CMS Interoperability Rule Overview and State Impact

Overview

On March 9, 2020, through ONC and CMS, HHS published final rules that detail the regulatory and enforcement framework regulating health care stakeholders' obligations regarding interoperability, information blocking, and patient access.

CMS Interoperability and Patient Access Final Rule Details (CMS-9115-F)

The Centers for Medicare and Medicaid Services (CMS) published Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers, specifying new requirements for individual data access impacting health plans and providers participating in federal health care programs. The following policies are summarized in the Final Rule:

1. Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges (*applicable April 1, 2022*)
2. Admission, Discharge, and Transfer Event Notifications (*applicable fall 2020*)
3. Patient Access API (*applicable January 1, 2021*)
4. Provider Directory API (*applicable January 1, 2021*)
5. Payer-to-Payer Data Exchange (*applicable January 1, 2022*)
6. Public Reporting and Information Blocking (*applicable late 2020*)
7. Digital Contact Information (*applicable late 2020*)

The following summaries outline the Final Rule policies with summaries, requirements, standards, and other details to help inform the planning and execution of projects.

1. Admission, Discharge, and Transfer Event Notifications

CMS is modifying Conditions of Participation (CoPs) to require hospitals, including psychiatric hospitals and CAHs, to send electronic notifications of a patient's admission, discharge, and/or transfer to another healthcare facility or to another community provider or practitioner. This will improve care coordination by allowing a receiving provider, facility, or practitioner to reach out to the patient and deliver appropriate follow-up care in a timely manner. Hospitals can send notifications to other providers and entities including payers.

- A patient's established primary care practitioner or group.
- Post-acute care service providers for transitions of care.
- Other practitioners, groups or entities, identified by the patient as primarily care team members.

Applicable date: 6 months from publication for Final Rule (*November 1, 2020*) (New date May 1, 2020)

Required stakeholders: Hospitals, Psychiatric hospitals, Critical Access Hospitals (CAHs)

Considerations:

- A hospital can exclusively use an intermediary if they desire to meet the CoP notification requirement.
- Hospitals, or an intermediary that facilitates exchange of health information on their behalf, can tailor the delivery of notifications based on the preferences of the receiving provider (i.e. the provider only wants to receive discharge notifications).
- An intermediary must connect to a wide range of recipients and not impose restrictions on which recipients are able to receive notifications (i.e. the intermediary cannot limit the delivery of notifications within a specific integration delivery system).
- If the hospital and patient are not able to identify a provider to share the notification with, the hospital is not required to send a notification for that patient.
- CMS expects hospitals to have policies and procedures in place to identify the provider(s) who should receive a notification and incorporate this information into the notification system, or through recording information received from patients about their providers.

Requirements

To demonstrate compliance with this requirement a hospital must show its system meetings the following requirements:

- The hospital notification system is fully operational and complies with all applicable law and patient's expressed privacy preferences regarding sending notifications.
- The system sends notifications at the time of the patient's admission/registration to the hospital and either immediately prior to or at the time of the patient's discharge and/or transfer from the hospital.
- The hospital must demonstrate that it has made a reasonable effort to ensure that the system sends the notifications to required providers for treatment, care coordination, or quality improvement purposes
- The notification must include the required minimum patient health information, but CMS does not require specific content, format or transport standards for the notification.
    - The name of the patient.
    - The name of the treating provider; and
    - The name of the sending institution.

Standards: HL7 2.5.1 (other standards can be used to support the notification system, but it must at a minimum support 2.5.1 to conform with the CoP).

Enforcement: The notification requirement will be enforced through the survey and certification process. Prior to the effective date of the requirement (six months after publication), CMS will issue interpretive guidelines to surveyors on how they should determine compliance with the notification requirement.

2. Patient Access API

The Patient Access API policy focuses on improving interoperability by easing patients' ability to access their electronic data. The final rule requires certain payers to provide patients with access to their claims

data, similar to the Blue Button 2.0 program, and requires a number of actions by providers to improve interoperability. CMS emphasizes that this is only a first step to advance interoperability and patient access, and CMS will be taking additional steps in the future.

Standards: CMS-regulated stakeholders are required to implement and maintain a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice.

Data: CMS requires payers to make the following data available, at a minimum, via the API using a combination of the U.S. Core Data for Interoperability (USCDI), HIPAA Administrative Simplification transaction, and Part D e-prescribing transaction standards. Data must be made available within one business day after a claim is adjudicated or encounter data is received.

Applicable: January 1, 2021 (New July 1, 2021)

Required Stakeholders	Excluded Stakeholders
Medicare Advantage Plans Medicaid and Children's Health Insurance Program (CHIP) managed care plans State Agencies Qualified Health Plan (QHP) issuers on federally facilitated exchanges (collectively, "CMS Payers")	Issuers offering only Stand-alone dental plans (SADPs) and QHP issuers offering coverage in the Federally facilitated Small Business Health Options Program (FF-SHOP)

3. Provider Directory and Pharmacy Directory API

CMS-regulated payers are required by this rule to make **provider directory information** publicly available via a standards-based API. Making this information broadly available in this way will encourage innovation by allowing third-party application developers to access information so they can create services that help patients find providers for care and treatment, as well as help clinicians find other providers for care coordination, in the most user-friendly and intuitive ways possible. Making this information more widely accessible is also a driver for improving the quality, accuracy, and timeliness of this information.

MA plans that offer Medicare Part D Plans must also make publicly available via a FHIR based API, pharmacy directory data, including the pharmacy name, address, phone number, number of pharmacies in the network, and mix (specifically the type of pharmacy, such as "retail pharmacy"). For both requirements the payer must update its directory within 30 calendar days after it receives an update to information contained in the directory.

Applicable date: January 1, 2021 (New July 1, 2021)

Required Stakeholders	Excluded Stakeholders
Medicare Advantage Plans and Organizations Medicaid and Children's Health Insurance Program (CHIP) (FFS and Managed Care Plans, CHIP Managed Care Entities) State Agencies Qualified Health Plan (QHP) issuers*	Issuers offering only Stand-alone dental plans (SADPs) and QHP issuers offering coverage in the Federally facilitated Small Business Health Options Program (FF-SHOP)

*QHP issuers on the FFEs are already required to make provider directory information available in a specified, machine-readable format.

4. Payer-to-Payer Data Exchange:

CMS-regulated payers are required to exchange certain patient clinical data at the patient's request, allowing the patient to take their information with them as they move from payer to payer over time to help create a cumulative health record with their current payer. Having a patient's health information in one place will facilitate informed decision-making, efficient care, and ultimately can lead to better health outcomes.

- Payers must respond to requests from a patient to share their data, up to five years after their coverage ends.
- Covered payers that receive this data must incorporate it into their system.
- Payers can note which data is being exchanged was received from a previous payer but are under no obligation under this rule to update, validate, or correct data received from another payer.
- They also do not need to seek out and obtain data if they do not already have it.
- A payer is only required to send data received under this payer-to-payer data exchange requirement in the electronic form and format it was received.
- CMS allows payers to use multiple methods for the electronic exchange of this information, including use of APIs or an HIE.
- CMS notes that in future rulemaking they may consider requiring this payer-to-payer data exchange to occur via FHIR based APIs only.

Standards: Minimum data set using **U.S. Core Data for Interoperability (USCDI) version 1 data set**
Applicable date: January 1, 2022 (no new date)

5. Public Reporting and Information Blocking

CMS will publicly report eligible clinicians, hospitals, and critical access hospitals (CAHs) that may be information blocking based on how they attested to certain Promoting Interoperability Program requirements. Knowing which providers may have attested can help patients choose providers more likely to support electronic access to their health information.

Applicable: Late 2020

6. Digital Contact Information

CMS will begin publicly reporting in late 2020 those providers who do not list or update their digital contact information in the National Plan and Provider Enumeration System (NPPES). This includes providing digital contact information such as secure digital endpoints like a Direct Address and/or a FHIR API endpoint. Making the list of providers who do not provide this digital contact information public will encourage providers to make this valuable, secure contact information necessary to facilitate care coordination and data exchange easily accessible. CMS will release guidance later in 2020 outlining the public reporting mechanism and if certain providers will be exempt from public reporting. CMS notes they may consider adding a reporting requirement in future MIPS rule making.

Applicable: September 2020 (New Late 2020)

7. Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges

This final rule will update requirements for states to exchange certain enrollee data for individuals dually eligible for Medicare and Medicaid, including state buy-in files and "MMA files" (called the "MMA file" after the acronym for the Medicare Prescription Drug, Improvement and Modernization Act of 2003) from monthly to daily exchange to improve the dual eligible beneficiary experience, ensuring beneficiaries are getting access to appropriate services and that these services are billed appropriately the first time, eliminating waste and burden.

Applicable date: April 30, 2022 (no change to enforcement timeline)

Required Stakeholders: State Medicaid Agency