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

March 17, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Thank you for joining the ICAD task force call today. We appreciate you taking the time and hope everyone is well. We will go ahead and get started starting with the official role call. Sheryl Turney we know is going to be absent today. Alix Goss?

Alix Goss
Present.

Lauren Richie
Aaron Miri? Okay. Abby Sears also indicated she would be absent. Alexis Snyder?

Alexis Snyder
I'm here.

Lauren Richie
Great. Andy Truscott? Not yet, okay. Anil Jain?

Anil K. Jain
I'm here.

Lauren Richie
Great. Arien Malec?

Arien Malec
Good day.

Lauren Richie
Debra Strickland? Not yet. Denise Webb?

Alix Goss
Debra is on the other line. I can see her on the participant list but she's not bridged over yet.

Lauren Richie
Okay. Thanks.

Denise Webb
Present.

Lauren Richie
I think I heard Denise. Gaspere Geraci? Not yet. Jacki Monson you said will be absent, correct?

Alix Goss

Yes.

Lauren Richie
All right. James Pantelas?

James Pantelas
Yeah, I'm here.

Lauren Richie
Jim Jirjis?

Jim Jirjis
Yes, I'm here.

Lauren Richie
Jocelyn Keegan.

Jocelyn Keegan
Jocelyn is here, too.

Lauren Richie
Perfect. Les Lenert? Not yet, okay. Mary Greene?

Mary Greene
I'm on, yes, thanks.

Lauren Richie
Great. Ram Sriram?

Ram Sriram
I am here.

Lauren Richie
Great. Rich Landen? No Rich. Sasha TerMaat?

Sasha TerMaat
Hello.

Lauren Richie
Great. Steve Brown? And Tom Mason? Okay. Hopefully, the others –

Thomas Mason
Oh, I'm on, Lauren. This is Tom.

Lauren Richie

Great. Thank you. Okay.

Denise Webb
Lauren, this is Denise. I might have to hang up and call back in. I have a full signal but you all are coming across pretty garbled. I don't know if anybody else is noticing that so it might just be my connection.

Alix Goss
I can hear you okay, Denise, but I have noticed a wee bit of background noise.

Denise Webb
Oh, okay. Well, I'm going to call back in, okay, because people keep dropping – their voices keep dropping off. And it could just be a bad connection. I'm going to hang on for a little bit and if it keeps up then, I'll call back in. I'm going to mute myself right now.

Lauren Richie
Okay. And if anyone else is having audio troubles or anything like that, please feel free to send a note in the chat to our contractor. With that, I will turn it over to Alix to get us started.

Alix Goss
I thank you so very much and happy St. Patty's Day to everyone. I'm grateful for you all to be here at our second meeting of the Intersection of Clinical and Administrative Data task force, or ICAD. We are going to have an action-packed agenda today and, hopefully, a lot of robust discussion around our workflow examples that will help us set our focus for the workstreams that we may need to go down to achieve our end objectives of making recommendations related to the merging of clinical administrative data, its transport structures, rules and protections with a particular focus around electronic prior authorizations. But to help set some context today and following up with our discussion from the last inaugural meeting, we wanted to cover some of the authorities related to Federal Advisory Committees and ONC.

And so, what I'm going to do at this point while we're now convened and officially launched in this call, is to ask Lauren and Rebecca and Tom if they would walk us through the next couple of slides to help us bring clarity around the authorities of the Federal Advisory Committees and ONC. If we could advance to the next slide that would be great. And beyond that one. I believe, Lauren, please take us away.

Lauren Richie
Great. So, I know on our last call, we just had a couple of questions regarding the respective authorities between the two FACAs that are represented on this task force. So, I just wanted to take a few minutes to do that. And then, we'll also talk a little bit about the additional authorities around ONC's clinician burden reduction work. So, here you have just, as you know, HITAC being established under the 21st Century Cures Act. Also, we wanted to highlight, which is not here on this slide, is that the HITAC, essentially, replaced the previous HIT policy and standards committees that were in place at ONC. So, this HITAC represents both the policy and standards with the specific charge of providing recommendations in the areas of policy standards, specifications, and certification criteria for information exchange.

Cures also lays out kind of three priority target areas, information exchange, privacy and security, and patient access recognizing that those are fairly broad topic areas but always making sure that the

committees' activities circle back to one of those target areas. And so, clearly, that's kind of what leads us to this particular task force today. And then, we'll talk a little bit about the intersection between this FACA and that of the NCVHS is that language is also called out in Cures. So, I'll ask Rebecca to walk us through the next slide regarding NCVHS.

Rebecca Hines
Thanks, Lauren. So, many of you may be familiar with the committee. It's been around a long time, 70 years this year. And over the decades, it's maintained really a close relationship with HHS and as agencies working together on major health data, policy issues current at any given point in time. And the principle underlying this relationship is that good public policy depends on good information. And you may know Bill Stead, our current chair, has said that NCVHS puts facts into the system. It was charged by congress with advising HHS on information needs underlying national health policy. And the main areas are health data, statistics, privacy, and data standards. As you probably know in 1996, the committee's scope shifted rather significantly serving as a key advisor in the implementation of HIPAA administrative simplification and privacy protection provisions of the law. And as you can see on the slide, there is the link to the charter, which goes into greater detail.

The committee's recommendations and reports are submitted directly to the HHS secretary. And all of the letters and reports are posted on the website. In the last couple of years, they've been very much focused on standards and privacy. And last, the Office of the Assistant Secretary for Planning and Evaluation oversees the committee. Historically, it's been staffed by the National Center for Health Statistics, NCHS, which used to be housed directly within HHS but was moved into CDC a few decades ago to uphold NCHS's position as an objective and unbiased federal statistical agency. And that happened well before the additional responsibilities laid out in HIPAA. People always say why are you an NCHS. Historically, that's the reason that the center wasn't in CDC when the committee was originally established.

And we can go to the next slide. And as Lauren mentioned, Cures calls for coordination between the committee and the national coordinator looking to the committee for recommendations and comments that can be taken into consideration. And I think this really was the launchpad for this incredible collaboration that's been going on over the last year. It really helps HITAC and NCVHS in their respective work. I think we can go to – Tom, are you next?

Thomas Mason
Yes, I'm on. Next slide, please. So, I just wanted to talk a little bit about our clinician burden reduction work and the authorities under Cures that Cures, actually, didn't give us any new authorities from an ONC perspective but asked us to write this report. Actually, the secretary delegated authority to ONC to coordinate the report in collaboration with CMS. So, it really focused on developing goals, strategies, and recommendations with respect to the reduction of regulatory or administrative burdens. And it, specifically, called out a documentation requirement relating to the use of electronic health records. So, it called for broad stakeholder output or interacting in gathering input for this report. And if you could go to the next slide. The goals of the report were to impact specific areas. And if we could go to the next slide, it will pull that up. Great.

Recommendations that should address actions that improve the clinical documentation experience, actions that improve patient care, actions to be taken by the secretary and other entities, other areas as the

secretary determines appropriate to reducing the reporting burden required of healthcare providers. So, the report really more so focused on actions that HHS could take through regulatory actions to reduce clinician burden. And we worked really closely with CMS and focused on areas that we could impact burden, worked really closely with the CMS Center for Medicare, and made some really landmark changes through the physician fee schedule to help reduce burden. But I just wanted to make sure that I was clear that there weren't any new authorities per se that this provision within Cures granted ONC. It was more of a request from Congress that the HHS secretary was asked to create this report with the strategies, recommendations, and goals that it really still focuses on our current and existing authorities in terms of rulemaking that center around our certification program, US Core Data for Interoperability, our convening authority.

But the other key thing to mention is that the report was also exempt from the Federal Advisory Committee Act. So, they asked us to reach out directly to the stakeholder groups that were identified in the statute. And it is now transitioning into an action phase. So, we're really, at this point, looking at within the recommendations who is responsible for what, which parties that the recommendations pertain to can move forward within their respective authorities. So, from an ONC perspective, from a CMS perspective, from the industry perspective, there are recommendations there that really call for the industry to move forward without us, specifically, having new authorities or regulations in particular areas over the industry. The usability section is a great example there where we're not changing our certification program to add new criteria related to usability. But there are recommendations there that we, through our convening authority, could potentially help to pull together stakeholders.

But just I hope that adds a little bit of clarity that this was really a report the congress asked for through Cures that was meant to leverage our existing regulatory authorities in terms of reducing burden. And my apologies, I wasn't able to be on the call to have the discussion at our last meeting. But I'm happy to answer any questions or further discussion around that.

Alix Goss
Thank you, Lauren and Rebecca and Tom, for bringing some clarity around the authorities of the respective Federal Advisory Committees and ONC. I think it's all hands on deck to move us forward with convergence of clinical administrative data and, especially, I think we're all eager to dive into the prior authorization opportunity because it's ripe for problem-solving. Are there any questions that folks have for any of the presenters on the authorities? Seeing none, I'd like to propose that we go to the next slide. We're going to pivoting now on our agenda to talk about landscape analysis. I wanted to go to the next slide and clarify that for the members, we did send out some preliminary information related to a compendium of information related to historical artifacts. We sent that out last week.

I would love for you to take a look at that and let us know if you're missing something in specific to make that a full compendium. But as we just talked about on the last call, the separation of clinical and administrative data sets and systems has been leading to a burden, in particular, prior authorization. We've seen it has a lot of outdated and complex workflows from its original paper-based genesis of technical standards and policy approaches. The one size fits all does not really work in the marketplace. And we've had a variety of usability challenges in the various product offerings. We've had a lack of automation and templates to help us across the different payers and different rules that exist in the marketplace and the ongoing use of features such as fax, portal, and phone producing more burden and further complicating

patient service delays. In the 13th report to congress, the NCVHS community pulled together some information, as reflected on this slide.

And it really helps drive home the point that existing standards are not fully implemented despite a longstanding mandate for the HIPAA transaction sets. And this table has been updated from what was originally posted in the 13th report to congress to add a more current CAQH index information from 2019. So, really, what it's showing you here is that prior authorization has a pitiful rate of adoption using the 278 transaction. I don't believe this information has any pharmacy reflected transaction standard usage. I believe the pharmacy information will be included in subsequent CHUH index reports. But we're really looking at the medical side of the house in this chart and showing that, in contrast to what we've achieved in 96% claims submission rate using HIPAA standards, we're barely breaking 15 when it comes to prior authorization. Next slide, please.

The landscape of the industry has continued to understand that the prior authorization transaction adopted under HIPAA wasn't meeting our needs and has really come together over a number of years. We really highlighted the challenges back in the 2015/2016 timeframe with industries' input at a variety of hearings. And so, since that time, we've seen industry groups such as the AMA and WEDI and AHIP and CAQH Core take on what can we do to improve prior authorization from a conceptual level of agreements to standards body of work evolving modern technology solutions such as HL7 Da Vinci Project with creating a clinical conversation around coverage requirements, discovery, to the document templates and rules from payers being presented to wrapping up the conversation for prior authorization support in an API/FHIR enabled way that can maintain our HIPAA compliance, leverages, features through CDS Hooks and CQL standards.

So, what we're seeing is that the marketplace of the standards community, as well as business best practices, are coming together to really help understand the opportunities and to reduce the barriers that we currently in the prior authorization dynamic. And that will help us learn what opportunities, from a broader ecosystem perspective, we're going to have as we merge the clinical and administrative data standards and related policies and transport and protections. So, as members take a look at the compendium, we ask you to send us any information related to that compendium if it's short-sided. We've really pulled far and wide and hope that we have a pretty substantial body of work for your review. And really, we're when looking to jump into the next level of conversation because I think that we've all been involved in prior authorization for quite some time. And I know there are a number of people who are looking to this group to produce the "so what's different this time" in having a prior authorization conversation.

And so, if you have anything on the current landscape, please let us know. We can update that and make that available as appropriate. I'll take any questions on the current landscape and the compendium review request before I move on to the next slide.

Jocelyn Keegan
Hi, Alix. It's Jocelyn.

Alix Goss
Hi, Jocelyn.

Jocelyn Keegan

A couple of questions and I apologize, I've been offline so I have not read the entire giant file you sent us at the end of last week but we'll dig in. I noticed that you don't have NCPDP mentioned here. Are we looking at the scope of both pharmacy PA and medical PA? Or are we only looking at –

Alix Goss
No, we really are. And I think we've realized with EPA under MMA that things are humming along fairly well there. So, I don't think it was an intentional omission. It's a good I spy on your part.

Jocelyn Keegan
Right, right.

Alix Goss
But I think it was really kind of the landscape than more of the challenges we've been having on the medical side of the house. And I thank you for calling it out because we really, not only want to tackle medical and pharmacy but we also want to think about any of the specialty sort of dynamics related to prior authorization as we move forward.

Jocelyn Keegan
And I think that's the meat of where we're at is really trying to figure out how do we continue to get throughput with the really great uptake we've seen with Script. But I also think we're actively talking in workgroups about how to deal with things that butt up against this very space. And specialty medications definitely are right in the center of it. So, I can touch base with you offline and figure out who or what sort of data you think would be helpful to include here because I do think having folks understand that we are using a very specific solution with lots of success so that it works. You can get PA to work better but being able to also understand that there is room for us to unpack and do better.

Alix Goss
Thank you. Other questions. Okay. So, let's go on to the next slide, please. I'm going to ask Jim Jirjis to jump in with me on this one if you could go to the next slide. Jim has been really helpful. After our last call and his thoughtful remarks about really solidifying our work around the chasse, the body of the car to come later, he offered us some sample workflows. And we're going to walk through those today. And we think that it's really important that we have a shared understanding through a simplified, high-level model review so we can organize and drive our work. Some of this is going to feel like a little bit of ground level 101, vanilla flavor. But we figure it's very important to make sure that we build the house correctly and collect the things that we're missing along the way like unintentionally forgetting NCPDP on the last slide. So, I'm going to have Jim walk us through this high-level model today.

We want you to think of this as a general prototype that's a base that we can tweak over time to get to medical services, inpatient services, durable medical equipment, and pharmacy-related types of prior authorizations. Our goal today is to review this model and then, discuss how it can be leveraged to define and drive our work as we move forward. So, we appreciate your patience as we walk through a sample prototype. And then, we'll be opening it up for questions. So, Jim, can you verify that you're on audio?

Jim Jirjis
Yeah, can you hear me?

Alix Goss
I can. That's awesome. So, would you like to offer any other opening remarks before we dive into the sample prototype?

Jim Jirjis
No, I think you did a good job. And a suggestion for the group's consideration was if we were able to focus first on just what are the simplified steps realizing that for durable medical equipment versus medical service versus hospital services that there may be a little bit of tweaking. But if we understood what the steps are together, however simple it may be then, we have a song sheet we're all singing from. And then, we could go back and say hey, look, at Point A, what are the opportunities through the lens of what these two organizations have authority around, at the bottom in the green, you see around how would we develop standards –

Alix Goss
Jim, hold on a second. Can you advance to the next slide, please? Thank you. Go ahead, Jim.

Jim Jirjis
Oh, yeah, I'm sorry. So, in the green at the bottom, the notion is if we look at the workflow and kind of agree on what the different steps are that we could then, dissect it in an organized way and say what are the opportunities for automation, agreements on standards over content rules, maybe data fields, etc. So, what the first slide is is about something for the group to perfect. This is just sort of a draft suggestion. For example, a provider informs the payer that a treatment or diagnostic test or service is needed.

Arien Malec
Hey, before then, are we missing a step here that covers discovery and, potentially, sharing of procedural codes or other criteria for which PA is required? It's a very –

Alix Goss
I think that might have been Arien.

Arien Malec
Yeah. That's right. So, at the very minimum, we need to know that the patient is covered by Payer B or Payer A. And then, that at least needs to be prior to A. And then, I would suggest that we also might want to think about a process for discovering from the payer what procedures require PA or may require PA so that you can then, do the PA check.

Jim Jirjis
I think you're right on. If we skip to 16 just for a second, do you mind skipping –

Alix Goss
Yeah. I was kind of hoping you might be able to get through the sample prototype before we started having that discussion.

Jim Jirjis

That's a good idea. Let me finish it then, and talk about Slide 15 and 16 and then, open it up for discussion because I think you're on the right track that this is not complete by design. The work of the group is to make sure we don't miss any steps. So, the first might be, for example, what you said then, the provider and performance payer treatments needed. A payer enforced provider, whether it be a –

Alix Goss
I'm sorry. Jim, which slide do you want to be on at this point? Do you want to be on 14 so we can make sure to catch up with you?

Jim Jirjis
Yes, 14.

Alix Goss
Thank you.

Jim Jirjis
So, there's a trigger that a provider informs the payer of service or treatments needed. Payer then, informs the provider whether there is a PA required and requests information. We'll get to the details of that in a couple of slides. The provider then, responds to the PA request with all information required. Then, the payer responds with a timely decision. And it's either approved, requests more information, or is denied in which case there are three options. The provider agrees, the provider appeals the denial, which might then, go to a peer-to-peer review process that then, circles back to, again, probably D, or payer recommends an alternative. For example, an alternative in the inpatient might be an alternative like observation versus inpatient. In medications, it might be step therapy or it might be alternative recommendations, etc. You kind of get the drift.

If you go to Slide 14 – and this Slide 14 is not meant to be perfect. I think you're exactly right. The group needs to make sure things aren't missing. Go to Slide 15, the next slide. The questions that might come up as we move on to 16 are other missing elements or the high-level components, as we just discussed that are missing. Can we use the model to together come up with what is an ideal state from a payer perspective, provider, or patient? What are the opportunities at each step in this workflow? And then, who are the major actors who should be considered or consulted that currently would be impacted by alterations? How do we represent the work that's already been done so that it's not like we're all starting from scratch? Da Vinci has done some great works, others have. One model, once we get to the ideal state, would be to back in and say okay, what have other people already worked on that we can leverage and put in the model. And then, what is left and how do we use then, that work to define and drive the workstreams?

And the last slide before we get to the discussion is just – go to Slide 16. This is an example. This is not mean to be exhaustive at all. But just, for example, where you guys were going a minute ago, one opportunity might be pre-agreed upon set of rules to know if prior authorization will be needed based on a set of CPT codes. Maybe there is a scoring mechanism. Between B and C might be an opportunity to have a pre-agreed upon set of rules and data requirements for prior auths. Maybe an opportunity is an automated payer adjudication process. Or if you go down to No. 4, provider response timing considerations. For example, with CDS Hooks, the notion that a set of data is needed for a prior authorization, we would want

to make sure that the provider had the opportunity to make sure all of the data was collected so that we don't inadvertently get a denial that then, has to go through a laborious, inefficient process.

Automated process to allow for clinical status changes along the way, patient status changes. No. 6 might be automated response has an appropriate level of granularity with the clinical administrative reasons for denial in order to improve over time documentation of patient care. An automated peer-to-peer process. Lots of friction and effort when something is rejected and there is a peer-to-peer, could there be standards for that more conversational dialogue that could take a lot of frustration, work, and cost out of the system. So, these aren't meant to be exhaustive. I think the work of the group would be to say half of those are wrong or you've missed a whole bunch of them. And so, Slide 17 the notion is if we – the suggestion was if we use the workflow for the areas of interest, we could use that as a way to ground us into a lexicon of opportunities. And the first step might be what are we missing on the letters, the A, B, C, D, E, F, G in the process, are we missing anything.

And then, we might go back and say from the payer's standpoint and provider and patient's standpoint, what could we do at each step to either automate, create data standards, data models, workflow integration, transport methods to just start with maybe the less controversial area of just removing friction for things like information back and forth so that people aren't dealing with five different insurance companies, insurance companies aren't dealing with seven different EMRs. And instead, we have standards. And then, we can get to the "how come you're denying it." And so, that's a suggestion. Slide 17 is maybe a set of starter questions. I think the chairs might want to take the ball back.

Alix Goss
Thank you for that. One of the things I would love to do is we've got some great tools and I can already see Anil is using that by raising his hand. So, why don't you kick us off with questions? So, if we could ask the task force members to use the raise hand feature that would be great. And then, I will do my best to keep it in honest order. And I think Anil got first, Jocelyn got second. And what I would like to do is – and then, Arien, you're third. And so, what I would like to do is go back to the prior slide because I think – and I noticed you, Rich. Okay. So, let's get off to the races, folks. Anil?

Anil K. Jain
Yeah, sure. Thank you. So, Jim, great overview of, I think, a pretty straight forward, contemplative process. But one of the questions I have is around the scope of what work we're going to do and if prior auth is our first case of how we start to align clinical and administrative data to reduce burden then, I would just simply ask are we also tasked with reimagining what some of these steps could look like in a world where there is a lot more data flowing? So, if the whole goal of prior authorization is to create some sort of trust and transparency framework for medical necessity then, some of these steps that have, historically, been multiple transactions may not be needed if we put the right data upfront as opposed to trying to create, from an informatics point of view, every step that we traditionally see if that makes sense. I'm wondering whether we have the permission, if you will, from our committee to really think through.

So, if you'll just take an example of Step A here, provider informs payer treatment is needed, Arien already mentioned one, which is having a data set of what the payer is requiring that even needs PA. But another one would be that whenever something is "ordered" that the information about the patient that's relevant for that order travels with that order. And, therefore, you obligate the need for some of the steps

downstream. So, I'm just asking the question of what is our scope here. Are we trying to recreate the current workflow in a more data-enabled way or reimagine what a more efficient process could eventually look like and maybe eliminate multiple steps along the way?

Alix Goss
My reaction to that question is that I think we should go for the gusto and try to figure out what it can really look like with more data, more real-time options. So, I think we should not limit ourselves to just what the existing process is or the process steps are.

Thomas Mason
This is Tom. I agree, Alix. I think that's a good approach. I think it would be great if we could do both that we could think about ways to improve the existing but also think about ways that we can reimagine and make more efficient with the data that we have and the technology that we have. But I couldn't agree more. I think we really need to use this team to help reimagine and think about the things that we can do.

Anil K. Jain
Okay, thank you.

Alix Goss
Thank you, Anil. So, I believe next, we have Jocelyn.

Jocelyn Keegan
Thanks, Alix. And I agree with everything Anil said and want to, I think, probably want to get down and maybe burrow into the point that Arien was trying to get at, which is from my experience rolling prior auth solutions, even ones that help you automate in the market into physician organizations, there are a couple of realities. And I think that this concept of transparency of information is really critical. So, I just want to level that on what the current world looks like. Today, the quality of the data that's available upstream drives whether or not someone from a physician's office today picks up the phone, goes to a portal, or starts a fax. And so, way ahead of this event in workflow, often, there is a decision to understand what the patient's benefits are. And once I have to do that using a non-digitized format, I'm pretty much stuck in that lane. So, I think if we think about this workflow, it really needs to expose what's happening upfront.

And so, some observations that I have from just being out in the market, working with folks on this is the quality of the data – the data is available today. Often, the providers don't trust the data that they see. So, they ignore it and they, basically, leave some stops further in the solution. Either it's the nurse on their team or it's the pharmacy catching a Script to, basically, catch whether PA is really needed or not because they, basically, don't trust what they're seeing. In my experience, providers don't do PA, unless it's a single doc shop. It's a nurse or an MA that's doing that, generally, signing for the doc based on procedures that they have. And the really smart practices have created cheat sheets to, basically, back out of all of the existing rules in their particular market as general rules.

But that because we don't have a specific plan ID and there is so much variability and even just in the last 10 years in the industry about how much variability there is at a plan design level, the ability to sort of come up with these rules out of the gate of doing it based on CPT codes or not is really challenging because the inability to really understand, at a plan level, what somebody's benefits are that you have to be really at the

patient level to understand at a particular time during the plan year and that particular patient's benefits what that patient's benefits are at a given point in time really drives whether or not something would be covered or not covered or pushed to something else on formularies. That's really what keeps that administrative or nursing staff really in the role of doing that in that each of these steps has a repeat because the primary care doc is doing this work. And then, they're handing a patient off to a specialist. And people are, literally, checking PA coverage and PA rules and submitting for PAs the first time somebody makes an appointment, before somebody shows up for the appointment, the morning of a procedure.

And so, I think the simplicity of the picture belies the complexity of the burden because everyone is double-checking because, generally, if you don't get off right or you trust the old op, it becomes a big P&L cost to the provider organization. And even when people have put things like gold carding in place, it's a trust issue. That person that's responsible for getting the op done at a doctor's office doesn't want to be the reason that a $50,000.00 procedure gets written off, right. And so, this upfront, and I'm a little bit of a soliloquy here today so I apologize, this upfront idea of data and transparency and trusted information that matches the current patient that's in front of you, I think, has got to be the thing that we unlock before we talk about how we automate it if anything.

Alix Goss
Jocelyn, when you talk about unlocking it, the trust of the data and the rules, the transparency around the rules, what do you mean we need to unlock that first?

Jocelyn Keegan
Well, I think that there are a lot of capabilities in the existing standards to get the information. And payers and PDMs do that varying degrees of success. But there are so many places that data can degrade in how it's stored and shared. So, moving to real-time API access back to the payer or the PDM as a source of truth like the work we're doing in real-time benefits check is critically important and the work we're doing with coverage requirement discovery in Da Vinci becomes important because it gets to that state that, I think, was being discussed earlier of really being able to say I know for this particular patient what is required today. So, you can actually impact the change to say I'm going to choose this option because it's part of their benefits package and completely avoid the need to do a prior authorization.

Where today, the concept of what's paid for by somebody's insurer is completely separated from what actually happens while they're sitting in their physician's office talking to the physician because this other side of the team is actually doing all of this administrative work. And so, the ability to bring those two worlds back together is what I mean by unlocking it. It's that your benefits are intrinsically tied to your adherence of whatever you and your doctor decide what you need to do.

Alix Goss
So, really what I'm hearing is the fact that we need to have a pre-step of the discovery state pre the workflow that gets us at the benefits level on the diagram.

Jocelyn Keegan
Yeah. I think that you intrinsically have to understand the patient's benefits in the current world we live in without making radical changes to the way plan design works with payers. It has to be patient-specific.

Alix Goss
Okay. Thank you. Arien, I think you're next. Did you put your hand down? Arien?

Arien Malec
That would be the mute button that I needed to push. So, I think we've already belabored the coverage discovery and benefit discovery piece of this. I do think it's incredibly important. Secondly, I think we need to put the patient in the diagram. So, understanding that there are PA requirements. If we can't adjudicate the PA requirement in line in the encounter, which should be the norm that we strive for then, we need to make sure that we've got patient access to the PA status with an implied state machine of where is it in the process. And then, as Anil said, I think there are a bunch of places where we have mechanic steps in this workflow that I think we should replace by processes. So, for example, it would be far more efficient once we discovered that there is a PA required for an order that's about to be placed that when we place the order, we also send off the PA with appropriate patient information to adjudicate the PA response.

So, there are areas where I think we're automating a manual process that's inefficient where instead we should be seeking to design a process that has all of the information that's required at each stage of the process. And in doing so, we might collapse a whole bunch of steps. And then, No. 3 is I think for each of the major steps, and we should really design around happy path and degenerate path, but around the happy path case, we really should be thinking about what delight looks like and what metrics are associated with delight. And in particular, I think our goal should be that most PA gets adjudicated inline in the encounter. And then, we define clear SLAs and clear requirements for anyplace where we can't adjudicate inline in the encounter. But we should make sure our standards are set up to be able to handle real-time inline adjudication or near real-time adjudication in the context of the patient encounter.

Alix Goss
So, if I heard you correctly, you're echoing the CRD, coverage requirements, discovery, Jocelyn's comments around the benefits that we really need to drive this. Then, it was the patients should be added in the diagram and added in the aspect of the real-time workflow integration and replacing the current steps with more automation to enable that to happen echoing some of the Neal sentiments. And then, I think your final major theme was the happy path, which I love and the metrics that delight to get us to those nuts and bolts of what would utopia look like with prior authorization. Did I capture all of those?

Arien Malec
That's absolutely correct. Yeah. Thank you so much.

Alix Goss
Awesome.

Jim Jirjis
I heard one more thing that I thought was intriguing just on his topic. You had mentioned a state machine, which is really important so that people understand where everything is in the process. I didn't hear that in the summary playback. Can you talk a little bit more about the state machine?

Alix Goss
Who are you directing that question to? I think that was Jim.

Jim Jirjis
It was Jim, yeah. He had gone through a bunch of things and then, you summarized it. But one of the intriguing additions I thought, too, was this notion of an implied state machine that's keeping track of status of the authorization requests.

Jocelyn Keegan
Jim, this is Jocelyn. I think that's a really important point because I think the uncertainty about where the prior auth is in the process when it's not done in an automated fashion is part of what causes a lot of the distress of the process and the re-work.

Alix Goss
So, in essence, he was talking –

James Pantelas
This is Jim Pantelas.

Alix Goss
Go ahead, Jim.

James Pantelas
I'm sorry. I can't raise my hand because I can't get this to work on my system. But if I could raise my hand here.

Alix Goss
Okay. Go ahead and then, we'll get back in the queue. Thank you. So, I will acknowledge that you raised your hand, Jim. And so, thank you for everyone's patience while I just wanted to make sure I heard all of Arien's great points. And I think that means that Alexis, you're next. Then, Jim Jirjis, you had your hand up at one point. And then, we're to Jim Pantelas.

Alexis Snyder
Hi. This is Alexis. Thank you. I wholeheartedly agree with everything that Jocelyn said. And I really think that – and I'm sorry whoever was just speaking about interjecting the patient into the prototype here is a giant piece that's missing. And I just want to call attention to back up to the beginning of the prototype starting with Step A that in the patient and caregiver perspective that this isn't even Step A or Step 1. Step A or Step 1 for the majority of patients, especially those that deal with this on a regular basis because of complexity, is the provider ordering medication or ordering a test or ordering treatment or ordering durable medical equipment and the patient or caregiver trying to obtain it.

That's Step A because it goes back to that piece that we were all just talking about not being aware universally when a PA may be required or not because of the insurance process being so different across all of the levels and why we may not be able to come up with a universal decision between insurers of when a PA is going to be required or not because that's a tremendous undertaking for a completely different task force. But there does need to be a streamlined way to make everybody, including the patient, not just the provider, aware from the beginning when a PA may be needed or not. So, Step A is, usually, trying to obtain

it. Step B is then, usually, a patient or a caregiver going back to the office and not getting in contact with a provider but a medical assistant or a nurse or another admin person to explain what's happening and what they need. Then, as Jocelyn stated, most of the time, the docs are not the ones filling these out.

They may be the ones signing off on them but the problem is that sometimes, someone who is not trained correctly and/or doesn't understand what is actually needed to go in it is filling it in incorrectly the first time and getting a denial right off the bat just for lack of not understanding when it's required and what's required at the time. So, there are a whole bunch of steps missing here. And I think, even when you get down the end towards the denial and the FPH area, that's not even how it flows realistically for patients either. It's if you're getting a denial, the patient is the one hearing it from the pharmacist or another specialty provider or the durable medical supplier. And then, the patient is the one burdened in the middle going back to try to get it resolved. So, there are a lot of steps in between that need to be streamlined. And a lot of it goes also to the transparency that the patient is not getting during this process.

So, the process that was just mentioned by Arien, I believe, about trying to find a streamlined way, not only for patients to be able to see where the PA process – the status of it is so they can get involved quicker and try to get that streamlined quicker. And just to give you a very minimal example, a patient can go to the pharmacy to get a medication that was sent over without a PA, find out you need the PA, go back to the office, have them try to put the PA in. And quite often, more often than not, it's a he said/she said battle with the patient or the caregiver stuck in the middle of is it the physician's office's responsibility to try to fix this. Is it the pharmacist or whatever other PA process we're talking about, durable medical equipment, etc.? And the patient is getting mixed information from both sides. The pharmacist says go back to your provider. The provider says we did what we did. The pharmacist has to do something, etc. So, there is a whole bunch of burdens and pieces missing here.

And I think we need to break it down even more because we're going to jump over steps that aren't going to improve the process.

Alix Goss
So, Alexis, to that point, this is Alix, let me get your thoughts on whether you think that we need to have a prototype by audience member. One of the things I've been thinking about is the actors in the process. But maybe we need to step back and look at prototypes from the patient, from the clinician, from the payer perspective. What do you think? Would that help?

Alexis Snyder
I think that would be great. And then, if there is a way to combine that all, at some point, to bring it all together. But it definitely would make more of a presence to show where the burden is and where all of the problems are that need to be resolved going into fixing the overall dilemma for sure.

Alix Goss
And I think it probably makes sense to start with trying to just do the happy path and then, try to get down to the alternate path. Otherwise, I think it's going to get a little overwhelming, initially, in trying to get our arms around all of this. And I see a great little chat going on that yeah, we could use swim lanes for each actor, certainly, as an approach as opposed to separate views. But my concern about starting with – I'm wondering if it wouldn't be beneficial to just take it from a patient – at least the two views, the patient views

and the caregiver views versus the clinician and the payer views. But this is something we all get to think about as we move on with further commentary.

Alexis Snyder
I think they go together because we all need to work together. It's not just the provider's responsibility and it's not just the patient's responsibility to try to get something resolves. And that's where the conundrum is on how you're talking about the flow and the different actors and the different systems.

Alix Goss
That, actually, speaks to not having it and doing more of the swim lane approach. So, this is some good input. I want to respect that Jim Pantelas is next in the queue then, Rich Landen then, Mary Greene.

James Pantelas
Okay. I just want to – I'm going to add on to what Alexis already said. My thought on all of this is that the piece that's missing, and Arien mentioned this, is the patient or the caregiver. And what's missing is that we're not copied on any of this. What we end up doing is getting down to a denial before we even hear about it or see the documentation. And then, what ends up happening is that we have to correct what was initially submitted so that it could be submitted again. As someone that has a child that's in a wheelchair and needs a lot of durable medical equipment and is growing, I can tell you that the last time we ordered a wheelchair for her, it took about a year. And by the time we got it, she was almost grown out of it. So, there are pieces here that are just missing copying the patient or caregiver, right. That creates complete transparency.

I don't know why anybody would submit something for prior authorization and not copy the patient or caregiver. I also don't see a piece in here that says anything about the patient or caregiver's financial obligation and the determination of that in the process. If you get all the way down to the approval and the patient can't pay the co-pay then, it's kind of silly. And when you're talking about a $14,000.00 or $20,000.00 wheelchair or piece of equipment, it can make a big difference. Again, it's just a matter of opening it up and including everybody in the process, which means that all communication should copy the patient and caregiver.

Alix Goss
I think that's a really important point and also the financial price transparency aspect, I think, is another one that we need to make sure we capture. So, thank you for bringing that up. Rich Landen, I believe you're next.

Rich Landen
Thanks. Voice check. Am I coming through?

Alix Goss
You are, Rich.

Rich Landen
Okay. Thanks. Both on the slides and the narrative, as we went through them, the terms high-level, major, and key were consistent themes. And if we're staying at the very highest level and looking at the areas of

the system then, I think the prototype A through K is spot on. But it begs the question of what do we need this prototype to do because if we're going to use this to test ideas and validate things and talk about workflow then, it is way too high-level for all of the reasons the previous four have mentioned. So, in order to figure out what the appropriate level for this model is, I think it takes more discussion. Also, add me to the list of people that want to put the patient in here. And I would propose, actually, that we need a system model, which is, essentially, the sample prototype elaborated a little bit more and going down a few levels but not all the way down the rabbit holes. But we also need a workflow model that is, essentially, the same thing, as I look at it, from what does the patient see.

What do the patient's eyes see at each step of the way and then, what are the data flows, what are the data exchanges at each step of that way? Because that's really the pragmatic model of what it takes to actually implement something. And in the middle, there are a whole bunch of questions like who are we building this model for. Are we building it for large payers who are well integrated and large providers who have the resources to become well integrated? Or are we building it for the smaller entities and organizations whose internal systems this PA process? The workflow processes a lot of separate smokestacks and is not well integrated. Some are phone, some are automated, some are through vendors, some are outsourced. So, going back to the basic question then, for this prototype, what do we want this prototype to do?

And I suspect we will need a high-level system view. And we will need a from the bottom, patient eyes view to actually get the workflows and the processes understood if we want to use this to validate any of the ideas that this group is going to come up with. But I love the comments. I love the energy. It seems we're all thinking in terms of the same goal so I'm very pleased with this conversation so far.

Alix Goss
Thank you. Helpful input to think about the system versus the workflow models. And I think that when we're trying to build this, I think we're having – from a national perspective, we need to think about including the large, the small, and the in-between to get something that's really going to move the needle so to speak. But that's just my personal opinion. But thank you, Rich, for that input. Mary Greene?

Mary Greene
Actually, I think most folks mentioned things I was going to mention already. But I just want to support the beneficiary being part of the process. And some of it is because of things that were already mentioned that sometimes, they have to step into the process for the process to reset. But also, some health plans, apparently, also require the beneficiaries to trigger the appeal. And so, there's an issue about delays in even appealing something because the beneficiary, very often, doesn't know what to do and the providers have to step in or the providers just offer to help because of the complexity of the problem. So, that's one piece that was a surprise to us when we were hearing about some of the challenges that the beneficiaries face that sometimes, they're the ones who actually have to trigger the appeal. I agree completely that I recognize that we might want to look at these processes from the different stakeholders' perspectives.

But I bet you the solution will be different if we think about the provider and the patient absolutely being a team going through this process because there won't be as many iterative steps where the beneficiary might not get left out in a number of steps. I also want to mention about the peer-to-peer process. I know that, very often, the peer-to-peer process discussion is triggered when there is a denial and it's triggered as part of the appeal process. There are some plans who have that peer-to-peer conversation happen

before an appeal, actually. And I recognize that the goal here is to try to get processes adjudicated automatically so there is very little need for peer-to-peer.

But if there is some question about whether the plan truly agrees with the clinician or there are nuances here that might require more specialty conversation, the right kind of peer conversation then, it would actually speed up the process if that happened before the denial actually occurred that there was some visibility into the process to trigger that escalation in the conversation before denial because the denial just slows everything down. It resets some of the timelines for the next step and when the next steps actually get to be accomplished.

Alix Goss
So, thank you, Mary. What I took away from that was the criticality of looking at the actors' different points of view but to, actually, combine the provider and the patient view because that may give us a different kind of value in assessing this. And that also, there could be some creativity applied with peer-to-peer reviews. I want to make sure I'm capturing people's key points as we're going along. So, if I didn't get that right, please let me know. I'm also noticing that there are folks typing some comments in the chat box. So, we'll pull those out later to help us with our thinking. Because what I'm imagining will happen is that all of the feedback that you're giving us today will be taken and will produce the next version of this prototype to help us structure our work. So, Jim, I wanted to open it up back to you to see if you had any other thoughts as you've been listening to this as the one that put this sample prototype together.

Jim Jirjis
Yeah. I was thinking the same thing. Taking the transcript and everybody's ideas and then, coming up with the next versions. And what I think I heard is there is the current state, which none of us like. But we need to map out – and then, there is the if we were taking out a bunch of steps view. The other thing I heard was we probably do need to tease out the outpatient versus inpatient versus meds because there are some nuances around timing and what's automated and what's not that might be helpful. And then, the other thing I heard was we need to really take it down another level of detail that this is too high a level and we're missing too many steps to actually be actionable. And we can work together on the next drafts if you'd like. Was that correct?

Alix Goss
It resonated with me. I'm curious to see if others – how they feel about the summation that Jim just offered. And do we have any folks who would like to roll up their sleeves and either take a particular approach – I feel like we want to – I'd love to get a patient advocate focused individual to help us, Jim, in advancing this prototype to make sure we're getting all of those caregiver and patient perspectives.

Jim Jirjis
That would be awesome.

James Pantelas
I'd be happy to help with that, Jim. This is Jim Pantelas.

Alix Goss
The dynamic duo of Jims.

James Pantelas
There are never too many Jims.

Alix Goss
Well, thank you, Jim and Jim, for that. Someone else was going to chime in and I'm not sure who that was speaking.

Jocelyn Keegan
Alix, it's Jocelyn. One thing I found helpful is we've gone through different happy path scenarios and added additional roles and actors over the years on the NCPDP front is sort of nailing the format of how you want to do that more UML version of the picture is good. And then, we can sort of decide whether we're tracking it by type or by complexity. So, I think if we can figure out what the next version of Jim's picture looks like then, I think we can probably separate to have a few folks do a couple of different of the iterations. Are we going to look at DME pharmacy, pharma med, procedure and services as different paths? Or are we going to look at it as are there one time really simple CPT driven approval/denials versus an episodic type of approval versus a recurring approval? I think we have to pick how we want to slice it.

Alix Goss
Yeah. Can we talk a little bit about that? Because that's one of the things I've been struggling with. I'd love to get to that level and I'm not sure if we need to kick the tires a little bit more and see what naturally falls out or if we should see if folks have an opinion about what kind of view. Clearly, we can represent the actors in swim lanes. We can represent the system workflows. But should we be doing it by a particular view or by a particular flavor of prior auth?

Jim Jirjis
Well, it's Jim Jirjis here. I've got a thought about – to me, it seems like there are two things. There are some concepts that are going to apply to all four that just will apply to any of the four areas. And then, there are nuances to the medication like step therapy for medication, for example. I don't know that that exists when you're an inpatient looking for inpatient OBS, for example, right. But the notion for both of them that a service is needed and that a set of information is needed is a common theme. So, to me, it seems like one way would be maybe to break out of the four different types, map those out and then, come together and find what are the common pieces and then, what are the differences between them that we don't want to forget.

Jocelyn Keegan
I, actually, really like that because I think there are steps you have to take. So, there is a common theme of getting a patient enrolled that cuts across medication and DME and infusions and sometimes services like PT or behavioral health that are in addition to the PA. And it's a lot of the same data that flows. So, I like that idea of what are the common steps. And then, you're either on or off for that particular type that it's required or not required.

Alix Goss
Thank you. Alexis and then, Gus.

Alexis Snyder
Yeah. I was going to agree before Jocelyn had chimed in as well with what Jim was saying about definitely making a statement for each separate type of prior authorization and seeing where the standard issues are, the standard problems are to come up with a way to mainstream it across the board. And I just also wanted to add that I think flipping the table and thinking of the outcome of all of this when things don't go right and where the true burden is and looking at it from that and then, going back is really the patient, at the end of all of this, receiving a denial and waiting and waiting and, oftentimes, deteriorating, not getting what they need.

And I think when you put that focus and you show people what that bottom line is, people then, jump to it more to take the steps from the beginning to the end to streamline a process that reduces the work burden for the provider, the burden placed on the patient or the caregiver in the middle to resolve it, ultimately, fixes the care for the patient who is at the end of the line waiting for something that they need that insurance is blocking.

Jim Jirjis
Jim Jirjis here. Can I make a quick comment? The one area that is a little tweaked on is in the hospital. So, many of these we call prior auth as if something can't happen until all of this is done. The one arena that is different is the hospital where patients actually admitted through the ER, for example, not electively and, in fact, after the fact, people are trying to get authorization, if you will because it, by definition, couldn't be prior. And I think that is a different set of dynamics because it's really fighting over whether people are going to pay for something or not.

Alix Goss
It seems to me that that's a really great way to kind of build on this idea of getting the basics. Build out this prototype for the stuff we've already identified we've missed and then, get that agreed to and have a happy path. And then, start to build that out for the specialty sort of frameworks that we've been discussing. And also, all of the failure points. Gus?

Gaspere C. Geraci
Yeah. This is Gus Geraci. Thank you, Alix. I think one key issue here is I'm an absolute believer in transparency. However, sometimes, the items requested for prior auth are inappropriate. And the physician then has the burden of explaining why they're asking for something that actually is inappropriate for the patient. The assumption that somehow things are being denied for payment by the evil insurance company ignores the fact that a lot of denials are completely appropriate. And that denial is sometimes damning to the provider because they, basically, asked for the wrong thing or were trying to do something that is not under current standards of care. And then, my second comment is, I think, to try and create a general prototype process without dividing it into all of the different nuances of inpatient, outpatient, drug, prior auth, DME, etc., has to start with who is your insurance company.

Just one example given, observation, the observation contract by an insurer may be very different. Some pay a standard fee for observation no matter what it's for. And others pay on an adjusted fee for service basis for every item done during observation. So, and I apologize for my dog. The first question is matching the patient to the insurer. And then, following the path that that insurer's criteria are in place because if

something requires prior auth, it may require prior auth by one insurer and not another, which is also an extreme.

Alix Goss
Thank you. I think, Jim Jirjis.

Jim Jirjis
Yeah. I wanted to comment on that. Those are great points. I think the point about the reason for denial so, in the hospital, for example, 62% of denials are overturned for us. So, there is rich opportunity there to say wow, couldn't we have a system that made that 62% or at least some fraction of that go away. So, you're right. So, 38% don't go away and maybe they're inappropriate services perhaps. But if you look at Figure 6, part of it was whether it's outpatient medications, whether it's inpatient, getting a granular enough reason for why the denial occurred empowers the provider to have an intelligent conversation with the patient or to learn and understand what was missed or what was not documented appropriately. So, I just want to echo both points. I think we'll either help where denials are inappropriate or we'll empower the providers with the information they need to actually explain or change the behavior.

Gaspere C. Geraci
And Jim, this is Gus. If I can just jump in. If you're getting 62% overturned, I hate to say this –

Jim Jirjis
Yes, we are.

Gaspere C. Geraci
As an insurance guy, look at what you're submitting to make sure that what you're submitting is rich enough to get approval from the get-go. But I'm sorry to interrupt.

Jim Jirjis
It gets back to the timing issue that I mentioned earlier. For example, information, at a certain point in time, doesn't have all of the information and is a denial and then, the information comes later. That's what I meant by the timing issues are really important when we're automating. That's what I mean.

Gaspere C. Geraci
Sure. And it can entirely be a process issue because insurers are under a very tight timeframe to get approvals. And the default when insufficient information is given or available is denial.

Jim Jirjis
Yeah. I think that's something for follow up, too. The external pressures that we hear pressures insurance companies to prematurely make a denial decision that creates additional burden on the provider. That should be some research behind this because that's driving behaviors that might be deleterious to our cause.

Gaspere C. Geraci
And, again, that's a process issue for you guys to figure out with the insurer that's doing that to you or all insurers that are doing it to you.

James Pantelas
It might also be an argument for including patients closer up to the front of the process because an awful lot of the denials that I've seen as a patient and as a caregiver happen because things are left off of the initial application that would have been caught had I seen it.

Alix Goss
Thank you, whoever that last speaker was. But I didn't recognize your voice.

James Pantelas
I'm sorry. It's Jim Pantelas.

Alix Goss
No worries, Jim. I'll learn it soon enough. Lauren, I note that we are officially at the period of public comment although we still have hands up. Please indicate how you want to proceed.

Lauren Richie
Yeah. Why don't we take this moment to just transition to the public comment? If we could pull the phone number up please and then, operator, if we could open the public line and we'll see if we have any public comments.

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

Lauren Richie
Okay. We'll just remind members of the public that during the last few minutes or so, in the lower-left corner of the Adobe, the public comment phone number will be available. If we get any additional comments, Alix, I will let you know. But I'll turn it back to you for the last eight minutes or so.

Alix Goss
Thanks so very much. Actually, I want to make sure that the Jim, Jim, and Gus conversation got wrapped up before I pivot to Mary Greene. Gentlemen, did you have anything else you wanted to add on that thread?

Jim Jirjis
Not me.

James Pantelas
I'm good.

Alix Goss
So, Mary, it's all yours.

Mary Greene
Actually, I was just going to comment on what we were talking about before so it's, essentially, been said. I agree that a certain number of the denials or portion of the denials are that the submissions are not complete. And I think that just speaks to what many people have been saying already is the requirements need to be understood up front early in the process to try to avoid some of that. There is no question that it happens. And I was going to mention also that we heard many stories about a beneficiary who just happens to understand the prior authorization process really well couldn't get herself inserted into the process to find out what was going on and what was actually being submitted. And she, herself, when she was able to get inserted into the process, realized that there was some information about her background that was missing from the submission.

She thought if she were involved early on, if the transmission was transparent, she might have been able to help. Beneficiaries vary on how involved they want to be, of course. But that was pretty telling, too, that she might have been able to speed up the process if she were involved. The other question I had was just going back to the issue of transparency and just mentioning that with a payer and provider conversation, some of that is the provider may be realizing that their approach might not be the best approach. And I wonder if transparency, even with the beneficiary in the loop there, could help. I don't know how strongly I feel about that one way or the other. But I feel like the patient probably should be considered a partner in all of those conversations. And so, everybody is getting smarter and everybody is getting better. But what's the plan perspective there? Would you be reticent to have that kind of conversation if the beneficiary was part of that information flow?

Alix Goss
It's better **[inaudible] [01:20:36]**. Mary?

Mary Greene
What's that?

Alix Goss
I wasn't sure who you were asking that question to and you were going back to the conversation with Gus or just –

Mary Greene
Oh, sorry. I'm not sure who it was that was speaking to the plan's perspective and how sometimes the conversation is really that the physician might not be doing the right thing and that was the reason for the denial.

Gaspere C. Geraci
That's me, Gus Geraci.

Mary Greene
Sorry, Gus. Thank you.

Gaspere C. Geraci

I've been on both sides of this sad, sad state. So, I think, again, being a believer in transparency, I think it is necessary for the patient or representative to be involved. But I think we have to, again, be careful about how that occurs and where it occurs because I believe it should be closer to the front rather than the back, basically, the information that's being submitted to make sure that it is complete. Because what I've heard now several times, and I'm horrified by some of the stories having worked for multiple insurers, I can't believe the wheelchair took a year, but anyway, I will tell you in my personal experience when I've gone to a hearing, which is kind of the last step, you go before an administrative law judge, the times that I have personally overturned a decision was when I learned something new in the administrative law judge hearing where I was told something that I had never heard up to that point. Because sometimes, that is the first time that the patient actually gets involved.

So, I agree with some involvement and, again, with transparency. But I think we have to tread carefully because I've had conversations with providers in peer-to-peers where I had to explain to them that they were practicing medicine that was from 30 years ago.

Mary Greene
Thank you. I appreciate that.

James Pantelas
Don't you think that that would be important for a patient to know?

Gaspere C. Geraci
Well, that's a whole other discussion.

James Pantelas
But it's part of the – we're the ones that are paying for the service, ultimately, if we pay for insurance. And if we have a provider that's practicing medicine as it was practiced 30 years ago and that would be deemed significant to deny, shouldn't the patient know that? I don't know why that would be hidden from the patient and why that wouldn't be malpractice.

Gaspere C. Geraci
I'm not suggesting that it should be hidden. I'm merely suggesting that we have to tread carefully.

James Pantelas
Okay.

Alix Goss
I believe we have about three minutes left and Denise has been very patient with her hand up. So, I'm going to turn it over to you, Denise.

Denise Webb
I just was thinking about the comments that Jim and Mary had about the role of the beneficiary or the patient in this whole process. And I just wanted to chime in and say that I really think, oftentimes, patients are left out on both the payer side and the provider side in terms of how they can be empowered and have a role. And starting with the payer's side, I just know from myself, personally, it is really helpful to have information

about really straight forward, transparent information about what does require prior authorization in your benefits plan and have that easily accessible and, actually, have the payer engage the beneficiary in a partnership. So, I think it would be really great if we do illustrate the role of the beneficiary/patient in this process.

Alix Goss
Thank you. This has been really a great conversation today. We have a lot of themes around trust and transparency and the process. We have patients being at the center of all of this with their caregivers and really helping them to be an integral part of a future happy path. And I keep wanting to weave in here metrics that delight because I just think it's a phenomenal phrase. And I think that we have a prototype that needs to evolve and really to have a full reflection of the common pieces that can then be broken down to add any nuances related to specialties. And if we can get those happy path common pieces defined, we can then, evolve the framework along with the failures that we need to identify and mitigate. But also, I'm hearing that there may be a set of general principles about what we expect the new perfect world of prior auth to actually accomplish.

So, we have our homework cut out for ourselves within the next week or so to produce some additional prototypes. I'm grateful that Jim and Jim and Alexis and Carolyn volunteered. I think Jocelyn half volunteered or at least offered some NCPDP UML examples that we might be able to leverage. So, if I've missed any volunteering, please let me know. If you think I've missed any key themes, certainly, let us know. The team will be meeting after this call to think about all of the wonderful input that we got today and to create some discussion documents for our next meeting, which will be a week from today. And thank you all for your time. We look forward to seeing you our hearing you on the 24th. With that said, I believe we can call the question.

Lauren Richie
Thank you all. Have a great day.