The Office of the National Coordinator for Health Information Technology

# Transcript

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

June 2, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

# Speakers

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

**Lauren Richie**
Good afternoon, everyone. Welcome to another episode of our Intersection of Clinical and Administrative Data task force. We will also be joined by our colleagues at CMS and MITRE today for a presentation on the DRLS. So, with that, we'll go ahead and get started with a quick roll call, then we'll jump right into it. Sheryl Turney?

**Sheryl Turney**
Sheryl's here.

**Lauren Richie**
Alix Goss?

**Alix Goss**
Present.

**Lauren Richie**
Aaron Miri? Abby Sears? Alexis Snyder?

**Alexis Snyder**
Here.

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

**Anil Jain**
I'm here.

**Lauren Richie**
All right. Arien Malec?

**Arien Malec**
I'm here.

**Lauren Richie**
Deb Strickland? Denise Webb?

**Denise Webb**
Here.

**Lauren Richie**
Okay. And, I think I saw Gus on the Adobe. Jacki Monson?

**Jacki Monson**
Here.

**Lauren Richie**
Jim Jirjis?

**Jim Jirjis**
Present.

**Lauren Richie**
Jocelyn Keegan?

**Jocelyn Keegan**
Here.

**Lauren Richie**
Les Lenert? Alex Mugge?

**Alex Mugge**
Here.

**Lauren Richie**
Ram Sriram?

**Ram Sriram**
I'm here.

**Lauren Richie**
Great. Rich Landen?

**Sheryl Turney**
He'll be off today.

**Lauren Richie**
Okay. Sasha TerMaat?

**Sasha TerMaat**
Here.

**Lauren Richie**
Great. Steve Brown?

**Steve Brown**
Here.

**Lauren Richie**
Great. Tom Mason?

**Thomas Mason**
I'm on.

**Lauren Richie**
Okay. Sheryl, I will turn it over to you to get us started.

**Sheryl Turney**
All right. For some reason, the Excel spreadsheet is not coming up as an accepted format, and that's why I can't share it, so I apologize, but Josh, if you're on today, if you wouldn't mind sharing your…

**Lauren Richie**
I think we –

**Alix Goss**
This is Alix Goss. I think we've unfortunately just lost Sheryl, who's indicated in the private chat that she is dialing back in, so let me go ahead and step in here to help her out while she gets herself situated. I can very much commiserate with her dynamic, as the system kicked me out of a recent call as well. So, for today's meeting, we're going to be – we've already handled roll call and welcome. I wanted to give you a brief update on our last all before we go into our presentation today from the Centers for Medicare and Medicaid Services, who will be giving us a documentation requirement lookup service demonstration and discussion. Then, presuming all is well, Sheryl will dial back in and continue to facilitate us with the data classes update, and then I'm going to bring us home with a conversation around next steps, a timeline consideration, and some specific work focus for us, and of course, we will have public comments. Could we go ahead one more slide? I'm getting a bit of background noise, and I'm hoping that you're not hearing that, folks. If you are, please let me know. If not, please put yourself on mute.

So, at the last meeting, we took a deep dive into the guiding principles and ideal state work. As you may recall, we had an offline small work group that identified a variety of ideal state and guiding principle considerations. We produced and distributed to the task force members a working document, and then walked through that document for discussion, except for the privacy and security aspects. The goal is that the guiding principles and ideal state will help us with creating recommendations that will go into our report, and we are currently still focused on the prior authorization realm. The privacy and security aspect that we carved out was because we have a small working group taking a deep dive into those considerations, and we'll be coming back again soon to give you more updates from that work, and also, we're incorporating the tremendous feedback we've received from the taskforce on the overarching guiding principles and ideal state.

We also then took a detailed look at the "data classes and data elements" workbook tab. Thanks to Josh, Sheryl, and the team. We talked a lot about overall code dispositions, burden considerations, and update schedules, also with a focus around business process modeling, and have some discussion related to federal data model alignment, so those efforts are also evolving offline through the small work group and the folks that are participating in that.

We wrapped up rather quickly at the last meeting, as we had an action-packed discussion, but we had a quick update around our overall timelines talking about the realities of how HITAC has a break over the summer. That made us pause for a little bit and rethink our timeline for delivering draft recommendations to them, which is a step in the process before we can incorporate and finalize our overall report feedback. We were expecting to submit the final report by the end of September, but we're now more likely looking at October. I'm going to pause there and see if my co-chair Sheryl has returned…and she has. There you go.

**Sheryl Turney**
I'm so sorry.

**Alix Goss**
Hey, technology is great when it works, it's frustrating when it doesn't, and we all get our turn with the gremlins. So, I think at this point, I've brought us home on the last meeting, Sheryl, and I think we're about ready to turn it over to our presenters, if that's okay with you.

**Sheryl Turney**
Yes, it is. Go right ahead. Thank you, Alix.

**Alix Goss**
You're welcome. So, without further ado, I believe we have a handful of presenters and maybe a few backup resources to assist as questions emerge. In our presentation today, Ashley Stedding, Nalini Ambrose, and Larry Decelles will be talking us through the slide deck, which was also sent out to the task force members in advance, so without further ado, I believe I'm turning it over to Ashley.

**Ashley Stedding**
Yes. Thank you, Alix, and good afternoon, everyone. Thank you for joining us today and inviting us to present on the work that CMS is doing in conjunction with the HL7 Da Vinci project to develop a Medicare fee-for-service documentation requirement lookup service prototype, and we're certainly hopeful that this group will find the content that we'll share today to be helpful and informative to the objectives of this task force. So, before we dive in, I'll make some brief introductions. My name is Ashley Stedding. I'm a management analyst, and I work in the provider compliance group at the Centers for Medicare and Medicaid Services, and also, I'm the government task lead for this initiative. Also listening today are two members from the MITRE team that is assisting CMS with this initiative. There's Nalini Ambrose, who is the project lead, and Larry Decelles, who is the technical lead for the DRLS project. Next slide.

The objective of this presentation is to provide education on CMS's documentation requirement lookup service initiative, known as DRLS for short, and its role as a precursor to many important clinician activities related to providing items and services for patients. Following this presentation, you should have a better understanding of the reasoning behind the development of DRLS, how clinicians are intended to use it, and what technologies enable it, as well as the lessons learned along the way, the current status of the DRLS prototype development, and next steps. Next slide.

So, to kick things off, I'm going to spend a couple of minutes sharing some background information on why CMS is interested in this initiative and give a quick overview of the DRLS. So, why is CMS interested in this initiative? Throughout a number of provider listening sessions, CMS has been hearing feedback from

providers saying that documentation requirements are too hard to find. For Medicare as well as other payers, documentation requirements often appear in various locations, and this causes burden to those providers who must navigate the various websites to find those coverage requirements, including both documentation and prior authorization requirements.

CMS has also heard repeated suggestions that payers should publicly disclose their requirements in a searchable electronic format and clearly communicate to prescribing and ordering providers what supporting documentation is needed, so this initiative is really one of the steps that CMS is taking toward displaying our Medicare fee-for-service rules in electronic format that will be easily accessible to providers from within their actual clinical workflow. Next slide.

In the interests of time, I won't go into this slide in great detail, but at a high level, we just wanted to share some additional context to the reasoning behind the development of the DRLS and show a small sample of the supplemental improper payment report data from CMS supporting the logic behind some of the initial topics selected for DRLS full-set development, which we'll touch on a little bit more later in the slides, but these include items like oxygen and CPAP, which you can see here are the leading items in total contribution to the 2019 **[inaudible] [00:10:37]** improper payment rates for durable medical equipment items. Next slide.

So, the Medicare fee-for-service DRLS prototype is software that will allow providers to discover our Medicare fee-for-service prior authorization and documentation requirements right at the time of service and right within their electronic health record or integrated practice management system as opposed to going out to different websites outside of their actual regular clinical workflow. So, essentially, the DRLS prototype is introducing automation to what is currently a largely manual process by streamlining workflow access to those coverage requirements, and we strongly believe this automation provides significant time efficiencies to the process of discovering prior authorization and documentation requirements right at the time of service, thereby helping to ultimately reduce provider burden, reduce improper payments and appeals, and improve provider-to-payer information exchange. Next slide.

So, this image here shows how these two Da Vinci Project use cases – coverage requirement discovery, or CRD, and documentation templates and coverage rules, or DTR – make up the DRLS prototype. So, coverage requirement discovery is represented by the top two blue arrows that you see there, and this allows the provider in their clinical workflow to ask the payer the question "Is there anything I need to know or do to support this planned treatment? Is prior authorization required? Are there certain document requirements that I need to comply with?"

The payer will then answer back that either no specific requirements are needed or yes, in which case it includes additional information, such as needing specific documentation in the medical record to support the demonstration of medical necessity or appropriateness and an item requiring or not requiring prior authorization. And then, documentation templates and coverage rules, or DTR, is the second set of blue arrows on the bottom of this slide, which allows the provider to actually pull down the payer rules – in our case, Medicare fee-for-service rules – which show the provider what needs to be documented in the clinical record to support that particular service item that is being considered or ordered by the provider. At this point, I am going to hand it off to Larry to discuss the standards and technologies behind DRLS.

**Larry Decelles**

Thanks, Ashley. Hi, everybody. So, let's take a look at what's going on under the DRLS hood and take a deeper dive into what Ashley presented as far as CRD and DTR. This workflow that you're looking at is one example used to help illustrate the DRLS VPIs, and may not directly map to your particular workflow, but it's meant to show a little bit of the technology we're using. The first three blue rectangles shown on this slide are used to determine if there are documentation and/or prior auth requirements for coverage. For example, a DME nurse might order some durable medical equipment, like home oxygen therapy. The EHR would allow the ordering of home oxygen therapy. The EHR would then compose a FHIR-based message to be used when calling coverage requirements in discovery, shown in the third light blue box above, which is also known as CRD. CRD then runs rules to determine if there are documentation or prior auth requirements for coverage.

In this scenario, a response is sent back to the DME nurse or EHR in the form of a CDS Hooks card, saying there are documentation requirements. In the CDS Hooks card, there's a link that would allow the DME nurse to launch the smart app, also known as document templates and rules, to retrieve templates and rules from a remote repository. Currently, DRLS supports three repository APIs: CDS Connect, a GitHub API, and a local storage API.

Assuming the DME nurse wants to fill out the required documentation, the DME nurse would click the smart app link, which would retrieve the rules and template and populate a FHIR-based questionnaire. Then, the DME nurse would manually populate fields that did not get populated. The DME nurse then would save the FHIR-based questionnaire back to the EHR. At this point, the questionnaire response could be sent to any ancillary service, like a DME fulfillment service, a payer service, and/or a service to get a prior auth number. Next slide, please.

Now, we're going to get into a little bit of how the current prior authorization works. Next slide, please. So, DRLS is made up of two HL7/Da Vinci use cases. Da Vinci is an HL7/FHIR accelerator. A FHIR accelerator is designed to assist communities and collaborative groups across the global healthcare spectrum in the creation and adoption of high-quality FHIR implementation guides and standard artifacts to move toward the realization of global health data interoperability. So, up above is CRD, as Ashley had mentioned earlier. It allows the provider's EHR to ask the payer system if there are prior auth and/or documentation requirements, receiving a yes or no. Then, DTR – document templates and rules – enables the EHR to request and receive documents, templates, and rules from the payer system. It then pre-populates the required documentation.

So, DRLS is comprised of CRD and DTR, so the combination of those two use cases within Da Vinci are what make up DRLS. CRD and DTR are foundational use cases in the Da Vinci electronic prior auth process. PAS is an ancillary use case that is dependent on CRD and DTR, or the equivalent. For example, CRD and DTR are currently used by Da Vinci payers and other vendors to gather required documentation in a FHIR-based format in order to get a prior auth number and/or X-12 translation by a PAS. Next slide, please. I'm not sure if it's slow or I'm not seeing it for some reason.

**Alix Goss**

Larry, I'm seeing a "DRLS and the Clinician Workflow" present.

**Larry Decelles**
Okay, it's just not showing up on my screen. That's fine. It might be me. No worries. So, this is just another recap of the flow. I won't get into it in a lot of detail, but essentially, the clinician would initiate DRLS with entry into the EHR to identify the Medicare fee-for-service payer coverage and prior auth documentation. If the coverage or prior auth documentation is required, DRLS returns "yes," stating what is required and providing a link to the request. When clicking the link, again, DRLS retrieves the required rules and the EHR extracts existing patient data. The clinician manually enters the missing information and completes the documentation – so, this is more of a graphic view of that. Next slide, please. So, we'll go over some of the testing and DRLS standards. Next slide, please. My screen isn't changing, so could you go to –

**Alix Goss**
We're on a timeline slide, the "DRLS Implementation Guides and Connectathon Visual."

**Larry Decelles**
Perfect. As part of the Da Vinci accelerator, we participate in connectathons and HIMSS interoperability showcases. These are the events we have participated in over the past few years. This is where we test and pilot CRD and DTR reference implementation in order to show that the implementation guides are correct and well-designed. We have also developed and validated the DTR implementation guides. For those who don't know, an implementation guide is a set of guidelines about how FHIR resources are used and/or should be used to solve a problem with associated documentation to support and clarify usage. The reference implementation is a standard from which all other implementations and corresponding customizations are derived.

So, you can see above that we have attended several connectathons over the past couple years at HIMSS and also some of the balloting that goes on, so it's quite a process as far as developing a standard and pushing it through the HL7 process. Next slide, please. These are actually links – assuming you're seeing the slide that says "CRD and DTR Reference Links" – these are live links if folks have access to the slide deck. Each use case, CRD, and DTR has its implementation guide. They have a link to the source code. We can see the reference location and links to confluence artifacts, which are all the information about individual use cases that Da Vinci holds. It goes from the beginning, when it was a concept, to where it is now, so you can read up on the status, where it's been, and where it's going in that regard. Next slide, please.

So, this is "DRLS Rule Sets for Pilot Testing." So, on the DRLS project group building up several rule sets – within CMS, we call them "topics." I had mentioned home oxygen therapy earlier, and I won't read this whole list, but it's quite an array of pulmonary-type topics, home health services – so, you get a service there, where home oxygen therapy is a DME item. We're just getting into immunosuppressive drugs or handling medication requests, so it's a lot of mapping of data and mapping of rules to that data and the templates that are involved. Next slide, please.

So, this is similar to a slide that you saw before. It is basically showing CRD, which is the top two arrows, and DTR, which is the bottom two arrows, and it basically shows how we test it in some of our connectathons and at HIMSS. No. 1 is basically a point-to-point test where it would be one provider and one payer, No. 2 would be multi-payer – one provider and multiple payers – and the third is where we get a real clinician

involved to really help us understand and accept the workflow and design of DRLS and try to understand – it's kind of an acceptance test for the provider. And, that's it. I'm now going to hand it over to Nalini Ambrose.

**Nalini Ambrose**

Great. Thanks, Larry. Good afternoon, everyone. Next slide, please. I would like to speak a little to some of the stakeholder engagement efforts that we have been involved in for DRLS. We've seen that industry participation has been such a critical part of our work, so we've engaged industry partners through the convening of a DRLS stakeholder leadership group, and we've gotten a lot of great feedback from the leadership group. It's a group that's comprised of more than 50 members, both from government and commercial industry, including commercial payers, healthcare providers, EHR vendors, et cetera, and they have been a very engaged group. We've seen a lot of success with this group. We do have a couple of co-chairs from the industry who are leading this group. We have a physician from a provider group and a key stakeholder from a commercial payer group, and they've really driven this work forward, and we are getting a lot of feedback about what they see as their needs in a digital solution like DRLS.

And, on a smaller basis, we are also conducting a DRLS work group that is a smaller subset of the larger group that conducts some focused working sessions targeting some specific topics, and we've seen feedback related to topics such as alignment of requirements across the board, data element standardization, integration with clinical workflows, et cetera, so this has helped build a lot of awareness about DRLS, but not just that. It's also to obtain their ongoing feedback and input into how DRLS might be developed and pilot-tested in the future. Next slide, please.

So, we've learned some key lessons in the past two years of DRLS development and testing. We started in June of 2018, so we've compiled a list of lessons learned here, both from a CMS engagement perspective as well as from the stakeholder engagement perspective. The primary lessons we learned from a CMS engagement perspective is that DRLS is really seen as a critical and important first step in building and enhancing interoperability between provider systems and payer systems – in this case, the CMS Medicare fee-for-service system – in order to improve data exchange related to prior authorization requirements. And, in collaboration with HL7 and the Da Vinci Project, which acts as a pilot accelerator – as Larry pointed out, we see that as being a key beacon and mode to help move interoperability progress faster in industry and to keep that engine moving in an expedited way.

And, we also found that in order for the DRLS initiative to maintain that momentum in industry, that sustained leadership is needed with a strong governance process – that's seen as needed, and in addition to developing the prototype itself, we've found that an iterative and incremental development of DRLS has really allowed for ongoing improvements over time, so, with our engagement in HL7 connectathons and other pilot testing efforts and engagement efforts, we've really seen enhancements to the DRLS software prototype itself.

And, you can see that the common factor across all of these lessons learned is that CMS is really seen as a key driver and collaborator in all of these efforts, and the DRLS work could potentially be leveraged across multiple programs that CMS is currently engaged in in other initiatives or better alignment with the interoperability standards that are currently being used. And, we spoke to several stakeholder leadership group members and pilot test participants who all articulated that they see CMS as really a champion and leader in this effort in moving DRLS forward in their collaboration with industry to get the standards to a

tipping for a level of maturity where industry can then pick up and adopt for future DRLS implementation. Next slide, please.

So, again, lessons learned from a stakeholder engagement perspective: We found that there are still EHR vendors who are not up to par with the current functionality that's needed, as Larry laid out. The prototype is being developed with FHIR R4, and, we are currently working with pilot testing with some providers and EHR systems that do have versions of FHIR that are supported by DRLS, and we've recently moved to supporting solely FHIR R4, and we see that the recent interoperability rules by ONC and CMS will really help move that needle forward with health IT systems embracing these current versions of FHIR that would then help deploy DRLS faster in the industry.

And, we see that continued pilot testing of DRLS is really critical to this effort because we are seeing growing functionality in the industry for these standards and for newer versions of the standards, so continued pilot testing is really seen as critical for standards to reach that level of maturity, and we found that clinicians and providers are a key industry player in this group. As Larry pointed out, we are working toward clinician acceptance testing, which has included clinician assessments of how DRLS would fit within their clinical workflow without impeding their interactions with their patients at the point of service and care. And, we also heard through our stakeholder work group members that clinicians really need to understand the value proposition of the DRLS solution – how it would potentially reduce burden at their end – and so, we have been looking at making some recommendations related to the provision in future incentives and really building DRLS with that end goal in mind.

And, again, we heard across the board the need for collaborative work on a solution for clinicians, EHR vendors, and others to really come together to the table to solve this problem in a collaborative and interactive way. Next slide, please. So, there are just three main factors we see at an overarching level for continuing DRLS. One is to establish that solid state for DRLS and establish a solid foundation for the standards to continue developing and maturing, and to make sure we're maintaining that momentum and interest among industry stakeholders, and also to obtain early and ongoing feedback, which we saw as very critical. Next slide, please.

So, in order to continue DRLS development, just to sum up – next slide, please – we see four main components for continued development. The first is standards development, as we talked about: Continuing the development of the coverage requirements discovery and the documentation templates and rules implementation guides and reference implementations through 2021 following the current HL7 balloting process. And also, continued rule set development – as Larry showed, we are also in the process of developing 10 rule sets, but there are various other rule sets that need to be developed in order to get to a point where DRLS could be deployed in the industry. Pilot testing, again, is a critical part of this work, and last but not least, continued stakeholder engagement is something we see as really crucial to the successful implementation and adoption of DRLS in the future. So, with that, I'll hand it back to Ashley to wind up, and we have time for questions and answers.

**Ashley Stedding**
Thanks, Nalini. I know we're just a minute away from 3:40, when our presentation is supposed to wrap up, so I'm not sure – do we have time –

**Alix Goss**
We're going to take Q&A. I was just writing a note to the team. Please go ahead and do your wrap-up. Sheryl and I have already orchestrated offline. We're going to be flexible with the agenda because we certainly want the opportunity for some Q&A dialogue after your super presentation today.

**Ashley Stedding**
Okay, that pretty much wraps it up. If there are folks who think of questions after the fact or who don't want to speak up in the call, we have our CMS mailbox address listed on this slide, as well as the link to our CMS.gov webpage. At this time, we're happy to open it up for questions if there are any.

**Alix Goss**
Thank you, Ashley. The way this works is I'm going to MC us through questions. We'll have members that raise their hands and have gotten in the queue. We'll call on them sequentially. Sheryl, are we good for 10 minutes or so?

**Sheryl Turney**
Yes, 10 minutes.

**Alix Goss**
Sweet. So, Jocelyn Keegan is up first in the queue. Your question, madam?

**Jocelyn Keegan**
I have a two-parter. I want to say thank you, Larry, Nalini, and Ashley. You guys did a great job. I can't overstate the importance of the contributions that CMS and the MITRE team have made on Da Vinci. They've been there since the beginning, and you can see the work progress, not just in this presentation, but in the fact that Kirk Anderson from Cambia and Patrick Murda from Humana are all building on the same base to put this into production, so thank you guys so much. I have a couple of specific questions. I feel out of touch because I haven't talked to you guys in a while, but maybe a couple – when we look at implementations, are you guys actually piloting now? Are there people live with this, or are you still in the pilot/planning phase?

**Larry Decelles**
Hi, Jocelyn. This is Larry. We had a pilot going with Rush Medical University out of Chicago, and then the COVID crisis hit, and that was pretty much put on hold. We had plans to pilot with a few other providers, and we're still talking with them. That's as far as we've gotten with our pilots.

**Jocelyn Keegan**
Okay, awesome. So, you have actually gone into pilots. That's great. A follow-on to that is one of the important points about building to the standards is this concept of testing. Are you guys leveraging the existing testing tools to certify the API itself? I know you guys are in an interesting seat, driving the maturity of the IG, and you're the owners of it from a project team perspective, but you're also the implementers, and I didn't know if you had been exercising people's compliance with these emerging standards.

**Larry Decelles**

Wherever possible, we try to use some of the newer tools. I'll give you one example. There's a new tool called FHIR Shorthand that MITRE developed under the umbrella of HL7, and that's been something that hasn't been easy for folks developing IGs over the last couple of years, so we're taking a hard look at that. It's getting really good acceptance in the HL7/FHIR-based community right now, so we're taking a look at that. And then, other tools – of course, we're using AEGIS Touchstone, and everywhere else, we're trying to leverage some of the tools that we can.

**Jocelyn Keegan**
So, we'll be able to see that consistency in implementation that somebody literally could **[inaudible – crosstalk] [00:36:36]** to another.

**Larry Decelles**
Exactly. One thing we're doing, too, is trying to – because we're building a lot of rule sets, and one thing we're doing is using an NLM tool to build out the questionnaires, and then we're looking at the CDS authoring tool to build out the CQL. What that'll do is give us a somewhat consistent look and feel for the rule sets that we're developing. And then, a next step would be to come out with common pieces of our rule sets that can be reused by other folks as needed.

**Jocelyn Keegan**
Awesome, thank you.

**Alix Goss**
Thanks very much for that. Next in the queue is Arien, and then I think Sheryl is after Arien.

**Arien Malec**
Thank you very much. Great minds think alike. I was going to ask the same question on pilots. So, if I'm understanding you correctly, you were in the middle of setting up a pilot, and now you're on hold in pilots, so the intent is to get back into a true production post-COVID – when you talk pilots, are you talking production pilots? Are you actually using this in workflow to address end-to-end PA for respiratory DME, or are you talking about going through a mock simulation end to end?

**Larry Decelles**
It's not production yet, but ideally, our pilots are as close to production as possible. These are development environments right now, but we're working with real EHRs. Ideally, in a future pilot, we'll be doing more end-to-end, working with real PHIs and that type of thing, so to speak.

**Arien Malec**
Perfect. I got it, thank you. And then, you said you're dependent on R4. Most of the deployed world has been R2 because that's what Argonaut got started with back in the day and what Apple has endorsed, too, so as we complete the system upgrade to R4, is that an ecosystem dependency for you guys?

**Larry Decelles**
We built out two of our rule sets with SQ3. We're going to build all of our new stuff toward the new R4 4.01. DSQ2 – depending on where we're integrating, we're actually working out – now, we're working out an

integration with Cerner, and a lot of their stuff is DSQ2, so we have some of that capability, but the new – we're not going to remove the older DSQ2/SQ3 code, but all new development will be R4.

**Arien Malec**
Got it. Again, just for the rest of the task force, the back story here is that Argonaut got started when we were in an R2 world. Most of the deployed footprint for FHIR-based APIs is deployed around R2, and then, R3 came out, and most people decided to skip it and go to R4, so we're in the middle of a broad-scale upgrade. And then, the preconditions for getting this capability to work is primarily that folks have implemented decision support hooks. Is that right, or are there other preconditions that are foundational?

**Larry Decelles**
Yeah, that's part of CRD. We currently support the order sign hook and order select hook. Those are the two newer hooks. So, we do have order view and medication request. Those have been deprecated, as you might know, but we still support that. Moving forward, it will probably be deprecated in our code.

**Arien Malec**
Got it. So, there are some preconditions for implementing decision support hooks, and then some preconditions in terms of what sorts of triggers are supported. Fantastic. And then, how are you assembling your network – you're basically going party by party, health system by health system to look at who wants to volunteer, and then working with your EHR vendor to implement to your specification. Is that the way it's working right now?

**Larry Decelles**
Yeah. Nalini, do you want to talk about some of our pilot research and pilot participant research? You might be better at responding to that.

**Nalini Ambrose**
Sure, Larry. I'm happy to. Yes, we did. Last year, under the aegis of HL7, we actually surveyed a lot of EHR vendors, provider systems, associations, and so on, asking about their current functionality and asking about their interest in potential pilot participation. We also conduct special open-door forums sponsored by CMS, where there is essentially a net cast out for pilot participants. We've received interest there. We've also focused on HL7/Da Vinci members and used the members to essentially connect us with other healthcare systems that may have the current functionality to move us forward. So, we have a good, solid list of potential pilot participants for this first round, and as Larry pointed out, we've engaged with several of these provider groups and EHR vendor systems, and we've looked at the combination of larger systems versus smaller clinician practices, larger EHR vendors versus smaller vendors, different geographical areas, and so on, so there's some criteria for selecting potential participants, but if you are aware of other participants, please feel free to let us know, and we're happy to connect with them.

**Arien Malec**
Got it, thank you. Go ahead.

**Alix Goss**
Sheryl, I think you had your hand up. If you have a question, great, and if you don't, okay. So, we had one last question that came in the chat box from Raj about whether or not you're planning to share the rule set.

**Larry Decelles**
Good question. It's open source, so certainly, we will be sharing those, and as we develop – they're on the internet now on GitHub, if you're familiar with GitHub. So, you can click the links that we have in the deck where it says "Reference Implementation," and you can drill right through to the Da Vinci – basically, the root repository in GitHub, and then, you can get all those rule sets.

**Alix Goss**
Terrific. Raj appreciates that answer as well. He's in the chat box. So, this has been a really great presentation. It's another view of how the marketplace is advancing our ability to interact related to prior authorization, medical necessity, and tech coverage requests using emerging technologies, and builds out the presentations that we've had so far, and we'll have a couple more over the next month, but without further ado, I would like to say thank you to our presenters and turn it over to Sheryl Turney to take us into the next portion of our agenda related to data classes.

**Sheryl Turney**
Thank you so much, Alix, and with all hope, my phone will get connected this time. So, I am sharing – can we go to the next screen with what I'm sharing? Can you guys see it?

**Alix Goss**
However, we're not seeing – okay, I think they're trying to bring it up now.

**Sheryl Turney**
Yes, they're trying to bring it up now.

**Alix Goss**
Just as a point of reference, can you see any of the Adobe Connect boxes?

**Sheryl Turney**
Yes, I can, but right now, it's still saying "stop sharing," but I can't actually see what's being shared. Can you see this?

**Alix Goss**
Yeah, "patient identity," "patient demographics," "insurance plan."

**Sheryl Turney**
Okay, perfect. All right, so, I want to start here. In our meeting last week, we talked about the definitions that were added to many of the data classes. There were a few questions that were raised, so we went in and added some narrative related to those. One was patient identity. We added a question in terms of whether there were any data elements specific to patient identity that must be shared between constituents specific to a prior auth request or this information about a member beneficiary was sufficient for purposes of prior auth. No one has gone in and added any notes related to this. I can at least add from a payer perspective what is required in terms of patient identity, but it would be good from those that are more aware of – especially some of the prior auths that we were talking about for medical devices, which I think

in particular may require patient information that may be different that would be helpful here. That would be great to add.

Since we met last – and, I'll scroll back so you can actually see it – we added a few additional classes, and one of them was a prior authorization response. One of the things I wanted to bring up is if you look at the picture that CMS just brought up with the DRLS and the CRD, we're back and forth. In our prior authorization HL7 meetings that we're having, which we're having every week as well, we talked about those use cases because they're the basis for everything that's done with prior auth, even beyond the CMS work. But, I specifically questioned whether or not we needed something specific for this in the Da Vinci model, and the response that I received last week was that if we have and send a request, if it's still pending, we're going to get back a response that basically allows the clinician to know whether it's been approved, denied, or pending.

Now, it's not going to give you a status unless you put in the request to check on that status, so it's not going to be automatic, but that functionality is present in the way in which the use cases have been designed based on the Da Vinci use cases. So, I wasn't 100% sure of the best way to represent that, but what I defined it to be is the information provided by the payer in response to a provider request regarding the treatment, procedure, service, or product for which the prior authorization was requested. The response could be an acknowledgement of receipt of the request, which could happen via one of the transactions – an X-12 transaction – or a request from the payer for additional information from the provider. It could be an approval or a denial.

So, that's what it is, but it doesn't necessarily mean that we have to utilize a separate use case in order to get this status, but we called it out so that we as a work group would realize that there has to be functionality that supports the status, and we would then have to determine how we would want to move that forward if we say we want to somehow accelerate the pilots for Da Vinci so that these services, which are already existing in the Da Vinci use case model, can be more widely and quickly adopted. Does that make sense? Okay.

So, the next one was the prior authorization rules. Also, this is covered based on what we just saw in the CMS request, and I wish I could flip quickly over to that slide, but that's not the way this data-sharing thing works. But, there is a slide there as well that basically either brings back the rule or brings back the documentation requirement, and what we defined this to be was the information provided by the payer regarding the coverage rules, which the prior authorization requester must satisfy in order to obtain approval. So, that's what this category of data is, and then, again, we need to populate over here to the right how that would be delivered or what state that is currently in relative to some of the work that's already being done by CMS and by HL7 and Da Vinci because parts of this do exist.

There also was the discussion in the HL7 meeting last week about one of the vendors, who they mentioned earlier today, who is doing some work to actually make these rules more available as an add-in to the EMR system, and again, I don't know if we'd want to speak to that in our recommendations related to how that would work, but that's also something that does exist out there that we should at least be aware of and acknowledge.

The next one was the prior authorization data requirements. And so, I defined this as the information provided by the payer regarding the data required to be submitted by the provider detailing the data required to be supplied to the payer to support the PA decision. So, I probably can reword that one. I think I worded that one awkwardly, but if anyone has any suggestions, please let me know. Otherwise, I'll try to improve that one so it's a little bit clearer and more efficient. I'm just going to take a pause. Are there any questions about what we added to the definitions? I think there was one more, which was down here, which is the reason for denial.

This was the response from the payer to provider indicating the specifics of what elements of the predefined rule were not met and why, allowing the provider to have insights to improve their processes to either avoid seeking authorizations that do not meet the rule criteria, avoiding unnecessary administrative work, or to ensure appropriate capture for items that do get approved, avoiding administrative cost and burden on appeals and rework. And, we actually discussed that one quite a bit last week, so I did want to call it out.

And then, I added that we updated the prior auth status, which includes information related to the status of a prior auth, which really is the second half of the one above, which is the request for the status – this is just the response – and then the prior auth appeal, which is the additional information provided by the providers to the payer satisfying the requirements specified in the prior auth response data class, such as documentation, supporting medical necessity, history of past treatments provided, clinical diagnoses, and responding to any gaps identified by the payer or supplemental information required. So, these are the things that changed from our last meeting, and so, now, please weigh in.

**Alix Goss**
Okay. Sheryl, at this point, I see one hand raised so far – Alexis.

**Alexis Snyder**
Hi, yes. So, I don't see any of the pieces we talked about transparency and information to the patient in that flow, and then, I also don't see a piece where we talked about if PA is denied. We had some wording in there about clear documentation for the denial, and not just necessarily a miscellaneous code.

**Sheryl Turney**
Patient transparency – all right, let me add that so that we work on that for next week, Alexis, and then, let me go up to the denial. Hold on a second. All right. So, here, we need to add the requirement to have a complete explanation, and not a general code.

**Alexis Snyder**
And, that's across the board. That's part of the transparency as well because EOBs and explanations come to the patients as well, and they quite often have a 999 miscellaneous code.

**Sheryl Turney**
Okay, I captured both of those. And, we do have another opportunity to discuss these coming up in the next couple of weeks.

**Alexis Snyder**

Okay. We just discussed them in great detail and added a bunch of stuff that's no longer there, so that was my question. So, there's still a lot of patient transparency throughout the process. That's not there anymore.

**Larry Decelles**
I thought that was in…

**Sheryl Turney**
I didn't pick this up, so I don't know what you're – I don't know what happened because it wasn't there when I went out and worked in the workbook.

**Alix Goss**
So, we need to circle back around. Folks, keep in mind that we're in the "data classes" tab, not the "guiding principles and ideal state" section, which we've actually taken out of this portion, and we're not using that tab. We're using a Word document, so please don't muddy the waters by going to that tab because we've transformed that work…

**Sheryl Turney**
I think that's what happened. I think that's what you're looking for, Alexis, and it wasn't in this tab.

**Alexis Snyder**
It's not, but we can talk about this offline. I'm talking about data classes.

**Alix Goss**
Yes, because Alexis, it's actually playing in both work groups now because we're on a hiatus with the large guiding principles and ideal state discussion, whether we take the small –

**Alexis Snyder**
No, I'm not in the data class group, Alix. It was on the call for the full task force last week.

**Alix Goss**
Sorry for the confusion. You're the data modeling. So, Jim Jirjis, bring us home with the last question, and then we'll pivot to next steps.

**Jim Jirjis**
It's along the lines of what she was just saying about when there's a denial, I think we should be more explicit in the reason for the denial than just saying – not allowing a miscellaneous code because the denial should – we should be precise to say that the denial should demonstrate either what data was missing and what rule was violated that led to the denial instead of some super category that doesn't mean anything to anybody. I'd hate to have people just rename "miscellaneous" to something equally abstract. I think that the reason for denial should be tied to the rules and what didn't meet the rules specifically. Is that clear?

**Sheryl Turney**
I think that's clear, and I added that note. Unfortunately –

**Alix Goss**

And, Alexis is –

**Jim Jirjis**
I'm not saying – what cell?

**Sheryl Turney**
Sorry, I just want to clarify that I don't have access to the Google doc. I had to copy this down, so you won't see these back there until later.

**Jim Jirjis**
Oh, I'm sorry, I thought you were changing things and it wasn't happening on my screen.

**Sheryl Turney**
No, I can't. My work firewalls us off from it, so I have to incorporate these later. All right. Any…?

**Alix Goss**
Okay, I think we're good. It looks like Alexis was supporting Jim's point, so let's go ahead and pivot back to the regular slide deck. We're going to talk a little bit about timelines and next steps, making sure that we have time for public comment, which we'll put up as details in probably about 10 minutes or so for those in the public that would like to make some comments, so you have the appropriate instructions. But first, let's go ahead and talk about our ICAD task force timeline. As I noted at the beginning of the call, we had a little bit of an epiphany around our availability to present to HITAC over the summer during their hiatus, and realized that was sort of a gift because we have the ability to add a few more presentations from the marketplace to help us with our broader thinking around the prior authorization activities, and also to get some – thinking about workflows, EHR integration, operating rules, and granularity of messages.

So, we have had a number of contacts and idea generation to support presentations being scheduled over the next month or so. As you can see on the screen, we are looking to have AHIP present an update on their piloting efforts. At next week's call, we may have another presentation. If not, we'll be jumping into some other content discussions. We think we may also be able to have a presentation on the 16th, but we're leaving those as TBDs until we get confirmation, but we are slated on the 16th to have the privacy and security ideal state and guiding principle discussion. We've had a short run of meetings that are going to produce content for presentation, and to be incorporated into the word document that we've already been reviewing, so we'll likely give you some updates on that larger document in addition to the privacy and security content that Jacki and I have been working on with Denise, Ram, and a few others who I forget off the top of my head.

So, following the June 16th mid-month touch-base, we're looking to have a HEMA and CAQH core present to us, and on the 30th, we'll look at process mapping discussions and a little bit more about the integrated federal data model discussion and alignment that we started last week. By July 7th, we hope we'll be able to wrap up the data classes and the overarching ideal state and guiding principles, and if we haven't already started some recommendation brainstorming, we'll take a deep dive into that. Mid-July, we're going to pivot to the convergence of clinical and administrative data, really taking the work that we've done with the exemplar of prior authorization and start to bring it up to a larger level of focus and abstract to the areas we think we need to consider as a part of our upcoming report.

To that end, we're going to need to start to develop those draft recommendations not only for prior auth, but also the larger intersection conversation. On the Google spreadsheet, we've created and have been updating a tab related to an outline for the report format. We will need to figure out how to divide and conquer creating the report, but we feel like in June and July, we'll have a lot of good content developed that will help give us a framework that we can start to write towards.

We think that by August 4th, we can start to have a full set of recommendations – at least, in draft form – enabling us to iterate through that in August, and then, on September 9th, to present those draft recommendations to HITAC for feedback, enabling us in the month of September to then start incorporating that feedback and producing our final report and submission on October 21st to HITAC.

To add to the overall timeline, I want to talk a little bit about next steps and then open it up for some questions and discussion. We are definitely going to need everybody to roll up their sleeves and give feedback on the workbook. We will need membership support on the outline of the report and initial recommendations. I've talked about what's coming up in the queue, and really, this coming month is focused on a variety of presentations and taking all the work we've done so far and producing the first set of discrete and concrete prior authorization-related recommendations because you guys are probably – hopefully can still hear me, but I have just lost my connection to the network, so I can't see any of the control panels or manage Q&A. Sheryl, now it's your turn to jump in.

**Sheryl Turney**
Don't worry.

**Alix Goss**
Awesome, thank you. And so, without further ado, I think we should open it up for questions, whether it's on the timeline slide or on the next steps slide, which I happen to have already open on my desktop, so I'm happy to take questions along with Sheryl.

**Sheryl Turney**
All right. So, hopefully, people will have some questions. I don't see anybody's hands raised right now.

**Alix Goss**
So, one of the things that's important for us all to factor into this timeline is that we did a checkpoint about two months ago to see if we needed to look at our schedule differently and how to be respectful of what's happening in the landscape with COVID and the demands on our schedules, and we thought we should continue on a weekly basis. We thought that we could still make our target. We've got a little bit of breathing room with the extra month, but we still have a lot of work to do, folks, and I want to be considerate of the summer months where people might be taking some time off.

So, hopefully, folks can start to think about how their summer schedules look, take a look at the workbook and the report outline, and think about where you want to play in drafting sections of the report or helping to create an outline of a section of report or even specific recommendations. That offline work has been tremendously helpful in advancing the effort, so we all have an opportunity to continue to influence the trajectory because as you know, I'm extremely interested in having this time be different, and that we really

make concrete recommendations that can be acted upon, reduce burden, and increase efficiency, and the quality of the experience for the patients. I have now returned to the land of Adobe panels.

**Sheryl Turney**
Okay. I'm still not seeing any hands raised. One of the things we could also talk about, Alix – because we have a little bit of time before our public comment – is volunteers who might want to start talking about the sections of information that should be covered in the final report because we are definitely going to need some help with the writing of the report, so if there are stakeholders on the meeting today who would like to volunteer, we can at least start aligning those folks to different parts of the work that we would like to get done. I think Arien's got his hand raised.

**Arien Malec**
Yeah, thank you. I am more than willing to volunteer on the end state and that level of work. One thing that we haven't talked about as a task force are policy levers. We've talked a lot about what this should look like and about a current-state landscape. I don't know if that's in our remit or not, but in my experience, policy levers make the world go round.

**Sheryl Turney**
I don't know if we lost Alix, but I think –

**Alix Goss**
Alix is here, but I feel like we just lost Arien. Did you finish?

**Arien Malec**
No, I did finish. I said policy levers make the world go round, and then I dropped mic.

**Sheryl Turney**
I think that's an excellent point, and I do think we need to devote some time to talk about policy levers and make sure that's a topic on one of our future meetings, Alix.

**Alix Goss**
Got it. Thank you very much.

**Sheryl Turney**
We have one more question from Jocelyn before we go to public comment.

**Jocelyn Keegan**
I was just going to volunteer to help work on what the outline of the report should look like.

**Sheryl Turney**
Fabulous, two volunteers.

**Alix Goss**
So, maybe what we'll do is start forming a small group, and Sheryl and I can chat with that when we – we always have a debrief after these calls, so we'll start to think about that and engage with the volunteers.

Thanks so very much. You both have been volunteering quite a bit, and I appreciate your time and ongoing support.

**Sheryl Turney**
Exactly. Do we want to put up the public slide for public comment?

**Lauren Richie**
Sure. I also put the phone number in the chat box, so while we get the slide pulled up, operator, if we can open the public line.

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

**Lauren Richie**
Okay. Alix and Sheryl, I'll let you know if any others come through.

**Sheryl Turney**
So, Alix, I don't know if you wanted to add any other commentary to next steps, but I do think we would be – it is not too soon, as Jocelyn and Arien have already volunteered to step forward. If you can participate, I think what we had talked about doing in terms of the final paper – which I think will help us in the meetings also because we're probably going to take quite some time to develop the content for that paper – is to start working on what should be included in each of the various sections, and that will also help ensure that we've included all those topics in our general discussion, and that we have multiple iterations because we have lots of people taking notes, but as was even evidenced today, not everything is captured the way the participants intended the first time, so we want to provide ample opportunities for you to see and ingest all of the work that we are doing and putting forward, and then be able to massage those papers, and time does fly.

Here we're already in June, and time is ticking, so we want to make sure that we have ample time in order to develop recommendations to outline what the various levers are in terms of moving the agenda forward, and then, specifically what we're going to try to recommend – we haven't even really started talking about those recommendations.

The other group that has been working offline – the privacy group that Alix probably touched upon in the beginning – is still working to develop their material to present, and also, the group that was working on the process models. There's been a lot of discussion going on in terms of what the process models will look like. It's a couple weeks off, but I do want to indicate that that work has started, and folks are spending time on trying to make sure that what's presented is the most useful for this group to process and be able to comment on and help move our work forward. Any other questions or comments at this time? Alix, I don't know if you wanted to add anything.

**Alix Goss**

I don't. I think you summarized it. I think the ongoing support of the members is great. I really think that we'll look to create a small working group with Jocelyn and Arien, and we'll look for other volunteers that might want to help with that report-framing brainstorming and getting us going on the policy levers as well, so if you're game to play there and influence the starting point for subsequent discussions, I highly encourage you to raise your hand, reach out, or send an email. We'll certainly include you. Otherwise, we'll go ahead and get going with the small group. Don't feel shy about volunteering.

**Sheryl Turney**
That sounds good. Has any public comment come in?

**Alix Goss**
No. Katherine just indicated in the chat box that no others have come in. I think what we do is give everybody back eight minutes of their day.

**Sheryl Turney**
I love that.

**Lauren Richie**
Thanks, everyone. Have a good day.

**Sheryl Turney**
Thank you.

**Arien Malec**
Thanks, all.

**Jim Jirjis**
Thanks.

**Alix Goss**
Bye-bye.

**Alexis Snyder**
Thank you.