PALMETTO GBA
NCVHS
CIO FORUM 2018
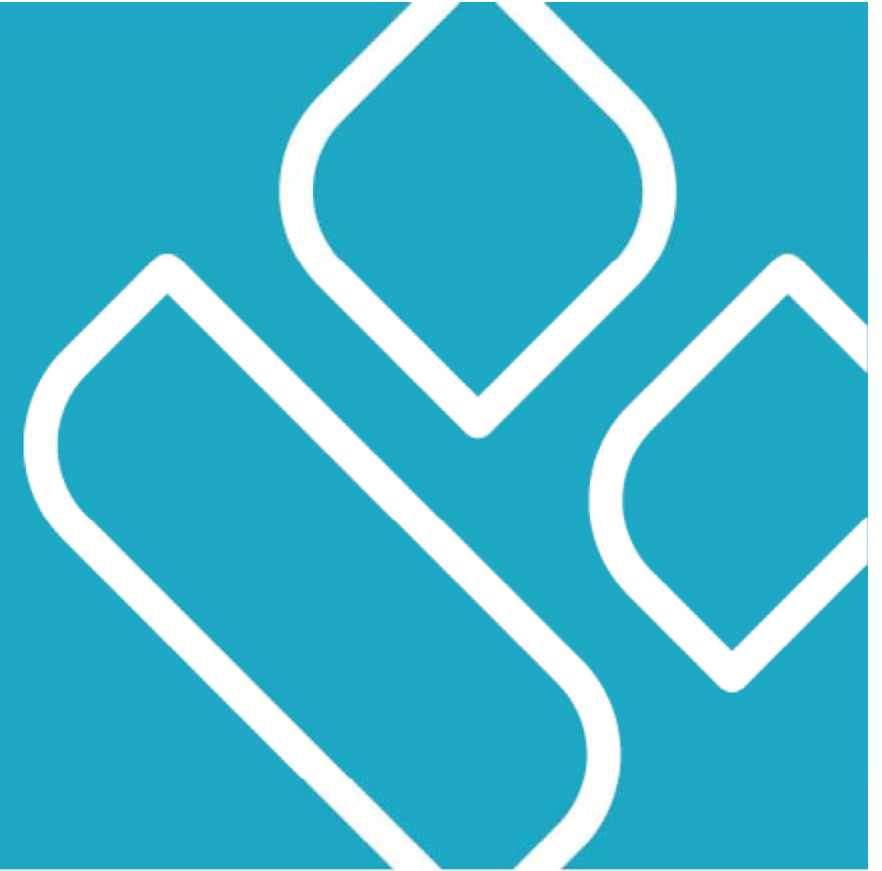
PALMETTO GBA®
A CELERIAN GROUP COMPANY

Mike Barlow,
Vice President Operations

Experience w/ Standard Transactions

Challenges

- Standard setting process does not embrace, nor promote innovation.
- Implementation of future version of standards takes at least a decade.
- Standard setting organizations hold numerous meetings across all transactions, very difficult for an organization my size to monitor all the changes that may negatively impact my business.
- Update request for a standard transaction takes years – very time and staff resource intensive. Need to present in numerous forums, numerous votes, cost saving values discounted.
- Standard transactions are focused solely on machine to machine interactions, while our clients have processes that require manual resources, such as claim rejections, denials.

Opportunities

- Standard transactions exchange information between payers and providers and are the preferred method of communication.
- Require no change to providers workflow.
- ACA creates opportunity for more frequent version upgrades.
- 45 CFR §162.940 Exceptions from standards to permit testing of proposed modifications provide opportunity to bring new and revised capabilities to market faster. Palmetto GBA implemented ACE editing in October 2014.
- Increase payer frontend informational message content to allow providers to self correct common claim submission errors. This capability decreased our providers' claims handling cost and our expense from unnecessary phone calls, appeals and claim suspense requiring additional handling.

Palmetto GBA

Objective: Reduce overhead cost, realize Medicare program cost savings, due to increased pressure from CERT findings, targeted education/medical review requirements and phone calls/unnecessary denials costs. Solution needed to be easy for provider practices to adopt with minimal capital cost/effort.

Findings: Increased automated actionable communication with providers earlier within the providers workflow, results in providers reviewing, correcting, and resubmitting certain to deny claims, before they deny. These issues include inappropriate coding and utilization.

Innovation:

- Claims Acknowledgment triggered direct from Palmetto GBA to provider practices with enhanced payer-specific messaging/ instruction within the STC12 field for provider to review and resubmit certain to deny claims.

- The cost savings of the program were validated (cover next slide).

- Evolved the technology and business use cases.
  - Last 12 months, 2.4% of claims received rejections for "likely to deny" edits, 85.4% were resubmitted with changes.
  - Comparative billing alerts/credentialing notices
  - Continue to evaluate provider satisfaction, claim rejection and resubmission stats, cost savings and new opportunities to increase transparency and communication between Palmetto GBA and our provider settings.
  - Increase provider practice staff and partner vendor education and increase specificity of Claim Status Codes.

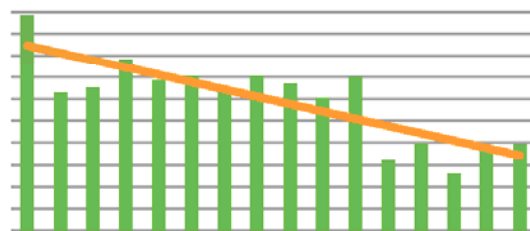# Enhanced Messaging Administrative Impacts
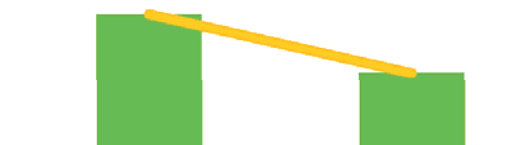
13% reduction in appeals requests

CSR Denial Call %

32% reduction claims suspense

Redeterminations Monthy Average

24.5% drop in denial-related calls to CSRs

Part B Claims Suspense %

Cooperative Exchange
The National Clearinghouse Association

NCVHS CIO Forum

Presented by

Joe Bell, Chair Cooperative Exchange

eSolutions

May 17, 2018

Industry Experience with Standards and Operating Rules

Experience: X12 was to update versions every 2 years, it has been over 10 years and the 7030 version implementation staging is expected to still be out a few years for adoption. In the interim, new technology has emerged, including FHIR (still have challenges to work on), Restful API's and API Key Authorization. Industry slow to adopt mandated operating rules and proposed operating rules are not always aligned with industry best practices and stakeholders business needs.

Industry Impact: Impedes interoperability, costly and protracted EDI implementations; creates a need for IT system workarounds that defeats the intention of standards; impedes the ability to implement new IT Technology

Recommendations: Consider a governing entity with the skill set and financial backing to enable a methodology/process to assist in coordinating business and clinical needs across SDOs so the industry can implement emerging technology standards and operating rules proactively to expedite stakeholders existing / future business needs within their respective workflows.

Industry Initiatives to Improve Business Processes

- **Supporting Emerging Technology**
  - FHIR
  - Restful API's
  - Privacy & Security
  - Cognitive Computing
  - Blockchain
- **Pilot Programs – Industry Collaboration while waiting for Regulations**
  - Attachments
  - Prior Authorization
  - Facilitating Administrative and Clinical Information Exchange
  - FHIR Application for Interoperability

Healthcare Interoperability: The Adventure Continues

Mandi Bishop

@MandiBPro

Research Director, Healthcare

CIO Industry Research

About Gartner:

"We equip leaders with indispensable insights, advice and tools to achieve mission-critical priorities and build the successful organizations of tomorrow."

About Mandi:

**Long-time healthcare industry consultant and thought leader.
Participant in multiple S&I Framework workgroup.
Lived deep in the trenches of clinical data integration – and survived.**

Gartner®

We all know patients suffer from the lack of interop.

It also adversely affects payer/provider partnerships that need to work to improve health outcomes and experience.

"When considering the state of alignment of your organization's business interactions with its [provider] [payer] partners, in which of these areas is there misalignment - i.e., where is alignment absent?"	U.S. Healthcare Payers	U.S. Healthcare Providers
Data sharing and exchange (e.g., eligibility, Dx, Rx, utilization)	67%	46%
Value-based compensation terms and reconciliation	58%	37%
Care management coordination	38%	34%

Gartner®

So I research what's working, what's not, and what we can collectively do about it.

Gartner®

Andrew Burchett
Chief Information Officer
aburchett@uhin.org

UHIN

DRIVING HEALTHCARE SOLUTIONS FORWARD

Convened by the community

Board includes Providers, Commercial Payers, Governmental Payers, Physicians, Hospital and Physician Associations

25 years of data exchange process as a community-based non-profit

Primary goal has been to reduce administrative costs for our healthcare community

Nationally-recognized standards development organization (SDO)

EXPERIENCE WITH
STANDARDS & OPERATING RULES

CURRENT INITIATIVES

X12 7030 Review / Comment

Blockchain Pilot

DaVinci Project Pilot on Attachments/Pre-Authorization

+ POSITIVES | NEGATIVES -

Administrative Cost Savings

Automation

Timeframes are long & unpredictable

Rapid changes in healthcare landscape

UHIN

NCVHS CIO FORUM

BRAD GNAGY
DIRECTOR OF TECHNOLOGY
HEALTHPAC COMPUTER SYSTEMS INC.

EXPERIENCE STANDARD TRANSACTIONS

Challenges

➢ Lack of payer adoption, information and compliance with the standard transactions that require costly one-off workarounds and cause providers lack of adoption due to limited value.

➢ Standard doesn't keep up with pace of innovation.

➢ Standard needs comprehensive built-in extensibility.

➢ Lack of solid business case and customer demand to support capital investment for some of the current mandated standards.

Opportunities

▶ Standard data dictionary and standardized mapping

▶ Increased payer-specific transparency

▶ Minimum floor allowance for required transactions.

▶ Expansion of ONC API transparency requirements to administrative use cases.

▶ Release dates of new/revised standards to occur at a set time each year with a minimum of 12 month period prior to a mandated implementation date.

▶ The determination of business need and a positive return on investment prior to NCVHS recommendation to the Secretary of any new standard or operating rule. (Pilot testing, sharing specific compelling business cases, and comparing the implementation and ongoing costs, (e.g., support, training of users) incurred by stakeholders versus the expected value to the industry. Similar to Argonaut Project and DaVinci initiatives.)

▶ Convergence of administrative and clinical data to meet verified use cases, interoperability principles, and the exploration of emerging administrative and clinical use cases.

▶ Innovation to stay ahead of information exchange needs among stakeholders by the selection of a multi-stakeholder organization or association collaborative to monitor emerging trends and develop recommendations to the Committee.

healthpac

HATA
HEALTHCARE ADMINISTRATIVE
TECHNOLOGY ASSOCIATION

National Committee on Vital and Health Statistics (NCVHS)

Subcommittee on Standards

CIO Forum

May 17, 2018

Testimony from the Pennsylvania Medical Society

Presented by James A. Goodyear, MD, FACS

The Pennsylvania Medical Society (PAMED) thanks the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards for the opportunity to address the CIO Forum concerning updates to administrative standards and operating rules. As a representative of the end-user community, I look forward to the exchange of ideas on how administrative standards and operations can provide improved efficiency and burden reduction as it relates to independent physician practice moving forward with the predictability roadmap.

As a practicing physician for more than 30 years, I have experienced the changes in billing and remittances, and the conversion of local and regional codes to standards and code sets. After 1996 and the implementation of HIPAA, my practice underwent a significant financial outlay with the purchase of a computerized practice management system. Our investment has resulted in improved efficiency to handle the day-to-day standard transactions implemented into our workflow.

The benefits of electronic transactions far outweigh the shortfalls. After the transition period, our practice experienced reduced accounts receivable days, which allowed for a more streamlined source of revenue and permitted our business office to budget finances in a more predictable way. Utilizing electronic transactions has reduced duplicative work of manual entry. Manual entry creates the opportunity for an increase in errors, which interferes with workflows. Overwhelmingly, small practices who were able to make the leap to electronic claims submissions would not wish to go back to paper.

The introduction of the 837 transaction has been paramount in the flow of claims data to payers and has reduced the cost of claims submissions significantly. However, when an 835 remittance advice is returned to our practice, it is evident there is a lack of consistency between payers. The billing office has stated repeatedly that when a denial is reviewed, the Claim Adjustment Reason Codes (CARC)

and Remittance Advice Remark Codes (RARC) do not always match the explanation of adjustments or match the reason for denial.

At times it appears lines on submitted claims have been manipulated in order to process for payment, creating a workaround pushing claims through systems to enforce policy. For example, it is not uncommon for a modifier to be moved to another procedure code on a claim, or the modifier may be amended to something entirely different. Additionally, a copay for an evaluation and management code could be moved to another procedure code billed on the same claim.

The claim status function has been helpful. Using practice management software, claims reports are monitored daily to look for errors that prevent claims from transmitting successfully. We can cross reference these reports with claims status reports to identify any issues that need to be addressed within a timely filing limit. The claim status responses have been helpful in timely filing and front-end edits. The method of processing results of these reports continues to remain fairly manual. Smaller practices continue to log into a provider portal or clearinghouse portal to rework claims that have not been accepted for adjudication.

The eligibility function is most helpful when verifying if a patient is enrolled in a plan, and depending on the plan, it may also name any other plans in which a patient may participate. On the other hand, the eligibility function has not been as advantageous as we would have hoped. Deductibles, coinsurance, and copayment data is not drilled down far enough to be valuable. Expected copayments may be incorrect due to physician tiering based on preferred network status, or a specialist copay may be reflected as a result of a primary care practice query. Often, deductible amounts are not accurately reflected when running an eligibility verification.

This is also true when referencing coordination of benefits. CAQH said it best in their Administrative Inefficiency in Coordination of Benefits (COB) whitepaper, "[…]transaction standards are only effective if payers and providers have good information about all of the forms of coverage involved so that the transactions can be sent to the correct health plans."[1]

More often than not, there is not enough data to facilitate COB, since billing departments need more than the health plan name to comply. It would be beneficial if the health plan could share a patient identification number of the additional plan or plans, alleviating the guesswork in the billing department. There are patients who sometimes are not aware they are covered under additional plans, or they may not comply when additional information is requested by either the payer or the provider. This tends to leave the charges uncollectible, or fruitlessly attempting to collect the obligation from the patient.

Authorization requests are where our practice and physician practices on a national level would like to see more innovation. **This is an issue of high priority for both PAMED and the American Medical Association (AMA).** We need to see a more efficient approach for prior authorization of procedural care. In an age where we can attach consolidated clinical document architecture (C-CDA) to a direct secure message for a referral to another provider, how can we integrate this with our payers? Large and small physician groups hire additional staff to work on prior authorizations, and most requests continue to be fulfilled via fax, telephone, and even mail. I understand electronic prior authorization can be initiated by an electronic request or through a provider portal – for example, Navinet – but most follow up occurs by telephone or fax. This is an administrative burden and we

ask that payers be held to the same standard as providers. The workload is unsustainable and interrupts patient care. Processes need to be streamlined and accountability shared equally between the two entities.

Using the direct secure message could allow for burden reduction simply by allowing for the attachment of the C-CDA to send any necessary documentation and ease communication barriers between end users and payers.

My fear is that with the advancement of application programming interfaces (APIs) to complete the prior authorization task, end-users will only have to bear more expense. **I ask that you urge health plans to reduce their prior authorization requirements and limit application to true outliers and to consider using existing infrastructure of the practice management system/electronic health record to enable the prior authorization request, encouraging interoperability, transparency, and the ability to manage data in one central location.**

With the expectations and regulations put upon providers, practices are focusing their resources on referrals and prior authorization. Overwhelmed billing departments are contracting out these transactions due to workflow and lack of confidence. Depending on the type of billing agreement a practice has with their vendor, these costs can range between a few hundred to a few thousand dollars a month.

Overhead has not decreased, dollars have not been saved. Funds have been reappropriated to technology support, vendors, security risk analysis, and upgrades to hardware and software. These changes to electronic standards and operations have the potential to disrupt these workflows and have a significant financial impact to a small practice due to upgrade costs or fees passed down through software support. I ask you to be mindful of these costs as decisions are made to advance innovation through technology and setting a standard for the frequency of these updates.

Thank you for the opportunity to provide feedback on the impact of the current work as an end-user of administrative standards. I appreciate having a voice as an industry stakeholder to help identify a roadmap that can benefit everyone. As we move toward predictability, transparency, and interoperability, I look forward to continuing the discussion as to how we can encourage innovation and advance meaningful data exchange that allows all users marked improvement in efficiency in the business of health care.

[1]Administrative Inefficiency in Coordination of Benefits, Prepared with assistance from Manatt Health Solutions, February 2014. Available at:
https://www.caqh.org/sites/default/files/solutions/cob-smart/COBwhitepaper.pdf

NCVHS
CIO Forum 2018

Kerri Grizer
Sr. Product Manager
Optum360 - Claims and Payment Services

May 17, 2018

OPTUM360°®

1

Experience with EDI standard transactions

Challenges

- Satisfying clients' business needs timely within standard transactions

- Version updates—labor & time-intensive, major investment– still require workarounds

- More transparency to meet business needs
  - Payer – payer-specific billing and payment rules
  - Provider – HEDIS/Stars information, supporting documentation for claims/prior authorization etc.

- Lack of stakeholder adoption

- Technology readiness varies

- Lack of flexibility for innovation

- Cost and time to implement non-mandated transactions, often requiring additional capital

- Manual processes still in play (phone calls, fax)

Opportunities

- Lower capital expense using existing standards

- Increase adoption when passing information via standard transactions and leveraging existing end user workflows

- Increase information exchange prior to claim submission

- Decrease costs of working unnecessary denials, with claim scrubbing and actionable feedback earlier in the EDI stream

- Identify business needs and positive ROI when passing standard transactions.

- Real time pricing transparency - HHS priority

OPTUM360°®

UnitedHealthcare
Pre Check My Script

PreCheck MyScript delivers more timely prescriptions, less administrative hassle and a better patient experience.

Writing a prescription continues to be one of the most common activities in a care provider visit. What's more, care providers are prescribing specialty drugs in increasing numbers – medications that often trigger a PA. With PreCheck MyScript, care providers have the knowledge they need to prescribe the most appropriate, lowest-cost and covered medication before each patient leaves.

PreCheck MyScript frees care providers to spend more time with patients and helps eliminates the uncertainties that can delay or frustrate patients in getting the prescriptions they need, which can result in medication nonadherence.

This first-of-its-kind solution is a collaboration between UnitedHealthcare, OptumRx, care providers and electronic medical record companies.*

Better for care providers.

- Takes the guesswork out of determining whether a prescription is covered by the patient's benefit plan and if prior authorization is needed.
- Automates prior authorizations, when needed, eliminating the need for phone calls or faxes.
- Enhances the quality of care provided.

Better for patients.

- Provides pricing information at the time of prescribing, helping eliminate sticker shock when a patient gets to the pharmacy.
- Dramatically reduces claim rejections at the pharmacy window.
- Helps improve outcomes and adherence.

All this in seconds.
Right from the care provider's workflow.

9:12:05 a.m.

Access patient EMR.

- Enter the medication.

9:12:06 a.m.

See the results of a trial claim.

- Learn about preferred alternatives for that patient.
- Determine the appropriate medication based on the PA results.*
- If needed, complete an electronic PA.

  *Typically, the PA request is approved immediately. If it cannot, the request is routed for clinical review. The doctor and patient are notified if additional medical information is needed and once the decision is made.

9:12:07 a.m.

Tell the patient what the medication will cost at her specific pharmacy.

- Submit the electronic Rx.

The PreCheck MyScript interface appears as an integrated part of the EMR workflow.

The patient leaves the care provider's office **knowing the price she will pay** for her medication and **feeling confident that she won't be delayed** at the pharmacy by needing a prior authorization.
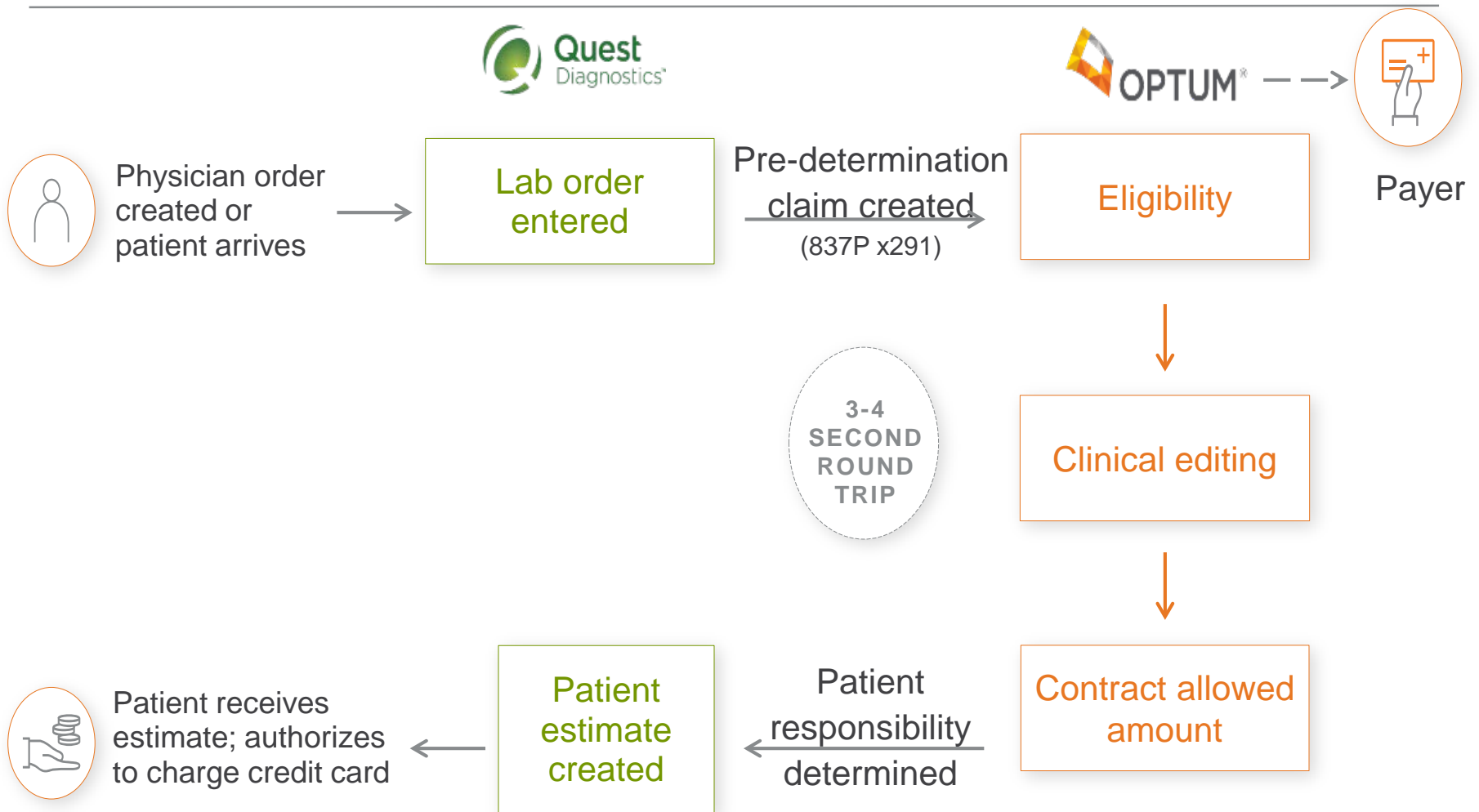
In just the first **120 days:** | **20K** care providers | **>1M** trial claims | **21%+** of transactions resulted in a change by the prescriber | Saving **time** and reducing **costs**

OPTUM 360°®

3

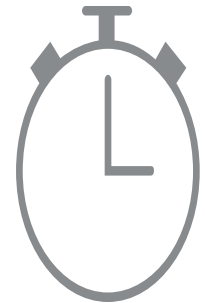# Patient Estimation Workflow

Patient Estimation Pilot Results

2.1M
Total transactions
processed
(Oct 2017−Apr 2018)

95%
of Patient
estimates
returned via 835;
exceeding client
goal of 85%

15%
Goal for increase
in patient credit card
collection rate

25 Number of
Payers
currently live

~3 seconds
Average time to
deliver the
patient estimate
(SLA ≤ 10 sec)

OPTUM 360°®

Sequoia Project Quick Introduction for the National Committee on Vital and Health Statistics CIO Forum

Eric Heflin, CIO/CTO

www.sequoiaproject.org

Current Sequoia Project Initiatives

The **eHealth Exchange** is the oldest and largest public-private health data sharing network in the U.S.

Carequality is a national-level interoperability framework to inter-connect networks.

RSNA Image Share Validation Program is an interoperability testing program to enable sharing of medical images and reports.

eHealth Exchange is Largest Public-Private Health Data Sharing Network

Supporting More Than 120 Million Patients Across:

All 50 states

70,000 medical groups

Four federal agencies
(DoD, VA, HHS including CMS, and SSA)

3,200 dialysis centers

70% U.S. hospitals

8,300 pharmacies

59 regional and state health information exchanges

Shared Governance and Trust Agreement

Common Standards, Specifications & Policies

eHealth Exchange™ *An initiative of* the Sequoia project

Broad Range of Patient-centric Use Cases

Treatment / Care Coordination

Social Security Benefits Determination

Immunization

Authorized Release of Information – Consumer Access to Health Information

Syndromic Surveillance

Encounter Alerts

Authorized Release of Information – Life Insurance

Prescription Drug Monitoring Program (PDMP)

Electronic Lab Reporting (in support of public health)

Image Share Use Case

eHealth Exchange™ *An initiative of* the sequoia project

The Power of Connecting Communities

How do you get nationwide connectivity? Clinic by clinic, hospital by hospital?

Data sharing networks have already connected many participants. The connections grow exponentially by connecting these user communities to one another, as groups.

➤ If you connect six clinics, you might reach a few dozen physicians.

➤ If you connect six networks, you can reach thousands of physicians.

Accelerating Health Data Sharing in America

35,000+ Clinics

1,250 Hospitals

600K+ Providers

2.4M Clinical Documents
        Exchanged Monthly
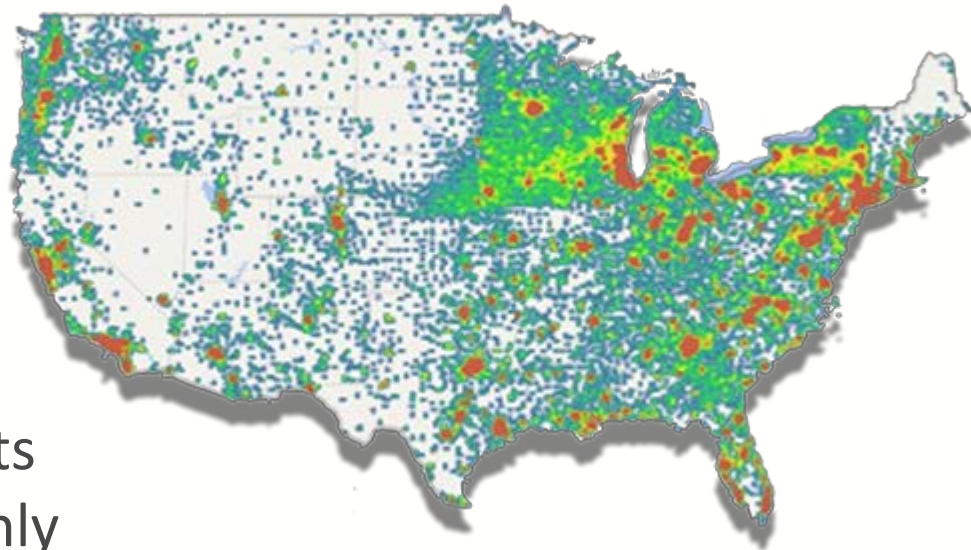
Why Image Sharing Matters

- Enables Patient Access/Workflows
- Benefit of historical exam during interpretation
- Concerns about cost of imaging over-utilization
  - Redundant exams ordered when recent exams are not accessible
- Radiation exposure – reduce unnecessary patient risk due to redundant exams
- Quality
  - Better, more efficient care through easy availability of imaging examinations

the
sequoia project

Providing for Healthcare Needs in Alternative Settings Requires Alternative Health IT Support

A project of **sequoia** the project

Standards Initiatives

- All Sequoia initiatives are based exclusively on standards including:
- FHIR – Argonaut directory specs (first to deploy)
- IHE profiles for HIE
- HL7 V2 ADT
- IETF for security
- HL7 for clinical content
- W3C for XML and digital signatures

Lessons Learned Summary

- Scalability to national-sized deployments are now proven
- Structured clinical data can be exchanged, and interoperable, at scale
- Must accommodate a holistic view
- Standards are necessary but insufficient
- Governance, a scalable legal framework, community building, education, security, operations, durable business model, version management, iteration, validation program cannot be omitted
- Industry liaison and coordination is critical
  - SDOs
  - Agencies
  - Vendors
  - All other networks, even those sometimes portrayed of as competitors
  - Providers
  - HIEs
  - Hospitals
  - Trade associations
- Technology MUST be subordinate to use cases, and use cases must be subordinate to policies/goals

the sequoia project

Thank You!

Convene   Collaborate   Interoperate

NCVHS CIO Forum

Liz Johnson, MS, FAAN, FCHIME, FHIMSS, CHCIO, RN-BC

Chief Information Officer, Acute Care Hospitals & Applied Clinical Informatics
Tenet Healthcare

May 17, 2018

Liz Johnson, MS, FAAN, FCHIME, FHIMSS, CHCIO, RN-BC

- Tenet – as Chief Information Officer, Acute Care Hospitals & Applied Clinical Informatics, provides the strategic vision and tactical planning for all clinical, patient management, imaging, productivity and supply chain systems used across Tenet's acute care hospitals nationwide

- Health Information Technology Standards Committee (ONC) 2009- 2016

- Current Chair, CHIME Policy Committee

- Current Chair, CHIME Foundation Board

- Immediate past Board Chair of CHIME

About CHIME

- Established in 1992
- An executive organization serving more than 2,600 members across the globe
- Offers membership to CIOs and senior IT leaders at healthcare related organizations are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation.
- A typical CHIME member oversees the information services department and chairs the information technology steering committee within their organization. Additional responsibilities often include telecommunications, medical records, and health informatics.
- Our members represent a variety of provider organizations, including large hospital systems, community hospitals, for-profit hospitals and small or rural hospitals.

CHiME

Overarching Challenges

- Standards are necessary for semantic interoperability across the care continuum

- Achieving "value" in the healthcare system will continue to be elusive without this

- Critical to bridge the administrative and clinical streams of healthcare data – way to standardize attachments critical

- Interoperability requirements being placed on providers that are often outside their control.

- Implications stemming from 21st Century Cures that are still unfolding around data blocking and TEFCA

CMS Projects
Interoperability Initiatives in Medicare FFS and Medicare Advantage

Kevin Larsen MD, FACP
Director Strategy and Improvement
Office of the Administrator
CMS

The Da Vinci Project

Open Captioning Area

The Da Vinci Project Goals

1. **Improve "Provider to Payer" information exchange**
   - At the time of service
   - Integrated into the provider's workflow
   - Examples:
     - Is **prior authorization** required by my patient's insurance company for the item I'm about to order?
     - Does my patient's insurance company have a **documentation template** for the service for which I'm about to refer my patient?

2. **Improve "Provider to Provider" interoperability**
   - Kill the fax machine!
   - Allow electronic sending of orders, plans of care and other types of medical records

Open Captioning Area

How and Who?

How Will The Da Vinci Team Accomplish the Goals?

1. Create **implementation guides** based on **Fast Healthcare Interoperability Resources (FHIR) standards** and **sample code** to prove it works
2. Launch **pilots**

Who are the Da Vinci Participants (founding members)?

- 10 payers
- 4 Health IT Vendors
- 3 EHRs
- 6 providers

Open Captioning Area

The Da Vinci Project Use Cases

Phase 1 (Mar 2018 – Mar 2019)

Documentation Requirement Discovery	**Documentation Templates and Coverage Rules**	**30 Day Medication Reconciliation**

Phase 1.5 (Jul 2018 – Jul 2019)

Medical Record Exchange

Phase 2 (2019 +)

ADT* Notifications	**Authorization Support** (support for prior authorization)	**Lab Results**	**Quality Measure Reporting**	**Risk-Based Contract Member Identification**

* ADT = Admit/Discharge/Transfer

Open Captioning Area

Why Is CMS Interested in Da Vinci?

Improper payment rate in Medicare FFS is too high

Documentation requirements are **too hard to find**

Providers are too reliant on **fax machines**

Open Captioning Area

Step 1:
The Provider Documentation Manual

First topic (oxygen) in summer 2018:

- Goal:
  - 4 topics by 12/18
  - 8 topics in 2019

All coverage and payment documentation requirements will be IN ONE PLACE:

- Each topic will have a Self-Audit Checklist so that providers know what is required
- Each topic will have links to PDF Clinical Templates
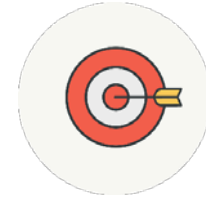
It will reference and allow you to easily find other online resources:

- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- CMS Manual Instructions

Open Captioning Area

Step 2:
The Documentation Requirement Lookup Service

Long Term Project:

- 2018:
  - ✓ Medicare FFS
  - ✓ Some Medicare Adv plans
  - ✓ Some private payers
  - ✓ Some EHR vendors
- Future:
  - ✓ More Medicare Adv Plans?
  - ✓ Medicaid Plans?
  - ✓ More IT vendors

Work closely with Standards Development Organizations (SDOs):

- FHIR-based standards
- Payers build "Rules Libraries"
  - ✓ In a common format
  - ✓ With an "API" (to allow easy access)
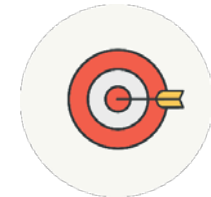
Allow providers to discover documentation requirements at the time of service:

- Right in the
  - ✓ EHR or
  - ✓ Practice Management System
- Including:
  - ✓ Prior Auth required?
  - ✓ Template available?

Open Captioning Area

How Will the Requirement Lookup Service Work for Providers?

THE DOCUMENTATION REQUIREMENT LOOKUP SERVICE

PROVIDERS

EHR
ELECTRONIC HEALTH RECORD

ARE THERE PRIOR AUTH (PA) OR DOCN REQUIREMENTS?

YES OR NO

SHOW ME THE PA/DOCN RULES/TEMPLATES

HERE ARE THE RULES/TEMPLATES

FHIR-BASED EXCHANGE

MEDICARE

PAYER 2

PAYER 3

PAYER 4
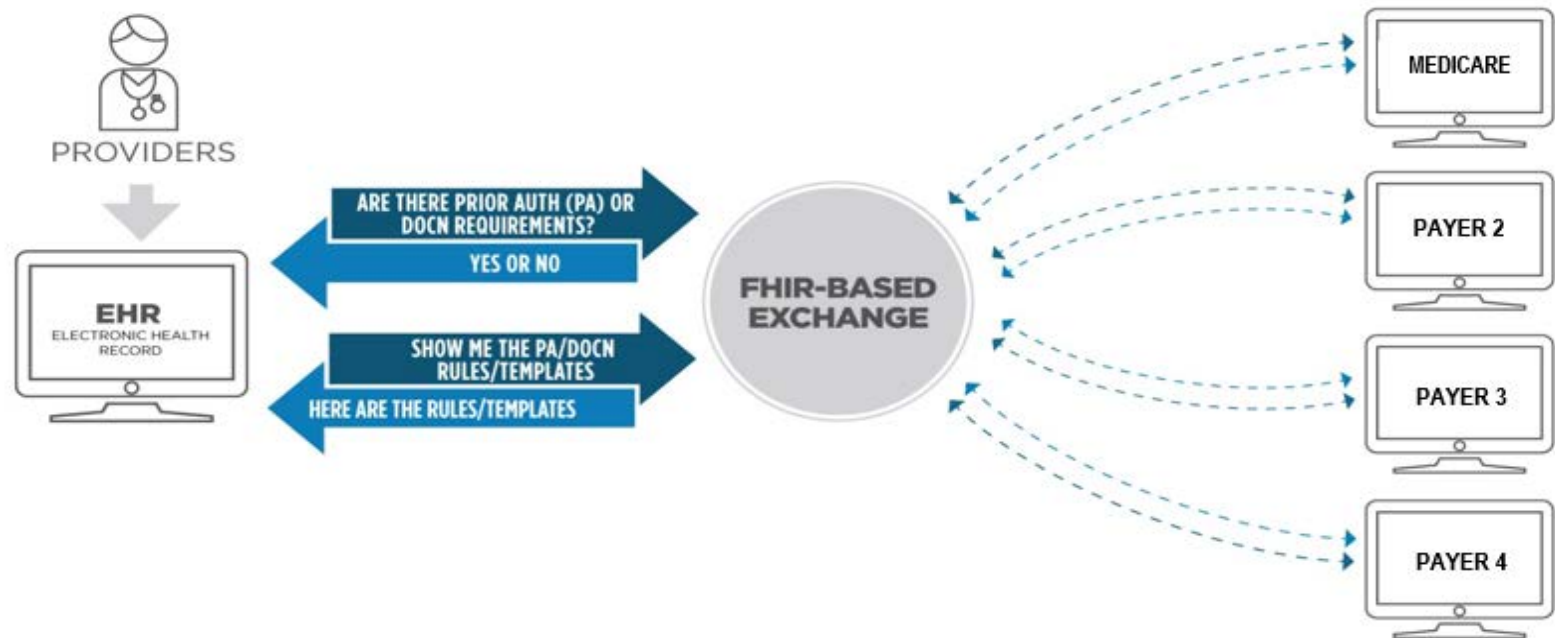
*FHIR - FAST HEALTHCARE INTEROPERABILITY RESOURCES

Open Captioning Area

How Might the Requirement Lookup Service Work for MACs?

MAC J1 CARD*	MAC J2 CARD	MAC J3 CARD
API	API	API

API

Medicare
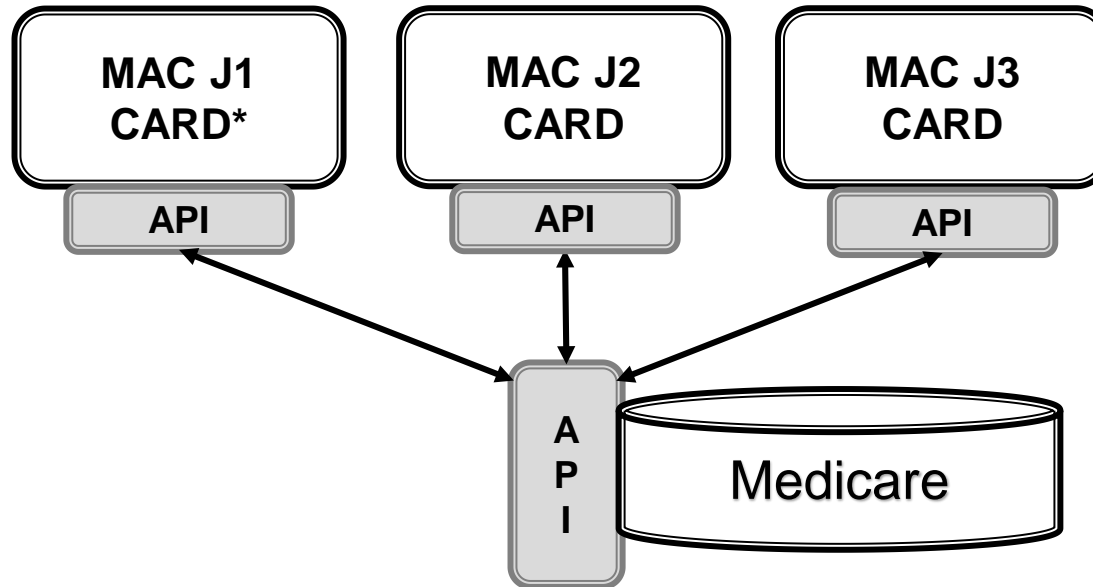
If CMS required the MACs to use the Requirement Lookup Service, CMS would help to ensure the Lookup Service stays current.

*Computer-Assisted Review of Documentation (CARD)

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Timeline

- Spring 2018: CPI/PCG will task **<u>Mitre</u>** with building the **Temporary** Documentation Requirement Repository

- Summer 2018: CPI/PCG is considering hiring a **<u>small business</u>** to develop Business Requirements for the **Permanent** Documentation Requirement Repository

- Fall 2018: CPI/PCG is considering hiring a **<u>small business</u>** to build the **Permanent** Documentation Requirement Repository

Open Captioning Area

Impact on MA Plans and Part D Plans

Is my organization already planning to build a documentation requirement repository?

If not, should we have it on our radar screen for next year?

Open Captioning Area

Medicare's Blue Button 2.0

What is Blue Button?

- **The Blue Button symbol identifies places to get your personal health records electronically**

- **With Blue Button, you can:**

Reference
your health records to be reminded when you had your last shot, or the exact date of a procedure.

Check
the accuracy of your records, monitor changes, and stay aware of your health status.

Share
with your doctor or someone else you trust, when traveling, seeking a second opinion, moving, switching insurance, or in case of emergency.

Use Apps
to help better manage and coordinate your healthcare to achieve your health goals.

Open Captioning Area

A Brief History of Blue Button

2018

2010

May 2010: CMS & VA hold innovation event to increase consumer access to data through PHRs

Aug 2010: VA releases Blue Button download

Sept 2010: CMS releases Blue Button download

March 2018: CMS launches Blue Button 2.0 to add developer-friendly, standards-based API to the existing text and PDF downloads

Open Captioning Area

CMS Blue Button in Use Pre-2018

Federally Inspired

Blue Button Community

- VA
- DoD (TRICARE)
- CMS

20–30k

Downloads per Month

Private sector applications ingest, optimize, and visualize data from Blue Button text files

1.5M

CMS users

Beneficiaries can download up to 3 years of claims data

- Hospital
- Physician
- Prescription drugs

2x text downloads

Your Report: JOHN A DOE

Personal Profile

Name:	JOHN A DOE
Address:	123 ANY ROAD ANYTOWN, IN 46250
Phone Number:	215-248-0684
Email:	siteuser-1@gmail.com

Emergency Contact

Primary

Name:	Josh Doe
Address Type:	Home
Address:	123 Sample Road Anytown, IN 46250
Relationship:	Grandchild
Phone Number:	

PDF

Text

Demographic

Source: MyMedicare.gov

Name: JOHN DOE

Date of Birth: 1/1/1910

Address Line 1: 123 ANY ROAD

Address Line 2:

City: ANYTOWN

State: IN

Zip: 46250

Number: 215-248-0684

Effective Date: 2/1/2014

Effective Date: 2/1/2014

Open Captioning Area

Why Improve Blue Button?

- The original Blue Button was an essential first step, but it left the patient to do the heavy lifting to use and/or share their health data

- Patients should have access and control to easily and securely share their data with whomever they want, making the patient the center of our health care system

- Vision for Blue Button 2.0 at CMS:

Developer-friendly, standards-based data API that enables beneficiaries to connect their data to the applications, services, and research programs they trust

Open Captioning Area

Medicare Blue Button 2.0 Design

- Open source front-end application that manages developer and beneficiary access. Beneficiary access is integrated with MyMedicare.gov

- Standard open source reference implementation of Fast Healthcare Interoperability Resource (FHIR®) server

- Claims data for 53M Medicare beneficiaries sourced from the CCW

API

MyMedicare Site (Benes)

Developer Portal

FHIR® Server

Chronic Condition Warehouse (CCW)
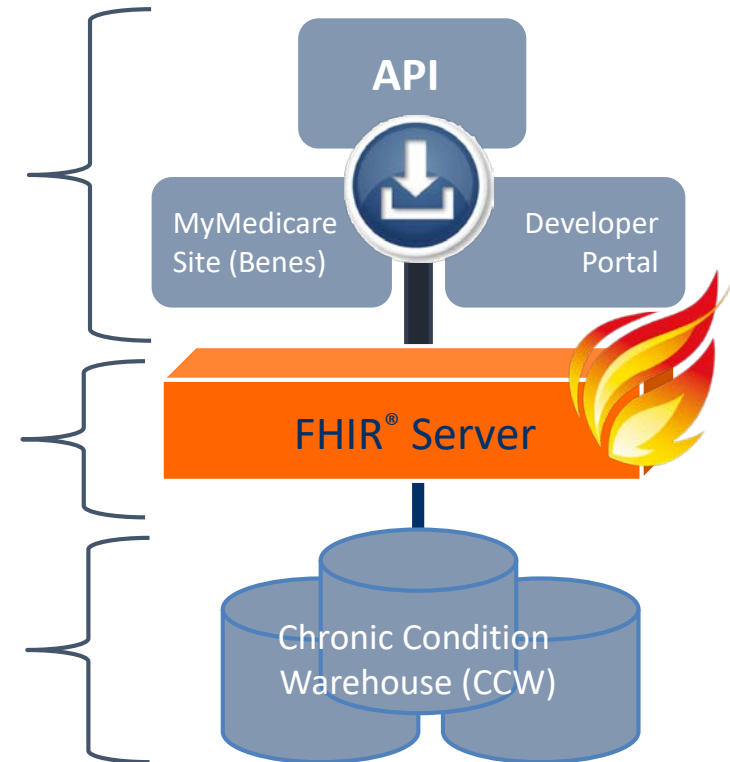
Open Captioning Area

Why Do We Need an API?

- **More secure for beneficiaries**
- **A better alternative to screen scraping**
  - Apps have resorted to automating login to retrieve Blue Button files for beneficiaries
- **More granular management of connected applications**
- **Data is presented in a structured form for easier processing**
  - Parsing text file is challenging

CMS Blue Button Data File

```
Claim Number: 1014118206420
Provider: SELENA W ELLIS MD
Provider Billing Address: 3000 COLBY ST SUITE 305 BER
Service Start Date: 04/17/2014
Service End Date: 04/17/2014
Amount Charged: $250.00
Medicare Approved: $162.99
Provider Paid: $127.78
You May be Billed: $32.60
Claim Type: PartB
Diagnosis Code 1: 7812
Diagnosis Code 2: 3569
Diagnosis Code 3: 7820
Diagnosis Code 4: 38611
--------------------------------
Claim Lines for Claim Number: 1014118206420
--------------------------------

Line number:  1
Date of Service From:  04/17/2014
Date of Service To:  04/17/2014
Procedure Code/Description:  99215 – Established Pati
Modifier 1/Description:
Modifier 2/Description:
Modifier 3/Description:
Modifier 4/Description:
Quantity Billed/Units:  1
Submitted Amount/Charges:  $250.00
Allowed Amount:  $162.99
```

```
MYMEDICARE.GOV PERSONAL HEALTH INFORMATION
--------------------------------
**********CONFIDENTIAL**********
Produced by the Blue Button (v2.0)
12/22/2014 9:17 AM


--------------------------------
Demographic
--------------------------------
Source: MyMedicare.gov


Name: –REDACTED–
Date of Birth: –REDACTED–
Address Line 1: –REDACTED–
Address Line 2:
City: –REDACTED–
State: –REDACTED–
Zip: –REDACTED–
Phone Number: –REDACTED–6
Email: re-edit
Part A Effective Date: 2/1/1998
Part B Effective Date: 2/1/1998
```

Open Captioning Area

Electronic Clinical Quality Measurement

- eCQMs are quality measures where providers collect, analyze and submit data using electronic data and documentation

- Required part of the Meaningful Use- EHR incentive program

- Require technical standards for implementation across the country

eCQM standards

- Built reference implementation – pophealth
- Built certification system- Cypress
- Established processes for continuous feedback and rapid cycle improvement of standards and specs
- Established and support a technical resource- website and open ticketing system (JIRA)

Technical resources

Ecqi.healthit.gov

Questions?

Email to: Melanie.Combs-Dyer@cms.hhs.gov

Kevin.larsen1@cms.hhs.gov

Open Captioning Area

About Kaiser Permanente

12.2M
people get care + coverage from Kaiser Permanente

39 hospitals

No. 1 for heart health in every place we provide care

213K employees

$71.6B annual operating revenue (2017)

684 medical offices

22K physicians

$3.5B invested to benefit our communities (2017)

300,000 volunteers donated blood to our research bank

400,000+ hospital admissions

225,000+ inpatient surgeries

100,000+ births

53+ million doctor office visits

77+ million virtual visits

293 million visits to kp.org

189 million mobile visits

26.1 million secure messages sent to providers

48.7 million lab results viewed online

25.5 million prescriptions submitted online

5.3 million appointments booked online

One that highlights your experience with the standards and operating rules – either positive or negative

- KP has implemented all mandated HIPAA 5010 transaction standards. For Health Care Review – Request and Response (X12 278) transactions, we do not currently have any trading partners who have expressed interested in conducting this transaction.

- KP has successfully implemented all the HIPAA mandated identifiers and code sets, such as ICD-10 CM-PCS, Employer Identification Number (EIN), and National Provider Identifier (NPI).

- KP has implemented the mandated CAQH CORE Operating Rules for Phase I, II and III. One KP region has completed the certification process as required by their state.

- KP has begun implementing the foundation for CAQH CORE Operating Rule Phase IV which is for the automated tracking and reconciliation of transactions.

- KP as a payer has not yet implemented the electronic transactions for attachments, as we are waiting for the national standards to be adopted.

- KP has successfully completed system preparations to handle the new Medicare Beneficiary Identifier (MBI).

One that describes new initiatives in which you are involved.

- We are currently working with X12 workgroups to review public comments, changes, and new requirements for version 7030 of the standard transactions.

- KP is supportive of NCVHS' efforts to develop a multi-year standards adoption roadmap.

- KP is supportive of CMS' new "Patients Over Paperwork Program."

- KP is supportive of CMS' and ONC's Burden Reduction Program for providers.

- KP is working with the industry to create better alignment between administrative and clinical standards – Electronic Health Records (EHR)

Standards Division Major Responsibilities/Roles

Direction

- Support HITAC identification of use case priorities and the standards and implementation specifications that support them
- Long-term maintenance of the USCDI
- Curate standards and implementation specifications that enable the appropriate sharing and processing of structured and non-structured health data

Innovation

- Support and coordinate with both innovation communities and innovators to meet ONC goals

Measurement

- Develop measures, analyze data, and evaluate programs that demonstrate progress in achieving ONC goals and objectives
- Improve our understanding of the current HIT infrastructure and where to place our future efforts

Engagement

- Translate real world experience into enhanced implementation specifications to advance HIT interoperability, reduce clinician burden, and improve patient access
- Provide technical subject matter expertise to ONC and stakeholders to influence the use of standards and technology in health and care

The Office of the National Coordinator for
Health Information Technology

ONC Projected Outcomes

	PATIENT	PROVIDER	COMPETITIVE MARKETPLACE
Interoperability	Movable health records to shop for and coordinate care	Ability to efficiently to send, receive, and analyze data	Improved data flow standards Accessible API's
Usability	Lower cost of care through greater provider efficiency More eye contact with providers	Burden reduction: • Less wasted time • Less hassle	Ability to support new business models and software applications

The Office of the National Coordinator for
Health Information Technology

Thank you!

Christopher.Muir@hhs.gov

@ONC_HealthIT   @HHSONC   HealthIT.gov

- David Nicholson, Executive Vice President AdvantEdge Healthcare Solutions (Previously, President of Baltimore based billing company – PMI)

- Member of the Government Relations committee of HBMA (Healthcare Business and Financial Management)

- AdvantEdge Healthcare Solutions, a Full Service Revenue Cycle Management Company
  - Over 800 Employees and 75 Certified Coders
  - Process > $3 Billion in Client Charges Annually
  - Over 50 Years Serving Physicians (1967)

- **The real world requirement to process the claim and capture client payment as efficiently and timely as possible, versus the purity of meeting the Standards (Workarounds).**

- **Frequency of Updates, versus the development and implementation time (For example, CPT/ICD changes each year).**

- **Areas for improvements – Enforce the HIPAA Standards with the same level of aggressiveness as the HIPAA Privacy Standards.**

OhioHealth

Margaret Schuler, System VP Revenue Cycle

NCVHS Subcommittee May 17, 2018 CIO Forum

5/17/2018

BELIEVE IN *WE*™ **OhioHealth**

HOW TO DESCRIBE US

OHIOHEALTH IS A NATIONALLY recognized, not-for-profit, charitable, healthcare outreach of the United Methodist Church. Based in Columbus, Ohio, OhioHealth is currently recognized by FORTUNE Magazine as one of the "100 Best Companies to Work For." Serving its communities since 1891, it is a family of 30,000 associates, physicians and volunteers, and a network of 10 hospitals, 60+ ambulatory sites, hospice, home-health, medical equipment and other health services spanning a 47-county area.

Represents Fiscal Year 2017 Data

BELIEVE IN *WE*™ 🔲 **OhioHealth**
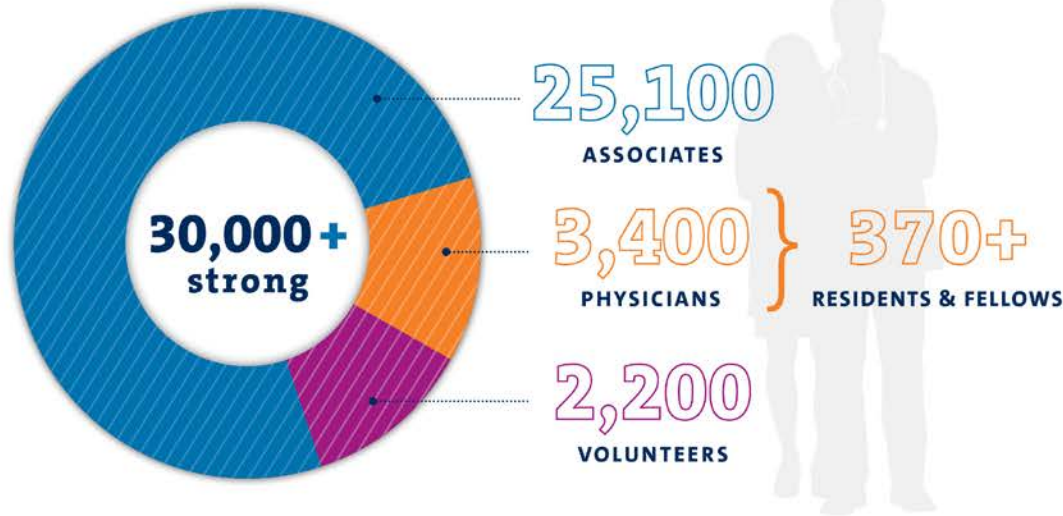
WHERE WE ARE

care site locations

hospital

1. OHIOHEALTH RIVERSIDE METHODIST
2. OHIOHEALTH GRANT MEDICAL CENTER
3. OHIOHEALTH DOCTORS HOSPITAL
4. OHIOHEALTH GRADY MEMORIAL
5. OHIOHEALTH DUBLIN METHODIST
6. OHIOHEALTH HARDIN MEMORIAL
7. OHIOHEALTH MARION GENERAL
8. OHIOHEALTH O'BLENESS HOSPITAL
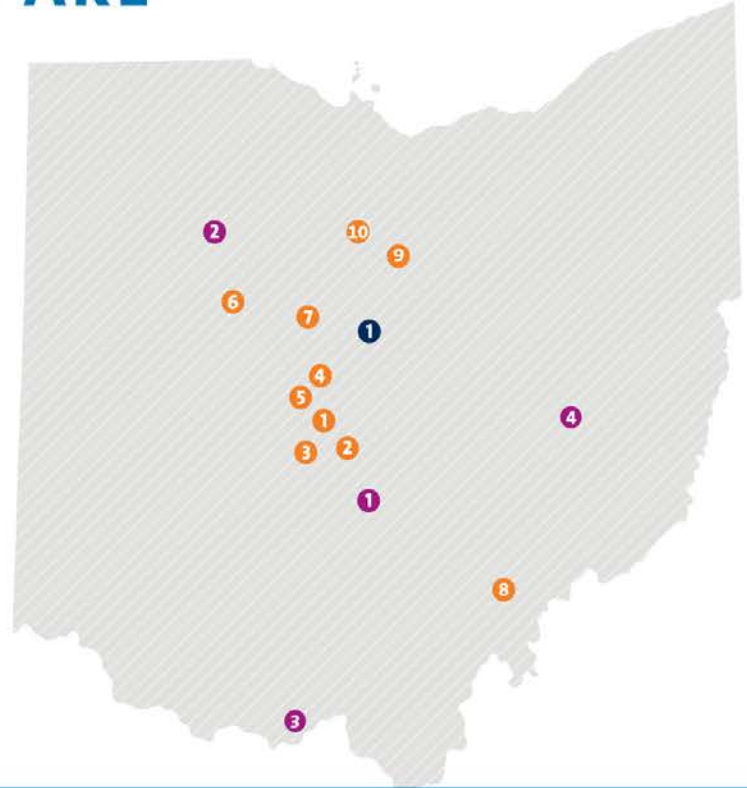9. OHIOHEALTH MANSFIELD HOSPITAL
10. OHIOHEALTH SHELBY HOSPITAL

managed

1. MORROW COUNTY HOSPITAL

affiliate

1. BERGER HEALTH SYSTEM
2. BLANCHARD VALLEY MEDICAL CENTER
3. SOUTHERN OHIO MEDICAL CENTER
4. SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER

60+

OUTPATIENT LOCATIONS

Represents Fiscal Year 2017

BELIEVE IN WE™ OhioHealth

4

WE'RE RATED

top
100 HOSPITALS 2018
BY IBM WATSON HEALTH
*(OhioHealth Doctors Hospital
and OhioHealth Dublin Methodist Hospital)*

100 BEST COMPANIES TO WORK FOR™
BY FORTUNE MAGAZINE

NATIONALLY RANKED

SIX OF OUR HOSPITALS HAVE RECEIVED
A SAFETY SCORE OF **A**
BY LEAPFROG IN 2018

12 YEARS IN A ROW

96th percentile
IN PHYSICIAN ENGAGEMENT
BY PRESS GANEY

$**3.8b**
IN OPERATING REVENUE

FINANCIAL STRENGTH RATINGS
AA+ BY STANDARD & POOR'S
Aa2 BY MOODY'S
AA+ BY FITCH

Represents Fiscal Year 2017 Data

BELIEVE IN *WE*™ OhioHealth

5

Introduction Margaret Schuler

- System VP Revenue Cycle, OhioHealth
- Scope of Responsibility:
  - Patient Access Services
  - Coding/Health Information Management
  - Business Office
  - Over 1500 FTEs

A Provider's Perspective

- Insurance Eligibility 270/271
- Notice of Admission 278
- Authorization
- Claim Status 276/277
- Claim 837
- Claim Attachments
- Remittance 835
- Payer Portals

BELIEVE IN *WE* OhioHealth

bwell

The heart of your
healthcare

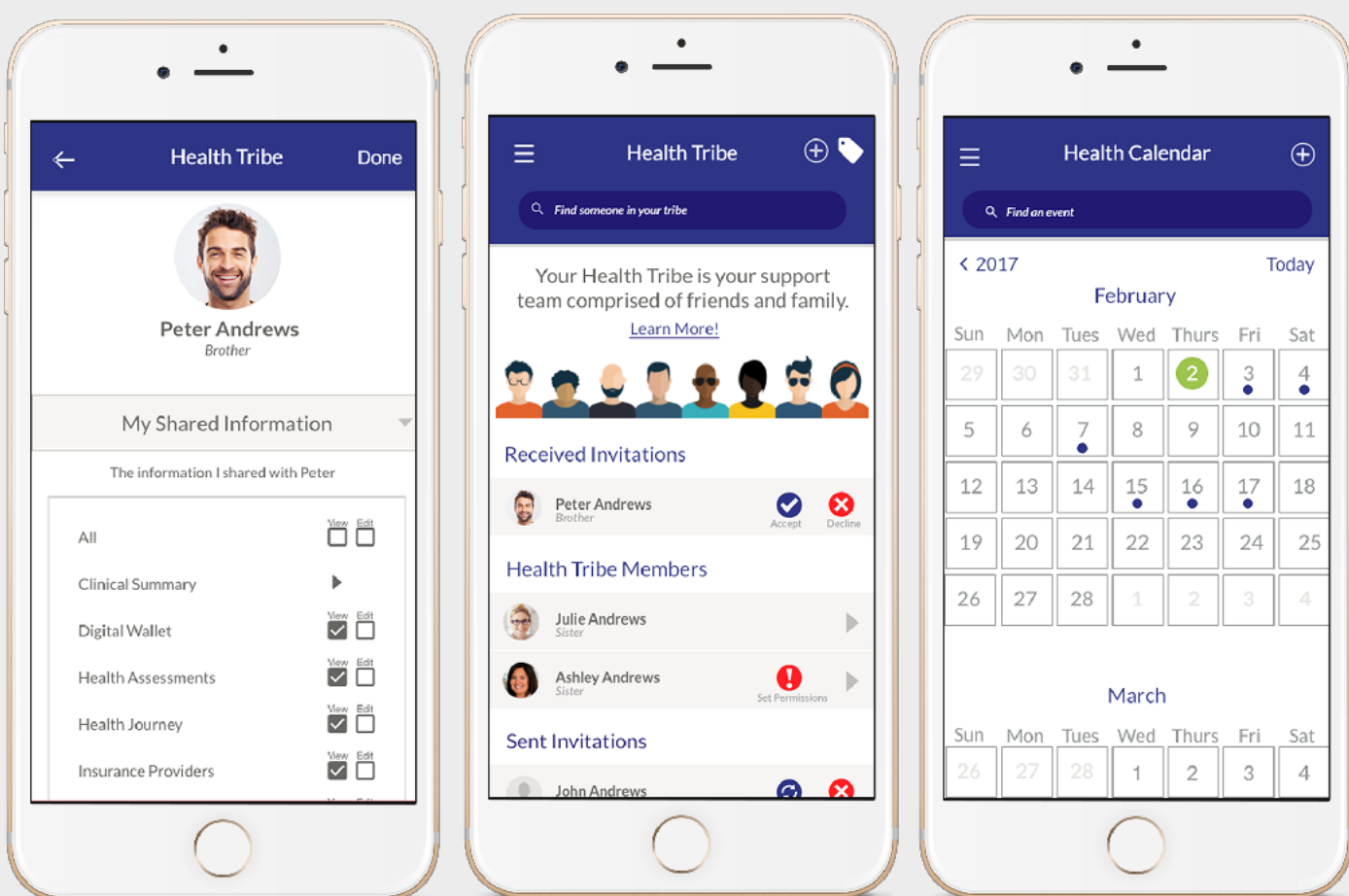# Integrated Consumer Health Platform

Personal Health Record

Personal Health Journey
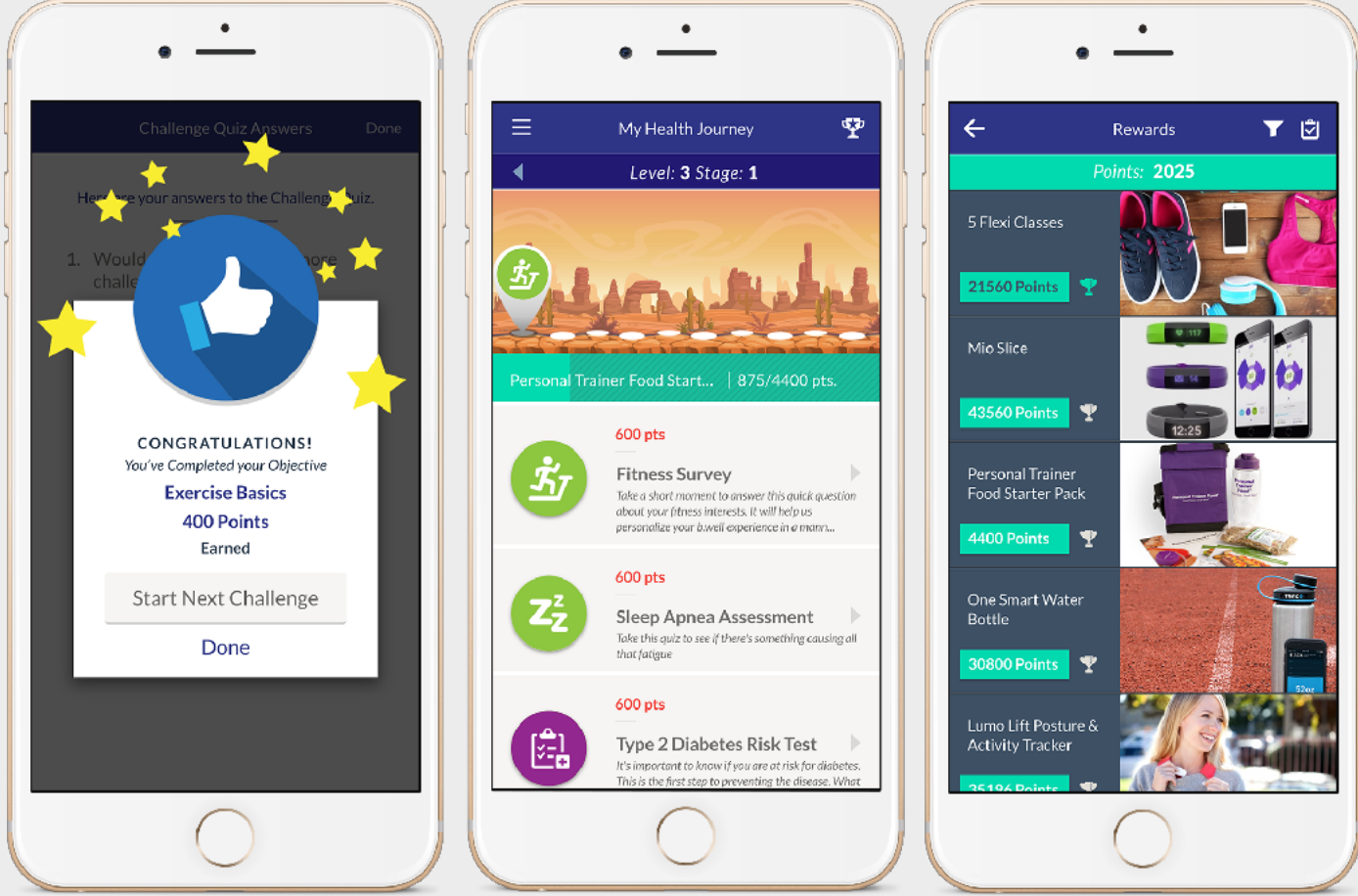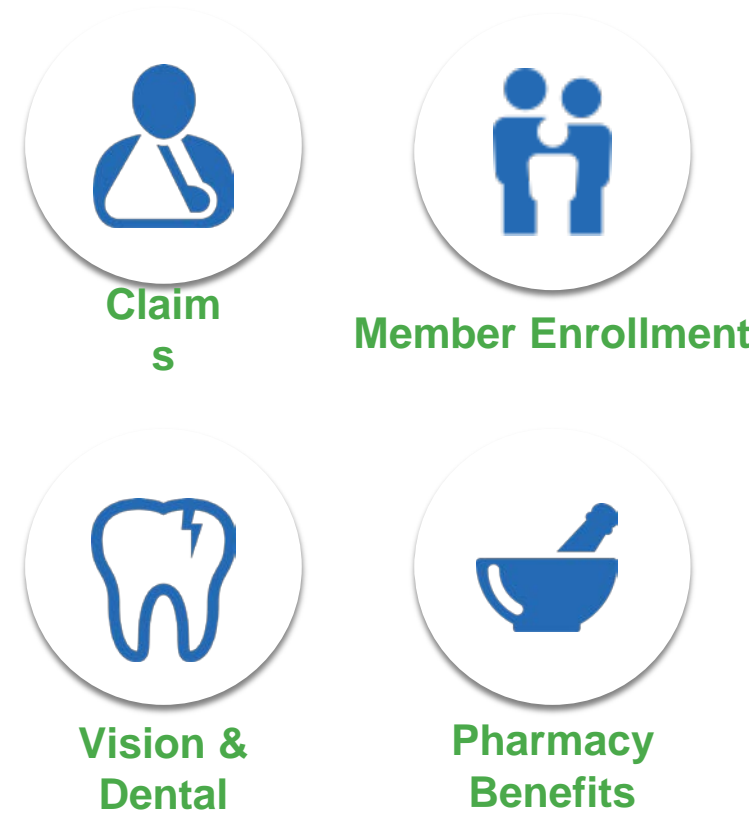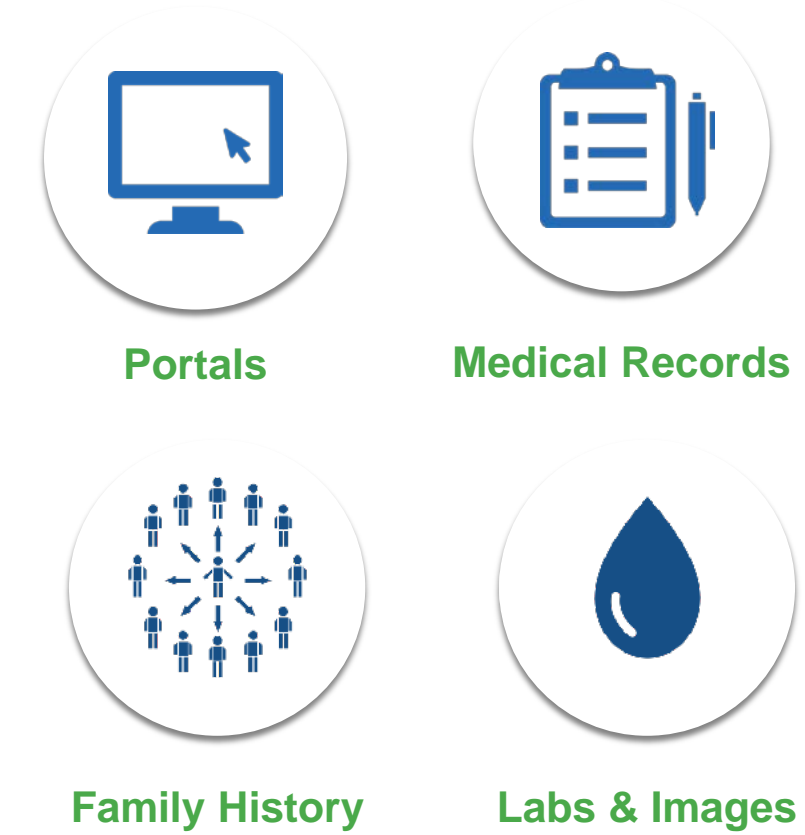
Personal Health Services
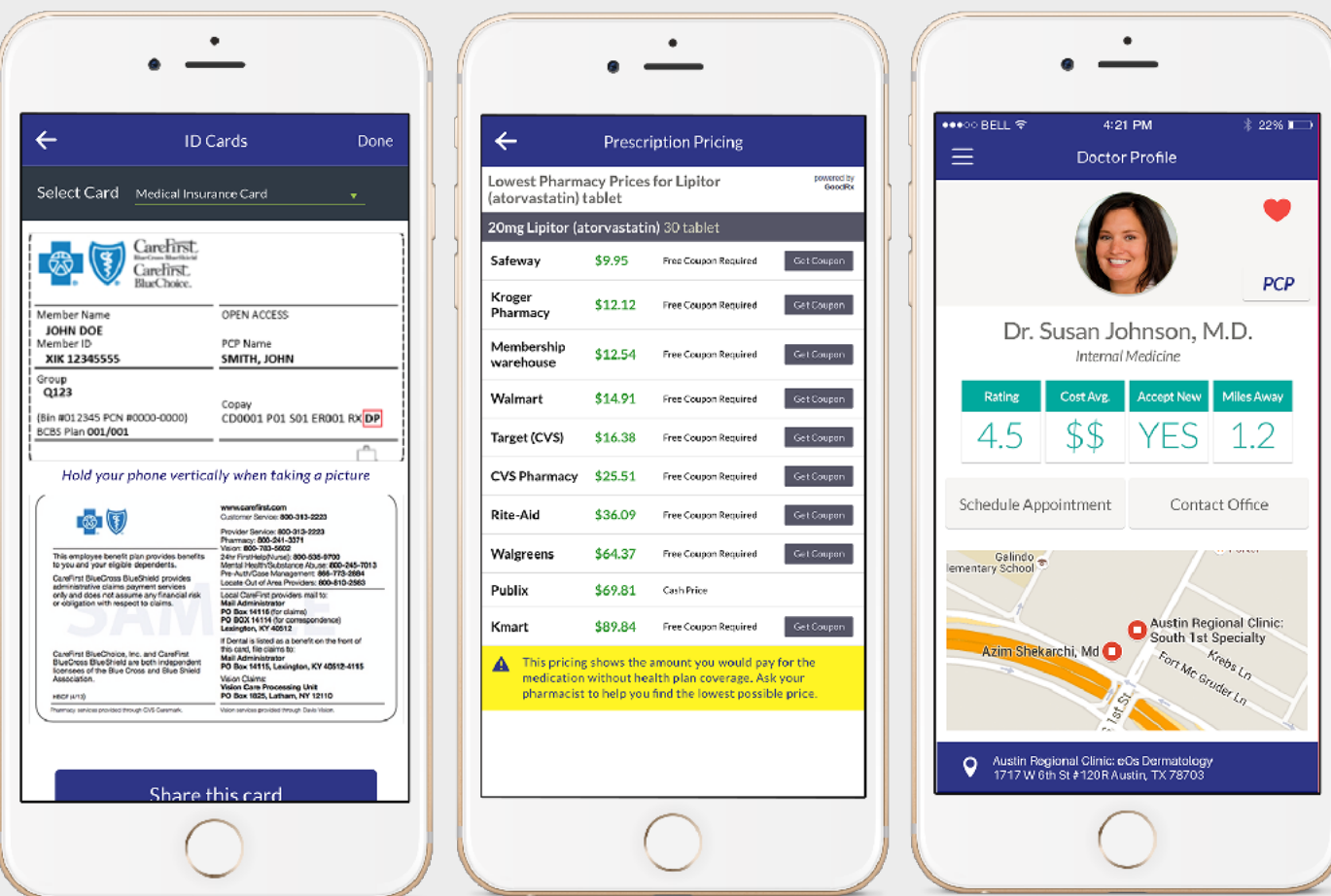
Health Tribe

Today's Consumer Health Experience

b.well
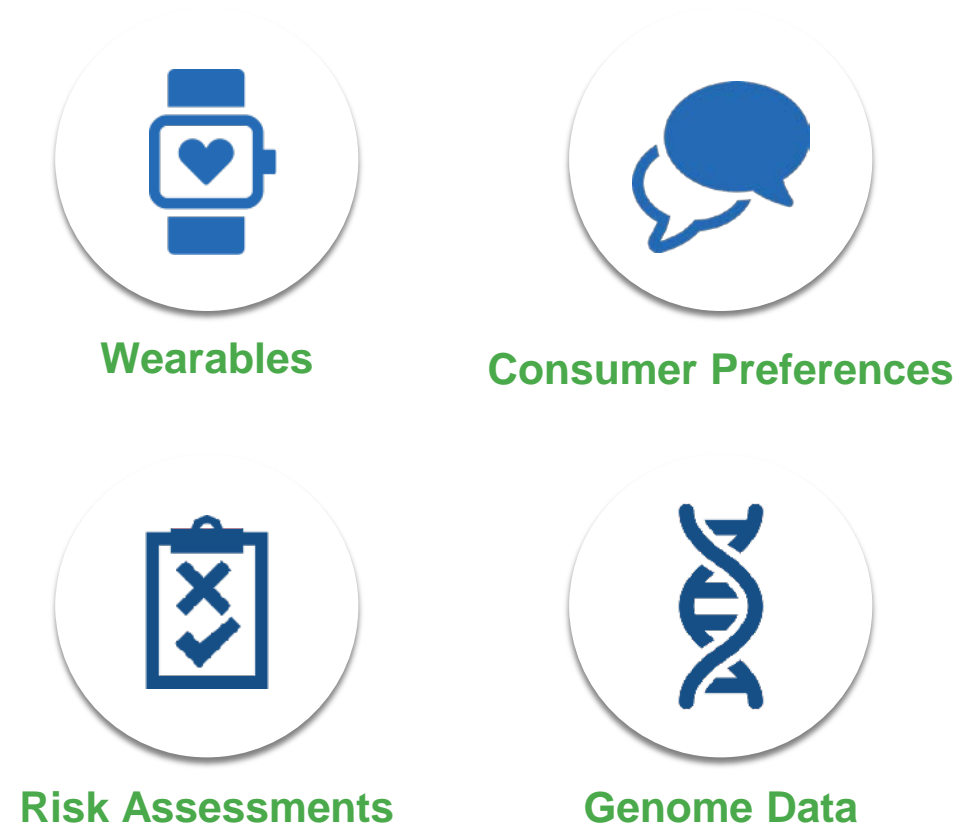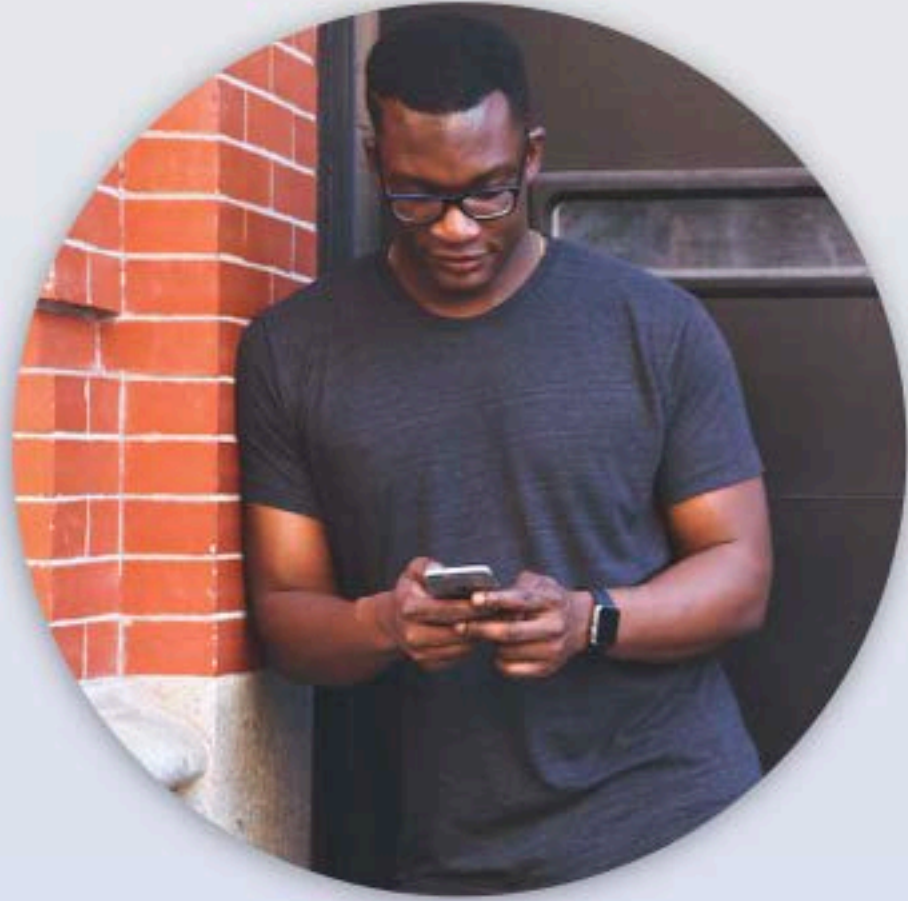
Consumers are paying more for healthcare than ever before and need the tools to shop for healthcare services

Employers are increasingly becoming payers and need to manage risk

Payers & Providers are moving to pay for value and need to connect to their population in real-time

Key Issues

❖ Data Harmonization—Need for clean, standardized data across all platforms

❖ Third Parties as Covered Entities—Patient's Right of Access is not the same as HIPAA Authorization

❖ Other Concerns:

- Patient's ability to easily correct medical records
- Patient's Right to Order Labs and obtain results
- Patient's Ability to Easily Access Telemedicine Services

THANK YOU

NCVHS CIO Forum

Pat Waller

Cambia Health Solutions is a company that is creating simple and personalized health experiences for people and their families.

Known for creating the first employer-based health plan in the country 100 years ago, we continue to put people at the heart of everything we do.

Today, we serve over 70 million Americans with simple and personalized health experiences.

Company Profile

A tax-paying nonprofit headquartered in the Pacific Northwest

Almost 5,000 employees in 30 states

Nationally recognized: Top 100 Healthiest Workplaces

Over 20 companies and growing

70+ million people touched nationwide

Cambia's experience with HIPAA Administrative Simplification

As we move to APIs, HIPAA can add complexity.

Planning & Standards

- Difficult to plan roadmap with uncertainty around the timing for which HIPAA transactions will be refreshed / adopted.
- HIPAA standards for Claims/Encounters, Remittance Advice/EFT, Eligibility Inquiry/Response and Claim Status Inquiry/Response high rates of usage and value.
- NCPDP widely used by our PBM.

Limited Usage & Reduced Value

- Referral/Auth has limited adoption. Many times additional documentation is needed (attachments).
- Spotty adoption for Membership and Premium Payment – can add value, but groups struggle with these transactions.

Consistency & Expense

- Heavy reliance on HIPAA clearinghouses to reduce number of provider connections and provide content consistency.
- Expense of building connectivity requirements of operating rules has not paid for itself
- Painful 4010 to 5010 transition

Our Innovation Efforts

Interoperability

- Rapidly develop a first-generation FHIR-based API and Core Data Services specification.
- Expanded info sharing for EHRs and other health info tech.

Da Vinci Project

- FHIR based workflows between provider and payers with a goal to help payers and providers to positively impact clinical, quality, cost and care management outcomes.

CARIN Alliance

- Rapidly advance the ability for consumers and their authorized caregivers to easily get, use, and share their digital health information when, where, and how they want to achieve their goals.

Cambia Innovation

- Create and expose APIs internally and externally.
- Personalized health experiences for people and their families.

NCVHS CIO Forum

Presented by :
Sherry Wilson, EVP and CCO
Jopari Solutions Inc.
May 17th 2018

- Lack of coordination between National Standards Organizations (SDO)
- Lack of data harmonization impedes interoperability
- Operating Rules and SDOs do not always align with stakeholder business needs
- SDOs are voluntary based with limited funding, resources and governance resulting in the inability to be agile to responds to industry needs.
- Inability to be agile has created missed opportunities to optimize business processes
- Lack of Industry Standard Roadmap – no clear direction on which new technology and or standard is the better solution for interoperability
- Industry Silos working on the same initiatives, however not always a coordinated effort
- Need a methodology/plan to leverage standards to meet the every changing business process landscape

- **Supporting Emerging Technology**
  - Data integration software tools to maximize information integration and data normalization
  - Artificial Intelligence – Cognitive Computing
  - Enterprise Data Mining
  - Data Analytics / Enhanced Stakeholder Self Service Access Tools
  - FHIR
  - Blockchain

- **Pilot Programs – Industry Collaboration Efforts**
  - Electronic Attachment Collaborations Projects Unsolicited and Solicited Models
  - Prior Authorization
  - FHIR Applications for Interoperability
  - Blockchain Collaborative Partnerships