CMS Proposal on Advancing Operability

Introduction

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on patient access to data and interoperability (CMS NPRM). Concurrently, the Office of the National Coordinator for Health Information Technology (ONC) released its proposed rule implementing provisions of the 21st Century Cures Act (Cures) related to electronic health information (EHI) blocking, interoperability and the ONC Certification Program.

In addition to promoting patient access and price transparency, these rules will impact interoperability and the way data is exchanged between patients, health providers, payers, technology developers, and other health care stakeholders. Together, they signal a major push by the Administration to remove all barriers it has identified as impeding patient access to data, and to greatly expand access for payers and third-party companies. Comments are due May 3rd.

CMS Proposed Rule on Advancing Interoperability and Patient Access to Health Data

CMS has identified several "challenges and barriers" to interoperability: (1) lack of a patient identifier and patient matching strategy; (2) lack of standardization; (3) information blocking; (4) lack of adoption/use of certified health IT among Post-Acute Care (PAC) settings; and (5) privacy concerns and the Health Information Portability and Accountability Act (HIPAA).

In response, the CMS NPRM is proposing to require all health plans subject to CMS authority to make certain clinical, claims, and coverage information available to patients and their personal representatives accessible through an open application programming interface (API).

Impacted entities include the Medicare Fee-for-Service (FFS) Program; state Medicaid and CHIP FFS Programs; Medicare Advantage (MA) Organizations; Medicaid and CHIP Managed Care plans/entities (managed care organizations (MCOs), prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs)); and qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs) (collectively, Impacted Entities).

Along with the policy proposals, CMS released two Requests for Information (RFIs) to obtain feedback on interoperability and health information technology (health IT) adoption in PAC settings, and the role of patient matching in interoperability and improved patient care.

Provisions applicable to payers and health plans

Patient Access to Data Through Open APIs. CMS is proposing to require Impacted Entities to implement, test, and monitor openly-published HL7® FHIR®-based APIs that allow patients to access a wide variety of clinical and claims information through third-party applications (apps) of their choosing. Patients must also have access to claims and encounter data (approved and denied adjudicated claims; encounters with capitated providers; provider remittances; enrollee cost-sharing; enrollee identifiers; dates of service; payment information; and all clinical data including laboratory results) within one business day after the Impacted Entity receives the data or processes the claim.

An MA plan's API must also provide access to a provider directory of the plan's network of contracted providers, including providers' names, addresses, phone numbers, and specialties. The provider directory data would need to be updated within 30 calendar days after any updates or changes to the information. If the MA plan includes Part D coverage, the API must also allow access to pharmacy directories (MA organizations offering Part D plans must also offer the number, mix, and addresses of pharmacies in their network) and formularies (Information about covered outpatient drugs and preferred drug lists). The provider directory must be available not only to current beneficiaries, but also to the public (including, future beneficiaries and clinicians).

The proposed requirements would go into effect on January 1, 2020 for MA organizations and QHPs. For Medicaid and CHIP organizations, the requirement would be effective July 1, 2020. CMS hopes that other stakeholders, such as state-operated exchanges and private payors, will adopt similar API requirements.

Health Information Exchange and Care Coordination Across Payers. If finalized, MA organizations, Medicaid and CHIP managed care plans/entities, and QHP issuers in the FFEs will be required to support electronic exchange of data for transitions of care as patients move between these plan types to ensure patients can maintain access to their health care information. This data includes information about diagnoses, procedures, tests and providers seen, as well as insights into a beneficiary's health and health care utilization. A payer must, if asked by the beneficiary, forward his or her information to a new plan or other entity designated by the beneficiary for up to 5 years after the beneficiary has disenrolled with the plan. Impacted Entities must exchange, at a minimum, the data elements in the United States Core Data for Interoperability (USCDI) standard at the patient's request.

Care Coordination Through Trusted Exchange Networks. To enable health information to flow securely and privately between plans and providers throughout the health care system, the proposal requires MA organizations (including MA-PD plans), Medicaid and CHIP managed care plans/entities, and QHP issuers in the FFEs (except for stand-alone dental plans) to participate in trust networks to improve interoperability. The trusted exchange network must be able to (1) exchange PHI in compliance with all applicable state and federal laws; (2) connect both inpatient EHRs and ambulatory EHRs; and (3) support secure messaging or electronic querying by and between patients, providers, and payers. Note that ONC has not yet finalized the Trusted Exchange Framework and Common Agreement (TEFCA), a set of policies and procedures for interoperable exchange to which CMS could eventually align this trusted exchange participation requirement; CMS is soliciting comment on whether this should occur once TEFCA is finalized.

Advancing Interoperability in Innovative Models. The Center for Medicare and Medicaid Innovation (CMMI) is seeking public comment on promoting interoperability among model participants and other health care providers as part of the design and testing of innovative payment and service delivery models. CMS plans to promote interoperability across the health care spectrum through model testing that focuses on using emerging standards, models leveraging non-traditional data and technology-enabled patient engagement platforms.

Improving the Dual Eligible Experience by Increasing Frequency of Federal-State Data Exchanges. CMS is proposing to update the frequency with which states are required to exchange certain Medicare/Medicaid data on dually eligible beneficiaries from a monthly exchange to a daily exchange to improve benefit coordination for the dual-eligible population. The data exchanged include files of all eligible Medicaid beneficiaries by state, as well as "buy-in" data, or information about beneficiaries states are using Medicaid funds to "buy-in" Medicare services.

Provisions applicable to providers

Public Reporting and Prevention of Information Blocking. To motivate clinicians, hospitals, and CAHs to refrain from information blocking, CMS is proposing to make publicly available a "no" response to any of the three attestation statements regarding the prevention of information blocking in the Promoting Interoperability Programs in the Quality Payment Program (QPP) and Medicare FFS.

Provider Digital Contact Information. As required by Cures, the National Plan and Provider Enumeration System (NPPES) has been updated to include one or more pieces of digital contact information that can be used to facilitate secure sharing of health information. To ensure that the NPPES is updated with this information, CMS is proposing to publicly report the names and National Provider Identifiers (NPIs) of those providers who have not added digital contact information to their entries in the NPPES system beginning in the second half of 2020.

Revisions to the Conditions of Participation (CoPs) for Hospitals and Critical Access Hospitals. CMS proposes to require as a condition of participation hospitals and CAHs to electronically send "patient event notifications" when a patient is admitted, discharged, or transferred (ADT) to a patient's health care providers. The requirement would be limited to only those Medicare- and Medicaid-participating hospitals and CAHs that possess EHRs systems with the technical capacity to generate information for electronic patient event notifications. It would, however, impose a new set of requirements related to the use of EHRs outside of the Promoting Interoperability program.

Requests for Information

RFI on Information Sharing Between Payers and Providers through APIs. CMS requests information about the possibility of providers being able to request a download from payers on a shared patient population and whether the APIs for patient access could be used to leverage to accomplish this task. CMS seeks specific comment surrounding issues of notice and consent, usefulness of the information, unintended consequences, and potential legal barriers.

RFI on Patient Matching. In conjunction with ONC, CMS is posing an RFI regarding how CMS could leverage its program authority to improve patient identification to facility improved patient safety, enable better care coordination, and advance interoperability. CMS also seeks comment on potential strategies to address patient matching including use of a patient matching algorithm or software.