



# Session 2

## CMS Interoperability Planning Collaborative

April 26, 2022



# CMS Interoperability Planning Collaborative

- Collaboration among counties to meet new CMS data sharing requirements
- Create strategic planning roadmap

**48 COUNTIES** participating

## Key Program Activities

- Group discussion and sharing
- Subject matter experts, health plan and industry references
- Resources and templates

## Special Thank You and Acknowledgement

This program is supported by a grant from the California Health Care Foundation.



California  
Health Care  
Foundation

# CMS Interoperability Planning Collaborative

|    | Meeting Topics and Focus   | Schedule                    |
|----|--|-----------------------------|
|    | <ul style="list-style-type: none"><li>• CMS Interoperability primer (optional)</li></ul>   | March 29                    |
| #1 | <ul style="list-style-type: none"><li>• FAQs from Primer and Compliance Updates</li><li>• Market summary and lessons</li><li>• County considerations</li></ul>             | April 5                     |
| #2 | <ul style="list-style-type: none"><li>• Recap and Key Takeaways So Far</li><li>• Some Questions</li><li>• Data Requirements</li></ul>                                      | April 26                    |
| #3 | <ul style="list-style-type: none"><li>• Identity management</li><li>• Consumer consent</li><li>• 3<sup>rd</sup>-party app registration</li></ul>                           | May 17 or 24                |
| #4 | <ul style="list-style-type: none"><li>• Core business requirements and “mini” gap analysis</li><li>• RFP template</li><li>• Lessons from health plan procurement</li></ul> | Early-mid June              |
| #5 | <ul style="list-style-type: none"><li>• Final group discussion</li><li>• Feedback on draft work plan and next steps</li></ul>  | July (2 <sup>nd</sup> week) |

# Admin Stuff

## Program email

- [interoperability@calmhsa.org](mailto:interoperability@calmhsa.org)

## Program materials and resources

- <https://www.calmhsa.org/cms-interoperability-planning>

The screenshot shows a web browser displaying the California Mental Health Services Authority (CalMHSA) website. The page is titled "CMS Interoperability Planning" and features a navigation menu with links for "About Us", "Members", "Programs", "CalAIM", "Announcements", and "Contact". The main content area includes a header image of a rocky coastline at sunset, followed by a section titled "CMS Interoperability Planning". Below this, there are three paragraphs of text: the first describes the program's purpose, the second details the project's activities (webinars), and the third mentions the funding source. A section titled "CMS Interoperability Planning Webinars: (For County Participants Only)" contains a table with two rows of webinar information.

| Session   | Date                              |
|---|-----------------------------------|
| Primer (optional) <ul style="list-style-type: none"><li>• <a href="#">Primer Recording</a></li><li>• <a href="#">Slides</a></li></ul> | March 31, 2022<br>9AM-10:30AM PST |
| Session 1 <ul style="list-style-type: none"><li>• <a href="#">Session 1 Recording</a></li><li>• <a href="#">Slides</a></li></ul>      | April 5, 2022<br>11AM-12:30PM PST |

# Program Staff and Guest Speakers



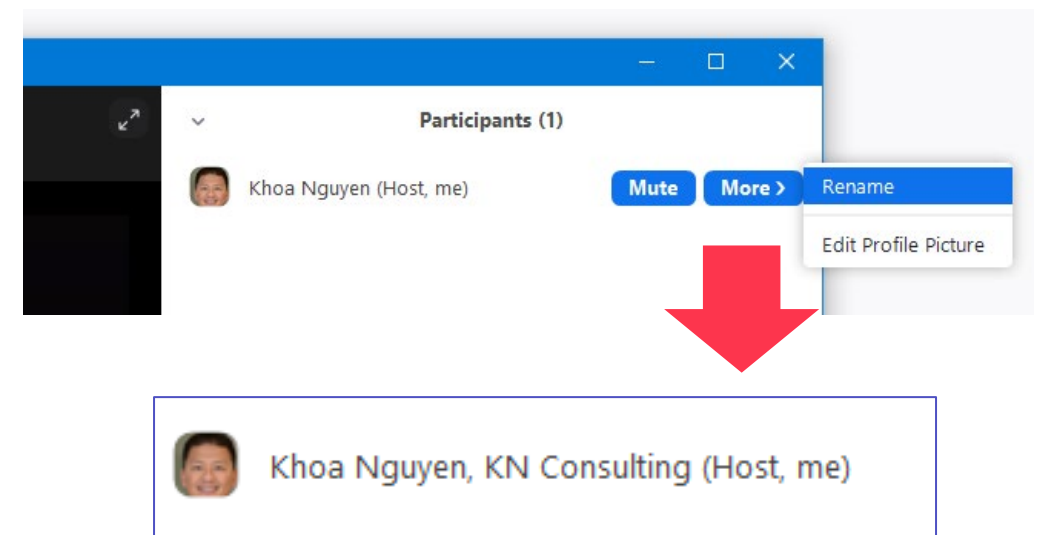
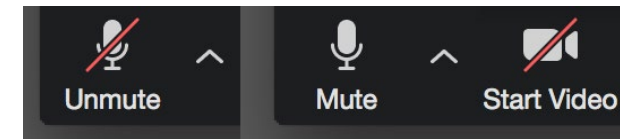
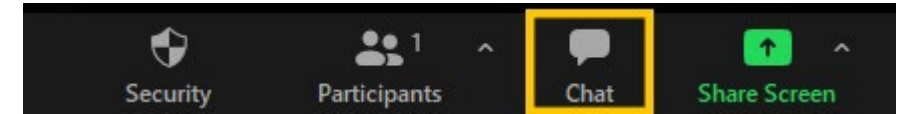
**Khoa Nguyen**  
CEO, KN Consulting LLC  
Project Director



**Dr. Chris Esguerra**  
Chief Medical Officer  
Health Plan of San Mateo

# Zoom Logistics

- Everyone will be muted to start
- Submit questions/comments in chat
- Unmute – through Zoom or phone (\*6)
- Video is encouraged
- **Zoom name display**
  - Participants menu
  - Name, county/ organization



# Today's Agenda and Discussion Framework

Program Goal – start the planning process

- Welcome and Admin Stuff
- Recap and Key Takeaways So Far
- Some Questions and Implications for Planning
- Data Requirements

# Survey Question: County Implementation Status

31 county responses (5 added)

Haven't started

Some early analysis  
or planning

Selected  
Vendor/ Consultant

Started  
Implementation

Live

16

8

6

2

0

Alameda, Amador  
Calaveras, De Norte,  
Imperial, Kern  
Kings, Marin,  
Mono, Nevada  
Riverside  
San Benito  
Stanislaus  
Tehama, Trinity  
Tulare

Butte  
El Dorado  
Orange  
Sonoma  
San Diego  
San Luis Obispo  
Yolo  
Ventura

Humboldt  
Merced  
Orange  
Shasta  
Solano  
San Bernardino

Contra Costa  
Tri-City



# Recap and Key Takeaways So Far

1. DHCS “expectations” not clear – and no urgency
2. Many states and health plans still not live, and little/ no 3<sup>rd</sup>-party app or consumer engagement
3. Lower priority relative to other implementations and initiatives
4. Lots of questions, still learning, new and complex requirements, counties as “plans”

“Low risk” of noncompliance

Build your work plan and timelines that fit your situation

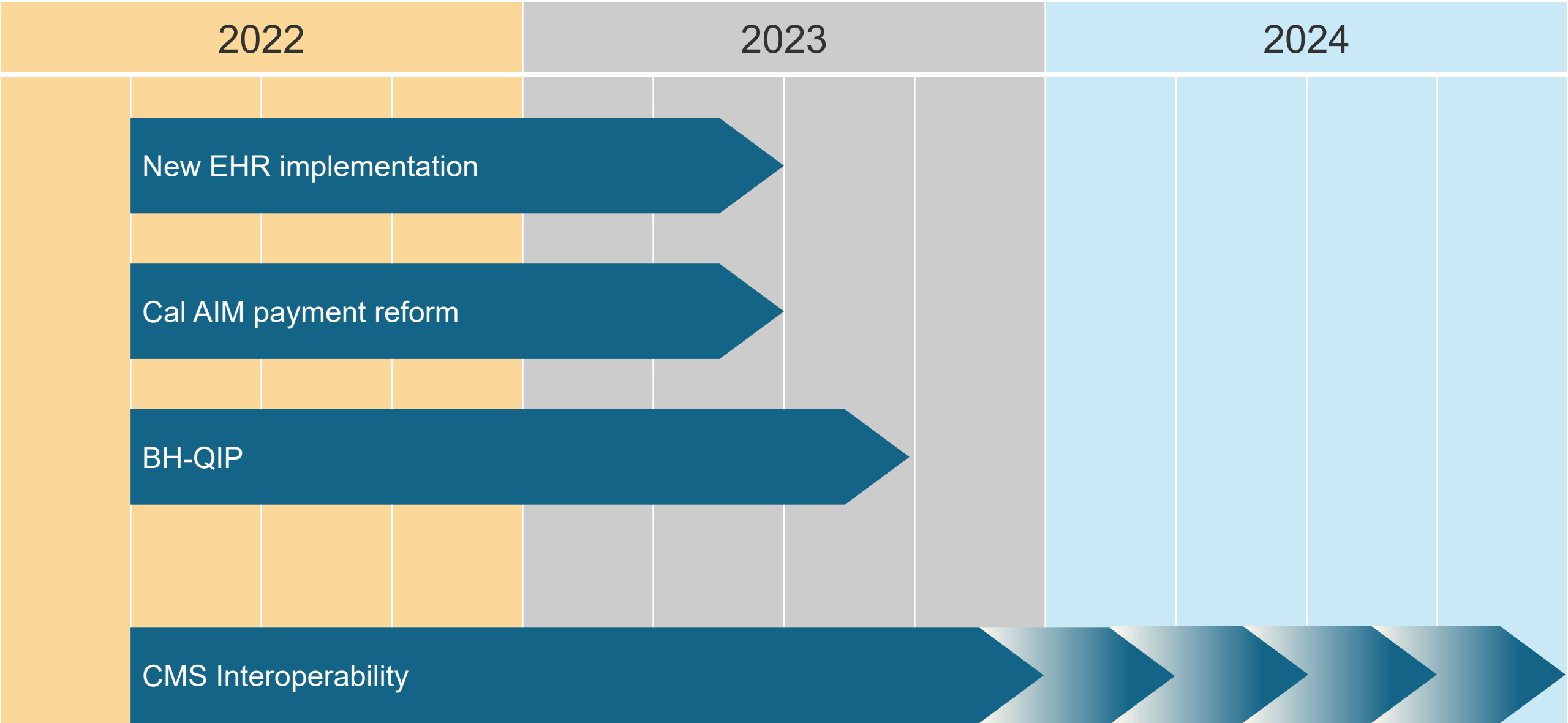
More education, Q&A and discussion

# County Considerations for CMS Interoperability Planning

- Have to do
- “Kinda have to do” -- compelling implications
- Highest Priorities and Timelines consistent with most counties
  - New EHR implementation (July 2023)
  - Cal AIM – both payment (July 2023) and documentation reform
  - BH-QIP interoperability requirement with HIE (Sept 2023)

“Well stated John (CalMHSA). Reverse engineer the timeline – collectively.”

# No Earlier than 2024 for CMS Interoperability



# Survey Responses: Potential Go-Live Date

22 county responses



## 5 counties “not sure yet – need more information”

- El Dorado, Imperial, Kings, Stanislaus, Sutter-Yuba

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for those implementing a new EHR or billing system, shouldn't the Interoperability requirements be at least a consideration or part of some of the decisions being made?

For CalMHSA, will there be a future discussion about planning for these CMS Interoperability requirements in regards to the Semi-Statewide EHR project?

if implementing an EHR in a roll out process, how would the timeline be affected. for example, inpatient is live and outpatient is in process?

# Role of EHR

Is there a way to have a list of where CMS interoperability and ONC requirements differ so we can properly see where EHRs may fall short?

- **Follow up:** Detailed review of potential role of/ for county EHR
  - what do they do now
  - what could they do for CMS interoperability
  - considerations for new EHR implementations

# Implementation Costs

Funding seems like the biggest hold back to successfully implement CMS interoperability. Our County only has 4 IT staff for the entire county.

The costs implement an API alone that access data from our EHR (Cerner) will be a huge. \$70K estimate for Cerner to export that data into a CSV file.

- **Follow up:** DHCS feedback about interoperability cost recognition and oversight/audit plan
- **Planning Considerations:** Provider Directory API before Patient Access API – lower costs, no reliant on EHR



# Data Privacy Protections

How do you do compliance with CFR 42 PART II for Substances Abuse Data for the API?

- **CMS guidance:** existing HIPAA right of access, and existing federal, state and local laws
- **Follow up:** Better understanding and framework for privacy considerations unique to behavioral health – 42 CFR Part 2, parents/minors, etc (foundation for P&Ps and vendor business requirements)

# FHIR 101

Where can I learn more about the FHIR data and API standards?

- **Some references**
  - FHIR overview (<https://www.hl7.org/fhir/>)
  - FHIR fact sheets (<https://www.healthit.gov/topic/standards-technology/standards/fhir-fact-sheets>)
- **Follow up:** FHIR education/ bootcamp for IT staff and data analysts

# Agenda and Discussion Framework

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# Core Requirements of County Behavioral Health Plans

- Patient access to eHI via application program interfaces (APIs)

|   |  | Effective Date                             | Data Exchange Partner                                  | Consumer Consent |
|---|--|--|--|------------------|
| 1 | Patient Access API<br>(similar to Blue Button 2.0) | <del>January 1, 2021</del><br>July 1, 2021 | Plan-to-Client<br>(through 3 <sup>rd</sup> -party app) | ✓                |
| 2 | Provider Directory API                             | <del>January 1, 2021</del><br>July 1, 2021 |  | ✗                |
| 3 | Payer-to-Payer*                                    | <del>January 1, 2022</del><br>???          | Payer-to-Payer<br>(bi-directional)                     | ✓                |

\* State Medicaid FFS is exempt from Payer-to-Payer requirements.

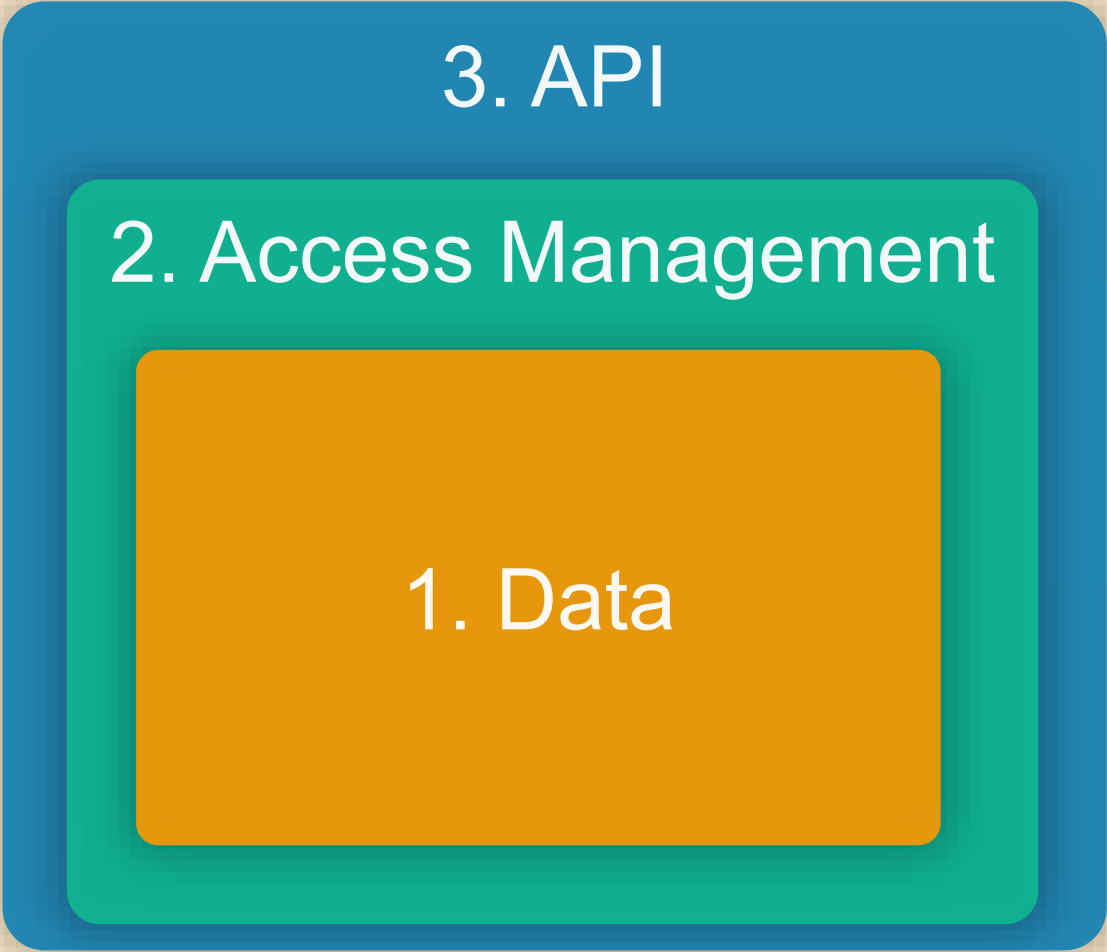
# Core Data Sharing Requirements

- Map required data to FHIR-based format using “implementation guides”

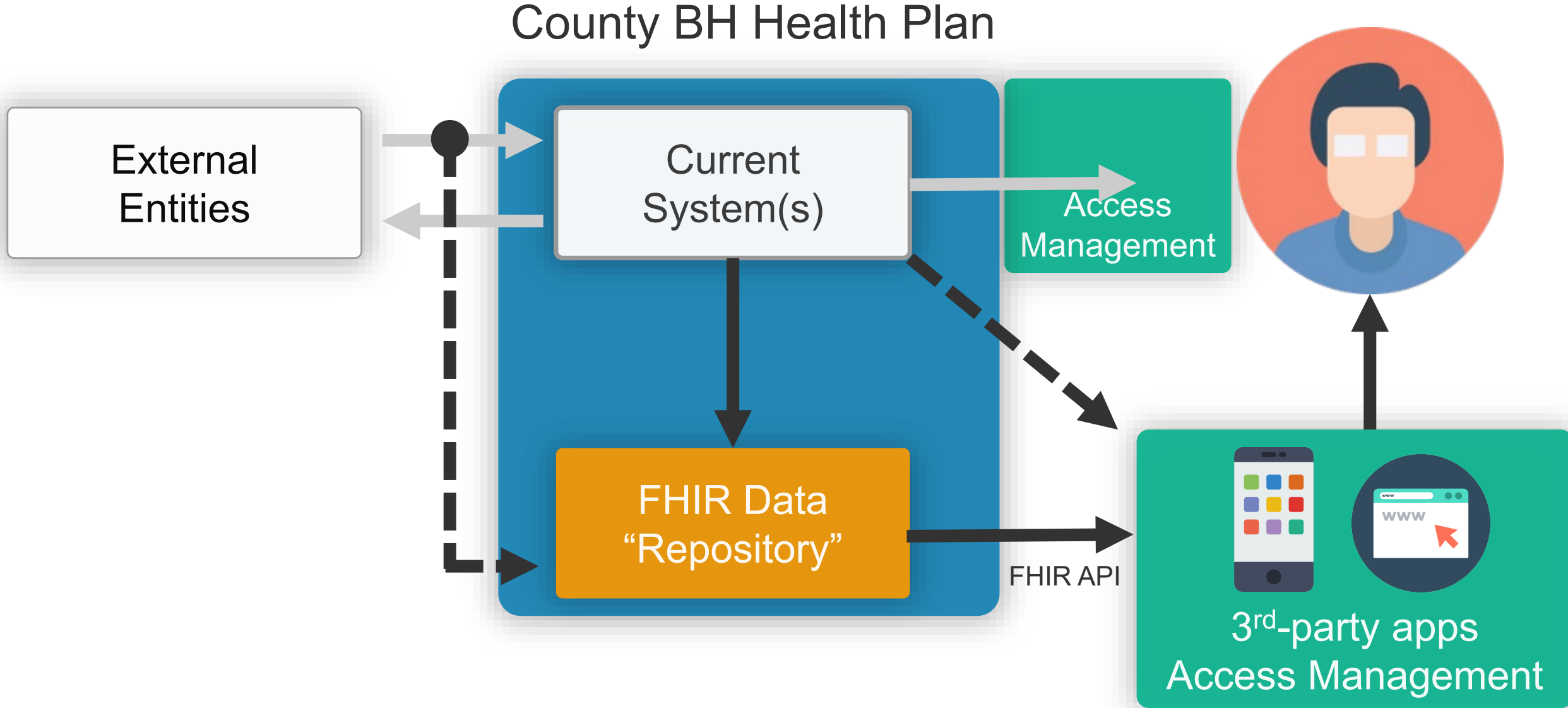
|   |                        | Claims and Encounters <sup>1</sup> | Clinical/USCDI <sup>2</sup> | Cost Data <sup>3</sup> | Formulary/ Preferred Drug List | Provider Directory |
|---|------------------------|------------------------------------|-----------------------------|------------------------|--------------------------------|--------------------|
| 1 | Patient Access API     | ✓                                  | ✓                           | ✓                      | ✓                              | X                  |
| 2 | Provider Directory API | X                                  | X                           | X                      | X                              | ✓                  |
| 3 | Payer-to-Payer         | X                                  | ✓                           | X                      | X                              | X                  |

<sup>1</sup> Including encounters with capitated or delegated providers. <sup>2</sup> USCDI = US Core Data Interoperability. <sup>3</sup> Provider payment amounts and enrollee cost-sharing amounts.

# Core Business Requirements



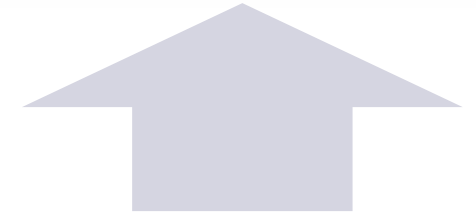
# Overview of Data Flow (Health Plans)



# FHIR Data Repository



Data transformation/ ingestion using open sourced, **“implementation guides”**



## Patient Access API

Claims and Encounters, with cost data

Clinical/ USCDI

**Formulary**

## Provider Directory API

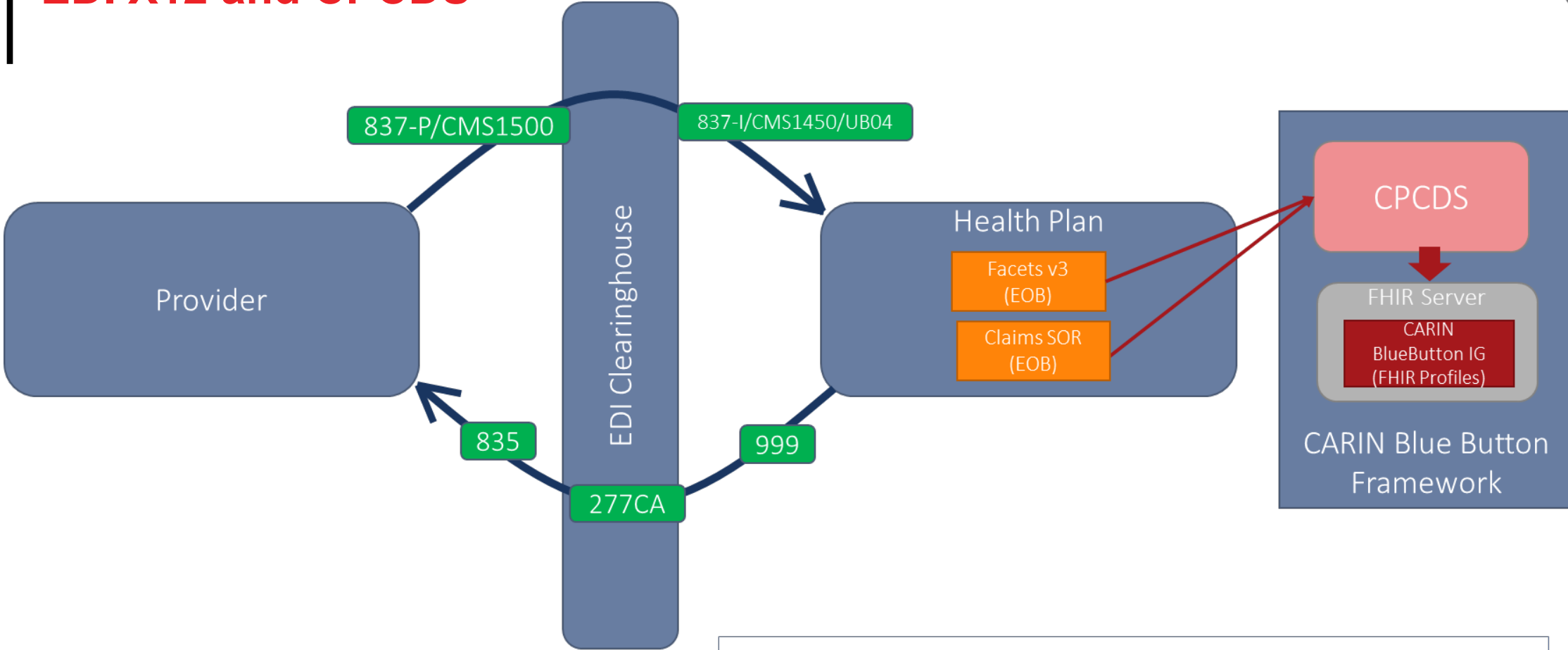
Providers, **Pharmacies**

\* Not required for Counties





# EDI X12 and CPCDS



| Key                                    |                      |
|--|----------------------|
| 999 Claims Submission Acknowledgement  | Covered Entity/BA    |
| 277CA Individual Claim Acknowledgement | EDI X12 Transactions |
| 835 Electronic Remittance Advice       | Mappings             |
|  | SOR                  |
|  | System of Record     |



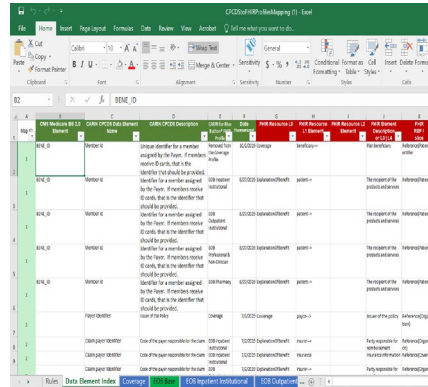
# Profiles Mapping Worksheet Maps CPCDS -> FHIR

## Common Payer Consumer Data Set (CPCDS)

| Map ID  | CPCDS Element                  | Description  |
|---------|--------------------------------|--|
| 90, 118 | Claim Service Start Date       | 90 - Date on which services began. UB04 (Form Locator 45).<br>118 - Date on which services began. Located on CMS 1500 (Form Locator 24A)   |
| 119     | Claim Service End Date         | Date on which services ended. Located on CMS 1500 (Form Locator 24A)   |
| 107     | Claim Paid Date                | The date the claim was paid.   |
| 88      | Claim Received Date            | The date the claim was received by the payer.  |
| 18      | Member Admission Date          | The date corresponding with admission of the beneficiary to a facility and the onset of services. May precede the Statement From Date if this claim is for a beneficiary who has been continuously under care.                     |
| 19      | Member Discharge Date          | Date the beneficiary was discharged from the facility, or died. Matches the Statement Thru Date. When there is a discharge date, the Patient Discharge Status Code indicates the final disposition of the patient after discharge. |
| 109     | Patient Account Number         | Provider submitted information that can be included on the claim.  |
| 110     | Medical Record Number          | Provider submitted information that can be included on the claim.  |
| 35      | Payer Claim Unique Identifier  | Identifier assigned by a payer for a claim received from a provider or subscriber. It is not the same identifier as that assigned by a provider.   |
| 111     | Claim Adjusted from Identifier | If the current claim represents a claim that has been adjusted and was given a prior claim number, this field represents the prior claim   |



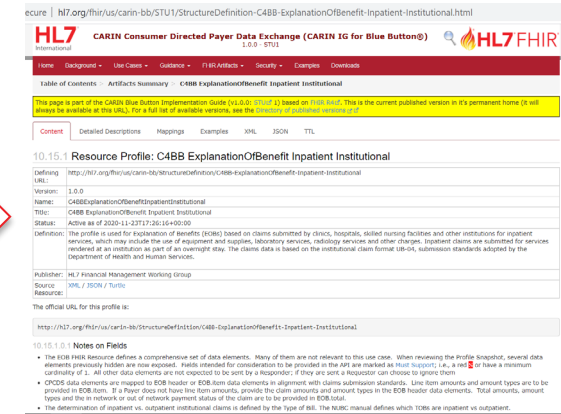
## CPCDS to FHIR Profiles Mapping



| CPCDS Element | FHIR Profile                                      | FHIR Element |
|---------------|---|--------------|
| 90, 118       | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 119           | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 107           | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 88            | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 18            | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 19            | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 109           | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
| 110           | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |
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| 111           | C488 ExplanationOfBenefit Inpatient Institutional | inpatient    |



## FHIR Profiles



HL7 CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®)

Table of Contents | Artifacts Summary | C488 ExplanationOfBenefit Inpatient Institutional

This page is part of the CARIN Blue Button Implementation Guide (1.0.0) (1/17) based on FHIR R4. This is the current published version in its permanent home (it will always be available at this URL). For a full list of available versions, see the Directory of published versions (it).

Content | Detailed Descriptors | Mappings | Examples | XML | JSON | TTL

10.15.1 Resource Profile: C488 ExplanationOfBenefit Inpatient Institutional

Definition URL: http://hl7.org/fhir/us/carin-ig/StructureDefinition/C488-ExplanationOfBenefit-Inpatient-Institutional

Version: 1.0.0

Name: C488ExplanationOfBenefitInpatientInstitutional

Title: C488 ExplanationOfBenefit Inpatient Institutional

Status: Active as of 2020-11-23T17:26:16+00:00

Definition: The profile is used for submission of benefits (claims) based on claims submitted by clinic, hospital, defined nursing facility and other institutions for inpatient services, which may include the use of equipment and supplies, laboratory services, radiology services and other charges. Inpatient claims are submitted for services rendered at an institution as part of an overnight stay. The claims data is based on the institutional claim format (UB-04), submission standards adopted by the Department of Health and Human Services.

Publisher: HL7 Financial Management Working Group

Source: HL7 / JSON / TTL

The official URL for this profile is: http://hl7.org/fhir/us/car-in-ig/StructureDefinition/C488-ExplanationOfBenefit-Inpatient-Institutional

10.15.1.1 Notes on Fields

- The EOB FHIR Resource defines a comprehensive set of data elements. Many of them are not relevant to this use case. When reviewing the Profile Snapshot, several data elements previously hidden are now exposed. Fields intended for consideration to be provided in the API are marked as **Must Support**, i.e., a **red M** or have a minimum cardinality of 1. All other data elements are not expected to be sent by a Responder, if they are sent a Responder can choose to ignore them.
- CPCDS data elements are mapped to EOB header or EOB item data elements in alignment with claims submission standards. Line item amounts and amount types are to be provided in EOB items. If a Payer does not have item amounts, provide the claim amount and amount types in the EOB header data elements. Total amounts, amount types and the in-network or out-of-network payment status of the claim are to be provided in EOB total.
- The determination of inpatient vs. outpatient institutional claims is defined by the type of bill. The table manual defines which UB04 are inpatient vs. outpatient.

The CPCDS is a logical data set that meets CMS Blue Button 2.0 API content

Aids implementers in understanding the data representation requirements of each EOB Profile and the referenced resources used by these profiles.

Based on CPCDS, define the minimum mandatory elements, extensions and terminology requirements that must be present in the FHIR resource





## Allergies and Intolerances \*NEW



- Substance (Medication)
- Substance (Drug Class) \*NEW
- Reaction \*NEW

## Assessment and Plan of Treatment



## Care Team Members



## Clinical Notes \*NEW

- Consultation Note
- Discharge Summary Note
- History & Physical
- Imaging Narrative
- Laboratory Report Narrative
- Pathology Report Narrative
- Procedure Note
- Progress Note



## Goals



## Health Concerns



## Immunizations



## Laboratory

- Tests
- Values/Results



## Medications



## Patient Demographics

- First Name
- Last Name
- Previous Name
- Middle Name (incl. middle initial)
- Suffix
- Birth Sex
- Date of Birth
- Race
- Ethnicity
- Preferred Language
- Current Address \*NEW
- Previous Address \*NEW
- Phone Number \*NEW
- Phone Number Type \*NEW
- Email Address \*NEW



## Problems



## Procedures



## Provenance \*NEW

- Author Time Stamp
- Author Organization



## Smoking Status



## Unique Device Identifier(s) for a Patient's Implantable Device(s)



## Vital Signs

- Diastolic Blood Pressure
- Systolic Blood Pressure
- Body Height
- Body Weight
- Heart Rate
- Respiratory Rate
- Body Temperature
- Pulse Oximetry
- Inhaled Oxygen Concentration
- BMI Percentile (2-20 Years) \*NEW
- Weight-for-length Percentile (Birth - 36 Months) \*NEW
- Occipital-frontal Head Circumference Percentile (Birth - 36 Months) \*NEW



For more info:

[HealthIT.gov/USCDI](http://HealthIT.gov/USCDI)

# Considerations for Data Requirements

- By relevant data categories
  - Mental health vs DMC-ODS
  - County providers vs contracted providers
  - Others?
- Meets “maintains definition”
  - Access to, Control of, Ability to share via API
- Data Acquisition: method, format, frequency
- Where/ Who: primary data source for FHIR data

Claims/  
Encounters, with  
cost data

Clinical/ USCDI

# Provider Directory API

- Updated no later than 30 calendar days after a health plan receives the provider directory information or updates to the provider directory information
- Consent and authentication requirements do not apply – already public information

## Required for Counties

### Provider Network

1. Name
2. Address
3. Phone number
4. Specialty

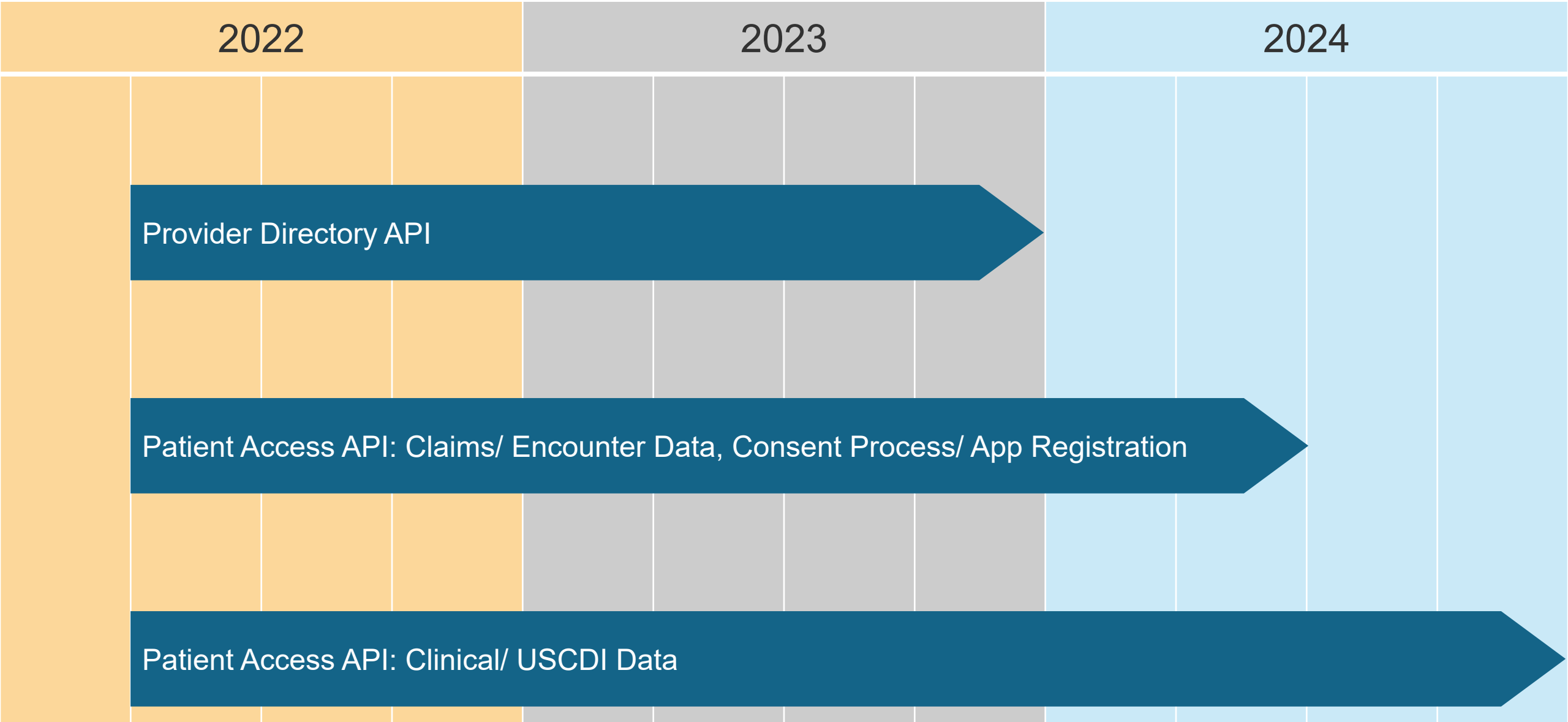
Not Required for Counties because  
Medi-Cal pharmacy is carved-out  
and managed by DHCS

### Pharmacy Network



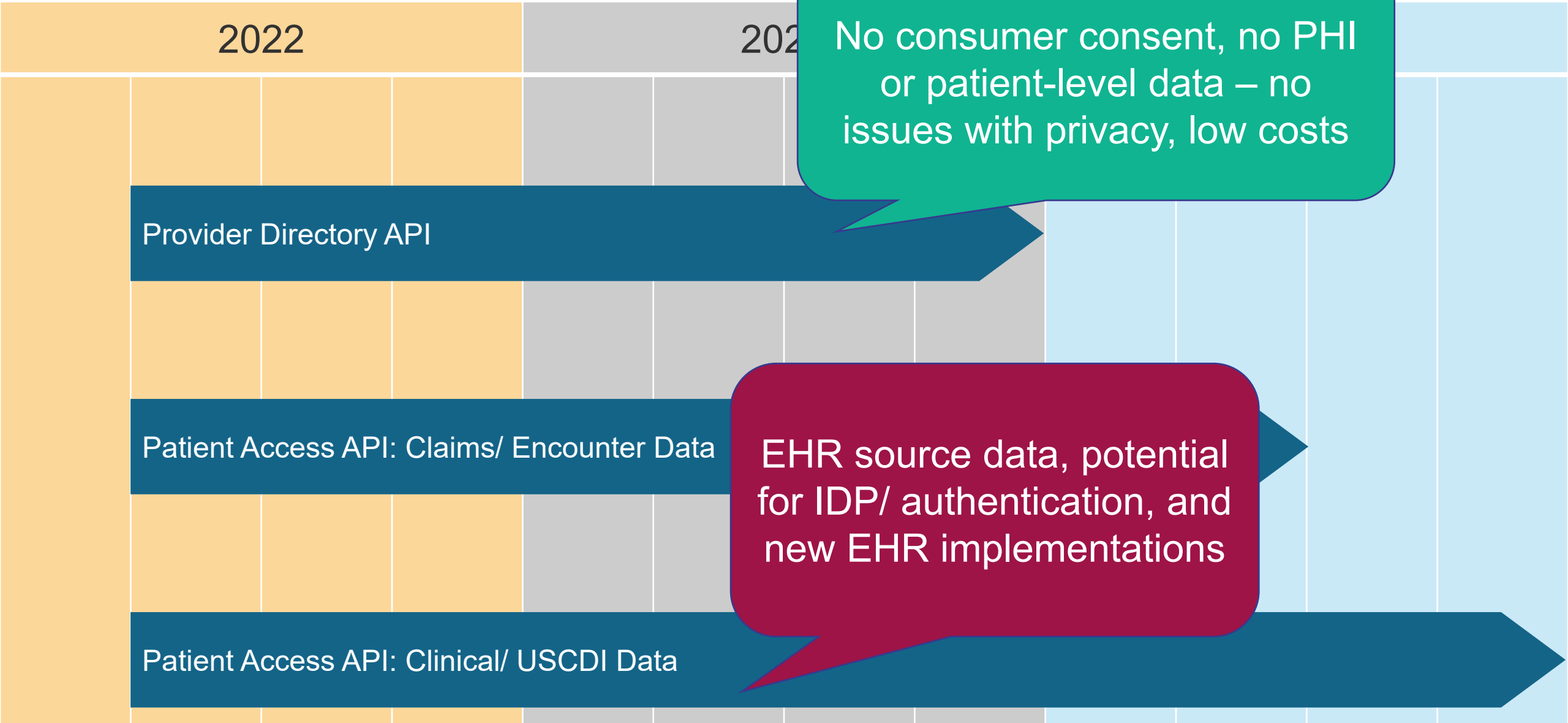
# Considerations for CMS Interoperability Timelines

## Phased Approach



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## Phased Approach



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Q&A

The image features a stylized logo consisting of the letters 'Q', '&', and 'A'. The 'Q' is a large, orange-red letter with a white question mark inside its central opening. The ampersand is a light blue letter. The 'A' is a green letter with a dark green shadow or outline. The letters are overlapping and have a slight 3D effect. The 'Q' is on the left, the ampersand is in the middle, and the 'A' is on the right. The background is white.

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