Making an Impact Through Public Innovation: Critical National and State Health IT Policy Initiatives

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Agenda

- Introduction to HIMSS
- Key Health IT Public Policy Issues
  - Quality Payment Program Implementation
  - Telehealth/Remote Patient Monitoring
  - Interoperability/Data Exchange
  - New HHS Secretary
- How to Get Involved and Leverage HIMSS Resources
- Discussion/Q&A

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Background on HIMSS

- HIMSS is a cause-based, global enterprise producing health IT thought leadership, education, events, market research and media services around the world
  - Focused on health information and technology enabling healthcare transformation
  - Founded in 1961
- HIMSS encompasses more than 68,000 individuals, of which more than two-thirds work in healthcare provider, governmental and not-for-profit organizations across the globe
  - 640 corporations
  - 500 not-for-profit partner organizations
- HIMSS18 is in Las Vegas, NV, March 5-9, 2018

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HIMSS Strategic Advocacy Framework

- Focus on the value of health IT through:
  - Supporting Healthcare Transformation
    - Ensuring Interoperability Across the Spectrum of Care
  - Expanding Access to High Quality Care
    - Particularly for underserved (both urban and rural) and remotely located patient populations
  - Increasing Economic Opportunity
    - Economic Growth by expanding health IT export opportunities
  - Making Communities Healthier
    - Healthcare Payment/Delivery System Reform/Innovations in Care Delivery

Key Health IT Public Policy Issues

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Value-Based Care Delivery Critical to Healthcare Transformation

- Value-based approach favored by both parties
  - Economic argument
    - Value-based care is required for the sustainability of Medicare and entire health system
    - Lower healthcare costs will be key to economic growth policies
  - Quality argument
    - Higher quality care will deliver better outcomes and more value

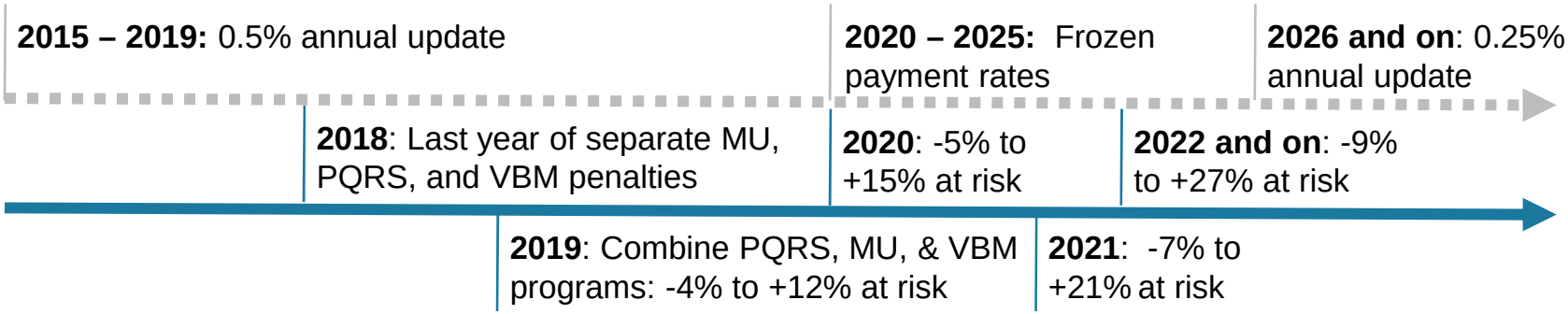
The Medicare Access & CHIP Reauthorization Act of 2015

- Passed into law April 2015
- Repeals the SGR Formula
- Streamlines multiple quality reporting programs into MIPS – a goal is to decrease clinician burden
- Incentive payments for participating in Advanced Alternative Payment Models (APMs)
- Sustain Medicare by paying for what works
- CMS is implementing MACRA as the Quality Payment Program (QPP)

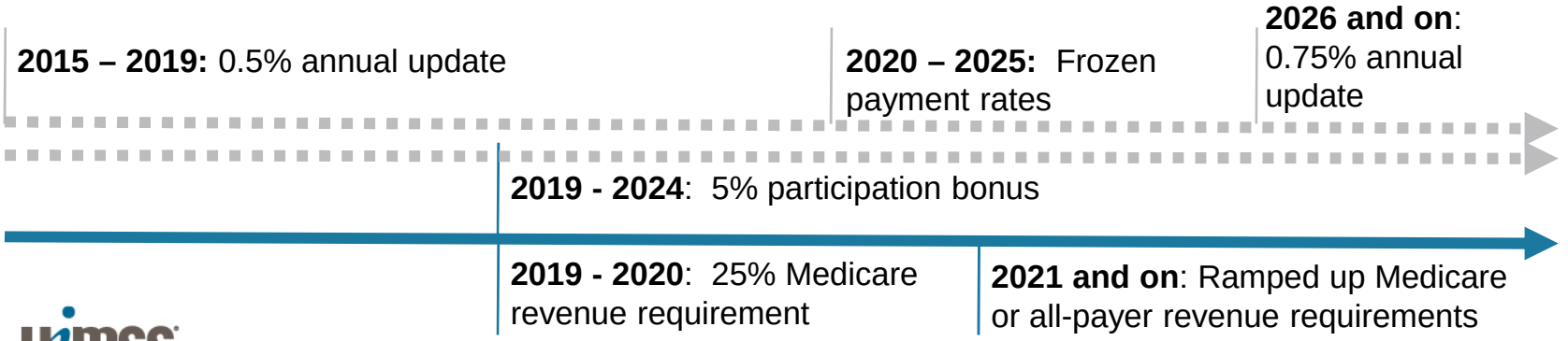
MACRA Created Two Tracks for Providers

Providers May be Subject to either MIPS or APM Track, not both

Merit-Based Incentive Payment System (MIPS)



Advanced Alternative Payment Models (APMs)



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Slide courtesy of the Centers for Medicare & Medicaid Services

For 2018, Reducing Clinician Burden Remains of Paramount Concern

- CMS continues to emphasize the importance of minimizing the reporting and administrative burden on clinicians
- CMS finalized the low-volume threshold that excluded clinicians from participating in MIPS reporting requirements and payment adjustments for 2018
  - < or = to $90,000 in Medicare Part B allowed charges
  - < or = to 200 Medicare Part B patients
- CMS is estimating that 622,000 ECs will be subject to MIPS reporting and adjustments in 2018
- Increase in the low-volume threshold is expected to exclude 540,000 clinicians who do not exceed the low-volume threshold and are not required to participate in MIPS

For ACI Performance Category, ECs Have CEHRT Choices

- MIPS eligible clinicians may continue to use EHR technology certified to the 2014 Edition for the 2018 Performance Period
  - Clinicians may also choose to use the 2015 Edition CEHRT or a combination of 2014 and 2015 Edition CEHRT
  - EHR technology must support the ACI objectives and measures to which they plan to attest
- ACI hardship exception also available
  - 0% weighting to the ACI Performance Category in the MIPS final score for MIPS eligible clinicians who successfully demonstrate a significant hardship
- Clinicians must lack
  - Sufficient internet connectivity
  - Face extreme and uncontrollable circumstances
  - Lack control over the availability of CEHRT
  - Do not have face-to-face interactions with patients

CMS Utilizing a Bonus Point Structure Across QPP

- CMS has finalized a 5-point small practice and a 5-point complex patient bonus for the 2018 Performance Period/2020 MIPS Payment Period
  - Have 15 or fewer clinicians and that submit data on at least one performance category
  - Uses the Medicare-Medicaid dual eligibility ratio and the average HCC risk score
- Under the ACI Performance Category, there is a possible 25 additional bonus percentage points
  - CMS finalized a bonus of 10% for ECs who report these Objectives and Measures for 2018 using only 2015 Edition CEHRT
  - Clinicians can earn a 5% bonus for reporting to more than one public health agency or clinical data registry to meet any of the relevant measures
  - Clinicians can earn a 10% bonus if they report their Improvement Activities using CEHRT

MIPS in 2018: Four Components

Quality: 50%	Advancing Care Information: 25%	Improvement Activities: 15%	Cost: 10%

- Cost performance category will require no separate submissions for participation, which will minimize the burden on clinicians
  - Cost performance will be calculated using administrative claims data
- Quality and Cost Performance Categories must report for is a full year in 2018 (January 1, 2018 through December 31, 2018) as well as a full year in 2019
- Performance period for the Improvement Activities and ACI Performance Categories is a minimum of a continuous 90-day period within 2018, up to and including the full year

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MIPS Creates a Final Score Based on each Performance Category

- Clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments
  - Final MIPS score will be compared against the MIPS performance threshold of 15 points for 2020
    - A 15-point final score equal to the performance threshold can be achieved via multiple pathways and continues the gradual transition into MIPS
    - The additional performance threshold for exceptional performance will remain at 70 points, the same as in 2017

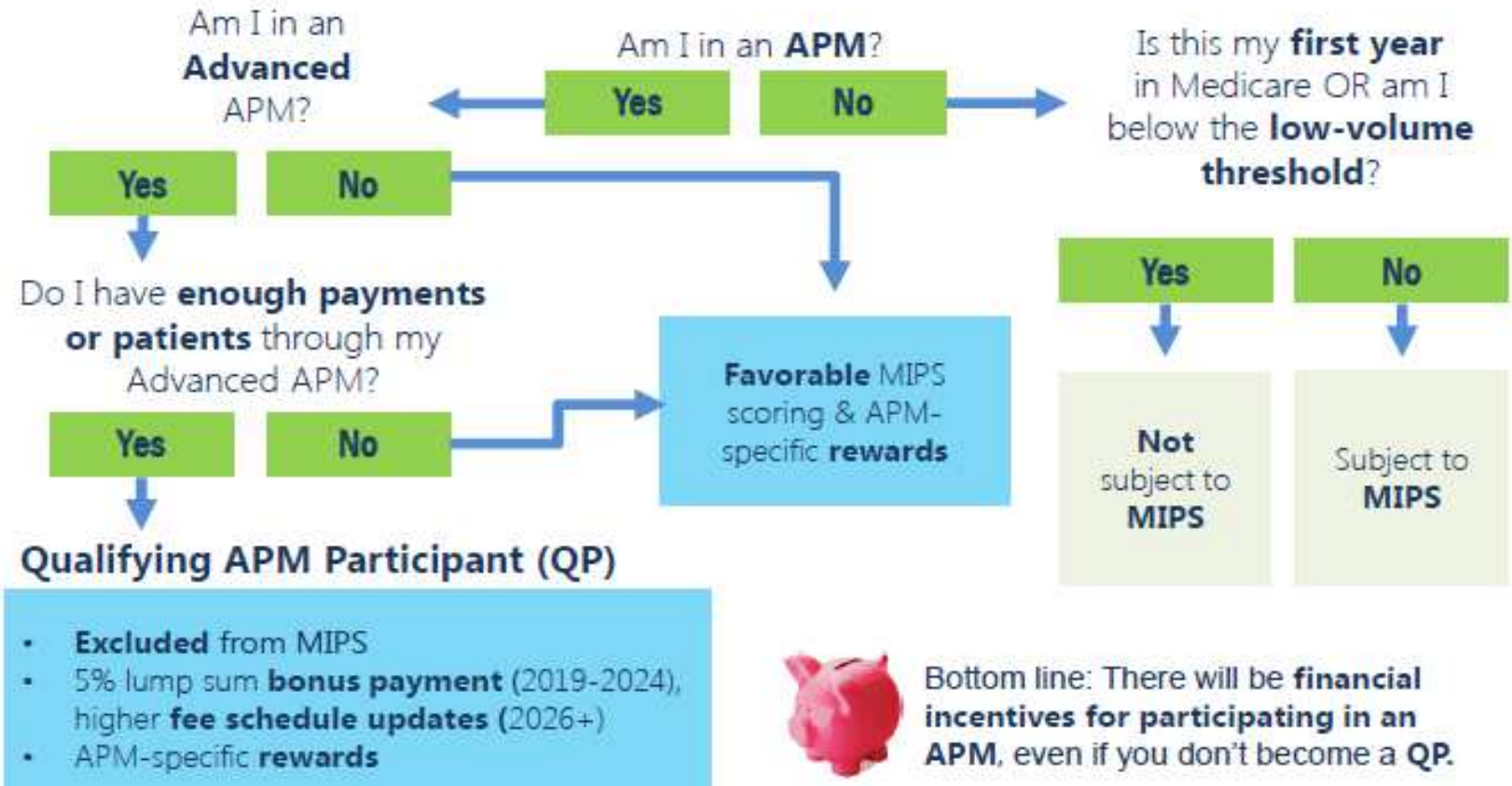
Advanced APM Participation Includes 5% Lump Sum Bonus Payment

- Advanced APMs enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes
- 5% bonus payment based on the QP's estimated aggregate payments for Medicare Part B covered professional services (services paid under or based on the Medicare PFS) for the prior year
- QPP does not change the design or incentive structure for any particular APM
  - It creates extra incentives for a sufficient degree of participation in an Advanced APM

Clinician Participation in Advanced APMs Expected to Jump for 2018/2020

- CMS currently estimates that approximately 185,000 to 250,000 eligible clinicians may become QPs for the 2018 Performance Period/2020 Payment Period
  - CMS estimated that for CY 2017/2019, 70,000 to 120,000 eligible clinicians would be QPs
- New Advanced APMs available
  - Medicare ACO Track 1 Plus (1+) Model
  - Reopening of the application process to new participants for some current Advanced APMs—Next Generation ACO Model and Comprehensive Primary Care Plus (CPC+) Model
- Total lump sum APM incentive payments will be between $675 million and $900 million for the 2020 QPP payment year

As a Medicare Clinician, What Are the Possible Scenarios Under MACRA?



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CMS Adding Several PFS Telehealth Codes

- CMS finalized the addition of several codes to the list of telehealth services, including: HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility) and CPT codes 90839 and 90840 (Psychotherapy for Crisis)
  - Eliminating the required reporting of the telehealth modifier GT for professional claims
- CMS reviewing broader stakeholder comments about additional steps that the agency could take to expand access to telehealth services within its current statutory authority
  - Pay appropriately for services that take full advantage of communication technologies
- Medicare payment for telehealth services is restricted by statute
  - Establishes the services initially eligible for Medicare telehealth and limits the use of telehealth by defining both eligible originating sites and the distant site practitioners who may furnish and bill for telehealth services
- QPP does not prioritize the use of telehealth or digital technologies in its 2018 Final Rule
  - No specific telehealth-related Improvement Activities in this Final Rule's inventory

Separate PFS Payment for Remote Patient Monitoring

- CMS finalized CPT code 99091 for separate payment in 2018
  - For collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time
- The information must be interpreted by a physician or other qualified health care professional
- Practitioner must obtain advance beneficiary consent for the service and document this in the patient's medical record
- CMS is requiring initiation of the service during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial Preventive Physical Exam
  - This code cannot be reported more than once in a 30-day period
- CMS also alluded to forthcoming coding changes through the CPT process that it anticipates will better describe the role of RPM

HIMSS Interoperability Call to Action

- Demand Integration between the Interoperability Approaches and Trusted Exchange Frameworks for the Public Good
- Ensure Stakeholder Participation from Across the Care Continuum, Including Patients and Caregivers
- Identify the “Minimum Necessary” Business Rules for Trusted Exchange to Enhance Care Coordination
- Educate the Community to Appropriately Implement Existing and Emerging Standards, Data Formats, and Use Cases to Ensure a Comprehensive, Integrated Approach to Care
- Standardize and Adopt Identity Management Approaches
- Improve Usability for Data Use to Support Direct Care and Research

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Access the Full Call to Action Here!

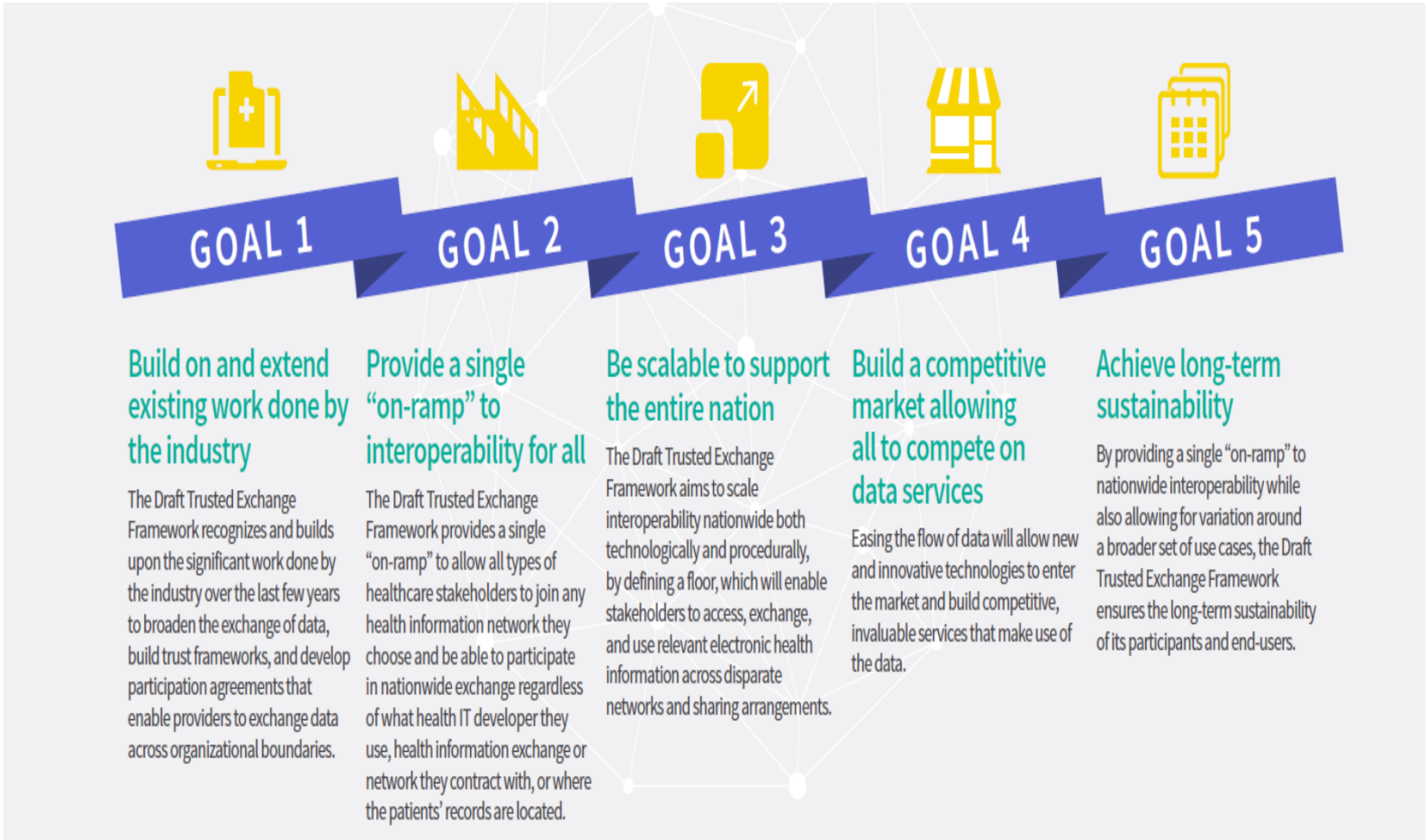
Interoperability Defined

- Establishes a new federal definition of interoperability
- Capabilities include:
  - Enabling the secure exchange of electronic health information with, and use of electronic health information from, other health IT without special effort on the part of the user
  - Allowing complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law
  - Does not constitute information blocking (as defined in law)
- Strengthens “trusted exchange framework”; requires ONC to collaborate with NIST and other agencies

Information Blocking Provisions

- Information blocking defined as a practice that is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information
  - If conducted by a health IT developer, exchange, or network, such developer, exchange, or network knows, or should know, that such practice is likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information
  - If conducted by a health care provider, such provider knows that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information

Goals of the Trusted Exchange Framework



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Graphic courtesy of the Office of the National Coordinator for Health IT

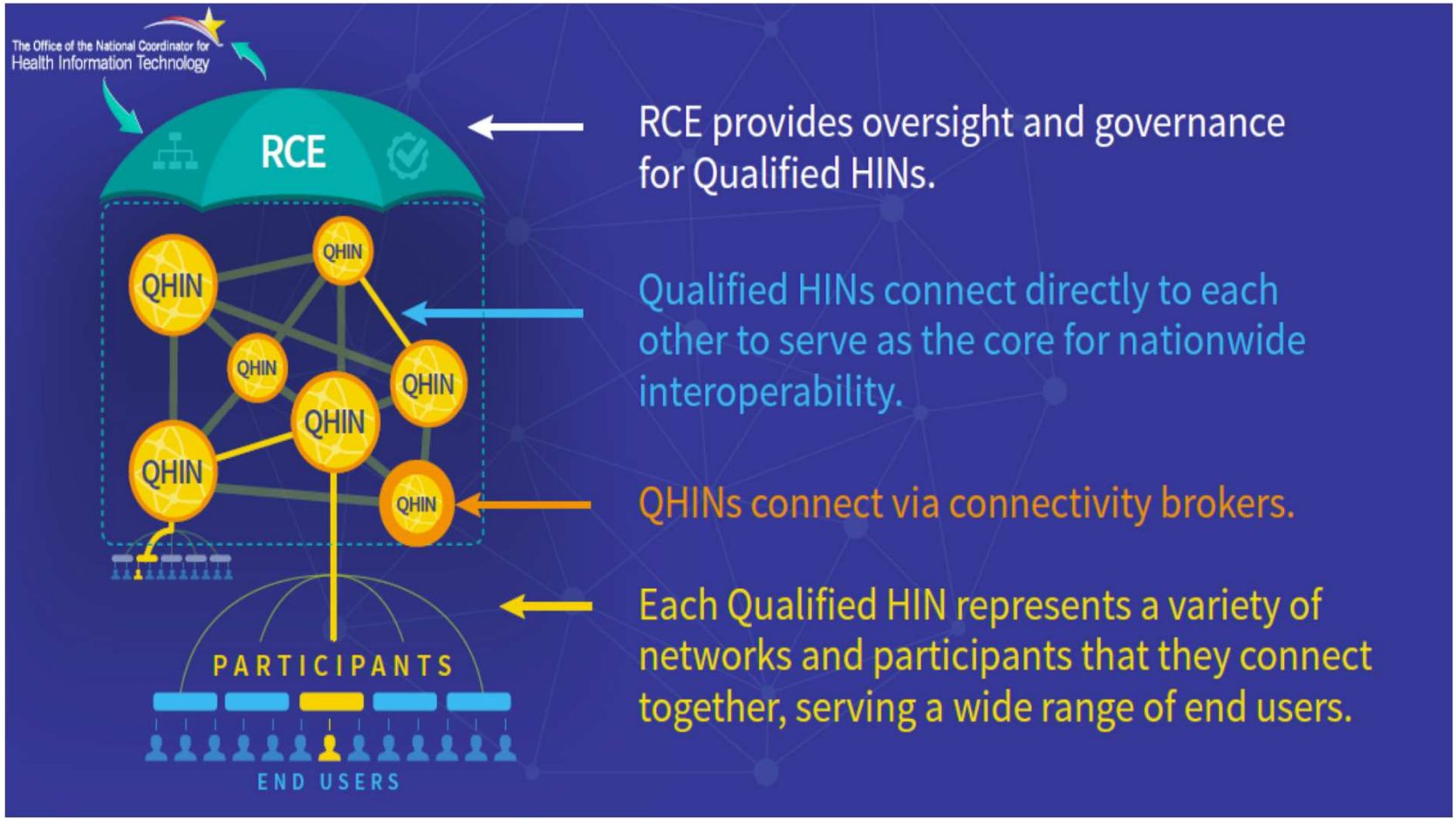
Two Parts to the Trusted Exchange Framework

- Part A—Principles for Trusted Exchange
- General principles that provide guardrails to engender trust between Health Information Networks (HINs)
  - Principle 1 - Standardization: Adhere to industry and federally recognized standards, policies, best practices, and procedures.
  - Principle 2 - Transparency: Conduct all exchange openly and transparently
  - Principle 3 - Cooperation and Non-Discrimination: Collaborate with stakeholders across the continuum of care to exchange electronic health information, even when a stakeholder may be a business competitor
  - Principle 4 - Security and Patient Safety: Exchange electronic health information securely and in a manner that promotes patient safety and ensures data integrity
  - Principle 5 - Access: Ensure that patients and their caregivers have easy access to their electronic health information
  - Principle 6 - Data-driven Accountability: Exchange multiple records at one time to enable identification and trending of data to lower the cost of care and improve the health of the population

Additional Facts on TEFCA

- Part B—Minimum Required Terms and Conditions for Trusted Exchange
- A minimum set of terms and conditions for the purpose of ensuring that common practices are in place and required of all participants who participate in the Trusted Exchange Framework, including:
  - Common authentication processes of trusted health information network participants;
  - A common set of rules for trusted exchange;
  - A minimum core set of organizational and operational policies to enable the exchange of electronic health information among networks
- ONC also released several additional resources
  - User's Guide to Understanding the Trusted Exchange Framework
  - US Core Data for Interoperability (USCDI) Glide Path to identify a roadmap for broadening the data that can be exchanged via TEFCA

How Will the Trusted Exchange Framework Work?



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Information Blocking Rule Upcoming

- ONC to Release a Proposed Rule on Information Blocking in the Spring of 2018
  - One of the significant pieces to keep in mind is that ONC will be looking to define what the exceptions should be for blocking information
    - When is it acceptable for a provider, vendor, or other entity to not allow for the seamless exchange of information?

My Initial Thoughts/Questions

- TEFCA is a necessary first step on the road to nationwide interoperability
- TEFCA is voluntary guidance for the community
  - Needs regulatory policy levers to formulate requirements for stakeholders
- Fully aligned with HIPAA
- Does it add another layer of complexity?
- Costs-does it add to costs for providers and ultimately individuals?

Alex Azar Set to Become Next HHS Secretary

- Served as HHS General Counsel and Deputy Secretary under President George W. Bush
    - Helped create ONC
    - Former Pharma Executive
- Interested in a number of HIMSS priority policy issues
    - Telehealth
    - Shift to value-based care
    - Implementation of 21st Century Cures Act
    - Usability
- Health IT "should be an enabler and not something to detract”

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How to Get Involved and Leverage HIMSS Resources

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HIMSS Chapter Advocacy Roundtable (CAR)

- Supports better health through information and technology by informing, empowering, and mobilizing HIMSS Chapters to take advocacy action at the state and local level
- Strategic Aims
  - Connect federal, state, and local health IT efforts through active engagement of state officials
  - Support a learning health IT community by conducting monthly conference calls, regional networking and educational opportunities including webinars
  - Leverage existing opportunities to further health IT policy objectives by identifying one or more chapter advocates, increasing participation in HIMSS NA events

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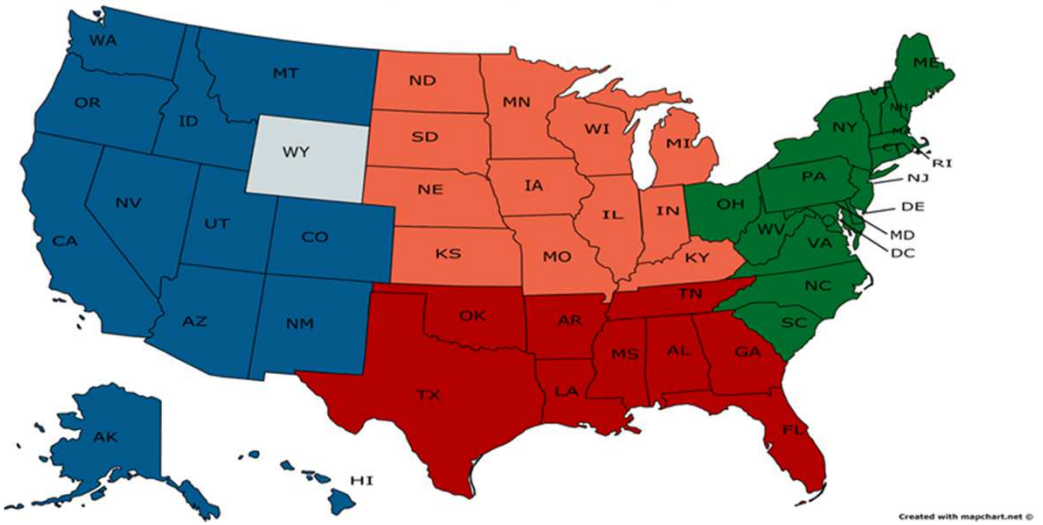
Chapter Advocacy in Every Region



Lauren Wiseman, Chair
Greater Illinois Chapter

Kevin Conway
Vice Chair of Midwest Region
Nebraska Chapter

Rick Moore
Vice Chair of Eastern Region
Central & Southern Ohio Chapter

Chad Cothern
Vice Chair of Southern Region
Louisiana Chapter

Shanti Wilson
Vice Chair of West Region
Northern California Chapter

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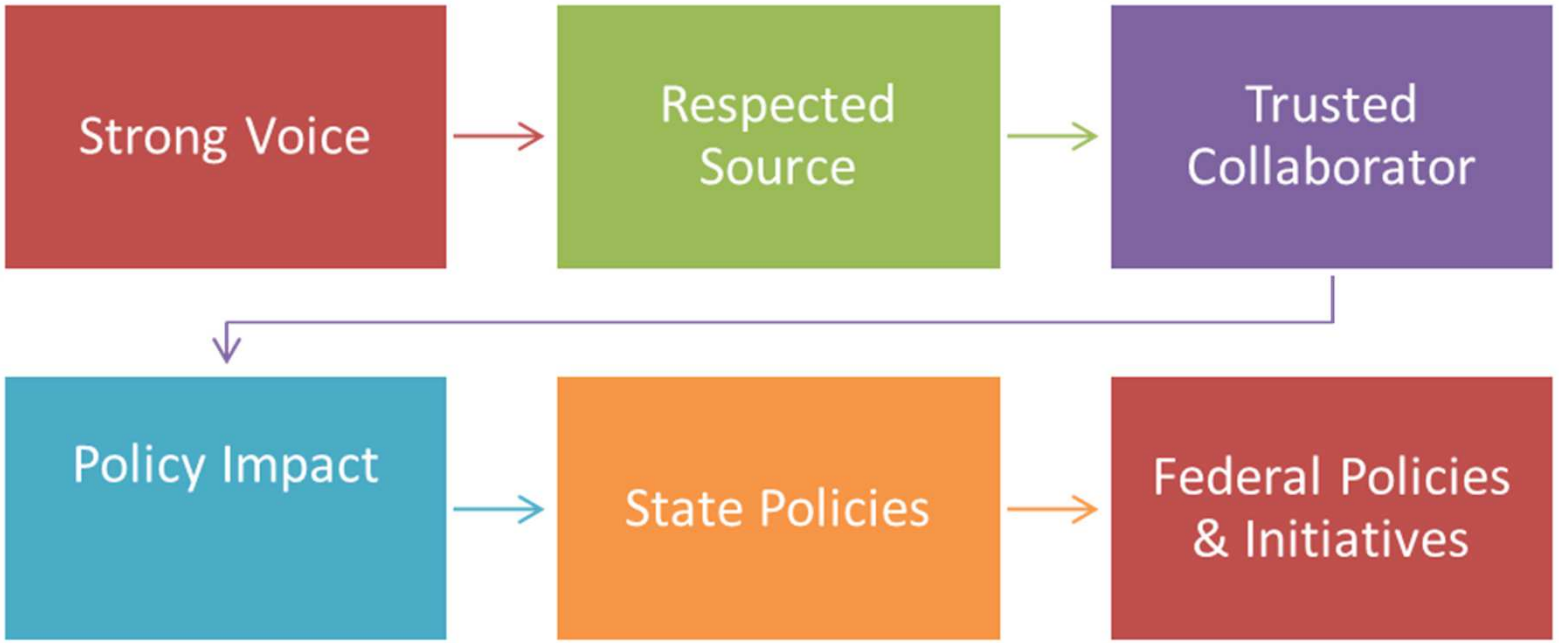
HIMSS Chapter Advocates Build Meaningful & Sustainable Partnerships



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Building Relationships

- Critical to interact with officials from both state and local levels of government

- Potential like-minded organizations and partners
  - State HIT Coordinators
  - Regional Extension Centers
  - Non-Profit Associations
  - Health Information Exchanges
  - Academia
  - Provider health settings
  - State Medicaid and Health Directors
  - State Innovation Model Awardees

Become Involved

- Invite state and federal legislators and district staff on **FACILITY TOURS**
- **SCHEDULE MEETINGS** with members of Congress and state legislators in their district offices
- Make advocacy a priority in your chapter. **FUND ATTENDANCE** at public policy event
- **INVITE LEGISLATORS** to your chapter events ***~ year round***
- Weigh in on current issues – **YOUR OPINION COUNTS**
- Present a member of Congress or state official with an award or **REQUEST A RESOLUTION**
- Advocacy resources you provide for your members every day – **PUBLICIZE IT!**
- **FOLLOW UP** with the legislators and staffers
- **PLAN** your 2018 Advocacy calendar

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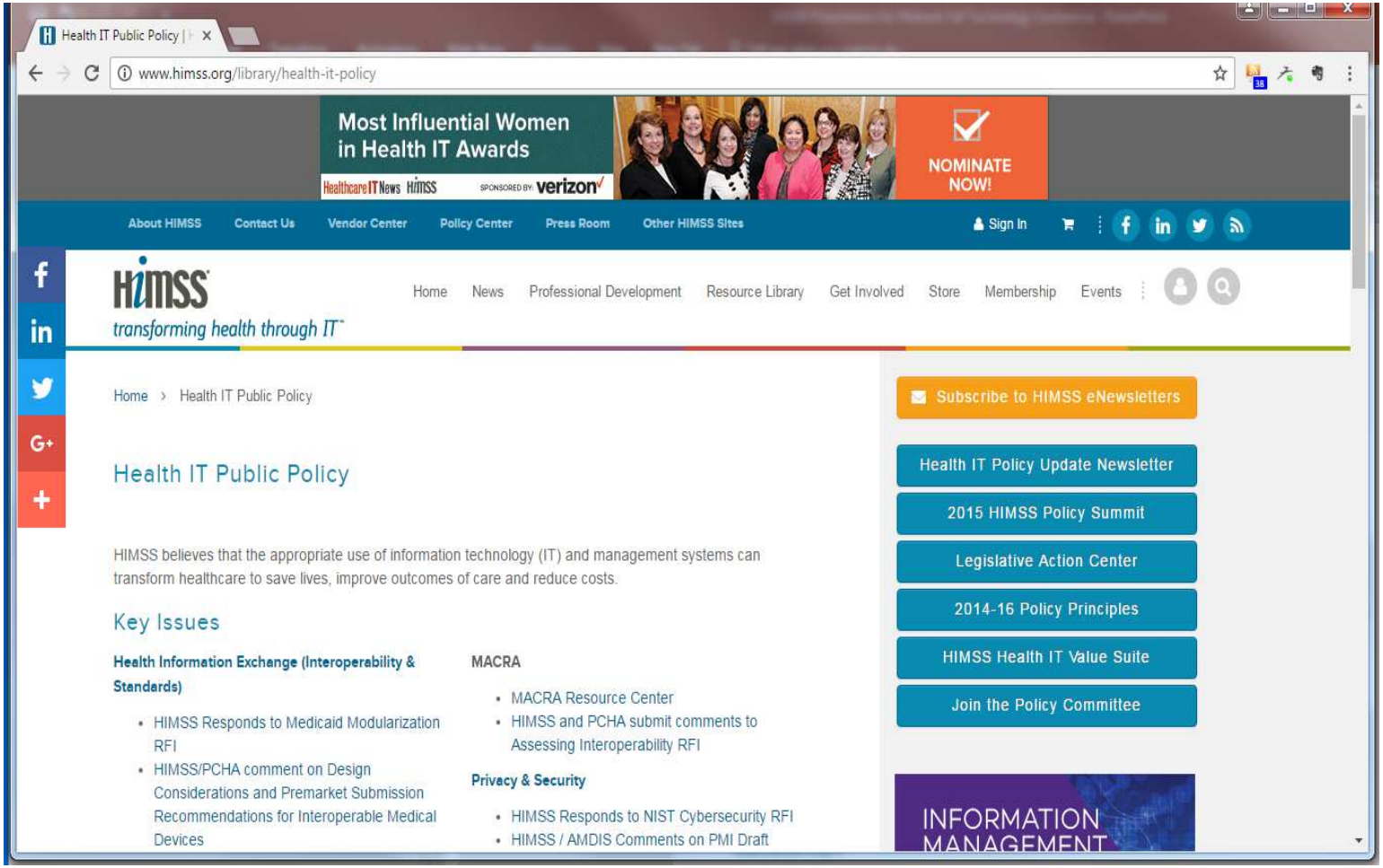
Work with your Chapter Advocates to Contribute Success Stories

- We are looking for narratives that we can use to tell compelling stories of success on value-based care delivery and interoperability
  - Helpful info would include:
    - Providers involved
    - City, state, and zip code
    - Health IT tools used
    - How/why policy is being pursued
    - Results/outcomes realized
    - Supporting sources/links

HIMSS Policy Center



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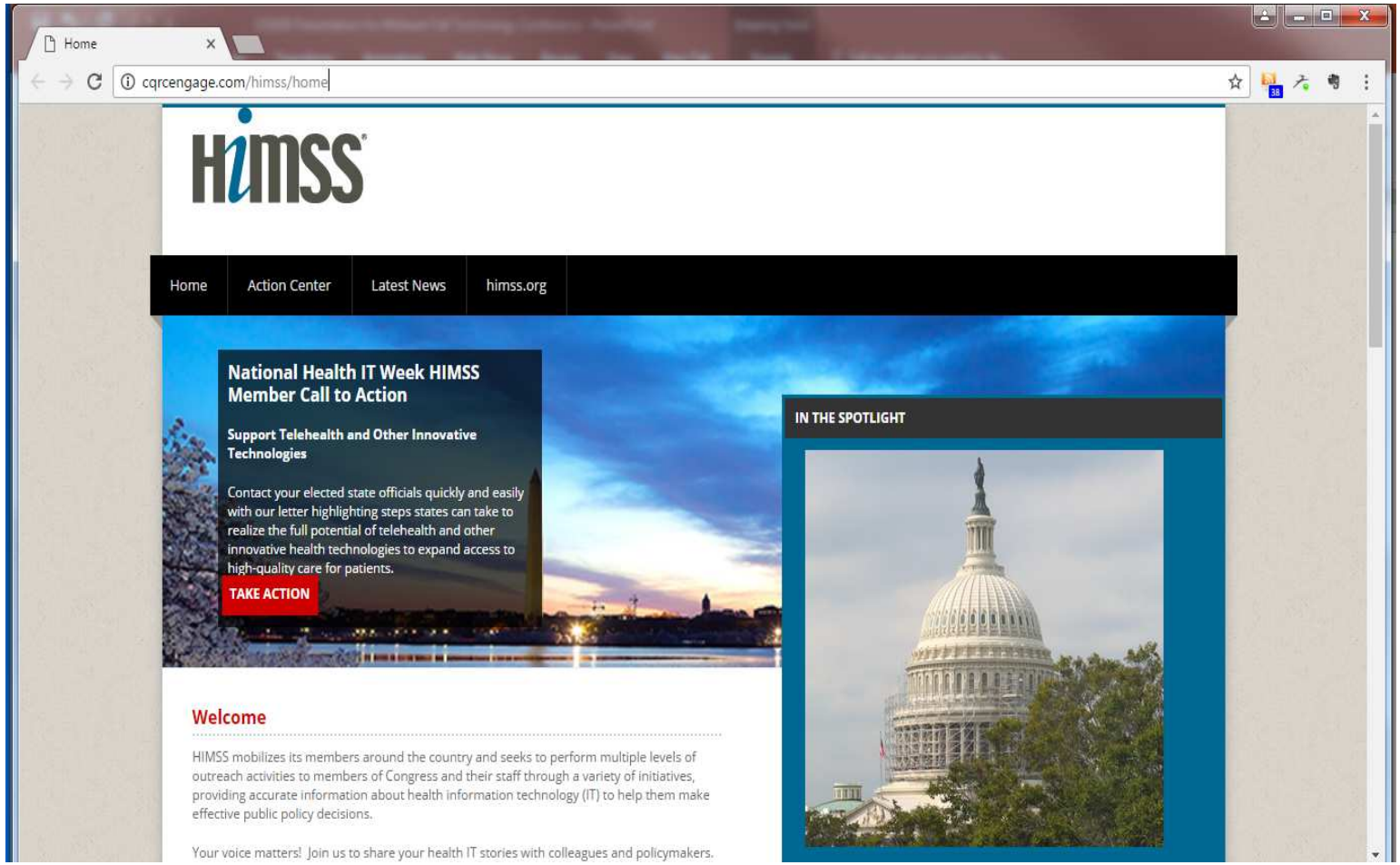
HIMSS Legislative Action Center



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Questions?

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Thank You!

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