The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE MEETING

May 5, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Alix Goss	Imprado Consulting, a division of DynaVet Solutions	Co-Chair
Sheryl Turney	Anthem, Inc.	Co-Chair
Steven Brown	United States Department of Veterans Affairs	Member
Gaspere C. Geraci	Individual	Member
Alex Mugge	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Thomas Mason	Office of the National Coordinator	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Jacki Monson	Sutter Health/NCVHS	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Ram Sriram	National Institute of Standards and Technology	Member
Debra Strickland	Conduent/NCVHS	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Denise Webb	Individual	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Michael Wittie	Office of the National Coordinator	Staff Lead
Patrick Murta	Humana	Presenter
Phillip Britt	Humana	Presenter
Kirk Anderson	Regence	Presenter
David DeGandi	Regence	Presenter
Heidi Kriz	Regence	Presenter
Julie Lindberg	Regence	Presenter

Lauren Richie
Good afternoon, everyone. Welcome to the ICAD task force. Apologies for the brief delay here. Quick roll call and then, we'll jump right into it. On the phone, the members I see in Adobe, I see we have Sheryl Turney, Alix Goss, Alexis Snyder, Anil Jain, Arien Malec, Denise Webb, Gus Geraci, Jacki Monson, Jim Jirjis, Jocelyn Keegan, Alex Mugge, Ram Sriram, Sasha TerMaat, and Tom Mason. Are there any other task force members that have not announced themselves on the phone? Okay. With that, I'd also like to welcome and thank our guest presenters for joining us today. We'll allow them to introduce themselves shortly here. But first, I will turn it over to our co-chairs to get us started.

Alix Goss
Well, thank you so very much. We appreciate advancing to the next slide, today's agenda. I wanted to just give you a little bit of overview that we will do a brief recap today of our efforts from the last call providing an opportunity before our presenters to give us a brief introduction to the HL7 Da Vinci Project to then, receive a presentation from Humana and from Regence, sometimes also called Cambia Health Solutions. But it will really be Regence demonstrating today. Humana and Regence have come to talk to us about medical prior authorizations and giving us context of how the Da Vinci use case implementation guides could advance prior authorization in particular. And then, of course, we'll have time for public comments. I am going to move along fairly quickly here to the next slide please so that we can give you an update on the next slide related to the last meeting.

So, we did review the progress on the workbook that has been advancing offline thanks to the small working groups that are taking a review of the data categories and classes as well as the guiding principles and ideal state. We did have extensive work by Sheryl to capture input that had been received by HITAC by other entities, third parties, who had presented to HITAC other considerations and recommendations applicable to our scope of work. So, we're encouraging all of the task force members to take a review of those other considerations and recommendations tap and add any input that they would like to offer that will add the small work group efforts as well as the larger discussions that we will have once some of that offline work is brought back for full discussion and vetting. We do encourage all of the task force members to be taking a look at that workbook and providing input to help us advance the efforts that will be the foundation for the recommendation works that we'll start taking on next month.

More especially, at the last meeting, we saw demonstrations from a pharmacy side of the house and electronic prior authorization thanks to Surescripts and CoverMyMeds. We really had a great opportunity to look at real time benefit checks and took a deeper dive into the considerations related to multiple payers, scenarios for patients, insurance coverage, and what that means for coordination of benefits and how that might impact some of the work we have moving forward. Sheryl, did you want to add anything to that last meeting update?

Sheryl Turney
All very well said, Alix. I'm good.

Alix Goss
Thanks very much. So, I think now, without further ado, we want to move on to our next presenters or our presenters for today. I believe that we have several presenters from Humana. They're not only going to talk about their scope of work with medical prior authorization but I think they're also going to give us a little bit

of a primer when it comes to what is the Da Vinci Project. So, I believe that our presenters today are Patrick and Phillip. But I'll turn it over to you if you wouldn't mind doing a bit of an instruction. And I think we also would like you to instruct us when you want us to change the slides. Lauren, are there any other housekeeping items we need to take care of?

Lauren Richie
That's it. I would also just remind our task force members to state your name before a question or comment just because we have a number of guests with us today. Thank you.

Patrick Murta
Great. So, this is Patrick Murta from Humana. Alix, can you do a quick sound check? I'm having a little bit of microphone trouble today. I want to make sure I'm coming in loud and clear.

Alix Goss
I hear you loud and clear, Patrick. Thank you. I'll let you know if something changes.

Patrick Murta
Great. Thank you. And so, I'll do a quick introduction and then, I'll ask my peer at Humana, Phil Britt, who is our director of utilization management, to do a quick intro as well. So, again, I am Patrick Murta. I am very happy to be coming to present to the team today. I am the Chief Interoperability Architect for Humana. So, in that role, I, basically, help lead the organization as it relates to integration, including the classic X12 models, including 278 for prior authorization, and also the more contemporary FHIR CDS hooks and other adjacent technologies as well. So, in that role, I work across the organization, including with folks like Phil in our clinical space but also, quite a bit in the industry with Alix on quite a few initiatives, on the coordinating committee with Jocelyn and a bunch of others as it relates to Da Vinci. I am the co-chief architect for the FAST Initiative with ONC and also dabble in organized Gravity Project and the CARIN Alliance as well. So, in the interest of time, I'll kick it over to Phil. If you could quickly give a quick introduction, we will move forward.

Phil Britt
Thanks, Patrick, and thank you, everyone, for having me here today. My name is Phillip Britt. I'm with Humana. I'm the director of our business improvement area focused on our utilization management clinical technology end to end. So, my team oversees really the end to end process and trying to find ways to help streamline the process but for Humana and our providers to be able to take provider abrasion out of the system and to streamline that end to end process so we're making quick and timely decisions. I'll keep it short because I think we have a lot to get through. So, Patrick, I'll turn it back over to you.

Patrick Murta
All right. Thanks, Phil. And as Phil and I go through the slides, given the content of the presentation, I'm going to kind of lead the conversation but I'll ask Phil for comments and commentary so that we're giving the perspective both from an architecture and an integration and interoperability perspective. But also, to make sure that we're also talking about business enablers, impacted business, and operations and those types of things. So, again, as Phil noted, there's quite a bit of information to cover. And I know that we have Regence after this. I want to make sure that we give appropriate time. I think that we have about 20 minutes. So, I'm going to go pretty crisply through this. Again, I think we'll do question and answers at the end, Alix,

if I'm not wrong. But let me start by quickly giving an overview of the Da Vinci Project. So, the Da Vinci Project goes back several years. It was one of the original HL7 FHIR accelerators.

And, again, the FHIR accelerators are just projects that run under the auspices of HL7 that take advantage of the bold capabilities that are made available in FHIR and adjacent technologies to solve business needs and provide enablers, remove abrasions, and make data available at the right time in the right workflow with the right clinician. Now, the Da Vinci Project is one of the HL7 accelerators focuses on payer to provider integration. A lot of it driven by what we're doing from a value-based care arrangement. So, initially, when we started meeting two to three years ago, and there are a lot of folks on the call that were, actually, at that first meeting, a lot of the conversation was that we have a new model in value based care. And in that model, folks recognized on all sides of the table that sharing of information is absolutely critical for the success of physicians, provider, and also for the success of payers, and, most importantly, for better outcomes for patients.

And so, it was very evident that the fact that we needed to share information and, basically, come together as an industry, agree on a set of use cases and the appropriate implementations of those uses cases so that we could build once for all payers, all EHR vendors and then, basically, have one on ramp for each of the use cases as opposed to the classic proprietary model in which we all built custom solutions, including for prior authorization. And we're, actually, going to walk through some of those today, but in the other use cases as well. So, the beauty of what we're doing from a Da Vinci perspective is that we're using contemporary technology and industry standard use cases that we agree on to provide a framework for everybody to follow. And although we're going to focus a lot on prior authorization today, there are many other use cases that we are funning under the Da Vinci Project. Things such as cost transparency, provider data exchange or payer data exchange, clinical data exchange, again, which means payers requesting from providers.

Payer data exchange is providers requesting from payers. Data exchange for quality measures, priority authorization support, again, which is going to be one of the primary use cases I'm going to talk about today. Coverage requirement discovery, document template and rules. I know I'm using a lot of buzz words. But as I think we go through the demo here, we're going to, actually, show some slides of what those look like running in a sandbox environment. But keep in mind the Da Vinci Project's primary goal is to facilitate the development and implementation of use cases including their associated implementation guides and reference architectures that allow payers and providers to solve real world use cases, like I was just describing, using contemporary technology. So, from a high level that is the Da Vinci Initiative. With that being said, in the interest of time, I think I will go ahead and go forward.

And what we're going to do, if we could go to the next slide please, is we're going to frame up – first of all, we need to frame up our organization a little bit because understanding how Humana is looking at prior authorization from the lens of an organization that recognizes that there are issues with prior authorizations, that there are unnecessary abrasions, there are a lot of inefficiencies that need to be solved. And looking at what we're doing from a Da Vinci perspective in light or with the perspective of other things that we're doing for prior authorization as well. And one of the things that has been an eye opener for us as an organization, I know Phil and I have talked about it a couple of times, is that the 278 is a standard for Humana. And we assumed the rest of the industry was also using 278 as a standard. But we've come to

recognize, through conversations and also some of the research that we've done that not everybody is doing medical electronic prior authorization.

And keep in mind I am talking about medical prior authorization today. For us, ePA from a pharmacy perspective is a different discussion. So, we're not going to talk about that much today. We're going to talk about the medical side of the world. So, again, we are very much a 278-focused organization. So, we get those, basically, in real time. And we process everything in real time. Regardless, if it was in a batch, it's part of a clearinghouse model or whatever the case may be. We process 278 requests with a real time response. So, we have a business rules engine that takes the transactions in. And within a couple of seconds after the rules process is done, we'll render some response. That is our contract with everyone that integrates with Humana from a prior auth perspective. So, that is our bias. So, keep that in mind. We're very much 278 centric. Now, with that being said, we do about 35,000 278's per day. That's both inpatient and outpatient.

So, we call them, actually, referrals and authorizations from a Humana perspective. But under the coverage, it's still a 278 transaction that is either for a referral to a specialist or for an inpatient or outpatient visit to a facility. So, 80% of our transactions are 278's or automated approvals meaning that when the transaction hits our rules engine, we render response within a couple of seconds saying your authorization is approved. So, keep that in mind, again, understanding the mindset of how we do prior authorization. That's what our current metrics look like. And we validated those about three hours ago to make sure they were still accurate. So, again, if somebody is sitting in a web portal and doing an authorization, they're going to get a real time response. If they're doing a B2B transaction, meaning they're going through a clearinghouse but they have a practice management system or an HMS HIIM system that is sending the authorizations to us, they're going to get a real time response.

Even if, for some reason, they were batched up the night before and collected by the clearinghouse, from a Humana perspective, they are still processed as real time transactions. And, again, we respond backed up by the onesies with the response. So, keep that in mind. So, 70% of our transactions that come in as 278's are real time electronic, meaning they come in from a B to D connection or from a B2B connection or from a web portal. So, again, not trying to beat a dead horse here but I want you to understand the unique perspective of how we do authorizations today, which I think may be a little bit unique or perhaps a little bit different than many of our partners in the industry. Phillip, would you like to add any color commentary to what I just said there?

Phil Britt
No. I think it was perfect.

Patrick Murta
All right. Next slide, please. Okay. So, industry overview. I was, actually, quite excited when the folks reached out for us to give this presentation because we have been focused on prior authorization for a long time. It was one of the original – as one of the original implementors back 20 years ago of the HIPAA rule, prior authorization has been a focus of the organization for a long time. And given the fact that we recognize that even in a model in which you truly do 278's that doesn't necessarily eliminate abrasions. So, I pulled out some documentation and Phil and I went through it the other day regarding some of the research that we did starting back in 2017 going up and through 2019. Now, I condensed about 300 pages worth of

research that we did for the provider groups and honed it in to just a couple of sentences as it relates to prior authorization.

And, again, I'm not going to read this to you but I'm going to get the highlights that we recognize that, although prior authorization adds value to the model, it also introduces significant cost. And I think it says on here like $25 billion. So, it's not significant in the administrative burden that prior authorization provides. Now, keeping in mind that Humana has been a real time 278 company for many years, we recognize that that may not be necessarily true across the industry in the sense that others may not be on the 278 standard. From a Humana perspective, even if you call us and we take the information over the phone that is still represented internally as 278 and we execute our rules against it. So, that's how 278 centric our mindset is. Given the fact that the rest of the industry may not have that particular mindset, we went ahead and continued the research to figure out what was preventing others from adopting this standard. And the prevailing thought was that ePA was meant to help with administrative burden.

But given some of the barriers, it still has relatively low use or did back in 2018. I suspect that's gotten better but still not where it probably should be. And some of the barriers that were mentioned by the physician focus groups were lack of operating rules, ubiquity of payer portals, payer **[inaudible] [00:17:51]** portals in state laws. And also, my personal favorite is that some components of the workflow occur outside of the scope of the electronic standard. And this is a common theme and is going to be reflected when we show what happens in the Da Vinci prior auth support use case is that taking people out of their native workflow can be an issue. Because when you're logging into a system, you're making a phone call and you're firing up your fax machine that is significantly disruptive to the workflow. And although I don't have it noted here, I think some of the time studies that were done as part of this showed that a prior authorization took about 17 minutes between the time the physician or the physician's staff tried to figure out does the payer even require prior authorization.

And if they do, should we go ahead and submit it or should we submit it if we don't even know if it's required? So, it's quite a cumbersome process. And even above and beyond that, although Humana is very much a 278 centric organization, we recognize that PA is progressive. It moves the ball forward. But it's not transformative in the way that we think of it today. There are other levers that can help some of this inefficient communication and providing better data integration for better efficiencies and outcome. So, again, that is a nice, gentle way into moving what we're doing from a Da Vinci perspective and some of the other initiatives that we have on our overall portfolio for 278 and prior auth improvement. I did take a snippet out of one of our studies. I didn't put all of the information here because it's a really, really big chart. But some of the opportunities that our clinicians told us and, again, this is not Humana specific, this was just a generic research project, is that you'll notice on the left side, the axis is going higher.

There are seven or eight things below that. But you'll see that streamlined authorization was very high at the top. And then, right atop of that was real time health plan coverage, which folds nicely into the coverage requirements discovery use case that we're going to walk through from a prototype perspective in a few minutes here. So, again, two of the things that we knew were abrasion points in the industry were reflected back to us in the research that we did with physicians. Next slide, please. So, I think, at this point, I am going to turn it over to Phil to talk about some of the initiatives. Again, he's going to start with Da Vinci just from a high level that talk about some of the other initiatives that we've got going on across the organization

to give a little bit of perspective of how Da Vinci and the prior auth use case fits in with some of our other initiatives as well. Phil?

Phil Britt

Thanks, Patrick. Yeah. And I think what Patrick hit on in that last little snippet there was streamlining authorizations. And it's really what we've been spending a lot of time and focus on is looking end to end and figuring out where can we improve each step of the process and what new opportunities exist for us to be able to do that. So, Da Vinci prior auth support is definitely one of those and being able to move that work forward. But there are several other initiatives, too, that I wanted to at least call out on things that we're doing as a company and, hopefully, can help support some of the work within the industry. So, electronic health records and working with those EMR systems, specifically, to be able to keep providers and provider support teams in their native workflow, as Patrick mentioned earlier, and being able to submit that prior auth or that authorization request right at the time that they need to into our systems and provide back a real time response.

So, we're working very, very diligently on trying to do that and reduce some of the administrative burden for our providers. At the same point in time, also provide by questionnaires along with that submission, which will allow us to be able to make a more timely decision in those authorization requests. Internally, or more focused internally, we have some automation bots that we're also in the process of scaling to be able to help take internal administrative burden off our UM process so that we can allow our clinicians to spend more time on the data that we get in to be able to make an informed decision and a timely decision back to our provider partners. Same thing really for analytics. A lot of different analytics capabilities exist on the market and how do we continue to take advantage of what exists today.

So, looking at all of the data that we receive from EHR's today and being able to take that along with the authorization information that is submitted to be able to possibly streamline the approvals based on the data that we have, historically, in the current situation that that patient or member is in. Right along with that NLP OCR, we realize that we'd like to have a lot of documentation to be able to support those decisions. A lot of those come over in an unfriendly format and is very time consuming both for our providers to be able to submit that information to us but also our internal teams to be able to read through and capture that information. So, leveraging all of the different capabilities that exist with natural language processing to be able to pull out information to format, to be able to streamline and highlight the data that is in that end structure images that could come over to us in a fax.

And right along with that, the fax automation in the next bullet there really taking a look at how we receive faxes and being able to connect those right away into the appropriate place in our system so that we can have our doctors and clinicians be able to pick that up in a more streamlined fashion, instead of having to research where that authorization request or the fax should go to. And then, finally, really in line with some of the other analytics is just leveraging some of the Watson tools that we put into place in that IVR system to be able to submit authorizations and then, in the future, also to be able to update those and provide back a real time response. So, you can see lots of different use cases. And we're really trying to take a look across the spectrum of our process to figure out how we can streamline prior authorizations and to reduce all of the administrative burden that could come with that process. Patrick, anything you would jump in and add there or anything else that you would like to touch on?

Patrick Murta

Actually, I think you've covered it very well. So, no, I think we're good. Next slide, please. So, now that you've got a little bit of a history of the Humana approach to prior authorization going back to the original 278 implementation, the fact that all of our stuff runs in a real time manner on our platforms, even if it appears as a batch somewhere else in the technology stack and the fact that we recognize that there are issues with abrasion. And the more we get information into the workflow of the clinician, the better off things are going to be. So, what we're going to walk through here is we debated showing some of the videos that we've recording or doing a live demo.

But given the time constraints and the fact that we wanted to make sure we were talking through content, we elected to distill this down and kind of show, I know it's a little bit hard to read, basically, how the Da Vinci prior auth support works from a high level, and I know that Dave and Kirk on the Regent side are probably going to walk through a very similar slide, and how that relates to the things that we are doing as an organization. And then, we're going to talk through a couple of key components on the next slide after this. But if we think about Da Vinci prior authorization support, the real goal is to provide the right information from the payer into the EHR system so that folks can stay in native workflow, information can be made available when it's needed, information gathered and an authorization submitted without going through an out of band process. So, given the referral or the authorization need, the prior authorization simply becomes, basically, a component of an existing process.

Trying to avoid going to an out of band process is what we're trying to get here. Now, the first step in this – and I'm going to talk about the top where it has CDS hooks and CQL questionnaire and then, I'm going to drop down to the bottom to show what we represent as part of our PLC. So, the first part of the prior authorization workflow is that a physician or some clinician is looking to do an authorization, either for inpatient or referral to a specialist or whatever the case may be. And, invariably, the first question that comes up is what does the payer require. Does the payer require prior authorization? Oh, it's Humana. Let me check all of my Post It notes because I'm not sure what Humana requires or let me call Humana or let me log on and look at their PAL list on a website or I may even not even go down that path. I'm just going to go ahead and do a prior authorization because I don't know if they require one.

Those are the types of things that physicians and their support staff go through when they're trying to determine or start the process of prior authorization. What we're doing here is that as the order is being entered in the EHR workflow, either an inpatient order or an order for referrals to a specialist then, behind the scenes, a technology called CDS hooks, clinical decision support, I'm sure the clinicians and others on the call probably recognize that, triggers an event in which a message is sent in real time over to the payer that says, "Hey, payer," in this case Humana, "We are about to do an inpatient admission for your patient. Are there any requirements for prior authorization or anything that you need from us to approve a prior authorization?" That's, basically, the message that goes from the EHR system over to the payer. In this model, that's called coverage requirements discovery, a very creative name indeed but we're always very creative on the Da Vinci Project.

And response comes back with information that is actionable. Now, keep in mind in today's world, that is a guessing game. It's a phone call. It is logging into a web portal trying to figure out if the payer even requires prior auth. In this model, I'm not sure who is driving the screen, but if you could please put your mouse over the very colorful orange and gray box in the lower left corner in which we have CRD. And in that case, you'll

see that the message, basically, says, I know it's kind of squinty there, that prior authorization is required. So, based upon this particular procedure code or diagnosis code or whatever the case may be, we're saying that prior authorization is required and that medical necessity documentation is available. Meaning that we've got information to help accelerate this prior authorization because there could be some attachments or some type of information that we need attestation on so that we can, basically, go ahead and approve the authorization.

So, in this case, it, actually, says source Humana. It's not a Humana specific implementation. It's generic to the EHR. But, of course, it makes sense to say that the payer that is responding to that request is Humana. So, in that case, the physician is going to click on medical necessity documentation. When I say physician, it could be support staff. But somebody in the clinical setting is going to click on medical necessity documentation. In that case, we're going to the second part of the workflow. And going back to the top where it says CQL, clinical query language, and questionnaire. And then, on either side, it says documentation templates and coverage rules. Again, a very creative name from a Da Vinci perspective that, basically, means that we are going to provide a SMART on FHIR application that is going to use CQL to try to get the information with the appropriate security. Again, it's being granted security appropriately by the EHR to get the needed information from the EHR to, basically, provide the clinicals needed for prior authorization.

And then, for whatever it can't find inside of the EHR, it's presenting a template, which is the DTR. I'm pointing at my screen. You, obviously, can't see my finger pointing. But the DTR SMART app in the middle in which it, basically, has the clinical criteria based upon industry standard guidelines for this particular CHF admission. So, in this case, I think the physician is ready to click something in the lower left corner. I see a mouse there. It's really hard to read that one. But he or she is, basically, providing the medical documentation because, for some reason, the SMART app was not able to get it out of the EHR. But Table 2 then, it will automatically populate the boxes. And then, we go into the right side, the prior authorization response. Now, we're down to the bottom line where it says prior authorization support on the left and right. And in the middle, we have a transaction set. In this particular case, the transaction is going from the EHR system over to a transformation layer, which, in this case, is a clearinghouse or an intermediary.

The clearinghouse is taking the FHIR messages, the FHIR claim, the FHIR bundle, converting those into a HIPAA X12 278 and also a HIPAA X12 275 if there happens to be some medical attachments and then, submitting those to the payer using existing modalities. So, that's a key point. In this model, the prior authorization support, since it's going through an intermediary, is going from FHIR to a 278 and then, to the payer using existing 278 channels like I've been describing for the first 10 minutes of the presentation or so. And then, I know it's really difficult to read, the payer responds. In this case, Humana responds in real time because that's the way our prior authorization engine works. And then, there is an authorization number in the lower right corner with the green bar there. So, I know it's really small to see but that's what the green bar is. So, in this case, I have assumed an intermediary. The model could work without an intermediary.

But for the purpose of this, we're assuming that the existing infrastructure stays in place. All right. I know I've covered a lot of material there. So, Phil, before we go on, I know we're probably taking a little bit too much time, any question or any additional comments before we go to the next slide?

Phil Britt
No. I won't take up too much time. I think, for me, every time I see this from our end to end process and the future say to where we want to go, this is exactly what we want to do in trying to be able to streamline decisions and being able to allow our providers to be able to work in their native workflow. So, I continue to be impressed with it and this is where we're going to spend a lot of time and focus.

Patrick Murta
Great. Thanks, Phil. Next slide, please. And I think we kind of hinted at this at the beginning. But I want to give a little bit of a broader perspective. We've talked about the Humana model. We've talked about some of the industry work that we're engaged in and some of the research. But I'm going to frame it up from a couple of perspectives. And Phil did a great job of describing the fact that Da Vinci is one of our initiatives but it's, certainly, not the only initiative that we're doing with prior authorization. We do have a senior vice president in the company who is not on the call today. Phil and I affectionately call her the senior vice president of 278. I'm not sure she really likes that title. But her focus is, basically, making sure that prior authorization is the most seamless, transparent, effective process for the organization.

And so, we have a prior auth collaborative of which both Phil and I sit on every week going through all of the initiatives that Phil talked about a few minutes ago. Da Vinci and our integration pattern with FHIR are one of those pillars. They generate quite a bit of excitement in the organization. So, we're, certainly, looking for this as a way forward from a prior authorization perspective. Again, it's one of many FHIR initiatives for Humana. So, we've got a lot of other Da Vinci use cases that are currently in development. We also work with CARIN, with FAST, of course. But we consider PA to be one of the most critical because PA is just a focus. It's an abrasion point. And we want to do our part as an organization and for the common good and for the benefit of our members and providers to do our part to eliminate those unnecessary abrasions. We also know, and this frequently comes up, that FHIR provides mechanisms, which complement the X12 baseline.

So, the model in which I just described – and, again, we are a 278 organization so I get the fact that we may be biased but I want to call that out in the sense that the way that I described that Da Vinci use case is one in which we are using FHIR as complementary transactions. So, we've got coverage of requirements discovery, which uses CDS hooks and FHIR, to help smooth over or smooth along, I should say, smooth along is not a phrase but bear with me, the overall authorization process. So, that's something that we're using. And also, the document template and rules streamlining in which we're using FHIR to, basically, provide information and to inform the process so that the 278, given the fact that it's a mandated transaction, is, basically, I don't want to say a proforma but it becomes almost an automated transaction in which the EHR has enough information to submit the 278 on behalf of the provider as opposed to having somebody retype everything into a web form.

And then, we also get that payer agnosticism is a key consideration. The fact that we consider, and I think most of our partners in the industry would consider, the fact that if we have a Humana-specific application, a Regent-specific app, or any specific payer app, that's only going to go so far. We share panels with other payers. So, the fact that we may have our own rules and we may have our own processes but as long as we're able to represent those in an implementation guide is absolutely critical. So, I'm going to pause there. And I think we've covered a lot of material. And I think, Alix, I don't know if you want to go ahead and do Q&A or if we're saving that towards the end.

Alix Goss
Yeah. That would be great. What I want to do is see if there are questions from the members by having them raise their hands. I know that Jim Jirjis is asking a question in the chat box related to how many and which EMR's. I think that was a directed question to you, Patrick. Hopefully, Jim, I got that question correct.

Jim Jirjis
Yeah. Hey, it's Jim Jirjis. I was just curious because what a commitment. How impressive that you're using all of these different technologies live to, actually, adjudicate this. But I was curious on which EHR platforms are able to participate. Is it one and, if so, which and did you test out the ability of a variety of EMR's to play in this space?

Patrick Murta
Yeah. Great question, Jim. And I'll phrase it into two answers and then, give Phil a chance to respond. A lot of the technologies that Phil went over on the slide when we talked about the entire portfolio, those are completely EHR agnostic. So, they, typically, operate either on the Humana side or somewhere in the cloud between the transactions. So, those are. As far as the Da Vinci-specific use case, we are, currently, testing in a sandbox environment, not production, but in a sandbox environment with Epic. So, we've tested from a connected-on perspective there. Also, with Rush Medical, of course, is an Epic user as well so did a couple of different installations. We have a group in Virginia that we are going to start doing some prototype testing on as well and also, of course, working with Availity as a clearinghouse to bring them into the fold as well.

Alix Goss
Thank you. Our next question is from Arien Malec.

Arien Malec
Thanks. So, maybe part of the answer to this is we're still working in pre-production mode. But one question on the front end of this, which is to what extent does the workflow anticipate or require an eligibility check on the front end before you go into coverage discovery or to what extent is the eligibility transaction built into coverage discovery. And then if you can address what are the peer requirements. So, it sounds like you started with a real time platform for doing PA already. You were already set up on the 278. And so, there is a whole set of stuff that you had from a rules engine perspective that was up running and working. But what are the pre-requirements for a payer to quasi adjudicate some of the ePA work?

Patrick Murta
Got you. Those are really, really good questions. I think I've forgotten the first one.

Arien Malec
Eligibility on the front end.

Patrick Murta
Yeah. That's one that intrigues me because this is one that always tends to make folks a little bit I don't want to say nervous but we need to make sure we run these by our Legal Department in the sense that this model I don't want to say assumes. But given that a 270, 271 E&B transaction is part of the prior workflow,

it typically happens before the clinical work happens is that the coverage requirements discovery doesn't, technically, require that a 270 or 271 has already occurred. I think, given the nature of clinical workflow, it's almost assumed that it has. And to your point, the coverage requirements discovery, under the covers, of course, determines if this is a Humana member or not. So, it has to know that you're a Humana member before it can respond back with this is something specific to this plan or whatever.

Arien Malec
And you referenced E&B but I think you mean just plain old 270, 271 for a medical benefit, right?

Patrick Murta
Yeah.

Arien Malec
Because E&B would be for a prescription benefit.

Patrick Murta
Yeah, 270, 271. We call them E&B's internally, but yeah, it's 270, 271.

Arien Malec
Yeah. I got it. Okay. Perfect. It's so helpful. So, your assumption, basically, if this is already a Humana member, already a covered member, you're getting a beneficiary ID and you're doing a secondary check on the back end. But you already assumed the confirmation of eligibility. Thank you. And then, in terms of for maybe speaking on behalf of the payer industry as a whole as opposed to particular to Humana, maybe some of the assumptions here are the ability to run some of these workflows in real time and some of the infrastructure that you already had built you would think would be a precondition for building functionality and capability.

Patrick Murta
Yes. So, I think from a – and let me make sure I understand your question. For example, other payers in this space, you would have to have the technical capacity and infrastructure to be able to execute, basically, in real time. So, I think that's a given in the sense that you've got to be able to respond with the performance that an EHR can support and also the ability to respond to 278 transactions in addition to the FHIR transactions in real time. That's correct.

Arien Malec
And then, do you have a response time that you're targeting for your production environment? What, based on your experience, is the interactive response time that's required? And you've got, presumably, a physician who is in the middle of an order workflow relative to ePA. Do you have a target response time that you're looking at?

Patrick Murta
Yeah. We do have a target response time. Please don't hold me to these. And they're, typically, based on what we do from an X12 perspective as well. So, you mentioned 270, 271, which, on average, runs in about 1.5 seconds through the clearinghouse to Humana and back. So, from a CRD, coverage requirements discovery, we're shooting for the two to three second range round trip, given the fact that somebody is

waiting on it. The same for the document template and rules. We are tracking something. And if you look at the video, you, actually, see it that the rendering of the SMART app inside of the EHR is taking a little bit longer than we would expect in a sandbox. So, we're a little bit above those couple of second thresholds that we were talking about. So, that's something we're, certainly, tracking. But we want to keep it in, certainly, the two to five second range. The actual 278 decisioning is probably a little bit broader. Although in the sandbox, it runs really, really quickly.

We see that in production running it through the rules engine, getting a response back can take, on average, maybe three to four seconds round trip from a request to the engine and back. But there are some – it does tend to have a fairly wide distribution meaning some of those get up into seven or eight seconds as well. So, it's something we have our eye on. And the interesting thing is we're turning over internal utilization management system. It's got a few years on it, at this point. So, we're hoping to get better performance out of that. We'd need to have it in less than 10 seconds. We'd like to have it a lot less than 10 seconds.

Arien Malec
Perfect. Thank you so much.

Alix Goss
Gentlemen, thank you so much for that really interesting discussion around just how fast the transaction flow can really happen. We did have another question from Ram but, unfortunately, we're at the point where we're over our allocated time. So, what I would ask is if you could hold your questions. If we have time after we get through Regence's presentation, we'll come back to those. So, I'm going to turn it over to Sheryl Turney to guide us through in supporting the Regence/Cambia Q&A. But I think we're just going to jump right into their session.

Sheryl Turney
Thank you.

Alix Goss
Really fabulous job, Patrick.

Patrick Murta
Thank you.

Sheryl Turney
So, now we're going to transition to Kirk Anderson and David DeGandi for Cambia. And take it away.

Kirk Anderson
Good afternoon, everyone. This is Kirk Anderson. I am the Vice President and Chief Technology Officer at Cambia Health Solutions, which includes our insurance business, Regence Blue Cross Blue Shield. I, actually, have one of our business experts, our Vice President of Clinical Services, Julie Lindberg, who is going to be our primary speaker today talking about Regence's journey in prior auth. We've also keyed up a demo of the prior authorization Da Vinci use cases that we have been working on. So, I think overall without trying, we've got a nice complementary set of content here to the great stuff that the Humana folks have just shared. So, with that, I will turn it over to Julie Lindberg.

Lauren Richie
If you're speaking, you may be on mute.

Kirk Anderson
Hopefully, we haven't lost Julie.

Lauren Richie
We are just checking on the audio line.

Kirk Anderson
Okay.

Lauren Richie
It doesn't look like she's dialed in. We'll have our contractor reach out separately and see if we can get her on.

Kirk Anderson
Okay. Well, I think I can wing it and do my Julie impersonation until we can get Julie back on. I know we don't have a lot of time. Oh, that's right. Heidi, I forgot. I'm going to turn it over to you, Heidi. So, if you want to go ahead and advance to the next slide. And Heidi, if you could just introduce yourself and pinch hit here until we can get Julie back online.

Heidi Kriz
Okay. So, I'll do my best. Can you guys hear me okay?

Kirk Anderson
Yes.

Heidi Kriz
All right. So, I'm going to talk off the cuff. So, my name is Heidi Kriz. I am a manager of medical policy at Cambia Regence. And then, I have worked a lot on prior authorization transformation more from the medical policy side of the house. And I'm sorry, I'm getting a really bad echo in my ear right now so I'm going to try to talk through this. And so, as an organization, we've prioritized conforming the prior authorization process from a variety of perspectives from the member experience to the provider experience. And so, there are a lot of initiatives happening right now. And really, the benefits to the healthcare consumer are around getting quality of care and safety of care. And so, that's partly why we have maintained prior authorization. And then, the assurance of coverage so avoiding balanced billing. So, trying to get up front with the members and the providers what requires prior authorization and what doesn't.

So, we have a variety of initiatives round that. And then, the prevention of over treatment. So, we've maintained prior authorization to ensure that members are receiving the appropriate care within their clinical pathways. And then, the reduction of healthcare costs associated with fraud, waste, and abuse. And if you guys want to jump over to the next slide here. And Kirk, I don't know, do you guys want to talk through this?

Alix Goss

I wonder if we lost Kirk's audio or he's on mute. So, Dave, why don't you jump in?

Kirk Anderson
Am I back? How about now?

Alix Goss
Yes.

Kirk Anderson
You can hear me. Okay, great. Well, this is going smooth. Thanks, Heidi. So, yes, while we are getting Julie back online, let me speak a little bit to the prior authorization journey or the history within Regence. And oversimplifying a little bit, but just to demonstrate that, historically, there are a lot of reasons why, even though there is value in the prior authorization process itself, as Heidi was alluding to, it's been a painful process. And it's been one that has been one of the most significant pain points, not only for the healthcare consumer, first and foremost, but for providers and payers alike. Historically, these interactions would take place, certainly, not in real time. In some cases, using fax machines or even more antiquated communication mechanisms and ending up with a lot of manual work both inside the providers' offices and inside the payers.

So, you can go to the next slide. So, starting three or four years ago, and, Heidi, you can chime here as well, Regence, like Humana, started to look at how it could bring automation and real time response within its own four walls. So, focusing on what we like to think of as payer side automation, we launched a project and a strategic initiative inside Regence that we called eAuth, which was all about trying to automate the responses that we would get from a provider for prior authorization. So, this involved – it kind of aligned with some other modernization efforts and embracing API's inside, again, the four walls of Regence. The downside of this, as alluded to from our friends at Humana, is that even with this move forward, it still required providers to leave their native EMR workflow. So, primarily, the way that we were realizing the benefits of the eAuth initiative was by extending the automation to the provider through a portal.

And while that was an improvement in a lot of ways, certainly over the fax machines, it did disrupt and create what our provider partners called provider abrasion and, as a result, really detracted in their adoption of the automation we were bringing inside of Regence. And we were really at a point where we needed something like the Da Vinci Project to allow us to bring the automation and the real time latency that we are seeking for our members into the provider's office, into that EM workflow. So, if you go to the next slide, this one, Heidi, is one you can speak to before we go to the Da Vinci phase. Can you speak a little bit about the eAuth and autoAuth?

Heidi Kriz
Yeah, sure. So, we launched our eAuth and our autoAuth project, actually, a few years ago now. And we are continuing to build upon it and improve upon it. And so, what we were really trying to accomplish on the eAuth side was greater transparency for the providers and really focusing on that PA check, as Humana was talking about earlier so that the providers know exactly what requires prior authorization and what doesn't at that PA check point. And then, what that's allowed us to do, as you can see here in the improvements, is really reduce the waste. So, 65% of the electronic authorization requests, actually, did not require prior authorization. So, the members – can you guys hear me? My screen just went gray.

David DeGandi
Yeah, we can hear you fine.

Heidi Kriz
Oh, good. Okay. So, 65% of the authorizations that were coming through, actually, did not require prior authorizations. And so, the providers could, actually, move straight into providing that service. And the members could also receive that service right away. And that was a big win for us. It also reduced just the administrative burden as well for, not only the providers but for us internally. And then, 87% of the authorization requests are completed within at least equal to or less than five calendar days. And then, if all of the clinical information is received at the time of the request, you can see 85% of those are completed within 2 days or less and then, 98% within 5 days or less. And then, the other piece, after we launched our eAuth project just getting the electronic authorization, the benefits, the eligibility check, and the providers finding out if the service requires prior authorization or not, we built in a second phase, which allows for auto authorization when policy criteria are met.

And so, when they put that code in, it will check for prior authorization. If the code requires prior authorization then, it will seamlessly drive the provider over to our auto authorization tool in which we've built out our medical policies and the criteria. And that's the criteria required to achieve medical necessity. And so, they will see the criteria. They can check off what's relevant to their patient. And then, we have logic in the background that will know, based on what they check, is the medical necessity criteria met for that policy or is it not. And if it is and we've determined that that cause can auto approve then, they will get an instant auto approval on that policy again. They can move forward with the service and the member can get their medically necessary services. And I think I just lost connection. Can you guys still hear me?

Kirk Anderson
Well, I still hear you. People still hear you.

Heidi Kriz
Great. It said I lost connection. And so, we're really excited about the auto approval functionality piece of all of that so it can be a complete transaction for the provider for a prior authorization request. And then, some of the limitations of these functionalities are just requiring submission through separate portals. We, actually, did just build in our vendor. So, we use AIM and eviCore for prior authorizations of those services for imaging and then, some of our other physical medicine types of modalities. And so, we did build that in recently and so that's launching. And then, the auto authorization process has had challenges. It adds additional time to the providers and their office staff, which, traditionally, they would just fax in the request and we would take it, find all of that clinical information and then, give them a response back. Whereas that puts some of the burden on the provider.

So, we're working really actively right now with our providers in that space to figure out how to make that more seamless and how to collaborate with them. And then, the clinical records still continues to be a challenge and getting the right clinical information for that prior authorization. We are auditing the auto approvals on the back end and consistently are seeing that we don't have the clinical documentation to support what was selected in the policy criteria. And so, again, that's where some sort of EHR integration would be really ideal for us. Kirk, am I going to turn it over to you or David next?

Kirk Anderson
Oh, we got Julie finally.

Julie Lindberg
Well, Heidi, thank you so much for pinch hitting. I apologize, everyone. I'm sure it was user error that I couldn't seem to get the computer into the meeting because I could hear everything. But I just want to keep my technical folks around for issues like this. So, let me, just in the interest of time, let me just make a couple more points and we can go to the next slide. And then, I do want to give us time for the demo and some questions. I think Heidi made the critical points. The eAuth got us part of the way towards improvement. But it really didn't improve the provider experience other than they didn't have to submit an authorization that was required. They still had to exit through the EHR. They still had to send records. And the records were a bulk of records. And our clinical staff still had to redo all of the records and look for the clinical points **[audio interference]** decision around authorization and **[audio interference]**.

So, the next generation and what we define our standards have removed the barrier and are allowing us to do it. And the slide is not advancing on my end. I don't know if you all tried to advance the slide or not but we could go to the – there we go. Okay. So, I call FHIR our game changer. The next thing we want to do, and we'll see the demo, is we want providers to be able to submit an authorization without having to leave the EHR. We want the exchange of clinical information to occur in an automated way where the salient clinical information gets pulled in an automated way from the EHR. It's bounced up against a set of clinical criteria, again, in an automated way. If it requires additional review on our side, the clinical points get in front of our clinical staff so that they can quickly review the necessary information and render a decision. Time for the provider could happen if the automated clinical review is successful. Our goal is that the authorization decision is rendered before a patient leaves the office if possible.

Ideally, even while the provider is making decisions about care. So, with that, I think I will turn it over to Kirk and Dave to go through some of the technical information and the demo.

Kirk Anderson
Great. So, you can go to the next slide. And just to dive in a little bit and this, again, follows on some of the content that Humana was sharing, while we are able to push forward here in an open standards based way using FHIR, we still do have to, of course, comply with current clinical data standards, including the X12 standards, 278 and, when attachments are involved, 275's, in the prior auth workflow. And the nice thing about the Da Vinci use cases and the Da Vinci Project is the implementation guides are there to support our insertion of a bridge, if you will, between FHIR end points so that we can continue to leverage X12 where we are required to while, basically, having the FHIR standards in place outside of that bridge. Ideally, going forward, we'd love to see a future where we did not have to insert this bridge.

But until we reach that future, this is really critical for adoption and for us to be able to demonstrate the value of the future of prior auth end to end with our provider partners. All right. So, after all of our connectivity issues, I think it's probably – it might be crazy to pivot to a live demo but that's what we're going to do or at least a recorded demo. Dave, can you take it from here?

David DeGandi

It's a recorded demo. And at 32 seconds, I'll ask that you pause for a moment. And I believe that you're part way into it already. So, this runs within the Epic workflow. It's a SMART on FHIR application that we have. And it's, actually, hosted by Rush. Most of the data is pre-filled. The user has to enter in the servicing provider information, as you can see now it's happening. Then, they also have to enter the service code for the user and **[inaudible] [01:05:24]** information. And then, they review their request and pause here, please. So, that last string was at the end of the coverage, you'll find the discovery where it says there's a pre auth required. In this case, a preauthorization is required. And the doctor will launch – we have an organization that we manage our policies through called MCG. And they have a SMART on FHIR application also.

And so, the provider launches the MCG app. Go ahead and continue the video, please. It will pop into the areas specific to that procedure and diagnosis and automatically pull in any information or attachment that's needed and then, return back to the SMART app where the authorization will be submitted. And then, that goes out through Availity through the X12 translations and comes back into the app here and will come back auto approved or whatever state would be determined in real time. And that's it.

Kirk Anderson
All right. Thanks, Dave. Okay. We made it through that. It's 1:15. I think we still have a little bit of time left for any questions.

Alix Goss
We do. And we have a question that's up for Arien Malec. And Ram, I will come back to you because I know you still had a question for Humana and we'll come back to that after Arien's question. Go ahead.

Arien Malec
I apologize. I just left my hand up.

Alix Goss
Oh, okay. Any questions for Cambia then? I don't see any questions with hands raised right now. So, why don't we take Ram's question for Humana and then, we can come back if folks put themselves in the cue. Ram's question, and Ram, I don't know if you want to put yourself off of mute –

Ram Sriram
Yeah. I have a couple of quick questions. One is on Slide 6 because we heard this from **[inaudible] [01:07:50]** last time so what is the role of folks like **[inaudible] [01:07:53]** in that slide. And the second question I have is about you talked about artificial intelligence. Now, do you use both at the payer side and the provider side like you have a SMART app on the provider side, which probably does some analysis and then, when you go into the payer side, you could potentially have an AI system there figuring out whether the prior auth is, actually, required like can we give it or not or whatever it is. So, that's the question I have.

Patrick Murta
Thanks, Ram. And that was for Humana, correct?

Ram Sriram
Yeah. That's right, yeah.

Patrick Murta
So, the CoverMyMeds, although we do test integration with CoverMyMeds since they are part of our pharmacy offering, nothing that I showed on that particular page is part of the CoverMyMeds implementation. We're in the process, we've got it in our sandbox, but we will be supporting the CARIN RTBC for using CoverMyMeds and the CARIN Alliance's implementation type guide. So, the experience will be that, actually, on the member app as far as showing what the drug is going to cost with the co-pay alternatives and those types of things. But it really is not part of any of the slides that I showed. It would be a different deck that we have for different purposes.

Ram Sriram
Thank you. And my final was on the AI.

Patrick Murta
Yeah. So, I think you're talking about, and I'll let Phil respond to this as well, I believe it was the last bullet point when it said we were using Watson. Is that what you –

Ram Sriram
Yeah. I'm just wondering how we are using Watson.

Patrick Murta
That's a good question because it has been a long journey for Humana. We've been working with Watson for many, many years. And so, the current implementation that we have with Watson is that Watson will, actually, talk to providers and support staff as they call in to Humana. So, if a support staff person were to call in to Humana and say I would like authorization for Phil Britt and then, Watson would ask questions. It would read our internal data. It would read our internal rules and then, create responses and also coverages, plan information, what it knew about the member. And then, Watson would interact with the person via the phone in real time. The technology has not gone beyond that so it is not part of the Da Vinci integration stack or our FHIR technology at this point. It may be in the future. As of right now, we're, basically, tuning it so that Watson can communicate with humans and, basically, be able to respond with a prior authorization.

Ram Sriram
Thank you. That answers my question.

Sheryl Turney
Thank you. That's very good. At this point in time, we're going to take a pause because it's time for us to have our public comment. And there is a slide up right now for anyone that is listening to this call that's part of the public with the instructions on how to cue up. And Lauren, can you see if we have anybody who is awaiting public comment?

Lauren Richie
Sure. Let's first ask the operator to open the public lines.

Operator

Yes. If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment while we poll for questions. There are no comments at this time.

Lauren Richie
Okay. I know we may be expecting another comment or two but, Sheryl, I'll hand it back over to you.

Sheryl Turney
Thank you, Lauren. And let us know if we have any public comments. Are there any other of the folks on this work group that have questions for either Humana or for Cambia, please let us know now. We do have a few more minutes before we do the wrap up.

Jocelyn
Hey, Sheryl, this is Jocelyn.

Sheryl Turney
Go ahead.

Jocelyn
Sorry. I'm just on the phone today. I just want to thank both the Cambia and the Humana team for taking the time to come and give an update today. I really appreciate it.

Sheryl Turney
Thank you so much for that. I was about to say the same thing. Everybody is working remotely for the most part on this entire group. And I think trying to orchestrate these things is never easy but I appreciate everybody's patience while we went through this process. The information that was shared with us today is very important to the work that we're doing and will help definitely inform as we are working on our recommendations and considerations for our final papers. So, having this information is really important in really understanding what the challenges are that all of the organizations are facing. From that perspective, I think that it's really important to understand that every stakeholder in the healthcare landscape is dealing with some amount of burden. Obviously, providers but patients as well as payers and all of the providers of medical services along that healthcare journey.

So, it's really important that we understand what all of those issues are and what the levers are and the incentives are that we can work towards in order to make our recommendations more meaningful. So, any other questions? I don't see any other hands raised. How about anybody on the phone?

Operator
There are no comments at this time.

Sheryl Turney
Okay. Well, thank you all for participating today. I guess we're going to close early. I would ask all of the work –

Operator
Excuse me.

Sheryl Turney
Yes?

Operator
We just have somebody that came in with a comment.

Sheryl Turney
Okay. Perfect. So, let's open the line.

Operator
Heather McComas with American Medical, please go ahead.

Heather McComas
Hi, thank you. Sorry. It took me a minute to get cued up there. I have a question and it's probably for both speakers today, maybe Humana first. And everyone's presentations were really, hugely helpful and thank you for your time. There were a lot of references to auto adjudication during both presentations, which is great because it indicates that, obviously, care would not be delayed in those cases and it's something that's, obviously, important to all of us. I was wondering if both Humana and Regence and Cambia could talk a little bit about if that model requires an attestation system versus actual review of clinical data. I know there is the Humana example template showing some boxes to check. And one of the examples was a patient has abnormal electrolytes and that, obviously, is kind of a yes/no thing.

That could be processed quickly by machine versus, actually, the clinical data showing abnormal potassium values or sodium values that someone would, actually, have to review and approve. And then, also maybe more for the Cambia Regence side, it sounded like when there is auto attestation that can involve a retrospective review and submission of clinical data that might, in some cases, involve the clinical criteria not being met and the claim possibly being retroactively denied. So, I was wondering if you could talk a little bit more about the whole auto adjudication and what model you need to make that work. Thank you.

Patrick Murta
So, this is Patrick from Humana. Phil, do you want to take a first cut of that and then, we can kick it over to Dave and Kirk from Cambia?

Phil Britt
Yeah. I can. I need to make sure I got the question right here. But we talked about auto adjudication and being able to take information and data that's available, I think we're looking at several different ways to be able to extract that information and process it appropriately. So, from a systems perspective, I'm more a person from a systems perspective. I think we have several different capabilities that we can go after to be able to make that happen. Patrick, is there anything else you could add in there?

Patrick Murta

Yeah. And I think, Heather, a really good question. And I think maybe the app that we showed on that screen is a prototype. So, when we're talking about the auto adjudication, in that particular use case, in the sandbox it did approve. When we're talking about the auto approval initiatives other than Da Vinci, those are ones that, typically, exist in today's world. And they can, usually, be approved via the rule's engine based upon the content of the 278 or based upon data that's readily available inside of the organization without attachments. That's kind of a general statement. But we can, of course, do some NLP and other type of OCR. But for the most part, in todays world in auto approval, when you say autoAuth, I'm assuming you mean auto approval, is one in which the content of the 278 and given other information that we already have internally is enough for the rules engine to automatically say yes, this is auto approved.

And that was, I think, 80% of the transactions that I mentioned. The other 20% go into a pending status in which a human, to your point, does have to look at I think you said abnormal potassium but something like that in which a human would have to look at it to make sure that it is appropriate for the authorization. We suspect that we'll get better in the future as the machines can do a better job at reading clinical documentation and making recommendations and learning and stuff like that. But in today's world, it's mostly because the authorization itself is fairly cohesive and the supporting information that we already have is documented and ready to go.

Phil Britt
Yeah. I agree, Patrick, with what you said and my focus was more on the 20% there and how do we continue to decrease that 20% to be able to get to that auto approval or auto adjudication for approvals. And I think there are several different things employed for that.

Patrick Murta
Heather, does that help before we kick it over to Regence to make sure we're on the right page?

Heather McComas
Yeah. That's really helpful. It sounds like, right now, the kind of auto approval model then is for something that doesn't require clinical attachments or documentation review on the plan side.

Patrick Murta
That's a good generalization. That's correct.

Sheryl Turney
From the Regence side now?

Heidi Kriz
This is Heidi. I'll take the questions. We have built out our autoAuth tool primarily around clinical criteria and they would select off what is relevant to the patient. And then, like I said, there is logic in the background that is hidden that the provider can't see. We do have, in those clinical criteria, an attestation statement that the providers check off attesting that what they're doing does not fall into any sort of investigational or not medical necessary indications. So, there is a clinical criteria and then, an attestation to the non-coverage indications. We do have one area that we built out a strict attestation on. And so, there is one of those. And all they do is go into the system and, basically, check a box attesting to what they're doing and indications of the patient. And then, they get our quick auto approval from that.

As far as the audit goes, we are auditing a subset of those auto approvals and looking at the criteria that was submitted by the provider and what was checked off. Unfortunately, we do have to comb through the documents, which are the attachments at the end of the process. What we've done is when we've identified issues, we are really trying to collaborate with the providers and provide education about what they did in the system and what should have happened or what clinical documentation was not provided. And our experience to date so far with that has been very positive. The providers are really taking to heart that collaboration and really trying to make this work for them. They see the benefits when they get quick auto approvals. And so, we have not gotten into a situation yet where you mentioned retroactively reversing a denial or recouping some of that money.

We have not gotten to that situation yet just because we've been really collaborative with the providers and they've really engaged back with us. As far as our strategy, too, what helps is we did choose policies that had significantly higher approval ratings historically. And those are the ones that we are auto approving. So, I think that helps with protecting us from really high cost types of services auto approving inappropriately. So, for example, we don't auto approve varicose veins or bariatric surgery. So, we have some built in protection.

Sheryl Turney
Thank you so much, Heidi, for that. We do have one other question from the group. I'm going to let them ask it even though we're at time. And, hopefully, we can get through that. Our next task force meeting is May 12. But Ram, what was your question because I know you've been waiting?

Ram Sriram
My question is what percentage of the prior auths are, actually, rejected after going through the to-and-fro process between the doctor, the provider, and the insurance company. Exactly, like you said, are there statistics on how much of it is what percentage are rejected if rejected?

Patrick Murta
I heard that question and could sense the urgency so I stayed on the call. I know it's, actually, very small. I don't know that I have the percentage. Phil, do you? So, 20% going to a pend status, most of those will eventually approve. I don't know that I know exactly which ones are never going to approved status. Phil, do you have any idea on that number?

Phil Britt
I don't have the numbers, honestly, to be able to communicate that. But I think you're right directionally. If we don't approve the authorization, it's mostly going to pend and then, eventually, will turn into approval status. So, the actual denial or rejection would be very small.

Patrick Murta
And I think it's in the low single digits. I just don't know that I know the exact percentage.

Ram Sriram
So, if you approve everything then, you'll save money though with all of these transactions if that's the case. I'm just wondering out loud here in terms of the cost benefit analysis.

Sheryl Turney
So, maybe we can take that up after the fact. If you have something you want to put in writing, Ram, we can send it off to them because we are beyond the meeting time.

Ram Sriram
No, no. I'm really not much – I'm just wondering what is the cost benefit and savings from this whole thing for them.

Julie Lindberg
This is Julie from Regence. I would say the reason why we're so excited about the FHIR standards and doing the PA use case with Da Vinci is because where we're at today, the eAuth system and the autoAuth system is not really performing as well as we'd like. So, while it's better, there is a long way to go, I think. And so, whatever this group can do to clear barriers, technology and standard barriers, for us is really helping us go further.

Sheryl Turney
Thank you so much for that. So, I just want to wrap up for next week. Again, our meeting is May 12 at 3:00. We're having a demonstration of the CMS VRLS work, which will be another great demonstration and then, AMA presentation. But also, we would really like the members of the work group to start getting into the other considerations and recommendations tab of the workbook and give us some comments because there are not a lot of comments that have been added out there. And as soon as these demonstrations are over, we are going to start talking about those again. So, it would be great if you could go in there and start reviewing these and then, give us your thoughts and questions regarding that so that we'll have the work set up for us. And then, looking at more additional work on the use cases and planning for our May 19 meeting.

So, any questions? Thanks, everybody, for staying long. We really appreciate it and hope you have a wonderful evening.