2019-05-24 Payer Coverage Decision Exchange Meeting

Chair: Dr.Nita Thingalayaand Dr. Julia Skapik

Scribe: Dana Marcelonis

Attendees

Present	Name	Affiliation
☑	Robert Dieterle	Enablecare
☑	Viet Nguyen	Stratametrics
☑	Nita Thingalaya	IBC
☐	David DeGandi	Cambia Health Solutions
☐	Duane Walker	BCBSM
☐	Gregory Magazu	CaseNet
☐	Jeanie Smith	BCBSFL
☐	Corey Spears	Infor
☐	Greg Linden	
☑	Joseph Quinn	Optum
☐	Ashley Stedding	CMS
☐	Barbara Antuna	AIM Specialty Health/ Anthem
☑	Mary Kay McDaniel	Cognosante
☑	Michael Gould	IBC

☑	Laurie Burckhardt	WPS Health Systems
☐	Serafina Versaggi	
☐	Sreenivas Mallipeddi	MCG Health
☐	Susan Bellile	Availity
☑	Susan Langford	BCBST
☐	Taha Anjarwalla	CAQH
☑	Tony Benson	BCBSAL
☐	Tracey McCutcheon	KPMG
☐	Brent Woodman	BCBSM
☐	Sonja Ziegler	Optum
☑	Dawn Perreault	
☑	Melanie Combs-Dyer	CMS
☐	Anupam Thakur	BCBS FL
☑	Christol Green	Anthem
☑	Jeffrey Danford	Allscripts

Present	Name	Affiliation
☑	John Bialowicz	BCBSM
☑	Nandini Ganguly	Scope Info Tech/ EMDI

☑	Peter Muir	
☑	Rachel E. Foerster	
☑	Pallavi Talekar	Scope Info Tech
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Minutes Approved as Presented

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This is to approve minutes via general consent. *"You have received the minutes. Are there any corrections to the minutes? (pause) Hearing none, if there are no objections, the minutes are approved as printed."*

Agenda Topics

Agenda Outline	Agenda Item	Meeting Minutes from Discussion	Decision Link(if not child)

Management	Review ANSI Anti-Trust Policy		

	Ballot and Connectathon Schedule	• Jacksonville Connectathon - May 29-30
		• Goal is to ballot for September ballot cycle
		  • Jun 30th -- NIB
		  • Jul 14rd – Initial content
		  • Jul 21st - Ballot Review Period Starts
		  • Aug 4th – Final content
		  • July 8th - Ballot sign up starts
		  • Aug 9th – ballot voting starts
		• HL7 Atlanta Connectathon - end of September	

	Payer Coverage Decision Exchange Overview	• Addressing CMS NPRM preamble language/ intent to support continuity of treatment without burdening the provider regarding current treatment that was covered by the prior payer when a covered member moves to plan to plan
		• Member directed payer to payer exchange of USCDI data
		• NPRM did not specify that new payer 2 has to cover everything that payer 1 covered
		  • We're not forcing new payer to do anything, but to the extent its a covered service under their contract, etc. they have the opportunity to make the decision without going back to the provider and asking for the same documentation, or discontinuing treatment while they figure out if they're going to authorize it
		• Difference between PDex and Payer Coverage Decision Exchange Overview use cases?
		  • PDex is another Da Vinci use case that allows member directed payer to payer exchange for up to 5 years after member leaves a plan - provides for exchange of a clinical data set (without context) - it doesn't talk about guidelines used to make a Prior Auth decision, or assemble information needed to support that Prior Auth decision
		  • PDex - Payer 1 can send everything about a patient to Payer 2 (excluding claims)
		  • Payer Coverage Decision Exchange - Payer 1 is only sending clinical information about the current treatment and the guidelines that led to the decision to authorize that treatment to Payer 2
		  • This is common in Medicaid world - "Plan Transfer" - from state to state forms vary, but forms and processes are in place to do this
		  • Coming into another Medicaid plan or coming off a Medicaid plan
		  • Mary Kay McDaniel will forward this info to Nita Thingalaya, Robert Dieterle and Julia
		• Immediate requirement: support for exchange regarding ongoing treatment
		  • Information
		  • Relevant diagnoses
		  • Current treatments (not history of treatments)
		  • Guidlines for Prior Authorization (e.g., specific Milliman guideline)
		  • Clinical information that went into decision for treatment coverage
		  • Exchange methods - member directed exchange (e.g., Blue Button 2.0 or Apple health record)	

		Do any plans transfer this type of information to other plans today?
		
		• Medicare FFS does not transfer this type of information to other plans
		• Medicaid does this transfer to other plans via paper/fax
		• Today, plans go back to the provider to get this information again
		
		• Medicare FFS
		  • First Claim Review (not Prior Auth) - when a patient has never had an oxygen claim, and supplier sends in claim for first time, the claim is stopped for review and documentation/ information is requested from provider - then the claim is marked that it should be paid and future claims should be paid
		• Decide what guidelines/ what can be obtained, to make the use case work
		  • If the guidelines are listed in the documentation requirement lookup service, there could be a numbering scheme so that reference could be made to that instead of re-copying the guidelines
		  • Medicaid has some high level rules
		  • Commercial plans - what is the policy of transfering guidelines? Publically available or not?
		  • Could reference the guideline even if not publically available, because we don't necessarily need to exchange the guideline itself (don't want to run into issues with proprietary information)
		• Mary Kay chat comment:
		  • States must also consider the need to minimize disruption in any ongoing course of treatment when enrollees transition from FFS to managed care or between MCOs. To improve health outcomes and beneficiaries' overall care experience, the updated regulation sets standards for care coordination, assessments, and treatment plans. It requires that Medicaid and State Children's Health Insurance Program managed care plans coordinate to ensure that individuals are able to make smooth transitions between settings of care to enhance access to services, and new beneficiaries complete an initial health risk assessment within 90 days of enrollment
		  • https://www.macpac.gov/subtopic/enrollment-process-for-medicaid-managed-care/
		• Many payers are moving to commercial guidelines (e.g., Milliman, Interqual, etc.) - if that's true, then in many cases we'll be able to point to a guideline
		  • There will be situations with some payers where those guidelines are internal/ proprietary - we would need to indicate that so that the receiver understands they're not getting a pointer to a commercial guideline
		  • What is that set of information that's necessary to give Payer 2 the option NOT to go back to the provider for more info
		• Clinical information and payer authorization of that is covered by Prior Auth use case, but we still need to represent how they came to that decision
		  • Start with Oxygen scenario - clinical information was provided, it's been approved with Payer 1
		  • Intent is to communicate treatments patient is receiving, regardless of whether they need prior auth or not
		  • Medicare FFS - indicate patient currently on oxygen therapy, paid for by CMS, copy of CMN, copy of LCD (or point to it) - to extent of audit/ review, send a copy of that as well
		  • Goal is to communicate treatment the patient is currently RECEIVING and being PAID FOR by payer 1 - not the treatments that are COVERED by payer 1
		  • Grid to lay this out? Items that do require Prior Auth, items that do not require Prior Auth - not black and white or just approved/ denied
		  • If patient is getting oxygen, let them stay on oxygen - if payer 2 needs to reassess (to approve/ deny), that's their choice once the member has transitioned to them but not relevant to the exchange of this initial set of data
		• Should use documentation from last coverage determination
		  • Depends upon the clinical scenario (e.g., oxygen has a different review process than some transplant procedure)
		  • Need to discuss further in Jacksonville	

Management	Next agenda		
Adjournment		Adjourned at 3pm ET	

Supporting Documents

Outline Reference	Supporting Document
Minute Approval	

Action items

- [ ]

Create Decision from template