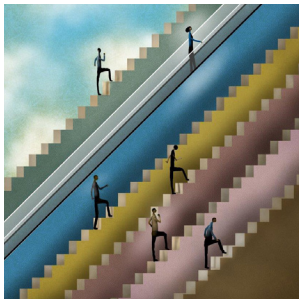
CAQH Insights

ISSUE BRIEF



How Health Plans Connect: Payer-to-Payer Data Sharing

March 2023

Background

The COVID-19 pandemic highlighted numerous shortcomings in the U.S. healthcare system, including the lack of interoperable systems and insufficient data sharing, which often left patients and their providers with incomplete data to make timely and appropriate clinical decisions. In an effort to advance interoperability and reduce inefficiencies in the healthcare industry, in May 2020, The Centers for Medicare and Medicaid Services (CMS) released a series of proposals[1] to improve the electronic exchange of healthcare data between patients, health plans, and providers. The Interoperability and Patient Access Rule outlines requirements for how plans must offer members enrolled in CMS covered programs access to their health care data through application programming interfaces (APIs), and includes three parts: the Patient Access API, Provider Directory API, and Payer-to-Payer Data Exchange.[2]

Requirements under the Interoperability and Patient Access Rule

Patient Access API (required July 1, 2021): Requires CMS-regulated payers to provide patients with claims and encounter information, as well as available clinical information through a third-party application of their choice.

Provider Directory API (required July 1, 2021): Requires CMS-regulated payers to make provider directory information publicly available.

Payer-to-Payer Data Exchange (proposed rule out for comment): Requires CMS-regulated payers, upon a member's request, to share member patient access information with a member's new payer.

The Rule requires health plans to implement and maintain standards-based APIs. CMS and the Office of the National Coordinator for Health Information Technology (ONC) identified Health Level 7 (HL7) FHIR (Fast Healthcare Interoperability Resources) Release 4.0.1 (R4) as the standard to support the data exchanges required under this rule.[3] The HL7 FHIR R4 standards outline how clinical and administrative data can be exchanged between payers, providers, and patients via APIs.

One of the Rule requirements, the Payer-to-Payer Data Exchange, requires payers to share a member's utilization and clinical data with a member's new payer. The process, which would occur at a member's request, requires CMS-regulated health plans to transmit patient data between each other when a patient enrolls in a new health plan. In the new CMS proposed interoperability rule open for comment, CMS proposes to require payers to use FHIR APIs to exchange this data between payers.

Focus Group Findings

In November 2022, CAQH held a focus group with health plans to better understand strategies and considerations for implementing payer-to-payer data exchanges. The participants discussed their organization's overall interoperability strategy, resources considered when establishing the exchange, and lessons learned to promote and encourage adoption.

Interoperability Strategy

Overall, most payers and the broader healthcare industry lack a well-defined interoperability strategy, especially as it relates to FHIR implementation. Many health plans indicated that they only update their interoperability workflows to fulfill CMS's or other certification requirements making interoperability a compliance exercise rather than a strategic decision.

While FHIR technology can be applied to multiple business use cases, organizations are opting to implement it disparately and without a clear strategy, increasing the likelihood of burdensome and inefficient processes.

Payer-to-Payer Data Exchange: Varying Implementation Strategies

The original timeframe outlined in the Interoperability and Patient Access Final Rule required compliance by July 1, 2021, allowing organizations 14 months to design, test, and implement their payer-to-payer data exchange workflows. Among the organizations that participated in the focus group, three implementation strategies were discussed: build internally, buy or outsource services and systems, or a combination of both. In our focus group, an equal number of health plans implemented these strategies citing advantages and challenges with each.

BUILD INTERNALLY

For those health plans that indicated that they built their own system, they had the benefit of established FHIR servers that were used for other use cases, allowing for a quicker and more efficient build. Resource dependencies proved challenging for one organization who opted to build internally as they did not expect to need experienced digital resources and had trouble securing them which resulted in build delays. Overall, having experienced specialists and other FHIR implementation experience greatly reduced the implementation timeframes and resource requirements.

OUTSOURCE SERVICE AND SYSTEMS

Health plans that chose to pursue an outsourced solution did so due to a lack of internal resources and expertise and to meet the compliance date. One organization stated that "leveraging a vendor was key" when considering the large volume of data to manage. Despite the many benefits of using vendors, health plans warned of the significant cost, but that in most cases, they had no alternative. Outsourcing proved effective in meeting the compliance deadline.

BUILD AND OUTSOURCE

Other health plans chose a hybrid approach by partnering with a vendor and doing significant development to ensure a robust strategy. One health plan that had already implemented FHIR technology for other use cases indicated that developing the payer-to-payer data exchange workflows was difficult due to the tight turnaround time. In this case, the organization used their cloud-based service provider along with a vendor for their inbound data to achieve their strategic goals.

We use a vendor for incoming data and broker the inbound data. For outbound data, we use our own processes.

As organizations were refining and implementing their strategies, on December 8, 2021, CMS announced they were delaying enforcement of payer-to-payer data exchange until they can improve the policies through future rulemaking.[4] This delay prompted many organizations to pause development of the payer-to-payer data exchange.

Challenges Faced Meeting Payer-to-Payer Data Exchange Requirements

Regardless of the organization's approach to implementing the payer-to-payer data exchange requirements, specific challenges emerged, and effective mitigation strategies were identified.

1. Developing and Communicating an API Strategy

To gain support for payer-to-payer data exchange efforts within their organization, some teams found it challenging to translate the value of FHIR beyond meeting the CMS mandated requirements. Although FHIR is not an easily definable solution, being able to articulate how API and FHIR-based technologies simplify data exchange can lead to a more diverse data strategy in the future.

2. Determining and Allocating Appropriate Resources

Updating any business process and implementing new technologies requires organizations to determine and allocate resources. In some cases, it is unclear what resources are initially needed given that processes and requirements are new. Among organizations that chose to internally build workflows, they found that business analysts, technical staff, subject matter experts, and security resources were needed. Properly planning for resource is an important step in the project.

Overall, organizations indicated that more detailed guidance and roadmaps related to interoperability rules and regulations could improve predictability and aid in planning. A thorough outlook can help organizations plan and allocate resources appropriately and ease significant drains in resources with short timelines.

3. Controlling for Changes in Versioning and Requirements

As APIs and FHIR technologies mature, Implementation Guides (IGs) will be updated to reflect changing business needs. This may create challenges with versioning that could impact interoperability and use. Specifically, payer-to-payer exchanges are subject to changing clinical data elements which may result in different versions being implemented. Achieving interoperable systems and data exchange will be challenging when requirements change on a frequent basis. Roles and responsibilities should be determined among trading partners to ensure interoperability is supported and grows.

4. Securing Patient Data

Protecting patient health data from unwanted threats is a universal concern. Recent data breaches have heightened organizations' awareness of the need to ensure security while developing data exchanges. Health plans' workflow development included establishing appropriate firewalls and resources to mitigate risk when exchanging patient data among health plans and making it available to patients.

Moving Forward: Success through Collaboration and Information Sharing

As the industry continues to promote interoperability and engage with FHIR, organizations suggested that sharing experiences and best practices is needed and beneficial. Most notable, organizations indicated the following:

1. Partnering and sharing experiences among health plans is critical as they navigate payer-to-payer use cases, CMS's requirements, and IG versions.

- Establishing payer-to-payer relationships to test data is beneficial to everyone and helps identify technical, security, and content-specific issues that may be missed during internal testing alone.
- Creating a shared service testing model allows health plans to exchange and test data related to the payer-to-payer data exchange use case. This testing model can also be replicated for future use cases.

2. Involving all stakeholders in discussions is crucial to successful development and implementation of payer-to-payer data exchanges.

- Industry should create opportunities for all stakeholders—payers, providers, and vendors—to discuss issues and best practices encountered during implementation and adoption. These can be in the form of round table discussions, focus groups, and "digital ecosystems."
- Engaging all aspects of an organization—beyond technology implementation teams—including business analysts, operations teams, and clinicians will add value to the development of the data exchange and will help ensure all implementation challenges are addressed.

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1 "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," CMS, May 01, 2020, https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

2 Requirements apply to CMS-regulated payers: Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans and CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federal Facilitated Exchange (FFEs).

3 "Interoperability and Patient Access Fact Sheet," CMS, March 09, 2020, https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet.

4 "Interoperability and the Connected Health Care System," CMS, December 08, 2021, https://www.cms.gov/blog/interoperability-and-connected-health-care-system.