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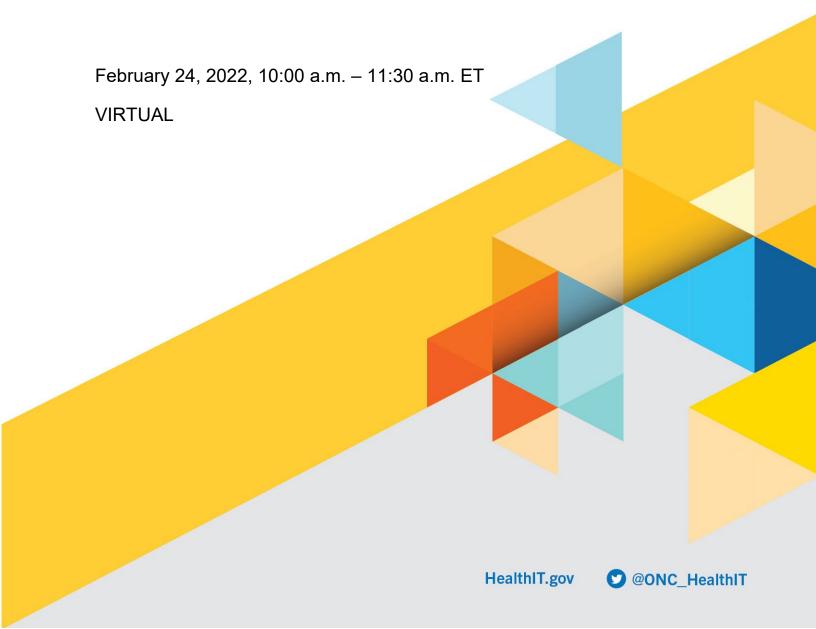# HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) e-PRIOR AUTHORIZATION REQUEST FOR INFORMATION TASK FORCE 2022

February 24, 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

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

Michael Berry
And, hello, everyone. I am Mike Berry with ONC, and I would like to thank you for joining the Electronic Prior Authorization RFI Taskforce. We are glad you could join us, and your feedback, I wanted to note during this meeting, is always welcome, which can be typed in the chat feature throughout the meeting, or can be made verbally during the public comment period that is scheduled at about 11:20 Eastern Time this morning. So, I would like to begin roll call of our taskforce members, so when I call your name, please indicate that you are here with us today, 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?

Dave DeGandi
Good morning.

Michael Berry
Raj Godavarthi? Jim Jirjis? Rich Landen?

Rich Landen
Good morning.

Michael Berry
Heather McComas?

Heather McComas
Good morning.

Michael Berry
Aaron Miri? Patrick Murta?

Patrick Murta
Good morning.

Michael Berry
Eliel Oliveira?

Eliel Oliveira
Good morning.

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

Welcome Remarks, Review of Plan & Summary of HITAC Update (00:01:22)

Sheryl Turney
Thank you so much, Michael, and we have a very packed agenda today, so I am going to provide a very small update on the summary that we provided to HITAC, which went very, very well. Then, we have a presentation by Hans to discuss the EPA workflow, which hopefully will help us understand a little bit better about the modules and the bundles. And then, Tammy will lead the working document review, and thank you, everybody, for doing your homework. We are in a really good spot, I think, in terms of getting and gathering comments. Then, we are going to have public comment at 11:20, and then we will discuss our homework and next steps. So, we can go to the next slide.

And, this is our work plan, and where we are right now, February 24th, we really only have about a week and a half to go, 10 more days, so we are coming in for a landing, doing a lot of work trying to get the document in shape for what we are going to submit to HITAC on March 10th, so we will have a PowerPoint presentation as well as our ending recommendations and response to all of the RFI questions. We will have some homework assigned again this week, particularly for folks to look at Sections 4 through 7, and then we will talk about that a little bit more at the end. We have another meeting next week at the same time, and then, our last meeting is actually going to be on Monday, March 7th, so just make sure you know your calendars. It is a different day of the week. Any questions about the work plan? All right, let's get to the HITAC update.

We provided an update to HITAC on February 17th. You can see here there is a link with the slides available. I think overall, we got very positive input from HITAC, particularly on the points of including the patient at the center, trying to incorporate some of the major themes from the intersection of clinical and administrative data, and our discussion on how prior authorizations relate to cost estimates and the importance of recognizing that there are various levels of maturity in the PA process.

Highlighted on the slide are a few specific areas of discussion, and I am going to talk a little bit about some of those. Several HITAC members brought up the point of, basically, cost estimates and the patient's right to understand cost in the prior auths as part of the requested service. In fact, one member suggested the need to have options for cash pricing and other types of provider options beyond what would be included in a prior auth.

I am going to leave it to this group, but it does seem like that goes way beyond the scope of our charge. We do want to make sure that we have a few statements in how important it is for the patient to have A). Options, B). Some cost estimate for the approved prior auth, but also, in some cases, providers provide good options for cash pricing if the procedure gets denied, and that is certainly the patient's right to decide to go that route. So, again, whatever verbiage we include that speaks to that, I do think it needs to be put in the proper perspective because having to remember this is not really about cost transparency, it is about getting electronic prior authorizations into a better place where we can better support that digital interchange.

Then, also, there was a discussion around the intersection between eligible transactions and prior auths, and really, what that discussion was all about was having good data up front related to what requires a prior authorization and what documentation is required for that prior authorization, what substantiation is required, and having that information reviewed annually, timely updated, and areas area where prior authorizations are likely approved a large percentage of the times. What about the gold-carding process? All those things were also discussed in HITAC, and I think the sentiments were they agreed with the points that we had made in the discussions that we had around that topic.

Also, the discussion around attachments came up, and that was really related to what we were thinking regarding an attachment requirement, what would be best in terms of recommendations for FHIR, if attachments are still necessary, and really, what our thinking is in that area, which I think we are going to discuss a little bit more today and formulate more recommendations around that point.

And then, the last major theme area was really around the point we brought up about the need for a possible exception to the processes to replace the X-12 transactions with FHIR to complement or replace, and again, what type of onramp we would want to recommend so that we do not add burden by requiring both be done, but we allow for the flexibility for an onramp, if you will, so that we can naturally migrate to the more FHIR-based processes as those are available. Tammy, do you want to add anything to what I took away from the conversation?

Tammy Banks
No, I think you stated it very accurately, and just to underscore the importance that HITAC put on the price and cost transparency, understanding when a patient is eligible, when you get that prior authorization, and including the patient in these workflows, which we are not seeing in the workflows that we are discussing today, it is just very important for any standard development organization or anybody looking at these to really begin to realize the patients want it today, they do not want it after we get the other solution in place.

So, you will see when we get the complete document for you to review additional language that was put in, embellishing on the points that you already made. They were very pleased with the conversations, especially the conversations about thinking about the treatment plan and the bundle of services, requesting payers to take a look at this from an episode-of-care perspective versus a single-service durable medical equipment item, and so, I think they really appreciated the patient-focused conversations that we are having, but we just have to figure out how to get moving in those gaps that we currently have today. Sorry, just to embellish, because it was pretty important on that call.

Sheryl Turney

Yeah, and I want to reinforce a point that you made, and that is that overall, we got very positive responses, both verbally and in the chat, so we are definitely on the right track, and everyone is looking forward to the results of our RFI input. So, I think with that, are there any comments from the subcommittee before we move on? I do not see any hands raised, so, Tammy, do you want to introduce Hans in the discussion?

Tammy Banks

I am really excited. Hans and I had a conversation, and Hans has been very vocal on the point, very accurately, that there are a lot of different vendors that can be part of the piece of the complete workflow, and so, he is going to walk through and really put a visual to that statement, which will really help set us up for continued discussion of 1.1 to 1.3, so as you are listening to his presentation, be thinking about that section of RFI questions that we wish to flesh out. Hans, again, you put an amazing amount of work in this. I really appreciate it.

Presentation on ePA Workflow (00:10:32)

Hans Buitendijk

Thank you very much, and thank you for the opportunity to step through it. The thoughts that are in here are still being evolved, I think, through the discussion that we have. I am engaging with the EHRA to get the different perspectives there as well, so do not take these as final suggestions, but rather as awareness in where we might be thinking. That really starts when you go to the next slide. The other part of where this is coming from is that to date, since ePA is being talked about here, not only about the capabilities, but also how that relates to certification, based on the experience that we have had for certification to date with EHRs specifically, which has been the focus, and it has been widened at this point in time, it is not just about EHRs anymore, and ePA is a very good example of that.

So, what we see is if we just take that flow and say if we are putting in HIT, where are things being initiated, what we are starting to see, and what Da Vinci has been starting to look at with the guides, is that it can be initiated in a variety of different places. It is not just the EHR, as that is not a monolithic entity. It could be started in the scheduling environment, where I want to schedule something. Can I actually do it? Do I need to have prior authorization, registration, be it at the beginning or at the end of an admission? Can I extend it? Utilization, case management, other types of areas, clearly EHR when you start to place an order as well. But, these kinds of capabilities are not necessarily housed in one system. So, that is on the front end, just initiating it.

Then, the supporting data that is needed to support the claim. Yes, a lot of that data is expected to be in the EHR, but not necessarily everything, or there might be better sources out there based on how health systems might have organized their IT environment. So, an HIM might have some documents that EHRs reference, but not necessarily store inside the EHR, so there are different systems in play, or there might be some other areas where you have a more longitudinal perspective that I can pull that data in as well, or have access to more. So, that would be another one that is supporting data, yes, mostly in the EHR, but not necessarily everything.

And then, once we get the authorization back, there is the interest to get the data ready to submit with the claim at the right time, so, to recognize that, but that means that we are starting to look at some of the back-half capabilities, like revenue cycle, practice management, etc. Up until this point, with these couple things, I do not think they are limited to these. There are a variety of different places depending on whether you

have a smaller organization, you might find less systems, if you have a large health system, you find more systems, and anything in between. And, I am only looking at the provider side. I am not looking at the payer side, where I understand similar situations may be in play, but I am only looking at the provider side. And, the last one is that we are also seeing that, as we started with Da Vinci, smart apps have a very interesting and unique opportunity and role in this as well, so they are coming into play as well to help facilitate some of this.

If you go to the next slide, the general picture that then comes from that that you can think of is that we are talking in the middle about Capability 1 through N. That is where we are going back and forth. What are really the pieces of the puzzles just looking functionally? And then, on the right-hand side, we see there are a number of implementation guides, standards, CRD, DTR, PAS, or the Da Vinci ones that are currently in place, but depending on how you are looking at it, I may only need to look at Smart, or CDS Hooks, or FHIR US CORE. Yes, they are all referenced in CRD/DTR/PAS, but depending on what you are doing, you might not have to support all of CRD or DTR, etc., so that is why I put them just next to it, to keep them in mind.

Again, I am not talking about the payer side. There have been some comments made. Rich has made some comments that similar situations exist on that side. Again, I am not looking at that right here. On the left-hand side, you see I can have the different type of HIT in the front office, scheduling registration, the data sources, the clinical, where most of the supporting information might be, and the back office, and there may or may not be smart apps or intermediaries in the middle to help facilitate, so these capabilities are distributed somewhere across these depending on what is happening, and where you start, and how you go through it.

So, if you go to the next slide, then you see that these are just a couple of the different ways in which these capabilities might be distributed. You might have scheduling and registration by one HIT supplier, then an EHR by another, and a revenue cycle by somebody else. It is possible. We see it out there. You might have the scheduling and registration combined with the EHR and others, but the revenue cycle, the back office, is somewhere else, etc. These are just four different ways. On the right-hand side, everything is in one system. That happens too. So, there are many different ways in which this could be put together depending on the size, the type of organization, how they came together through mergers, acquisitions, or otherwise, all kinds of different ways that are out there.

So, we really have to keep that in mind, that visual that we are not necessarily dealing with trying to figure out ePA on one system, EHR, and we are done. We need to figure out how this works, where there are multiple HITs in place because different aspects, different capabilities of the ePA flow naturally then fall in a particular IT environment that is currently in place, and that is the reality of where we are. That is how that has grown.

If you go to the next slide, the challenges, therefore, that we are looking at… We see that the Da Vinci IGs that are being asked about really address the main interactions necessary for ePA. Nobody is really going to question that. But, the question becomes more if I am now going to try to introduce certification to the process, and understanding over the last 10-12 years what certification does, how that works, and what that means if you are going to be subjected to that, that means that we really need to be very crisp about what the expectation is that you are going to do. So far, most of the certification criteria only needed to be satisfied by a singular system, EHRs predominantly, and yes, there were some relied-upon software

scenarios out there, but by and large, it was a singular system that needed to be able to do this, and we were not looking at the other side of the equation, of what other systems may need to do with it.

ePA is clearly an example of where that is not true anymore. We now need to look at a more complex workflow to make that happen. So, that means that the guides that we have need to be very clear that if you say that parts of it are actually satisfied by different HIT, we need to understand what are those parts so that the HIT that is attempting to be certified can do so correctly against the right subset of that IG, not the entire IG. They may, but they should not have to in order to just satisfy what they need to do.

So, that is one of the key parts, is that is not necessarily about if the interactions are there or not, but if we really understand the distribution across capabilities that we are defining to understand what would be necessary if your HIT only does part of the flow, but not everything. So, that is the second bullet there, that you need to have valid and demonstrated distributional capabilities because you do not need to fully support every IG to be a participant and a contributor to that flow.

At the same point in time now, flipping it around and not looking at the HIT, but looking in the other direction, certifying one system for the role in the ePA does not yield the overall value of what we are looking for with certification, which is where we are trying to make sure that all the pieces of the puzzle work and that we have end-to-end capabilities, so that creates complexity that we are not used to yet. What that also indicates is that all or none should be subject to certification, effectively, because if we are only going to focus on one system, saying your piece of the puzzle and what you do is certified, but the other side or the other parts are not, are we still sure that everything works together? So, if we look at certification of ePA, we need to look at all parties that are playing a role in there.

So, it is not just a part of what has been called CEHRT to date, and still is a very common term, but also, the term that is more appropriate and that has been introduced by ONC clearly in the last round that we are currently focusing on is CHIT, certified health IT, so that we can recognize it is not just about EHRs, it is about all the different systems that are part of it, and it can be fewer, but it also can be more, based on the reality.

So, if we then go through that to the next slide, this is an initial sketch that says we have these capabilities. On the left-hand side is not a literal list of the ones that were in the RFI. There is a slight adjustment to that based on our interpretation so far that we feel that it might look that way, plus there is one in there that we have some questions around whether that is really appropriate or not, so we will come back to that. That is the yellow one. The other ones are a reasonable representation of what is there, and subject to the discussions that we have. On the right-hand side, you see the different guides that are in place that exist for FHIR with the three ones in green, CRD, DTR, and PAS, that we are talking about mostly, but the other ones to provide context.

So, if you go to the next slide, the sense is that when you look at this and say, "Now, how do I map to that?", it looks like we need to be able to organize those guides in smaller chunks. This one is representing nine chunks. We can argue whether it should be eight or 10, and that is perfectly okay, this is not meant to be a final proposal in that regard, but it is more than the three that we have. We need to organize these guides into ways that we can say what particular parts they really support. There is somewhat of a close alignment

on the left-hand side, but you will see that as we run through it from these capabilities to what are now these building blocks that we can then associate with certification, what that looks like.

So, if you go to the next slide, we went through a little bit of a compare and said, "Let's look at two examples of how these capabilities can be distributed across IT/HIT." The first one to have a brief look-at is the provider HIT with the smart app manages the ePA flow, and the other one is doing it without the smart app, and where you would start to look at where it would occur, and kept on that point in time the focus on an EHR, but as we talked about earlier, some of the things could be done by a scheduling system or by a registration system that initiated those variations and did not create, though we can do that as well, but these are probably the two relative extremes on one side or the other, and then there are many variations in between that to occur, but they all seem to go back to needing to use those building blocks in those ovals in the middle.

So, with that in mind, you can go to the next slide. If you now assume that I am going to have either an EHR or a registration and scheduling system, and I am going to make a comment about registration scheduling in a moment in this context… Go to the next slide, sorry. I already jumped on my own slide deck there. If you look at that as an EHR initiative, I have to be able to initiate a smart app. That is reasonable. So, that is the dark blue on the left with the white text, pointing to in order to do that capability, I need to be able to have a building block of initiating a smart app, the dark blue oval in the middle with white text.

And, in order do to that, a little bit to the right, I need to be able to certainly support smart, and depending on how far it is necessary, the CDS Hooks is the clear way to help initiate that smart app with the right information, but it is actually possible, we have done it in connectathons, to just start the smart app and let them go back and get the rest of the information that they need to do to now go to the next step, request authorization, and the necessity of that, the actual query to the payers. That is really what the biggest chunk of CRD is.

You do not see an arrow from Capability 1 to "request authorization necessity" because the EHR need not do that. That could be done by the smart app, and that is fully described in the CRD. Then, the notification back to say, "Hey, I need authorization or not," I need to somehow get that back. So, here, you can see three different things that are in play. The CRD covers everything, but if I am only an EHR and I do not need to talk to the payer because, on the next slide when we go there, the smart app does. I do not need to do it. So, am I really clear what the building blocks are in here to do these?

Now, if I then continue with that and say, "Hey, the smart app is **[inaudible] [00:26:04]**," the EHR is not going to request documentation requirements, so the Capability 2 is not pointing to that. It is the smart app that is going to do it, so, no need to support DTR. But, you need to be accessible to get data to support the request, but the only thing that you really need for that is FHIR US CORE, and none of the rest of DTR, so how do I know what that is? It is fairly easy to state, but I do not need to do anything in DTR. So, that is kind of the flow to go through and say, "Hey, this is what is happening on the left-hand side, the dark blues are the ones that really the EHR needs to do," and actually, I should have kept registrations getting somewhat out because they are not likely to be the ones to access the supporting documentation. So there, you see that if that is where it starts, now I have the scheduling and the registration that need to be done first, I need to start the smart app, at the end, I want to get the information back, they have a notification as well, but they are not necessarily the source for the supporting documentation. I need to go elsewhere.

So, if you jump to the next slide, on the other hand now, the smart app is part of this configuration. They need to do a lot, so they are pretty much going to be supporting everything in the CRD/DTR/PAS, and if you go to the next slide, you see that it is a lot more light-colored instead of the dark blue. You see that other source systems only need to be able to be accessible to get the data. And, if you go to the last of this series, the next one, you look at the revenue cycle back office, in this kind of distribution, they need to only be able to receive the response back because everything else is taken care of by somebody else.

So, that is the kind of environment you can see here. I am going to come back to the yellow statement in the moment. So, that is one example. Now, flipping it, going to the next slide, that is just the title, so there is no smart app in the middle. You will see that the EHR was now chosen to be the primary coordinator. They now need to do a lot more. They do not need to initiate a smart app, they already are capable to get to some other things, so now, there are a lot of things they can take on.

But, depending on where you are or what you are trying to do, they should not have to support everything from the start because there are other ways to do it, so this is where the "How many of the building blocks do you need?" question comes in, and that becomes an interesting question. If you then go to the next slide, you still have other systems you may have to tap into for additional information, and then, at the ends, in this particular case, on the next slide, the variant is that the revenue cycle still does the same thing.

So, just two ends of the spectrum, in a way, where these building blocks, these parts of CRD, DTR, and PAS, that depending on how you go about it, that you move forward, and where we are at is that you may start out with relying on the smart app, you may grow over time to do a bit more in the EHR, but not necessarily everything, you need to be worried about other systems that initiate as well, the scheduling system or a registration system, you need to be worried that the EHR is not the sole repository of all the information that you might be interested in.

It creates a bit of a complex environment that the intent of the building blocks is to have reusable chunks that certification can then be tied to, if we go that path, that can recognize what it is, which means we need to subdivide the CRD/DTR/PAS, not by breaking up the IG, but by recognizing which pieces of those puzzles are relevant so that if I tie them to certification criteria, I can tie them specifically, scope them, and I know exactly what I am supposed to be able to do, and then I can support one or more building blocks. That is up to you, then, to determine what is the best way to move forward. And, the combination needs to totally work from a provider perspective, otherwise that is not going to work either. You cannot just show up with one thing and that is it.

There is a side question mark, the review-and-sign, and we will come back to that discussion on e-signature. There is really a question we are struggling with, that if we are on this path of automation, interacting with the payer, getting the information back on what is needed, and we can get that information automatically using FHIR APIs to get to it, what is the purpose of an initiating provider to still, on top of that, do a review and a signature of that data before it goes out to submit. So, there are some questions that are going to come back there, put it in the picture, but we do not want to highlight it too much further today.

So, when you go to the next slide, a couple of considerations that come out of that complex puzzle that we are trying to put together. Again, we do not think that the Da Vinci IGs are sufficiently granular, that when

you go to certification criteria where we must have unambiguous statements of what is required to support, what interactions they are, what the guidance is, to do that in a multiple-HIT environment, which we will and which we are, we need to be more granular, and that can be done inside the existing guide, but that needs to be fleshed out a bit more.

Additionally, we have seen a variety of different configurations and approaches there, but there is still some maturation to be done in production to really see that yes, it works, and we know that this can float. Now, all indications are that we can do it, we have seen it, we are interacting with the smart apps in a couple different contexts, but the exact boundaries of the necessary building blocks have not been totally settled. During the Da Vinci projects, we have been working individually. That says, "Hey, this is the piece that I am able to do, this is the piece that you can do," so that has been talked about and negotiated, if you will, individually, but now we need to formalize that to understand that yes, those are the building blocks. So, we can also say that from a provider perspective, we need to make sure that we have all building blocks in play across the HIT, we want to do a lot of it, multiple could do it, but all need to be there to make it work.

Therefore, these building blocks that you saw in the slides are our current interpretation of what we think the boundaries look like, but they might not be totally agreed to. That would be quite understandable given where we are at, so it is not a consensus that it reflects, but we are in a situation where there is a ballot open right now, as of last Monday, on these guides, so this is a perfect opportunity to provide input and feedback into those around can we organize the guides a little bit more so that we are able to recognize what these key building blocks are that could be distributed across HIT that then can be used for certification purposes and clarity in that regard, which gets us to the last slide.

On the next one is a sketch of that, and again, this is just some initial thoughts that we started to talk about in the context of the EHRA, so it has that perspective of having been involved with certification, and to date in that area, generally, we could think about multiple stages where the provider is provided with a functional requirement to be active in ePA. We could look in that space on the payer side, and again, we did not further address it, so I fully expect comments and considerations there, but on the payer side, we have these standards in play so that we know what we are aiming for so that this is not going to be a "Hey, let's everybody just go off on their own." We know that is a target there.

But then, on the provider HIT side, we do not start out with certification criteria with precise boundaries. We will still try to figure out what that is. But, having the APIs available on the payer side, we know what we are aiming for when you interact, but we are not sure yet exactly who is doing what piece. We have that flexibility to work with, so, be very careful starting on the provider HIT side with certification criteria because that locks it down too quickly based on the maturity that we have. But then, in Stage 2, where we now have that experience, we understand how it all can work together in production, not just in connectathons and additional rollouts. Now we are more comfortable to say now we know exactly what we can certify against. And then, you can move to where is the provider of the role with incentives or other programs that says it is not only a functional requirement that can play in, but the use of certified HIT, because now we know that we can get there.

Another consideration that is not instead of, but in addition to, focusing on CRD and PAS first, followed by DTR, document templates and collecting the supporting information is the more complicated part of this, the workflow that is needed. Do I have everything immediately, do I need to have some follow-up, do I need

to get some additional data, etc.? All those things are more complex in this path. Is there a stepping stone that is in combination with the first thoughts that we state that as well so that the initial focus is primarily on CRD and PAS, absolutely continuing to move forward with DTR and learning about it, but do not put a strict certification requirement around that because that is where the major challenges are going to be.

So, those are the thoughts. I am trying to put the complexity of the ePA that is going well beyond what we have seen in certification to date because it involves multiple HIT, trying to visualize that a little bit more. It might not be the most perfect slides there, but hopefully that helps and gives a better context of why the thoughts are in these last two slides of how we can stage this in a way that there are still parts to learn and take advantage of the current ballot cycle. There are three more weeks to go, I think, to provide this input to help improve on the ability to support parts of them, depending on what HIT you are. I am going to stop there and ask for questions.

Tammy Banks
I appreciate it, Hans. I am going to set some guiderails around these questions so that we can move a little bit quicker, but I really appreciate the visual with what is the revenue cycle management versus the EHR versus the FHIR app and who takes over the different functional capabilities. Now, one thing we are going to go in in our conversation is to talk about the functional criteria that is contained in the CRD and PAS, so we will flesh those out a little bit further, so I think we can hold those types of questions. Are there any questions for Hans in regard to the workflow and the minimum requirements that he mentioned, recognizing that we are going to have that conversation as soon as we are finished with the questions?

I just have one question, if no one does. Hans, you recommended or questioned the need for the digital signature. Is that more from a technical perspective, thinking it could be automated? Because from a patient perspective, I want to make sure my physician reviews my record and makes sure it is accurate before it gets pulled. Could you just expand on your thought process in regards to that? Is it more technical automation-focused, or is it more business need and quality control?

Hans Buitendijk
It is more the burden that that may introduce as we progress. For a particular service item, something that needs to be preauthorized, when you send that, there is a set of data that is relevant to support that, and our aim over time is to have the collection of the data as automated as possible, so the more that those rules and the data are based on what is already collected in the systems that I can therefore pull using FHIR APIs, the more that is more structured and well defined, then I can automate more and require less interaction by user to gather that data.

Once I have now reached for a particular item, that ability, it only needed to know if there was a result of a particular kind in the last three months, and then it is authorized or not. If it is at that kind of a scale, if I can do that, do I want to reintroduce the user into the flow to ask if we got that right? So, that is the thought behind it. What does that really mean, and is it more that we know this is coming from a trusted environment, so it is more of an organizational system-level statement that we did that? And, if there is sufficient transparency into what data is needed for what authorization, do we really need that level of "interaction" by the user to revalidate that this is the right data that came along?

So, that is where the question comes in. Is that really the intent? Because if we put in an e-signature requirement on that data set that is going to come along, that means that we need to reintroduce the user into the flow, which then is going to possibly delay. Is that really necessary for what we are trying to do? That is where the question is coming from.

Tammy Banks

Sheryl?

Sheryl Turney

Hi, Tammy, I think I had my hand up, and then Patrick.

Tammy Banks

Sorry. Patrick is right after you there.

Sheryl Turney

But, the point that I wanted to raise was in the flow, really good pictures. I think it gives us another dimension and another way to look at it. But, the communication back and forth with the patient is really left out of that whole process, and I do think it is fair to say that the patient access API does not have any workflow at all for passing prior authorizations or anything at this point, so we may need to include the updates of that implementation guide as necessary as part of this process.

Hans Buitendijk

I completely agree. For purposes of this conversation, I did not include that because the discussion still needs to happen on where it fits or not. No need to go back on the slides, but when you look at particularly the PAS monitoring the repressed status, it is one of the places where the question is. Should that also be accessible and usable, not only by a provider system, but by a consumer app? And, in order to do that, what are the additional interactions to enable the consumer app, if you will, to be able to know what authorization they are actually looking for and which payer to ask for? So, those are the additional flows that are currently not necessarily as clearly defined in the guides as well, whether it is carving out or otherwise, but at that point in time, that would certainly be additional steps to take.

Sheryl Turney

Shall we go to Patrick?

Patrick Murta

Yup, and I will be brief, and Tammy and Sheryl, if you need to cut me off to go on, feel free. Hans, as you were talking about the DTR app or lack of DTR running in the EHR and the clinical space, thank you for putting this together, by the way, but I was a little confused by your description, and maybe if you could just spend a few seconds on it. You were saying that if the DTR app is there, it is one level of complexity or abstraction in the EHR, but there may be a whole new level of complexity in the EHR if the DTR app is not there or not needed. And, I tend to think of this as a set of capabilities that are defined by the IG, and the DTR app is really meant to reduce the complexity on the EHR. If the EHR supports smart and also has FHIR interoperability, CQL, or whatever, then you are actually lessening the burden on the EHR. So, can you explain what you meant by the DTR app is there or the DTR app is not there?

Hans Buitendijk

The thing is that it is a couple parts. If the EHR is able to initiate the smart app, the smart app can go out and pull the documentation requirements once it identifies that it needs to get authorization. It goes out, it gets the CQL and/or questionnaire back, and it can translate into FHIR calls that can go out into the EHR, so at that point in time, the EHR need not support CQL, need not support questionnaire, it only needs to support FHIR US CORE as it expands to be able to have that data accessible that the smart app can pull out and pull together into a questionnaire response, etc., and go from there.

So, that is part of it. Once you start to get into the process of "What data do I need?" and begin to identify that I cannot pull everything automatically, I may need to do it over time, need to do it manually, or need to do other things. That is where the complexity comes in of the workflow, the management, the back-and-forth, etc. that makes the DTR process just generally, as a process, more complex. So, that is where I was not as clear. That is not necessarily the IG capabilities that are defining the interactions, but the sequence in between is that when I say, "Whoops, I cannot go any further," I need a manual person to interact, or I need to have a handoff, or I am panning, or I find out I need to get additional information. That is where that managing workflow, making sure it progresses, the handoff, is where it becomes more challenging, where we do know that people have made progress, but everybody is in different stages there to make that happen. They fully rely on a smart app, they have already done some of it, but not all of it. That is where the complexity is coming. Does that help?

Patrick Murta

Yes, thank you.

Working Document Review and Discussion (00:46:13)

Tammy Banks

All right. With that, any other questions? Otherwise, we are going to go further into 1.3 questions, and the first question I really want to talk about is the one module versus individual criteria. Now, I received some clarification, and Alex, please jump in If there are additional questions on this, but typically, no more than one vendor is certifying to each HIT module, but it could certify to multiple criteria. So, if we look at a module-type approach, we would need to continue down the line of fleshing out which groups of the capabilities might be performed by a separate app. So, if we just had a module, and an app would have to meet that criteria, or the EHR, or the revenue cycle.

And also, the other option is when we look at this criteria, we have been really good at looking at the universe of healthcare stakeholders, and how do we make sure that this functional criteria is across the table with the payer, with the vendor, and with the provider to ensure that that accurate information exchanges and a complete, successful prior authorization occurs quickly. And so, with that, you will see when you look through the first draft, it includes language about payer certification or payer accountability, which is a better word than "certification," to this piece, as well as there could be a provider piece, like meaningful use. Promoting interoperability requires the exchange of certain types of documents with those functional criteria. So, there are other stakeholders that we can think about to complement the functional criteria that we lay out, either in a single or module approach, and Alex, from my understanding, there can be individual criteria or there can be a module approach, so can there be both?

Alex Baker

14

Yup. I think that is right. I just want to remind folks that requirements on providers to use this are not part of the ONC certification program, but rather other authorities in HHS that point to use of certified technology.

Tammy Banks
And, the only reason to bring that up is in the concern with the one module, providers need that complete functional criteria to be available and usable in order to make the prior auth work, and so, that is one option to make sure that that happens. So, the question to the group and the discussion here is I took all the comments that we had, and we fell in two camps. One is the one-module, which the majority of people fell into, and then, we also had the separate criteria, and with the separate criteria, again, it was still in support of the full automation, but anyway, before we go through both of these, David, you laid out the separate criteria in a way that pulled out the functional criteria for each of the guides. Could you run through that? I think some of us on the call are not familiar with what the actual functional criteria is encompassed in a guide, and when we say CRD or PAS, we do not see the granular level that Hans needs to get to.

David DeGandi
Right, and that granular level that Hans showed is accurate and representative of what actually happens.

Tammy Banks
Oh yeah. So, if you just want to go through how you broke this down with your recommendation of the single versus modular approach? And, I have it up on the screen.

David DeGandi
Right. So, the difference between the singular and modular approach would be the EHR doing the work itself versus Smart on FHIR would be the modular approach, I believe. It requires the EHR to expose the needed functionality to the Smart on FHIR app in order to manage the automation, the flow of the order for authorization through the workflow in the EHR… Ideally, the EHR single module would kick off a CDS Hook automatically based on the order submit kind of thing, whatever event is appropriate for a specific EHR. I do not know the actual event names; I am just saying that is what would happen. I do not know if that makes sense or not.

Tammy Banks
Okay, so that is what would happen with the CRD?

David DeGandi
Right. The CDS Hook would kick off eh EHR automation, or a Smart on FHIR app would have to be launched by an administrative provider for the Smart on FHIR option.

Patrick Murta
Or from the Hook.

Hans Buitendijk
Right, it can be.

Patrick Murta

It comes from the Hook. So, maybe if I can just add a little color commentary to what Dave was saying, if you do not mind?

Tammy Banks
That would be great.

Patrick Murta
Transparently, I am in support of individual module or individual testing and certification within overall certification as well, and the reason for that is really two things. You have discrete atomic parts of the flow, which can be tested, the CDS Hook, which is invoked by order sign, order request, or whatever happens in the EHR, invokes a discrete unit of work with the payer, pre-fetch the CDS Hook, and then, the API responds with a CDS card that says for Patrick Murta for orthopedic surgery, prior authorization is required or not, and here is a link to the smart app for additional medical necessity documentation processing. So, you can test and certify, from my perspective, that CDS Hook interaction on its own. That is a standalone feature, and also, it allows flexibility in incremental rollouts.

So, for example, even in today's world, many payers have that functionality or will have that functionality in play while they are building the other DTRs or the PAS, so it allows functional or incremental progress on discrete units of work, discrete units of the different implementation guides. So, you have the CDS Hook that says prior auth is required or not, and a link to a Smart on FHIR application, which will be provided by the payer or, to Hans's point, another HIT provider on the part of the payer, which now is interacting with the EHR and is either doing a FHIR query to get additional information, CQL, or whatever the case may be. So, again, that is a testable component.

Between the EHR and the payer, does the Smart on FHIR app invoke, and can it address the local FHIR APIs with CQL or whatever the case may be? That is a testable thing. The third piece is "All right, we have enough information, we know prior authorization is required, we have an indicator on the CDS response on the card that medical necessity documentation was required, we have collected that, now we can submit a FHIR bundle to an intermediary, to an HIT provider, per Hans's presentation earlier, directly to the payer," and that, again, is a discrete unit of work, so we have at least three things there. So, you can be certified individually on those, and then, when you can prove you have all three individual certifications, then you get the super gold star that says you are now prior-auth certified.

Tammy Banks
We all like super gold stars.

Hans Buitendijk
Tammy, if I may jump in there, I agree with Patrick on just about everything, but a question on the first part, which is a small one, and the last part. The initiation of the smart app in CDS Hooks would have the appropriate capabilities there. We would need to understand functionally what exactly is that, so you would point to that and say that is what you need to do. Then, we are clear on that so you can be certified against that. There may still be a little bit of a debate, and we have seen it, that it can work, but it is not as clean, for sure, is that we just need to initiate the smart app and the smart app comes back using FHIR US CORE and coverage resources to pull the rest of the data that otherwise would have given on the CDS Hook. It is more user interaction, but it is actually a smaller step than CDS Hooks just to recognize that.

On the back end, the necessity is done, and I have it. There is a clarification of it is one thing that he smart app at that point in time or the other HIT can continue, but you would like to go back to the party, the EHR, the scheduling system, the registration system, and say yes, you need to be aware this one needs authorization, so that one is going to kick off, or no, it does not, keep on going. So, they may control at that point in time if I am going to put something on hold or not. We need to be clear what that notification looks like as well. If they started with the CDS Hooks, then it is more clear. If they did not start that way, what does it look like? So, I think those are the kinds of things where I wonder if we are all clear on what those subsets are so I can be certified against that. The overall gold star part of it is the bigger question, and I am not sure whether I heard correctly that you said we need an individual item certification criteria, where I think we are completely in sync. We might quibble on some of the boundaries, but I think we are in sync on that.

But, what would a certification overall mean? I might have three, four, five, six different HITs in the entire flow to make that work. What does that mean? I think that is the hard part of these more complicated workflows on how to do that, because the concept is good, in a way, when you look at it from the perspective of the provider needs to make sure all pieces are in play, but whose responsibility is it? How do we make sure that we know in order to make it really work, we need these nine capabilities and all the HIT pieces that are contributing to that contribute enough that it works in total? Where do you put the responsibility?

Tammy Banks

I just want to put guiderails around our conversation right now because where you are saying is exactly where we have to go, but we are not there yet. We have to take our steps to get there. And so, right now, what I want you to keep in your mind is we are focused on health IT across all vendors. So, I know some of you are saying Smart on FHIR, some of you are saying EHR. We are vendor-agnostic right now. Take your hat off. It does not matter who is doing what. We are going to drive on what is the functional criteria, and I have another spreadsheet we are going to get to, and we are going to drive to what do we think is minimal, and then we will get to what is the actual specificity of that functional criteria, then we can move into what goes into which module if time permits or if we get extended time to do that. But, we have to get our baseline set first. Heather, do you have a comment?

Heather McComas

Yeah, and I will not take much time because I think I am just echoing what Hans just said. I am getting this modular approach, and you need each of these pieces put together, but as Hans has said, from the provider perspective, you need the whole thing to work, but the question is who would be certifying that piece? To Patrick's point, I get that the super gold certified is what the physician wants to know because if just one piece of it works, it is going to fizzle out and they are not going to be able to do the prior authorization process, so I think the overall approach is needed, I am just not sure, as Hans said, who would be getting that super gold star certification if there are all these different players involved, but so I do not derail us, it sounds like that is a step ahead of where we are right now.

Tammy Banks

Right, and that is where we are going to back into, but we do have to remember on our principle, we all agreed that whichever provider was purchasing this product is going to be responsible for ensuring that they have the complete prior auth package because we need to make sure that the provider has the option

to either do a Piamat revenue cycle, or an EHR, or a Smart on FHIR, or any of these combinations. And so, we are going to have to talk about that complexity too because it is not as easy as I just said. Raj?

Rajesh Godavarthi

Listening to the comments, I am a little bit worried that we are going in circles in a way that what is the value to the provider at the end of the day? The prior auth workflow is complex. It goes from one end to another end, and the value is measured at every point. So, the previous calls, the maturity needed to be there. It will probably take a couple of years to get there. So, what can we discretely identify part of the certification as a first step while we are thinking about all the capabilities, while we are thinking about other HIT systems, while we are thinking about every possible thing? We have to lay the ground as a starting point, and as long as you focus there, I think we will achieve something.

Tammy Banks

Hey Raj, we are going to get there. You are head of us, okay? So, the question now is we had some comments that were for the one module because we need that uniform workflow, and I think we are all in agreement that regardless if it is one model or individual, there needs to be some type of criteria or oversight body to ensure that all that functionality is available and will be able to move, not just with the health IT, but with the payers, and be used by the providers. So, for right now, can we just focus on the health IT piece? Anybody have any comments on the individual versus one module, or do we need a combination based on bundling what would be the complete minimum functional capabilities that would have to be provided across one or more vendors? I think we all agree with the separate criteria that we would bundle, but the question is do we also think we should have a one-module certification that then would provide an option for one or more health IT vendors to pair up?

Hans Buitendijk

When you say "one module," if we have the individual capabilities clearly understood, currently distributed across the three IGs, if you have certified against all of them, now I am effectively a one-module. And, if we recognize that, then I think within that, we do go back to the question that Raj, myself, and others raised. What was the right division of those capabilities, and what is that overall "gold star" on the provider side and on the whatever side to make sure that I have a good understanding to know what I need to do to make sure that I have all capabilities in play, whether it is done through one module by somebody or distributed across multiple HITs by multiple?

Rajesh Godavarthi

Sorry I did not raise my hand, but I like what you and Hans said, Tammy. I think keeping the certification criteria in chunks, and then, somebody can say collectively that we did all of them because that is the way to collaborate and keep the ball rolling.

Tammy Banks

Okay, is anybody in disagreement with this statement here? One-module is specific functional criteria to allow individual functional capability that can be performed across multiple health IT vendors. Again, written much better, this is just on the fly, trying to get the basic, and then I can take all your comments and brain that around there for wordsmithing.

Rajesh Godavarthi

I think it is modular.

Tammy Banks
Heather?

Heather McComas
Yeah, I think that looks right. Not to get ahead, but is the gold-level certification… I guess my concern is how do we make sure that all these different pieces are working together? Whose responsibility is that? Because from a provider perspective, if I have all nine pieces but they are not working together, who is the one who is going to ensure that the package I have works as a whole entity? I guess I am not sure how that is going to be handled.

Tammy Banks
Okay, can we go into the functional criteria piece, and then see if we can back into it? I am trying to figure out how to take this in a step-by-step approach because it is just so much information. What I did is I took the ONC RFI functional capabilities and I highlighted each of those functionalities because we agreed on or had in our taskforce recommendations each one of these points. I know Hans raised the digital signature as a question at this point on if that should be minimal criteria. I did not flag that here, but we can include that in our conversation. Then, I took Hans's demo of all the functional criteria that he mentioned. Everything that he mentioned was in the original question from the RFI.

So, then what I did, just to get us all in the same page, is I put the functional criteria that we have that are compiled comments from our group on that this functional criteria could be, and David, that is why I had you and Patrick go through the PAS and the DMC, because I do not know how granular that functional capability is, which you laid out. I am thinking we are in agreement and I want to double-check. Anything that is highlighted that matches what was in the RFI, are we in agreement that that needs to be included as minimal criteria first? Is there anybody who is in disagreement with that?

Hans Buitendijk
Are you sharing a different screen or different form? Because we do not see it.

Tammy Banks
You do not see my spreadsheet?

Hans Buitendijk
No, we still have the Word document.

Tammy Banks
Oh man, I was showing you some good stuff. Okay, why is that? Just a second. Okay, you are seeing this. How do I stop share? I apologize, folks. It is really pretty. I should not say that because then you will not think it is by the time I get there.

Patrick Murta
While you are transitioning, can I ask my question?

Tammy Banks
You sure can.

Patrick Murta
All right. So, is the certification currently against a software vendor/provider, or is it against a provider/installation?

Hans Buitendijk
It is against a software solution. There is a base EHR capability, and then there are other capabilities beyond that that an HIT may opt to certify against some or all. We do not have to certify against everything always, and that is typically driven by, for what you are trying to do and your client base, what is actually most critical, most important, not needed ever, whatever that might be. So, it is against the software, and it is against certain software configurations.

Tammy Banks
Okay. So, just the highlighted squares is the ONC RFI functional criteria they asked about, an then, highlighted in this middle section is what Hans mentioned. The only thing that really was not expressly in there was the additional request for information after information was sent, but I figure that functional capability is within the other pieces, so I did not pull that out. And then, I highlighted in our recommendations that functional criteria that meets the greyed-out areas under the RFI and Hans, and I am just asking if that functional criteria that Hans went through, minus the digital signature because that is a comment that is up for debate, do you agree that that is all minimum functionality that we need to recommend? Can we blanket that and just agree that is minimum? It is vendor agnostic. Can we agree with that, and then move into those areas that would be additional criteria? Hans?

Hans Buitendijk
Yeah, just generally, I would react as yes, but I do not think you shared this spreadsheet in an email.

Tammy Banks
This is on the Google docs. All I did is take the functional criteria that everybody put forward, and I put it in this document, so I am trying to get a blanket agreement that the functional criteria that Hans went through and that is mentioned in the RFI is minimal. Let's forget about who is doing it, forget about the specifics of CDS Hooks and how. Do we agree that this functional criteria needs to be in our recommendation as minimum? And then, we will go through the additional functional criteria that is listed to see if that should be added at minimum. We will get to the specificity; this is one step to get there.

Hans Buitendijk
So, the comment that I would have that I am not sure falls in the latter part or the first part is that I think it is missing the initiation of the smart app, and the notification on Row 9 is actually not the equivalent of what you have in the ONC column.

Tammy Banks
So, this is new?

Hans Buitendijk

Well, yes and no. It is part of the first CRD-related part. It is not part of DTR.

Tammy Banks
Forget the guides. All we are talking about is functional criteria. It does not matter if someone is going to receive a 278 back and get notification, right? It does not matter. Is the functional criteria that is listed the functional criteria we have to meet with the specifics of either triggering a smart app, using CDS Hooks, or using a 278? Do we agree that those highlighted items are the minimal requirements that we would recommend, and then we are going to add to it, or not? These are what we discussed and was put in a few of these that are highlighted, which we did not discuss as a group, but otherwise, we did. We did discuss "Identify when a prior authorization is necessary." So, we did discuss the capture of the digital signatures, but Hans has put a question on that one. Yes, Patrick?

Patrick Murta
Just to nail it down, for example, are you saying 12C, since it is highlighted, are we agreeing that that is a functional requirement? Is that what you are asking?

Tammy Banks
Yes, and then we can go into specifics after we agree what is our minimum criteria, and all these that are highlighted are in Hans's presentations and in the RFI which ONC is asking clarification on, and in my mind, in addition to a few of these other ones, they are needed in order to support a complete prior auth regardless of vendor-agnostic perspective. Can we agree on that? We have discussed and compiled each one of these highlighted ones on a call. We will wordsmith later. It is the content we are talking about today, not words.

Rajesh Godavarthi
Yeah, as long as you put a color to the signature piece, maybe some other color. I think everything else is good.

Tammy Banks
Okay, then it is just the highlighted. We are going to go through the ones that are not highlighted because we did not agree as a group if it should be minimum or a phased-in.

Patrick Murta
Tammy, maybe for myself and a few others, some of this wording is extremely specific, so if you are saying we are agreeing conceptually with what it says but we can wordsmith it, that is a much easier ask.

Tammy Banks
Yes.

Patrick Murta
Okay.

Tammy Banks
I am just trying to move this a little quicker, know what I mean?

Patrick Murta

Yeah, I am with you now.

Tammy Banks
Okay. If there is any disagreement that the content of these highlighted functional criteria, which is represented in the presentation, represented in the ONC RFI, and we discussed previously should not be a minimum criteria, let me know.

Hans Buitendijk
Generally, in agreement. I am just having a tough time getting to the Google document to be able to read everything specifically. It is not popping up.

Tammy Banks
We will wordsmith it. It is the functional capability.

Hans Buitendijk
I am just trying to get access to the Google doc. That is what I am trying to say.

Tammy Banks
Okay. Again, we do not have much time, so we are not going to get totally where we needed to be, but let's go to the ability to place a patient flag to identify if a plan's PA requirement for a particular patient service is waived due to the ordering physician being gold card. Is this a minimum requirement? Is this a physician-requested functional criteria for their particular vendor? Those are the two questions I need. So, should it be a minimum or should it be a recommended optional item?

Rajesh Godavarthi
I would say recommendation.

Tammy Banks
Sorry, recommended?

Rajesh Godavarthi
Recommendation, yeah.

Tammy Banks
Okay, so, an optional recommendation.

Patrick Murta
I agree because in reality, wouldn't it just be "authorization not required"? That is all it is. If we are saying this is the rule, that either requiring the authorization or is not requiring the authorization, it concerns me a little bit because we are saying if a provider is gold-carded, authorization is not required.

Tammy Banks
So, recommendation, not criteria. Heather?

Heather McComas

Yeah, I guess I am a little confused about the "recommendation, not criteria" thing, and I guess I am a little fuzzy on what that means. I do think it is important that the system can support this. Texas has a law requiring health plans to offer gold-carding programs, and it is likely that in other states, and perhaps even federally, this will be required, so it would be important that technology should support it. I think it should be part of the criteria, part of the initial "Is a prior auth required?" piece. I guess I am not sure what we are saying.

Patrick Murta
Heather, I think what we are saying is the response will be "Authorization is not required," and we know under the engine, the decision was made based upon the fact that that provider is gold-carded. The question is do we need to respond back and say prior authorization is not required, and the reason is because they are gold-carded? That is where the distinction is. Typically, we just say it is not required.

Tammy Banks
Heather, correct me, but I think where Heather is coming is even before the prior auth process, you are going to know what prior auth procedures are going to be gold carded, and you do not even need to submit for one. How do you put a patient flag in so you know you do not need to submit for prior auth because you have been gold-carded out of that procedure? So, that question is more of a technical question for me. I hate to put that requirement if there is a certain place in the workflow the provider wants it because this can easily be built. It is not hard to put a patient flag in, relatively. So, that is why I did not know if it should be more a recommendation than a criteria, because otherwise, you have to determine the workflow for that piece of it, which is really pre-prior auth, right?

Patrick Murta
It is CRD.

David DeGandi
And, the source of that data is the payer, not the EHR, so it is not going to be on the patient EHR. They are going to have to query the payer either way.

Tammy Banks
Okay, David. Raj? Let's keep this **[inaudible – crosstalk] [01:16:40]** because we have eight more.

Rajesh Godavarthi
Exactly, I agree. I am good. I think David is correct. This is a payer's criteria. This has nothing to do with the provider's ability to do anything because the payer would respond based on the gold-carded information.

Tammy Banks
So, this is important for a consideration from a developer perspective, but not a mandated requirement.

Rajesh Godavarthi
Right.

Heather McComas

Sorry, aren't all the prior auth requirements from the payer's side? All CRD is dictated by whether or not a payer requires prior auth for a particular patient on a particular service, so I am not sure how this is different.

Tammy Banks

You are asking for an ability to say when a prior auth is not needed before the procedure, correct?

Rajesh Godavarthi

If you read that line, it is about flagging a patient. That is what we are saying is not a criterion. We are not saying the automation part. Read the first phrase of the requirement. That will make sense. The ability to place a patient flag is what we are saying is not a criteria because you would get it automatically because if the gold card does not require, it happens on the payer system. The gold comes through the CRD. But, why would we be on the provider side, as a mandate, flag the patient because of this? That is before it even happens, so it is pretty hard to do it, so that is why we are saying it is a recommendation, not a criterion.

Heather McComas

I see what you are saying, and I am fine with it. If we could work the gold-carding piece into that first green box, I am totally okay because I think it is all part of that first… Raj is like, "Yes, Heather, you are finally getting what I am trying to say." I think if the gold-carding piece is clear in that first green box, the request authorization necessity piece, then I am cool.

Tammy Banks

Okay, so you want that changed back to the way it was. We can do that. Okay, digital ID cards. Is that out of scope? Again, with a prerequisite that that is recommended to continue to look into how digital ID cards can…

Hans Buitendijk

Considering the flows where this is initiated, the patient should have already been known, so I am not sure what this is unique or specific that needs to be reintroduced into the ePA flow from a provider perspective. If there is a need that a patient is going to start the prior authorization flow, which I understand is not the case, they would like to be up to date with where it is, but they are not going to initiate it, so that is why I am not sure where this fits.

Tammy Banks

Sheryl, do you mind speaking to it from an ICAD perspective. I am not quite sure where to put it. I understand the value, I am just not sure where this would make sense.

Sheryl Turney

I think I am going to have to think about this a little bit in terms of where to put it, but I do think that it needs to be addressed, and maybe it is an overall principle. That might work.

Tammy Banks

Okay. "Electronically support patient requests for advance EOBs to provide estimated costs for approval." Now, I know that the patient is not built in the workflow right now, so I am seeing that is a forward-thinking future criteria that we need to have mentioned so that people can build to it. Anybody in disagreement with that?

Hans Buitendijk
Sheryl raised her hand.

Sheryl Turney
No, but I think we need to take a break, Tammy, because we are beyond the time for public comment.

Tammy Banks
Oh, how did that happen?

Sheryl Turney
Well, we have a very robust conversation today, so maybe we need to move to public comment.

Tammy Banks
Okay, and then we can come back to this one.

Sheryl Turney
Yeah.

Public Comment (01:21:00)

Michael Berry
All right, thank you, Sheryl and Tammy. We are going to now open up our meeting for any verbal public comment. So, if you are on Zoom and would like to make a comment, please use the hand-raise function, which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to unmute your line. We will pause for just a moment to see if we have any public comments. Okay, I am not seeing any public comments, so I will turn it back to Sheryl and Tammy.

Sheryl Turney
All right, go ahead, Tammy. See if we can finish up that point.

Tammy Banks
Okay. I cannot use the screen. So, anything with the patient request I will put as future criteria. I do not know if I can get the screen back. I think we have to have the public comment stuff up. Okay. The other is "Ability to access authorization status using a patient-level indicator with the inclusion of gold card." Would that be a minimum or moving toward next-phase criteria?

Hans Buitendijk
Can you share the spreadsheet again? We do not have it.

Tammy Banks
I cannot, because we have to show the hand-raise function. So, it is "Ability to access authorization status using a patient-level indicator flag includes information related to the status of the PA request for a specific patient and ultimate PA determination." I am thinking it should be minimum. Anybody in disagreement with that?

Rajesh Godavarthi
If it falls in the category of "patient needs to know the status," then yes.

Tammy Banks
Okay. The other one we have is "Clinical workflow auto-triggers CDA on behalf of the physician or designated healthcare staff." Does that need to be minimum criteria? I guess it has to be minimum criteria.

Rajesh Godavarthi
Can you paste it in the chat?

Tammy Banks
Okay, that would work. Just a second, I have to figure out how to get to the chat. Oh, here. It looks like I can take the screen again. Here we go. "Clinical workflow auto-triggers CDA on behalf of the physician or designated healthcare staff." Is that a minimum, or is that something we have to drive toward?

Hans Buitendijk
I am not sure what that means.

Heather McComas
Is it supposed to be "CDS," maybe? I am confused about what that even means.

Hans Buitendijk
Right.

Tammy Banks
I would think that this is the document piece.

David DeGandi
I think discrete pieces of data would be more useful than a full CDA.

Hans Buitendijk
Right, and it is C-CDA, then, I think, and it could be multiples.

Tammy Banks
So, it would be both, right? It is the document and the artifacts both?

Rajesh Godavarthi
It is what we call a bundle.

Hans Buitendijk
It is just a data set.

Tammy Banks
And, the data set can be document or…

Hans Buitendijk
It could be anything.

Tammy Banks
Okay, auto-triggered. I think it is a collection. Someone wanted to make the point that the documentation support would be auto-triggered. I think that is what was trying to be made in that one.

Hans Buitendijk
Yeah. I think this needs a little bit more review because I must say I am having a very hard time following this, not having the spreadsheet.

Tammy Banks
Okay. It is right on Google docs, the top of the Google docs, but we are going to be putting this document up so that you can start looking on this one. So, minimum would be in that vein, obviously. And, what about acknowledgement? "Receive and record acknowledgement of receipt from payer." Is that a minimum? I think it is.

David DeGandi
Yes.

Tammy Banks
Okay. The other is "role-based workflows." I think that is a minimum. I cannot even imagine how you would do this without that. Anybody disagree? I know we talked about that. All the patients I am going to put as the phased. "Triggers for expiring PA to promote renewal activities." I think it is a minimum. Anybody disagree with the minimum? Okay, "Automatic forwarding copies of all submission responses to those patients." Is this one still a forward-thinking, or is it a minimum? I do not know where the capabilities are today.

Sheryl Turney
I do not know. I would say this is forward-thinking because I do not know, if patients opted in, if they would want to see everything, either. They may want to only know where it is and at what state versus everything that has been submitted.

Tammy Banks
Okay. And then, "All health IT vendors, including business associates, shall implement procedures and utilize mechanisms to ensure the confidentiality of medical information." This is definitely minimum.

Sheryl Turney
Yeah, that is minimum. All right, I think we are going to have to leave it there, Tammy, because we only have a couple minutes to do our homework assignments.

Tammy Banks
Okay. Can I give a quick update, and then you can take it away?

Sheryl Turney

Yeah.

Tammy Banks

I am going to be updating this document. What I am going to really be leaning on, all the technical experts out there, is to put in this extra column. It will be what functional specific criteria standards can be used to satisfy those functional criteria that we have identified. By the end of the day, I will also be putting a complete Word document with the RFI questions and our consensus responses. I am not going to redline anything, so review everything, and this is our time to start wordsmithing. Put comments in, and I will either get them incorporated or we will discuss them on our next call. All the content should be on that Word document. I will be going to the Google docs and pulling everything out, so now, we should be able to move toward wordsmithing on the majority of these questions, and we do need cost numbers, so anybody who has cost numbers, please get them to us, okay?

Hans Buitendijk

Tammy, just to clarify, the column that you are looking at that is the taskforce column, the aim is there to be at the level of granularity that we think the functional capabilities, and therefore the certification criteria, would need to be, correct?

Tammy Banks

Yes.

Hans Buitendijk

So, with that, I do expect that there are going to be some suggestions to still split some of the cells into multiple.

Tammy Banks

Yes, that is fine.

Hans Buitendijk

And, from that perspective, that spreadsheet is really helpful. I understand that it is all over in the Google docs in the early start.

Tammy Banks

No, all I did was took the functional criteria that we talked about or people provided and put it together in that Google docs, and I only took the Google docs and put it here, so nothing was added except for recommendations from our taskforce, so all the comments and content should be there, so now we should be able to flesh it out into the approach that I think Raj was mentioning. Then, we can figure out how we can bundle some of these actual specs, but we have to do a lot of this work behind the scenes, and then go through the wordsmithing on our next two calls.

Homework and Next Steps (01:29:22)

Sheryl Turney

Yeah. Next Thursday, we have a meeting from 10:00 to 11:30, and also, please add to your calendars that additional meeting on March 7th at the same time. So, I will reinforce what Tammy said. It is going to be

very important for everyone to go in, reread the entire document, make sure that any additional comments are made, and any areas that are not complete or do not feel complete, make sure you add your comments there as well. And, hopefully if you can please have all your comments made, I would say by next Tuesday night would be preferable. That way, Tammy and I will have the time to go in and then clean up anything that we need and get it prepared for our meeting on Thursday.

Tammy Banks
Okay, so we have one meeting next week and then two meetings the following week?

Sheryl Turney
No, we only have one meeting next week, and then the 7th, and that is it.

Tammy Banks
I thought we were adding an extra meeting in there.

Sheryl Turney
We did, but the submission is the 10th, so we only have two meetings left, so we have a lot to do in two meetings.

Tammy Banks
Okay. You guys, really, if you can look at this on Friday or over the weekend so we can have all the comments in on Monday, because we are still working on the attachment. It took a little bit. I think it will make it easier for us to get this more finalized and use people's time more wisely.

Sheryl Turney
Okay. Monday for the homework.

Tammy Banks
Thank you.

Hans Buitendijk
Thank you.

Sheryl Turney
Thank you, Tammy, and thank you, everybody, for your hard work on this.

Adjourn (01:31:08)