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 07, 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
Thank you, all lines are now bridged.

Lauren Richie
Good afternoon everyone and happy Tuesday. Welcome to the ICAD Task Force meeting. Just a quick role call and we will jump right into it. Of the members that have dialed in already, I have Sheryl Turney, Alix Goss, Alexis Snyder, Anil Jain, Arien Malec, Denise Webb, Gus Geraci, Jacki Monson, Jocelyn Keegan, Ram Sriram, and Sasha TerMaat. Are there any other members that have joined that I did not call?

Alix Goss
There are a couple of people that are not dialed in yet. I see Deb Strickland has joined in the public chat, looks like Rich Landen has not been looped in yet. I'm skimming down I am not sure if there are other members who are still waiting to get bridged in.

Lauren Richie
Okay. Well hopefully they can join the audio here shortly, we'll have the operator be on the lookout. And Jim as well. Okay, great. So, Alix, I'll turn it over to you to get us started on our summary and action plan.

Alix Goss
Well thanks so very much everyone, it's great to have everybody here on Tuesday, April the 7th. We are going to, let's start out with a review of the agenda and sort of manage our expectations about where we've come from and where we're headed to. So, now that we have completed our necessary roll call and welcome, today is really about first level setting as we really jump into the deep end of the pool with editing the prior authorization table. From there, we'll also, time permitting, move into guiding principles and some ideal state discussions and then wrap it up along with our public comments. So, if we could advance the slides that would be great to keep going.

Awesome, thank you. At the last meeting, we really evolved from our prior work where we had been developing workflows to help us dissect the prior authorization process as the exemplar for what it might mean to convert or intersect clinical and administrative data. We're using the prior authorization use case as a tremendous point of burden in the industry to not only help us figure out how to improve that specific workflow aspect in healthcare but also to inform our work related to the larger convergence conversation.

To help us advance the workflow discussions, the content was pivoted into a table format enabling us to really get our arms around data categories and considerations related to the prior authorization use case. During the last call, Sheryl presented the table along with our colleague Josh Harvey from HCA who is supporting us thanks to our task force member Jim's ability to recruit staff to give us some additional support. That offline work is really providing us with an opportunity to get detailed consideration from the task force members, into the table, and then enable us to not only add content but also comment. So, what we are going to be doing in the next portion of this call is Sheryl and Josh are going to walk us through a review of the feedback we have received to date. And then hopefully do additional work to capture thoughts and considerations from the task force members. And then as we advance that work, we are going to start to fill out additional tabs that you may have noticed have been added into the workbook to help us with capturing our guiding principles and ideal state. You may recall from the last call that Sheryl talked about this ability to see what we think is going to be the end goal. The documentation that we are going to look

for to produce to take back the HITAC committee for their review and approval so we want to not only be advancing the detailed table work but we also want to be thinking about the end state so we can have the processes meet in the middle. Sheryl, would you like to add anything else to the set up before we jump into the actual working portion of the call today?

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

Alix Goss
Thanks, Sheryl. So with that said I will turn it to you and Josh to pull up the table and get us deep into the weeds, hopefully, this afternoon, so we can start to put some real shape to what it will mean to advance prior authorization.

Sheryl Turney
Okay, wonderful. Josh is going to be sharing his screen which we will show in a moment, the grid. We also – I tried to take some of the comments made in the last meeting, particularly from those of you that had specific comments to build them into some component on the grid. If I wasn't exactly sure where it was if I did not see you had gone in and edited it during the week. There were not a lot of edits to the grid itself, unfortunately, so that is one of the things we want to talk about. Can we make it so Josh is sharing his screen? I see it in the little window, but I don't see it in the big one. That's just going to take us a moment. There we go, can everyone see that? Now, per our usual, if you don't mind raising your hand and if you are on the call and you are not on the Adobe Connect meeting let us know when we have a pause if you have a question.

One of the things we did in the last meeting to sort of restart this for those of you that have not seen it, you can make it a little bit bigger if you click on the box to the right in your little Adobe Connect grid so that way you can see it more clearly if you can't read it. I am one of those and there may be others who I can't see it through my firewall, so actually I have it on my other machine so I can look at it while I'm looking at this and actually read it. But we had taken the picture and made it into data categories if you recall from the last meeting. And we started talking about some of those data categories and the structure of the grid, so one of the hopes we had coming out of this was the goal to make the recommendations related to how can we reimagine prior authorizations?

I went into a bit of a description of what would a reimagined prior authorization be. I only took one example where you go into a doctor's office and while you are in the office you can get a response on whether or not something they're recommending is, you're able to get it and let's take the example of the wheelchair that we already documented. What that would mean is whatever condition you are getting that for, I used the condition that you had surgery and you knew coming out of your hip surgery or your femur surgery that you would be in need of a wheelchair at least for a couple of months while you're recovering. So, there is specific information that they would need in order for you to have that, and that's really what we are talking about. We are talking about both the deliverers of the service as well as those ordering the service as well as the patient and the provider while you are in the visit, can actually get their service approved and know how much it is going to cost. And be able to walk out of the office and know I am going to have this surgery on such, and such a date and I am going to get a wheelchair when I leave and I'm going to know that. And quite honestly, conversations with doctors don't go to that level today. So we are talking about removing burden but I can tell you as the example I presented in the case of my daughter, she did not know she was going to need a wheelchair leaving the hospital and it would have been nice to know that.

Because then we could have made other arrangements for her when she was coming out of the hospital. But in that case, it all goes to the physician knowing what is going to be needed and communicating that to the patient. So, everybody is knowledgeable at that point in time. But in that case, we looked at this grid and said well there is a lot of information the physician would need to know. Some of it may be information that the provider of the wheelchair would need to know and then the information that the payer would need to know in order to provide that.

And people gave examples which I don't know if we even captured some of those. But things like, there might be add-ons to the wheelchair that are necessary. Or this, like in the case of my daughter who is small, she needed a smaller than normal adult size wheelchair, and they wouldn't know that if they didn't know her height or weight or any of those things. So those are things we talked about, where would that be in the grid in terms of data category. Well, is that going to be information that is patient-generated? Is it information that talks about the justification as to why the patient needs that information? Or this is the additional information that we added sort of at the bottom, where we were talking about the cost to the plan or the cost to the patient. Or who needs the information, and then we added some other indicators like metadata and process data. What's needed in the process?

So, looking at this, I could not look at this and say, oh I know whether site of service, meaning where is the wheelchair going to be delivered or where is the visit taking place? At the end of the day is that something that is in the USCDI or is that a structured piece of data that can be made available today? Who captures that data? These are the discussions that we are looking to have to look at all of the standards that exist and say, is that something that is captured today? And if it's captured, where?

So, with that in mind, this is a sort of refresher on how all this works, let's look at some of the groups of data categories like patient identity and patient demographic. I think for most of those, this is data that probably does exist in someplace. Either within content standards or within the USCDI we said patient demographics exist. So other emerging standards. I don't know the answers to all of those. We said in this case if you go over to the right, we added that the provider would be providing that data. Certainly, they collect it from the member. Some of that information, and then, not only does the provider act upon it but also, they'll be others that will act upon it. The deliverer of the wheelchair will need to act upon it. So, I guess what I am looking at is how do we get down to the standards that are needed?

And looking at, are we collecting or are we defining all of the appropriate data categories? How do we get to that next level to make this more meaningful for all of us so we can get to the recommendations? Again, this was the tool to try to get us there and I am not sure we're there yet. So, I am asking that question of the group. Can we have a greater conversation around is there a problem with the way we structured this? Or did you guys not see any additional data categories we needed to add? Or do we need to add descriptions to these? Where do we go with this next to make this more meaningful for our work?

Lauren Richie
Sheryl, this is Lauren, really quickly, maybe we can ask Josh if it is possible to zoom in? And maybe we can kind of focus on a few columns or rows at a time. That will help for the viewers at home, thanks.

Sheryl Turney
Yea, it is really hard to see. If I didn't have my own copy up I wouldn't really be able to see it even with my glasses on. I mean, you can do a few things. I mean, everybody whose been on the Adobe meetings, you can click on the little zoom in button. But then it is hard to figure out where everyone is because it cuts out half of the picture.

Alix Goss
Right so, Sheryl one of the things you may not be seeing is that Gus Geraci has his hand up.

Sheryl Turney
Okay, Gus?

Gus Geraci
So I think in my view, you captured all of the broad categories but when I have done projects like this before with folks, and it relates to data categories and specific data fields, things like patient identity demographics, are, I mean there are probably a dozen fields underneath that. And it may be out of complete ignorance, but are there standards for patient identity and demographics? Because I have been involved in many long discussions about how many phone numbers do you keep for an individual or a person?

Sheryl Turney
I think that if we, my answer to that is if we look at the USCDI list there's definitely detail under the broader categories and they may not be complete with what is required for prior authorization. So, I do think we should, for some of these, to the extent that you folks believe, we need to drill down a little bit to say what is there? And what is needed? And it may be different depending on the type of prior authorization it is. Certainly, you need one set of details specifically for something like a wheelchair that might be quite different than what is needed for a prescription renewal. And that's generated some additional questions.

So I am agreeing with you Gus but I am not sure how we go to the next level. So I saw –

Alix Goss
You have two in the queue.

Sheryl Turney
Yep okay. I saw Jocelyn first and but then I saw Sasha after that.

Jocelyn Keegan
I want to reinforce Jim's point. I think it's a really good one, I have been through this exercise in a couple of different areas around enrollment and prior authorization sort of in a group setting and I think we can spend a lot of time getting the rows right. And I think if we look at the rows as categories not this level of detail, but just that there is a category that will then get unpacked by SMEs around that category. And then you look at populating the data within the cell itself of the table, I think that's probably going to be between the time that we have between now and September, to progress this, that's where we should put our effort. Who does what at what level of maturity today around these categories. I think really what we need to understand is that. Otherwise, we are going to end up with so much specificity without taking the time to say what is the lens pullback of the row, category against standards, and be able to clearly see gaps where none of the standards do what we need them to do or where hybrids of using a couple of different standards or transactions of within standards are really going to get us where we need to be.

Sheryl Turney
I agree with that. All right. Let's go next to Sasha.

Sasha TerMaat

Hi, this is Sasha, I had a similar, I think feeling, that it would be maybe useful to have a description of the categories so that we would fill it out with consistent expectations. I, for example, am not entirely sure what type of data is envisioned for patient identity. Is it specifically identifiers? In which case, do you know if a particular standard or system expresses them? We need to know which identifiers. Not just a broad category. And so while I don't know that it will be practical for this workgroup to get into very specific items, if we're trying to assess whether a specific demographic like the patient's phone number is going to be expressed in a particular standard, like in NCPDP, I think we're going to have to actually be more specific to do it with precision.

Sheryl Turney
Okay. That's fair. All right.

Alix Goss
So, Sasha, you are talking about not only, you are building on Jocelyn's ideas of getting to the standards that we think will meet aspects of our data categories but then also make sure that we're clear about what is the scope of the data category and its definition but then also maybe there's not just that there's an answer like a standard exists but there is a maturity level that we need to be thinking about? Is that maybe something else that goes along with content standards to give us that low, medium, high maturity level? Or am I going in a different direction than you were intending?

Sasha TerMaat
I was not really going in the maturity direction. I would actually say that it should be out of scope for this workgroup to think about maturity. I think we should defer to other sources that may be the ISA for the assessment of maturity or adoption of particular standards. Otherwise, we will be working at this for a long time. And there are other ways to try to assess that. But I guess, from my perspective, if we were to try to fill out this spreadsheet, some of the rows are more specific than others currently and some of them, I think, when I look at primary insurance plan I think we could probably fill out that row with that level of specificity. But within patient demographics, if we mean any patient demographic then we could probably put yes across the board. If we're really thinking there are 20 critical patient demographics, then to fill out this row, we have to list out what the 20 are, and compare each of the 20 to each of the standards, to say, does x12 support previous address, does NCPDP support previous address does FHIR support previous address and so forth.

Sheryl Turney
Yes, that is very important. And that is going to be more important too, I think as we look to what are the other standards and what are they currently using for patient identifiers because I think that is really the key. All right let's see I think there are a lot of hands raised now. I saw Denise next oh is it Rich?

Alix Goss
Yes, I think it keeps it in the queue in order of how they were raised.

Sheryl Turney
All right, great then Rich you are next.

Rich Landen
Thanks, I am struggling a little bit, like others have voiced, about what level of detail we need to be at here. But specifically, for the patient demographics, I think if we keep in mind that it's really a transaction that we are doing from the provider to the health plan. And it may simplify our lives considerably if we just make an

explicit assumption that the provider will have done the HIPAA standard eligibility transaction and whatever patient identification information the health plan needs, the provider will already have obtained that from both the primary payer and the secondary payer if any. So, we just need to build into our model here a bit of logic that makes that assumption, and possibly to assist the provider to know what identifier a particular health plan needs. But I think fundamentally a lot of the detail, we can just kind of skirt the issue here if we make the assumption that the provider has current 278 information on file that information is accurate from the payers.

Sheryl Turney
I like that because I think that is something that currently exists that they would normally do. And again, it doesn't add anything onto the burden. Does that make sense to everyone else here, I mean, certainly, weigh in on that, but thank you for that. Denise?

Denise Webb
Hi, so I was going to make a few comments. We keep mentioning the USCDI is a standard and it's really a standard of standards, and what it is, is a standard of health data classes and constituent data elements for exchange. So if you go into it the USCDI, I actually have a printed copy in front of me, if you look at patient demographics it has 15 data elements under that data class and when you look at the 15 data elements, some of them have associated standards with them. Such as birth sex and race, but the others don't. So, you know, I agree with the comment Sasha made that we need to get to a level of granularity underneath some of these areas. And that we should at least, I think I heard this from other folks that commented, that we should at least have, for instance, patient demographics. What are the demographics that typically the payer needs in most cases? And then start looking at where those elements exist within the various standards that are used like NCPDP or so forth. And the other comment I was going to make is this is a really large group and it seems like once we figure out how we want to flush this spreadsheet out, maybe we need to break off into some smaller groups to work on parts of it. I think it is going to be difficult for a group this large to do that as a group.

Sheryl Turney
All right, that is a suggestion that we can talk about that in a little bit because we talked about what is the best way to go forward. And so, let's hold on that note, I preserved it and we will come back to that. Arien?

Arien Malec
Thank you, so first of all as a correction, the 278 is indeed the prior authorization standard. The 270/271 is where you get the eligibility request-response, which I agree should be a precondition for the rest of the flows. I will take maybe the controversial perspective that what we have right now is probably sufficient for the purpose that we're engaging in. We should be thoughtful about this information as primarily the broad-scale classes of information to the extent possible we probably should be aligning with USCDI. But we are not the organization or the group that is going to define the standard or the data representations or all of the details associated with conducting a prior authorization electronically. I think we should be looking at, A., making sure we get a representation from Da Vinci and other groups that have already done a lot of leg work here and see where the state-of-the-art is. And number two is, look at the policy enablers and policy hooks that would be necessary to get broader scale pilot testing, use, and adoption of some of these transactions. And also, to look at and make recommendations relative to policy gaps. So as a kind of point example, the 278 transaction was named by CMS as an EDI based transaction and based on some of the guidance that CMS has given, they want to name or they believe they have the authority to name only one standard. And so the Da Vinci Project built basically a FHIR based wrapper around the 278 transaction,

where there may be some recommendations on policy flexibility or other kinds of guidance about making a transition from primarily EDI based world to a world that is better served through FHIR based transactions.

So, it's the long way of saying I think we have done a fair amount of work at looking at the data required by each of the actors in the ecosystem. I suggest before we get super detailed about each of the data and data classes, we do an evaluation of some of the work that has already been done. But look at the policy enablers, the policy hooks and what is required of the ecosystem to get a broader scale robust pilot testing and broader scale roll-out of the transactions. And maybe we can learn from, for example, the NCPDP experience in enabling ePA in the pharmacy space since we are thinking about ePA for DME. Look at best success patterns and rolling out electronic transactions with respect to the work forces that are already out there like eligibility, claiming and remittance.

Put together a policy framework that goes along with some of the standards work that has already been done and do a needs assessment for where the gaps are. Because I feel like if we go through the nth degree of the data classes, we are doing work that other people are frankly better at, and not leveraging the unique skill set of this particular task force.

Sheryl Turney
Okay, thank you, Arien, I think you bring up a lot of fair points. So maybe what we need to do again is pivot to more of a needs assessment as you have said of where we would need to start in order to look at some of the policy and standard recommendations are that we would have. Jocelyn, you had your hand raised again.

Jocelyn Keegan
Hi, sorry, yes, I just made a comment. I agree with the points that Arien was making. I think one of the things that are important is, maybe the columns get to a level of granularity about particular transactions themselves. Because I think you are going to get workhorses like the 270/271, depending on their rigor which has been implemented, you are going to get better quality data to answer some of the challenges like: is auth required from a really mature 271 that actually the payer is really supporting? And building that concept out. Or the vendor that is declaring **[inaudible] [00:30:15]** and spent time and is invested in that, versus a more generic full set clearinghouse that 271 might not give you that result, even though the capabilities are there for the transaction. And I think that gets to a different standard body of the FDOs themselves. There're tools in each of them and each of the tools does very different things well with the potential to do well. And I think looking at not just the transactions, you need to look at the policy tools that we may have, but also what are the blockers that have stopped them from being adopted to date. And as a frequent NCVHS listener, I think we have heard from the industry on many occasions why we're not seeing the output that we would we expect to see in the existing toolset.

Arien Malec
That's silence or is someone speaking into mute?

Alix Goss
This is Alix I thought we lost audio.

Sheryl Turney
I am sorry, Alix, I think you had something you wanted to say.

Alix Goss

I did. I wanted to raise my hand and chime in here a bit. I am listening to some of the earlier comments and I have heard some guiding principles that have come out of what Jocelyn, Sasha, and Arien have been saying. But at the same time, I have also been hearing, we have this table that is going to really give us a big picture view. Let's not wade into the deep end of the pool like the standards bodies are doing but try to keep this a high enough level so this table can help bring out the opportunities to improve the process. So that might speak to Denise's point which is we might want to look at, maybe if there are people that have a particular flavor or expertise that might want to be able to advance the table, maybe we could make it an offline small group that three or four people agree to work on a particular aspect within the table as part of the homework. But I also want to make sure that as we evolve the conversation, Sheryl, we start to capture on the new tab we added, guiding principles and ideal state, some of the things we are hearing today. Like deferring to the ISA for the maturity level. Looking at like Sasha brought up and Rich brought up the idea of eligibility transaction has been completed in the identity of the patient is already confirmed. I think leverage, Arien had one about, leverage the work of others for the detailed standards work and I think that is a great thing as we can come back and have demos or presentations to help us really understand how the standards that are evolving now to meet what we will eventually define at our ideal state. That may also help us capture something around the policy framework aspect that Arien brought up. So, I think it's really neat to see us start to put some context to the table as you envisioned Sheryl. Thank you. If you are talking Sheryl, I am not hearing you, I'm seeing the next person in the queue is Arien.

Sheryl Turney
Sorry, I was on mute. Can we go back to the guiding principles tab, because there we captured last week some of the points, the patient at the center, Arien what you had mentioned, the definition of metrics that delight levels of detail that are needed. Providers have information about what events require prior authorizations upfront or readily available. Information required for recommendation and decision making should be provided one time by the source whenever possible. And then we started talking about, again, what does the ideal state look like? My ideal state I am describing doesn't necessarily need to be the one we are going to recommend. But we should at least have a recommendation as part of our paper that sort of depicts, and hopefully, we can get someone, a nice person on my group who is wonderful with pictures can maybe make a picture for us that we can utilize to help depict what our ideal is looking like for some of the recommendations that we already talked about. Where we use existing eligibility efforts. Maybe we transition EDI 278 to something that is more FHIR based and then depict that in a picture or a cluster of pictures where we have a description of what we are looking for. We are going to add to the guiding principles list, and I would love it if you guys went into this document and added additional detail. I did capture in my notes some of the things that you guys were saying today that I do think belong in the guiding principles that we are talking about. But sadly, I am not the standards expert, so I look at the data categories that we have back on the data categories tab, and to complete some of those, just farming out, for instance, patient identifiers, I am assuming we are going to be able to validate those through some of the eligibility transactions.

To me, I think it is going to be a bit of a struggle as we try to build this out, so let's look at that for one second and I know that, Arien, you have a question, but if you could bear with me one moment. What would it look like if we said let's assume the eligibility transaction occurs? We have that mentioned in a couple of different places so where would we capture that in our grid so it can help us and help all of you understand how would we update this? I am looking at this saying, is that part of patient identity? Would we include there the eligibility transactions, 270/271? Or are we going to include that as part of– let's see, we have routing information that is not yet the approval or request. Beneficiary; all right so that is part of the benefits of primary and secondary. And then we have primary and secondary insurance plans. So, with all of those

four fields which are in rows 12 to 15, actually 10 to 15, those would all be confirmed basically through a 270 or a 271. Is what I'm seeing, are you guys following me?

I don't know, Josh, if that is something that we would put in, under the X12 row, because those currently do exist. So, you have to have the primary payer, secondary payer, primary insurance and the benefits. Would those all be components of the 270/271? Is that what we would want to put in there under the X12 column for those?

And Arien I know that's not why you raised your hand.

Arien Malec
That actually is one of the reasons I raised my hand. And I am really following on Jocelyn's question. But in some of these areas we have transactions that are capable of sending a lot more information than they already are and may not be so if you look at the 271 for example, I believe that all it is required to send back is, yes it is eligible. And many 271s actually send back a fair amount of coverage and benefits information that provides additional levels of specificity about benefit information. So at least one way to think about our task here is to follow the happy path. That the ideal state, end state, happy path and then answer questions about what do we assume comes back it an eligibility transaction whether it's a 270 or 271 or future FHIR based role or I think we would know that I should be able to ask a benefits question, is this patient covered? But is the patient covered for this benefit? Is this patient covered for this procedure? Which is a very different question from the questions that a 270/271 is typically configured to answer. If we follow back that path for the happy path, we should then be able to look at and do an environment survey on what information typically is returned and what information typically isn't returned and what are the policy levers that we can make recommendations relative to, to improve the transition towards a more electronic world?

Sheryl Turney
Okay. So, if we were to take that thought, all right Jocelyn I see you have a question, why don't we go with your question first and then we will go with the thought.

Jocelyn Keegan
Arien is absolutely saying what's in my brain out loud. I think we have similar backgrounds having worked in a multiple payer environment around these transaction sets and there is a tremendous amount of variability and I think that ability to understand what is possible but what is likely, probable, what is happening in the market today is important. But I really feel like, I don't know if I am being too presumptive here, I really feel like the concrete thing we can do is just get to another layer of column granularity and say does it do it or does it not do it. So, we can start **[inaudible] [00:41:30]** and broadband understand where we have some transaction set perspective at the SDO level because that will show us where there are signs of light. I am biased because I spent a lot of time implementing the transactions sets in the market, to be able to say I think we can grade them across a couple of different vectors. I think we can say how mature are they? Because that matters. I think we can say, from independent sources, how much have they been adopted? Because something might be really mature and have low adoption and why. And I think we can do that with color-coding, with footnotes, so we will create a picture I think that will inform where we could go and make some of these the policy decisions or challenge maybe conventional wisdom about how we have been rolling out the transaction sets in the market today. And I don't know if I put my hand up or down. Let me see if I can figure out how to lower it. Okay.

Sheryl Turney

Okay, I think those are all really good points. Any other questions before we try to make a path forward? Does it make sense then to say all right, if we normally would start with a patient presenting at the office and the doctor saying yes, we need to do something, then does it make sense that we look at rows, I think Rich mentioned 8 to 13 should rely on X12 270 to 271? Except for number nine.

Alix Goss
For medical.

Sheryl Turney
Right.

Alix Goss
That would have to be for medical not necessary for pharmacy so we will have to think about that dynamic.

Sheryl Turney
All right so why don't we add descriptors for the 271, and I am not sure that is the best way to present this because it so going to get messy. But maybe that is what we need in order to say what is the best way to represent it? But if we said all right, we would use for medical, we could use M for medical. 270-271 and that would basically be there for all of those 1-13.

All right. Because that's what we are trying to define right now. Patient demographics would not be there. All right so we have eligibility. Let's assume we have some eligibility. And I put that in, Josh, it does look like when I update it on my home computer you can see it. So that is good. So, we put that in, but at the end of the day, now that we know this person has eligibility, then we say all right, well what is the service that we are recommending for this person? And what do we need in order to justify that? Normally there would be some sort of 278 which was the other transaction that was mentioned, which is the prior authorization. So, they need to know whether a 278 is required. So, let's look at the data category list and say all right, we are not 100% sure on the benefits because some of those might be there and some of them might not be there. But we are going to assume in our discussion that the benefit information is there. And one of the parking lot items would be that we need to let's see, for the M, 270, 271, but we want to ensure that detailed benefit information is provided to the provider with these transactions. So maybe today it is not, and it is all over the place but maybe we want that to be one of our recommendations. That the information needs to be there.

So, then we need to say all right, for this medical visit, we need to know where the visit is going to take place. I don't know, does that normally go in a 278 transaction? Do we normally include that information, someone who can tell us? Denise? You have your hand raised.

Denise Webb
No, I did not.

Arien Malec
Hi, this is Arien, I would say 278 is so poorly penetrated, that making speculation about what a 278 does or does not do is, at that stage, we should be looking at what is the transaction that we hope for do and do for us? Whether it's a 278 or FHIR based transaction.

Sheryl Turney
Okay so then –

Arien Malec
But definitely the 278 would be the analog for the prior authorization transaction.

Sheryl Turney
Right, but what you are saying, though, if I'm hearing you right, is what it includes is not the standard. So, we would not necessarily as part of that be providing all this information.

Arien Malec
Yea, penetration of 278 is very low.

Sheryl Turney
What if we said then that per the recommendation of the color code, we would need the site of the service now, I don't know how to add color to a field here in Google docs. Someone else will have to help us do that because I don't know how to do that

Alix Goss
Even if you just change the text, the color field, that will help.

Sheryl Turney
So, we would need site of service somehow in something, right? Because they need to know where this procedure or where the wheelchair is going to be delivered or whatever. So, we need to know the site of service.

Jocelyn Keegan
Sheryl, sometimes auth's sort of unroll, right? You might decide upfront that you are going to go and figure out what needs an auth and get an auth in place and you may not have all the information at the beginning of the patient journey but someone in the office may be submitting a 278 or proprietary request for an authorization without that information. Just to understand does it need an authorization or does it not need an authorization, right? Sort of getting my ducks in a row, getting the basic information and criteria, sort of starting the conversation. As Arien described, typically with the 278 today does is submit and start the process and all that analog information that ideally would be in a 275 big blob of data that is required, to support the 278 would carry more of that detailed contextual clinical information on the patient. So, what happens typically today, is somebody submits the 278 and that starts an offline discussion with the supplemental information that builds out and get to completeness and a final determination.

Sheryl Turney
Okay.

Jocelyn Keegan
And there is a lot of proprietary things that have been put on top or around if a UI perspective around the 278 submission to enable that to get to the specificity that varies from payer to payer.

Sheryl Turney
So, with the struggle with the 278, thinking about our future goal, which is we go into the office and get an answer about a prior authorization while we are there. Would we be wanting, not just a 278 transaction but some type of FHIR based transaction, to allow the provider to provide more of the information up front so he can get an answer back that he can count on? So, if that is what we are saying, right? Would our goal

then be that we want to move from FHIR, from 278 to a FHIR based transaction if possible, which would require a policy change. And then that FHIR request would include more information for the payer so that the approval can come more, immediately, right? That is what we are all hoping for?

Jocelyn Keegan
I think maybe refine what you are doing into two steps. The first we need to do is understand what is out there today. And I think what you are driving into is solutioning what we could do. I think that there are a number of potential solutions in the market. I happen to have gotten to spend time to see what we do on the NCPDP front, because I brought the **[inaudible] [00:51:01]** standards by. We use the 271 there, the script standard NCPDP, ePA standard and then there are conversations about what we could do to augment that with better clinical data and make it happen in more of a real time basis. That is the pharmacy side of the house. On the medical side of the house, as Arien described, typically we are doing a lot of submits of the 278 with a pend and a determination after the fact. There's some chattiness that happens offline without. We are seeing automation from 278s for the **[inaudible] [00:51:33]** that are happening and we are seeing proprietary solutions. We are doing work over on the Da Vinci front (another project I get to work on), where we are proposing alternative ways to be able to expose that information that you would get via a 271, to get that patient specific scenario. As Arien so eloquently described, what you really need in workflow for a provider to understand patient specific benefits, leveraging the tools that come with FHIR and the ability to get in workflow. Option 2, being able to submit the 278. I think that is a decision or a recommendation that we would make as a group once we gave everyone on this group the opportunity to understand what is out there in the market today. But I think if we can capture and maybe we take the time between now and the next meeting to flesh out what are the standards and capabilities that I have, so we can make recommendations to say who do we want to have come show and tell what some of these capabilities are? or what do we want to dredge up from prior testimony to share with this group so everyone is on the same page, I think that would be helpful. So, we are all operating with the same knowledge, because I feel like I'm little lopsided because I live and breathe the stuff day to day and I know there are folks on the call that are not as familiar with the terminology that we're throwing around.

Sheryl Turney
I would agree with you there. I definitely think that we are all in a slightly different place coming from different points of view and I do like that suggestion and I know that our support group at ONC and others have put another information we can share with the group. I know we shared links to it, but it may require a deep dive into some of the existing current affairs of prior authorizations in order for us to get to where we want to be with recommendations. So, thank you for that and Arien your hand is raised again?

Arien Malec
Yes, I think Jocelyn mentioned that the 275 transaction, which is a claims attachment transaction which actually is getting some reasonable support. And it suggests that at some point we may be in a hybrid world where we have automated coverage discovery, but rely on attaching a variety of information that could include a consolidated CDA or a new equivalent thereof, along with traditional paper based and letter of medical necessity-based attachments. And all of that is by way of saying I agree, we should do a current state assessment but also define a transitional path from where we are to the future happy state and taking advantage of the work that is already done and up and running in these areas and getting better awareness about what's there, what works relatively universally, what works incredibly clumsily like the 278 workflows that were just described and what is starting to emerge as a work in practice like a 275 based plans attachment. And getting a lay of the land from Da Vinci, in terms of the coverage discovery work that has been done as well as some of the assumptions that have been done around the prior authorization work in Da Vinci would also be really helpful for this group.

Sheryl Turney
Yes. So, I am going to ask a question, then. Jocelyn, who would do you recommend we could reach out to from a coverage discovery point of view. To start with Da Vinci? I know you bring a lot of that expertise yourself but sounds like–

Jocelyn Keegan
I think it would be good to have someone from the team. Let me talk to the PMO team offline and figure out who makes the most sense. I think what we will talk about is whether or not we want someone from the actual project team or whether we want to have someone that is actively implementing it that already owns other auth workloads. Have one of our members that's really an early adopter come and talk versus having one of us on the project team give an update. So, let me talk to them and see where it goes, to see what makes the most sense.

Sheryl Turney
I think an early adopter would be great because they can then bring forward what their experience is. That can help inform us into are there even are additional things that we need to consider.

Jocelyn Keegan
We have one member I am thinking of that is actually adopting also working with their clearing house vendor and has real time 278 transaction content in production today. So I think what's really important there, and again I think Arien and I are similar page here, there are swim lanes of activity here and we have progress and we want to continue to move people forward using the tools they are using and create space, where we can for people to innovate and do better. I think that being able to understand not just the technical reasons why people are making these decisions, but the business drivers and the changing relationships between payers and providers that are allowing those changing behaviors and changing conversations to happen, I think is a really great overtone as we look at real world recommendations.

Sheryl Turney
Yes, I absolutely agree with that. I want to take a time check in terms of where we are. We have until about ten after four when Alix was going to go over next steps. So, we have ten minutes where we can be talking about the grid, or answering questions if folks have additional questions. So, are there other questions out there? The other thing that both Arien bought up and others, was also the understanding some other current states that we talked about. We talked about what Da Vinci is doing. Again, there has been material shared in either the first or second meeting with a lot of links to current events that are going on related to the state of prior authorizations and there are a lot of different groups doing different things. AHIP has a pilot that is going on and I know Anthem is participating in that. There are other groups that are doing activities. They mentioned NCPDP for prescription drugs, so does it make sense for us to review some of these materials in this meeting? Would that be helpful to the group before and take a pause from our in the group deep dive on this spreadsheet? Would that help us to get that to the next level of where we need to go with this? Is that what I am hearing from folks? Can a few people respond to that recommendation? I don't see any hands raised right now.

Alix Goss
This is Alix.

Jocelyn Keegan
I think, go ahead.

Alix Goss
Thank you, Jocelyn, I see Arien also raised his hand. For me, I'm feeling like we were just starting to get mojo around the table and some guiding principles. I think, Arien, whether he realizes it or not has been giving us a lot of guiding principles throughout his chat and comments he has been making. I feel like getting our arms around the data, the categories, where some standards exist, and populating out those guiding principles will start to help us work at the two ends of the book to try to get to the middle to that sort of, what is today? What is aspirational? And where that is transitional plan really is going to need to be as a part of our recommendation? So, that is my initial reaction and I see you have others in the queue, Sheryl.

Sheryl Turney
Thank you, Alix, and I appreciate that. All right let's go to Arien next.

Arien Malec
Thank you, I tend to agree. I would recommend we take some time and articulate the future state, sort of the ideal state. Maybe take a little more time with the grid articulating in that future state what has to be true? What do you have to assume to be true in terms of the information flows? And then kind of armed, but not go down to the nitty-gritty detail about well, what the standard for identity and where is a benefits number carried (et cetera et cetera)?. With the assumption that we have coverage information for the patient, and we know that the patient requires, this procedure requires prior authorization et cetera.

And then armed with that future state vision and enough view on some of the informational assumptions, then we do the current state survey on what is there and what are folks at Da Vinci working on and get a perspective on where the policy and technology and business model obstacles are. And then armed with those two, then start to draft recommendations. And you guys are the masters of the calendar, but maybe spend a couple more sessions on future state back and do a current state survey, and then circle back around and draft some policy recommendations.

Sheryl Turney
Thank you, I think that's a great suggestion, Arien. Appreciate your help in getting us there, Richard?

Richard Landen
I would also be reluctant to stop work on our grid because I think that is important. And we have learned a lot today. So, I very much like Sheryl's suggestion let's take a look and see what is out there. In helping us define our vision, what does the happy path look like when we get to the end of it. But also, referencing it to the grid. If there pieces of the grid where if we look around the industry and we see the various projects going on, if those projects have solved or are or have a decent, viable theory for solving some of the components within our grid, then we can just plug those components into the grid. And in this group, we don't have to sweat nearly as much the detail within the categories. As we otherwise would. So that is the way I see us going forward on two problems there. Thanks.

Sheryl Turney
All right, thank you. Let me come back to here. All right so I don't see more hands raised so what I just heard was it would be helpful to the team if we have more definitions for data categories, so that is going to be one of the assignments we have. Populating more of the guiding principles, so we have more data around how we are working on all of this and really the guiding principles around prior authorization if you will. And then a description of the desired happy path, of course in reference to what is currently a path from where we are today to there. So, in order to support that happy path, we then need to have some view

of the current state assessment. Which we will need in our paper as well. With a recommendation of how to get from the current state to the desired happy path.

And it may be slightly different for each different type of prior authorization that we already talked about. There might be one path that we're going to recommend for medical that might be different from pharmacy which might be different from durable medical equipment, which might be different from whatever else we have not thought of. So, at the end of the day, what would be helpful, I think, for us for next steps would be for folks to volunteer to go out here and help us build out the guiding principles and even defining the categories. Yes, we put the categories out here but, again, hopefully we are not owning it ourselves, we'd be happy to have people go out and provide a definition as you see it of what the different categories are. And whether we need to divide that up and conquer. Maybe we can get two or three people to sign up to help define the data categories and a couple of people to sign up to volunteer to build out the guiding principles and maybe a couple more people willing to take on the description of the future state. Because it is not the future state according to Sheryl. Although I love the world according to Sheryl, I don't live in this world by myself. I realize it is better to share that with others. Also then for me, I have learned so much. I don't know everything about this, I only have a limited viewpoint. I don't even work in the prior authorization area an Anthem so everything I get I have to get from other people. What I understand is data sharing and that is my background so it's really helpful for me to hear what you guys have to say.

With that in mind, could I ask the team to sign up and take a topic and be willing to do that work between now and next week so next week when we come back, we can have some population of all of these different topics? And then also we already have some material with the current state and perhaps we can come back with some of that information at a future meeting and then talk about what we would want to incorporate in our final paper relative to that current state. Because again, it is important that we are able to describe in the narrative and/or pictures how we are going to take what the current state is and move to the future happy picture. So, would I be able to some get volunteers from this group to take on the topics? Don't all jump at once, and if you want you can put it in the chat.

Arien Malec
I am happy to volunteer, in whatever you want to throw me at.

Sheryl Turney
I like your guiding principles, so I would say, Arien, if you have some more guiding principles, I would love to see you in that space, if you wouldn't mind helping to build some more of those out. You have been helpful in that space already.

Arien Malec
Happy to do so, Thanks.

Alix Goss
So I just heard Arien put in the guiding principles group and I saw Jocelyn raise her hand in the comment box for the table work. So, I'm just capturing a few things.

Jocelyn Keegan
I am happy to review the draft of guiding principles as well, this is Jocelyn.

Alix Goss

I am hoping this week we will get everyone's access issues to the table revolved, which may have impacted people commenting. So I think that if we can get people to volunteer to focus in a guiding principles or advancing the table, that may give us some substantive commentary to review during the next call. I am thinking we are going to focus on is the guiding principles and ideal state in one vein that will enable us to marry it up, so we know what we have to understand about the current state so we can start to think about the happy path and ultimately the recommendations.

So, I think we are starting to get people to, okay we have a happy place. So, Sheryl do we want the guiding principles and ideal state to be in one path? I think they go hand and hand in my idea, but I want to make sure as you go through your vision, I understand if you have ideal state and guiding principles as one work group.

Sheryl Turney
Yea, I think that makes sense. At the end of the day, that is what is going to get us to the future. So, I agree with that 100%.

Jocelyn Keegan
Sorry Alix. Can I volunteer Tom to join the conversation about guiding principles and future state given the work on burden reduction?

Alix Goss
You're talking about Tom Mason?

Jocelyn Keegan
Yes Dr. Mason please.

Alix Goss
Yes. In all fairness, he is not on the call today. So in all fairness we will take it back but you know, hopefully he will have the bandwidth to do it. So, I am going to capture, Alexis you are in the happy path guiding principles. Anil, okay, so you're going to be in that group as well. I am going to call that the happy path table. So happy path and table are the two groups. And Ram, I'm not sure if you're just commenting or volunteering for a group?

Sheryl Turney
Yea, I wasn't sure about that either.

Ram Sriram
This is Ram here. I can volunteer for a group, but I just was wondering because as I hear through the whole conversation I think there are some issues. You mentioned the current and future state and how to get there. In terms of there is a lot of technology plus policies, **[inaudible] [01:11:00]** access in a sense. There are both technologies and policies that need to be put into place to make that happen. So, I don't know how it fits into your framework I would like to volunteer.

Alix Goss
It sounds to me like you are naturally moving towards the happy path group. Because I really do feel, there are guiding principles to ideal state to get you thinking about some of the stuff in the in-between. So, Jocelyn is over by herself on the table work, anyone willing to join Jocelyn over there?

Sheryl Turney
Yea, I am going to volunteer to help do some of the definitions of the data categories although I will say, I took them on as the picture so I may not do them justice but I am willing to do that if someone else might want to help do that as well.

[inaudible] [01:12:03]

Ram Sriram
I can volunteer for that, Ram here.

Sheryl Turney
Perfect thank you, Ram.

Alix Goss
Thank you, Ram

Jocelyn Keegan
Yes, Ram we can send you presentations we have done, and we really have good details about how it fits in and how Da Vinci's co-exist with the X12. We have been working closely with the team over at X12 to make it work, so I think that would be good background to get an independent eye on those diagrams as well.

Ram Sriram
Okay. That'd be great. We have some other views on FHIR and things like that that I can talk to you about that.

Jocelyn Keegan
Awesome. We have not said the word block chain once during any of these meetings I am going to say that out loud.

Alix Goss
Okay. All right so I show, Jocelyn, Sheryl and Ram I have on the table. Arien, Alexis, Anil and Tom Mason who has been voluntold, so I'm told, on the happy path which is a larger bucket.

Josh Harvey
This is Josh. I would love to stay involved in the table work, if possible. I have some ideas for distilling some of the comments from Arien, Jocelyn, and Sasha as well. I have some ideas on how we can incorporate that and find a happy medium in terms of how much detail we pull out with the goal of identifying real policy levers that could be used to effect change.

Alix Goss
That would be awesome, Josh. It looks like Alexis indicated that Jim may have had to leave of the call, so he may also want to continue with this because as he was very energetic and did a lot of the early work along long with you, Josh. So I think we can add him to that group. And I think if we have two groups, what I am thinking is that over the next week that the people that volunteered will go into the Google doc and start to really massage the content on those work sheets and if they want to get a call together certainly can do so. If you need assistance please reach out to us. I suspect all of you have e-mail and meeting platforms and it would be easier for you to collaborate together or to do it asynchronously. But that gives

us four or five people on each team that can do substantive modifications to the content we have already developed and that will give us really good discussion points for the next call. This has been a really robust discussion and I am trying to sort of wrap us up here because we are about to head into a public comment in a couple of minutes. So, I think where we're at is we have gotten people to raise their hands to dive in on the homework of modifying the spreadsheet for the applicable tab that they signed up for.

That sign up does not preclude anyone else. We invite all of you, including myself, to update that worksheet with your thoughts and check in on it over the next week or two. Before the next week or so while we advance it and we will regroup next Tuesday and do a deep dive on reviewing it. But one of the things we did want to ask about that we have not discussed so far, and Sheryl I'm not sure if you know if this is on point for today. Back up on the slide, please. We wanted to talk about whether we needed need to look at different use cases. Would you like to punt on that conversation for today? Since we've got the other game plan in motion.

Sheryl Turney
Yes, I think, lets hold that off for a week and we can come back to it after we see where we are next week.

Alix Goss
Awesome, I agree with that and with no further ado let's pivot to the public comments side, please.

Lauren Richie
Great, and can we ask the Operator to open the public line.

Operator
If you would like to make a public comment, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star two 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 the star keys.

Lauren Richie
Thank you, operator, any comments in the queue?

Operator
There seem to be no comments at this time.

Lauren Richie
Okay. Alix and Sheryl, we will let you know if we get any other comments before we wrap up.

Sheryl Turney
Thank you. So, Alix you want to take it back?

Alix Goss
Sure, we are sort of at this point where I think we have recapped already but I will run through it again. The next steps are to get the data categories defined. The table team will work on that with Sheryl as well as building out some of the other standards information that will help us start to get ourselves wrapped around, at a high level, what standards are at play, but we are not going to take a deep dives. We are going to assume the deep dives will be done elsewhere. We are going to capture our ideal happy path which will be underpinned by guiding principles. So, the happy path group will start to populate that worksheet tab and

along the way we may start to also capture some current state assessments. That I suspect will really come out of the next couple of weeks after we get this next real update to the table.

And as we have a more populated table of the prior authorization content and the happy path state, we can look at really understanding the current to transitional state which will help us to get to the draft recommendations. Along the way, we think we are going to want to get demonstrations. Jocelyn will reach out to her community in Da Vinci and look at what implementor member may have the bandwidth and interest to come present to this community (this task force) in the near not so distant future. ETA to be determined. I think those are the key points of the recap. If I missed anything, oh, Jocelyn is saying we should have an ePA demo with pharmacy as well. Margaret Weiker is also on the call. I know Jocelyn you play in NCPDP land, so if you guys have any ideas about who we can an ePA demo from, that would be fabulous. You both have my email or you can let us know if you have thoughts specifically about that. Are there any other public comments that we should be mindful of or ready to continue with the wrap-up, Lauren?

Lauren Richie
Operator, did we get any more comments in?

Operator
No, no comments at this time.

Lauren Richie
I think that is it we can probably start to wrap up if Sheryl didn't have anything else.

Sheryl Turney
Yes. I wanted to add one thing. I added another tab to the spreadsheet which is recommendations. I do think as we are starting to build out both the happy path and the guiding principles as well as the rest of the grid if there are things that you want to start to at least capture in the form of what a potential recommendation would be, certainly put them out there and we will start looking at those as well. And those can sort of be used as an outline as we go in the future. I just don't want to lose anything. We can always evaluate it as a group and determine where we are. If there is something you want to put down so you don't lose the thought, I will be happy to add it to the list.

Lauren Richie
Okay if there's nothing else. Alix, anything on your end?

Alix Goss
I don't think so. I think we got some to some good mind meld on the call. We got some homework assignments. Some people got some Voluntold' s. I think it is a normal meeting, so I think this is good.

Lauren Richie
Sounds great

Sheryl Turney
Thanks, everybody.

Lauren Richie
Thank you, we'll talk again next week, stay well. Bye.

Sheryl Turney
Bye, thank you.