

## CMS & ONC INTEROPERABILITY RULES: AN OVERVIEW

### Overview of CMS Rule

On Feb. 11, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) both released proposed rules in an unofficial format, which are intended to further the state of interoperability in the healthcare system. The official versions of the rules were published on March 4 and the comments on both are due on May 3. The administration also recently published an [op-ed](#) in *Fortune* detailing their policies to improve patient access to their medical records electronically.

CHIME and our affiliate organizations, AEHIT, AEHIA & AEHIS, will submit comments on both rules. If you are interested in speaking with our public policy team about the rules, please contact us at [policy@chimecentral.org](mailto:policy@chimecentral.org).

This cheat sheet will focus on the CMS rule. Please see our summary of the information blocking provisions of the ONC Rule [here](#).

### **Where Can I find the Rules & Fact Sheets?**

#### **CMS**

- [Proposed Rule](#)
- [Fact Sheet](#)
- [Press Release](#)
- Go [here](#) to comment

#### **ONC**

- [Proposed Rule](#)
- [Fact sheets](#)
- Go [here](#) to comment

### **CMS Rule Overview – Key Provisions**

#### **Overview:**

This rule is intended to support the administration's goals of interoperability, as well as the vision of the 21st Century Cures Act, and [Executive Order 13813](#) aimed at competition and choice. The policies laid out in the rule are largely directed at supporting patient access to their health data electronically. The agency states that this rule is the first phase of a larger plan by CMS to advance interoperability and foster patient access to their information. CMS wants patients to be able to move health plan to health plan, provider to provider, and have their clinical and administrative info travel with them. They state, "When a patient is discharged from a hospital to a post-acute care (PAC) setting there should be no question as to how, when, or where their data will be exchanged. Likewise, when an enrollee changes health plans or ages into Medicare, the enrollee should be able to have their claims history and encounter data follow so that information is not lost."

**Requirements for Payers:** CMS proposes to require certain payers make certain patient data available via an open application programming interface (API). Impacted payers include Medicare Advantage organizations, Medicaid state agencies, Medicaid managed care plans, Children's Health Insurance Program (CHIP) agencies, CHIP managed care entities, and Qualified Health Plans (QHPs) in federally-facilitated Exchanges (FFEs). CMS is not proposing to require health plan issuers to use systems certified by ONC. API standards would mimic the standards ONC has proposed in their rule. CMS encourages other payers to follow suit.

Data for which these payers would have to allow third-party access – with patient approval – include but are not limited to adjudicated claims data, encounters from capitated providers and clinical data (including labs). Timeline for making data available would be one day from when the claim is adjudicated, processed or received, depending on payer type; lab data would be one day after the claim is processed.

Additionally, CMS is proposing that the above payers would be required to participate in a trusted exchange network starting Jan. 1, 2020. And, they would be required to make available to patients upon request, their data spanning up to five years after disenrollment. Plans would also be required to maintain a process to coordinate care between plans by exchanging, at a minimum, the data contained in USCDI (Version 1) at enrollee request at any time during their coverage and up to five years after their coverage ends.

**Admission, Transfer, Discharge (ADT) alerts:** CMS has proposed requiring Medicare-participating hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to send electronic notifications when a patient is admitted, discharged or transferred. Specifically, hospitals would be required to send electronic patient event notifications of a patient's admission, discharge, and/or transfer to another healthcare facility or to another community provider. Hospitals would have to convey, at a minimum, the patient's basic personal or demographic information, as well as the name of the sending institution, treating practitioner's name, and, if not prohibited by other applicable law, the diagnosis.

This mandate would be limited to hospitals with an EHR with the ability to generate basic patient personal or demographic information for electronic patient event (ADT) notifications. There is no criterion under the ONC Health IT Certification Program that certifies health IT to create and send electronic patient event notifications. CMS is not requiring hospitals' systems use a particular standard to accomplish this.

Affected hospitals would need to demonstrate they send notifications directly, or through an intermediary that facilitates exchange of health information, and at the time of the patient's admission to the hospital, to licensed and qualified practitioners, other patient care team members, and post-acute care (PAC) services providers and suppliers that:

1. receive the notification for treatment, care coordination, or quality improvement purposes;

2. have an established care relationship with the patient relevant to his or her care; and
3. for whom the hospital has a reasonable certainty of receipt of notifications.

CMS says they recognize that factors outside of the hospital's control may determine whether or not a notification is successfully received and utilized by a practitioner. As such, they state a hospital would only need to send notifications to those practitioners for whom the hospital has reasonable certainty of receipt of notifications. And, CMS says hospitals should send notifications to those practitioners or providers that have an established care relationship with the patient relevant to their care.

This requirement would become a Medicare Condition of Participation (CoP). Failure to meet a Medicare CoP risks a hospital's entire Medicare reimbursement.

**Data Blocking Attestations:** CMS proposes that hospitals that attest "no" or leave blank one of the three information blocking attestation statements required under the Promoting Interoperability program be posted online starting in 2020. Additionally, for physicians, a similar indicator would appear on the Physician Compare website.

**Advancing Interoperability in Innovative Models:** CMS is pondering – but did not propose – the notion of updating the Promoting Interoperability (PI) requirements to encourage hospitals to engage in certain activities focused on interoperability. This includes a possible future strategy of creating a set of priority IT / interoperability activities that would serve as an alternative to PI. This would be intended to offer flexibility and reduce burden. Examples of activities could include: participating in a network part of Trusted Exchange Framework and Common Agreement (TEFCA); maintaining open API allowing persistent third-party access; and participating in pilots and testing of new standards to support emerging use cases. CMS says they plan on including this proposal in rulemaking this year.

**Provider Directories:** There are two proposals in the rule pertaining to provider directories. The first relates to a requirement for the payers to make available provider directories via an open API. The second proposal responds to a directive in the Cures Act for the creation of a provider digital directory. To meet this mandate, CMS seeks to increase the number of clinicians with valid and current digital contact information available through the National Plan and Provider Enumeration System (NPPES). Specifically, CMS calls for clinicians to update their information in the NPPES regarding their electronic addresses (i.e. Direct address, FHIR server URL, query endpoint or other digital contact information) to help foster better interoperability. CMS proposes to make publicly available the names of those clinicians who have not updated their information starting during the second half of 2020.

**Patient Matching:** Since 1999, Congress has maintained a ban that prohibits HHS from spending any resources to identify and name a patient identification standard. Following years of CHIME leading advocacy efforts on Capitol Hill and working with other

stakeholders to raise awareness around patient identification as pivotal to interoperability, progress has been gaining momentum over the past three years.

First, CHIME led the efforts with Congress to get favorable report language in 2017 and 2018 in the Labor Health and Human Service (HHS) appropriations bill, which paved the way for HHS to work with the industry on private-sector led solutions for patient matching. This in turn has led to increasing policy conversations within the administration around this topic and its importance. In fact, in 2017 ONC launched a [patient matching challenge](#) awarding \$75,000 in prizes. And, CHIME helped ensure a provision was included in the 21<sup>st</sup> Cures Act that directed the Government Accountability Office (GAO) to study patient matching. They published their [report](#) in January.

In what amounts to an enormous step forward, and building on the momentum, both CMS and ONC have included RFIs in their rules seeking feedback from the public on the topic of patient matching and cited a previous CHIME report on this topic. The agencies seek comments on:

- Additional opportunities that may exist in the patient matching space and ways ONC can lead and contribute to coordination efforts with respect to patient matching.
- ONC is particularly interested in ways that patient matching can facilitate improved patient safety, better care coordination and advanced interoperability.
- ONC seeks feedback on the potential effect that data collection standards may have on the quality of health data that is captured and stored and the impact that such standards may have on accurate patient matching.
- ONC seeks input on other solutions that may increase the likelihood of accurate data capture, including the implementation of technology that supports the verification and authentication of certain demographic data elements such as mailing address, as well as other efforts that support ongoing data quality improvement efforts.
- What additional data elements could be defined to assist in patient matching as well as input on a required minimum set of elements that need to be collected and exchanged.
- What requirements for electronic health records could be established to assure data used for patient matching is collected accurately and completely for every patient.
- There are unique matching issues related to pediatrics and we seek comment on innovative and effective technical or nontechnical approaches that could support accurate pediatric record matching.
- Potential solutions that include patients through a variety of methods and technical platforms in the capture, update and maintenance of their own demographic and health data, including privacy criteria and the role of providers as educators and advocates.
- CMS seeks comments on how they can leverage their program authority to provide support to those working to improve patient matching?
- Should CMS require payers (Medicare Advantage organizations, Medicaid state agencies, Medicaid managed care plans, Children's Health Insurance Program (CHIP) agencies, CHIP managed care entities, and Qualified Health Plans (QHPs) in

federally-facilitated Exchanges (FEEs)) use a patient matching algorithm with a proven success rate of a certain percentage where the algorithm and real-world processes associated with the algorithm used are validated by HHS or a third party?

- Should CMS require those payers to use a particular patient matching software solution with a proven success rate of a certain percentage validated by HHS or a third party?
- Should CMS expand the recent Medicare ID card efforts by requiring a CMS-wide identifier which is used for all beneficiaries and enrollees in healthcare programs under CMS administration and authority?
- Should CMS advance more standardized data elements across all appropriate programs for matching purposes, perhaps leveraging the USCDI proposed by ONC for HHS adoption?
- Should CMS complement CMS data and plan data with one or more verifying data sources for identity proofing?
- What potential data source should be considered? What are possible restrictions or limitations to accessing such information?
- To what extent should patient-generated data complement the patient-matching efforts?

**Advancing Interoperability Across the Care Continuum:** CMS has a request for information (RFI) in the rule centered around how to foster interoperability across the care continuum (i.e. post-acute). CMS seeks comments on several related issues:

- How HHS can more broadly incentivize the adoption of interoperable health IT systems and use of interoperable data across settings such as long-term and PAC, behavioral health, and those settings serving individuals who are dually eligible for Medicare and Medicaid and/or receiving home and community-based services.
- Measure concepts that assess interoperability, including measure concepts that address PAC, behavioral health, home and community-based services, and other provider settings.
- Needed measure development work and quality improvement efforts focused on assuring individuals receive sufficient needed services across the care continuum.
- To enable the bidirectional exchange of this health information, CMS seeks public comment on whether hospitals and physicians should adopt the capability to collect and electronically exchange a subset of the same PAC standardized patient assessment data elements (for example, functional status, pressure ulcers/injuries) in their EHRs.
- Whether to move toward the adoption of PAC standardized data elements through the expansion of the USCDI process.
- If the standardized patient assessment data elements that are implemented in CMS PAC assessment instruments in satisfaction of the IMPACT Act would be appropriate?
- What implementation timeline would be most appropriate for requiring adoption of these data elements in provider and hospital systems under the ONC Health IT Certification Program?

