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

May 12, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

# Speakers

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

**Operator**
All lines are now bridged.

**Lauren Richie**
Good afternoon, everyone. Welcome to our Tuesday edition of our ICAD task force. Of the task force members, I have Sherly Turney, Alix Goss, Anil Jain, Arien Malec, Denise Webb, Gus Geraci, Jim Jirjis, Jocelyn Keegan, Alex Mugge, Rich Landen, Sasha TerMaat, and Tom Mason. Are there any other members on the phone that I may have missed? Okay, I would also like to welcome and thank our guests from the AMA who will be joining us shortly, soon to do a demonstration. At this point, I will turn it over to Alix and Sheryl to get us started with a brief recap from our last meeting.

**Alix Goss**
Well, thanks so very much. This is Alix Goss. I'll go ahead and get us started today. If we could go ahead and advance to the next slide that would be great. Actually, to the last meeting slide. Awesome. Thanks very much. For the last couple of weeks, we've been having presentations to help expand our understanding of the current landscape and more, especially of the standards that are emerging within the health IT landscape for pharmacy and medical prior authorization. Last week's set of presentations were by Humana and Regence, also known as Cambia. We really heard some interesting set up information related to the Da Vinci Project using the Fast Healthcare Interoperability Standard or FHIR standard from HL7. I'm getting a lot of background noise. And so, if you could put yourself on mute, I would greatly appreciate it. So, Patrick Murta started us out with kind of level setting about what is the Da Vinci Project and how the community has come together to address burden reduction area related to prior authorization.

So, he gave us a little bit of background information before going into a Humana centric conversation about their 278 prior authorization activities and framing in how they are real time oriented in 278 data content oriented. They talked about their current efforts in automation and working in native work flows with their provider community along with some state law variability. We saw some similar demonstration and discussion from the Regence team who talked about their efforts in the prior authorization activities, also leveraging some of the Da Vinci use case implementation guides. It was very helpful to have last week's medical perspective because it rounded out the prior week's information from Surescripts and CoverMyMeds to help us with pharmacy prior auths. So, we had some robust discussion from those presentations and today, we're going to be building on our perspectives from the industry with a presentation by the American Medical Association.

I believe that sets up to go into the next session. I believe we are caught up on time as well, Lauren. So, today's presenters, I believe, Heather McComas, are you going to go ahead and introduce yourself and your team? I believe your slide decks were distributed to the task force members. And if you'd like to set us up and help us think, not only about the current landscape but also to give us consideration and food for thought as the task force advances the work on the guiding principles and ideal state, along with the data categories to help us really start to create the framing for the report and related recommendations that we'll be crafting here shortly. Thanks so very much for coming today, Heather.

**Heather McComas**
Thank you so much. Can you hear me okay?

**Alix Goss**
I can, loud and clear.

**Heather McComas**
Great. Thanks so much. This is Heather McComas from AMA. I sit in the AMA Health Policy shop in our Chicago office. And my colleagues, Laura Hoffman and Matt Reid, are on the phone if they want to quickly say hello and introduce themselves.

**Laura Hoffman**
Sure. My name is Laura Hoffman. I'm assistant director of federal affairs with the American Medical Association.

**Matt Reid**
This is Matt Reid. I work in the Washington DC office with Laura in Federal Affairs.

**Heather McComas**
Great. Thanks so much. First of all, we really appreciate the invitation to speak to the task force today on behalf of the AMA's physician and student members. Prior authorization is a huge concern to remember. So, we really are so glad you're doing this work and are happy to have the opportunity to share our thoughts with you. You can go to the next slide, please. This just gives a brief overview of what we're going to cover today. We're going to quickly review some of the research the AMA has done on the current state of prior authorization as physicians see it from their vantage point and practices. And then, we're also going to review some of the prior authorization reform efforts that AMA has been involved in on collaboration with other industry stakeholders. I know that you have looked at some of the materials but just we'll give a brief refresher on that. But we're going to spend most of the time today talking about our observations on the task force work to date and offer some thoughts and suggestions for your path forward. So, you can go ahead to the next slide, please.

So, in December of 2018, the AMA fielded a survey of 1,000 practicing physicians to capture the impact of prior authorization on both patients and physicians. And the data clearly show that prior authorization does, in fact, the delivery of patient care. And it's very much aligned with what we hear from our members. They, certainly, are frustrated by the amount of time the prior authorization consumed in their daily practice. But they are much more troubled by the fact that their patients sometimes do not get care in a timely fashion due to prior authorization. As you can see on this slide, 91% of the surveyed physicians indicated that prior authorization can delay access to necessary care. And if we move on to the next slide, we can see the impact of these care delays. Three-quarters of physicians in our survey indicated that prior authorization can lead to treatment abandonment. I think there was some good discussion about this a few weeks ago when our friends in the prescription drug ePA community were talking about treatment abandonment in the pharmacy setting.

That is a very common scenario of a patient shows up at the pharmacy and they can't pick up their drug right away due to prior authorization. They might never come back and that's very concerning. But it can also, in fact, happen with medical services. We've heard of cases where a procedure is scheduled and then, at the last moment, has to be canceled because prior authorization is not completed yet. And then, sometimes, the patient falls off of radar. They don't reschedule. And, again, they have abandoned their

care that their physician ordered for them. And if we go to the next slide, we begin to see how all of this adds up in terms of clinical outcomes. So, 91% of physicians in our survey said that prior authorization can lead to negative patient clinical outcomes. And then, on the following slide, even more concerning, 28% of our surveyed physicians indicated that prior authorization has led to serious averse event for a patient in their care.

And this is, obviously, very troubling both first in terms, of course, of the human cost of this. These are very serious medical events for the patient. But also, if we think strictly in financial terms, this is very expensive. These are things like hospitalizations, permanent injuries, ER visits, that sort of thing, which are very costly for our overall healthcare system. If you go to the next slide, we also have some information about the burden on physician practices posed by prior authorization. Practices reported completing an average of 31 prior authorizations per physician per week. And this workload, just for a single physician, consumed nearly 15 hours or approximately 2 business days of physician and staff time. It's not surprising, therefore, that over 1/3 of physicians reporting that they have staff who work exclusively on prior authorization. So, I think that numbers are very helpful in capturing the magnitude and impact of prior authorization on physicians and patients.

I think this captures the size and scope of the problem. But for me, I think it always helps to put a human face on an issue. And if we go to the next slide, we will see a picture of Linda Holler. She is a family member of a patient impacted by prior authorization. We've captured numerous physician and patient stories about prior authorization on our six prior auth website. Linda's son, Collin, was diagnosed with metastatic melanoma in his 20s and very sadly passed away at the age of 27. And Linda reports that his every three month scans were delayed every single time during the course of his illness due to prior authorization. And she's now left to wonder, in retrospect after Collin passed away, if the scans had been done on time, maybe they would have caught the progression of his disease sooner and it could have saved his life. If you go to the next slide, this is Collin Holler. So, this is the face of prior authorization and how it can hurt patients like Collin.

So, if you go to the next slide, obviously, at the AMA, we hear these stories all of the time from physicians and also sometimes from patients directly like Mrs. Holler. We've put this issue on the front burner in terms of her advocacy work because it is such a huge concern for us. And we've also partnered with other groups that are interested in improving this process. And an important landmark in this reform work was the release in early 2018 of the consensus statement on improving the prior authorization process. This document represents an agreement between both national provider and health plan groups on key prior authorization reforms. There were five broad areas of reforms addressed in the document. The first two, the selective application of prior authorization and the review and adjustment of prior authorization lists deal with reducing and ensuring manageable volume of prior authorization overall. There was an objective of improving the transparency of prior authorization requirements. Ensuring patient continuity of care was also discussed.

And then, finally, improving the process in terms of efficiency and transparency by automation, which is, obviously, within the sweet spot of this task force was also part of that agreement. And I believe that you've looked at this document in the course of your deliberations. So, I won't say more about that. But if you go ahead to the next slide, I guess, the important question is that was released almost 2.5 years ago. And so, the question is where are we today with those agreed upon reforms. And, unfortunately, progress on prior authorization improvement has been quite sluggish. The overwhelming majority of physicians report that

prior authorization volume has increased over the past five years. Nearly 70% of physicians say that it is difficult to determine whether a prescription of medical service requires prior authorization. Now, this task force has been discussing a lot the problems with transparency and prior authorization requirements.

And then, the past couple of weeks, we had been looking at some automated processes for prior authorization and those are really interesting presentations. I'll discuss this a little bit more later. But I think it's important to mention that those technologies are not widely available in physician practices today. Only 21% of the physicians in our survey indicated that their electronic health record has the technology to support electronic prior authorization for prescription medications. That was discussed with this task force two weeks ago. And for both drug and medical services prior authorization, physicians reported that phone and fax are still the most common methods they use to complete the process. So, again, this is still a very, very manual process for most physicians today. Go to the next slide then, please. So, we have been listening avidly at the AMA to the task force discussions over the past two months plus. And we are so glad that you are taking the time and putting all of the effort into this work.

We think it's really important. We've heard that you're taking a very broad approach to this issue and setting the sky as the limit. And we, certainly, appreciate that ambitious nature but we are concerned that September is swiftly approaching and worry if it might be hard to accomplish everything that you've talked about getting done in the next couple of months. And we also noticed that the task force has, at times, mentioned allowing multiple standards to complete an automated process and establishing both floors and ceilings for accomplishing the same tasks. And our concern there is that if plans are requiring physicians to support the different processes, use different standards for the same process that is very cumbersome and expensive for physician practices.

The past two weeks, again, have been very informative and interesting. When we listened to the prescription drug electronic prior auth process two weeks ago, we, I think, all heard that there is an established standard, the NCPDP SCRIPT ePA standard that is in production right now and is being used. However, its implementation is variable across electronic health records. And payers, again, also with the physicians reported that only about 1/5 of them have access to that technology right now. And then, one thing that we noticed is that both of the ePA vendors that were represented in that discussion two weeks ago indicated that they recommend practices institute a centralized prior authorization team to complete the ePA question stats. And that is concerning. It indicates to us there still is a fair amount of time and burden involved in completing this process, even when it is automated.

We also heard that vendors are offering real time pharmacy benefit technologies that allow physicians to see at the point of prescribing if prior authorization is required and also may present alternative medications that may have a more favorable, less expensive formulary status for the particular patient. And we think that technology is really important. We hear all of the time from physicians who would very much like to know and have insight into a particular physician's prescription drug benefit at the point of prescribing. However, it's important to note that there is not a finalized standard yet for that technology and the solutions that are out there right now are proprietary and they don't offer the data across all prescription drug plans and for all patients. So, until that technology presents data across all patients that a physician might encounter during a day of practice that will be a limitation of that moving forward.

And then, in terms of medical services prior authorizations, we thought the Humana and the Cambia demonstrations last week were both very interesting. I think we've heard throughout the task force discussions that the adoption of the HIPAA mandated X12 278 is weak, at this point, and there is no mandated standard for exchange of supporting clinical documentation or attachments. And then, last week, we, certainly, saw that there is strong interest and energy in advancing technology in this area. But over and over again, during that discussion, we heard the terms prototype and sandbox environment being used. And, again, this work is very interesting. And I think it holds great promise. But these are things that are not in production yet. They're not available across all payers. And it's only been tested for limited services. So, again, the question is are these really solutions that could be widely scaled across the industry and would be available to physician practices within a reasonable period of time.

So, I think this is a lot to digest and to think about and organize in our heads about what could be recommended and what things could be come up with in the next 12 months before the task force has to deliver the report in September. And I guess I will admit maybe I've got sucked into quarantine brain here a little bit. We've heard over and over again about people doing quarantine baking. And as I started thinking about this, I started thinking about the charge of the task force in terms of baking and, specifically, baking a cake. If you go ahead to the next slide, and I think this issue is so important to us at the AMA. We very much want the rainbow cake on the left side that looks delicious to be the outcome of this task force group. And we don't want the cake to implode, as we see on the right, which is what I would make if I were left to bake. And that's why my husband is in charge of the cooking in our family. Anyway, you can go to the next slide, please.

But to continue the cake metaphor here and hope that you'll indulge me as I lay things out this way, but we think that underlying this whole deliberation needs to be the idea that there needs to be a foundation for the prior authorization process. And the bottom layer has to be a standard technology integrated into physicians' EHR that ensures that physicians can determine, at the point of care, if a particular doctor service requires prior authorization. That is fundamental. And then, moving up to the top layer, if prior authorization is, indeed, required that there needs to be a standard electronic process for that that is integrated within the EHR workflow. And it's the same process across all payers. I believe Patrick, from Humana, last week used the payer agnostic. And I shamelessly looked at that because that's exactly what we need. The process needs to be the same across all payers from the physicians' perspective. And also, the process needs to minimize provider burden.

If the automated process still requires the practice to have a centralized PA team, that's still very burdensome. And a lot of smaller practices just simply can't afford to have a dedicated team just to do prior authorization. We also need some icing on our cake. We need something to hold these layers together and ensure that these standards, when they're available and mature, are widely implemented and available for physicians and the physicians have access to that technology. And then, also we need to think about the recipe for our cake and think about what information we need to make good decisions about standard selection before we start mixing the batter. We need to make sure we have common understanding of how to prepare and doing things. If the recipe says zest the orange, do we all know what zest means and are we all using the same tools to zest? If I use a fancy William Sonoma zester and someone else uses a potato peeler, does that make a difference?

Does it matter if we're doing things in a different way or is that going to be different from physicians when they have to consume that transaction? We also need to establish what metrics we need for success and how we're going to evaluate progress going forward and make sure that we're measuring things in the correct way. Anyone who has mixed up a tablespoon and a teaspoon will tell you the disasters that happen if you don't use the correct measurement scales. And then, finally, we need to make sure that our recipe is scalable. We might need to multiply the recipe many, many times to support big PA cake we're baking here. And are the solutions and standards we're looking at going to be able to support the huge universe of prior authorization that exists today? The many drugs and many services right now that payers are requiring prior authorization for. And I know the task force has talked about some other kind of new, novel things to include in your recommendations.

And we think these things are all important. We've heard things about including patients in the prior authorization communication process. And we would agree that is something very valuable. Getting patients cost information before they get care so they are aware of costs. And that is important, too. Coordination of benefits is also important. But we think, at this point, when there are such huge problems and challenges in just getting the provider to have plan communication done in an efficient, standardized way that perhaps we should make sure our cake is stable before we get these kind of extra goodies like the ice cream and the cherry on top. So, maybe these are things that the task force could suggest we look at at the next level of development of this process. Go ahead to the next slide, please.

So, I'm not going to hit on every single thing that is in this table. But we try to think about what could come out of the task force event in September and kind of broke things down by prescription drug and medical services prior authorization. I think that ways to think about this perhaps for the task force could be does a viable standard already exist for a particular process. Whether it's determining prior authorization requirements or, actually, completing a prior authorization itself. And if it does, you could recommend adoption of that standard via the appropriate regulatory mechanism. And then, if there are ways that that transaction could be made further efficient, for example, by mapping ePA questions for the NCPDP standard to coded references, which is, in fact, part of that implementation guide, you could recommend that, which would further reduce provider burdens because it will allow for auto extraction of data from electronic health records.

In other cases where there is not nearly as clear a path on what standards should be selected, perhaps this is an area that you should request further information and further research. I know that, obviously, we've been hearing a lot of discussion about different possibilities for medical services prior authorization. What is the role of the X12 278? I think there were some good questions that came up last month about using an attachment with a CCBA. That could be mapped to payer criteria. It would be more of a document based approach to getting the clinical data to the payer versus what we heard last week was more of a data element based approach using Da Vinci PA support, again, actually, mapping the specific PA criteria to the fields in electronic health records. So, these are things that could be explored. And I think it's definitely worthwhile in seeing what different payers' needs are in terms of this. Would they support using a document?

Would they rather use data elements? What's the most basic need for the payers and what will most of them support to be able to automate the process? For both medical services and drug prior authorization, I think it's key that, again, physicians have access to this technology and moving it forward so both, EHR

vendors and payers are offering this so that it can be accessed by physicians. In terms of the recipe and ingredients, again, I think that maybe doing some more research and asking payers to provide more information about their PA criteria and their documentation needs would be very helpful to determine if the various standards you're looking at would meet their needs and also looking if common data sets would be a possible way to ease the burden of implementing these solutions.

We also think it's really key that, for both prescription drug and medical services prior authorization that some baseline data be gathered on prior authorization volume and the different methods being used and how commonly each is being used and tracking that over time and also, establishing metrics for improvement so we can keep track of those and seeing how we're doing in the years that come. And then, finally, again, we think it's very important to look at these solutions in terms of the cost and time for practices and for vendors and payers to implement a solution across all services and payers. Again, if we have to build out a different prior authorization request for each particular service for each payer and multiply that out, this could be a very time consuming process. It would take a really, really long time for that cake to bake. And I don't think that physicians or patients have that much time to wait for a better solution to this problem.

Go ahead to the next slide. I would like to make the point that these aren't fringe ideas. They're not half baked. In fact, a lot of these concepts are included in ONC's burden report that was published earlier this year. If we think about the bottom layer of the cake, getting the PA requirements to physicians to the point of care that was referenced in that report. There are coverage rules into the EHR workflow. The top layer, having standardized transactions for prior authorization and standard data elements and templates that was part of the report. The icing of incentivizing use and implementation of these technologies was addressed in the report. The recipe of gathering the data that you need to make the cost decisions. The report mentioned multiple times supporting pilots. So, we think that's a great idea to gather more data. And then, finally, the idea of scalability was included. The report referenced the volume of prior authorization requests.

Again, we think it's really important to put all of these considerations and terms and quantify them in terms of requiring a prior authorization and make sure that the cake we're baking can support the volume of prior authorizations we have on the table right now. Go to the next slide, please. And some final thoughts here. We just underscore the thought that prior authorization reform is really urgent for physicians and also for patients like Collin. And we really urge the task force to think about what concrete, immediately actionable recommendations you could make that could be acted upon in October if moving that would be possible. If there is an existing viable standard, recommend its adoption and, if possible, ways to improve its implementation. But if there is not a clearly viable standard, we urge you to reach out and get some more data from payers and vendors bout what is the most viable technology. What is something that everyone could use?

Because, again, if there are multiple processes and technologies, we need very different payers. So, at the end of the day, that's not going to be efficient for physicians. We encourage you to look at baseline metrics that can measure progress going forward. We also think that wanting to use the common data sets to meet prior authorization requests needs is a really interesting idea and it could definitely make things much more scalable in a much more efficient, faster manner. And then, also you would be exploring common data sets and USCDI would also be applied to other kinds of data exchange across payers and providers. We think

it would be a really good idea to set timelines for all of your actions and recommendations. And then, we also would caution you in thinking about flexibility. Flexibility sounds really great but, at the end of the day, again, if physicians and their practices have to support multiple processes and standards, it's very expensive and it's not efficient from their perspective.

And most small practices just can't afford to do that. And finally, we do urge you to keep small physician practices in mind. They've already been strapped for resources. They have a hard time paying for technology as it is. And as we are, right now, very well aware of during the current pandemic, they are really hurting. So, keeping that in mind as you formulate your recommendations would be something we really would appreciate. Thank you so much. I don't know if Laura or Matt have anything to chime in with right away.

**Laura Hoffman**
Nothing from me, thank you.

**Matt Reid**
No, nothing from me. Thank you.

**Alix Goss**
Heather, this was phenomenal. And I have to applaud your ability to walk us through a story grounded in facts and research to giving us an analogy that we can put our arms around. And, actually, I think if you could go back to your final thoughts and considerations slide, could we back up, I would like to leave that one. I think this slide and the prior one are very interesting slides in that, I think, as a task force, we can use this input as kind of a check on what we're doing. But I know being involved with the small group working on guiding principles and ideal state, we've looked at the consensus process. But I feel like I want to take this deck and kind of look back at the body of our work and really just make sure that we're hitting all of these points because sometimes, words have similar meanings, even if they look different. So, I think this, for me, has been a really great opportunity to paint the picture.

And while I've been acknowledging the tremendous work that you've done to pull this deck together since we last spoke on Thursday, I see we have a couple of questions in the cue. Gus Geraci?

**Gaspere C. Geraci**
Yes, Heather and team, this is Gus Geraci. I believe we met when I worked for the Pennsylvania Medical Society. But I think one of the things that we touched on early in our meetings was the idea that prior auth does have to exist because one of your basic concepts was to adhere to standards of care. And as a former family doc clinician and a now former CMO for managed care organizations, I can't tell you how many times we denied appropriately unnecessary surgeries, unnecessary diagnostic testing, unnecessary radiology testing. And I think that your concept of having a baseline and I see a big role for the AMA here to figure out, which is something we have not tackled and I'm not sure it's part of our charge, but to figure out what to do about the physicians that consistently and regularly get a high volume of denials appropriately because they keep trying to practice the way they trained 20, 25 years ago. They may not be as sharp clinically as they should be.

And I understand you're not going to show the slides where unnecessary surgery was prevented by PA. You're not going to show the slides where unnecessary testing was prevented by PA. But I think the role of the AMA in deciding how to – what to do about physicians who regularly exceed the norm in denials has to be part of your charge. And I don't know how we're going to wrap it into our charge but it's something that I am concerned about. Insurance companies are so desperate for providers, they very, very rarely kick out a provider. But as a former CMO, there were lots of times when I wished I could kick people out.

**Heather McComas**
Thanks, Gus. A couple of thoughts on that. First point and I just want to make sure I captured that; I want to be very clear that the AMA is not calling for a complete elimination of prior authorization. We've been very clear from early 2017 when we released our initial set of prior authorization and utilization management reform principles that we are asking for prior authorization to be reformed and right sized to ensure that patients aren't being harmed and we're not introducing unnecessary cost into our healthcare system. But we do realize that it's here to stay. We don't think it's a viable starting point for conversations of plans to completely get rid of it. So, I just want to be completely clear about that. Also, to your question and I didn't really highlight this and I think, in part, because thinking about would a task force – most of your conversations have been and also your scope, we do include in the consensus statement, I don't know if you can backtrack that many slides but the first element is the concept of select application of prior authorization.

And I think that it does get to your point about physicians that are following guidelines and having the prior authorizations always approved versus those who perhaps are not. And the idea that we could get rid of some of the volume and reduce some of the hassles and burdens of the systems for the majority of physicians that are following guidelines or getting their prior auths approved versus those outliers who are not and then, would be subject to those requirements still. So, again, we see it as an important thing. I think technology has a huge role, actually, in that. It's, obviously, analytics and it would require also in the EHR system, flagging for the physician, whether or not they need prior auth. That would need to be built in if we, actually, had a viable gold carding system. So, I think there is a role for that and it could address the volume issue. Again, our concern is that, given the volume of prior authorization, any kind of solution is going to require a lot of programming and building on both the EHR and payer communities.

And we're just concerned that it will be five years from now and we're still having the same conversation. And just for all of the patients out there right now that are waiting for care, we just hope that we can do better in a more timely fashion.

**Gaspere C. Geraci**
I absolutely agree. And I recognize having suffered through the pains of prior authorization and being one of the docs that very, very, very rarely got a denial that was, ultimately, not overturned. I completely understand that side of the clinical space, again, having been on the other side. It would be awesome if part of the output of this entire process would be some kind of profiling. And believe me, gold carding is something I have pushed whenever I've had an opportunity to do that in a plan to look at practices that, virtually, get zero denial and just say we exempt you from prior auth altogether. Unfortunately, those are very few and far between. And often, this is personal experience, not data driven but personal experience anecdotally, it's the smallest practices who are the best and the worst. And so, the idea of taking a really

good practice and giving them a gold card, the problem with doing that in a plan is that, often, those small practices did not have enough data with the plan that I was in.

Whereas if we had a universal database of all insurers and we could see across all insurers that Dr. Smith's family practice in Podunk rarely had any denials across any payers, and somehow get them a gold card across all payers because each individual payer, often, did not have the data to support giving them a gold card because there weren't enough cases from Dr. Smith.

**Heather McComas**
I think those are all great thoughts and great points. And we would love to talk more about operationalizing gold carding. I know that a lot of the concerns that you've raised with it payers have raised. And there are concerns of would you be able to gold card a physician for every single service and is it going to be different and would it be different for each plan. Would they have different gold card status? And it would be, obviously, very hard to track versus doing something aggregate. That's a good question. And, certainly, we are very interested in the topic. And anyone who wants to go talk with us more about how to, actually, make gold carding a thing that could work in practice, we would love to talk about it because we think it would be beneficial.

But the thing is we see this as it's win/win for everybody because, from our perspective, if a physician's prior auths are almost always getting approved then, all that we've done is waste administrative time and costs and delay care because the payer ends up paying for the service because it was approved. And they also had to pay for the staff to process the prior auth. The physician's office has had to pay the staff or themselves to spend the time on doing the prior auth. So, nothing has been accomplished there. So, if we can remove that from the system, it would be a win/win from everyone's perspective, I think.

**Gaspere C. Geraci**
Absolutely. I completely agree. And it would benefit everyone all around if we could figure out how to do that better and also target the high denial docs with some kind of correction plan, which is, actually, very difficult to do inside of a plan.

**Alix Goss**
This has been a fascinating discussion. I'm proposing that we continue with the questions in the cue, even if it may mean that we don't get to a few of our small work group updates because I think this is a very important discussion. And so, Gus, thank you for kicking us off. Arien, I think you're next.

**Arien Malec**
Excellent. Thank you. So, one comment and then, maybe for your reaction and then, one question. So, the comment on floors and ceilings has been based on some of our historic work in this space where an approach where there has to be one standard that needs to be researched and evolved and then, rolled out leads us to big bang rollouts in things like ICD-10, in things like 5010 and then, 7030, and in large scale EHR certification rollouts. So, the thought process on floors and ceilings is the notion that we gradually raised the floor to provide regulatory flexibility for organizations that want to pilot, implement, and rollout advanced capabilities and definitely acknowledge that interoperability and/or/if/and from a perspective of the EHR vendor and sometimes from the perspective of particularly larger providers. So, I definitely

acknowledge that point but I just wanted to clarify the notion of floors and ceilings as we've been discussing it.

I think about the MIPA, the rollout of e prescribing, and the role that the MIPA incentive had to play in driving the adoption of electronic prescribing. I also think about the early days of EBI and claiming and the roles that payer incentives had and CMS mandates had in rolling out adoption of claiming relative to the much slower adoption of eligibility, which I think does drive significant workflow improvements but was much slower to ramp out. So, I'd be interested in your thoughts both in terms of floors and ceilings, if you have any additional thoughts that you haven't presented but more on what's the role of incentives. What's the role on payment policies and coordinated work between CMS's largest payer, the **[inaudible] [00:41:40]**, and the commercial insurers in terms of providing incentives and also in potentially providing mandates relative to ePA? Thanks.

**Heather McComas**
This is Heather. And, certainly, Matt and Laura, jump in here. I was scribbling and trying to keep track of everything. So, first of all, the floor and ceiling concept, I hear what you're saying there. I think that, first of all, it's important that the floor always be available. And maybe the ceiling is something that practices and maybe systems or resources can explore with payers. But our concern is that, as providers, the contract negotiation power, unfortunately, often isn't on our side. And so, if a payer is requiring use of a particular standard, maybe the ceiling standard instead of the part of contract network participation that is a concern. So, just a concern always that the floor option always be available. And I think also one thing that came to mind maybe a month or so ago in discussions is that the idea that the floor, I'm getting these mixed up now as I'm talking, but the floor has to be a workable option. For example, one could say folks would always have to be able to use the X12 278.

But then, folks who might want to use Da Vinci, FHIR, that sort of thing that would be the ceiling option. As I think we've talked about, the 278 by itself, in many cases, doesn't offer enough capability to transmit the robust clinical data needed to support many medical services prior auths. So, the fact that we're kind of leaving the floor practices without a fully viable option would be concerning. So, again, the idea that the more basic option is something fully workable that wouldn't drive practices to have to go to a portal or use the phone or a fax to complete the process. But they send them in 278 that says, as it often does today, it's pended. You have to go to a portal. You need to fax us, etc. So, those are some thoughts on that. In terms of the incentives, I think that's an interesting thing. I think right now, obviously, we're still at the point where the technology is not widely available through EHRs. And even the company might offer it but it might not be turned on or implemented in the particular practice's system.

So, it's kind of making sure the technology is available. And I, certainly, am concerned with a mandate. Obviously, again, the cost concerns, especially probably now with the Covid crisis when many practices are having a very hard time keeping afloat and even reopening their doors. The idea that we'd have to buy additional technology to comply with the mandate would be a concern. But I do believe that this is such a huge issue. If the technology was working, I think there would be a real interest in processes adopting it. I think, again, it's an availability issue. And some of it is, obviously, an awareness issue, too, because it's not something they're aware is even available. I'm sorry. This is a little salesy. But the AMA does have a short, ePA educational video series for physicians on our website. It's, I think, 10 minutes total. And it does give an overview of how the process works. And we are encouraging physicians to be more aware of the

capability for the drug ePA process. I don't know, Laura or Matt, do you have any thoughts on those questions?

**Alix Goss**
They may be on mute.

**Laura Hoffman**
I would defer to Matt. He has more kind of experience in terms of rolling out large scale technology upgrades in sufficient practices. I guess just anecdotally, I would say that for a lot of the members we talk to, they feel like they are already trying to keep up with constant evolution in their technology. A lot of them are even uncertain about what to invest in right now for some of the technology discussions surrounding prior auth. Going back to what Heather was saying about the different standards and the 278 versus use of FHIR and Da Vinci and everything, I suppose there hasn't been a real standard means established. People aren't really sure which direction they should pursue right now. So, I think that's part of why we just want to highlight in our final thoughts and considerations a real need for someone to, essentially, make some decisions on what these standards would be.

And if we need to conduct pilots to understand how to get there then, I think that's a thing we would be very supportive of. But I think this uncertainty right now is really difficult for practices of all sizes, frankly, but particularly, those with fewer resources to make smart decisions about the kinds of technology they should invest in moving forward.

**Arien Malec**
Yeah. So, I may be putting you on the spot but there is sort of a tension in the conversation between rollout something that works and maybe the 278 doesn't work as well as we want it to because it tends to drive people to one-off payer specific portals. Don't mandate anything because we're already kind of up to our eyeballs in mandates. But this is a real urgent problem and we want you to solve some of the workflow issues. And so, there is sort of an inherent tension there. It sounds like there would be willingness to accept a let's go do something in a concerted way so long as it had been appropriately tested, worked and addressed the significant workflow constraints if there was a tradeoff between making somebody do something. But making somebody do something but where that thing, actually, led to significant workflow improvements that sounds like it's a tradeoff that's worth making.

And maybe there is a potential. But if we don't do something like that that we're stuck in this situation that we've been relative to attachments or relative to the 278 standard itself of lack of concerted adoption on both sides of the network that leads to nothing happening and the workflow issues that are currently existing. I'm sorry. That was a little rambling but just pointing out that there is an inherent tradeoff here when we're thinking about network adoption. And it sounds like there is both hey, don't make us do anything. On the other hand, this is a really urgent problem and let's go solve it. Let's make sure the solution, actually, works. And maybe there's a pareto optimal approach here where maybe we make some people do some things. But it, actually, drives significant workflow improvements.

**Laura Hoffman**
Yeah. And, Heather, correct me if I'm wrong but I think the AMA would be very supportive of a singular standard. For a long time, there has been this back and forth discussion going that – and I know everyone

seems frozen on their heels a little bit. So, I understand and hear what you're saying about sometimes there is this tension of tell us which way to go but don't have a mandate. But I think, in this particular situation, because of the – frankly, as you know, there is the 278 mandate. But when it comes to attachments and other things, we just haven't seen good uptake on it. So, I think in this case, there is a real – we do see and appreciate the need for a named standard that everyone can get behind and work towards and, to your point, give it a conservative effort to go and make people use it. But then, how you go about making people use it may be a separate discussion that will, of course, be varying opinions about for sure.

**Arien Malec**
I definitely appreciate that. Thank you. Great conversation.

**Heather McComas**
And this is Heather. And I've said this before but, I guess, I am **[inaudible] [00:50:57]** this idea so I will say it again. But I think it's a helpful model to maybe look at. Way back, I'm going to say the wrong year here, I think in 2005/2006, AHRQ did an e-prescribing study that included electronic prior auth for drugs and, in fact, evaluated at several sites using the 278 for prescription drug PA and, basically, came to the determination that that standard was not the right path to go down for a prescription drug PA. And that's why NCPP went off and developed a standard that was worked through e-prescribing and would fit into the physician's workflow. And I think that kind of model, different payers highlighting this and evaluating this work in a formal report and everyone can look at the data is a very helpful thing to think about.

And I don't know if that's something the task force feels that's inappropriate to make that kind of recommendation. But, again, I think that pilots with some kind of formal report would be really helpful in teasing out the standard. Again, I think it's important that we do pick the right standard. And I think that it's a little – obviously, we want this to be better really fast. But we do want to be something that's workable. And we've been really, really stuck in this area for a long time without an attachment standard. And it's not going to move forward. and I think if the first step is research then, maybe the recommendation is to research with a timeline to a decision.

**Arien Malec**
Again, really helpful. Thank you.

**Sheryl Turney**
Should we go to the next question, Alix? I see Rich has a question. Rich, why don't you go next?

**Rich Landen**
Thanks. Heather, Rich Landen. It's a great presentation. You've packed a lot of compelling information into a very small package so it's well done. There are a couple of themes that came across the presentation. The uniformity across all payers, the scalability. And then, in both of the layers of your cake, and I love that analogy, the primary ingredient seemed to be information technology. So, I can see how an IT driven solution to prior authorization in our industry would work for medium and large sized organizations. What I'm struggling a little bit with is how can we scale that down so that it works for the very small organizations, the 123 physician practices. So, if you could, could you speak just a little bit more to that final bullet on your Slide 23 and what are some of the things that AMA is thinking about how a prior auth system would have to look in order for it to be successful at meeting the small practice where that small practice lives.

The small practices, typically, from experience are more challenged to make the IT investment and are more challenged to keep up with the – or to do and then, keep up with the training on how to use the technology. Thanks.

**Heather McComas**

Thanks, Rich. And that's a really great question. And I'm sorry if I – Matt, could maybe jump in, too, because I know he probably has some really good thoughts about practice costs. But I think that the questions you asked are very important. And I think that, ideally, if the task force is looking at recommending any kind of pilots, including providers, practices of small, medium, and large would be really, really important because, as you indicated, the situation is so different from different practice sizes. And, again, not to beat this dead horse but the reference that was made on the prescription drug presentation, having a centralized PA team, I'm sure that does improve efficiency. But that's the system reference there was kind of a larger system, I think, in Illinois and southern Wisconsin. This is not a viable approach for smaller practice.

So, the idea of if there are any pilots that would be done, including those smaller practices and seeing if it's workable because, again, we're going to leave them behind. And they're already going to be behind. And we use the ones that are least able to shoulder that administrative burden behind, it's going to be a huge issue. So, it is a concern. I think also, a lot of the Da Vinci work, again, excellent, so promising. I think there are larger systems that are involved in that work in provider sites thus far. And then, if we could get some different sized providers involved, it would be really helpful to see how this would work and, again, evaluating costs to how affordable is this first model practice and having that be part of the decision making process in your recommendations is that is this a solution that could work for everybody or is this something that only would really work for large systems and who are we leaving out. Matt, do you have any thoughts on that? I know that's one of your sweet spots is feasibility and practice sites and that kind of thing.

**Matt Reid**

Yeah. Thanks, Heather. I think two other real important points, and I'll be really quick about this, 1.) I have a background in working in a medium sized practice. But I've engaged with several smaller practices. And something that's kind of an expectation that comes out of a certification program or purchasing an EHR for participating reporting programs is if I'm buying this product, it should be able to do everything I need it to do to participate, to care for my patients, to manage care, to facilitate payer/provider interactions. So, how do we ensure that all of these efforts are a part of the core components or can leverage the core component of an EHR such that a physician is not having to purchase a bolt on or some additional module just to be able to support something that is important but could be profoundly costly for them to implement.

And I think if we're thinking about standards that are our there, the USCDI is a great concept we need to be thinking about. ONC's certification process has a bit of a long term effect. It takes two or three years to really go into effect for physicians. So, what we're working on now, we need to figure out how to leverage what an EHR is capable of doing in the short term. And if we want to do more than that, how do we improve the certification and the products that far out? So, that's kind of one side of the story. The other side of the story is, and it's something Heather has already talked about, uniformity. Back in our practice, we had many different times a service provider would come to us and say we can give you this really great opportunity, this really great feature but it's going to be something that we need to build on. We need to do some customization to your product to be able to support.

And if we have payers and different standards out there and every pair, every service, every procedure has something unique to it that the payer is going to need that really kind of leads to a lot of one offs. And a large system or a large practice can manage a number of one offs. But a small physician's practice, a lot of them right now are just trying to keep the doors open. So, if they've already got an EHR, let's see what we can do that an EHR can already capably give them. And let's try to keep the one offs to a minimum. And we need to figure out how the payer community and health IT community, pretty much everybody that's involved in this conversation, can work together such that we've got one process that's widely applicable and, to the point that was brought up earlier, scalable, not just large but down to the small practices. So, leverage the technology that's already in place to the greatest extent possible and make sure that we don't have a lot of one offs and try to make this as uniform as possible. I think those are two really important points for a small practice.

**Alix Goss**
Sheryl, this is Alix. I've got my audio back. So, do we want to continue to take questions or do we need to pivot to get to the HITAC update before this week.

**Sheryl Turney**
I think we had one more. Why don't we just take Jocelyn's question and then, we can move on?

**Alix Goss**
Fabulous. Jocelyn.

**Jocelyn Keegan**
Hi. This is great. And Heather and I have been in the trenches here for many years since we got the NCPDP standard live. So, I really appreciate when you come and evangelize about current world and current states. I guess my one question for you guys as a team, since you've got the stage today, is I think there are some really great points that come up in the conversation. Whatever we need to do needs to be all payer. I think it needs to make the small and mid-sized guys be able to play the same way the big guys do. I think we can all agree the shift towards APIs and getting in workflow in the EHR is critically important to be able to sort of move the dial and to make this, actually, work. I guess what I'm really curious about is if you have the magic wand today and you could picture what a pilot would look like, how do you think that you would structure it?

Because I feel like part of the conversation that we're having is we're really rolling out the capabilities that are coming out of the work that I'm doing with Da Vinci and my experience having rolled out ePA across really the long tail of the providers since my time at NaviNet is this idea that there are ecosystems and that all payer aspect is really important because if you're gold carding, I need to know if I'm seeing that provider organization that I'm really gold carded and it's not that I just can skip prior auths because nobody wants to make the decision to be the person to not do the prior auths if they think they're gold carded and then, eat an expense because they skipped a step. So, it needs to really save that provider. And I think that sort of all payer aspect of it is really important.

And then, do we need to  solve it across everything in each one of these ecosystems or can we target specific disease states or specific treatment areas to be able to start to get some of that uniformity to prove things out to show that they work and show that they have promise so you can actually make it attractive

for providers to take the investment and to take the hits to adopt a new technology. It's so hard to get people to pick something up if it's not as good as or better than what they're using today. So, I guess, Matt, Heather, and company, if you were going to be able to set up a pilot, what would it look like and do you have ideas of how and where it should live? Because I do think that experimentation is going to be critically important for us to be able to really move out of the current state and stalled efforts that we've been in for the last few years. Thanks.

**Heather McComas**
This is Heather and I will start but will definitely phone my friends, Matt and Laura, to help out, too. It's a good question, Jocelyn, and the more brains on this, the better. I think it is a complicated thing and it does make my head hurt. I do think that, obviously, getting all of the major payers involved in a single pilot thing, I would imagine it would probably need to be a narrow set of services just because the universe, the PA cake, is so huge right now that we can't do all of it. And I do think that, again, getting the scalability issues, thinking about is there a need and a payer appetite to make this dog bark to get some standardization. And at least in the PA data element request, I think, obviously, asking uniformed clinical criteria across plans is probably too big. Don't get me wrong. We would love that, physicians would love that. But that might be a big ask. But can we at least agree that, for this service, we all will agree that these are the data points that we need?

And then, for the physicians, always know that that's what they need to send for this CPT **[inaudible] [01:04:00]** code, for example. And I think, again, we're talking about getting different sized practices involved is really important. Getting a mix of the EHR vendors also would be important and then, have kind of agreed upon things we're measuring. I think, again, the work that we saw presented last week is so interesting but it's not clear to me is it representative. Both the payers, they kind of were showing some kind of an attestation model, yes/no versus I know, at least I'm pretty sure, a lot of payers do, actually, want to see the clinical data. And so, that is a difference. And we need to make sure whatever the result will accommodate what all payers need because, otherwise, we have not really fixed anything. But I think it's really something we're thinking through and sitting down and really designing, frankly, as scientifically as we can because this is a really important question. Matt, Laura?

**Laura Hoffman**
This is Laura. I guess I would just reiterate Heather's suggestion and points about whether there are certain services, for example, that we could receive some kind of common agreement on the data elements required. I think that would be a really huge advancement for physicians and dealing with this problem just in terms of simplifying knowing what that is needed ahead of time. But we'll put that to the side at this moment. I guess in terms of what various pilots could look like, we've, certainly, batted around, internally at the AMA, what path do we go down here because, as Heather has noted, we clearly see the value in and promise of the work that Da Vinci is doing but we hear from, again, physician practices who aren't sure when they would ever really be able to adopt these newer prioritized technologies for their practice. So, we kind of ping pong back and forth internally a lot. And I don't know that we have a definite answer, which is why we keep coming back to this pilot concept.

And I'm trying to distill out the different questions that need to be answered around functionality. So, did the standards support the exchange of the data that's needed in a usable format and is the workflow and the additional steps that may be needed of physicians and plans, are those minimized, at the same time? But

then, also thinking about outcomes and impacts and even the time to the solution. So, again, it's these same themes. And I think that it could be a really interesting concept. I'm not as familiar about this. Heather has told me about this. But in the past, AHRQ did some pilot studies for e-prescribing. And what if we were to come up with something very similar where there were pilots that take a 278 plus attachment standards track and a FHIR enabled prior authorization track and we focus on a few different services, we focus on a few different payers, different practice sizes and really gather some of that data on where the balance is?

And it likely will not be perfect for every practice. We won't come away with a golden solution necessarily but at least we'll have more information about saying hey, in terms of functionality and better outcomes, this is the clear winner. And yeah, it's going to take some time to scale up and it might be offensive but, kind of to the point Arien was making earlier, we have a direction now that we want to go in. And we know that there are communication hurdles to get there but now, we are all swimming in the same direction. So, I think that, generally speaking, the AMA would be really supportive of some kind of pilot like that to help the industry make a decision one way or the other about direction we're headed and we would, certainly, be happy to continue to think through what pilots would look like with all of you or provide additional recommendations.

**Sheryl Turney**
Thank you. This is Sheryl. I really want to say thank all three of you for coming and making this presentation. It was very, very useful. As Alix already stated, I think it gave us exactly what we needed in order to spur a conversation in the right direction and to utilize, as a reference as we're looking at our workbooks and the work that we have coming in the next several weeks. So, we look forward to your continued participation in our meetings as we go forward. And thank you so much for coming today. If anyone else has additional questions, we can, certainly, entertain them offline. But now, we're going to move on to the next component of our agenda. Can you go to the next slide, please? Thank you so much. So, we do have a HITAC meeting that is coming up this week tomorrow. And Alix and I will be providing an update to HITAC on our activities of the intersection of clinical administrative data update.

So, what we'll do is we'll review the task force charge, the vision, the approach that we took to try and establish a framework for the work groups and the small groups that we've been working in. We'll review the schedule of meetings that we had put together and the progress that we have to date. It's only five or six small slides and then, we will talk a little bit about next steps. And then, we had some discussion questions for HITAC. And I wanted to review the discussion questions for HITAC with this group here before we, actually, present them to HITAC. So, can you go to the next slide, please? These were some of the questions that we had for this task force, as well as input from HITAC that we wanted to entertain. We only have about five minutes to have some discussion on these items in this meeting right now before we have public comment. But, certainly, once public comment is over, we can talk a little bit more.

But really, the idea behind these questions was to generate conversation in our next meeting that we can then, utilize some of the thoughts that, hopefully, you'll share with us to the work that we've been doing in the workbook. As you know, there has been some small group work that's continued to go forward both with the ideal state guiding principles as well as the data classes and the recommendations. So, we need to start transitioning that into our paper that we're going to frame. But we also wanted to be sure that we were getting more input from the folks, stakeholders that are on this call. So, just briefly, some of the questions that we have here we wanted to look at, as we move from the prior authorization focus to the

broader intersection of clinical and administrative data, what are the specific goal areas that this group feels that we should cover.

And I know we don't want to boil the ocean. We want to carve out a component of the scope that we believe we can, actually, influence and move. And I think that is something we need to emphasize because there are quite a number of areas that we could focus in. Other groups have been doing this for years. I think what we really need to focus on is what are the activities that are currently going on that we need to support and move forward. We heard some great things today and in prior calls about uniformity and looking across payers and understanding more visibility into the processes that we've been talking about also in terms of the data requirements that the various demands for clinical and administrative require. So, looking at that information and understanding it in the greater context is really what we're talking about. Another area that we wanted you folks to think out was what are the key considerations for the task force as we think about coordination of benefits and cost transparency.

These are themes that have come up multiple times in prior meetings. And folks have shared some questions and some thoughts. But there is not a lot in our workbook or guidelines around some of these topics. So, if you have specific areas that you think we need to focus on then, let's incorporate those in the material that we're going to be dealing with related to our guiding principles, as well as our future recommendation state. And then, what should we say about timeliness of prior approvals across the spectrum? And this really wasn't just meant on timeliness. It's a concern that prior auths A.) take a long time, B.) it's not always easy to know what's the status. Once you put in a request, where is it and how long is it going to take? All of those things that have to do with the process really need to be more transparent. So, what do we want to say about that in terms of how we're going to deal with our work?

I'm, actually, going to take a break in terms of doing the questions so we can move to public comment. And then, we can come back and just reframe these questions and finish them. But if you want to put up the slide for that, we can move forward to the public comment component since it's time.

**Lauren Richie**
Operator, can we please open up public lines?

**Operator**
Yes. If you would like to make a comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. If you would like to remove your comment from the cue, you may press star 2 on your telephone keypad. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

**Lauren Richie**
Thank you. And do we have any comments in the cue?

**Operator**
There are no comments at this time.

**Lauren Richie**
Okay. Sheryl and Alix, I'll let you know if we have additional comments.

**Sheryl Turney**
Great. Thank you. So, we probably should keep this slide up. So, I'm going to just go back and speak to the questions I have in front of me, even though you guys can't see them. But they're going to come to you and we can switch off the public comment slide.

**Alix Goss**
Hey, Sheryl. I just wanted to make sure you were aware that Lauren typed into the information into the chat box. So, if that would be helpful, the information on the slide is also in the public comment chat.

**Sheryl Turney**
Perfect. Thank you.

**Alix Goss**
You're welcome.

**Sheryl Turney**
So, the next question that we wanted you guys to think about was what about the standards of adoption of attachment requirements. There are already recommendations that are out there. We need to have recommendations for years. Is that something that we should recommend moves forward? And then, the Da Vinci Project has also done some work regarding prior authorizations and the use of these transactions. So, how should we think about that? And then, where does that work lie in terms of our recommendations? And how should that be framed up? Another topic that we talked about has to do with barriers and changes for EMR systems. We heard today and in prior calls that there are challenges dealing with the vendors just like there are with all the constituents that are involved in this process. But making something a standard so that it's payer agnostic, I've heard, is all well and good.

But some of the challenges that we face today are that in order for – in the current framework of the landscape that we're dealing with, in order for a payer to move forward to do something to improve the automation of prior authorization, we have the Da Vinci use cases that we can utilize. But often, it is entering into some sort of contractual arrangement with a vendor in order to make that go live or active. And, unfortunately then, it becomes a business arrangement between each payer and EMR system in order how to make that happen. So, what is it we do need to do in order to have the entire spectrum of all of those integrated payer clinical transactions uniform and standard across the spectrum is a little bit more difficult because without a mandate or without a standard to rise to, it really does become something that's more of a negotiated business arrangement between the two entities. And that does not necessarily align to the direction that we've discussed where we really want these things to be uniform and consistent.

So, it's not only easier for the provider and reduces that burden but I think, in the long run, it's probably easier for the entire scope of all of the payers and all of the providers. But at the end of the day, without having that channel or having that connection standardized in a way that makes that available, it doesn't lend itself to that type of service. So, that's part of the issue. And I know with some of you, we've even talked about is there open source type of solutions that can be utilized to plug into some of these things so that payers can plug into it and then, all of the EMR systems can utilize it. is there space? Is that something we should talk about as far as that goes? And then, the last question we had is is there a way to standardize

the data request across payers, which clinical decisions are based upon. So, can at least the data that's being asked for from all providers be the same?

And maybe different decisions are made by different payers but at least it's the same data set. And that would lend itself to is there a component of data within USCDI or something of that nature that we can say this is the data set that we need and everyone is going to agree that we'll utilize it for whatever the decision making is so at least it's uniform from the payer and EMR system – or from the provider and the EMR system out to the payer. Can we go back and see if there are any more questions on the public line, Lauren?

**Alix Goss**
Lauren was just verifying that.

**Lauren Richie**
No comments.

**Sheryl Turney**
No questions, okay. So, these were just some of the questions that we had for this group. And, of course, it's meant to sort of spur our conversation for next week as we come together. We may also, for next week, have another demonstration. We're not 100% sure of that yet but we will have that framed up, hopefully, in the next couple of days. I don't know if anyone has any discussion about this but if you have questions, great, we'll take them. Otherwise, we'll go to the next slide and talk about next steps. Jocelyn.

**Jocelyn Keegan**
Hey, Sheryl. I just got a little spongy on the third bullet point. I don't know if we want to reword that for a little bit more clarify and crispness. Because even when you were talking about it, it didn't get quite to me about the point that we're trying to get out of these guys. Are we saying about the time delays caused by prior authorization, the ability to do them prospectively versus retrospectively? I just want to get a better understanding of what that question is trying to unpack.

**Sheryl Turney**
I think what I was trying to get to is we've heard a lot of things about the timing. And so, it might be that we need to make recommendations around not everything could probably be done in real time. So, maybe there are some things that fall into that. And those that cannot, what do we need to know about the prior authorization over time in terms of what's the status of is there a commitment that we could recommend that, within 48 hours, responses for prior authorizations that have all of the information are responded to. What are the timeliness type requirements –

**[Crosstalk – inaudible]**

**Jocelyn Keegan**
I think is what might be helpful is what we talk about is maybe the idea of removing uncertainty about the processing of prior authorizations. Because I think that all of those characteristics that you're talking about are the I don't know where it is, when it is, who is going to give me an update about it, do I need to give more data.

**Sheryl Turney**
Yeah.

**Jocelyn Keegan**
It might be a way to reframe that. That's all.

**Sheryl Turney**
Okay. I'm just making a note.

**Alix Goss**
Sure. While you're doing that, Rich, do you want to read out your comment?

**Rich Landen**
Sorry. It took me a minute to get off mute. The barriers and changes to EMR systems, I'm wondering how actionable any answers to that might be since we're really not at the point on the task force where we're, actually, outlining some sort of solution that would describe what the role of the EMR would be. And if we don't know what the role of the EMR is then, how much value would a discussion of barriers or changes be at this point in time? I suspect it's a slam dunk that we're going to tie into the EMR systems, eventually. But until we know what that's going to look like, I'm not sure the value of the answers we'll be getting and then, hence, the value of taking the time of HITAC to respond. Are there any rationales that I'm missing?

**Sheryl Turney**
I think that's a good point, Rich.

**Jocelyn Keegan**
Hey, Sheryl, it's Jocelyn again. I might take a different stance there in the idea of I think that I agree with Rich that we don't know what the "what "is or I should say how we would make the change. But I think that what would be good to understand is, for the workflow implications, the where, I think, is important to understand that one of the big challenges right now is all of this activity happens in a back office someplace outside of the EHR. And PA isn't happening and awareness around patients' benefit coverage isn't happening in the workflow. So, having the conversations about how and where in workflow you would surface that information and what barriers there might be to injecting or how you might inject things into workflow would be, I think, good questions to sort of posit.

**Arien Malec**
This is Arien. I would agree. I think we've noted, as part of our happy path that driving PA in workflow is important. Driving PA upstream, as upstream as possible at the time of referral, at the time of order, is important. And so, given that recommendation, I think it's appropriate to ask the question how to best do that in workflow in ways that work with EHRs as opposed to against them.

**Sheryl Turney**
Yeah. Exactly. That's great. So, I can reframe that question. I know we're over time. Any final? I don't know, Alix, what we have for next time. I don't think we're 100% certain so can we just move to the next step slides. Go head.

**Alix Goss**
I was agreeing with you. Keep going.

**Sheryl Turney**
So, I know we're a little bit uncertain on the agenda for the next meeting. It will either be a deep dive into some of the discussion of the small groups and some of the questions that we're asking today. But there might, additionally, be one more presentation. That's not 100% yet. And then, we need to talk a little bit more longer term on the other use cases. And if we want to continue the exploration of those or how we're going to continue that exploration and really the framing up of the paper that we want to see at the end. I think that in the next couple of weeks, we want to transition to at least a template for that so that it can be something that's more tangible. Everybody can sort of see it and then, understand where we need to explore more. Some of the things we heard today, we need to explore a little bit more about what's going to be expected by some of the actors within the framework of prior auths and the intersection of clinical administrative. And then, once we can quantify that a little bit more then, some of these questions that we're asking today will come to life a little bit.

**Alix Goss**
Yeah. And one other thing we're likely to talk about next week is the formation of the focused group on privacy and security coming out of the guiding principles and ideal state group. We thought that particular, scope of topics needed to have much more focus. And so, Jacki Monson who was not able to be with us today, due to some healthcare delivery priority focus, has agreed to work with me and a small team to have a couple of calls around that to advance privacy and security specific considerations beyond the high level concepts we've captured so far in guiding principles. So, stay tuned as we continue to evolve that opportunity as well.

**Sheryl Turney**
I think that's a wrap. Thanks, everybody, and we hope you have a wonderful week. We look forward to your input and **[audio distortion]**.