The Twenty-Third National HIPAA Summit
Are we there yet? What is next and why is it taking so long? Can we pedal faster?

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- Business process consultant focusing on electronic health records, and electronic transactions between organizations
- Former positions with MGMA, University of Denver, Dartmouth College
- Active leader in the Workgroup for Electronic Data Interchange (WEDI)
- Speaker and author (two books on HIPAA Security and one on electronic health records)
- Recipient of Vision and Leadership Award as WEDI Chairman, WEDI Corporate Leadership Award, and WEDI Distinguished Service Awards
- Consultant to CAQH CORE Project
- HIPAA Expert Witness
- Consultant to three successful EHNAC applicants

Strategies for workflow, productivity, quality and patient satisfaction improvement through health care information

- -- **Strategic IT business process planning**
- -- **ROI/Benefits realization**
- -- **Project management and oversight**
- -- **Workflow redesign**
- -- **Education and training**
- -- **Vendor selection and enhanced use of vendor products**
- -- **Facilitate collaborations among organizations to share/exchange health care information**
- -- **EHR and HIE training and facilitation**
- -- **Medical Banking**
- -- **EHNAC Support**

Where are we going?

- “If you don’t know where you are going, any road will get you there”, Alice in Wonderland, Lewis Carrol, 1865.
- “The healthcare industry has regulatory fatigue”, thought leader from a vendor, 2015.

Basis for Presenter's Observations

- Dr. Lazarus has conducted more than 100 health care executive interviews across multiple client sponsored engagements, primarily with thought leaders.
- Actively engaged in Administrative Simplification since 1992 (contributor to WEDI 1992 and 1993 reports, past WEDI Chair, HIPAA Summit transactions Co-CHAIR since 2000, continuous active HIPAA consulting practice since 2001).

Agenda

1. What is taking so long?
2. Regulation versus business case – the tide is shifting
3. We cannot get there if we don’t know where we are going

1. What is Taking so Long?

1. Regulation fatigue – historically few have wanted to invest IT and business process resources **on an ongoing basis** to make revenue cycle management (RCM) changes
   - Instead, the industry approaches IT regulations one at a time (required: ICD-10), and not required when it suits their business purpose, except when mandated by federal law (e.g., Medicare electronic claims for most providers).

1. What is Taking so Long?

2. Regulation uncertainty
   - Will ACA be repealed? Republicans have tried 56 times as of February 3, 2015 and failed. What will the Supreme Court do?
   - ICD-10 is delayed, and yet some want to delay it further or never wanted it to happen.
   - HPID – what is its purpose and when will it be required?
   - There will be a new Administration in January, 2017 and we can expect a six month delay on all new regulations.
3. Hospitals and eligible providers have been focusing their IT investment resources on Meaningful Use - $28 billion in incentives have been paid out by CMS so far

1. What is Taking so Long?

4. Most vendors wait until the last minute to test and deliver system upgrades to implement and test for new regulatory requirements
   - Part of this is due to the vendor R&D development and investment cycle which is subject to regulatory uncertainty (both in timing and specifics).
   - Vendors often only implement what is minimally required by the regulations (e.g., acknowledgements are not required by HIPAA but have a proven business case).
   - Vendors know from experience that if they build it, the providers may not come.

1. What is Taking so Long?

4. Unclear business case
   - Compliance versus saving costs/being efficient.
   - Before we adopted ACA Operating Rules, compliance was the focus, but that is changing.

2. Regulation Versus Business Case – the Tide is Shifting

1. HIPAA and ACA compliance do not mandate that providers utilize electronic transactions and operating rules
   - They can use paper or fax.
   - They can use the phone.
   - They can do nothing (e.g., claim status inquiry, eligibility, etc.).
   - They can continue to receive paper checks.
   - This results in unnecessary labor costs and lots of money left on the table in the form of write-offs and bad debt. The CAQH 2014 Index estimates that providers could save $7.2 billion and health plans could save $1.1 billion annually if all of the standard transactions and operating rules were fully implemented.

2. Regulation Versus Business Case – the Tide is Shifting

2. The business case is rapidly becoming compelling to utilize electronic standard transactions and operating rules
   - Hospitals and other providers are experiencing lower price "rate pressure", through tougher negotiations by health plans.
   - Electronic eligibility can help significantly in understanding benefits and remaining deductible, especially for patients on health care reform insurance policies that may not be well understood by the patient.
   - ACO, integrated delivery systems, and other care coordination approaches **require near real-time access** to clinical and administrative data.

2. Regulation Versus Business Case – the Tide is Shifting

- Provider success with reimbursement reform (e.g., bundled payments, outcome based payments etc.) will depend heavily on access to consistent, quality data on patient services, clinical information and new standard measurements that are not well utilized today (e.g., outcomes).
- One thought leader reported that his hospital group lowered costs enough through aggressive use of Administrative Simplification to significantly mitigate the lost revenue from health plans' lower reimbursement and new reimbursement models.

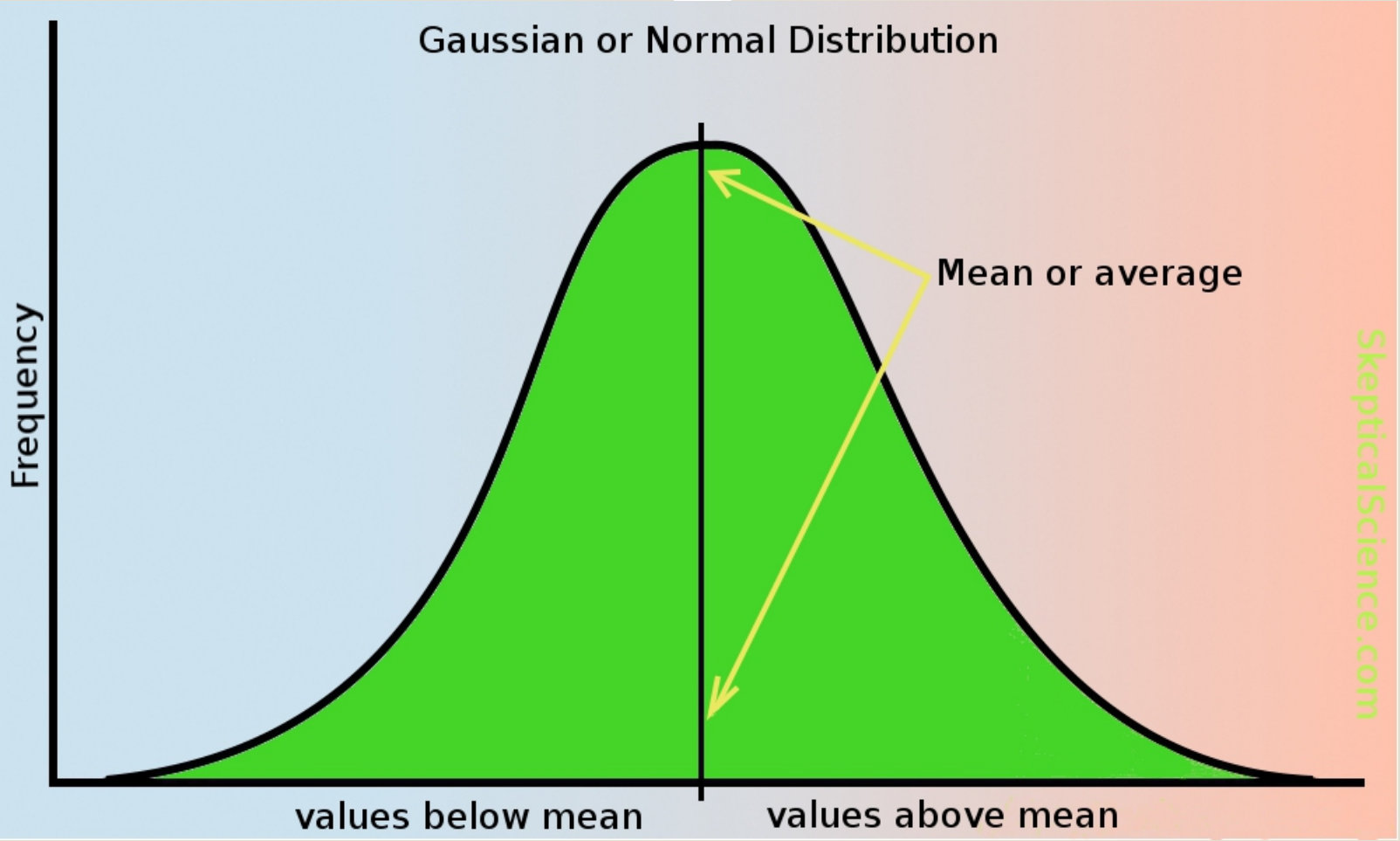
3. Patient satisfaction

- Patient satisfaction will increasingly be based on timely, valid information about their benefits and financial responsibility.
- A new Revenue Cycle Model for the patient financial experience will be presented by the HIMSS Revenue Cycle Improvement Task Force at HIMSS 15.

2. Regulation Versus Business Case – the Tide is Shifting

4. Understanding how the implementation strategy for providers has changed since 2000
   - It used to be the case that the implementation of the HIPAA standards followed a bell-shaped curve, with a small percentage of health plans and providers implementing the new standards about a year after regulations are published.
   - The bulk of the health care industry then spends the second year testing and implementing the standard transactions, with a big push in the last 90 days prior to compliance.
   - Claims come first, the other transactions historically have followed; but that might not be the case in the future with increase use of eligibility, remittance advice and EFT.

The Past: 2000-2013



2. Regulation Versus Business Case – the Tide is Shifting

- Then, because CMS wants this to work with a consultative approach rather than a penalty approach, it provides a contingency for three months or more for the laggers to implement the regulations
- In addition, clearinghouses often help in the process long after the compliance date
  - For years after 4010 was required, many clearinghouses were making a nice profit on converting paper claims to 4010 claims.
  - As recently as 2014, clearinghouses report still receiving 4010 version claims for processing.

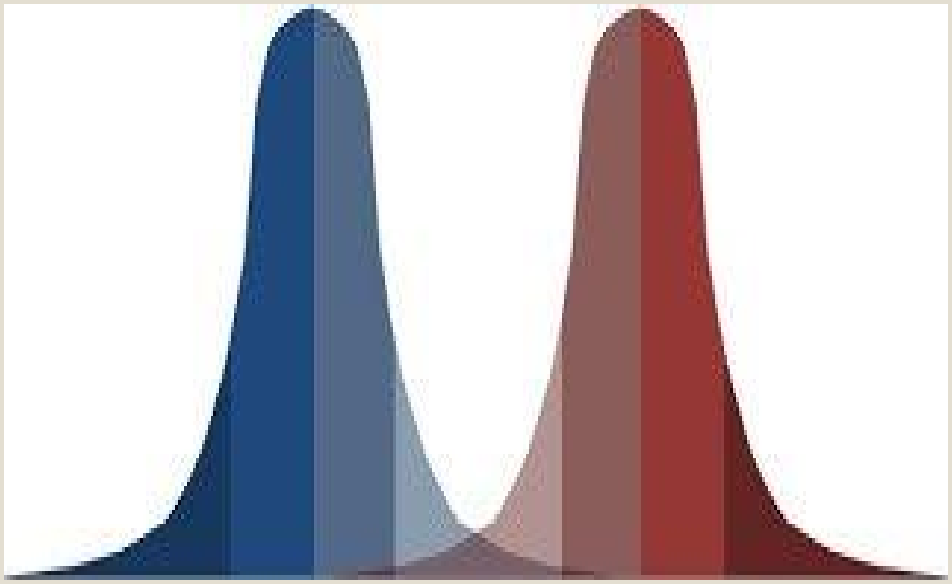
The Future Trend

- Outcomes based reimbursement and bundling requires data and analytical tools, as well as clinical decision support, often in real-time.
- Thought leaders and advanced provider organizations have realized this and moved aggressively to develop an information systems infrastructure, based in part on the standards and operating rules, to support their future business needs.

The Future Trend

- Some thought leaders who have accomplished this change indicate that it will take years for the others to catch up once the reimbursement reform changes occur if they do not have these infrastructures in place throughout their enterprise and the skilled personnel and tools to use them effectively.
- The emerging industry implementation looks more like two bell-shaped curves as shown in the next slide. Currently, the curve on the right represents a smaller population of providers, but that could shift significantly over the next five years.

The Future Trend: 2014-2020 and Beyond



3. We Cannot Get There if we Don't Know Where we are Going

1. Where are we going?
   - There will be a big shift in the next five or so years.
   - Many providers and others in the industry will not be able to keep pace, resulting in a **"bi-readiness"** level in the industry for clinical and administrative use and sharing of electronic information
   - The laggers are evidenced by those who do not want ICD-10, are only using electronic claims for major payers, have not started to implement Meaningful Use, etc.
   - Hospital acquisitions of other hospitals and physicians, other provider type mergers, and increased reliance on **"helpful"** third party vendors for revenue cycle management tools are already underway as part of their approach to keep moving ahead.

3. We Cannot Get There if we Don't Know Where we are Going

2. Employer sponsored health plans, TPAs, and smaller commercial/government health plans face a big challenge too
   - The successful strategy no longer depends on saving money by shifting from paper to electronic transactions.
   - The strategy to success involves data analytics for negotiation, quality improvement and better patient outcomes; as well as improved transparency and communication with patients.
   - Communicating electronic images of paper, while helpful as a migration process, is not the end game.
   - There are economies of scale for IT infrastructure and staff expertise. Small organizations will have to acquire these resources through outsourcing, being acquired, or form a consortium with other similar organizations (and hope that it works).

3. We Cannot Get There if we Don't Know Where we are Going

3. What does the five to ten year provider information resource structure look like?
   - Real-time for almost everything, clinical and administrative, except for "complex" claims and prior authorization.
   - Interoperability based on standard data definitions with electronically recognizable tags (perhaps XML or something similar) which can be exported and imported for use in clinical decision support systems, logic models at the provider level that can determine prior authorization and benefits through tools supplied by health plans, etc.
   - Standardized mapping of code sets into "summary" level codes (e.g., mapping of multiple LOINC codes in a standard way to one universally understood code for a diabetes lab test order or result).

3. We Cannot Get There if we Don't Know Where we are Going

- A technology and personnel expertise infrastructure that supports on ongoing change and improvement for revenue cycle management, clinical decision support, patient transparency, and improved quality of care at lower cost.
- Rigorous security at a level acceptable to all trading partners with a standard approach to minimize the expense and management of the providers with multiple trading partner relationships.
- Significant, ongoing health plan and provider thought leader and expert participation on an ongoing basis. These issues (clinical, administrative, workflow, revenue cycle management, etc.) are needed to move from where we are to where we need to be in the next five years. This has to be health plan and provider driven based on business cases; not based on technology or the business needs of vendors and consultants (who have a role to play, but not a policy decision making role).

3. We Cannot Get There if we Don't Know Where we are Going

4. This change must be driven by a government and industry partnership
   - The government will have to have a leadership role in mandating this (law and regulation) and providing some funding.
   - The Federal Government will have to mandate that all Medicaid programs adhere to the requirements that are determined in a timely fashion.
   - This approach will be consistent with the Medicare and Medicaid receiving a solid return on their Meaningful Use investment
   - Technology is not the solution. It is a tool that can help us get there.
   - We need one roadmap for the next five years, updated annually by adding the next year out each year.

3. We Cannot Get There if we Don't Know Where we are Going

4. This change must be driven by a government and industry partnership (continued)
   - ONC is working on interoperability standards, including standards for clinical use. Administrative Simplification is absent from ONC's current initiative.
   - Legislation is also likely to be part of the process.
   - Representative Burgess, MD, is drafting legislation that calls for devising new methods for measuring whether EHR vendors are compliant with interoperability standards. This is just one example of legislation that is likely to be proposed to continue to refine healthcare IT to support the improvement of quality of healthcare, patient transparency, and reduce costs in the administrative and clinical areas.

The Days of a Leisurely Bike Ride are Over

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Contact Slide

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