HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) e-PRIOR AUTHORIZATION REQUEST FOR INFORMATION TASK FORCE 2022

February 10, 2022, 10:00 a.m. – 11:30 a.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Tammy Banks	**Individual**	**Co-Chair**
Sheryl Turney	**Anthem, Inc.**	**Co-Chair**
Hans Buitendijk	Cerner	Member
David DeGandi	Cambia Health Solutions	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Jim Jirjis	HCA Healthcare	Member
Rich Landen	Individual/NCVHS	Member
Heather McComas	American Medical Association	Member
Aaron Miri	Baptist Health	Member
Patrick Murta	Humana	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Debra Strickland	Conduent/NCVHS	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Michael Wittie	Office of the National Coordinator for Health Information Technology	ONC Staff Lead
Alex Baker	Office of the National Coordinator for Health Information Technology	ONC Staff Lead
Viet Nguyen	HL7 Da Vinci Project	Presenter

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

Michael Berry
And, hello, everyone, and thank you for joining the Electronic Prior Authorization RFI Task Force. I am Mike Berry with ONC, and we are very happy that you could be with us again today. As a reminder, your feedback is always welcome, which can be typed in the chat feature to everyone throughout the meeting or can be made verbally during the public comment period that is scheduled at approximately 11:20 Eastern Time this morning. I am going to begin with roll call of our Task Force members, so when I call your name, please indicate that you are here, and I will start with our cochairs. Sheryl Turney?

Sheryl Turney
Sheryl is here.

Michael Berry
Tammy Banks?

Tammy Banks
Here.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Present.

Michael Berry
Dave DeGandi? Raj Godavarthi?

Rajesh Godavarthi
I am here.

Michael Berry
Jim Jirjis?

Jim Jirjis
Present.

Michael Berry
Rich Landen?

Rich Landen
I am here.

Michael Berry
Heather McComas?

Heather McComas
Good morning, here.

Michael Berry
Aaron Miri? Patrick Murta?

Patrick Murta
Here.

Michael Berry
Eliel Oliveira?

Eliel Oliveira
Eliel is here.

Michael Berry
Debra Strickland? All right, well, thank you, everyone, and now, please join me in welcoming Sheryl and Tammy for their opening remarks.

Welcome Remarks, Review of Plan (00:01:35)

Sheryl Turney
Wonderful. I think before we get started, we would like to have a couple of our new Task Force members introduce themselves. I think Patrick actually joined the last meeting, but did not get that opportunity, and also Dave, so, Dave, can you go first, and then we will go to Patrick? Maybe Dave is on mute. All right, why don't we go to Patrick?

Patrick Murta
Thank you, Sheryl. Patrick Murta with Humana. I am our Chief Interoperability Architect and represent the organization in a lot of our industry work, so, I am glad to be here and thank you for the invite.

Sheryl Turney
Very glad to have you. As you can see, we have a very full agenda today, and we are going to kick it off with a brief overview of the implementation guides that are referenced in the RFI, and we have Viet Nguyen, who is here from HL7 Da Vinci, to provide that overview. We are very happy and thankful that he was able to join us. Also, we are going to have another robust discussion of our working document, and I want to thank everyone for their thoughtful comments. We have gotten quite a lot of updates to our Google doc, and so, Tammy once again will lead us through the review of the comments, and hopefully today, we are going to focus on some of the questions that were included in the RFI related to certification requirements, etc. Then we have our public comment at 11:20, and then we will review our homework and next steps, and then we will adjourn.

One point I would like to call out is that we will be providing an update to HITAC next week in the HITAC meeting on the 15th, and so, after today's meeting, Tammy and I will work with ONC and Excel to put together that presentation and make it available to you folks once we have presented it. But, basically, it is

a small progress report in terms of how the subcommittee is doing. Any questions on the agenda or our goals for today? All right, I am going to turn it over to Tammy if she would like to add anything.

Tammy Banks
No, just very thankful and appreciative that Viet is here to present and answer questions in regards to the IGs related to prior authorization, so I am hopeful that you did review Section 2 and the questions so that you are able to glean the information that we needed in order to respond to those questions. We do have an option to bring him back; however, always good to take advantage of him while he is here. So, again, I appreciate it, Viet. Sheryl, do you want me to just hand it over to Viet?

Sheryl Turney
Absolutely, go ahead.

Tammy Banks
Viet, take it away. I appreciate it.

Da Vinci Project IG Presentation (00:04:32)

Viet Nguyen
Great. Thank you very much for the invitation to present to the Task Force, so let's go ahead and jump in to the next slide. I just want to briefly thank our Da Vinci membership. They really are huge drivers in allowing us to do this important work. They fund our work and provide their in-kind subject matter expertise, and have really been participating in the development of these implementation guides, and the important thing here is that there is a wide swath of participation from payers to providers, EHR vendors, and our partner organizations, so I just wanted to thank them. Next slide, please.

So, I wanted to put the four implementation guides that I will be discussing into context of the work that Da Vinci has been doing over the past four years. The burden reduction collection of guides includes the coverage requirements, discovery documentation, templates and rules, and prior authorization that were identified in the RFI, but I also wanted to highlight that I will be discussing the clinical data exchange, or CDex guide, which is not directly referenced in the RFI, but is suitable for discussion around attachments and exchange of clinical data for patient care and administrative purposes, but it is one of the two guides we use to support exchange of clinical data between providers and other providers, as well as payers and providers.

Important here to help orient you on this slide: We have updated it to give it a little bit more flavor in terms of helping understand where our guides are. So, at the bottom, there is a legend that you can see in three colors: Green for most mature, light blue for active growth, and a kind of tan color for the least mature and under development. So, as you look at these, you can see a number of these are already green, and most of them are at least the blue color. And then, the dial shows where they are in the current process for updating these guides.

As you may be aware, HL7 takes guides and puts them through a public community feedback process called balloting, and almost all of these guides have been through at least one ballot, and a number of them have gone through a second set of ballots, and a number of them that we are going to talk about today are going to go into ballot in the next month or so for an update. So, that is recognizing the ongoing journey of

standards development, where we develop the guides, we test them, we try to mature them through real-world implementations, and then improve them in that feedback loop. Next slide, please.

So, the first three set of implementation guides that we will be discussing are the burden reduction guides around prior authorization. They include the coverage requirements discovery, which is focused on enabling the exchange of coverage information within the provider workflow, so it answers the important first question of "Do I need a prior authorization?" because if we can answer that quickly and let them know that there is not, they can continue delivering patient care, and if there is a requirement for prior authorization, it is known early so that it can be addressed in order to prevent delays in patient care and decision making.

The second guide, "Documentation Templates and Rules," can be driven both by itself, but typically would be launched through a response of the coverage requirements discovery. When we know that we need documentation, it allows the provider to launch a Smart on FHIR application to gather the information necessary to support the prior authorization or just the documentation requirements if it is required for post-payment review or administrative purposes.

The key there is that the documentation templates and rules allows for us to use Smart on FHIR, which is part of ONC certification, it allows us to predefine for the provider the documentation requirements that are needed in order to support prior authorization, and then, utilize the functionality that FHIR enables for us to gather that structured information automatically from the EHR, and then present it to the provider, and minimize the burden of having to gather data manually, and then, as the provider can find that information and see what may be missing, we can try to address any missing information or necessary information, ideally while the patient is there, but if we have to schedule additional studies and tests, that can be done immediately too in order to, again, prevent the delay in patient care delivery.

And then, finally, with that information gathered, we can then store it, and then also forward that information as part of the prior authorization support implementation guide directly to the payer, utilizing both FHIR as well as the HIPAA 278 transaction in order to get an ideally real-time, or at least near-real-time, response so that we can continue on the process of delivering care.

These three guides were named in the 2020 proposed Rule 9123-P, and we anticipate, based on the unified agenda, that CMS will be rereleasing some additional regulatory guidance around these guides this year, so it is important that we take the opportunity, as we have, to update the guides, to make sure that any gaps that we have identified over the course of the last year or so get addressed, and then go back out for community feedback. Next slide, please.

So, the next three slides are going to build on themselves in order to provide a little context, but coverage **[inaudible] [00:11:11]** discovery utilizes a FHIR technology called CDS Hooks, and I will be highlighting these in a set of summary slides a little bit, but the idea with CDS Hooks is that it allows for the EHR to initiate clinical decision support services during the workflow, and the concept here is to allow the provider, when they go to order or review an order, like a referral or request of some kind, it utilizes CDS Hooks and the order details to reach out to a payer CDS services, and that payer CDS service takes that information around the patient, their coverage, what is being requested, and, utilizing their business rules, responds with the answer of either "Yes, this needs prior authorization" or "No, it does not need prior authorization," and that is encased within the CDS Hooks.

So, this is functionality right now not required by EHR vendors, and is an important aspect of the prior authorization burden reduction IGs we are going to outline here, but also, I think it also, in my opinion as an informaticist, provides an opportunity to give a lot of information at the point of care for the right patient around their condition. That is going to be very beneficial to patient care and minimizing burden for providers. Next slide.

In the response of the CDS Hooks from the payer, they can provide information that is in what we call a card, and that card is then displayed by the EHR, and in that card can be information about the procedure or the coverage details, it can link to information externally, like a webpage, but most importantly, it allows for us to link to a Smart on FHIR launch application where we can put all the security parameters on so that we can then launch the application and display the documentation requirements for the provider.

So, these documentation requirements are based on a FHIR resource called questionnaire and questionnaire response, and behind the scenes is another FHIR technology called the clinical collated language. Together, that allows us to identify the data based on FHIR. Using CQL, we can provide logic behind that, and using FHIR and the Smart on FHIR authorization authentication, we can retrieve that data programmatically. So, if we had to order oxygen and the requirement was for pulse oximetry, we can use the LOINC code that is embedded in the CQL or the questionnaire and automatically retrieve that, and then display that for the provider. That is really beneficial because so much of prior authorization is gathering the right information that the payer would need to adjudicate the coverage and provide an authorization adjudication, so, being able to do this programmatically using the structured data will save time for the provider, and then, whatever is not in structured data or is missing can be highlighted for the provider so that that information can be addressed and labs, studies, or other things can be ordered as well.

The other thing that is very useful around the questionnaire is the ability to start using skip logic, so if certain data is available, it may preclude the requirement of gathering additional data, so, adding this additional logic, again, saves time and energy for the provider and makes sure that the proper information is gathered for the payer. Next slide.

So, once this information is gathered and completed, we use the functionality outlined in the prior authorization support implementation guide that then packages that data, gathers the necessary information around X-12 codes and such, so that we can package it and submit it as a FHIR operation to an endpoint, and that endpoint could be the payer, it could be another vendor working with the payer or the provider, that then would translate or transform that data into an X-12 278 transaction, so we want to make sure we support the data elements from X-12 that the payer would need in order to do their adjudication as well as provide a mechanism for attaching the clinical data to the transaction in order to send it over to the payer.

This was done because of the current HIPAA requirements around the 278, but we also want to note that the Da Vinci project received an exception from CMS in order to pilot the use of a pure FHIR-to-FHIR approach to this transaction, but it would still be based on the foundational work that X-12 has done around the transaction coding. So, this provides us the opportunity to submit the prior authorization using FHIR and doing real-time transactions, as well as the ability to query if the adjudication and response is not an immediate response from the payer, so this allows for the polling that is helpful to the providers because

today, many of them have to monitor, communicate, and do a lot of work through multiple different payer portals, which can, again, be a burden to the providers. So, we think this whole approach provides an improvement in the current work of doing prior authorizations, putting it into workflow, making sure that we answer the important questions around coverage needs, and making sure that data is collected appropriately to support prior authorization. Next slide.

So, this is just another workflow description, using an example of durable medical equipment, where we link the CDS Hooks process, the response from the payer using a library of coverage rules and templates, and then responding with CDS Hooks, and then launching the Smart on FHIR app if additional information is necessary, so it really does take the guesswork out of some very specific patient coverage information that providers would most often know generally about a patient's coverage, but they may not have the specifics, and often would not know whether prior auth was required for a given order or request. Next slide.

So, in the next three slides, I just want to highlight some core base FHIR technologies that are identified in these guides. It is not a complete list because ideally you would go to the implementation guides to find all these details, but I think this can help the Task Force to identify opportunities for testing and certification. We test all these components during our connectathon and our testing events, so there are already opportunities to do this testing for FHIR conformance, and so, these may additionally be opportunities to do testing for certification. For the coverage requirements discovery, as I mentioned, we use CDS Hooks, so, in order to do that, we need the ability for EHRs to be able to trigger CDS Hooks at the appropriate time, such as for order select or order sign. We have to have the ability for payers to have CDS services to respond to these requests and properly match the patient, and their coverage, and what is being ordered in order to provide that response, and, from the CDS Hooks specification, the ability to provide the smart launch context or link inside those cards so that the provider can launch that Smart on FHIR app.

The CRD IG leverages FHIR US CORE, a number of profiled resources, including patient, provider, encounter, we utilize the coverage to make sure we have the right patient, the right coverage, and then, we utilize the device request and member request resources to exchange the details of the device, medication, or nutrition order that is being requested. It also builds upon the current US CORE profiles and terminologies, including the service request codes that we need today around CBT. We use SNOMED, HCSPCS, and LOINC. So, each of these are opportunities that we can use to currently test, but maybe go for consideration for certification testing. Next slide, please.

In order to support documentation templates and rules, we need a number of core FHIR technologies. We have the Smart on FHIR app launch in the security, like OAuth 2.0, associated with that. That is already in ONC's certification plans. We need to be able to support CDS Hooks, as I mentioned before. We need to be able to do structured data capture, which is part of the questionnaire and the questionnaire response, so that allows us to make sure that we structure these questionnaires in a way that is standardized for not only the app, but in the future, if EHRs wanted to adopt these technologies within their own EHRs, we want to be able to have that.

And then, CQL, or clinical quality language, which allows us to put in those rules, the rules both around what is required and how to retrieve that information, as well as the adjudication rules can be supported by CQL. An easy example is a patient who a provider wants to order oxygen for, the payer may require that room air oxygen saturation is below 88, and we can retrieve that with a specific LOINC code or lab code,

and then take the value and use that value as part of the CQL calculations to say we have met one or more of the criteria, so that CQL is a really powerful language, and it is leveraged in other FHIR implementation guides, including the work around quality measures.

We also, again, want to be able to support US CORE, which is already well underway, but also this questionnaire and questionnaire response, as well as this task resource, which is also relatively new, but it has been proven out in our connectathon testing where you can create tasks and assign them to others, and this was put in because we recognize that there are times when all the data may not be available, and we have to do a handoff in order to order additional tests and studies, get them done, and make sure that the prior authorization is readdressed when the data is available, and this is going to be used later on in a lot of other guides as well. Next slide, please.
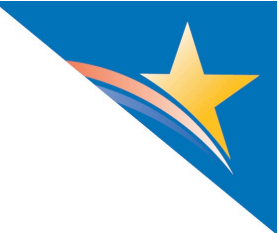
For the prior authorization support, we are leveraging two FHIR operations, this ability to submit a FHIR claim resource with all the X-12 information as well as the clinical information that was gathered, and then, the ability for providers to do a query on that prior authorization. I know it says "claim," "claim" is more of a FHIR terminology, but really, it is a submission for a prior authorization. And, in the bundle of information, it includes the beneficiary information, the codes necessary for the payers, as well as the coverage information and what is being requested, and we leveraged the existing X-12 code sets, some codes from the AHA. Of course, we get permission to do testing on these, but we expect that implementers would follow any required licensing agreements to use these codes in production. We have really great cooperation from X-12 to allow us to point the developers to a set of X-12 resources in order to do testing, so we appreciate that collaboration. Next slide, please.

So, those are the three that are around burden reduction. I just want to highlight in the little bit of time left an additional implementation guide called the Clinical Data Exchange. This guide is going to be published at the end of this quarter, but really, we want to highlight its ability to facilitate and automate the processes for both payer-to-provider as well as for provider-to-provider clinical data exchange. Workflows can include referrals, adding attachments to claim submissions, documenting information for post-payment review or claims audits, and then using it for supplemental data for other workloads, including prior auth, risk adjustment, and quality measures.

We call this supplemental data because each of these guides, just like the prior auth I just described, already have a method for collecting data, but there will be times, hopefully very rarely, that additional data will be requested by the payer, and using this clinical data exchange methodology, they can request that in a programmatic, predefined way, saying, "I need a certain lab, I need a certain document of clinical note," and then, it allows the payer and provider, depending on their relationship, to either create tasks for the provider to retrieve this information and allow the provider to review it or, as we have seen with some of our Da Vinci members, who have a very close working relationship with their payers in their contracts, allow payers to directly query their EHRs in order to get this information.

The key here is that it is this balance between being able to identify the data you need in advance using FHIR to automate the query and collection of that data and allow the payer and provider, depending on the level of their contracted relationships, to either do it in a way that requires minimal human review all the way to totally direct queries. And so, anything that is available in FHIR today and is supported by the EHR can be retrieved through this IG. Next slide.

I did not want to give you all the words, so we put in a little graphic to show that we can initiate requests from a system, either a provider or a payer. The request goes into the EHR of the receiving provider, the data provider, and then can be either done automatically, depending on the relationship, or can be reviewed in advance. We think that this is also a great opportunity for us to improve the data sharing for clinicians when referrals are made. We had a call with our clinical advisory committee, and that came out as a really big value for them because that is a direct way we can use data to improve patient care and, again, prevent the delay in clinical decision making awaiting data. Next slide, please.

Some of the key technologies that are part of CDex: The core FHIR restful queries that are available today are really at the core of this when you want to do direct, but also, the ability to do tasks and subscriptions when you want to both define the request as well as give the request receiver the opportunity to review them. We have the ability to do polling of this task so that the requester can know the status of the progress of the request, and then, the data provider can respond to these requests and return to the requesting group. So, these are really useful. We have created the "submit attachment" operation in order to create these bundles of information as well. We also support, which is noted in the RFI, the ability to do signatures in the data content that we are leveraging the core FHIR guidance around that, and we have added a number of value sets based on requests from the community of providers around understanding the purpose of the data request, the reason for the attachments, and then provide work queues to monitor these requests. Next slide, please.

So, just to highlight things that are happening in the rest of this year, we have our burden reduction. These three guides are going back in as an early ballot to HL7. It will be starting in the next few weeks as we are putting together all our ballot content. We have done this because these are pretty significant implementation guides, and we wanted to balance the work that we are asking the HL7 community and the broader community between the January ballot and a large FHIR R5 ballot happening in May, so we are hoping that by putting it in this time, they will be able to give it the thorough review that we hope to have to make it better.

We hope then to take the ballot comments and do what we call reconciliation, addressing the concerns, questions, and comments from the ballot, and then, ideally, aspirationally, we want to have this published by Q4 of this year. For the clinical data exchange, we anticipate it will be published at the end of this quarter or early the next quarter at the latest, but of course, we want to have ongoing testing and feedback of what is in that guide, as well as we are publishing this guide with some draft content. It is not part of the STU, but we highlighted this because it came out of the initial ballot reconciliation of content, such as doing unsolicited push for, say, the claims or referrals. We wanted to make sure we had guidance out there so that the community could pick it up and start to do some testing around it so that when we take CDex back to the next STU update, we will have a good amount of testing on this draft content. Last slide.

I put a link to a number of these implementation guides for the Task Force, as well as for the community to find it more easily, so we welcome feedback. If you see anything you have concerns about when you look at these, every FHIR specification webpage has a link at the bottom for providing feedback, so we believe in constant, continuous improvement, so please give us feedback if things are unclear or you are having issues with any of our guides. Our last slide is just some contact information. Feel free to reach out to me, Jocelyn Keegan, or Vanessa Candelora from our program management. We look forward to answering

questions, and if necessary, come back and elaborate on some of these ideas if you would like. I was able to stay on time.

Tammy Banks

You are great, Viet. Thank you for being so concise. We have a bunch of questions for you, if you do not mind me just firing them away, and if I ask your question and you need clarification, please feel free to jump on. They are all in the chat, Viet, if you need a little more context, just to get the time moving with our limited time here. But, I wanted to start with a question from Hans. One of the points that we have really been pondering on is the perception in a lot of these presentations is all this happens in the EHR, and in fact, in the provider or hospital setting, it could be an external administrative system, it could be an RCM or a PMS, it could be an app, so it is not such a clear workflow, but it is easier to discuss it as "one software package does this all."

So, with that context, let me just ask the question that Hans laid out. "The slides imply that EHR back-office systems directly interact with a payer. They do not indicate how this would flow with a smart app, and intermediaries may fulfill certain capabilities, thus yielding a different configuration of interactions between EHR and payers. Additionally, on the provider side, multiple HIT beyond the EHR is likely involved for the back-office systems from different HIT suppliers. How do you propose that we get the clarity to avoid certifications that take too much of a monolithic or a one-model approach rather than enabling a more flexible configuration approach to meet the configurations where they are at today?"

Viet Nguyen

We definitely recognize that, as a terminologist, I would say "EHR" is a little bit ambiguous because we know there are EHRs that have revenue cycle management components that are integrally connected to their clinical systems, and there are others that are not. I would say to the extent that we do not have a specific recommendation yet, I think we will need at least terminology modules within the EHR component that support the ability to send and receive these X-12 or CPT codes in order for the payers to receive the codes that they need in order to do the initial coverage determinations as well as to be able to provide the codes needed in the prior authorization support transactions, the submit transactions to support the prior auth. So, I think we are going to have to provide some additional guidance around that, and it has been a little challenging because of the differences in these configurations. We were able to at least identify how this would work in a provider workflow and be able to identify data elements that we needed for the X-12 transaction support.

Tammy Banks

Hans, did you want to expand on that question?

Hans Buitendijk

Sure, just a little bit, and that is that perhaps one of the steps that IGs can look at, which might not be sufficient, but within the IGs, better recognize the boundaries between these interactions that could be spread across and be between these different components so it becomes easier from a certification perspective or otherwise to point to that specifically, and you know what is expected or not in that context. To date, the IGs have been working well to get projects going because the participants had a good idea what they needed to pull from each IG to make a particular interaction work, but if we are in certification

mode, it needs to be much more specific and clear what they are. So, I suggest that as part of this ballot cycle that that be addressed in some fashion as well to have that.

And, the other part is that just to clarify, there may be systems that the ability to have combined EHRs in that cycle, and HIM, etc., all those components. That still does not mean that the provider has all those components from the same supplier. There are plenty of providers that, yes, they could have had "everything" from one, but they have opted not to because they have a revenue cycle from one, a clinician from another, and HIM from someone else. There are all kinds of different variations there that are out there, so we should not only look at what has been offered, we need to look at what is out there, and based on that, say what are some realistic boundaries where these interactions need to cross HIT, and because we are thinking certification, we need to formalize that more than what we need today because the community had a pretty good idea what they were expect to do or not, and from there. So, thank you.

Viet Nguyen
I will take that feedback back to the team. And, one way for the community to help us is to bring your configurations and your challenges to us. We have had really good participation from the larger EHRs, but for those who, as you described, have primarily clinical data and not necessarily the revenue cycle components come to our testing events and our connecathons because we need that feedback in order to improve these guides.

Tammy Banks
Okay. The next question is in regards to the FHIR questionnaire. "We are looking at non-provider workflows versus the clinician workflows, so can you address delegating the FHIR questionnaire completion from clinician to other practice staff and/or putting in the work queue to store initiated PA requests for later completion. Do the guides address that type of rule-based workflow?"

Viet Nguyen
Yes, we are working on that, and actually working with the EHR vendors around that because we need to be able to understand how they manage work queues, and the general term we have been using around is "delegation," because in the ideal happy path, all the information is there, and we can complete the documentation template and rules, but we know that sometimes, it is not there, and so, being able to delegate and hand off the gathering of additional information or handing off to complete another task to generate data is going to be important.

Tammy Banks
Another question is "As we talk about these IGs/balloting, there are also some production implementation of these approaches."

Viet Nguyen
Yes, and actually, maybe my colleague Jocelyn can send a link. We had a really great presentation from our members back in January at our community roundtable where they demonstrated how they put these guides into production to demonstrate this. I think that may have been the crux of the question, because we always have a question of where is this happening and is it real, so, having our members bring their production-level demonstrations to the community is the way we try to respond to that, so we have monthly

community roundtables to highlight the efforts of our members and others to implement our guides in the real world.

Tammy Banks

And then, another one is in regards to certification requirements for EMRs to support CDS Hooks and CQL. "Could it eliminate the need for EMR vendors to support multiple Smart on FHIR apps for every payer UM vendor?" They thought that this might be an issue for the model of needing the Smart on FHIR app to mediate between the guides and the EMR provider workflow.

Viet Nguyen

I think that is a potential. I do not know if it would eliminate. That is a very strong, exact word. I think it would certainly facilitate the ability for EHRs to do the functionality that is embedded inside the Smart on FHIR app.

Sheryl Turney

Tammy, we have a couple people with their hands raised.

Tammy Banks

Okay, I was just trying to get through the questions in the chat first, and then we will get the raised hands, just because for time, it is quicker to get through these. "DTR does not clearly address how a smart app would gather the data from the source system. There has been general consensus that FHIR US CORE would be a starting point, beyond which various other techniques can be deployed. Until FHIR US CORE incorporates that data, the source system need not…" Hans, you have a lot of words here. "…need not support CQL or questionnaire responses. Rather, have FHIR US CORE-based API available to enable the smart app to gather the data. Will that be clarified in an upcoming version?"

Viet Nguyen

Well, US CORE is already built into the expected functionality of the EHRs, and assuming the scope of the Smart on FHIR app allows the provider scope, which is very broad, we should be able to use standardized US CORE queries and the terminology codes that are inherent in observations, medications, or allergies, things like that. We should be able to retrieve them using US CORE. So, that is part of the Smart on FHIR functionality. It is the FHIR part of the Smart on FHIR functionality, for those who are not familiar.

Hans Buitendijk

If the system is certified, we can expect that FHIR US CORE is there. If it is not certified, the guidance might be helpful because they might not have it.

Viet Nguyen

Fair, yes.

Tammy Banks

Okay, and then, two questions about the supplemental data. One is "We have been trying to come with what is the use case when supplemental data would be used." That is the first part of the question, and the second is a clarification question about "CDS is not meant for use within DTR to gather the relevant data,

rather, for supplemental data where the initial data set turns out to be incomplete." So, could you address those two together?

Viet Nguyen

Sure. So, the DTR, the FHIR questionnaire, and the CQL information sent over by the payer that defines their data needs are things that you would expect the payer to know in advance that they need. That may work very well when we have really good, structured requirements around coverage, but we recognize that that is even with the happy path, which is going to be 80 percent or more, there are going to be times when payers may need additional clarifying data that they do during their adjudication.

Always, the happy path is good, structured data, well-articulated adjudication rules, and a real-time or near-real-time response, but the real world is they may need more data, and by using CDex, it allows the payer to define that data that they need as FHIR queries, and inside a communication request or a task, and it is those FHIR queries that can be reviewed by the provider, and then, ideally, they press "approve" and FHIR, in the background, retrieves all that information as opposed to having them do a task list of "retrieve the labs, retrieve the medications," etc. So, that is the ability for using CDex to gather additional data. That additional data may be, say, for that risk adjustment. Right now, that risk adjustment implementation guide is really focused on identifying the list of patients where there may be historical suspected conditions, but currently, because CMS does not take in FHIR data per se for risk data, "evidence" is too strong a word, but payers need that clinical data to provide supporting data for when they do risk-adjusted payments. So, that is an opportunity to use CDex to gather supplemental data.

And, for quality measures in the paradigm of FHIR, the data requirements to support them and the algorithms are built into the quality measure themselves, into the CQL and using FHIR, but there may be times where there is additional data needed to support a given quality measure for, say, auditing, or a HEDIS review, or some other activity, and so, CDex, again, can be akin to what we are asking payers to do today, which is to go into the EHR and do screenshots or do things that are very manual. We would like to be able to do that in an automated way.

Tammy Banks

The next question is "How scalable is this model? Would CDex allow for exchange to HIEs, QHINs, etc. for the more complete view of the clinical data to support the pre-authorizations, or is it limited to payer/provider?"

Viet Nguyen

Well, prior authorization is certainly payer/provider in that relationship. I think the QHINs definitely have an approach that they could support. It depends on whether or not a system wants to do federated or centralized, the role of the HIEs in providing patient engagement in their data, so I think we would have to answer that by asking about specific cases. I am always hesitant to do broad statements if I do not have a specific workflow that I can apply a technology to, and that is kind of a core of what we do. If you have a good workflow, we can evaluate it.

Tammy Banks

Now, another person is saying, "Based on the timeline slide, is it fair to say that these guides are in flux until best case scenario, end of this year?" And then, add on, you said it is in the growth-maturity stage. Where do you feel these guides are at in regards to maturity?

Viet Nguyen
So, the CDex guide is being implemented today by members. The published content is ready to be picked up and put into production and pilots. The draft content, we think, can work because a lot of it is already based on core FHIR technologies, but we also want to do more testing and a variety of those packages, those lists of the data requests. We want to elaborate that more. For the burden reduction, again, it is already having our members and others putting these into productions. What we have added we have added in response to things that we have heard in either ballot reconciliation or things that have come up from the original NPRM. So, I do not want people to have the impression that these are all new. They are incremental improvements on the guides themselves. So, they are constantly maturing, but they are constantly maturing in the way an athlete matures their way to going to the pros, if I can use a metaphor, so we want folks to help us expedite the maturation by doing those implementations, coming to testing events, and giving us feedback.

Tammy Banks
Sorry for this rapid-fire questioning. This will help us when we have our conversations. Rich, you had a question, and then we will do Heather and Eli, and then we are going to have to close it so that we can continue our Task Force discussion on this topic. Rich?

Rich Landen
Yeah, thanks. Great presentation, very informative. One comment and one question. The comment is that everything Hans Buitendijk said about the complexity of the multiple systems that providers deal with also applies on the payer side in combination with in-house and external business associate vendor systems there as well. The question is given the testing that has been done, staying very high-level, do you have any real preliminary results, and are there any particular categories of prior auth that are working better than other categories?

Viet Nguyen
Yes. I would say that where the data is well structured and supported by US CORE so that they can be retrieved, and where the testers and the vendors who come and have maturity around CQL can use that data to do adjudication to both the vendors and the payers, those are going to go more smoothly, and so, there is a fair amount of knowledge work to be done when it comes to taking what has been historically human-readable beneficiary rules and making them more and more automated using CQL. So, I think we have very promising work and good early pilots from our members. As I mentioned, you can see more in the community roundtable recording.

So, I am very optimistic. I would not say that we can do all prior auth now. I think that is hard to be able to say but over time, we will be able to do more and more, and not necessarily the goal of this IG, but as payers and providers are sharing more and more of this clinical data and we use this automated method and can be able to track the successes or where the algorithms break down, we can start looking at AI and machine learning and improve the ability to prior auth from both, right now, this very algorithmic, deterministic approach to more of an AI approach that takes into account the provider history, and the

patient history, and additional clinical data. So, that is where I think some of the promise for the future will be around this.

Rich Landen
Thanks.

Tammy Banks
Heather?

Heather McComas
Thanks so much, and thanks so much, Viet, for being here today. This has been super helpful, and I appreciate the new information you added about the metrics on the maturity of the guides. That is really helpful. I had not seen that before. I wanted to loop back to the idea of the delegation to other practice staff because I want to be honest, sometimes we start talking to physicians who are not familiar with the guides at all, and they hear about this, and they are like, "Oh, it is going to tell me in my EHR that prior auth is required and what information is needed." That is great, but then they start getting anxious, like, "Oh, you mean me myself, I have to do all this right know when the patient is still there? I cannot give it to my staff like I am doing today?" We certainly do not want to go to a situation where physicians are actually doing more of this administrative work than they are right now. That is kind of a horror story, and there is some real angst around that.

So, I wonder if you could talk a little bit more in terms of where the guides are right now about that delegation capacity, and I know there has been a lot of discussion about this in some of the Da Vinci workgroups of late, and particularly this idea of how you store a request for later, and this concept of transient data, and is it going to be stored with a payer, which his really concerning from a provider and, I would think, from a patient perspective because this is not actually a full-blown prior auth request yet. Is that going to be stored in the EHR system? My understanding is the EHRs are not able to do that yet. So, just understanding this really important ability to delegate, to match the way things work in the practice setting now, and how close these guides are now. You have to be able to do that to match the way things work today in a physician practice.

Viet Nguyen
I would say that this is the ongoing work that we need to have the EHR vendors at the table because I think we can do it from the interoperability side and define how we would do it if we were in what I call an all-FHIR, all the time approach, but we recognize we are working with existing technology and needing to do these things that we can represent in FHIR in a real-world EHR. So, I would say that we know there is the need around delegation, and we have a framework that we need to do more testing, and we need the EHR vendors to work with us, and a number of them have been, but the more we can have participation, the better.

But, the other thing I do want to address clearly is around the clinician burden. Having been a practicing physician, I do recognize that there is an additional ask when we want clinicians to review their documentation requirements, but the hopefully very small amount of additional ask in their time in front of the patient will ideally save what has become hours of additional work that they do in what we have traditionally called the pajama time, or the documenting after the hours when they get a knock on the door

that says, "Dr. Nguyen, you saw this patient today who asked for a prior auth, and they did not have an oxygen saturation. We have to bring them back into the office, we have to do that, we have to document before we can submit this prior authorization." So, there may be hopefully very small additional time to make sure the documentation is there. We would definitely benefit from the support of the staff to make sure that documentation is complete, and that goes to the delegation part, but the goal is really to reduce the overall burden on the provider office and ultimately reduce the delay in care delivery for the patient.

Tammy Banks
Viet, just to wrap it up here, and I know we will be sending you questions, and I know you have some other stuff to expand here, but the last question is in regards to the CDex IG. There are also some questions in the RFI in regards to attachments. Could you expand at all on how CDex IG could support attachments, and if there are any alternative approaches, just give us any guidance in that piece?

Viet Nguyen
Yes, we think CDex could be a very viable approach to providing clinical data as attachments, and again, as a terminologist, I think we make the distinction between capital-A attachments and HIPAA transactions and attaching clinical data to support workflows. And so, we have identified a number of opportunities within the CDex, and I listed them in the slides around referrals, adding a FHIR bundle as an attachment to a claim, and the benefit there is that that data is well structured in FHIR, it can be retrieved programmatically using FHIR queries, just like we would in a post-payment review kind of request, and would make it so that the payer, when they receive that data, can use it as purifier resources so they can evaluate and use the codified components of it, they can ingest it really quickly, so there are a lot of benefits in using the CDex approach for a number of what would be workflows and needs from the capital-A attachments transactions.

Tammy Banks
And, that is for internal and external to the EHR. Rather, they reside in an external database, Smart on FHIR.

Viet Nguyen
There would be places, yeah, to assemble it using Smart on FHIR or using it creating programmatic use. So, let's say you had a hospital discharge for a particular condition and payers can define that almost all the time, we ask for 1 through 10 data elements when we do post-payment review. Let's get them to define those in advance, and then have that agreed by the providers and say that when they get a post-payment review, here is what we would expect. It is easy for the payer because then they could pull off the shelf a package of data that they need for a particular purpose, and the providers would know in advance that this is data that is often requested, and they can support it in their systems.

Tammy Banks
Thank you again, Viet, and thanks for putting this all in a compressed timeframe and taking this rapid-fire questioning, but again, we are just trying to maximize our use of our time, and we definitely will be reaching out. Thanks also to your partner there, Jocelyn, for her clarifications as well. So, I will let you go, and please stay on in case there are any additional points you wish to make. While I transition to the Google doc and bring up Section 2, David DeGandi, do you mind introducing yourself?

David DeGandi

Sure. Dave DeGandi, Cambia Health Solutions. We were part of that presentation of the community roundtable that Viet was referring to, along with MCG, and we have Raj on the phone from that too. We developed that Smart on FHIR solution with our provider partners, MultiCare and OFSU, providers out here in the Northwest, so we are pushing the needle on preauth.

Working Document Review and Discussion (00:58:27)

Tammy Banks
Excellent. Thank you, David, and I apologize for mispronouncing your last name there. I should know better by now. All right, so we only have 20 minutes, so I really want to ask all of you to go to the Google docs because we did get some revised language assignments, and Raj and Jim did a great job reviewing the attachments, and I also took the functional criteria and put it in a workflow order, and we will get back to that conversation, but we really need your comments or agreement with what is there in Google docs over the week.

But, right now, let's go over Discussion Questions 2.1 and 2.7. I pulled the comments that were already in the Google docs, and we are kind of over the board, but the first question I really wanted to discuss was what do you think the current readiness is for CRD, DTR, and PAS, and I know a lot of you are working with Da Vinci, so we do have a lot of expertise on this panel for adoption as part of the certification criteria, feasible timeline, and if additional changes are needed. I think everybody agreed that they are not ready for adoption, and more real-world testing is needed, and that this is a key area that needs continued monitoring, but we were over the board from two years piloting and continued to reintegrate the implementation guides, and then, the other was one year, and the other was that there just needs to be more adoption. Does anybody have any comments on what is listed there? I lost you guys here. Just a second.

Patrick Murta
Tammy, it is Patrick.

Tammy Banks
Thank you, Patrick. I lost the hands.

Patrick Murta
You are good. I think "IG is not ready for adoption" is kind of a fairly strong statement. For example, for DTR, there are already implementations, so I am not saying we do not need additional testing or additional real-world validation, but the blanket statement that they are not ready for adoption is just a little bit concerning to me.

Tammy Banks
Anybody else have any other comments?

Sheryl Turney
Raj has a comment.

Tammy Banks
Thank you, Sheryl. I do not know how to get the…

Sheryl Turney
I will call the hands.

Tammy Banks
Oh, thank you.

Sheryl Turney
Then, we have Heather, but go ahead, Raj.

Rajesh Godavarthi
I agree with Patrick. I think that is a pretty strong statement. I warn all the committee that when we look at the implementation guides and the scope of prior auth, they will never be ready for industry, even five years from now. The way we have to approach this is when you think about the whole workflow, what are the pieces that would add value? What is the minimum viable product? What are the pieces in the CDR and DTR that would help? As an example, can the IG help us to answer if prior auth is required? If that one question is being answered, that would reduce the burden for the provider to some extent. A lot of times, they ask these things annoyingly, and spend a lot of hours.

The other piece of that is can we find the status of the prior auth and share with the members? That would reduce the anxiety for the member. "What happened to my request?" So, we have to take a granular approach where there is already maturity and this prediction of burden and value, and then we have to allow for maturity where other functional workflows will grow. So, that is true for any use case, but even for this one, given the magnitude of this use case, we just have to be careful when we make the strong statements because there is value in a lot of places that is already in production.

Tammy Banks
And remember, I need help with what type of consensus response we want to move toward.

Sheryl Turney
All right. We have a couple more hands raised, but I think we are going to have to provide some gradation to the response and not have it be all or nothing because I think what everyone is saying is that there are different levels of maturity for each of the implementation guides, and some of them have been implemented, like CRD, for certain purposes. This is a different use, so there is going to have to be learning to occur because of this different use, but let's go to Hans. I see a lot of nodding heads, so I think I paraphrased it correctly. Go ahead, Hans.

Hans Buitendijk
I would agree. It is not a blanket statement. There is variation there. I am looking at the chat and Rich's last comment. I would agree that is probably more at the overall. But, I would also think that if you look back at the parties that have participated in the development and journey to get there, it is very ready to be used and to find the boundaries where things need to be among that group that has been so deeply ingrained with it today. But, we are now looking at how it can be used for certification, which is a different world, having gone through that for the last 10-12 years on the meaningful use, promoting interoperability, and whatnot.

So, it is a different way of looking at it because now, it is a part of is the requirement unambiguous and can I have good testing and validation against it because in some ways, it is a pass/fail. It is not that we will work it out, find the boundaries, and work with that. In the latter regard, the guides are a great start, sufficiently mature to get people on a path. For certification, I think they are not fully ready, and at a minimum, as was added there, we need to do a little more work to understand in that variety of configurations, certainly on the provider side and, as Rich Landen identified, also on the payer side, how are these variations that we are in need of looking more at the direction levels because they could be separated across different HIT rather than the IGs as an individual one to three, or even as the big three and saying you must support all three, or you must support either one of them, or you can have all of them and have some optionality.

The IG level today would not be sufficiently granular to unambiguously understand what am I expected and what is the combination of things I must have as a minimum to make the ePA flow properly, recognizing that even though it could be, not everything is going to be part of a singular HIT solution. It is just not going to happen in the beginning across the board. There might be some, and there will be some others that do not because that is not where they are at.

Tammy Banks
Okay. I know we are going to get into the modular questions again, and Hans, that totally makes sense. Since I think we are all pretty much saying the same thing, I am going to be putting this in the Google docs for you guys to comment on in regards to the readiness question, and then, if we could go to the timeline, one of them just said that you cannot really mention what the timeline can be. Do we need more testing, or does anybody want to put a stake in the ground that we should address timeline with funding? One was two to three years' testing and piloting. Any comments on that piece?

Sheryl Turney
Heather has her hand raised, so let's get her in there.

Tammy Banks
Sorry, Heather. Thanks.

Heather McComas
Just picking up the thread that Sheryl raised earlier that strict black and knowing all of this is hard, but hopefully, we can take an approach, and I know this Task Force has a limited timeframe to it, of forcing ourselves into a box of saying, "Yes, no, this time right now might be premature." From what Viet just said, the guides might be very different at this time next year, and we might be in a better position to make a recommendation on any of this, particularly related to timeline, so I wonder if there is a way to say things are in flux right now, but we can continue to evaluate this and urge everyone to take another look at this in a year's time or whatever when the guides have been through the ballot reconciliation process.

And also, picking up the point that Hans was just making, from a certification perspective, from a production standpoint, the guides are ready to be used and tested and such, but that is very different than certification. We have to remember that when we are talking about adopting the guides for certification, we are saying that practices that want to participate in government payment programs are going to have to have this

technology, and that is a pretty big thing to put on providers when there is obviously so much in flux right now and so many questions about the functionalities of the guides.

Tammy Banks
Good point. I will drop these three timelines in the Google docs. It sounds like the third timeline, just based on the conversation… Raj, did you want to speak to the timeline?

Rajesh Godavarthi
Yeah. I will make a quick comment.

Tammy Banks
No worries.

Rajesh Godavarthi
I think the timeline should be around what is ready and what providers value. So, it is tied to the first comment we made, that it is not ready for adoption at scale, but for the pieces that are ready that providers value, we always have to look at what is the value to the providers and the members, and then put the timeline around those pieces, and then **[inaudible] [01:08:53]**.

Tammy Banks
Now, do you feel comfortable taking those IGs and assigning a timeline to them?

Rajesh Godavarthi
Yeah, and for anybody who would like to be part of that, I would be happy to take a **[audio cuts out]**.

Unidentified Speaker
Raj, I would like to partner up with you.

David DeGandi
I will help you with that.

Sheryl Turney
I do not want to throw a wrench into it, but I do want to at least say this, and maybe we need to speak to it at some point, but the adoption and the timelines also need to be relative to the scope of what is going to be required, and we have already heard that there may be some complex situations which are not going to be ready on day one, so I do not know the best way to express the scope, but I do think in answer to this question, we need to provide some context of scope.

Rajesh Godavarthi
Exactly. I totally understand.

Tammy Banks
Perfect, good point. So, we will hold this one to go back after we determine the minimized functional criteria. Okay, No. 2, IGs are not ready. Should ONC still propose certification? While there is agreement this is a high priority to continue, monitor, and evaluate, it was split on adding criteria and timing. The most thought

that it should be proposed, and you can read these comments. I will not go through it. There was one "do not add." Does anyone want to speak to this?

David DeGandi
Is there a timeframe that the certification would be enforced or in place? Can it be staged for more complexity further down the line in future certifications?

Tammy Banks
Yes. We could propose, too, that it not be mandatory and it just be forward visioning. "This is where the certification is going so that it can help those innovative vendors plan for the future." Is that where you were going?

David DeGandi
Yeah, because the IGs lay out a path to full automation, which is going to take a long time and a lot of steps to get there, a lot of functionality in different areas, and taking an incremental approach will allow us to complete that full-automation dream.

Rajesh Godavarthi
We have to have some level of ONC guidance on these things. Otherwise, EMRs will not adopt. It is a chicken-and-egg problem we have to solve.

David DeGandi
Right. Is it an option to do an iterative certification-tightening?

Rajesh Godavarthi
Yeah.

David DeGandi
Cool.

Sheryl Turney
Yeah. I think that is the way to frame it, and again, I do not know the right wording, but I do think it should be iterative, and I do think there should be a stake in the ground around a timeline. Otherwise, we will not get the EHR systems to adopt it, and really, the goal is if we have the standard, then more of us can adopt it and scale more quickly.

Rajesh Godavarthi
I completely agree. Hans has his hand up.

Hans Buitendijk
Yeah, a couple reactions. To make it work, we need to have all the stakeholders in the ePA flow adopt sufficient to make it work. I think we have to be careful to point out that we want the EHRs to adopt it, we want the payers to adopt it, we want to have the right other systems adopt it so that the combination works. That is the ultimate goal that we have. The challenge that I see that I am still struggling with on how to phrase it here is that there are different levels of certification criteria that can be there. They can start with

a functional requirement, and then, the implementer or developer of that capability can fill it out as they best see fit. To the extent that you do that for something that the HIT supply can be relatively independent, that works, or with some additional perspective.

We **[inaudible] [01:13:17]** of that where it partially works or otherwise is that the APIs were initially in without technical specifications. Now they are in, but everybody is working against FHIR R4 and US CORE. So, that is a two-step approach, so that can be done, but this is a complex workflow. So, on the one hand, you really need to have the specificity in the IG so that you can figure that out, and in the absence of one singular, monolithic approach, if you just put in a functional requirement, which part of the puzzle am I now obligated for aiming for or would like to fulfill to make sure that that piece, together with all the other pieces, makes it work? That is the part that I am struggling with, and that is why I have not put in more comments than what I have done, because I am not sure how to phrase that. I do not think we would call it ready yet for the guides as they are, although they can be very rapidly there with additional guidance, but if you do it functionally, how do you know that I end up with ePA workflow across the components that actually works? I do not have the answer to that yet. I am not sure how to do that yet.

Tammy Banks

I thought there was a question tied to that, but I hear what you are saying. David?

David DeGandi

What is the scope of the certification requirements? In the other parties that Hans is referring to, can we specify payer certification, or is it just EMR certification?

Tammy Banks

Alex, I may ask you to talk about the module versus individual because I think that is going to be important here, but my understanding is that this is a health IT certification, so it could be any software vendor would be under the umbrella, so the functional criteria could be housed in the EHR, it could be housed in the PMS, it could be housed in the FHIR app, but it would not be a payer certification. However, what we have created, David, is principles or prerequisites, like the payer needs to disclose the prior auth requirement in order to have some of that automatic decisioning, so that is where we have been putting the payer ask in this conversation for this report.

Sheryl Turney

Recall, though, Tammy, one of the questions does ask if there should be payer certifications, and again, I do not know how that would work because I am not familiar enough with how the certification criteria applied today, but it is a good question. We will have to just keep noodling on it.

Alex Baker

This is Alex. I would support that, that it is important to remember the health IT certification program is not specific to one type of vendor or one type of product, even though of course, historically, it has mostly focused on EHR systems, but it is a tool that could be used to certify any type of product if that would be useful to advance interoperability, and I think those are the questions in that final section of the RFI. Would certification be useful, for instance, on the payer end of this chain? Is that something that payers and the vendors they work with might make use of and be interested in? And then, the secondary question of if

certification was directed to those other parties, there may need to be changes in how that certification is designed to ensure it is relevant to those products.

Tammy Banks

Thank you. Hans, do you want to expand on your comment? I am not sure how to ask that.

Hans Buitendijk

The thing is that the scope of ONC and CHIT certification, and Alex and others at ONC can correct, but our impression is that it covers HIT, but it has focused to date mostly on EHRs, but you see in the last one or two certification criteria rounds that it is opening up to HIT. So, if we believe that the ePA workflow is supported by HIT to make that work, the question is then, if there are multiple HIT components across the workflow to make that work, are not all pieces then HIT, and therefore, all the actors that provide that HIT have the opportunity to participate in the certification program, recognizing that becoming CHIT is a voluntary activity, although clearly, based on the incentives put by CMS and others on it, there is a strong drive to have CHIT available.

So, I am looking at that progression and seeing that if ePA is supported by HIT, it is considered part of the HIT environment to make that happen. Before you know it, all the actors are in play, and therefore all could certainly be eligible if they want to, but it seems that that opens the scope. But, again, ONC and CMS need to further clarify, and it may have to go back to the 2004 executive order that established ONC and their scope.

Alex Baker

Hans, that is a very good point, and it is important to remember that ONC's certification program is voluntary in that requirements by any parties to adopt certified technology are based on other policy mandates from other parts of HHS. So, obviously, the main EHR incentive programs have placed those requirements on payers, so another thing to think about in terms of certification for other parties is what other levers would be available to require use by those other parties because that would not come from the certification program.

Sheryl Turney

That is a great point. I think we are going to move to public comment now.

Public Comment (01:20:10)

Michael Berry

That sounds great, and we are going to open up the call to the public if they would like to make a comment. If you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your lines. So, we will pause for a moment to see if any members of the public have a comment. I see no hands raised, so we could resume. I would leave this slide up for a moment in case anyone would like to make a comment. Thank you. Sheryl, Tammy?

Sheryl Turney

Thank you so much, and we have Heather with her hand raised on the prior subject, so, Heather, go ahead.

Heather McComas

Sure. Getting back to the idea of payer certification, I am wondering what folks' thoughts are on the relationship of the CMS prior auth burden reduction NPRM that was out last year and appears to be on the docket to be coming out again in the relatively near future, which would require payers to use these three implementation guides that we have been talking about for prior authorization, a certain set of payers, at least. I wonder, what is the relationship between this RFI and, theoretically, an NPRM out there and, theoretically, in the near future that would require payers to adopt these guides? Because that would be a payer requirement, and are these two pieces of something bigger? I know this may be an intellectual question, but I think it is maybe something we should be thinking about, and is there a need for payer certification if there is this other piece out there that would be mandating payers to use a technology?

Sheryl Turney

I think those are good questions, Heather. We had a couple people with their hands raised that would like to respond. Go ahead, Raj.

Rajesh Godavarthi

Following upon Heather's point, I was wondering if we could have CMS come and share their thoughts like Viet did today. That would be a good session to hear what they are thinking in terms of alignment.

Tammy Banks

Good point.

Sheryl Turney

Good point. Patrick?

Patrick Murta

Just to echo or amplify what Raj was saying, these two, on the ONC side for EHRs and on the CMS side for payers, they have to be in lockstep because if either side is out of balance, there is not reciprocity, and if we are not going through the same implementation guides and the same interfaces, we are creating a bigger problem than what we have today. We are back to one-off, proprietary solutions. So, from my perspective, it is absolutely critical, regardless of if payers have to be certified, that the regulations on both sides bring these two together for a solution both from a payer perspective and from a provider perspective.

Sheryl Turney

Yeah, I underline your comments. I absolutely agree. Then, we have Dave from Cambia, who would like to also weigh in.
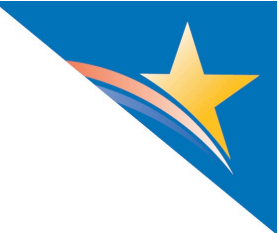
David DeGandi

I have a comment similar to what Patrick was saying. Certification would give us evidence that the APIs are compatible, if that makes sense, where we know a certified payer will work with a certified EHR connection. So, there is value in the payer certification if you want to go there.

Sheryl Turney

Exactly. So, it looks like, Heather, you have agreement from all of the commenters that having some sort of ability to come together and provide confirmation that we are all matching to the same requirements via

certification or something would be helpful. Can we just pause one more moment and see if we have anyone with their hand raised for public comment?

Michael Berry

I do not see any hands raised, Sheryl.

Homework and Next Steps (01:24:18)

Sheryl Turney

Okay, why don't we go to wrap-up, then? Can we go to the next slide? So, as we stated in the beginning, we do have an update for the HITAC meeting next week that the cochairs and I, Excel, and ONC will work on, and then we will share that with you, so you will have that as part of materials for next week. There are homework assignments again, and Heather, I do not know if we need to assign some specifically. I will leave that to you to highlight today, but our next meeting is on the 16th, which is a day earlier because of the HITAC meeting, and then, we are looking next week to refine our recommendations, finalize our updates, and then… Oh, I have the date wrong. The HITAC update is the 17th. Of course, that is why we are changing the meeting. And then, we did also include the links to the implementation guides that Viet went over today so that those are there for you in the deck. Tammy, do you want to add anything?

Tammy Banks

Yes. Just remember, you have the payer/provider/patient section assignments. We are going to be needing to have that completed in the next two weeks, but for next week, we have John Kelly coming, who is going to be speaking about the status of attachments from both CDA and FHIR-enabled attachments, so please, look at Section 3 and the questions relating to attachments and respond, those of you who are able, prior to that meeting in preparation. Also, I am going to be posting, and Alex, hopefully you can help me, a document that gives Raj and Jim's recommendations for the functional criteria for attachments, and I have put them in a different document because I think it will be easier to look at in workflow order.

Your comments are needed on that document. The more we work outside of this meeting and can bring forward what appears to be consensus comments and discuss them, we will be able to move quicker, so if you can go to Google docs this week and spend a little bit of time, it will really help us on this Task Force move forward. But, I really appreciate your comments, and thank you again, Viet, for being on the call, and I look forward to hearing from John from WEDI next week. Any questions? All right, then I think we can give everybody a couple minutes, so you now have a couple minutes to jump in that Google doc and add some more comments. Thank you.

Sheryl Turney

Thank you, Tammy. Thanks, everybody, for your input and your conversation today.

Michael Berry

Thank you all.

Tammy Banks

Bye, thank you.

Adjourn (01:27:37)