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June 2016

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June 2016
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Part 1
New Proposed Regulation
Rebrands and Retools Meaningful
Use

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By Tony Schueth, Editor-in-Chief

What's happening with meaningful use (MU), especially since the rumors of its demise were greatly exaggerated? Stakeholders have been eagerly awaiting the answer from the Centers for Medicare and Medicaid Services (CMS). Now we have a much better idea of its fate: CMS has rebranded and retooled the program, which is now called Advancing Care Information (ACI). Details are in a newly released Notice of Proposed Rulemaking (NPRM).

We got hints earlier this year about MU's future when it was announced that some MU elements would be rolled up into a new program created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA provided CMS with the legislative vehicle to address physician payment reform, streamline quality-based programs payments and create an MU replacement.

But in typical government fashion, MU's replacement is not very straightforward. It is, in fact, quite complex. ACI is a program within a program within a program. It begins as part of a new Quality Payment Program "framework," which was created under MACRA.

The Quality Payment Program has two tracks providers can use to have their Medicare payments adjusted. The one of most interest to HIT Perspectives readers is called the Merit-Based Incentive Payment System (MIPS), which most Medicare clinicians are expected to use. The other is called Advanced Alternative Payment models. For more information, see the CMS fact sheet.

MIPS Overview. MIPS replaces Medicare's former payment adjustment system, which was based on the reviled Sustainable Growth Rate formula. MIPS is supposed to simplify Medicare's former patchwork of payment and quality programs by consolidating the Physician Quality Reporting System, the Value Modifier Program and MU. The health information technology (health IT) certification program by the Office of the National Coordinator for Health Information Technology (ONC) will continue as it did under MU. Certified electronic health records (EHRs) — or certified modules, such as application program interfaces — must be used to achieve MIPS objectives.

However, the heart of MIPS is another carrot-and-stick incentive program. As described below, physicians will respond to — and report on — the following weighted metrics:

- **Cost** (10% of the total score). It replaces the cost component of the Value Modifier Program, also known as Resource Use. The score will be based on Medicare claims, meaning there will be no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.

- **Quality** (50% of the total score). It replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program. Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category offers clinicians reporting options to accommodate differences in specialty and practices.

- **Clinical Practice Improvement Activities** (15% of the total score). Clinicians would be rewarded for clinical practice improvement activities, such as those focused on care coordination, beneficiary engagement and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in alternative payment models and in patient-centered medical homes.

- **Advancing Care Information** (25% of the total score). This renamed component is a repurposed version of MU. Clinicians would choose to report customizable measures that reflect how they use EHRs in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing MU program, this category would not require all-or-nothing EHR measurement or quarterly reporting.

These four components will be added together to create a base score. The base score will be used by Medicare to increase or decrease a physician's overall Medicare payment by certain percentages. Doctors can earn

bonuses (or receive penalties) of up to 4% starting in 2019, a number that grows to 9% by 2022 based on how well they perform.

CMS will begin measuring performance of doctors and other clinicians through MIPS in January 2017, with payments based on those measures beginning in 2019.

A closer look at Advancing Care Information. If MU wasn't complicated enough, ACI is very complex—even though its underlying logic is fairly easy to understand. CMS listened to physicians, who wanted flexibility in measures and reporting. However, the devil's in the details — especially in how the ACI is computed.

As mentioned previously, the ACI counts toward a quarter of the MIPS payment adjustment. The overall score of 100 points in this category is comprised of subscores in three categories.

1. **Base score**. The first is the base score, which accounts for up to 50 points of the ACI score. It is comprised of six objectives and measures, which will sound very familiar to those who've been embroiled in MU over the past seven years.

   • Protect Patient Health Information Using a Risk Analysis (mandatory)

   • Electronic Prescribing

   • Public Health and Clinical Data Registry Reporting

   • Immunization registry reporting is mandatory; other registry reporting is optional

   • Health Information Exchange

   • Coordination of Care Through Patient Engagement

   • Patient Electronic Access

2. **Performance Score**. Next is the performance score, which accounts for up to 80 points toward the total ACI category score. Physicians and other clinicians select the measures that best fit their practice from three objectives: electronic patient access, coordination of care through patient engagement and health information exchange. These, again, harken back to MU's objectives and measures.

3. **Public Health Registry Bonus Point**. Immunization registry reporting is required. A bonus point can be earned for reporting to other public health registries.

Total Score. The base score, performance score and bonus point (if applicable) are added together to achieve the total ACI score. Note that they add up to a possible 131 points, while only 100 points are needed to receive the maximum points in the ACI category. There is no reward for exceeding the 100-point total. However, participants' overall score in MIPS declines proportionately if they do not meet the 100-point threshold. Scoring is not all-or-nothing.

What does it mean? The Point-of-Care Partners (POCP) team will be analyzing the new NPRM and what it means to various stakeholders. We do, however, have a few top-of-mind observations.

The first is that physicians who have participated in MU should be able to easily achieve the ACI measures due to the similarity of the objectives. By the same token, they should be able to use their certified EHRs to report on quality and clinical practice improvement measures. The laggards will continue to risk having their Medicare payments dinged unless they get with the digital age — except this time there won't be any money available to help defray the costs of getting wired.

Protecting patient health information using a risk analysis also should be easy to attain since this is a requirement under the regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA). That is likely easier said than done. We would make a healthy bet that most providers have never heard of the HIPAA security rule, even though it has been in effect for more than a decade.

MIPS will continue to push adoption of electronic prescribing (ePrescribing) through regulation. This tried-and-true approach has resulted in 80% of office-based based physicians using this technology. However, there is still room for growth. Given that the remainder are hard-core laggards, it remains to be seen how much MIPS moves the adoption needle.

It is clear that the government will be moving MIPS beyond the measurement of EHR adoption and has created a renewed focus on patient-centered care using patient-centered health information technology. This was underscored in a blog post by CMS Acting Administrator Andy Slavitt and National Coordinator Karen DeSalvo, M.D. They said MIPS is "more patient-centric, practice-driven and focused on connectivity." We undoubtedly will continue to see this emphasis as MIPS rolls out in the future because it aligns with other ONC and CMS programs and initiatives. That said, patient-centered care hasn't gained much traction despite the government's best efforts to date. It's too soon to tell whether the piling on of MIPS' new regulatory requirements will help to create a tipping point.

Comment period. The NPRM provides for a 60-day comment period, which closes at 5 p.m. on June 27, 2016. This gives stakeholders an opportunity to make recommendations, which will be considered in the final regulation that will be issued in the fall. Because POCP will have a detailed understanding of the NPRM and its impacts, we can help you write and submit your comments. Please give us a call or send us an e-mail.

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2 **Part 2:** Real-Time Benefit Inquiry: A New Kind of Clinical Decision Support

By Pooja Babbrah, Senior Consultant

Clinical decision support (CDS) has long been recognized as a set of tools that can improve clinical decision making and patient safety, both as functionalities in electronic health records (EHRs) and electronic prescribing (ePrescribing) systems. Familiar examples include computerized alerts and reminders to care providers and patients, clinical guidelines and condition-specific order sets. Now the definition of CDS is being broadened to include other tools that provide "knowledge and person-specific information, intelligently filtered or presented at appropriate times." One of the newest is the real-time benefit inquiry (RTBI), whose value lies in its potential for providing real-time, patient-specific formulary and benefit information at the point of care.

Why benefit verification? Benefit verification is a key step in the ePrescribing process because it helps the clinician know if a medication will be covered under a patient's medical insurance coverage or prescription benefit coverage; if covered, how much a patient's insurance will pay and how much the patient is responsible for paying. This is important for several reasons. Prescribing a medication that is not covered by insurance can cause treatment delays while the pharmacy and insurance company identify an alternative that is on formulary. This also can result in claim denials and a bad experience at the pharmacy. High out-of-pocket costs to the patient for an off-formulary drug can lead to prescription abandonment and medication noncompliance. The latter results in as much as $289 billion a year in unnecessary deaths, needless hospitalizations and doctor visits, and lost productivity.

Benefits checks and ePrescribing. Today's ePrescribing systems and EHRs with ePrescribing modules already have the ability to perform formulary and benefit (F&B) checks. While the information is useful, it is not as complete, accurate or timely as a clinician would prefer. That is why RTBI is viewed as a useful adjunct to today's ePrescribing F&B check. RTBI provides real-time information about patient-specific utilization management programs (such as prior authorization and step therapy), true out-of-pocket costs for a medication (specific copay/coinsurance amount and deductible information), alternative pharmacy pricing (such as for a 90-day supply) and which pharmacy will be most cost effective in light of the patient's insurance coverage and available pharmacy benefit. This should help the prescriber identify the most cost-effective medication at the point of prescribing. It also should result in a cleaner prescription, which will minimize treatment delays and unacceptable out-of-pocket costs to the patient.

RTBI Progress. The industry is already making progress toward making RTBI a reality. At the National Council for Prescription Drug Programs (NCPDP) annual meeting in early May, Point-of-Care Partners (POCP) co-presented a session on RTBI with DrFirst and Humana. The latter two presenters discussed how their companies' partnership created a recently launched RTBI service, which is based on a modified version of the NCPDP Telecomm D.0 Standard. Early results of this service show that prescriber behavior changes when the RTBI reveals that a drug isn't covered by a patient's insurance. In addition, use of the RTBI increases adoption of the new electronic prior authorization standard, which ultimately will increase speed to therapy.

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The Future of RTBI. In terms of incorporating RTBI in EHRs, it's not a question of standards so much as prioritization of development, which depends on what the government is requiring or what business model is being used by clients. Both payers and EHRs have expenses and a lot on their plates, so fitting in new ways of communicating formulary information must be prioritized and placed accordingly in the development queue. However, given the broader definition of CDS that has emerged and the early results we are starting to see in the marketplace, payers and EHRs are likely to put RTBI development into their product road maps sooner rather than later. RTBI is a sophisticated CDS component, and it will continue to be an example of how providing clinical decision support at the point of care will help improve patient health and safety.

POCP is working on the forefront of RTBI standards and adoption. Write us or give us a call. We'd be happy to bring you up to date.

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3 Part 3: Top 10 Themes at Health Datapalooza 2016

By Tony Schueth, Editor-in-Chief

The final bell has rung on this year's Health Datapalooza, which convened May 8-11 in Washington. It was the seventh annual get-together of number crunchers, developers, academics, policy makers, health advocates and entrepreneurs, who came from the public and private sectors to promote innovation around the availability and use of health data. Conceived by former Department of Health and Human Services (HHS) Chief Technology Officer Todd Park, Health Datapalooza grew from a one-day event with 45 attendees to nearly 2,000 attendees sharing insights on innovation in health data over three days. Ten themes emerged over the course of this year's meeting.

Improved data access. Health Datapalooza was founded to help "liberate" data — or at least drastically improve access to the massive amounts of health data created by the federal and state governments, payers, providers and others. The government continues to lead by example in this respect. In her keynote address, HHS Secretary Sylvia Matthews Burwell noted that seven years ago, "…we had a mere 10 data sets around Medicare cost and quality that were openly available to the public. Today, there are more than 2,100 datasets available on HealthData.gov." The Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services are at the head of the pack, with each contributing more than 400 data sets.

Transforming data into information. The world seems to be drowning in health data, but the challenge is transforming those data into actionable information. That was heard again and again from speakers and audience participants, who definitely issued a cry for help. Just making data available and crunching numbers isn't enough. Skills, tools and other support are needed to help individuals (such as practitioners) and organizations identify what internal and external data are needed, gain access to and link the data sets, and perform various kinds of specific, meaningful analyses. Attendees made it clear that the federal government could play a bigger role in terms of technical assistance.

More and rapid innovation. The call for speedier innovation was brought home in the keynote address by Vice President Joe Biden. He challenged attendees to ramp up the innovation that has been seen in the past five years around open access and the sharing of health data with the hope of curing cancer by 2020 — a personal and administration "moonshot" goal. Many stakeholders, it seems, have already internalized the call for action and have been working to move the innovation needle forward more quickly. For example, the American Medical Association (AMA) recently joined with Chicago-based incubator Matter to create the AMA Interaction Studio at Matter, a simulated health care space for physicians and entrepreneurs to team up on the development and testing of new technologies.

The value of transforming health data. It hasn't always been easy to sell the need for — and value of — mining health data to address organizations' financial goals and return on investment, improve the quality of care and patient outcomes, and transform the ways in which health care does business. Maybe that value proposition has finally taken hold. Health Datapalooza is not just a convention for data nerds, policy wonks and technology geeks. Many speakers and attendees this year were from the highest levels of the government and the private sector, and their attendance indicated the value of their spending time at a meeting about health data. Examples included AMA Chief Executive Officer and Executive Vice President James L. Madara, MD, and Chet Burrell, who is the president and chief executive officer of CareFirst Blue Cross Blue Shield.

Improving data transparency. Health Datapalooza featured many innovations in the collection and reporting of health data, which have taken on increased importance in this new era of value-based purchasing and patient-centered care. This year's meeting seemed to focus very little on data blocking, which was a hot topic for a while. The transition to quality-based systems and reimbursement will create new business models and reasons for organizations and technology vendors

to share information, rather than hoard it to protect proprietary interests.

The importance of APIs. Application program interfaces (APIs) are one of the shiniest toys in the box. They are one way to allow third-party programmers (and hence, users) to bridge from existing systems to other software. The government has been promoting the use of APIs for several years in the belief that they provide the fastest and most innovative ways to create interoperability and applications for patient-focused care and patient engagement. Venture capitalists, entrepreneurs and developers have taken note, with many resulting and very cool APIs being featured at Health Datapalooza. On an interesting side note, most of the APIs at the meeting were based on Fast Healthcare Interoperability Resources (FHIR, pronounced "Fire"), which is one of the latest in the HL7 family of standards. FHIR is appealing because it is essentially an interoperability standard for health care data exchange based on a web services approach (similar to that used by companies such as Yahoo, Facebook and Google). As a result, it is easier for systems to exchange very specific, well-defined pieces of information rather than entire documents. This should make data exchange faster and more efficient, as well as more user-friendly for clinicians, patients and caregivers.

Renewed focus on the patient. Patient-centered care and patient engagement have been on the government's radar for the past several years. For example, they were key features of meaningful use and now the Merit-Based Incentive Payment System (MIPS). There was quite a bit of buzz around Health Datapalooza concerning how access to data can empower consumers. That can range from better care coordination (since consumers often are left out of the loop) to giving them access to medical records — a byproduct of which is their ability to identify mistakes that could go uncorrected for years and result in deadly errors. Providers are now being asked to think differently about their use of data and systems to manage individuals and populations. This has created unprecedented opportunities to use data and analytics to enhance the management of patients and populations, as well as increase patient engagement and satisfaction. Patients and scientists also are leveraging technology to make patients active participants in studies, which is changing the face of research.

Increased privacy and security. The privacy and security of health data — from the health business side and the patient side — continue to be among the industry's major challenges. And there is a definite tradeoff between disclosing and protecting health care information, especially given the increasing number of

data breaches and cyberattacks that are occurring. In addition, there is the need to use data to address the rising number of medical errors, which are among the major causes of deaths in the United States. The importance of these issues were addressed in individual presentations and sessions, as well as by the fact that a whole post-conference day was devoted to these topics.

Innovation challenges. Contests apparently are a big thing and the federal government unveiled several at the meeting. Secretary Burwell announced the government's first challenge to help develop a new medical bill design, "A Bill You Can Understand." AARP and Mad Pow are collaborating with HHS to administer the challenge and work to draw attention to the impact of medical billing to patients. Two winners — selected for design and a transformational approach to the medical billing system — each will receive $5,000. The challenge is open until August 10 and the winners will be announced in September. The government also hosted a challenge along the lines of TV's Shark Tank. In the closing plenary session, a select group of tech entrepreneurs competed on the main Health Datapalooza stage to convince judges and audience members that they have the best consumer product that can turn health data into meaningful and useful tools for consumers and patients. Finally, six team finalists were announced for the first phase of competition for the Open Science Prize. Each received $80,000 to develop products to overcome hurdles in big data access and usage. The Open Science Prize is a partnership between the Wellcome Trust, the US National Institutes of Health (NIH) and the Howard Hughes Medical Institute to "unleash the power of open content and data to advance biomedical research and its application for health benefit."

Not as much press coverage. In previous years, Health Datapalooza dominated the trade press for a few days. This year, not so much. The phenomenon may be explained by the Gartner hype cycle, which is a graphical representation of the life cycle stages a technology goes through from conception to maturity and widespread adoption. Using this model, Health Datapalooza has left the innovation trigger, the beginning of the cycle, and as well as the second segment, the Peak of Inflated Expectations. That means the meeting is heading toward the Trough of Disillusionment, which marks the middle of the cycle. While Health Datapalooza has a long way to go to reach the bottom of the Trough of Disillusionment, it's not surprising that media coverage is starting to drop off after the meeting's bright beginning and expectations. If the Gartner model holds true for Health Datapalooza, it should eventually head back uphill toward the Slope of Enlightenment, where many innovations will come to fruition in the future.