NEHI Network for Excellence in Health Innovation

Massachusetts Health Data Consortium

Automating Prior Authorization Across Massachusetts: We can do this, together

Network for Excellence in Health Innovation &
Massachusetts Health Data Consortium

Wednesday, May 24 | 11:30am-1:00pm ET

Housekeeping

We are recording the meeting. The recording and slide deck will be made available on the NEHI and MHDC websites.

We have allotted 15 min at the end for Q & A. Please use the Zoom Q & A feature to submit your questions for the panelists.

Agenda

1. Why Automation?
2. Automation Explanation
3. Panel 1: Automation Technology
4. Implementing Automation in Massachusetts
5. Panel 2: Stakeholder Reactions
6. Audience Q & A

Massachusetts Health Data Consortium

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Massachusetts Health Data Consortium

MHDC's **vision** is a patient-centered health data economy that engages individuals to manage their health as they see fit.

MHDC's **mission** is to be a trusted facilitator of the health information and technology transformation required to achieve a person-centered health data economy.

Network for Excellence in Health Innovation

NEHI's **vision** is to be a trusted voice in shaping policies and activities that address unmet needs, drive better health outcomes, and provide equitable access to effective innovations.

NEHI's **mission** is to solve complex problems and achieve value in health care by fostering interdisciplinary collaboration and innovation.

Lauren Bedel, MPH

Senior Health Policy & Program Associate

Network for Excellence in Health Innovation

Denny Brennan

Executive Director & CEO

Massachusetts Health Data Consortium

David Delano

Senior Director

Massachusetts Health Data Consortium

&

Executive Director

New England Healthcare Exchange Network Inc

Wendy Warring, JD

President & CEO

Network for Excellence in Health Innovation

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Why Automation?

NEHI examined issues related to the PA process & prioritized solutions based on stakeholder consensus

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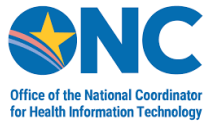
Issues Considered

- Frequency with which PA is applied
- Variation among payers in services/pharmaceuticals subject to PA
- Variation in PA criteria
- Variation in documentation required by plans to satisfy medical necessity

Identified Solutions

- Create incentives for full automation of PA
- Embed care pathways/utilization management on a condition basis
- Remove multiple and repeat PAs for a continuous course of treatment
- Expand use of family/group codes
- Share data that incentivizes collaborative change
- Establish processes that require collaboration
- Create economic incentives to reduce PA
- Remove PA for certain services with high rates of approval
- Remove PA for certain physicians based on their performance (gold-carding)
- Remove PAs for physicians in ACOs or risk-based arrangements
- Substitute payer PA with use of clinical decision support tools

NEHI & MHDC's project tested automation receptivity and requirements with the goal of automating in 2 years



Commonwealth of Massachusetts
Executive Office of Health and Human Services

Health New England

Primary project activities

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01

Aligned stakeholders on end-to-end automation definition and workflow

02

Assessed stakeholder implementation concerns and priorities

03

Shared draft recommendations with advisory group prior to finalizing

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'Thank You' to our project sponsors

CHANGE HEALTHCARE

cohere HEALTH

HOOK

MASSACHUSETTS HEALTH POLICY COMMISSION

ZeOmega

Defining Prior Authorization Automation

What is “automation” of prior authorization?

- Adoption of an end-end prior authorization request (i.e., request → response) completed electronically using a defined set of data exchange standards and technologies
  - Process exhibits little or no need for human intervention
  - The same data standards are used by the entire community
- Automation is not the same as digitization
  - The use of web portals or interactive voice responses is not “automation”

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Simplified end-end automation workflow

01

Provider decides on an order/ treatment/etc.

02

Prior authorization & coverage requirements automatically shared between Payer & Provider systems

03

Payer gathers information for the prior authorization request from the Provider's EMR

04

Provider has the opportunity to review the data that was automatically pulled from the EMR

05

Payer/Intermediary processes request & Payer sends decision

06

(Possible) Payer requests additional info/documents from Provider

Benefits of an end-end automation workflow

01

Provider decides on an order/ treatment/etc.

02

Provider receives immediate response as to whether prior authorization is required or not

03

Data needed to satisfy medical necessity criteria is pulled automatically from the EMR, eliminating the need for manual data entry in most cases

04

Documentation is submitted electronically, rather than via telephone or facsimile, saving both provider and payer time

05

Decision is sent to the EMR in real time, reducing delays in patient care

Enabling automation

- **Application Programming Interface (API):** Connects apps via web-based standards
  - Example: Travelocity
  - In context: Provider's Clinical Decision Support (CDS) API connects to the payer's API service and pulls information and options based on the patient & request to determine whether PA is needed

- **Fast Healthcare Interoperability Resource (FHIR):** A framework of structured data definitions organized into 'resources' for APIs to use as stand-alone data exchanges or integrated with other web-based services
  - Defines data elements
  - Serves as the transport mechanism
  - In context: Provider can launch a SMART on FHIR App from the EMR that can automatically pull data satisfying the payer's medical necessity criteria and auto-populate the questionnaire

CMS is advancing interoperability & requiring PA process changes, including automation

- **Requires all impacted payers to implement and maintain a FHIR based* Prior Authorization Requirements, Documentation, and Decision (PARDD) API**, a Provider Access API, changes to the Patient Access API, and Payer-to-Payer Data Exchange

- The proposed rule also includes calls for data reporting that would increase transparency and understanding of the efficiency and efficacy of the PA process and API usage

- Proposed rule (CMS-0057-P)
  - Released 12/6/22
  - Comment period closed 3/13/23
  - Effective 1/1/26 (2.5 years)
- Applies to:
  - Medicare Advantage (MA) organizations,
  - State Medicaid and CHIP FFS programs,
  - Medicaid managed care plans
  - CHIP managed care entities
  - QHP issuers on FFEs

*DaVinci IG's are not required but HIGHLY recommended

The industry has been testing & refining automation of PA with increasing support

- **Health Level 7 (HL7)** is a standards developing organization for the exchange, integration, sharing, and retrieval of electronic health information
- Offers members and participating organizations opportunities to participate in workgroups, projects, & initiatives
- Several demonstration projects are live today using some variations of the standards

- The **Da Vinci Project** has developed implementation guides (IG's) for automating PA workflow specifically the CRD, DTR and PAS IG's
  - In continual development setting the baseline for automation methods
  - Not 'required' in the CMS Rule but HIGHLY recommended
- The Da Vinci Project is an HL7 FHIR accelerator project
  - Members include prominent payer, provider, and vendor organizations
  - Goal: to accelerate the adoption of FHIR standards across payers and providers

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Panel 1: Automation Technology

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Dave Delano (moderator)
Senior Director
MHDC

Executive Director
NEHEN

Kevin Carroll
Chief Growth Officer
Hook MD

Mike Gould
Associate VP, Interoperability Solutions
ZeOmega

Andrew Johnson
VP of Growth and Innovation
Change Healthcare

Niall O'Connor
Chief Technology Officer
Cohere Health

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Implementation!

Start Now: Prior Authorization Automation Implementation Timeline

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May 2023
TAAG (Phase 1) work is completed

Presentation of implementation strategy to HPC

Oct 2023
Conformance criteria complete

End-point directory drafted

Technology inventory completed

Task Force members confirmed

Responses to RFPs reviewed and vendor partners selected

Payer and provider participation agreements drafted

Apr 2024
First tranch of CRD* prototyping completed

Second tranche of CRD prototyping starts

Second tranche of participation agreements signed

Task Force meeting #2

Oct 2024
Third tranche of CRD* prototypes completed

First implementation of DTR/PAS** prototypes completed

Final tranche of participation agreements signed

Apr 2025
Third tranche of DTR/PAS prototyping (if necessary) complete

Site-specific transaction testing (Tranches 1, 2) starts

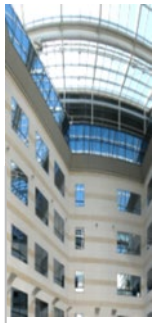
Initial reporting requirements complete

Oct 2025
Site-specific transaction testing (Tranches 3, 4) complete

Reporting testing complete

Site-specific production (Tranches 1,2) starts
















Jul 2023
Task Force roster complete

HPC ePA review and recommendations complete

RFPs to ePA vendors issued

Payer and provider conformance criteria drafted

Jan 2024
First tranche of participation agreements signed

First tranche of CRD* prototyping starts

End-point directory completed

Task Force meeting #1

Jul 2024
Second tranche of CRD prototyping completed

Third tranche of participation agreements signed

Third tranche of CRD prototyping starts

Jan 2025
Final tranche of CRD implementations complete

Second tranche of DTR/PAS prototyping completed

Funding support in place

Reporting requirements, aligned with CMS, completed

Jul 2025
Site-specific transaction testing (Tranches 1,2) complete

Site-specific transaction testing (Tranches 3, 4) starts

Reporting testing continues

Jan 2026
Site-specific production (Tranches 3, 4) starts

ePA production complete

CMS-aligned reporting complete

Implementation Planning Complete, Conformance Criteria Complete, and Task Force Convened → Participation Agreements, Funding Support and ePA Prototyping Complete → Site-Specific Transaction Testing Complete, Production and Reporting Begins

* CRD: Coverage Requirements Discovery will assist providers in submitting unnecessary PA requests to payers.

** DTR/PAS: Documentation Templates and Rules/Prior Authorization Support complete the automated exchange of documents and approval of requests.

Our project advisory group agreed upon the following:

- Massachusetts can and should take a leadership role in promoting the automation of prior authorization
- Implementation efforts should start now. Full compliance with federal directives will require at least the time allotted.
- The Da Vinci implementation guides are a strong base for an automation roadmap. There is no need to reinvent the wheel.
- Organization and coordination will improve implementation
- Providers and Payers will need technical and financial support in varying degrees.

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Panel 2: Stakeholder Reactions

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John Glaser, PhD (moderator)
Executive in Residence
Harvard Medical School

Barbara Spivak MD
President & Internist
Mount Auburn Cambridge IPA (MACIPA)

President
Massachusetts Medical Society (MMS)

Liz Leahy, Esq
Chief of Staff, Senior Vice President of Advocacy and Engagement
Massachusetts Association of Health Plans (MAHP)

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Questions & Answers

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Thank You!

Please take a minute to complete the poll on your screen.