COMMUNITY HEALTH CARE ASSOCIATION of New York State

CHCANYS NYS-HCCN presents

Implications of CMS Interoperability & Prior Authorization Final Rule and Social Drivers of Health Z-Coding

September 26, 2024

For more information, please email Anita Li at ali@CHCANYS.org

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09.2024

Housekeeping

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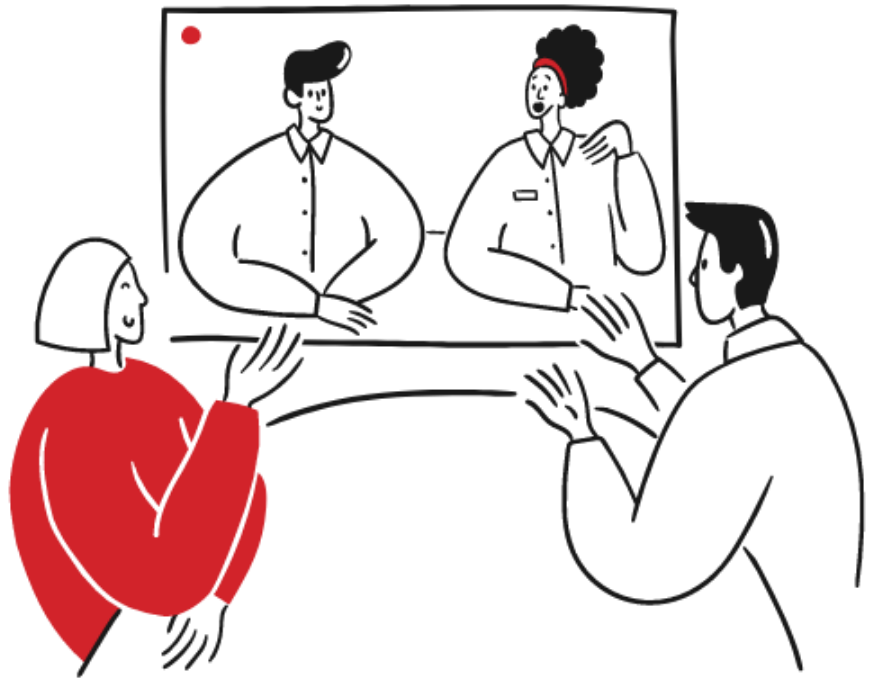
- Please share your questions in the chat. CHCANYS staff will raise your questions to our speakers and follow up as needed if there are unanswered questions.
- The webinar is being recorded and will be shared after the session along with the slide deck.
- A webinar evaluation will be shared with participants



Agenda

1. Introductions
2. CMS Interoperability & Prior Authorization Final Rule
3. Social Drivers of Health Z-Coding
4. Q&A
5. Closing and Evaluations

New York State HCCN Objectives

Project Period 2022-2025

1. **Clinical Quality**
2. **Patient-Centered Care**
3. **Provider and Staff Wellbeing**

2022-2025 Project Period

- Patient Engagement
- Patient Privacy & Cybersecurity
- Social Risk Factor Intervention
- Disaggregated Patient-level Data (UDS+)
- Interoperable Data Exchange & Integration
- Data Utilization
- Leveraging Digital Health Tools
- Health IT Usability & Adoption
- Health Equity and REaL Data Collection*
- Improving Digital Health Tools- Closed Loop Referrals*

** - Applicant Choice Objective*
Bold- Objective Carried over into 2022-2025

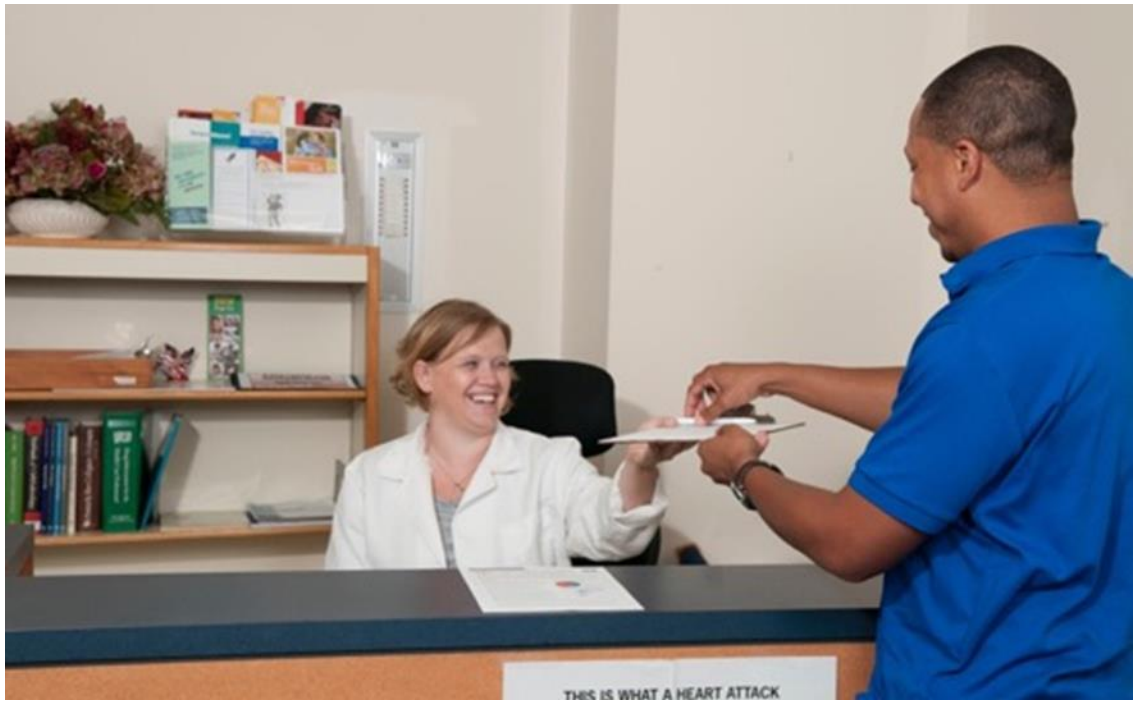
Implications of CMS Interoperability & Prior Authorization Final Rule and Social Drivers of Health Z-Coding

Frank M. Winter

CMS New York Local Engagement

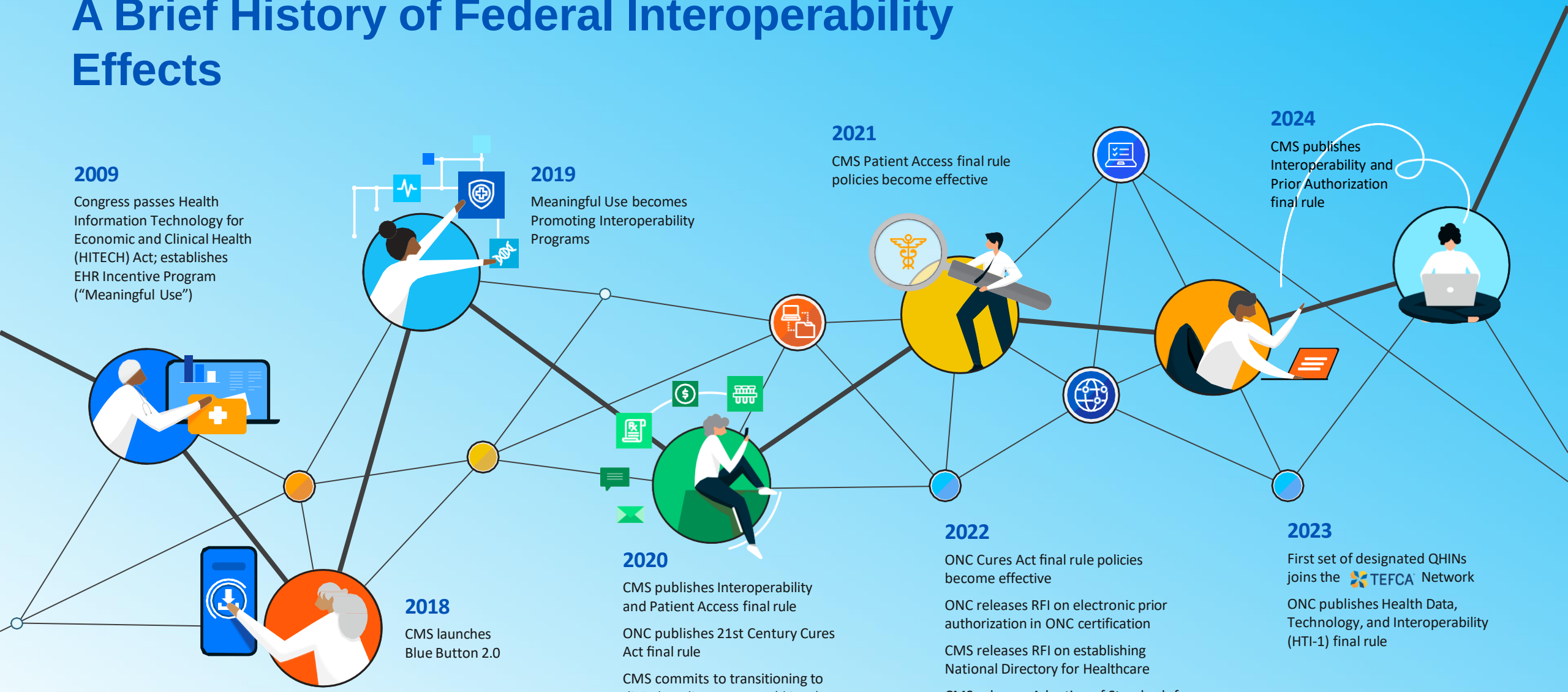
Centers for Medicare & Medicaid Services

Interoperability Rule & Z Codes



Frank M. Winter
CMS New York Local Engagement

A Brief History of Federal Interoperability Effects



2009

Congress passes Health Information Technology for Economic and Clinical Health (HITECH) Act; establishes EHR Incentive Program ("Meaningful Use")

2018

CMS launches Blue Button 2.0

2019

Meaningful Use becomes Promoting Interoperability Programs

2020

CMS publishes Interoperability and Patient Access final rule

ONC publishes 21st Century Cures Act final rule

CMS commits to transitioning to digital quality measures (dQMs)

2021

CMS Patient Access final rule policies become effective

2022

ONC Cures Act final rule policies become effective

ONC releases RFI on electronic prior authorization in ONC certification

CMS releases RFI on establishing National Directory for Healthcare

CMS releases Adoption of Standards for Health Care Attachment Transaction proposed rule

2023

First set of designated QHINs joins the TEFCA Network

ONC publishes Health Data, Technology, and Interoperability (HTI-1) final rule

2024

CMS publishes Interoperability and Prior Authorization final rule

CMS INTEROPERABILITY

CMS

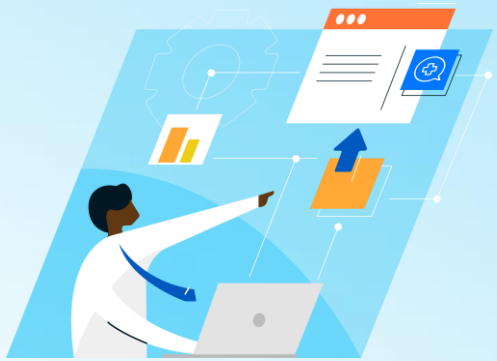
Overview

On January 17, 2024, CMS released the *CMS Interoperability and Prior Authorization* final rule (CMS-0057-F).

This rule demonstrates CMS' continued commitment to increasing efficiency by ***ensuring that health information is readily available*** by leveraging Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standards.

Impacted payers are required to implement certain provisions generally by January 1, 2026. In response to stakeholder comments on the proposed rule, impacted payers have until at least **January 1, 2027**, to meet the application programming interface (API) development and enhancement requirements in this final rule.

The final rule will reduce patient, provider, and payer burden by ***streamlining prior authorization processes and moving the industry toward electronic prior authorization.***



Ultimately, reduced provider burden means more quality time with patients.

Final Rule Overview

Provisions

- Patient Access API
- Provider Access API
- Payer-to-Payer API
- Prior Authorization API
- Improving Prior Authorization Processes
- New measures for Electronic Prior Authorization for the Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

Impacted Providers

- Eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program
- MIPs eligible clinicians participating in the MIPS Promoting Interoperability performance category

Impacted Payers

- Medicare Advantage (MA) Organizations
- State Medicaid and Children's Health Insurance Program (CHIP) agencies
- Medicaid Managed Care Plans and CHIP Managed Care Entities
- Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs)

Patient Access API

NEW DATA REQUIREMENTS (Beginning January 1, 2027)
Impacted payers are required to include certain information about patients' prior authorization requests and decisions (excluding those for drugs)

API USE METRICS (Effective January 1, 2026)
Impacted payers will annually report metrics in the form of aggregated, de-identified data to CMS about patient use of the Patient Access API

Provider Access API

Beginning January 1, 2027

API REQUIREMENTS Impacted payers must implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship.

DATA REQUIREMENTS
The API must make available individual claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in a content standard adopted by ONC (USCDI) and specified prior authorization information (excluding those for drugs).

ATTRIBUTION
Impacted payers are required to develop an attribution process to associate patients with their providers to ensure that a payer only sends data to providers for patients with whom they have a treatment relationship.

OPT OUT
Impacted payers are required to maintain a process for patients to opt out of having their health information available and shared under the Provider Access API requirements.

Payer-to-Payer API

Beginning January 1, 2027

API & DATA REQUIREMENTS

Impacted payers must implement and maintain a Payer-to-Payer API to make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information), all data classes and data elements in a content standard adopted by ONC (USCDI), and information about prior authorizations (excluding those for drugs and those that were denied).

IMPACTED PAYERS MUST IDENTIFY PREVIOUS AND CONCURRENT PAYERS AND GIVE PATIENTS OPPORTUNITY TO OPT IN

This must be done generally no later than one week after the start of coverage.

NEW PAYERS MUST REQUEST PATIENT DATA FROM ANY PREVIOUS PAYERS NO LATER THAN ONE WEEK AFTER THE START OF COVERAGE, IF THE PATIENT HAS OPTED IN.

Previous payers will have to provide the data they maintain with dates of service within five years of the date of the request, and they must provide this data within one day of receiving the request. Patient data must then be incorporated into the new payer's patient record.

CONCURRENT COVERAGE DATA EXCHANGE

Where a patient has concurrent coverage with two or more payers, impacted payers are required to exchange patient data within one week of the start of coverage and at least quarterly thereafter.

Patient and Provider Educational Resources

Effective January 1, 2027

PROVIDER ACCESS API

Impacted payers must provide plain language resources to **both**:

- Patients about the benefits of API data exchange with their providers, and their ability to opt out; and
- Providers about the process for requesting patient data and the payer's attribution process

PAYER-TO-PAYER API

Impacted payers must provide plain language materials to patients about the benefits of Payer-to-Payer API data exchange, their ability to opt in or withdraw a previous opt in decision, and instructions for doing so.

Prior Authorization API

Beginning January 1, 2027

API REQUIREMENT
Impacted payers must implement and maintain a Prior Authorization API.

IDENTIFYING WHETHER AN ITEM OR SERVICE REQUIRES PRIOR AUTHORIZATION
The API must be populated with the list of items and services (excluding drugs) that require prior authorization from the payer.

PAYER-SPECIFIC DOCUMENTATION REQUIREMENTS
The API must identify the payer's documentation requirements for all items and services (excluding drugs) that require a prior authorization request.

EXCHANGING PRIOR AUTHORIZATION REQUESTS AND RESPONSES
The API must support the creation and exchange of prior authorization requests from providers and responses from payers.

Improving Prior Authorization Processes

Beginning January 1, 2026

PRIOR AUTHORIZATION DECISION TIMEFRAMES

Certain impacted payers are required to send standard prior authorization decisions within 7 calendar days and expedited prior authorization decisions within 72 hours. This policy change for standard decisions does **not** include QHPs on the FFEs.

PROVIDING A SPECIFIC REASON FOR DENIAL

Payers must provide specific information about prior authorization denials, regardless of how the prior authorization request is submitted.

PRIOR AUTHORIZATION METRICS

Impacted payers are required to report certain metrics about their prior authorization processes on their public website on an annual basis. This includes the percent of prior authorization requests approved, denied, and approved after appeal, and average time between submission and decision.

Electronic Prior Authorization Measures

The Electronic Prior Authorization Measures are **yes/no measures** instead of the proposed numerator/denominator measures. Participants are required to report a **yes** response or claim an exclusion to satisfy the reporting requirements for the **CY 2027 performance period/2029 MIPS payment year or the CY 2027 EHR reporting period** (for the Medicare Promoting Interoperability Program).

PARTICIPATING PROGRAMS

- MIPS Promoting Interoperability performance category (under the HIE objective)
- Medicare Promoting Interoperability Program for Eligible Hospitals and CAHs (under the HIE objective)

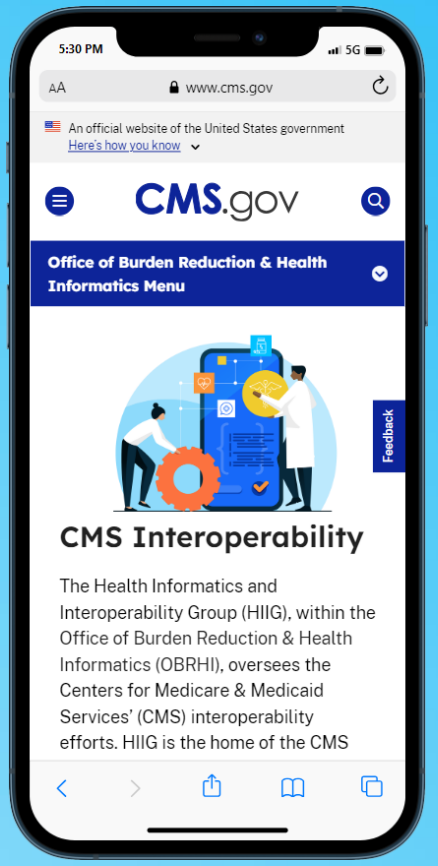
Resources

Interoperability Rules

- 2024 CMS *Interoperability and Prior Authorization* final rule: Final rule, Fact Sheet
- 2023 ONC Health Data, Technology, and Interoperability (HTI-1) final rule: Federal Register, Fact Sheet
- 2020 CMS *Interoperability and Patient Access* final rule: Federal Register, Fact Sheet, and Frequently Asked Questions
- 2020 ONC 21st Century Cures Act final rule: Federal Register

Technical Standards and Implementation Support

- Technical Standards: FHIR, SMART IG/OAuth 2.0, OpenID Connect, USCDI
- Implementation Support for APIs: CARIN for Blue Button IG, PDex IG, PDex Formulary IG, PDex Plan Net IG, US Core IG, CRD IG, DTR IG, PAS IG, Bulk Data Access IG



Visit the CMS Interoperability website for additional resources and information!

Social Determinants of Health (SDOH) and ICD-10-CM SDOH-related Z codes

Disclaimer

- This information is current at the time of presentation but Medicare, Medicaid and Marketplace policy is subject to change. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

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CMS Strategic Plan

CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.

STRATEGIC PILLARS

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote valuebased, personcentered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations

CMS Framework for Health Equity

- Allows a framework for CMS to operationalize health equity
- Expanded on the CMS Equity Plan to include all CMS programs: Medicare, Marketplace, and Medicaid and CHIP
- Identifies 5 Priority Areas
- Evidence-based
  - CMS's approach to advancing health equity is informed by decades of research and years of dedicated, focused stakeholder input, and evidence review.
  - Gather and synthesize input from health care providers; federal, state, and local partners; tribal nations; individuals and families; researchers; policymakers; and quality improvement and innovation contractors.

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

CMS Framework for Health Equity: 5 Priority Areas

- Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
- Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
- Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
- Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
- Priority 5: Increase All Forms of Accessibility to Health Care Services & Coverage

CMS Office of Minority Health's Data White Paper

The Path Forward: Improving Data to Advance Health Equity Solutions:

"Accurate and complete data elements support CMS in its efforts to create evidence-based policies and regulations and to assess how well these policies and regulations align with the needs of the communities and individuals that CMS serves."

- Describes the current state of health equity data collection and consolidation across CMS programs
- Details progress to date
- Defines CMS' future actions to continue the improvement of health equity data and achieve a future vision of health equity data at CMS

https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf

- Sociodemographic and SDOH health equity data can help drive quality improvement and improve program/policy evaluation
- Despite progress, there are gaps in the availability, completeness, and quality of health equity data remain across CMS programs
- CMS is committed to improving the quality, accuracy, and completeness of data that can enable improvements in health equity
- Efforts to address these health equity-related data issues are already underway and will be prioritized

CMS & Administration Strategies

CMS Framework for Health Equity
Administrator's Strategic Vision Release
Executive Order 13985

Program Rules & Guidance

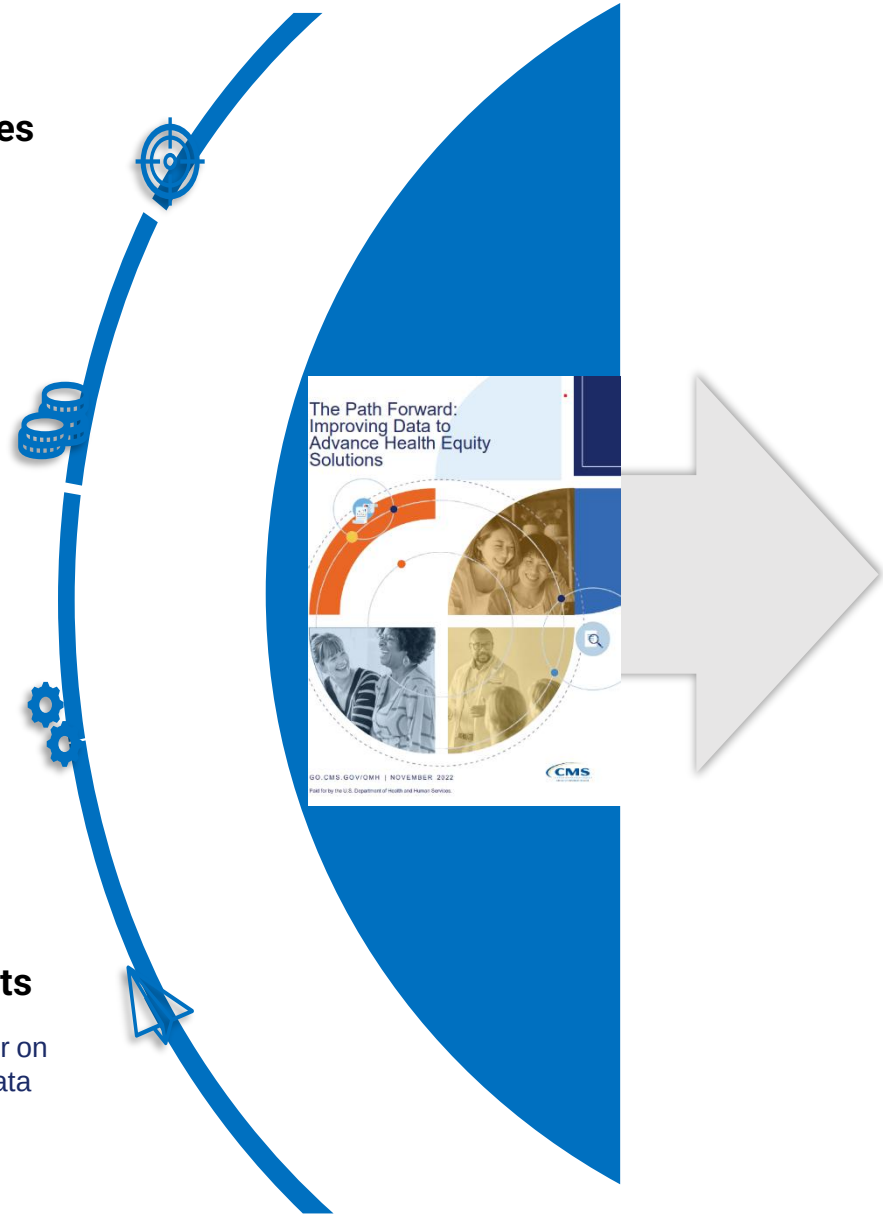
Proposed and Final rules for Medicare
Guidance letters to insurers and state
Medicaid officials

Stakeholder Feedback

Responses to recent RFIs on health equity indices and other programs; Input from across CMS, ONC, and HRSA

CMS Internal Documents

E.g., memo to the Administrator on current state of health equity data

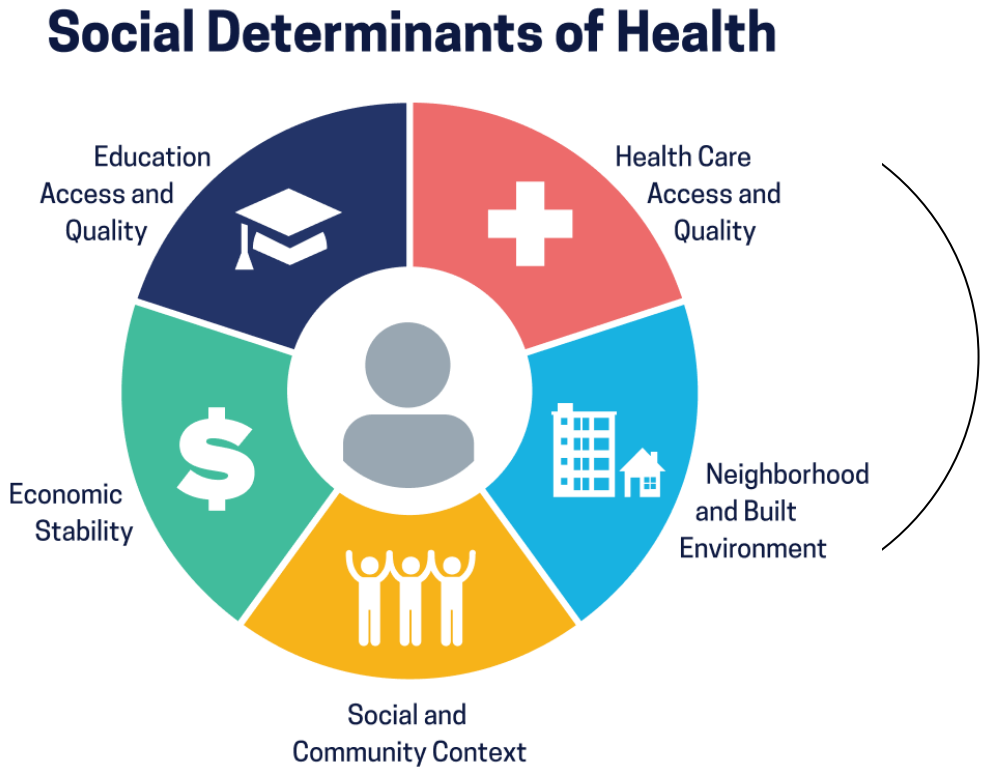


Intended Outcomes

- CMS has a comprehensive resource that summarizes the current state and future goals for health equity data
- Public and industry have knowledge of CMS' current state
- Public and industry understand CMS' commitment to driving health equity through improved data

Social Determinants of Health: Healthy People 2030

- Education Access and Quality
- Economic Stability
- Social and Community Context
- Neighborhood and Built Environment
- Health Care Access and Quality



Social Determinants of Health in Medicare

SDOH in the Medicare Program: Value-Based Care

For one of the first times, traditional Medicare has identified payments that may be used to address beneficiary social needs directly and in collaboration with local community-based organization

- This is in the form of Advanced Investment Payments, which are upfront shared savings payments to new, smaller Shared Savings Program Accountable Care Organizations (ACOs)
- These payments are expected to grow ACO participation in rural and other underserved areas, and will start on January 1st, 2024

SDOH in the Medicare Program: Quality Reporting

CMS has instituted new quality measures in the Hospital Inpatient Quality Reporting system that measure the percentage of individuals who are screened for health-related social needs (food, housing, transportation, personal safety, utilities) and the percentage who screen positive

- This is the first step to increase reporting of these measures, before they would be adopted into the Hospital Value-Based Purchasing program

CMS has also instituted the "Hospital Commitment to Equity" measure as part of the Hospital Quality Reporting system

- Hospitals must attest that they have completed actions that demonstrate equity is a strategic priority, data collection (by demographic and/or social factors) is underway, data is being analyzed for disparities, the hospital is participating in quality improvement activities related to disparity reduction, and that hospital leadership is engaged and annually reviews strategic plans for health equity

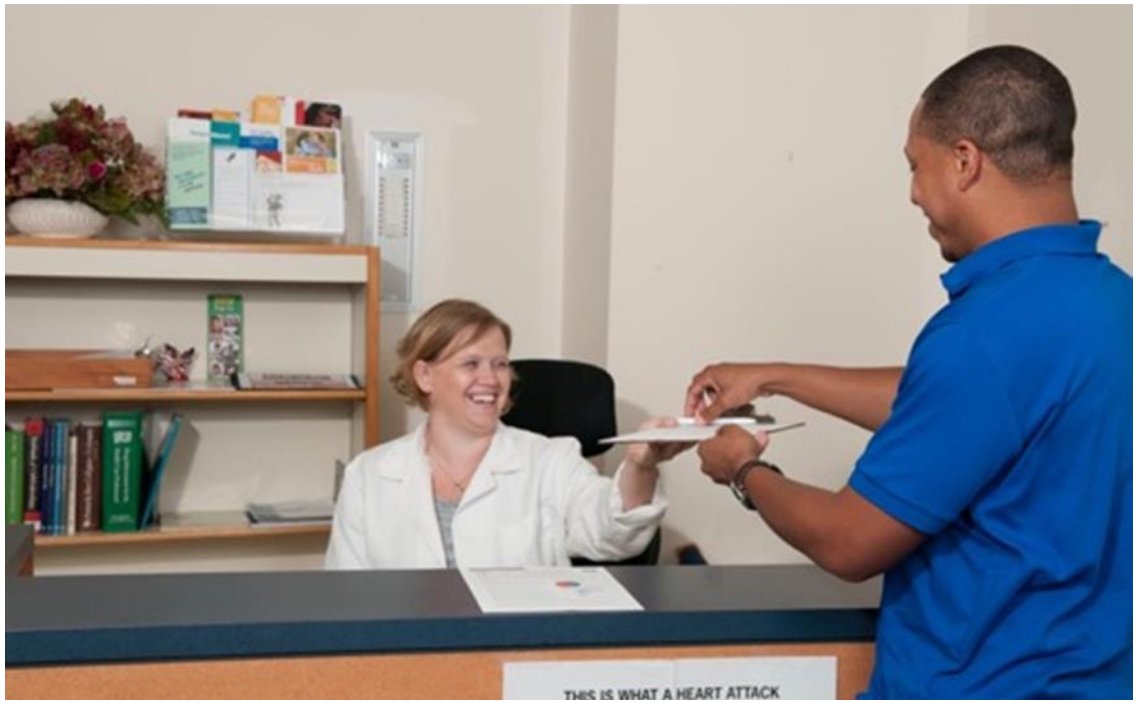
SDOH in Dual Plans, Medicare Advantage and CMS Innovation Center Models

- CMS requires that dual Special Needs Plans, as part of the health risk assessment, must screen beneficiaries for the health-related social needs of food, housing, and transportation needs on health risk assessments
- Beginning in 2023, CMS requires that MA organizations report under medical loss ratio reporting the amounts they spend on various types of supplemental benefits not available under original Medicare (e.g., dental, vision, hearing, transportation)
- The Value-Based Insurance Design Model in the CMS Innovation Center has 25 plans participating in South Carolina that offer additional benefits to enrollees through the model, such as reductions in cost sharing (in some cases to zero) for Part D drugs and healthy food cards for enrollees who receive low income subsidies (LIS)

Engaging Healthcare Systems on SDOH

- Numerous policies to reward excellent care for underserved populations:
- A new health equity index in Medicare Advantage Star Ratings for 2024
- A similar Health Equity Adjustment in the Medicare Shared Savings Program for 2023
- A health equity adjustment for hospital value-based purchasing in the FY 2024 IPPS final rule
- CMS also just finalized a policy to recognize the higher costs that hospitals incur when treating people experiencing homelessness when hospitals report social determinants of health codes on claims.
- For 2024, CMS proposed to pay separately under the physician fee schedule for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care.

Using Z Codes: Social Determinants of Health (SDOH) Journey to Better Outcomes



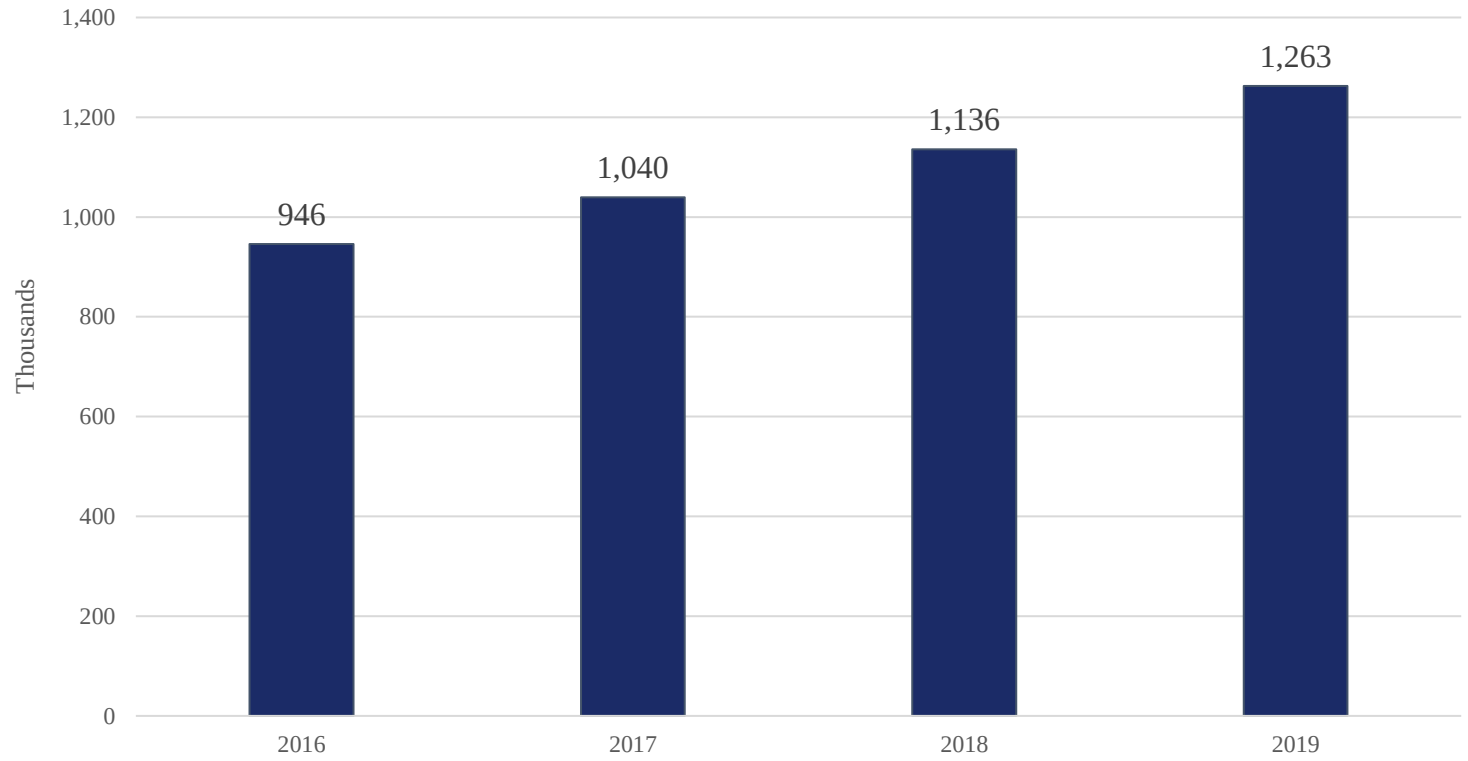
Research on Z Codes

Utilization of Z Codes for Social Determinants of Health among a Sample of Medicare Advantage Enrollees, 2017 and 2019 (PDF)

Volume 30 – April 2022

This data highlight focuses on analyzing the utilization of Z codes in a sample of Medicare Advantage enrollees from 2016 to 2019. The report describes sociodemographic data, Z codes claims data collected, and highlights potential incentives to increasing the use of Z codes to help reduce health care disparities.

Change in Total Number of Z Code Claims, 2016 to 2019



The total number of Z code claims was 945,755 in 2016, 1,039,790 in 2017, and 1,135,642 in 2018.

In 2019, there were 1,262,563 Z code claims, representing **0.11%** of all FFS claims that year and an increase of 95,852 (9.2%) from 2018 and an increase of 189,887 (20.1%) from 2016.

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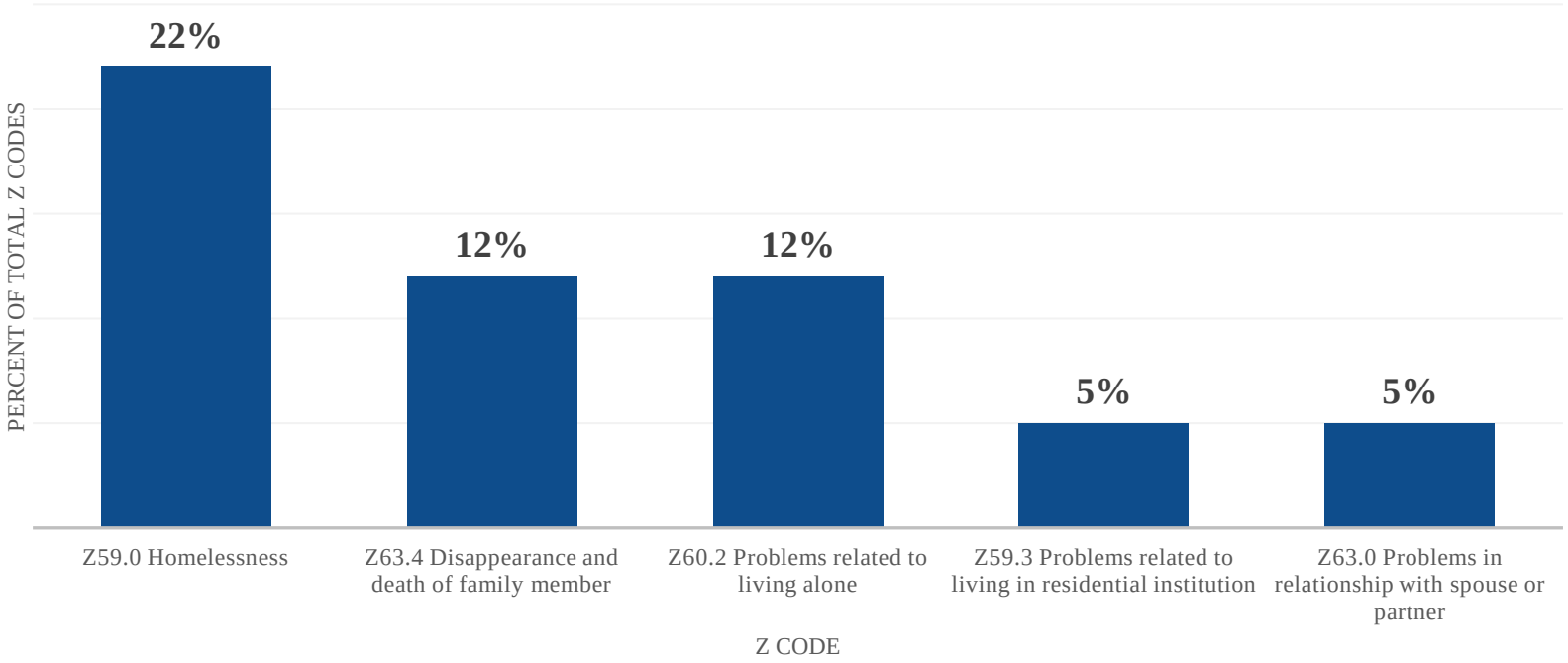
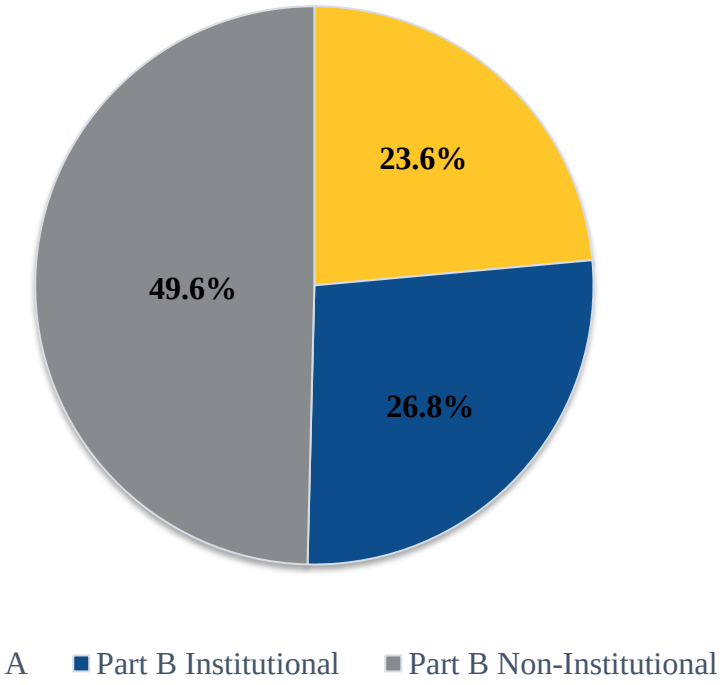
The Top Five Z Codes, 2019



Z code	Description	n/1,262,563	Proportion of all Z code claims
Z59.0	Homelessness	310,089	22%
Z63.4	Disappearance and death of family member	164,829	12%
Z60.2	Problems related to living alone	163,259	12%
Z59.3	Problems related to living in a residential institution	66,842	5%
Z63.0	Problems in relationship with spouse or partner	62,572	5%

Proportion of Medicare FFS Z Code Claims by Type, 2019



In 2019, Medicare Part B Non-institutional claims represented 82% of all claims submitted with Z codes, while Part B Institutional represented 16% and Part A represented 2%.

Recap

- Similarly low rates of utilization of Z codes as was found in FFS (1.6% in FFS and 1.1% in this MA sample in 2019)
- Patterns of overrepresentation were not dissimilar to those observed in FFS:
  - —MA beneficiaries with any Z code claim appeared to be disproportionately younger (aged 18-64 years), female, and Black or African American
  - —2/3 of enrollees with a homelessness Z code were aged 18-64 years, and were disproportionately male, Black or African American, and residents of urban areas
  - —1/3 of enrollees with problems related to living alone were aged 85 years and older
  - —Primary care physicians (internists, family practitioners), mental health practitioners (psychiatrists, psychologists), and social workers were most common in making use of Z codes

Findings

SDOH Z codes are underutilized in billing and clinical coding across ambulatory settings

Z Codes in Practice

- Organizations reported challenges using SDOH Z codes that are not well defined (e.g., codes associated with nutrition)
- Organizations reported higher use of SDOH Z codes that are well aligned to SDOH screening tools (e.g., PRAPARE) and standard coding vocabularies (e.g., LOINC, SNOMED)
- Although 2018 guidance expanded the categories of providers who can assign Z codes, the awareness of this was unclear and questions remained
  - The FY2022 ICD-10-CM Official Guidelines for Coding and Reporting clarifies further, who may document SDOH for utilization by coding professionals

https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf

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Challenges

Several challenges limit SDOH capture and Z code use

Key Barriers

- Lack of standardized SDOH screening tools
- Challenges integrating SDOH data capture and documentation in existing workflows
- Gaps in Z codes for common SDOH data concepts
  - —New or revised categories and Z codes have been adopted
    - Eg. Category Z58 - Problems related to physical environment, has been added
    - Eg. Category Z59 - Problems related to housing and economic circumstances has been expanded to offer additional subcategories and Z codes related to homelessness and housing instability
  - —Additional submissions continue to be proposed to the ICD-10-CM Coordination and Maintenance Committee
- Need for educational resources to support providers in coding SDOH data

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Z Code Journey Map

The goal of the Journey Map is to fill a gap in training and awareness by illustrating how to collect, document, and use SDOH Z code to help improve health care outcomes

Target Audience

- Health care administrators
- Health care team
- Coding professionals

Key Messages

- Use standardized tools to document SDOH
- Emphasize person-centered care
- Z codes are setting and provider agnostic

https://www.cms.gov/files/document/zcodes-infographic.pdf

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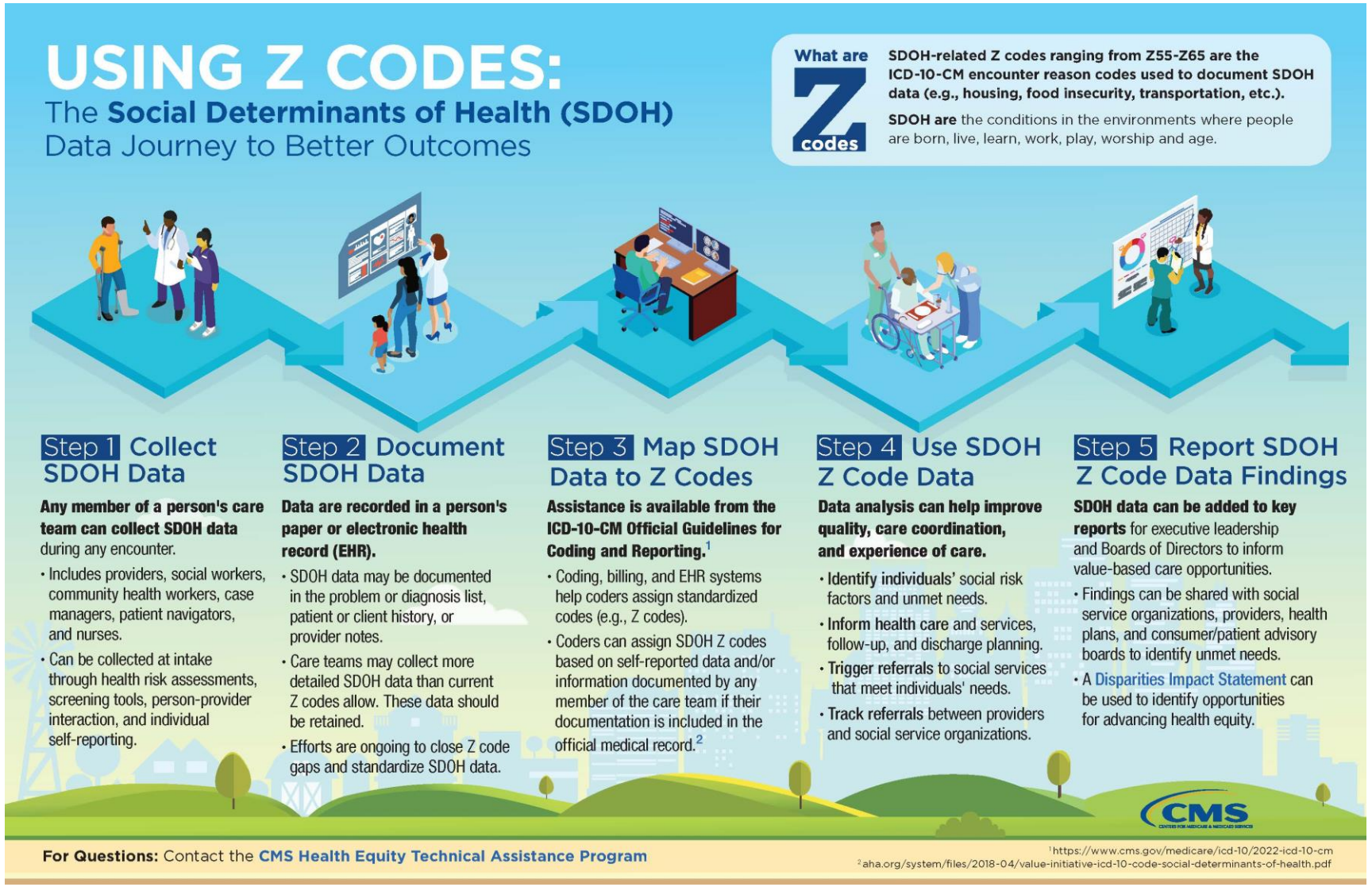
Using Z Codes Infographic

What SDOH Z codes are, how to collect and document SDOH with Z codes, and how to use these data

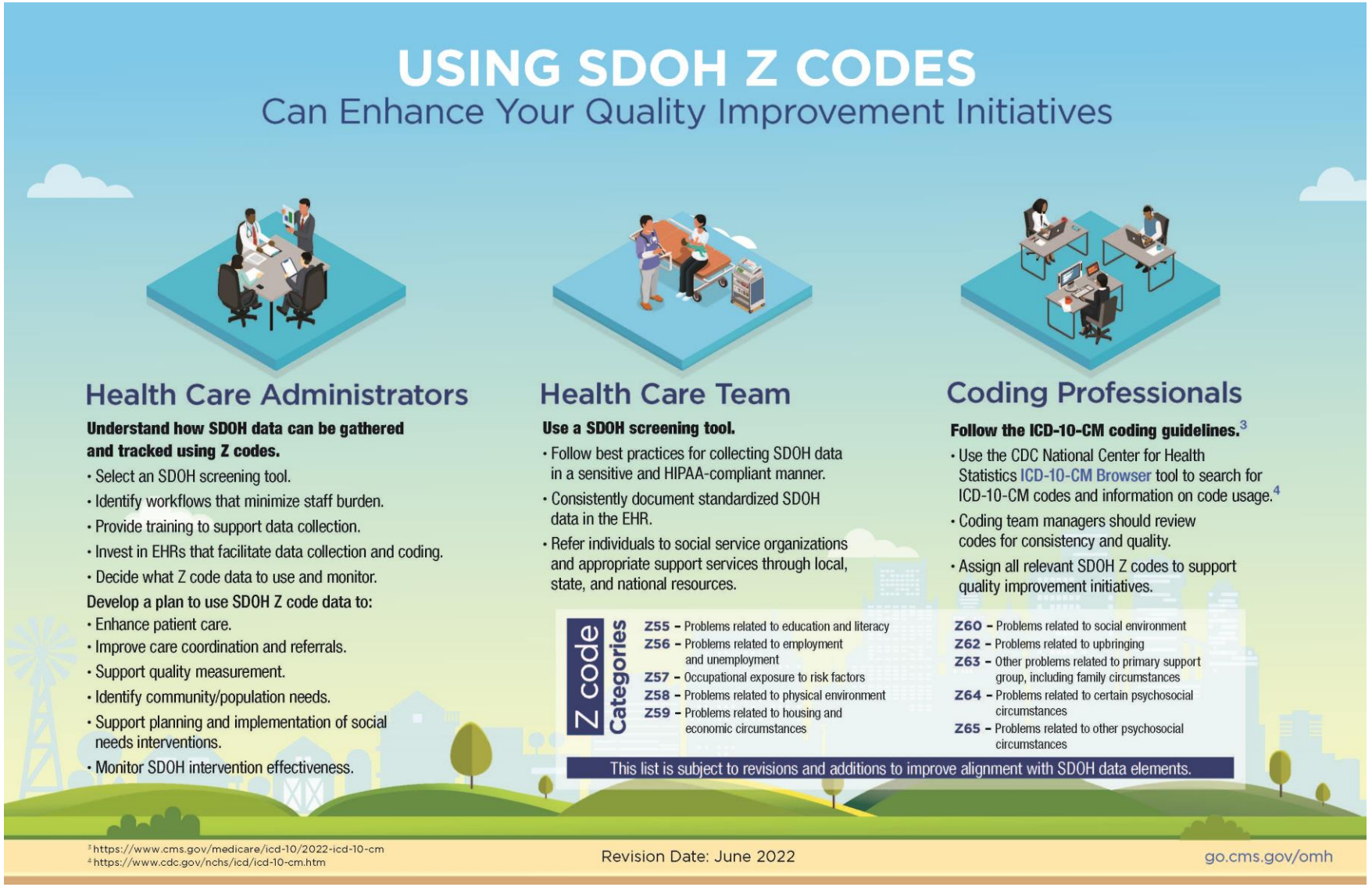
There are also links to key resources on coding and also on equity



Using Z Codes Infographic (continued)

Resources and guidance to improve SDOH Z code collection and use

There is also a link to a key resources for ICD-10-CM codes



Summary: Opportunities to Increase Z Code Utilization

How can health systems focus resources to improve SDOH coding and related care coordination?

Multiple opportunities exist to increase Z code use

- Reduce reliance on providers to collect and document SDOH by utilizing other clinicians
- Follow ICD-10-CM Official Guidelines for Coding and Reporting FY 2023
- See Section I.C.21.c.17. for additional information regarding coding social determinants of health. https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf
- Identify optimal workflows to collect, document, and code SDOH data

Summary (continued)

- Increase training and education for providers in form of guidelines, best practices, and training resources https://www.cms.gov/files/document/zcodes-infographic.pdf, https://www.cms.gov/about-cms/agency-information/omh/research-and-data/health-care-disparities-data/data-highlights
- Fill gaps in SDOH-related Z codes (The Gravity Project) https://thegravityproject.net/
- Support ongoing efforts to standardize SDOH data elements (The Gravity Project)
- Use SDOH Z code data to support quality improvement initiatives, care coordination, and referral tracking (be aware of Community-Based Organization (CBO) services for social needs)

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Questions?

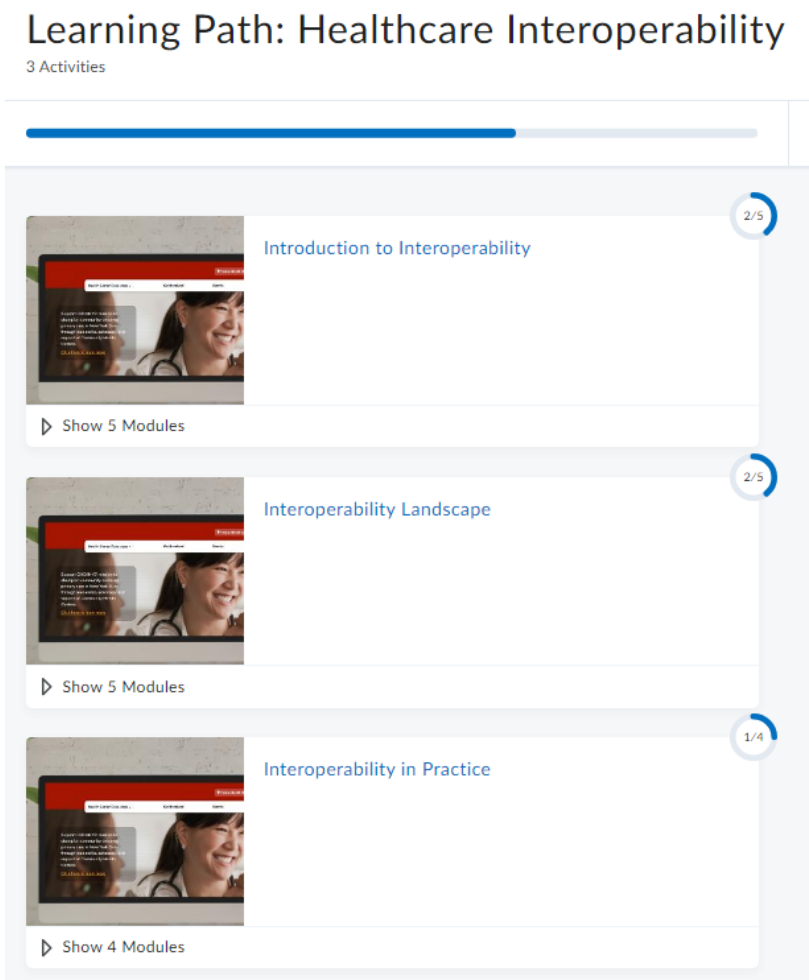
Please fill out our survey!

Please share your feedback using the survey link in the chat, the QR code, or the link in the follow up email!

Completing your survey helps us to provide relevant and helpful information. Thank you in advance!

Interoperability 101 Course

- Join the CHCANYS Hub!



Healthcare Interoperability

View Here

This **Healthcare Interoperability Learning Pathway** includes 3 courses and is designed for technology and EHR staff that are interested in learning the basics about interoperability in health care.

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