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

June 16, 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
Alex Mugge	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
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
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
Cathy Sheppard	X12	Presenter

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Happy Tuesday. Welcome again to the ICAD Task Force meeting. Of the members so far, I have Sheryl Turney, Alexis Snyder, Anil Jain, Denise Webb, Gus Geraci, Jim Jirjis, Jocelyn Keegan, Ram Sriram, and Sasha TerMaat. Are there any other members who are on the phone or who haven't been announced?

Alix Goss
Alix Goss is present.

Lauren Richie
Did I miss you, Alix? Sorry about that.

Alix Goss
No worries.

Lauren Richie
Okay. With that, I will turn it over to Alix and Sheryl to get us started.

Summary and Action Plan (00:00:48)

Sheryl Turney
Thank you so much, and we appreciate your time today. We have a very packed agenda. We're going to go to the next slide, please. We've got X12, who's going to do a presentation. Thank you very much. Just to recap what we did for last meeting, we had Kate Berry come and present from AHIP. The material that she presented included the Fast PATH initiative, which is a pilot that they're doing for prior authorization, and described their multipronged strategy on prior authorization.

The results showed that there were some opportunities for improvement based on improving processes as well as automation, and then, they also shared with us their landscape survey, which they released on the day of our meeting, which was fabulous, and the landscape survey actually has a great infographic that I hope everybody has a chance to take a look at. That material is going to be added to our compendium along with the other presentation we had last week from Premier and the presentation that we're going to see today, but the survey results had a great two-page infographic as well as some additional detail information, and it really was over some of the information that they collected from both providers and health systems related to prior authorization.

Premier did a presentation – they had three individuals who participated in the call, led by Meryl, and they presented on a new product that they're piloting for an automated prior authorization experience that's actually integrated within EHR systems. Obviously, it's predicated on the fact that there is an automated

EHR system, so it would not have any impact in a non-automated EHR office, but it was a very interesting demonstration, and one that presents some definite advantages in terms of reducing burden because a lot of the reminders and even the data collection happened in the background. So, it was very interesting and will add to our conversation.

Lastly, we had Alix, who presented an introduction to the guiding principles and ideal states, which she will take a deep dive into today, and then we did a brief review of our timeline. Just to remind everybody, our focus is to have recommendations by the end of July, and also have a recommendation presentation to HITAC by the full meeting in September, so we've still got a lot to do, and we thank you all for participating. So, I'm going to move it right along unless anyone has any questions. I don't see any hands up. So, we're going to move it on to Cathy Sheppard, the Executive Director from X12, who's going to be providing a presentation for us about their efforts in this area.

X12 Presentation and Discussion (00:04:06)

Cathy Sheppard
Hi, Sheryl. Thank you, and thank you guys for having me today. I appreciate the opportunity. I did include some slides in the deck that we don't need to spend a lot of time on today because I know that you guys can all read the details for yourselves later, so we're going to go at a pretty quick pace. I want to make sure I leave time for your questions at the end. Next slide, please. You can skip that one too. That's a slide we have to have.

And, onto the first one that has some real things to talk about. Since I'm not sure that all of you know as much about the X12 organization as some of you may, I thought I would start with some quick bullets reminding people of our background and what X12 is. We're consensus-based. We're approved by ANSI. We've been producing EDI-based standards for more than 40 years, and differently than many of the ASDs, we support multiple industries – not just healthcare, but finance, government, insurance, supply chain, transportation, and others as well. Next slide, please.

We don't have a lot of staff, but we have a lot of members and member representatives to participate in our collaborations and reviews. The standards that are produced there are really the workhorse standards for business-to-business exchanges, and many other partner-to-partner "proprietary standards" are developed based on the intellectual property that we produced to assist the various industries. Next slide.

Our data model is well-defined, and it's been use-tested in production systems over many years, some as many as 40 years, some as few as 15 years. We have millions of MCs that have established X12 infrastructure within their organization, and that represents a significant investment that organizations depend on and find valuable on an ongoing basis. Next slide, please.

One thing that most people don't understand is that there are billions of X12 transactions utilized daily. Rail, Inc., which is a supply chain organization, estimates more than 9 million a day, and the Department of Defense uses over 100 million in a month. Those transactions are conducted in many syntaxes. Most people are familiar with the EDI standard, but we also have the EDI standard in our metadata represented in other syntaxes and plan to increase the number of syntaxes that are supported based on needs that come from our various industries and the implementors of our standards. Next slide, please.

So, X12 is organized in a familiar way, but what some people aren't as familiar with is that there are two committees within X12. So, the ASC committee is the one that many of you may be familiar with. That's where the X12 in health insurance and other insurance subcommittee lives. We also have another committee that is a peer to the ASC, and it's called the RSC. The reason it's important to your group is because the RSC is the maintainer of our external code lists, which are used in preauthorization transactions and are the main direct interaction that X12 has with some of the clinical work that's going on and the clinical improvements that are going on today.

So, if you look on the RSC side of that chart, you can see that X12-03, which is the name of a subcommittee, is called "ECO," and that's the external code list oversight subcommittee. That's the group that maintains X12's terminology, code sets, vocabulary, resources – there are a lot of names for what happens over there. I believe that work is going to be important to your group as you consider preauthorization improvements. Next slide, please. This is a summary of what I just said, for the people who don't get the pleasure of hearing my voice. Next slide.

I think most of you are familiar with our technical reports, but I wanted to provide a quick list emphasizing that the EDI standard has hundreds of transactions, not just the ones that you guys are familiar with today, and some of those transactions can be very beneficial, with quick turnaround times to the healthcare industry. For example, there are a number of organizations that have implemented a supply chain transaction, known as the 148 transaction, to assist with their COVID-19 reporting. So, the power of the standard isn't limited to the transactions that you're familiar with. We have other transactions that can assist if you come up with other needs that need to be accommodated in the X12 syntax. Next slide, please.

We just want to take this opportunity to remind the group that X12 is open minded. We're looking forward to upcoming opportunities and challenges in the industries that we support. We are responsive when presented with other people's visions and insights, and we collaborate enthusiastically with many organizations. Next slide, please.

We have a financial model that ensures the financial health of the organization in the long term, and that model is offering us a very secure platform to grow from, and we focus our collaboration meetings on solutions, not on revenue generation, which is different than a number of organizations. X12 members don't pay anything to come together and collaborate on our standards, and nonmembers only pay a small fee to cover the cost of the meeting part of that collaboration. So, anyone who wants to come collaborate with us should reach out and know that that's not an onerous process, and it's not expensive. So, if you haven't been participating because meeting costs are a concern, give me a chance to talk to you, and maybe we can solve those concerns and get you over to our table, where you can help develop solutions on both sides. Next slide, please.

One thing that I said a moment ago was that we are responsive to needs, and we received many communications that we needed to have a faster, simpler process to get work out on the street, and I'm happy to let you know that in 2020, we have implemented what we're calling our ARC – that's an annual release cycle – and it reduces the burden on our member representatives and also reduces the burden on the industry in that the reviews that industry implementers are asked to do are significantly reduced in

volume so that we focus on small, incremental changes that happen regularly instead of larger changes that happen less frequently.

This means that we'll be able to put new functionality and additional data into the X12 transactions to support any clinical findings or any clinical needs that come up on the preauthorization side, or to address any barriers that are identified in the implementation guide instructions or the transaction itself, but I will point out that that doesn't change the federal rulemaking. The mandate will remain the mandate until that changes, and that's outside of X12's control. Next slide, please.

In case you were wondering who I was talking about when I was saying that we are open to collaborations and we have a lot of active collaborations going on, this is a partial list of the people that we are engaged with currently on different initiatives and opportunities. You probably don't recognize all of those acronyms, but that's okay, and if you do recognize any and have questions, I encourage you to reach out to me, and I will be happy to talk to you about the collaborations that we have underway. Next slide, please.

We have a deep understanding at X12 of the business environment of our stakeholders, who represent a number of industries, and some of the pitfalls. Some of the newer initiatives and programs may be able to learn from some of the lessons X12 has already experienced, and we are happy to work with anyone to try to smooth the path forward for implementers, particularly across healthcare. There's no reason for everyone to make the same mistakes. Let's work together so that the newcomers don't have to make the ones that have already been made in the past. Next slide, please.

So, I was asked in particular to talk about the prior auth situation, which is what is of great interest to many people. Next slide. We know that there are many groups. You guys have entertained a number of them, and there are others working to provide solutions, efficient processes, and ways to move prior authorizations forward. Most of the issues that have been raised so far are related to operationalizing the processes consistently across the industry, and with some of the challenges, it is well known that there are competitive considerations. There are many different approaches to what the purpose or value of the prior authorization transmission is, and those aren't always aligned. Next slide, please.

One of the major problems is that there are a lot of stakeholders with an interest in the prior authorization, and they each have their own set of needs, and what the industry needs to define is a balance that works for all the stakeholders, for most of the stakeholders, or the industry needs to decide that one group's interests prevail over the interests of the others, and if we can come to an agreement on whose problems we're trying to solve first, then we might be able to move solutions forward at a pace that would allow us to drive increased benefit very quickly. Next slide, please.

X12 itself is doing a few things. We are working on updating the prior authorization implementation guides to a new version, and the additional functionality that's being added or the functionality that's being improved is related to decision-making and reporting. Those are based on some feedback that we've had. At this time, we're still unaware of any technical syntax or implementation instruction-related issues that would be a barrier to effective transmission of prior authorization messages, but we are standing ready to work with anyone who does cover anything that X12 needs to address in its transaction or implementation guide. Next slide, please.

One thing that would be good for us all is if we could make sure that our statements are definitive enough. Too often, we hear the statement that the prior authorization transaction doesn't work, and when you peel back the layers and sit down and talk with people, the actual statement they're trying to make is that the industry's current practices don't align to support effective prior authorization data exchange. And, if we don't get the problem statement right when we're discussing it and looking for solutions, we won't end up with a solution that addresses the real issues, and we won't end up with improved prior authorization throughput that automates prior authorizations in a way that reduces burden across the industry and provides information to the consumer, who, at the end of the day, is the person who needs to know the most about what is being authorized and what is not. Next slide, please.

So, what are we doing? I said we're publishing updates to our prior authorization implementation guide. Those changes are currently in the final approval stage, and they'll be published and available later this year. Once that's done, X12 will take under consideration any decision to move forward for a new federal mandate so that the industry could take advantage of the enhancements. The reason I'm pointing this out is that if there's anything that needs to be done, the quicker it comes to X12's attention, the sooner we can put that into play in a way that the industry can get access to it. We are also working with Da Vinci and CAQH CORE to ensure that the 278 requirements in the implementation guides reflect the industry's current prior authorization needs and practices. Next slide, please.

We're enhancing our code list to address the feedback that additional code-side details would improve clarity in the prior authorization transmission. We're working to increase the number of clinical data experts and users who participate in our code list maintenance processes, and we're exploring some options for connecting clinical systems more directly to the administrative systems that support the 278 transaction as proof of concept. Next slide, please.

The last thing that I was asked to bring for discussion is some recommendations that X12 might have for groups like yourself that are working hard to make improvements that will add value across the entire healthcare industry, and one is that we suggest that you don't miss out on the value of our mature administrative data information model. We are very interested in making sure that data intersects smoothly with the clinical data, and we want to partner to make sure that both sides use the same kinds of definitions and terms. In X12, we think we need to separate the issues that are related to clinical and administrative systems, not facilitating smooth movement and data from the issues that are related to nonaligned clinical and administrative data definitions because those are two different problems that both need to be solved, and separating them increases the likelihood that we can solve them in a timely way as opposed to trying to tackle everything together. Next slide.

We also encourage everyone to educate implementors to bring their concerns related to the 278 transaction and the prior auth implementation guides or X12 code sets directly to us so we can collaborate on solutions quickly and efficiently, and we like to remind people to bring us their discussions early because we want to be a partner, not try frantically to align with whatever findings come up after the fact. And, that is a very quick summary or high-level statement of the things I wanted to bring forward for your consideration today. Next slide. I even made it a few minutes early.

Alix Goss

It's all good, Cathy. We've got plenty of time.

Cathy Sheppard
So, I think the next item on your list is for people to pose any questions they might have, and I'm happy to entertain those.

Alix Goss
That's awesome. This is Alix, and I'm going to support the question and answer session for this portion of our agenda item. We do have ample time for questions today, as we only have one presenter, so I'm hoping that our members will raise their hands so that we can go ahead and get everybody in the queue. It looks like we already have one out of the gate. Jocelyn Keegan, would you like to ask your question?

Jocelyn Keegan
Hey, Cathy, it's Jocelyn. How are you?

Cathy Sheppard
Hi, Jocelyn. I'm doing well.

Jocelyn Keegan
I really appreciate all the points that you made today, and I think that it really talks about the strength of investment we already have in the 278 in the industry. I think one of the challenges that I've seen in the work I've been able to do around X12, NCPDP, and now the work we're doing in Da Vinci – and, you'd appreciate that John Kelly and I have had many philosophical conversations about this – it wants the power and the flexibility of the 278, and then the lack of adoption of its use and specificity around particular domain problems at scale in a standardized way, and I'm wondering if you could maybe comment on the work – because I've been away from the 278 for the last couple years – the work that's been done with CORE to really get better about the specificity required in particular scenarios to really get to all that power and flexibility in implementing the 278 across business areas or particular diagnosis types.

Cathy Sheppard
That is a very fair statement, and I think those of you who have been around X12 know it is kind of a pendulum. People want X12 to give them all the flexibility and power they want, and then, people want X12 to tell them exactly what to do, and we swing between those sides of the fence, so to speak. What X12 has been doing with the Da Vinci project and with CAQH CORE in particular is considering the places that the industry itself is demanding less flexibility and more consistency.

Traditionally, one thing that has happened is that CAQH core initiates an operating rule, the operating rule constrains something that X12 has left very flexible based on industry demands for flexibility, and then we let that operating rule run its head for a little while, and then decide whether the operating rule effectively gives the industry what it needs and should be applied to the X12 implementation guide itself as a direct requirement of the implementation guide. That process works not just for the prior authorizations, but across all of the X12 transactions that CORE has provided operating rules for, and both organizations intend for that to continue. So, we have the opportunity to test out, so to speak, some more tightly constrained operations and run them through the operating rule process for a while.

On the Da Vinci side, what we have been learning from Da Vinci's work and in our cooperative work with them is that the past industry demands of "I don't want 10 preauthorization instruction sets on my desk, I want one" may have turned the tide, and it may be beneficial for X12 to produce the kind of distinct business function implementation guides that are working so well in the Da Vinci realm, and that is instead of saying, "Here's how you do preauth across the industry," we would say, "Here's how you do a preauthorization for an ambulance transport. Here's how you do one for another use case, here's how you do one for another use case." I'm just making up examples.

We don't have any of those detailed implementation guides in the pipeline right now, but that is the discussion that is being directed towards X12 at higher levels in the industry right now, and X12 will be looking for more feedback from organizations, from associations, and from other STOs related to the value of one-stop shopping, so to speak, in a reference that provides detailed instructions for many purposes versus the value of many smaller instruction sets that provide details for one purpose. You can expect to hear more about those activities from us in the coming months, and I think that's what you're looking for, is the question of whether to be all things to all people or very specific in our presentation. Did that answer your question, Jocelyn?

Jocelyn Keegan
I think that's a great way to lay it out, and you know I'm in the thick of a lot of these conversations, so I don't think those people who are outside of the problems, not living and breathing them on a day-to-day basis, really understand all that nuance that you just described.

Cathy Sheppard
Oh, good. Thank you for giving me the opportunity.

Alix Goss
Cathy, this is Alix. I'm going to jump in here with the next couple questions because I technically raised and lowered my hand without anybody noticing it, and I see no one else in the queue, so please get yourself in the queue. I wrote down a handful of questions as you were giving an update, and I think it is important that folks have an opportunity to understand the X12 history. Having participated myself in X12 for nearly a decade, I have an appreciation of the history and the complexities that are brought forward to an organization that has its work products promulgated, and it creates some unique situations, and as technology has evolved, X12 infrastructure has been there – if I recall correctly, getting its genesis in the Berlin airlift.

But, more proximate to today's discussion around prior authorization, we have had some presentations related to the 278 and the Da Vinci IGs, and we're looking forward to an upcoming session from CAQH CORE to talk about their new operating rules, but I really have a question around this 278, the clinical proof of concept that you referenced back on Slide 28, I think, and also, you talked about some of the work you've been doing with Da Vinci, so it'd be interesting to have a little bit more commentary around the work that you're doing there with the mapping because technologies have come far and we're finding different vehicles for getting the information exchange, but yet, we have a set of installed base, and as we've heard from some of our prior presenters, they've got a 278 mindset for their data organization and structure – that model you mentioned – so if you could talk more about the 278 to clinical integration proof

of concepts, what that looks like, and what lessons you may have learned, I would love to hear more about that.

Cathy Sheppard
Sure. And, if I don't remember to go back to the first question, remind me at the end. Early on, Da Vinci and X12 started working together, establishing things that were important and in the interest of both groups, and one thing we said immediately and we've never wavered from is that it's okay for people to want to consume the standardized information in the way that works best for them. What we've got to make sure is that the information that's represented moves correctly from one syntax to another, and when we talk about data elements, we're sure that we're all talking about the same ones.

So, right away, we determined a mapping that would say, "Here's where an X12 data element shows up in a FHIR transaction that supports preauthorization," and so, in order to move that work forward as quickly as possible because the industry wants that consistent declaration of "This data on this side equates to this data on that side," we put together a pilot that is a mapping, and to move it quickly, Da Vinci took the first steps in our pilot. So, the Da Vinci Project is working on a map that says, "This piece of information in this FHIR" – oh, you guys are going to catch me out now – bundle, resource… I'm not sure of the correct word. Someone can help me if they need to. But, "The FHIR portion equates to this element in this segment of the 278 transactions," and that map is nearing completion, and when Da Vinci is satisfied with that data map, what will happen is they will turn it over to X12, and we'll take it through a consensus-based review process to ensure that we believe the data elements in the 278 were appropriately mapped and described in that document.

And then, we will maintain that data map within the Da Vinci implementation guides and we will notate those cross-references within the X12 implementation guides, so no matter which reference you're looking at, you will understand the corresponding data in the other syntax or in the other process. That's our first joint effort at getting closer to the end.

Alix Goss
That's really helpful. Go for it, Jocelyn.

Jocelyn Keegan
I'd like to chime in and say that this work, and we purposefully made a decision early in the process – and, Cathy has been great working with the team – to use what I affectionately refer to as our unicorn inside of the Da Vinci Project – members that are members of both Da Vinci and the FHIR community and know the X12 transactions cold – to basically be offline, doing work sessions and the mapping exercise, and I hope I can get across to everyone on the phone that this is not a cut-and-dry exercise. This is very complicated, and there are not very many people in the industry that know this content syntactically and how it actually behaves in production today to be able to do that mapping, so I'd love to give a huge shout-out to Mary Kay McDaniel from Cognosante, who has spent hundreds and hundreds of hours on this, and Cathy, I'm sure you know who else is on the team, but this mapping standard is really hard work.

Cathy Sheppard
That is absolutely true. I think we started over about 50 times, trying to make sure that it is crystal clear accurate the whole way through from start to finish.

Alix Goss
Yeah, and I think there's also an aspect related to the data mapping that is the one-to-one data element type of match, but there's also the handling of the messaging that can go inside of a response message to reflect the processing that happens either in a request-and-response kind of exchange, and one of the things that we've heard about is the granularity challenges that some folks are having, and Cathy, I really appreciated you talking about that pendulum swing that we've been going through, and I actually mentioned it earlier, and I was really focused on the CARC and RARC codes because I was stuck in that 835 payment data kind of moment, recognizing my need to dust off my memory on how the 278 was structured, and recognized from that effort that there's sort of a high-level response value that's provided by an internal code list initially that meets the lowest-level technology capability where it's at.

And then, as you expand out your capabilities with using a 278 structure, you can start to get to a much more robust level of granularity exchange capacity using an external code list, like a LOINC code. So, I was curious if you could talk a little bit about the data element mapping – which you already did, I'm sorry – move to if there's any aspect in your proof of concept related to the pended or determination-response granularity level. Is there any aspect of that in the data mapping or any other feedback that you've been trying to look at in response to industry feedback?

Cathy Sheppard
Well, in the data-mapping exercise that's ongoing right now, we've tried loosely – I don't want you to think there's any hard and fast rules because we have adjusted over time to accommodate different situations, but what we decided was that if we stuck with what exists now in the first pass, we could get something out quickly that matches what people can do now, and then it would be easier to move forward and say, "Okay, now, how do we enhance this with different codes, with different code lists, or with different parties providing input after we have a strong, solid base?"

So, we've identified some areas that we want to explore more about how codes or code lists could enhance the transaction. That's going to be what you might call phase next. There is another part, though, to the work we're doing now, and it was a little bit unexpected, and I think it's going to turn out to be beneficial on both sides, and that is that the Da Vinci Project has identified some portions of the data content in the 278 and said, "Well, these aren't necessary," and they gave us some preliminary examples of what those might be because we have some concerns on our side about that, and it turns out that when the mapping work is finished and we sit down with more representation on each side, we believe that what we're going to find out is there are some things that Da Vinci, in their work so far, has said isn't necessary that really is necessary for the healthcare functions that are in place today.

But, the right people are at that Da Vinci table, and we believe that on our side, we are going to identify some things that can come out of the 278, reducing its complexity because, in fact, although they used to be functionalities that the industry depended on, they may not be any longer, and what we're hoping is that we're going to do some significant industry surveys when we get to that point that will go out broadly, and then we'll be able to assess the feedback to say, "Okay, so, this is a contention point. Do we need this particular function? Because if we need it on one side, we need it on the other, and if we don't need it on either" – we need to be consistent between the transactions. So, not only are we going to end up with

consistent data mapping, but we're going to end up with a verification or a validation of what current industry practice demands out of the 278 and out of the use cases that Da Vinci is expanding.

Alix Goss
So, along that line, it's great to hear the level of collaboration and industry cross-learning that we're doing, and it's always nice when you've built something from a particular perch to get someone to look at it from a different perch, and all of a sudden, you can see opportunities on both sides. So, I'm kind of curious as your – you made an earlier – I'm trying to link this portion of the discussion to a comment you made earlier in your very informative presentation related to the ARC cycle timing, and I'm kind of curious as to – we know that right now, we're mandated under what's called a Version 5010 technical reports, very specific business function technical reports within the X12 standard Version 5010.

And so, as you're going through this, the industry collaborations as your ARC cycle is kicking off in 2020, just now, this year, how is your work for versions since 5010 through 2019 going to reflect these lessons learned so the next version we might get – some people speculate it's 7030, some people are speculating 8010, it could be something different as a number I don't even know yet – could you talk a little bit about how this all might come together in the next six months to a year to reflect the lessons learned, streamline the 278 capabilities based upon that experience, and get it in that pipeline for consideration as the next promulgated version?

Cathy Sheppard
I can. Unfortunately, if you're not an X12 geek, try to stay with me here, and if you have questions when we finish or if you need a little tutorial, you can contact me outside of this forum. The 7030 version of the 278 transaction set is where the enhancements that have been requested since 5010 will be applied for the first time. The 7030 versions are not being completed under the new annual release cycle or ARC process because all the 7030 work was too far down the stream to change to a different maintenance process at the point in time. So, 7030 will be completed in the previous maintenance process, and 7030 and 8010 are going to be identical. Then, moving forward from 8010, once a year, we will have a new version that will be published that will have incremental changes since the last time. So, let's say for the 278, somebody right now turned in a work group request that said, "We need an extra phone number in the PER segment" – because I don't want to talk about something that might be controversial.

Alix Goss
Good idea.

Cathy Sheppard
We would run adding a phone number into the PER segment through our maintenance process, and that would probably – so, we'll publish the 8020 version in 2021, and that will include all of the work that was approved in 2020. So, if a miracle happened and somebody turned in a maintenance request right now that said, "Add another number to the PER segment" and that maintenance request was approved in our fall meeting, the new phone number would be in 8020 at the beginning of next year. If the maintenance request isn't presented until January, say, of this year and the maintenance request can run through our annual process and be part of our balloting that occurs in 2021, it would be available at the beginning of 2022. So, small pieces of work – go ahead.

Alix Goss
I was just going to say I think you actually kept that about as simple as you possibly could, and I think it was very succinctly said, and I want to call out for folks that are listening to this that this is a monumental pivot for X12 and the way the cycles of business requests transform implementation guides and how quickly we could start to move toward smaller, more regular upgrades to reflect the in – and have predictability in that process.

Cathy Sheppard
Thank you. It is a monumental shift for us, and like everything, change is painful, maybe more painful to the internal people than the external people, but the X12 member representatives are starting to see the potential and become very excited about this ability to move small changes forward very quickly, and we look forward to being able to respond to the kind of changes that may come out of this group's work or that may come out of the AHIP work in a way that we've never been able to respond to them in the past.

Alix Goss
Thank you. I'm going to just do a scan for one last call of questions. Well, Cathy, thank you so very much for preparing the presentation and addressing our questions. We'll add this content, along with the rest of our presentations, into our compendium, as Sheryl noted at the beginning of the call, and we really thank you for your time and your energy and look forward to ongoing collaboration, as we know it's where we start in the industry now and it's the basis on which we can all fulfill our business models.

Cathy Sheppard
Thank you. Thanks for having me, and know that I will come back at any time if I can offer any value. Thanks, everyone.

Privacy and Security Ideal State and Guiding Principles (00:46:04)

Alix Goss
Thank you. I appreciate it, Cathy. Folks, that was really informative, and it was great to get another industry perspective on the landscape of prior authorization, and we'll continue some additional presentations over the next month, but we propose at this point now that we will go to the next agenda item, which is to talk about the privacy and security guiding principles and ideal state content. We initially highlighted that the new content was available last week. We introduced that we had pivoted from the workbook to a new Google doc to support us in creating one spot that would contain all of our guiding principles and ideal states, meaning that we added the privacy and security small group content to the master document from the other small group, and I just wanted to give you a heads up that if you've been looking at that guiding principle/ideal state Google doc, which we will be displaying shortly if it isn't up already, we will also be using that document to capture straw man recommendations.

There is a small group of us that has started to get together. We've had a couple meetings, and we're going to continue to have a couple more meetings before coming back to you over the last half of this month and giving you a starting point on recommendations. Please know that if you're interested in jumping into this work, you can either add comments yourself directly to the Google doc or you are more than welcome to join our small group. Just reach out to me, and we can get you folded into those offline conference calls that are happening every week.

So, without further ado, what I would like to do is to invite those that participated in the privacy and security small group discussions to assist what we're about to walk through. Jacki Monson co-facilitated this work with me, which was tremendously helpful with her background and expertise in privacy and security matters, and also from wearing her hat on the provider side of the house. We also had Sasha from Epic there, Denise Webb, Ram from NIST, Gus Geraci – I've got a couple different people that have been participating in these small groups, and I'm probably going to miss somebody who's been participating in those, and I apologize, but please know that you are encouraged to chime in as we go through. First, I'm going to walk through the guiding principles and take questions, then I'm going to walk through the ideal state and take questions, and it will be a group effort to address any questions that you might have, and I do have the ability to see hands raised, but I always appreciate Sheryl's support. Any questions as we get going on this portion of the agenda? Okay.

So, just to orient you for the Google doc, we're going to be working on Page 6 today. If you see it in purple, that's where we're doing straw man, but we essentially have these categories for our overarching guiding principles and ideal state document, but today, we're going to be focusing on information security and privacy. Please recognize that the other sections have been modified since we last presented it to reflect the feedback that you gave us on our last task force call. Without making you too dizzy, I'm now going to go back down to the privacy and security section and talk about the guiding principles. The task force recommendations are grounded in foundational security and privacy consideration, which is intended to benefit the subsequent design of processes and technologies.

We thought it was really important that everything that we were going to do in our recommendations and body of work should take into account the protection of individually identifiable data and protected health information, and that we should secure that throughout our design processes and methodologies to ensure that we were accomplishing our second guiding principle, which is that our recommendations and solutions should meet current health information and patients' rights regulations, such as HIPAA privacy, security and breach notification, the confidentiality of substance use disorder patient records, and state laws as applicable. Those are the first two guiding principles. I'll open it up to Jacki. Do you want to say anything at this point? I apologize, I wanted to punt over to you if you wanted to make any opening remarks.

Jacki Monson
No, I'm good. I'm happy to answer any questions that folks have.

Alix Goss
Okay. Rich Landen has his hand raised.

Rich Landen
I just thought I'd point out that we don't specify federal versus state at this point. All the examples are federal.

Alix Goss
That's because I missed it when I read it, Rich, because we actually – it says, "…and state laws as applicable." We did call out the big federal ones because we felt they were important, and I should also

have pointed out that thanks to Tom Mason, who was a part of this group, we also had the involvement of Kathryn Marchesini from ONC as a privacy officer, and also, Ram brought in several resources from NIST to give us some additional input. So, with that hanging chad closed, Rich, we do, in fact, address state laws, but it's a little buried. Is that a concern?

Rich Landen
It's not a concern, it just read a little bit funny to me. I'll probably toss this one back to Jacki because we talk about health information, patient rights, and regulations, and that's presumably the federal law, and then we talk about state laws. What I'm wondering about is if we're differentiating between laws and regulations, why we're saying "regulations" at the federal level, but at the state level, we're not talking about state regulation, but state law. That's a nit, but it strikes me as a little bit of an inconsistency, but you guys know more about that than I do. Thanks.

Jacki Monson
Rich, I don't think it was a purposeful inconsistency. I think "law" and "regulation" is the same thing, and what we were just trying to encapsulate were the notable federal ones that we absolutely know will impact this, and then, as I'm sure you know, there are hundreds, if not thousands, of state laws that might apply depending on the scope, and so, there would be no way to specifically list them out, but we can certainly clarify the difference between laws and regulations if you think that's helpful.

Rich Landen
It would be helpful to me, but you guys are the experts, so I'll go with whichever you decide.

Alix Goss
I'm proposing that we should say something like "laws and regulations, such as the federal…HIPAA privacy, blah blah blah, and state laws as applicable." Would that help clean it up?

Sheryl Turney
Hi, Alix. This is Sheryl. I think what he's saying is there are also state regulations that apply that are not actually laws, so maybe they both need to have that reference.

Alix Goss
Okay. Maybe it's really like this. Something along those lines to sort of – because we're talking about laws and regulations globally, then we're giving examples of federal and state, and maybe we need to put something in here as a qualifier – I don't mean to do that. Okay. So, we can come back and certainly tweak that. Rich, am I now getting a better grasp on your feedback?

Rich Landen
Yes. Thanks, Alix.

Alix Goss
You're welcome. Okay, so, moving on now to the next guiding principle, the solution the task force designs should meet the minimum necessary standard when requesting and disclosing information. We note that the minimum necessary is often defined differently in provisions such as HIPAA privacy rule, state laws, data use agreements, and business associate agreements. The final guiding principle – the

solution the task force recommends – empowering the patient to have a role in proactively providing and expediting his or her consent when required to share information necessary for prior authorization decisions. One example discussed was around reversing previous self-pay restrictions.

One of the things that I learned in our small group discussions was a situation that I had never anticipated, which was that when a citizen decides to self-pay for service because they want to ultimately keep something confidential, such as an HIV test, they may be forced financially into having to reverse their decision because they then realize that the cost of the services to treat that scenario may be prohibitive without their insurance, so they're left with no recourse but to decide no longer to proceed with a self-pay situation, and now we run into a situation where the diagnostic test was self-pay and cannot be shared, and then the patient gets the results, determines that they want to proceed with the treatment, and that they want to activate that insurance coverage. However, in a preapproval scenario, that test, which was self-pay and restricted from being paid, is no longer – because it was isolated, it has to be freed, so to speak, so it can be shared to comply with HIPAA omnibus. Sheryl? I see your hand raised.

Sheryl Turney
I'm hitting on that same point that you're trying to make, Alix, in that we've also seen from both the payer and the patient perspective where the patient is in the doctor's office, and they get a call to see if something requires a prior auth, and they say no, and they say, "Okay, go ahead, do whatever the procedure is," and then later find out it did require a prior auth because some piece of information was missing.

So, I think in this statement that you have here, there needs to be something said regarding the tracking or the consistency from the beginning of the process to the end of the process that carries that through because what happens today is 9 times out of 10, it's either a query or a phone call that's not recorded anywhere, and then the patient says, "Well, wait a minute, I was in the office when the person called, and they said it wasn't requiring, and now you're saying it is," and then their financial responsibility is different. So, somehow, in the ideal state or the operation of this, I think what we're trying to say is that there should be some continuity from start to finish with the process, and that also… I'm sorry, now you moved the –

Alix Goss
I did because I was thinking that maybe what you were asking for was down below, and I'm sorry I was – as I'm making it – yeah.

Sheryl Turney
Okay. Yeah, because I was looking at it more in terms of patient's role because today – I know I've mentioned this before – from a payer's perspective, most payers don't have a portal where patients can see what the status of their prior auths are. Either you get a letter, or you have to make a phone call. So, having that track from beginning to end – which would include the first phone call or the first engagement in the doctor's office – that process needs to be consistent across the spectrum.

Alix Goss
Thank you. I see that Denise has her hand up, and I also see Alexis in the chat box, so let's start with Denise. Do you want to respond to that, or is this a separate topic?

Denise Webb
I just have a small editorial, Alix. When we were reading it, I was like, "Something doesn't sound right." "The solution the task force recommends empowers the patient to have a role." That needs to be "empowers." That's what I was tripping over.

Alix Goss
I read it, and I thought, "Something's not right here" too. Thank you. Sometimes, when we look at these too long, we can't even see –

Denise Webb
Yeah, I read it a couple times, and I'm going, "Something's not right here."

Alix Goss
All right. So, I want to pull in Alexis here because her chat indicated that this carrying through the process when requirements for prior authorization could change – that continuity – Alexis, I swear we already have that somewhere in here. That's why I was starting to scroll. So, you think it's in another portion, not privacy. Is it transparency?

Alexis Snyder
Well, I think we have it in ideal state and guiding principles. I know we do; I'm not exactly sure where, but my comment in the chat box was just more – how does that apply to the privacy portion? Because that's really the following through from beginning to end in the transparency and information within a different place, but the fact that you just called them now made them more that I was listening and looking. I'm not even sure it should be the solution that a task force recommends empowerment because you can empower people all you want, but unless there's actually a place where, once they're empowered, the patient can actually have a role, it doesn't matter, and even without empowering someone who's already activated to get involved and follow it through from beginning to end, it's not there. I'm not even sure "empowering" as a typo correction even works. Does that make sense?

Denise Webb
If I could jump in, I think what you just said is what we were trying to say here. Whatever the task force ends up recommending, it would actually empower the patient to have a role. It would actually have some proactive or active steps. So, in the case of an HIV test where the patient can actually see that an HIV test is required and that they can have a role in saying, "Oh, I give permission to release this so I can get this treatment," that's really – what you just said is what we were trying to say.

Alexis Snyder
Yeah, I hear you, but what I'm saying is when I hear the word "empower" – and, I actually use that word a lot as an engagement specialist; I talk about empowering patients to engage in their care – I feel like that's a motivating factor. You're empowering someone to do something, but it doesn't mean that they can actually do it because the information, the rule, or the guideline isn't there for them to move ahead with it. There's a little bit of a difference. When I read this, I take it as encouraging someone to try to do something. You're not really empowering somebody; you're giving them the way to actually do it.

Alix Goss
You just used the word "giving." So, rather than saying "empowers the patient to have a role," "empowers the patient by giving them a role" – actually giving them a role in the process –

Alexis Snyder
Right. I don't know if I'd use the word "giving," but the pieces need to be in place for the patient to be able to follow through and do something about it. You can't just empower someone, and then it's not there.

Alix Goss
I totally agree.

Alexis Snyder
We'll have to think about the language. I don't think "giving" sounds right, but something along those lines. "Providing"?

Alix Goss
One of the things I noted is that we wrote this section very differently than we wrote all the other sections, and so, there's going to have to be some normalizing of our text as we go from this work effort to the report-writing effort. I've tried to capture Sheryl's comment, Alexis's comment, and…I just want to put that… All right. I just want to make sure we capture that. Are there other comments or questions on the four guiding principles that we talked about?

So now, let's talk about ideal states. The first one is "Prior authorization stakeholders achieve common agreement on implementation of prior authorization minimum necessary protective health information sharing. Data elements that constitute 'minimum necessary' for prior auth are identified and can be compiled efficiently to facilitate the goal of automating as much as possible to improve workflow and reduce burden. Patients are empowered and understand their privacy rights and actively manage consent for sharing their data. This includes aspects related to self-pay scenarios." That's what we've just done.

"Consent format consistency is established for automated collection and use when required beyond HIPAA, treatment, payment, and operation permission. Simplified individual consent collection processes are used for sharing individually identifiable information for prior authorization when required by state or federal law by 1). Automating the process within the prior authorization workflow to the extent possible, reducing manual steps, 2). Informing the clinician prior to or close to the time of the submitting order that patient consent may be needed, and 3). Empower the patient to have a role in facilitating and expediting the collection process."

The final ideal state concept that we captured was "State law variances are addressed through automation to facilitate goals such as automating collecting necessary consents above. The idea state will include ubiquitous machine-readable expressions of privacy restrictions, such as when consent is necessary or how 'minimum necessary' is defined in state laws. This will allow technology to better accommodate state variation in policy without needing human personal judgment." That represents the body of recommended guiding principles and ideal states. Are there any comments? Alexis?

Alexis Snyder

Yeah. Let me see. E(3) is just the same thing I was saying before, rewording "empower the patient to have a role." So, just the same comment from before – just a rewording of actually providing a way to be active in that role.

Alix Goss
Okay. Anything else, Alexis?

Alexis Snyder
No, I think that's it.

Alix Goss
Okay. Rich Landen?

Rich Landen
Yeah. "State law variances" – there are two types of variances. One is variances that are allowed within the state pursuant to the state legislation or regulations, but I think what you're talking about is when you've got conflicts or discrepancies across different states. I think we need to clarify what we mean by "variances."

Alix Goss
You mean state law variances across the country?

Rich Landen
I think what we're talking about here is say California has one law and Nevada has a different law, so the rules are not the same across the state lines. I think what we're saying here is that the software will have to figure out how to create a solution that complies with both states' laws and regulations.

Alix Goss
I'm too close, Rich. I'm looking at this going, "But that's what it says," but I'm just too close. So, I'm trying to figure out what the right tweaking that we need to do here is.

Rich Landen
The issue is whether we're talking about interstate variances or intrastate variances.

Sasha TerMaat
Rich, I think we were actually thinking of both in the examples that the small group thought about because certainly, one way to ease interpretation – and, this comes to the last sentence, "without needing human and personal judgment." Right now, we have intrastate variation meaning two different health systems reading and understanding something differently, and that comes from the way regulations are written at the state level having ambiguity, and if there is a machine-readable expression in it, that might help in removing some of the ambiguity of what's expected and standardizing the interpretation of what's expected across the state.

I think we also have a challenge that we've discussed in the small group of health systems and providers who operate in many different states, and then we, who are developing policy for a whole country, have to

accommodate the challenge of many different state laws and being familiar with what those need, and that is also challenging for different reasons. Again, if we could automate that to a greater extent, which is what this part of the ideal state is about, that eases the burden because it would be less challenging to accommodate the differences in variation between Wisconsin and Illinois and Minnesota and Iowa if, at least, the ambiguity on those states is reduced and those all could have clear policies that would be imported into software. So, I think both were intended to be addressed here; we could certainly try to clarify if that wasn't expressed.

Rich Landen
Okay. And then, let me also go back to my previous point. I've seen the references throughout the document here. We tend to talk about legislation, but I'm thinking that because we're talking about health information technology, we're talking software programming, programming is always done through regulations. Regulations – if you conform to the regulations, then because the regulations are always within the scope of the legislation, by definition, you conform to the legislation as well. So, my suggestion would be globally throughout the document, any time we talk about legislation, whether it be state or federal, we say "legislation and regulation."

Alix Goss
Okay, I'm hoping that captured the spirit. Consider that any time we talk about legislation, say "legislation and regulation" are both in play. It's a whole-document –

Rich Landen
Yeah, and just as a really simple example, legislation is at the policy level. "Thou shalt protect privacy." Well, that doesn't help you program. So, what you need to do with the program is say, "Okay, that legislation is there. What are the regulations that either HHS or the state agency developed to implement that legislation?" That's really what you need to program to.

Alix Goss
Yeah, and I think it's important to understand that the laws are the lay of the land; the regulations govern how we actually effect the law of the land. Rich, I think you're trying to get at the combination of those two, but really, the automation aspect is really that the regulations get us down to the level of specificity that we need.

Rich Landen
Right.

Alix Goss
Okay. Hopefully, I've captured that as a whole-document effort appropriately.

Rich Landen
Thanks.

Alix Goss
Alexis and Sheryl, I apologize. I don't know who raised their hand first.

Alexis Snyder
Sheryl can go ahead.

Sheryl Turney
Okay, thank you. I'm still stuck on "empowering the patient to have a role in facilitating and expediting the collection process," because here, we're talking about consent collection process. So, are we really saying that we want the patient to have the ability to either, in an automated way, provide that consent or an automated view of the consent? Because I'm not clear on what it is we're trying to make available to the patient that isn't available today.

Alix Goss
I think there's been – go ahead.

Alexis Snyder
I was going to piggyback off of that, but if you want to answer that first…

Alix Goss
My initial reaction is that I believe there is a longstanding gap in citizens understanding how they are empowered and how they have a role in the healthcare process, and there are opportunities to educate them and to give them the tools to be more effective in facilitating their opinions being expressed. So, it is not just that we want to give them better capabilities for expressing it and to offer it up as far as providing their consent, but it is also that education. So, to me, "empowered" was broader than just automation.

Sheryl Turney
Right, but this is in the section that's specifically talking about consent collection process, so that's why I'm trying to figure out what it is because they have to provide consent today. There's a paper they have to sign. Most of the time, it is a paper, so maybe what we're saying is that it needs to be electronic so that not only is that recorded in the system – and, I don't know; every system handles it differently – but that they have access to see that prior auth as it's moving. But then, that's not what this section is talking about. Here, it's really talking about consent selection, and I'm just trying to figure out what it is we're trying to empower in that part. That's all. I agree with you overall. They need to have more visibility and more interaction with the process. I'm just not clear on what that would be here, and I think we need to make – maybe I'm trying to be too specific, but I think we need to have clear recommendations on how we would see this differently, and I'm not understanding it from here, so maybe it's just me.

Alix Goss
I think it's part of a bigger puzzle piece, but go ahead, Alexis or Denise. I'm not sure which one of you is chiming in.

Alexis Snyder
This is Alexis. I was actually going to say that it piggybacks off the comment I had raised my hand about, so I might comment on this piece too. Empowering the patient in the consent process – most of the time, it's actually not paper, so if we're looking for a way to be less broad and more specific, the piece that's sometimes missing is actually knowing what you're signing because it's electronic. Sometimes, people will say, "Oh, sign this pad because X, Y, and Z. Can you sign this for X, Y, and Z?" The patient actually

ends up signing things and agreeing to things that they actually don't have in writing and don't see, to answer some of what Sheryl was saying.

That actually piggybacks off of – there were two things I was thinking. When I was sitting here and looking at it more, under E, where it says "simplified individual consent," using the word "simplified" worries me a little bit exactly for the reasons I just said. Sometimes, it's already pretty simple, and the more simplified it gets, the less the patient realizes what they are giving consent to, and so, maybe it's more streamlined or a less burdensome process, however you want to put it, but I'd be a little weary of saying "simplify" unless we put in a specific piece in there that says it's simplified, but we have made sure it's transparent.

And then, my other piece went back to the discussion about F with the state laws, and this is more of an observational thought as I listen and read it again and probably more of a question for some of the privacy experts on the call. What happens – and, where is there a place in here to put a guideline, perhaps – about residing in one state and getting care in another, where the states might have different privacy laws? I don't know how we capture that, but again, I think there's a transparency piece that needs to be addressed, so if someone's coming from one state, they understand that the privacy piece may be different where they're getting care.

Alix Goss
Okay. I've been getting nudged that we are over time for pulling up the public comment slide. Denise, I duly note your hand is patiently raised. I believe it's beyond my control at the moment. If we have time, I will come back to you first.

Public Comment (01:20:26)

Lauren Richie
Okay. Operator, can we open the public line?

Operator
Yes. If you would like to make a comment, please press *1 on your telephone keypad. You may press *2 if you would like to remove your comment from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. One moment while we poll for comments. There are no comments at this time.

Lauren Richie
Okay. Alix, we'll let you know if we do get comments in.

Alix Goss
Would it be possible to resume sharing? Okay, awesome. So, Alexis, "Consider transparency piece for citizen moving across country living in different states." I think it's two-pronged. If you're not on a Blues plan and you're in different states with different rules and different dynamics, even if you're just traveling, not just residing – moving from one part to the next. I think we'll take that back into consideration. Hopefully, I've captured that appropriately.

Alexis Snyder

Yes.

Alix Goss
Okay. Denise, thank you for your patience.

Denise Webb
No problem. I appreciate Alexis's comment about using the word "streamlined" instead of "simplified." I have quite a bit of input on this where the patient is involved because it seems like in the current prior authorization process – and, I can even take myself as an example, where I just got a letter that I had prior authorization for some physical therapy that I didn't even know prior authorization was required, but let's just say there was something they needed, and they needed my consent to share it. By building the patient into the automated process where we can see – as Sheryl was mentioning, where the patient can see the status of their PA. So, if you take that HIV example, the patient had an HIV test self-paid, and has restricted sharing of that HIV test, and now wants to get treatment that's going to require prior authorization, and of course, the health plan may need to know where the evidence is that there's HIV. Well, there has to be a test.

So, if the patient had a distinct role – they were actually part of the automated process – and this was done in a streamlined way, they would get a notification that they need to provide something, and they would be informed, be able to see that their PA is held up, why it's held up, and that it requires consent to release that HIV test. If that could be done in a simplified – that's where we came up with "simplified" – in a simplified manner instead of people having to get on telephones, find the patient, and get them to sign something… That's what we were trying to get at. So, maybe "streamlined" is a better word, but we're really trying to – in the ideal state, the patient is also an actor in the automated PA process and workflow to help facilitate, make it efficient, and go more quickly so they can get the care they need.

Alexis Snyder
Absolutely, because right now, they're really not a part of it.

Alix Goss
I'm hoping I captured everything I was supposed to. I really appreciated that bringing us home, Denise. I believe it's time for us to pivot to the next steps, and I think Sheryl is going to bring us home on that today.

Next Steps (01:24:34)

Sheryl Turney
Thank you so much, Alix. I think this was a great discussion today on the material that your work group brought forward. I think this is exactly the kind of input we're looking for from everybody, so thank you to everyone who participated in putting that together and for the input we received today because it really makes it all the more meaningful. Quickly, to recap where we're going, next week, on the 23rd, we have AHIMA coming with a presentation, and also CAQH CORE, which will be very important, especially based on what you heard today with X12, and then, last week with AHIP. And then, we'll be reviewing the first round of some draft recommendations that we put together and the work group that is working on that,

and then we've got some additional things coming up for the future weeks that we've highlighted here. I'm not going to go into them all. Can we go to the next slide?

So, just as a reminder to everyone in the group, it's really going to be important for you to go out to these Google docs and provide your input, comments, and updates in between the sessions so we can have more information to discuss when we come back together. The recommendation small group will continue to work. Again, they're bringing forward their recommendations in a couple weeks. We also have a small group working on the new process model, and they've been working on those now for about two weeks, so hopefully, they'll be ready to present in a couple of weeks as well. I already mentioned what we have next week, and then for the longer term. Any final questions or comments from anyone? How about Alix? Do you have anything final you would like to add?

Alix Goss
No. There's lots of work to do. I'm really looking forward to people's input as we move forward and get into these documents because we've done a lot of great work, but it's going to be a lift to get us from the framework and the small working group efforts to the report. So, I'm excited for the summer and for the task force to come up with concrete recommendations on prior auth and the larger intersecting conversation.

Sheryl Turney
I agree. Thank you, everybody. I see that we still don't have anyone for public comment, so with that, we're going to call this a wrap, and we hope everybody has a wonderful week, and we really look forward to your input, and we'll see you next week on the 23rd at 3:00 p.m. Eastern.

Lauren Richie
Thanks, folks.

Alix Goss
Thanks, everyone.

Rich Landen
Thank you guys.

Sasha TerMaat
Bye.

Adjourn