The Office of the National Coordinator for Health Information Technology

Transcript

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

April 21, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome again to the ICAD task force. I'll take a quick roll call of our task force members, and then we'll get started. Sheryl Turney?

Sheryl Turney
Present.

Lauren Richie
Alix Goss?

Alix Goss
Present.

Lauren Richie
Aaron Miri? Abby Sears? Alexis Snyder?

Alexis Snyder
I'm here.

Lauren Richie
Andy Truscott?

Andrew Truscott
Present.

Lauren Richie
Anil Jain?

Anil Jain
Present.

Lauren Richie
Arien Malec indicated he would be absent. Deb Strickland?

Debra Strickland
Here.

Lauren Richie
Denise Webb?

Denise Webb
Here.

Lauren Richie
Gus Geraci?

Gaspere Geraci
Here.

Lauren Richie
Jacki Monson?

Jacki Monson
Here.

Lauren Richie
James Pantelas said he would be absent as well. Jim Jirjis?

Jim Jirjis
Present.

Lauren Richie
Jocelyn Keegan?

Jocelyn Keegan
Here.

Lauren Richie
Great. Les Lenert? Either Mary Greene or Alex Muggie from CMS? Ram Sriram?

Ram Sriram
Present.

Lauren Richie
Rich Landen?

Rich Landen
I'm here.

Lauren Richie
Sasha TerMaat?

Sasha TerMaat
Present.

Lauren Richie
Steve Brown? Tom Mason?

Thomas Mason
I'm on.

Lauren Richie
I think that's it. I will now turn it over to Alix to do a bit of a summary and action item.

Alix Goss
Thank you very much. I appreciate you doing the roll call, and thanks for people joining in today. We are going to do a little bit of background, just refresh ourselves on the last call and the game plan for today, then I'm going to lead us into a discussion with a small group participating that took a look at the "guiding principles and ideal state" table since last call. Sheryl and Josh will lead us through a discussion of the "data classes and categories" table as a follow-up, and then we want to have a brief discussion around some demonstrations and activities for next steps before we take public comment. So, that gives us an agenda for today. If we want to go ahead and – summary and action plan is our next item, so let's go to the next slide, please. Thank you.

So, at the last call, we took a deep dive into the prior authorization information table or workbook – specifically, the tab around the data classes. They really evolved the framework for the data classes into a new structure that aligns with USCDI that really seemed to resonate on the last call for folks, and we had some additional work that was done, and we'll be showcasing that in the second half of today's call. We also discussed the work of the happy path group. That's really about the "guiding principles and ideal state" tab within our overall workbook. We had some great discussion around – or, started some great discussion around the initial content that had been submitted, and we want to pick up with a continuing review of that content today.

At the last call, we also wrapped it up with a set of detailed comments from the American Medical Association CoverMyMeds. We're anticipating being able to distribute the detailed comments from AMA as they submit those in writing, so we'll get those out to everyone after the call. But, what I think is really nice to see is that we rolled up our sleeves, we're starting to really give shape to the content in the workbook, and industry is starting to help us with some additional thoughts and considerations as we move through our body of work.

I'm getting a fair amount of background noise. I'm not sure if that's just me. So, the approach for today's call, as I noted, is to spend a fair amount of time in the workbook today. We are going to start with No. 2, "guiding principles and ideal state" in the data categories, but Sheryl, I think we wanted to make a comment around some of the content you've been adding in "recommendations." Do you want to describe that new sub-bullet to Item 4?

Sheryl Turney
Absolutely. So, for the group, both in the "other considerations" tab as well as the "recommendations" tab, I've been going back through presentations that have been made to HITAC through various meetings that we've had over the past year and adding placeholders, if you will, of things that we may want to review or consider that have come up as a result of the presentations that have been made describing the burdens, and some of them included recommendations, some of them included considerations, so what I have done

is just try to extract out of all of those artifacts the considerations that were brought forward, as well as the recommendations, without trying to edit them myself.

So, when it's appropriate with the timing of this work that we're doing, we will then start looking at considerations and the recommendations, and then we can decide to edit out some of these things, but I have included in the references not only what the recommendations were, but the document that they came from, the group that put the document forward, and the date that document was presented to either the ONC or HITAC. So, that way, if there were questions, we would be able to link back to the source document. So, people will see over the next – not done with all of this. There's more work that needs to be done, but I will be completing that work, hopefully by the end of this week, and then, when we get to reviewing that data as we try to bring all of these things into our recommendations paper, we can at least evaluate what some stakeholders who come to ONC and HITAC have already recommended to see whether or not those are appropriate and how we want to frame those out.

Alix Goss
Thank you for that update, Sheryl. I believe also, in addition to your work to extrapolate prior HITAC content and recommendations, we'll also have an update on the compendium coming out shortly that will just add in some of the other industry artifacts that were suggested. I believe on the last call, there were several recommendations to tap into the Da Vinci guiding principles, so we want to make sure to give a link to folks out there as well.

So, with a wee bit of setup there, what I'd like to do is suggest that we roll up our sleeves and dive into the "guiding principles and ideal state" discussion. If we could have Josh start to screen-share…that would be great. There we go. So, this past Monday, several of us gathered to take a look at the "happy path" table, the "guiding principles and ideal state," and I want to do a shout-out to Anil, Alexis, and Tom Mason, who joined me to work on this tab.

Specifically, we took a look at two things. The first was the content that I had added previously from the WEDI paper, and we cleaned that up, reworking that content a little bit, and that was a nice setup for today's discussion because we didn't get to look at that on the last call; we ran out of time. The other thing we looked at was the guiding principles from the Clinical Advisory Council of the Da Vinci Project to see what content we might be able to incorporate into this tab.

So, I've invited Anil, Tom, and Alexis to join in and round out our content today. I'm hoping that we can present to you the work that we've done and then advance it, and hopefully, we'll be able to capture all of that on the fly, and if not, we'll have the transcript to aid our work.

One of the things that we started with was the guiding principles, and although we looked at the guiding principles of the Clinical Advisory Council, we found a lot of those might actually be beneficial to our ideal state, but one of the things that we noted is that there's a commonality of concern around the concept of minimum necessary restrictions – I'm on Row 8 – and we decided to revise the language for minimum necessary restrictions accounted for as a guiding principle. I wanted to propose for consideration a reword to "minimum necessary information that is agreeable to 1). HIPAA, 2). Local and state laws, and 3). Data usage agreements and business associate agreements." I'll open it up for comments from those in the

meeting if you have anything to say or raised hands from those who might want to ask a question about that proposed reword.

Sheryl Turney
Alix, this is Sheryl, and I didn't raise my hand, but I did have one suggestion because I know this came up in other meetings with other stakeholders, but we know that in some cases, conflicts already exist between HIPAA and data use agreements and business associate agreements, so when you're referring to this as "minimum necessary," you're just really talking about the minimum necessary required by whatever that data share is –

Alix Goss
Yeah, I think the concept is that we want to be mindful to only share what we really need to share, so there will be some work that happens in the standards development world for the implementation guides that does some data requirement gathering at that level and gives us a framework for information, but when a system engages – when systems or people need to add content, they need to be using the lens to supply only that which is required as the minimum necessary to perform the business function, and so, that is really governed by HIPAA as the law of the land with minimum necessary and further influenced by the legal frameworks of states and business associates. And so, we wanted to put in there that concept that there was sort of a scale of considerations related to "minimum necessary," and those are sort of outside of our realm of control. There might be something that we want to address related to that, but for right now, that's how I'm viewing our modifications. Would others like to add color commentary on that?

Anil Jain
This is Anil. I think you said it well, Alix. Sheryl, we have to **[audio cuts out] [00:12:16]** that the easy thing to do is to send an entire packet of data in order to satisfy some sort of ePA type of mechanism, but just as Alix said, we really want to be a thoughtful minimum necessary – to give you an example of something that might be influenced by local and state laws, there could be STD testing in adolescents. If you don't need that information, just make sure it doesn't become part of the packet of data that's sent over, and we ought to be really careful and make sure that whatever we do, the guiding principle should be minimum necessary, not just by HIPAA, but whatever the local policies are. And then, in conjunction with that, to your point earlier, the BAA that might impact the two entities ought to be reflecting that as well, but we ought not to create a model where it's just too easy to send more information than is necessary.

Sheryl Turney
I absolutely agree with you, and I guess in my head, where I was getting a little bit fuzzy is with the new interoperability rule where in some cases, what you must send is the minimum – Version 1 of the USCDI. What if all that is the minimum of – the first set of Version 1 of USCDI isn't necessary for minimum necessary? How do we reconcile that? That was my only question in my head. Maybe that would never happen. I don't know.

Jim Jirjis
This is Jim Jirjis. I –

Anil Jain
Well, I – yeah, go ahead, Jim.

Jim Jirjis
I was just going to say that some of the discussions we had about that in the larger HITAC meeting were about segmentation. So, is segmentation a requirement? Because that would get us to the point where we could send subsets instead of the entire USCDI. They talked about a requirement for the next version being segmented data so you could only send purpose-driven data instead of the whole packet.

Anil Jain
This is Anil. I think that's one mechanism, but even short of that, I don't think the intent was ever that if you have a business purpose that is fairly limited in scope, the entire USCDI – the entire patient's **[audio cuts out] [00:14:48]** into the standards as depicted by USCDI should be exchanged. I think the principle of exchanging what is minimally necessary to do the work is not somehow supplanted by the new interoperability rules – at least, that's the way I understand it.

Alix Goss
This is Alix. I would agree with that, that there are different wheelhouses and there's an overarching policy objective in the HIPAA and legal frameworks in contrast to the concepts of data availability within the USCDI, and my thought would be that those two should eventually sync up with standards intersecting the two worlds. Jocelyn, I see your hand up.

Jocelyn Keegan
I just wanted to say I completely agree with where the conversation is headed. We have grappled with this quite a bit as we've been fielding the first couple generations of ballot comments on the Da Vinci implementation guides, with everybody really wanting us to solve the eternity's challenges around data-sharing inside our implementation guides. So, I've shared the link to the published version of our guiding principles that we use. Our intent is to essentially insert a subset of these principles that then links back to a sort of homepage around the principles in all of our implementation guides, but I think it gets at the heart of that last string of commentary. I see USCDI as really being the floor of content that we want to free and make liquid in the industry, but the role of trading partner relationships and the data being sent for purpose can be narrower or larger than USCDI. It's all about trading partners at a contractual relationship level deciding what data they're exchanging for what scenarios and making sure that the end user has enough controls in place to validate, review, and look at that data before they hit "go" to be able to share it.

[Crosstalk]

Sasha TerMaat
I have a question, if I could virtually raise my hand.

Alix Goss
Sure. I'm sorry, I'm not certain who's speaking.

Sasha TerMaat
This is Sasha.

Alix Goss
Hi, Sasha.

Sasha TerMaat
I was just curious – maybe this will help me follow what's envisioned with "minimum necessary," but if we take a class of data in USCDI like diagnoses, is the vision for prior authorization that a particular user, like the clerk who's filling out a prior authorization, would pick which diagnosis of a list of 20 was relevant for this particular authorization and send just that, or that all the diagnoses would be sent except for particular ones which were marked as sensitive in some fashion, or something else that isn't either of those choices?

Jocelyn Keegan
Alix, I can speak to that a little bit from a Da Vinci perspective.

Alix Goss
Yeah, that would be good because I was trying to think through – there's a multitude here of the way – if you're doing systems interactions versus whether you're doing human interactions, so, from an automated extraction perspective, Da Vinci would be a great perch from which to answer.

Jocelyn Keegan
I can try that up from both hats. So, I think the sentiment that you're sharing, which is "I'm picking the right diagnosis for the thing I'm doing today," versus sending over an entire record of the patient's history for a set period of time, is much more preferred from an implementation standpoint, and those are the active discussions that are happening in the inside work that we're doing because we want to make sure that the workflow and the content are appropriate for what's going to be happening with the end user that's going to be putting the data in, and there's a DACA MA at the end of the day.

To me, it's not just necessarily narrowing around the diag code; it could also be a period of time – time-bounding it – so, not anything that was ever put in the record about this patient, but within the last six months, and those would be parameters that you could set at the UI level, or that trading partners have agreed upon as part of the contractual relationships that they have with each other about what they're going to share. I think that depending on which workflow –

Sheryl Turney
Jocelyn, to that end, to what degree does the implementation guide fit into there? How does the implementation start –

Jocelyn Keegan
The implementation guide tells you what's possible.

Sheryl Turney
Right.

Jocelyn Keegan
It literally speaks only to what's possible, but when you're actually putting it into production and agreeing to use it with a trading partner, that's where the rubber hits the road, and I'd say philosophically, a lot of the conversations that we've had around the space of – we really brought this document to our Clinical Advisory Council that we created last fall to get input from across the industry, and there are nurses and pharmacists there on the council, and a lot of the sentiment from the conversations was that we have this desire to want

to control things at the API level, but that's not where that content gets controlled today. It literally gets controlled in the relationship documents. Someday, we might live in a world where the APIs are smart enough to be able to control it all, but the vast majority of that work is done today, and will continue to be done at the permissioning and contract, not at the code level.

I had this really great testimonial from a number of the physicians and nurses that were deep into advanced informatics within these large IDMs saying that when they did it – when they got really specific about it at the implementation level, it came back to bite them later because it made the data very inflexible for them to repurpose for their own improvement areas at a later point in time because they had hamstrung themselves to get that control at the code level versus at the contact level.

Thomas Mason
This is Tom. That's very helpful, Jocelyn, and just to add to the conversation and to also answer Sasha's question in part, for me, it helps to think about specific examples, and one that's going through my mind was let's say there was a prior authorization for etanercept for an autoimmune disease, and the requirements would be, say, that the patient must have a diagnosis of rheumatoid arthritis, and that within the medication list, there should be evidence of either methotrexate or prednisone as meds that have been used during the initial course of medication therapy or a reason why the patient was contraindicated for those medicines. So, I was thinking more along the lines of very specific diagnosis from the record and very specific medications as opposed to having access to the entire list of diagnoses and medications, but that sort of helps me think about the ideal workflow to adhere to that minimum necessary requirement for information.

Alix Goss
Thank you, Tom, for that because one of the things I was really appreciative of in our discussion yesterday about these guiding principles was trying to keep our lens at the right level, and Anil seemed to really help us come back to what it is that we as a task force need to be putting forward. So, as I'm thinking about this "minimum necessary" rewording, we're trying to create these guardrails and frames, but then we've taken a really interesting deep dive into the nuance of a system-to-system exchange or to go in and extract data out, and then share it for a prior authorization purpose. So, are we feeling that there's this revised guiding principle that we want to capture relating to the diagnosis and medication lists, or is that too detailed for us to get into in these guiding principles? Any thoughts on that?

Thomas Mason
For me, I think that is a little too detailed because I'm just thinking that – using that as an example because there are so many different types of prior auth that I think we want to keep it at a higher level, but still capture the spirit of what we've been discussing these past few minutes.

Andrew Truscott
Yeah, that's not a principle.

Alix Goss
Jocelyn, I see you have your hand up.

Andrew Truscott

I don't have a hand up because it's not working. I'm hitting the screen, and nothing's happening.

Alix Goss
Andrew, that was great. I got your comment. I just saw she was following up after you. Do you still have something to offer on that, or are you just putting your hand back down, Jocelyn? Okay, Anil?

Anil Jain
I just wanted to say that I think the guiding principles should be general enough that they can flow from detail to detail as opposed to being too detail-oriented, so I think we're all saying the same thing. It's fine to have examples that clarify the guiding principles, but the guiding principles should be something that we don't need to come back to over and over again as we hammer out details. That's just my perspective.

Alix Goss
Okay. Jocelyn, is your hand back up again?

Jocelyn Keegan
It is. I'm just on mute over here.

Alix Goss
All right, we're having fun. You're up next.

Jocelyn Keegan
It's a Tuesday afternoon. So, I agree. I think the points that Tom, Anil, and the speaker in between just made – to me, there are so many different variations of how people are going to introduce improved automation, and I think that the spirit of the principle needs to be around just the right data at the right time, and no more, and that makes sense, and when we get more prescriptive than that, you really get into implementation, and you get into the how, and I think we really want to stay at the guiding principle level, up around the idea of how and where this decision should be made, not into the weeds of how it's going to get implemented because I think that will handcuff us and make us revisit unnecessarily.

Alix Goss
Thank you for that. Seeing no more hands raised, I'm going to suggest that – and, Andrew, we've been having other sporadic issues, such as some people who can't see the caption transcript box, so if your hand-raising isn't working, just chime in, or anybody else who's having technical issues, assume it's not you and just speak up and jump in.

Andrew Truscott
Will do, and just rest assured the captioner doesn't understand a word I say, either.

Alix Goss
It's the accent, maybe. All right. So, what I want to propose is that – I'm hearing that Row 8 works, but maybe what we need is a guiding principle that underscores the "right data at the right time" concept that Jocelyn said, maybe using an example like the one Sasha brought up to craft a guiding principle there. I'm going to move along to No. 14 if there are no other comments. So, on Row 14, the small group – I believe this… "The standardized minimum data will align with USCDI and will be the basis for data exchange for

prior authorization. To that end, if key/priority data is not currently present in USCDI, then the ICAD task force will prioritize feedback to the USCDI task force for consideration in subsequent versions." Any comments on that guiding principle?

Anil Jain
This is Anil. Can I just clarify something which is not clear in what we wrote yesterday? We're not suggesting that the minimum data that is being exchanged is the entire USCDI core data. It's just that whatever data gets used should get standardized with the guardrails of the USCDI.

Alix Goss
So, should we be saying, "If key/priority prior auth data is not currently present," or is it –

Anil Jain
No, what I'm getting at is the first part of Line 14. The word "minimal" could be misinterpreted. We're not suggesting that the minimum data for exchange should be the entirety of what is spelled out in the USCDI. We should still be looking at Line 8 as a minimum, but if you're going to exchange data for the purposes of prior authorization, then the data – we should not be coming up with yet another set of standards. It should be aligned with USCDI.

Alix Goss
So, the point is that we should delete the word "minimal" from Row 14 in the first line.

Anil Jain
I think so.

Alix Goss
I agree. I think we were so in the Row 8 conversation that we just carried it over. Jocelyn, I see your hand up. So, "Yes, please, delete the 'minimal.'" Thank you, Josh. Yes, Jocelyn?

Jocelyn Keegan
My friends at ONC will chuckle if they hear me talking about this, but there are definitely some resources on the FHIR side of the world that need to be matured to be ready for primetime in USCDI between payers and providers around prior authorization, so I'm more than happy to share what we've learned as we've been working on the prior auth workflows themselves with this workgroup as things that need to be prioritized. I'd like to use an example – when we talk about the minimal data, I would use the example of somebody that's trying to get a prescription for human growth hormone. If you ask whether somebody's pregnant or not pregnant and get the right diag code, that's the only information you need to get an automated approval versus having to share a much larger subset of data. So, in some cases where you can be tactful and precise, you're sharing two or three data points versus hundreds of data fields about a particular patient to get the approval put into place.

Alix Goss
I'm not sure whether there was a guiding principle in the first part of that commentary that you wanted to add or you were just giving color commentary. I'm not sure how to process that first part, Jocelyn.

Jocelyn Keegan
The first piece is just that we know there are gaps, and when we get into the tactical side of it, I can help share where we found gaps in what we need for USCDI.

Alix Goss
All right, thank you. Any other comments on Row 14? Row 15: "The small group noted that prior authorization process reform and improvements will be driven by patient safety, evidence-based medicine, and reduced burden." Any comments on that as a guiding principle? Hearing none, I'd like to scroll down so that we have Row 17 at the top of the screen, if that'd be possible, Josh. We're getting there, okay. That's fine. So, on the last call, we briefly touched upon the background information between Row 18 and 35, as that was information that had come from prior discussions or captured here, but what we didn't do – if we can scroll to Row 37 – is have an opportunity to take a look at the "ideal state" rows that are highlighted here. These were extracts that were taken from a review of the WEDI whitepaper.

So, the first one on Row 37 – I'm going to go through the first couple of them fairly quickly. A small group of us did discuss these, and really spent a lot of time working between Rows 32 and 47, but first, let's talk about 37 through 40. The first one – and, I'm reading these because we have some people who aren't able to get into Adobe today. So, for 37, an ideal state would be that we would increase end-to-end automation for extracting prior authorization data request and response. It's pretty straightforward. Are there any comments on that automation ideal state?

Sheryl Turney
Alix, this is Sheryl. Is there any reason why we have "extracting" in there? To me, we need end-to-end prior authorization, which includes whether or not a prior auth is required, so I'm not sure it reads right if we say "extracting."

Alix Goss
Well, I think there's a reason that I like the word "extracting," and maybe it's my focus that I'm hoping we have the word "extracting" going with "automation." So, what I'm envisioning in the increased end-to-end automation for extracting is that there's an EHR and a payer system that are interacting, and that for the majority of that interaction, they don't need human interaction to enable that message to be completed, generated, and sent. With that context, how would you modify Row 37? "Producing"? Is it "extracting" for "producing"?

Sheryl Turney
I don't know. I would say "processing" because that's what we're talking about, and – I don't know. To me, "extracting" is different. I don't want to pick on words, but…

Alix Goss
Well, it's important that we – because these words matter here, so I'm okay with "processing." "Increased end-to-end information for processing prior auth data request and response." Any concerns with making that change, folks?

Alexis Snyder
"Processing" makes sense.

Alix Goss
Awesome. Let's change that. Thank you, Josh. I'm going to keep moving along. Feel free to stop me at any point. Row 38: "Standards adopted to support end-to-end automation." So, think of this as saying if we're going to really want to take a system-to-system processing approach, we need standards to be recognized for that to occur. Do we need to say "national standards," or is "standards" good enough for folks?

Sheryl Turney
I like the vision.

Alix Goss
Okay.

Andrew Truscott
In general, I'm not sure we should be talking about new standards so much as embracing existing ones as much as possible. I wasn't quite sure what you were trying to achieve with this.

Alix Goss
I think that it probably fits in with some of the next couple of rows, so let's talk about Nos. 39 and 40 because they really fit in here. So, Row 39 indicates that policy permits use of multiple standards for exchange versus only one standard for data content or datasets and operating rules. So, currently, we have a pharmacy path and we have a medical path, and we have a ceiling that is currently set, as we're addressing in Row 40, that says a policy adopts a floor of standards, not a ceiling, and when the small group met, we said that part should definitely be reworded to say, "If you create a floor, then innovation leaders will still need to support foundational standards for consistency in practice." So, let's take a step back here and think about Rows 38, 39, and 40 in a big bucket with different aspects related to our ideal state.

Today, for instance, in the medical world, we have a 278 that is the standard for medical prior authorization. That is the ceiling. There has been discussion in the industry that having ceiling standards prevents innovation, and that there could be an opportunity to pivot the way we approach adoption of national standards to establish a floor – the basic minimum that everybody has to support. There's also been discussion in the industry that we would not just want to say there's only one way to do this, since many of our standards are electronic-data-interchanged-based transaction messaging, in contrast to newer technologies and the direction that we seem to be heading in with the approach with application programming interfaces.

So, if we could create a floor that supported the 278, for instance, in the medical world, and an API FHIR-based solution, we might create a foundation that lets the market figure out what makes best for them in the information exchange and business processing environments. What we could then do is have that floor where everybody has to have a common framework that we operate on – either EDI or API. We could then not prevent the front-runners who want to evolve the next set of standards and test those out from doing so, and be able to support the foundational floor standards, as well as providing any innovation that they and their trading partners would like to use. That provides color commentary for Rows 38 through 40, with the idea of the standards adopted might not be a really good ideal state – it's kind of a simplistic statement, but it really sets the stage, and maybe should be replaced by Rows 39 and 40. Thoughts on that? Is silence endorsement, or is silence that you're all scratching your heads, wondering what the heck I just said?

[Crosstalk]

Jocelyn Keegan
It's Jocelyn. I like where you're headed.

Andrew Truscott
I agree.

Alix Goss
Okay, so it's support. Okay, cool. Maybe what we need to do is clean up 39 and 40 – I think we'll have to come back and look at that, so I'll just make myself a note. So, we then – after we kick – yes, ma'am?

Jocelyn Keegan
It's Jocelyn. I do want to share, though, having spent some time here – I do think that when we start to call up specific exception processes for particular healthcare professionals, it does tend to act as, say, a trigger word for some readers, so I don't know if you guys have spent any time wordsmithing or debating that, if there's discussion in the group calling out specific examples like "gold-carding" because I just wouldn't want us to use language that would necessarily shut down readers or push them on a more negative bent.

Alix Goss
Are you perhaps on Row 47?

Jocelyn Keegan
Yes.

Alix Goss
Yes, that's interesting. I put it in there, and I was hesitant to put it in there when we were talking yesterday, but yes, it does – "gold-carding" does have some negative connotations, and I do think we're trying to be sensitive, but it was a shorthand about what that sentence – Row 47 – was getting at.

Jocelyn Keegan
As long as you covered that, then I'm good.

Alix Goss
Well, let's come back to that. Excuse me. So, in Row 42, we started to look at the consensus positions from January 2018, and what we did was we broke those – they were originally all bullets within Row 42, and we broke them out, so let's go one by one. So, Row 43: "To accelerate industry adoption of national iconic standards for prior auth and improve transparency of formulary information and coverage restrictions at the point of care." From an ideal state, how do folks feel about that row? Any concerns?

Alexis Snyder
It's Alexis. I think you may have left off at the end of that sentence not just formulary information and coverage restrictions at the point of care, but something that is showing that transparency and communication is continuing beyond the original point of care. So, maybe a continuity in transparency as

we go along. I'm not sure how to wordsmith that, but that's my thought. Not just "point of care," because it doesn't end there.

Jocelyn Keegan
Alexis, do you mean the continuity of care, to ensure that…?

Alexis Snyder
Yeah, not just the continuity of the care, but if we're talking about being transparent about coverage restrictions or formulary information, it's going to evolve over the process of the steps that the PA is going through. So, not just to have an exchange or a transparency of that information rate at that point of care being the patient visit at the very beginning, but a continuity of communication along the way.

Alix Goss
So, would it really be a second sentence that says, "Transparency will be maintained as a concept throughout the care continuum"?

Alexis Snyder
Sure. You could make it a second one, but if you wanted to keep it smaller, you could just put a semicolon after "point of care" and add it there. Either way.

Alix Goss
Anil, I see your hand up.

Anil Jain
Can you hear me?

Alix Goss
I can now.

Anil Jain
Okay. It's really about – it may start at the point of care, but it's through the plan – that's what we're trying to get at. The words probably don't matter **[audio cuts out] [00:44:37]** the concept of care, the treatment continuum, but I think the point is that it's in between the various **[audio cuts out]** that a patient may have with their physician. I think that's what I'm hearing, and it's really the treatment plan that **[audio cuts out]** flows through, and a lot of folks have goals **[audio cuts out]** caregiver **[audio cuts out]** their aspect of making sure information is –

Alix Goss
Anil, you are really cutting out. We got about every third word on that one.

Anil Jain
Hopefully, they were the important words. Let me try calling back in.

Alix Goss

Okay. I'm also realizing as I'm looking at the monitor and trying to track this that we're passed our allotted time, Sheryl, so we probably need to wrap this up and continue discussions. So, what I would like to do is, for Row 43, add "continuity of transparency" beyond the point of care, so we'll figure out how to add that in, and Sheryl, I yield the floor to you for picking up with Josh on the authorization – the table.

Sheryl Turney
All right. I don't know if the… Well, I wasn't participating in the group on Monday. I had a conflict, so Josh, I'm going to let you move over to the table. It looks great; I did look at it earlier today, but I'll let Josh lead the discussion on the table.

Josh Harvey
Thanks, Sheryl. I'll go ahead and provide an overview, but Jocelyn, Ram, and I were able to meet earlier – actually, a couple times over this past week – to iterate on the table a little bit based on the conversation that we had last week as a group. So, first things first, just to orient everyone, we got a lot of good feedback on the rearranging of the data elements that we've been discussing and the "data class versus data element" format. So, what we decided to do was for an initial pass at an assessment to start at the data class level to make sure we're hitting the high points and setting ourselves up for a future exercise where we might go through at more of a data element level to make sure all the different data needs that we deemed necessary for an effective prior auth process are captured in the existing standard.

So, on the left-hand side, you'll see a list of those data classes. Then, across the table, you'll see columns for each of the different standards that we decided to include in the first round of our assessment. And then, within each of the columns, we went through class by class to try to identify where we thought there was some usefulness in an existing standard as it pertains to moving data between different actors for that particular data class.

We then tried to capture what the capabilities were for each of those standards, and you'll see a table – a legend at the top for the capabilities that we described, ranging from "not available" all the way – progressing through "emerging capabilities," "available capabilities" – so, something that's fully fleshed out but not necessarily in use in the real-world environment – and then, lastly, "in use," which will be something that's actively being used across the industry today.

We then further fleshed out that assessment by using color coding, so the other legend you'll see at the top is a color coding based on the adoption level that we were able to find for each standard using the ISA that ONC publishes. So, we included a few different ranges here. The low, medium, and high grades were where we could individually track something using the ISA's five-star ranking system and then bucket it in a low, medium, or high category. Most of what we've seen thus far fell cleanly into the low category or the high category. We also had added a couple of different parameters here for standards that were proprietary in nature, so there's some sort of semblance of a standard, but it's not been promulgated through regulation or necessarily drafted/balloted with HL7 or some other standards development organization or accrediting body.

And then, we also have a draft standard categorization for particularly the FHIR implementation guides from Da Vinci and their progress through the balloting process with HL7. So, all the way through a high level, this is the heat map – that might be the best way that we've described this – that we've developed through

this point, and then, I'll yield to Jocelyn and Ram to add color commentary before we open it up for comments and feedback. I know there are a couple things in particular we wanted to ask of the group to help us plan for the next step of this.

So, first, you'll see that at a glance, there are several standards that prove to be useful in some capacity here for prior auth purposes. Some things that immediately bubble to the surface – and, I think this has been reflected in the conversation thus far – are that some of these standards seem to prove quite useful in some areas on their face; however, some of those same standards seem to be ones where adoption is lagging, so I think that's where we need to take a step back and analyze why adoption may not be higher in those areas, and whether or not those standards may be viable and useful in the long term as we plot out what the ideal feature state of prior auth looks like.

So, I think X12 is a good example of that, where we know some of these transaction sets are purpose-built. We've discussed them quite a bit in these task force meetings. However, the 270/271 transactions for benefits checking are essentially the ones that have been most readily adopted by the industry. The 278 for prior auth – while it does seem to be purpose-built and has the capabilities that we've discussed as being priority for us – just doesn't have the same level of adoption as the 270/271, which I don't think has surprised anyone, but we're starting to try to paint a picture here to drive some of our recommendations.

Moving across the right, in the NCPDP world, for medications, we see that the script standard is in use and has high adoption. There's also some work going on that we'd love to acknowledge with the real-time benefits tool documenting that. That is the potential basis for a feature standard that's in the works for NCPDP. Not to interrupt the flow, but Jocelyn, I know you had some thoughts on this. I don't know if there's any other color commentary you want to provide on that piece before we move on to the FHIR-related stuff.

Alix Goss
Josh, you're in share screen mode, and you may not have seen that Jocelyn indicated her call dropped, and she would be back, but she's not answering.

Jocelyn Keegan
I'm back.

Alix Goss
There you go. Okay.

Jocelyn Keegan
He's doing a great job. He's totally killing it, describing all of our discussion yesterday and last week, but a real-time benefits tool or real-time benefits check – however you want to fish out the different words for it – has been in pretty significant usage in the industry for a couple years now, so as we start to judge it against other technologies that are out there as we move forward with recommendations, I think we're just going to want to make sure that we get a full briefing on where the standard is as compared to what we've learned by having standards like proprietary solutions out there in the market while people are waiting for the standards body to catch up with itself.

Josh Harvey

Thanks, Jocelyn. We'll move on to the FHIR-related implementation guides. So, Jocelyn said that Da Vinci did a lot of work coming through this and made sure we had appropriately captured everything that the Da Vinci group is working on right now, so you'll see here that for the most part, the FHIR implementation guides are more comprehensive in nature than some of their predecessor standards, like in the X12 world. However, they are newer, and so, adoption is another factor that we wanted to capture to better reflect how much they're in real-world use today.

The other thing I'll mention is in the HL7, CCDA, and V2 world, we did include these as standards that we reviewed in our initial assessment. However, we did not color-code these, mainly because we were not confident in their use in the context of prior auth, so there are standards, primarily for moving clinical data from Point A to Point B, and given the context of prior auth and transitioning data between providers, payers, intermediaries, PBMs, there's just another wrinkle here that we wanted to capture that was essentially – though there may be a standard, it may not be heavily in use today for prior auth and may not be a strong foundation for recommendations for moving in that direction. So, that's the high-level flyby of the work we've done to date. Jocelyn and Ram, any color commentary to add before we open it up to the group for some questions, comments, or feedback?

Jocelyn Keegan
I think you did a great job. Thanks.

Ram Sriram
You did a great job, Josh. On the HL7 CCDA, let me just go because I can think about the color coding there too. Some of the standards that we talked about – when we said "emerging," we had a color code on that as a graph standard, so in HL7, you're right that it's not being used for prior auth, but some of the elements there can be used. So, although it's used for other purposes, you could potentially use the CCDA information in a future prior auth whenever they talk about standards there.

Jocelyn Keegan
I think this is an important point, and I think it gets back to this idea of everybody's at a different level of maturity with the specific standard that they've implemented and invested in, so we've seen progress with folks putting a CCDA inside of a 275 wrapper to be able to share that information, and that is better than a PDF or an image inside of a 275, but I don't think any of us were comfortable in – if we were going to say CCDA and V2, those are in use across the industry at high volumes, but not for these particular use cases. I think we're warring with how we want to report out on it, but not underplaying the value that these standards have in other workflows out in the market today. I'd love to hear from this group whether taking that mirror task of the adoption of these standards for this workflow is the right way to go or we should come up with some other categorization to show that these things are tried and true, but have light adoption in this specific workflow area.

Ram Sriram
Jocelyn, following on the workflow, we talked about it yesterday. If we had some nice scenarios of the various interactions, then we could potentially place the standards within those scenarios. Remember the workflow diagrams or the event diagrams – actually, the agent-to-agent interaction diagrams.

Jocelyn Keegan

I think this is critical. Now that we've gotten through this exercise and you guys have laid down the guidelines themselves – what our operating guidelines or guiding principles are – I think that the three of us were very much like, "We need to start to draw pictures for roles and actors because there are different types of prior auth that are happening," and how you use and what you can take off the shelf to use at a given point in time is going to vary based on where we started a couple weeks ago. We were talking about the complexity and the simplicity of one op versus another, and how episodic it is versus recurring.

Sheryl Turney
This is Sheryl. I am really happy we're having this conversation about the HL7 and the CCDA. In the HITAC meeting last summer – Ram, you probably were there as well – Leslie Lenert brought up a recommendation that we should just give them all the CCDA, and then they have everything, and they don't need anything more from us. I actually went back and talked to folks inside of Anthem and Blue Cross relative to whether we've attempted to try to use the CCDA to address things with prior auth, and most likely, the issues we have had have to do with the form in which we've received the CCDA and whether or not it's being structured, but they actually did attempt to do that as part of some of the LPR work we've done with the longitudinal patient records, and because the form in which we were getting it wasn't structured or codified, it really became a humongous lift to try to utilize that CCDA to pull out or extract the appropriate data.

So, I understand why this has probably not been widely adopted because certainly, that's something that if all the data is there – but, I think with every interchange, there are specific reasons why a physician says, "Well, we need to move to this next step, and these are all the things that we have done as far as this goes," and some of these records are extremely huge, as you know. I would like to have a little bit more conversation around that issue and get the input from what this team thinks because as I started talking about this more as a concept or an idea, I got more and more pushback from multiple stakeholders as to why it probably wasn't the right way to go. Jocelyn, I see you raised your hand.

Jocelyn Keegan
I think there are two sides to this coin around the "send everything" idea with the CCDA. Maybe if I can share some experience from the NCPDP side of the house, where we've gotten a really good throughput of automation, in some cases by reducing and removing things like attachments as proof and working on getting codified values in answers to a question set that can be automated. We've had this really ongoing debate – it's been about nine months now – about expanding the number of attachments somebody can send in with an NCPDP script message to be able to support our friends on the specialty side of the business that aren't as mature and are earlier on that adoption curve around standards. How do we serve both those actors?

A number of our PBM partners have actually spoken up and talked about that statistically, they actually see that when providers send more information in, they often give more reasons or more data to be able to cause a denial to happen than if they had not sent the attachment, then it would have been approved. To me, I think it gets back to that guiding principle around just the minimum amount of data. Now, that doesn't mean that we shouldn't figure out CCDA as sidebar to a 278 or to a FHIR implementation guide – implementation to be able to figure out how to automate – I just think that we want to be very cautious when we think about things in those terms because the more data we send, the more fuel you might be giving that person that's doing the determination on the other side, especially in a non-automated world, and when there's data that can't be codified, that often drops to manual review inside these organizations.

Sheryl Turney
Thank you for that input. I also see that Ram's had his hand up.

Ram Sriram
Again, this is Ram here. A couple of things here. One is the short-term solution and the long-term. The short-term – we can send data in a structured format with whatever attribute value – place and so on – which you can fill in any of the standards. But again, there is a long-term solution, which I think – especially when you're talking about PA justification, PA response, and those types of things – CCDA has a lot of English language in there which needs to be parsed and semantically understood, so there needs to be some computer processing out there using AI and natural-language-processing techniques. And then, what you do is map that into some case frames, which, again, can easily be computer-interpretable.

So, I will say that I want us to consider both these short-term and long-term solutions because it will be pretty easy, especially when you're talking about justifications and those kinds of things, so you take this particular piece from the CCDA or from the EHR sends the CCDA document to the other side. And then, what you do is there's a template out there at the receiving end, and you can use natural language processing techniques to map this particular text into that template. The technology is there; it's just that someone has to implement it. I'm done.

Sheryl Turney
I agree with what you're saying, Ram, because we had actually brought in a natural language processing vendor, and even with that, we were still struggling – again, because the data wasn't codified, and we were having to have people translate that data, and I don't think that's the appropriate way to do it. The more people touch the data and then translate it, the more likely you are to have things change over time, just like – in my opinion – the telephone game, so I particularly don't like it if we are taking things in and have to transform them, because that transforms them from their original state, and that's not usually good.

I do think, though, that we should include – and, I will add as a consideration that we discussed this conversation about utilizing the CCDA, but really, the ideal solution would be to focus on "minimum necessary" and have that minimum necessary data be codified so that however it's exchanged and operable in both he sending and receiving systems, if there are more than one, then it streamlines the process because any translation is going to slow things down, but at least we can discuss that we have discussed this as an option. I think that's going to be required because when it goes back to HITAC, Leslie is going to bring it up because it was his suggestion last summer. Jocelyn, I see your hand up again.

Jocelyn Keegan
No, I think it just didn't come down before.

Sheryl Turney
All right. Anybody else want to weigh in on this conversation? I think you guys did a great job.

Alix Goss
Sheryl, I'd like to weigh in. This is Alix. As I'm listening to the discussion and appreciating the complexities related to workflow data capture by the clinicians into the EHR, we're actually flowing data in blobs of text that can't be effectively processed – if I'm tracking with Ram's commentary along with all of yours, Sheryl

– and, I'm starting to wonder if we need a guiding principle relating to some aspect of guiding principles or ideal states tied to the workflow captured because I think this is – systems are great at exchanging codified, discrete data elements, but we as humans don't think that way. On the fly, when you're in that interaction with your patient and your clinicians, that data's getting captured into an EHR, and ultimately, to reduce burden and increase automation, we have to think about that aspect. So, that was just a takeaway I observed from that last discussion, and I may have prompted some other commentary because the hands are coming up.

Sheryl Turney
Yeah, I think that's really important. I'll move over to that. Anil?

Anil Jain
I don't remember which group I made this comment to, but I think it relates back to exactly what we're discussing, which is that the entire aspect of prior authorization is not done in a vacuum, and if we're not looking at the full way that clinicians are making decisions. So, the comment about how a lot of things that might important might not be in a computable form – they're not going to be structured, they're not going to be accessible in a way that is machine-readable – is very true, but I would argue that if it's important to make a decision about whether something is going to be covered or not, it's just as important from a clinical decision support, and therefore should be computable in the context of the EHR.

So, I think one of the guiding principles that I would recommend we include is that prior authorization should not be considered an activity done in a vacuum, but should be examined the context of the way that a clinician and their patients are making decisions, meaning that it should relate to the clinical decision support system, it should relate to the way that patients want transparency of what's happening with their care, it should relate to how a clinician might create a care plan. I don't know the best way to say that from a standards point of view, but the idea is that this cannot be done in a vacuum. It needs to all connect together. Otherwise, we'll have created yet another problem.

Sheryl Turney
Okay. I'm going to add something to guiding principles that we can go over when we meet next when we have this on the agenda to go over, but I do think we need to add those because I think those are really key points, and that's part of the struggle. When you're looking at prior authorizations, we're doing a pilot right now with wound care, and even standardizing images is an issue, so things of that nature all need to be talked about. Jocelyn?

Jocelyn Keegan
I think this is a really important point, and I think that both Anil and Alix did a good job of bringing it to the – what I have found is that we have automated – and, it's manual automation – inside of the heads of all of the nurses inside of all of our care settings across the country, that they have programmatically deconstructed the UM requirements of all of the payers in the country for the ones that they care about and that they have to service, and we can't undersell the point that Anil just made, which is that we don't code things into EHRs and into patient records to get approval for prior authorization, and that work – that computing – today is done inside the brains of the nurses and the MAs that are submitting the PAs, and to get to automation, there has to be a leap between what's in the EHR and what you need to describe what's

happened to the patient, the patient's journey, and the patient's state for approval today, and that we need to figure out how to reduce that burden.

People don't code for PA approval, they code for patient care and for medical records, so to me, we can't lose that because otherwise, you end up implementing things that won't succeed because we're taking out the years of investment that individuals, nurses, and MAs have created around expertise on how to get PAs approved. It's just reality.

Sheryl Turney
I think that's a really valid point. Any other questions or comments on either this point or any of the others that were made today on the data classes? I think the representation is really very helpful, and I think we'll be able to utilize this as a reference in our ongoing work, so I think this is excellent. I know we're getting very close to when we have our open discussion from the public – the public comment. Any other questions or comments before we move to that? All right, Lauren, can we move to public comment early? We might as well put this slide up.

Lauren Richie
Sure. We are doing that now, so while we are letting folks dial in, I'll just remind everyone that you do have the ability to provide comments in the public comment chat feature in the box there, so if at any point you don't have time to provide comment or dial in at the scheduled time, feel free to submit your comment there as well. With this, I will ask the operator to open the public line.

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

Lauren Richie
Thanks.

Sheryl Turney
Wonderful. All right, well, why don't we then move to – we wanted to do a brief outline of what we have in mind for next week's call. Let me open that slide while we keep the public comment slide open. Alix, do you want to take that, or do you want me to take it?

Alix Goss
Sure, I'm happy to do that. I've been working on the demos. So, one of the things that we were envisioning based upon some prior discussions is to aid our work moving forward, it might be helpful to see what's actually happening in the industry today to better understand the current state and the needs, so we've had some discussions around specialty drug ordering, the Da Vinci Project, maybe even CMS's document record lookup service – DRLS – roll out, that uses some of the Da Vinci use cases.

So, what we've done, thanks to some extensive support from Jocelyn, is to identify different players in the industry who might be helpful and actually built on a public comment made at the last meeting. So, we are looking at having some pharmacy-related presentation on April 28th. It looks like SureScripts and CoverMyMeds will be giving us some information from their view in the industry on current state and advancing standards capabilities, and then looking to focus on the medical prior authorization on May 5th, possibly with some Da Vinci implementing members. We're looking for folks who are really rolling up their sleeves and making this stuff real in the marketplace. So, we are working on having those demos slated for 4/28 and 5/5. We are thinking that if we're – I don't want to keep moving along if we have any public comments coming in. If not, I'd like to advance to our "next steps" slides, which I believe start on Slide 13.

So, I talked about the demos, which was Slide 12. Slide 13 would be why we're queuing ourselves up to have demonstrations to find out what's happening in the marketplace. We will need to continue our work. Specifically, we would love to have individuals or small group meetings really go take a look at the tabs in the workbook and give us feedback by the close of business this week – Friday the 24th. Really, we're looking to be able to advance the data categories work as well as the "ideal state and guiding principles" tabs in particular. You're more than welcome to look at the other tabs. If you have some commentary you'd like to add there, that'd be great.

In addition to getting your thought leadership to advance the respective tabs, we really are looking to see if you have any thoughts about some of the challenges and possible solutions that you might want to consider as we move into the next phase. We do have the goal of creating recommendations not just around prior auth, but also to extrapolate those up to the larger concept of the intersection of clinical and administrative data, and that will be the basis for our full scope of recommendations, which we really need to start working on by the end of May.

To that end, we're thinking we need to revisit the conversation around the additional use cases. We started out with the wheelchair DME as an example and moved ourselves into the revised table that we saw today from Josh, but we're wondering if we really need to think about the other additional use cases, so we wanted to queue that up that we thought by the middle of May, we really wanted to have our arms around that. Sheryl, do you want to make some additional comments?

Sheryl Turney
No, I think you've said it very well, Alix. We really appreciate everybody's contribution so far. I think we have a great start to where we want to go, and we don't want to lose any momentum, so with the demos that we have coming forward, we'll continue reviewing the material, and hopefully there will be some time, either in the full-group meeting or the meeting after that, where we can finish your other considerations, and then we'll also look at the recommendations that are out there. But please, take a look at those tabs in particular as well and make any additional comments to what's already been put there or any additional suggestions that you might have in new cells. Thank you, Alix.

Alix Goss
With that said, I think – we've got a few minutes left in the call. Are there any questions or comments from task force members?

Jocelyn Keegan

Alix, I put one comment in the chat box. It's Jocelyn.

Alix Goss
Yeah, the one about the stab at a workflow next? Is that the comment you're talking about?

Jocelyn Keegan
Yeah, I think we need to draw some pictures.

Alix Goss
Okay, because I wasn't sure what you were thinking there. So, you think we need to draw something? We started out with pictures, and we moved away from them, so I'm just trying to think about what's pulling you back to picture land.

Jocelyn Keegan
I think it's when we're starting to talk about how you'd apply the different potential solutions in the market. I think you really need to think about who's involved where in what workflow, and even that easy/medium/hard component. Ram, I don't know if you want to add some color here. We were going back and forth in our discussion Thursday and Monday about this.

Ram Sriram
Yeah, this was about 10 or 15 years ago. We wrote a report, and I sent it to Jocelyn. If you're interested, I can send it to you.

Jocelyn Keegan
I have not read it yet.

Ram Sriram
Okay. So, Jocelyn, why don't you take a look at it and see if it's appropriate, and then we can talk later?

Jocelyn Keegan
And we can share it with this group? Okay. So, you can put a pause on it then, Alix. We'll come back.

Alix Goss
Oh, that's awesome. But, I do think that there's something very apropos about thinking about getting to the actor level to try to help us in the workflow and start to think about what our recommendations might end up meaning. I think that's where you're headed.

Ram Sriram
That's right.

Alix Goss
Awesome.

Jim Jirjis

Could going back to the workflows validate and elucidate how we use the data in each step – so, a reality check? We have this grid, but if we were to map out a workflow and, at each point, talk about what data would be available and how it would be transported – where the gaps are…

Sheryl Turney
Well, we certainly have the workflows that we started with that we can use as a reality check, as you mentioned, and so, that's one of the things we want to do in the future. I don't see any reason why we wouldn't do that, but it's probably going to be a few weeks off before we can get to that with all the things now that we have teed up for next week and the week after.

Jocelyn Keegan
Sheryl, if you don't mind, I'll poke the SureScripts and CoverMyMeds folks a little bit too to talk about why we've seen so much success in the retrospective prior auths – the ones that come out of pharmacy versus the ones that come from the providers directly – because I think that gets exactly at the point that was just made about who has the right data to make it actionable to actually get the prior auths done at a given point in time. I think really, we'll show in the real world today who the actor is that can really get all the right information to get the PA approved versus an idealized view that people want us to get to tomorrow.

Sheryl Turney
All right, that sounds great. Any other questions or comments before we close?

Alix Goss
I think this has been another productive call. I think that the small group members deserve an additional applause for all their in-between meeting work. It's greatly appreciated, and I know the group I've been working with – I'll be reaching out to schedule our next meeting and appreciate the ongoing input from the full task force.

Sheryl Turney
I absolutely agree with that 100%, Alix. Jim, Joshua, Ram, and Jocelyn working on the small group and the data classes has made a huge difference in terms of our ability to see this in a more meaningful way, so thank you very much. All right, I think we can call it. Thanks, everybody.

Alix Goss
Thank you, everyone.

Lauren Richie
Thank you.

Alix Goss
Take care. Bye-bye.

Anil Jain
Thanks.