How Payers Drive Healthcare Transformation Through Tech Collaboration

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INTRODUCTION

The slow pace of change that has historically characterized healthcare appears to be finally shifting into a faster gear. It has been heartening to see in just the past year how advancements in technology, CMS rule changes, and the willingness of payers and providers to embrace clinically validated tech innovation are paving the way for healthcare organizations to solve some of the industry's pain points. Clinician and patient frustration with prior authorization delays, for example, has led to a reckoning with payers removing prior authorization requirements for some services, particularly for Medicare Advantage plans, such as for cataract surgery and physical therapy.

Health tech has a key role to play in these and related issues by reducing friction in communication and data sharing between providers, payers and patients. The low-hanging fruit for artificial intelligence to automate certain administrative functions is already beginning to make a difference in streamlining care delivery. Looking ahead at CMS rule changes rolling out in the next few years, health tech will be critical to support policy compliance for transparency in coverage, interoperability, and changes to Medicare Advantage plans.

Although some of these developments have been a long time in coming, it's imperative for payers to work with other healthcare stakeholders to harness, rigorously test and refine health tech. Expectations for each new generation of health tech will continue to increase. It's important that health tech vendors continue to move ahead with the challenging tasks of ensuring the data upon which they train algorithms to analyze, assess and make clinical recommendations represent the most diverse patient populations across race, age, sex, income and other relevant demographic criteria. It is also incumbent upon healthcare stakeholders to leverage tech not only to improve interoperability but also health equity and access to healthcare for underserved populations. Failing that, the consequences are that the digital revolution in healthcare leads to wider disparities in healthcare delivery and patient outcomes with little to no impact on healthcare costs.

At the ViVE Payer Insights Program, speakers shared views on progress with AI, prior authorization provider readiness and infrastructure challenges, investment in Social Determinants of Health (SDoH), data sharing initiatives and the use of data sandboxes to support collaboration between healthcare stakeholders.

This eBook highlights some of the talking points that emerged from these conversations and what merits our attention in 2024 and beyond.

PRIOR AUTHORIZATION PROGRESS: BENEFITS VS COSTS, TRANSPARENCY, AND THE ROLE OF AUTOMATION

Perhaps no other issue has symbolized dissatisfaction in healthcare and the need for policy change and tech to fix it more than prior authorization. Although payers have wielded prior authorization as a means of reining in costs by reducing unnecessary tests and procedures, the process has frustrated clinicians when little to no rationale is offered for how these decisions are made. Push back from clinicians can also be time consuming, which may needlessly delay critical, time-sensitive care and undermine the patient-doctor relationship. Each payer's rationale for why they approve of certain procedures, tests and medications may differ, which causes further confusion and frustration. Last year, AMA President Jesse Ehrenfeld suggested that prior authorization has overtaken the EHR as the number one pain point among physicians.

Some of the most common treatments that trigger prior authorization, according to a survey by the American Health Insurance Plans association are:

- genetic testing
- specialty drugs
- elective in-patient surgery
- high-tech imaging
- cardiology
- orthopedics

PRIOR AUTHORIZATION BACKLASH

The outrage over the bureaucracy clinicians face in getting payers to agree to cover the care they prescribe and the inevitable delays it creates has led states to take matters into their own hands. Nine states passed prior authorization legislation last year, according to the AMA's website. But from the perspective of Ginny Whitman, Alliance of Community Health Plans Senior Manager, Public Policy, these state laws will only add to the confusion. In a panel discussion on prior authorization at the ViVE Payer Insights Program, Whitman said the consequences of these laws will mean states will have conflicting regulations with federal policies. Ultimately, that will force providers and health plans to navigate two sets of confusing regulations.

PRIOR AUTHORIZATION ALTERNATIVES

One way clinicians and payers are trying to reduce long wait times for prior authorization requests is through a practice referred to as "greenlighting". Physicians have to qualify for greenlighting based on high prior authorization approval rates. Greenlighting uses physician-specific and code-specific data to qualify physicians to avoid prior authorization requirements while maintaining quality and cost control, according to a Medical Economics article.

Gold carding is another program that physicians can use to accelerate prior authorization requests. Some of the criteria physicians must meet, according to AHIP, include:

- A low prior authorization denial rate
- The provider submits a minimum number of prior authorization requests
- Participation in a risk-based contract

Despite the criteria, critics of Gold Carding say the application program can be challenging and time consuming. There are also a variety of differences, depending on the state where physicians reside. Five states have passed some form of gold carding program, according to a KFF Health News article: Louisiana, Michigan, Texas, Vermont, and West Virginia. The AMA is tracking active gold carding bills in 13 states, including Missouri, according to the article.

But changes to improve the prior authorization morass are afoot. Payers such as Aetna, Cigna, and Humana have shared plans to eliminate prior authorization for certain health services such as physical therapy and cataract surgery for some, if not all, of their members. The Centers for Medicare and Medicaid Services has issued a final rule to provide more transparency for how payers make prior authorization decisions. Among the provisions of the CMS Final Rule on Interoperability and Prior Authorization, according to the agency's website, are:

- Starting primarily in 2026, affected payers will have to send prior authorization decisions within 72 hours for urgent requests and seven days for non-urgent requests.
- Payers will also have to specifically state why they denied a prior authorization request.
- Under the rule, payers will also have to implement a Health Level 7 Fast Healthcare Interoperability Resources (FHIR) Prior Authorization application programming interface (API). This will create a more streamlined electronic prior authorization process between providers and payers.

- CMS is finalizing API requirements to "increase health data exchange and foster a more efficient health care system for all." CMS said it is delaying the dates for API policy compliance from January 1, 2026, to January 1, 2027.
- Starting in January 2027, payers will also be required to expand their current Patient Access API to "include information about prior authorizations and to implement a Provider Access API that providers can use to retrieve their patients' claims, encounter, clinical, and prior authorization data."

Whitman welcomed the transparency the Final Rule will add to the prior authorization process in 2027 through the use of APIs to share data.

"These rules are going to offer transparency into metrics around prior authorization. Not only will providers have an easier time, patients will be able to see metrics about their health plans and the various determinations that are being approved, what was approved after an appeal, in 2027. Big changes are happening in this space."

Timothy Law, Highmark Health Chief Medical Officer and Vice President of Integrative Care Delivery, shared that Highmark has a 92% approval rate for prior authorization requests and that rises to 93% after prior authorization appeals.

He explained that the company is looking for ways to automate up to 80% of authorizations for care so that physicians are able to provide more efficient and timely care.

"We're trying to get to the point where we're getting out of the way of physicians," Law said.

"As automation becomes more [common], and we can match codes, diagnoses, and say that this procedure is approved 99% of the time, why do we have to have three or four different human beings review it? Why can't you just pass it on through the system? So that's one of the ways we're trying to make things quicker."

AI will be critical for making prior authorization requests and decisions more efficient. Health tech vendors developing AI tools will need to work closely with payers and providers to rigorously test their software so that it can meet the efficient data sharing needs of the CMS Final Rule requirements.

HOW CAN THE TRANSPARENCY IN COVERAGE FINAL RULE PROVIDE OPPORTUNITIES FOR INNOVATIVE TECH COLLABORATION TO SUPPORT VALUE-BASED CARE PAYMENTS?

Although the 2020 Transparency in Coverage Final Rule was intended to bring more clarity to healthcare costs in the commercial market, similar to what price transparency rules for hospitals were intended to do, most self-insured employers are unable to convert the massive amount of data they now have access to into actionable information.

The Transparency in Coverage final rule establishes a multiphase timeframe requiring most group health plans and health insurance issuers in the individual and group markets to share provider-specific reimbursement rates and, ultimately, provide member-specific, on-demand cost-sharing estimates for any desired service, including prescription drugs, according to Milliman's website. An assessment of the Final Rule by Milliman noted that due to the contractual arrangement between a payer and a provider, it may not be possible for a payer to report an accurate dollar amount for items and services in advance of these items/services being provided, for various reasons.

A panel discussion on the Future of Payment Innovation during the Payer Insights Program at ViVE unpacked some of these complexities in the context of value-based care and how companies can address them.

Shawn Gremminger, National Alliance of Healthcare Purchaser Coalitions president and CEO, noted that self-insured employers have fiduciary oversight over their health plan dollars, compelling them to find ways to use this newly available data from commercial plans. But most companies, even those with as many as 10,000 employees, don't have the capacity to build, evaluate, and ultimately manage value-based contracts.

Health tech business Lyric is an AI-first platform company that simplifies the business of care through payment accuracy solutions. Tawfiq Bajjali, Lyric General Manager of Platform Solutions,

described some of the ways the Transparency in Coverage Rule creates opportunities for health tech vendors to step up and address some of these challenges.

“It creates a lot of opportunity to bring that data onto a platform and use that platform to come up with insights that you can then feed back to [users].“

Bajjali called attention to the cost estimator tool that’s highlighted in the final rule. He envisioned an AI-enabled platform that could create a personalized, engaging experience using the newly available commercial payer data for a patient who needs a knee replacement. An AI algorithm could match the right procedure code with the right place of service.

“A platform approach is really a good way to make sure you are able to seamlessly deploy different capabilities without having to fund the integration costs to build for every one of those,” Bajjali said. “That’s our philosophy when we think about how to enable the delivery of digital transformation. We’re seeing a lot of headway being made in adopting these tools and incorporating them in the shift to value-based care.”

WHEN IT COMES TO VALUE-BASED CARE, DATA IS EVERYTHING

Andréa Caballero is the program director with Catalyst for Payment Reform, a nonprofit that works with large, public and private, self-funded purchasers. Caballero said she measures how much payment reform is occurring in the country each year.

An annual survey of health plans on the top barriers and facilitators to value-based payment by Health Care Payment Learning & Action Network ("WeCPLAN) has produced the same results every year for the past seven years, Caballero noted. Provider readiness and provider infrastructure are the barriers. Data stewardship – who owns that data and the ability to access that data – is a tug of war for employer purchasers, Caballero observed.

"It really comes down to the timely transfer of data," Caballero said. "You can't expect providers to get into risk-based contracting if they don't get timely transfer of data [from payers]. If they can't monitor where they are, how can they set goals?"

The push towards value-based care depends, in part, on obtaining data on race, ethnicity and gender to support health equity and quantify social determinants of health among members.

Sharing findings from CPLAN's most recent annual survey, Caballero said 44% of health plans were incentivized to collect race and language data. Another 26% were incentivized to collect sexual orientation and sexual identity data. She acknowledged that one challenge health plans face with data collection is that people of color may be reluctant to share this data because they don't trust that the people collecting this data will use it to their benefit.

Many people in marginalized communities are skeptical about sharing race and ethnicity data which means that even if a company has the best incentives in place for sharing that data, gaps will continue to occur. If healthcare organizations are to improve their ability to collect sensitive data such as race, language, and sexual orientation, they need to be as transparent as possible with how they will use the data they collect.

Caballero acknowledged that it's not as easy to say that payment reform will reduce health disparities but programs need to be designed to do a better job of collecting data to improve quality and performance.

Gremminger emphasized that when companies design alternative payment models, they should include equity as part of their measures of success.

Panelists agreed that there is a lot of investment in technology companies seeking to help plans and providers address social determinants of health.

Gremminger also shared that employers and purchasers are looking for the total cost of care.

"We can move from fee-for-service, which sucks, to alternative plan models, but if we are paying as much or more for alternative plan models as fee-for-service, we will have failed."

HEALTHCARE INNOVATION IS A TEAM SPORT

Of all the challenges facing health tech, outdated or inaccurate data are cited time and again as a source of frustration and holding back the effectiveness of health tech for applications such as healthcare navigation. The risk with AI is that it has the potential to magnify these challenges. That was one of the takeaways in a conversation on tech transformation which called attention to different ways companies such as Blue Shield of California, Workday and Elevance Health are working to refine tech applications for generative AI and other AI-driven digital health tools.

Workday is an HR software company that collaborates with several different industries including healthcare. In fact, payers are a significant part of their healthcare business. Dave Sohigian, Workday Global CTO, highlighted the need to refine the user experience in healthcare as well as improve the quality of data collection.

Emphasizing the need for accurate data, Sohigan noted that the problem with many of the chatbots is that inaccurate data is a feature, not a bug and that can easily undermine trust that the chatbot is a source of reliable information.

Sohigan noted that one challenge with generative AI, such as Chat GPT, is that some believe it can function as a substitute for refining the user experience.

"We always need to keep humans in the loop when it comes to AI," Sohigan said. "Chatbots are a user interface but they are not ideal. If we couple a great user interface that guides users down a path with a chatbot" that could significantly improve how consumers navigate healthcare.

"Payers and providers have the same end goal in mind – to serve the consumer. Oftentimes, there are blindspots as to what the consumer needs," Sohigan noted.

Piloting and validating health tech through data exchange framework digital sandboxes is critical for refining AI applications in healthcare. One example is the California nonprofit organization Connecting for Better Health. Shruti Kothari, Blue Shield of California Director of Industry Initiatives, called attention to the work it is doing.

Connecting for Better Health provides a dynamic learning environment for providers, community-based organizations, health plans, public health agencies and social service organizations to pursue cutting-edge data sharing approaches with meaningful cross-sector collaboration, according to the nonprofit's website. It provides a safe environment for pilots using electronic health records, data stores, care management platforms, interoperability interfaces, and APIs that have to share information to coordinate care and improve health outcomes.

Kothari recommended that providers, payers and health tech companies join these data exchange frameworks in their region.

"It is in our best interest to figure out as an ecosystem how to make things better."

Elevance, formerly Anthem, has a digital data sandbox as well to build and train AI tools and collaborate with companies to advance healthcare. Omid Toloui, Vice President of Innovation, Elevance Health & Carelon Digital Platforms, emphasized that "innovation is a team sport."

Toloui highlighted the development of Health OS, a clinical data platform to reduce burdensome paperwork. Health OS enables doctors to view patients' records from other physicians, labs, and healthcare providers. It can also highlight relevant medications or services and identify patterns in lab results, according to Elevance's website. It helps speed up follow-up prescriptions and referrals, and reduces the time it takes for members to fill out forms and answer questions.

Toloui noted that Health OS has led to a 25% improvement in medication adherence among users.

One of the ambitions for health tech applications is improving not only access to care but also digital health equity, sometimes referred to as "techquity". Toloui also talked about Get Connected for Health, a coalition of providers, caregivers, health plans, patient advocates, innovators, and community-based organizations based in California. The coalition's members are aligned around the goal of improving the state's data sharing infrastructure with a goal of transforming health and social outcomes.

Launched in January 2024, the initiative puts smartphones preloaded with digital health applications into the hands of people who need them the most. For example, the "Sydney" app connects users for a chat with a virtual nurse, which can fill prescriptions online. The app packages vary by state.

"If you are trying to scale tech, you are doing a pilot – impacting a large cohort at scale," Toloui said. "Our philosophy is to go deep on the problem first – applying human-centered design [to develop solutions]."

SUPPORTING NICHE ALTERNATIVE PAYMENT MODELS

Perhaps one of the most interesting areas of healthcare innovation are the developments geared to niche populations who qualify for Medicare and Medicaid. Panelists discussing dual eligibles highlighted several policy developments happening across the country that will be rolled out over the next few years, some of which they welcomed and others for which they expressed concern regarding the potential impact.

Grace Totman is a director with Capstone Health, a consulting firm that works with institutional investors to help them understand the impact of policy changes on their portfolios.

"I'm excited about the Health Equity Index for Medicare Advantage plans coming in 2027. It will affect how health equity is valued from a Medicare perspective. I am excited to see the innovation that brings," Totman said.

Several expressed concern about telehealth coverage for Medicare and Medicaid members evaporating following the end of the pandemic. But Kate Paris, vice president of policy and advocacy at UnitedHealthcare, used claims data from a state in the Southeast to show that telehealth still has a critical role to play, particularly in behavioral health.

"The vast majority, in the upper 90%, are coming from providers already in-network that are using a telehealth claim," Paris said. "Sixty percent of telehealth utilization (for Medicare) is for behavioral health. The top five conditions being treated through telehealth are behavioral health conditions."

One of the niche populations highlighted by the panel is Medicaid for postpartum women. Programs in development are more tailored to the specialized treatment they require.

Another niche population is healthcare coverage for prison inmates, particularly inmates nearing release. An estimated 14 states have programs in place in various stages of development with the primary goal of reducing recidivism. The programs may include peer services, healthcare navigation, lining up primary care providers and housing support.

CMCS has made a big push in collaboration with California to cover prison inmates with Medicaid services up to 90 days ahead of their release. Les Ybarra, President of Anthem Blue Cross's California Medicaid Program, a subsidiary of Elevance Health, said its work with individuals has initially focused on post-release, but plans to expand to pre-release this fall. It is beginning to set up partnerships to support care coordination, data exchange and enhanced care management programs. One consideration with identifying partners is lived experience.

Innovation around Federally Qualified Health Centers (FQHCs) were also a focus of interest. Yuvo Health, for example, is a startup that provides administrative and managed-care contracting services to FQHCs.

Dr. Andrey Ostrovsky, Social Innovation Ventures managing partner, also serves as a pediatrician and works with FQHCs. He called attention to an emerging trend of helping FQHCs get financially rewarded for the outcomes they produce not only by physicians but also dieticians, health navigators and therapists.

"My bias is that FQHCs and similar safety net providers have a disproportionate opportunity to help keep people out of the hospital and thriving in the community."

Potential applications of AI for dual eligibles also came up for discussion. Lee Bowers, Florida Blue Medicare President and Guidewell senior vice president, said his organization used it for prior authorization to reduce administrative burden.

"I think it's great," Ybarra said. "The ability of AI to support decision making in the continuum of a person's care is very powerful to help staff."

CONCLUSION

Payers have a major role to play in driving change in healthcare. As they have demonstrated with prior authorization, they are well positioned to alleviate some of the most challenging stumbling blocks in healthcare.

With the massive amounts of member data representing the diverse demographic makeup of the U.S at their disposal, there are many more challenges where they can play an active role. They should continue to support efforts to cover virtual care as a way to improve access to healthcare, especially mental health, and work with health tech vendors and clinicians to promote best practice. When it comes to reducing friction in communication, medication adherence, and helping members navigate healthcare options, there are lots of opportunities for AI to be leveraged and refined. As custodians of member data, payers should continue to develop ways to earn the trust of members reluctant to share data on race, language, sexual orientation to optimize care for a diverse patient population.

As CMS final rule changes are rolled out in the coming years, such as provisions of the Transparency in Coverage final rule, payers will continue to be challenged to change their practices. Collaboration with health tech, hospitals and other healthcare organizations is crucial to prepare for these changes.

ABOUT THE VIVE PAYER INSIGHTS PROGRAM

This program focuses on the latest regulatory changes, evolving care models and new tech solutions for transforming the member experience, optimizing data insights, minimizing costs and expanding access to care, as well as the shift to value-based care.

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