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.
**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.

*May 17, 2018*

*The information in this presentation is confidential and considered proprietary to Palmetto GBA.*
Enhanced Messaging Administrative Impacts

13% reduction in appeals requests

CSR Denial Call %

32% reduction claims suspense

Redeterminations Monthly Average

24.5% drop in denial-related calls to CSRs

Part B Claims Suspense %

The information in this presentation is confidential and considered proprietary to Palmetto GBA.
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:

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?”

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Data sharing and exchange (e.g., eligibility, Dx, Rx, utilization)</td>
<td>67%</td>
<td>46%</td>
</tr>
<tr>
<td>Value-based compensation terms and reconciliation</td>
<td>58%</td>
<td>37%</td>
</tr>
<tr>
<td>Care management coordination</td>
<td>38%</td>
<td>34%</td>
</tr>
</tbody>
</table>
So I research what’s working, what’s not, and what we can collectively do about it.
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

- Administrative Cost Savings
- Automation

NEGATIVES -

- Timeframes are long & unpredictable
- Rapid changes in healthcare landscape
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.
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.”

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.

1Administrative Inefficiency in Coordination of Benefits, Prepared with assistance from Manatt
Health Solutions, February 2014. Available at:
## Experience with EDI standard transactions

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
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</thead>
<tbody>
<tr>
<td>• Satisfying clients’ business needs timely within standard transactions</td>
<td>• Lower capital expense using existing standards</td>
</tr>
<tr>
<td>• Version updates—labor &amp; time-intensive, major investment—still require</td>
<td>• Increase adoption when passing information via</td>
</tr>
<tr>
<td>workarounds</td>
<td>standard transactions and leveraging existing</td>
</tr>
<tr>
<td>• More transparency to meet business needs</td>
<td>end user workflows</td>
</tr>
<tr>
<td>• Payer – payer-specific billing and payment rules</td>
<td>• Increase information exchange prior to claim</td>
</tr>
<tr>
<td>• Provider – HEDIS/Stars information, supporting documentation for</td>
<td>submission</td>
</tr>
<tr>
<td>claims/prior authorization etc.</td>
<td>• Decrease costs of working unnecessary denials, with</td>
</tr>
<tr>
<td>• Lack of stakeholder adoption</td>
<td>claim scrubbing and actionable feedback earlier in the</td>
</tr>
<tr>
<td>• Technology readiness varies</td>
<td>EDI stream</td>
</tr>
<tr>
<td>• Lack of flexibility for innovation</td>
<td>• Identify business needs and positive ROI when</td>
</tr>
<tr>
<td>• Cost and time to implement non-mandated transactions, often requiring</td>
<td>passing standard transactions.</td>
</tr>
<tr>
<td>additional capital</td>
<td>• Real time pricing transparency - HHS priority</td>
</tr>
<tr>
<td>• Manual processes still in play (phone calls, fax)</td>
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</table>
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 goes to the pharmacy.
- Dramatically reduces claim rejections at the pharmacy window.
- Helps improve outcomes and adherence.

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

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.
Patient Estimation Workflow

1. Physician order created or patient arrives
   - Lab order entered
   - Pre-determination claim created (837P x291)

2. Eligibility

3. Clinical editing

4. Contract allowed amount

5. Patient receives estimate; authorizes to charge credit card
   - Patient estimate created
   - Patient responsibility determined
Patient Estimation Pilot Results

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

15%
Goal for increase in patient credit card collection rate

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

25
Number of Payers currently live

~3 seconds
Average time to deliver the patient estimate (SLA ≤ 10 sec)
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
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
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
Providing for Healthcare Needs in Alternative Settings Requires Alternative Health IT Support
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
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.
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
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
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
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
## 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?
How Will the Requirement Lookup Service Work for Providers?
How Might the Requirement Lookup Service Work for MACs?

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)
Timeline

• Spring 2018: CPI/PCG will task Mitre with building the Temporary Documentation Requirement Repository

• Summer 2018: CPI/PCG is considering hiring a small business to develop Business Requirements for the Permanent Documentation Requirement Repository

• Fall 2018: CPI/PCG is considering hiring a small business to build the Permanent Documentation Requirement Repository
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?
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.
A Brief History of Blue Button

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

**1.5M**
CMS users

Beneficiaries can download up to 3 years of claims data
- Hospital
- Physician
- Prescription drugs

**20–30k**
Downloads per Month

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

**2x text downloads**

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
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
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)
Questions?

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

Kevin.larsen1@cms.hhs.gov
About Kaiser Permanente

- 12.2M people get care + coverage from Kaiser Permanente
- 39 hospitals
- 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

- 100,000+ births
- 400,000+ hospital admissions
- 225,000+ inpatient surgeries
- 25.5 million prescriptions submitted online
- 48.7 million lab results viewed online
- 26.1 million secure messages sent to providers
- 77+ million virtual visits
- 5.3 million appointments booked online
- 293 million visits to kp.org
- 400,000+ births
- 225,000+ inpatient surgeries
- 100,000+ births
- 53+ million doctor office visits
- 225,000+ inpatient surgeries
- 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
- 300,000 volunteers donated blood to our research bank
- 22K physicians
- $3.5B invested to benefit our communities (2017)
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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)
<table>
<thead>
<tr>
<th>Standards Division Major Responsibilities/Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direction</strong></td>
</tr>
<tr>
<td>• Support HITAC identification of use case priorities and the standards and implementation specifications that support them</td>
</tr>
<tr>
<td>• Long-term maintenance of the USCDI</td>
</tr>
<tr>
<td>• Curate standards and implementation specifications that enable the appropriate sharing and processing of structured and non-structured health data</td>
</tr>
<tr>
<td><strong>Innovation</strong></td>
</tr>
<tr>
<td>• Support and coordinate with both innovation communities and innovators to meet ONC goals</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
</tr>
<tr>
<td>• Develop measures, analyze data, and evaluate programs that demonstrate progress in achieving ONC goals and objectives</td>
</tr>
<tr>
<td>• Improve our understanding of the current HIT infrastructure and where to place our future efforts</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
</tr>
<tr>
<td>• Translate real world experience into enhanced implementation specifications to advance HIT interoperability, reduce clinician burden, and improve patient access</td>
</tr>
<tr>
<td>• Provide technical subject matter expertise to ONC and stakeholders to influence the use of standards and technology in health and care</td>
</tr>
</tbody>
</table>
## ONC Projected Outcomes

### PATIENT
- Movable health records to shop for and coordinate care

### PROVIDER
- Ability to efficiently to send, receive, and analyze data
- Burden reduction:
  - Less wasted time
  - Less hassle

### COMPETITIVE MARKETPLACE
- Improved data flow standards
- Accessible API’s
- Ability to support new business models and software applications

**Interoperability**

**Usability**
Thank you!

Christopher.Muir@hhs.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.
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
WE are a faith-based, not-for-profit healthcare system.
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
WE’RE RATED

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

NATIONALLY RANKED

100 BEST COMPANIES TO WORK FOR™
BY FORTUNE MAGAZINE

12 YEARS IN A ROW

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

96th percent ile
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
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
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

Doctor Portals

Insurance Portals

Consumer Apps

employer Wellness

HSA / FSA

Medication Reminders

Mango Health

Running Apps

mapmyrun

Telemedicine

Dr. ON DEMAND

Wearables

WATCH

Optometrist

Optum

Cardiologist

MyChart

Primary Care

MyMercy

Previous Health Insurance

Wells Fargo

Wells Fargo

FSA

FSA

HSA

Current Health Insurance

UnitedHealthcare

Health Risk Assessment

Welltok

Wellness Programs

Biometrics

Incentives & Rewards

Advocacy & Navigation

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HSA / FSA
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
b.well

THANK YOU
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
Experience with Standards and Operating Rules

- 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 respond 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
Initiatives to Improve Business Processes

• 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