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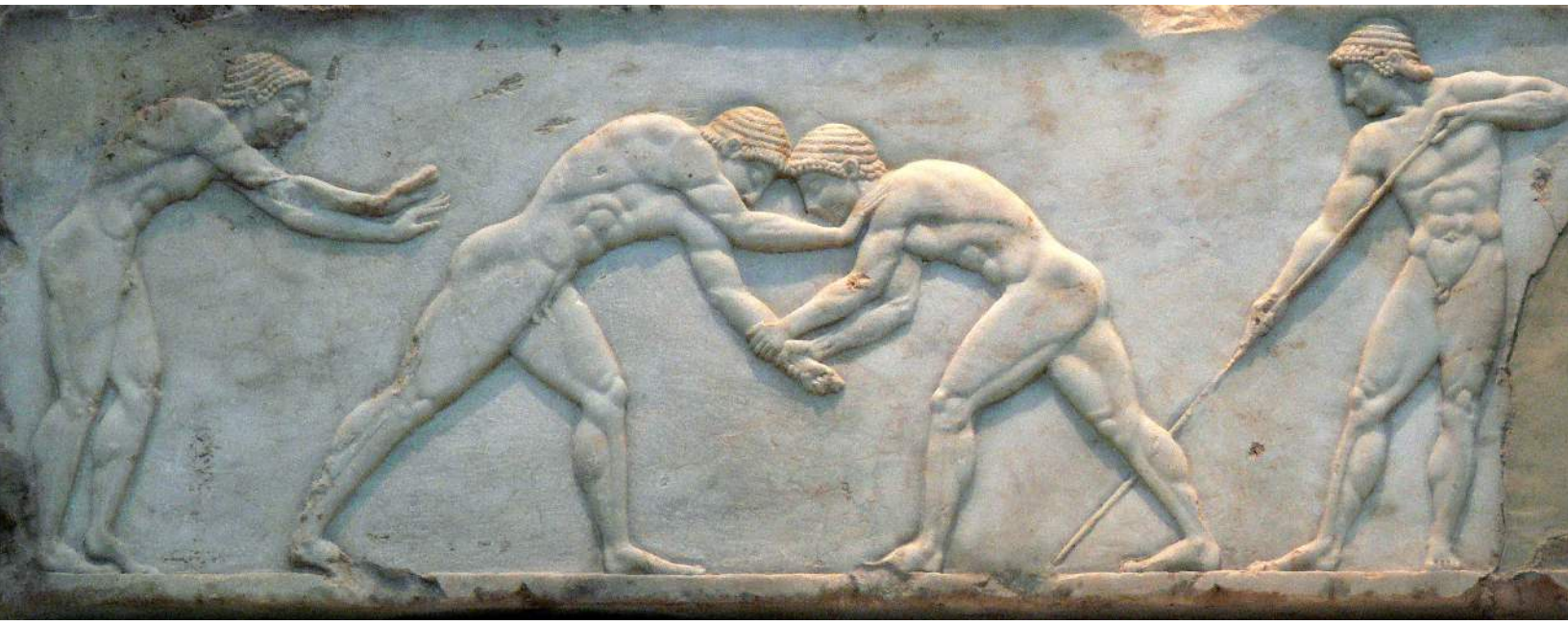

NEW SOLUTIONS TO ADDRESS PROVIDER-PAYER FRICTION

CHILMARK RESEARCH

MARKET SCAN REPORT

ABOUT CHILMARK RESEARCH

Chilmark Research is a global research and advisory firm whose sole focus is the market for healthcare IT solutions. This focus allows us to provide our clients with the most in-depth and accurate research on the critical technology and adoption trends occurring throughout the healthcare sector. Areas of current research focus include among others: Clinician Network Management, Cloud-computing Models for Healthcare, IT-enabled Accountable Care Organizations, Care Coordination, Adoption of Mobile Technology and Consumer-facing Health and Wellness Applications and Services.

Using a pragmatic, evidence-based research methodology with a strong emphasis on primary research, Chilmark Research structures its research reports to serve the needs of technology adopters, consultants, investors and technology vendors. In addition to reports for the general market, Chilmark Research performs research for clients based on their specific needs. Such research has included competitive analyses, market opportunity assessments, strategic assessment of market and vendors for partnership and/or acquisition.

In 2012, Chilmark Research launched its newest service, the Chilmark Advisory Service (CAS). The CAS was created in direct response to clients' request for a continuous feed of research on the most pertinent trends in the adoption and use of healthcare IT. This is an annual subscription that provides not only access to a number of re-search reports throughout the year, but also direct access to Chilmark Research analysts to answer specific client needs. Please contact us directly for further information about CAS.

Chilmark Research is proud of the clients it has had the pleasure to serve including Abbott Labs, Bluetooth Special Interest Group, Catholic Healthcare East, Cerner, HCA, Highmark, IBM, Kaiser-Permanente, McKesson, McKinsey, Microsoft, and Thomson Reuters to name a few. It is our hope that at some future date we will have the pleasure to serve you as well.

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EXECUTIVE SUMMARY

I am a provider and I have a stack of Prior Auths to submit. Hmm, is it best for me use the phone, the fax, my clearing-house portal, one of many payer portals, my HIE, my EHR, or my other UM software to assist? ...shake, shake, shake... my Magic 8-Ball suggests I should just mail them in...

Prior authorization (PA) requirements have a long-standing history of creating friction between providers and payers. Their mandatory one-size-fits-all nature, inconsistent policies across the payer landscape, and cumbersome manual processes frustrate providers who say the requirements interfere with care decisions. Few of the efforts over the last several years to automate this process have helped significantly. Industry stakeholders are increasingly voicing loud concern and calling for PA reform.

Providers and payers both benefit when they converge on a patient-centric approach to PA. This pharmacy vendor's observation sums things up for both the pharmacy and medical industries:

> *"Prior authorization...is...right at the intersection where a doctor is making a decision about the tradeoffs between the cost of a treatment and its efficacy... The goal is to help doctors make more intelligent consumption decisions."*
>
> - *Matt Scantland, CEO, CoverMyMeds*

PA is on the cusp of having a breakout moment. Throughout 2017, providers and payers will see new solutions that will make PA more effective and efficient so it can more broadly serve as a vital aspect of revenue cycle, cost containment, and population health management strategies. Importantly, these new solutions will be better for consumers.

Provider-payer convergence, though currently in an experimental pilot stage, stands to benefit from new PA solutions. To uncover a likely vanguard for greater convergence, we followed the money and looked at how PA affects the beginning of the revenue cycle. What happens to the traditional payer PA approach as risk and PHM accountabilities shift to providers? Is PA shifting, too? And if so, is it shifting from a process perspective, a technology perspective, or both?

KEY TAKEAWAYS

- PA processes are not going away despite increasing provider adoption of value-based care (VBC), though a new PA model is emerging that promises to deliver mutually beneficial results for providers and payers with far less pain.
- The challenge to automate PA processes that require clinical review has paralyzed the industry from adopting any form of PA automation; the low-hanging fruit of automating administrative reviews with 278 transactions represents a tremendous efficiency and cost savings opportunity for providers and payers.
- New solutions for clinical PA automation are now available, but vet them carefully as most have not yet demonstrated ability to scale.
- Real-time clinical PA adjudication, fully integrated with Clinical Decision Support (CDS), enables clinical and coverage decision optimization at the point of care, an essential "gold standard" tool to enable VBC success.
- Chilmark Research projects that this new evolution in PA technology will serve as a petri dish for greater forms of provider-payer convergence that will then spread to other VBC and Population Health Management (PHM) strategies.

ABOUT THE AUTHOR

Jennifer brings comprehensive Population Health and managed healthcare experience to her role as Senior Analyst with Chilmark Research. Chilmark Research is a global research and advisory firm whose focus is the market for healthcare IT solutions that drive the greatest impact; Jennifer's research domains are Population Health (Lead Analyst), Care Management, and Provider-Payer Convergence (evolving collaborative business and clinical models). Immediately prior to this role, Jennifer was National Senior Director, Clinical Quality and Stars for Optum/UnitedHealthGroup.

Throughout her career, Jennifer performed at an "Exceeds" level in various key functions of population health and care management, including Operations, Account Management, Sales, Reporting, Market Management, and Product Development/Management.

She started her career as an RN in surgical intensive care and has worked the past twenty-five years across the continuum of clinical care management including leveraging Population Health strategies to ensure appropriate interventions in Utilization and Case Management, Chronic and Complex Condition Management, Consumer Engagement and Incentives, Stars and RAF, Nurseline and Advocacy, Behavioral Health, Wellness, Reporting and Analysis.

Jennifer has a Bachelor's degree in Nursing (BSN) from The Pennsylvania State University and a Master's degree in Public Policy & Management (MPM), with a concentration in Information Systems, from Carnegie Mellon. She is certified as a Managed Health Professional (MHP) through what is now America's Health Insurance Plans (AHIP) and completed additional coursework in Legal/Governance of Healthplans. Both education and experience have provided Jennifer with strong foundational knowledge of the insurance industry, health policy, and healthplan operations, including value-based care and Commercial, Medicare, and Medicaid regulatory challenges. She also has achieved 2015 Certification from PMI for Associate Project Management (CAPM).

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