The Automation Advisory Group Second Meeting

NEHI & MHDC

August 24, 2022

3:00-4:00 pm (EST)

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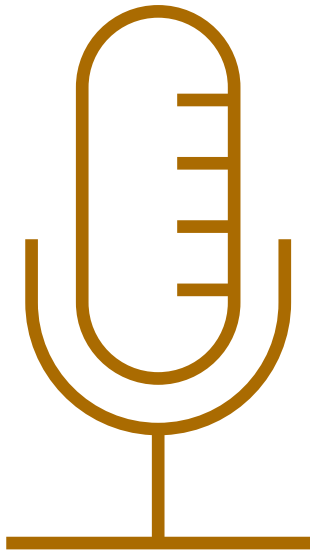
Agenda

Update on Project Activities (5 min)

Discuss Proposed Services for Review of Automation Requirements (10 min)

Discuss Details Associated with CRD (40 min)

Next Steps, i.e., homework! (5 min)

Housekeeping

- We are recording the meeting to ensure we capture the essential elements of the discussion

- We will delete the recording after our final report is completed

Project overview

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Goal

To make recommendations that result in the adoption of automated prior authorization among payers and providers in Massachusetts in the next two years

Phase 1: Formulation of Elements of End-End Automation

Phase 2: Stakeholder Assessment

- **Evaluate how participating payers and providers would implement the chosen use case(s)**
- Incorporate MHDC implementation prototype findings
- Interview stakeholders (20-25 interviews)
  - Technology service providers / vendors
  - Payers & providers
  - Personnel involved in proposing legislative & regulatory processes

Phase 3: Policy Recommendations

Will cover necessary incentives, including financial & technical assistance, rewards, & mandates

Phase 4: Dissemination

MHDC & NEHI joint public webinar

Organizations interviewed

Organizations	
BCBSMA	Hook
BMC HealthNet	MassHealth
Boston Children's Primary Care Alliance	Meditech
Change Healthcare	MGB
CMS	MHDC/NEHEN
Cohere	Mt Auburn Cambridge IPA
Community Care Cooperative	ONC
EOHHS	Point32Health
Epic	Reliant Medical Group
Fallon	Steward
Health New England	ZeOmega

Our project is well-timed

- Jan 2021: CMS finalizes rule to require payers in Medicaid, CHIP, and QHP programs to streamline prior authorization by supporting data exchange and electronic prior authorization (ePA)
  - Biden Administration withdraws the rule in February 2021; notes the matter is under further review

- Signals have accumulated pointing toward a reissue of CMS's rule sometime in **September** (2022)
  - HHS Unified Agenda includes CMS rule
  - ONC's Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria
  - "Improving Seniors' Timely Access to Care Act"
    - "To amend title XVIII of the SSA to establish requirements with respect to the use of PA under MA plans, and for other purposes"
    - MA plans must establish an ePA program to provide real-time decisions on certain items and services. (Definition of "real-time" would be determined by Federal regulators).
    - Insurers must meet transparency requirements (e.g., # denials, # approvals, etc.)

Jan 2021 rule components

- **Document Requirement Lookup Service (DRLS) API:** a FHIR-enabled DRLS API that could be integrated with a provider's electronic health record (EHR) to allow providers to electronically locate prior authorization requirements for each specific payer from within the provider's workflow.

- **Prior Authorization Support (PAS) API:** a FHIR-enabled electronic Prior Authorization Support API that has the capability to send prior authorization requests and receive responses electronically within their existing workflow (while maintaining the integrity of the HIPAA transaction standards).

ALSO:

- **Denial Reason:** payers must include a specific reason when denying a prior authorization request, regardless of the method used to send the prior authorization decision

- **Shorter Prior Authorization Timeframes:** CMS is proposing to require impacted payers (not including QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for standard requests.

- **Prior Authorization Metrics:** CMS is proposing that impacted payers publicly report data about their prior authorization process, such as the percent of prior authorization requests approved, denied, and ultimately approved after appeal, and average time between submission and determination, to improve transparency into the prior authorization process.

API: Application programming interfaces; **FHIR**: Fast Healthcare Interoperability Resources; **QHP**: Qualified Health Plan; **FFEs**: Federally-facilitated Exchanges

PROPOSED SERVICES FOR REVIEW OF AUTOMATION REQUIREMENTS

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Discussion table setting

- Use cases are intended to help us apply the Da Vinci guidelines. They will help us assess how useful and/or difficult it is to implement the automation requirements, as well as evaluate modifications.

- We assumed that use cases would be most "useful" if they had the following characteristics:
  - Straightforward medical necessity criteria
  - Subject to denials for lack of documentation
  - Relatively sizeable percentage of PA denials
  - Generally handled "in-house" by payers

Potential use cases...

- Bariatric surgery

- DME

- Genetic Testing

- Home Health

- PT/OT

- Consideration of Medications and High-Cost Imaging

DECISION!!!!!!!!

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WE HAVE TO START SOMEWHERE: DETAILS ASSOCIATED WITH COVERAGE REQUIREMENTS DISCOVERY (CRD)

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Simplified end-end automation workflow

01 Provider decides on an order/treatment/etc.

02 Prior authorization & coverage requirements shared between Payer & Provider

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

04 Provider verifies & submits request

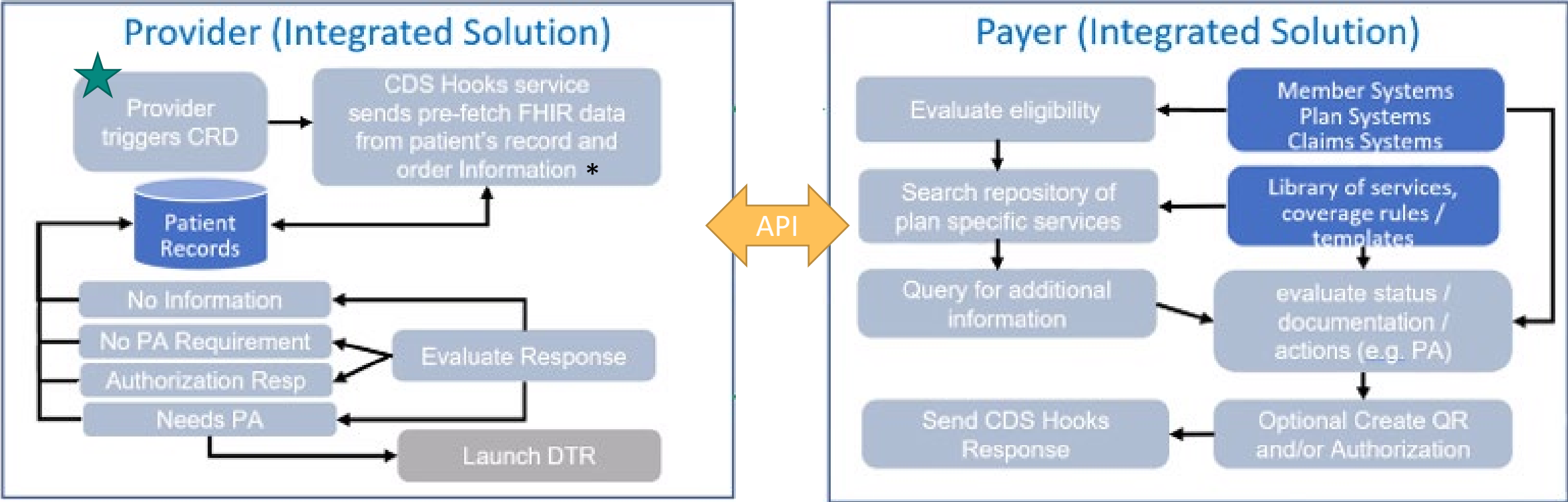05 Payer/Intermediary processes request & Payer sends decision

06 (Possible) Payer requests additional info/documents from Provider

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CRD workflow (CDS Hooks)

DSTU2 - FHIR Bundle of MedicationOrder, DiagnosticOrder, DeviceUseRequest, ReferralRequest, ProcedureRequest, NutritionOrder, VisionPrescription

⭐ Trigger is automatic and provider does not need to "click" anything

appointment-book, encounter-start, encounter-discharge, order-select, and order-sign

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Let's discuss

- What (minimal) information do payers need (from providers) to make a coverage & PA determination?
  - <u>Member ID</u> (*Coverage.SubscriberId, Coverage.beneficiary*)
  - <u>Performer</u> (Inpat, Outp), etc. (*Implies launch of SMART App)*
  - <u>Order information</u> *DSTU2 – FHIR Bundle of *MedicationOrder, DiagnosticOrder, DeviceUseRequest, ReferralRequest, ProcedureRequest, NutritionOrder, VisionPrescription*

- What information do providers need back from payers (CDS Cards)?
  - Services covered (Y/N)
  - PA required (Y/N)
  - Others? (*e.g., Copay, Deductible Amt., Alt services, Locations, etc.)*

- What data should be 'fetched' at the time of CRD from the EHR?
  - Prefetch template (Payer defines) for FHIR resources *(e.g., 'Coverage' to retrieve* Coverage.SubscriberId*)*
  - Prefetch tokens (Provider defines) for 'context' access to FHIR resources on the EHR side

- How 'intrusive' are CDS Cards to provider workflow? Configuration options from the Payer to control responses to CRD / CDS
  - Some EHRs already have CDS workflows that are separate from CRD workflows

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Discuss: Auditability of ePA requests and responses

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CDS Card Attributes:

Field	Optionality	Type	Description
uuid*	OPTIONAL	string	Unique identifier of the card. MAY be used for auditing and logging cards and SHALL be included in any subsequent calls to the CDS service's feedback endpoint.
summary	REQUIRED	string	One-sentence, <140-character summary message for display to the user inside of this card.
detail	OPTIONAL	string	Optional detailed information to display; if provided MUST be represented in (GitHub Flavored) Markdown. (For non-urgent cards, the CDS Client **may** hide these details until the user clicks a link like "view more details").
indicator	REQUIRED	string	Urgency/importance of what this card conveys. Allowed values, in order of increasing urgency, are: info, warning, critical. The CDS Client MAY use this field to help make UI display decisions such as sort order or coloring.
source	REQUIRED	object	Grouping structure for the Source of the information displayed on this card. The source should be the primary source of guidance for the decision support the card represents.
suggestions	OPTIONAL	array of Suggestions	Allows a service to suggest a set of changes in the context of the current activity (e.g. changing the dose of a medication currently being prescribed, for the order-sign activity). If suggestions are present, selectionBehavior MUST also be provided.
selectionBehavior	CONDITIONAL	string	Describes the intended selection behavior of the suggestions in the card. Allowed values are: at-most-one, indicating that the user may choose none or at most one of the suggestions; any, indicating that the end user may choose any number of suggestions including none of them and all of them. CDS Clients that do not understand the value MUST treat the card as an error.
overrideReasons	OPTIONAL	array of Coding	Override reasons can be selected by the end user when overriding a card without taking the suggested recommendations. The CDS service MAY return a list of override reasons to the CDS client. If override reasons are present, the CDS Service MUST populate a display value for each reason's Coding. The CDS Client SHOULD present these reasons to the clinician when they dismiss a card. A CDS Client MAY augment the override reasons presented to the user with its own reasons.
links	OPTIONAL	array of Links	Allows a service to suggest a link to an app that the user might want to run for additional information or to help guide a decision.

*uuid and responses should be kept / associated with the order in the EHR

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NEXT STEPS

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Homework!

- What is the essential information exchange between provider and payer that will reduce some burden associated with the prior authorization process?

- Assuming this initial exchange of information is possible, what burden reduction measures would you propose to use to demonstrate value?

Project next steps

CONDUCT SMALL FOCUS GROUPS TO ASSESS INITIAL RESOURCE REQUIREMENTS AND RECOMMENDATIONS
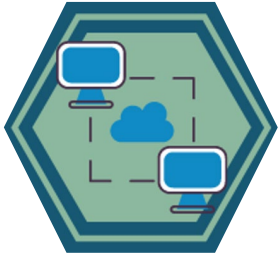
DRAFT INTERIM REPORT

MEET WITH HPC TO ALIGN ON CONTINUING AUTOMATION JOURNEY

Thank you!

THE DETAILS FOR REFERENCE

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CRD / CDS Hooks Considerations

- **Why CDS Hooks for CRD**

- **Required CDS Card Attributes (Auditability)**

- **Prefetch data approach - Prefetch Tokens from the provider side <u>and/or</u> Prefetch Templates from the payer side**

  - Prefetched data per 'registered prefetch templates' from the CDS Service to the CDS Client – as specified by the <u>payer's CDS service</u> (more efficient - performance)

  - Access tokens provided to the CDS Service (from the CDS client) and allowing the CDS service to retrieve FHIR resources for the PA, in the context of the token(s) (less efficient - performance)

- **Payer data needs for our use-cases (CRD)**

  - Is the required data available at the time of ordering in the EHR / FHIR resources? For example; Performing Provider & Location

Discuss: Others?

Discuss: CDS Hooks Pros & Cons

Pros

- It's an adopted API standard (non-proprietary)
- Most EHR's do/will support it and the OrderSign and OrderSelect Hooks
- FHIR resources fit with ePA CRD*
  - *Question: Data available at the time of order vs payer requirements for CRD?*
- May be leveraged for other uses like cost transparency, CDS, etc.
- Supports any number of actions including SMART on FHIR launch, URL Launch, References, Cost Transparency, etc.
- Supports prefetch Access Tokens and/or Registered Templates, from the CDS Service
- Immediate feedback to the provider

Cons

- CDS Hooks responses are 'Cards' at the time of order / trigger which can be intrusive for providers
  - Machine discerning actions to be taken from the content of various Cards can be a challenge versus a binary Y/N response for Prior Auth

- It is designed for 'Decision Support' generally
  - Availability of coverage, need for prior authorization, need for additional documentation, required first-line therapies, in-network vs. out-of-network considerations, potential duplication of orders, guidance on adherence to protocols, and cost for service, etc..

*DSTU2 - FHIR Bundle of MedicationOrder, DiagnosticOrder, DeviceUseRequest, ReferralRequest, ProcedureRequest, NutritionOrder, VisionPrescription

Discuss: Our focus is ePA CRD only at this time

Prefetch Templates Option

The prefetch templates are published in the CDS Service for response by the CDS client with the initial CDS Hook request for coverage requirements

Example:

```
{
"prefetch" : {
"patient" : "Patient/{{context.patientId}}",
"hemoglobin-a1c" : "Observation?patient={{context.patientId}}&code=4548-4&_count=1&sort:desc=date",
"diabetes-type2" : "Condition?patient={{context.patientId}}&code=44054006&category=problem-list-item&status=active",
"user" : "PractitionerRole?_id={{userPractitionerRoleId}}"
  }
}
```

Key	Description
patient	Patient demographics.
hemoglobin-a1c	Most recent Hemoglobin A1c reading for this patient.
diabetes-type2	If the patient has an active condition of diabetes mellitus on their problem list.
user	Information on the current user.

- The CDS Client MAY have some of the desired prefetched data already in memory, thereby removing the need for any network call
- Clients may respond to one, many or none of the templates from the service
- The CDS Client MAY compute an efficient set of prefetch templates from multiple CDS Services, thereby reducing the number of calls to a minimum
- The CDS Client MAY satisfy some of the desired prefetched templates via some internal service or even its own FHIR server.

Discuss: Data available to the CDS Service will depend on what data is present in the context of the patient, that has been previously entered in the EHR

Prefetch Tokens Option

The below tokens can be pasted to the CDS Service (payer side) from the CDS Client (provider side) to set the context for FHIR resource(s) retrieval from the EHR FHIR services

DSTU2 - FHIR Bundle of MedicationOrder, DiagnosticOrder, DeviceUseRequest, ReferralRequest, ProcedureRequest, NutritionOrder, VisionPrescription

{{userPractitionerId}}	**FHIR id of the Practitioner resource corresponding to the current user.**
{{userPractitionerRoleId}}	FHIR id of the PractitionerRole resource corresponding to the current user.
{{userPatientId}}	FHIR id of the Patient resource corresponding to the current user.
{{userRelatedPersonId}}	FHIR id of the RelatedPerson resource corresponding to the current user.

- Tokens may be provided in addition to templates
- The use of tokens for FHIR data retrieval is ROCOMMENDED to be limited to a subset of the full FHIR specifications (see implementation guide)
- A template may include any of the prefetch tokens on the list to the left
- Any FHIR data available in the context of the token may be queried by the CDS service

Discuss: Performance of the CRD response is dependent on the speed of the round-trip CRD inquiry – Templates are faster

Payer Data Needs for CRD

Example data needs for CRD:

	Payer 1	Payer 2	Payer 3	Etc.
Patient ID {mrn}	X		X	
Member ID	X	X	X	
Plan	X	X		
Procedure {code}	X	X	X	
Procedure date			X	

Discuss: Besides member ID, plan and procedure, are there any additional data requirements to determine if a PA is required?