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LEGAL ADVICE FOR HEALTH PLANS

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Interoperability Requirements for Health Plans Proposed
Health Plans to Provide Data on Demand to Individuals and Other Plans
CMS Extends Comment Period Through June 3

Today, the Centers for Medicare and Medicaid Services (CMS) formally[1] published an extension of the comment period for proposed rules that would impose "interoperability" requirements on health plans; the extension postpones the deadline for submitting comments on the proposed rules until June 3. Previous "interoperability" rules have focused primarily on health care providers and their ability to exchange Electronic Medical Records quickly and efficiently through "Meaningful Use" standards adopted under the Affordable Care Act. The proposed rules, however, would require health plans that contract with CMS to begin making claims and other health information available so that plan members may access the information using mobile phone and similar applications (Apps) as early as next year.

The proposed "interoperability" requirements would apply to health plans that participate in programs that CMS regulates—Medicare Advantage organizations, Medicaid and CHIP managed care organizations, and issuers of Qualified Health Plans in Federally-Facilitated Exchanges (CMS-Regulated Health Plans). The proposed rules would not apply to commercial lines of business. The rules would, among other things, require CMS-Regulated Health Plans to:

- Give current and former members "immediate electronic access" to claims and encounter data as well as any "clinical data, including laboratory results" that the health plan maintains;
- Provide to (and accept from) other health plans specified "data classes and elements" about an individual who is a current member or has been a member in the previous five (5) years;
- Publish provider directory data and (in some cases) pharmacy directory data and formulary information;[2] and

[1] The extension was first published on April 19th, when CMS filed it with the Office of the Federal Register.

[2] Provider, pharmacy, and formulary directory requirements would not apply to issuers of Qualified Health Plans in Federally-Facilitated Exchanges due to similar requirements already imposed on such health plans.

- Participate in a "Trusted Exchange Network" that will enable individuals and covered entities to access health information quickly and easily from anywhere in the country.

CMS-Regulated Health Plans would be required to make information available to members and other health plans through an "open Application Programming Interface," or "open API." The API will need to meet specified technical and data format standards to ensure "interoperability" so that all parties involved will "have the ability to exchange data seamlessly." As CMS explains:

> "An API can be thought of as a set of commands, functions, protocols, or tools published by [a health plan] that enable . . . software developers to create programs (applications or 'apps') that can interact with [the health plan's] software without needing to know the internal workings of [the health plan's] software, all while maintaining consumer privacy data standards. This is how API technology enables the seamless user experiences associated with applications familiar from other aspects of many consumers' daily lives, such as travel and personal finance. Standardized, transparent, and procompetitive API technology can enable similar benefits to consumers of health care services."

An "open" API is one for which programmers can develop Apps for use by the general public (*e.g.*, through Apple's App Store or Android's Google Play). The proposed rules would, therefore, require CMS-Regulated Health Plans to implement an open API using specified technical and data content standards so that App developers could create Apps for the health plan's members to obtain claims and other information directly from the health plan's internal systems.

Although the effective date initially published for the proposed rule was January 1, 2020 (July 1, 2020 for Medicaid and CHIP plans), CMS acknowledged in the comment period extension that it would be necessary to "adjust the effective date of [the rules] to allow for adequate implementation timelines. The proposed rules are published at 84 *Federal Register* 7610 (click here). The extension of the comment period is published at 84 *Federal Register* 16834 (click here).

Member-Accessible Claims Information

Since 2010, CMS has made claims information available to Medicare beneficiaries through Medicare "Blue Button." CMS claims that it "has over 1500 application developers building tools" for use with the most recent version of the Blue Button API and it hopes to achieve similar results with the health plans subject to the proposed rules. CMS believes that the proposed member-access requirements will, among other things, ensure that "consumers who have immediate access to their health information are empowered to make more informed decisions when discussing their health care needs with providers or when considering changing to a different health plan."

CMS-Regulated Health Plans will be required to make information about a claim available through the API within one business day of adjudication. The claim information is to include provider remittance and enrollee cost-sharing. In addition, the API must provide within one business day of the health plan's receipt (i) any encounter data (for encounters with providers subject to capitation) and (ii) any clinical data, including laboratory results, that the health plan maintains about the member. The proposed rule does not specify the number of years for which claims (and other) data must be made available, so it would appear that health plans will be required to provide all such data that they maintain.

Data for (or from) Other Health Plans

Under the proposed rule, a CMS-Regulated Health Plan would be required to provide information about a current or former member to another health plan upon request by the member for up to five years after the member was enrolled with the plan. A CMS-Regulated Health Plan would also be required to accept information about a current member from any health plan that had been asked to provide it and then "incorporate[the information] into the recipient plan's systems." CMS's goal in imposing this requirement is "to require payers to support beneficiaries in coordinating their own care via payer to payer care coordination." Specifically, CMS believes that "[l]everaging interoperability to facilitate care coordination among plans can . . . significantly reduce unnecessary care, as well as ensure that health care providers are able to spend their time providing care rather than performing unnecessary administrative tasks."

The information to be exchanged among health plans under this provision would be in the form and format established in the United States Core Data for Interoperability (USCDI) and include the content of the USCDI. The Department of Health and Human Services describes this data set as "a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange." The USCDI appears to be a provider-oriented construct—it includes data classes such as "Assessment and Plan of Treatment," "Care Team Members," "Clinical Notes," and "Vital Signs." It is not yet clear, therefore, how a USCDI record can be populated with information that a health plan maintains.

Provider Directory Information

Medicare Advantage, Medicaid Managed Care, and CHIP Managed Care Organizations will be required to make provider directory information available through an open API. Provider directories must include the names, address, phone numbers, and specialties of network providers and must be updated within 30 days of any changes. Medicare Advantage Prescription Drug plans would also be required to make available through the open API pharmacy directories and "formulary data that includes covered Part D drugs, and any tiered formulary structure or utilization management procedure [that] pertains to those drugs." Medicaid and CHIP Managed Care Organizations' APIs would need to include information about covered outpatient medications and (when applicable) a preferred drug list. This

information (or any change to the information) must be available within one business day of the date on which it is effective.

Trusted Exchange Networks

Finally, CMS-Regulated Health Plans would be required to participate in a "Trusted Exchange Network." A Trusted Exchange Network is a qualified "Health Information Network" that, among other things, "supports secure messaging or electronic querying by and between providers, payers, and patients." In addition, these Networks must be capable of (i) exchanging protected health information in compliance with HIPAA and other applicable law; and (ii) connecting to electronic health records. CMS believes that health plans' participation in Trusted Exchange Networks is important because:

> "[health plans'] and patients' ability to communicate between themselves and with health care providers could considerably improve patient access to data, reduce provider burden, and reduce redundant and unnecessary procedures. Trusted exchange networks allow for broader interoperability beyond one health system or point to point connections among payers, patients, and providers. Such networks establish rules of the road for interoperability."

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