



HEALTHCARE



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DIGITAL SYSTEMS & TECHNOLOGY

How a Real-Time Automated Decision Support Tool Can Cure the Prior Authorization Time Drain

A pilot program to automate medical and administrative policies conducted by Cognizant, New England Healthcare Exchange Network and Informatics In Context revealed significant time and cost savings. This proven solution can be scaled to produce effective outcomes for health insurance companies and providers.

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EXECUTIVE SUMMARY

Many existing prior authorization (PA) processes are comprised of submit-and-forget tasks that drain time, money and resources, both for health insurance companies and healthcare providers. Working with the New England Healthcare Exchange Network (NEHEN) and Informatics In Context (IIC), Cognizant tested a real-time, automated PA system for medical and administrative policies. At completion, this pilot generated projected savings of \$16 per PA (\$9,820 over the span of 597 transactions). Leveraging learnings from this implementation can help health insurance companies and providers achieve cost savings, streamline rules and create a more effective PA strategy.

This proven solution can be scaled to include related processes and additional payer-provider partnerships. By investing in custom-fit PA automations, payers and providers can streamline requirements, reduce administrative burdens, make rules more transparent and deliver care more efficiently to patients.

Cognizant partnered with Leavitt Partners, a healthcare intelligence company, to document this PA solution. This white paper contextualizes these promising results and extrapolates how other organizations can leverage learnings to implement a PA solution that reduces waste and helps deliver timely care. Key applied learnings include:

- Commit to a real-time, automated, standards-based solution.
- Integrate clinical and business logic.
- Get buy-in from all relevant personnel.
- Choose your processes intentionally.
- Choose collaborative partners with the right expertise.

“NEHEN’s real-time prior authorization is the perfect example of a successful proof-of-concept pilot. The pilot has shown tremendous success in automating the entire prior authorization process and reducing the need for human touch points.”

Dave Delano, Executive Director, NEHEN

65 %

ASSESSING MARKET NEEDS

Tensions surrounding PAs have intensified over the past several years, as health insurance companies (e.g., payers) use these processes to rein in costs and avoid the utilization of low-value, overused treatments. The problem with this approach is that it can delay the delivery of care. It has also increased the administrative burden of getting treatments approved by payers.

Why Prior Authorizations Are Used

An annual survey of 600 large employers by Willis Towers Watson identified minimizing overused (and often expensive) procedures as one of employers' major priorities to reduce healthcare costs.¹ Additionally, 88% of employers identified managing pharmacy costs (e.g., specialty drugs) as a top priority. In 2010, 30% of the top-selling drugs were specialty; in 2020, the projection rises to nine of the 10 top-selling drugs (see Figure 1).² PAs offer health plans and employers a tool to reduce unwarranted, low-value spending, especially on specialty drugs and overused medical procedures with low value.^{3,4,5}

Growing Frustration with Prior Authorizations

A risk of reducing expensive medications and overused procedures through PAs, however, is delaying treatment for patients and exacerbating the administrative burden on providers. Providers indicate that their staff members spend an average of 20 hours or more per week obtaining PAs.^{6,7} In a fully manual process, this includes filling out and submitting supporting documents for each PA request via paper-based methods.

Likewise, payers receive PA requests, enter them into their care management or utilization management systems containing business and clinical logic, and then review and approve or deny the requests. Once a PA request is received by a payer, it can take an average of six to seven days to pass through the manual review process. Only then can a provider confidently schedule the procedure.

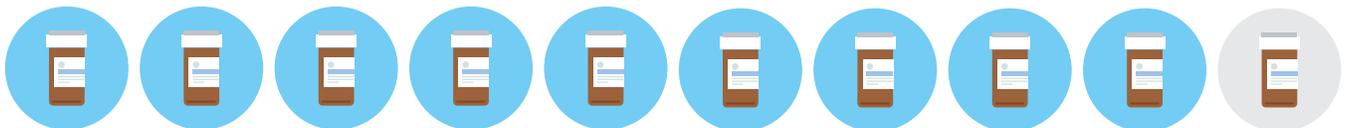
Specialty Drugs on the Rise

By 2020, nine of the 10 top-selling drugs will be specialty

2010



2020



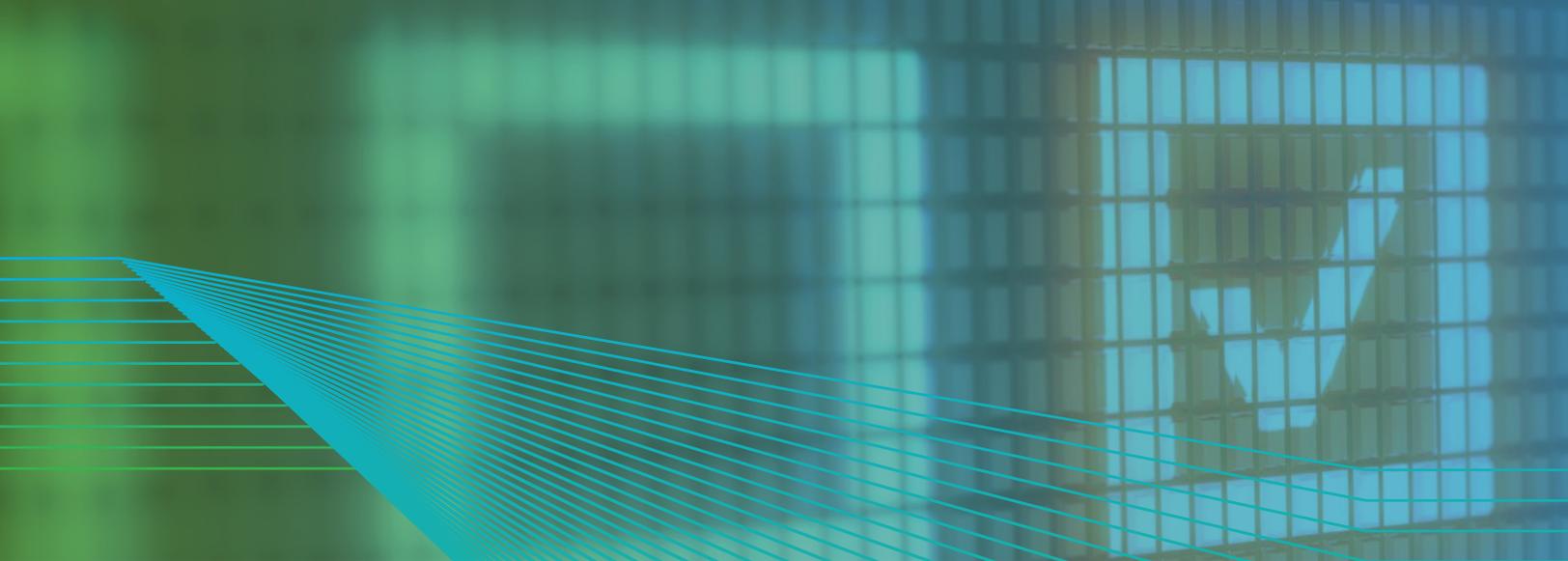
● Specialty Drugs ● Non-specialty Drugs

Source: Drug Channels

Figure 1

“In addition to reducing processing times, IIC’s automated platform has exhibited how clinical information can be communicated in a more systematic way. It’s reduced the need for human intervention, while still allowing for effective evaluation of authorizations. Being part of this pilot gave us the opportunity to be part of something that is innovative and seldom heard of in the world of prior authorizations.”

Rhonda Starkey, Director of eBusiness Services,
Harvard Pilgrim Health Care



In a series of provider interviews conducted by Leavitt Partners, one of the most consistent frustrations voiced about the payer/provider relationship was the PA process, specifically the administrative burden it places on providers and inconsistency across payers. In a qualitative study led by the American Medical Association, poor EHR usability was found to be physicians' highest source of dissatisfaction, followed directly by dissatisfaction with payers. PAs – which fall at the intersection of these two frustrations – were often cited by providers as a significant burden. Approximately 90% of the physicians interviewed reported that the PA process sometimes, often or always delays access to care.⁸

Not only do delays in access to care impact providers' ability to effectively treat patients, but they can also impact providers' bottom line – negatively impacting providers' quality measure results.

For example, delays in access to care can negatively impact providers' ability to score well on timeliness-of-care quality standards. The 2016 CAHPS Survey for Accountable Care Organizations (ACOs) asks patients to rate how easy it was to receive timely care and whether they “got answers over the phone as soon as they needed.”⁹ Other quality measures require providers to “act early” to address chronic problems and “facilitate rapid, effective” treatments and “promptly prescribe” pharmacological interventions.¹⁰ Waiting for a PA to be processed directly interferes with providers' ability to give a timely response and potentially meet their quality measure standards.

PA processes augment providers' frustration by increasing administrative burdens, negatively impacting quality measures and taking the provider away from patients to focus on PA processes.

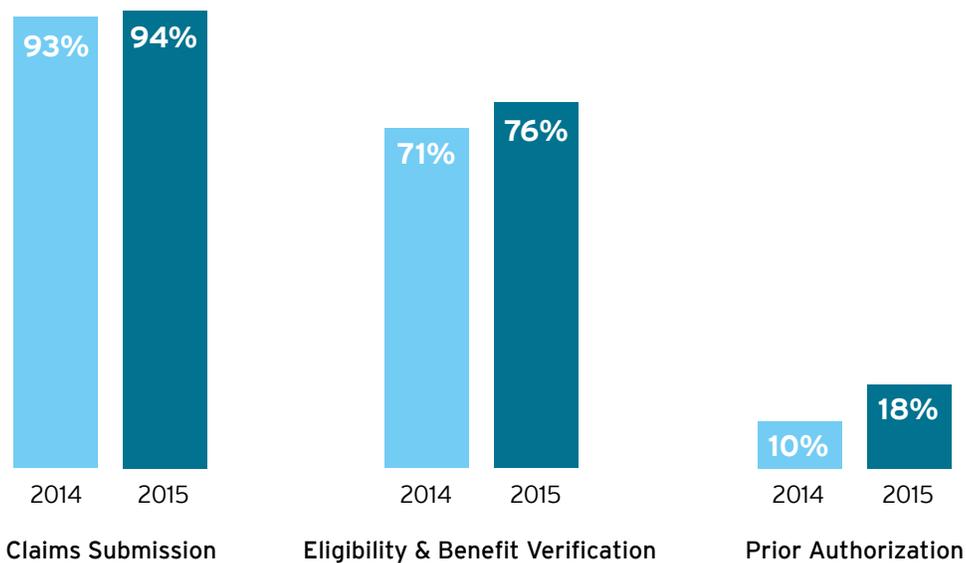
In January 2017, the AMA called for reform, demanding a system that streamlines requirements, reduces administrative burdens, and increases timely access and transparency.¹¹ Without a federal effort to streamline PA processes, 28 states have begun implementing their own legislation.¹² The problem with these efforts, however, is that they aren't synchronized. For example:

- California legislation calls for an electronic submission for medication PAs using a standardized form.
- Legislation in Louisiana only dictates that a standard form be used, but does not require electronic submission.¹³
- Legislation in Massachusetts requires all health plans to use a standardized form, but that form is onerous for providers to use and doesn't necessarily coincide with information required by payers.

As such, payers and providers continue to look for solutions to address the PA time drain.

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Adoption of Fully Electronic Transactions



Source: 2016 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings

Figure 2

Unraveling Prior Authorization Processes

Unraveling complex PA medical and administrative policies is an incredibly cumbersome process, with a mixture of manual and electronic components for each unique provider/payer relationship. Health systems are increasingly taking advantage of partially and fully electronic PA support tools, with adoption rates of fully electronic transactions increasing from 8% in 2014 to 18% in 2015.¹⁴

However, compared to 2015 reports of fully electronic claims submission adoption (94%) or eligibility and benefit verification adoption (76%), the low adoption rates of electronic PAs offer an area for significant cost and time savings as well as the potential to get treatments to patients more efficiently (see Figure 2). PAs with attachments have shown a high savings opportunity per transaction, with estimates upward of \$45 per transaction.¹⁵

When factoring in this additional time and costs, potential industry-wide savings from using a real-time, automated PA decision-support tool increase astronomically, translating into faster, more efficient care for patients.

Responding to this need, CAQH CORE – a national initiative to streamline electronic interoperability – has initiated a series of webinars that evaluate challenges and successes faced while implementing electronic healthcare claims attachments^{16,17} and provided an overview of industry efforts to adopt electronic PA transactions.¹⁸

Potential Savings by Switching to Electronic Prior Authorizations

Using staff time and resources to submit, coordinate and follow up on PAs translates into tangible costs. Both payers and providers could reduce these costs by implementing electronic PA processes. The 2016 CAQH Index found that health plans could save roughly \$90 million, and providers could save \$323 million.¹⁹

In addition to potential cost savings, the 2016 CAQH Index reports that both payers and providers could drastically reduce time spent on each manual PA. Inputting each manual PA takes a provider an average of 20 minutes per transaction; electronic PA submissions, however, take an average of six minutes.

Given that providers completed roughly 57 million transactions manually in 2015, they could have saved 13.3 million hours (798 million minutes) by completing these PAs electronically (see Figure 3, next page). This estimate, however, does not include time or costs related to preparing materials, resolving issues or follow-up.

Even processes that use electronic aspects usually include manual components either on the provider's or the payer's end. For example, some providers send PAs manually to a clearinghouse or another partner, which then converts these records to an electronic format for the payer. Conversely, a provider may have to manually submit information using a payer's web portal; so while the process is "electronic" on the payer's end, the transaction still takes time and resources to be manually inputted on the provider's end. Many of these solutions don't utilize real-time authentication or touchless technology. If the industry is going to keep up with increasing demands, there needs to be drastic improvement to prevent a bottleneck of care, mired in paperwork.

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Potential Time Savings for Providers Switching to Electronic PAs

$$\begin{array}{ccc}
 14 & \times & 57\text{M} & = & 13.3\text{M} \\
 \text{MINUTES} & & \text{TRANSACTIONS} & & \text{HOURS SAVED}
 \end{array}$$

Source: Leavitt Partners analysis using 2016 CAQH Index

Figure 3

A BETTER WAY FORWARD

Cognizant's recent endeavor to develop a truly automated, electronic PA solution reveals promising results. In partnership, New England Healthcare Exchange Network (NEHEN), Cognizant and Informatics In Context (IIC) have created a real-time, automated solution that has shown significant time and cost savings in addition to other ancillary benefits.

Developing a Real-Time, Automated Solution

NEHEN spent 12 months conducting interviews with payers and providers on what improvements are needed in administrative data exchange. The interviews uncovered significant efficiency shortcomings in the PA and referral processes. Based on an analysis of these needs, NEHEN, working in partnership with Cognizant, selected IIC to conduct a proof-of-concept project. The pilot project was to develop a rules engine to connect with payer utilization management systems, which would automate payer-specific medical and administrative policies.

Using the decision-support tool developed by IIC, providers enter and upload information specifically needed for the clinical service PA being requested via a web portal. The web portal allows them to submit the necessary data to the payer in real time, leveraging standard EDI 278/275 transactions.

IIC helped automate payers' business and clinical rules to provide immediate feedback for providers, while following EDI 278/275 standards. The feedback reveals what information is required to process an authorization approval in real time – thereby eliminating the manual review process, wait time and follow-up by providers. This approach significantly simplifies administrative processing for payers and providers, reduces unnecessary delays and lowers costs.

During implementation, NEHEN, Cognizant and IIC collaborated to adapt processes and add abilities based on user needs. For example, the system allowed a group of providers to identify upcoming patients that would likely need PAs. The providers could use a batch format, using scheduled patient appointments, to process patients' PAs before their appointments. Once submitted in this manner, the PAs are prequalified by the payer-specific medical and administrative rules before the patients even arrive for their appointments.

Selected Medical Policy Categories

The pilot targeted three high-utilization medical policy categories: home healthcare; select pharmacy drugs (Rituxan, Aloxi, Emend and Anzemet); and select surgical policies (knee arthroplasty, varicose vein procedures, breast surgeries, hysterectomies and cholecystectomies) in both inpatient and ambulatory settings.

Home healthcare – which tends to have more business requirements and fewer clinical requirements than the other two categories – was chosen due to its high-volume, straightforward nature. The other two processes (pharmacy and surgical) were selected because of their highly complex, clinical requirements.

Working with Payers and Providers

While operationalizing the PA decision-support tool, the developers considered provider needs, keeping the process straightforward, standards-based and automated. The developers also built in the ability for providers to identify errors before PA submission, prompting them to provide supplemental information within the transaction itself. This real-time, automated decision-support tool has increased the number of requests that are auto-approved based on providers' delivery of requested data.

Initial pilot project participants included:

- Harvard Pilgrim Health Care (HPHC).
- VNA Care Network.
- Beth Israel Deaconess Medical Center, Department of Surgery and Ambulatory Operations OBGYN Services.
- Partners Healthcare.

These providers were trained on the system via online webinars, led by a facilitator. Each webinar included a representative from the participating payer. These 20-minute training sessions walked the providers through the process, introducing them to the online portal.

Pilot Results: Time and Cost Savings

Pilot implementation – running November 14, 2016, to April 30, 2017 – revealed a drastic improvement in the PA process, saving participating payers and providers considerable time and costs.

As of May 5, 2017, 82.2% of the pilot's PA transactions were touchless – meaning they did not require either payer intervention or provider follow-up. Additionally, the pilot allowed providers to track submissions with real-time adjudication status rather than submitting a fax to request this information, or not knowing the status at all. Real-time tracking is projected to generate over 85% in cost and resource savings.

One pilot participant reported that the IIC platform had reduced its processing time from one week to 20 minutes, allowing highly-skilled clinical staff to focus on care management activities rather than manual processes.

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Calculating PA Process Improvements

Transaction Info	As of December 1, 2016	As of January 6, 2017	As of April 30, 2017
Total Submitted	68 (HC-61, Surg-7)	243 (HC-213, Rx-2 Surg-28)	597 (HC-531, Rx-16, Surg-50)
Total Touchless	62 (91.2%)	210 (86.42%)	491 (82.24%)
Requiring HPHC Intervention	6	33	106
Cost Savings for Providers & Payers	\$1,240	\$4,200	\$9,820 (Projected)

Source: Cognizant

Figure 4

Pre-pilot averages indicated that each transaction could take up to six days to secure PAs; post-pilot averages report 15 minutes per transaction. CAQH estimates actual costs for both provider and payer manual processing of PA transactions, with attachments, at \$45 per transaction. This pilot used a conservative estimate of \$20 per manual PA transaction as a baseline for comparison and cost savings. The results report that of 597 transactions, 491 required no intervention, a net savings of \$16 per PA transaction, or \$9,820, conservatively calculated (see Figure 4).

Intangible Benefits

In addition to time and cost savings, intangible benefits from using this automated PA solution were also realized. Early advantages revealed in the pilot include:

- Easy-to-understand processes and minimized number of input fields.
- The potential to reduce fraud.
- Reconciled requests against payer policies prior to submission, ensuring compliance and reducing denials, appeals and medical reviews.
- Improved patient outcomes.
- Capacity to concurrently populate payers' utilization management systems and providers' complete requests.
- Ability to extend patient visits without additional paperwork.
- Improvements to patient intake and reduced scheduling time.
- Real-time validation, evaluation and adjudication of medical policies.
- Single point of access for PAs and real-time ability to check eligibility.

Provider participants appreciate the partnership they have formed with NEHEN, Cognizant and IIC through this pilot and have expressed interest in continuing to work on the project post-pilot.

APPLIED LEARNINGS

The benefits to providers and payers from utilizing this type of system are transferable to the overall industry. By implementing a true real-time, touchless, transparent PA system, providers can connect patients with the right care when they need it, while following proper procedure. As other payers and providers seek to leverage these benefits, they should consider the following learnings.

Commit to a Real-Time, Automated, Standards-Based Solution

Effective PA solutions are real-time, automated and standards-based. The first two characteristics save both time and money. The third streamlines and simplifies the integration process, similar to what EDI 270 has enabled for eligibility checks. To maximize efficiency, payers and providers should look for PA tools that have all three characteristics.

Solutions that stop short of a truly real-time, automated, standards-based process fail to fully leverage cost and time efficiencies. Payers, especially, need to commit to a truly automated system, investing resources up front and trusting that the return on investment will come. Too often, PAs are submit-and-forget processes. The best results come from end-to-end solutions, in which the provider is prompted through all requirements and standards, and receives real-time feedback and direction.

Integrate Clinical and Business Logic

Many PA solutions focus on either clinical or business requirements. The most effective solutions, however, integrate provider, payer and health system knowledge to provide a singular, streamlined process.

Each payer's infrastructure is unique, as are its business rules and personnel jurisdictions. Additionally, providers are often confused or unaware of the payer's unique business logic. To account for these individualized systems, PA solutions should integrate the payer's clinical and business requirements. If the electronic solution can prompt the provider on what is needed, the payer's rules become transparent and actionable. At the end of the process, the provider is clear on what is and what is not approved – and why – and can move forward to implement a treatment plan knowing it will be reimbursed.

Get Buy-In from All Relevant Personnel

Change – even positive change – is hard. And the difficulty that comes with change multiplies with the more people that are involved. In large organizations, the PA process is often decentralized on both the payer and provider side, with different people involved in different processes. A crucial part of implementing a real-time solution is identifying who does what and when, and then aligning all parties.

- **On the payer side**, make sure to identify and communicate with everyone that contributes to both the clinical and business requirements associated with PAs, including the clinical, information technology (IT), operations and revenue teams.
- **On the provider side**, invest in training once the PA solution has been implemented. These trainings can be conducted in person or through webinars. The more streamlined the process is, the easier it will be to onboard new providers.

A payer can identify the most complex processes – ones that require the support of both clinical and medical teams to unravel their internal rules – because these are the processes that would benefit most from being streamlined.

Choose Your Processes Intentionally

When selecting the PA processes to target for inclusion in a real-time, automated solution, payers can take different strategies. The key is to intentionally choose a strategy and understand how to measure its effectiveness. For example, a payer can identify the most complex processes – ones that require the support of both clinical and medical teams to unravel their internal rules – because these are the processes that would benefit most from being streamlined. These processes also often have the highest payoff.

On the other hand, a payer may want to focus first on simple processes that tend to be high-volume, where mistakes can hide and create a resource-draining, back-and-forth exchange between the payer and provider.

Choose Collaborative Partners with the Right Expertise

Because payers and providers have unique workflows and each treatment may require individual configurations, it's critical to work with partners that have both the technical knowledge as well as the willingness to act and react with flexibility. Each partner organization may have its own expertise, but they need to share a vision and an agenda. A true partnership brings together a breadth of resources, where each organization collaborates and is committed to shared success.

LOOKING AHEAD

The potential to scale the pilot's time and cost savings industry-wide is exciting. Shrinking the PA window from six days to 15 minutes means that patients can receive care when they need it. Integrating both administrative and clinical requirements in real-time adjudication also drastically increases system transparency, alleviating tensions between payers and providers. All these changes mean that patients can receive more streamlined, time-efficient care.

With a proven solution in place, payers and providers can tackle other medical processes to multiply time and cost savings. By investing in custom-fit PA automations, organizations can streamline requirements, reduce administrative burdens, make rules more transparent and more efficiently deliver care to patients.

ACKNOWLEDGMENTS

This white paper was written in partnership with Leavitt Partners, a healthcare intelligence business. The firm helps clients navigate the evolving role of value in healthcare by informing, advising and convening industry leaders on value market analytics, alternative payment models, federal strategies, insurance market insights and alliances. Through its family of businesses, the firm provides investment support, data and analytics, member-based alliances and direct services to clients to support decision-making strategies in the value economy. For more information, visit leavittpartners.com.

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FOOTNOTES

- ¹ High-performance insights – best practices in health care 2016; 21st Annual Willis Towers Watson Best Practices in Health Care Employer Survey [Internet]. Willis Towers Watson; 2017 Jan [cited 2017 Apr 7]. Available from: www.willistowerswatson.com/en/insights/2017/01/full-report-2016-21st-annual-willis-towers-watson-best-practices-in-health-care-employer-survey
- ² Fein AJ, Ph.D. Future Vision: The Top 10 Drugs of 2020 [Internet]. [cited 2017 Apr 7]. Available from: www.drugchannels.net/2014/07/future-vision-top-10-drugs-of-2020.html
- ³ Lotvin AM, Shrank WH, Singh SC, Falit BP, Brennan TA. Specialty Medications: Traditional And Novel Tools Can Address Rising Spending On These Costly Drugs. Health Aff (Millwood). 2014 Oct 1;33(10):1736-44.
- ⁴ Keehan SP, Stone DA, Poisal JA, Cuckler GA, Sisko AM, Smith SD, et al. National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector To 20 Percent Of Economy. Health Aff (Millwood). 2017 Mar 1;36(3):553-63.
- ⁵ Mercer | National Survey of Employer-Sponsored Health Plans, 2016 [Internet]. [cited 2017 Apr 7]. Available from: www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html
- ⁶ Prior Authorization Hurts Patient Care, AMA Survey Finds | Preauthorization, Health Care Companies, Physicians | HealthLeaders Media [Internet]. [cited 2017 Apr 7]. Available from: www.healthleadersmedia.com/physician-leaders/prior-authorization-hurts-patient-care-ama-survey-finds#
- ⁷ Standardization of prior authorization process for medical services white paper [Internet]. American Medical Association; 2011 Jun [cited 2017 Apr 7]. Available from: <http://massneuro.org/Resources/Transfer%20from%20old%20sit/AMA%20White%20Paper%20on%20Standardizing%20Prior%20Authorization.pdf>
- ⁸ Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews. [Internet]. 2016 Oct [cited 2017 Apr 7]. Available from: www.ama-assn.org/sites/default/files/media-browser/public/ps2/ps2-dartmouth-study-111016.pdf
- ⁹ CAHPS Survey for Accountable Care Organizations (ACOs) Participating in Medicare Initiatives [Internet]. CMS; 2016 [cited 2017 Apr 7]. Available from: http://acocahps.cms.gov/globalassets/aco---epi-2-new-site/pdfs-for-aco/survey-instruments/2016-aco-survey/english/2016_aco-9_mail_survey_english.pdf
- ¹⁰ Accountable Care Organization 2016 Program Quality Measure Narrative Specifications [Internet]. Centers for Medicare & Medicaid Services; 2016 Jan [cited 2017 Apr 14]. Available from: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2016-ACO-NarrativeMeasures-Specs.pdf
- ¹¹ Health Care Coalition Calls for Prior Authorization Reform | American Medical Association [Internet]. [cited 2017 Apr 7]. Available from: www.ama-assn.org/health-care-coalition-calls-prior-authorization-reform
- ¹² 2017 Electronic Prior Authorization (ePA) National Adoption Scorecard [Internet]. [cited 2017 Apr 7]. Available from: <https://epascorecard.covermy meds.com>
- ¹³ *ibid.*
- ¹⁴ 2016 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings [Internet]. CAQH; 2017 Jan [cited 2017 Apr 4]. Available from: www.caqh.org/sites/default/files/explorations/index/report/2016-caqh-index-report.pdf
- ¹⁵ 2015 CAQH Index: Reporting Standards and Data Submission Guide – Health Plans Numbers of Transactions and Costs per Transaction [Internet]. [cited 2017 Apr 7]. Available from: www.caqh.org/sites/default/files/explorations/index/report/index_guide.pdf
- ¹⁶ CAQH CORE Attachments Webinar Series Part 1: Laying the Foundation for Electronic Healthcare Attachments [Internet]. Webinar presented at; 2017 Mar 2 [cited 2017 May 30]. Available from: www.caqh.org/about/event/use-and-adoption-attachments-healthcare-administration-part-i
- ¹⁷ CAQH CORE Attachments Webinar Series: Session 2 [Internet]. Webinar presented at; 2017 May 25 [cited 2017 May 30]. Available from: www.caqh.org/about/event/use-and-adoption-attachments-healthcare-administration-part-ii
- ¹⁸ CORE Participant Call on Overview of CAQH CORE Approach to Adoption of Electronic Prior Authorization Transactions [Internet]. Webinar presented at; 2017 Jun 19 [cited 2017 May 30]. Available from: www.caqh.org/about/event/core-participant-call-overview-caqh-core-approach-adoption-electronic-prior
- ¹⁹ Op Cit. footnote 14.

AT A GLANCE: KEY PARTNERS



Founded in 1998, the New England Healthcare Exchange Network (NEHEN) is a consortium of regional payers and providers that has designed and implemented a secure and innovative health information exchange with the intent of reducing administrative costs and improving the quality, safety, and efficiency of patients. NEHEN is known to be an agile, innovative and collaborative organization serving both payer and provider member organizations. For more information: www.nehen.net



Informatics In Context (IIC) offers payers a transformative standards- based solution that fully automates their authorization process to become real-time based on the ACA mandated EDI 278 standard for medical procedures, tests, labs and drugs covered under medical benefits. IIC is able to achieve a high level of touchless adjudication by automating all of the payer's policies and guidelines, including all business and clinical rules, required for real-time responses. For more information: informaticsincontext.com



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