Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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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

Point·of·Care PARTNERS
HEALTH IT MANAGEMENT CONSULTANTS

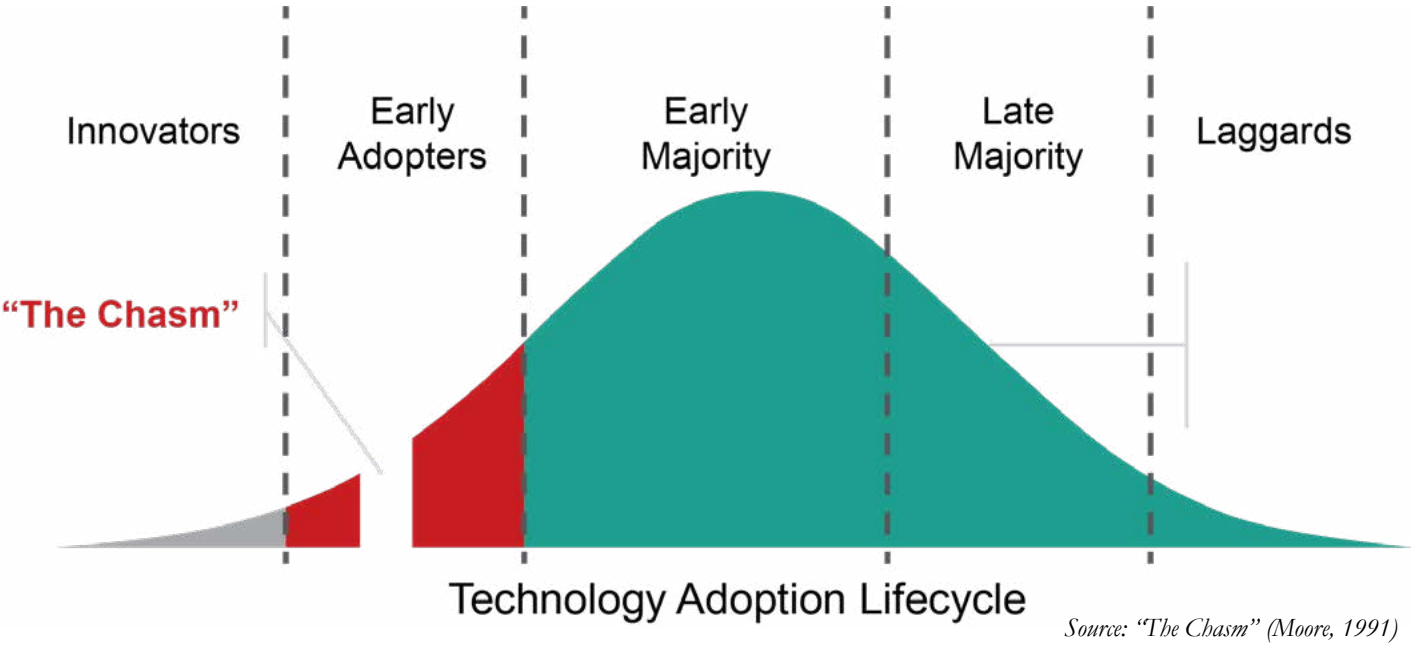
1 Part 1: Top 2020 Health IT Predictions: Opportunities Abound

By Tony Schueth, Editor-in-Chief, and Ken Kleinberg, Innovative Technologies Lead

2020 is still young and we are prepped to help our clients with challenges and opportunities in the coming year. We've put together our top predictions for key areas, led by the continued shift to value-based care (VBC) and the many other areas it drives, including improved payer-provider coordination, price transparency, the high cost and use of specialty medications and interoperability standards.

1. Innovators and early adopters of VBC will cross the chasm. In 2018, I heard former Secretary of Health and Human Services and Governor of Utah Michael Leavitt say that we are 25 years into a 40-year transition to value-based care. His observation resonated with me because, well, it takes time to fundamentally change the way health care is reimbursed, and people too often get discouraged at the pace of change in health care. I thought it put things in perspective.

2020 will be the year innovators and early adopters begin implementing technology that supports VBC. Some will cross the chasm; some won't. Some have a culture of doing it themselves while others will get help from experts who have been involved in the development of use cases and standards and have experience implementing technology. Regardless of expert help or not, it'll take time to transform the health information technology (health IT) ecosphere because many stakeholders are using 1980-90s technology.



Source: "The Chasm" (Moore, 1991)

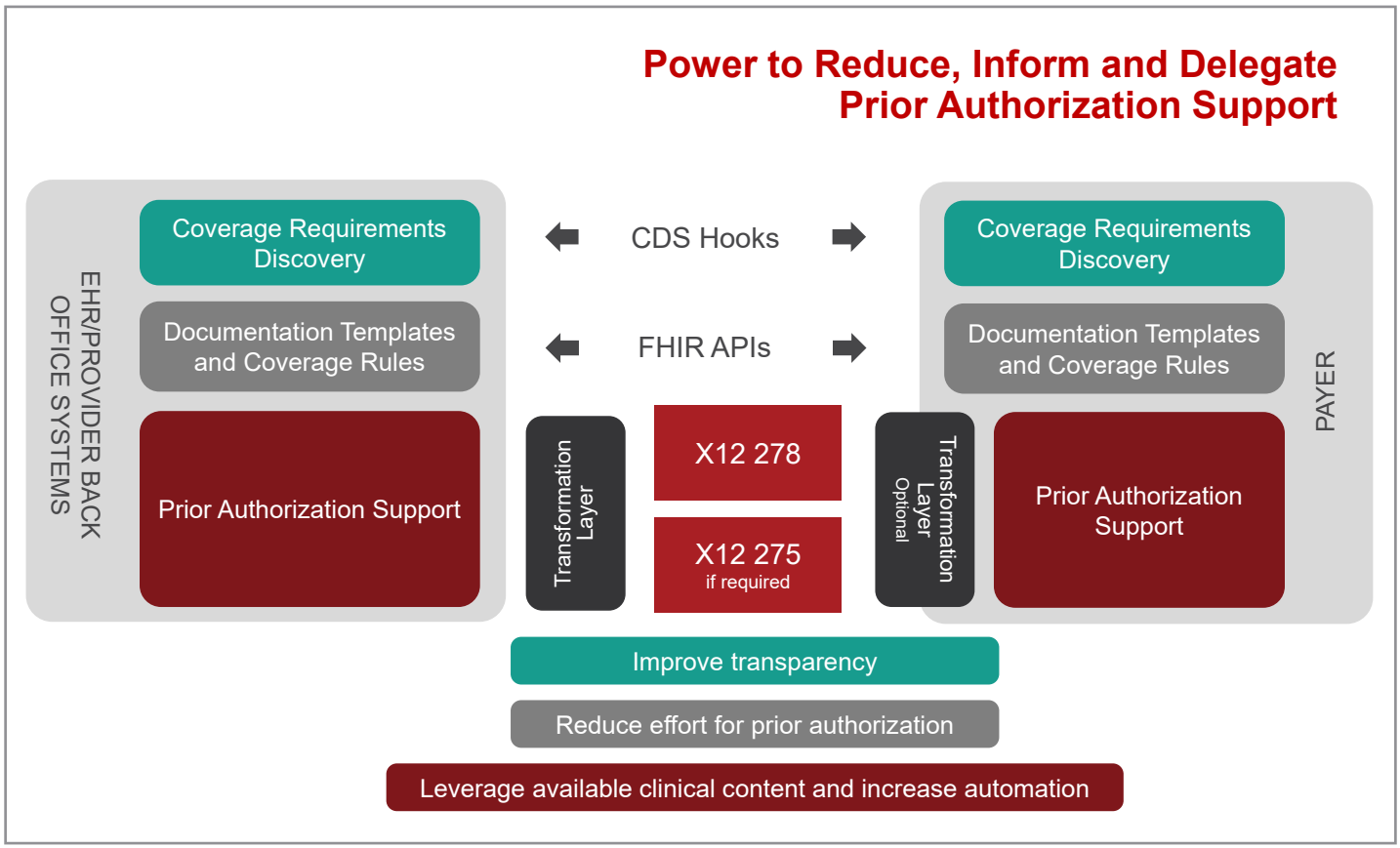
`` Without a doubt, there will be an expanded use of the Health Level 7 (HL7) Fast Healthcare Interoperability Resource (FHIR) standard. We expect payers, providers and other stakeholders involved in the Da Vinci Project to start using it. But it will be the innovators and early adopters who work out any issues with the standard and measure return on investment. Transactions among innovators and early adopters, however, will only get us so far, so scaling FHIR will be imperative. **Technical architectural barriers** and possible solutions to scaling FHIR have been identified by the FHIR at Scale Taskforce, convened by the Office of the National Coordinator for Healthcare Information Technology (ONC). **(Click here to read our article on FAST.)**

2. **Electronic prior authorization (ePA) will mature and expand to include drugs and devices covered under the medical benefit.** 2020 will be a busy year for ePA, as many stakeholders push to make it the norm rather than the exception in order to address providers' challenges and concerns related to administrative burden and delayed time to therapy. A major shift we'll see in 2020 will be from ePA 1.0 to ePA 2.0, meaning that the focus to automate will expand to include not only drugs covered under a patient's pharmacy benefit but also drugs and devices covered under a patient's medical benefit **(click here to read our article on the subject)**. Use cases are being developed and balloted, such as the **prior authorization support use case** spearheaded by the Health Level Seven (HL7) **Da Vinci project** (for which POCP is program manager).

Also in 2020, we will see a shift from payers denying payment to more guiding of care. Recognizing that prior authorization (PA) restrictions are often unrealistic and burdensome/expensive for everyone involved, an increasing number of payers will wrestle with the need for PA and may choose new approaches such as implementing Da Vinci uses cases designed to reduce, inform and delegate prior authorization support and exploring possible uses of artificial intelligence.

In addition, America's Health Insurance Plans (AHIP), a major insurance industry group, and several member insurers (covering 60 million lives) also launched a pilot to evaluate different approaches to ePA. During the recent ONC annual meeting, Kate Berry, AHIP senior vice president for clinical affairs and strategic partnerships, made it clear that payers will be working hard on ePA in 2020 saying, "Believe it or not, plans don't like prior authorization either; we know there are lots of opportunities for improvement." There will be an independent measurement done, and Point-of-Care Partners (POCP) will serve as subject matter experts to that effort.

Part of this shift will go beyond automating PA and also include payers being more transparent with physicians about which drugs or devices require PA and suggesting evidence-



based alternatives that don't. With myriad approaches to streamlining PA and increasing adoption of ePA, there are sure to be challenges in determining the approach and implementation plan that will work best within a particular organization. Because of our work on Da Vinci, participation as a subject matter expert in the AHIP pilots and our up-close understanding of electronic health record (her) capability and limitations and provider workflow, we are uniquely positioned to help.

3. The intricacies of price transparency will begin to unravel, revealing opportunities. The federal government will be implementing its vision and use every lever at its disposal – including rulemaking – to make health care function more like a normal market where publicly available pricing information empowers patients to shop competitively for care, increasing competition among hospitals and insurers.

2020 will see progress in efforts to chip away at the complexities of price transparency, including list price vs negotiated prices vs patient out-of-pocket costs. For example, the Transparency in Coverage **proposed rule** would (if finalized) require insurers and health plans to provide beneficiaries real-time, personalized access to cost-sharing information. Similarly, a separate **final rule** would require 6,002 hospitals to publish payer-specific negotiated prices for items and services beginning on January 1, 2021.

To be sure, immediate benefits won't be seen from these recent price transparency rules but should be a catalyst for stakeholders to explore how they can transform something they must do into something that differentiates them in the market.

Rather than doing the bare minimum, smart stakeholders will be thoughtful about what information is most helpful to patients and ways to provide that information in the most user-friendly way. They will also see opportunity in augmenting their price transparence tools with effective patient education and outreach to meet patients where they are, bring them up to speed and equip them to make more informed decisions based on not only price but value.

A lot of work has been done around prescription price transparency and that will continue to be refined in 2020. Price transparency tools, such as the consumer-facing, real-time pharmacy benefit check standard being developed by the

CARIN Alliance, will be rolled out along with other real-time pharmacy benefit tools which will help patients, their doctors and other stakeholders make better decisions on prescriptions. Under a new final rule, Medicare Part D plans must adopt one or more real-time benefit tools by January 1, 2021. They will inform prescribers when lower-cost alternative therapies are available under the beneficiary's prescription drug benefit, which can improve medication adherence, lower prescription drug costs, and minimize beneficiary out-of-pocket costs.

But payers and providers now have an opportunity to use price transparency to increase competitive advantage and to better support value-based care.

4. **Automated specialty enrollment will begin the process of streamlining the specialty prescription process.** We expect to see continued action and opportunity around specialty pharmacy automation. As we've noted in **previous posts**, use of specialty medication is accelerating, with these drugs accounting for half of the drug spend and continuing to grow. Yet specialty pharmacy is still largely unautomated. An automated means for specialty enrollment will be a primary goal for bringing specialty pharmacy into the 21st century. This should ease the enrollment burden surrounding the crucial first step involved with obtaining a specialty medication. Standards work will continue to be the backbone of progress, with a new specialty standard likely to be voted on within the National Council for Prescription Drug Programs this year.

5. **FHIR adoption will accelerate as will key work addressing infrastructural barriers.** Use of the FHIR standard will continue to pick up momentum, bringing health care data exchange to a more modern level. Drivers to accelerate adoption include efforts by several initiatives like **Da Vinci**, **Sequoia**, **Argonaut** and **FAST**, as well as government policies, principally from ONC. We predict there will be new use cases and pilots to improve the use of FHIR as a mechanism to get information both into and out of EHRs, especially as it relates to taking advantage of the anticipated finalization of information blocking rules. At the same time, the industry will move to identify infrastructure gaps to support those use cases. We see the industry moving toward standardized, FHIR-based transactions to address those needs rather than push most requirements back on providers. Clearly, FHIR has been tapped by industry leaders and government agencies as a key tool to improve data exchange and interoperability. Organizations that haven't yet hopped on the FHIR train may need some help to catch up.

6. **Trusted Exchange Framework and Common Agreement (TEFCA) publication will establish a "single on-ramp).** Many see the future of national-scale health data exchange as being based on the long-awaited and yet-to-be published final rule being developed for the Trusted Exchange Framework and Common Agreement (**TEFCA**). Its goal is to provide a standardized, secure and scalable data exchange framework that will serve as a "single on-ramp." This will create opportunities for some, but shouldn't change the landscape all that much, as information exchange is more a function of business' willingness to share information than technology. We expect the final regulation will be similar to what was originally proposed but we will be sure to keep our eye on TEFCA, analyze the final rule and help our clients understand how it may impact them.

7. **EHR- companies will finally know how information-blocking rules will impact them.** Just about everyone has been on hold awaiting the final rule concerning information blocking to drop. EHRs are at the head of that list – whether they must provide access or will gain access to valuable patient data. This pause may impede progress toward interoperability. For example, many EHR vendors have held off expanded capabilities related to application program interfaces. If the final rule is similar to **what was proposed** – especially regarding vendors only being allowed to recoup costs that are "reasonably incurred" (which is what we predict) – profit centers for EHRs may be affected. This could mean that some EHRs will do the bare minimum to comply. Competitors may use the requirements as a hammer against one another, which could level the playing field between bigger and smaller players. Other HIT vendors also have much to gain or lose. •

Conclusion. *POCP expects 2020 to be a busy year. Which challenges and opportunities will we help you tackle in 2020? Reach out to us at* **tonys@pocp.com** *and ken.kleinberg@pocp.com. POCP can help make 2020 your most innovative and productive year yet.*

2 Part 2: How Payers and Providers Can Succeed in Value-Based Care

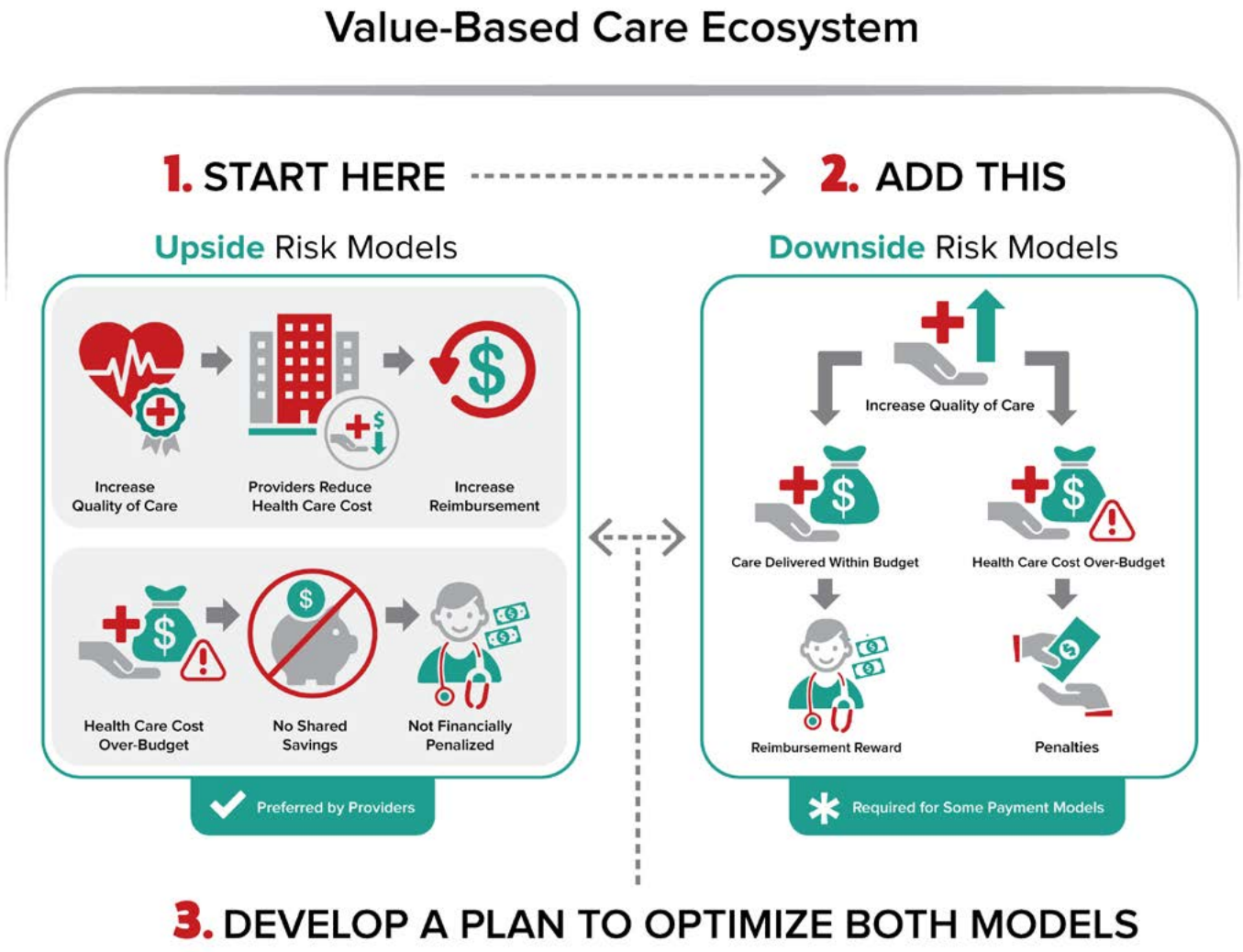
By Jocelyn Keegan, Payer Practice Lead, and Gary Austin, Payer/Provider Interoperability Lead

How we pay for health care is undergoing a disruptive, fundamental shift. We are rapidly moving away from the traditional fee-for-service, pay-for-volume approach to value-based care (VBC) programs that pay based upon demonstrated value. According to the Health Care Payment Learning & Action Network (LAN), nearly 36% of total American health care payments were tied to alternative payment models in 2018, specifically shared risk/shared savings categories.

These efforts have been successful with payers reducing unnecessary medical costs **by nearly 6%** as a result of their value-based care strategies. While progress has been made, there still are opportunities for payers and providers to make their transition to value-based care even more successful. Here are several things that will pave the on-ramp to VBC.

1. Embrace upside risk. Tectonic shifts in the market are moving it toward new models of financial risk sharing as the backbone of VBC models. These are aimed at making providers more accountable and financially responsible for the care they provide. One-sided or "upside risk" models allow providers to share in the savings they generate when they provide more efficient care based on certain cost, care delivery and quality metrics. In the second model, called "downside risk" arrangements, providers' payments can get dinged when they go beyond contractually set financial and clinical levels. In fact, they may even be required to refund a portion of their payments if they go over an agreed-upon amount for a certain group of services. There are even hybrid models that can include both types of risk sharing.

Evolution of Value-Based Data



Payers and providers will have a hard time ignoring these risk models going forward. By 2025, LAN projects 100% of Medicare and 50% of Medicaid and commercial payments will be tied to two-sided risk alternative payment models or APMs (categories 3B, 4A, 4B, & 4C of the **LAN's Refreshed APM Framework**). By starting with upside risk and maturing to downside risk, payers will be able to increase care quality, reduce costs and increase reimbursement. Here are a few reasons why.

- **There are benefits.** Payers save money. Providers can earn bonuses and are not liable to repay financial losses if care costs go over budget.
- **The train has left the station.** The number of payers and providers participating in upside-only risk contracting is on the rise. This is fueled by a specialized risk-contracting method called accountable care organizations (ACOs). **According to one estimate**, in early 2018 there were 1,477 ACOs among public and private payers, covering about 32.7 million patients. Of those, nearly half were Medicare ACOs, the majority of which were participating in upside-only contracts. Medicare Advantage (MA) plans also are a factor. There were **more than 3,000 MA plans in 2019** with an enrollment of 22 million (about a third of all Medicare beneficiaries). Medicare is the big dog on the block and Medicaid and private insurers generally follow suit.
- **There are risks for nonparticipation.** To be sure, there are many markets where shared savings arrangements are not dominant. However, that is changing and there are consequences for payers and providers who don't join

SELF-ASSESSMENT QUESTIONS:

- Do you understand the landscape?
- Where is your organization now?
- Do you have a roadmap for advancing your value-based care strategy?

in. Remaining independent providers that aren't onboard risk sustainability, may join networks of other independent providers, become boutique providers or get absorbed in a merger or acquisition. Market forces and Medicare are driving commercial payers into risk-sharing arrangements. These new contracts are being written that will both create and cement trust relationships as well as establish partnerships that speak to future viability. Those who are late adopters or laggards are apt to struggle for market share and achieve competitive advantage farther down the line.

- **There's already a transition to downside risk.** Payers are already starting to move from upside risk arrangements to embrace downside risk arrangements. Leading the pack is Medicare's "**Pathways to Success**," which went live on January 1, 2020. There will be two payment tracks. ACOs in the BASIC track will be required to accept modest downside risk after two years, but this eventually will increase over time. ACOs in the ENHANCED track are eligible to share 75% of the savings they earn but also face downside risk of 40% to 75% of losses if their actual spending exceeds their annual benchmark. **For 2018**, Medicare paid approximately $285 million as shared savings to ACOs and recouped nearly $64 million as shared losses.

2. Leverage health information technology to manage and analyze data. Risk-based arrangements depend on data. There's plenty of data about patients, costs, care delivery and quality, and the volume is growing using disparate clinical and administrative databases. That said, there are challenges in capturing and analyzing the data as well as sharing the information among payers, providers, patients and their caregivers.

Providers and payers are key to the required data. Payers provide a broader view from pharmacy benefits and claims, while providers have information about individual patients, costs and quality metrics through their electronic health records (EHRs). The technical challenges are exacerbated when dealing with various patient populations. At the same time, organizations will need health information technology (health IT) to help make their organizations more **consumer centric**, recognizing that consumer satisfaction and loyalty are critical to success in a value-based care environment.

Here are some of the ways payers and providers can leverage health IT in the world of VBC.

- **Move to APIs.** Payers and providers will need to embrace the move to share data through application program interfaces (APIs). This is already happening with heavy impetus from the federal government. Examples include requirements in implementing the 21st Century Cures Act and the new **five-year roadmap** from the Office of the National Coordinator for Healthcare Information Technology. It emphasizes use of apps and APIs to help patients and providers access and share patient data. Medicare launched its **Blue Button 2.0**, which is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to various applications, services and research programs. In addition, fee-for-service Medicare has funded significant API standards development around payer-to-provider collaboration through Health Level 7's (HL7) **Da Vinci Project**.

Mobile health (mhealth) also represents a real opportunity since nearly everybody has a smart phone. Innovative mobile applications are flooding the market. **It is estimated** there are now over 318,000 health apps available on the top app stores worldwide — roughly twice the number available in 2015. More than 200 apps hit the market each day. Moreover, there is at least one high-quality app for each step of the

patient journey. Such mhealth apps show promise for better doctor-patient communication and enhanced data management, as well as improved patient monitoring and engagement in their care. For example, use of digital health apps has been shown to reduce acute care utilization in five key patient groups (diabetes prevention, diabetes, asthma, cardiac rehabilitation and pulmonary rehabilitation). This could save health care an **estimated $7 billion per year**.

- **Embrace data analytics.** Data analytics will be vital to understanding the costs and outcomes of care. For payers, this will take the form of artificial intelligence (AI). AI's computing power can make sense of large, complex data streams. The result: actionable information for decision making. For example, risk-sharing models analyze **prescribing patterns** to manage high-cost patients. Providers will use the analytics in their EHRs to evaluate cost and quality performance in real time.
- **Standardize rules about data sharing among trading partners.** Data sharing also is important to VBC but is challenged by variations in technologies and standards. This will be mitigated, to some extent, by the upcoming final rule being developed for the **Trusted Exchange Framework and Common Agreement (TEFCA)**. Its goal is to provide a standardized, secure and scalable data exchange framework that will serve as a "single on- ramp." Yet the individual stakeholders must internalize those requirements. Moreover, it will take a while to get TEFCA implemented. In the meantime, stakeholders must deal with trading partners whose health IT systems have different capabilities and are undergirded by different versions of standards — or even different standards. Everyone must be on the same page and trading partners need to standardize data-sharing rules among them. There's no sense reinventing the wheel with each trading partner agreement.
- **Develop a compliance roadmap.** As the industry forges ahead with a paradigm shift to value-based care, stakeholders need a multi-faceted approach to ensure compliance with evolving standards and mandates and to take judicious advantage of industry pilots.
- **Get involved with cross-industry collaborations concerning standards or stay informed at a minimum.** Payers and providers should participate in new stakeholder initiatives concerning standards. It may not seem revolutionary, but it is a way to make sure your voice is heard, and your concerns are addressed. It also is a way to develop subject-matter expertise. There are several collaborations from which to choose -- and they are growing. For example, several leading payers, providers, vendors and standards groups are driving to advance electronic prior authorization (ePA). America's Health Insurance Plans (AHIP), a major insurance industry group, and several member insurers (covering 60 million lives) recently **launched a pilot program** based on the ePA standard. HL7's **Da Vinci Project** is working to advance the use of the Fast Healthcare Interoperability Resource standard in support of VBC data exchange across communities. Da Vinci's open business model process enables payers, health systems and other industry participants to identify and enumerate use cases that involve managing and sharing clinical and administrative data between industry partners.

That said, most industry standards development organizations and collaboratives depend on paid staff and volunteers — either on their own time or on loan from their day jobs. The latter may not be practical for some organizations. To be sure, there is a broader world beyond the collaboratives that smart organizations need to keep on top of. This is an essential part of the compliance roadmap (referenced previously) and a necessity in creating strategic positioning, return on investment and compliance. •

Next Steps to VBC Success

VBC and health IT are complex, rapidly growing and inextricably intertwined. Point-of-Care Partners (POCP) is a major player. We are actively involved in the development and adoption of standards for pharmacy, health data exchange and price transparency. We are the program management office for Da Vinci. Let us put our expertise to work for you. We can be your trusted partner and resource, keeping you current on trends and developments and helping you build and execute a roadmap for success and compliance. Reach out to us at **gary.austin@pocp.com** or **jocelyn.keegan@pocp.com**.

3 Part 3: *FAST*: The Coalition Aiming to Strengthen the FHIR Interoperability Infrastructure

By Dana Marcelonis, Account Director, Payer Services

Health Level 7's (HL7) FHIR (Fast Healthcare Interoperability Resources) standard is rapidly becoming the standard of choice to enable the exchange of clinical and, increasingly, coverage-related data. Its uptake will continue to accelerate because of work on functional use cases developed by various coalitions, including the HL7 DaVinci Project and the CARIN Alliance.

But the road from inspiration to implementation is not smooth. As coalitions pursue their respective functional use cases, they're encountering similar challenges stemming from the existing hybrid environment. Just a few examples include how to locate and interact with the right payer without managing scores of one-on-one connections, how to mediate the range of versions and profiles in use, and how to integrate new FHIR exchanges with existing partners and infrastructure.

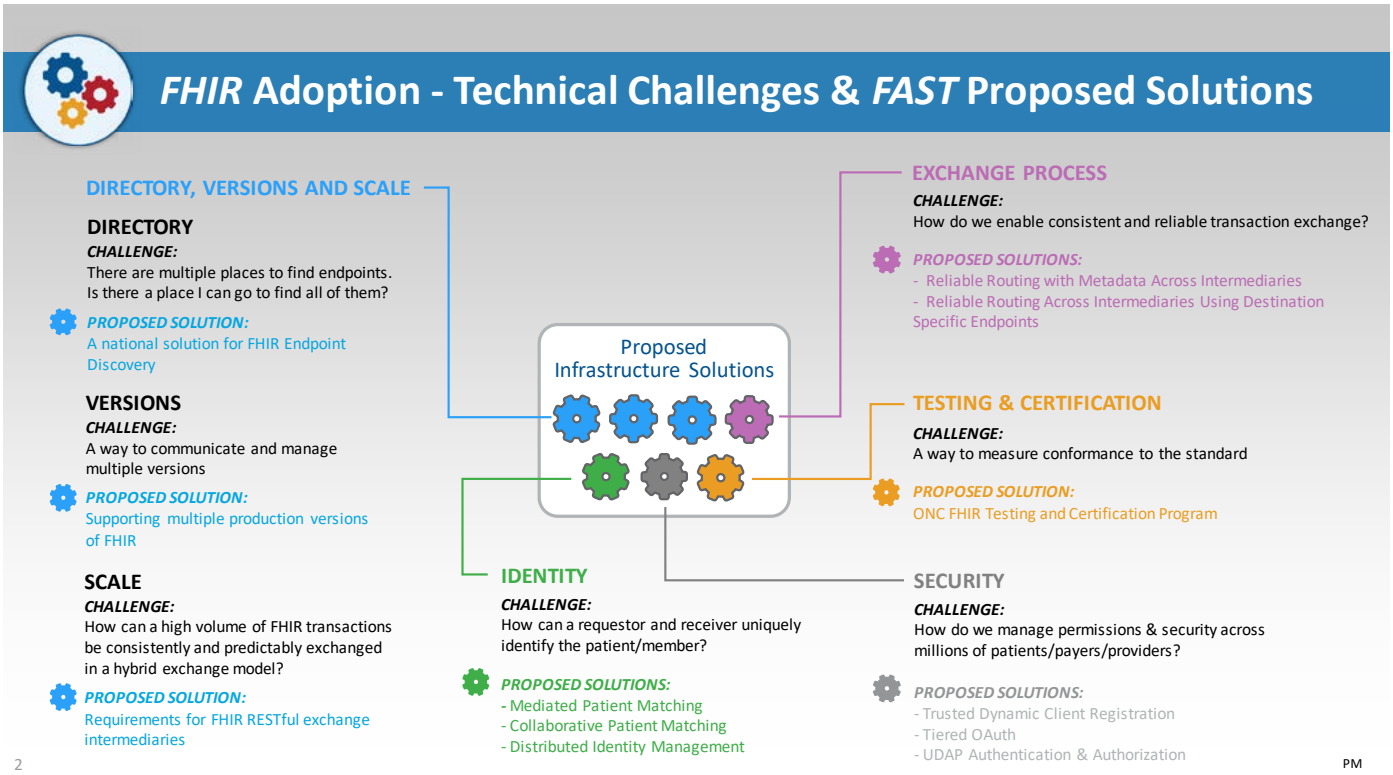
It became clear to early adopters that such challenges are common and needn't be addressed over and over again within and across the individual functional use cases. **Enter FHIR at Scale Taskforce (*FAST*)**, whose mission is to address those shared architectural barriers and gaps. *FAST* — convened at the request of industry leaders by the Office of the National Coordinator for Healthcare Information Technology (ONC) — is set to tackle key areas of common challenges and develop forward-looking potential solutions. The aim of these analyses is to address current barriers and establish an interoperability architecture to support FHIR adoption at scale.

Addressing technical challenges.

FAST is taking a Tiger Team approach to address these technical challenges that currently limit FHIR adoption. The first step in addressing these challenges was for the Ecosystem Tiger Team to analyze several functional use cases and identify common barriers. Although the analyses are focused on FHIR, they highlight common infrastructure issues that must be resolved to facilitate interoperability across various standards, technical platforms and use cases.

See the diagram below for brief problem statement descriptions for the *FAST* Tiger Teams and current proposed solutions still under development.

1. **Directory.** The need for accurate, complete and up-to-date directories of providers and payers is a pain point that FAST is addressing. Inaccuracies and gaps may limit access to care, delay speed to therapy and create complicated billing problems. **Proposed solution: A**
2. **Versioning.** Ensuring that everyone is on the same page with the respect to standards versions has been challenging since health information technology (health IT) standards were introduced as part of the Health Insurance Portability and Accountability Act (HIPAA). The problem has become even more complicated with the rollout of new standards, health



*Source: ONC FAST 101 PowerPoint Presentation (**https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/FAST+101+and+Keystone+Slide+Decks**)*

care's ubiquitous dependence on health IT, and use cases in which stakeholders adopt various versions of standards. Implementation guides need harmonization. **Proposed solution: Supporting multiple production versions of FHIR.**

3. **Scaling.** This issue has two components: the growing volume of FHIR-based transactions and the growing number and complexity of data exchange models. How do we make response times more predictable and consistent to better support real-time exchanges? How can standards be successfully implemented to support hybrid exchange models? Proposed solution: **Requirements for FHIR RESTful exchange intermediaries**.[1]
4. **Testing and certification.** These are key components of ensuring that health IT systems are in sync with current requirements for FHIR adoption and deployment. How do we test and version across multiple stakeholders with varying degrees of maturity? How do we adequately test/validate consistently in a scalable environment? What are the minimum necessary requirements? While ONC currently has a health IT certification program, its focus is broader than FHIR and aimed at ensuring health IT systems meet federal requirements. **Proposed solution: ONC FHIR testing and certification program.**
5. **Security.** Protecting the security of health care data and their exchange are perennial problems that continue to be front-and-center issues affecting FHIR adoption. Factors include the amount of data being exchanged; the size and number of entities involved (solo practice vs multisite integrated delivery network); the need for permission to access and share data; and protections and responses to a variety of internal and external threats and vulnerabilities. Risk must be mitigated. **Proposed solutions: Trusted client dynamic registration and token request.**
6. **Identity (patient and provider identity management).** Correctly identifying patients is vital to correct billing, patient safety and high-quality health care. Because Congress prohibited the creation of a unique patient identifier using federal funds, there is no single way to correctly identify patients. As a result, payers, providers and others use complicated algorithms and patient-related information to identify patients and link them to their records. In addition, providers and patients must be correctly identified when real-time transactions are conducted. **Proposed solutions: Mediated patient matching; collaborative patient matching; and distributed identity management.**
7. **Exchange.** There are many technical challenges involved in consistently and reliably exchanging clinical data across a hybrid system, especially when partners may use one or more intermediaries for technical and business operations. **Proposed solutions: Reliable routing and metadata access across intermediaries.**

Importantly, these Tiger Teams aren't working in a vacuum. Each of these proposed solutions has been presented to the *FAST* **Technical Learning Community (TLC)** to gain feedback and will be further vetted through smaller sessions with subject-matter experts for refinement and strengthening before they move to the next stage. Artifacts could come in the form of implementation guides, industry guidance or best practices.

Want to get involved?

Request to join a Tiger Team or participate in the TLC. You can **sign up to join** the *FAST* Technical Learning Community to get updates, provide input on technical and regulatory barriers, new use cases and potential solutions on the ***FAST* confluence page**. **There also is a LinkedIn Group.** •

Point-of-Care Partners (POCP) can also be a valuable resource on FHIR, program management of multistakeholder initiatives and related matters. We are the project management organization for Da Vinci (contact jocelyn.keegan@pocp.com) and provide support staff for FAST (learn more on the FAST Confluence page). We are involved in several stakeholder efforts aimed at health IT standards and adoption. We'd be pleased to explain how these developments affect health IT in general and your organization.