Reducing Provider Burden
HL7 ® Da Vinci Project

HIMSS19 Interoperability Showcase

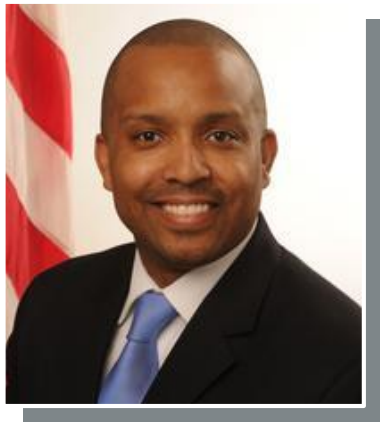
February 13, 2019

Panelists

Melanie Combs-Dyer

Director, Provider Compliance Group, Center for Program Integrity, CMS

Da Vinci Steering Committee



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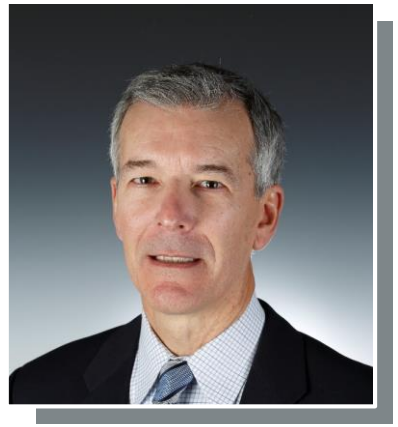


Mike Funk

Vice President, Office of the Chief Medical Officer, Humana, Da Vinci Steering Committee

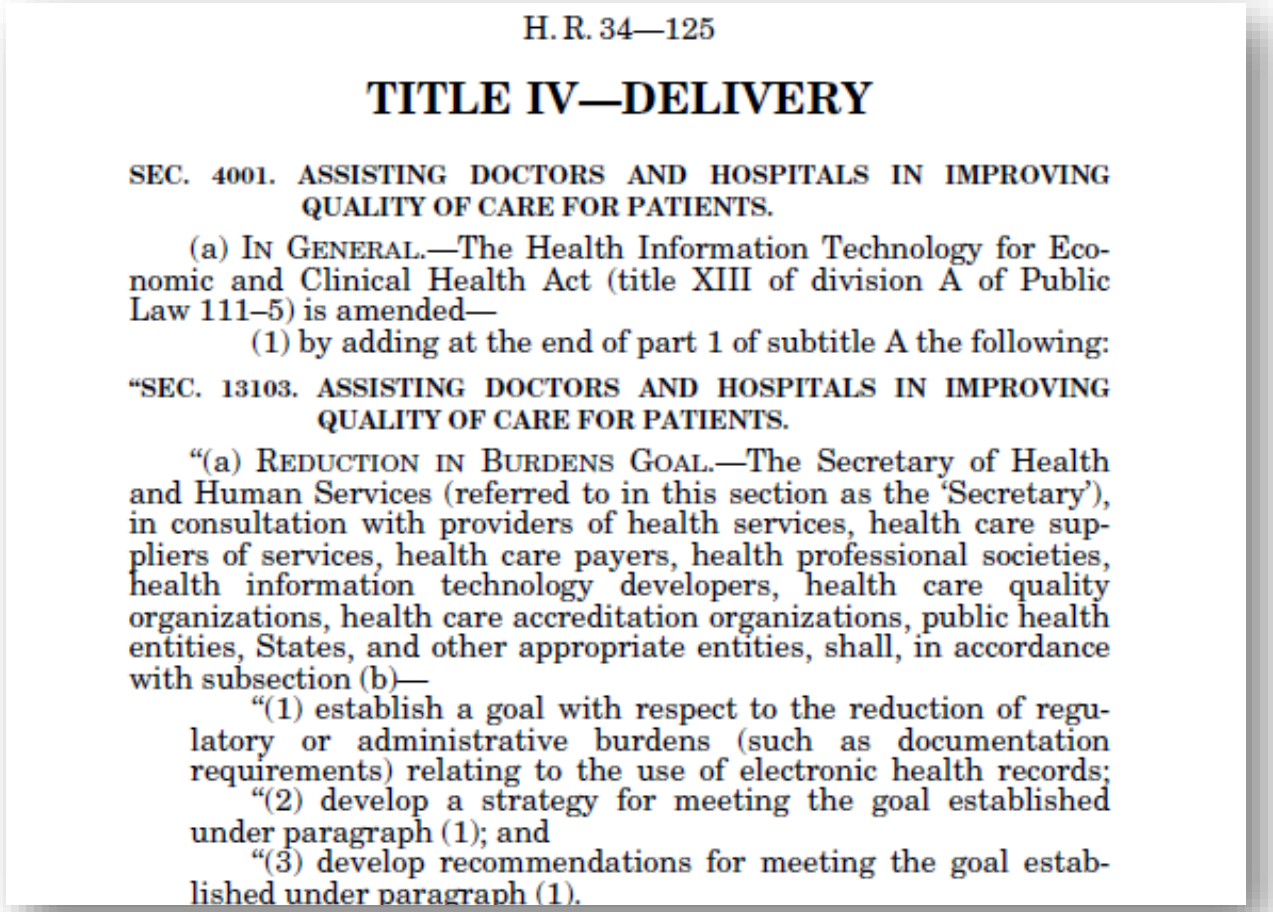
The Office of the National Coordinator for Health Information Technology

Unlocking Payer Data to Reduce Payer and Provider Burden – HIMSS 19 Panel Discussion

21st Century Cures Act: 4001(a) HHS Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Thomas Mason, M.D.
ONC Chief Medical Officer

21st Century Cures Act 4001 (a) – Reduce Clinician Burden



H. R. 34—125

TITLE IV—DELIVERY

SEC. 4001. ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.

(a) IN GENERAL.—The Health Information Technology for Economic and Clinical Health Act (title XIII of division A of Public Law 111–5) is amended—

(1) by adding at the end of part 1 of subtitle A the following:

"SEC. 13103. ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.

"(a) REDUCTION IN BURDENS GOAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary'), in consultation with providers of health services, health care suppliers of services, health care payers, health professional societies, health information technology developers, health care quality organizations, health care accreditation organizations, public health entities, States, and other appropriate entities, shall, in accordance with subsection (b)—

"(1) establish a goal with respect to the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records;

"(2) develop a strategy for meeting the goal established under paragraph (1); and

"(3) develop recommendations for meeting the goal established under paragraph (1).

21st Century Cures Act - Section 4001 (a)
Clinician Burden Reduction Report

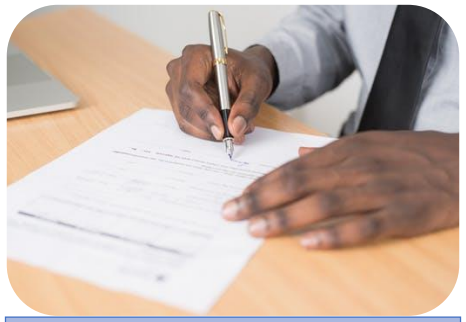
HHS Charge:

- *Establish a goal for burden reduction*
- *Develop strategies to support the goal*
- *Make recommendations to drive the strategies*

CMS and ONC collaborated to gain stakeholder feedback

Chief burdens reported by stakeholders

Billing-related documentation "note bloat"



Prior authorization

Quality measurement

Poor user experience with health IT and clinical workflow

Too much time outside of patient care spent on electronic records

PDMPs poorly integrated into EHRs

Strategies to Reduce Clinician Burden

Health IT Usability and the User Experience

EHR Reporting

Public Health Reporting

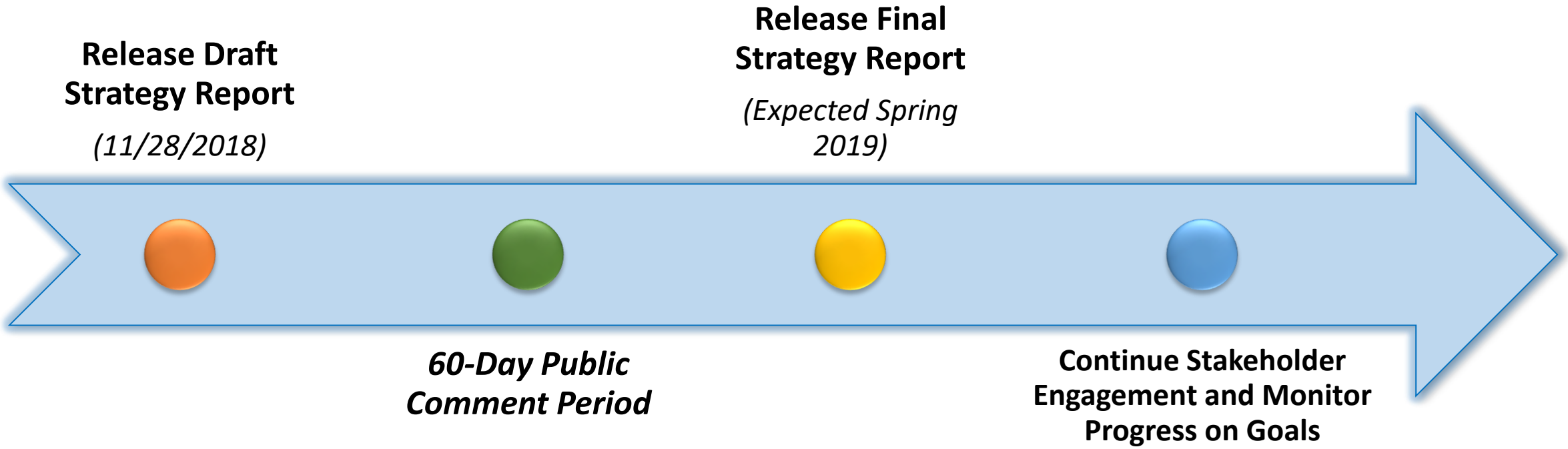
Clinical Documentation

Strategies to Reduce Clinician Burden

Clinical Documentation

- Reduce regulatory burden around documentation requirements for patient visits.
- Clinician partnership - documentation best practices.
- Reduce documentation burden tied to prior authorization.

Anticipated Timeline for Clinical Burden Reduction Strategy



Provider Perspective

Steven Lane, MD

Providers want/need data from payers for

- Treatment
  - Performed by other providers, including @ the payer
    - What **conditions** have been diagnosed/treated
    - What **services** have been provided – Labs, imaging, procedures, other health maintenance
    - What **medications** have been prescribed, filled
    - **Clinical data** - notes, results, vitals, etc. for incorporation into local records / databases
- Healthcare Operations
  - Risk adjustment – Optimize HCC coding
  - Quality reporting – Optimize HEDIS reporting; avoid unnecessary outreach/testing
  - Population health analytics
  - Population risk assessment for contracting
- Payment
  - Benefits determination
  - Prior authorization, including coverage requirements

Payers want/need data from providers for

- Treatment (“Healthcare Operations” under HIPAA when done by payers)
  - Care management – acute and chronic
  - Care coordination – identifying and closing care gaps
- Healthcare Operations
  - Benefits determination
  - Prior authorization
  - Quality reporting e.g., HEDIS
- Payment:
  - Risk adjustment – HCC coding
  - Claims adjudication
- Other:
  - Provider contracting
  - Coverage & plan determination – Individual/group contracting

Provider Anxieties

- Privacy
  - Release appropriate data for appropriate patients
  - Minimum Necessary requirements
  - Self-pay restrictions
  - Confidential data
  - Data contributed by unaffiliated providers
  - Re-purposing of data
- Will shared data be used against me or my patients?
  - Coverage and benefits determination
  - Contracting
  - Litigation

Da Vinci Panel Discussion

Mike Funk, FACHE, CMP
Vice President, Office of the Chief Medical Officer

Humana®

Humana Value-based Care: Better Outcomes And Lower Costs Than Traditional Fee-for-service Models

20 PERCENT — Higher HEDIS scores for physicians in a value-based setting, compared to standard Medicare Advantage settings.

15 PERCENT — Lower medical costs for patients treated by physicians in Humana value-based settings, versus original FFS Medicare.

16 PERCENT — Total payments Humana distributed to health care providers in 2016 was to value-based PCPs

PREVENTION*

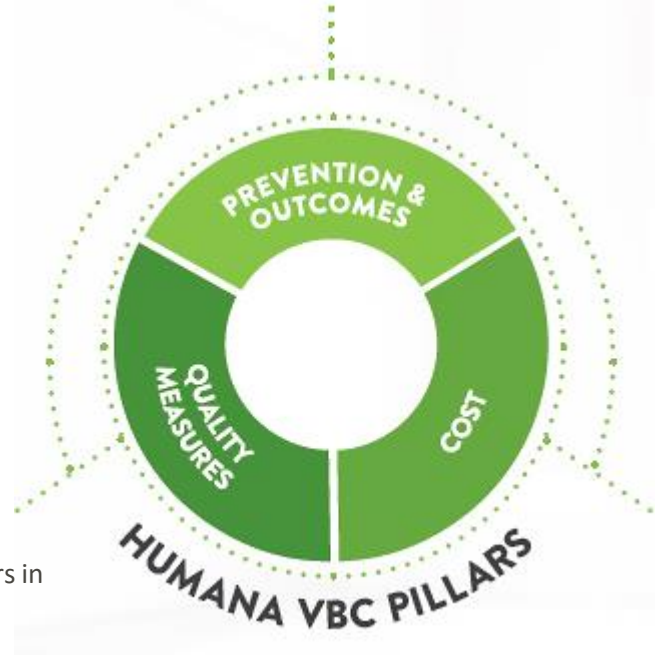
+13% Colorectal cancer screenings

+8% Breast cancer screenings

QUALITY MEASURES

26% higher overall HEDIS scores for physicians

90+% Member retention for MA members in VBC settings



OUTCOMES

Emergency department visits **7% fewer****

Hospital inpatient admissions **5% fewer****

PAYMENTS AND COST

16.8% of every dollar spent on patient care went to Humana VB PCPs (vs 6% national average)

Total health care costs were **15% lower** vs. original fee-for-service Medicare

*Quality Measures" (Healthcare Effectiveness Data and Information Set, HEDIS) and "Prevention" results were from a study of 1.65 million Humana MA members affiliated with physicians in value-based agreements compared to 191,000 Humana MA members affiliated with physicians under standard MA settings.
**"Outcomes" and "Cost" results were from a study of approximately 1.4 million Humana MA members affiliated with physicians in value-based agreements compared to 216,000 Humana MA members affiliated with physicians under standard MA settings.
***"Net Promoter Score" results were from a total of 581 physician and/or staff interviews.

Health IT Interoperability Critical To Successfully Transitioning to VBC

- Administrative Complexity
- Regulatory Burden
- Analytics
- Data Sharing/ Usage
- Structure of Data
- Transparency
- Standardization

Bridging the Payer-Provider Data Divide

- Rapid multi-stakeholder process
- Minimize unique solutions/create standards adoption
- Standards (HL-7 FHIR)
- Implementation Guides
- Use Cases
  - Gaps in Care and Information
  - Prior Authorization Support

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Reducing Provider and Payer Burden

Melanie Combs-Dyer

Director, Provider Compliance Group,
Center for Program Integrity, CMS

Why is CMS Interested in the DRLS?

What We Heard from Providers

[The American Medical Association (AMA): Prior Authorization and Utilization Management Reform Principles]

"Utilization review entities should publically disclose, in a **searchable electronic format**, patient-specific utilization management **requirements**, including prior authorization, applied to individual drugs and medical services. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers **what supporting documentation is needed** to complete every prior authorization and step therapy override request."

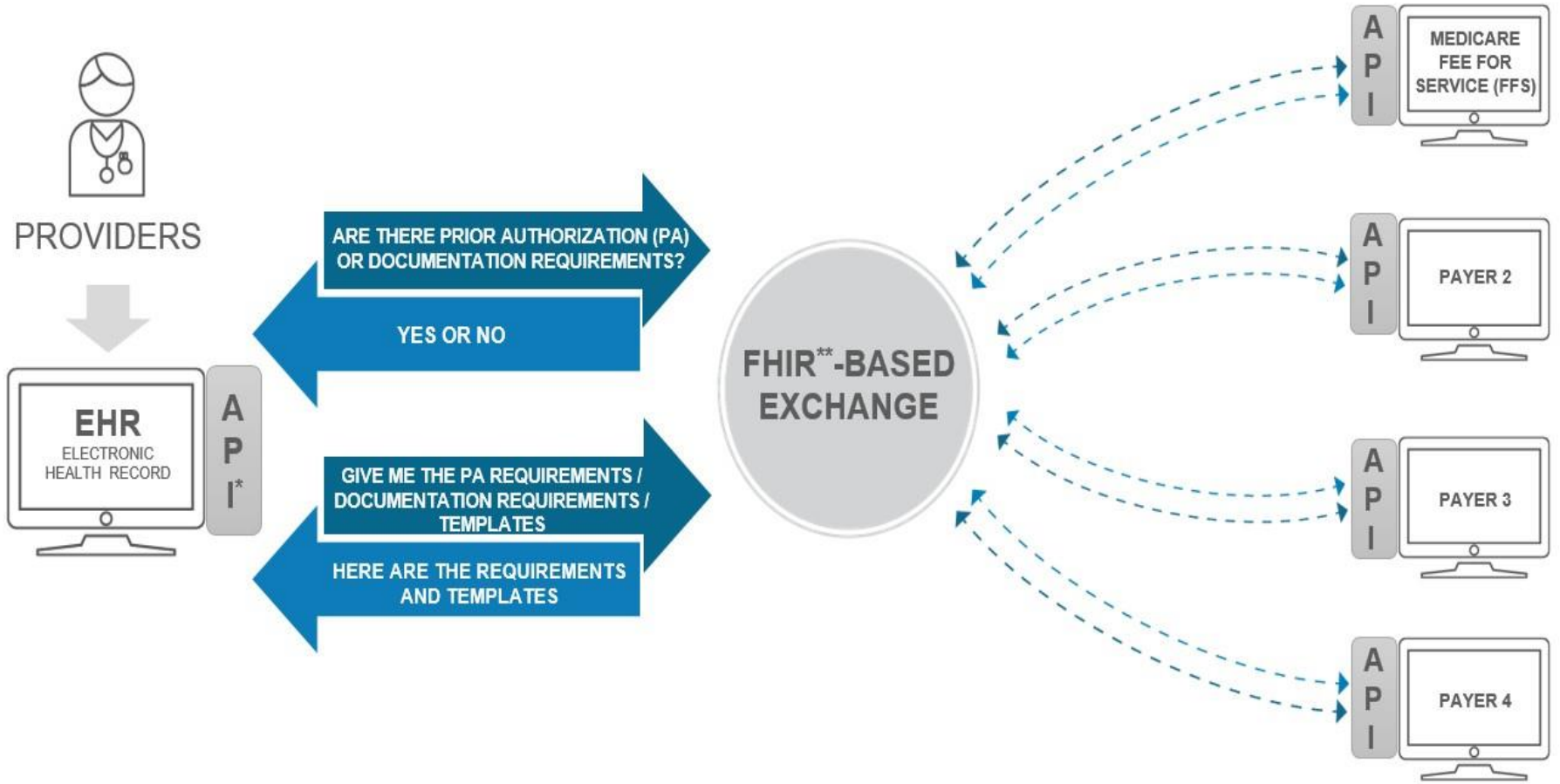
What is the Documentation Requirement Lookup Service (DRLS)?

DRLS will allow providers to discover prior authorization and documentation requirements at the time of service in their electronic health record (EHR) or integrated practice management system through electronic data exchange with a payer system

DRLS Goals:

		Reduce provider burden
		Reduce improper payments and appeals
		Improve “provider to payer” information exchange

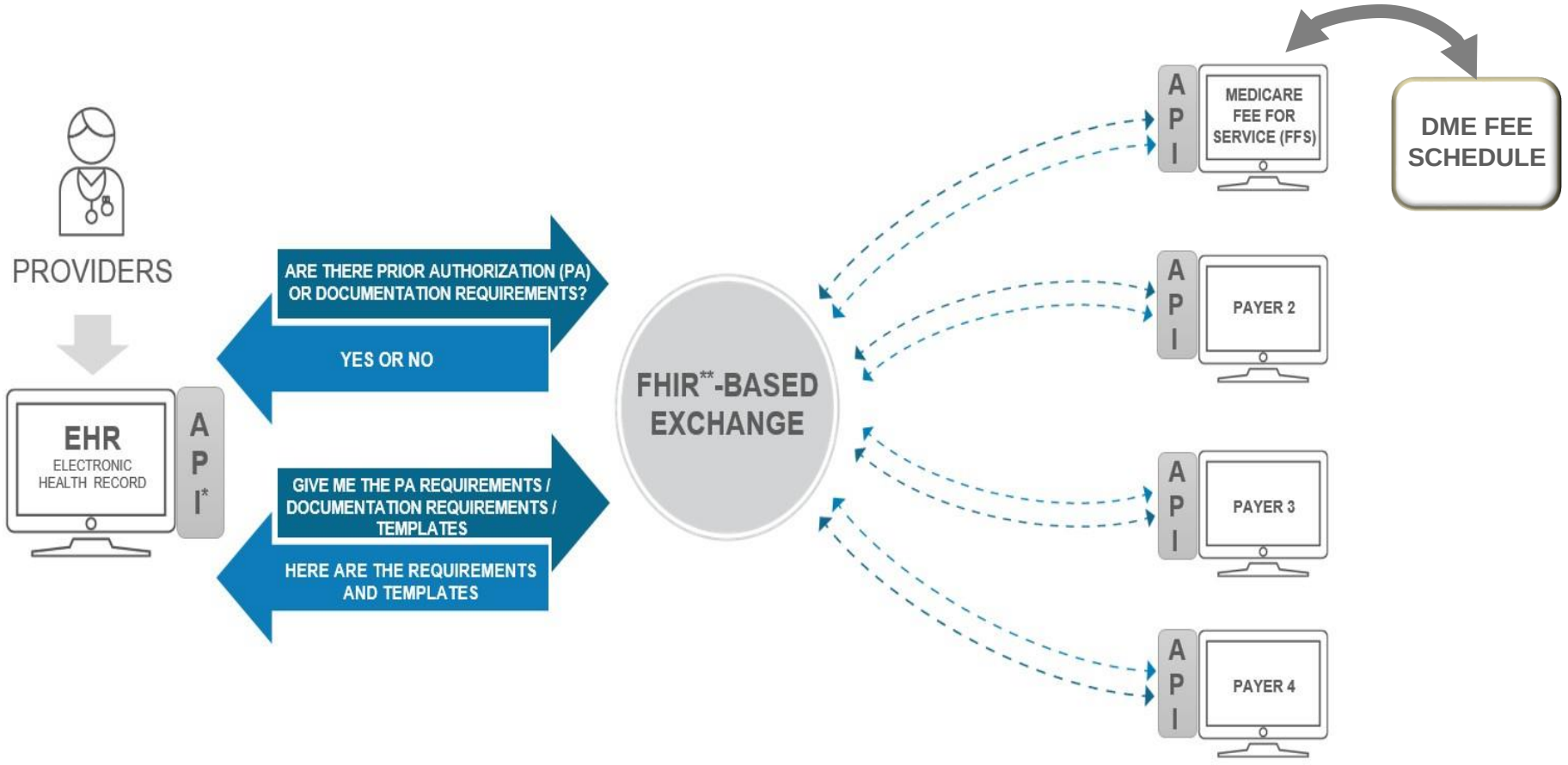
How Will DRLS Work for Providers?



*API – APPLICATION PROGRAMMING INTERFACE
**FHIR – FAST HEALTHCARE INTEROPERABILITY RESOURCES

go.cms.gov/MedicareRequirementsLookup

Limited Cost Transparency



go.cms.gov/MedicareRequirementsLookup

Example of Documentation Requirements and Cost Transparency

Medicare Fee For Service -- Home Oxygen Therapy Requirements

1) diagnoses requiring supplemental oxygen
2) testing to confirm hypoxia in chronic stable state performed and evaluated
3) documentation that alternative therapies were tried and not completely effective
4) patient is mobile if portable O2 supplies are ordered
5) click here for information regarding Group 1 and Group 2 criteria

Patient Monthly Cost Information (Florida) Metro / Rural Copay (20%)

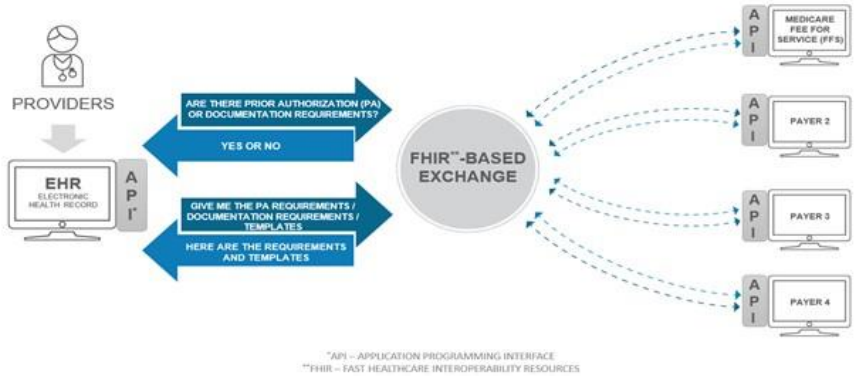
E0424:	Stationary compressed gaseous oxygen system	$14.64 / $26.94
E0431:	Portable gaseous oxygen system	$ 7.32 / $13.47
E0433:	Portable liquid oxygen system	$ 7.32 / $13.47
E0439 :	Stationary liquid oxygen system	$14.64 / $26.94
E0441:	Stationary gaseous oxygen system	$ 9.78 / $12.84
E1390:	Oxygen concentrator (85% or greater O2)	$14.64 / $26.94

Subject to deductible and may be covered by supplemental insurance

How Will The Team Accomplish the Goals?

- **CMS/CPI hired MITRE to work with the Da Vinci Team to:**
  - Create implementation guides based on FHIR standards
  - Create reference implementation to prove it works
  - Launch pilots

The commercial vendor community will have access to a CRD Implementation Guide and Reference Implementation available in the public domain to accelerate its development of standards-based solutions that work with DRLS.



Leveraging Industry Efforts

The Da Vinci Project:

- **Convened by HL7 International**
  - A Health Care Standards Development Organization
- **Da Vinci is an industry-led effort to:**
  - Establish a ***rapid multi-stakeholder*** process to identify and implement critical use cases ***for the exchange of information between payers and providers***
  - ***Minimize*** the development and deployment of ***unique solutions***
  - ***Focus on*** reference architectures that will promote ***industry-wide standards and adoption***
- **Members include:**
  - ***12 payers, 10 HIT Vendors, 3 EHRs, 6 Providers***

The Da Vinci Project Use Cases

Data Exchange for Quality Measures

Coverage Requirements Discovery

Documentation Templates and Coverage Rules

DRLS is based on these two use cases

Health Record Exchange: Clinical Data Exchange

Health Record Exchange: Payer Data Exchange

Prior-Authorization Support

Gaps in Care & Information

Risk Based Contract Member Identification

Alerts: Notification (ADT), Transitions in Care, ER admit/discharge

Performing Laboratory Reporting

Chronic Illness Documentation for Risk Adjustment

Patient Cost Transparency

Project Deliverables

- ❑ Define requirements (technical, business and testing)
- ❑ Create Implementation Guide
- ❑ Create and test Reference Implementation (prove the guide works)
- ❑ Pilot the solution
- ❑ Deploy the solution

In HL7 ballot reconciliation as draft standard

Under active development

Planned 2019 Use Cases

Future Use Case

Discussion

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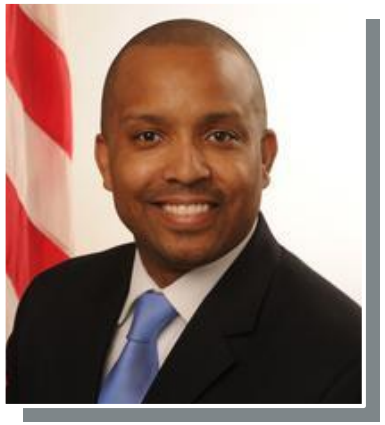

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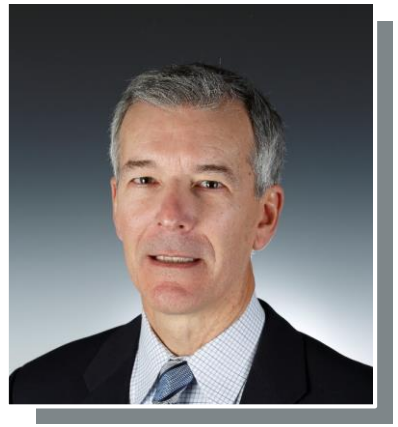

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Follow Progress, Develop, Test, Implement

Da Vinci Resources

- Listserv signups
- Background collateral
- Draft Implementation Guides
- Reference Implementation links

HL7 Public Confluence Site - https://confluence.hl7.org/display/DVP/

General Comments or Recommendations on CMS Document Requirement Lookup Service?

- Monitor DRLS progress or for information on upcoming SODF calls: go.cms.gov/MedicareRequirementsLookup
- Send feedback and suggestions on the Documentation Requirement Lookup Service - MedicareDRLS@cms.hhs.gov

2019 Use Case Alignment

Data Exchange for Quality Measures	Coverage Requirements Discovery	Documentation Templates and Coverage Rules
Health Record Exchange: Clinical Data Exchange	Health Record Exchange: Payer Data Exchange	Prior-Authorization Support
Gaps in Care & Information	Risk Based Contract Member Identification	Alerts: Notification (ADT), Transitions in Care, ER admit/discharge
Performing Laboratory Reporting	Chronic Illness Documentation for Risk Adjustment	Patient Cost Transparency

Project Outputs

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Use Case Status

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- Under active development
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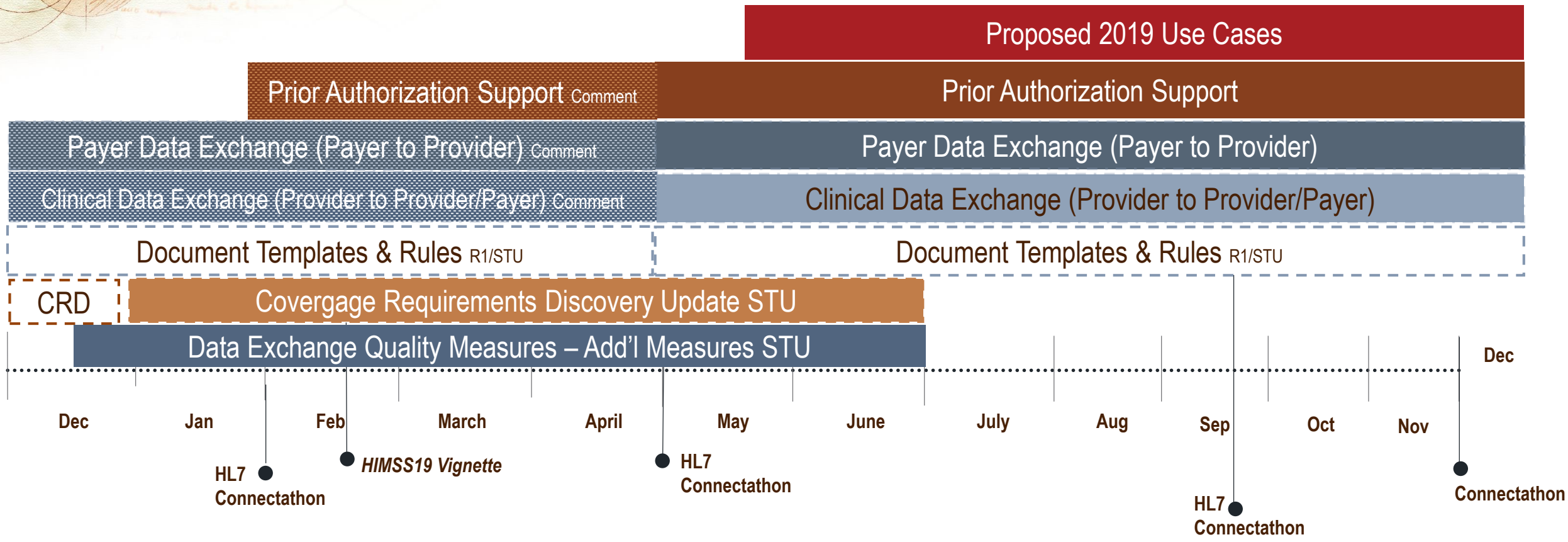
Da Vinci 2019 Use Cases –Year 2