CCO/DCO Interoperability Final Rules Follow-up Webinar

January 25, 2021

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Welcome! A bit of housekeeping…

- This webinar is being recorded and will be posted on OHIT's final rules webpage within a week (see link below)
- Please remain muted when not speaking to minimize background noise
- If only your phone number displays, please rename yourself (first name is fine)
- We encourage questions and discussion!
  - Please 'raise your hand' if you'd like to speak, we'll then call on you
  - Feel free to enter questions and comments into the chat
  - We may not get to every question during the webinar, but we'll be sure to add all questions to an FAQ document available on OHIT's final rules webpage
- OHIT final rules webpage: https://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/Federal-Rules.aspx

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Webinar Agenda

- CMS Interoperability and Prior Authorization Final Rule Overview (20 min)
- CCO Interoperability Final Rules Survey Results and Questions (20 min)
- CCO/DCO Roundtable (60 min)
- Discussion about collaboration opportunities (10 min)
- Wrap-up and next steps (5 min)

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Before we get started…

- DCOs confirmed to be subject to the rules – invited at the last minute.
- Rim Cothren, National HIT Expert and OHA Consultant will present on the new final rule and answer final rule-specific questions
- Upcoming contract requirement:
  - Contractor shall review the ONC 21st Century Cures Act Final Rule to determine its obligation to comply with the final rule. Specifically, Contractor shall review the terms "Health Information Exchange" (HIE) and "Health Information Network" (HIN) which are defined in 45 CFR § 171.102, and the exceptions to information blocking as amended by Section 4004 of the Cures Act and as found in 42 USC § 300jj-52, in relation to their contractual and financial relationships. Contractor shall notify OHA, via Administrative Notice, no later than **January 31, 2021**, whether Contractor meets the definition for an HIE/HIN as it pertains to information blocking.

CMS Interoperability and Prior Authorization Final Rule

Rim Cothren
National HIT Expert and OHA Consultant

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CMS Released a New Final Rule

Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information (*CMS Interoperability and Prior Authorization* final rule)

- Published by CMS on Friday, January 15, 2021
- Not yet published in Federal Register
- *New administration has put a hold on this rule until it has reviewed/approved the rule – may include additional comment period and delay of effective date*
- Fact Sheet available at https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients-0

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CMS Released a New Final Rule

Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information

- Applies to "impacted payers":
  - Medicaid and CHIP managed care plans (including prepaid ambulatory health plans; PAHPs)
  - Medicaid and CHIP fee-for-service programs
  - Issuers Qualified Health Plans (QHP) on the Federally-facilitated Exchanges (FFEs)

Includes five key provisions

1. Patient Access API

Starting 1/1/2023, requires impacted payers to:

- In addition to claims, encounter, and clinical data, also include pending and active prior authorization decisions
- Establish, implement, and maintain an attestation process for 3rd party apps to attest to certain privacy provisions prior to receiving data
- Report annual metrics to CMS about patient use of the API

2. Provider Access API

Starting 1/1/2023, requires impacted payers to:

- Build and maintain a Provider Access API for payer-to-provider data sharing
- API includes
  - Claims and encounter data (not including cost data)
  - Clinical data defined by US Core Data for Interoperability (USCDI) version 1 that is maintained by the payer
  - Pending and active prior authorization decisions for individual patients and patient groups

3. Prior Authorization API

Starting 1/1/2024, requires impacted payers to:

- Build and maintain a FHIR-based Document Requirements Lookup Service (DRLS) API to enable providers to electronically locate requirements
- Build and maintain a FHIR-based Prior Authorization Support (PAS) API to facilitate sending requests and receiving responses electronically

While not specific to the API, also requires impacted payers to:

- Include a specific reason for all denials (even if not using PAS)
- Send decisions (through PAS or otherwise) with 72 hours for urgent request and 7 calendar days for standard requests
- Publicly report on outcomes of the use of authorization policies and practices

4. Payer-to-Payer Data Exchange API

Starting 1/1/2023, requires impacted payers to:

- Use FHIR R4 for Payer-to-Payer Data Exchange
- In addition to clinical data, also include:
  - Claims and encounter data (not including cost data)
  - Pending and active prior authorization decisions
- Share claims and encounter data, clinical data, and pending and active authorization decisions with other payers at enrollment

5. Adoption of Implementation Specs

Requires impacted payers to use implementation specifications (guides) adopted by ONC in 45 CFR 170.215 (see https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.170#se45.2.170_1215)

Currently, those specifications include:

- Standards:
  - HL7® Fast Healthcare Interoperability Resources (FHIR ®) Release 4.0.1
  - OpenID Connect Core 1.0, incorporating errata set 1
- Implementation Guides
  - HL7 FHIR® US Core Implementation Guide STU 3.1.1
  - HL7 SMART Application Launch Framework Implementation Guide Release 1.0.0
  - FHIR Bulk Data Access (Flat FHIR) v1.0.0: STU 1

What this means to CCOs…

- Expands Patient API requirements to include authorization decisions
- Specifies that FHIR is to be used for Payer-to-Payer Exchange
- Expands Payer-to-Payer Exchange requirements to include claims, encounters, and authorization decisions
- Creates a new requirement to support APIs for prior authorization requirements, and request submissions and responses
- Creates a new requirement for Payer-to-Provider Exchange
- Specifies the standards to be used for all APIs, tying it to a separate ONC regulation (that may change over time)
- Creates new requirements to report metrics

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CCO Final Rules Survey Results

Marta Makarushka
Lead Policy Analyst, Office of Health IT, OHA

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Overview of Survey Results

13 CCOs are represented in the results, with all reporting that they are subject to all three CMS payer requirements

- Patient Access API
  - Almost half are uncertain about their ability to meet the deadlines
  - Some questions remain about data required to be provided via the APIs**
  - A couple of CCOs have not yet identified where data resides within their systems
  - More than half do not have a system in place to manage login credentials and a few are unsure of how they will address this requirement
  - A few have selected a vendor
  - Most have a budget estimate and a plan to cover costs
  - Over half are interested in or already collaborating with others

Overview of Survey Results

Patient Access API Questions

- More information about clinical data requirements
  - Poll: Are you interested in a 30-minute work session to further explore Patient Access API clinical data requirements?
- The USCDI and FHIR do not always align perfectly (e.g. provenance) and without case precedent we would like to understand what the rest of the industry is doing to address those gaps.
- Some concepts are unclear or undefined, such as what "Data Under Management" really means and applies to. Different interpretations could result in wasted efforts.
  - What additional concepts are unclear?
  - Poll: Are you interested in a 30-minute work session to further explore Patient Access API concepts/terms?

Overview of Survey Results

- Provider Directory API
  - Almost half are uncertain about their ability to meet the deadlines
  - A few have data gaps or questions about the data
    - Survey question: Identify any elements beyond Names, Addresses, Phone Numbers & Specialties.
  - Over half have not yet selected a vendor
  - Over half are interested in or already collaborating with others
  - Though most have a plan, a couple remain unsure of how they will cover the costs
- Payer-to-Payer Exchange
  - CCOs expressed significant support for and interest in a technical standard for payer-to-payer exchange

Overview of Survey Results

Information Blocking

- About a third have questions about the definition of Health Information Network (HIN); 1 CCO reports qualifying as an HIN
- More than half are unsure if they are subject to the provisions of information blocking
    - ONC defines HIN as an individual or entity that determines, controls or has the discretion to administer any requirement, policy or agreement that permits, enables or requires the use of any technology or services for access, exchange or use of electronic PHI among more than two unaffiliated individuals or entities that are enabled to exchange with each other for a treatment, payment, or healthcare operations purpose.
- Most still have questions about the exceptions to information blocking
    - Poll: Are you interested in a 30-minute work session to further explore the exceptions to information blocking?

Overview of Survey Results

Additional Questions/Comments

- An OHA/CCO workgroup (similar to TOC, APST) would be helpful.
- Other questions?

CCO/DCO Roundtable

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Roundtable: Path to Meeting the Interoperability Final Rule Requirements

Please take 5 minutes to share about your organization's:

- Current status (planning, implementing, selecting vendor(s))
- Approach, process (e.g., steps taken or planned), and/or progress
- Challenges
- Areas for potential collaboration

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Discussion

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Wrap-up and Next Steps

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Wrap-up and Next Steps

- Thank you for your participation in this webinar!
- FAQ will be updated with today's questions/answers
- Will continue to keep you informed via email
- Future webinars will be scheduled as needed/requested
- CCOs/DCOs encouraged to continue conversations
- Please contact us with questions

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Resources

- Please visit the Office of Health IT's Interoperability Final Rules webpage https://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/Federal-Rules.aspx for
  - Links to federal resources
  - Recordings and materials from OHA webinars
  - FAQs
- Questions? Please contact Marta Makarushka at marta.m.makarushka@dhsoha.state.or.us

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