Making an Impact on Critical Healthcare Public Policy Issues: National and State Initiatives

Holy MACRA! It's Interoperate 2016!

CSOHIMSS 2016 Fall Conference

October 28, 2016

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Agenda

- Key Health IT Public Policy Issues
  - The Shift to Value-Based Care and a Learning Health System
  - Quality Payment Program Implementation
  - Cybersecurity
  - Precision Medicine Initiative
- What's Next on the Agenda in Washington, DC
- HIMSS State Policy-Related Activities
- Discussion/Q&A

The Shift to Value-Based Care and a Learning Health System

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Health Care Delivery System Reform will Result in Better Care, Smarter Spending, and Healthier People

Public and Private Sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

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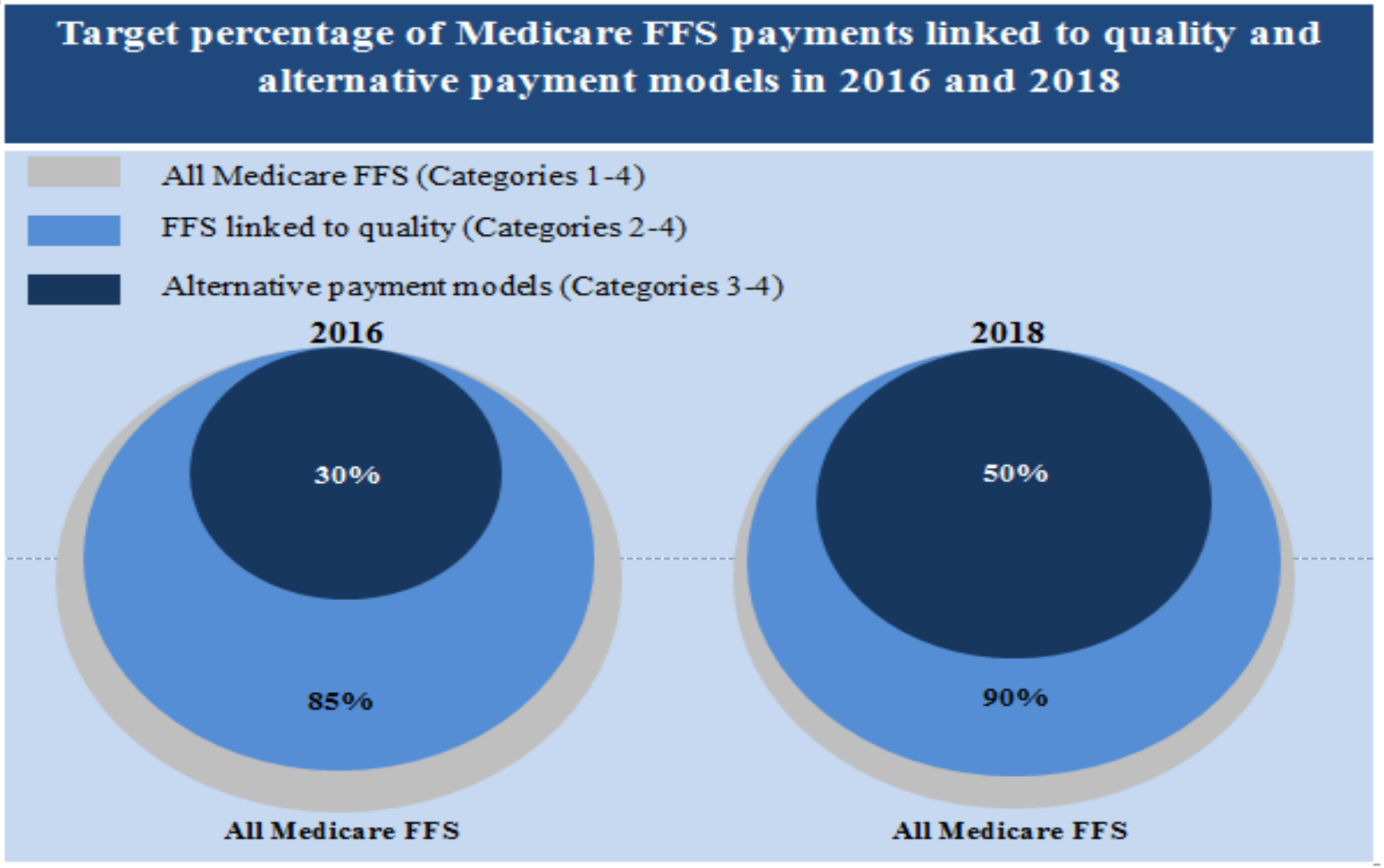
HHS Set Firm Goals for the Move to Value-Based Care



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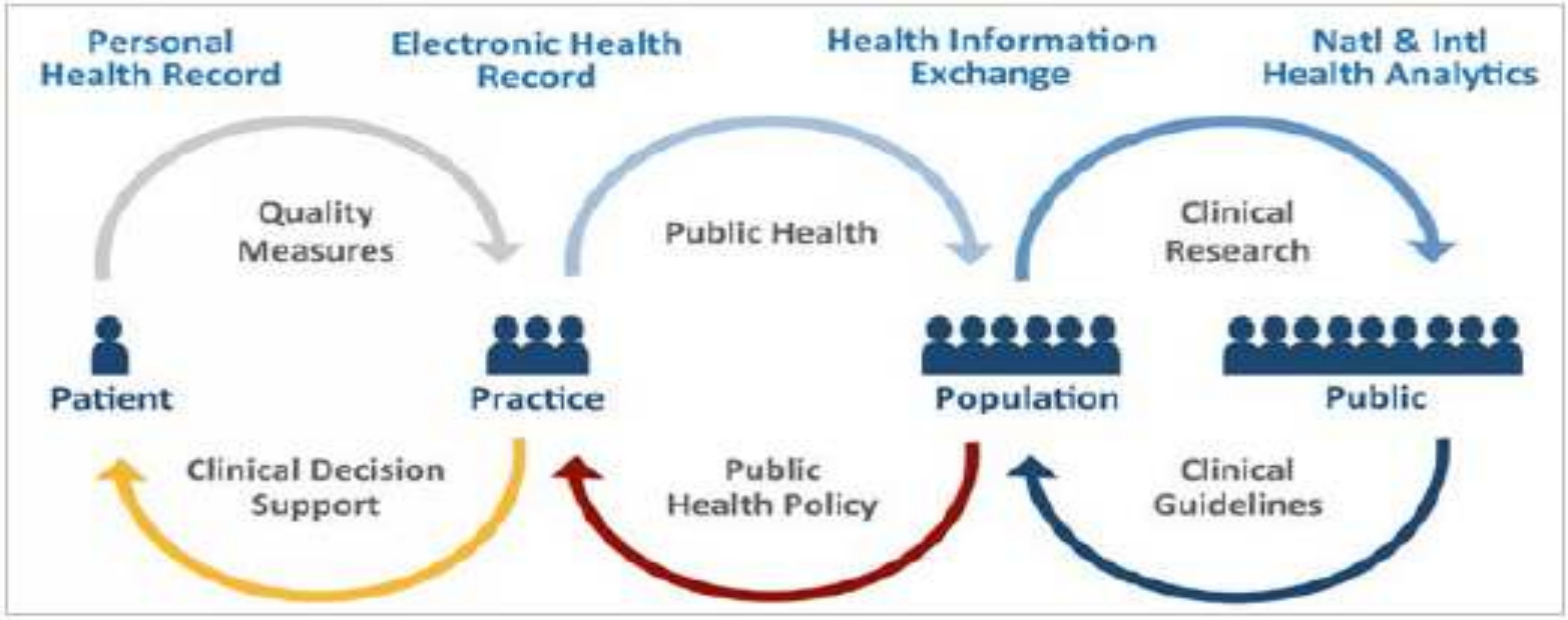
Interoperability Efforts Support the Shift to a Learning Health System

- This shift requires a high degree of information sharing between individuals, providers and organizations and therefore a high degree of interoperability between many different types of health IT, such that systems can exchange and use electronic health information without special effort
  - The goal of this shift is to a nationwide learning health system



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Quality Payment Program Implementation

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The Medicare Access & CHIP Reauthorization Act of 2015

- Passed into law April 2015
- Repeals the SGR Formula
- Streamlines multiple quality reporting programs into a Merit-based Incentive Payment System (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

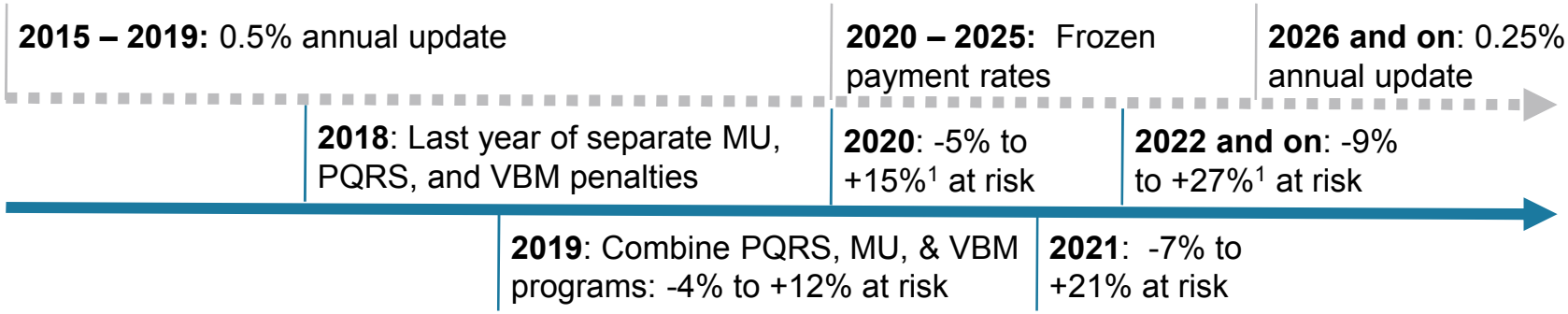
Quality Payment Program (QPP) Focus: The Medicare Clinician Community

- QPP focuses on clinicians who bill Medicare for Part B Services
  - No direct impact on hospitals or Medicaid providers
- Rule also includes modifications to the Meaningful Use (MU) Program
  - Impacts **all Medicare** MU Eligible Professionals, Eligible Hospitals and Critical Access Hospitals

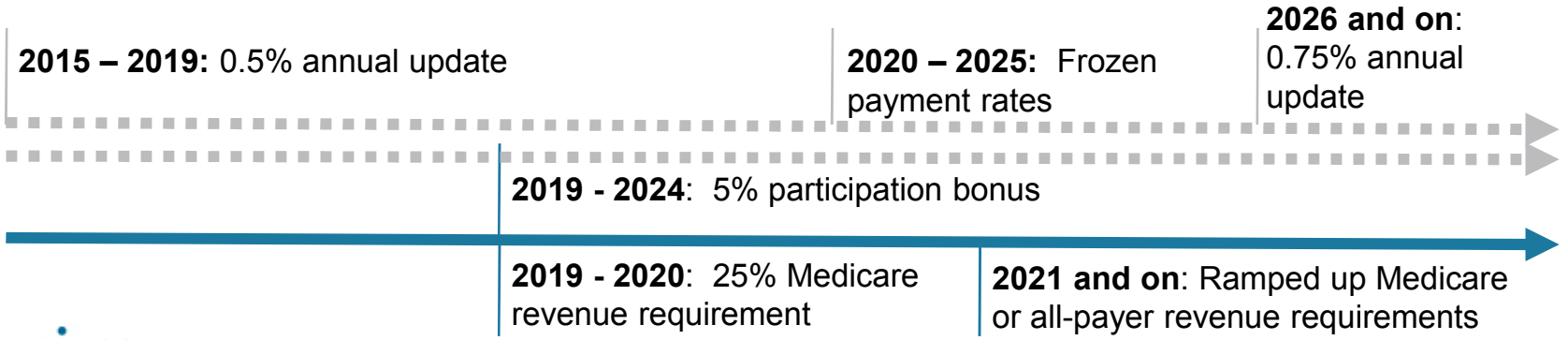
MACRA Creates Two Tracks for Providers

Providers Must Choose 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

MIPS Eligible Clinicians

Years 1 – 2 (2017-2018)

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Potential additional ECs (2019+)

- Physical or Occupational Therapists
- Speech Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Pathologists
- Clinical Psychologists
- Dietitians/Nutritional Professionals

Program Cycle for 2017 Performance Year/2019 Payment Year

- During 2017, clinicians will record quality data and how they used technology to support their practice
- If an Advanced APM fits their practice, then they can provide care during the year through that model
- Medicare gives them feedback about their performance after they send in their data

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Graphic courtesy of the Centers for Medicare & Medicaid Services

MIPS: Four Components

Quality: 60%	Advancing Care Information: 25%	Improvement Activities: 15%	Cost: 0%

- Increased quality weight in 2017 from 50% to 60%
- Renamed proposed “Clinical Practice Improvement Activities” to “Improvement Activities”
- Renamed “Resource Use” to “Cost” and delayed until performance

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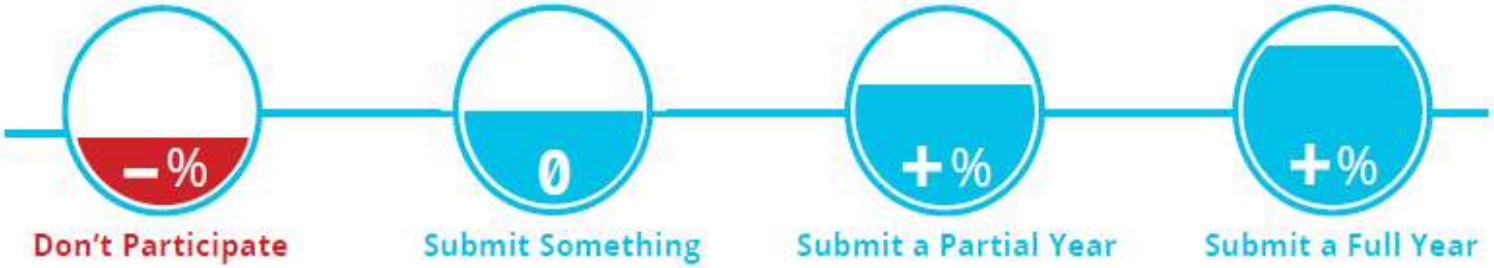
MIPS Exclusions

- Total Part B ECs estimated at approximately 750,000
- ECs who fall below low volume Medicare threshold

  ($30,000 **OR** less than 101 beneficiaries annually)
- CMS estimates 32.5% or 380,000 to be excluded
- First year Medicare ECs
- APM qualifying/partially qualifying participants
  - 70,000 – 120,000 expected in 2017

Pick Your Pace in MIPS: 3 Options if Clinicians Participate



Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

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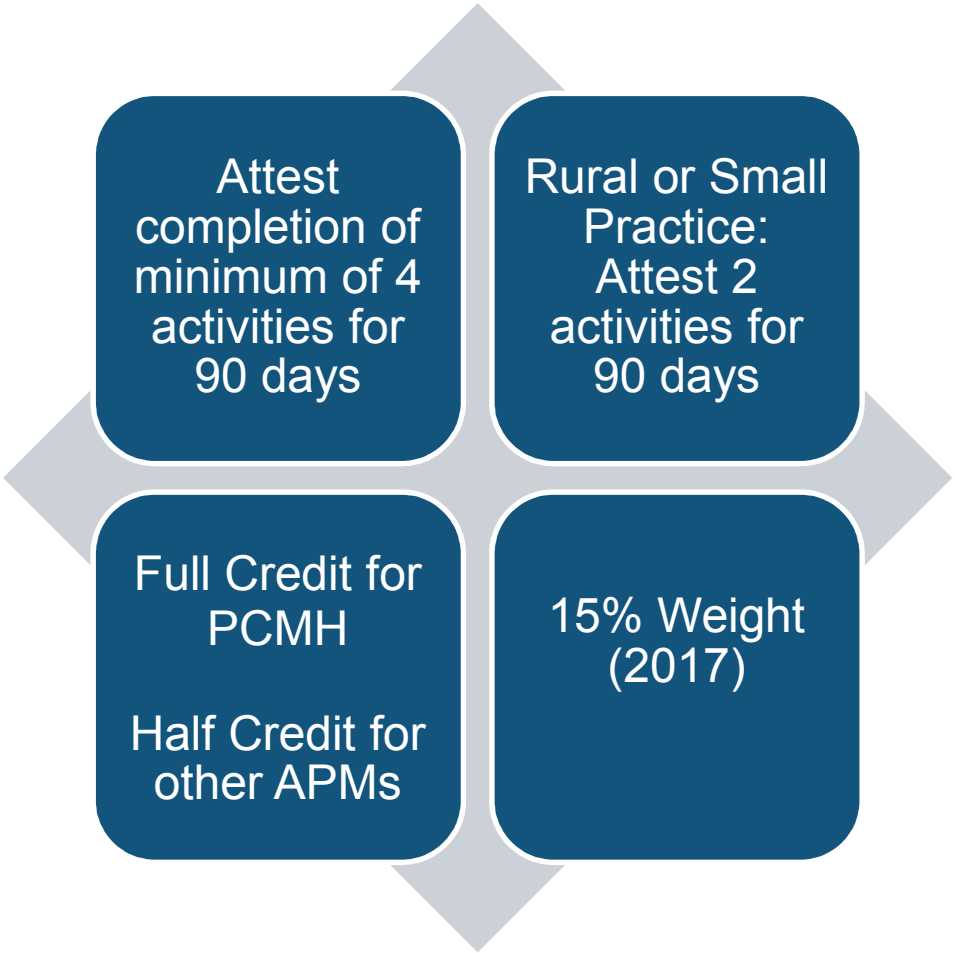
MIPS Quality Measures Reporting

- Reporting one quality measure for 90 consecutive days to MIPS will avoid the negative payment adjustment for CY17/2019 Payment Year
- For small practices, reporting 6 measures including one outcomes measure for 90 consecutive days will result in a neutral payment adjustment
  - Performance above national mean and median is required for a small positive adjustment.
- To get the maximum non-APM positive payment adjustment, ECs must report on 6 measures for the full calendar year and achieve performance above the national mean and median
  - There is a bonus for reporting using CEHRT.
- Large groups that choose to do group reporting via the CMS interface have to report on all 17 CMS web interface measures for the full calendar year
- Cross cutting measure reporting is no longer required. There are bonuses for reporting on more than one outcomes measure or a cross cutting measure

MIPS: Improvement Activities Reporting



MIPS: Advancing Care Information Reporting

Has base and performance reporting components

Final rule reduced required "base" measures from 11 to 5

9 performance measures

2015 CEHRT required to report in the ACI category in 2018

90-day performance period (reduction from full year)

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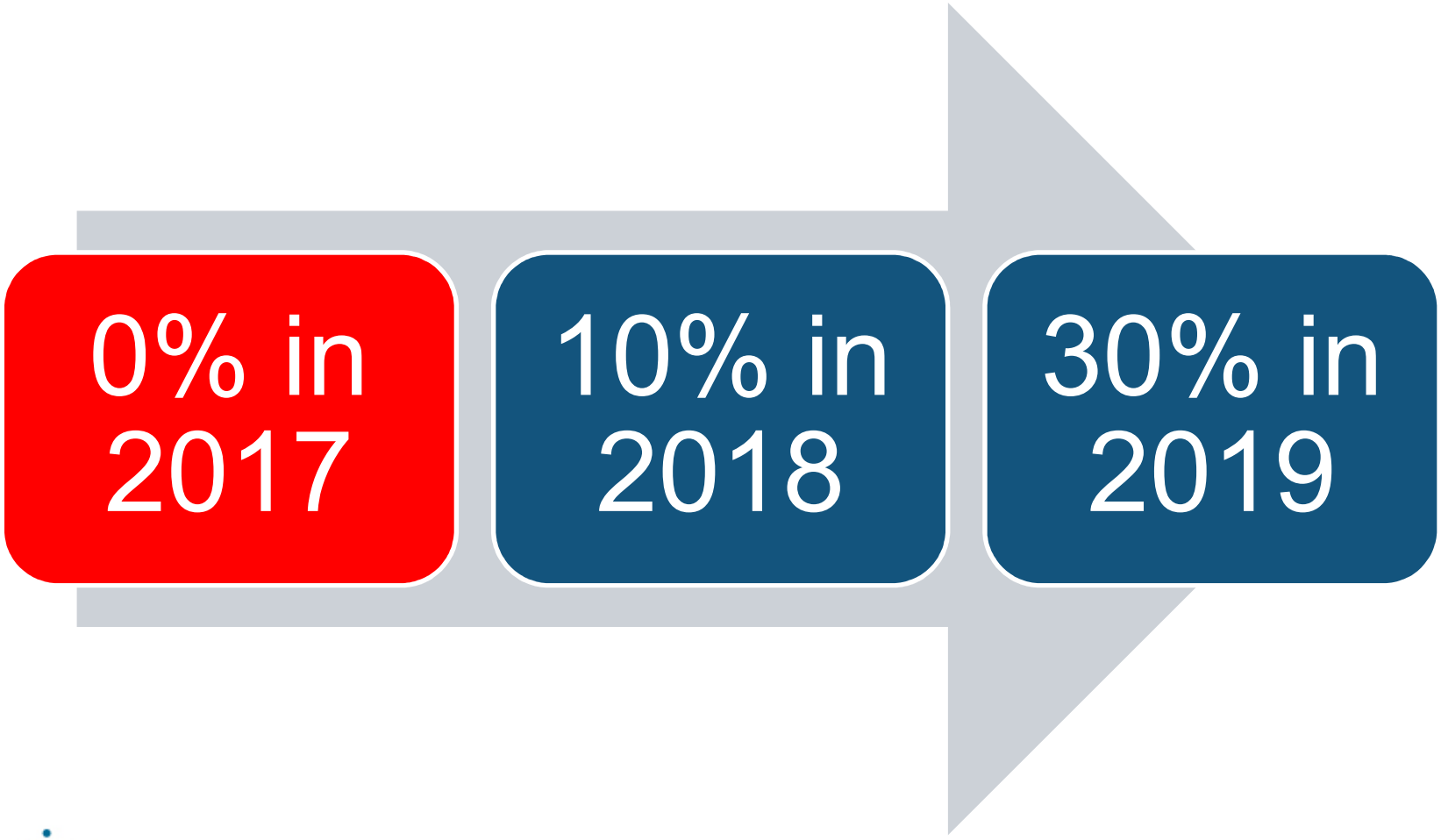
MIPS: Cost Reporting



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MIPS: Calculating the Composite Performance Score (CPS)

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MIPS: Budget Neutral

- 90% est. to receive positive or neutral MIPS payment adjustment
- 90% of practices w/ 1-9 clinicians est. to receive positive or neutral payment adjustment
- CMS “Flattening the Curve”: score distribution will be more limited
- 3x scaling factor can increase or decrease composite scores to ensure budget neutrality

Size	% Positive/ Neutral	% Negative	Aggregate Positive/ Neutral	Aggregate Negative	Aggregate $500 M	Net
1-9	90%	10%	$72	-$99	$173	$145
10-24	90%	10%	$24	-$37	$55	$42
25-99	92.6%	7.4%	$31	-$47	$70	$54
100+	98.5%	1.5%	$72	-$16	$202	$258

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Figures in Millions

Aggregate Positive/Neutral = $199
Aggregate Negative = -$199

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

Payment or Patient Thresholds Must be Met for Advanced APM Participation

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

- For performance years 2017 and 2018, the participation requirements only apply to Medicare payments and patients
- Starting in performance year 2019, clinicians may also meet an alternative standard for Advanced APMs that will include non-Medicare payments and patients

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Graphic courtesy of the Centers for Medicare & Medicaid Services

Advanced APMs for 2017 Performance Year

- Clinicians may earn a 5% incentive payment through sufficient participation in the following Advanced APMs:
  - Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement)
  - Comprehensive ESRD Care Model (non-LDO arrangement)
  - Comprehensive Primary Care Plus (CPC+)
  - Medicare Shared Savings Program ACOs - Track 2
  - Medicare Shared Savings Program ACOs - Track 3
  - Next Generation ACO Model
  - Oncology Care Model (two-sided risk arrangement)

Possible Advanced APMs for 2018 Performance Year

- CMS anticipates that clinicians may also earn the incentive payment through sufficient participation in the following models:
  - ACO Track 1+
  - New voluntary bundled payment model
  - Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
  - Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)

Additional Requirements in MACRA Final Rule for All MU Providers

- CMS is adding two requirements for certified EHR technology to the attestation requirements under MU, the ACI performance category score under MIPS, and reporting under the APM track

New Requirements for ACI Clinicians and All MU Providers	
Providers must attest that they have cooperated with the ONC direct review of certified health IT There is also optional attestation for ONC-ACB surveillance cooperation	Providers must attest to facilitating health information exchange, not blocking information, and demonstrate their adherence to model interoperability and exchange practices

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Cybersecurity

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Cybersecurity Call to Action

1. Adopt a Universal Information Privacy and Security Framework for the Health Sector.
   - Establish a new normal for information privacy and security
   - Adopt a voluntary, universal information privacy and security framework that is scalable and includes replicable use cases and implementation guidance
   - Enable use of the tools developed in accordance with national investment identified in Section 405 of the Cybersecurity Act: "voluntary, consensus-based, and industry-led guidelines, best practices, methodologies, procedures, and processes."
   - HIMSS recommends NIST's Cybersecurity Framework.

Cybersecurity Call to Action

2. Create an HHS Cyber Leader role
   - White House appointed the first federal government CISO as called for in the Cybersecurity National Action Plan
   - Health sector needs a champion at HHS to encourage stakeholders to be proactive and vigilant about cybersecurity
     - Elevate the CISO with internal and external portfolios
     - Coordinate with OCR, ONC, and ASPR to improve preparedness and threat mitigation

Cybersecurity Call to Action

3. Address Shortage of Qualified Cybersecurity Professionals
   - Our 2016 Cybersecurity Survey found that 59% of respondents identified the lack of appropriately-trained cybersecurity personnel as the #1 barrier to mitigating security incidents

- Increase number of educated and qualified cybersecurity personnel through the use of education and certification programs:
  - Graduates of the NSA's Centers of Academic Excellence in Cybersecurity
- Encourage innovation with an eye towards more technology-driven solutions for cybersecurity.
- Convene stakeholder meetings (associations, academia, government) to devise a plan of action for short, medium, and long term steps to resolving the shortage

HHS Announced New Cyber Grant Awardees

- $350,000 awarded to strengthen the ability of health care and public health sector partners to respond to cybersecurity threats
- National Health Information Sharing and Analysis Center (NH-ISAC) won both awards:
  - Provide cybersecurity information and education on cyber threats to healthcare sector stakeholders
  - Help build the infrastructure necessary to receive and disseminate cyber threat information securely from/to healthcare partners

Precision Medicine Initiative

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Background on PMI

- President Obama announced the intention to launch PMI in State of the Union Address on January 20, 2015
- Vision is for PMI to enhance innovation in biomedical research with the ultimate goal of moving the U.S. into an era where medical treatment can be tailored to each patient
  - The idea is that it would deliver the right treatment at the right time to the right person, taking into account individuals' health history, genes, environments, and lifestyles
- Approach to disease treatment that seeks to redefine disease onset and progression, treatment response, and outcomes
- Will lead to more accurate diagnoses, rational prevention strategies, better treatment selection, and more novel therapies
- Takes the following into account to maximize effectiveness:
  - Individual variability in genes
  - Environment
  - Lifestyle

Focus is Currently on Developing the One Million Person Research Cohort

- NIH released a report in September 2015 with a plan for cohort assembly, including guidelines for participant engagement, data collection, biobanking, and defining governance specifications
- The goal of the PMI Cohort Program is to set the foundation for a new way of doing research that fosters open, responsible data sharing with the highest regard to participant privacy, and that puts engaged participants at the center of research efforts
- Timing is perfect for this effort
  - Americans are engaging in improving their health and participating in health research
  - EHRs have been widely adopted
  - Genomic analysis costs have dropped significantly
  - Data science has become increasingly sophisticated, and health technologies have become mobile

Complementary Efforts to PMI are Underway Across the Federal Government

- PMI also includes ongoing efforts through VA which has enrolled over 450,000 Veterans in the Million Veteran Program (MVP), a participant-driven research cohort
  - DOD is partnering with the VA to expand the MVP and open it up to active duty men and women who wish to participate
  - Enrollment is expected to begin soon
- FDA launched its first precisionFDA challenge to encourage the genomics community to advance quality standards and achieve more consistent and accurate DNA test results, advancing the goal of better personalized care
- HHS Office for Civil Rights issued additional guidance on individuals' rights to access their health information under HIPAA
  - This new resource addresses the right of an individual to have copies of their health information sent to anyone they designate, including to contribute it for research
- NIH, in partnership with HRSA, is collaborating with community health centers to expand the reach of PMI and refine approaches to engaging underserved and underrepresented individuals, families, and communities

PMI May Refocus But Effort is Likely to Endure into 2017 and Beyond

- With a change in the White House in 2017, the push for personalized medicine will likely remain a key focus area for either a Republican or a Democrat
  - PMI may be rebranded in a new Administration, but the underpinnings of the current program should remain functional across the government
  - Bipartisan support for this overall effort exists in Congress and would likely continue, further propping up the program in a new Administration
- NIH has been integrally involved in the medical research end of this effort and would likely continue in that lead role
- Health IT would continue to be a critical part of any personalized medicine initiative as ensuring that researchers could access EHR data will be integral piece

What's Next on the Agenda in Washington, DC

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Policy Developments

- MACRA implementation/requirements
- Rethinking ACA
- Precision Medicine Initiative and Telehealth
- Future of the Innovation/21st Century Cures legislation
- Republican and Democratic Policy Directions
- State Government Concerns
  - Opioid Epidemic
  - Zika and other Public Health Crises
  - Job Creation/Economic Stimulus related to Innovation
  - Behavioral Health System integration/connectivity

Republican Policy Direction

- Repeal of ACA – although challenging
- Push for value-based care continues
- Regulatory changes – make government smaller/ less intrusive
- Jobs and economic growth
- A President Trump would appear to support
  - Repeal/Replace ACA; Let Speaker Ryan lead efforts?
  - Insurance market reforms
  - Leveraging telehealth – particularly for veterans healthcare

Democratic Policy Direction

- Push for VBC, PMI, and Cancer Moonshot
  - Failed 1993 health reform effort should figure prominently
- Workforce development/reducing disparities
- Push for Medicaid modernization
- Jobs and economic growth
- A President Clinton appears to support
  - Using technology to improve care
  - Telehealth expansion for rural communities
  - The value/importance of health centers
  - Transparency in health data

Conclusions: Market and Policy Implications for Health IT

- MACRA/VBP creates pressure on data delivery, interoperability, and certification
- Telehealth opportunities
- Synching federal and state health and human services requirements
- Medicaid Modernization/Modularization possibilities
- At least minor ACA changes inevitable

HIMSS State Policy-Related Activities

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HIMSS Chapter Advocacy Roundtable (CAR)

- Supports 'better health through IT' 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 and conferences
  - Leverage existing opportunities to further health IT policy objectives by identifying one or more chapter advocates, increasing participation in HIMSS NA events

Chapter Advocacy in Every Region

Lauren Wiseman, Chair
Greater Illinois Chapter

Joy Selleck
Vice Chair of Midwest Region
Iowa Chapter

Chad Cothern
Vice Chair of Southern Region
Louisiana Chapter

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

Ian Slade
Vice Chair of West Region
Southern California Chapter

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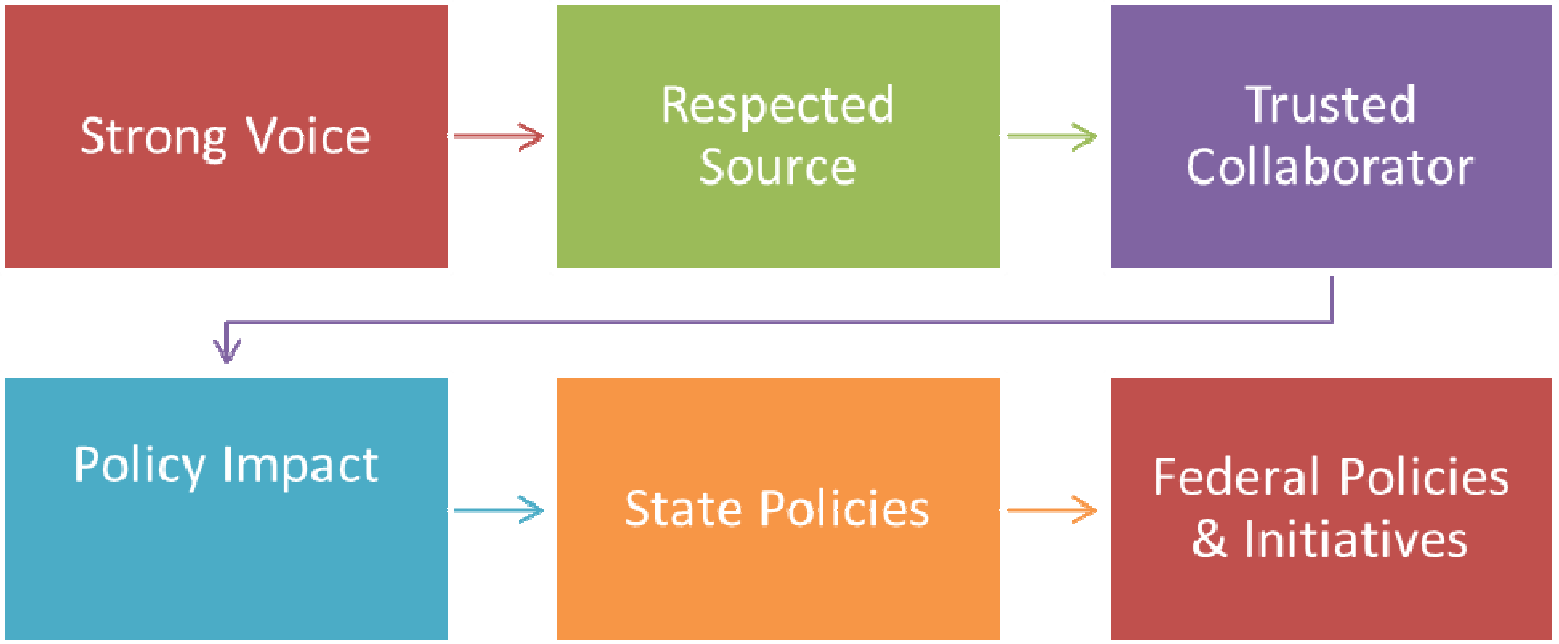
HIMSS Chapter Advocates Build Meaningful & Sustainable Partnerships



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Building Relationships

State and Local Levels of Government

Like-minded organizations

- 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

Be 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 correspondents.

PLAN your 2017 Advocacy calendar

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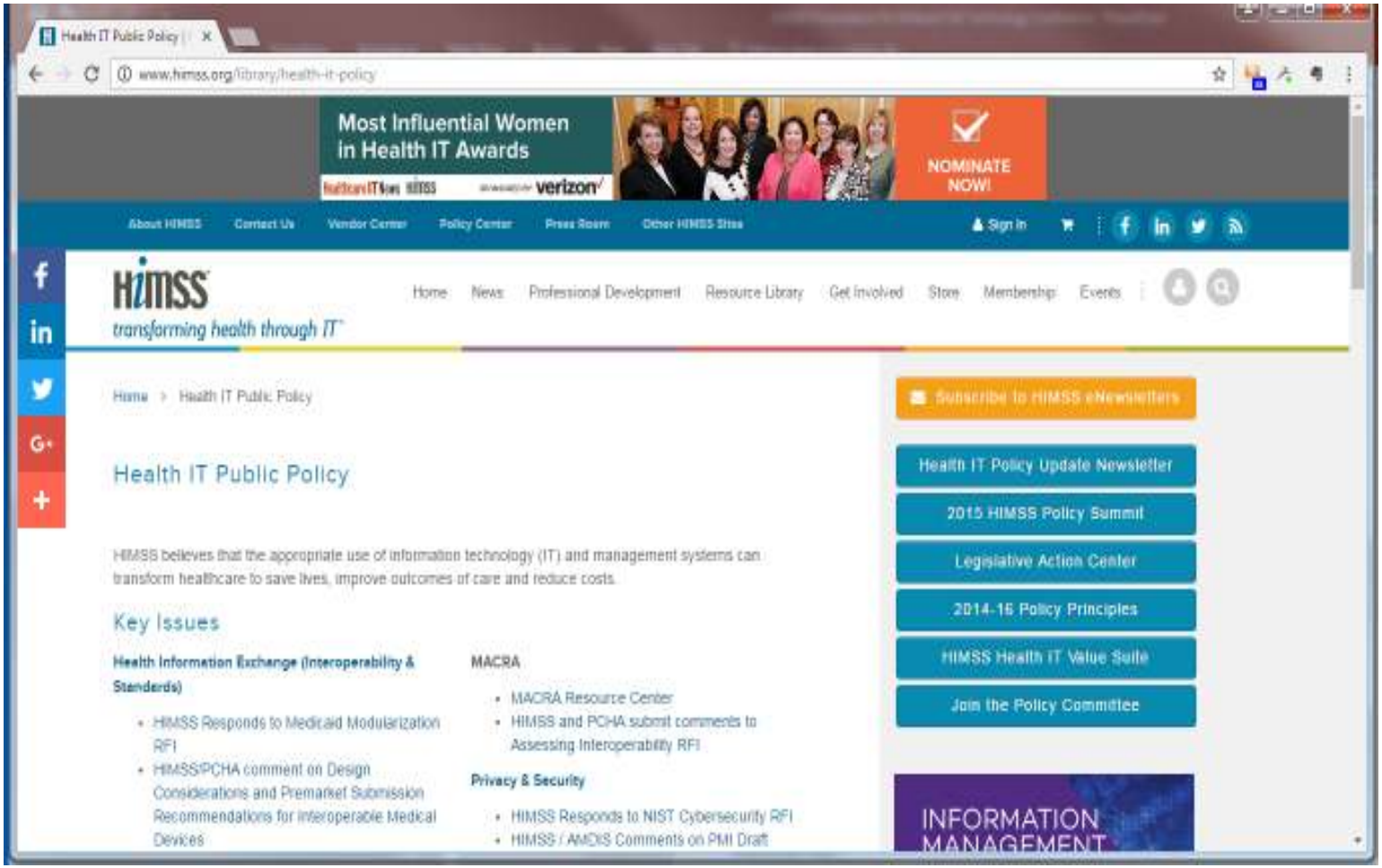
Work with your Chapter Advocates to Contribute Success Stories

- 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



HIMSS Legislative Action Center

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NHIT Week Call to Action on Telehealth

- Ask your state legislators to enact policies that help realize the full potential of telehealth services
- Five recommendations
  - Enact Payment Parity Laws for Telehealth Services
  - Expand Access to Telehealth Services for Medicaid Beneficiaries
  - Expand Telehealth Coverage to Other Healthcare Services
  - Support Robust Interoperability & Health Information Exchange of Telehealth and Medical Devices and Patient Generated Health Data
  - Support Healthcare Provider Access to Affordable Broadband

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HIMSS17

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Questions?

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Thank You!

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