the x-ray/MRI example – ahead of the patient visit so that the provider can discuss options, already having an informed basis of cost-alternative treatments?"

**Anil Jain**
I think that's a great point. Rich, do you want to expand on that?

**Rich Landen**
I half figured the number. It should be row 46.

**Alix Goss**
Okay. I read it because Josh can't see any of the comments, so I wanted to make sure we captured it.

**Rich Landen**
I'll just say one quick comment. Most clinicians that I work with – and, I practice part-time – I don't know how much time we have to spend with the information before we see a patient. I would love to get other people's thoughts, but I think if we had the luxury of being able to get that kind of information prior to the visit, that'd be awesome, but I think most of the time, we're spending that time in the office with the patient trying to figure some of this stuff out, so I'll just leave it at that, but I think it's a great idea.

**Alix Goss**
Yeah, and I also struggle with the fact that for a lot of them, you get into the visit and you don't know what you're necessarily going to need. If it's a chronic condition and you're there on a regular basis, there might be a better indication of where you're headed, but…it's kind of hard because sometimes, you just don't know until you get there. You think it's one thing, and it's actually something else. I'm seeing – Rich, your hand went up, but is it on the same topic or a different one? I'm not sure how to queue you up.

**Rich Landen**
Yes, I'm continuing on the same topic. I have two thoughts, actually. We're talking about an ideal state, so having the availability to do that would be fine. That's in regard to understanding alternatives beforehand. My second observation is that it doesn't necessarily have to be the provider himself or herself, and in most large organizations, there are staff that can be assigned to handle that function if the organization chooses to make that necessary. That's it.

**Alix Goss**
Yeah. Thank you for that. Jocelyn was chiming in and saying this is key. I don't know if you had an additional comment. We need to pivot to public comment, so if you could bring us home, Jocelyn, and thanks to Josh for being our savior and typing today. As Jocelyn gives us some final comments if she has any, I think that we're going to pivot back to Lauren and public comment slides.

**Jocelyn Keegan**
I think this is a great segue, Alix, to get back to what is the current state and what happens today. Docs don't do PAs, right? There are staff or nurses, depending on the organization. There are support staff that actually queue it up. When we think about lessening the burden and improving automation, it's about what you can do in real time that is automated and is about getting better information. I think it was Anil who was speaking about how in an ideal world, you could see all that information at a glance. We get that a little bit in pharmacy today, and real-time benefit check is making that better so you can have a conversation with a patient, but if and when a PA needs to be done, it's generally passed off to staff, and I think being able to build tools where it can be automated, become seamless, and nobody even understands that a PA is happening by the team is the ideal state, but if and when there needs to be review and content collected and curated for prior auth, we need to acknowledge that that work is generally being done by the nursing staff and not by an actual provider.

Providers have such limited time with patients; they're not going to stop to walk through a questionnaire while they've got somebody in an exam room with them. I think if we keep that in mind and we keep that

patient-centered focus in mind, then I think the rest of our decisions get easier about what's pragmatically going to help us make process here.

**Alix Goss**
I'd like you to hold onto that thought while we go to public comment and think about what that might mean for our next steps and thinking about the current state, the demonstrations, or the engagement with some industry experts to expand our thinking around things, and we'll come back to that as part of the agenda item of next steps, which Sheryl and I will bring home after we defer to public comment. Lauren?

**Lauren Richie**
Thanks, Alix. Operator, can we open the line?

**Operator**
Yes, 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 if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing *. Our first comment is from Heather McComas with Greer Medical Group. Please proceed.

**Heather McComas**
Hi there. This is Heather McComas from American Medical Association. Can you hear me okay?

**Operator**
We can, Heather. Welcome.

**Heather McComas**
Thanks so much. First of all, I want to express my appreciation for the task force efforts thus far. Unfortunately, during our public health emergency, I think the importance of your work is really highlighted to reduce administrative burden for clinicians so they can focus on patient care. As I'm sure you're aware, the AMA places a high priority on reforming prior authorization. We've done extensive research on how this process can impact both patients and physician practices. As you referenced just a few minutes ago, we partnered with other national healthcare professional organizations and health insurance organizations in early 2018 to release a consensus statement that outlined key prior authorization improvements, and we regularly participate in standards development organizations that are involved in creating transactions for electronic prior authorization.

So, we'd first just like to offer assistance to the group at any time, and please consider that a standing offer. This is obviously a huge priority for us, so please consider that – put up the Bat signal, and we'll be there to help out. For now, I'd just like to offer two basic comments. The first is more of an observation, and the second is a suggestion. We've observed that the task group has been using the term "delight" often throughout its discussion to date, and we really appreciate your enthusiasm and your optimism, but we have to stress that preauthorization in its current state is anything but delightful for patients or physicians.

In our 2018 prior authorization physician survey, over a quarter of physicians indicated that prior authorization has led to a serious adverse event for a patient in their care, and I also think about many of

those stories that are found on our Fix Prior Authorization website. One particularly comes to mind from a patient – "I was diagnosed with Crohn's disease. The medicine my doctor prescribed required prior authorization. While waiting for the appeal, my colon perforated. I received my approval later the day I had emergency surgery to remove my colon." So, obviously, that's just a devastating consequence for that patient, and our survey data and this story highlight the magnitude of the current problem and the urgency of moving the industry toward a viable solution. So, we encourage the task force to review our survey results and identify how your efforts will resolve the direct impact on both patients and clinicians.

We've also noticed that the task force has identified many important issues to tackle, and we appreciate the fact that you have taken a "sky is the limit" approach to your work. However, we have to note the fact that you do have a deadline of September, unless that's been changed, and so, because of that looming deadline, we encourage you to perhaps think about limiting the scope of your work so that you will have meaningful, actionable recommendations in that limited timeframe. Here are some things to maybe think about in terms of scope. Where is the standards guidance for prior authorization most desperately needed? As you've been talking about, there is a standard for prescription drug prior authorization and NCPDP ePA transactions, and that transaction is accepted in the industry; it was named in an MPA RM last year. However, in contrast, as you all have discussed multiple times, the X12 278 transaction has very little adoption, and there is currently not a standard to exchange clinical data. So, it seems to us that perhaps focusing on medical services prior authorization might be something to consider.

We also would ask you, as you are thinking about issues and trying to solve things outside of prior authorization – we've noticed that there's not a lot of discussion about price transparency and patient cost, and we fully agree that these are critical issues, and they can very much impact a patient's ability to access care. However, we would argue that they may involve different processes or transactions, such as real-time adjudication or predeterminations that might be outside of prior authorization, workflows, and processes.

And then, we also – I think this came up just a few minutes ago – think about what information and work has already been done in the industry – things like, again, the 2018 consensus statement that represents an agreement from both providers and health plans on key prior authorization reforms. Also, we think about the Da Vinci Clinical Advisory Council guiding principles that were developed, and they address many of the privacy and security concerns that the task force has addressed, and we encourage you to take a look at those and incorporate those in your work. But, there are many things that 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 various standards approaches, whether it's X12 278 and attachment versus FHIR? Do we need pilots? It seems like these would be really important data points for you, and things that other groups haven't done yet to date. We encourage –

**Alix Goss**
Heather, this is really important input, and I want to make sure we get all of these thoughts. We do have another commenter in the queue with only two minutes left in the meeting. Would there be an ability for us – I think you might have written these up because they're extraordinarily thoughtful and detailed. Could we get a copy of this? I think you started to go into the Da Vinci CAC guiding principles on some very actionable things we might want to consider. Can we correspond?

**Heather McComas**

Absolutely. Sure thing.

**Alix Goss**
Great. I very much want to see the rest of that list. Operator, I believe you have another commenter.

**Operator**
Yes, thank you. Our next comment is from Kim Boyd with CoverMyMeds. Please proceed.

**Kim Boyd**
Hello, and thank you. Can you hear me okay?

**Operator**
We can, thank you.

**Kim Boyd**
Thank you so much, task force committee, for opening up a dialogue with the public around the initiatives that you're addressing as a task force committee. We are very interested in how the details from this committee will play out for the bulk of the health information technology world, especially associated with prior authorization. My name, again, is Kim Boyd, and I'm with CoverMyMeds. CoverMyMeds is part of McKesson Prescription Technology Solutions, and we're actually one of the fastest-growing healthcare tech companies in the U.S. and have been consistently recognized as one of the best places to work in the country.

But, not only are we industry professionals, we're also patients ourselves, so we are keenly aware that patients are challenged every day to obtain their needed medications. Our mission as a health IT company is to get patients the medications they need to live healthy lives, and I just wanted to quickly reference our concurrence with a lot of the comments that have been made by the task force committee members around prior authorization and the need to continue to evaluate how to automate/codify that process. CoverMyMeds has been very involved in creating those technology solutions in the medication prescription benefits space to automate that process. We've taken what was a very arduous fax 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 that are available in the industry today.

Now, there is still room for improvement, obviously, and again, we're very glad that the task force is looking at ways to improve that by infusing other things like FHIR and API types of technology, but I do want to concur with task force members who talk about price transparency and real-time benefit tools. As task force committee member Jocelyn Keegan noted, these tools have been on the market for about a year now, and we do have one of those private tools on the market, and I can tell you that these tools are creating great opportunities to actually mitigate the need for a prior authorization altogether because the tools will reference that transparency information that patients and providers need to make thoughtful decision support around the prescription therapy for that patient, and many times, we're finding that in dialogue with their patients, physicians are actually choosing medications that don't require a PA.

So, they'll see that a PA is needed, they'll see that the patient is able to afford it based on the transparency structure that surfaced in these tools, and many times, you'll go, "No, I'm going to go to the alternative

because it doesn't require PA and it's still just as efficacious for the patient." So, I would encourage task force committee members to still consider that there are other tools out there that can help mitigate requiring the PA altogether, such as real-time benefit tools, but continue to evaluate how to codify and merge these clinical and administrative functions more thoroughly. Of course, as one of the leaders in the industry, we are more than happy to be a reference or resource for this committee and provide mutual details to what is working in the prior authorization space today as we see it, where it needs to be evolved, and, of course, around price transparency. That's it. Thank you so much.

**Alix Goss**
Thank you, Kim. So, we are at 4:33. It is fabulous to get public comments. I think this is the first meeting we've actually had it, so it's great to get your thoughts and input, and I look forward to getting the follow-up from Heather and appreciate the offer from CoverMyMeds. I would have ideally spent some time doing some next steps and wrap-up. Sheryl, I think we have to decide on the fly whether we want to ask people to stay a few more minutes or just think about doing our usual debrief after the call and figure out next steps, and then we can conclude the agenda.

**Sheryl Turney**
To be respectful of people's time, let's do that, but I would ask – we're not done with this tool yet, so please resolve your issues – if you have them – with getting into Google docs. Please go in, and we'll let you know when Josh has updated the first page, and then we'd appreciate it if people would go in and make comments to that, and we'll provide some additional instructions for the homework. This is exactly the kind of input we need in a meeting. I'd much prefer to run out of time. So, I think next time, we'll continue with where we are, and I want to thank everybody for this great meeting today and their input to date.

**Alix Goss**
Well said. Be well.

**Lauren Richie**
Okay. With that, I think we are adjourned, and we'll pick up on the next steps for the group next week, the 21st. So, thanks, everyone, for your time today.

**Alix Goss**
Thank you, Lauren. Thanks, everyone.

**Anil Jain**
Thanks, everybody.

**Jocelyn Keegan**
Thanks, everyone.