



**CMS Interoperability and Patient Access Final Rule
March 9, 2020**

Admission, Discharge & Transfer (ADT) Notice Provisions

Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) proposed to revise the Conditions of Participation (CoP) to require hospitals, psychiatric hospitals and critical access hospitals (CAHs) send electronic patient event notifications, specifically upon admission, discharge or transfer of patients to established providers, where the hospitals had certified electronic health records (EHR) systems capable of sending such notices.

Final Rule

CMS finalized a slightly modified version of its proposal. Based on the final rule, hospitals, psychiatric hospitals and critical access hospitals (CAHs) will be required to send electronic notices of admission, discharge or transfer (ADT) to certain providers where they have certified EHR systems capable of sending such notices. At a high level, the final rule:

- Narrows the group of providers to whom patient event notifications must be sent.
- Provides for a six-month implementation timeline.
- Allows hospitals to exercise reasonable effort to send patient event notification.
- Declines to specify a standard that must be used for patient event notifications.
- Determines the circumstances under which a patient event notification is to be sent.
- Clarifies the implications of this rule on patient privacy.

Affected hospitals

Hospitals without an EHR system with the technical capacity to generate information for electronic patient event notifications, defined as a system conformant with the ADT messaging standard (HL7 2.5.1), will not be subject to this final rule. CMS clarified that EHR systems capable of sending such notices include systems where the EHR itself is incapable of sending ADT notices BUT a related administrative system has the capacity to do so.

Recipients

The proposed rule would have required ADT notices be sent to providers with whom the patient has an “established care relationship.” Based on comments, CMS determined this group of providers to be too broad and finalized a more limited group of required recipients. This group is limited to post-acute care services providers and suppliers with whom the patient has an established care relationship prior to admission or to whom the patient is being transferred or referred AND:

- The patient’s established primary care practitioner;
- The patient’s established primary care practice group or entity; or

- Other practitioners or practice groups or entities, identified by the patient as the practitioner, or practice group or entity, primarily responsible for his or her care.

CMS clearly states no notification would be expected in cases where a hospital is unable to identify a primary care practitioner, the patient has not identified a provider to whom he or she would like information about the care to be sent, or there is no applicable post-acute care provider or supplier identified.

Triggering events

ADT notices are to be sent upon patient's:

- Registration in the hospital's emergency department (ED)
- Admission to the hospital's inpatient services
- Discharge or transfer from the hospital's ED
- Discharge or transfer from the hospital's inpatient services.

Registration in the hospital's ED is intended to ensure that notices are sent for all patients, including those under "observation status," and not solely those admitted for inpatient care. ADT notices do not need to be sent when patients are transferred between inpatient services.

Content

According to the final rule, ADT notifications are to include the names of the patient, treating practitioner and sending institution. Diagnosis is not required to be included as part of the patient event notification, given the length of time it may take clinicians to reach a diagnosis. Instead, CMS opts for a notice that can be sent to required practitioners in a more timely fashion.

Notification transmission and receipt

Patient event notifications are to be transmitted either immediately prior to or at the time of admission, transfer or discharge.

The agency opted not to require a specific standard for transmitting the ADT notices, allowing affected hospitals flexibility to send the notices based on their current system capabilities. According to the final rule, CMS believes there are a variety of low-cost solutions in existence that will allow hospitals to comply with the requirements of this rule.

The final rule requires hospitals to use "reasonable effort to ensure" that the specified providers are notified of the patient's status. This is specifically intended to allow for situations where providers are unable to receive electronic patient event notifications in an acknowledgement that not all providers will be able to do so. The agency declined to set a specific benchmark for the number of ADT notifications to be sent.

Use of intermediaries

Additionally, the final rule specifies that using an intermediary to send ADT notices would meet the CoP where the hospital demonstrates that an intermediary connects to a wide range of recipients and does not impose restrictions on which recipients are able to receive notifications through the intermediary.

Interaction with other state and federal laws

CMS acknowledges that this regulation may conflict with other federal or state laws. For instance, under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, patients have the ability to limit the disclosure of their health information to practitioners of their choosing. The final rule allows patients to retain that right and clarifies that patient event notifications are only to be sent “to the extent permissible under applicable federal and state law and regulations, and not [in a manner] inconsistent with the patient’s expressed privacy preferences.”

Implementation timeline

CMS acknowledged comments that indicated a new requirement of this nature would require more than the traditional 60-day implementation period. Instead, the ADT provisions will be effective in six months.

Data Blocking Attestations

The Promoting Interoperability program requires hospitals attest to three statements pertaining to data blocking. CMS proposed and finalized its plan to post online the “no” responses to any of the three statements. The agency will post information beginning with attestations for the 2019 EHR reporting period and anticipates the information will be posted later this year. Where hospitals leave response blank, no information will be posted pertaining to the attestation statements and they will be considered incomplete. CMS intends to establish a 30-day preview period for each program year that will allow hospitals to review the information before it is publicly posted. Changes will be considered on a case-by-case basis. A similar proposal for physicians was also finalized, requiring CMS to post the attestation-related information on Physician Compare.

Patient Access Application Programming Interface (API)

By Jan. 1, 2021, CMS will require payers it regulates to provide access, upon patient consent, to certain data through a third-party API that is secure and standards-based.

Affected payers include:

- Medicare Advantage organizations
- Medicaid Fee-for-Service (FFS) programs
- Medicaid managed care plans
- Children’s Health Insurance Program (CHIP) fee for service (FFS) programs
- CHIP managed care entities
- Qualified Health Plan (QHP) issuers on the Federally Funded Exchanges (FfEs), excluding those offering only stand-alone dental plans and those offering coverage in the Federally-facilitated Small Business Health Options Program.

API standards will mimic the standards finalized by the Office of the National Coordinator for Health Information Technology (ONC) in the 21st Century Cures final regulation.

The API must include data maintained by the payers on claims for dates of service of Jan. 1, 2016.

Commenters recommended that Blue Button 2.0 be used as a common platform to provide patients with access to their data. CMS declined to adopt this recommendation; instead, the agency will allow for a market-based approach, encouraging the development of multiple APIs to be selected among by affected payers.

Upon patient consent, payers will be required to make certain data available through the Patient Access API within one day of receipt. The required data includes:

- Adjudicated claims (including cost)
- Encounters with capitated providers
- Provider remittances
- Enrollee cost-sharing
- Clinical data, including laboratory results, where maintained by the applicable payer.

With the exception of QHP issuers on the FFEs, all affected payers will also be required to provide formularies or preferred drug lists in the Patient Access API. CMS specifies that payers will not be required to validate or correct clinical data received from another source, nor are providers obligated to notify payers of errors in their data. That said, the agency does encourage stakeholders to work together to ensure the accuracy of information of information they maintain and share to the extent possible.

CMS intends to produce educational materials and patient resources that can be tailored by payers to assist patients in navigating and understanding their health information.

The proposed requirement that payers participate in a trusted exchange network was not finalized, given concerns raised by commenters regarding the need for a more mature Trusted Exchange Framework and Common Agreement to be in place first. However, the agency did finalize two additional proposals pertaining to payers, including its proposal to require payers to make available to patients upon request, their data spanning up to five years after disenrollment.

Additionally, payers will need to be able to participate in enrollee-approved and directed payer-to-payer exchanges of data contained in the U.S. Core Data for Interoperability (USCDI; Version 1) beginning Jan. 1, 2022. The agency is not imposing an API-based solution at this time; however, it has acknowledged the benefits and will consider future rulemakings regarding this matter. The regulation specifies that payers will only be required to send data in the electronic form and format it was received. Payers are required to exchange data for dates of service beginning Jan. 1, 2016.

Provider Directories

CMS originally proposed to require the inclusion of provider directories in the secure APIs. However, as a result of overlap concerns between this proposal and its proposal for a public-facing Provider Directory API, the agency opted not to finalize this proposal.

The final rule did include a requirement that regulated payers, with the exception of QHPs on the FFEs, maintain a public-facing Provider Directory API by Jan. 1, 2021. Existing regulations already require that these payers maintain an accessible provider directory and specify the content of the directory. This regulation essentially requires that the accessible provider directory be available in API form, rather than changing the required content. Plans will be required to update the Provider Directory API within 30 days of receiving notice of a change.

CMS did not include any requirements for clinicians to ensure the accuracy of their data in the Provider Directory API. The agency intends to verify compliance with this requirement by accessing a random sample of affected payers' websites for these publicly accessible APIs beginning on Jan. 1, 2021.

Additionally, in response to a directive in the Cures Act for the creation of a provider digital directory, CMS needs to increase the number of clinicians with valid and current digital contact information available through the National Plan and Provider Enumeration System (NPPES). In addition to reminders regarding providers' obligation to update their NPPES information within 30 days of a change, the agency has finalized its proposal to make publicly available the names of those clinicians who have not updated their information starting during the second half of 2020. It intends to release additional information pertaining to the public reporting mechanism and potential exemptions for certain categories of providers available shortly.

Federal-State Data Exchange for Dual Eligible Individuals

Beginning April 1, 2022, states will be required to participate in a daily exchange of data with CMS to improve the experience of dually eligible individuals and the ability of providers and payers to coordinate eligibility, enrollment, benefits and care for this population. Federal matching funds of 50% for administration are available to support states' costs for doing so. They also may be eligible for additional funds for the costs of developing and implementing any system changes necessitated by this new requirement, as well as for system maintenance and operation costs. The agency will provide any necessary technical assistance to the states.

Proposed Rule Requests for Information (RFIs)

The proposed rule contained two RFIs: one on patient matching and the other on fostering interoperability across the care continuum. In the final rule, CMS thanks commenters for their shared insights and notes that they will be kept in mind for future rulemaking. No further discussion of submitted comments pertaining to the RFIs is included in the final rule.