Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

About the newsletter

HIT Perspectives is published by Point-of-Care Partners. Individuals at the leading management consulting firm assist healthcare organizations in the evaluation, development and implementation of winning health information management strategies in a rapidly evolving electronic world. The team of accomplished healthcare consultants, core services and methodologies are focused on positioning organizations for success in the integrated, data-driven world of value-based care.

Contact information

Tony Schueth
CEO & Managing Partner
tonys@pocp.com
info@pocp.com

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POINT-OF-CARE PARTNERS
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1 Part 1: Top 10 Takeaways from HIMSS 2014

By Tony Schueth, Editor-in-Chief

As we've been saying for the past couple of years, the annual meetings of the Healthcare Information Management and Systems Society (HIMSS) keep getting bigger and, for us, better. This year is no exception. Some 37,000+ health information technology (health IT) professionals, clinicians, executives and vendors packed the Orange County Convention Center in Orlando. More than that, HIMSS 2014 was — hands down — the most substantive and informative meeting anywhere about products, policies and issues related to health IT.

HIMSS is so vast and multifaceted that if you're not part of a team or have a plan of attack it can be totally overwhelming, with information overload setting in quickly. Knowing this beforehand, the Point-of-Care Partners (POCP) team paces itself and follows a game plan prepared in advance. This makes it possible for us to cover a lot of territory and gain many valuable insights by covering exhibits, attending numerous presentations, speaking with key players in government and industry, meeting with clients and connecting with colleagues. Based on those conversations and learnings, here are our top 10 takeaways from HIMSS 2014.

1. **Interoperability is still a dominant theme.** Interoperability has been a dominant theme throughout the past several HIMSS meetings, and its importance continues to resonate. The expanded Interoperability Showcase highlighted a dazzling array of technologies related to health data exchange. There's no doubt about it — the technology is available to facilitate open movement of data and knowledge between systems, and it continues to evolve. More importantly, people are finally beginning to understand what interoperability is.

However, there is still an underlying tension between the public and private sectors with respect to interoperability and data exchange. While the federal government tries to break down barriers and get data flowing, some in the private sector are dragging their feet.

The most recent move by the feds was proposed legislation that would have repealed Medicare's sustainable growth rate (SGR) requirements and mandated that all electronic health records (EHRs) achieve interoperability by 2017. One provision would have prohibited vendors from deliberately blocking information sharing with other EHR vendor products. This legislation was stillborn in the House and replaced by the Protecting Access to Medicare Act of 2014, which stripped out those health IT provisions. However, the thrust of the earlier proposed bill's health IT provisions is a harbinger of things to come.

The problem, of course, is not that vendors are blocking, per se. All EHRs are more than willing to interface with other EHRs (i.e., those of competitors) — at a price, of course, and that price goes up if it's not one of their own (Epic-to-Epic or Cerner-to-Cerner, for example). Their clients, of course, are hospitals and providers. While hospitals contend that interoperability is mission critical and a key driver for their continued growth and ability to serve patients, they are reluctant to exchange data outside of those entities that are part of their closed health system (even if it's Epic-to-Epic or Cerner-to-Cerner). Providers are concerned about liability and who might have access to the information once it leaves their control.

2. **Payment reform: another driver for value.** Let's face it, not much changes unless reimbursement changes. Or, put another way, we will keep on doing the same thing and getting the same result unless behavior is tied to payment. Medicare has known this for years. That is why Medicare payment reforms have changed provider behavior, which has then trickled down to the private sector. This year's HIMSS highlighted opportunities whereby payment reform — and value-based purchasing — can make a difference. For example, payment on a per patient, per episode-of-care basis is out of sync with encouraging population health, which requires a much broader view and payment for outcomes for a cohort of patients or plan members. The expanded role of the pharmacist in health care also is impeded by current reimbursement policies. We have written periodically about the value of pharmacists on health care teams and, in particular, performing medication reconciliation at a more advanced level than, say, a nurse or pharmacy technician. But such value is stifled because health plans do not want to pay pharmacists more for doing advanced work. That attitude may change as value-based purchasing becomes more the norm.

3. **2014 is the year of the patient.** This turned out to be the centerpiece of HIMSS 2014 and a surprise takeaway of the meeting for the POCP team. There was a keynote highlighting consumer health by Aetna CEO Mark Bertolini and at least three-dozen education sessions focusing on patient engagement themes. A lot of prime real estate on the convention floor was allotted to the Connected Patient Learning Gallery. Vendors showcased the latest and greatest in "patient activation" — patient engagement, health engagement and consumer empowerment. Hospitals are investing heavily in coordination of care, so the exhibits featured many coordination tools (mostly inpatient) for setting expectations for discharge, evaluating readmission risk and monitoring the care plan. These systems were designed for full-time care coordinators. One included measures of consistency between care coordinators in the hospital.

That being said, the devil's still in the details. Although everyone was talking about patient engagement and activation, it was clear there was no common understanding of what these actually mean. The real overarching themes were patient centeredness and enhancing the patient experience. Health care is not just about medications, technology and payment. Getting patients involved and responsible for their own health is just as important as giving them the tools to do so. Both will be imperative to bending the cost curve. In addition, patient satisfaction and quality will become increasingly important as

patients become more engaged in the costs of their care, such as through high-deductible health plans and greater out-of-pocket expenditures. That is why providers will be looking to use technology to quantify their performance along those dimensions and use results to gain market share.

4. **Health information exchanges are in for a bumpy ride.** Health information exchanges (HIEs) are in a somewhat interesting place in their evolution, and this was reinforced in presentations and exhibits at HIMSS 2014. We at POCP would place them in the "trough of disillusionment," as it is called in the Gartner hype cycle. This means that the bloom is off the rose and interest in them is waning because of failed implementations and tenuous business models. Nonetheless, bluer skies could lie ahead. The next phases will involve more widespread understanding of benefits through pilots, later-generation offerings and clearer-cut business models. Then, mainstream adoption should start to take off. We believe this depiction has merit. The key will be for HIEs to weather this rocky period as technologies, sustainability and adoption willpower all bottom out.

5. **What's next after the EHR land grab?** In years past, the health IT market was focused on the EHR land grab, which is winding down. What's next? The answer is: several things. For one, EHR vendors are looking for new sources of revenue. Smarter organizations are shifting from direct sales of EHR licenses toward monetizing the size and breadth of the users of their software. Others are looking to value adds for which clients would be willing to pay, such as on-site resources. Because some partnerships have not necessarily panned out, still others are taking another tack to streamline operations and generate revenue.

Meaningful use (MU) is less of a driving force. Now that the basic requirements of MU have been incorporated into surviving EHRs, MU is becoming "standard equipment" at this point, and interoperability should be ubiquitous in a couple of years, given interest in this at the federal level. Despite rising adoption rates, buyers see the EHR market as confusing and busy. As a result, there needs to be deliberate review of each organization's capabilities, which must by synced with its analytical needs and clinical care goals.

In addition, many early adopters have decisions to make. Dissatisfaction with current EHRs is widespread and it's time for upgrades, anyway. The question is: Should practices "rip and replace" or stick with their current vendor? We saw a presentation from one health system faced with that conundrum. It eventually decided to redouble efforts to configure its existing system with new documentation templates, order sets and triggers. Training was also a big part of this effort. The advantages realized were increased efficiency and quality. Buyers and developers are interested in clinical decision support (CDS). One surprise is that, these days, CDS seems to be a one-off, based on multiple studies and guidelines from competing organizations that were used to arrive at unique, site-specific conclusions.

6. **Technology and population health come together.** As we reported in the last issue of HIT Perspectives, population health is gaining traction everywhere. This was true at HIMSS 2014. Various keynotes and presentations highlighted the importance of population health and how its success depends on a strong health IT infrastructure. The exhibit hall featured numerous vendors debuting new population health management (PHM) tools. The size and scope of such offerings may mark the beginning of a new land grab, if we take to heart the findings from a recent KLAS report. According to KLAS, no single PHM vendor is leading at this point, but a handful are beginning to emerge as early segment leaders. This also signals that using technology to facilitate PHM will be an even bigger theme next year.

7. **Technology will influence success of value-based models.** As mentioned previously, the impact of value-based reimbursement as a driver for change was a prominent theme at HIMSS 2014. Critics have argued that today's flavors of capitation are really not much different than what we experienced in the 1980s. However, numerous speakers at the meeting, including newly named head of the Office of the National Coordinator for Health Information Technology, Karen DeSalvo, MD, pointed out that today's capitated world is different. It depends heavily on technology to understand and successfully manage the moving parts, as well as reduce costs and improve quality and safety. We at POCP are cautiously optimistic that things will be different this time around because of the increasing sophistication and value of health IT. However, technology will need to continue to mature and become embedded in health care's culture and processes before that value can be fully realized.

8. **We're over "Big Data."** Big Data was last year's buzzword but was eclipsed by data analytics at HIMSS 2014. While we're over the term, we're not over the concept. Data analytics was featured prominently in presentations and on the exhibit floor. Again, the devil's in the details. Although there are many providers and payers who would like to share and analyze large data sets, it's easier said than done. The reality is that the majority of providers and payers continue to make progress with "small data." They are focusing on how to create financial, operational and clinical value by analyzing smaller data sets from individual departments or clients. Similarly, CDS tends to be a one-off and site specific. Predictive analytics certainly is a concept whose time has come. The field and supporting technology are rapidly emerging, so maybe there will be an appetite to use them on bigger data sets down the road. Population health will likely be a driver in the near future.

9. **Genomics gains traction.** Genomics is becoming more and more mainstream, as we saw in the exhibit hall. Dell, for example, has developed a technology for speeding up genome sequencing, which will help doctors quickly find the most effective treatments for patients. Allscripts, Lockheed Martin, First Databank and Northrop Grumman were among the vendors talking about integrating genomics into CDS and using data analytics in conjunction with genomics to support better diagnoses and create better outcomes. We expect to see even more next year.

10. **Key stakeholders are missing in action.** Most major health care and health IT stakeholders participate heavily in HIMSS, except for pharmacies, pharmaceutical companies and biotechnology firms. That point was made to us directly at a session in which POCP unveiled its eMedication management model. Building on previous work, the model shows how technology and the health IT infrastructure may be leveraged to improve medication management and care collaboration across health care silos and stakeholders (click here to learn more). One attendee commented that while HIMSS, in general, should be of interest to pharmacies, pharmaceutical companies and biotechnology firms, they don't understand the value of attendance. HIMSS could do more to cater to these constituencies by conducting more presentations relevant to them and keynotes from their leadership. Indeed, HIMSS has an opportunity to reach out to these underrepresented stakeholders and involve them in future programming, which will benefit everyone.

Continue to article two.

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2 What's Next for Meaningful Use?

By Michael Solomon, eCare Management Practice Lead

Meaningful use (MU) is at an interesting place in its evolution — that funny space between the end of stage 2 and the beginning of stage 3. Speculation about its future was rampant at the 2014 annual meeting of the Healthcare Information Management and Systems Society (HIMSS). As nationally recognized experts on health information technology, Point of Care Partners (POCP) has some thoughts about the whys and next steps for MU.

When you think about it, MU stage 2 led several lives. In the beginning, stage 2 was bright with the hope that it would pave the way toward a better future for providers, payers and patients. That shine rapidly began to tarnish, in part because of the scope of the undertaking, the requirements themselves, tight timelines and the inexperience of policy makers, providers and vendors in going boldly where nobody had gone before.

Now we are at the end of stage 2, and the denouement is shaping up like this:

- There is widespread dissatisfaction with electronic health records (EHRs). One in four medical practices using EHRs is thinking about replacing its system, according to a recent survey. Usability issues, lack of capabilities to support value-based care and limited interoperability are fueling this dissatisfaction.

- A large number of vendors are not yet certified for 2014. This is leaving many providers in the lurch because their systems are not up to snuff and they cannot implement MU stage 2. In addition, such providers would be liable for penalties of 2% or more if they do not implement a certified system by July 1. Recognizing that this is a problem, the federal government offered "2014 EHR vendor issues" as a reason for eligible providers and hospitals to apply for a fiscal year 2015 hardship exemption.

- The decline in complete and modular EHRs certified to 2014 standards compared with 2011 certification is an indicator of consolidation that is now taking place in the vendor market. Many vendors do not have the resources to fund the complex development needed to support interoperability, decision support and patient engagement.

- Provider participation varies. Hospitals appear to be in the best shape, with 82% qualifying in November 2013, although we are hearing that many will experience significant delays in qualifying for stage 2. On the other hand, fewer than 80% of ambulatory physicians have registered for attestation and less than 50% have actually qualified. The rest had until the March 31 deadline, so it will be interesting to see the final numbers. If history is any indication, there could be a large number of dropouts. The General Accountability Office (GAO) found that a substantial percentage of providers that participated in 2011 did not participate in 2012. Attestations are increasing (14,000 qualified in January compared with 9,000 in December 2013). However, these are much lower than expected, with monthly numbers being about half of what they were a year ago.

The ultimate success of MU will be influenced by several factors going forward, including stage 3 requirements and new legislation.

Stage 3 requirements. A key driver for the future of MU is the stage 3 requirements themselves. At its March 11 meeting, the Health IT Policy Committee (HITPC) accepted its MU workgroup's draft stage 3 recommendations. The recommendations are being sent to the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology. After digesting them, a notice of proposed rulemaking (NPRM) will be issued this fall by CMS. A final rule is on the radar for 2015.

The recommendations have caused quite a bit of consternation for HITPC members, according to media reports. Some are concerned that the recommendations were scaled back by 30%, with significant setbacks to the strategic goal of improving quality of care and safety, in particular. One troubling choice was the decision to remove a requirement related to medication adherence. (Click here for a deeper dive into this issue.) Excision of such criteria could be attributed, in part, to confusion on the part of stakeholders involved in implementing those objectives (e.g., access of images) or industry resistance to standards (e.g., pharmacy use of fill status to track adherence). Other HITPC participants called for even more pruning, claiming that providers and vendors are already overburdened.

We believe the narrower set of criteria in the stage 3 recommendations is the right approach, especially if the result is more robust certified EHRs to support clinical decision support (CDS) and patient engagement. The HITPC is linking CDS quality measures to the National Quality Forum's national priorities. This gives forward-thinking health care leaders the opportunity to focus on CDS that advances their organizations' patient-centered care model and improved care coordination efforts — critical to success in an accountable care organization. Medication management has a central role in the CDS interventions, with advanced medication-related decision support and more complete medication lists highlighted.

Anyone hoping for relief on the patient engagement front will likely be disappointed. Stage 3 objectives and criteria raise the bar, requiring providers to demonstrate receipt of provider-requested and patient-generated data. This requirement could finally push the envelope on the development of workable models for storing patient-generated data in EHRs.

Our take is that the stage 3 revision process is far from complete; some self-examination and realignment will be necessary. More changes will occur in response to the NPRM. It will be interesting to see how this core set of requirements changes due to stakeholders' concerns, and whether some are dropped and others added in response to the comments received.

New legislation. The latest example of how new legislation would impact MU was the first round of legislation (H.R. 4015/S. 2000), which would have repealed Medicare's sustainable growth rate (SGR) requirements. As per usual with much legislation, a bunch of health IT provisions were tucked inside: a mandate that all EHRs achieve interoperability by 2017, a prohibition for vendors from deliberately blocking information sharing with other EHR vendor products, and creating a reimbursement process for clinical imaging based on appropriate use criteria (read more about the latter in this issue of HIT Perspectives).

In addition, the legislation would have rolled MU into a gigantic new program called the Merit-Based Incentive Payment System (MIPS) in 2017, along with the Physician Quality Reporting System (PQRS) and the Value-Based Modifier (VBM). This would have put most of the federal government's quality-based pay-for-performance requirements in one place, with MIPS being the only Medicare quality reporting program.

Had it materialized, the MIPS implementation would have depended on a strong health IT backbone. Beginning in 2018, MIPS would have provided bonuses ranging from 4% to 9% for physicians who scored well along the dimensions of quality, resource use, MU and clinical practice improvement activities. Quality reporting was anticipated through EHRs or qualified clinical data registries. Participation in a qualified clinical data registry would also have counted as a clinical practice improvement activity.

All of these activities are very far reaching, but will not happen. The proposed bills were supplanted by the Protecting Access to Medicare Act of 2014, which stripped out those health IT provisions. However, given the legislative process, they are likely to reappear in one form or another in subsequent bills. After all, Congress must take another shot at "fixing" the SGR formula issue next year because this year's legislation only staves off SGR-based payment cuts for Medicare physicians until March 2015. (It should be pointed out that this year's temporary SGR "fix" was the 17th such patch Congress enacted since the SGR formula became law in 1997.) Of course, there will be plenty of legislation throughout the rest of the year that could be vehicles for health IT-related provisions.

The Protecting Access to Medicare Act also delayed International Classification of Diseases, 10th edition (ICD-10) implementation for a year. While this temporarily relieves hospitals and physician organizations of the stress of implementing ICD-10 and MU stage 2 requirements in tandem, the delay in ICD-10 implementation signals how things can play out due to delays or abrupt changes in program direction. First, this delay will be expensive. Many organizations have spent considerable time and money to get with the program. Code mapping and crosswalks have been under way for several years. The result: an additional $1 billion to $6.6 billion on top of what has already been incurred due to the previous implementation delays, according to the American Health Information Management Association. There also will be consternation among trading partners — those that have implemented and those that have not. While voluntary trading partner agreements are likely to be the way things play out, it is not beyond the realm of possibility that the government will step in and issue some kind of regulatory guidance, as was with the case with the Health Insurance Portability and Accountability Act. Finally, delaying ICD-10 adds to the uncertainty and complexity of implementing the health IT infrastructure needed to support population health management and value-based reimbursement, which is not a good thing in our opinion.

POCP is closely monitoring developments with MU and on the legislative front. We are working with our clients as they: 1) align their MU compliance strategies with the broader strategic priorities of population health management, clinical integration and quality-based performance monitoring; 2) transform their organizations to succeed in a value-based payment environment. We would be happy to help your organization interpret the MU landscape and its impacts, as well as assist with the development of comment letters when the NPRM is issued in the fall.

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3 Part 3: Reading the Tea Leaves: Prior Authorization for Advanced Imaging Services Is in Our Future

By Michael Burger, Senior Consultant

Legislation is commonly proposed to change provider behavior; for example, as a way to decrease the number of orders for high-cost procedures and improve use of evidenced-based medicine. That is the point of some provisions of the newly enacted Protecting Access to Medicare Act of 2014. It delays the payment cuts that Medicare physicians would have sustained under the sustainable growth rate formula. The fine print also sets up a program that would require prior authorization (PA) for certain advanced imaging services. Reimbursement would be contingent on following certain protocols, with payment penalties for those that have exceeded usage thresholds.

Why is this important to those of us in the health information technology (health IT) business? Because it will ultimately require additional use of electronic health records (EHRs) to accommodate the necessary changes in standards as well as handle data exchange. It is also a harbinger of electronic prior authorization (ePA) for other procedures and devices.

How it would work. In the short term, the law calls for identifying appropriate use criteria (AUCs) — kissing cousins to guidelines, we reckon — for diagnostic imaging, either developed or endorsed by medical specialty societies. Most likely, a federal advisory committee will be set up to recommend which AUCs to use. The AUCs must be identified by November 15, 2015 through rulemaking. Although they are not named, we're guessing that the drafters of the legislation had magnetic resonance imaging and computed tomography and positron emission tomography scans in mind as "certain advanced imaging procedures."

Then, in consultation with stakeholders, the government will identify clinical decision support (CDS) mechanisms that physicians and other will need to consult when ordering advanced imaging services for Medicare patients. The mechanisms may be part of a certified EHR and at least one must be free of charge. At a high level, the CDS mechanism — whether embedded in an EHR or not — must handle the mechanics of showing the AUCs were checked beforehand and documenting the encounter. Then, beginning January 1, 2017, payment will only be made if the claim shows that the ordering professional consulted with a qualified CDS mechanism; the ordered service adheres to the applicable AUC(s) and contains the national provider identifier of the ordering professional. This may be the first time Medicare would require providers to use such point-of-care, evidence-based ordering for exams or procedures, according to the American College of Radiology.

Also beginning in 2017 and in consultation with stakeholders, the Centers for Medicare and Medicaid Services (CMS) will identify "ordering professionals" who are not adhering to a threshold of applicable AUC(s), based on two years of data. These outlier physicians will be subject to PA for applicable imaging services in 2020. What

that means has yet to be defined, which likely will be in regulations down the road. The legislation provides CMS with $5 million in each of 2019, 2020 and 2021 to carry out the PA program.

Impacts. Now we get to the impacts. Like just about all regulatory requirements these days, the time frames are tight. There's not much time to officially get stakeholders together, for regulations to be promulgated, for vendors to build to them, for changes in health information exchanges to be made and for physicians to learn how to make this part of their work flow. Even if the dates are pushed back (which happens with regularity for most programs), a couple of years is not a lot of time to get everything done that needs doing.

Given the lead time required to pass legislation, promulgate regulations and create technical guidelines, vendors may really have to scramble once the certification criteria are established. It must be recognized that this will be hard work for vendors to absorb on top of all the other regulatory requirements, including meaningful use stage 3. (For more details about how stage 3 is shaping up, see the article in this issue of HIT Perspectives.)

PA for procedures and devices currently is a paper/phone/fax-based process that is tedious, time consuming and ripe for automation. To accommodate the program spelled out in the law, changes may be needed to the ASC X12 278 standard. ASC X12 278 is designed and used for PA but it is not widely adopted by providers or payers. Given our experience with PA for medications, an ePA standard for procedures and devices is not beyond the realm of possibility. However it's implemented, this legislation plants the seeds to make broader use of ePA a requirement across the board in the coming years.

To our way of thinking, if PA for high-cost imaging is on the horizon, can its use for other procedures and devices be too far behind, especially once the health IT infrastructure and standards are in place? Point-of-Care Partners is closely monitoring what seems like a complex program to get off the ground. We will be keeping tabs on the many moving parts, which stakeholders end up in the driver's seat and which imaging procedures end up on the firing line. Stay tuned because more ePA is coming your way.