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Industry Integration, HEDIS and the Rule Making Process

March 21, 2019

Agenda

- Integration in Healthcare
- HEDIS : Health Plan Perspective
- Rulemaking Process – The CMS and ONC Proposed Rules

In the news

With aligned incentives, complimentary data sets, and combined assets these kind of alliances are redefining roles and disrupting market dynamics[1]

[1]The Advisory Board

Trends

- Eighty-four percent of Fortune 50 companies are involved with healthcare
- Venture capital funding for digital health startups is projected to top $6.9 billion in 2018, an increase of 230% from five years ago
- American consumers are eager to embrace more convenient, digitally enabled and affordable care
- Private equity firms closed 487 healthcare deals in the first three quarters of 2018. That number is projected to hit nearly 750 in 2019[1]

"The number of physicians employed by hospitals and health systems grew by nearly 50% from 2012 to 2015, with a corresponding decline in the number of independently practicing physicians"[2]

"The health care sector is actively experimenting with increasingly integrated care delivery models. Rather than remaining a loosely linked set of health care services, the sector is realigning and restructuring itself strategically to deliver seamless end-to-end patient care"[3]

"Organizations have to be willing to step outside of their comfort zone. If they don't, they will miss opportunities and fall behind," "Whether you are a hospital, health system or private-equity firm, you need to find ways where you can add value."[4]

[1]PWC
[2]Avalere Care
[3]E&Y
[4]John D'Andrea, Drinker Biddle

Integration in Healthcare

The ACA created economic pressure for both providers and health plans

- With the continued consolidation amongst health plans, two thirds of the market is now served by just 10 health plans
- Beyond merger and acquisition activity, health plans are also developing strategic partnerships to achieve the benefits of consolidation and greater economies of scale

Entities outside of healthcare see opportunities for expansion and revenue growth

Vertical Integration

Expanding services up and down the continuum of care

Horizontal Integration

Increasing and integrating points of care

Health Plan Strategies

Strategies will be dictated by

- The consumer-driven marketplace and digital health tools
- Expanded virtual care services
- Increased emphasis on value based care

OLIVER WYMAN

Three major business model archetypes for payers to consider

	Skinny and Simple	Value Experience	Healthcare Partner
Value Vision	*Low cost, simple health insurance*	*Superior experience from high value, preferred providers*	*Trusted advisor to help you navigate & make better choices*
Solution Design	• Narrow network, high deductible, operational excellence	• Alternative product focused on care and experience • Partnered or owned assets	• Healthcare service model • Advice and access
Price Advantage	• ~10%, Highly certain	• 10%, up to 20%+ long term • Varied certainty unless full risk	• 10%, up to 20%+ long term
Experience Potential	• Moderate to low	• Med-High, but variable	• High, and unique
Strategic Control	• Low • Relatively easy to replicate • Provider consolidation threatens	• Low-High (varies by exclusivity) • Brand value accrues to partner, vs. Payer	• High • "Own" consumer influence, network becomes "irrelevant"
To Consider	• **Short-term must-do** • **Major scale to sustain** • **Local vs. absolute scale?**	• **Partner or own assets?** • **Avoid commoditizing** • **Challenge of scaling**	• **Major change in business** • **Layer with other strategies** • **Scale vs. investment?**

Source: Oliver Wyman analysis
www.oliverwyman.com

Implications for Patient Care

- The PBM consolidations may improve efficiencies and lower drug costs for consumers
- Studies have shown quality does not improve when markets become more consolidated
- Premiums tend to increase significantly following health plan mergers
- Consumer choice becomes more limited e.g., if you like your physician keep him/her……not so much

Implications for Providers

- Lose power of negotiation
- Larger patient panels = less time to spend with patients
- Do more get paid less
- Providers have data health plans need
- System implications
  - Upgrades needed ?

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HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS®)

- NCQA collects HEDIS data from health plans, health care organizations and government agencies
- 190 million people are enrolled in plans that report HEDIS results
- 90 HEDIS measures are divided into six "domains of care":
  - Effectiveness of Care
  - Access/Availability of Care
  - Experience of Care
  - Utilization and Relative Resource Use
  - Health Plan Descriptive Information
  - Measures Collected Using Electronic Clinical Data Systems
- Designed to allow consumers to compare health plan performance to other plans on an “apples-to-apples” basis

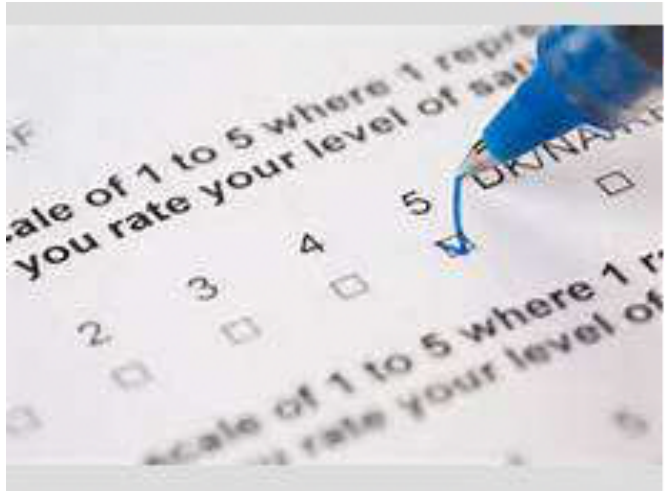
Why is HEDIS® Important to the Provider?

- A tool for providers to ensure timely and appropriate care for their patients
- HEDIS® assists providers in identifying and eliminating gaps in care for the patients assigned to their panel
- As HEDIS® rates increase, there is potential for providers to earn maximum or additional revenue through the Pay for Quality, Value Based Services, and other pay-for-performance models
- Measure rates can be used as a tool to monitor compliance with incentive programs

How is Data Collected for HEDIS®?

Three sources:

- Administrative
- Hybrid
- Survey of Member Experience

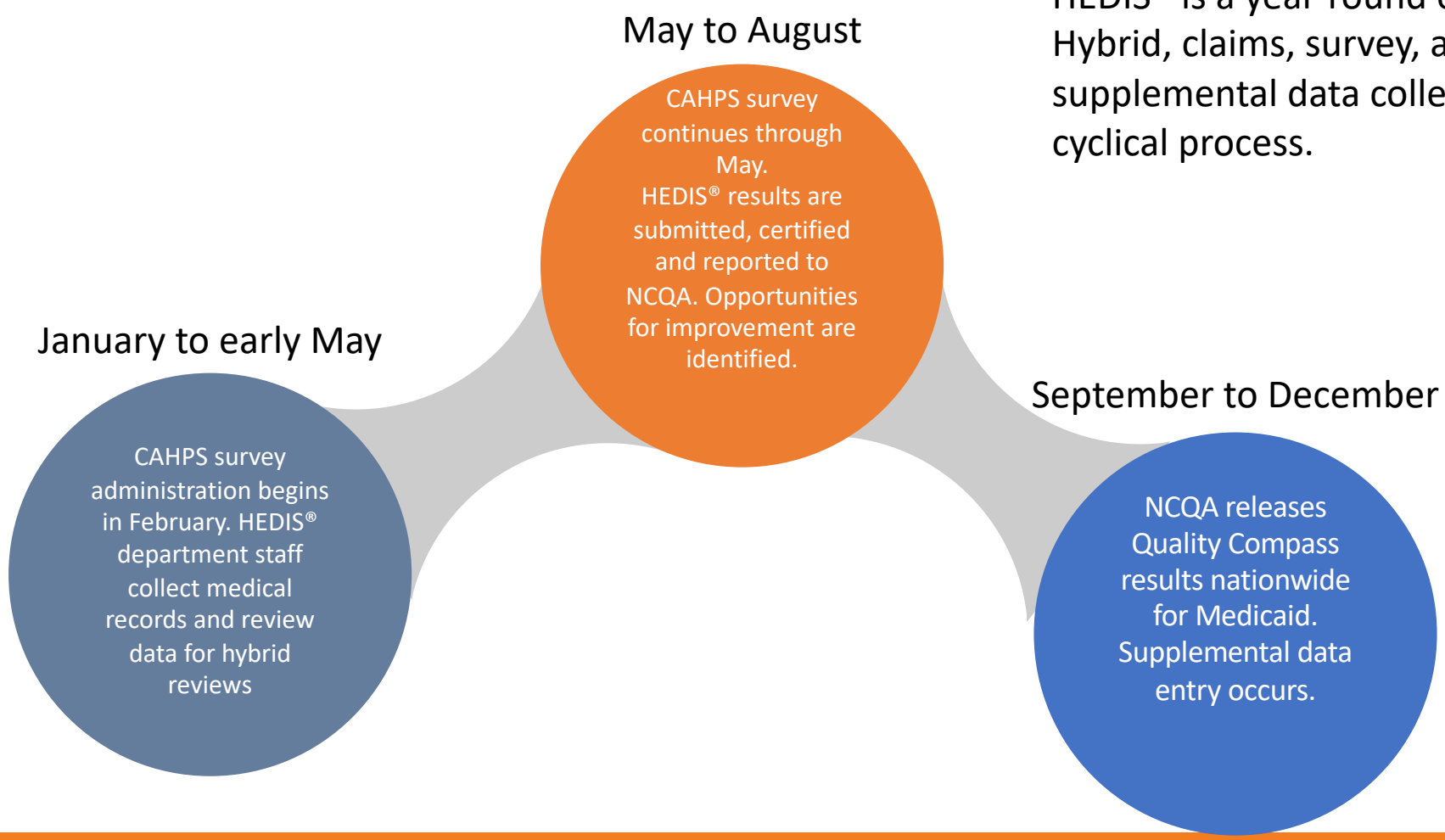


How is Data Collected for HEDIS® Reporting?

- **Administrative measures** use **claims/encounters** for hospitalizations, medical office visits and procedures or pharmacy data
- **Hybrid** measures combine data obtained from the **member's medical record** with administrative data
- **Survey** measures compile data collected directly from members via the CAHPS survey
- The ultimate goal is for providers to submit claims/encounters with coding that administratively captures all required HEDIS® data via claims
- This decreases or removes the need for medical record (hybrid) review

HEDIS® Annual Timeline

HEDIS® is a year-round effort. Hybrid, claims, survey, and supplemental data collection is a cyclical process.



HIPAA and HEDIS®

- Under the HIPAA Privacy Rule, release of information for the purpose of HEDIS® data collection is permitted and does not require patient consent or authorization
- Disclosure is permitted as part of quality assessment and improvement activities
- Member PHI that collected by health plans is maintained in accordance with all federal and state laws
- HEDIS® data is reported collectively
  - Rates represent aggregate data
  - No individual identifiers are included

What is the Provider's Role in HEDIS®?

- Provide appropriate care within the designated timeframes
- Document clearly and accurately in the medical record **all** of the patient care you provide
- Accurately code all claims
- Know your HEDIS® measures documentation requirements and specific parameters
- Respond to health plan requests for medical records within 5 – 7 days

How Can Providers Improve HEDIS® Scores?

- Be sure you are coding correctly for all the services you provide
- Use CPT II billing codes to help increase scores for BMI's, BMI percentiles, labs, etc.
- Conduct and bill a well visit with a sick visit for a member who has not had his/her annual physical
- Expand a basic sports physical, especially for adolescents, to include education and anticipatory guidance. Including these components will increase the Adolescent Well Visit and Well child rates
- Contact patients who are delinquent in needed care and schedule services
- Be sure that follow-up instructions are clear and documented in the medical record (e.g., for future appointments and what to do)
- Schedule the next appointment before the patient leaves the office
- Collaborate with the health plan on programs and interventions

CAHPs Survey – A Component of HEDIS®

Member Satisfaction Survey - A Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey is also a part of HEDIS®

The CAHPS survey includes questions about access to care and care delivery over the last 6 months. Patients' experience with their provider is a main focus in this survey. Here are a few examples of the survey questions:

- When you needed care right away, how often did you get care as soon as you needed?
- How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
- On a scale of 0 -10 where 0 is worst and 10 is best, what number would you use to rate your personal doctor?
- How often did your personal doctor listen to you and show you respect?

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Rulemaking

The Rulemaking Process

How does an agency decide to begin rulemaking?

- Congress may pass a law that directs an agency to take action on a certain subject and set a schedule for the agency to follow in issuing rules
- More often, an agency surveys its area of legal responsibility, and then decides which issues or goals have priority for rulemaking

What is the role of the President in developing a proposed rule?

- Before a proposed rule is published in the Federal Register for public comment, the President, as head of the Executive branch, may take the opportunity to review the rule
- The Office of Information & Regulatory Affairs (OIRA), which analyzes draft proposed rules when they are significant due to economic effects or because they raise important policy issues Assist the President

When can the public learn that an agency plans to start a rulemaking?

- Agencies are required to publish a Regulatory Plan once a year in the Fall and an Agenda of Regulatory and Deregulatory Actions in the Spring and Fall
- The Regulatory Plan and the Regulatory Agenda are often referred to as the Unified Agenda
- The Unified Agenda is how agencies announce future rulemaking activities update the public on pending and completed regulatory actions

How does an agency involve the public in developing a proposed rule?

- An agency may take some preliminary steps before issuing a proposed rule. They gather information through unstructured processes and informal conversations with people and organizations interested in the issues
- An agency that is in the preliminary stages of rulemaking may publish an “Advance Notice of Proposed Rulemaking” in the Federal Register to get more information

The Rulemaking Process

Before the Proposed Rule

•Agencies get their authority to issue regulations from laws (statutes) enacted by Congress.
•Agencies must follow an open public process when they issue regulations, according to the Administrative Procedure Act (APA). This includes publishing a statement of rulemaking authority in the Federal Register for all proposed and final rules.

The Proposed Rule

•The proposed rule, or Notice of Proposed Rulemaking (NPRM), is the official document that announces and explains the agency's plan to address a problem or accomplish a goal. All proposed rules must be published in the Federal Register to notify the public and to give them an opportunity to submit comments. The proposed rule and the public comments received on it form the basis of the final rule
•A proposed rule begins with a Summary of the issues and actions under consideration. It also states why the rule is necessary. The agency invites everyone to comment on the proposed rule, sets a date for comments to be submitted, and specifies various methods for conveying comments.

Before the Final Rule

•To move forward with a final rule, the agency must conclude that its proposed solution will help accomplish the goals or solve the problems identified. It must also consider whether alternate solutions would be more effective or cost less.
•If the rulemaking record contains persuasive new data or policy arguments, or poses difficult questions or criticisms, the agency may decide to terminate the rulemaking
•The agency may decide to continue the rulemaking but change aspects of the rule to reflect these new issues
•If the changes are major, the agency may publish a supplemental proposed rule

The Final Rule

•The final rule published in the Federal Register begins with a Summary of the societal problems and regulatory goals and explains why the rule is necessary.
•Every final rule must have an Effective Date. However, any portions that are subject to later approval under the Paperwork Reduction Act or are subject to Congressional approval may be excepted from that effective date.
•The agency must state the basis and purpose of the rule. This statement sets out the goals or problems the rule addresses, describes the facts and data the agency relies on, responds to major criticisms in the proposed rule comments, and explains why the agency did not choose other alternatives.
•The agency must identify its legal authority for issuing the rule and publish the regulatory text in full.

After the Final Rule

•Agencies must publish the changes to the Code of Federal Regulations (CFR) in the final rule, instructing how amendments add, revise, remove, or re-designate regulatory text.
•The regulatory process enters the compliance, interpretation, and review phase after a final rule is published.

Key Takeaways from Proposed Rules

The CMS Proposed Rule

- Patient Access and Information Flow through APIs
- Restricting “Information Blocking” Practices
- Increased Adoption and Use of Health Information Networks (HIEs)

The ONC Proposed Rule

- Common API Criteria and Standards to Improve Access
- More on Information Blocking

THE ONC HEALTH IT CERTIFICATION PROGRAM PROPOSED RULE

What is the proposed rule designed to do?

- Increase innovation and competition by giving patients and their healthcare providers safe and secure access to health information and to new tools, allowing for more choice in care and treatment
- Identify exceptions to the definition of information blocking that the HHS Office of the Inspector General (OIG) would consider in their enforcement of the information blocking provisions in the 21st Century Cures Act (Cures Act)
- Adopt standardized application programming interfaces (APIs) in the healthcare industry which would help allow individuals to securely and easily access structured EHI using smartphone applications
- Place a strong focus on a patient's ability to access their health information through a provision requiring that patients can electronically access all of their electronic health information (structured and/or unstructured) at no cost

What actions are being proposed?

- The proposed rule would update the existing 2015 Edition certification criteria to ensure certified health IT systems can (1) send and receive EHI in a structured format, (2) make that EHI available without special effort through the use of APIs, and (3) export a single patient's or multiple patients' EHI from the health IT system to a location designated by the patient
- The proposed rule would implement the information blocking provisions of the Cures Act by outlining seven proposed exceptions to the definition of information blocking under the law
- The proposed rule includes a request for information on the parameters and implications of including price information within the scope of EHI and if that information would help the public see the prices they are paying for their healthcare

Publicizing the Price of Healthcare

- ONC has a unique role in setting the stage for such future actions by establishing the framework to prevent the blocking of price information. Given that price information impacts the ability of patients to shop for and make decisions about their care, we seek comment on the parameters and implications of including price information within the scope of EHI for purposes of information blocking
  - Reflect the amount to be charged to and paid for by the patient's health plan (if the patient is insured) and the amount to be charged to and collected from the patient (as permitted by the provider's agreement with the patient's health plan), including for drugs or medical devices;
  - Include various pricing information such as charge master price, negotiated prices, pricing based on CPT codes or DRGs, bundled prices, and price to payer;
  - Be reasonably available in advance and at the point of sale;
  - Reflect all out-of-pocket costs such as deductibles, copayments and coinsurance (for insured patients); and/or Include a reference price as a comparison tool such as the Medicare rate and, if so, what is the most meaningful reference?
  - Should price information be made available on public web sites so that patients can shop for care without having to contact individual providers, and if so, who should be responsible for posting such information?

ONC Proposed Rule pages 346-350

THE CMS PROPOSED RULE

What is the proposed rule designed to do?

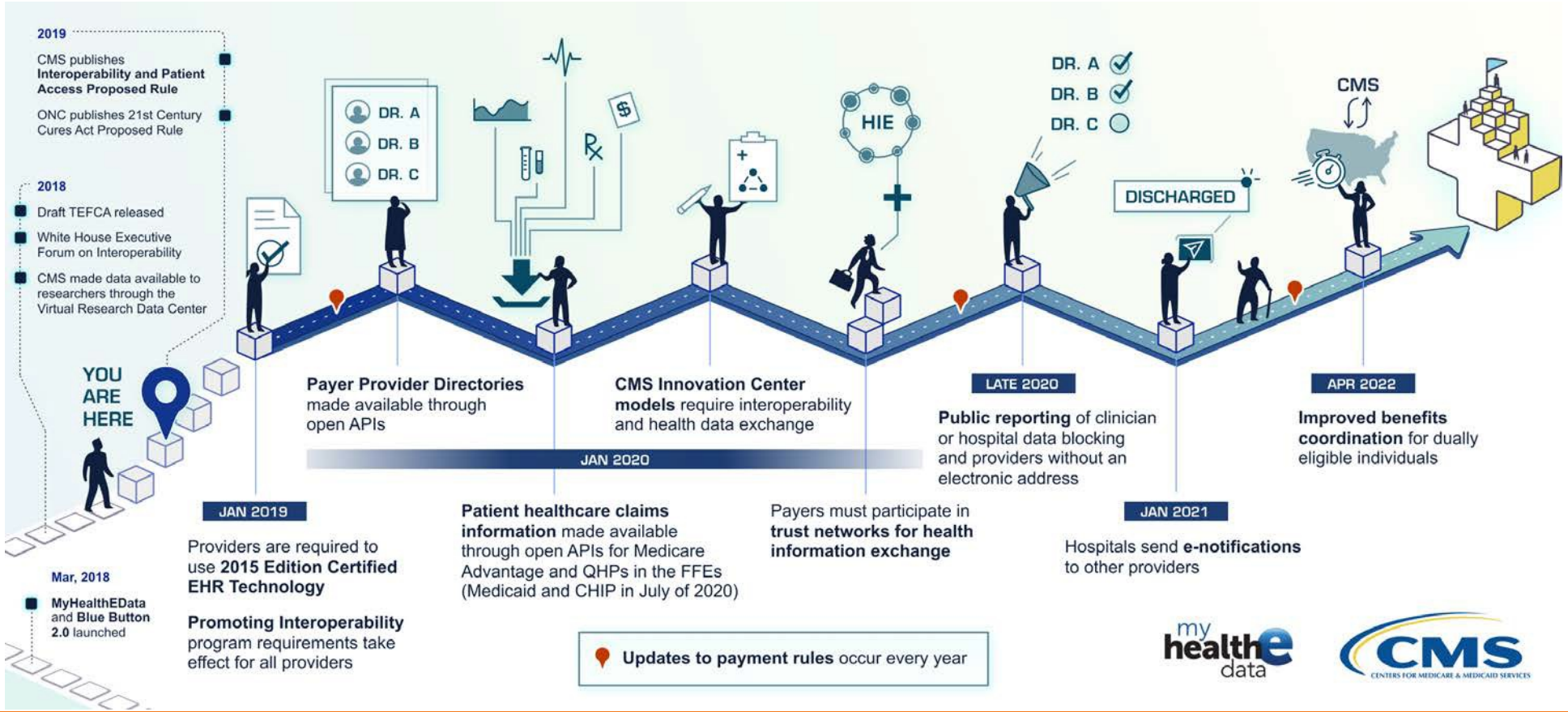
- Strives for greater interoperability in the health care industry by requiring that all governmental health plans as well as all health plans offered through the federal Affordable Care Act (Covered Plans) provide patients with free control of, and increased access to, their HIPAA protected health information (PHI).
- Among other things, the CMS rule would require Covered Plans to implement, test, monitor, and maintain PHI APIs to:
    - Make patient claims and other PHI available to patients through third-party applications and developers
    - Simplify and increase the ease and access for patients to transition between insurance plans and providers by facilitating the flow of PHI.

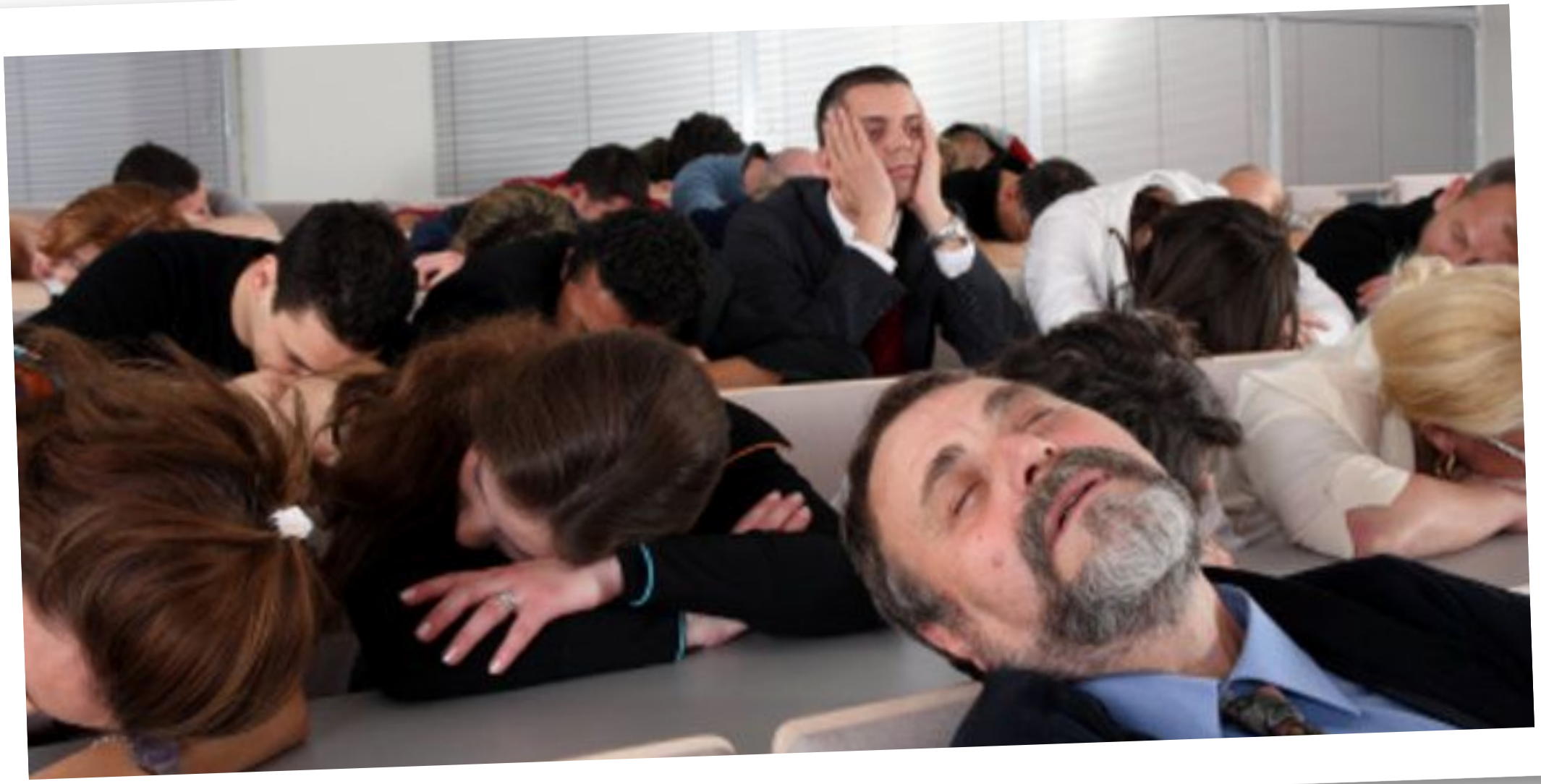
What actions are being proposed?

- Issuers of these Covered Plans would have until 2020 to comply with the proposed rule, should it go into effect.
- CMS would publicly post information about health care organizations that submit information indicating the engagement in some form of information blocking. The reporting would apply to clinicians under the Merit-based Incentive Payment System (MIPS), hospitals participating in Medicare and/or Medicaid, and critical access hospitals in rural areas serving residents otherwise far from emergency care.
- The rule would incentivize payers to join any health information network they choose and be able to participate in regional and nationwide exchange of data. Certain CMS qualified plans would be required to participate in trust networks to improve interoperability

The proposed rule would lay the foundation for healthcare interoperability

How might we get there?





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Questions?

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