

PRIMARY OBJECTIVE

The primary goal of the **CARIN Alliance Health Plan Workgroup** is to develop an agreed upon, consensus-based approach regarding the data elements that would “meet or exceed the capabilities of CMS’ Blue Button 2.0” and could be released to consumers using Open APIs and promoted with policy makers, standards organizations, and industry.

BACKGROUND

The CARIN Alliance is a bi-partisan, multi-sector alliance convened by David Brailer, Aneesh Chopra, and Mike Leavitt, to unite industry leaders in advancing the adoption of consumer-directed health care information exchange across the U.S. In collaboration with government leaders, the group seeks to rapidly advance the ability for consumers and their authorized caregivers to easily obtain, use, and share their digital health information in order to achieve more efficient use of health care services and improve overall health.

The CARIN Alliance is uniquely positioned at the intersection of public and private organizations seeking to advance the enablement of patient-centered, value-driven health care through the adoption of consumer directed health information exchange. As an Alliance, now is the time to act as we have a tremendous opportunity to lead, direct and drive the future of consumer-directed health care information transparency and enablement.

INDUSTRY CALL TO ACTION

In the 2019 Medicare Advantage Call letter, CMS indicated the following:

Expanding use of Electronic Health Data for MA Enrollees

In March, CMS launched Blue Button 2.0, which puts patients in charge of their own health data. Blue Button 2.0 provides secure beneficiary-directed data transport in a structured Fast Healthcare Interoperability Resources (FHIR) format that is developer-friendly. This will enable beneficiaries to connect their data to applications, services, and research programs they trust. Blue Button 2.0 uses open source code that is available for all plans at <https://bluebutton.cms.gov/developers/>.

CMS recommends and encourages plans to adopt data release platforms for their enrollees that meet or exceed the capabilities of CMS’s Blue Button 2.0. CMS is contemplating future rule-making in this area to require the adoption of such platforms by MA plans beginning CY2020."

The group will focus on what ‘meet or exceed the capabilities of Blue Button 2.0’ means in the MA and Commercial payer context. The group will use as its baseline the mapping CMS has already performed between their RIF file and the FHIR EOB and other resources. We will also examine the CCLF file, Trizetto data mapping, and the mapping with Medicaid claims systems.

PROBLEM STATEMENT/IDENTIFIABLE OBJECTIVE

Today, there is no single framework for how we enable a consumer to better understand and become empowered with respect to their health care and to facilitate evolutionary advancements in consumer directed health care outcomes. Consumers can benefit greatly from digital applications, even that outside of the applications provided by traditional stakeholders in the health care delivery system. Creating a more longitudinal view across the

personal spectrum allows consumers to engage with digital applications they perceive to be necessary to support their health. Only the consumer can actually change his or her behavior and therefore has the opportunity to improve the likelihood of better health thus leading to true cost reduction.

Data from payers is not currently available to a consumer through an open API framework and therefore is not accessible by third party applications authorized by the consumer. As an Alliance, we have already achieved success across the spectrum of stakeholders in establishing a framework for clinical data exchange to third party applications through the use of FHIR and are now seeking to advance the adoption of consumer-directed health insurance data exchange.

The Alliance will facilitate multiple stakeholders to create the framework for a new industry standard for information sharing surrounding health insurance data before any standard is regulated without guidance from industry stakeholders. The objective of the Alliance is to identify, discuss, and reach consensus on the data elements to be made available.

MULTI-SECTOR INTEREST

The Alliance is comprised of stakeholders representing all areas of the health care delivery system including government, providers, payers, health systems, consumers, patient advocates, EHR providers and third-party consumer solutions.

CMS is the first payer to standardize around the FHIR specifications and is already in testing with more than 250+ solution providers leveraging access to CMS claim data on behalf of consumers.

TIMING RIPE FOR RESOLUTION

The trend toward digital in health care is undeniable. Industry studies all support significant changes in how consumers view their role in health care and the methods by which they want to engage. Key trends include:

- Consumers now prefer to partner with doctors instead of relying passively on them to make treatment decisions.
- Consumers' use of technology to measure fitness and health improvement goals has almost doubled in recent years and is highest in the millennial population who now demand a digital first approach. More than 60 percent of technology users say that utilizing health technologies has had a significant positive impact on their health behavior.
- Use of technology to monitor health issues has also risen, nearly doubling among individuals with chronic conditions that have a major impact on their daily life.
- Rates of conferring with doctors via email, texting, or video have more than doubled in the last two years, suggesting digital communication between consumers and providers will continue trending upward.
- Over half of current medication users express interest in using technology to prompt them to take their medication.

If we can unify now as a truly impactful health care Alliance, we have a tremendous opportunity to direct, inform and shape the policies around consumer-directed health care information. This will enable the industry to align on the tenets of a framework in which we can innovate and empower substantially better health outcomes for a fraction of systemic cost that restricts potential solutions today.

BENEFITS TO THE PAYER ORGANIZATION

Enabling a truly consumer-directed health care information framework brings substantial value for payers, providers, health systems, employers and consumers alike. By allowing third party applications to access payer data, they can directly impact the triple aim of health care to provide the right service to the right member at the right time. Members will undoubtedly engage at higher rates because they self-select the applications they find most appropriate to their unique circumstance.

In addition, consumer data exchange is bi-directional. A consumer's right to access their health data can include an opt-in provision allowing sharing of their historical health information with their health plan. Within days of enrollment vs the months it typically takes, a plan can appropriately assess risk, identify gaps in care and triage the member to appropriate plan resources such as case management, care management, or disease management to name a few.

While the benefits of third-party applications targeting a consumer are vast, below are a few examples of benefits a plan can achieve:

- All of the data exchange is based on the foundation of a consumer who invokes their individual right of access or consent to request their own health information. This type of data exchange does not involve any covered entity to covered entity data exchange.
- Reduced administrative expenses for payers resulting from the migration of expensive care management into consumer self-management and from fewer customer service inquiries regarding eligibility, claims, and benefits. Administrative cost reductions create increased profit opportunities for self-insured business and especially for insured business given the MLR provisions of the Affordable Care Act.
- Reduced medical expenses for consumers and payers resulting from more efficient use, fewer repeat diagnostic tests, and lower overall demand for health care services. Patient engagement which is enabled by data driven digital applications empowers consumers to stay healthy, share data with providers and thereby eliminate wasteful repeat services.
- Redirected use of health care services away from facility and office-based care to a less expensive setting through the efficient use of telemedicine and telehealth. Online purchasing, banking, communication and social networking are mainstream so why shouldn't medical services be provided online as well? Studies show that use of telemedicine and telehealth results in fewer trips to the emergency department and urgent care centers thus reducing medical expenses and freeing hospitals to focus on higher acuity patients.
- Increased medication adherence, a focus of many applications, results in fewer acute care episodes and reduced emergency department utilization.
- Reduced gaps in care will benefit payers when consumers and providers share vital information regarding chronic illnesses. Appropriate periodic evaluation and treatment is essential to having fewer acute care episodes and emergency department usage.

Outside of clinically focused applications, there is a growing need to focus on managing the financial aspects of health:

- Various studies estimate that as much as 40% of the health care spend in the United States is wasteful. By empowering consumers, payers, and providers with data driven applications utilizing payer data, we can engage consumers to reduce a significant portion of the waste. Even if we're only modestly successful by reducing waste by just 10%, the savings to consumers and payers is enormous and the health of actively engaged consumers is improved.
- Currently, 62% of all bankruptcies in the US are due to unforeseen medical bills. With only 4% of Americans having a basic understanding of their financials surrounding health care and over 70% of families not saving for future health expenses, we have an opportunity for financial services applications to intervene with planning, forecasted expenditures and financial solutions for consumers. Creating a comprehensive view into a consumer's finances that includes health care spend will ultimately lead to reduction in bad debt on premiums and medical payments owed to payers and providers.

INTRO TO FHIR/ARGONAUT STANDARD

The Argonaut Project is a private sector initiative to advance industry adoption of modern, open interoperability standards. The purpose of the Argonaut Project is to rapidly develop a first-generation RESTful-based API and Core Data Services specification to enable expanded information sharing for electronic health records and other health information technology based on internet standards and architectural patterns and styles. This effort follows on recommendations from the Joint HIT Standards and Policy Committee's [*JASON Task Force Report*](#), the HIT Standards Committee's [*NwHIN Power Team*](#), the MITRE JASON Reports of [*2013*](#) and [*2014*](#), and the [*2010 PCAST Report*](#).

The result of the Argonaut Project has been the creation of FHIR (<http://hl7.org/fhir/>). FHIR has become the de-facto successor to HL7 and is currently being pushed as the new standard for digital health information exchange. EMR vendors such as Epic, Cerner, Allscripts, and more have settled on this standard to transition their external integrations to supporting.

One of the biggest advancements of FHIR over HL7 is the standardization of data formats beyond the traditional medical record. The standard has been expanded to reflect data objects that would be used by insurance payers and providers such as financials, work flows, clinical reasoning, and more. By having all parties in the medical ecosystem agree on a unified data model, we can rapidly accelerate the advancement of digital technology in health care to improve outcomes and reduce costs.

A big advantage of the FHIR standard is that its information scope is almost universally set for an individual. All access and security protocols outlined at <http://hl7.org/fhir/security.html> require the end user to provide approval before any application can make benefits on its behalf through the consent model included in FHIR (<http://hl7.org/fhir/consent.html>). This approach ensures that data is not shared for populations as a whole and that data cannot be used by third parties to reverse engineer important details such as provider contracts, fee schedules, and other proprietary payer intel.

The DaVinci project is an initiative within HL7 involving covered entity to covered entity exchange between payers and providers. Its primary goal is to pull the missing clinical data required for value base care contracting. The

CARIN workgroup is primarily centered around the data fields the industry would like to release to the consumer which would inform the future work of standards-based organizations.

PROPOSED DATA TO BE RELEASED TO CONSUMERS

The financial module of the FHIR standard (<https://www.hl7.org/fhir/financial-module.html>) is designed specifically for handling all elements of a financial manner related to the health care ecosystem. Specifically, the following endpoints outlined below are most applicable to payers and provide the greatest value to all parties involved.

Eligibility

- <https://www.hl7.org/fhir/coverage.html>
- <https://www.hl7.org/fhir/eligibilityrequest.html>
- <https://www.hl7.org/fhir/eligibilityresponse.html>

FHIR eligibility calls allow for pulling the critical eligibility information associated to a user's insurance information. Specific information that can be requested includes an overview of the insured's coverage along with their current eligibility information. This empowers users to better understand their coverage and reduces inquiries to payer call centers to understand this information.

Claims

- <https://www.hl7.org/fhir/explanationofbenefit.html>
- <https://www.hl7.org/fhir/claim.html>
- <https://www.hl7.org/fhir/claimresponse.html>

The Explanation of Benefits (EOB) endpoint is the most important endpoint requested by the ecosystem. It contains the full combination of all details and information related to a specific claim which provides all traditional insights covered by a paper EOB. This endpoint coupled with the claims endpoints allow the patient to understand the amounts owed for their service, where those amounts come from, where current claims sit in being processed, and more.

We are also looking at preventative services, pre-authorizations, and up to date provider network information.

Payments

- <https://www.hl7.org/fhir/paymentreconciliation.html>
- <https://www.hl7.org/fhir/paymentnotice.html>

Payment endpoints allow an end user to better understand whether all money owed for a specific encounter has been paid and registered by all parties involved. It insures that payments have been collected, processed, and applied as asserted by the patient. The payment data can be utilized by consumers for financial planning pertaining to health care and to match to financial services available for health care from the industry at large.



GET INVOLVED

We are looking for forward thinking payers aligned with the mission of the CARIN Alliance to join us and help define the standards for consumer-directed health information exchange for health plans. In addition to CMS, we are also looking for payers who will take the lead and implement the data sharing framework to trusted third party applications designated by consumers to receive their health insurance data.

If you would like to get involved, please contact Ryan Howells, Principal at Leavitt Partners at ryan.howells@leavittpartners.com.