The Office of the National Coordinator for Health Information Technology

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE MEETING

August 18, 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
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
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

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome, again, to our ICAD task force meeting. I know we have a couple of members who are absent today. But of those who are here, we have Sheryl Turney, Alix Goss, Andy Truscott, Anil Jain, Deb Strickland, Denise Webb, Gus Geraci, Jim Jirjis, Mary Greene, Ram Sriram, and Steve Brown. Are there any others that I may have missed on the phone or Adobe?

Alexis Snyder
Hi, Lauren. It's Alexis Snyder.

Lauren Richie
Hi, Alexis. Anyone else? Great. I am turning it over to our co-chairs to get us started.

Summary and Action Plan (00:00:45)

Alix Goss
Well, thank you. This is Alix Goss. And I'm going to go ahead and get us started today. Hopefully, you can all hear me. We are going to launch our meeting with the usual summary and action plan review followed by a deep dive into contributions to our draft paper and the comments that have been submitted. Do a shout out to Alexis for working in the document. Sheryl and I have done some review with the team on the comments received. And so, Sheryl is going to be walking us through the draft document and some other related artifacts with the support of Michael Wittie who is our lead staff from ONC and, currently, dubbed our editor extraordinaire. We're also going to tackle a few of the plans moving forward and provide time for public comment. With that said, if we could go to the next slide please. So, our last meeting was a really productive session building on our review of the work of the synthesizing teams.

We had, last week, a deep dive into the recommendations work that had been prepared so far. Thanks to Rich Landen walking us through the process that he and Arien Malec took to synthesize the documentation from earlier work on recommendations. And we walked through their body of recommendations and gotten some further clarity and got some feedback that will help Rich and Arien who I do not believe are available today but for them to finish up that work. It also provides us with a lot of opportunity to refresh ourselves on the work from the last few months now that we've had a review of the guiding principles, ideal state and now, recommendations work. We also started to talk more about the approach to the draft report and how we would be engaging in a master draft working document. We're going to continue some of the discussion of that draft report structure today. So, without further ado, I want to do a shout out to acknowledge that Arien has joined us.

And go to the next slide, which I believe we're going to be, actually, pivoting to an approach where Sheryl is going to be walking us through content today. And Michael will be sharing his screen. And I'm going to support the two of you through managing Q&A.

Review Draft Paper and Comments (00:03:25)

Sheryl Turney
That's correct. Thank you, Alix. We're going to start by looking at the document that Deb and I worked on related to gaps in the recommendations, ideal state, and guiding principles. So, Michael is going to share that. And he's, actually, going to be flipping between that document and the recommendations that we reviewed last week so that you guys can see it and we can have some discussions on the fly. Right now, Michael, we're seeing a blue screen.

Michael Wittie
Yeah, I'm getting there. Apparently, I shared and then, unshared somehow.

Sheryl Turney
Okay. We can wait a second.

Michael Wittie
There you go. Do you see the gaps?

Sheryl Turney
It came on and then, it went away. I've had some issues with my computer today.

Alix Goss
It's not you, Sheryl. It was there for a brief moment and then, went away. So, I believe he stopped sharing it. It looks like he may be resharing in one of the allocated pods at the moment.

Michael Wittie
That's what I am doing. There we are. Can you see that?

Sheryl Turney
I'm just glad I have access to my computer again. I was like oh, no, I have so many things going on today. Okay. So, here are the recommendations that were made. And there were some comments that we will walk through to the recommendations. But the first thing we're going to look at is the gap document. Now, Michael, you'll have to bear with me because I can't read that. So, I, actually, have it up on my screen so I can, actually, read the version. So, on the first gap, I'll read it. It, basically, was the priority target area of patient access to personal health information. And we had indicated that the gap that had been called out was the ability to check on the status of a prior authorization electronically by the patient does not currently exist today. In today's world, the patient has to call both the provider and the payer to check on the status to find out why it's stuck. So, the second bullet was patients don't know who to contact if they have issues with a prior authorization.

When they call the payer, they're, basically, only given a customer service number. And often, they don't even know the prior authorization is in process. So, they never can really get an updated status on what's going on. And Recommendation 7 in the ICAD recommendations does, actually, speak to a patient centered workflow. But it doesn't, specifically, call out what we're talking about relative to that. So, if you bring up the

recommendations, Michael, maybe it's easier if you keep the recommendations up and I'll just talk about the gaps that were brought up.

Alix Goss
Sheryl, I would agree with you that if you could talk through because I think what he was showing was a tracked changes document. It may be easier for you to just walk him through there.

Sheryl Turney
Yeah. I think that's what I'll do. So, you might need to make it a little bit bigger for them to read it, Michael, because it's a little hard to read.

Michael Wittie
Does that help?

Sheryl Turney
Okay. Is that better? I can read it now. We want to go to Recommendation 7. So, in 7, it's develop patient centered workflow and standards. And here, we talk about a work horse, administrative standards in the second paragraph like eligibility, claiming, and electronic EOB remittance that are traditionally considered provider to payer should allow access to the same API frameworks already supporting API access. Convergence of clinical administrative workflows, including prior authorizations should be designed to support API access and patient engagement as a matter of course. I don't know if that was detailed enough to provide the vision that we were looking at. And also, here, we talked about the current EOB API. But really, the EOB API is the patient access API. So, I'm thinking we need to standardize the wording so that we're consistent across our document on what API we would be talking about.

Because today, what's in the EOB is what would be the patient access.

Arien Malec
Yeah. So, just to be clear in this section, I definitely agree with the intent. And if the wording isn't making it clear then, we need to change the wording. But just in the context of this sentence, the intent is to say that the status – first of all, the intent here is to say that all administrative standards are designed for patient access and involvement. That's inclusive of even work horse administrative standards like eligibility claiming and EOB. And that not only as is currently available in the Smart and FHIR APIs for payer blue button that are EOB at the end of the process that this should be available throughout the claiming process. But, again, completely – the intent is super clear so totally harmonized on the intent. And if we need to change the wording to make the intent clear, totally good on that.

Sheryl Turney
I just wanted to make sure that – because that was the connection point. And I think that just updating the wording and if you're fine with that then, we can make sure we're talking about the same thing. So, I think we're good.

Arien Malec
Yeah.

Sheryl Turney
So, then the next one that had been called out was in the priority target area of interoperability. And here, we had a variety of comments. But one of them was collaborate with industry to establish standardized definitions of three of these data elements so payers and providers can write the rules knowing the precise definition and format of the data to enable the API standards for prior authorization and to be moved forward. So, there were a number of recommendations that focused on convergence of standards and code sets. But I don't know if we, actually, either in 6 or 9 got down to the level of definitions of terminology. Because where there was expressed some concern was the fact that today providers have many payers they have to interface with who all have different terms and they're all defined differently. So, although we may not be able to have all of the exact same rules, certainly, any terms that are common to the industry should be defined in a consistent way so that there can be an API or a programmatic interface that can be based on that standard terminology.

So, I think we just wanted to make sure in the recommendation how could we modify that slightly in either 6 or 9 to also include the definitions of common terminology that's not currently – I guess, not 9 because that's attachment standards. So, it's like 5 and 6 where –

Arien Malec
Yeah. So, if I'm reading you right or hearing you right, 6 is about making the standards available to implement. What we want is an additional recommendation that says we need to focus on standardizing the terminology for administrative workflows to make sure that all actors are using common terms.

Sheryl Turney
So, you would see that as a new recommendation?

Arien Malec
I'd see that as a new recommendation, maybe new recommendation detail as part of one of the existing recommendations. I think it's a great point and definitely needs to be added.

Sheryl Turney
All right. So, harmonize definitions. You do have a very good way of saying things. I'm going to put in a holding point so I can come back to that. All right. And good. So, that was another one of the gaps that Deb and I had identified. And then, I need to go down to this one. So, we had one that was related to establishing – and Deb, I have to apologize because I'm not sure I understood this one. And we're not going to flash it up there. But it was establish a light weight and feasible exception process to achieve the spirit of 162.940. And I have to apologize because I don't know exactly what 162.940 is referring to. But it says the exception process for national standards is burdensome for innovation and requires a level of orchestration that leads to a nonstarter. History shows this by the lack of requests. NCPDP asked in the rule to permit a script example. So, the gap that was captured was might this cause a high level of experimentation in the industry thus increasing burden on partners.

So, I put it for a discussion item because one of the comments was partners would be willing participants in some sort of pilot or only well vetted options should be considered based on X amount of internal and external successful testing with partners. So, a personal interview by the ISA team so they can vet the

success. So, really, to me, it sounds like vetting the success of exceptions and how the exception process should work with the ISA. And I'm not familiar with that process.

Debra Strickland
Right. So, what it was, initially, targeting is that there is a process for people to go ahead and pilot new things. But a lot of people have not submitted the request to do that and to start to partake in any of these pilots to try new transactions and new things with partners and so forth. So, while there is a way to do that, it is highly unused. And I think part of it is because a lot of people didn't necessarily know. They weren't aware that it was necessarily there and they could do that. And also, I think people didn't understand or the process was too cumbersome for people to say, "Hey, I've been working with these two payers or payers and vendors or clearinghouses and I've got a great thing that seems to be working for us. Let's put in for a pilot and try to get this exercised so that we can create some criteria of success so that we can present it to the powers that be to see if people want to adopt this new thing."

Sheryl Turney
Okay.

Alix Goss
So, to that point, I think we may want to scroll up to Recommendation 2 because I think what's happening here is some people may recall that Deb volunteered to take on looking at the gaps that we may have between some of our discussions over the last couple of months. There has been some side work back and forth between Deb Strickland and Sheryl Turney. And what they're doing is they're bringing the results of that synthesis effort forward and they've identified a challenge with what I believe to be Recommendation 2.

Sheryl Turney
Okay. So, we would need to add an additional point. That's great, Alix. I didn't know where to put it. So, I'll make a note in here that we need to add an exception to the exception standards.

Alix Goss
Yeah. It was trying to link, actually, the HIPAA world meets the tremendous new flexibility that ONC has promulgated for us.

Sheryl Turney
Okay. That's perfect because I wasn't sure where this one belonged. And you guys were right on the spot. Let me go to the next one. The next one is really talking about promoting and implementing a national piloting process, which we don't, specifically, call out in our recommendations. So, I don't know if we need to add a recommendation regarding that or if we left it off because there are a lot of complexities with pilots. Within HL7, there is a formal pilot process.

Alix Goss
If I could jump in here for a second. I want to be careful to distinguish between testing that's done at HL7 in the form of a Connectathon from the concepts of true piloting to get measurement and qualitative and quantitative feedback on the viability of an actual standard in a more representative environment –

Arien Malec
I agree with both of those comments and think we should add them both to Recommendation 2.

Alix Goss
Well, I would like to, actually, talk about this a little bit, Arien, because I think it makes a lot of sense. But I'm wondering if we might be diluting our message if we try to put this all into one bucket because this concept of the standards version advancement process is new. But this issue of will we test it in a robust manner to support us in being able to make wise adoption choices is a separate issue.

Arien Malec
I'm good on that. So, I agree with the point and good with adding a separate recommendation for both testing and piloting.

Alix Goss
And I think those could go together to some degree, yes.

Sheryl Turney
We're saying we would want to add a testing and piloting recommendation. And I'm thinking that should go further down here like maybe after Recommendation 6 unless you have a better place you want to put it.

Alix Goss
After you get Arien's response to that, I will note that Jocelyn has raised her hand.

Sheryl Turney
Arien, would you be able to –

Arien Malec
I'll just take the point and do an editing pass.

Sheryl Turney
Okay.

Alix Goss
Thank you for doing that. So, we want to add a placeholder for Arien to do is editing pass to add testing and piloting, which I believe we've always intended to include on our list.

Sheryl Turney
All right. Yes. And I am adding that note right now. We can go ahead to the next question.

Alix Goss
Jocelyn has her hand raised. Ms. Keegan?

Jocelyn Keegan
Thanks, Alix. So, I completely, wholeheartedly agree with the idea that testing in piloting needs to be its own separate issue. I think, for me, one of the things, and Jim and Josh and I talked about this while we

were doing some of the standard landscape portion of the document, right now, the current ability for someone to innovate through our existing exception process is incredibly burdensome. So, I think whatever we say about piloting and measurement for success is that there needs to be a way to reduce that heavy lift that we currently place both from a creating the architecture, the agreements to get to an exception and the burden and the cost of actually being able to pilot something at scale. So, I don't know, Arien, if you can channel my inner point here to really talk about not just that we need to pilot and test but we need to do it in a place where you don't have to be one of the five big guys to, actually, have the resources and the time and the money to be able to experiment.

Arien Malec
Got it.

Sheryl Turney
Yeah. And I would like to say on that, too, having been personally involved in a number of opportunities to do pilots, quite honestly as a payer, we're still working on an agreement with some of the providers who we wanted to do pilots with. Others went very quickly. And some of the larger ones take forever. So, it really inhibits your ability to do the pilot when you can't agree on the terms of how you're going to share the data. Maybe that's outside of this but if there was a simpler structure that we could all be working on to do these pilots where we all agree to the same terms and operations to do so would be wonderful.

Alix Goss
So, Sheryl, let me ask you a question about that. Are you talking about having standardized synthetic data that we used? Is that what you – like an actual test environment stood up?

Sheryl Turney
Well, that's a technique. But since we don't have that today, just getting a data use agreement in place so we can do the pilot is challenging with some of our provider partners.

Alix Goss
Because it's not a compliant transaction. Okay.

Debra Strickland
Yeah, it's a chicken/egg problem.

Sheryl Turney
And so, that would be burdensome because then, you're talking about hundreds of hours with a lawyer that costs a lot of money, essentially, just to try to get what's the issue. So, to me, some of these things would be helpful if there was – we're not going to use the data for any other purpose and blah, blah, blah, we all agree to that, which is all of the things that normal people would want. Then, you can have a utility sort of set up and all agree to operate the same way. But in absence of that that does get in the way of your ability to do the pilot and, actually, get the benefits.

Debra Strickland
Yeah. And on the standards side, on the X12 side and stuff, for years we have had the issue where there is no hard and fast requirements on what the pilot must cover. It was kind of just thrown out there that it

had to be piloted and had to be successful but there is no success criteria. How and who judges what the success is of a pilot? And also, there was always the issue of willing trading partners to build out environments at their expense. There's not a lot of motivation to build an end to end system that mimics production.

Sheryl Turney
Yeah. So, if there was some sort of utility network that was already set up for this, to me, that would benefit all of us. It would be like you have to adhere to these common agreements in order to participate. And then, you plug in and you go rather than have these protracted obstacles that create burden for everyone and really don't have much value to them. If I wanted to pilot with five different provider groups, I have to have five sets of negotiations for a data use agreement. To me, maybe some of the things are to set up a template that says for all of the things we're piloting, these are the things that we would expect partners to adhere to and everybody agrees, hopefully. Maybe that's too much policy. All right. Let's move on to the next one. So, there was another one. So, this one was, again, focused on the automation and the workflow speaking about that today, there is no consistency across all of the payers as to what all of the required data is.

And we need to develop a consistent template so that for each type of condition or whatever needs to get approval, there is consistent data collected. Now, again, I do believe that recommendations do speak to this relative to the workflow. I just don't know if they go specific enough to capture all of the thoughts. I want to go back to the workflow one, which was Recommendation 7. And I just have to read this again. Right. So, would this language here be strong enough or detailed enough to include the concept that we had discussed that, basically, requires that the list of procedures that require prior authorization be communicated and for that list of procedures or services, all of the data requirements are defined and defined in a competent way?

Arien Malec
Yeah. I forget. So, I completely agree with the concept. I forget if I wrote that up or not. I thought I did and let me just take a little bit offline work and see if I can figure out where it lives right now.

Debra Strickland
So, I think, if I remember correctly back when I did this, I think it was sort of on the premise and remember the example of the wheelchair and how much the person weighs and collecting all of the data that is necessary in order to do the job effectively the first time.

Sheryl Turney
Yeah. You're right on, Deb.

Arien Malec
Yeah. I definitely agree on the point and I just want to make sure that it's not already captured language and if it's not, we, certainly, need to add it.

Sheryl Turney
Yeah. So, I think it belongs in 7. That's what I –

Arien Malec

I think it's 11. So, 7 is about patient engagement and 11 is about standards for prior authorization.

Sheryl Turney
Okay.

Alix Goss
Which is good if you want to take a look at 11 because one of the things that we identified during last week's discussion, Arien, which I know you were unable to attend, we identified that there were multiple recommendations and we're trying to be extremely discrete. So, if you look there, you might have not only the ability to bolster one item but also break it into two recommendations.

Arien Malec
Yeah. Got it. So, it sounds like for 11, what we want to do is be more clear about the intent of 11 in addition to include documentation of what's required and what services require prior authorization and what steps are required in the prior authorization process. And also, we want to break any of these bulky recommendations down into recommendation lists so that they establish severability.

Sheryl Turney
Okay. I like that idea also. Okay. I like both of those.

Arien Malec
So, whoever has got the master and is putting notes in, if you can give me those annotations and flip it back and I'll, again, do the editing.

Sheryl Turney
I think we'll go with Michael because that's what he's adding some notes. And I added notes as well. Michael, I'll go back and add my notes to yours if we need to expand them.

Michael Wittie
I'm working in the document you sent, not in the live Google Doc. But I can move them over later on.

Sheryl Turney
Yeah. That sounds good. So, this is exactly what we wanted this gap document to do. And so far, we're finding some good things. So, we have another one, which was that it referred back to the workflow.

Alix Goss
I'm sorry, Sheryl, for interrupting. I just want to clarify that, Michael, I think you've gotten half of the requests for the nudge. Do you want Arien to give you a little bit of a reprise on the other concepts he wants to footnote on or comment on?

Michael Wittie
Sure.

Arien Malec

Yeah. So, I think the two things were 1.) making sure that we were breaking up 11 and 2.) is ensure that we have specific recommendations for making A) the list of procedures or other orderables that require prior authorization available and B) make sure that the requirements for the prior authorization are available for each of those procedures or orderables.

Debra Strickland
And that would be the content of what specifics are necessary, height of the person, weight of the person.

Arien Malec
Yeah, exactly.

Debra Strickland
Electric versus manual and just referencing that.

Arien Malec
By way of example, for a wheelchair, etc. Got it.

Sheryl Turney
Okay. That sounds good. Let me know when you're ready, Michael.

Michael Wittie
Okay.

Sheryl Turney
That was pretty much it for the – there were a lot of other things identified in the gap document but all of them really were addressed with recommendations that we already had discussed last week. But we did another little piece of work. And that was that Andrew, one of the supporting individuals from the ONC, developed a compendium with the recommendations from all of the third party vendors and agencies and representative stakeholders that came to do presentations for us. And out of those, we also did a comparison between what they recommended and our recommendations. So, I made a few notes based on those as well. And I don't know whether it – maybe it makes sense for us to review those in total, Michael, because this is not information that we've really shared at all with the group.

Michael Wittie
Sure. Do you need the document up?

Sheryl Turney
Yeah. Not yet. It's blue.

Alix Goss
Yeah. So, for people to understand, he's navigating on a different application. That's what grays it out.

Sheryl Turney
Now, we see it. Of course, it's not the most blue screen.

Michael Wittie
You see it now?

Sheryl Turney
Yes, we do. Thank you so much. I'll walk us through this document so people will understand. So, what they did was go through and pull out of the decks and the letters we got, emails, from each of these groups what the recommendations were. And what I did was, actually, make notes relative to the ones that appeared to maybe either go beyond what we had recommended or had different recommendations than what we had recommended or I wasn't clear on the recommendations so that we could discuss those. Because at the end of the day, we want to be able to say this is what we did, this is how we did it, this is all of the information we considered. And after all of this, these are the lists of recommendations that we had. So, essentially, the first thing up was cover my meds. And they had a number of ideas in terms of the ideal state and workflow. And then, they had made some steps to get to the ideal state. And one was better eligibility and benefits data shared real time like the real time benefit check that's being utilized by some providers but not all of them yet.

And so, they were looking to expand that to a wider and broader audience. But also, one of the questions I had here was the automated processes like when I read this, the DRLS process and the real time benefit check sort of need to adopt standards so that EMR systems are able to consistently present the administrative data for the verification of benefits at a granular level. So, they're required to provide accurate data in the file. So, really what I was thinking about there is that, again, some EMRs have adopted this. There are some pilots that are going on. But there is, actually, no rule that says you have to use this. So, as part of our process, maybe we want to recommend that there is more administrative capability to include this real time benefit check and the real time benefit transparency so that the EMR systems are required to have it for certification purposes and ability to execute on those in a real time benefit way consistently for all their interchanges.

And then, the administrative systems need to be able to provide the data as they currently do through the standard required to satisfy from HIPAA with the X12 transactions. So, I don't know if there is more that we would need to add to our recommendations. We definitely talk about standardizing and harmonizing code sets and standards. But I don't know if we go as far as saying that we want to encourage adoption of these types of electronic processes. What does the team think?

Alix Goss
Sheryl, are you asking us if we think that we should have some sort of a recommendation about more real time transaction processing generally as a concept?

Sheryl Turney
Yeah. Because a lot of these recommendations from all of these partners really cover the theme of requiring real time response for things like benefit check and the status of someone's deductible, all of that stuff.

Alix Goss
So, thank you for clarifying that. I thought that's what you were looking for. And we have our firsthand raised in Jocelyn followed by Arien.

Jocelyn Keegan
So, I think that this concept of getting to real time is incredibly important. I think that I would pair anytime we're talking about real time with workflow because I think where it gets serviced and how the data is made available ahead of the actual transaction happening is really at the heart of what we're trying to improve here. It's not just about automating an existing PA. It's about getting better data in place so you could, potentially, avoid a PA. You could get more information about that patient's specific benefits so that you could do the thing that me as an individual who has health insurance is covered by the plan I pay for and reduce waste for everybody that's involved if it **[inaudible] [00:38:59]**. And then, if and when I need to do more then, making that as automated as possible for the right person in the practice that needs to do that work and keeping it visible for me as a patient so that I'm not wasting time going to the pharmacy when I'm pended for PA.

So, I think that, to me, it's a wholistic ideal that is more than just automating the actual step. And I think this point I hear around – and we got to see CNM does a great job of masking that for the end user and in gapping where there aren't standards to do that. The only other point I would make here is I think that we have two worlds when it comes to PA. We see really great penetration with NCPDP and the prior auth workflows and the work to improve the real time benefit check in workflow for providers through the EHRs. And all of the EHRs talk NCPDP today in their e-prescribing app. I don't think we want to necessarily break that. I think we want to augment that. And we want to get the other half of the world, which is order entry either inside of a facility or outside of a facility that requires prior authorization or other predecessor staff to somebody, actually, getting what was ordered, diagnosed, what therapy they're being put on is automated as we achieve over on the pharmacy side.

And that was a little bit of a soliloquy. I apologize but I feel like I don't want to make the search for real time masking these underlying earlier steps that could help reduce or remove throw the baby out with the bath water because we're just on the search for automation.

Sheryl Turney
Yeah. I think what you're saying is the accurate thing, Jocelyn because I will just share this one example where, recently, there has been noted a lot of false positives with Covid. And it doesn't really apply to the prior authorization model but it does apply to the intersection of clinical administrative data and it was an awkward situation where a number of people were saying I got calls about being positive when I'm not positive. And they weren't understanding what that means. And so, if there was the ability for, not only the administrative system to get the test results of lab work like that in addition to the provider then, prevention of those types of things could occur because what may be happening in some scenarios, certainly not all, is this person called the doctor and said I don't know why I'm getting called because this was negative. And they say, "Oh, we get reimbursed more for a positive test." And that's what they were told on the phone. And that happened to more than one person.

But in that scenario, the whole thing could be avoided if payers, as well as providers, get the test results for the Covid because then, it's a self-auditing type of system. And that's another reason why the intersection of clinical and administrative data is so important because it's going to prevent those types of situations from occurring. And I know I sort of changed what you were saying, Jocelyn, but I do think an important point isn't real time, it's having the data where you need it when decisions and actions are made on it that's

important. And it needs to be in some timely way but it, certainly, doesn't need to be real time. But I don't know if our recommendations go far enough to say that.

Debra Strickland
Right. So, Jocelyn, are you saying that there should be a way for us to have a pre-conversation about what's needed in order to create a good solid PA? So, if you say I need a wheelchair and they say, "Okay, these are the things I'm going to need from you in order for us to get this order right," size of the person, weight of the person, height, automated, manual wheelchair or electric wheelchair, that kind of stuff and make sure that they come back and tell us everything we're going to need so that when we send in the PA, it's everything and most likely to get approved. Is that what you're saying? If we do real time, to kind of put it as a conversational step in the beginning.

Jocelyn Keegan
And it's funny. I wouldn't say that we don't want to do real time. I think that we're working towards API. So, we want things to be as automated and as real time as possible. I just don't want to overemphasize real time and forget about the predecessor stats that you're discussing, Alexis, which is really the transparency piece and the understanding of what somebody's actual benefits are and where they are in the plan year and what they've experienced, succeeded, and failed in in the past is all part of those clinical records that either the provider or the payer has and freeing that data to be looked at and reviewed and made digital if and when you need to do the prior auth. We, of course, want to automate. We, of course, want things to be real time. I just think that it's not the ultimate goal. There are also things we could be doing to completely avoid and reduce the number of prior authorizations that we're submitting.

And to your point, Alexis, if I knew exactly what the criteria is and I knew that I was going to meet the criteria –

Alexis Snyder
I'm just going to interrupt you because I don't know who was speaking but it wasn't Alexis.

Debra Strickland
It was Deb.

Alexis Snyder
That's why everyone should say who they are and maybe raise their hands.

Debra Strickland
Sorry.

Jocelyn Keegan
Sorry, Deb.

Debra Strickland
No, it's okay.

Jocelyn Keegan

I think that at the heart of what my point is that not that anything we're saying here about real time is a negative. I think it's where we want to head. I just think there are a set of effective steps to creating a transparency and understanding what the rules are the coverage details are whether it's on the pharmacy side or the medical side so that the provider and the patient can, actually, understand that before they move forward so we can just reduce the total number of prior auths they're requesting. And to your point that the rules are clear so when somebody goes to submit, they submit clean and it doesn't become this four weeklong exercise to make sure there are five different handoffs back and forth to get all of the data in place. You, actually, know what you need to submit to meet criteria.

Sheryl Turney
Yeah.

Alix Goss
So, I think that we're getting this captured, hopefully. And so, let's just keep folks oriented that what we're looking at fodder from the presentations we've received. And Sheryl feels there are some areas we may need to tease out for modifying or adding to our existing recommendations. So, what I'm hearing is that we need to clearly look at when we're talking about the workflows and automation, we also want to be making sure we've clearly thought about and made a choice on to what degree we think real time is important as a recommendation in and of itself. But these are components of the overall recommendation flow if I'm hearing this whole conversation correctly. Sheryl, you can validate or redirect me there.

Sheryl Turney
Yes, 100%.

Alix Goss
Okay. So, you now have Arien, Jim, and Anil in the cue.

Sheryl Turney
All right. Go ahead, Arien.

Arien Malec
All right. So, I've got two hats on. One is a task force member hat and the other is an editor hat. And I'm trying to keep those two things separate. So, with my task force member hat on, and I don't think this is in the document, but I think we've talked about the need for eligibility checks to have more precision and data available to them to drive more downstream workflows. So, I'm going to put that out there as a possible recommendation. And also, I think there was a possible recommendation for industry to adopt and, potentially, to certify against the real time benefit check standard. And I want to make sure that we either contemplate not that that's a recommendation. So, now with my editor hat on, the notion that we should be designing standards so that they can be auditable in workflow is definitely recommendation fodder and already agreed on by the task force and, hopefully, is in the recommendations as drafted. And if they're not, it's an editing error and needs to be added to that.

So, maybe I'm trying to distinguish between three different things. 1.) Is the need for more data and eligibility checks to distinguish downstream to better inform downstream information; 2.) Is whether the real time benefit check standard, the NCPDP standard for benefit discovery and electronic prior auth in the pharmacy

workflow needs to be added as a recommendation; and 3.) is I believe that there are adequate recommendation intents at least, even if it's not fully captured in the text to drive automation in workflow. And I'm more than happy to take another path to make sure that the wording there is super clear. And if there are areas where people don't feel like it's captured, feel free to point it out to me and I'm happy to make sure that that gets edited back in.

Alix Goss
So, I think to that point, if I may just chime in, Rich did indicate that you had not 100% completed all of the recommendation integration work. So, this is a good check for us, too. And I think, Michael, he's looking for not only the drive for automation and workflow but also the aspect related to eligibility was the other piece that he said during his summary there that he probably wants a footnote on.

Sheryl Turney
And one of the things I just wanted to add, Arien, to what you were saying about the intersection and the exchange of data, I think a lot of the comments that were made throughout the third party stakeholders were things like if a patient goes to a lab that's attached to a hospital then, that data is visible in the EMR. But if they don't then, it isn't. And so, having consistent process to get that same lab data within the EMR system of the physician that needs it, I think, is also a component of this. So, that's the only reason why I kind of called it out as well because I think that came out in that cover my meds discussion. So, we can move on to Anil.

Anil Jain
Yeah. Thank you. So, I'm not sure if this is even a relevant comment anymore because we've talked a lot about the real time and then, automation. But I heard some comments. I just want to make sure that from a clinician point of view, we only want the patient to really think about that he or she knows where the clinical decisions are being made. And I think some of the conversation sounded like you could have multiple copies of, for example, test results sent to the provider and the payer so that the patient could seek opinions from both. I think that's very dangerous. I think we don't want to use the intersection of clinical and administrative data and the work that needs to be put in there to further confuse the patient as to how those clinical decisions are being made. I'm all for automation of administrative workflows and getting information earlier that would be relevant for a prior auth.

But when you start to talk about care, I hope we can all agree that that should still be the purview of the clinician provider, if you will, and a payer who may not have a full clinical history or maybe just have bits of data. And maybe I misheard but I think it's really important that we focus whatever we do on bringing these two disparate universes together that we don't want to mess up the relationship that a patient has with their providers.

Sheryl Turney
I think we would all agree with that, Anil.

Alix Goss
Thank you, Anil. I noticed that Jim had his hand up. He took it down but now, he's writing in the chat box. So, I'm not sure if he still wanted to chat.

Jim Jirjis
Hey, there. Thank you. I was going to bumper Jocelyn's comment about defining real time a bit because her last comment about making sure that there was enough time for completeness of data before a decision is rendered, one of the unintended consequences of automation and real time we experienced in a real world pilot was automation from the EMR to the payer of data, premature denials that then led to appeals that occurred only because not enough time had occurred for additional information to come in. So, I think this real time, when it comes to automating and extracting data to then lead to a decision needs to be tempered so that unintended consequences don't occur. There is a timing and a completeness factor that needs to be spoken to.

Sheryl Turney
Yeah. Important consideration.

Alix Goss
Yeah. I like Jocelyn just wrote not real time but at the right time with the right information. And it's really the R4, the right patient, the right time, the right provider, the right information. And Jocelyn is up in the cue next, Sheryl and then, Alexis.

Sheryl Turney
All right. Go ahead.

Jocelyn Keegan
I think my hand just didn't get unraised. I'm all set.

Alix Goss
Alexis?

Alexis Snyder
I was just confused about what Anil was – the point he was trying to get across about not confusing patients with too much information and jeopardizing the relationship between the clinician and the patient because they have too much information.

Anil Jain
No, that's not what I meant. I'm sorry, Alexis. What I'm saying is I think it was the example of the Covid test results where I think Sheryl mentioned that if the payer also got the results along with the provider then, the payer could help the patient understand. And what I can think of –

Sheryl Turney
I'm sorry. That's not what I meant. I meant if the payer got the results then, they would know that they were negative. And so, a provider is not going to be able to put that in as a positive test. Because in this case, there appear to be some providers that are over reporting because of reimbursements. And it has nothing to do with any engagement with the patient. But the patient, in this case, called the payer to see if they knew and they didn't know. It wasn't me suggesting that they know.

Alexis Snyder

And the payer should not know. The payer has no right to know that.

Sheryl Turney
The payers don't know. So, if they are paying more for a patient that, basically, we're told that tested positive, until we do an audit, we wouldn't know one way or the other. And, again, this shouldn't –

Alexis Snyder
Right. And you shouldn't unless it somehow comes up as a red flag for an audit because you shouldn't have information about diagnosis. Certainly, if a patient brings it to the payer's attention to say this is a mistake and did you know about this because they're billing you more than they should then, that's different. So, Anil, do you just take back anything rather than trying to explain what you meant because you were explaining something that was different than what she was talking about?

Anil Jain
Yeah. Let me make sure that I don't confuse us further. What I'm getting at is 1.) we don't want to disrupt the physician/patient relationship. I think we can all agree on that. 2.) Physicians may have more information about why certain results of tests, I'm just using that as an example, when in combination with other information may not tell the same story. And the example that Sheryl is bringing up, there are patients who will have a negative Covid test but will have a CT scan that clearly shows consistent with Covid and, therefore, the doctor may diagnose the patient with Covid. Patients may understand that. They may not. I don't know. It depends on the relationship and the communication style. But if all the payer had was a negative test result, they could make the wrong conclusion. So, what I'm trying to say is, of course, more information for the patient is good. But if the payer had information that was in a vacuum of the provider/patient relationship then, we could have unintended consequences.

And what we don't want to do in the work of bringing the administrative and clinical data together is inadvertently create, and I think Jim said this already, the unintended consequences of perhaps the wrong information at the wrong time in the wrong context. And I'm not saying that physicians are flawless. And there may be physicians who are gaming the system. But the vast majority of them, I'm sure, are trying to do the right thing. And they may have more information than snippets of data that a payer might get. That's what I was trying to say.

Jim Jirjis
Do you mind if I piggyback on that?

Anil Jain
Of course.

Jim Jirjis
The examples where there is gray area, where it really – sometimes, the logic for the rule set the payer is using is pretty crisp and well defined. But in many instances, there is gray area or suspicion of tuberculosis leads to needing therapy for it but there is no tuberculosis test back yet. Those are examples, I think, of what you're talking about, right, where we could get so ahead of ourselves that we have inappropriate denials because we think the EMR has all of the data needed to make a definitive authorization decision. Is that the kind of topic you're talking about?

Anil Jain
Yeah. And I think it's even more murky when if you go beyond just the automation required for the transaction like in the case of PA but you start to think about a world where the payer would somehow also have all of that data in advance but doesn't have the same relationship. They have a relationship but not the same relationship with the patient. The patient may be confused as to who is making the clinical decision. And that's not a place where we want to take the way medicine is organized right now.

Sheryl Turney
I think those are really important points to note as well. At the end of the day, we don't want our recommendations to disturb the patient/provider relationship. We want them to support that so it's a stronger relationship. So, I think this goes along with the goal and the ideal state where we don't want to create more burden. And we don't want to create more confusion. So, I think that those are all really valid points. Okay. So, there are a few more things to discuss from the recommendations. So, do you want to go down? The next one that I thought we should talk about is, I think, on the third or fourth page. Premiere, which is at the bottom of the third page, Michael, they recommended there should be incentives for using health IT that reduce burden and provide value to clinicians. I don't think we've put anything in our recommendations related to incentives. I don't know if we want to.

Arien Malec
I believe that's there. It's just couched in a way that people may not understand it. So, all of the language around aligning CMS programs and certification criteria is intended to provide the regulatory avenue for incentives. And, again, this may just be too deep in the regulatory weeds to understand how people who aren't that deep read all of that.

Sheryl Turney
Yeah. And that's what I was thinking also. So, that's why I just asked the question because I wasn't sure. I know these systems like the one Premiere created and the one that Epic has for the payer portal are quite expensive. And I don't know who the incentives for utilizing those would be intended to go to. But both providers and payers would be paying for them. So, it's an expensive proposition for both sides. And really, it appears that the smaller providers would be the ones that may not have the opportunity to utilize those without some substantial incentives because of their cost. All right. If we move down to the end of Page 4, there were a couple of questions here. EHRA made recommendations. And I don't know if these got addressed. They wanted to establish an authorization at a higher level than a procedure, a service, a test, or a DME. So, they wanted to shift from fee for service to value based.

I can say, as a payer in many of our value based arrangements, we and I know other payers eliminate the need for a number of prior authorizations. Not all of them but, certainly, the most common ones where there is sufficient data and the providers have risk related. I know we did many pilots on this and a number of these are being expanded. But I don't know what the lever is that they're looking for to include for value based payments. But that was their suggestion. And then, they indicated if there were opportunities where we could effectively have no need for authorizations, what can be done so that they're not needed. So, I don't know if there might be more piloting that could be recommended for the value based care arrangement. I know for us that was a very beneficial exercise. And now, we're, basically, taking it much

broader. But, again, I don't know exactly what they were looking to establish other than some sort of incentive to implement the reduction of prior authorizations in value based arrangements.

And I don't know if –

Alix Goss
Arien's hand is raised.

Sheryl Turney
Okay. Go ahead.

Alix Goss
I'm sorry, Sheryl. I apologize.

Arien Malec
I think this is an area that we talked about as a group and agreed on. And I made automated into the recommendation text if it definitely needs to. So, the conversation we had as a group was that, to the extent possible, PA should be eliminated in cases where incentives are appropriately aligned. So, if I'm approved for a bundle then, that should – you don't need to micromanage my decisions because I'm already approved for the bundle and already reimbursed for the bundle. So, I think we can make additional recommendation text for relative to including incentives in value based programs that reduce the need for prior authorization.

Sheryl Turney
Yes, that's it exactly.

Alix Goss
Sheryl, I raised my hand to follow on to Arien's point here because I don't think it's necessarily a piloting aspect but I do think it's this policy framework. And maybe there is somewhere tied into either – probably not as a part of our transparency per se on the medical policy but more of maybe a subset or a secondary related recommendation that might speak to, in value based care, there should already be the ability for disease state to enable that provider to make the determinations about what services are needed without prior auth. I think that's sort of what we're getting at.

Sheryl Turney
Yeah. I think we just need to say something more explicitly in the recommendations than what we've said regarding that.

Alix Goss
Clearly, I think there are sentiments along those lines. And, hopefully, if anyone is disagreeing with that philosophy, they'd speak up and let us know. Otherwise, we could be going down a rabbit hole on writing that we shouldn't be.

Sheryl Turney
Yeah. So, raise your hand if you have a comment.

Alix Goss
Anil has raised his hand.

Anil Jain
Yeah. And I think this may just be a subtlety. But I think what we're really saying is that anytime the physician or the clinician is taking on the risk, there really is no other further incentive to have prior auth. It's not just the value based.

Alix Goss
Yeah, why do you need one?

Sheryl Turney
Well, the incentive though is to expand the value based arrangement so there would be fewer and fewer PAs. That's the incentive. It's to expand the value –

Anil Jain
Yeah. I do want to make a comment that if it's what we're advocating that we don't need PAs in a setting where the doc is taking the risk in a value based arrangement then, what is the purpose of the PA is to simply reduce unnecessary expense when they're in a fee for service arrangement. And so, I think this could have a –

Alix Goss
Let me ask you a question there because I remember some earlier discussion. I think, actually, Gus might have made a comment or two in the past about being in an awkward situation where you want to not undermine the trust relationship between the patient and the doctor but the doctor may be, actually, prescribing an outdated treatment and that there was, actually, sort of a nice safety valve on behalf of the patient to have somebody else looking at it and considering it from evidence based medicine perspective. And I noticed that as I was chatting, I've seen Gus's hand go up and then, Alexis. So, I will defer. Gus?

Gaspere Geraci
Yes. Go ahead, I'll let you finish your thought.

Anil Jain
I was just going to say that the only way that I think we – the one way to make this language comfortable is to say that it then needs to be coupled with strong clinical support that the providers then take on. Because we're all saying that we want less PA. But what we don't want is because the risk is now shifted to the clinicians that wrong things still happen. It's not good for the patient. At the end of the day, we're supposed to be making this patient centric. And so, I think we need to say that in the event where the clinician is taking on risk in a value based engagement and is utilizing clinical decision support tools that provide them guidelines that the PA is unnecessary.

Gaspere Geraci
So, I'll jump in there and say the trouble with that is that if you've seen one value based program, you've seen one value based program. And they're all so very different in terms of what is being incented and how it's being incented. And to say that if you're in a value based arrangement you don't need PA is kind of

leaping to an ideal space but not a realistic one because the providers that go into a value based arrangement that may be entirely appropriate but it may still require PA in the sense that it's not just about the dollars. I love telling somebody they can't have a CAT scan because an MRI is more appropriate. So, requesting a CAT scan and then, discovering later that it was the wrong test and you should have done an MRI is as much of a waste of money as ordering an MRI when a CAT scan will do. So, I would be cautious about a broad statement like that given the various natures of value based arrangements.

And I do think that, and as Alix pointed out I've made this point before, sometimes the insurer is put in the position of saying that is the wrong test. That is the wrong treatment. I know you trained 20 years ago but update your information. And that accounts for a large number of the prior auths that are denied is just docs not staying up to date as they should be. So, I'll shut up there.

Alix Goss
You have Alexis and Jim in the cue, Sheryl.

Sheryl Turney
All right. Go ahead, Alexis.

Alexis Snyder
I was just, basically, going to agree with – I'll just agree now with what Jim was saying. I was going to call attention to what Alix brought up that we did have conversation that quite often, the payer ends up being the safety net. Honestly, as an aside, I don't think that that's what it's about. I think it's a loophole safety net because it's about cost in the end. It usually is. But there is this value piece that they do catch **[inaudible] [01:11:14]**. And it's kind of what I was getting at with what I was asking Anil before. And without the patient being able to have full transparency to that decision process and what went into the guidelines behind the PA decision, you can't intervene and correct things. And I, actually, recently had that happen. It wasn't the safety chew. However, I got the PA denial information by mail that was fully transparent about the process it went through surprisingly. Kudos to Signa for a good job this time and they were able to give me fully transparent information when I called.

I just wish that I didn't have to call and was able to look it up easily online. But it went through a process with a completely inaccurate patient diagnosis and why the medication was being requested. And so, without me being able to see that and get, again, unfortunately, having to be the go between to correct it, I was getting different information from the provider than from the payer. And I was able to go back to the provider and say no, that's not why it was denied. This is why it's denied. And it's because you didn't provide X, Y, and Z. And whoever filled out the prior authorization in your office put down the wrong diagnosis. So, there is that piece, too, beyond the safety piece. And just back to Anil's point in the beginning that I can understand the concerns over protecting relationship and it being the clinical decision and not being second guessed. But sometimes, unfortunately, it's helpful.

Sheryl Turney
Yeah. Very good points, Alexis. Thank you for sharing that. We have Jim now.

Jim Jirjis

Thank you. I think that your point, Anil, is good that why do you need a PA. Well, when we did some Medicare Advantage work and the risk did shift to the practice, the practice now wanted there to be a PA because they were on the hook. So, to me, the PA may not have to come from the insurer or payer because now they're not on the hook. But that infrastructure may be still helpful and useful to the practice. Because from my personal – some of bad decisions by docs, let's just say the instances where docs do the MRI and shouldn't, some of it is driven by just not being informed. But other times, it's driven by the microeconomics of the doctor in a busy practice. It takes a lot more time to explain to the patient why. It's not always unhelpful to have a third party, actually, say they're not going to approve it because we really need to do physical therapy first. It's not unhelpful. So, you're right. It may not be that there's an incentive for the payer to do the prior auth.

But if risk is shifted to me, I'd still want there to be a process in place so that inappropriate tests aren't ordered. And the payers may already have infrastructure in place that accomplishes that or combined with the practice efforts can control it. For example, in Medicare Advantage, reducing the number of inappropriate referrals to specialists is a major piece that the practices go after themselves instead of the insurance company. So, that's an example of a prior auth if you would. It's still very useful.

Sheryl Turney
Thanks, Jim. That's very good. If we don't have anymore questions on this point, I think we've got a lot of information we can use in the update process. There is one more point. And, again, I know we call out workflows and we do have a recommendation around the workflows. But one of the comments, and this came from multiple sources, not just the group that brought it forward in a formal recommendation from EHRA, but I received this in a separate group with the small providers from Connecticut was that there are many payers that push providers to utilize portals. Some are multi payer portals and some are not. But is there some process by which we can have the data integrated within the EMR so that it reduces the number of these outside portals that physicians need to utilize? Again, we did talk about the workflow and the automation. But maybe we need just to beef up some of the wording around with the intent to try to reduce the number of interfaces and portals that physicians have to support.

The ability to integrate these within some payer portal within EMR in a standard, consistent way using our FHIR transactions needs to be clear. And what do you guys think about that? And Arien, I'm pretty sure that this is what you meant by the wording that you have.

Arien Malec
Yeah. I think it's a worthwhile thing is that the intent is to reduce or eliminate the use of payer specific portals.

Sheryl Turney
Yeah. Okay. So, I think we can add that to that recommendation that really speaks to that one that that's one of the five benefits of it.

Alix Goss
I recognize that we are now at the time of public comment but I do want to come back to this because, in essence, there is also a very specific recommendation that may need to be made there because real time

capacity or clinical conversation capacity may not be what's promulgated today. So, maybe we can come back to that.

Sheryl Turney
Okay. Go ahead, Alix.

Alix Goss
I think it's over to Lauren.

Public Comment (01:17:39)

Lauren Richie
Yeah. We'll ask the operators to open the line please.

Operator
Thank you. If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 to remove your comment from the cue. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment while we poll for comments. There are no comments at this time.

Lauren Richie
Thank you. Alix and Sheryl, I'll let you know if any comments come in.

Sheryl Turney
Thank you, Lauren. So, Alix, do you want to continue the conversation on the last point?

Alix Goss
I think that might make sense to do that recognizing I wasn't clear if you had more in the document. I think you said that was the last point from the analysis of you reviewing the recommendation summary that Andrew completed.

Sheryl Turney
Yes.

Alix Goss
Okay. So, I also noticed that Alexis said something in the chat box about universal platform for PA regardless of the payer. I think it was something that she might want to speak to. But I also think that for the comment about reference to Davinci and there was a reference to portals and the objective of having integration with electronic health records so that the clinician at the point of care and their support team can be working in that one capacity or tool would need to have a different kind of integration. Because today, the 278 X12 transaction for prior authorization is not getting integrated to my knowledge all the way back into the EHR systems. And I think the EHRA was saying hey, we want to get more to the integration level. And so, I'm wondering if that means something along the lines of making a different kind of recommendation than we have today and whether we, as a body, would want to consider something that says we might have a 278 promulgated today.

We don't have an exception process that 162.940 reference that has proven out the ability for us to give the fodder to national standards group to maybe make a different standard available to do the prior authorization function. Do we want to go to the point of talking about that in our recommendations?

Sheryl Turney
Does anyone from the group have any thoughts on it? I do think that this is something that we should talk about. I guess what I was envisioning what Alexis said was more in line of having, essentially, as I said before in my ideal state, there is some open source type of solution where there is a payer portal that can be integrated into any EMR system based on this API that we've yet to develop to exchange that data and make the data available. Again, is it going to be real time? I don't know. But it would be data that is then readily available for the EMR system to be able to utilize because it would be pre-defined to a standard. That's sort of what I had envisioned when we first talked about this a few months ago.

Alexis Snyder
Sheryl, this is Alexis. And I think that's correct. And I think we did talk about that. But I was just typing in the chat box, too, in reference to what Alix was saying. I think that we, actually, talked about the complete opposite and it's in the recommendation and in the ideal state. And we went around in circles, I think, a lot over this language a couple of weeks ago in a conversation. And so, I'm not quite sure where it's landing now if it needs to be revisited. But we talked the opposite about making sure that while we were creating standards, we weren't setting up a monopoly for one group over another. I'm not familiar with all of the X12 and all of those letters and numbers that get thrown out. But we talked a lot about one not benefiting over another. And so, to your question do we need to change that and think more about something that becomes a national standard regardless.

Alix Goss
I think that you bring up a really good point, Alexis, which is we have been wordsmithing our wordsmithing. And so, today's effort was really to make sure that we had effectively woven a thread from our presentations through our recommendations work to make sure we weren't missing anything. And I think we all have the opportunity when we now have a chance to go look at the draft report because we will be seeing the updated content from Arien and Rich as well as the other feedback that we've captured today being placed into our master draft document. And some of you have already been in there like you, Alexis, and making some comments. I think I saw Gus was in there as well. So, what I'm hoping is that folks will, with today's conversation, which we've, actually, been checking off a lot of loose ends and I really want to do a shout out to Sheryl for her deep dive over the weekend to help us tie those threads up so that what can happen now is that, on the close of today's meeting with Michael's assistance, we'll refresh.

We'll update any applicable sections and then, we'll get some further updates from Arien and Rich. But along the way, you can all go out and review the draft report and start to make comments about whatever you're seeing in the document. But you can also be thinking about are we finding the right balancing act to move the industry forward with a better approach to prior authorization through our recommendations and have we gone far enough to, actually, create some notable change. Before our next – go ahead, Sheryl.

Sheryl Turney
I just wanted to say that's a very good point, Alix.

Next Steps (01:24:40)

Alix Goss
Thank you. Next week, I apologize but I will not be here nor will several of your other teammates as there is an NCVHS hearing on Wednesday and Thursday of next week. So, we will not be able to participate in the task force call. And Sheryl will be walking you through review of the report. And it's kind of two parts. 1.) Making sure you're becoming more familiar with it; and 2.) to help with resolution of the comments. What we've instituted is a weekly sort of touch base of looking at the comments that are coming in to support our ability to resolve anything that needs some team discussion. Some things will need to be – I think we need to wordsmith it. Here are some comments and edits that we can incorporate pretty straight forward. But there will be other times where we might have to have some philosophical kicking of the tires. And so, that approach we will be doing regularly until we're complete with the report.

However, we will also want to start, at some point, whether it's next week or the week after, the broader intersection of clinical administrative data discussion. One of the things that we will hope to do, I think it's either next week or the week following, is to socialize our presentation to the HITAC, the slide deck Sheryl has already started working on, and we want to make sure you're understanding what we're going to present on September 9. So, we'll be socializing that a bit, I believe. Sheryl, keep me straight. It's either next week or the week after.

Sheryl Turney
That's correct. After you give me your comments, Alix, then I'll update it and we will review it with the group.

Alix Goss
So, we are striving to be able to do that as early as next week. So, the game plan is everybody on the task force has access to the Google Doc. Please go out and review the report. Start making comments and editing it and know that we will continue to make that request. We are coming to the point where we are going to be starting to build out the content to reflect the broader intersection discussion. So, that will be a major part of our work in September. Sheryl, would you like to add any further comments?

Sheryl Turney
No. Just great job, Alix. I just want to thank everybody for their participation today. This is exactly the kind of input that we need. And next week, I think as we're stepping through the report and reviewing the comments, hopefully, it will become more familiar. And please, if anyone cannot access the Google Doc, please copy us and ONC so we can get your access granted so that you will be able to provide your input.

Alix Goss
I think that's a wrap for today, folks.

Adjourn (01:27:54)