ANALYST BRIEF
Sponsored by: InterSystems

A strategy to comply with the final rule issued by the U.S. Centers for Medicare & Medicaid Services suggests that payers should unify organizations and systems around their members' longitudinal health records.

The Unstated Fifth Mandated CMS Requirement for Payers by 2027

May 2024

Written by: Jeff Rivkin, Research Director, Payer IT Strategies

Introduction

The U.S. Centers for Medicare & Medicaid Services (CMS) recently finalized a regulation that includes mandates designed to speed the electronic exchange of information, streamline the processes related to prior authorization (PA), and improve patient care.

As part of CMS-0057-F, CMS finalized proposals for payers to:

- Implement and maintain an application programming interface (API) to support and streamline PA processes, respond to requests within certain time frames, provide a specific reason for denials, and publicly report on approvals, denials, and appeals.
- Expand the payer-to-patient data access API that was put in place to address earlier mandates. The API must now share information about patient PA decisions to help patients understand their payer's PA process and its impact on their care.
- Deploy a payer-to-payer data exchange access API to share patient data (with the patient's permission) when a patient has multiple health plans or changes health plans. Data includes claims and encounter data (excluding costs), data elements described in U.S. Core Data for Interoperability v1 (USCDIv1), and PA requests and decisions.
- Deploy a payer-to-provider data exchange access API to share patient data with in-network providers with existing patient treatment relationships. Data includes patient claims and encounter data (excluding costs), data elements described in USCDIv1, and PA requests and decisions.

AT A GLANCE

WHAT'S IMPORTANT

- The U.S. Centers for Medicare & Medicaid Services recently finalized a proposed rule designed to speed the electronic exchange of information, streamline the processes related to prior authorization, and improve patient care.
- Data factory approaches, master data management techniques, and data fabric payer technology trends have been accelerated by these mandates.
- Organizations should allow requirements around mandates to be a driver of innovation instead of a necessary evil to be dispatched.

KEY TAKEAWAY

What is not stated but is heavily implied in the CMS ruling is the architectural implication that the payer-to-payer API is intended to be used by payers to populate longitudinal health records for their members, effectively a fifth requirement.

In short, these four mandates mean shorter turnaround times for prior authorizations, increased transparency and reporting requirements, and new standards and collaboration requirements around PA submissions and data exchanges.

Analysis

The rule also states that payers will be required to integrate any data they receive in response to a payer-to-payer data exchange into the patient's record and that, because payers receive claims or encounter data from each provider that sees a patient, they typically possess the most complete historical patient record. In other words, what is heavily implied in the CMS ruling is the architectural implication that the payer-to-payer API is intended to be used by payers to create longitudinal health records for their members, effectively a fifth requirement.

Some call this a member-360 data store. If payers haven't already established this as an architectural pillar in response to the early-and-yet-to-mature interoperable healthcare landscape, these rulings cement that need.

As technology stack of the payer has evolved, its centralized enrollment and claims system has grown to address care. Clinically focused applications like wellness and care coordination; hospital-input admission, discharge, and transfer (ADT); and the beginning of the integration of multiple providers' electronic health records (EHRs) have sprung up, usually in silos. Similarly, the mandated focus on risk adjustment, care quality, equity (SDOH), and compliance data challenged the payer's tech stack and were also usually siloed.

Recently, the interoperability mandates have led to a new focus: the need for coordination in data sharing and consent to that sharing across the healthcare ecosystem. That challenge continues to evolve with no comprehensive solution adopted to date. Some applications enable local data sharing within a system, but the industry needs a global standard approach to this common problem among providers, payers, and patients (and their designees).

Instead of silos, when all of this is merged into a longitudinal patient record (member-360), this data becomes a centrally deployed asset that can be used to allow the customer service, enrollment, claims, compliance, metrics, sales, marketing, and care coordination teams to access and use the same information base to profile members, provide common interoperability, and provide the level of service members require in today's consumerized world of healthcare and health insurance.

Benefits

A member-360 data store serves as a bridging asset between the clinical and administrative components of the organization, both of which are essential to full compliance with the operational and technical elements of the regulation. This can be done holistically by expanding use of the member-360 longitudinal health record to show activity rather than just state of being. It brings PA transactional data back into the organization. That internalization can give the care management and customer service functions the longitudinal data that they need to do a better job with care and administration for members. Payers also have an opportunity to unify their use and disclosure of member data within the enterprise and to the public, not just in the context of mandates.

Considerations

Multiple Input Formats

In the short term, because of the mandate, payers must be prepared to support all PA intake formats (fax, phone, portal, X12, FHIR) to meet providers where they are along the PA maturity curve.

The X12 standard will most likely result in providers submitting full medical records with prior authorizations. This means:

- A higher need for optical character recognition to identify the relevant clinical documentation
- A wave of AI applications utilized to parse the record and identify relevant clinical documentation

The implication of the FHIR standard is that it will allow payers to receive and review only applicable documentation to the prior authorization and streamline decision-making in support of the reduced turnaround time requirements.

Overhaul of Care Management/PA Interfaces

After establishing the member-360, payers can add a seamless workflow that can trigger PA request issuance when necessary for items in a prescribed care plan or trigger care management involvement upon the request of a (perhaps unrelated) PA. The functions of processing a PA transaction (today in a contextual vacuum) combined with the whole-person care coordination/management process show a member that the payer is a "partner in care."

Overhaul of Other Utilization Management

Just as a 360-degree understanding of members should evolve to become more comprehensive, so should a payer's plans to comply with the evolving regulatory requirements of utilization management. Payers should:

- Take a broader perspective on analyzing cost-of-care impact to include the auth rule ROI, coding practices, variation, and value-based payments.
- Redirect site of care based on facility/provider quality or most appropriate level of care (inpatient, outpatient, home).
- Expand fraud, waste, and abuse rules to monitor inappropriate use in place of existing ineffective prior authorization rules.
- Monitor treatment quality to reduce redundancies and time to treatment; improve Star and HEDIS performance.
- Consider subsidizing provider automation tools to increase PA/appeals automation adoption.
- Take the opportunity to overhaul the tools of all utilization management programs in the context of interoperable API and portals.
- Ensure that step therapy, formularies, and appeals have a clinically accurate foundation. Optimally, the referenced clinical information would be readily available to the prescribing/ordering provider and the public.

Via the member-360, payers have an opportunity to streamline their use and disclosure of guidelines, overrides, and plan changes enterprisewide and to the public at large, not just in the context of PA mandates.

Other Considerations

Payers should also look to:

- Fold in risk adjustment metric calculations into the member-360. This unifies metrics, care management, and gaps in care, and it allows real-time modification of scores based on changing risk factors.
- Include SDOH data in the member-360 to allow "equity index"–mandated reporting to be unified.
- Develop applications that partition the member-360 and allow data sharing consent preferences to be specified. This is in anticipation of member-facing apps that allow a patient to "bring their own data" along with them as an empowered patient to all of their providers at the point of care, regardless of location.

Trends

The implementation of a longitudinal health record/member-360 is not just an architectural construct. To implement this enterprise initiative, payers are reassessing their entire approach to data management. Consider the trends examined in the sections that follow.

A Data Factory Approach

Payers cannot keep writing ETL programs every time a new set of desired data is identified.

Similarly, they cannot keep writing code every time there is a new set of desired output, either from within the enterprise or in the evolving interoperability sphere.

So payers are adopting the "data factory" approach, where data is easily loaded, curated, stored, accessed, aggregated, and archived. Applications and analytics are quickly spun up and down once the data, workflow, and services are in place. This approach centers on a "canonical data model" and is based on standards (such as the HL7, FHIR, and the Office of the National Coordinator for Health Information Technology, U.S. Core Data for Interoperability) or the Observational Medical Outcomes Partnership data model, which is an approved USCDI model that is mappable with public information to FHIR standards.

The member-360 data platform not only is the structure of the data but also includes the workflow around ingestion, mapping, cleansing, codifying, and verifying person identification and data quality. Once staged, services layers or applications can point to the data in its various forms of aggregation and content. Services are enabled for analytic workbenches, models, reports, dashboards, and machine learning opportunities.

Master Data Management and Governance

Data governance in master data management is usually seen as the ability to:

- Create data roles and assign permissions.
- Design workflows for verifying information updates.
- Limit data usage and sharing.

- Collaborate and coordinate in merging multiple data assets.
- Protect data and conform to compliance standards, such as HIPAA and GDPR.
- Ensure that data is safe from security risks.

Data Fabrics

Recently, data fabrics have emerged as a much-needed architectural approach to providing accurate visibility across the entire business without the problems associated with data warehouses and data lakes. Data fabrics can transform and harmonize data from multiple sources on demand to make it usable and actionable. Smart data fabrics take the approach a step further by incorporating a wide range of analytics capabilities, including data exploration, business intelligence, natural language processing, and machine learning, enabling organizations to gain new insights and power intelligent prescriptive services and applications.

Sophisticated organizations are leveraging smart data fabrics to power a wide variety of mission-critical initiatives. In healthcare, examples include risk modeling for individuals and populations, real-time performance monitoring, workflow optimization, and outcomes management.

Conclusion

The most appropriate path for payers seems to be establishing an overall vision and road map of where the enterprise approach is going on its mandates journey and then implementing sections of the necessary technology architecture in a modular way.

The member-360 foundation is the core of the payer enterprise operating model. The mandates; the interoperable landscape; the need for more and more member data to be unified, shared, and reported; and the turbulent payer business landscape all point to a comprehensive longitudinal health record as a strategic asset.

The member-360 foundation is the core of the payer enterprise operating model.

About the Analyst

Jeff Rivkin, *Research Director, Payer IT Strategies*

Jeff Rivkin is research director of Payer IT Strategies for IDC Health Insights. In that role, he is responsible for research coverage on payer business and technology priorities; constituent and consumer engagement strategies; technology and business implications for consumer engagement; front-, middle-, and back-office functions; value-based reimbursement; risk; and quality-based payment and incentive programs, among other trends and technologies important to the payer community.

MESSAGE FROM THE SPONSOR

For decades, InterSystems has been helping public and commercial healthcare payers to connect and bring together disparate data sources to enhance operations, improve outcomes, and address data-related regulatory mandates.

Health insurers leverage the Member 360 capabilities of InterSystems longitudinal health record, HealthShare, as the foundation for value-based care insights, performance measurement and collaboration. InterSystems smart data fabric and software development tools power health plan innovation. The company also delivers provider data management capabilities, a digital front-door platform, and low-code FHIR-based automation functionality.

As you evaluate your approach to addressing regulatory mandates like CMS-0057-F, while furthering your enterprise data strategy, InterSystems payer services for interoperability, prior authorization, and care management offer a flexible path to value – whether you need a single API to support provider to payer data sharing or a comprehensive solution.

For more information about InterSystems and its payer solutions, go to: https://www.intersystems.com/industries/public-private-payers/.

IDC Custom Solutions

The content in this paper was adapted from existing IDC research published on www.idc.com.

This publication was produced by IDC Custom Solutions. The opinion, analysis, and research results presented herein are drawn from more detailed research and analysis independently conducted and published by IDC, unless specific vendor sponsorship is noted. IDC Custom Solutions makes IDC content available in a wide range of formats for distribution by various companies. A license to distribute IDC content does not imply endorsement of or opinion about the licensee.

IDC Research, Inc.
140 Kendrick Street
Building B
Needham, MA 02494, USA
T 508.872.8200
F 508.935.4015
Twitter @IDC
idc-insights-community.com
www.idc.com