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

July 7, 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
Hans Buitendijk	EHRA	Presenter

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

Operator
Thank you. All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Happy Tuesday to you. Welcome to the ICAD task force. Let's do a quick roll call. We have Sheryl Turney and Alix Goss, our co-chairs, Alexis Snyder, Anil Jain, Deb Strickland, Jim Jirjis, Jocelyn Keegan, Mary Greene, Ram Sriram, Rich Landen, Sasha TerMaat, and Steve Brown. Are there any other task force members that I may have missed? Okay. I would also like to welcome our guests from EHRA. We'll let them introduce themselves later, but first, I'll turn it over to our co-chairs to get us started.

Summary (BPM+) and Action Plan (00:00:45)

Alix Goss
Thank you, Lauren. This is Alix Goss, and I'm going to kick us off today. As Lauren noted, we're going to have an EHRA presentation. We'll then follow that up with a brainstorming session around prior authorization recommendations. Of course, we'll have our public comment and then move into next steps. So, to go ahead and stay on track today, I'd like to propose that we go one more slide. As in our due form, we like to orient folks to what we discussed on the last call before jumping into the deep end of the pool for today's topics.

So, at the last meeting, we had a really robust discussion around the business process model. It was a very impressive model, very well presented by Robert. We're very grateful for his support and effort in transforming a narrative into a very polished end product. It was really focused on the automated aspects of prior authorization between the provider and the payer. We clearly identified some opportunities to further expand upon the patient interactions and what was envisioned as an ideal state moving forward for automation, and that was part of our discussion in understanding what the objective of producing that model was. It was a little confusing about the care setting and possibly whether it was current and future state, and I think it became very clear that it was really a focus of the future around the automation aspects of what we've already discussed so far for our ideal state.

We know that there is some opportunity to leverage this work as we move forward with generating our report, so as we are continuing to identify other subject matter areas that we need for the report, like the recommendations, we're going to be revisiting that. We've been coordinating with Steve, Robert, Jim, and some others offline in regard to how to best use that report, and so, Sheryl and I have been continuing to consider that work as we have been working on preparing a framework for the report that will address not only the prior authorization focus, but our larger discussion of the intersection of clinical and administrative data. So, we're going to leave you with a teaser of more to come on that. We started a framework for the report, and we're definitely going to be doing a shoutout to get some leads for various sections to help us bring that home over the next six to eight weeks.

But, without further ado, I would like to introduce Hans. Hans, I think you're the only one presenting today from EHRA, but you may have other colleagues with you on the call. The Electronic Health Record Association is a portion of HIMSS, and it's a trade association of electronic health record companies

addressing national efforts to create interoperable electronic health records in hospital and ambulatory care settings. The association operates on the premise that rapid widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system, and as a part of our engagement with industry, learning from those on the front lines, and receiving some additional thoughts for consideration, we're rounding out a series of presentations today with the Electronic Health Record Association, and we're really excited to have Hans present to us today on behalf of that committee.

Hans Buitendijk
Thank you, Alix. I'm here today **[inaudible] [00:04:28]**.

Alix Goss
I'm hearing an echo too, Hans. Has it gotten any better for you?

Hans Buitendijk
[Inaudible] from you or from me?

Alix Goss
You're breaking up. I think it might be from your end. Are you on your computer, or are you – you're dialed in with a headset, right?

Hans Buitendijk
I'm dialed in **[inaudible]**.

Alix Goss
Operator, could you possibly – they're texting me via our chat buttons. They're working with the operator on improving the clarity of your line, Hans. We think your line is breaking up.

Lauren Richie
You may just want to use a phone line if you can, not over the computer. That may be where the feedback is from – if you have audio from your phone as well as your computer. Hans, we'll send you a note separately, but if you can hear us and you're able to dial in from a landline or separate line, that may be better.

Hans Buitendijk
If you can hear me, I'm going to try to dial in with a cell phone this time over a different channel. So, I'm going to hang up –

Alix Goss
Okay, but all of a sudden, you got way better, Hans.

EHRA Presentation (00:06:18)

Hans Buitendijk
I didn't do anything! All right. I like it when that happens. So, I'll give it a try before it strikes again. So, I really appreciate the opportunity on behalf of the EHRA to talk with this committee a little bit further about

prior authorization, and as a little introduction to EHRA – I know a number of people on the committee, but not everybody, so I'm not sure how familiar you are. On the next slide, we have about 30 members that are part of the organization, and as Alix indicated, we really are trying to focus on enabling our clients in the industry with capabilities that directly support providers in the healthcare setting – it's a wide range – hospitals, ambulatory, post-acute – so there are a number of different settings there – as well as their interactions with any of the stakeholders that they need to get data from or that they need to provide data to, whoever that may be.

So, in that context. I want to share a couple of thoughts around prior authorization. Please go to the next slide. We believe – and I clearly agree – that we need to streamline. We hear from our clients frequently that the process, the steps, the documentation – all the things that are needed to get prior authorization for the items that are being ordered, considered, and otherwise – are taking a lot of time and effort, and this has a number of challenges in a variety of different ways. So, I wanted to touch on some of those challenges today, but we clearly agree that we have to figure out something collectively to improve on that, and it will require participation and effort across a number of different parties. It's not only the EHR, it's not only the providers, it's not only the payers – it is everybody collectively to make something better out of what we currently have. Please go to the next slide.

When we look at prior authorization, we like to make a distinction between prior authorization for medications and for everything else. For prior authorization for prescription medications, we see a much more widespread introduction of that. With the efforts and the connections of CoverMyMeds and Surescripts, there has been a substantial uptake on that, from which we have clearly seen a substantial benefit across the provider community, and with the adoption of the latest SCRIPT standard, we have further enabled improvement of those capabilities.

So, in the medication area, we are very pleased by how far we have been able to collectively get. In the area of other services, we have clearly been collectively lagging. There is more to be done. Attempts have been made in the past to do some of the efforts, but generally, we run into some challenges on actually making that work and fitting that into the workflow as easily. Please go to the next slide.

Some of the challenges that we recognize and hear about are about the level of detail at which prior authorization is required. So, it needs to be done for individual procedures, individual tests, individual DME, and individual services where that may be required. The data requirements and the need for them vary. They vary by payer – federal, state, or commercial – as to when somebody needs to have authorization, and for what. So, it's not only that the number of items that prior authorization needs to be done for is high, but also that the variations in what is needed to do so and to request for it if it's needed or not are substantial, and that makes it very challenging to manage.

Additionally, to date, it has been a challenge to have efficient data exchange methods and technologies with the payers to interact with them, as attempts at using X12 and infrastructures that were in place just did not enable us to integrate the flow and the data as easily into the workflows with minimum impact on the user. Delays and lags occurred because the technologies were just not there to have a smooth interaction. So, that has made it challenging as well to make the necessary progress. And then, overall, data capture of workflow integration – how to ensure that it fits in the right spot, in the right place – has

been challenging with the variety of data requirements that are needed. So, I recognize the set of challenges there that we need to figure out how to overcome. Please go to the next slide.

Clearly, the EHRs have a good amount of data available that is relevant to prior authorization, but the needs of prior authorization at the time of order are not always clearly understood. So, there's an understanding of when you need it and when you not, and I just mentioned that earlier as well. It requires additional documentation that is needed beyond what might otherwise be needed for treatment. So, the question becomes that we are trying to support our clients with the appropriate amount to perform their activities – clinical, administrative, et cetera – but this requires additional documentation to support the authorization request, which is then additional to everything else they need to do, which can increase the burden of documentation.

It is also not always clear what additional documentation is needed, and for whom. Yes, there is some general guidance on that that is available through portals and other means, but it is not easily obtainable, and it's hard to make that process work efficiently within the workflow. Data may not exist in an EHR itself. It might be sitting in a different system that might be relevant, such as a document management system it's associated with, but there might be other places we need to go depending on the configurations that are in place, so it's not necessary that all the information is in one system. It might be distributed across a couple of different systems as needed. And then, the lags that we have experienced in accessing exchanges with payer systems – if that is not fast enough, if that does not fit within the workflow of the user, then at that point, it's not going to be very successful to get it up and running.

And, when we look at those challenges, they are projected frequently – and unfortunately – onto the EHRs rather than the combination and particularly the additional data requirements and infrastructure that need to be in place on the other side to be able to get access to the information in a timely fashion and to make it work. So, again, like anything with interoperability, it is not a one-size-fits-all, it is an issue and a challenge that needs to have participation and contributions by everybody to make it work so that the systems on both sides are in place, standards are in place and accepted, and the technology is efficient enough to make it work for the user. Next slide, please.

So, a couple of recommendations that we see that should be considered generally fall in the following four buckets. First, where it is possible to provide authorization at a higher level than the individual procedure, service, test, or DME, that would be very helpful, and the shift from fee-for-service to value-based payments has that opportunity to identify, based on patient condition and other more general criteria, if there is a set that is effectively already authorized once you are in that category. Where can that be done? Or, the fact that you're in value-based payments – are there scenarios based on that shared risk that the need for prior authorization is not as essential and is more on the back end as part of the reporting that is sufficient? So, are there opportunities by which there is effectively no need for authorization to be embedded as deeply into the workflows and at each individual procedure, service, et cetera? So, that's one area to look at. What can we do there so that it's not needed?

The second recommendation is that we all proactively work on how we can integrate it into the EHR workflow so we are less reliant on separate payer third-party portals to get access to that information, but to put it in line, and there are a couple of different ways that are currently being explored, particularly in Da Vinci and other places, to see how we can make that happen. So, there is still a fair amount of work to

be done there, but if we can integrate it, the key is how we can do that with the least amount of documentation requirements, data capture, and offline interaction with the payer.

So, automating data capture and prior authorization request as much as possible is essential to make that happen. Otherwise, it adds to the burden, and that's not going to work. So, we need to be looking at the technology standards that are better suited to real-time interactions across systems, and with recent developments around CDS Hooks, RESTful, HL7 FHIR, and SMART, there is a toolkit that is starting to become available that has the opportunity to establish the level of integration and interaction that makes it more viable than what we had available before.

So, those are the main areas we are looking at on how we can make progress and work together to make that happen. If you go to the next slide, then we actually already are in the questions and answers. I don't want to go too much deeper at this point in time, but rather, hear questions that you have and areas that you would like to dive a little bit deeper into to have that discussion. Generally, to reemphasize, there is a need, there is an interest, and we need to work together to figure out how we can best integrate this, and there might be a couple of different paths to achieve that, and there's not necessarily one way that we all need to do it, but there are common characteristics of how to make that happen that can enable the users to have a better flow of their prior authorization and a less burdensome flow of the prior authorization. I'll stop there and pass it back for any questions, comments, or discussion.

Alix Goss
Thank you, Hans. This is Alix again, and what I'm going to do is facilitate the Q&A portion of this part of our call. The way we handle this is we have our members raise their hands, and then I'll call on them, and they'll ask questions. I think it might be useful to go back to the prior slide because there may be some questions on that, but before I make that leap, I'm going to first call on Alexis Snyder, as she has her hand raised.

Alexis Snyder
Thanks, Alix, and thanks for the presentation. To dive a little bit deeper, I had one question when you talked about your first recommendation on the list to establish authorization at a higher level than the procedure itself. You referenced the move from fee-based care to a value-based care system and how that would be helpful, so I was wondering if you could elaborate a little bit more.

Hans Buitendijk
Yes. The question is that at this point in time, particularly in fee-for-service, authorization is needed individually for a number of procedures, services, et cetera as they're being considered. The question that then comes up is if a patient falls in a certain category based on their condition, diagnosis, or otherwise, however that can be reasonably established – I'm not a clinician, so I'll leave that to them to provide more background on that, but given that, other than a certain set of procedures, tests, equipment, or otherwise that are expected to be part of the healthcare delivery, therefore, because of the fact that you are in that category of care, you don't need to ask for authorization individually for each and every time that you need to order a particular test or not. It's already part of that "package." So, that's one way of looking at it.

The other way of looking at it in that context is to say that if value-based payment programs are risk-based, and therefore there's an incentive on both the payer and provider sides to balance the quality and

the cost at that point in time, is that sufficient incentives on everybody's part that there is appropriate ordering, placement, and utilization happening that you therefore also don't need to do that? There is still opportunity for analysis and looking for outliers and otherwise. At that point in time, is that sufficient to manage what we're trying to achieve, which is balancing quality and cost? So, it's just a consideration of if we can reduce the number of times that we need to ask for prior authorization on individual items.

Alexis Snyder
Thank you.

Alix Goss
Next in the queue, we have Rich Landen.

Rich Landen
Hey, Hans. It's Rich Landen. I had two questions, but Alexis asked and you answered the first one. My second is also on the same slide – the fourth bullet. You're talking about some examples of better-suited technologies and standards. The question is does the current X12 transaction set fit into those new technologies and standards as a component, or would the X12 have to be abandoned completely in favor of these other standards and technologies?

Hans Buitendijk
That's a loaded question. Thank you for that. I would say if we are looking at level of interaction that is needed to communicate back and forth with payers, then at that point in time, the kind of data that needs to go back and forth, the triggering to initiate when to ask for certain information, to obtain the information, then I think we're starting to see – certainly compared with attempts that have been made in the past – that these newer technologies – RESTful-based – that we see that the formats that are being used with the nimbler sizes that HL7 FHIR can enable, we look at ensuring that there are appropriate security connections – it seems that this has very promising capabilities that move forward. We've already seen the very promising work from Da Vinci that has been demonstrated, that this is very powerful technology can be used.

So, like anything, I'll be a little bit more neutral in it. I think it has a lot of promise, and we need to look at that. We need to continue that and let it prove out, and if at that point in time, it looks like this technology can indeed much more quickly and efficiently manage the workflow between provider and payer, then let it take over. If not, then we have to look at it at that point in time again, but let's not let the fact that there is currently a standard that has been very successful in a number of areas but has been challenging to pick up in this particular space sit in the way of exploring, moving this forward, and then, based on the actual results, deciding what to do next in the position of X12.

Alix Goss
Any follow-up question on that, Rich, or are you good?

Rich Landen
I'm good, thanks.

Alix Goss

Thank you. Next in the queue is Jocelyn Keegan.

Jocelyn Keegan
Hi, Hans. I think you did a great job with that answer. So, I have two questions for you, and I loved hearing from you with your EHRA hat on since I normally get to hear you with your Da Vinci hat on. The first is around – I think you did a great job of covering the existing EPA workflows with pharmacy, so I'm curious to know what you think about the integration of real-time benefit check into those workflows to replace some of the weaknesses around existing formulary and benefit styles. That's my first question. My second question is I know because we've had conversations, but can you unpack a little bit the idea behind smart applications and how you think they could be used to improve or reduce the need for prior auth?

Hans Buitendijk
Yes. So, on the real-time benefits, it's an interesting one because do we look at it separately from prior authorization or together with prior authorization? It seems that the main question that one is trying to address with prior authorization is do I need to have that approval from the payer in context of the care and the condition of the payer to move forward with that? That's one thing. At the same point in time, assuming that it has been approved or that it can be approved, but then, together with everything else that doesn't need prior authorization, you effectively have the question of real-time benefits, of price transparency, of what it's going to cost to whom. It's not that they are completely tied at the hip, but they're definitely related. During the process, prior authorization initiated by the provider and real-time benefits are combined with the provider and patient/consumer to make an informed decision about whether that is the right thing to do in the context of the financial implications, which needs to be considered at times as well.

So, I would keep them somewhat separate in that, particularly because real-time benefits and price transparency need to be done regardless of prior authorization. That doesn't mean that in the workflow where that happens, there might be a very natural place for those things that you do with prior authorization, but you have the opportunity to also look in that context in the real-time benefits aspect as well. Before I go to your other question, does that address your question?

Jocelyn Keegan
That's great. I think it does, and I think that it's something we need to keep in mind. There's a codependency there, but RTBC sort of stands on its own for other reasons.

Hans Buitendijk
Right. On the other point, I believe that your question was to go a little bit more about smart apps and how they can play a role in prior auth. Is that…?

Jocelyn Keegan
I think so, yeah. From an EHRA perspective, is there any more evolved thinking about what that role of that smart app is? When we think about what we've been doing from a Da Vinci perspective, but just in general about creating transparency in workflow about a patient's benefits.

Hans Buitendijk

I cannot give you an EHRA opinion about –

Jocelyn Keegan
I'll settle for Hans's opinion. That's okay.

Hans Buitendijk
But, EHRA has not really discussed – nor is it likely to discuss – one method that I'm going to describe and another method – which one is the one that we all do. I think at this point in time, there are effectively two that are being explored and pursued, and both have benefits and opportunities, and interestingly enough, they can utilize the same interactions with a payer, just being executed in a different spot, and there are pros and cons to both, so no value judgments from an EHRA perspective at this point.

One approach is that you can take the interaction that you need to have with the payer, and you can fully, deeply embed it in the existing workflow so that based on where things are, either a clinician and/or an administrative staff combination typically can really initiate "Do I need prior authorization?", and then, at that point, go out and come back with information. If there's a need for additional follow-up, it needs to go into a queue to have somebody else follow up on that because the clinician is not going to stop for that thing; they want to progress. So, there are always going to be multiple users in play to do that. You can deeply embed it into the workflow natively and make it happen.

The other approach is the smart app approach, where those capabilities are extracted away a little bit more from the workflow. You can still integrate it with the workflow in that it's triggered by – that's where CDS Hooks comes into play on either technique that you use. "When do I need to ask for prior authorization?" So, something gets initiated. But then, you have the opportunity for a smart app that you then interact with, who, in turn, can take on the coordination with the different payers and interaction with the payers otherwise and identify what kinds of data needs to be collected, go back and interact with the system using FHIR-based APIs to get the data, and at the time, they identify "Oh, I need more information than I can get; I'm going to ask for that information."

Similarly, if you have it deeply integrated, something similar would happen – "How much information is available? I need to ask for these three extra things" – but you would have a smart app effectively take care of that. There are pros and cons to either approach. They are both very valid, and the interesting part is that the way the interactions are being defined right now would enable either approach to be taken so that we can explore both of them as a community, and some will find one to be a better fit and others will find the other one to be a better fit, but both work. Does that help?

Jocelyn Keegan
Thanks so much. That was great.

Alix Goss
Hans, this is Alix. Let me build on that. So, we've got this ability to deeply integrate technology and workflows together in the EHR products or the platform that's being used by the clinician. We've also got this ability for these applications – these smart apps – to be bolted into that infrastructure that can do the calls and the queries back and forth, and is sort of dependent upon the data being captured and stored in the right data element for the smart apps to leverage. Is that fair?

Hans Buitendijk
That's fair. So, you can use FHIR APIs that already exist or are emerging and expanding on the EHR side to support USCDI as it's growing. You can utilize that so the smart app can take advantage of that and consistently go from one system to another as that becomes more widespread. The other thing is that the smart app might have capabilities in other things that the EHR is not going to necessarily deploy as quickly or there is not as big a need for it, but other ones in the smart app can quickly deploy that. Otherwise, there is a variety of different sides of the coin that you can start to look at. One is not exclusive of the other. There are benefits associated with that, and the smart app can evolve at its pace and the EHR can evolve at its pace, and which one is appropriate depends on the party. So, that's why I said there's no value judgment here of which one is better than the other. It all depends on the context of the EHR, the payers, and the smart apps which one fits best.

Alix Goss
I think we've seen over time that different organizations make different architecture and business investments and technologies, so they're meeting folks where they are, and what I'm hearing you describe with this deep workflow integration aspect and the smart app is that you're really – we've got the right tools in the toolbox right now to let the market innovate and really shake out what's going to work best and reduce burden the most, and one of the things I heard you say in your initial presentation of this slide of the recommendations – when you were referring to the fourth bullet, you said something about toolkit availability, and I didn't know if you wanted to expand upon that. What is the toolkit, where does one get it, and how would it help? With this market shaking out, what are the best models to meet the workflows and the end users where they're at?

Hans Buitendijk
I think we need to look at the term "toolkit" there as we have the standards for CDS Hooks that are emerging, evolving, and expanding, so you see there a capability that is starting to be included in a number of EHRs that will be progressing, and it can help with triggering when you should invoke something out there based on where you are in the workflow. You see RESTful as a technology that can enable communication across the internet, web-based applications that can support quite well, et cetera. You see with HL7 FHIR a set of building blocks to define what data I need to be communicating effectively – so, your resources, your building block – and particularly when you are using smart apps, you see that it can establish an authorization authentication environment. So, when I say "toolkit," I really mean it in that sense.

So, is there a single place right now that you can go to a store and get everything together, in play, and it runs? Not at this point in time, but we do know that there are a number of parties that are pulling the pieces together and are working on smart apps. There are people that are working to embed it in their EHR, so it is more in that sense that the toolkit is starting to have all the parts that you need to get started. Da Vinci has been working on implementation guides that folks are starting to work with, so in that sense, there are pieces of the puzzle that are starting to get to the point that you can say, "Yeah, I can seriously now try to make it actually happen in an initial capability." So, we're getting there. We're not there at this point in time yet, but we're getting very close.

Alix Goss

So, Hans, as a wrap-up portion of today's agenda item, it seems to me that the interoperability rules – the patient access from CMS and the certification rules from ONC – are really going to help put those pieces of the puzzle in play within payer, provider, and vendor organizations, so that's a really big step to help us have the right pieces of the puzzle start to come together in the technology choices that organizations will be making.

Hans Buitendijk
Right, and there's a lot of opportunity there to enable this kind of workflow, so yes, I'm looking forward to how that is going to unfold, but there's quite a bit of opportunity to help out. Hopefully, we are not going to just automate existing processes and prior authorizations, but go back to the first bullet – what are opportunities to streamline it a little bit more so that overall, the impact is lowered, the effort is lowered, and we can more efficiently progress with what we need to do?

Alix Goss
That's an excellent wrap-up point on your part. Unfortunately, we do have one more question that came in the queue. Rich Landen?

Rich Landen
I have one more question. In the slide before this, you talked in a couple of the bullets about orders. So, I'm hearing – or, reading – that for the EHR to invoke anything with prior auth, there has to be some sort of order, but I'm struggling to understand what kind of order. Is it an order for prior auth that someone would enter, or is there some sort of internal logic that, as something as specific as a lab test or radiology procedure is ordered, that would trigger a query out to the relevant health plan to determine whether prior auth is necessary or not, and then, what data is necessary to support that? Could you talk a little bit more about that order concept and how that works in the EHRA vision?

Hans Buitendijk
Yeah. There are probably a couple of places, and order is probably the most frequent one. If you take "prescription" as a synonym for "order," at the time of prescription, there is a need for prior authorization, so that's a kind of order. If you need to have a certain lab test or certain image services, there is a need for a request or an order to that area, so that is typically the time at which it's contemplated, saying, "Hey, we would like to do this, and therefore, we're finding out that to do it, we need the prior authorization."

So, if you take the concept of "order" more generically, there is a need to do something, and that typically then requires a request or communication to another part of the organization or to another organization that, as part of that, I need to get authorization as well. So, depending on how quickly you can interact and obtain authorization, you have different points in the workflow that you can start that or that you have to start it, or that you cannot complete it and finalize the request until you have obtained the authorization. So, it is in that entire flow – I want to do something, there is a request, there is an order, there is an appointment that I would like to make, but I first need to make sure I have authorization to visit, so there are a number of different words that can be used. I probably should have used a more generic term than "order."

Rich Landen

And, how does that fit with the EHR recommendations on the next slide that talk about establish authorization at a higher level than a procedure or service?

Hans Buitendijk
So, what that would mean is that right now, if I'm requesting a procedure or a visit, or ordering a service or a test, or ordering DME, every time that I'm initiating or starting that workflow, in a way, rather than having to invoke, evaluate, and submit a prior authorization request to the payer, can we base on the characteristics of the patient and the relationship – are they part of ACO in a program? Are they **[audio cuts out] [00:41:37]** fee-for-service? Perhaps I need to do it more at the individual levels. If I'm in one of the other programs, I may need to do it less because there's already an understanding that if this is what you're ordering, you don't need it. It's already assumed to be in place. Or, you're taking on the risk, so it's okay. Take on the risk.

Rich Landen
Okay, thanks. That's very clear now, and I get it. There's one order that triggers the whole suite. That ties in nicely to a conversation we had in the task force about a month ago. When you first presented this first bullet there at the higher level, I had assumed erroneously that that was more prior auth based on a clinical condition rather than a request for a specific service, so thank you for explaining.

Alix Goss
Thank you so very much, Hans, for delivering some thoughts and considerations for the task force to consume as we advance our work toward prior authorization recommendations. We appreciate the time and energy that your team put together in preparing EHRA's content, and thank you so very much for joining us and answering all of our questions today. It was very helpful.

Hans Buitendijk
You're welcome. Thank you.

Prior Authorization Recommendations Brainstorming (00:43:05)

Alix Goss
You're welcome. Have a great rest of your day, Hans. So, folks, now we're going to pivot to the prior authorization recommendations brainstorming. Hopefully, you can all see the document that I'm sharing. It is the Google document that actually started out as being the guiding principles and future state document. We've looked at this previously a couple times, most recently when we reviewed the privacy and security information from the small workgroup.

What we did was to build on that framework of guiding principles and ideal state where we had a variety of categories that we identified, and a small workgroup got together to create a starting point for recommendations, and we've had a handful of calls. As a team, we have identified an initial brainstorm of policy levers that we might want to be considering as we move forward. We've also talked about some of the orchestration and implementation opportunities, so let's think of this as policy levers or things that can happen within the federal government control and authority's rulemaking, guidance, et cetera. Then, we think of the orchestration and implementation aspect related to the technologies, standards, and roles, and the industry level of activities that can happen. We have a strong industry association community, we have several advisors, and we have others that are working together collaboratively to try to improve the

process overall through their varying influencing capabilities, such as influencing legislation that may be emerging.

So, I offer this to help get your heads into the recommendation space. We really want to continue to build on the work of this small workgroup. We haven't seen their recommendations work yet. This will be the first foray into the group discussion. We have tackled the items in black on this list, meaning that the last five bullets – we've done a preliminary tackling of recommendations for those, including the uncategorized one option, which we subsequently relocated to putting in the section of "patient" at the center during our discussion yesterday.

We have four areas where we have not done any brainstorming, and to help us all get in the creative wordsmithing and idea-generation process, we thought today that we would start tackling these four areas, so we'll see how far we get today, and we'll continue the work next week. Before I get started any further, I want to stop and see if there are any questions about what we're going to be doing today in going through the first four bullet areas of categories and trying to – I'll do a brief recap of what the category itself has indicated, and then open it up for ideas from the membership. I believe Sheryl is going to help me with managing Q&A here – at least, that's what I remember from our call yesterday, Sheryl. Keep me honest.

Sheryl Turney
You're absolutely right.

Alix Goss
Thank you. So, before we get started, are there any general questions about what we're doing, why we're doing it, and how it's going to be used? Okay, I'm not seeing any hands pop up. So, without further ado, let's take a look. For those of you who are on the small working group, you may have noticed that I reorganized a few of these, and I just did this for simplicity purposes so we wouldn't be jumping around in the document. I didn't want to make everybody dizzy today through our working of the document.

So, the first one is real-time data capture and workflow automation. This is a pretty extensive set of ideal state attributes. We've seen some of this in our recent business process modeling, but let's dust ourselves off as to the scope of the ideal state of routinely collecting nearly all the data during the ordering step, and regardless of the venue of care, the prior authorization process should be mechanically similar for the clinician and the patient regardless of the health plan since patients move across the healthcare ecosystem. We further went on to say we should support automation of ordering and prior auth processes for medical and equipment through adoption of standardized templates, elements, and real-time transactions.

Any workflow utilized to support the prior authorization should auto-generate editable content to document the progress notes and visit notes of the medical necessities so the clinicians don't have to redocument what they just did to justify their prior authorization request. All insurance coverage will be identified in related **[audio cuts out] [00:48:47]-[00:49:15]**.

Lauren Richie
I think we lost Alix's audio. I just texted her to let her know.

Sheryl Turney
Okay, thanks. Hopefully she'll come back in. Well, while she's coming back in, what she was reviewing was the information that had already been defined by the group as information to share to get input from this larger group. I'm struggling to read what she's got. Unfortunately, I don't have my own copy of it, so if she's out on No. 6, it was "Information required for recommendations and decision-making should be provided one time for the source." So, this is capture once and reuse, which is part of the underlying principles that we had identified for the group. No. 7 was to automate prior authorizations through health IT and focus on what information can be exchanged to make any coverage decisions better, faster, and more transparent. Am I hearing Alix back in? Nope, she's still on hold.

All right. Then, the next is, again, "Collect once and reuse as permitted." So, it looks like we're saying that in two different ways, but the same concept. No. 9 is "Increase end-to-end automation for processing prior authorization data requests and response using recognized standards and code set values." It's very important as we move forward to ensure that we're all speaking the same language as we're sharing the data for specific data fields. No. 10 was to protect continuity of care for patients who are on an ongoing active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers, or prior authorization requirements, and this often happens when a patient moves from one plan to another or at the end of a plan year. Sometimes, they're asked to resubmit that data all over again with no apparent connection to what has changed. Does that mean they can't hear me now either?

Lauren Richie
No, you're good, Sheryl. We can hear you.

Sheryl Turney
Okay. That's particularly problematic for patients because that often happens with medications, and also, I know my daughter has this happen a lot – when they change the PBM vendor for some particular reason – specialty drugs or whatever – all of a sudden, she has to go through this prior authorization process that takes forever, and there's nobody who understands why she's going through it, and all the data that was already collected never goes to the new provider. No. 11 was "Workflow practices: Include triggers for expiring prior authorization to prompt renewal activities if applicable." So, that would be good to know before it expires so that patients and providers would know what they need to put in place so the patient is not left where they're not able to get what they need.

No. 12 was the greater use of clinical decision support tools. Somebody's got their – yeah, accountable care models and consensus-based guidelines to reduce the volume of prior authorization requests while increasing the value of responses and shared treatment decision-making. So, this obviously would be very helpful in order to understand when a prior authorization really is necessary. I think this is when we're talking about things where if they request a prior auth and a prior auth is then almost always approved, then why are we putting in the request for that if the clinical decision support model says that this care, treatment, or test would always be required? Is Alix back on the line?

Alix Goss
– line, and I thank you for walking us through those. I'm not really sure what happened there, but we seem to have a variety of us who are having phone line issues today, so I appreciate you tag-teaming. I

believe you walked us through those, and I think what we want to do is pivot to some general ideas that were starting to bubble up. We had some initial discussion around the aspect of potential recommendation areas we might want to think about. These may help folks with raising their hand to make suggestions about specific recommendations.

We've talked about multiple insurance dynamics, coordination of benefits, and the complex nature of a wide net of insurance coverages, and making sure that we understand those processes in who's covering a patient. Another area above and beyond – and, sort of related to multiple insurances – is this idea of member ID cards and the fact that we don't have any standardization there. The aspect of normalizing EHR capabilities, standards support normalizing workflow with technology was another area we thought about, and some response time norms – these were some preliminary areas that we thought might warrant specific recommendations building on the 14 points that we've reviewed.

Sheryl Turney
Yeah, and if you want, Alix, I can start us off, and then I see Jocelyn has raised her hand. I brought up the member ID cards. I actually had some meetings with some small to medium-sized providers in the Connecticut area. They all brought up the fact that member ID cards are problematic because there are no standards today for them, so even though they all have to either copy them or scan them, they're only saved as an image, and that data then has to be transposed into their mechanical or electronic system, and there's always an opportunity for errors.

So, what would be great would be to have a standard ID card format that could be digitized that all the payers would use, and that way, when a patient presents either their digital or paper card, that data can be automatically captured in a digital way, and the system can utilize it as is rather than having someone have to then transcribe the image or figure out how to read the image. So, that was really where that came from. It's probably more beneficial to the provider than the patient, but it will help the patient if the quality of the data is more accurate the first time that it's captured.

Alix Goss
I notice from one of our attendees in the public that there is a standard for health ID cards – thank you, Mary K. – and I also remember that WEDI has done some work around this space in the past. What I'm hearing is that we want to pursue standardized member ID cards with an eye toward…"consumption" is the word I'm looking for – consumption of content into EHR or something like that. I hope I captured your thoughts there.

Sheryl Turney
Yeah, and I really appreciate the people that brought it up in the chat as well because I wasn't aware that there wasn't a standard and it just wasn't… It's great – I guess it really focuses on the fact that there are a lot of standards, but they're not required to be used, and so, a lot of the vendors are not adopting them, so I guess that's where the disconnect is. It needs to be updated so it is a requirement to be electronically captured. We also do have a couple of people with their hands raised. Can I call on them as well, Alix?

Alix Goss
Go for it. Thank you.

Sheryl Turney
All right. Alexis, you had your hand raised first.

Alexis Snyder
My comment or recommendation was in reference to the list that Alix started and you picked up when we lost her audio, so I don't know if you can bring that slide –

Alix Goss
I can because it's all right here in the document.

Alexis Snyder
So, right there – No. 11 – let's go back down.

Alix Goss
This one?

Alexis Snyder
So, "Workflow practices include triggers for expiring," which is great because I know we talked about that a lot, but I think we could add a piece to that that we also talked about, which kind of tag-teams with No. 10. So, if there are no changes, and we've literally just been given a PA for medication, and it expires six months or a year later, and nothing in your diagnosis has changed – age hasn't changed, weight hasn't changed, there's no reason to need another one except for the fact that it expired – you really should have a simple, streamlined process that doesn't start all over again to get a new prior authorization again. You should be able to keep extending that expiration unless there's a change. I don't know how we want to word that, but I think that's probably an important piece.

And then, I just wanted to mention – as you were running through them, when you talked about wordsmithing, I really did not catch what No. 12 was about at all until Sheryl started to break it down for all of us and explain it further, so we may just need to revisit some of them. I was getting thrown off with the shared treatment decision and where that tied back in until she explained it.

Alix Goss
Okay, I'll capture that one. You gave us two things. First, let me go down and try to capture this one, which is something related to…

Alexis Snyder
Extending the life of the prior authorization.

Alix Goss
Yeah. "In lieu of a new prior auth for a continuing service, create/pursue renewal feature." I think that captures at least enough of it. How else might you want me to word that?

Alexis Snyder
I think it does, except after "continuing service," just put "i.e. ongoing medication" or something like that.

Sheryl Turney
Right. I do think, too, though, we should add the note, Alexis – if you agree – that simply because a payer changes PBMs is not a reason why the patient needs another prior authorization.

Alexis Snyder
Oh, for sure.

Sheryl Turney
That does not seem reasonable at all.

Alexis Snyder
It doesn't.

Alix Goss
Okay, awesome. Next in the queue?

Sheryl Turney
Next, we have Jocelyn.

Jocelyn Keegan
Just to tie onto that point that Alexis just made, which I think is really important, I do think that there is wording and intent in the CMS 1/1/22 rules that we could build on around that portability of UM determination. From a resource perspective, I think we should point to that. But, I actually put my hand up, put it down, and then back up about the idea of the member ID card because I feel like – and, I can't believe I'm going to say this out loud on a public standards call – the reason the member ID becomes so important is because we don't have a way to uniquely identify lines of business, and I think that when I entered healthcare IT from a different industry about 10 years ago, the concept of a plan ID was out there, and it just died on the vine and never got implemented in force.

But, as our plan design gets more and more complicated, I do think we need to revisit how we're uniquely identifying these products in the market, and if the most recent wave of mergers and acquisitions haven't proven that point to us, I don't know what will, but I do feel like it's more than member ID because if you can uniquely identify the product somebody's bought, it makes the patient-specific information so much less needed, which actually allows you to not have to deal with as much PHI, and I think that's important.

Alix Goss
So, more than a member ID recommendation may be needed.

Jocelyn Keegan
I think so. I think that's –

Alix Goss
So, is that because you're getting back to the line of business? Give me more meat on that bone.

Jocelyn Keegan

I think it's the ability to uniquely identify the actual product the patient has purchased or the employer group or member has purchased to be able to understand what the attributes of that product are. When you look at the complexity of prior auths or something for CMS, where everybody gets the same rule, there's a world of difference as soon as you move into the commercial or even MA lines of business to understand what that particular line of business has for rules.

Sheryl Turney
Right. That is particularly important, Jocelyn, when it comes to the formularies that apply to each individual product, and I was talking to one set of providers at one point, and the real issue was that the software that they used didn't go down to the product level, so they would often think, "Oh, this is in the formulary," but then find out this employer group had scooped that out of the formulary –

Jocelyn Keegan
A carve-out, yeah.

Sheryl Turney
– and there was no way to know that if you didn't go down to the product level.

Jocelyn Keegan
It's sort of anecdotal. The anecdotal expression that I use is our ability to design products to sell and purchase healthcare has far outstripped our ability to manage those for anything other than the claims engine, and one of the limitations is this ability to really understand which version of plan at the gold you're actually talking about because there is no unique identifier, so you have to go to the member's date of birth – you have to go to PII – to get an answer. I'm going to step off my soapbox now.

Alix Goss
Don't let it go too far away. We need more recommendations. All right, are there any other hands up, Sheryl, that we should be looking at for recommendations on this particular area?

Sheryl Turney
I don't see any more hands up right now.

Alix Goss
Okay. In the time we have remaining before we go to public comment, I'm going to move on to the next one. Information security and privacy. So, this one was laid out a little bit differently than our other items in that there were very clear guiding principles created, whereas with the other parts, the guiding principles were at the category level. From a guiding principle perspective, we were really making privacy and security foundational to the design of everything we wanted to do.

Whatever recommendations we have, they should meet the current health information and patient rights laws and regulations – the green text you're seeing here are the tweaks we identified during the last meeting – and that the solutions we design should meet the minimum necessary standard when requesting the disclosing information, and so, we gave a couple examples related to that. Whatever we recommend should continue to empower the patient to have a role in proactively providing and expediting his or her consent when required to share. This really then helped us with crafting an ideal state around

prior authorization stakeholders achieving common agreement on implementation of prior auth minimum necessary protected health information sharing.

The data elements that constitute that minimum necessary for prior auth would be identified and can be compiled efficiently to support the goal of automating, very similar to what we've just talked about. The patients are empowered in understanding their privacy rights and actively manage their consent for sharing, and this includes the aspects related to that pesky little self-pay scenario and their ability to change perspective on what they self-pay for versus what they don't.

In the consent format, consistency is established for automated collection and use when required beyond TPO or HIPAA framework. Streamlined or simplified individual consent collection processes are used for sharing individually identifiable information for prior auth when required by state or federal law by automating the process, informing the clinician prior to or close to the time of submitting the order that patient consent may be needed, and empowering the patient to have a role in facilitating and expediting the data collection process.

There was a lot of discussion in our privacy and security work about the variability with state laws, and that we need to address them from an inter- and intrastate perspective. So, that's what's used not only within the state, but across state lines as patients move and new plans may be selected. We'd like to see these laws addressed through automation. That would then help us with more easily instituting automation and logic to minimize the human interaction. So, these are some of the ideal state areas. I'm going to leave this page up while I do a call for questions – sorry, a call for recommendations you'd like to offer or any questions or clarifications you'd seek. Alexis?

Alexis Snyder
Hi. On Letter C, I suggest that maybe we reword it. "Patients are empowered and understand their privacy rights." I think I mentioned this before on a different one that we have green notes on. You can empower somebody all you want, but if the information is not understandable, that's different than empowering someone to look for it and understand it, so I'm not quite sure this is making the point that you want. I don't know if I'm being clear, but when I read it… Even empowering someone doesn't mean they're going to understand what it means. Right now, there are honestly a lot of loopholes in privacy regulations and rights, and it's very difficult, so I think maybe transparency needs to be more in there than – "empower patients to seek it, but make it clear and transparent" – something along those lines.

Alix Goss
Yeah, I think that we – there was a robust discussion related to this one about when we actually get down to the point of infusing a day in/day out education system to actually speak to some of this because I think people are generally shut down to understanding – they just see a HIPAA privacy form and they just sign it and move on. They don't take the time to understand the rights, opportunities, and responsibilities related to it.

Alexis Snyder
Right. Well, most of the time, it's not even transparent unless the patient specifically says they want to see it. Most of the time, they just walk in, and like you said, they're used to "Oh, here's the HIPAA regulations, can you sign this?" It's usually an electronic pad, and they haven't even seen it. So,

empowering people to ask for it – or even to just make sure that it's transparent before you ask – but even at that point, some of it is very difficult to understand. It just needs to be clear and transparent.

Alix Goss
Yeah, that's a big implication. Do we think there is a specific – building on this comment of a clarity opportunity, do you think we could turn this into a recommendation, Alexis, along the lines of that kind of educational material? I think the Office of Civil Rights has done an awesome job of translating HIPAA privacy and security rules into videos and fact sheets, but I don't think the average person is going to the Office of Civil Rights to look up how to interface with their providers related to the protection of their data and their authority related to that, so just because we may have materials – whether they're easy to understand and transparent is a separate piece. I think we have two parts that are emerging. I think there is an education piece – "clear and easy to consume, easy to understand" – and then I think there's the availability or the performance of the education. So, there's education, clear and easy-to-understand materials…

Alexis Snyder
I think you start to get in the weeds there, though. We could go on and on with what that means. "Clear and easy" – depending upon how health-literate or English-literate you are, it might be difficult.

Alix Goss
So, how do we want to make – let's avoid the radical there. I appreciate that. So, we need to have educational materials. I think we've got some of those out there already. Then, educational materials need to be available, but how do we get the actual citizens to consume them, absorb them, and understand them?

Alexis Snyder
Well, I think that's part of the transparency. It needs to be clear at the point of care. It needs to be handed out with links to where you can find more information.

Alix Goss
I think Deb Strickland has her hand up, and I think she wants to chime in on this particular conversation.

Debra Strickland
Can you hear me?

Alix Goss
Yes.

Debra Strickland
I think you have to hit them where they're at, and unfortunately, we're all at home right now, but in normal times, people would be in the waiting room of a doctor's office or lab, maybe at a pharmacy or something of that nature. Maybe you have to put out flyers or materials – one-liners that are very easy, four blocks of information. "Do you know you have rights to this?" Make little posters so that people can glance at it and get that education. No one is going to read any documentation with a font size of 4. So, I think we need to

hit them where they're at and try to get basic, high-level information out and available to them where they're going to be.

Alix Goss
You can even extend that to telehealth, or even preregistration, because if someone's online preregistering and/or using a telehealth visit, it's very easy to send that same thing that would be hanging in a waiting room via the instruction page.

Debra Strickland
Yeah, or even dangling those stupid ads that are on Facebook or whatever that light up on the side or something like that, just to be there on the page and be present so they can actually look at them, and if they want more information, it can be a little bit of a clickbait where you can go in there to get more, or it can just be to send the immediate message.

Alix Goss
I think that's what you said. Okay, Deb. Your hand is still up. Do you have another question or are you a hanging chad?

Debra Strickland
No…

Alix Goss
If you are, that's all right. So, clearly, education is something that we feel strongly about, and it's about getting the resources for key messaging to empower citizens, and the idea of promoting distribution vehicles to meet patients where they're at, and to do so in a… I'm not sure how I'm going to go there with that, so I'm not going to do that right now. I believe we are now at the moment of needing to pivot to public comment, so I think we're going to do that before we continue. Lauren, are you going to review this, or would you like me to? I'm not sure if Lauren is still having audio issues. We would encourage anyone who is interested in making a public comment to follow these instructions.

Public Comment (01:17:35)

Operator
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. For participants using speaker equipment, it may be necessary to pick up your handset before pressing *.

Sheryl Turney
Thank you so much. This is Sheryl. We'll give it a minute to see if we get any comments. If not, we will move forward and take a pause if any comments come in. Do we have any requests for comment?

Operator
There are no public comments at this time.

Next Steps (01:18:15)

Sheryl Turney
All right, thank you. Can we move forward to the next slide? I know Lauren put the phone number in the chat. So, we had a very rich discussion today, and I'm really happy about that. One of the things that Alix and I talked about as we were looking at where we were against our stated objectives and timeline offline is that we have created a lot of input for the team to react to, and one of the components of the final report that we would like to include is some gap statements. I know we've done a lot of work on ideal state and our guidelines that we're trying to follow in terms of what we would like the end solution to look like. We've started working on recommendations. What's inherent there are gaps, but we haven't actually documented gaps as a gap analysis, so we wanted to reach out to the members of the task force to see if we could get someone to volunteer to review our materials to try to tease out some of the gaps that do exist that we've all discussed, but haven't actually committed to writing. Is there someone on the task force that would be willing to take on that responsibility? I'm hearing crickets. No volunteers?

Alix Goss
Sheryl, can you describe what you're thinking of the process that you'd like someone to undertake? Is it looking at past notes? How might somebody get started?

Sheryl Turney
I think if they could review the ideal state and information that we put together for the data classes… All of those things – even our original workflow with the durable medical equipment – had inherent to them identified gaps, and we did discuss them, but we didn't really document them as gaps. So, what I'm thinking is that if someone was willing to review the materials that we currently have available to come up with a gap list that we could then bring back to the group and then expand out and utilize, it would help us because it will be easier in our final report if we can say, "Hey, this is the landscape of what we had looked at and what's currently going on, these are some of the gaps that we had identified and discussed, and these are some of the recommendations that we want to pursue to address those gaps.

One gap is the fact that today, some of the processes for prior authorizations are not electronic, so we've already made recommendations that we haven't reviewed as a group, but we've talked about them where we want to have electronic capability to see all the services that are required for prior authorization. We want to know what use those services are and what the documentation requirements are. That's obviously a gap today.

I don't want to say for every recommendation, we're going to have a gap, but obviously, for some, there will be one, so calling those out is going to make it easier to identify when we look at our recommendation solutions whether we address the major gap areas that – we talked a lot about these during our discussions with the durable medical equipment; we just didn't capture it in a list. So, that's what we're talking about here, and I do think it would be helpful to have for the final paper. So, again, I was hoping that someone would volunteer to take a stab at it. Again, it doesn't have to be 100% complete, but at least it's the start of a list that we can share with this task force in future meetings and then build off of. I'm not hearing any volunteers.

Alix Goss

I agree. Deb Strickland just put her hand up.

Debra Strickland
Alix, I can take a stab at that if you want. Do you need that in one week's time?

Sheryl Turney
I think we have a couple of weeks to work on this, Deb. Alix, what do you think?

Alix Goss
I think that's spot on. It would be really great if, maybe within two weeks, we would have a draft list that we could come back and look at on another call. We've been putting a lot of the pieces together, and this is definitely a missing component – dare I say a gap? – in our documentation, so I would appreciate that support, Deb.

Debra Strickland
Sure. So, even on the next meeting, I can show some progress, but maybe not be fully through it. I can certainly give it a start.

Alix Goss
That would be fabulous. Unfortunately, Sheryl's not going to be with us next week, but we can carry this request forward.

Sheryl Turney
Yes, and I actually just put a couple things on paper, Deb, so I can send those to you, and at least you won't have to start with a blank page in front of you.

Debra Strickland
Okay, sounds great.

Sheryl Turney
Perfect, okay. So, thank you for that. I really appreciate it. This is a hard job that we have here in addition to our regular workdays. Next week, we are going to do more deep dives. Alix is going to lead the entire meeting, as she mentioned – I'm not going to be here next week – and really talk about the recommendations. Also, I believe Jim and Josh are going to provide a final review and wrap-up of the data classes. There were some adjustments made to that wording that have not been shared.

And then, for next steps, we've got the next couple of meetings specked out in the deck regarding looking at – when I come back on the 21st – an integrated federal data model discussion as a recommendation, and also, we want to move into the convergence of clinical and administrative data and do a deep dive. We also wanted to then talk about the draft report writing, and then, hopefully have assignments for all of the task force members to take on just a small component of that final paper so we can bring it all back together, and then have something we can review as a whole, and obviously, it will require a lot of review by this team as a group because we all won't be writing with one voice, but hopefully, once we've reviewed it a few times, we will be able to have something that makes sense and flows, as the task force is hoping. Any questions on next steps? I want to thank everybody for today. I think this was a really great

meeting, and I want to thank Hans for the presentation from EHRA. It was very helpful and generated a lot of good discussion. Alix, do you want to add anything?

Alix Goss
I think you said it very nicely.

Sheryl Turney
All right. I want to thank everybody again for their time and commitment to this important activity, and we hope you have a wonderful week.

Lauren Richie
Thanks, everyone. Bye-bye.

Adjourn (01:27:01)