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 14, 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
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
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
Josh Harvey	Clinical Services Group of Hospital Corporation of America	Presenter

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome again to the ICAD task force meeting. Sheryl Turney cannot be with us today, but we have our other co-chair, Alix Goss. In addition to that, I see we have Anil Jain, Denise Webb, Jim Jirjis, Mary Greene, Rich Landen, and Sasha TerMaat. Are there any other task force members that are on the phone?

Jacki Monson
Jacki Monson is on.

Lauren Richie
Hi, Jacki. Anyone else?

Gaspere C. Geraci
Gus Geraci.

Lauren Richie
Hi, Gus. Anyone else?

Alix Goss
Deb Strickland just chatted in the box that she's here, and I think I just talked over Steve Brown. My apologies.

Lauren Richie
Deb and Steve. Okay, great. I think with that, we're all set. And I'll turn it over to you, Alix.

Summary and Action Plan (00:00:53)

Alix Goss
Well, thanks very much. So, welcome, everyone. My name's Alix Goss, and I'm going to be your moderator today. And to kick us off, after we do a little bit of level setting on just kind of orienting us from last week's call to this week's call, I'll be turning it over to Jim. He'll be doing a walk-through I believe with Josh on the data classes wrap-up. That will then lead us into a prior authorization recommendation brainstorming effort. We're going to continue some work from last week, and we've some good jump-off points thanks to the small workgroup efforts of last week, last Friday. And then we'll have a public comment before wrapping up with next steps.

With that said, let's go one more slide. At our last meeting, we had a presentation from Hans, the overview of the Electronic Health Record Association presentation. As noted, this gave us the perspective of the electronic health record vendors in the mix of the prior authorization conversation and presentations we've been having from industry. It was good to hear from them. They set us up with some framework around maturity levels such as the pharmacy electronic prior authorization and real-time benefits check being much more progressive and prior authorization than we're seeing on the medical side of the house; spoke to us a lot about the payer variability of when data is needed and what data is

then needed in the process of a prior authorization; led us into some very robust interaction among a Q&A, which was really great to extend our thinking, building upon a lot of the earlier things we've heard from other presenters from the industry.

And following that robust discussion, we started brainstorming with the full task force around the prior authorization recommendations. You may recall that we've done prior work with guiding principles and ideal state to keep the thread moving forward towards our recommendations. We were using the one master document for all of those pieces of the puzzle. And we are continuing to leverage this interplay between task force discussions, building on the small working group efforts. And what I'm hoping is that today, we can bring home the last remaining portions of that brainstorming effort that will really help us have the remaining pieces of the puzzle for the report. So, it's a really good discussion last week around recommendations. And so, we've been capturing that in the working document. And so, that's available and I'd encourage all members to be reviewing that. So, without any further ado, I think we're going to go ahead and pivot unless there's any questions on that wrap-up. At this point I think Jim and Josh, are you guys ready to go at this point?

Jim Jirjis

Yes. Yes, we are.

Alix Goss

Awesome.

Data Classes Wrap-up (00:04:05)

Jim Jirjis

All right. I'm going to tee it up a bit. As you recall, we all first started by looking at workflows and realized wow, that's really complicated. It's really all about the data, and it's about standards and what we recommend appropriately as a HITAC group that can make recommendations to ONC for how to actually reduce inefficiencies and costs, reduce provider burden, increase interoperability around clinical administrative data, in this case specifically the prior auth use case which we all know creates so much burden. And so, this is the culmination of multiple weeks, and what Josh is going to walk through is the legend and then what we think the key data classes are, a little description of it, and then what we think the content standards, what's the status of what's out there. Josh, you want to go ahead and take it away?

Josh Harvey

Yeah. Thank you. So, as Dr. Jirjis just said, this is really to close the loop on all of the input we have received. I do just want to take a minute to say thank you to everyone who has contributed to this. I know Jocelyn and Ram have both been very instrumental in getting in the weeds with me on this and helping to form kind of the basis for the look and feel and make sure we're capturing everything on the page to help support the eventual recommendations of the task force. But in addition to that, many of you have weighed in, whether it's through our various task force calls or email after the call or follow-up conversations, and we really appreciate all the engagement and effort on behalf of the group to help drive this and make sure we have a clean vision of what's out there today that can help drive our recommendations.

So, just to orient everybody a bit, at the top you'll see a legend. So, we described all of these different content standards, both in terms of their capability as well as their relative adoption rate across the industry today. So, in terms of capability, when you see a blank space like, for instance, under X12 and the first line, there's a couple of blanks. What this means is that there's not a particular utilization of that transaction or standard when it comes to a specific data class that's referenced. We also have categories

for proprietary standards. So, this would be kind of the best word that we came up with to describe this, but more along the lines of one-off solutions that are being developed in the industry today to meet specific needs. So, not a standard per se but something where there have been industry-driven efforts to close the gap.

You'll also see the terms 'emerging,' 'available,' and 'in use,' and what we tried to do here was capture the delineation between there being a standard that is in existence of some kind that may be very early on in the adoption curve, so we categorize that as an 'emerging' standard. 'Available' would speak more to the fact that a particular standard has been developed and deployed fully but may not be utilized as heavily as some others out there. And then, 'in use' is really the one that describes the standards that are -- have essentially been fully deployed or are saturated in the sense that they are in practical use today and have proven real-world usefulness.

Then when it comes to the color coding, when you see a blank – so, probably the best example of this would be in the HL7, CCDA and Version 2 columns. You'll notice that these are classified as 'in use,' but then they are not filled in with a color, and the methodology behind that is that these standards do carry the data described in the data classes on the left-hand side of this depiction but their usefulness and their use in terms of practical real-world use is less clear. So, some organizations may be using it, but I guess the best way to say it would be these aren't necessarily purpose-built standards for prior auth. You'll notice there is another mention of proprietary in the color coding, and that's mainly to accommodate this real-time pharmacy benefits tool area where there is an emerging standard that's being built on an existing industry proprietary standard.

And then, we move into the draft standards where the best example would be in the FHIR space with the Da Vinci implementation guides where all these have been classified as emerging standards, and they're in draft today. The last three are the ones that are really in practical use to some extent, and what we used as a base for categorizing these is low, medium or high adoption rate. The information we were able to get from ONC's Interoperability Standards Advisory or ISA. So, they use a five-star ranking mechanism for evaluating the adoption models of each standard. So, we tried to align with that as best we can. For things that were on the one-star end of the spectrum, we categorized it as low, five-star end of the spectrum has been categorized as high, and then everything kind of in the middle has been categorized as medium. So, I believe when we did our review, everything cleanly fit into one-star, three-star or five-star bucket. So, there's not, like, a four-star that we had to figure out where to put it. That made our analysis a little more clean.

So, in terms of the rest of the document, so just on the left-hand side, we've got our data classes described succinctly with a name and then a more lengthy description of what constitutes that particular data class. We'll walk through each of these in a little bit more detail and talk about our evaluation line by line. On the right-hand side, you'll see the standards we evaluated. So, these were the X12 standards, the NCPDP standards for the pharmacy side of the house, the FHIR implementation guides that Da Vinci has developed to date that have applicability in the prior auth space. And then as I mentioned before, HL7, CCDA and v2 were included, mostly with the idea of being we wanted to be comprehensive and making sure we were evaluating anything that was in use today.

So, when it comes to X12, those are broken out into the three major transaction types that are used in the prior auth space. So, you'll see that certain transactions are more purpose built for satisfying pieces of the equation, while others satisfy the other parts of the equation. And then moving down the line, depending on the nature of the standard, that may be broken up a little bit differently. For FHIR, for instance, there's the three different implementation guides we reviewed.

Okay. So, I think that's it in terms of orientation. I'll start going through line by line in talking through our findings for each data class. Starting with patient identity, this is really just the minimum necessary data that organizations need in order to ensure that the patient they are talking about is the patient that should

be discussed in the context of a payer and provider relationship. So, what we identified here was the fact that each of the standards in its own way does capture some of the data in this data class that we would envision in this data class. As you can see, it's a little bit different for X12. It has a purpose-built transaction versus the Da Vinci implementation guides, which each of the implementation guides addresses that particular one in its own way. But again, across the board, there's varying levels of adoption that you can see based on the color coding that I've described before.

For patient demographics, this is just the basic demographics information that may be necessary for use throughout the prior auth process. Again, each of the standards does address those in some capacity with varying degrees of adoption. Moving on to the insurance plan data class, this is the information that is required for a provider to know which payer and which plan is in play for a specific patient. And so, you'll notice that we also describe the primary, secondary and tertiary I-plans that may be necessary for a patient. A lot of that is based on input from the task force, talking about the fact that there may be more than one payer that a patient has; if we go through the prior auth process for one particular payer, there may be a need to, in the case of a denial, resort to doing that same process for a secondary insurance plan. So, again, all the different standards that are out there today capture this with varying degrees of adoption.

On the patient benefits transparency line, so this is where we get into coverage details specific to the patient. This is kind of the initial bare bones necessary information to understand what a patient's coverage is under a particular plan. And again, it's addressed by each of the standards in some capacity. The next line item is getting into some of our more tricky ones where not everything is covered by a particular standard. So, we've discussed as a group the notion that a patient may have input that's necessary for the prior auth process to work efficiently. And so, what we found is that this is really a key gap area where none of the standards are really particularly addressing this use case. You can see how that might help drive some of the eventual recommendations of the task force as an example when there may be a gap today.

The next series of data classes are all kind of associated with the actual prior auth process itself. And I'll talk about them a little bit all together and then go back through them one at a time. So, from a FOIA perspective, this is kind of a linear depiction if you were to map it out. So, initially there is a request for a prior auth that's generated by a provider and submitted to a payer at which point it becomes necessary for the payer to review the rules and the data requirements in order for that prior auth to be successfully processed. The prior auth justification data class is then that data class which would allow a provider to submit all of the necessary documentation to drive the approval of a prior auth. The next data class is this notion of a follow-up. So, that would be in the event that the payer received justification for the prior auth but deemed the information provided to be insufficient in some capacity. It could then be circled back to the provider to fill in the gaps as necessary. And then, the determination data class is where there is actually an approval or a denial that's being communicated by the payer back to the provider.

The last few, they're not quite as part of the process that we've described before. So, in the appeal data class, what we're talking about here is being able to efficiently escalate a denial through the appeal process in the event a provider believes that it was inappropriately denied. And then, the PA status data class is kind of a metadata data class, but this is trying to discuss the notion that we discussed as a group where there's a need for insight of all the different constituents in the process, payer, provider, patient, to be able to understand exactly where a prior auth request is in the process so that there's clear communication between all those constituents and transparent information about the status.

So, going back through everything in a little more detail. So, I think what we'll find is the pieces of the prior auth process going from request to that determination of approval or denial are all covered in some capacity by the different standards. So, the differences lie in the differences in the variation in adoption and of course, Da Vinci is the prior auth support implementation guide is still considered to be an emerging standard, draft standard. There gets to be a little bit of a clearer depiction of maybe where

some gaps are that could be addressed is when we get down to the appeal and status components. So, for the appeal process, really there seems to be a lot of opportunities for both X12 and Da Vinci to help address the problem of efficiently escalating appeals. On the status, that's another one where there really isn't a clear notion of status for any of these, so in terms of recommendations you can see how the need for that information to be transparent to all the constituents, how that might drive a recommendation from the task force as well.

And then, the last two I'll wrap up with here. So, a fairly recent addition that I'm not sure we've discussed as a larger group is this service completion. So, what we're trying to address here is the idea that ultimately the goal of the prior auth process is to provide what is necessary for the patient's care and also ensure appropriate and timely payment for the service provider. So, what we wanted to do was depict that as part of the prior auth equation because ultimately, some of the pain points lie in the fact that a provider could actually get an approval of a prior auth and then have a difficult time in actually getting payment for that service. So, that would be the need for a common terminology for an approval that could be relied upon when it comes to payment as well. Something that carries all the way through the process. As you can see, this is something that isn't clearly addressed in any of the standards out there today.

And then lastly, it comes to the metadata. So, in particular, the main crux of this class was around information required for the different systems that are required for prior auth communication to interoperate with one another. So, probably the best example of this would be the end points required to actually send the data back and forth between the different constituents. So, again, I think this is an area where largely one-off solutions are being deployed. One note is that when it comes to FHIR, there have been some discussions as part of the FAST initiative to help build out what a standard for that kind of data might look like.

So, that wraps up my quick high-level walkthrough through the document. You may notice that since we talked about this last, this has been reformatted a little bit to be in a Word document. So, the idea behind that was to use this as supplementary material to go along with the recommendations of the task force that's been cited throughout. So, that's part of the idea behind the reformatting. The other idea is just to really come to a place of finalization on this. So, a big part of why we wanted to come back today and present the work that's been done was to kind of officially close this out, entertain any final questions that might be around the format and the exercise that was completed. So, I think I was able to walk through this quick enough to be able to entertain some questions, though I will note I'm not sure that I heard Jocelyn or Ram as part of the roll call, so you may be unfortunately just relying on me and Dr. Jirjis to help field your questions, but we would certainly be happy to do that at this point.

Alix Goss

Happy to hear that Jocelyn has join ready the call since you started all of this. So, thank you for that most excellent walk-through. Very nicely summarized and painted a picture. I think we also had sent out this document for a working draft for members to take a look at as well. So, what I'd like to do, Josh, is help facilitate questions that you may receive from our membership. So, I'm going to start with Jocelyn who's already in the queue.

Jocelyn Keegan

So, first, I want to say Josh did a great job with that. It has been a very interactive discussion and lively debate trying to figure out how to represent this. It is a draft, and I think that we want everybody's eyeballs on it. I was receiving some texts while you were talking, Josh, and I didn't realize when we added status as its own category, we should go ahead and flag that status is actually available with X12, so we should put that in as available under X12 for the status box. This looks great. I haven't seen this version of it.

Alix Goss

Thank you, Jocelyn. I think I also saw that so just to clarify, you're referring to the 278 having the status. Is that what you were referring to?

Jocelyn Keegan

Mm-hmm. I am, thank you.

Alix Goss

Okay. Is it that box? You're welcome. So, it would be under the 278 box that would need to be color coded correspondingly. Thank you for – okay. So, I also think I saw some other folks. Rich, I think you might have typed something in the chat box. Did you have a comment or an edit, something in addition? Oh, he can't unmute. Okay. So, let me go back. I'll scroll up. Rich, I think you said something about in the TA justification box, you'd like to see test results added.

Josh Harvey

Yep. I am adding that right now. I think that is a good call-out. It's hard to be comprehensive with these examples, but I think that's definitely a good one to add.

Jocelyn Keegan

Agreed.

Alix Goss

Awesome. He's agreeing and thanks you for that. Okay. So, I noted in the discussion that this is really a wrap-up and that this is a really great representation of the work that we've done over the last couple of months, and it's great for all of us to be thinking about the inclusion of our analyses in the reports that we're going to be generating. And so, I know we've been working on recommendations brainstorming, but that's been really around the guiding principles of the future ideal state. I'm wondering if during your discussions, if you've identified some other recommendations that maybe we need to be pulling into the master document to reflect the opportunities that you guys actually sort of naturally talked through related to gaps like patient-generated, appeals, service completion.

Josh Harvey

Yeah. I think that's definitely something that we need to make sure we're liaising with you guys on the brainstorming exercises for the recommendations. I think the patient-generated example is a pretty good one that I think as a group, it probably makes sense to decide what might the recommendation be there, what's our span of influence, so to say. So, clearly, Da Vinci is an emerging standard where there may be some opportunity to try to factor that into some upcoming work there. I'm less clear on maybe what the recommendations might be related to other standards. And Jocelyn may have input as well on both of those points. But I think in my mind –

Jim Jirjis

Hey, Josh?

Josh Harvey

Yep. Go ahead.

Jim Jirjis

Oh, no, I was going to say, just being new to the committee, in past programs when there had been gaps like this, what has the recommendation been? Has it been to build out on a standard that you could build it upon that already exists, or has it been to recommend that ONC address and facilitate standard

development in that area? What are our choices, I guess, and what's been done before when we've encountered it?

Alix Goss

I see Jocelyn's hands up, and I also know that our upcoming discussion today may also help provide some commentary around this. But Jocelyn, go ahead.

Jocelyn Keegan

Yeah. I think our main goal here was to really be able to identify what the current state was and where – I think if you think about our entire conversation in the last two months, it's really been about it's more than just the 278 submission, right, that we're focused on. We're trying to show all of the steps that somebody needs to take to get somebody on therapy or to get MEDSURG approved or get a DME delivered. And so, I think being able to show the panoply of standards in use today and show that none of them particularly do all the things I think is really the goal for this picture at this point in time. I think the question I think we need to ask ourselves as we go to recommendations is should we be making recommendations for ONC or CMS to identify or to recommend or to move forward in filling those gaps, or do we think that there's a blend of options across these standard capabilities that we should be recommending and allow the industry to fill the gaps with the existing standards that are in place to be able to sew them together. Something we'll definitely get to argue about for the next month.

Alix Goss

I think I'm also, as we're talking, making a note that on our recommendations work, I think we do need to go back and revisit to tease out the clearer recommendations. Okay. Are there other questions from the members? I'm not seeing any hands up. I'm not seeing that Andy or Rich who seem to be more able to chat today. Nothing coming through the chat box. Andy, thank you for letting me know you're good. So, from sort of a writing perspective, I think that there's a lot of parallel efforts going on. Sheryl and I have been actively working on building out an approach to crafting the report, recruiting teammates to help us with translating or transforming the work of the task force to date into some cleaner content that could go in a report structure.

So, I'm going to kind of put a hold on probably that thought process for right now and know that we're going to be able to revisit the recommendations work related to this very elegant data classes synthesis. The simpler and easier-to-consume an artifact is, it really is indicative of the level of lift behind the scenes. And I'm most appreciative to the small working group that has enabled us to iterate the spreadsheet work into this very clean synthesized approach.

Jim Jirjis

Can I add one more question?

Alix Goss

Sure, please.

Jim Jirjis

Yeah. It's Jim Jirjis. Hey, on the bottom, the metadata one. It almost looks like a footnote because it's at the bottom, but I see proprietary all across it. And when you look at it, it talks about this data collection includes pertinent information of different systems required to interoperate like the end points. And when we say that the information should be transparent, what kind of recommendation would we make given that its proprietary? Is that the kind of info that makes these things operationally doable? You know, how big a deal is that, the fact that so many of the details are proprietary, and what would be our recommendation?

Alix Goss

And I feel like part of what we're trying to address within the FHIR at-scale task force, ONC's sponsored sort of collaborative initiative of the public/private partnership, trying to really figure out what it's going to mean to scale the use of the FHIR standard across our country. I think they're looking specifically at that metadata area and may bring to us sort of the aspect related to the data about the data that needs to be in that wrapper and that information exchange so that computer systems can then interpret and understand the data which it's perceiving in the payload and use it appropriately. We haven't really had the frameworks before related to more electronic data interchange, wanting to address the metadata aspects at more of a standardized level. But we are looking at that from a FAST perspective. And I see Jocelyn's hand just popped up. I suspect that she'd like to add some commentary here.

Jocelyn Keegan

So, I think that there's another point in here, which is as the industry as a whole is moving to service-oriented architecture and API-based infrastructure, I think this idea of the value of the investment we had on a lot of these existing mature standards is there, and I think you can see movements happening across the different standard bodies to really try and figure out how do we move from these big kitchen-sink interactions to more point-to-point API-based or on-demand increase response-based interactions. So, I think this concept of having better and improved ways to be able to share and transport sort of all this investment is going to be really an incredibly important discussion as we report as an industry well beyond sort of prior authorization.

I think that Alix is right, ONC FAST is having a ton of discussions around it, but I do think that we're going to be able to call out that that discussion needs to expand beyond FAST and really across the universe of transactions that are in play in the market, based on the hundreds of millions and probably billions of dollars of investment by all the players in the status quo. I'm going to get off my philosophical soapbox right now, though.

Prior Authorization Recommendations Brainstorming (00:35:41)

Alix Goss

Thank you. Are there any other questions for Josh, Jim, and team? Okay. Without further ado, thank you so very much to your leadership, Jim and Josh. This has been really helpful, and certainly we're going to circle back with you and your team on the analysis efforts as we do need to address the gap areas to extend our recommendations work and as we pivot to our next agenda item, you'll see that I've captured that note as I'm going to start sharing my screen now to help us with the prior authorization recommendations brainstorming work that we've been doing. So, hopefully everyone is able to see the guiding principles ideal state documents. It's become very colorful.

Content in purple reflects the notes from our strawman development work. We used orange to help tease out the two areas that we'd like to talk about today. You may recall from last week, I noted that the small working group had done some brainstorming related to different policy readers. But notice we have some robust considerations for the team today. Last week, I think that was just Friday, perhaps, the small working group met, and we were able to think through the design for the future while solving the needs of today. So, what I'm going to do is sort of set a context about what the four points are related to designing for the future, and then I'm going to walk through the strawman recommendations, and then I would ask that at that point then we'll take questions and hopefully iterate this content to the point where the task force is happy with that point, and then we can move on to the final area that we haven't tackled yet for recommendations related to prior authorization.

In regards to design for the future while solving the needs of today, we really want to strive for dramatic improvement from which we will learn and apply to the more complex scenarios. Our approach should be sensitive to all potential burden to drive adoption and obtain desired results. Should the floor be

established – we're talking about standard floor – ensuring corresponding operating rules and regulatory rules allow for rapid standards development and evolution so as to not preclude innovation. So, keep in mind as I'm talking about this section today, some of these ideal statements really take into an account other portions of our guiding principles and ideal state consideration, such as this floor being established for national standards; as we know, under HIPAA, we've had a ceiling approach.

And the final point is also related to operating rules, that they should continue to raise the foundational level of adoption while encouraging and supporting organizations raising the ceiling capabilities. With those four consideration points, the team came up with five recommendations. The first one is to establish a single, national coordination function across administrative and clinical standards. This may involve syncing the authorities of the newly created CMS Office of Burden Reduction along with the HHS's Office of National Coordinator.

Two. Establish a unified process for standards advancement for clinical and administrative data. This would permit organizations to innovate on administrative functions as will now be permitted for clinical standards under Standards Versions Advancement Process affectionately referred to as SVAP. And SVAP kicks in and can be applied once a standard has been formally adopted.

Third, advance the framework of interoperability standards advisory to aid convergence efforts and advancing standards versions. We've included by way of reference a little bit about the ontology of the standards of the ISA for those who may not be familiar with it. We thought it might be helpful to reference that it's got the vocabulary, the semantics level that includes terminology standards, et cetera. We've got the content standard structures, standards, and implementation specifications, the syntax, and the third part is the standards and implementation specifications for services, the infrastructure components deployed and used to address specific interoperability needs.

Fourth recommendation is to align national frameworks to a single standards platform inclusive of content specification, terminology, and transport. For instance, FHIR as a content standard and terminology addressed by NLM established crosswalks. We went on to further share that clinical encounters capture data that feeds administrative and other functions downstream. Therefore, we need one set of standards that support current and emerging use cases, and there should not be an artificial separation between clinical and administrative standards. The standards should be friendly to innovators in licensing and acquisition aspects. In other words, for all standards, both content, structure, and transport aspects and terminology we need to address at a nationwide level the ability to establish an appropriate, sustainable process while providing open content licenses for all to use to enable and support interoperability and reduce burden.

Fifth, to establish a lightweight and feasible exception process to achieve the spirit of – I probably should elaborate on the citation – 45 CFR 162.940, which is the exception process for national standards, which is currently viewed as burdensome for innovation and requires a level of orchestration that leads to a non-starter. We had a couple other areas we might like to explore, but I thought at this point I'd open it up for questions about these recommendations and to see if there's any concerns with them, if we need to wordsmith them, or we're good to go. I do see a hand raised. Anil?

Anil K. Jain

Yeah. Regarding point B that's on the screen right now, and I'm probably overreading this or maybe not understanding, but how is that different in terms of establishing a unified process different than the USCDI and the work that we've discussed previously in the broader committee? Am I mixing up stuff, or are we're talking about advancing standards?

Alix Goss

Yeah, what I think we're trying to do is that right now we have the SVAP, the standards versions advancement process, which is the way that ONC can advance their health IT standards, and this is just from the new interoperability rules. So, once they have formally adopted and incorporated by reference a standard, then they have the ability to use their other tools in their toolbox to build on that foundational adopted standard and give an easier glide path to a newer version. Whereas we don't have that same functionality today for administrative data. And before I go any further, I saw Arien's hand come up, and I was wondering if you were also looking to help me answer this question, Arien.

Arien Malec

Absolutely. So, I think just for reference, I think what we're proposing is that administrative standards align with the same process that's used to update USCDI. So, as I think in the past, we saw administrative standards be a completely separate process, separate workflow often implemented in completely separate IT systems. So, you had a practice management system that implemented eligibility in claiming, or you had an HIS that implemented the patient account on the financial side of the record. Then you had an EHR. In the modern era, those systems are aligned. The workflows, as we've discussed, are aligned. There's a need for much more complex adjudication and in areas like prior auth, we've really exposed the need to have a single harmonized set of records. So, Anil, what you're saying is exactly right on. We're looking to align these two processes rather than the current state where they're separated.

Anil K. Jain

Okay. That helps tremendously. Thank you guys.

Arien Malec

Yep.

Alix Goss

Well thank you for that, because I realized we could strengthen the clarity of the second sentence, so I did modify it to start with, "This aligns with," and "would permit," to kind of give that clearer linkage. If we could strengthen it further, please let me know, Anil. Jocelyn. I see your hand up.

Jocelyn Keegan

Yeah, the only thing I would add to that is I do think when we think about USCDI, it really has been focused on clinical data and the work coming out of ONC and FHIR, I think for the large part. And as we've brought the payer community and these administrative workflows into this world, and I'm sure others as well, the need to understand the maturity and resources available in that emerging standard I think is important but also understanding that that dataset itself probably needs more input from folks from the administrative side of the house. And so, I've been really excited to see the progress ONC has been making in developing a process for us to mature and evolve USCDI in a meaningful way outside of sort of yearly updates or biyearly updates. But we're going to need people's brains and time to really make sure that we are doing that in a thoughtful and meaningful way when things are ready to be added.

Alix Goss

So, to that point, Jocelyn, you know, this really is getting more either towards needing to bolster the ISA recommendation or possibly is there a new recommendation when you talk about this reality of the data model, the USCDI sort of aspects, there probably is a disconnect in aligning the administrative and clinical standards. Do we need to cull that out more specifically, or do you think it's a natural part of this next recommendation about the ISA?

Jocelyn Keegan

I think the crosswalk is at the heart of this, which is how are we making sure that people can walk from one standard to another standard, and that we're going to provide the ability to get to parity across those different datasets and data models and value sets that are used and where we need to harmonize or where we see as an industry and need to evolve there I think those conversations will become more obvious. Right now we're doing it manually over and over again across so many different organizations in ad hoc ways. And we could take a huge amount of lift and pain out if we actually allowed for those conversations to be happening at a national level across the standards organization.

Alix Goss

Okay. I made a little bit of a tweak there related to the NLM for the national libraries medicine cross-walking aspect just to tie in and bring in that USCDI aspect. I don't want to lose that point. I was kind of hoping this discussion today might get a little, you know, people might really get jazzed up about these recommendations, either like, "Yes! We're causing change," or, "No, you guys have gone off the deep end of the pool." So, looking for some more feedback. Anil, I see your hand is up.

Anil K. Jain

Yeah. This is probably not that helpful of a comment, but I will say that I think somewhere in there there's artificial separation between clinical and administrative data. But when you start thinking about structure and function, the functions of clinical operations is different than administrative. And I don't know how to better represent that, but I think what we're saying is we want to harmonize it to make things significantly more efficient for the patient/member of the plan and not make it burdensome. I like that. But how do we also keep in mind that the administrative aspects of health care today are different. They have different, in some cases, regulatory aspects to them than the clinical. There's at least today different latency when it comes to what's happening clinically. And especially in certain settings like in the intensive care unit, it wouldn't make sense to think about it administratively.

Not suggesting any change, but it just struck me that it's not an unnecessary separation. It's a separation because that's the way our health care system is set up. And what we really are trying to do is to the best we can, harmonize them so that we remove unnecessary burden from doing the right thing at the right time for the right person. And I'm not sure that's captured. It sounds like to me that what's currently written, it's like a technical issue. We have an unnecessary separation. It's not just a technical issue. It's a structure and function of how our health care is reimbursed and delivered.

Alix Goss

I see several hands jumped up as you were wrapping up there, so it looks like they want to chime in on your discussion. Say again, Anil? You broke up on me.

Anil K. Jain

No, I was going to say, and if everyone disagrees with what I said, then that's fine. We don't need to talk about it.

Alix Goss

Okay. Well, first let me see if Rich or Jocelyn, did you have something specific to Anil, Rich?

Rich Landen

No, a different question.

Alix Goss

Okay. Jocelyn, were you on that?

Jocelyn Keegan

I want to double down on what Anil just said, having lived between both medical and pharmacy and between clinical and medical in different roles. I think that how we code things based on payment versus permission is radically different. And I think to Anil's point, it's more about business process and purpose than it is about people are trying to do the right thing, and there's a level of precision because of the duplexity that we've put into the market of how our system works that derives to those different vocabularies and knowledge bases.

I think that calling out that reality that they are different universes and vocabularies that are used for very different business and patient care purposes I think is actually really important for us to do. Because I think we need to acknowledge it to then figure out how to better synthesize them. I love that point.

Alix Goss

Okay. So, I'm hearing it. I'm not readily coming to a what I should do in this document determination. So, looking for a little bit more guidance there for what people are thinking.

Anil K. Jain

Well, how about this, Alix. Instead of saying unnecessary separation, just say that there is currently a distinction that is a byproduct of the differences in how administrative business functions of health care are different than clinical functions. And the goal is to harmonize the best we can while still respecting that there are differences. It's probably a lot more verbose, what I just said, than it needs to be, but the bottom line is to acknowledge the differences instead of saying that it's unnecessary differences, and then say that the best guiding principle would be to bring those closer together while still respecting the differences. Does that help at all?

Alix Goss

I think so.

Anil K. Jain

And to make it more clear, you can say the differences in the business needs for administrative and clinical operations. But that's fine, too, I suppose. Yeah.

Alix Goss

I'm not sure I captured all of that because I was going one place and then I tried to adjust on the fly. "Therefore, we need one set of standards that support current and emerging use cases while respecting the inherent differences in administrative and clinical data, business and operational needs?"

Anil K. Jain

I would say inherent differences in the business needs for administrative and clinical operations that may dictate the need for data, or something to that effect, tying it back to data. That may dictate differences in data standards.

Alix Goss

How it may be impacted. Okay. We're going to get there eventually. But I know that if we don't at least get the thoughts captured here, it makes it a lot harder down the stream for us. So, thank you for bringing that back. I see Rich's hand's still up.

Rich Landen

Yes, I found my mute button, thank you.

Alix Goss

Awesome.

Rich Landen
A couple of comments. First, I think, and A and B, talking about really aligning the regulatory process between

Alix Goss
You're talking about, I'm sorry, high-level A and B, not the little ones, the big ones. These?

Rich Landen
Correct. Capital A, capital B.

Alix Goss
Thank you.

Rich Landen
Aligning the regulatory process is probably one of the best long-term contributions that could come out of this task force. I think on a long-term basis, that harnesses the lessons we've learned from HIPAA and all the struggles we have learned on the clinical standards development side. So, I'm really strongly in support of those. The second comment is I'm not clear in here where the hooks are to incorporate into our recommendations some of the products we've been talking about in this meeting and previous meetings of the task force. For instance, the data classes, and then a couple of weeks ago the modeling. So, I'm making an assumption, and just looking to get that verified, that those models will be incorporated into the recommendations of the report somehow.

Alix Goss
I think you're spot on, and I think we're planning to have some discussion next week, I believe, when Sheryl returns, related to the federal health architectural data model, possibly. So, we're doing a little bit of work, and we're actually doing a lot of work in parallel right now. But I think that we know we need to incorporate the data classes team into the recommendations work, and then I'll add the data model aspect as well, Rich.

Rich Landen
Yeah, as well as the ideal state. Some of the other things we have been working on. They're just not explicitly in here, but I'm positive we're not going to abandon that work. All right. Next comment. I'm a little surprised that the recommendations don't really specify some sort of pilot project. Earlier in our conversations we were talking about patients ordering or getting wheelchairs for patients. And I'm not necessarily objecting to that, I'm just wondering what happened to that concept, or has that fallen by the wayside, or is that an omission? Just what happened to the concept of picking a pilot and moving toward the development of that particular pilot, and then making that expandable and scalable as a concept across the wider body of prior auth?

And then my final comment is that implicit in these recommendations, I'm seeing a lot of financial burden put on the providers and particularly the small providers in terms of better integrating their disparate IT systems. Somebody talked earlier about the billing system, the practice management system, the clinic EHR and that type of thing. And I suspect that requiring or recommending that that happen is probably critical to success for automating prior authorization, but it's going to be a heavy lift for a lot of small providers, and we need to think about how we socialize that and kind of get that across, because that's going to be a challenge to come up with capital for the small businesses that need to more fully integrate their IT capabilities. That's it.

Alix Goss
Robust feedback. Thank you so very much, Rich. First, the national piloting process is something we did have as an item to build out for a recommendation, ran out of time on Friday. So, it is here. I think what

we need to do is to build some language about what we think that needs to look like. So, I can leave that placeholder. The next thing I think is this. As we try to make the system better and we institute changes, there's going to be a ripple effect into the marketplace that will result in financial impacts. And when we're trying to remove burden, we may actually unintentionally create burden if I could synthesize what you've just said. So, I think that there's this idea of having some kind of a recommendation I believe is where you were headed to what we could do to sort of address the burden for providers. Did I hear correctly?

Rich Landen
Mostly, yeah. And while we're reducing the workflow burden, we are imposing a rather significant financial burden on particularly the small providers. I'm less concerned about large providers, integrated delivery services, and health plans because they have the wherewithal to take that stride. Small providers, I don't think, have that. So, I think it's going to be important to socialize. I'm not saying we need to make a recommendation, but to socialize that implication of our recommendations, you know, and I guess the way to do that, and I'm probably going too far afield here, is to work with those organizations that have been supportive of this process. Specifically, I'm thinking of AMA, MGMA, and others.

Alix Goss
Okay. I just put a placeholder for right now.

Rich Landen
Thanks.

Alix Goss
You're welcome. Arien, I see your hand's up. Please, take us away. What's your question?

Arien Malec
Yeah, I just wanted to go back to the point about the differences. To some extent, clearly there is a different business process and workflow process to document and encounter and to adjudicate a claim. I do think it is important acknowledging that to state that we were searching for harmonization. And the history here is that to the extent that we just start from the reference point that they're different, we end up building duplicative processes. So, for example, we end up building processes where the same encounter has to be coded twice because, of course, administrative codes and clinical codes are different, as opposed to adopting a reference point that says, "Well, we want the clinical coding to drive administrative coding to the extent possible." Or, "Of course we need to have a PA process separated from the clinical process because one's an administrative process and the other's a clinical process."

So, I think this language gets close. I think this language does get close. It's just that I think we need to put the frame on they're different, so therefore they're different to – well, the actual clinical encounter is same, and one drives a clinical workflow, and the other drives an administrative workflow. The workflows are different, but the actual stuff that happens to the patient is the same, and it's really the ground truth for both these processes.

Alix Goss
Yeah, so you could really flip everything on its head. If we somehow made a recommendation to say modernize administrative data needs and make it all based on clinical. That would be like one of the things we talked about in the small group is how this time's going to be different and calling out what we think is right. And if we do that, we can work towards that.

Arien Malec
Correct.

Alix Goss

And figure out how to get there. So, are you really calling out this dynamic of administrative started in one camp set of purposes, clinical was in another purpose? Those are now trying to come together. And do we have a foundational philosophical approach that has to be redone?

Arien Malec
That's right. I think that's exactly right. And the workflows, the use of the data, are absolutely, and for good reason, different. It is a different process to adjudicate a claim than to document a record for clinical decision-making. But the ground truth of the encounter, the ground truth of what happened to the patient, what the physician did, what the staff did, is the same ground truth, and it's sort of starting from that perspective is a really important frame. And I like the way you put that of moving towards a more integrated process.

Alix Goss
How do other people feel about this whole idea that we have the source of truth as the doctor and patient and that was captured there, and then all of these, we do have this idea of record once and reuse. And so, if we're going to record once, how do we get those downstream processes like, "I go to the doctor. I have insurance through my employer or through my own acquisition to help me cover the expenses of my care," and more of that's moving towards a value-based care environment, but there's still fee for service pretty much out there, folks. And so what does this mean as far as recommendations as we move forward? Do people agree that we should push the envelope here?

Arien Malec
And I guess one meta-comment before that is I think we've exposed in ePA; I think we've exposed in DME. I think value-based care is another really good proof point. The world is pushing us towards that perspective. The environment, the ecosystem's pushing us towards that perspective, and in many cases we're trying to solve problems from the perspective of these being very different processes with different standards. And that creates some of the burden that we're talking about.

Alix Goss
Anil, please.

Anil K. Jain
Yeah. Can you hear me okay?

Alix Goss
I can.

Anil K. Jain
I was just going to second what Arien was saying about the various business models, between health care providers and administrative health plans, for example, are forcing this direction like in population health. But I do think it's worth us trying to understand what are the unintended consequences. We typically think about the administrative data. And again, just thinking about the minimum data needed to carry on a business transaction kind of flies in the face sometimes of trying to create a world where any clinical data can be used. Or I'm not suggesting that Arien said this, but that any and all clinical data and any and all administrative need to be harmonized into a single thing. So, I think the patient may not see it that way. And perhaps even the providers.

This idea that in order for administrative business transaction, we should use a minimal information needed to get that business transaction done should be a guiding principle for how we think about this. I'm not suggesting that the standards don't need to be harmonized, but I don't think we should use the standards to force together business practices that, by design, should be in some cases distinct. And I'm not suggesting Arien said that. I think the workflow comment he made, made it clear that the workflows are different. It's just that it could be misinterpreted.

Arien Malec
Got it. Sorry for going out of process, if I can just clarify what you're saying, your concern would be that if we say the standards and the workflows need to be harmonized, we're unintentionally thought of as saying the data needs to 100% flow across all settings, and it's important to state the context because the business needs are different and because we've got a minimum necessary requirement that we're not sending HIV tests to adjudicate the toenail fungus claim.

Anil K. Jain
Yes. It's too easy. Once all the data is where it needs to be. It's too easy to hit the button and say, "I'll send everything," instead of carefully picking through what needs to be sent. And sometimes, having differences in transport mechanisms or standards forces that exercise to be done. And in the absence of that exercise, it's too easy to share everything.

Arien Malec
And shoutout to the transcriber who transcribed the HIV test to adjudicate the toenail fungus claim perfectly.

Alix Goss
Thank you. So, I'm really curious to hear from others. I mean, there's this idea of standardization. You can have plenty of standards, and you can crosswalk them till the cows come home. There's still burden in all of that. How far do we really want to push the envelope, folks?

Jocelyn Keegan
Hey, Alix, it's Jocelyn. I walked away from my computer so I can't raise my hand. As we know, I've been doing product development for I don't know, 25-30 years building stuff. And I think that incremental progress is important, and I think forcing the hard discussion to the right level to be dealt with is what we need to focus on, because these are really big topics that are going to require thoughtful application of regulation, concession, and agreement with folks that haven't typically been talking to each other, and I think that we need to pave a path forward and know that it's going to get incrementally better. But I think that the point, and I don't know if it was Rich or Anil that brought it up initially, the unintentional consequence of adding additional burden without any relief I think is something we're going to need to be very mindful of in our recommendations.

I think that as a humankind, not as an industry – this is not a health care problem, I've worked in other industries – we need to understand the costs of new and maintaining current and that there has to be dual and there has to be ways to get to new. And if we try and plan something that doesn't acknowledge that, we end up in the world we're in right now with trying to upgrade X12, that it's this multiyear effort with tons of investment because everybody has to go at once. I think we'd all agree that being able to make that incremental progress for the thought leaders and then nudging people behind while having all the hard conversations is the way that we need to go.

Alix Goss
Thank you, Jocelyn. Rich?

Rich Landen
Yeah, to answer Alix's question, we really need to push this envelope pretty hard and far. And a couple of reasons are, one, the ability of the industry as it now exists as best I can understand from the various presentations we've had over the last couple of months, the industry is not capable of doing that now without major investment in its systems' integrations. The second reason, equally important, is when we look back at the models we're thinking of, we're building in from green field a role for the patient, and we've got to define that and that entire link to the patient has to be built from scratch, both by the providers and the payers. That's something that doesn't exist now, and the history probably a bit more so from the administrative standards has always been a business-to-business mentality. Slightly less so on the clinical standards. But in both worlds, really, really active and meaningful patient engagement doesn't

exist yet. So, in order to build that into the real world, we are really going to have to push the envelope here. Thanks.

Alix Goss
So, I think Rich is giving us sage advice that we need to push the envelope here. And some of what is in this section is much more of the broader intersection of clinical and administrative data discussion, but it's very germane to this prior authorization conversation. And is anybody uncomfortable so far with the fact that we've brought forward strawman recommendations that are intended to turn things upside down a little bit and really look towards the future that we think is right, and recognizing that we're going to have to be effective in managing the change along the way to minimize burden or to come up with some way that enables us to rip the duct tape off quickly and make the pivot? Are we giving heartburn to anybody in the task force?

Jocelyn Keegan
Jocelyn: Isn't that why we're here, Alix?

Alix Goss
I think it is, but I really want to just make sure that we're all on the same page so that when we start to get recommendations translating into narrative in a report that you're going to read, I don't want any surprises downstream. So, thank you, Andy, for sharing your no heartburn and Denise giving us a checkmark that we're on the right path. That's important, you know. So, with that said, are there any other thoughts that people are having about to – I'm sorry, Denise, do you want me to call on you, or are you just giving us a thumbs up?

Denise Webb
Yes, yes. No, I just wanted to echo Rich's comments related to the patient. As I think about it, that is a place where we are going to have to really push the envelope. Because as I think about the way things exist today, like if the patient wants to get a status on their PA, it usually involves a phone call, or they have to log into their member portal or their health plan. I mean, I can say personally as a patient, I wish I only had to interact with my provider organization and get the answer, truthfully. I mean, I should be able to check on the status of my PA through my provider in a seamless fashion and not have to go over to the health plan to find out what's going on with my PA. And as I was thinking about this and when you think about other industries, if you think about ordering a package, ordering something on Amazon, you're able to track your order from the time you place it all the way until the time it's delivered at your door. And we need to have the same thing as patients in the PA process.

Alix Goss
So, like my ability to check my Amazon order, I can simply get on any time day or night that I want to and see exactly where it is, that kind of ability to self-service?

Denise Webb
Yeah. And when it's with the shipper, you know what city it's in, each step it takes along the way.

Anil K. Jain
And who to call?

Denise Webb
To the point where it's at your door.

Alix Goss
But ironically, I'll tell you even that process isn't ideal because I was supposed to have a shipment delivered Friday, and I'm still waiting for it. They're letting me come back for a refund if it still doesn't get here today. So, nothing is perfect. But at least I have transparency, and my expectations are being managed because I have information at my fingertips.

Denise Webb
If you think about the patient being in a doctor's office and a PA needs to be done, the patient shouldn't have to then go to the health plan to find out what's going on. I just think that it needs to be a seamless flow for the patient. So, the point Rich was making about really pushing the envelope when it comes to the patient interaction in this process, because as we saw in the table earlier that it was blank when it came to standards and data and what that interaction looks like for the patient, particularly around status and patient-generated data. I'm just reinforcing and agreeing with what he has said.

Alix Goss
Thank you. I appreciate that. It is officially time for our public comment. I do know that Andy's been giving us some comment in the chat box, and Jocelyn has her hand up. And I will come back to those in a moment. But without further ado, we'd like to see the public comment slide. Thank you. And we also have Lauren that's placed the comments in the box. So, Lauren, I think I'll turn it over to you.

Public Comment (01:18:53)

Lauren Richie
Yeah. Operator, can we open the line?

Operator
Yes. 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. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. We will pause to poll for comments. There are no comments at this time.

Alix Goss
Well, thank you so very much. So, Andy, I believe you're only able to communicate via the chat box. What I am inferring from what I'm seeing so far is that we should take out B and leave C because it's not as subjective. Yes. Okay. I'm going to go ahead and do that, because I think you're right, and part of what we were getting at there is our stream of thinking, so I think it's much cleaner. And then, I'm going to say Jocelyn, you were next in the queue.

Jocelyn Keegan
So, Denise's comments I think really drove home something we've experienced with electronic prior auth, right? So, we had a standard in the market for eight or nine years. When we first brought that standard live, we had knock-down, drag out arguments about the provider being the only one to own and control that prior authorization process. And then, we saw massive adoption with retrospective prior authorizations, as you heard CoverMyMeds and Surescripts talk about, because the pharmacist essentially was driving the PA process. So, in the last two years, we've added the ability for the pharmacist to be a roll-in player to submit prior authorizations and acknowledge their role in this process, but as part of that, we actually created a communication transaction that literally is to allow people to monitor the status of where the PA is being done and who's doing it, so the different parties don't create duplicate prior authorizations.

And that transparency, that ability via API to understand, we always kind of affectionately referred to it as the "Who's on first." I think it's incredibly important because to Alix's point with your Amazon delivery, your expectations are being managed because you know that when there's a delay, you have the ability to go and check it, but it also has the ability to be able to update you asynchronously when status changes, or to change the course like your refunds. And we get frustrated as consumers when we can't get that level of service with a delivery coming to our house for a book or some sort of a consumable device, right? But we completely tolerate it when it comes to life-saving and life-altering medications, procedures, and

equipment that we need to live our lives from a health care perspective. So, I think raising the bar to make sure that that patient can always know where things are from a status perspective is incredibly important.

Denise Webb
I wouldn't say we tolerate it. I think we're helpless. Not toleration, helplessness.

Jocelyn Keegan
I will totally take that.

Alix Goss
So, I've tried to also make sure that we're getting some of this aspect of the patient involvement, and I think that's more in the transparency with the patient at the center. So, I want to do a cross-check into those areas. But I'm not sure that it fits in. I'm not sure to what degree we have a recommendation at this point for this section. I don't want to be short-sighted, Denise. Is there something maybe you were looking for a little bit more?

Denise Webb
No, no. It probably needs to be in the other section, but I just wanted to make the point.

Alix Goss
I think it's good. We'll follow up and make sure that it's in the other section. So, thank you for confirming that. Anil, I see your hand up.

Anil K. Jain
Yeah. I think as we move toward that integrated data model and sharing becomes easier and perhaps even the norm for all the purposes we've been talking about and provides some of that transparency, we have to make sure that policy is aligned to that. I know we talked about privacy and security in prior meetings, but just think about trust. So, as a clinician, if I'm with my patient and we're putting together a reason for why they might need a DME, is the plan or payer allowed to use that information for other purposes, or can they only use it for this purpose and so on? So, I think I'm trying to think about going beyond the technical standards and thinking about implementation. Rich brought up the cost of IT systems that small group practices might have to bear. But there's also other policy implications where if we're not fully aligned, then we'll have some very elegant recommendations around standards around an integrated data model, perhaps, but very little to show in terms of how we're going to foster that adoption for widespread use. Go ahead.

Next Steps (01:24:36)

Alix Goss
No, no, no. This is good. I was thinking about what you were saying, and I was also seeing Andy's chat, and I'm thinking with this integrated data model kind of aspect and sort of where we're going, if that's a perfect setup for our next steps. So, if we could flip over to that slide deck because we're coming to the end of our time here today. And we had no further public comments. Thank you for letting us know that. So, one of the things that we're going to be doing on next week's call, I believe, is that there's going to be some discussion. I think at some point we were going to talk a little bit about some data models and the alignment with the federal health model, but I think we're going to do that when Sheryl gets back. And I thought that was on our agenda for next week. We may have taken off temporarily. But I think to the point here at the end of the discussion between Anil and Andy, I think we really do need to add that to our discussion.

So, Michael Wittie, if you could help us keep that in mind as we do our debrief and plan for the next call, I do think there's this sort of linking the data classes conversation with the data modeling sort of exploration with what does it really mean to look at an integrated data model or an interoperable data model as Andy is calling it. I think we need to have some conversation around that. So, I want to cue that up because I don't want to short-change that just because we're at the end of the call.

For our next steps, we are actively working on volunteer recruitment, and I thank those who have already accepted my invitation to play within the report-writing effort. We believe that we will be able to synthesize or transform, as I noted earlier, the work that has been done by a variety of small groups and brought back for discussion here with the task force. We'll transform those and start to put it into a cleaner status so that we can then start to compile a report. We're working closely with Lauren Richie and team to understand sort of the benchmarks to which we write and helping us with crafting recommendations in a way that will fit with the overarching database and also the norms of the HITAC report structures. So, we've been working on that a fair bit offline. Stay tuned. We will be bringing back some additional frameworks for everyone as we got our Is and cross our Ts on our thinking.

We are looking to move next week from discussing the prior authorization example to the broader discussion of integration. So, let's just hold on to our hats for a little bit for that one. We are also thinking through what that might look like, and we may not do it next week. We may kick it off the following week. So, a little bit of fluidity in our agenda topics. But clearly for the next month, we are going to be not only continuing our pivot to the larger intersection of clinical and administrative data, but we're also going to be cleaning up a parallel writing effort. We have a lot to accomplish before we are expected to deliver an update and draft report on September 9th to the task force. So, I knew that there was an integrated federal data model discussion in our timeline, and here it is, July 21st. So, thank you for advancing us to that slide. So, I think we'll kick off with that next time and then give you an update on the writing report effort and any time remaining, we will pivot to the convergence conversation.

So, without further ado, I want to thank everybody for their time and their input today. We look forward to having you back next week, July 21st, at 3:00. On that note, have a great rest of your day, everybody.

Lauren Richie
Thanks, everyone.

Anil K. Jain
Bye, everyone.

Adjourn (01:28:46)