Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

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

February 16, 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
John Kelly	WEDI	Presenter

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

Mike Berry
And, good morning, everyone, and thank you for joining the Electronic Prior Authorization RFI Task force. My name is Mike Berry with ONC, and we are always pleased to see everyone joining us today, so, thank you, and a special thanks to our task force cochairs and all the task force members. We are really happy that you could help us out with this project. As a reminder, your feedback is always welcomed, 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 will begin with roll call of our task force members, so when I call your name, please indicate that you are present, and I will start with our cochairs. Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Tammy Banks?

Tammy Banks
Good morning.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Dave DeGandi? Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry
Jim Jirjis? Rich Landen?

Rich Landen
Good morning.

Michael Berry
Heather McComas?

Heather McComas
Good morning.

Michael Berry
Aaron Miri? Patrick Murta? Eliel Oliveira?

Eliel Oliveira
Good morning.

Michael Berry
And, Debra Strickland?

Debra Strickland
Good morning.

Michael Berry
Good morning, everyone, and thank you, and now, please join me in welcoming Sheryl and Tammy for their opening remarks. Sheryl, Tammy?

Welcome Remarks, Review of Plan (00:01:36)

Sheryl Turney
Thank you so much. As you can see, we have a very packed agenda again today. Thanks, everybody, for attending. We are making fabulous progress. We want to thank everybody for their input, their robust conversations, and updating of the Google doc, and their comments. Today, we have a special speaker, John Kelly from WEDI, who is going to review some information with us regarding attachments for C-CDA and FHIR, and we really appreciate him taking the time to come speak with us today. I know that is going to answer a lot of questions that people have about attachments specifically. Also, we will have our working document session. Tammy is going to lead us through the document. The homework assignment for today was to review the questions in Section 3, and that is what we are going to focus on in our conversation today, so we do appreciate that, and we do believe we will get through that entire portion in today's call. Then, we have opportunity for public comment at 11:20, and then we will review our next steps and homework. We can go to the next slide. There we go.

I just wanted to show everyone the work plan in terms of where we are and where we are going. As you may recall, we do have an update to HITAC that Tammy and I will be providing tomorrow, and that is just going to give them a highlight of how we formulated, what our process is, some of the basic discussion that we are having around our recommendations because as you know, this has been a very short time period that we have to do our work, and then we will highlight for them, hopefully, what we will be submitting as a final product in the March 10th HITAC meeting.

The other thing is that we have been discussing potentially adding, for any of those that are able to join, an additional work session on March 7th, and that would be specifically to do any last-minute final edits to the report and/or the presentation that we anticipate to put forward to HITAC, just to give everybody the opportunity to have a final word before we actually do the final submission. Any questions from the subcommittee on our work plan? All right, I think we can go to the next slide, and then, Tammy, would you like to make any comments?

Tammy Banks

If I could just introduce John again, I know you did it well, but John Kelly is presenting on behalf of the Workgroup on Electronic Data Exchange. He is going to be presenting on the current state of attachments. He is principal business advisor over at Edifecs, and task force members, just a reminder to place your questions in the chat because we are going to hold all questions until the end, just to keep the presentation short, concise, and to the point since we have a lot to cover today. So, John, I really appreciate you taking the time to work with WEDI and compile this presentation, so, take it away.

Attachments: CCDA and FHIR (00:04:59)

John Kelly

Thank you, Tammy. I appreciate the opportunity. Next slide, please. So, I think when we talk about attachments and what we in the industry need to do in terms of moving forward in some kind of agreement as to how we are all going to think about attachments, it is important to understand the context. If someone discovers a new, dangerous virus in St. Louis and needs to ship it to the CDC, if they just stick it in a box and write on the outside "CDC Georgia," it is not going to be an effective payload. It needs to have an address on it, it needs to have a symbol for hazardous waste, so we need to think about attachments within the context. Take the standards out. What are we trying to accomplish? What are we doing? When you think about PA, really, the job that has to get done in terms of the movement of the attachments is the transaction, the process needs to address administrative metadata, just the outside, process articulation to support routing so you can automate it, process automation support, the things that are included in the overall payload beyond just the "attachment" in order to support real automation of an end-to-end process.

And then, what is critical in PA: The body of information of patient data itself is really not of high value unless you understand the eligibility and the benefits and requirements surrounding it, so when you think about the attachments process, you have to address the metadata and the administrative components. You also have to address the transport and the process mediation: The connectivity, the orchestration, the state management. And then, the clinical presentation itself, and if we think about the history of attachments, and the progress, and the setbacks over the last 10 to 15 years or more, what has really been missing? In terms of meetings I have attended and listened to, it is the clinical presentation component. When you are doing prior authorization, there is a component where a provider or somebody says, "I want to do this test, I want to do this procedure, and I am not sure whether I should or should not. I need to review this."

So, they talk to a specialist, and the first thing the specialist really says is, "Present the patient to me. Articulate what is the information that you want to share with me." And, when you think about an automated process between prior authorization with payers and providers, first, you have to articulate what is the information you need, what is the request for additional information. And then, the key thing that is really the hampering element: When the AMA cites 16 hours a week per doctor for supporting prior authorization, a lot of that has to do with what I will call the articulation of the RFI, telling the practice what information they need, and somehow being able to, in an automated fashion, extract that information from what is documented in the EHR, and then organize that in a structure and a way that it can be transported back. Next slide, please.

So, this clinical presentation component is really the context where we are really wrestling, and have been, with attachments. So, when you look at what are the contexts in terms of the transaction, and when we look at attachment solutions and standards, the X-12 has a long history of supporting this business-to-business automation across industries, all of the metadata that you need to route things. When you look at C-CDA

and you look at FHIR, those are heavily focused on the clinical payload, the clinical information, and the interaction with the EHR, but they do not have the history of understanding what is all this extrinsic metadata that is required in order to actually automate the process, take those 16 hours a week off the doctor, allow clinical decision engines to work on the part of the payer, all that administrative metadata, different transactions address different components.

Same thing with the transport and the mediation, same thing with the clinical presentation. FHIR itself was designed in response to the places where there were gaps in C-CDA and other methods like LOINC to actually say this is what I need, and how do I actually get it out of the EMR without having providers and provider staff have to sit down in front of a keyboard and key things in, or pick up the phone, or write it down on a fax. Next slide, please.

So, when you look at these components, this context of the attachment, if you want to address the administrative metadata, the X-12 278 and the 275 have got lots of research and development in terms of addressing what is the metadata you need, and then, the component in terms of what is the clinical information. When you look at the Da Vinci IGs, the CRD, the DTR, the coverage requirements documentation, the documents, templates, and rules, those things to articulate at the administrative level what is the information I need and what is this for.

And, when you get to the transport and the process mediation, the 275 and the 278 at X-12 have a lot of history in terms of supporting the ability to say this is what it is, the address on the box to the CDC, Dr. So-and-So at 15 Main Street, Atlanta, Georgia, here is the ZIP code, and a little sticker that says, “This is biohazard, please be careful. Take it to the special entrance.” All that other stuff to manage the transport and the mediation. And then, the HL7 C-CDA also has history from the development of these processes to be able to support that. And then, the clinical presentation itself, the articulation and the extraction of the data from the EMR, the HL7, the C-CDA, and the Da Vinci FHIR and DTR PAS guidelines, the prior authorization support.

So, that is really the context of what we are talking about when we think about attachments and how you match the message to the medium, address everything in its totality. We do not just want to solve “I can send the payload, I can put something in a box and move it.” I want to make sure that the box is going to take off from the right place, that it is going to move through the right process in the middle, and that when it gets received, people know what it is, what to do with it, and most importantly, a machine can address all this from the metadata and the contents, the outside of the box and what is in the box. Next slide, please.

So, when we look at the RFI specifically, the word “translation” was used, and I know myself in a lot of conversations we have in various forms around PA, people talk about this translation. What is the right standard, FHR vs. CDA vs. X-12? I think we get into “Isn’t translation overhead a challenge?” Well, machines handle translation every day for us, on our iPhones, everyplace else. We have all kinds of formats of data, of music, of videos, and those iPhones address all of this in machines so people do not have to get engaged.

When you think about current process in healthcare, we take clinical data out of EHRs every day and map them to what is needed to perfect a claim in the PMS system, and then move it over to the payer using X-12. It is done billions of times a year, probably. And, the mapping of HL7, NCPDP, LOINC, X-12, FHIR, all

of this data in everybody's data warehouse and everybody's data repository, every day, we are mapping and translating data so that we create value out of it in the data analysis forms in the country, and every day, payers, clearinghouses, PMS vendors, and EHR vendors are currently supporting mapping work flows with the tooling that is in their system.

So, maturity matters in terms of these standards, but I would argue that we are using these standards every day. They do exist, they are mandated, they are out there, and what really matters more is the maturity of the workflow. So, when you think about adopting an attachment standard, you have to think about it more in terms of the work we need to do actually has more to do with the workflow, and when you are talking about workflow, you are talking about humans, and when you are talking about humans, and workflow, and doing new development in workflow and process, that means you want to rule in options, not rule them out. So, when you are talking about translating, and the various standards, and saying is it HL7, is it NCPDP, is it LOINC, is it FHIR, is it this, is it that, that is a distraction. What we need to focus on is what are the standards that can work, that are flexible enough to let people build workflows around them that give them the wiggle room they need within the process, but still an opportunity for standardization. Next slide, please.

So, the fundamentals of reducing burden… Let's talk about the standards themselves. Some of this stuff I have here is mom and apple pie, but in the second bullet here, C-CDA and FHIR are mandated capabilities for EHRS under meaningful use in the CURES Act. C-CDA goes back to the requirement and the certification in the EMRs under meaningful use going back to 2015 to be able to produce those C-CDAs. That capability exists. FHIR, under the patient APIs and the upcoming rules: These are mandated capabilities that are required for EMRs as well. So, these capabilities exist. When someone says the industry is not ready with the technology, the technology is there. How it is used, what IGs, what profiles, certain ways of incorporating that technology into the workflows, which I was referring to before, is definitely work to be done. Again, I would put forth that it is the maturity of the workflow, not the maturity of the standards, that matters here.

We also have billions of dollars invested in an X-12 highway that supports scalable machine-to-machine workflow integration. So, thinking about the first slide where you match the message to the medium, what transactions, what standards fit to really compose an end-to-end process that is going to reduce the burden on the providers, the payers, and most importantly, the patients? And, when you think about the other example, what is out there today that we know is working, in the appendix, there is some data and some information from Anthem, NGS, and CAQH that they demonstrate significant adoption, again, millions of transactions moving using fully electronic transactions, leveraging clinical standards like C-CDA, and also the X-12 transactions, the 278, and the 275, and the 277, and whatnot. These transactions are in place. They are working. They have not scaled across the country, they have not been broadly adopted, but again, I would put forth the idea that that is a result of not building the workflows, not a situation where the standards themselves are immature.

And, if we look back on the mandates driving the automation, if we look back at claims and eligibility in e-prescribing, these are hugely successful transactions, not because the standards were necessarily ready. There was not a lot of familiarity with some of these standards initially, but as soon as people were committed to developing the workflows around those… Just about every medical and **[inaudible] [00:16:03]** claim today comes in electronically. Billions and billions of transactions for eligibility, supporting convenience for patients, for providers, and first-pass claims pay rate at payers.

And then, e-prescribing. I am sure all of you have the experience when you walk out of the doctor's office, they say, "What is your pharmacy," and half the time, by the time you get to the pharmacy a couple hours later, it is actually already ready. So, learn from those fundamentals of reducing burden, learn that the transactions are not the problem, the technology is not the problem, it is the commitment to building the workflow around things that exist today. Next slide.

So, I have addressed most of this. At the last meeting, Hans brought up, and Tammy to some degree, the idea that when you cross business units, how do these standards apply? You talk about the X-12 environment in the billing area, but you talk about the FHIR and C-CDA environment in the provider setting, and that when you think about PA, it has to cross these various business settings within the office and the industry, and when it gets to the payer, you have another set of business processes. I think the key thing that you hear is you want to build an end-to-end process that crosses boundaries within and outside of an organization. The key, really, is mandating the process and the technology certification that drives the capabilities that exist in the community. I think what frequently happens, anyone who has been involved in any kind of process redesign in an organization, where it starts out is everybody says, "I need the process to do this, I need the process to do that," and you cannot build a process that makes everybody happy.

So, what you have when you mandate a standard for attachments, think about that people have to agree on what the standard is and that the actors in these processes and these various work environments have to plug into the process rather than trying to design a process that plugs into every actor in the industry with every business process they are doing. Next slide.

So, we know prior authorization and attachments really go hand in hand. It has been a question implied within the RFI and whatnot. I do not think I really need to address that as much here, though, but I think that the RFAI, the attachments process, and this goes back to the original NPRM that came out of CMS and the recommendations from NCVHS, we have to think about attachments as part of the broader process in the industry of requests for additional information. So, whatever standards we pick, we might solve the problem for prior authorization narrowly, but if we have not applied that to appeals, to chart pulls, toward claims, if we do not have a common process, a Swiss Army knife, essentially, for every actor that allows them to do all these different processes in any situation where a request for additional information is the underlying need, then I think we have done a disservice to the industry.

And, that is why when we look at, for example, the Da Vinci IGs, I noticed when Viet did his presentation last time, it sounded to me like a couple of people were not aware that the Da Vinci PAS IG included the orchestration and the integration with the X-12 processes. So, when you go underneath, the Da Vinci IGs are not just FHIR IGs, they are process and solution implementation guides, and they really do address an end-to-end process. And so, the process they describe there, which supports requests for additional information, all the way from CRD, through DTR, to the PAS is generalizable. The process for someone to request additional information, to articulate what it is they need, and then to move forward and get the process completed is in that IG. Next slide.

So, these are general knowledge. I think the key thing is following up. The one thing on here that I think from a recommendation point of view, the Da Vinci IGs do set out, alongside HL7 for C-CDA and along with X-12 for the 277 and the 275, these are the core components we believe are existing, mature capabilities

that can support not just prior authorization, but all of the processes. So, I am going to stop there so we have plenty of time for questions because I covered a lot of information very quickly here, and I want to make sure that people are getting where we are coming from.

Tammy Banks
Thank you, John. I had asked the task force members to put the comments in chat, so I am going to run through them quickly so we can try and get as many questions answered as possible, and then we will address any other questions. The first one was "Can you speak specifically to use of C-CDA 275 for prior authorization?" And, I did pass the information from the slide deck in regards to Anthem and their usage of the claims attachment because most claims operating reports have payers map their PA criteria data points to the CDA document to ensure that CDA captures all the necessary data, and does the CDA have all the data points requested in a FHIR questionnaire.

John Kelly
That is a lot. So, this goes back to when I started talking about can the payer articulate the request. So, can you articulate a request using the standard CDA and X-12 process using a LOINC code to say, "This the information I need"? Yes. But, when you think about why the C-CDA may not have been broadly adopted, what you end up with on the provider side is not a lot of granularity and specificity, and when the JASON Report came out in 2014 telling everybody in HIT that we really spent billions of dollars in the wrong direction because we did not realize there was this thing called the internet, and Google, and those technologies, that is what made FHIR come along.

So, C-CDA is document-based exchange of information, so you basically have to say, "I need a specific kind of report, a radiology report, an ops note report." That is somewhat cumbersome. So, what the industry tends to do, whether on the payer or provider side, is to say, "Well, give me the one-size-fits-all report, I will just cram all the information in there," and you get a very sparse, structured document. The other thing about CDA vs. C-CDA, I think 2.1, is that in the general C-CDA, which a lot of the documents at Anthem are coming in in, you can put an unstructured payload inside of the structured envelope inside of CDA.

And so, I get back to do not rule options out, rule them in. Any kind of rule can be written in such a way that there is some flexibility on the part of a provider who cannot look at the granularity of a FHIR resource request, which can be highly granularly articulated, the payer can say, "Using clinical quality language, CQL, this is specifically the data I need." That can be translated into FHIR resources, the very granular FHIR resources can query and interrogate the EHR, and pull out exactly the information that the payer needs to answer the question yes, no, or maybe on the prior auth request.

When you look at the CDA, it is like, "Well, I need this general type of information. Can you give me that?" This gets back to when the specialist says to the PCP, "Present the patient to me." Here is a kind of show-up-and-throw-up approach to "This is everything I know about the patient," push it into a CDA document, and then push it over to the payer, and then the payer can go through it and take what they need. That is a step forward.

Ideally, the three Da Vinci IGs together allow a very targeted articulation of the request on the part of the payer, a very targeted, specific response in terms of whether a PA is needed and required, and also a very automated ability to take that articulated request and interrogate the EHR to pull the information out so that

the doctor is not sitting there filling out forms and questionnaires. So, that is nirvana, but if you look at the accommodation within the HL7 standards and the 275 standards, it gives people the wiggle room to jump into the process where they are. It is kind of like if you think about here is the superhighway, it has three lanes. Some people are going to jump on the onramp, stay in the right lane, and go 55. Other people are going to jump in the middle. Some people are going to jump right onto the highway, move to the left lane, and fire along at 70 miles an hour.

There has to be the flexibility within the standards and the certifications that there is a minimum bar that everybody can create a structured payload, the CDA. That is what NGS has been very, very successful in supporting and getting very high adoption. As you go up the curve to where people have more and more capability, both on the payer and the provider side, then you can get into that left-lane highway, and that is why I think the WEDI position and a lot of folks I am talking to are advocating as long as the EHRs leverage the standards they currently support, the HL7 and the FHIR standards, and build workflows to put those into a PA process, as long as payers figure out how to start to articulate in more and more granular ways the requirements of the information they need, then you can have a process that says, “Here is a box.”

FedEx has five or six boxes that you can buy. You can put whatever you want in the box, but there is standardization about how does the address work on the outside, when do you want it delivered, all this metadata and choreography so that you address those Levels 1 and 2 of the attachments process, and then you give flexibility in Level 3, which is the clinical presentation of information. I know that was a long, contorted answer, but basically, I am saying what at least certainly WEDI and a lot of folks in the industry are thinking. If the standards support the minimum requirements to support the HL7, the FHIR, and the X-12, which 99.9% of all the payers, stakeholders, and providers in the industry can support, and then mandate more the process flow, that is how we are going to make progress in the industry.

Tammy Banks
John, just as passionate as you are about that point, this task force has been very passionate about looking at the patient involvement in prior authorization. And so, a question came in: “How would we be able to best inform patients on what is taking place from a PA standpoint? Would a patient presentation capability be best delivered by EHR vendors, EMS vendors, or some other way? We as patients are generally in the dark about what many medical services will cost and when/if something is authorized/covered or not.” So, any comments from a patient perspective?

John Kelly
Yeah, absolutely. Maybe the best example to learn from is the pivot that CMS did within the CURES Act, and ONC as well. If you adopt standards that convey information in a structured way and make them available through APIs, then anybody can create an interface for any actor in the system. So, if you think about the FHIR resources and the exposition of the data for through APIs, you take all the patient data, you put it in the FHIR server, you expose it the same way we look at information through all the rest of our lives, with Google and our phones and everything else, it is sitting there. If you add on the permissions, the consent management, and the identity management, which we have done for the patient API, and you have a standardization of what that data looks like, the “attachments,” then anybody can build a UI.

So, I would suggest that if there is a standard PA process, and everybody knows what the standards are, and everybody adopts those common standards, then a payer can create a UI for a patient to query any

time. A provider can create a UI that a patient can query any time. A third-party app vendor can create a UI to put on their mobile phone if the patient decides they would like some third party managing their healthcare for them. So, one of the beauties of the standards, especially the emerging API and FHIR standards, is that this data is well understood, it is formatted and structured in ways that anybody can build interaction capabilities with it, building UIs, building applications, and it is exposed in such a way that as long as you have the right permission, you establish your identity, you can get access to the data that is going to make your life better.

Tammy Banks
Thank you. I have two questions and one minute, but of course, we will take a little bit. Talk a little bit more about what WEDI is thinking when it says that CMS rules scope must address business and care workflows and how that would look different from previous regulatory language.

John Kelly
We are looking at the recent rules. I think when you look at the old rules under HIPAA and the previous rules, they mandated a standard, they mandated basic business processes from Point A to Point B. What the CMS rules did is actually write a standard that sets a bar of performance. They said yes, you have to use these FHIR standards, yes, you have to use open auth and open ID, but what they really said is the rule is patients have to have access to their data. So, they really created an aspirational experience as a standard, which is why we are having so many issues with it, why so many people are pushing back, but it is also why CMS and ONC have spent so much time saying, "This is what we meant."

It is hard for people to wrap their head around a standard of performance. If someone says they want to win a race at the Olympics, what does that mean? We all know what it means to win the gold medal, right? How are we going to get there? There are many paths to that gold medal, and I think when CMS and ONC set these aspirational standards of performance for the industry to serve the needs of all the stakeholders, then that is really how the standards have to look at going forward. What do you want to accomplish for PA? You want the thing to work for everybody. How do you do that? Well, start with these standards. Build the workflow. We do not know it. We cannot mature it until we start doing it, just like the athlete who wants to win a race. I hope that answers the question.

Tammy Banks
Okay. So, if data for a request for additional information can be a collection of granular data documents, is it necessary to organize and restructure that into a C-CDA or FHIR document rather than just collect as collection is gathered? This is kind of a two-part question. Are you suggesting to start in the PAS space and then build from there into support for the other IGs, or are you suggesting that FHIR US CORE API support with smart app plus that part of the Da Vinci PAS that addresses the format structure supporting information for an authorization?

John Kelly
I think maybe the best way to tackle that is to go back from that question about versus the Smart on FHIR app. I know I have had a number of conversations with Hans in saying this method works, but I do not want to support a thousand Smart on FHIR apps within Cerner. So, the idea is that yes, you do not need the IGs. Everybody could decide "This is how I am going to ask the question." If you say I am going to answer any question someone asks, and someone walks up to you in French, and another walks up in English, and

another walks up in Spanish, you have to know three languages, whereas if you establish a standard for the process, then you set a rule that says, “This is how we are going to ask for this information. This is how we are going to process it.”

So, when you look at the Da Vinci IGs, and a number of us demonstrated this, I think Raj is probably on the phone, he was part of this, and he knows more about this than I do, you can take payer rules, the medical policy is you can express them in a language called CQL, clinical quality, which evolved out of the decision support environment. That CQL was taken and applied to saying, “Here is how payers are going to figure out whether they are going to yes, no, or maybe on a rule.” You can take that CQL. The PAS guide says the payer will express their needs in CQL, it will be put into a card, the card will be moved over to the EHR, the EHR will be able to understand, using the definitions within the guide, how to unpack the information and how to look at the CQL, how to translate the CQL into FHIR resource requests, and then, using the FHIR resources that go, “Oh, I speak English, I can answer that question,” and then pack it up and send it back to the payer in the format.

Now, anyone who has dove into this a lot, that last little piece about taking the CQL and turning it into the FHIR resources: There is a bit of an open question there because there is not a standard engine for that, but I think what we have proved at HIMSS in 2019 and in 2020 is that it is just one more thing we have to agree on. If the process is defined, then folks at MITRE, folks at MCG, folks at MEDALS, folks to that effect, we have all sat down and said, “Okay, if this is how we are going to do it, then we will just have to agree on how that CQL-to-FHIR translation is going to take place.” But again, that is a maturity of process, not technology.

Tammy Banks
Excellent. Thank you, John. Hans has his hand up, and for the rest of the task force, we will be moving into the Section 3 questions, so if there is any other content that you wish to pull from John, please put the questions in the chat, and then we can move on and go through our consensus comments.

John Kelly
And Hans, I hope I did not misspeak for you in your statement about how you do not want to support hundreds of Smart on FHIR apps. I picked on you there as a real-world example.

Hans Buitendijk
That is definitely a challenge that you do not want to have too many smart apps in order to communicate with 1,800 health plans, but what we also know is that there are smart apps out there that are interacting with multiple payers, so that burden can be reduced as well, which, I think, is one of the challenges here, and I am curious what your perspective is on that. Some of these things can be distributed across different systems, showing that in the examples of this that I am hearing, CQL is being translated into FHIR codes by the EHR. That is a place where it can be done. It can also be done by the smart app, and it, in turn, which is actually what happened in a number of demonstrations and connectathons as well, is where that other party is translating that, and the EHR “only” needs to have the FHIR US CORE capabilities so it can get access to the data.

So, there are different configurations. On the one hand, I agree with you that having the process understood and clearly defined is a path and helps us get there, and I think that is what we have been doing so far with

the HIMSS demonstrations, connectathons, actual implementations, and the progress that is being made. The leap that we are talking about here is certification of those capabilities, which now, at this point in time, it then starts to formalize and allocate particular interactions with specific systems, which may be a subset of all the parties that are involved. So, that is why I am kind of curious in that area. How do you look at that? Because certification is putting a lot more rigor in that environment that may be too much at this stage of it to enable what you are indicating. If we define a process, and then we need to learn, and we can figure out, certification seems to be in conflict with that, so how would you resolve that at this point in time, given the interest in certification around this?

John Kelly
Well, I would look back to meaningful use and say that the original drafted certification requirements for meaningful use were higher than where they ended up. I think we could have a very long conversation on whether or not had we done more certification back in 2015, 2016, 2017, would we be in a better place today in terms of the capabilities and the EMR to, out of the box, support various workflows? So, I think my answer to your question is is there such a thing as too much certification? Probably, if you get too granular in how you are telling people to build software, but I think you would also agree that there are fundamental core capabilities. If you want to begin to build a core process, there are going to be core capabilities that everybody who steps up to the table… When I think about if we want to get from Point A to Point B and everybody has their own idea of how to do that, we are not going to build 100 highways, we are going to build one highway and we are going to have onramps.

Now, everybody has to use the onramp, everybody has to be able to pick a lane, but you have to be able to have four wheels on your car, and have a brake, and be able to maintain at least 45 miles an hour to get on, and if we pick a process like PA, and we pick the IGs, and we back into what is the minimum necessary capability that an EHR has to have to jump on the onramp, and what is a minimum capability that the payer has to have… I think you can turn this around that right now, a lot of payers' rules cannot work with data that is available in US CORE or USCDI. They are going to have to retool their rules. They are going to have to think, "If I cannot automate this rule using USCDI data, then that cannot be a rule because I am trying to get on the highway with three tires and no brakes." I hope that answers your question. Do I know exactly what the level of certification needed is? No, but let's say we are going to adopt these IGs. Let's examine these IGs. Let's inspect them and see what is the minimum capability that an EMR has to have.

The real question here, Hans, is this, and I think you probably know this as well as anybody. Providers are worried that the new rules are going to create expenses for them. The only way to really implement this in a way that is going to give a slow glide path to providers is if the capitalization of those capabilities is done within their technology vendor stack, i.e., the vendor is investing across the whole industry to capitalize the minimum capabilities for someone to adopt, for example, the Da Vinci FHIR IGs or even the HL7 structured CDA.

You can do a C-CDA in Cerner. You do not necessarily support every possible C-CDA-type document that would be required for prior auth. You will have to do that, but unless we do that for certification so that the capitalization of these new technology capabilities is spread across the entire country, across all of the stakeholders, across payers, providers, and even, to some degree, patients through their employer premiums, that is the only way we are going to accomplish that. So, I think there is a strong argument to be

made, but some level of certification needs to happen to make sure that everybody is enabled to adopt these IGs.

Tammy Banks
I just want to say thank you, John. I appreciate your time. I know you are going to stay on the call just in case there are any additional questions. I know we did not really get into FHIR capabilities, but I know we have quite a few people on the call as well who are familiar with those, so if we can steer into the questions because we do need to get through these today due to our short timeline. Now, prior to John's conversation with us, we had two different positions with the task force members. Would the specification within the CDA attachment IG, if adopted as part of a certification criteria, support more effective exchange of healthcare attachments for prior authorizations, and would any changes to the IG be needed? I know that we saw that the NGS is working on this effort and is beginning that this year. Does anybody have any specific comment or change to their comment based on that capability is already in the certification under the CURES Act and meaningful use? Does anybody wish to make a comment?

Working Document Review and Discussion (00:41:33)

Hans Buitendijk
Tammy, it is Hans. Is that okay? I am not sure whether that I am the first hand up.

Tammy Banks
Yup.

Hans Buitendijk
The question I have goes a little bit to some of John's comments. Support for C-CDA need not mean CDA attachment for IG or the C-CDA template for attachments, and therefore, I think part of that question is what is needed to do that? And, one other question I put in the chat and was curious about some reactions as well: As we are going on this FHIR path of interacting and collecting data, and we are going out and our aim is to collect as much as possible of the data electronically rather than by human intervention, it can start to get a collection of data in FHIR format, it can get some documents, some PDFs, whatever is appropriate to support that attachment or that authorization. What is the value of putting it into a CDA format and document rather than a FHIR document, and what is the value of doing it in a document format, particularly talking about e-signature as well versus it just being a collection of data that I gather that is sufficient to support the authorization request? So, I think part of the challenge in this area is that are we adding steps in a format that, as we are moving forward, do we still need that?

Tammy Banks
Can I ask you one question back, Hans, as an EHR vendor? We all agree prior auth is an extreme burden, and we know that functionality is all across the board. So, the question is we are really looking at two different types of prior authorization request workflow, one triggering with the 278, and then there is that gap of how does that additional information get back. And then, we are looking at where we want to be, where we also have the capabilities within the workflow, the more granular approach, and I do not think anybody is going to argue that that vision where we are going is where we want to be, but we are not there today, and we need to relieve this burden. Is there a problem with a phased-in approach where using the capabilities that are required under the CURES Act and meaningful use and providing both options…

Because I know we talked before about this functional capability, right? What is the baseline functional capability that will support both of those visions that will not require retooling down the road? And, if we agree with that tiered approach and moving toward that cutting-edge vision, then why would we not support this aspect because vendors are across the board with capabilities and the payers? Am I looking at this wrong based on our previous conversation, or are vendors wanting to put their investment dollars into other areas? But, it sounds like an investment has already been made.

Hans Buitendijk
Yeah, that is the question. If you ask if the investment is made in CDA attachments by EHRs, then I am not sure that the answer is widely that everybody has made that investment in CDA attachments in EHRs, so that is why I am raising the question, is just that as we are moving forward with this overall approach, where do we sit right now as we are embarking on that? And, perhaps this is still the right in C-CDA. It is close; therefore it is a shorter path to get there. So, that is where I was trying to understand, and it is more of a general question. Is a document the required format? And then, we can talk C-CDA or FHIR. Or, is it the collection of data that becomes more relevant to support the authorization request?

Tammy Banks
Heather?

Heather McComas
Thanks. I will actually start by picking up from what Hans just said. When John was talking, he mentioned the idea of the payer getting this big document and having to riffle through it to find exactly what they need, and I know that we have all talked so many times about concerns about patient care delays and that sort of thing, and so, I do have concerns. Are payers going to be able to process a document-based approach, and is it going to take longer for them to get back to the provider with a response, and does that involve care delays? So, I think that is something we need to think about.

And also, getting to Hans's point, what would it take for everybody involved to support both approaches, the whole highway that John was describing? Could payers really support both a document-based approach and more granular approach at the same time? Does everyone have enough money to build out both approaches? I realize obviously, we desperately want to do something as soon as possible, but in the long run, are we going to be investing in things that are not going to be used very much or not for very long? So, I think these are important things for us to think about.

Tammy Banks
Raj? You are on mute, Raj. Raj, go ahead. You were on mute. Now we can hear you.

Rajesh Godavarthi
Okay, sorry about that. So, I will give you an example of the experience I have had recently with implementation. In our first implementation of this particular implementation guide, when we were talking to both sides, like exactly what document details you need for this particular diagnosis, the choice of selection by both sides is that we need some of the attachments and we need some of the data collection. It is exactly the conversation we are discussing right now. I do not think we are at a place that we can define either. We should leverage the investment that is already made. We should stay at the process level. Do not go down to "We must support C-CDA, we must support FHIR" because the industry has not matured to

that level yet. We should give room for the payers and providers to decide what makes it work for them to reduce the burden with what they have already. Not all the providers are documenting to the point you can grab everything to FHIR data resources. A lot of this stuff is still coming through the attachments.

So, the way we came to our use case that we are implementing is we looked at both sides and we got the best stuff, and we are packaging it in the PAS. The PAS implementation guide sufficiently articulates how you can bundle the collection of data, whether it is FHIR or non-FHIR. That is beautiful in my view because you are allowing the implementers to do whatever is best for their organization and the customers they are working with with the investments they already made. Coming two or three years, the fast lane will evolve. People will make investments once they see that the FHIR data will enable them to automate the decisions because the data is structured, unlike the C-CDAs or CDAs, where the data is document in nature and you cannot leverage for automations. The maturity will come take place where we can define in the criteria for certain things. Until then, we should stay at the process level.

Tammy Banks
So, Raj, you are suggesting supporting it with a future vision of adding criteria to support the capabilities within PAS?

Rajesh Godavarthi
Yeah, for any specifics in terms of how a document should be collected. I am saying leave the room open for the people to do what works for them today.

Tammy Banks
Okay. So, support it or not, or just leave this one as the market chooses how to exchange documentation until PAS is…

Rajesh Godavarthi
Right, that is what the PAS implementation guide already suggests. You can bundle all the things into one as a FHIR bundle and give it to the payer. That includes structured data and structured data attachments, whatever they deem right.

Tammy Banks
Okay. What are the comments in regards to remaining neutral?

David DeGandi
I think we should be leaning in on the structured document over unstructured document, though, to encourage automation determination. Otherwise, we will not be able to do that.

Rajesh Godavarthi
Definitely, where applicable.

Hans Buitendijk
I think that goes also to the comments made earlier, that it has a provider side and payer side, where the rules are leaning towards data that we know exists to provide that, and where they mostly can be in structured format, it will help improve upon that as well, so I think it is two sides of the coin that needs to be

looked at there. It is similar to what is happening with ECQNs at CMS, where the quality measures are being developed more, understanding what data is electronically available and computable without additional documentation, how can the rules be defined for this purpose based on alignment on data that is there, does not require additional documentation, and already are on the path of being more structured. So, I think that is a balancing act back and forth, working together to make that happen.

Tammy Banks
So, Hans, do your comments mean you want to remain neutral or you support with the movement toward more data capture versus document capture?

Hans Buitendijk
I think it is more data capture, of which documents can be a part where they exist so that you minimize rework or additional transformation steps to say, "I have this data that supports it." The more that I can just pass that on and not have to transform it into a document, because we like a document format, that I can work with what it is, and at the same point in time, if we can work on focusing and streamlining it, then need to do less and less of that.

Tammy Banks
Okay. So, you support it, but using the C-CDA that the data can be pulled from, and not the PDF and the other types of document, or are you remaining neutral?

Hans Buitendijk
I am remaining neutral, and it is more looking at it as a collection of data that is relevant rather than that it must be in a document format. So, I think I am more aligned with the way that Raj did a great job in describing, the way that, in PAS currently, you can attach the data in there, but it need not be just a document or need not be just one set of data. I can go both ways, and I can let it evolve.

Tammy Banks
Okay. Did I capture it correctly, Raj and Hans?

Hans Buitendijk
If you put the word "format" after that, that would be great.

David DeGandi
I am also taking the opportunity to change the questions that are asked and the data that is being asked for from data that may not be available to data that is available, if we are able to answer the question in a different way, right.

Hans Buitendijk
Yeah, that is the other side of the coin of aligning data asks with data that is available electronically. And, that is an evolution, as we see in other areas, but it is very helpful.

Tammy Banks
Anybody have any other comments?

Rajesh Godavarthi
One comment I would like to make is part of the Da Vinci connectathons… Because of the HIPAA regulation that all the prior auth sections must comply with X-12 278, in several connectathons, we have tested the mapping between FHIR to X-12 278, knowing that these investments are made and these things are **[inaudible] [00:55:11]**, like as John Kelly mentioned before, so that part is baked into the implementation guide. So, if you think through that process, Da Vinci looks broader than FHIR to keep using the things that are already in place. So, these mappings are in place, these mappings are tested well, and that includes, for example, how you communicate the denial reasons between FHIR and X-12. You need a prior mapping for that **[inaudible]**. You need a proper mapping for that. So, they have gone to an extent to make sure all those things are fully mapped and tested in many connectathons as well.

Tammy Banks
Okay. Any of the other task force members? Remember, the support and not-support came from all of us, so, anybody have any strong feelings on "do not support," "support" or "neutral"?

Rajesh Godavarthi
Heather has a comment.

Tammy Banks
Heather?

Heather McComas
Yeah. I do not know if I am saying which direction my gut is going, but one thing that is important about this is the question is asking specifically about C-CDA attachments and documents, and that is only one part of the process. I know we are saying neutral, but what would be the envisioned way to do the equivalent of a CRD, DTR, or not using FHIR if we are going this route? Would it be using the 278 and returning a 278 response with a LOINC code? Because there are other pieces that would need to be involved to support the process using a C-CDA. That is just the clinical documentation piece of this, but to have a full equivalent for this method, we would need other pieces to get the documentation requirements to the provider. I am not clear what that would be, from what we have discussed.

Tammy Banks
Does anybody want to respond to that? That is basically the initial workflow that we have today. Hans?

Hans Buitendijk
I am not sure. I am hearing something that Heather is indicating that I would agree with. We want to be careful that if we just focus on the payload for the clinical supporting information, that is the document discussion, and then we have the part around it, which is what is the interaction using the transactions as CRD, DTR, etc., FHIR-based. I am not sure if it is a part of this conversation to just focus on the document part of supporting clinical information for the authorization irrespective of how the transmission goes.

Tammy Banks
Yes.

Hans Buitendijk

If that is the case, then I think we are fine here. If it goes beyond it, then I am going to go with Heather as well. We want to be careful that we are not going to mix too much because we would end up with varied implementations that actually do not connect. If I am going to just do FHIR and somebody else is going to do just X-12, it is not going to work.

Tammy Banks
David?

David DeGandi
If I heard you right, Heather, you said something about the CRD.

Tammy Banks
Let's stay focused on the question. So, would the specifications within the CDA attachment IG adopted as part of certification criteria support more effective exchange of healthcare attachments for prior auth? Would any changes need to be made to the IG, or would additional functionality standards be required for effective implementation? Now, I know we talked in one of the support about LOINC codes. We said that in addition to an attachment standard, other guides would need to be included, an X-12 envelope, 275, and LOINC to request a specific document template, for example.

But, we heard from two of you that you feel that we should not even be addressing this and remain neutral, and that is the question on the table, but before we had this conversation, there was pretty split support of either support, because the capability already exists with that caveat, or do not support, and just remain totally putting our resources in that future nirvana that we are working to get to, not taking into account the structure and the investment that has already been made. So, the question is do you not support, support, or remain neutral? And, I know where the conversation is going neutral. I personally would throw my hat in supporting it because not only does it help claims, it helps other types of functionality, it is already invested, and it is an option for the smaller payers and providers.

I think nirvana is where we want to go, but not everyone is going to be able to invest and leverage this in the short term, and since there is more maturity, so for me, I kind of side on the support, but we have heard reasons why others are neutral, so I need a little bit more information. It sounds like no one does not support. It appears to be either "support" or "neutral." Let me know if I am wrong on that point, and let me know your comments in regards to which path we as a workgroup wish to go down. Raj, you are the only picture you can see, and you are shaking your head, so do you remain neutral, or can I sway you to support with the same comments under "neutral," that we need to be focused on the exchanging of data, but recognizing the industry has a lot of different types of stakeholders that we want to bring as little burden as possible as quickly as possible based on the infrastructure that is in place today?

Rajesh Godavarthi
I am kind of wrestling. Maybe I need to think a little further.

Tammy Banks
I do not want to invest more, right? We do not want to invest more, but we want to make sure we can leverage what we have. In the short term is where I am going because providers are dying, and if we want to look at nirvana, shoot, we thought ePA with the attachment rule was nirvana 15 years ago. We have

been having this conversation for 15 years, so how do we make that phased approach, and are we going to throw out what is already invested and just remain neutral, or are we going to say, “Come on, now.” The 278 is not working because there were not attachments. That was the industry mantra for a long time. Can we get that criteria that those attachments need to be made, get that workflow, people used to sending either a PDF or C-CDA?

I know we do not like the document approach, but the fact is people are still sending faxes, so how are we as a committee going to support the industry at large and make a recommendation to reduce this burden as quickly as possible without investing more infrastructure? This is not a whole lot of infrastructure cost in addition to what already has been there because we know it is already a requirement, and 275 is being used. We already have the facts on that. But anyway, Eliel, did you have a comment?

Eliel Oliveira
I think generally, Tammy, I support, and I agree with Raj, but I think what might be missing here is a systematic approach on how we are going to go about this, and what I mean by that is that we have the connectathons and the tests, but I do not know if rewording implementations that have been done, and to me, that is going to drive some of the changes over time, meaning if we had a plan that is identifying what is the low-hanging fruit, things that we can address immediately, and maybe solve 80% of the cases, we see a lot of that in data. An example here might be just the initial implementation of the checking phase of if preauthorization requests needed or not. That might solve 80% of the situations, and we just get a yes or no.

And then, on the next phase, which required documents in all aspects, rewording implementation in some situations may be fine with a document, but granular data may be important. We all know here that 80% of review information is on notes, for instance, that natural language processing would be interesting. So, I guess what I am trying to say is I do not know how each one of these individual implementations to solve specific authorizations is going to go, but maybe having a committee or some group that is basically going to pilot these in real settings with the vision of selecting what is the ideal setup in every situation is the best. So, like Raj was saying, in the best situation for the timeframe, we are going to go with C-CDA for now, but we know that this is not ideal in the long run, so, for the next pilot implementation in real-time, real-world implementation, which may happen in a year or two years later, that group can then advance the process to the next level. So, I think that is what might be missing here, is a specific plan on how we are going to go about this, but I fully agree that it needs to be included for the time being to get things resolved quickly.

Tammy Banks
Okay. I am going to ask for a privilege here. I am going to rewrite this. Eliel, I think you really put the comments of both Raj and Hans and I in perspective. I am going to write something that is support-neutral and run it by Hans and Raj over the next couple days, and if you guys could all go to Google docs, take a look, add in your comments, and see if it does not convey what you think is appropriate. Is that okay, just to move us on to 3.2? Hans, are you okay with that?

Hans Buitendijk
Yes.

Tammy Banks

Okay. So, would the use of FHIR documents, if adopted as part of a certification criterion, support more effective exchange of healthcare attachments? I think we have already said yes. Are there any gaps or constraints that would need to be further specified, such as through an IG, in order for FHIR documents to be effective for this use case when implemented in certified health IT? Would the adoption of a certification criteria for FHIR support other administrative use cases beyond prior authorization? Now, the question for the group is we were wavering back and forth on the readiness to put criteria in the health IT, but we are leaning, and we are trying to get more information from CMS.

We know that there has been a lot of investment in regards to piloting and the use of these down the road, so, keeping that in mind, we are going to be getting more information on that, but otherwise, the only comment we really got was FHIR and FHIR bundles can support attachment exchanges noted in the Da Vinci PAS. This is complementary to other initiatives and regulations which require that data be exchanged as FHIR. Is there any other thing that we should be adding to that comment, or is that enough at this time, based on our other conversations and comments? Hans?

Hans Buitendijk
Yes. The thing is that FHIR document or CDA-based document, where the CDA-based document is a C-CDA or another type directly defined on the CDA architecture, is really a format issue. It is still a document, and documents have certain characteristics of structure, format, contents, etc., all those things that need to be in there. So, I think it is a much more fundamental question, which is between 3.1 and 3.2, is that is it necessary as we are going into this direction to create such a document based on the data that you gathered, where the data that you gathered can be a variety of levels of structure, it can be a document, it can be a PDF, it can be because I scanned it in and it is relevant to the authorization or additional information, etc. Am I going to put that additional wrapper of a document with everything around that in play, or do I just go with the selections?

So, I think 3.1 and 3.2 are very similar. It is a document, and is that valuable to put in there or not? Generally, if we are going in the FHIR direction, why switch back to a CDA-style document, particularly as we are automating the collection increasingly to get the data using FHIR resources? So, why go back to a CDA format if I already have, and increasingly will have, FHIR artifacts and resources? So, I think that is the dilemma that we are in right now between 3.1 and 3.2, and where we are at is that we do not quite have enough FHIR around yet for everything. Not everything is automatically retrievable, documents are in a variety of different formats, you might already start to see some FHIR documents popping up as well, so that is why I am going to go back to Raj's earlier comments. That neutral part is that PAS actually allows you to have that collection in different formats there. Do we want to invest a lot of time on reformatting it via the CDA or a FHIR document, but really, do we want to take the effort to format it as a document? What is the value behind it? And, there might be, but I have not heard it yet.

Rajesh Godavarthi
One other thing I would like to add: In the 3.2, documents support other administrative use cases beyond prior authorization. One thing that comes to mind is claims processing. So, we have to make sure whatever the criteria payers use for the claims processing transactions, maybe some language to preserve whatever the bundle is taking to the other side enhances what they have in place today.

Tammy Banks

Am I sort of on the right track, Raj?

Rajesh Godavarthi
Yeah, exactly, thank you.

Tammy Banks
Okay. Anybody else have anything else to add to this comment? After this, I am going to move to 3.3. Okay, given limited testing of these approaches today, what would be a feasible timeline for use of the CDA attachment IG or FHIR documents in production for prior authorization task force? We have "Must be mature and tested sufficiently for adoption at scale before mandates kick in," "Might consider a soft timeline such that when some specific quantitative testing threshold is reach, then its specific timeline for adoption would kick in," "Current industry implementation information on CDA or FHIR documents for PA would be very helpful in answering this question," and it seems like Raj's point really applies here too, is changing that approach from the document-based to the data-based is really where this task force is going, and if anybody disagrees with that, please voice it because I think all these have the same answer.

We want to leverage what is there, but we want to move to nirvana, and how do we do that, moving from a document to a data, and how do we get there, recognizing document is not going to always be there because it is not as efficient when we get systems up to where they need to be? Am I on the same page?

Sheryl Turney
Yeah. And, Tammy, this might be where, if there was the development of a proving ground that would provide for clinical testing and maturity, we might be able to reference, and we were talking offline about potentially adding an overall recommendation of developing a proving ground for the maturity of all of these implementation guides and the ability to go from documents to structured data.

Rajesh Godavarthi
Well said, Sheryl. That is perfect.

David DeGandi
I agree.

Tammy Banks
Okay, 3.4. Which of these approaches would better accommodate improvements over time to meet payer and provider needs? Should ONC consider adopting certification criteria referencing one or the other? And, we had "Agree, one approach only," and I think what I am hearing is we kind of agree, recognizing the key points of moving toward data over documents and leveraging technology, but moving that investment to nirvana, if I can use nirvana as the automatic auto-decisioning workflow. Do we ever get nirvana? We want to reach this this time, right? And in a shorter period of time than in the past. Anybody who said one approach only? Speak now, because we can obviously have a dialogue on that. And, those that I am not hearing from, be sure to speak up or let us know your thoughts because this is a task force approach, not just one.

Okay, I think we have five minutes. Task force, if the IGs developed by the Da Vinci project or alternative IGs addressing the full scope of prior auth workflows are not yet ready for adoption, should ONC propose

certification criteria to support healthcare attachment transactions for prior authorizations alone? And, I think we were all in agreement here with the iterative plan, which we talked to, and it is said much better than the way I had mentioned. We looked like we had consensus on 3.6, healthcare attachments are used for a wide range of operation and administrative workflows beyond prior auth. Are either of the standards expressed above commonly used in other administrative operations? Would there be a burden using them, etc.? And again, we went back to the iterative plan.

And now, we have to make sure that each workflow where attachments are used cannot be improved with discrete information. If they can, then a plan to evolving from attachment should be included, and again, to Heather's point, the 275/277 RFIs also need to be considered. Okay, and then, one more. I would have thought that was too good to be true. One more we did not have comments on. So, 3.7. I am not going to read it, but are there any comments on what we should respond to 3.7, or if we have any thoughts, or does the basic premise of what we have been talking about for all these questions apply to this as well?

Hans Buitendijk
Yeah, and I think it ties to this with the same general approach. In the current flow on how to ask, I was not totally clear when I heard Viet Nguyen's presentation last week, when you need to ask for additional information not part of the initial authorization request, what are we using? CDex? Something else? And, I think that needs to be clarified. There are a couple areas on the granularity of the IGs today, if requests are not granular enough, but this one is "Is it missing something?" For that additional data request, if you get the authorization, you get supporting information, you find out as a payer that that is not enough or it leads to additional data that you need, what do we use? And, if you just point to CRD, DTR, and PAS, you would not get the answer to that crisply, which means that it makes it very hard for certification, if we want to do that, on how to support that. If I am on that side, I would not be clear what I would have to do.

Patrick Murta
I know that CDex is an option, but also, an STU2 version of the PAS is being built out. That functionality is mentioned in there that needs to be defined, so that is coming.

Hans Buitendijk
Then I think it needs to be clear because one of the challenges is that on the one hand, taking a process approach is helpful, but particularly since we are in a workflow that cuts across different areas, different HIT, different actors that can interpret different ways, but it all needs to work together. It is a hard balance between if process definition is enough or if we really need to hone in on the standards to support certain interactions to make it work. I am more with the latter at this point in time because otherwise, I am not sure whether I am going to align with David, Raj, Patrick, John, or whomever else.

David DeGandi
I agree.

Hans Buitendijk
But, the current IGs are not sufficiently crisp enough at the level of which I believe the criterial need to exist to unambiguously state what I am expected to do. I think the information is there, but I cannot figure it out because I have been part of the process.

Tammy Banks
Anybody else on 3.7? Otherwise, we can go to public comment, and then see what time is left after that.

Eliel Oliveira
Tammy, I do not even know if this is the right question to add, but I keep thinking about it, and I want to comment. We talked a lot about the burden on developers, providers, and so on and so forth, and I believe there is a place for some analysis of that burden, and a benefit, actually, as well. I feel like in the end, there could be more improvement in workflows and reductions of staff time that actually provide a return on investment as opposed to a burden, but that is just a hypothesis, and so, maybe some study on the burden is a recommendation that I believe we should provide.

Tammy Banks
Did I sort of get what you were saying, Eliel? What would you add?

Eliel Oliveira
I think "return on investment" might be a good thing to add here, a "why" as well, in addition to reducing burden.

Tammy Banks
Now, would patient communication be a part of this? Is that any part of this attachment conversation on keeping the patient informed, or no?

Eliel Oliveira
I always **[inaudible] [01:20:12]**. That is my opinion.

Sheryl Turney
Yeah, and I think that will be the start of our discussion next week, too, Tammy, because it is all going to be about the patient and the providers, the next set of questions. If we could put up the public comment slide so they know how to raise their hand or get in the queue, I think that is where we are at right now. Thanks, everybody, for today.

Public Comment (01:20:55)

Michael Berry
We are going to open up the call for public comments. 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 are on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute or unmute your line. So, let's pause for a moment to see if we have any public comments. I do not see any public comment, so I will turn it back to Sheryl and Tammy. Thank you.

Homework and Next Steps (01:21:39)

Tammy Banks
Sheryl, if I can just add a couple things, and then I will whip it over to you. Thanks for those who put some comments in the chat. I was not able to look at them while I was doing this, so I will make sure I get that verbiage included, and Sheryl, I know we want to get to the patient, but I think before we do that, we are

going to need to go back up to 1.2 and talk about the bundle. There are a couple open questions. And then, I just want to reiterate to the task force to take a look at what you said, Sheryl: The patient, the developer, the provider, and the payer sections. Make sure that you are all in agreement with that consensus comment that has been compiled, or put your comments in the Google doc so that we can incorporate your points because I am hopeful that the next call will be actually looking at consensus language that we all agree on and we can just ensure is robust. But, I think we did a great job this call, so I really appreciated it.

Sheryl Turney
And also, I do want to note, Tammy, that in the comments, we did get one comment from a non-committee member who did speak about the patient. I am not going to read the entire comment, but the essence of it was that prior authorization and updating patients on the real-time status is a requirement, so I will save that also, and make sure that it makes it into our discussion next week on the patients. Where we are right now is we have two more sections to complete, the patients and providers, and as Tammy mentioned, going back to some of the Section 1 questions. We have a meeting on 2/24, and that is going to be a lot to accomplish in that meeting. We also have one for March 3rd.

So, the goal would be to get through all of the final sections, hopefully in the next meeting, so on the 3rd, we could start reviewing how we morph this into a final recommendation paper. We probably will not accomplish both of those things, so, again, we did suggest that we add an additional meeting on March 7th. It would be at a similar time, which would be 10:00 a.m. Eastern, and we would utilize that to review our final paper prior to it going to HITAC on March 10th. Any questions or comments relative to our plans for the future? If not, I want to make one final attempt to see if there are public comments that have come forward. Excel, do we have anyone?

Michael Berry
I see someone has raised their hand, so if you would press *6 to unmute your line and state your name, you have three minutes.

Steve Ken
Hi, thank you. My name is Dr. Steve Ken, and I am a practicing physician, as well as someone who has been focused on prior authorizations for the better part of a decade, and what I would say from the practical perspective of implementation is that these standards are definitely desirable to have a common highway, but it goes back to the point that Jim made from WEDI, the fact that one of the biggest challenges will always be the workflow and the processes, and that needs to be addressed in terms of the complexities and how we find a way that makes that meaningful in taking these standards and making the clinical document exchange to be one that is very useful. So, whereas the ability to translate these standards into practical, implementable end workflow results is where I think there should be some additional focus, attention, and discussion around.

I was the one that made the comment around patient engagement. I am very glad that that was listed. One of the things that is a frustration from a practical day-to-day provider perspective is that patients deserve to know what the processes are in terms of prior authorizations and the delay that can be experienced around that, and I think there are ways to do that. We are working and actually doing things around that aspect that do incorporate the ability to use the existing standards that are put out there and translate that. So, with that, I would just definitely like to emphasize the need to also consider the challenges around the workflow

in process implementation from both a practical perspective as well as a cost-of-implementation perspective. That is all I will say. Thank you.

Sheryl Turney
Thank you so much for that comment and the consideration of the panel as we further discuss this topic. Can we show the slides for the next steps and the homework?

Tammy Banks
I forgot. I was really remiss, Sheryl, and I am sorry. I know that we had spoken at a previous meeting about Hans taking a look at the various workflows that are in play in regards to the PMS/EMR smart FHIR app, and he has graciously created a presentation taking the functional criteria and laying out that vision, so he will kick off next meeting with that, and that will lead into that module conversation, but please, everybody, take a look at that patient/provider/payer section because we should be able to do that via email or Google docs and just be able to sign off on those pieces of the pie. So, thanks, Sheryl. I just wanted to let you know, and again, Hans, I really appreciate the good work that you put together.

Sheryl Turney
Wonderful. All right, so, thank you very much. We will meet again. It will be a week from today, Thursday the 24th, a reminder, going back to our regular time from 10:00 to 11:30. We will start with Hans's presentation, then we will go back and revisit Section 1, a bundle that we need to discuss, and then, if we have time, we will move on to patients and providers, and hopefully, we will finish up that work on March 3rd. Thanks, everybody, for their time and their efforts, and I really appreciate your input. This has been a very worthwhile exercise, and I think we will be able to provide some meaningful input to ONC on this topic, so, thank you.

Tammy Banks
Again, I just want to say thank you to John and WEDI for presenting on this call today. Very helpful.

John Kelly
You are welcome.

Sheryl Turney
Absolutely. Thank you, John. Very good discussion.

Adjourn (01:29:03)