Hello and welcome!

- The meeting will begin momentarily
- This meeting is being audio-recorded
- Links to meeting materials are in the 'handouts' and on the OHA's Office of Health IT website :
  - Slides: https://www.oregon.gov/oha/HPA/OHIT-HITOC/Federal%20Rules%20Meeting%20Documents/HITOC_InteropFinalRulesWebinarQandA_ForPayerWebinar.pdf
  - Handout: https://www.oregon.gov/oha/HPA/OHIT-HITOC/Federal%20Rules%20Meeting%20Documents/HITOC_FinalRulesWebinarHandoutFinal_RevForWebinar.pdf
- Have questions or comments during the webinar?
  - Please use the questions tab in the webinar control panel to submit questions

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CCO/Payer:
Federal Interoperability Final Rules

November 5, 2020

This webinar is being audio-recorded

Oregon Health Authority

Office of Health Information Technology (OHIT)

Agenda

- Webinar Introduction
- Final Rules Overview
- Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule
- Office of the National Coordinator for Health Information Technology (ONC) 21st Century Cures Act Final Rule

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Webinar Introduction/Purpose

- Intended to inform and educate CMS-regulated payers about relevant federal requirements to both rules:
  - CMS Interoperability and Patient Access Final Rule
  - ONC 21st Century Cures Act Final Rule
- Objectives include to provide payers with
  - An in-depth understanding of the requirements
  - Clearer picture of the steps involved
  - Opportunity for answering questions and discussion
- Final rules presentation by national health IT subject matter expert and OHA consultant Rim Cothren
- OHA staff are available to answer questions

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Key* OHA Staff in Attendance

Staff Name	Title	Office/Division
Ralph Magrish	Senior Policy Analyst	Federal Policy Unit/HSD
Dave Inbody	CCO Operations Manager	Health Systems Division
Cheryl Henning	CCO Contracts Administrator	Health Systems Division
Kellie Skenandore	DCO Contract Administrator	Health Systems Division
Steve Westberg	Agency Business Systems Manager	Health Systems Division
Christopher McFetridge	Systems Coordinator	Health Systems Division
Mary Durrant	Manager, Claims & Encounter Data Services Unit	Health Systems Division
Dan Pasch	Director of Health IT Programs	Office of Health IT/HPA
Karen Hale	Provider Directory Program Manager	Office of Health IT/HPA

*This list consists of OHA staff who are involved in analyzing, coordinating, and communicating about the federal interoperability rules.

Webinar Logistics

- Meeting is being audio-recorded
  - Recording will be posted on website
- Webinar slides and handouts are in ‘handouts’ and posted on the OHIT website
- Questions are welcome throughout the presentation
  - Enter your question into the questions tab in the webinar control panel
  - Unlikely that we will be able to answer all questions as some may require further research
  - 10/1 webinar Q&A to posted on OHIT website (see link below)
- For further information go to Office of Health IT website: https://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/Federal-Rules.aspx

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Federal Interoperability Final Rules

Rim Cothren, Consultant

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Two Separate Rules

- CMS Interoperability and Patient Access
  - **Patient Access Application Programming Interface (API)***
  - **Provider Directory API***
  - **Payer-to-Payer Data Exchange***
  - Increased Reporting on Dual Eligibles
  - Public Reporting and Information Blocking
  - Digital Contact Information
  - ADT Event Notifications
- ONC 21st Century Cures Act
  - Updates to EHR Certification Criteria
  - **Exceptions to Information Blocking****

* Denotes payer requirements

** May pertain to payers

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Links to Final Rules

- CMS Interoperability and Patient Access
  - Information and updates at https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index
  - Fact sheet at https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet
  - Rule at https://www.federalregister.gov/d/2020-05050
- ONC 21st Century Cures Act
  - Information and updates at https://www.healthit.gov/curesrule/
  - Fact sheets at https://www.healthit.gov/curesrule/resources/fact-sheets
  - Rule at https://www.federalregister.gov/d/2020-07419

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Goals of Final Rules

- CMS
  - Put patients first, giving them access to their health information when they need it most and in a way they can best use it
  - Liberate health information and move the healthcare system toward greater interoperability
- ONC
  - Give patients and their healthcare providers secure access to health information
  - Increase innovation and competition by fostering an ecosystem of new applications
  - Empower patients by putting them in charge of their health records

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Question Topics Submitted During Webinar Registration

- Applicability
- Patient Access API requirements
- Data sharing clarification
- Vendors offering solutions
- Plan for supporting payers

CMS Interoperability and Patient Access

Patient Experience

Apple Health

1upHealth

others

<u>Patients bring a third-party app of their own choosing</u>

- Payers must register apps that patients choose
- Currently approximately 12 on the market
- App vendors not required to be HIPAA compliant

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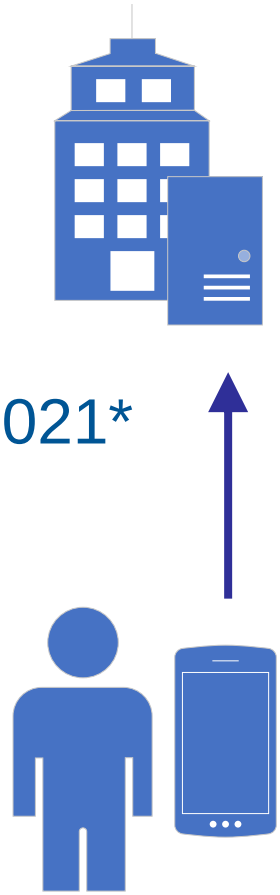
Patient Experience



By July 1, 2021*

Patients may request their data via third-party app of their choice

- Payers must implement the FHIR Application Programming Interface (API)
- **This is not another portal**

*By Jan 1, 2021 for MA and QHPs on FFEs

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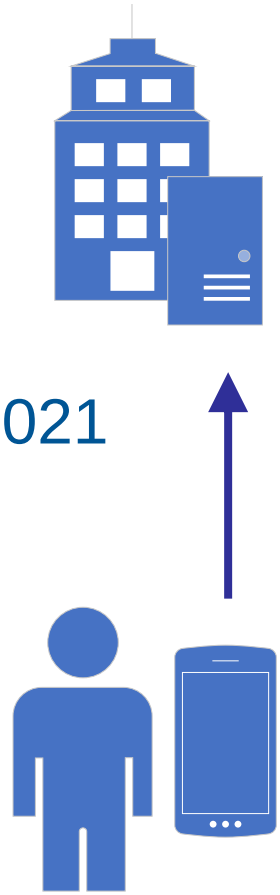
Patient Experience



By July 1, 2021

Patients' apps are authorized to retrieve data

- Payers must authenticate users
- Payers must manage login IDs and passwords for all patients

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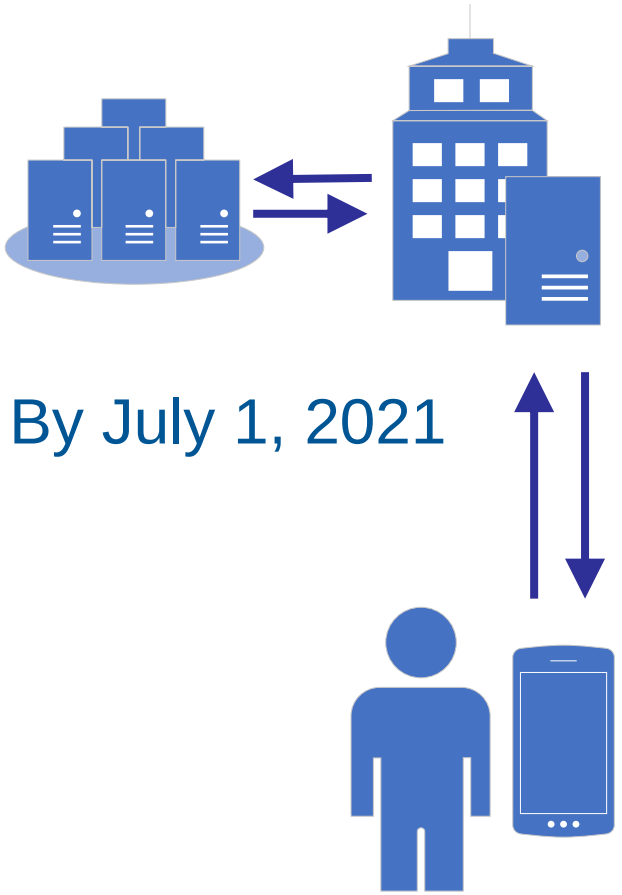
Patient Experience



By July 1, 2021

Patients receive their data

- Payers must locate and map historical claims and clinical data, formulary, benefits to FHIR
- Payer must map provider directory to FHIR

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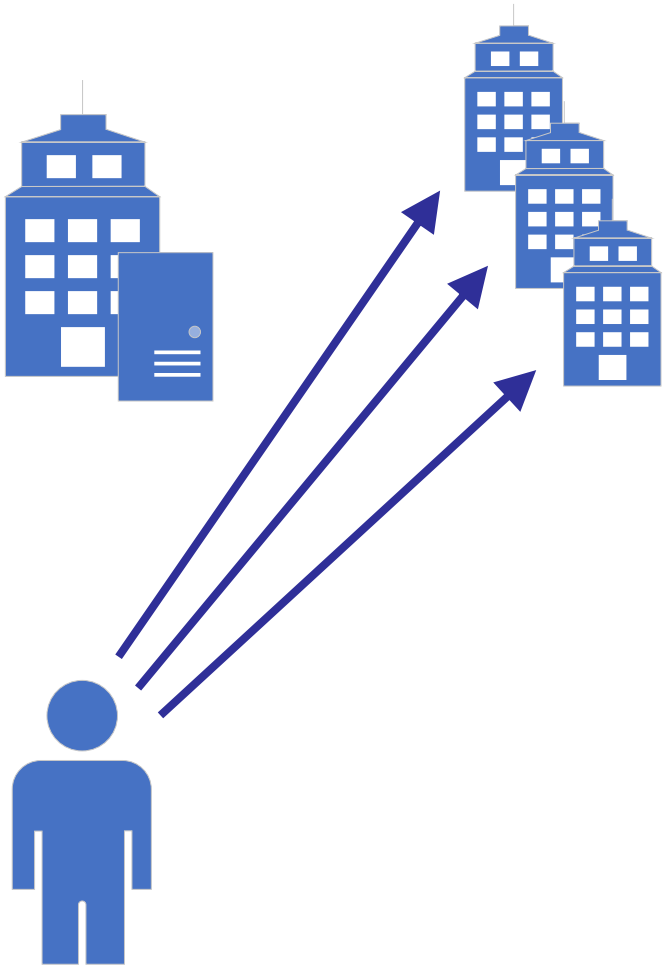
Patient Experience

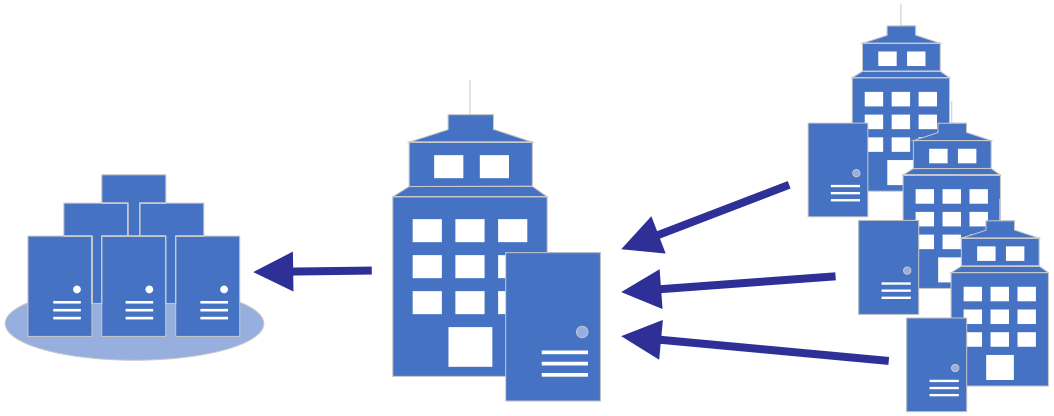


By July 1, 2022

Patients request prior payers to send data to their current payer

- CMS did not specify the method for the request

Patient Experience



By July 1, 2022

Prior payers must share data with current payer

- Includes only clinical data
- Payers must incorporate data, but need not act on it

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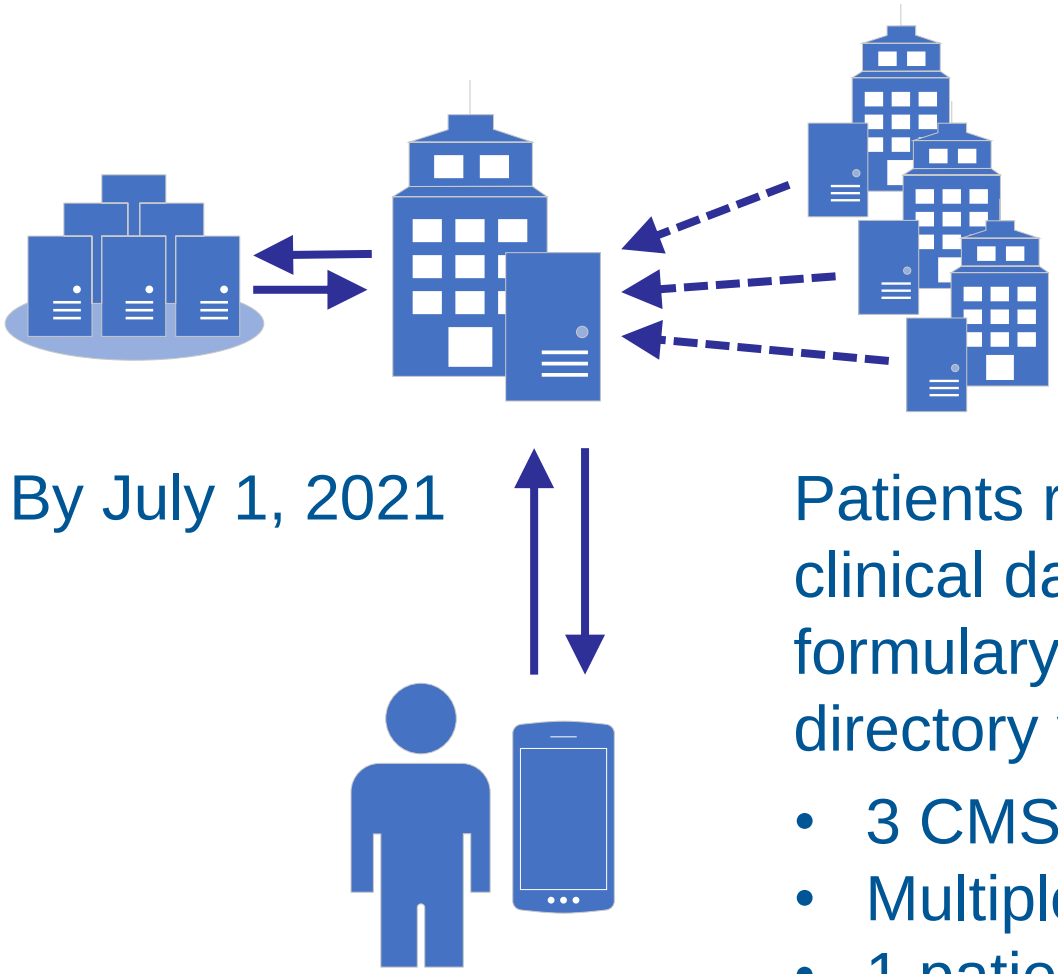
Patient Experience



By July 1, 2022

By July 1, 2021

Patients receive their claims and clinical data from all payers, formulary, benefits, provider directory via their app

- 3 CMS requirements
- Multiple payers
- 1 patient experience

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Summary of Data Requirements

- Data Requirements for Patient Access API
  - Claims including costs, back to 2016
  - Clinical data within USCDI that payer manages, back to 2016
  - Current benefits and formulary
- Data Requirements for Provider Directory API
  - Current provider and pharmacy information
  - Includes names, addresses, phone numbers, and specialties
- Data Requirements for Payer-to-Payer Exchange
  - Clinical data within USCDI that payer manages, back to 2016

Scope of the CMS Patient Access Final Rule

1. Patient Access API
2. Provider Directory API
3. Payer-to-Payer Data Exchange
4. Increased Reporting on Dual Eligibles
5. Public Reporting and Information Blocking
6. Digital Contact Information
7. ADT Event Notifications

Requirement Applicability

CMS-regulated Entity	Patient Access API	Provider Directory API	Payer-to-Payer Exchange
Medicaid managed care plans	X	X	X
Medicaid fee-for-service programs (OHA)	X	X	*
Medicare Advantage	X	X	X
CHIP fee-for-service programs (OHA)	X	X	*
CHIP managed care entities	X	X	X
Qualified health plan issuers on federally-facilitated exchanges	X		X

Note: Final rule excludes issuers offering only stand-alone dental plans or federally-facilitated small business health options. Providers are not subject to Patient Access API, Provider Directory API, or Payer-to-Payer Exchange in the CMS final rule.

*Though FFS is not currently subject to this requirement, it is expected that they will be in the future.

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Scope of the CMS Patient Access Final Rule

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Patient Access API

- Must implement patient access API
  - Must allow access to claims and encounter information
  - Must include cost and clinical information
  - Must include formulary and benefit information
  - Must allow use of 3rd-party app of patient's choosing
- Must use standards identified by ONC Final Rule
  1. Exchange via FHIR Release 4
  2. Clinical data must include USCDI data elements
  3. Authentication/authorization via OAuth2, OpenID Connect
- Potential CMS guidance documents can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

Patient Access API Considerations/Barriers

- Payers will need to budget for system changes
- Uses emerging standards unfamiliar to current vendors with immature implementation guides
- Must aggregate and map clinical data from administrative transactions
- Must manage beneficiary logins and passwords
- Must share EHI with app developers not covered by HIPAA, without a data sharing agreement
- Consider the user experience of the patient
- Provide patient education (see CMS resource)

Patient Experience Considerations

- Patients bring a third-party app of their own choosing
  - App vendor is not bound by HIPAA Privacy Rule
  - Payers are required to provide privacy education to patients (CMS has posted a payer resource with required/sample content)
- Patients may request their data via third-party app of their choice
  - Payers must register patient apps
  - Payers must maintain patient credentials (e.g., login ID and password) for up to 5 years after patients leave the plan
  - Patients have 5 years make request or data may not be retrievable
- Patients receive their claims and clinical data, and formulary, benefits
  - Payers must provide claims and clinical data from 2016 onward

Oregon Collaboration Opportunities

- Emerging standard unfamiliar to most vendors
- Collaboration opportunities might include:
  - Vetting vendors
  - Group purchasing
  - Best practices
  - Sharing lessons learned
  - Facilitated meetings

Patient Access API questions?

Scope of the CMS Patient Access Final Rule

1. Patient Access API
2. Provider Directory API
3. Payer-to-Payer Data Exchange
4. Increased Reporting on Dual Eligibles
5. Public Reporting and Information Blocking
6. Digital Contact Information
7. ADT Event Notifications

Provider Directory API

- Must implement provider directory API
  - Must allow patient access to complete provider and pharmacy list via third-party API of patient's choosing
  - Must include names of providers, addresses, phone numbers and specialty
- Must use standards identified by ONC Final Rule
  - Exchange via FHIR Release 4
- Potential CMS guidance documents can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

Provider Directory API Considerations/Barriers

- Payers will need to budget for system changes
- Uses emerging standards unfamiliar to current vendors with immature implementation guides
- Must collect any missing provider data
- Must map provider data from administrative transactions
- Must share information with app developers without a data sharing agreement

Patient Experience Considerations

- Patients bring a third-party app of their own choosing
  - Provider directory is not PHI and does not have the same privacy considerations
- Patients may request their data via third-party app of their choice
  - Payers must register patient apps
  - Authorization is not required
- Patients receive the provider directory (including pharmacy information)
  - Payers must share the current directory, with updates made available for download within 30 days

Relationship between CMS & ONC Rules

- CMS specified that Patient Access and Provider Directory APIs would use standards specified by ONC
  - API technical standards
  - Authentication/authorization standard
  - Clinical data requirements
    - USCDI requirements will change over time, perhaps annually
- Mirrors API standards required for patient access of clinical data in CEHRT

API Timeline

- Patient access and provider directory APIs to be implemented by January 1, 2021
- CMS will exercise enforcement discretion until July 1, 2021
- Payers must provide claims and clinical data via the Patient Access API for up to 5 years after a patient leaves the plan
- Payers must exchange clinical data with other payer for up to 5 years after a patient leaves the plan
- Payers must provide historical claims and clinical data from 2016 onward

Oregon Collaboration Opportunities

- Emerging standard unfamiliar to most vendors
- Collaboration opportunities might include:
  - Vetting vendors
  - Group purchasing
  - Best practices
  - Sharing lessons learned
  - Facilitated meetings

Provider Directory API questions?

OHA (Fee-for-Service) Update on API Work

Steve Westberg and Christopher McFetridge

- Current status: pursuing special procurement
- Steps taken
  - Reviewed CMS technical specifications guidance
  - Market analysis specific to MMIS system
- Decisions
  - 1 vendor for both Patient Access and Provider Directory APIs
- Timeline
  - 2 months for special procurement process
  - 5-6 months for development, testing, and implementation

Scope of the Final Rule

1. Patient Access API
2. Provider Directory API
3. Payer-to-Payer Data Exchange
4. Increased Reporting on Dual Eligibles
5. Public Reporting and Information Blocking
6. Digital Contact Information
7. Event Notification

Payer-to-Payer Data Exchange

- Must exchange clinical data at beneficiary request
  - Intended to allow patient to take their information with them as they move from payer to payer over time
  - Must respond to requests if individual was a beneficiary within the last 5 years
  - Must respond with all clinical data from 2016 onward
  - Patient must identify entities from which to request data
- Must include USCDI data elements
  - No interface standard is specified for API
  - Use of FHIR may be suggested by CMS, but not required
- Must be implemented by January 1, 2022

Payer-to-Payer Exchange Considerations/Barriers

- Payers may not have budgeted for associated costs
- Requires robust beneficiary identity and patient matching capabilities
- Uses data standards unfamiliar to current vendors, with changing requirements over time
- No technical standard is identified, must be coordinated
- Requires long-term data retention with on-line access
- Requires new processes for beneficiaries and plans to request information and fulfill those requests
- Coordinate with other payers

What CCOs/DCOs Needs To Do

As outlined in their contract, Oregon's Coordinated Care Organizations (CCOs) and Dental Care Organizations (DCOs) are required to comply with the federal requirements:

Contractor shall comply with the newly amended and adopted federal regulations set forth in the CMS Interoperability and Patient Access Final Rule…These rules include requirements relating to the:

(i) use of application programming interfaces (APIs) to:

(y) provide patient access to payer claims, encounter information, and costs, and

(z) make managed care plans' provider directories publicly available; and

(ii) exchange of certain patient clinical data between payers.

Patient Experience Considerations

- Patients request that previous payers retrieve data via their current payer
  - Patients have 5 years to make this request or data may not be retrievable
- Patients receive their claims and clinical data, and formulary, benefits, and provider directory

Oregon Collaboration Opportunities

CMS requirement is that payers exchange information with each other. Without a federally-mandated technical standard, it's in payers' common interest to agree on a common practice and standard. CMS encourages the use of FHIR, which is required for APIs

- Collaboration on common methodology
- Collaboration on exchange standards
- Other collaboration opportunities might include:
  - Best practices
  - Sharing lessons learned

Exchange Timeline

- Payer-to-payer exchange to be implemented by January 1, 2022
- CMS will exercise enforcement discretion until July 1, 2022
- Payers must exchange clinical data with other payers for up to 5 years after a patient leaves the plan
- Payers must provide historical clinical data from 2016 onward

Payer-Specific Implementation Considerations

- Need to think about ‘how’ to meet the requirement not just ‘what’ the requirement is
- There are potentially different interpretations of rule requirements
  - Each payer may need to make their own decisions about how they will meet requirements
  - Legal departments may need to be brought in to help interpret rule requirements as they pertain to each payer
- There are different technical approaches to meeting requirements
  - Each payer must consider their own existing systems, data, capabilities
  - A single approach won’t work for all

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CMS Resource: Guidance Document

Information for payers including

- Information and tools to help implement the Patient Access API and Provider Directory API
- Best Practices for payers and developers sharing and receiving patient data via FHIR-based APIs
- Information to support payers as they produce patient education resources tailored to their patient population

https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

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Payer-to-Payer Exchange questions?

Puzzling Through Interoperability
11/05/2020

David Stucky
Director, Technical Solutions

PacificSource

For Today

- Pieces of the Puzzle
- How We've Viewed Interop
- Initial Use Cases
- What's Different?
- Helpful Strategies
- Timing & Approach Highlights
- Looking Forward to 2021 and Beyond

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Pieces of the Puzzle

- Regulatory Environment
- Team
- Timing
- Partner Landscape
- Investment
- Technology

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How We View Interop…

- CMS rule telegraphs acceleration towards a data sharing standard that will fundamentally change the way we operate.
- Still lots of uncertainty and acceleration in the market, technology, guidance, etc.
- We're being cautious and mindful of the need to "future proof" our efforts as we go.
- Compliance will be challenging, but there are *many* value driven opportunities/use cases which will be enabled by the changes.

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Initial Use Cases (by 7/1/2021)

- Anybody can access our provider directory using FHIR
- Members and former members can access in-scope data using a FHIR-based application
  - “Can I have a copy of my claims history for 2016-2018?”
  - “Can you provide me a copy of my clinical records that you have in your keeping?”
  - “What was my provider paid for this claim?”
  - “What was my cost share in 2019?”
- We understand how to do B2B exchanges using FHIR.

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What's Different?

Today	Future
Data exchanges are mostly private	Data exchange is publicly accessible with consent
Data exchanges require timely, individual setup	Data exchanges are enabled instantly….assuming consent exists
Data is transferred mainly in the form of a file	Data is made available via an Application Programming Interface (API)
Data is transferred on a schedule, e.g. nightly.	Data is available on demand
HIPAA rules apply	HIPPA rules apply and some FTC rules apply to downstream data users
Data ownership is ambiguous	Data belongs to the patient…everyone else is just a caretaker
Few to no penalties for information blocking	Steep penalties (e.g. $1M/instance) for information blocking

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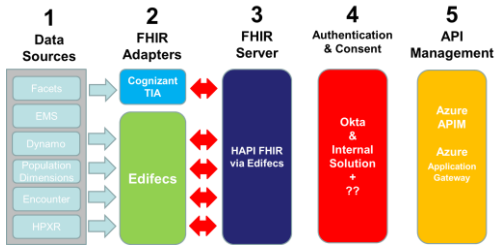
Helpful Strategies

- Recruited/enjoyed strongest possible leadership support.
- Quickly developed and began to rely upon a basic problem/solution model.
- Heavily leveraged our key partners as learning resources.
- Dedicated senior staff to the effort.
- Guiding Principle: Make necessary forward progress, but keep options as open as possible as long as possible.



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Timing

- Started exploring in earnest Q4 of 2019.
- Lots of speculation regarding final content of the rule.
- Our early take was: “Probably more work than time!”
- Of necessity, we quickly focused on minimum viable product approach:
    - “We’re a payer…let’s make sure we get claims and EOBs out there.”
- Spent first half of 2020 doing deep-dives into regs, partners, technologies

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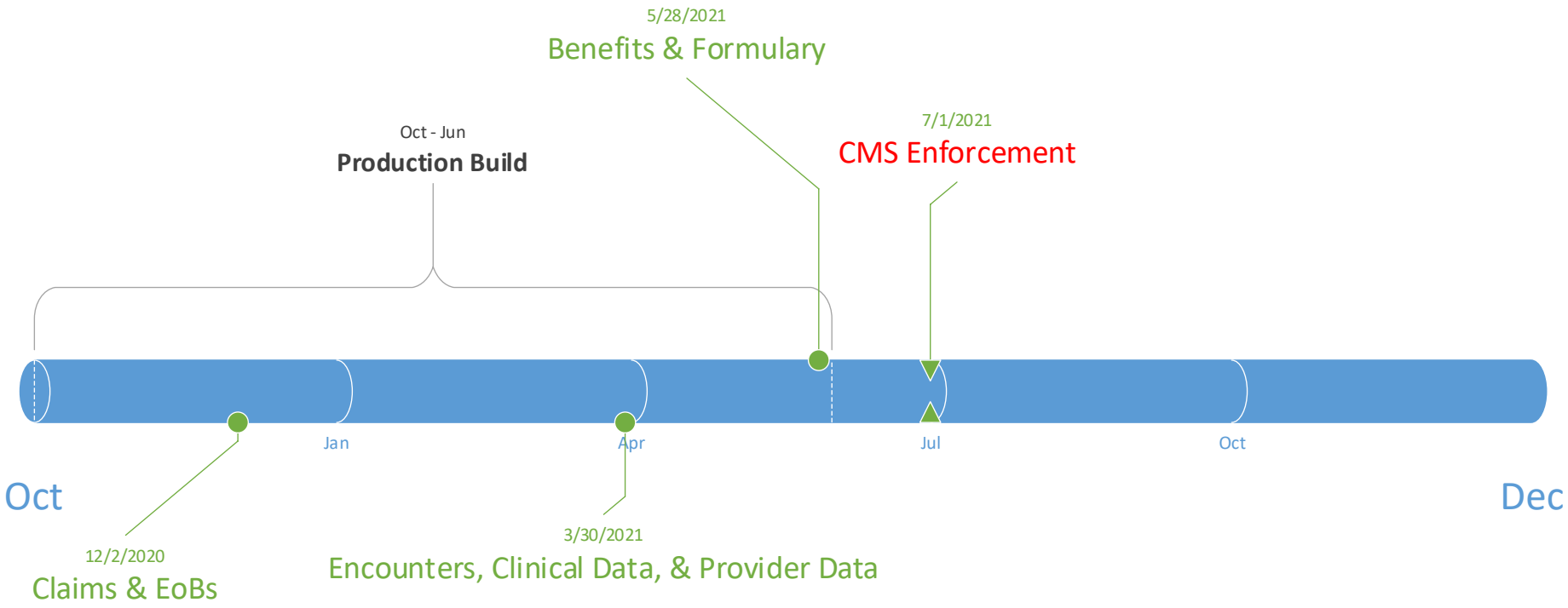
2020-2021 Readiness Timeline



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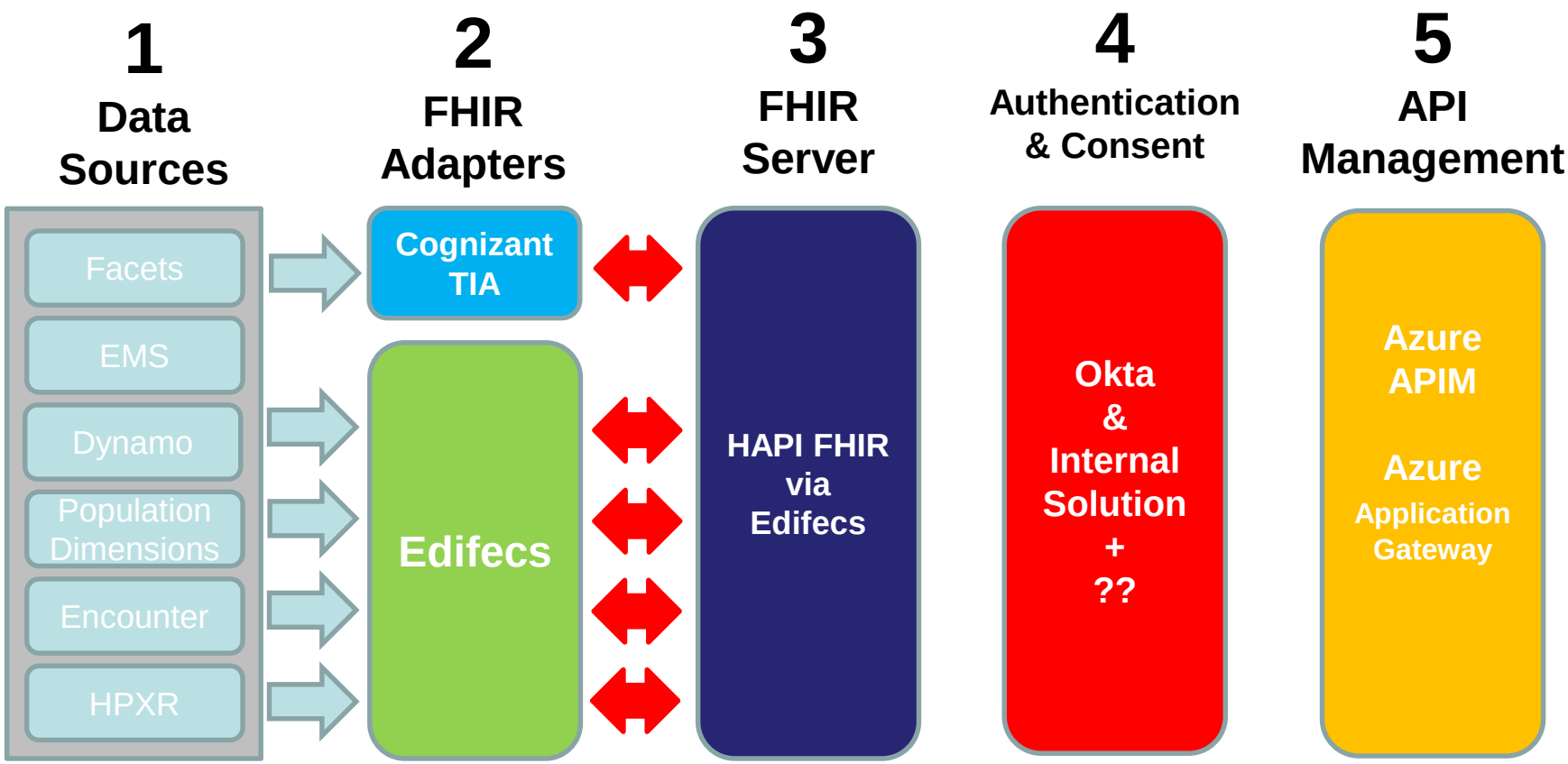
Major Solution Components



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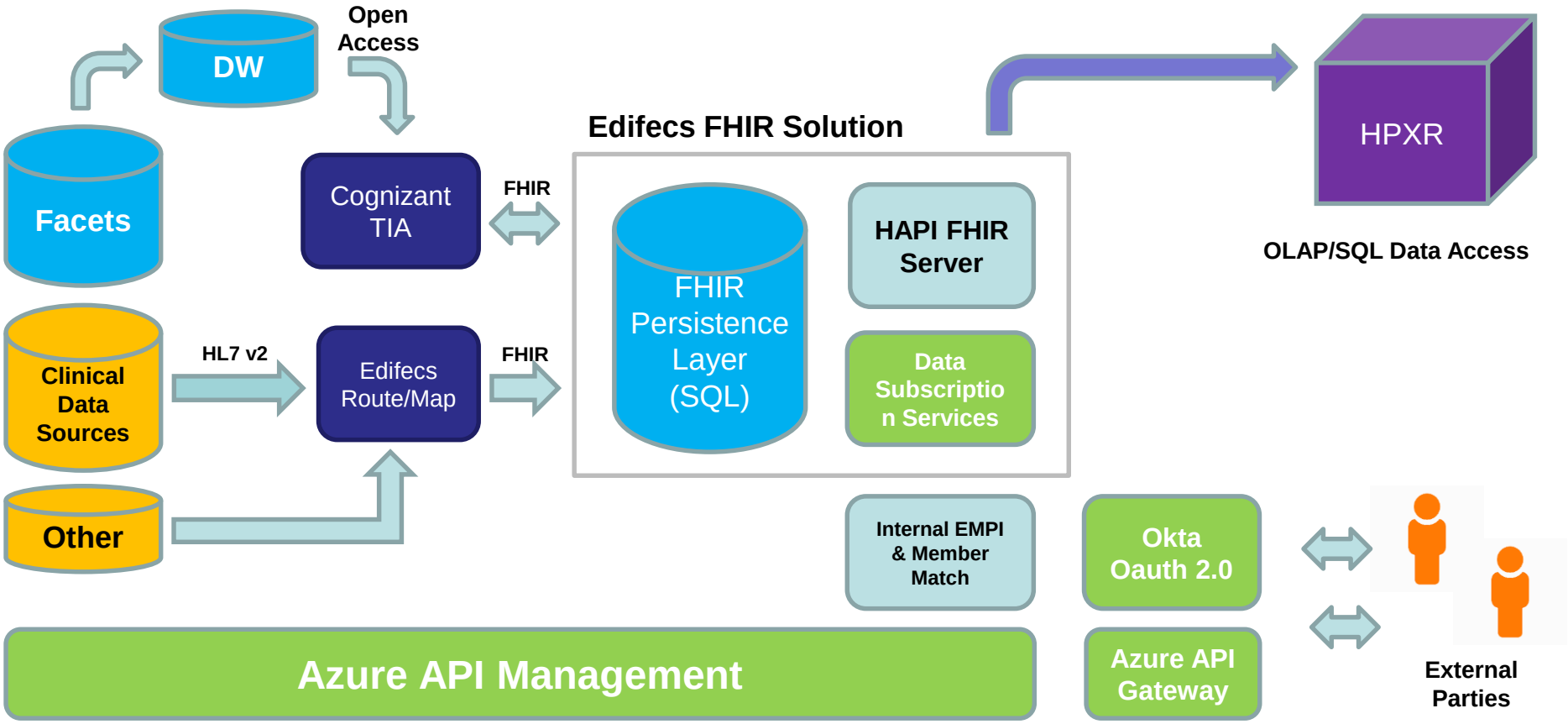
Basic Solution Structure



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Looking Forward: 2021 Interop Work

- Ongoing compliance work
- Oregon Provider Directory FHIR provider directory integration
- Provider partner FHIR-based membership/provider exchanges
- Gear up for Payer-to-Payer and bulk data exchanges
- Using FHIR for HIE partner work

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ONC 21st Century Cures Act

Linkage between ONC and CMS Rules

ONC Final Rule

1. Defines technical standards for patient access (API and security)
2. Defines clinical data to be exchanged
3. Defines health information networks for purposes of information blocking

CMS Final Rule

1. Uses same technical standards for patient access
2. Uses same definition for payer-to-payer exchange
3. Definition of health information network might apply to payers

Scope of the ONC Cures Act Final Rule

Regarding Information Blocking

- 21st Century Cures Act (i.e., Congress)
  - Defined information blocking
  - Expanded applicability to healthcare providers, health information exchanges, health information networks
  - Defined monetary penalties
- ONC Cures Act final rule
  - Defined healthcare providers, HIE, HIN
  - Defined exceptions to information blocking that allow Cures Act provisions to go into effect

Information Blocking

Defined by Cures Act as:

> "A practice by a health care provider, health IT developer, health information exchange, or health information network that, except as required by law or specified by the Secretary as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information."

ONC Definition of HIE and HIN

- ONC combined the definitions of HIE and HIN to create one definition that applies to both statutory terms
- HIN or HIE means 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
- Applies only to information blocking

Exceptions to Information Blocking

- "It will not be information blocking for an actor to engage in practices that are reasonable and necessary…
- …provided certain conditions are met."
- All instances of information blocking are subject to investigation by OIG
  - OIG is the only recourse for information blocking

https://www.healthit.gov/curesrule/final-rule-policy/information-blocking

Timeline for Information Blocking

- As of 11/4/2020, revised compliance date April 5, 2021 (Original compliance was November 2, 2020)
  - Includes exchange of USCDI data elements
- OIG proposed additional enforcement discretion for civil monetary penalties until 60 after publication of final rule
  - Healthcare providers are not subject to civil monetary penalties
- Enforcement for healthcare providers dependent upon additional rulemaking by DHHS
  - Rulemaking to define appropriate disincentives for healthcare providers

Considerations and Barriers

- Every organization must determine whether the definition of health information network applies to them
  - HIN/HIE is a functional definition that depends upon how an entity functions, not upon facts about the entity
  - Any specific business line might be considered a HIN
  - Generally, for the organization to be considered a HIN
    - More than two participants must exchange data
    - Participants must exchange information among themselves
    - Participants must exchange for treatment, payment, or healthcare operations purposes
  - Information blocking will be enforced on a case-by-case basis following OIG investigation

Information Blocking and Payers

- Every organization must determine whether the definition of health information network applies to them
  - Information blocking may attach to patient access or payer-to-payer exchange
  - Information blocking may attach to other activities if meeting the requirements of HIN

What CCOs/DCOs Needs To Do

As outlined in their contract, CCOs/DCOs are required to comply with the federal requirements:

OHA requires that Contractor review the ONC 21st Century Cures Act Final Rule to determine its obligation to comply with the final rule. Specifically, Contractor should review the terms "Health Information Exchange" (HIE) and "Health Information Network" (HIN) .... ***Contractor is required to notify OHA in writing by 1/31/2021 about whether Contractor meets the definition for an HIE/HIN as it pertains to information blocking.***

Questions?

ONC Cures Act Final Rule:
Information Blocking

Other Questions?

Next Steps

OHA Plan for CCO/DCO Communication and Support

- Survey to be sent to CCOs/DCOs early next week to collect information about CCO/DCO level of understanding and readiness to meet the payer requirements
  - CCOs: via CCO Health IT Advisory Group representatives
  - DCOs: via Kellie Skenandore
- Responses will be analyzed and presented at future CCO/DCO meetings (e.g., CCO CEO meeting, CCO Ops Collaborative, All Plan System Technical Meeting, ASU Rates Workgroup Meeting, DCO Contracts and Compliance)
- Results will also be shared with CMS

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What support do CCOs/DCOs need to meet the requirements?

- Want to hear from CCO/DCOs (survey input)
- OHA to convene meetings for collaboration and/or sharing of best practices
- Additional educational webinars and FAQs

Wrap-up

Please visit the Office of Health IT's federal final rules webpage https://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/Federal-Rules.aspx for additional resources, including 10/1 webinar recording, materials, and Q&A

If you have questions, please contact Marta Makarushka at Marta.M.Makarushka@dhsoha.state.or.us