Whitepaper: Interoperability

Interoperability, a new era in healthcare begins now

March 9, 2020, was a defining moment in the U.S. healthcare industry. One era ended. Another began.

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A new era dawns

On March 9th, debate about new interoperability rules ended when the Department of Health and Human Services (HHS) published its final rules, with deadlines on January 1, 2021, then less than 300 days away.[1]

At this same time, the realities of the global coronavirus pandemic on American shores caused waves of change. Within a few weeks, COVID-19 would impact American life, and the focus and priorities of every American healthcare institution, leader and worker.

The review period of the interoperability regulations had been controversial. Some industry stakeholders warned of the privacy risks and the aggressive timeline to improve data sharing (without jeopardizing data protections). Others emphasized the benefits to consumer rights, improved quality and reduced cost of care.

The pandemic only intensified the pressures of the two perspectives, and a lack of interoperable data made it impossible to wage the war against the virus with 21st century precision epidemiology. In this context, it remains to be determined what the Centers for Medicare and Medicaid Services (CMS) will do with the imminent interoperability deadlines, and their scope.

Over the last year, Cognizant has invested in interoperability. We see the importance of the regulations and understand their significance. We've developed thought leadership, trained resources in readiness, created targeted service offerings, enhanced current TriZetto® products such as the Facets® and QNXT™ platforms, and created new products for Connected Interoperability. We've also worked with multiple early leaders in defining and executing their interoperability strategies.

This whitepaper provides a brief overview of the new regulations, what health plans must do and what they may want to consider doing to improve their position in the market.

Cognizant anticipates interoperability, the lessons learned from and impacts of the pandemic, and more will shape a new era of healthcare, one that rewards visionary leadership, agility, compassion and precision execution.

[1] Final rules published on May 1, 2020, provide for six months of enforcement discretion after the effective date.

What is the mandate and what are the deadlines?

The first deadline of the CMS Interoperability and Patient Access Final Rule (CMS Rule) is January 1, 2021.[1]

Impacting government lines of business

The CMS Rule applies to government lines of business, specifically Medicare Advantage, Medicaid managed care, state Medicaid, Children's Health Insurance Program (CHIP), CHIP managed care, and qualified health plans (QHPs) on the federally facilitated exchanges.[2]

Publishing a patient access API and provider directory API

By January 1, 2021, health insurers with government lines of business need to do two things.[2] They must publish two APIs: a Patient Access API and a Provider Directory API. The Patient Access API enables members to get their health information via third-party applications. The Provider Directory API enables providers and members to access provider directory and network information.[3]

Payers must enable developers to register themselves and their apps with their organization. The payer must support a standardized method to allow these apps to transmit a member's consent and then download electronically stored administrative and clinical data, dating back to January 1, 2016. This data must be available to download to an app within a single day of when the data was created or received. A payer must periodically test and monitor these APIs. Payers must also educate their members—with the aid of content that CMS will provide—on the benefits and risks as well as how to use third-party apps to get to their data and the risk of sharing their data. In some ways, interoperability facilitates the access rights of the Health Insurance Portability and Accountability Act (HIPAA), realized for the digital era via contemporary technologies. Payers have to do this new data sharing and be fully compliant with all other laws and regulations—federal, state, tribal and local—including those addressing sensitive data such as substance abuse, behavioral health and HIV/AIDS.

Enabling payer-to-payer data exchange

By January 1, 2022, health insurers need to also enable payer-to-payer data exchange for the previously mentioned government lines of business. When one plan loses a member to a new plan, that member has the right to ask the old plan to send clinical data to the new plan to facilitate continuity of care. Members can ask this up to five years after they've left a health plan.

Looking at it from the other side, when a plan gains a member, that member has the right to ask that prior plans—those active within the last five years—to send clinical data (including any that may have been received from an upstream plan) to the new plan, which must incorporate this data into the members patient records.[4]

Other healthcare industry segments

There's more to the rule than these elements, at least for other industry segments. States must improve the experience of dually eligible members by increasing the frequency of federal-state date exchanges for eligibility. Importantly, future rule-making for providers will also eventually support the same data sharing with apps using the new standards. All hospitals and critical access hospitals (CAHs) must send electronic patient event notifications of a patient's admission, discharge and/or transfer to another healthcare facility or to another community provider or practitioner. Also, CMS will publicly report eligible clinicians, hospitals and CAHs that may be blocking information or not listing or updating their digital contact information in the National Plan and Provider Enumeration System (NPPES).

HHS has unambiguously said it wants to drive new innovation and competition in the industry.

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[2] This rule does not impact commercial lines of business.

[3] Key security technology standards include OAuth and OpenID. Key data formatting standards include the HL7 FHIR standard, Carin Alliance CPCDS, Da Vinci and more. Key terminology standards include ICD-10, SNOMED CT, LOINC, RxNorm, NDC, CPT, NPI, eNCPT, ITU-T E.123 and more. Many of these are new to a payer's development teams, but they will soon be familiar in every organization, as familiar as the language of EDI and its standard transactions.

[4] For instance, if the member had imaging done as part of a prior authorization, a new plan should consider it for its utilization management process.

What payers must do

Payers need to do a lot. Although some in the industry have emphasized their particular area of focus, interoperability is something that will affect all areas of the organization—membership, utilization management, provider data management, IT and more. It is a sizable impact, one that will necessitate a multi-year journey. Senior executives, and even the board of directors, need to understand this is a large transition with substantial cost implications and consequences that relate to other strategic decisions.

Cognizant has worked with a number of organizations to define their interoperability strategies. We recommend a program with six primary coordinated workstreams.

Organizational alignment: You need organizational alignment, program management with integrated planning and reporting, governance and organizational change management.

Business operations: A number of business processes will be impacted. Minimally, you need the participation of regulatory/compliance, customer support, legal and finance. You need to add business processes for developer relations, and you will likely need to uplift key businesses processes for member education and customer support. If you seek to do more and leverage the data to improve the member experience and operational excellence, then enrollment, utilization management, wellness and quality assurance teams will also be involved. Each of these organizations will need a seat at the table—to understand interoperability, coordinate change and realize the benefits.

Data management: For the HL7® FHIR® standard profiles of API, data must be sourced from internal, and possibly external, administrative[5] and clinical[6] sources of truth. As part of sourcing this data, data quality[7], periodicity[8] and availability issues may need to be addressed by one or more capability uplift projects.

Additionally, terminology normalization will require informatics skills and technologies, and unique member and provider identification may require enterprise master patient index and related capabilities.

Technology and architecture: In this workstream, your enterprise architects will need to evaluate existing and new technologies for achieving interoperability. These include an API gateway, an interoperability orchestration hub and a privacy engine.[9] Persons newly introduced to interoperability may think a FHIR Server is all that needs to be done; while it is one of the important components, it's only a portion of the solution.

Privacy, security and compliance: This workstream involves compliance requirements analysis (e.g., federal and state), consent management, sensitive data label/tagging and audit/reporting. Additionally, with new threats and scams that emerge through the API and attack vulnerable members, existing practices may require uplifts. These may include identity and access management, enterprise data protection, application security and threat management.

Testing: The final rule prescribes testing and monitoring.

Time is of the essence. Organizations that build in understanding of interoperability across teams, define their interoperability vision, map their data sources and evaluate technologies today will be better prepared to meet the requirements.

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[5] Administrative data includes CARIN CPCDS resources such as claims, EOBs, coverage, related persons, contracts, persons, medications dispensed, plan coverage and formularies, coverage plans, formulary drugs, provider directory, endpoints, healthcare services, insurance plans, locations, networks, organizations, organization affiliates, practitioners and bulk data exchange.

[6] Clinical data includes US CORE profiles such as allergies, care plans, care teams, conditions, diagnostic reports, document references, encounters, goals, immunizations, lab results, locations, medications, medication requests, patients, pediatric BMI, pediatric weight/height, practitioners, practitioner roles, procedures, provenance, pulse oximetry, smoking status and vital signs.

[7] While the rule doesn't specify data quality standards directly, there are other legal, clinical and ethical issues involved.

[8] The rule requires data to be available via the API within one day of receipt or processing (such as adjudication).

[9] TriZetto's new Connected Interoperability product provides these features.


REGULATIONS
RULES

What payers can do to achieve more benefits

There's much innovators will do with these changes to reposition themselves in their markets by improving operations and delighting members.

For instance, enrollment processes can be reimagined. Suppose, if upon enrollment, you captured the necessary member consent to receive data from prior plans that the new member has been in over the prior five years. That data could be used immediately, before coverage even begins. Primary care providers (PCPs) and specialists could be reviewed for network status and new assignments facilitated. Children's immunization histories could be reviewed. Risk factors could be identified and proactive steps taken. Wellness activities could be initiated. Quality measures could be pursued. New members would be amazed by the real-world difference in experience in engagement, transitions in care and prevention.

Beyond member enrollment, other processes such as utilization management, care management and member retention activities can be reimagined, too.

How Cognizant can help

We've prepared our organization to help yours. Our subject-matter experts and consulting organization can help you plan, organize and execute your interoperability program. On the product side, we've taught the Facets and QNXT platforms used by 170 payers "how to speak FHIR." We also have new Connected Interoperability products specifically for this need that can accelerate your solution. As of March 2020, we've trained over 580 associates on interoperability—across our organization complementing their existing skills in areas such as data, security and more. We can train your team, too. Cognizant is uniquely positioned to be your interoperability enabling partner.

Interoperability presents change and opportunity, how will you and your organization respond?

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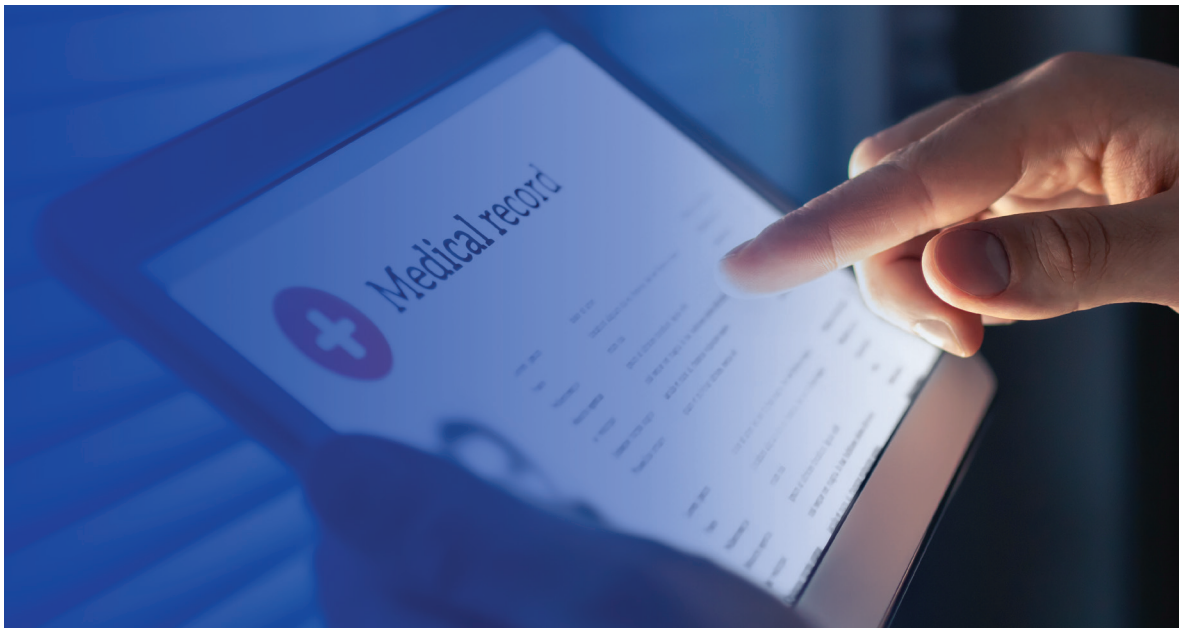

About TriZetto Healthcare Products

We help healthcare organizations enhance revenue growth, drive administrative efficiency, improve cost and quality of care, and improve the member and patient experience. Our extensive line of solutions and services harnesses the power of digital to optimize your business.
Visit us at **www.cognizant.com/trizetto** for more information.

About Cognizant

Cognizant (Nasdaq-100: CTSH) is one of the world's leading professional services companies, transforming clients' business, operating and technology models for the digital era. Our unique industry-based, consultative approach helps clients envision, build and run more innovative and efficient businesses. Headquartered in the U.S., Cognizant is ranked 194 on the Fortune 500 and is consistently listed among the most admired companies in the world. Learn how Cognizant helps clients lead with digital at **www.cognizant.com** or follow us **@Cognizant**.

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