Considerations for Improving Prior Authorization

February 26, 2019

Agenda

- **Welcome, Prior Authorization Collaborative Overview**
  - Jennifer Covich Bordenick, CEO, eHealth Initiative
- **Pain Points Around Prior Authorization**
  - Jon Zimmerman, athenahealth (Vendor Perspective)
  - Steven Waldren, MD, VP and Chief Medical Informatics Officer, American Academy of Family Physicians (Healthcare Professional Perspective)
- **Considerations Around Prior Authorization**
  - Anupam Goel, MD, Chief Health Information Officer, Clinical Services, UnitedHealthcare (Payer Perspective)
  - Robert Tennant, Director, Health Information Technology Policy, MGMA (Healthcare Professional Perspective)
- **What's Next**
  - William Thorwarth, MD, CEO, American College of Radiology (Healthcare Professional Perspective)
  - John Fleming, MD, Deputy Assistant Secretary of Health IT Reform, Office of the National Coordinator (ONC) (Policy Maker Perspective)
  - Foong-Khwan Siew, PhD, MBA, Director, eValue8, National Alliance of Healthcare Purchaser Coalitions (Employer Perspective)
  - Sagran Moodley, SVP, Clinical Data Services, UnitedHealthcare; Chairman, HL7 Da Vinci Steering Committee; Co-Chair, DRLS Medicare Fee for Service Prior Authorization Pilot (Payer Perspective)
- **Q&A**

Housekeeping Issues

- All participants are muted
  - To ask a question or make a comment, please submit via the Q&A feature and we will address as many as possible after the presentations.
- Q&A and Technical difficulties:
  - Use the chat box for technical difficulties and we will respond as soon as possible
  - Use Q&A box for your speaker questions
- Today's slides will be available for download on eHI's Resource page www.ehidc.org/resources

This Webinar is Generously Supported by

Our Mission

Convening executives from every stakeholder group in healthcare to discuss, identify and share best practices to transform the delivery of healthcare using technology and innovation.

Our Members

eHealth Resource Center www.ehidc.org/resources

- eHealth Resource Center Available With Best Practices & Findings Identifying and Disseminating Best Practices
- Online Resource Center: Over 600 new pieces content, 125 best practices added this year
- Most recent released eHI Reports: Cybersecurity, Predicting Risk through AI, Patient Generated Health Data

Prior Authorization Collaborative Overview

Jennifer Covich Bordenick
CEO, eHealth Initiative Foundation

Purpose of Collaborative

- Focus on improving, reforming, and streamlining the prior authorization process
- Aim to leverage technology and gain access to clinical guidelines and payer rules at the point of care to request and execute prior authorization
- Reduce physician burden, improve clinical outcomes, and increase patient satisfaction

Outline concepts to achieve meaningful improvements in the prior authorization process in *Considerations for Improving Prior Authorization*

Public & Private Sector Initiatives

Private and Not-For-Profit

- eHealth Initiative Prior Authorization Collaborative
- American Medical Association's (AMA) Prior Authorization Reform Workgroup, Prior Authorization and Utilization Management Reform Principles, and Prior Authorization Consensus Statement
- CAQH CORE's Operating Rules for Prior Authorization
- The Smart Prior Authorization (SPA) Solution from the Medical Society of Delaware, Delaware Health Information Network (DHIN) & Haven Health Solutions
- HL7 Da Vinci Project's 'Coverage Requirements Discovery' & 'Documentation Templates and Coverage Rules' use cases
- American College of Radiology's Appropriateness Criteria
- Workgroup for Electronic Data Interchange's (WEDI) Prior Authorization Workgroup
- Point of Care Partners' (POCP) Electronic Prior Authorization Industry Recommendations

Government

- ONC Payer + Provider (P2) FHIR Task Force
- 21st Century Cures Act – Report on Reduction in Clinician Burden
- CMS Documentation Requirement Lookup Service (DRLS)
- CMS Non-Emergent HBO Therapy Prior Authorization Model
- CMS Repetitive, Scheduled Non-Emergent Ambulance Transports Prior Authorization Model

Timeline for Collaborative

February 2018
- eHealth Initiative Executive Summit Held Value Based Care Roundtable, Identified Prior Authorization as Key Area, Discussed Pilot Program

Spring 2018
- Discussed potential pilots, conducted research, reconvened groups to try to develop principles or multi-stakeholder recommendations first.
- Conducted research on best practices and current initiatives

Sept-Nov 2018
- Improving Interoperability through Prior Authorization Workshops held in September, October, November
- Shared examples of pain points, data on initiatives, best practices
- Creation of first draft of considerations document

January 2019
- Simplifying Prior Authorization Executive Roundtable
- Prior Authorization Collaborative Virtual Meeting

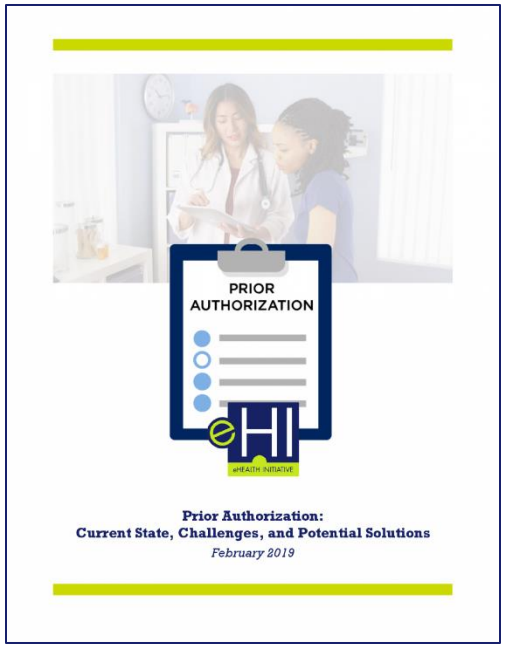
February 2019
- Finalization of Considerations for Improving Prior Authorization Document

March-
- Pilot Projects, Best Practices, Cost Transparency

Participants in Collaborative

- American Academy of Family Physicians (AAFP)
- America's Health Insurance Plans (AHIP)
- American College of Cardiology (ACC)
- American College of Radiology (ACR)
- American Heart Association (AHA)
- Automated Clinical Guidelines
- Council for Affordable Quality Healthcare (CAQH)
- Change Healthcare
- Delaware Health Information Network (DHIN)
- DirectTrust
- eHealth Initiative Foundation
- EnableCare, LLC
- eviCore Healthcare
- GE Healthcare
- Haven Health Solutions
- Highmark
- Health Level Seven International (HL7)
- Kaiser Permanente
- Marshfield Clinic
- Medical Society of Delaware
- Medical Group Management Association (MGMA)
- National Alliance of Healthcare Purchaser Coalitions
- Office of the National Coordinator for Health Information Technology (ONC)
- Point of Care Partners
- Stratametrics, LLC
- UnitedHealthcare
- Virence Health
- Workgroup for Electronic Data Interchange (WEDI)

Available for Download Now



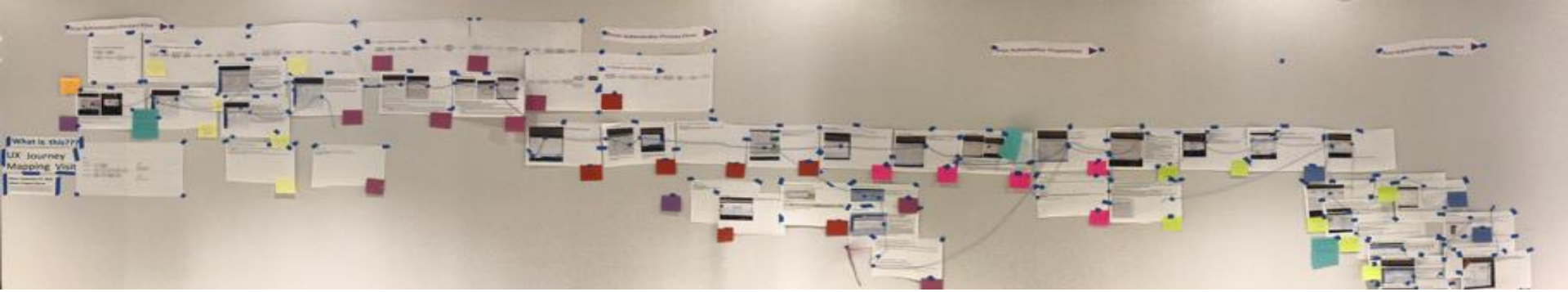
https://www.ehidc.org/priorauth

Pain Points Around Prior Authorization

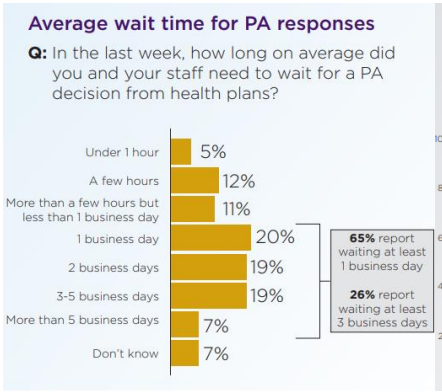
Jon Zimmerman

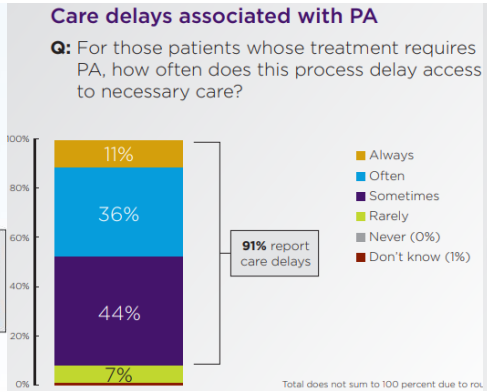
Athenahealth

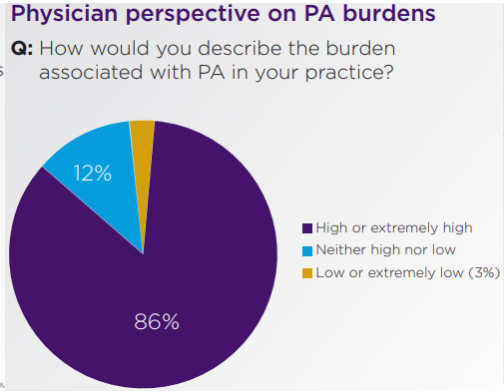
(Formerly GE Healthcare)

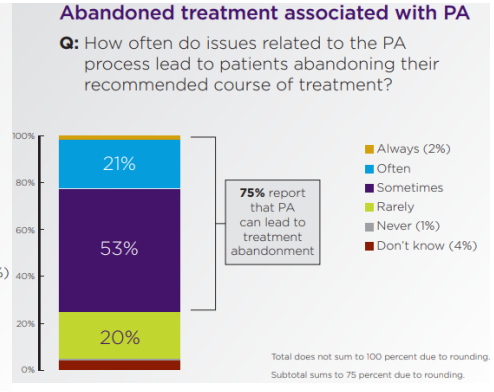


Customer Journey Map to Submit ONE Prior Auth









Source: 2018 AMA Prior Authorization Physician Survey

Pain Points Around Prior Authorization

Steven Waldren, MD

VP and Chief Medical Informatics Officer
American Academy of Family Physicians

Prior Auth and Paperwork

Source: 2018 AAFP Member Survey

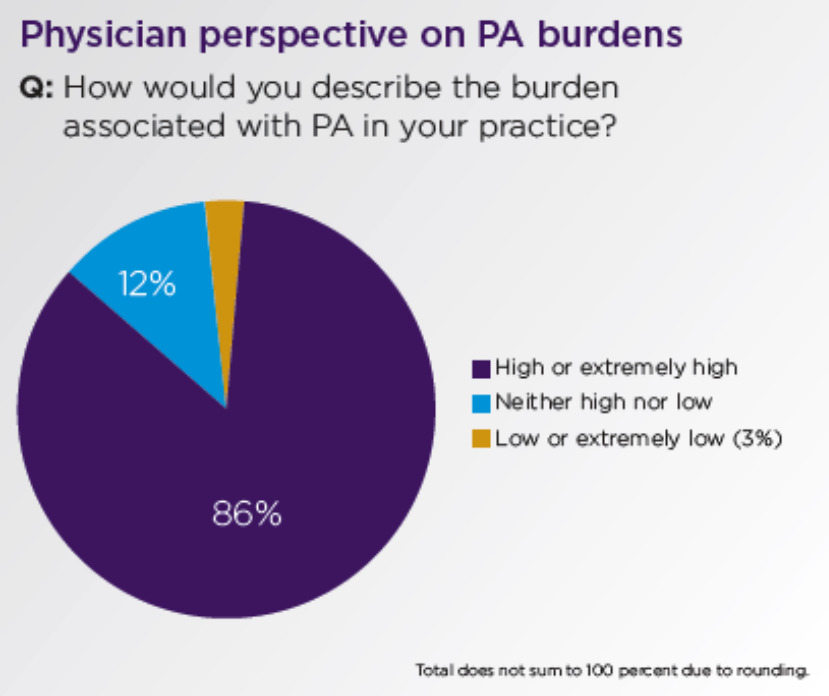
TOP 12 CHALLENGES

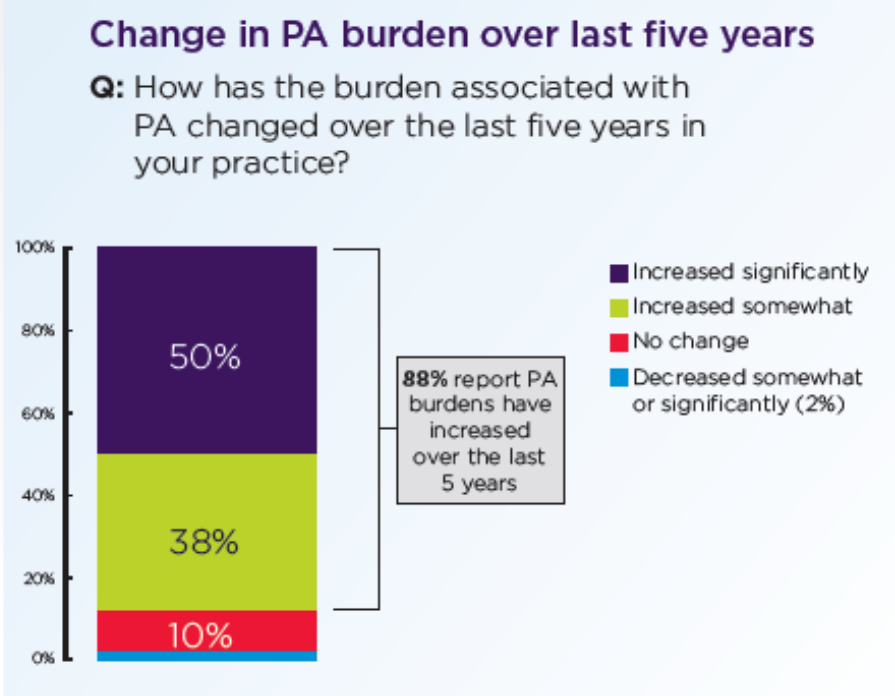
What are the three greatest issues or challenges you are facing today in your daily practice of medicine?

	Percent of Respondents	N
Administrative burden/paperwork	43.5%	754
Reimbursement/payment/salary	32.7%	566
EHR/EMR	29.8%	516
Burnout/physician wellness	20.8%	360
Government/other regulations	19.8%	343
Insurance issues	19.5%	338
Workload	12.0%	207
Access to healthcare	11.2%	194
Prior authorization	10.3%	178
Nurse practitioners/PAs/Mid-levels	10.1%	175
Certification/recertification/Maintenance of Certification (MOC)	10.0%	173
Time with patients	9.1%	157
None	3.3%	58

Physician Impact

Source: 2018 AMA Prior Auth Physician Survey



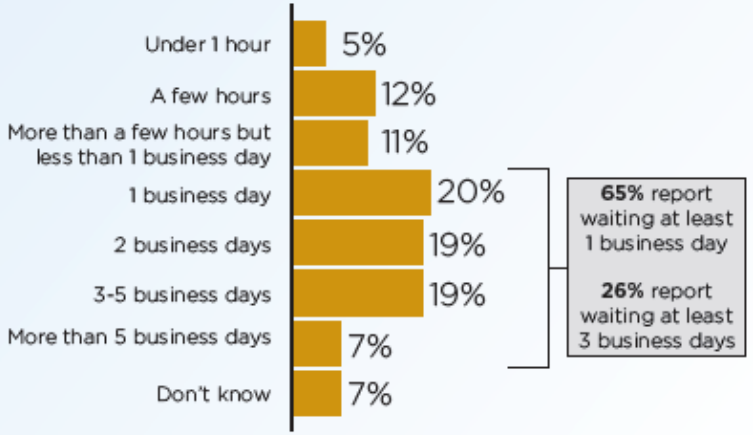


Patient Impact

Source: 2018 AMA Prior Auth Physician Survey

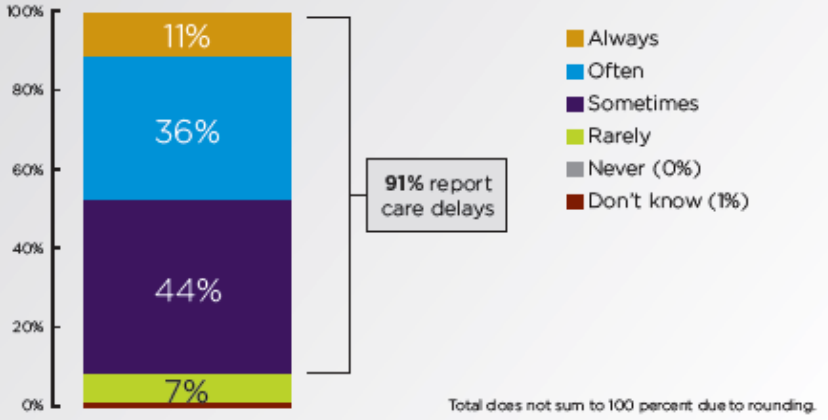
Average wait time for PA responses

Q: In the last week, how long on average did you and your staff need to wait for a PA decision from health plans?



Care delays associated with PA

Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



In your experience, has the PA process ever affected care delivery and led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient in your care?

28% reported PA led to a serious adverse event

Considerations for Prior Authorization

Anupam Goel, MD
Chief Health Information Officer
Clinical Services
UnitedHealthcare

Robert Tennant
Director
Health Information Technology Policy
MGMA

Consideration 1

Transparency of payer policy and evidence-based clinical guidelines available at the point of care will, in many cases, reduce the need for prior authorization and minimize care delays.

Consideration 1: What It Means

- The availability of eligibility, benefits coverage, clinical guidelines, payer documentation requirements, and patient financial responsibility at the point of care would facilitate the most appropriate decisions made by healthcare professionals and their patients. It should, however, be done in a way that reduces the burden on ordering healthcare professionals.

- When evidence-based clinical guidelines are presented within electronic health records (EHRs), healthcare professionals are more likely to order tests concordant with the published guidelines.

Consideration 1: What It Means (Cont'd)

- If payers were to designate certain evidence-based guidelines for integration into EHRs, prior authorization could be reduced to instances where healthcare professionals recommend services inconsistent with or not addressed by the evidence-based guidelines. Identification of such gaps in indication coverage will facilitate expansion of available guidelines.
- The American College of Radiology, American College of Cardiology, and other physician-led organizations have published evidence-based guidelines to help healthcare professionals determine the most appropriate tests to order in specific instances. The consultation of Appropriate Use Criteria (AUC), even when unneeded for coverage and if no procedure/treatment is performed, should be documented for system analysis and improvement when it is performed.

Consideration 1: What It Means (Cont'd)

- Additionally, integrating medical and pharmacy benefits information into vendor systems improves the transparency of that information for healthcare professionals and for administrative staff who are responsible for securing prior authorizations. **Accomplishing this task is incumbent on all stakeholders as no single stakeholder can do this alone.**
- Improvements in data interoperability and data science should facilitate processes and data sharing that reduce or eliminate the friction associated with the prior authorization process and enable monitoring of transactions. Any potential out-of-pocket costs for which the patient would be responsible should also be included at the point of care.

Consideration 2

Reducing the overall volume of services and drugs requiring prior authorization could decrease administrative burdens and costs for all stakeholders.

Consideration 2 (Cont'd)

As long as care continues to be consistent with evidence and the person's insurance coverage, prior authorization may not be needed (or needed as frequently) for :

- Patients who are taking medications chronically
- Patients undergoing repeat procedures and deemed by their healthcare professional to be medically stable
- Medications and procedures with low denial rates
- Healthcare professionals who historically meet prior authorization criteria regularly (sometimes referred to as "gold carding") with monitoring for continued qualification
- Healthcare professionals who are participating in risk-based payment contracts

Consideration 3

Payers, healthcare professionals, and vendors should use existing, industry-endorsed standards whenever possible and explore incorporating new electronic standards that have the capability to improve the prior authorization process.

Existing Standards:

- HL7 V2.x, V3, CCD
- DIRECT Messaging
- EDI (x12 278)

Emerging Standards:

- HL7 FHIR
- SMART (on FHIR)
- CDS Hooks

Consideration 3 (Cont'd)

- Use existing standards.
- Urge the government to augment existing standards and develop new standards, when appropriate, to improve the prior authorization process.
- As new standards and operating rules are endorsed, all members of the healthcare marketplace should outline an implementation roadmap to help partners update their own processes to move the industry forward.

Consideration 4

Payers and healthcare professionals should explore alternative payment models that **promote bundled authorization** for procedures, medications, and durable medical equipment that are associated with a particular episode of care.

Consideration 4 (Cont'd)

- Bundled authorizations could reduce the volume and burden of prior authorizations.
- Bundled authorizations may require payers and pharmacy benefit managers to coordinate their approval processes to minimize the administrative burden to ordering providers.

What’s Next

What's Next

For Healthcare Professionals:

William Thorwarth, MD

CEO

American College of Radiology

For Policymakers:

John Fleming, MD

Deputy Assistant Secretary of Health IT Reform

Office of the National Coordinator

For Employers:

Foong-Khwan Siew, PhD, MBA

Director, eValue8

National Alliance of Healthcare Purchaser Coalitions

For Payers:

Sagran Moodley

SVP, Clinical Data Services UnitedHealthcare; Chairman, Da Vinci Steering Committee; Co-Chair, DRLS Medicare Fee for Service Prior Authorization Pilot

DA VINCI PROJECT UPDATE

HIMSS19

Project Challenge

To ensure the success of the industry's **shift to Value Based Care**

Pre-Collaboration / Controlled Chaos:

Develop ***rapid multi-stakeholder*** process to identify, exercise and implement initial use cases.

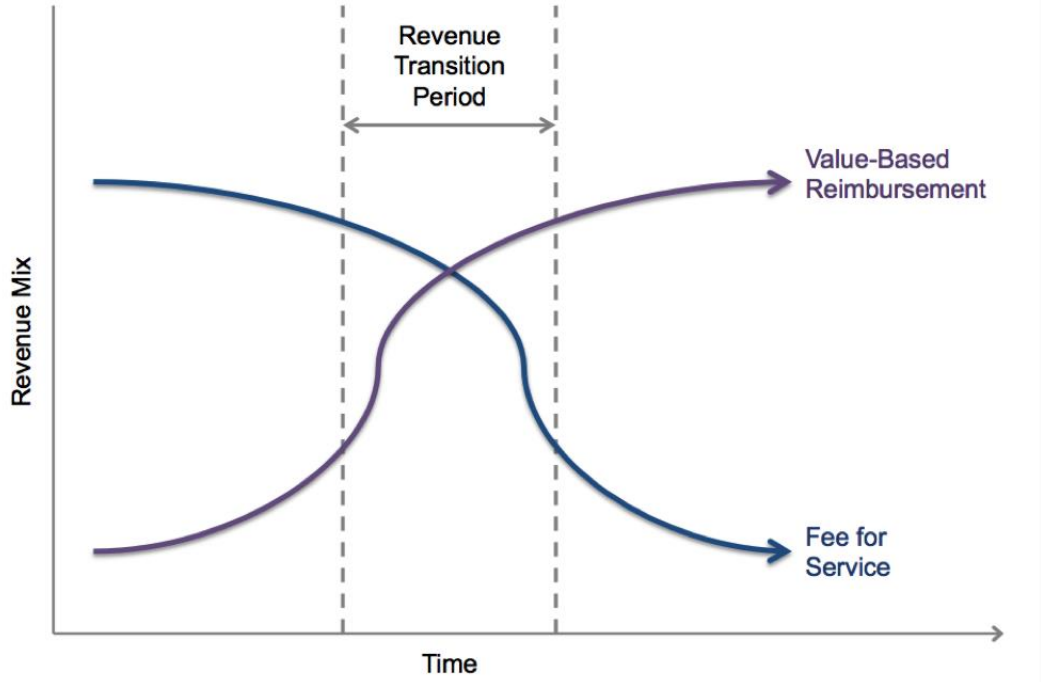
Collaboration:

Minimize the development and deployment of ***unique solutions.*** ***Promote*** industry wide ***standards*** and adoption.

Success Measures:

Use of FHIR®, implementation guides and pilot projects.

Empower End Users to Shift to Value



As a private industry project under HL7 International, Da Vinci will unleash critical data between payers and providers required for VBC workflows leveraging HL7® FHIR®

Source: © 2018 Health Catalyst

Founding Members

Members have begin to implementing use cases.

Da Vinci Members

Premier Members

Anthem

BlueCross BlueShield Association
An association of independent Blue Cross and Blue Shield companies

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

CAMBIA HEALTH SOLUTIONS

Blue Cross Blue Shield Blue Care Network of Michigan

OPTUM

UnitedHealthcare

Associates

Allscripts

of Tennessee

Cerner

Epic

GUIDEWELL

Humana

virence

For current membership: http://www.hl7.org/about/davinci/members.cfm

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edifecs

HealthLX

Independence

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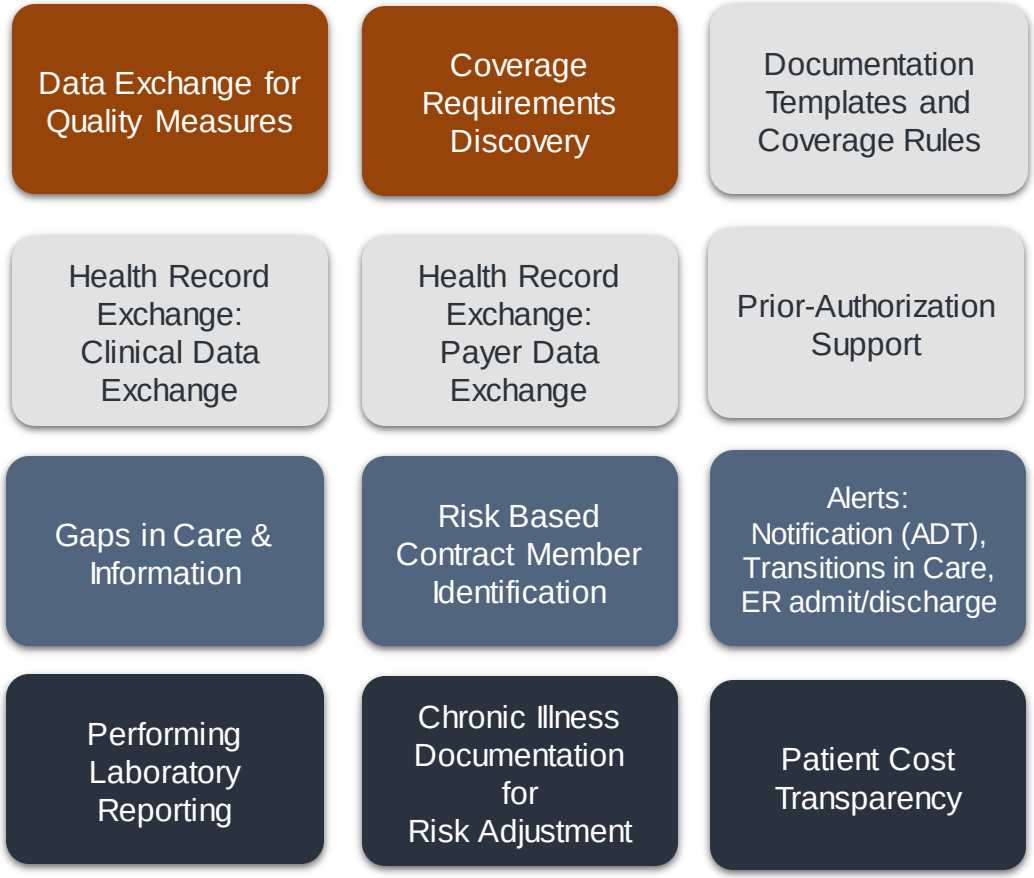
Use Case Alignment



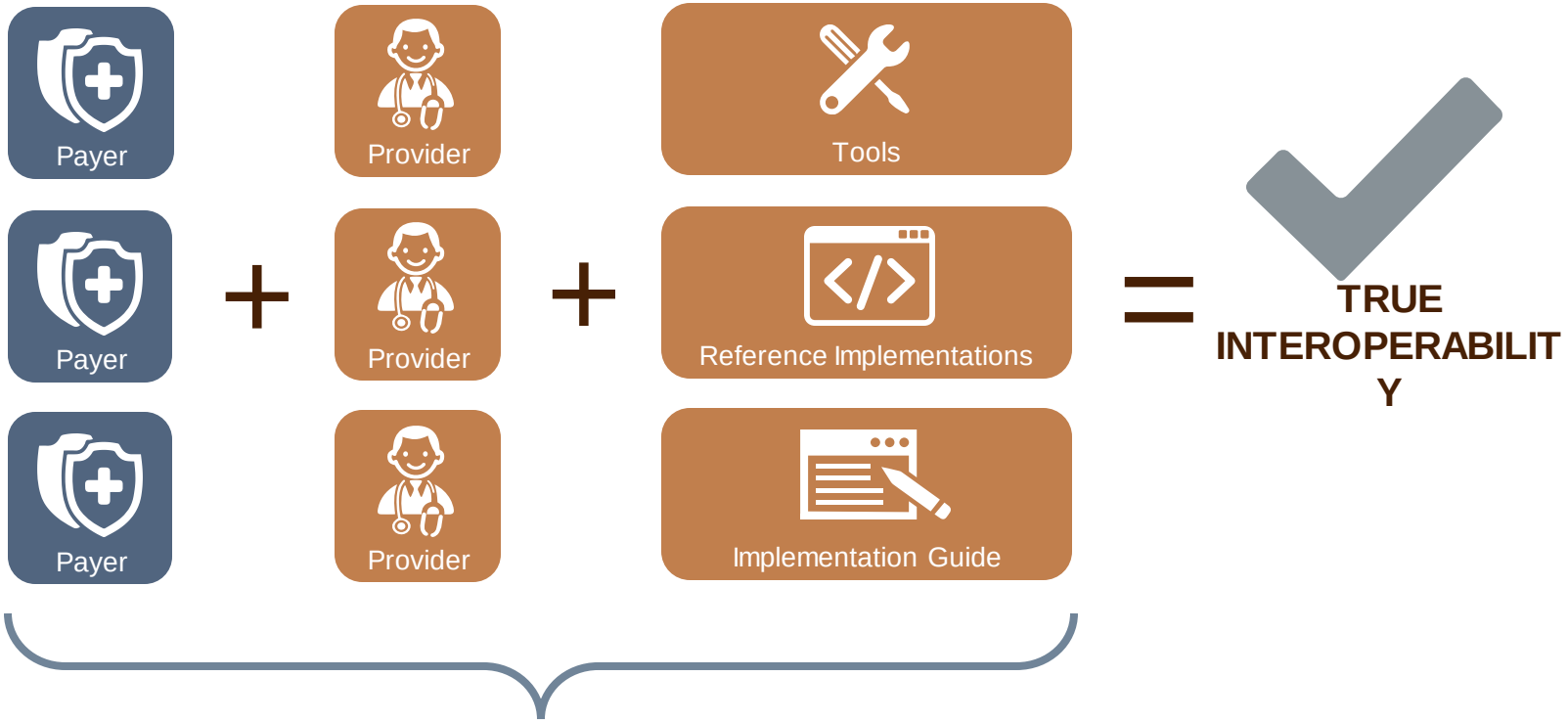
Project Outputs

- ❑ Define requirements (technical, business and testing)
- ❑ Create Implementation Guide
- ❑ Create and test Reference Implementation (prove the guide works)
- ❑ Pilot the solution
- ❑ Deploy the solution

Use Case Status

- In HL7 ballot reconciliation as draft standard
- Under active development
- Planned 2019 Use Cases
- Future Use Case

Progress Toward End Goal



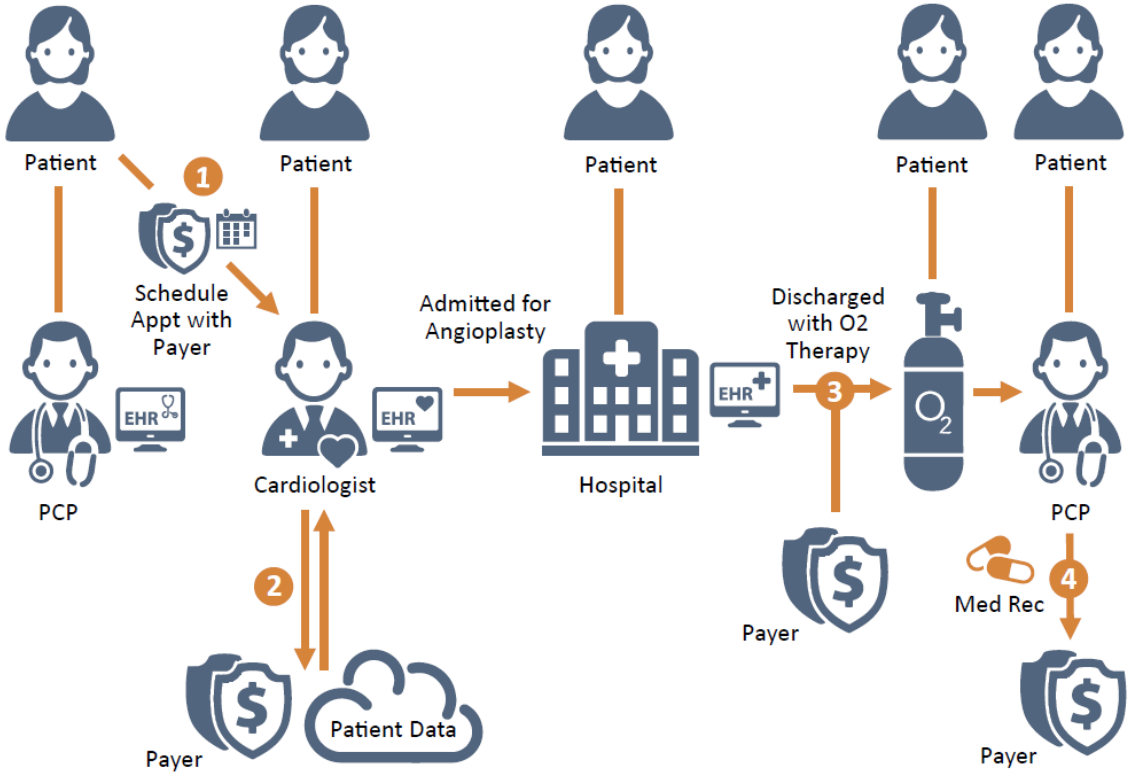
Build Your Implementation Success Story

2019 In Flight Use Cases

DRLS Vision	DRLS Goals
Reduce documentation errors and expedite accurate submission by streamlining workflow access to DME coverage and documentation requirements	Develop and test a prototype Medicare Fee for Service (FFS) Documentation Requirement Lookup Service (DRLS) for durable medical equipment (DME) coverage and documentation requirements by mid 2019 to reduce provider burden, reduce improper payments and appeals, and improve "provider to payer" information exchange

- DRLS will allow providers to discover prior authorization and documentation requirements at the time of service in their electronic health record (EHR) or integrated practice management system through electronic data exchange with a payer system.
- CMS is spearheading these efforts and participating in two workgroups hosted by HL7 and ONC respectively to promote development of standards supporting the Medicare FFS DRLS, thereby helping define the requirements and architect standards-based solutions.

HIMSS19 Interoperability Showcase



Follow Progress, Develop, Test, Implement

Da Vinci Resources

- Listserv signups
- Background collateral
- Draft Implementation Guides
- Reference Implementation links

HL7 Public Confluence Site - https://confluence.hl7.org/display/DVP/

General Comments or Recommendations on CMS Document Requirement Lookup Service?

- Monitor DRLS progress or for information on upcoming SODF calls: go.cms.gov/MedicareRequirementsLookup
- Send feedback and suggestions on the Documentation Requirement Lookup Service - MedicareDRLS@cms.hhs.gov


Q&A

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