Updates on HIPAA, MIPS, and Health Information Technology

Michael Brody, DPM

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First Things First…

- I am the president of TLD Systems : We provide support for podiatrists to excel in MIPS and support for providers to be HIPAA compliant
- I am the Chief Compliance Officer for ICS Software
- I am the Chief Medical Officer for MedXpress Registry
- I am a Health Information Technology Consultant for PICA
- I am a consultant for BAKO

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Now..

You can take everything I say today with the appropriate grains of salt

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We will start out with what is happening in the world of Health Information Technology Vendors

- It is as important to know what is happening in the market with the vendors who service us as it is to know the regulations that are being published by the government

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Allscripts has just announced

- That they have entered into an agreement to purchase Practice Fusion for 100 Million Dollars
- They have done this to increase their presence in the ambulatory market
- The deal is scheduled to be finalized in the first quarter of 2018
- What does this mean for current Practice Fusion Users?

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E Clinical Works has been hit with 2 Class Action Lawsuits

- The first lawsuit is from patients that have been harmed due to problems with the E-Clinical Works software
- They claim that their medical records were not available for doctors and as a result the patients experienced harm
- “A class action lawsuit filed in the U.S. District Court in the Southern District of New York alleges that electronic health records vendor eClinicalWorks failed “millions of patients by failing to maintain the integrity of patients’ records”

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Lets take a deep dive into this

- Patients have been harmed due to unavailability of medical records
- In this case the blame is being placed on the EHR Vendor
- But many times, when a provider wishes to switch from one EHR vendor to another there are problems with transferring the information to the new system
- This presents a number of financial and ethical challenges for the provider

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HIPAA and Medial Record Availability

- Under the HIPAA regulations you are required to maintain the confidentiality, integrity and AVAILABILITY of your patients records
- If you do not have access to the records this is a HIPAA violation
  - In addition to the risks associated with quality of care, and adverse outcomes related to not having access to medical records and the potential malpractice implications
  - Failure to have access to the records can potentially result in fines from the Federal Government due to HIPAA violations
- If YOU do not maintain access to your old records it is you who will be held responsible

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Second Class Action Lawsuit is from Doctors

- “Plaintiffs say they had to forfeit meaningful use incentive payments in 2014 and lost out on more money in 2017 because EHR did not meet requirements, though eClinicalWorks says the claims are without merit.”

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What does this mean for you

- Many times providers have felt that they are at the mercy of their vendor. A vendor is large and has significant resources, while a provider is relatively small with few resources.
- But we are now seeing providers ‘fighting back’ and banding together to try to right what they perceive as wrongs.

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The rules of the game are constantly changing

- When it comes to medical records, you are ultimately responsible for the Integrity and Availability of the medical records, but it is now appearing that both doctors and patients are trying to hold vendors accountable for their role in this ecosystem

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The Government is also holding EHR Vendors Responsible

- E Clinical Works seems to be the whipping boy of patients, doctors and even the government
- They were hit with a false claims act alleging that they falsified their certification test and paid approximately $155 Million dollars to settle that claim
  - In addition they were required to either provide free upgrades to doctors or
  - Provide a copy of the patient records to doctors so they could switch to another EHR

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Enter the 21st Century Cures Act

- This is just the beginning but..
- This law 'discourages' data blocking
- The law 'encourages' interoperability between EHR systems
- The law creates a reporting system on EHR Usability

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Encourages and Discourages

- These are not really strong words, and the law in it's original form made information blocking illegal and required interoperability, but pressure from industry resulted in the law getting watered down
- This law was passed in 2016
- All of the ramifications that have hit E-Clinical Works happened in 2017
- The pendulum is swinging in favor of providers and patients
- What the future will hold is still to be determined but you can play a role

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MIPS Changes for 2018

- Small providers can ‘OPT OUT’ of the Advancing Care Information portion of MIPS
- If a small provider ‘OPTS OUT’ the 25 points that would be associated with Advancing Care will be moved to the quality portion of MIPS
- You only need to report Advancing Care information for 90 days if you elect to participate in this section of MIPS

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What does this really mean?

- Without an EHR tracking quality is EXTREMELY DIFFICULT
- You WILL NOT score high in quality without an EHR
- So even if you elect to opt out of Advancing Care you will still need to use an EHR to score well in the MIPS program
- It is also much easier to score a perfect score in Advancing Care than in Quality. (we will get into that when we discuss quality reporting)
- So this is a great sound bite, but if you are using Certified Technology it is probably not in your best interest to opt out of this portion of MIPS

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Cost is now a factor in MIPS

- How much your patients cost Medicare / your ability to provide cost effective care will count for up to 10 of your MIPS points
- You really have very little control of this and it is still poorly understood

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Quality is now worth 50 Points

- And your reporting period for quality is the Full Year – not 90 days
  - Remember I said ACI was easier - for ACI you report your best 90 days
- You will still report on **at least** 6 quality measures
- You still need to score a 60 in quality to get a perfect score
- But now a score of 60 in quality only gets you 50 MIPS composite points

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Lets share some “Secrets” about quality reporting

- Secret 1 – Data Completeness
- For 2017 we had to have a ‘Data Completeness’ of at least 50%
- That means that if we have 100 times that we could have reported a quality measure, we are only required to report that measure 51 times
- How can you leverage this to your advantage?

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Lets look at how we can leverage this

- For these two examples lets assume you could have met a measure 100 times over the reporting period
- You actually met the measure 65 times over the reporting period

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Reporting Option 1 – Report 100% data completeness

- In this case you would report that you met the measure 65 / 100 times
- Your performance would be about a 65%
- Your reporting would be 100%
- Your points for the measure would be much less than 10

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Reporting Option 2 - Report more than 50% (60% for 2018) data completeness

- In this case you would report a performance of 65/65 or 100%
- Your data completeness would only be 65%
- But your score for the measure would be a **10**

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Both methods of reporting are 100% legitimate

- So why hurt your MIPS Score by choosing the first option?
- CMS is aware of this ‘loophole’
- As a result the Data Completeness threshold for 2018 has increased to 60%
- The Data Completeness threshold is likely to go up each successive year

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Now lets look at how to report with a Data Completeness of less than 100%

- Reporting Options include
  - Claims
  - EHR
  - Registry

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Claims Reporting

- With claims based reporting each claim will be evaluated by CMS to see if you could have reported
- Therefore with claims based reporting your reporting WILL be 100%
- You do not have the ability to use the ‘Data Completeness’ loophole with claims based reporting

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EHR-based Reporting

- Your EHR vendor must collect all data and provide you with the report to submit to CMS or they may report it for you, or send it to a registry for you
- You probably do not have the ability to ‘modify’ the data to allow for less than 100% data completeness
- This option is probably not in your best interest either

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Registry-based Reporting

- This is the method of reporting that provides you with the most flexibility
- You can generate reports from your EHR and then decide which information to provide to the registry
- With this method you are most likely to score a 10 on each measure

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Downside of this

- There is something known as End-to-End reporting.
- With End-to-End reporting the information is sent to CMS without ‘human’ intervention
- When you use End-to-End reporting you will get one bonus point for each measure
- By modifying the data, you will lose the bonus point
- But you will probably gain more in net score to offset this loss of the bonus point

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Best of Both Worlds

- If your EHR has already built in the ability to build reports that take ‘Data Completeness’ into account
- And the EHR then sends these reports to CMS
- Then you get the advantage of the Data Completeness and will still earn the end to end bonus
- So once again talk to your EHR vendor

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Practice Improvement Activities

- Still count for 15 MIPS composite Points
- If you use Improvement Activities that involve the use of your EHR you get extra bonus points in Advancing Care
- There is little change to Practice Improvement Activities for 2018
- Practice Improvement is a 90 day reporting period for 2018

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Advancing Care Information

- Still Counts for 25% of your MIPS Score
- Small providers can ‘opt out’ or Advancing Care.
  - If you opt out of Advancing Care all 25 points will be moved to the Quality Reporting making Quality Reporting worth 75 points.

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Advancing Care

- Two Types of Measures
  - Base
  - Non Base

- You must complete all Base Measures, and need to complete non base measures to get a perfect score in ACI

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The Base

- Is Worth 50%
  - E Prescribing – Send at least 1 prescription electronically
    - No bonus points available
  - Provide Patient Access – Provide at least 1 patient access to the portal
    - Up to 10% in bonus points available
  - Request / Accept Summary of Care – Get at least one referral electronically and import it into your EHR
    - Up to 10% in bonuses available
  - Security Risk Analysis – Complete your HIPAA Security Risk Analysis
    - No bonus points available
  - Send Summary of Care – Send at least 1 referral electronically so that it can be imported into the other doctors EHR
    - Up to 10% bonus points available

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Bonus Points

- We saw up to 30% in previous Screen
- Clinical Data Registry Reporting – send data to a clinical Registry
  - 5% in Bonus Points Available (all or nothing)

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Clinical Information Reconciliation

- When you get a Transition of Care document reconcile:
  - Medications
  - Medication Allergies
  - Current Problem List
    - Up to 10% in bonus points

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Electronic Case Reporting

- Engage with a Public Health Registry (Syndromic Surveillance, Cancer Registry)
  - 5% bonus available (all or nothing)

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Immunization Reporting

- Engage with an Immunization Registry
  - 10% bonus available (all or nothing)

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Patient Generated Health Data

- Incorporate patient generated data into your EHR
  - Up to 10% bonus points available

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Patient Specific Education

- Use EHR technology to identify patient education and provide patients with the education identified
  - Up to 10% bonus available

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Public Health Registry Reporting

- Engage with a Public Health Registry
  - 5% bonus available (all or nothing)

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Secure Messaging

- Send and receive secure messages to your patient using your EHR
  - Up to 10% bonus available

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Syndromic Surveillance Reporting

- Engage with a Public Health Agency to report Syndromic Surveillance Data
  - 5% all or nothing

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View, Download and Transmit

- Have your patients actually visit the portal to view, download or transmit their health information.
  - Up to 10%

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Complete a Practice Improvement Activity

- That involves the Use of your EHR System
  - 10% bonus (all or nothing)

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