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.
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Admin Stuff

Program email
• interoperability@calmhsa.org

Program materials and resources
• https://www.calmhsa.org/cms-interoperability-planning
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: 16
  - Alameda, Amador, Calaveras, De Norte, Imperial, Kern, Kings, Marin, Mono, Nevada, Riverside, San Benito, Stanislaus, Tehama, Trinity, Tulare

- Some early analysis or planning: 8
  - Butte, El Dorado, Orange, Sonoma, San Diego, San Luis Obispo, Yolo, Ventura

- Selected Vendor/Consultant: 6
  - Humboldt, Merced, Orange, Shasta, Solano, San Bernardino

- Started Implementation: 2
  - Contra Costa Tri-City

- Live: 0
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 3rd-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.”
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>2022</td>
<td>New EHR implementation</td>
</tr>
<tr>
<td></td>
<td>Cal AIM payment reform</td>
</tr>
<tr>
<td></td>
<td>BH-QIP</td>
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<tr>
<td>2023</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>No Earlier than 2024 for CMS Interoperability</td>
</tr>
</tbody>
</table>
Survey Responses: Potential Go-Live Date
22 county responses

January 2023
- Butte
- Humboldt
- Lake
- San Diego
- Marin
- Trinity
- Ventura

January 2024
- San Luis Obispo
- Siskiyou
- Orange
- Placer

July 2024

January 2025
- Tehama
- Sonoma
- Alameda
- San Benito
- Contra Costa
- Nevada

5 counties “not sure yet – need more information”
- El Dorado, Imperial, Kings, Stanislaus, Sutter-Yuba
Today’s Agenda and Discussion Framework

Program Goal – start the planning process

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- Data Requirements
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 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

- **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/)

- Follow up: FHIR education/ bootcamp for IT staff and data analysts
Agenda and Discussion Framework

• Welcome and Admin Stuff

• Recap and Key Takeaways So Far

• Some Questions

• Data Requirements
### Core Requirements of County Behavioral Health Plans

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

<table>
<thead>
<tr>
<th>#</th>
<th>Requirement</th>
<th>Effective Date</th>
<th>Data Exchange Partner</th>
<th>Consumer Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient Access API (similar to Blue Button 2.0)</td>
<td>January 1, 2021</td>
<td>Plan-to-Client (through 3rd-party app)</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 1, 2021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Provider Directory API</td>
<td>January 1, 2021</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 1, 2021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Payer-to-Payer*</td>
<td>January 1, 2022</td>
<td>Payer-to-Payer (bi-directional)</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>???</td>
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</tbody>
</table>

*State Medicaid FFS is exempt from Payer-to-Payer requirements.*
# Core Data Sharing Requirements

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

<table>
<thead>
<tr>
<th></th>
<th>Claims and Encounters&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Clinical/USCDI&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Cost Data&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Formulary/Preferred Drug List</th>
<th>Provider Directory</th>
</tr>
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<tr>
<td>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Patient Access API</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>&lt;sup&gt;2&lt;/sup&gt;</td>
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<sup>1</sup> Including encounters with capitated or delegated providers. 2 USCDI = US Core Data Interoperability. 3 Provider payment amounts and enrollee cost-sharing amounts.
Core Business Requirements

3. API

2. Access Management

1. Data
Overview of Data Flow (Health Plans)

County BH Health Plan

Current System(s)

External Entities

Access Management

FHIR Data “Repository”

3rd-party apps Access Management

FHIR API
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

Provider

EDI Clearinghouse

Health Plan

CPCDS

Key

999 Claims Submission Acknowledgement
277CA Individual Claim Acknowledgement
835 Electronic Remittance Advice

Covered Entity/BA

SOR EDI X12 Transactions Mappings

System of Record
Profiles Mapping Worksheet
Maps CPCDS -> FHIR

Common Payer Consumer Data Set (CPCDS)

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

CPCDS to FHIR Profiles Mapping

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

FHIR Profiles

Based on CPCDS, define the minimum mandatory elements, extensions and terminology requirements that must be present in the FHIR resource.
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
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 no apply – already public information

<table>
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<tr>
<th>Provider Network</th>
<th>Pharmacy Network</th>
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<tbody>
<tr>
<td>1. Name</td>
<td></td>
</tr>
<tr>
<td>2. Address</td>
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<td>3. Phone number</td>
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<td>4. Specialty</td>
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Not Required for Counties because Medi-Cal pharmacy is carved-out and managed by DHCS
## Considerations for CMS Interoperability Timelines

### Phased Approach

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Considerations for CMS Interoperability Timelines

Phased Approach

2022

- Provider Directory API

2023

- Patient Access API: Claims/ Encounter Data
  - No consumer consent, no PHI or patient-level data – no issues with privacy, low costs

2024

- Patient Access API: Clinical/ USCDI Data
  - EHR source data, potential for IDP/ authentication, and new EHR implementations
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?

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