Massachusetts Health Data Consortium

NEHEN

NEHI Network for Excellence in Health Innovation

TAAG Meeting 3

NEHI & MHDC

December 22, 2022, 10:00 AM – 12:00 PM ET

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

Agenda

Project Overview
The Proposed Federal Rule on Prior Authorization—Brief Summary
Proposed Recommendations
Break
Discussion & Questions
Next Steps
Post-Script: Update on BCBSMA/ NEBH/ Olive Prototype

Project Overview

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

- Stakeholder Interviews
- Evaluate implementation issues using chosen service examples
  - Focus groups
  - Post-TAAG homework
- Interim report: Submitted 12/05/22
- Incorporate MHDC implementation prototype findings

Phase 3: Policy Recommendations

- Will cover necessary incentives, including financial & technical assistance, rewards, & mandates
  - **TAAG #3 Meeting (12/22; virtual) to test recommendations with the group**

Phase 4: Dissemination

- MHDC & NEHI joint public webinar
- Final Report

Important Context: The proposed Federal Rule

Advancing Interoperability & Improving Prior Authorization

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Overview

- **Released on 12/6/22** with a 90-day comment period, which closes on March 13, 2023
- **Effective 1/1/26** (3 years)
- **Applies to**: Medicare Advantage (MA) organizations, state Medicaid and CHIP Fee-for-Service (FFS) programs, Medicaid managed care plans and Children's Health Insurance Program (CHIP) managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs)
- **Builds on the May 2020 85 FR 25510** Interoperability & Patient Access Final Rule
- **Requires the use of FHIR APIs but does not mandate compliance with the Da Vinci IGs.** They are 'highly recommended' for use cases in the 5 areas covered.

5 Key Provisions

1. **Patient Access API** using FHIR
   - Includes PA status from payer → patient
   - Requires impacted Payers to report annual metrics to CMS about patient use of the Patient Access API
2. **Provider Access API** using FHIR
   - Requires payers to make the following patient data elements available to in-network providers through an API
     - Claims & encounter data (excluding cost info)
     - Data elements identified in the USCDI version 1
     - PA requests & decisions
   - Includes an opt-out provision for patients to prevent sharing of their data
3. **Payer-to-Payer Data Exchange on FHIR®**
   - Includes data such as:
     - Claims & encounter data (excluding cost info)
     - Data elements identified in the USCDI version 1
     - PA requests & decisions
   - Proposes that if a patient has concurrent coverage with at least 2 payers, payers must share data with each other at least quarterly

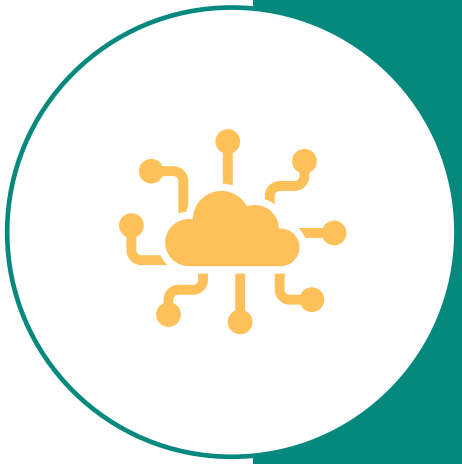
API: Application Programming Interface
USCDI: United States Core Data for Interoperability

5 Key Provisions cont'd

4. **Requires impacted payers to build and maintain a FHIR API (PARDD API)** that would automate the process for providers to determine whether a PA is required, identify PA information and documentation requirements, and facilitate the exchange of PA requests and decisions from their EHRs or practice management system
   - Excludes PAs for drugs (NCPDP Standard)
   - Includes the HIPAA-mandated X12 (278 and 275) transactions used
   - Includes a denial reason for any PAs that are not approved
   - Requires response for urgent requests within 72 hours and 7 calendar days for standard (non-urgent) requests (*seeking comments on this*)
   - Posting metrics on the Payer Website via hyperlinks annually
5. **Electronic Prior Authorization Measure for MIPS Eligible Clinicians and Hospitals and Critical Access Hospitals (CAHs)**
   - To meet the measure, a PA must be requested electronically from a PARDD API using data from certified EHR technology (CEHRT)

Key Takeaways: The proposed rule-

- **Affirms the functions (processes) that must be automated and the use of FHIR APIs**
  - Provides more flexibility than the Da Vinci IGs
    - Does mirror the pathway they provide
    - Does mention the IGs with the need for further testing and development
- **Requires payers & providers to convert FHIR Bundles to/from X12 278 & 275 transactions**
  - Can still apply for exceptions to using X12, though this includes more extensive reporting requirements and time to complete and receive the exception
- **Requires payers to provide reasons for denials**
  - Adds significant additional reporting requirements
- **Accelerates time frames for payer responses & appeals**
  - With respect to Medicaid & CHIP, affirms reliance on state-mandated reporting
- **Requests comments on how CMS can encourage uptake by providers & health IT developers**
  - Notes ONC's Jan 2022 RFI (EHR certification criteria)
- **Is somewhat unclear as to what funding is available to assist payers in complying with the Rule**



Proposed Recommendations

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The “What”

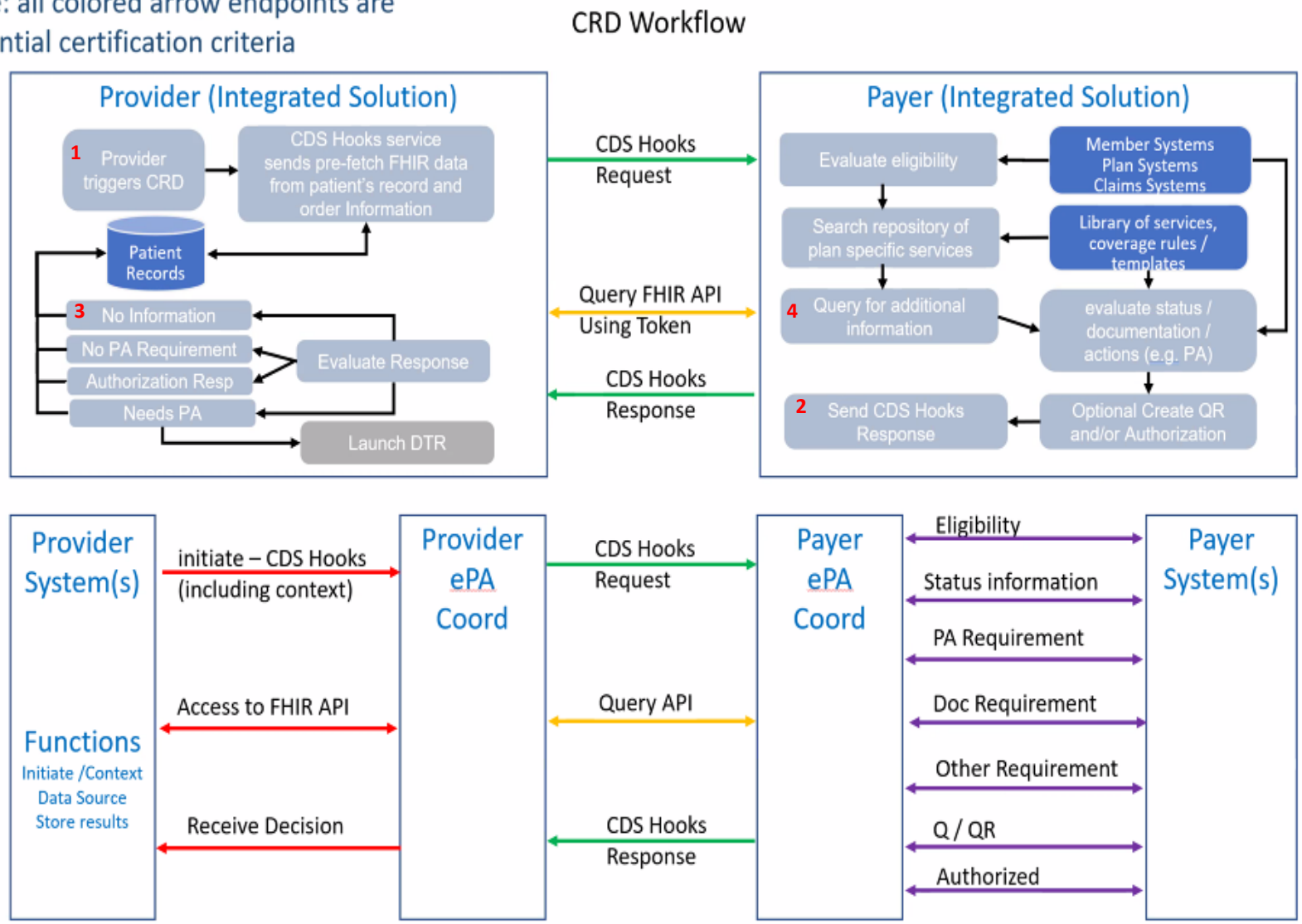
- Adopt major provisions of the proposed final rule on improving prior authorization
  - Secure implementation of key phases of automated processing for non-pharmacy services by commercial and public plans by January 1, 2026
  - Develop and publish measures relating to the efficiency and effectiveness of prior authorization (e.g., time to response; denial rate; provider adoption rate)
  - Require payers to comply with timeframes for decisions and appeals set forth in the Rule
  - Require payers to provide a reason for denial in response to PA requests
  - Continue to apply HIPAA rules pending further federal developments

With Additional Requirements and Modifications

- **Require compliance with the Da Vinci IGs**.
  - Follow IGs for CRD, DTR, and PAS (Functional equivalents of PARDD)
  - Prescribe rules for the application of the IGs including:
    - Use of a unique identifier in CDS cards (UUID), kept in association with the PA Bundle to allow auditability of PA transactions
    - Require that payers honor PA responses (above) for claims appeals processes
    - Allow adaptation of workflow in CRD to minimize provider disruption per EHR vendor design and provider preferences (i.e., run CRD as a 'background' process)
    - Eliminate the "no response" decision possibility in the payer response options
    - Use the "prefetch templates" method to gather required information from the EHR in support of the PA request (publish data requirement for each PA type)
    - Allow flexibility in the launch of DTR (either automatically after CRD or manually from a work-queue)
    - Require structured documentation requirements/questionnaires, ideally with Clinical Query Language (CQL) logic embedded
    - Prohibit the use of 'Adaptive Forms' that require back-and-forth between the provider and payer
    - Require payers to pre-populate information they (may) have available on the initial questionnaire response (SMART on FHIR)

Massachusetts Suggested Workflow – CRD with requirements

Note: all colored arrow endpoints are potential certification criteria



1 – **Flexible Workflow** - We require the use of the CDS Hooks standard for CRD with the caveat that it can / should be launchable from anywhere in the EHR workflow including as a 'background process' or manually launched at any time the user chooses. Launching via the CDS Hooks triggers should also be supported but optional.

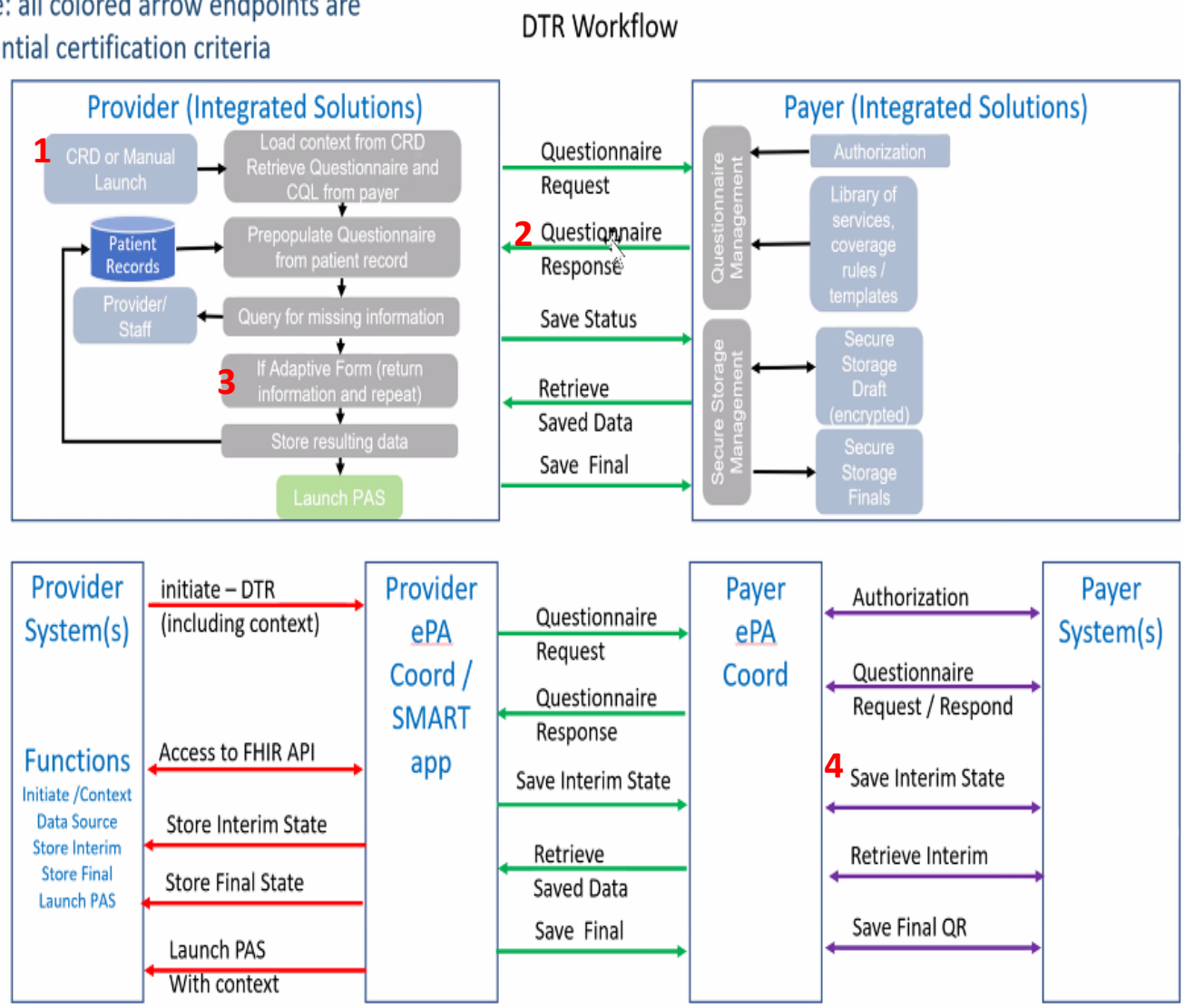
2 – **Transaction Auditability** - We require the UUID field within the CDS Cards response to be a REQUIRED field, to be kept in the EHR along with the status of the PA request as it was received from the payer, with the context from the provider, including any CPT (or other) codes sent in the CDS Hooks request, supporting documentation, etc.

3 – **No 'No-Responses'** - We require that a 'No Response' status from the payer is not allowed. The payer must indicate that there is no available PA rule for the requested service if that is the case. Timeout's due to a technical issue may result in 'no response' which should be treated as an error state.

4 – **Prefetch Templates** - We require the 'Prefetch Template' approach for gathering additional information by the payer, for the PA request. This is a more defined data approach where both payers and providers will know what additional data is needed at the time of a PA request. It is also more efficient (faster) from a transaction perspective.

Massachusetts Suggested Workflow – DTR with requirements

Note: all colored arrow endpoints are potential certification criteria



1 – **Flexible Workflow** - We require that DTR launch be a user-preference option. DTR can be launched automatically after CRD or manually launched from a work-queue in a delegated task model.

2 – **Structured Questionnaires** - The more structured the questionnaires are, including incorporating CQL logic into the CDS documentation requirements, to more efficient the data collection process will be.

3 – **Pre-filled Data** - if there is data the payer can provide to pre-fill or partially complete the initial PA required information then we are requiring payers to do that, to be included as part of the initial questionnaire response. Fields able to be pre-filled by the payer or collected in the CRD step (Prefetch Templates) are required to be pre-populated by the payer on the initial questionnaire response or in the SMART on FHIR App. The source information of those pre-filled data elements must be part of the meta-data associated with data for determining provenance (source) of the data.

4 – **No 'Adaptive Forms'** See #3 above. We will not be storing interim forms or retrieving interim forms.

The “How”

- Mandates
  - Medicaid: Legislative Directives
    - Participation Requirements for Managed Care Organizations
    - RFA (Request For Application) stipulations for Providers
- Financial Incentives
  - Commercial Insurers
    - Conditional Grants
- Oversight/Collaboration
  - HPC Grant Administration & Reporting Requirements
  - Multi-stakeholder Task Force Advice & Recommendations

Implementation Mandates

- Earmark funds in the MassHealth budget to enable implementation of prior authorization automation in accordance with automation requirements specified above. [RFI to define resource needs?]
- Require MassHealth to pursue federal funding available for implementation efforts.
- Require that Medicaid Managed Care Organizations demonstrate the ability to process prior authorization requests electronically in accordance with automation requirements specified above as of January 1, 2026.
- Condition provider participation in the MassHealth RFA on utilization of an EHR certified by ONC no later than one year after the publication of certification requirements.

Create Financial Incentives for Private Sector Adoption of Automation Requirements

- Establish funding to support the adoption of the required implementation activities by private entities through a specific allocation to the Healthcare Payment Reform Fund (the Fund) established under section 100 of chapter 194 of the acts of 2011.

- The allocation will be subject to the HPC's authority to administer the Fund.

- Certain sections of Chapter 6D, (sections 7 and 8) should be amended to supplement and clarify the HPC's authority and provide for the collection of data relating to the efficiency and effectiveness of administrative processes

Details

- **Add to the purposes for which grants from the Fund may be awarded** (amend section 7(a)): "to foster efficiency by, among other things, promoting the automation of prior authorization, revenue cycle, and billing processes."
- Further amend the Fund's purposes: "to promote reforms that reduce administrative burdens and costs affecting payers, providers, and patients."
- Amend section 7(h) to **provide** that prior to submitting its annual report on expenditures from the Healthcare Payment Reform Fund, **the Commission may require that providers and payers submit data relating to the efficiency and effectiveness of prior authorization**, provided that the Commission shall solicit recommendations from the Task Force [formal citation] comprising payers, providers, patients, and technology service companies in establishing reporting requirements.
- Amend section 8(g) to clarify that **the Commission shall request ongoing reports to evaluate the efficiency and effectiveness of administrative processes**, provided that the Commission shall solicit recommendations from the Task Force [formal citation] comprising payers, providers, patients, and technology service companies in establishing reporting requirements.

Notes

- Because the Proposed Federal Rule (section 8) and pending federal legislation contain multiple reporting requirements, the Commission should seek to focus reporting requirements on those that enhance trust and provide data for further reforms
- The Commission should consider information available from other sources and avoid increases in reporting requirements by reducing mandated reports in other areas

Establish a Task Force to Resolve Technical Ambiguities and Provide Essential Advice

Establish the Stakeholder Task Force to Improve Administrative Processes ("STF" or the Task Force) via Executive Order or Legislation

- **Composition**
  - STF shall fairly represent the interests of providers, payers, technical service companies and consumers. It will include approximately 15 members, 6 of whom shall be recommended by the Mass Collaborative and 3 of whom shall be consumer or patient advocacy organizations.

Task Force Responsibilities

- Address Technical Implementation Ambiguities and Provide Ongoing Technical Assistance. As delegated by the HPC [authority to be determined], the Task Force will answer technical questions from stakeholders and recommend modifications to the implementation guides in alignment with developing federal requirements, providing ongoing guidance on required steps in the adoption of automation.
- Grant Administration. The Task Force shall provide the HPC with recommended criteria for grant awards and such other information as the HPC may require to solicit proposals and oversee the administration and evaluation of grants for the adoption of automation and the improvement of prior authorization processes.

Task Force Responsibilities

Measures to Improve Trust, Transparency, and Process Improvement. Within 6 months of the Task Force's first meeting, members shall provide the HPC with a slate of recommended measures on which payers and providers will report annually. These shall enable stakeholders to (1) evaluate the implementation of automation on administrative costs, burden, and patient access to care; and (2) evaluate opportunities to reduce unnecessary variation in prior authorization processes.

Reform of Prior Authorization. The Task Force shall make recommendations to the HPC for reducing administrative burden and the use of low-value care, including the use of gold-carding and similar prior authorization reduction programs and the alignment of documentation required for approval of prior authorization requests and other ways to reduce variation in prior authorization processes.

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Consider: Payer and Provider Performance Incentives

To Be Discussed

Some Questions (and a quick break)

- Did we get the automation “requirements” right?
- Is the laissez-faire approach more acceptable: rely on individual efforts to comply with the federal rule rather than promote a statewide effort?
- How should the state estimate the amount of funding needed?
- Should the state attempt to mandate payer and provider compliance?

General Discussion & Questions

Next Steps

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Da Vinci FHIR Prototype with Olive / NEBH / NEHEN / BCBSMA

Da Vinci FHIR – Olive/ NEBH/ NEHEN/ BCBSMA

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- Business Objective
  - Create a market-ready business solution focused on the NEBH and BCBSMA ecosystem that leverages FHIR / Da Vinci standards around Coverage Requirements Discovery (CRD)

- Project Purpose
  - Create a scalable prototypical implementation of the Da Vinci use case for ePA and document for industry advancement of the project's key decisions, challenges, and successes. Olive can assist in sharing data with health plans via secure gateways. Data can be shared via HL7 APIs (FHIR).

Da Vinci FHIR – Olive/ NEBH/ NEHEN/ BCBSMA

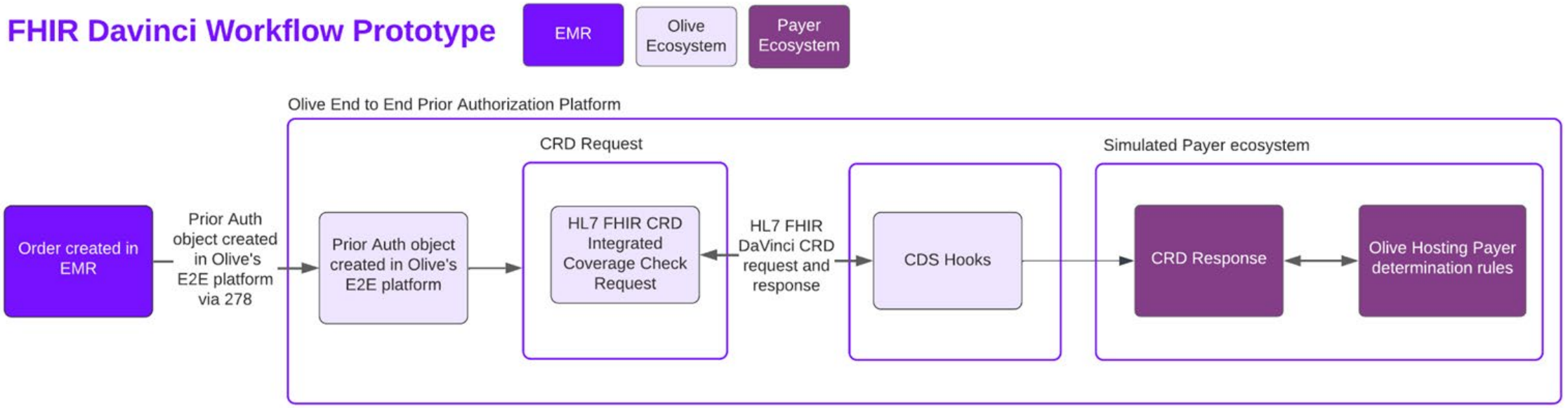
In-Scope

- Indications of whether prior authorization is required
- Hosting End to End CRD Request
- Hosting Payer Determination Rules
  - Payer will provide Olive with determination rules
- Facilitate determination request from EMR/Pathways
- Launch and verify results
- Focused group of 10 orthopedic CPT codes

Out-of-Scope

- Clinical Quality Language (CQL) Engine Support
- Documentation requirements and rules related to coverage
- Forms and templates to complete for Payer
- Alternative preferred/first-line/lower-cost services or products
- Bi-Directional Support between Payer and Provider EMR
- Will not support hosting payer rules post-prototype implementation

Da Vinci FHIR – Olive/ NEBH/ NEHEN/ BCBSMA



- Only support Coverage Requirements - 1.0.0 - STU 1
  - Indications of whether prior authorization is required
- Support connectivity of data through Pathway to FHIR CRD Requester
- Support Payer Response: We will extract patient records and interface authorization rule determination and results of status checking with pertinent authorization-related data.
  - Data can then be mapped back to the host system in support of an exception-based workflow.
  - FHIR API and proprietary API calls are configured and performed using basic authentication, or OAuth, by a system user account.

Da Vinci FHIR - Olive/ NEBH/ NEHEN/ BCBSMA

- The Da Vinci prototype was deployed to live on Saturday, December 10th, per the project plan. **The pilot is LIVE!**
- As of 12/14, four (4) PA submissions had been made:
  - Two (2) submissions for CPT breakdown: two (2) for total hip arthroplasty (27130) and two (2) for knee arthroplasty (27447)
  - All four (4) returned a "PA Required" response
  - Each submission had a different plan affiliation
- An end-of-week report is scheduled to be sent week of 12/19 to allow enough time for a full week of data

Da Vinci FHIR - Olive/ NEBH/ NEHEN/ BCBSMA

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Findings & Observations

- A comprehensive white paper documenting the program findings and results will be coming in the spring (4/8 – 4/30)
- It is possible to build a production-ready Da Vinci IG-compliant CRD service in a relatively short timeframe (6 months) for a limited set of use-cases
- Using third-party vendors and collaborators is a viable approach to achieving interoperability goals
- There may be a need for a centralized service to support API end-points (CRD), coordinate onboarding, ensure conformance, and centralize reporting to facilitate adoption
- A ‘service model’ approach to establishing CRD services works
- It is possible to co-exist Da Vinci IG transactions (i.e., begin automated processes) with other PA methods (transition over time); payers and providers can adopt processes over time rather than wait until January 2026 to make the switch.

DaVinci FHIR - Olive / NEBH / NEHEN / BCBSMA Pathway / FHIR Prototype Timeline

2022
6/15-8/2

Discovery & Planning

✓ Describe project scope
✓ Identify Pathways impact
✓Agree on CPT codes
✓Solidify determination rules
✓Log dependencies
✓Scope CRD requirements

Deliverable: Project plan & requirements document

2022
8/2-12/10

Build & Configure

✓Map CRD requirements
✓Connect Pathways/FHIR
✓Build integration gateway
✓Build payer platform
✓Conduct business & technical testing
❑ ~~Solution decision trees~~
(No longer applicable)

Deliverable: Viable prototype ready for pilot

2022/23
12/10-1/13

Launch & Monitor

✓ Launch product (go-live)
✓Begin reporting
✓Monitor results
❑ Identify trends
❑ ~~Adjust pilot as needed~~
(No longer applicable)

Deliverable: Success pilot launch with regular results

2023
1/13-3/1

Finalize & Report-out

❑ Analyze results
❑ Determine lessons learned
❑ Draft 'publication'
❑ Approve final versions
❑ Publish publication

❑ **Deliverable:** Published industry paper

Preliminary Results

PA Request ID (In Pathway)	Process Date	CPT Code	Plan Name	PA Requirement
1189572	12/12/2022	27447	Medicare PPO Blue	PA Needed
1523016	12/12/2022	27447	HMO Blue New England Saver $2000	PA Needed
1519028	12/13/2022	27130	Preferred Blue PPO Deductible	PA Needed
1196518	12/13/2022	27130	Network Blue New England	PA Needed
1589388	12/16/2022	63030	Blue Care Elect Preferred	PA Needed
1604334	12/16/2022	22551	Network Blue	PA Needed