Reducing the Burden of Prior Authorization for Medical Devices, Procedures

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Point-of-Care PARTNERS | HEALTH IT MANAGEMENT CONSULTANTS

Different Types of Prior Authorization

DRUGS

Covered under Pharmacy Benefit

Covered under Medical Benefit

DEVICES

Pacemakers

Infusion Pumps

Blood Glucose Meters

Nebulizers

PROCEDURES

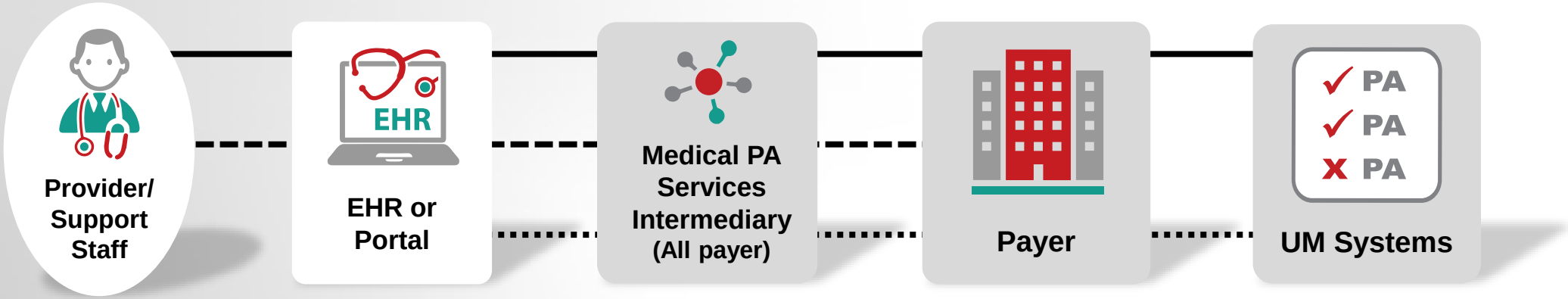
Radiology

MRI

Endoscopy

Chemotherapy

Transaction Flow of ePA for Medical Devices and Procedures



- Eligibility/benefit provider inquiry/payer response (x12n 270/271)
- Medical PA provider request/payer response (x12n 278)
- Question set & PA attachment (documentation) (x12n 275; other non-standard tx.)

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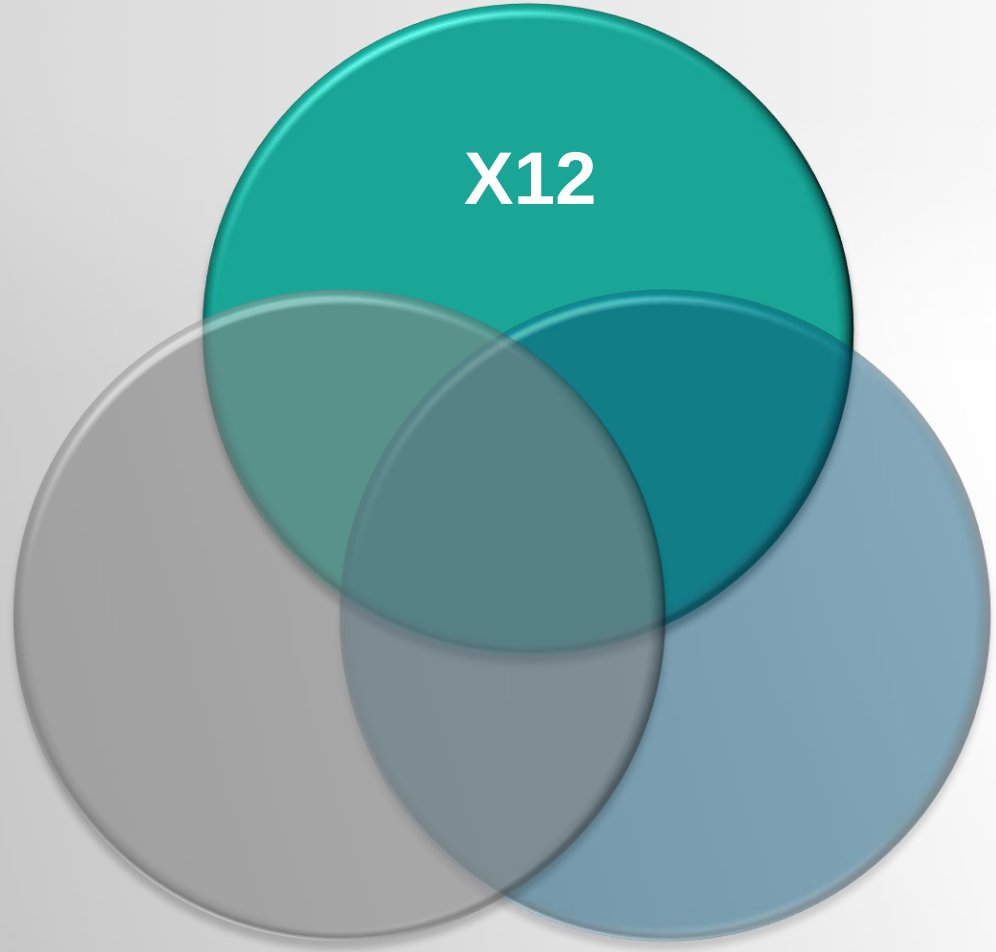
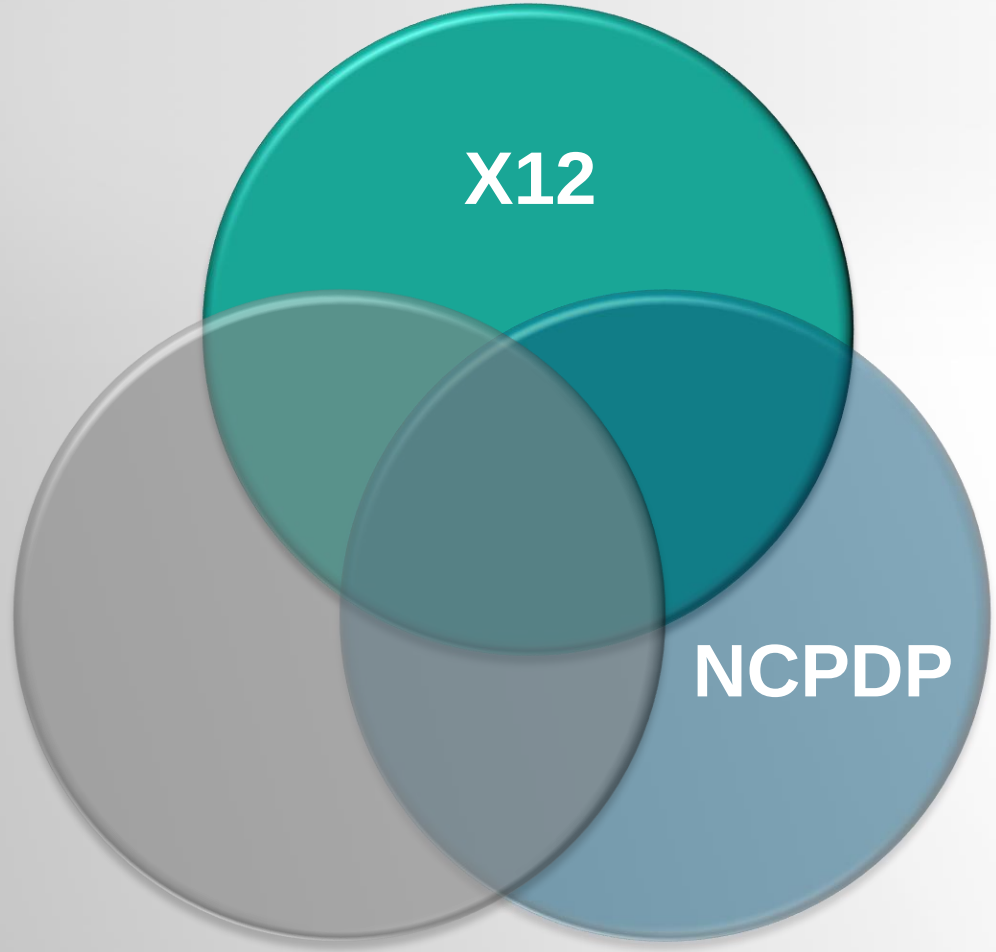
Medical Prior Authorization Standards Landscape



X12n

- Transaction set x12n 278 is the named standard HIPAA transaction for Prior Authorization workflows
- 270/271 is the contemplated transaction for eligibility.
- Limited adoption for full automation. Primarily submit via manual portal submission
- Majority of widescale implementations involve “sidecar” for additional content
- 2018 CMS NPRM includes language to add Attachments standard
  - Unclear whether/when regulation will name both x12n 275 and/or HL7 CCDA

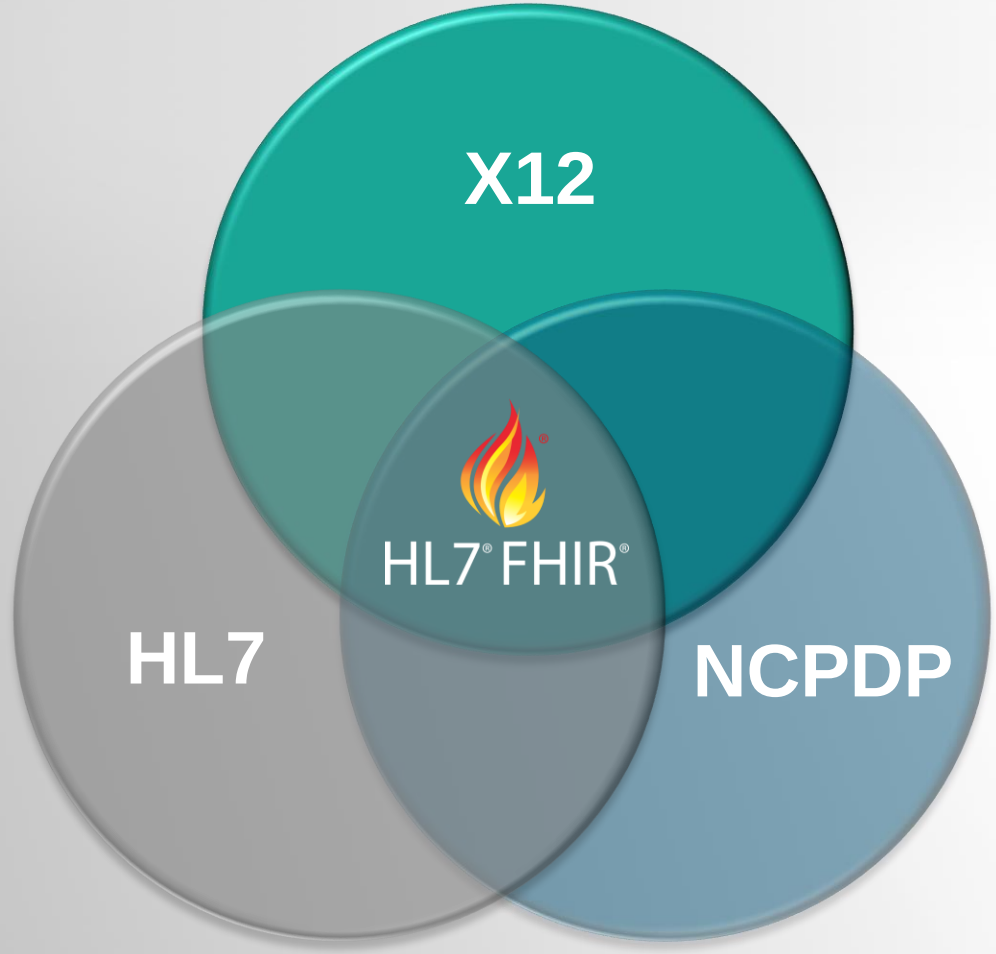
Medical Prior Authorization Standards Landscape *(cont)*



NCPDP & Pharmacy ePA

- Widespread adoption of XML based Pharmacy ePA transaction despite the fact that is not yet named as an exception to HIPAA rule for Pharmacy ePA
- Maturing with use cases expanding to include other participants i.e., Pharmacist can now submit PA on behalf of a provider
- Still predominantly retrospective, but traction at prescribing where Task is sent to support staff to complete PA
- PBMs/vendors focused now on increasing automation and data exchange with EHRs
- NCPDP board is proposing (May ’18) creation of new workgroup focused on Specialty workflows including:
  - Likely create focus on better identification of drugs on medical benefit
  - Active work to create an “enrollment” transaction data via a standard transaction, potentially leveraging FHIR

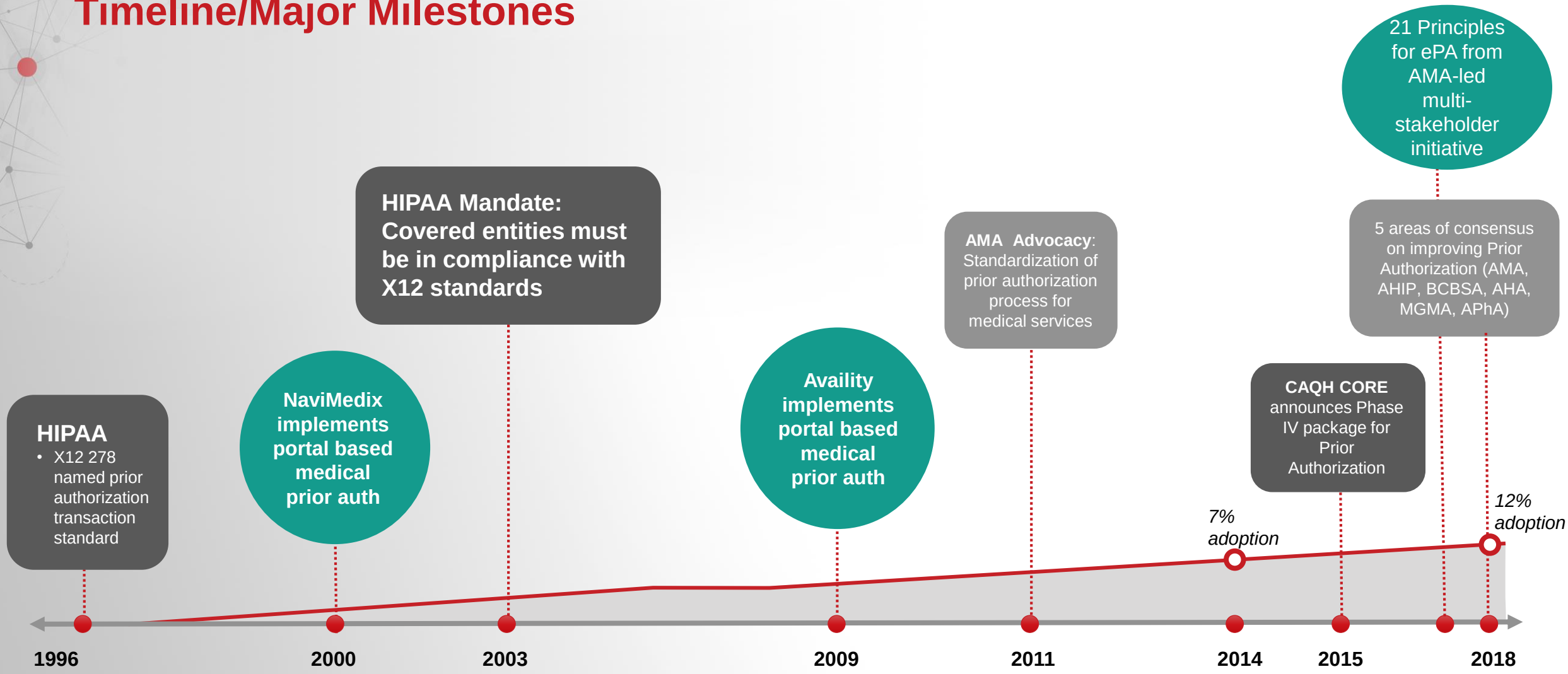
Medical Prior Authorization Standards Landscape *(cont)*



HL7 International

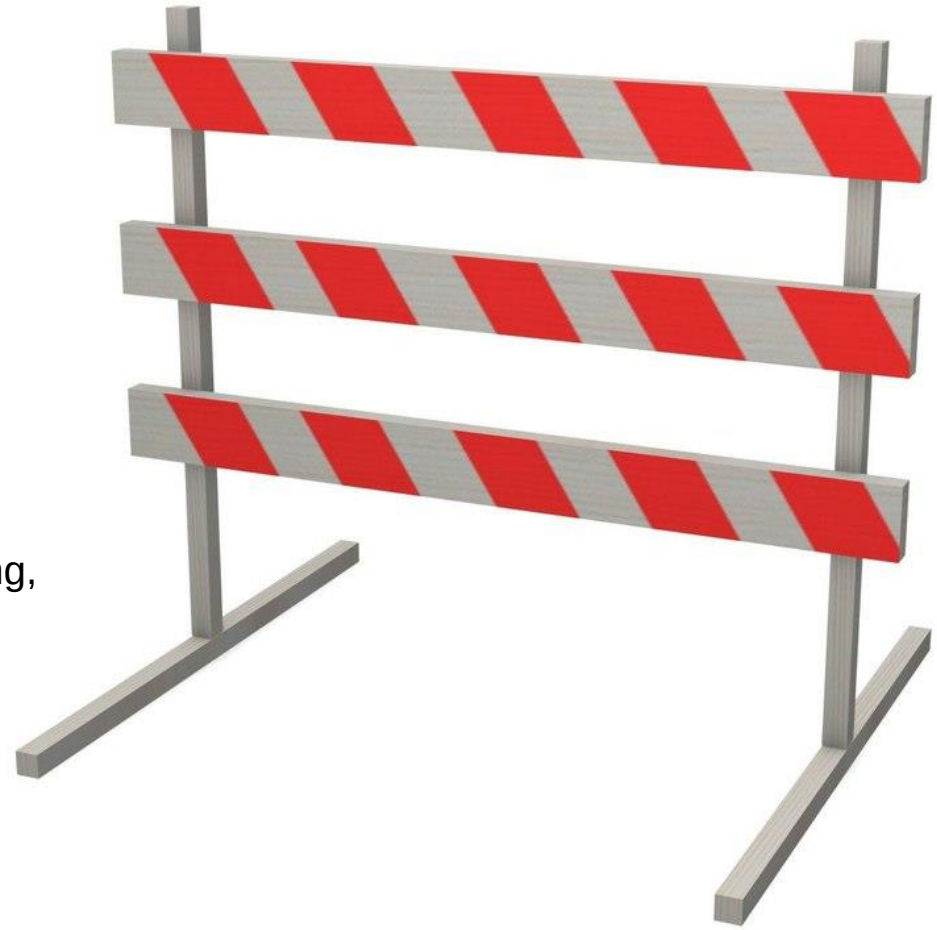
- Adoption of various CCDA format standards for clinical data exchange increasing
- HL7 FHIR © gaining traction
- FHIR is seen as best way to exchange fielded data in/out of EHR
- DaVinci is a multi-stakeholder effort to leverage FHIR APIs in support of value-based care
  - Two of the early use cases focus on requirement for PA and look to expose rules and documentation requirements for PA; use case to support auth being considered
  - Initial founding group contains 10 Payers, 5 EHRs, 6 Providers and IT Vendors

Timeline/Major Milestones



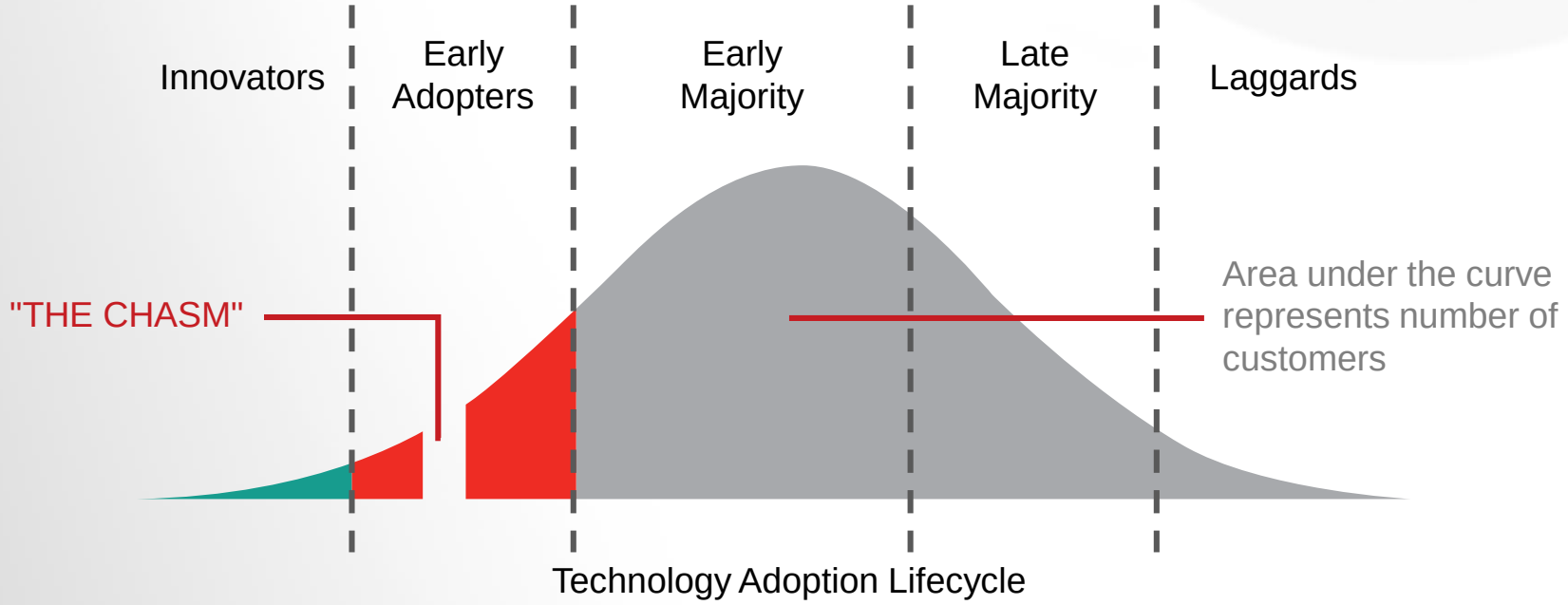
Barriers to Automation and Innovation

- HIPAA regulation named X12 278 as only option
  - Lacks “chattiness” or structured question and answer
  - Overly relies on out-of-transaction content for processing
  - Not specific enough for each use case or scenario that other HIPAA standards support (e.g. eligibility and claims)
  - Decades of no or low pressure for mandated adoption
- Workflow based upon a flawed assumption
  - Essentially benefits coverage is intrinsically part of clinical workflow
  - HIPAA relegated PA as a back-office transaction
  - At its core patient specific benefits are tied to clinical decision making, the separation of these decisions from process leaves highly paid nurses on phones, faxes or portals rekeying clinical data
- Trust
  - Ability to audit and ensure adherence to rules is key to payers
  - Clear understanding of data provenance and future use is key to provider increasing automation



Early, Unaided Market Response

- Mature practices have centralized function and developed manual automation to reduce back/forth, waste, time and abandonment
- Vendors continue to streamline and “digitize” what is manual today; eviCore, CoverMyMeds, Par8to
- EHRs are building interim solutions into workflow based upon provider demand
- Innovative plans are experimenting, piloting authorization reduction, gold carding and automation e.g., UnitedHealthcare, Humana



Key Medical Prior Authorization Trends

- Rising complexity and cost of many care interventions > more PAs
  - Volume of PA and complexity of criteria is increasing overall
    - Volume of PA (drug and medical) increased 33% during the period of 2015-2016
- Growth of specialty drugs covered under the medical benefit - significant driver in medical PA automation investments by payers

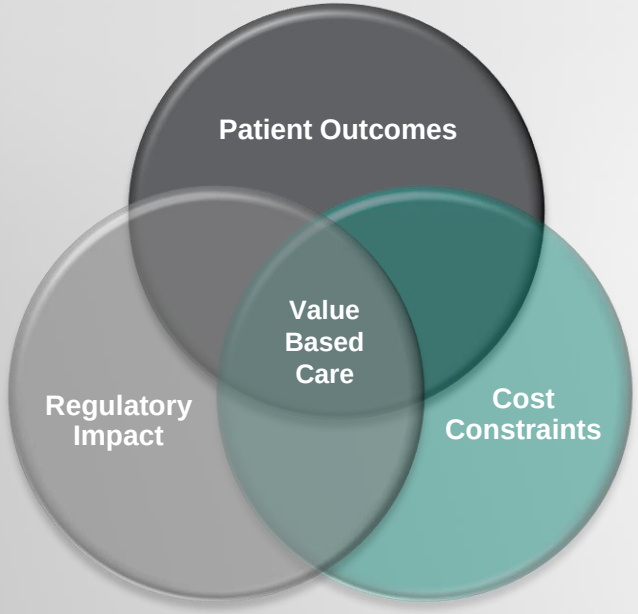
- ePA technologies and portal solutions maturing to support more procedures and question sets
  - Best practices from Drug ePA (workflow and standards development) apparent in leading medical PA vendors' efforts
  - As ePA technologies (e.g., analytics, rules engines) mature to enable significantly higher auto-adjudication rates, payer investments will likely increase

Prescriptions
Electronic PA is Fast and Efficient

Medical Procedures
Manual PA is Time Consuming and Burdensome – Major "Friction"

Industry Momentum

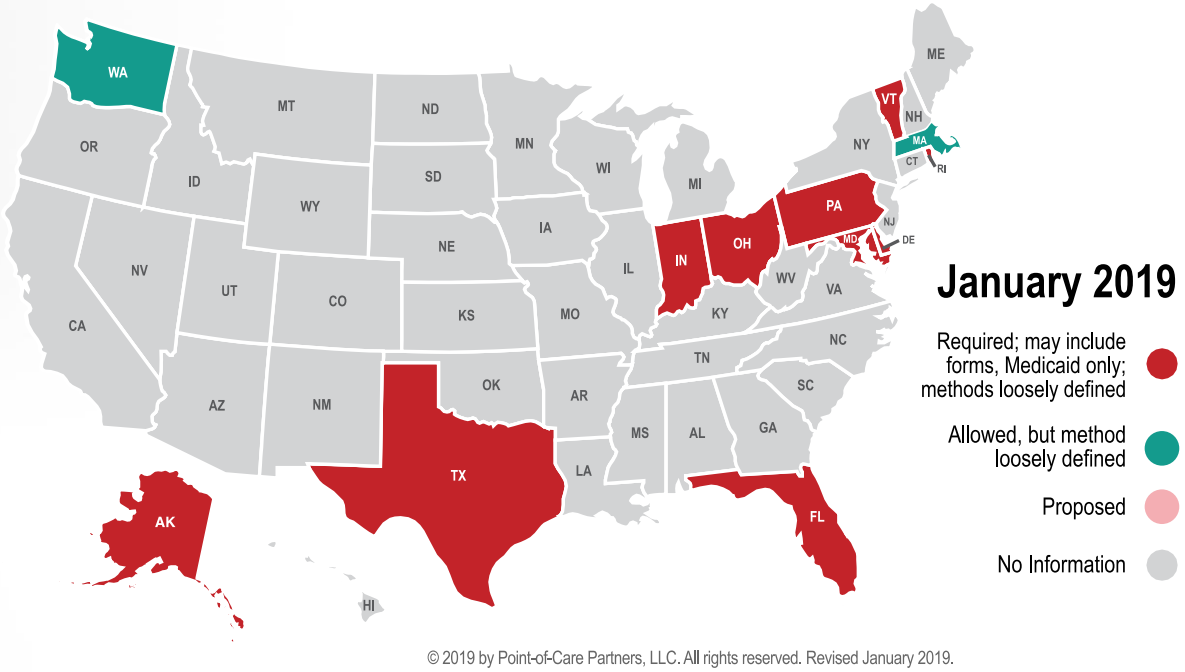
Growing frustration of providers with PA requirements



Quality Focus

- Focus on patient outcomes
- Increased in risk-based contracting
- Treat entire patient and care coordination

Medical Prior Authorization Laws



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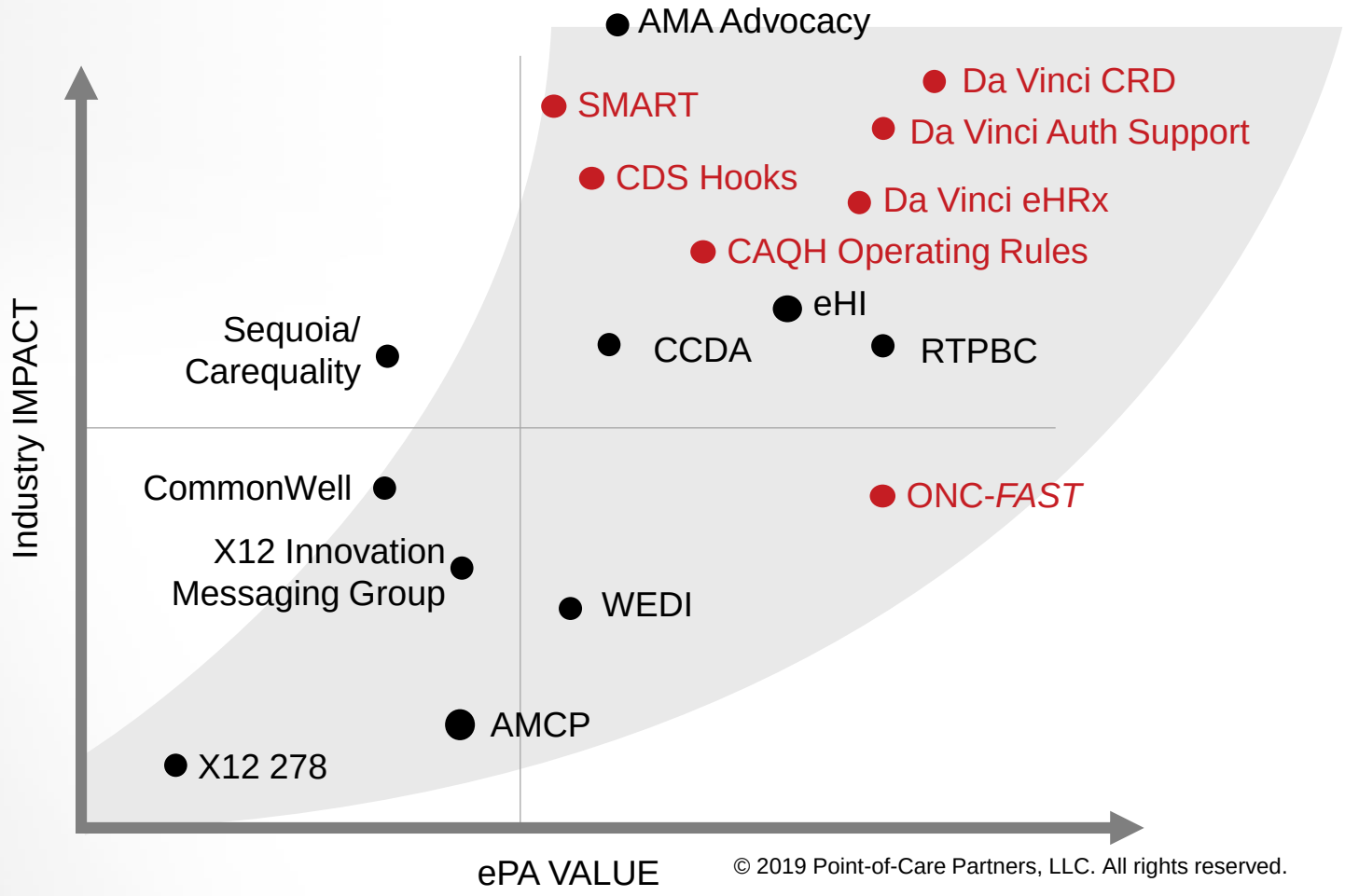
Regulatory Drivers

- State mandates
- H.R.6 - SUPPORT for Patients and Communities Act
- Trump Administration priority to reduce provider burden

Industry Efforts to address medical ePA

Technology & Collaboration

- AMA coalition advocating for PA simplification/automation
- Providers (AMA among others) and payers (AHIP) recently called for industry adoption of standards-based ePA transactions (drug and medical) and availability of coverage restrictions at the point-of-care in EHR systems
- Increase focus on standardizing clinical decision making and workflows for providers as volume of information and AI surfaces the need to get patient benefit information in workflow (in workflow decision)
- Bidirectional APIs in/out of EHR



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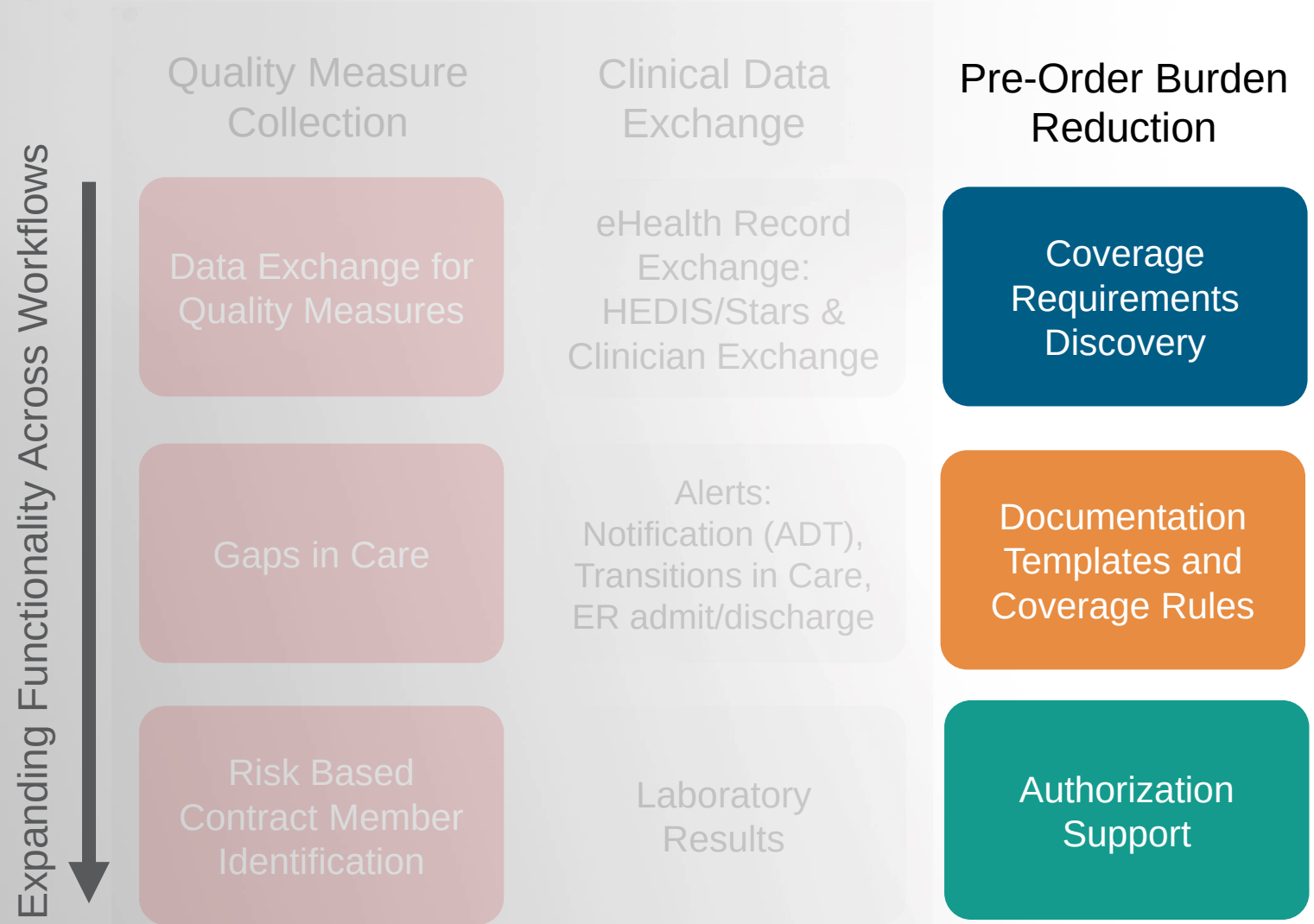
Key: HL7 FHIR focused initiatives

Da Vinci Use Case Alignment



Value Based Care Driving Integration

- Payers and Providers sharing risk are higher trust
- Data must flow in order for both parties to succeed
- Role of prior authorization shifts as providers want to establish better tools for their own risk management

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Pre Order Burden Reduction

USE CASE	USER HIGHLIGHTS
Coverage Requirements Discovery	Is authorization required? Are there predecessor tasks to be completed?
Documentation Templates and Coverage Rules	If there are pre-authorization tasks, then show me what I'm missing, or show me the criteria/rules so I can evaluate treatment options, locations, next steps
Authorization Support	If authorization is required, then either (basic) send me to place to complete it, (better) queue it for staff, or (high trust, deep integration) enable payer partner investigate the medical record to find necessity or only ask for missing information

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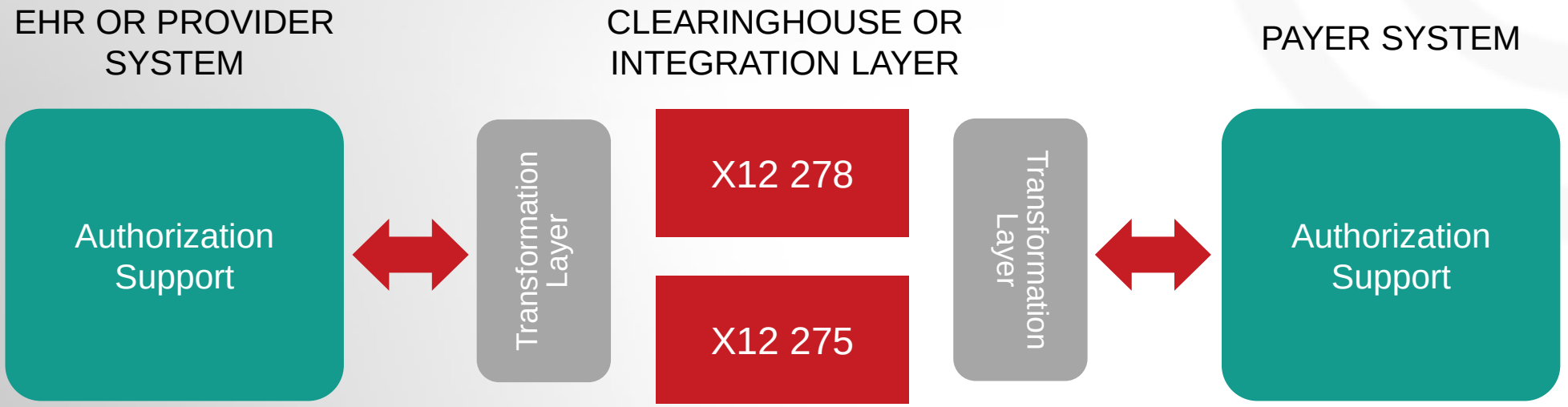
Authorization Support Abstraction/Transform for HIPAA Compliance



Clearinghouse or Integration Layer Out of Scope Due to HIPAA Regulation Requirements

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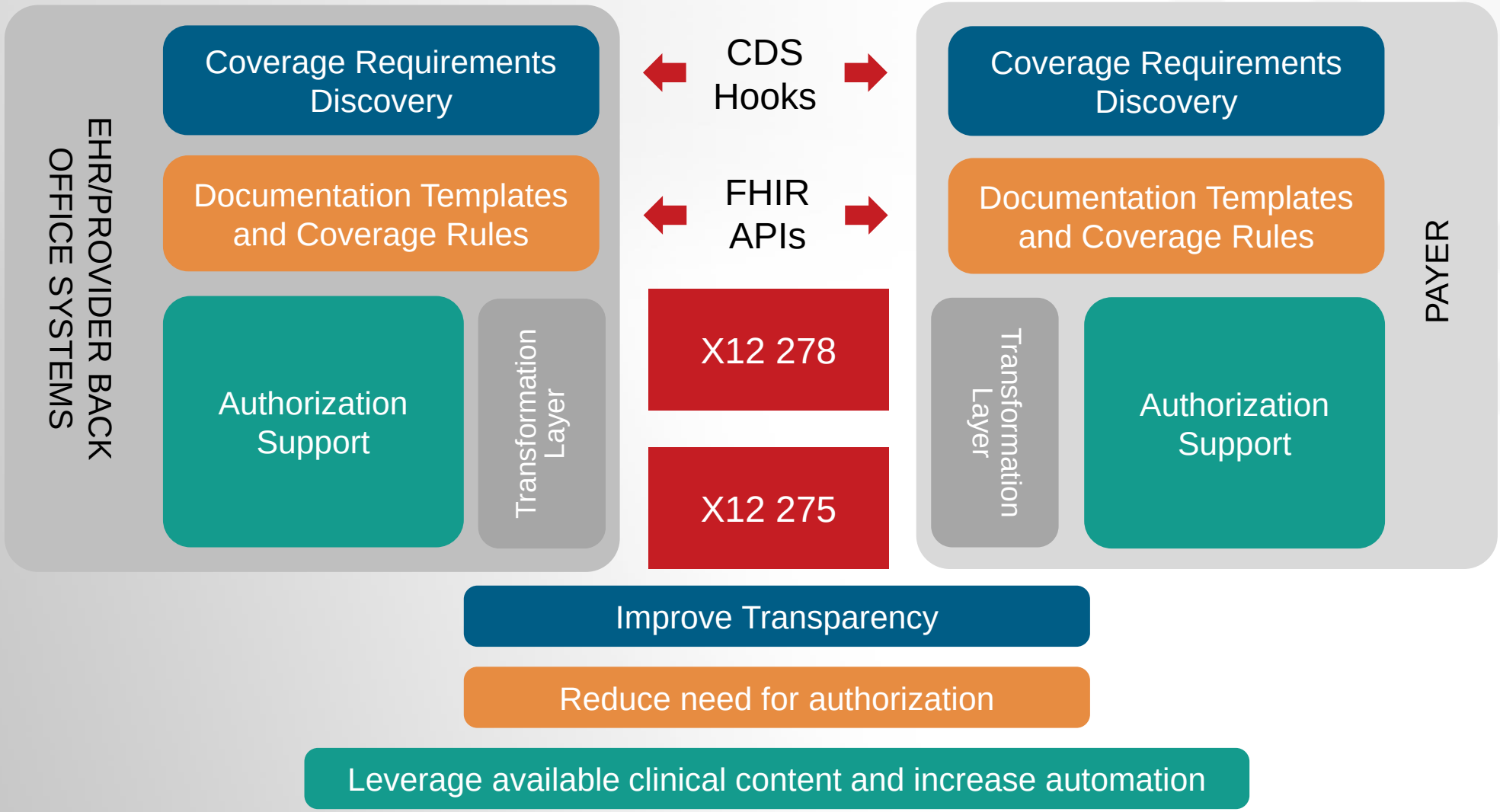
Power to Reduce, Inform and Delegate Prior Authorization



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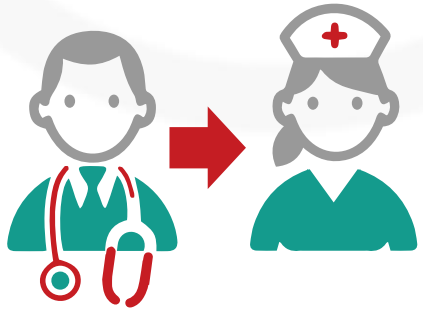
CAUTION: Don't Increase Provider Administration Burden

Solutions need to reduce, not redirect, work on the provider. Caution against putting up barriers in EHRs. Add tools that remove or reduce burden or allow providers to task/queue work to be done for right staff.

Send patient to complete requirement

Document missing information quickly

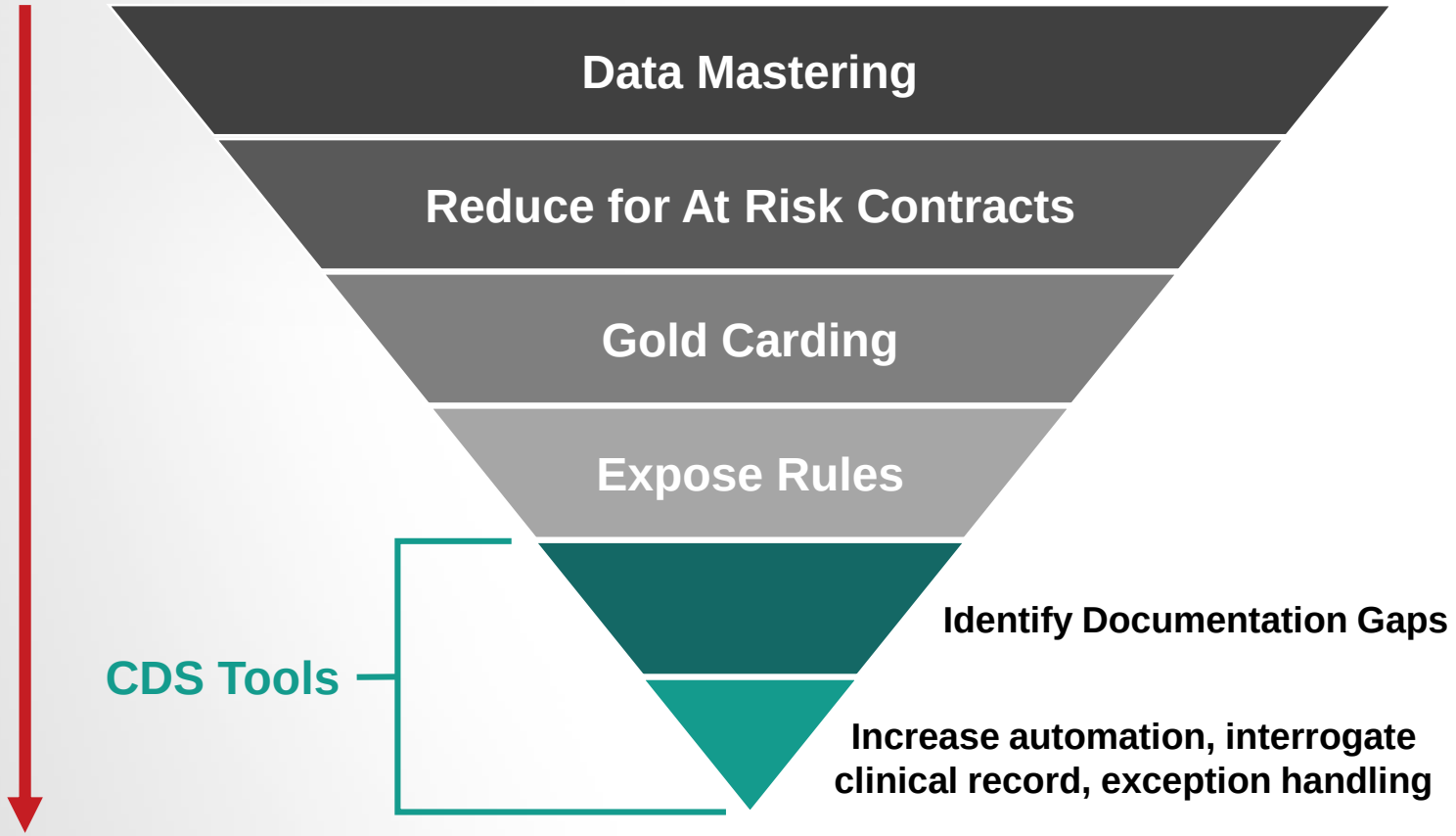
Doctor does the work



Go to a team member to complete the work

What Could Payers Do Before Triggering a PA?

Reduce PA and improve adherence to clinical guidelines with better patient specific information in workflow



ELIMINATE THE NEED FOR A PRIOR AUTHORIZATION

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ePrior Auth Predictions (from *HIT Perspectives*, Jan 30, 2019 issue)

Standards Development Will Continue

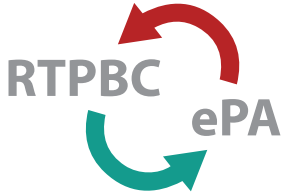
- Substantial progress will be made on electronic medical prior authorization (eMPA)
- NCPDP will continue to advance ePA standards focusing efforts on current gaps
- Incremental progress to standardize and automate delegated ePA for prescription drug ePA and for the drugs, devices and procedures covered under the patient's medical benefit

Regulatory Mandates Will Drive Adoption

- Federal and state mandates will drive drug ePA adoption past the tipping point by January 1, 2021 when HR 6 mandates ePA for Part D covered drugs
- CMS will name an ePA standard for drugs as part of HR6

Innovation and EHRs Will Remove Barriers

- Payers will remove the need to PA through innovative use of technology and provider pre-qualification (e.g. gold carding) when certain conditions are met
- ePA will move toward ubiquitous integration in EHRs



Real-Time Pharmacy Benefit Check (RTPBC) Will Work in Concert With ePA

- The industry will settle on a RTPBC standard to convey patient-level formulary benefit details, including flags indicating if PA is required
- Implementation deadline for adoption of the RTPBC by Medicare Part D will be moved back from January 1, 2020 to give EHR/Health IT vendors time to integrate it

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Thank You

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