Perspectives and Updates on
Health Care Information Technology

HIT Perspectives Biopharma Insights

About the newsletter

HIT Perspectives Biopharma Insights 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.

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1 Part 1: EHRS Can Expand the Quality and Scope of Physician Practices

By Brian Bamberger, Life Sciences Practice Lead

Electronic health records (EHRs) are a new tool for many physician practices, particularly with regard toward improving the treatment of diabetes, coronary heart disease and other chronic illnesses. EHRs can help physicians and practice staff take the necessary step of identifying at-risk patients for targeting interventions, then following up with various treatments and medication therapies as part of standardized treatment plans following association guidelines. The result: safer and improved quality of care for patients, an expanded scope of practice, potential new sources of revenue and measures of practice quality.

Drivers. The emphasis on using EHRs to identify and treat the chronically ill is a somewhat recent development. It is fueled by the convergence of several drivers:

- **Rise of chronic illness.** More than 133 million Americans currently live with a chronic condition. The incidence of chronic illness is accelerating as Baby Boomers age and younger generations become more sedentary and have unhealthy diets. Chronic illness is a major driver of health care costs. For example, 86% of all health care spending in 2010 was for people with at least one chronic medical condition. The total estimated cost of diagnosed diabetes in 2012 was $245 billion, including $176 billion in direct medical costs and $69 billion in decreased productivity.

- **Costs of specialty medications.** A related driver is the skyrocketing costs and use of specialty medications, which are used to treat chronic illnesses. Specialty medication outlays are expected to quadruple to $402 billion by 2020, and account for 50% of overall drug costs by 2018 for commercially insured individuals. These drugs are expensive, with costs per month generally ranging from $2,500 to $50,000 per patient. Eight of the 10 highest revenue drugs in 2016 will be specialty medications. Moreover, the cost curve continues to climb as new blockbuster therapies come to market.

- **Registries.** Disease or patient registries are collections of secondary data related to patients with a specific diagnosis, condition or procedure. Their use and content are expanding exponentially. Coupled with use of EHRs, registries are powerful tools that help physicians — especially in small family and internal medicine practices — track and manage chronic diseases within their patient panels. Registries can also play an important role in postmarketing surveillance of pharmaceuticals.

- **Meaningful use (MU).** MU is one of a number of public and private payer mandates that require physicians to use EHRs to achieve improvements in quality, safety and decision support for such high-priority national health status problems as obesity and diabetes. It also requires physicians to increasingly engage patients in their own health care.

- **Quality reporting and evaluation.** EHRs can be used to track clinical patient

data across a wide range of conditions and help physicians measure and report quality indicators against various payer and government requirements.

- **New payment models.** The world is slowly but surely changing from fee-for-service reimbursement to payment models based on pay for performance, quality and value-based based care. All of these link physicians' financial health more closely to the health of their patients.

How it works. Providers having electronic health information about their patients can more quickly and easily identify those who suffer from specific conditions. Because EHRs link to patients' insurance information and medication histories, the physician can identify which patients are appropriate and eligible for specific preventive and treatment measures for their individual conditions as well as all medications they are currently taking — or not. For example, providers might use EHRs to:

- Identify which hypertensive patients have their blood pressure under control, the medications they are taking and their adherence to drug therapies.
- Determine how many diabetics have their A1C in the appropriate range and have received screening and counseling.
- Identify patients for whom disease-specific education is appropriate. This includes third-party educational materials that can be provided via the EHR and a partnership by pharmaceutical companies.
- See which patients may be eligible for new drug therapies and have abandoned previous therapies.

Similarly, EHRs can help providers work with patients to manage specific risk factors or combinations of risk factors to improve patient outcomes — yet another metric used for quality and reimbursement purposes by Medicare and private payers.

Impacts. It is clear that use of EHRs can help physician practices improve the quality and safety of patient care. Doing so may help expand their scope by identifying and performing the various expanded services associated with chronic diseases, such as office visits, monitoring, vaccinations, counseling and patient education. This, in turn, directly relates to practice revenue streams. In short, EHRs are a required tool for physicians, and all new treatments or treatment changes need to be integrated into EHR work flows. While many physicians are not excited about this, they will grow to understand how EHRs create clinical value as opportunities for expanded services and reimbursement for physician practices increase.

2 Part 2: Physicians' Health IT Priorities to Focus on ICD-10 and Meaningful Use

By Michael Burger, Senior Consultant

For at least the next year or so, physician practices will be concentrating on two major initiatives involving health information technology (health IT): adoption of International Classification of Diseases, 10th Revision (ICD-10) coding for diagnoses and continued compliance with meaningful use (MU), the government's health IT incentive mandate.

Implementation of ICD-10 ranks among the top 10 issues for physicians to watch in 2015, according to a list published by the American Medical Association (AMA). For physician practices, the change to the new ICD-10 code set has proven to be one of the most complex and expensive undertakings in many years. The AMA's list also notes that myriad regulatory requirements, which take time away from patient care, are among physicians' greatest frustrations. That consternation will be heightened when practices will have to comply with the newly released MU regulations for stages 2 and 3.

ICD-10 transition. ICD-10 finally went live on October 1st, after nearly a decade of prompting by the federal government and certain standards organizations. Provider groups fought hard to delay its implementation and were successful. But now the time of reckoning has arrived, creating a great deal of pent-up anxiety.

Its overall introduction went fairly smoothly from a technology point of view. Health IT vendors have been prepared for the conversion for a long time. So have practice management system vendors, which, among other business operations, convert medical data within an electronic health record (EHR) into billing information for insurers. The government was confident things would go well, even as far back as a year ago, when more than 500 providers, suppliers, billing companies and clearinghouses participated in a test week. Almost 13,700 Medicare fee-for-service test claims were submitted, with 76% being accepted. That said, we can gauge how well ICD-10 implementation is working if and when there is a tsunami of denied claims in the next few months.

Now the devil's in the implementation details in the back office. While many physician office staff received training, using ICD-10 is easier said than done. The transition involves going from the 13,000 codes associated with ICD-9 to the 68,000 codes in the latest version of ICD-10. The ICD-9 code set was unable to keep pace with the myriad innovations in medical care, such as the discovery of many new conditions, the development of new treatments and the introduction of many new types of medical devices. More importantly, it ran out of space in many key parts of its hierarchical database, rendering it increasingly unusable. The ICD-10 code set is far more granular in describing the current practice of medicine and has the flexibility to adapt with change. It also has been in use by the international community for many years.

Vendors are offering to help practices code to ICD-10 for their claims and tools in order to help smooth the conversion, which makes sense because coding affects the revenue streams of physician practices. Incorrect coding translates to lost or delayed

reimbursements as well as delays in patient care.

Moreover, the physician office personnel need to fight through the learning curve on the business side of the equation. Getting up to speed with ICD-10 could delay bill processing. According to some estimates, accounts receivable could run from the usual 45-55 days to 55-75 days, depending on the staff's readiness and how quickly they can adapt. Smaller practices, in particular, have a "pay as we go" policy and lack large cash reserves, so the ICD-10 transition may create financial challenges if they aren't vigilant.

Needless to say, the transition to ICD-10 will continue to be a concern of physician practices for the next couple of years.

Meaningful use. Despite major pushback from physician organizations and Congressional concerns, MU stage 3 is set to be optional in 2017 and start on January 1, 2018. Providers have said it before and they'll say it again: this is too much, too soon. There is a lot of merit in that concern. Although the vast majority of providers are now using EHRs, more than 60% of hospitals and about 90% of physicians have yet to attest to MU stage 2.

There is a silver lining for providers. According to the government, the MU3 final rule adopts flexible reporting periods that are aligned with other programs, which ostensibly reduces burden on providers. For example, MU3 will move from fiscal year to calendar year reporting for all providers beginning with 2015 reports. Reporting periods also will change, with a 90-day reporting period in 2015 for all providers, for new participants in 2016 and 2017, and for any provider moving to stage 3 in 2017. However, providers are left with barely 90 days to attest for the 2014 reporting period, which doubtless will lead to confusion and consternation.

In the end, all this might be too much for many providers. They face a lack of readiness for stage 2, the end of the MU incentive money, and the perceived moving target of MU3 requirements. Also, the full details of MU stage 2 have just been finalized, leaving providers scrambling to comply. All this is likely to convince more providers to abandon MU in the near term, take any payment hits that might be entailed and hope things will get better in 2019, when the provisions kick in for the Medicare Access and CHIP Reauthorization Act of 2015 or MACRA.

MACRA. Speaking of MACRA, physicians will have to start addressing the next big MACRA-created program that replaces MU. MACRA sunsets MU, as we know and love it, at the end of 2018 and rolls it up with the Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VBPM) into one big reporting system at the beginning of 2019. The result: MU will be transformed from a stand-alone program to a component of a larger reporting system called the Merit-Based Incentive Payment Systems (MIPS) program, which will affect everyone for the next 10-12 years out. The Centers for Medicare and Medicaid Services (CMS) expects to issue a proposed rule regarding MIPS in the spring of 2016, which most likely will tie MU to physician payment. That is because MACRA originated as legislation to "fix" Medicare physician payment mechanisms and the other two programs in MIPS are tied to physician payment. We assume the goal is to link MU functionality and physician payment, which is the only thing that makes policy sense in creating a gigantic new reporting system. Will MIPS be an improvement in the sense that consolidating the three major programs will make things easier to coordinate or will it be too unwieldy? The government has asked for comments on how best to coordinate MACRA with MU3, so it will be interesting to see what stakeholders think and how CMS reacts. Anyone up for more rounds of rules making and new requirements? Anyone?

3 Part 3: Why Care About the EHR Interoperability Brouhaha?

By Brian Bamberger, Life Sciences Practice Lead

Do electronic health records (EHRs) talk to each other? Are they sufficiently interoperable? It depends on whom you ask. Providers and EHR vendors have different perspectives, and they have been pitted against each other in the press and on Capitol Hill over the dimensions of the issue. So, why should pharmaceutical manufacturers care? It all comes down to sharing patient-related data to improve the patient experience, quality of care and build data sets that can assist research.

The issue of EHR interoperability has been brewing for some time. It came to the forefront last April, when the federal Office of the National Coordinator for Health Information Technology (ONC) released a report finding some health information technology (health IT) vendors and health care providers are intentionally blocking the sharing of patient information. Sharply critical of EHR vendors, the report alleges that certain vendors create a climate ripe for information blocking through business practices and pricing. Lately, the issue seems to have taken on a life of its own.

We have a two-part take on the topic. The first part is that EHRs are interoperable. Their ability to "talk" to each other in a standardized way has increased significantly in recent years as a result of the EHR certification requirements within meaningful use (MU), the government's incentive mandate. In order to be eligible for incentives, physicians must use EHRs that are MU certified. The technical infrastructure needed for health data exchange also has expanded and improved. That said, could interoperability be better? Of course, and it continues to be a work in progress with new technologies, such as Fast Healthcare Interoperability Resources (FHIR), being adopted. In fact, a group of 12 major EHR vendors has agreed to adopt a set of metrics and engage in ongoing reporting to help assess the country's progress toward achieving interoperability.

According to a recent report from KLAS, physicians overwhelmingly report their vendors to be willing to help them share information. There is a pervasive perception, however, that vendors' business and revenue models interfere with data sharing. Physicians chafe at the reality that interoperability requires software licenses and connectivity fees to the health information exchange offering. But license and technical support fees are legitimate — and legal — ways in which vendors stay in business; they are not designed for the blocking of information. Sensitive to the issue, vendors are revisiting related revenue models to design a price structure that does not make interoperability cost prohibitive.

What about the providers? Again, it all comes down to business models and revenue. The KLAS report confirms what we've known all along: integrated delivery networks (IDNs) and physicians have been reluctant to share patient records with rival providers in order to control referrals, enhance market dominance and keep reimbursements within their own organizations. As the transition occurs from fee-for-service to quality-based reimbursement, business reasons will emerge for providers to share patient data — more informed diagnoses, improved

care coordination, better outcomes, reduced costs and elimination of duplicative testing. But in the meantime, IDNs and physicians will be reluctant to share patient data.

Why should pharmaceutical manufacturers care about data blocking? Or put another way, why should pharmaceutical manufacturers care about providers refusing to share patient data? Again, it all comes down to business models and revenues. Sharing patient data will make coordination of care between primary care providers and specialists easier. Exchanging information connects the health care system for the benefit of patients by reducing repeated questions and duplicative tests. Research entities will also benefit by having more complete data to power medical advances easier and ultimately save lives by helping researchers investigate drug-related side effects or the effectiveness of new treatments on patients. Sharing patient information will also aid in personalizing medicine, using genomes and biologics, as well as help providers connect patients with new therapies and clinical trials.

All of this has a direct impact on how pharmaceutical companies do business. Point-of-Care Partners is closely monitoring the information blocking issue. Let us keep you up-do-date on developments and impacts.