Top Nine Elements for an Optimal Genetic Test Benefit Program

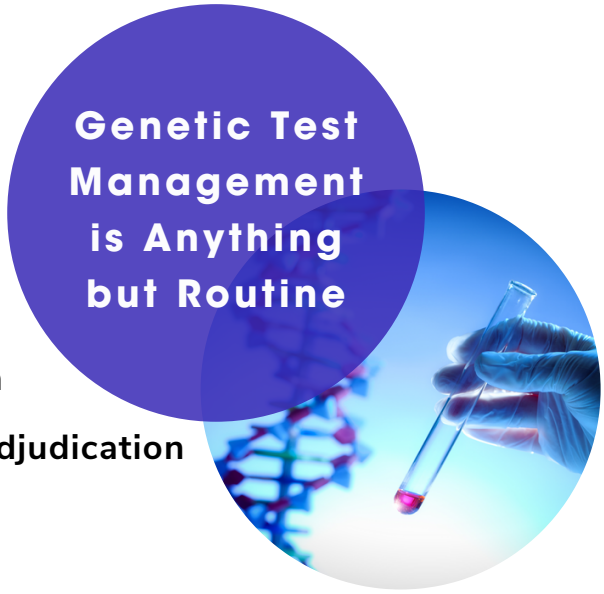
At Avalon Healthcare Solutions, we are devoted to sharing wisdom. We are driven to improve value-based outcomes – ensuring patients receive the proper test and care at the correct cost. We offer our Top Nine Elements for an Optimal Genetic Test Benefit Program in this spirit.

You will find some Elements familiar and others less so. Attribute those gaps to explosive genetic testing growth, manual prior authorization processes, and lack of specific test identification.

Genetic test management is anything but routine. The future of genetic test management requires a changed mindset. We develop these Elements through Avalon's deep lab expertise, evidence-based science, and proven delegated utilization management. By combining unique assets through our exclusive collaboration with Optum, we can now further control costs, improve quality, reduce abrasion, and improve compliance with regulations and statutes.

This document describes generalized best practices for a genetic test best-in-class program:

1. **Accreditation and regulatory compliance**
2. **Coverage criteria based on science**
3. **Ongoing evaluation of test quality**
4. **Expedited review of prior authorizations**
5. **Enhanced provider education and experience**
6. **Claim to authorization match during adjudication**
7. **Ongoing utilization management versus claims adjudication**
8. **Prevention of FWA**
9. **Optimized laboratory network**



Each Element is described more fully below.

We hope that the Top Nine Elements for an Optimal Genetic Test Benefit Program helps you navigate the complexity as you steer toward a successful genetic test management program.

Should you have any questions along the way, we're here to help. Contact us at: avalon-insights@avalonhcs.com

Top Nine Elements for an Optimal Genetic Test Benefit Program

1 Accreditation and regulatory compliance

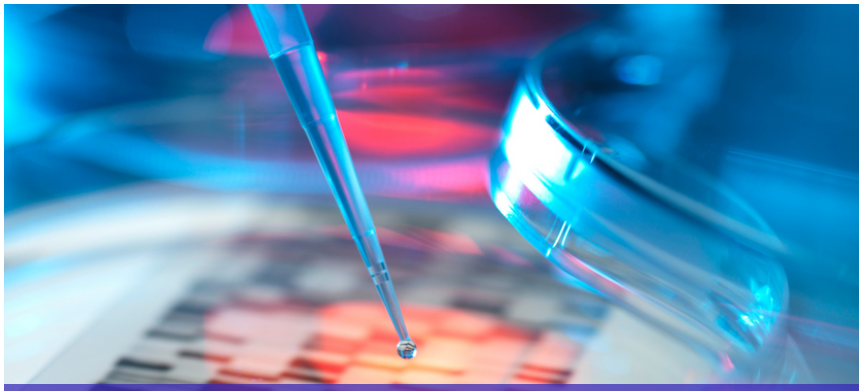
Utilization management helps ensure patients have the proper care and the required services without overusing resources. Accreditation by a national agency like NCQA and URAC and good standing with the state regulatory agencies help guarantee that organizations making these decisions follow objective, evidence-based best practices, a central tenant of genetic test management.

2 Coverage criteria based on science

Maintaining a current understanding of the clinical science and the appropriate coverage criteria documented in clinical policies necessitates a frequent review cycle. To ensure the latest science and clinical medicine are codified in medical policies, experienced working laboratorians, pathologists, and geneticists ought to perform a comprehensive scientific and clinical review of the latest literature, which must be completed no less than once yearly or more frequently as the science warrants.

3 Ongoing evaluation of test quality

Beyond coverage criteria creation and maintenance, the testing must meet appropriate scientific and clinical standards. Ensuring labs have completed sufficient scientific, technical, and clinical validations is vital to ensuring the information provided to the physician meaningfully informs the patients' healthcare needs. Plans should have staffing and systems to ensure laboratories are being evaluated beyond the credentialing requirements.



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4 Expedited review of prior authorizations

Prior authorizations are cumbersome for all involved parties. Health plans must ensure that the laboratory providers receive information detailing coverage criteria to expedite the review process. Using codes from programs like MolDX® is another key to automating prior authorization. Utilizing specific genetic billing codes increases test specificity and directly links the test and policy, enabling automation equivalent to specific CPT codes. Increased physician satisfaction, faster turnaround time for authorization requests, and lower costs for the health plan are all benefits.

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5 Enhanced provider education and experience

In many cases, laboratories will perform the same or similar genetic tests while billing with different combinations of CPT codes. Establishing coding requirements for each test at each laboratory would allow streamlined operations and more comparative analytics within the health plan. The test specificity concepts discussed provide a clean, robust, and efficient means to overcome potential code challenges and clarify provider billing requirements. Health plans adopting a specificity method for test identification will garner increased operational efficiency, increased laboratory and physician satisfaction, and reduced potential fraudulent billing practices.

6 Claim to authorization match during adjudication

In many cases, the criterion for matching allows broad, non-specific matches, which contribute to inappropriate payments, stopped claims for manual review, delays in claims payment, and the potential for fraud. Increasing the flexibility and specificity of matching criteria contributes to alleviating those challenges.

7 Ongoing utilization management versus claims adjudication

Plan best practices include a continual evaluation of laboratory tests, required coverage criteria, and historical laboratory performance to determine when a specific laboratory or a collection of tests should be adjudicated during the claims process without prior authorization or continue utilization reviews in a prior authorization process. Additional controls, such as periodic auditing of laboratories to ensure continued compliance, are recommended.

8 Prevention of FWA

Integrating test specificity and enhanced claim-to-authorization matching processes will reduce fraudulent billing practices, saving health plans money.

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9 Optimized laboratory network

Initiating a quality evaluation enables plans to promote high-quality laboratory providers differentially. Such promotional activities include marketing the tests directly to patients or physicians, calling physicians who use lower-quality laboratories, or tiering networks with increased benefits to patients and physicians using higher-tier laboratories. Health plans should expect unit price reductions from laboratories that benefit from differential promotional activities.

We manage lab benefits for over 38M lives; want to know more?

Avalon Healthcare Solutions is the world's first and only Lab Insights company, bringing together our proven Lab Benefit Management solutions, lab science expertise, digitized lab values, and proprietary analytics to help healthcare insurers proactively inform appropriate care, reduce costs, and improve clinical outcomes. Working with nationwide health plans, the company covers over 38 million lives and delivers 9 – 20% outpatient lab benefit savings. Avalon is pioneering a new era of value-driven care with its Lab Insights Platform that captures, digitizes, and analyzes lab results in real time to provide actionable insights for earlier disease detection, ensuring appropriate treatment protocols and driving down the overall cost.

More recently, with our next generation genetic test management solution, we united evidence-based lab policies, pre-service clinically led reviews, and automated policy adherence with individualized genetic codes for specificity and utility, enabling a move toward automated prior authorization. A unique component is access to a curated genetic lab network where contracting, cost, and quality control are managed alongside automated policy adherence, streamlined prior authorization, and an improved physician ordering experience. The result is improved compliance with MolDX's defensible content, trusted test quality and transparency, reduction in fraud, waste, abuse potential, and control of spend... in fact, Avalon estimates that their managed genetic test programs can lower health plan spending an estimated $0.50 to $0.65 per member per month.

For more information about Avalon, please visit www.avalonhcs.com.