



Health Level Seven® International

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HL7 January 2015 Payer Summit Executive Summary

The second offering of the HL7 Payer Summit was held January 22 – 23, 2015 in San Antonio, TX. HL7 established Payer Summit programming as part of an initiative to support the payer community and its effort to make the implementation of standards easier and more efficient.

Keynote - Performance Measures in CMS Programs

Dr. Kate Goodrich, Director of Quality Measurement and Health Assessment Group at the Center for Medicare and Medicaid Service (CMS), delivered the opening keynote address on the topics of delivery system and payment transformation, CMS's quality and measurement strategy, and electronic quality measure development.

Dr. Goodrich shared CMS's over-arching strategy for the development and implementation of quality measures and their framework for delivery system and payment transformation. She noted that the Department of Health and Human Services will focus on delivery system transformation with the goal of shifting from the current fee-for-service, volume driven and fragmented care to a future state of outcome driven, coordinated care that relies on different payment systems.

Dr. Goodrich also explained that delivery system and practice redesign from both the private and the public sector is key to moving toward population-based, alternative payment models. The effective management of a population of patients with good healthcare outcomes cannot be handled by CMS alone. This will require a significant financial investment from private payers to set the goals for population based payments or other alternative payment models.

Dr. Goodrich concluded her talk with a discussion of how to use value-based purchasing to reward providers and health systems that deliver better outcomes at lower costs. She emphasized quality measurement and health information technology as critical components of healthcare transformation. She also addressed the challenges of quality measurement development and the future state of e-Measure Development. She ended her presentation by observing that CMS must align private payers to better address the burdens posed by the needs of providers and patients, while maintaining focus on measures and policies that maximize quality improvement.

HEDIS and STARS Reporting - Leveraging Clinical Information Exchange for Quality Measurement Programs

Richard Sabbara of McKesson, Felix Bradbury of Accenture, and Crystal Kallem of Lantana Consulting gave an overview of the STARS rating programs and HEDIS measures. This was followed by a discussion of real-life complications and solutions affecting a payer's STARS rating, the challenges of HEDIS measures, and the HL7 clinical standards that support enhanced data capture.

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Mr. Sabbara's presentation highlighted his experience supporting and advising physicians. He included an outline of the challenges facing providers, why the common answers providers hear are not necessarily feasible, and gave an overview of how Health Information Exchanges (HIEs) might be a partial solution for physicians.

Mr. Bradbury provided an overview of the typical issues of a Medicare Advantage Plan and discussed how the CMS STARS rating program affects payers and providers. His presentation included best practices in the industry, operational factors that influence member perceptions of a plan's STARS results, and key questions to ask within your organization before undertaking analytics and quality improvement projects.

Crystal Kallem, Co-Chair of the HL7 Clinical Quality Information (CQI) Work Group, highlighted the activities of the work group. She provided an overview of how the work group creates and maintains information technology standards in support of improving healthcare quality as well as its mission to foster collaboration between quality measurement, outcomes, and relevant stakeholders.

Payer Selected Use Cases

The Payer Summit also featured a selection of use cases that highlighted real world problems around which payers are currently seeking solutions.

A Pre-Certification Use Case session looked broadly at how to leverage information standards such as HL7's Fast Healthcare Interoperability Resources (FHIR[®]) to improve the pre-certification process. A Lab Use Case presentation focused on how to improve disease management by using HL7 standards to identify beneficiaries with untreated diabetes. A Transitions in Care Use Case centered on the challenges inherent in transitions in care, and detailed how to get accurate, timely and useful administrative and clinical data that can inform referral and authorization decisions to improve disease management.

How to Build a FHIR: A Simple Implementation Case Study

David DeGandi and his team from Cambia Health Solutions demonstrated an HL7 FHIR interface built over the course of a few months. David DeGandi, Manager of Technology Strategy, and Amol Vyas, Senior Solutions Architect, provided firsthand knowledge from their payer development team about their experience with HL7's newest standard. The FHIR proof of concept (POC) implementation they demonstrated with specific prerequisites and goals validated that a FHIR-based solution has a faster time to market. This helps strategically position Cambia's HL7 framework for standards-based external integration.

Keynote - Sharing Value-Based Care Strategies

Esteban Lopez, MD, MBA, Regional President of Blue Cross and Blue Shield of Texas, delivered Friday morning's keynote address on enhanced care coordination between doctors, hospitals, and other healthcare entities who are coming together to provide high quality care under Accountable Care Organizations (ACOs). With the goals of coordinating care and chronic disease management while lowering costs, Dr. Lopez discussed how the ACO model is impacting the operational workflow (practice) redesign (ACOs, bundled payments, episodes of care, quality/performance analytics, etc.) and the cultural shift taking place as payers introduce new value-based programs.

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Dr. Lopez detailed how the value-based programs currently in place at Blue Cross and Blue Shield of Texas are gradually shifting accountability for quality outcomes and costs onto providers. He also stressed the importance of transparency in costs and the site of service offering the use of a Benefits Value Advisor, as an example of a concierge service to help members look up price differentials by zip code. He also noted the importance of the clinician's right to insist on specific facilities based on what makes clinical sense.

Dr. Lopez concluded his presentation with an overview of the practice pattern changes in value based care models, including the use of health information technology, patient risk stratification, gaps in care identification, and physician performance metrics.

What Providers Expect from Payers

Thomson Kuhn, Sr. Systems Architect, American College of Physicians, and Russell Leftwich, MD, Chief Medical Informatics Officer at Tennessee Office of eHealth Initiatives, presented the provider perspective of what physicians want from payers to better align both stakeholders on Accountable Care Organizations, Value-Based Programs and automated Prior Authorizations.

Dr. Leftwich led a discussion on the challenges of EHR adoption as well as the administrative burden and redundancies of prior authorization. Comparing the current state of health information exchange to a game of telephone, Dr. Leftwich outlined four key items physicians want from payment and quality reform: transparency; uniform, specialty appropriate requirements; evidenced-based metrics; and equity of technology cost share.

Mr. Kuhn presented clinical documentation in the 21st Century from the physician's perspective, stressing the provider's desire to use the system to track a patient's condition as well as communicate treatment decisions and commentary to the patient and other members of the care team. Providers increasingly feel as though paperwork comes before the patient, and that the evaluation and management of coding guidelines have complicated the use of documentation to improve care. He also shared the official positions of the American College of Physicians for the following areas: the primary purpose of clinical documentation, the purpose of the EHR in value-based care and accountable care models, the capturing of structure data, and the challenges presented by documents that entail unique data content and format requirements.

Payer Implementation Case Studies

The summit concluded with four implementation case studies. Dr. Mark Pilley, Medical Director of StrategicHealthSolutions, LLC, led a session on the esMD standards efforts and its applicability to the exchange of digitally-designed, structured documentation for clinical and administrative purposes.

Mariann Yeager, CEO of Healtheway, discussed the eHealth Exchange, which enables secure, trusted interoperable exchange of health information among federal agencies and roughly 30% of hospitals in the U.S. This represents 100 million patients. Participants in the eHealth Exchange share health information for treatment, care coordination and transitions of care. They also use the eHealth Exchange to report quality measures and automate the provision of medical records to the Social Security Administration for disability benefits determination.

Sherry Wilson, Executive Vice President and Chief Compliance Officer of Jopari Solutions, and Deborah Meisner, Vice President of Regulatory Strategy at Emdeon presented an implementation case study from the property and casualty insurance sector. She discussed how

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they use technology to encourage electronic submission of billing and supporting clinical documents, which previously had been paper-driven.

Seth Freedman, Director of Corporate Development & Innovation at Independence Blue Cross, presented the newly launched updated version of their member mobile application IBX Mobile. IBX Mobile allows members to access their available health information through the National Blue Button Initiative made possible by a partnership between payers and providers in Philadelphia.

During the Payer Summit, HL7 also announced the launch of the [Payer User Group](#). This user group is intended to provide implementation support to the payer community who work with HL7 standards. All interested parties are encouraged [to join](#). The first meeting of the Payer User Group is scheduled for April 1, 2015 at 2:00 PM and is free to join. The next HL7 Payer Summit is scheduled for January 2016 in conjunction with the working group meeting being held in Orlando, Florida.

About Health Level Seven International (HL7)

Founded in 1987, Health Level Seven International is the global authority for healthcare information interoperability and standards with affiliates established in more than 30 countries. HL7 is a non-profit, ANSI accredited standards development organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services. HL7's more than 2,000 members represent approximately 500 corporate members, which include more than 90 percent of the information systems vendors serving healthcare. HL7 collaborates with other standards developers and provider, payer, philanthropic and government agencies at the highest levels to ensure the development of comprehensive and reliable standards and successful interoperability efforts.