



March 2022 Newsletter

Working in the health data world can cause folks to focus on silos and specific areas at the expense of a cohesive whole. We look at interoperability and health information exchange as component regulations, models, methods, and standards and sometimes we ignore the broader context or look at each individual type of exchange in isolation rather than as part of a larger system. The Trusted Exchange Framework and Common Agreement, or TEFCA, seems to have evoked a similar focus on these components among some at the expense of ensuring that TEFCA moves us toward what successful interoperability and information exchange must accomplish.

Interoperability and information exchange must achieve both patient and population health goals. For patients, these goals include a complete personal health record, informed caregivers, ready access to health services and referrals on a national scale, security and privacy, accurate eligibility, timely prior authorizations, and accessible pathways to the open apps of their choice.

For population health, these goals range from the ability to address widespread problems to the capacity to measure outcomes across multiple axes. We need accessible public health systems and immunization registries able to deal with both urgent and systemic problems. This includes the ability to operate at both a national and local scale to combat Covid more effectively than we have done so far, as well as the ability to monitor more common health risks, illnesses, diseases, addictions, and viruses that harm public health. Further, we need to measure the value of health care for all; this is impossible if we don't measure its impact in improving health equity, access, value, and quality.

ONC sees TEFCA as part of this solution. What is TEFCA? TEFCA comprises two parts: the Trusted Exchange Framework and the Common Agreement. The Trusted Exchange Framework details standards and principles that participants must follow when sharing data and the Common Agreement is a legal agreement that this data sharing will follow specific standards and principles. The primary nodes of TEFCA are Qualified Health Information Networks (QHINs) that will act as the primary hubs to which national, regional, state, and local HIEs, providers, and others across the country can connect. TEFCA is often described as a single on-ramp that allows clinicians, hospitals, and other healthcare stakeholders to join any health information network (HIN) and immediately link and participate in nationwide health information exchange but is that accurate? Currently, TEFCA participation is voluntary.

Rather than debate the pros and cons of TEFCA, let's look instead at how effectively TEFCA moves us on this journey to better patient and population health.

TEFCA moves us closer to these goals in several ways. The nation needs an interoperable nationwide network for information exchange. TEFCA will provide increased access to health information to a subset of stakeholders such as health information networks, ambulatory practices, hospitals, health centers, federal government agencies, and public health agencies. Payers, patients, and other non-provider entities may also be participants but the specifics are nebulous. As National Coordinator Micky Tripathi described during MHDC's first Forum of 2022, it is a "business to business" exchange.

TEFCA raises the interoperability floor - and it is a floor, not a ceiling - for HIEs and others that adopt its standards and principles. This raised floor can enable participating networks to differentiate value specific to their users' needs. Whether these networks will survive this level of market disruption is a point of contention.

TEFCA is decidedly a government effort to enable the health care industry to share clinical and administrative data in a more standardized and structured manner, and it will do that. Whether or how effectively TEFCA moves our country toward better patient care and population health is another matter entirely.

TEFCA builds on the major exchange networks, like Carequality, and fixes many of their minor flaws, but it does little to advance the value of the exchanged data. ONC recognizes that health data exchange today relies heavily on older networks' standards - including Integrating the Healthcare Enterprise (IHE) profiles and HL7 Consolidated Clinical Document Architecture (C-CDA) - and that Fast Interoperability Healthcare Resources, or FHIR, will enable the much richer computing that patient care and population health require. However, FHIR is not currently part of TEFCA; ONC is working on incorporating it in the future and has developed a roadmap to do so.

TEFCA has been introduced as voluntary, but the final document is unclear about how a patient can avoid participation in this national network and retain control over where their data goes. From a technical standpoint, this is very difficult, if not impossible. Currently, TEFCA does not define how the system is voluntary from the perspective of the patient, describe how a patient opts-out of having an encounter from being entered into the system, how a patient is notified when an encounter is added to the system, and how an encounter is deleted from the system.

TEFCA fails to resolve patient identity and authentication. What happens when data is sent to the wrong individual or organization? How does it ensure that records from multiple sources are properly collated together and do not include data from different patients? How do we maintain proper consent and security? One piece that TEFCA does support is a requirement to comply with a set of core HIPAA rules regardless of whether each participant is technically covered by HIPAA.

Lastly, the framework does not provide a way to segment data, especially sensitive data. Data regarding behavioral health, substance use disorders, and sexually transmitted diseases are treated in the same fashion as vitals and lab results. So is data around social determinants of health, although the specific rules around consent of this data are still being formulated and, at this time, there is no additional legal restriction on its dissemination.

Health data networks must be distributed if real nationwide interoperability is to occur. Distributed, rather than centralized, networks make real interoperability possible. They enable the creation of a verifiable trust layer, proper patient identification and authentication, permissioned access to data (eliminating the need to exchange data), and increased security through certified verification of all participants. TEFCA moves us in the opposite direction. Further, 21st century networks should incorporate equity, security, patient-level consent, and identity and authentication by design. Granular patient consent and support for access to the patient's needs and wants will drive higher quality data and more equitable participation in this vast health data economy.

To meet these needs, ONC should accelerate the adoption of FHIR and the continued advancement of data standards (giving providers a transition period of document-based exchange but not indefinite permission to continue it), decentralize the network, and promote health data literacy and patient stewardship of their health data. This level of engagement will drive far more significant advancements in data quality, security, availability, exchange, and ethical use than an obsolete, centralized, voluntary (for now) business-to-business pipeline.

A handwritten signature in black ink, appearing to read "Denny Brennan". The signature is fluid and cursive, with a small dot at the end.

Denny Brennan, Executive Director

Email us at newsletter@mahealthdata.org with your thoughts about this newsletter. Thank you for your continued support and participation!



In Memorium: Joseph M. Heyman M.D., 1942-2022

MHDC Events

Upcoming MHDC meetings through March:

- DGC Deep Dive: Family History: March 30, 11am-1pm
- DGC Working Group: March 2, 9, 16, 23 11am-12:30pm
- DGC Steering Committee: March 9, 3-4:30pm
- NEHEN Business Users: March 3, 9-10am
- Spotlight Users Meeting: March 22, 2-3pm

Want to learn more about any of these meetings? Email info@mahealthdata.org

MHDC Webinars

Join us for our upcoming webinars:

[The Imperative Facing Every Tech Leader](#) presented by Ruby Raley of Axway on March 1 from 11am-12:30pm.

[Data Driven Value Based Care](#) presented by Dr. Matt Lambert of Curation Health on March 8 from 10am-12pm.

[How to Approach Healthcare Transformation Sparked by API Adoption](#) presented by Jocelyn Keegan of Point of Care Partners on March 24 from 12-2pm.

[Decision Models in Technology in Psychiatry](#) presented by Dr. Daniel Barron of Brigham and Women's Hospital on March 29 from 1-3pm.

Missed any of our webinars in 2022? Click [here](#) to see what you've missed!

Interested in holding an MHDC webinar or have an interesting topic you'd like to present? Contact us at webinars@mahealthdata.org

Spotlight Analytics Update

Spotlight Business Analytics helps healthcare organizations run custom analytics on health data including market share, patient origin, disease prevalence, cost of care, and comparative costs and outcomes for acute care hospitals.

Our partnership with the [Lown Institute](#) will add civic and care leadership measures to Spotlight. Augmenting Spotlight's market share, disease prevalence, and demographic analyses with the Institute's equity, value, and outcomes measures will provide Spotlight subscribers with a more comprehensive, robust, and relevant view of health system performance.

Please join us on March 22 at 2pm to learn more about the Lown Institute data within the Spotlight platform. We will discuss the role of the Lown data, use cases, and provide a live demo of the data elements for use. Register [here](#). This event is open to the public.

The current data status is:

Loaded & available for use:

- Massachusetts Hospital Inpatient Discharge Data FY20
- Massachusetts Emergency Department Visit Data FY20
- Massachusetts Observation Data FY20
- Rhode Island Hospital Inpatient Discharge Data FY20

Received & ready for use soon:

- Lown Institute measures

Future planned data:

- New Hampshire Facility Discharge Data Sets (Application pending)

- Maine Hospital Inpatient and Outpatient Data (Application pending)

Please feel free to drop us a line with any questions or comments at spotlight@mahealthdata.org. In the meantime, thank you for being a Spotlight Analytics user and a member of this community! Feel free to visit our [Spotlight Business Analytics page](#) or email us at the address above for more information.

DGC Update

The Data Governance Collaborative (DGC) at MHDC is a collection of payers and providers throughout the region exploring ways to better exchange health-related data incorporating industry standards and automation as much as possible.

Our next deep dive will be on family history on March 30 from 11am-1pm. We will explore current regulation and practices, data capabilities, workflows, data exchange, privacy and consent issues, and more. The event is open to the public; we encourage you to register [here](#).

Regulations are still a priority in our regular meetings, and we've also been reviewing several recent industry events. We've also been exploring several special projects with our Steering Committee and lending our expertise to some external projects run by others - watch this space for more information as these projects progress.

Membership in the DGC is open to any payer or provider with business in Massachusetts - big or small, general or specialist, traditional or alternative. Want to know more? Email datagovernance@mahealthdata.org

NEHEN Update

NEHEN reduces administrative burden through the adoption of standardized transactions. It is a cornerstone service for payer and provider trading partners wishing to exchange industry standard X12, HIPAA compliant transactions in a real-time, integrated manner using APIs. Because of our unique governance, non-profit status, and membership-based model, NEHEN is able to offer very competitive services relative to the market. Working with members and trading partners, NEHEN is also supporting a prototype electronic prior authorization (ePA) implementation that automates transactions using industry standard, open platform methods developed by the HL7 DaVinci Prior Authorization workgroup.

At the February Business Users meeting we discussed the ONC RFI for health IT certification around electronic prior authorizations (ePA) support. One of the key questions in the RFI is whether EHRs or other related technology should be certified for X12 transactions or FHIR transactions to support ePA. Our short answer to this question is "yes" - initially we think both should be supported.

Our long answer is that most health plans and providers are not fully using the FHIR transactions required to support the DaVinci IGs for prior authorization; it may take as long as several years to be fully compliant with those guides in some cases. At least some implementations will likely involve both types of transactions in the short-term with the possibility of fully migrating to using only FHIR APIs for these transactions in the future. The final CMS rule for the adoption of ePA is still not released so there is no current regulatory push to advance ePA more rapidly.

MHDC and NEHEN will be responding to the ONC RFI regarding the ePA certification for health IT and would welcome any feedback on any aspects of the RFI. We will be going over the high points at the March NEHEN Business User's meeting; all are welcome. Please reach out at epa@mahealthdata.org if you have comments or would like to attend the meeting.

We have started initial planning meetings with Blue Cross Blue Shield of Massachusetts around our ePA prototype project and are coordinating with them and with Olive and New England Baptist Hospital to begin joint project meetings. Our initial joint meetings will discuss current architectures while we start to determine the framework for moving forward on the prototype.

For more information about NEHEN please contact us at members@nehen.org or visit our website at www.nehen.org. For more information about the ePA project, please email epa@mahealthdata.org.

Industry Events

Interested in webinars and online conferences in March? Here are some we recommend (they're free unless otherwise noted):

- [AHIP: An Rx for Behavioral Health Equity— Digital Therapeutics](#): Mar 1, 1pm
- [HIMSS: How AI and automation are boosting patient \(and provider\) experience](#): Mar 1, 2pm
- [Beckers: Re-energizing value-based care](#): Mar 3, 2pm
- [AHIP: Using Personalized Behavioral Science to Engage High-Risk Members and Improve Health](#): Mar 8, 3pm
- [Beckers: Real remote care: the next frontier beyond telemedicine and RPM](#): Mar 9, 1pm
- [EHI: HIPAA for Dummies](#): Mar 9, 1pm
- [AHIP: A Pragmatic Approach to Addressing Health Equity](#): Mar 10, 2pm
- [Beckers: The end of healthcare's identity crisis — How 4 health systems are breaking down information siloes and building whole-person data](#): Mar 17, 1pm

- [Beckers: Why data-driven planning will work for healthcare](#): Mar 21, 1pm
- [EHI: Can the Interoperability Rule Change Healthcare Integration Forever?](#): Mar 22, 1pm
- [V-BID: Advancing Equity Summit](#): Mar 23, 12pm
- [AHIP: Supporting Vulnerable Members with Meals Can Impact Utilization and Cost of Care Mar](#): Mar 23, 2pm
- [Beckers: Consumer-centric healthcare: Reimagining care delivery for the connected consumer](#): Mar 23, 2pm
- [DaVinci Community Roundtable](#): Mar 23, 4pm
- [Beckers: Digital engagement in healthcare: What comes next?](#) : Mar 24, 1pm
- [Beckers: A closer look at AI's expanding role in healthcare](#): Mar 24, 1pm
- [Beckers: Improving the orthopedic patient and provider experience through interoperability](#): Mar 24, 2pm
- [EHI: EHR Usability and Optimization Solutions](#): Mar 29, 1pm
- [Beckers: Bridging gaps and eliminating health inequities: Key strategies from Duke, Mayo Clinic, Trinity Health of New England and Vituity](#): Mar 29, 1pm
- [AHIP: Data-Driven Strategies to Enable Next Best Action in Health Care](#): Mar 30, 12pm
- [Beckers: Provider data management enhances payer-provider partnerships](#): Mar 30, 1pm
- [Economist: Disrupting the market: is consumerism transforming health care?](#): Mar 31, 10am
- [Beckers: Virtual care transformation: Insights from leading health systems](#): Mar 31, 1pm
- [Beckers: How providers can use empathy to leverage power of connected experiences](#): Mar 31, 1pm
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We do periodically post webinars we plan to attend on social media, so feel free to follow us on Twitter ([@mahealthdata](#)) and [LinkedIn](#) for more webinar ideas and for our take on interoperability, data, health equity, telehealth, APIs, and other topics of interest.

Have an upcoming event next month to suggest? Write us at newsletter@mahealthdata.org - no self-promotion please.

USCDI in 2022

ONC released the USCDI v3 draft in mid-January as part of their annual update process. This draft is open for comment until April 30th with plans to develop a final version of USCDI v3 for release some time this July.

In parallel with this work, ONC is considering using its Standards Version Advancement Process (SVAP) to allow certified health IT vendors to optionally certify against USCDI v2 instead of USCDI v1 some time this fall. This would not change any regulatory requirements set by CMS or ONC or anyone else; in particular, CMS interoperability rules would still mandate exchange of USCDI v1 data.

USCDI v3 Draft Overview

The USCDI v3 draft release adds two new data classes, removes two old ones (they're absorbed into one of the new ones), adds six new demographic data elements, and adds three new elements to other existing data classes.

At the high level, it continues some trends from previous versions of USCDI, most notably inconsistency around names and how people are represented in the data (so far this has been cleaned up in the translation to US Core for FHIR use, but it may still be an issue for data that doesn't originate from FHIR data formats or data exchange) as well as continued upgrading of code system versions which might require updating coding standards (or use of a code mapping service to move from one version of a code set to another) when specific codes used in the data change from one version to another.

v3 draft is also the first version of USCDI that includes administrative data in the form of insurance information.

USCDI v3 Draft Addition and Removal Summary

The following data classes have been added to USCDI v3 draft:

- Health Insurance Information
- Health Status

The following data classes have been removed from USCDI v3 draft, having been subsumed into the Health Status data class:

- Health Concern
- Smoking Status

In addition, new data elements have been added to the existing Patient Demographics, Procedures, and Laboratory data classes in the USCDI v3 draft.

Health Insurance Information Data Class

The new Health Insurance Information data class includes the following data elements:

- Coverage Status: indicates the presence or absence of coverage for a specific encounter or claim.
- Coverage Type: indicates whether the insurance is Medicare, Medicaid, PPO, etc. (defined value set allowed)
- Relationship to Subscriber: freeform relationship descriptor
- Member Identifier: member identifier, format expected unclear (most likely either dependent code or subscriber ID + dependent code)
- Subscriber Identifier: the subscriber ID assigned by the payer
- Group Identifier: the group number assigned by the payer pertinent to the encounter or claim
- Payer Identifier: a payer identifier of unspecified format

There are some clear issues with this data class in its current form. First of all, the coverage status descriptor indicates that this is the insurance information specific to a particular claim or encounter but there is no mechanism for specifying or referencing whichever claim or encounter that is. If this is changed to be general insurance information for the patient, then it may not apply to every claim or encounter and there's no mechanism for specifying when it does. Further, in the latter case, there may be more than one group identifier needed as many plans have separate group numbers for pharmacy and other medical care (and there may be other variations as well).

Health Status Data Class

The Health Status data class includes the following data elements:

- Health Concern: Health related matter that is of interest, importance, or worry to the patient, patient's family, provider, etc. This data has been part of USCDI since v1 and has just been consolidated into this new data class.
- Functional Status: Represents assessments of a patient's capabilities, or their risks of development or worsening of a condition or problem
- Disability Status: Represents assessments of an individual's physical, cognitive, intellectual, or psychiatric disabilities
- Mental Function: Represents observations related to a patient's current level of cognitive functioning including alertness, orientation, comprehension, concentration, and memory
- Pregnancy Status: Indicates whether a patient is pregnant.
- Smoking Status: Indicates current smoking status of the patient. This data has been part of USCDI since v1 and has just been consolidated into this new data class.

This is a step in the right direction in terms of collecting data around additional areas like disability, but it's only a start. Many of these data elements are nebulous without any clear requirements or standardization (some do require use of a specific code

set), meaning that data can be compliant with USCDI v3 draft without being readily exchanged or being meaningful when it arrives at a destination other than its origin.

Additions to Patient Demographics Data Class

The following data elements have been added to the existing Patient Demographics data class:

- Date of Death: the freeform date of a deceased patient's death
- Tribal Affiliation: the freeform name of any tribal affiliation of the patient
- Related Person's Name: freeform name of a related person not directly considered a caregiver for the patient
- Related Person's Relationship: freeform description of relationship
- Occupation: chosen from a CDC value set on occupation
- Occupation Category: chosen from a CDC value set on occupation category

We believe that multiple sets of Related Person should be supported. Further, we feel that several of these elements should have associated formatting or value sets to help standardize the data. In particular, there should be standard date, time, and datetime formats across all of the data used for the Date of Death element. Also, the Tribal Affiliation element should use a standardized (extensible) value set.

There has been some discussion that the Related Person data elements could be used to construct family history health information by indicating which patient records to use to compile the information. However, we question its effectiveness for this purpose. First of all, it is unlikely all of the pertinent relatives, past and present, have entries in the same EHR system or even across the same set of exchange partners. Further, even if they do, privacy and consent requirements should limit how much information one patient is allowed to see about another patient even if they are related to each other. Automatically pulling data from one patient record to another to generate a family history, even one with holes for unknown or missing family members, does not seem reasonable to us.

Additions to Procedures and Laboratory Data Classes

The following data elements have been added to the existing Procedures and Laboratory data classes:

- Reason for Referral (Procedures): freeform explanation or justification for why the service was requested or performed
- Specimen Type (Laboratory): freeform indication of the bodily fluid (blood, urine, etc.) composing the specimen or type of medium (nasopharyngeal swab, wound swab, etc.) containing the specimen.
- Result Status (Laboratory): freeform indication of the completeness of a laboratory result

We think at least the referral reason and result status should probably have (extensible) value sets and the specimen type examples as listed likely should explicitly include solid matter types like cysts, polyps, and tumors to make it clear they're allowed/expected to be included.

USCDI v2 and the ONC Standards Version Advancement Process

The ONC has adopted an annual Standards Version Advancement Process or SVAP to voluntarily allow certified health IT developers to use more recent versions of certain standards than mandated in regulations. At recent public events including part 1 of the ONC Annual Meeting and the WEDI Spotlight on Health Equity ONC personnel have indicated USCDI v2 is likely to be part of the 2022 SVAP process.

USCDI v2 and US Core

A version of US Core that's compatible with USCDI v2 is under development (and nearly complete). It's publicly available if you make an effort to find it (the default US Core resources, Implementation Guide, and other information remains set on the version compatible with USCDI v1) and it includes quite a lot of changes and additions. Presumably it will become the de facto standard at the same time that USCDI v2 becomes the de facto standard.

Implications of SVAP for USCDI

As noted above, SVAP results in permission to voluntarily upgrade to a newer version of a standard that's part of ONC certification. It does not require anyone to upgrade, nor does it adjust or change versions of that standard required for any other regulations from ONC, CMS, or any other regulatory body. Thus, even if USCDI v2 is accepted into the 2022 SVAP and certified health IT developers are given permission to optionally support it, the following still remain true:

1. Information blocking rules apply to information contained in USCDI v1 until October 6, 2022 when they apply to all EHI whether or not ONC supports certifying to USCDI v2 before October 6. The requirement will not jump from USCDI v1 => USCDI v2 => EHI. This was explicitly confirmed by National Coordinator Micky Tripathi in our recent [Forum discussion](#).
2. All CMS regulations that require the use of USCDI will continue to require the use of USCDI v1 unless or until new regulations updating their version are published. This includes both Patient Access APIs and Payer to Payer data exchange. This was explicitly confirmed during part 1 of the ONC Annual Meeting.
3. It is unclear how US Core will handle having two versions of USCDI accepted for public use simultaneously rather than having a direct, serial upgrade process. Presumably the majority of folks will remain on USCDI v1 and thus the current version of US Core should remain the default version until such

time as regulations start requiring use of USCDI v2, but none of this has been determined yet so far as we can tell. In addition, there are many other Implementation Guides that are built on top of US Core and some of them may choose to move to the US Core version corresponding to USCDI v2 sooner than others do.

4. It will be important to ensure that trading partners are using the same version of USCDI as each other for the foreseeable future once two different versions are supported simultaneously. In particular, as providers start exchanging data via FHIR and using US Core, it's possible some of their EHRs or other certified health IT might start using USCDI v2 and its corresponding version of US Core before others do or before all exchange partners are ready to use it.

It is unclear exactly how this will work - perhaps EHRs will support both versions and present an option for how to connect with each exchange partner - but ensuring both partners are using the same version of US Core will be as much of a requirement as ensuring that both partners aren't just using FHIR but are using the same version of FHIR (of course, the regulations all explicitly require r4.0.1 so once all of the interoperability regulations are in place this should, in theory, no longer be an issue. In theory.). So, too, will be ensuring that all of the Implementation Guides used between two exchange partners expect or are built on top of the same version of US Core.

It will be interesting to see how this all works.

Wrapping Up

As you can see, ONC is moving forward on its promise to produce annual updates to USCDI with draft versions released in January and final versions released in July. We think that USCDI v3 draft has several improvements and steps forward, but that it still needs some work and some additional details need to be ironed out prior to finalizing it this July. We also note that USCDI v2 draft and the final USCDI v2 had significant changes beyond just consistency checks and clarifications of meaning and use - it had quite a few new elements that weren't in the draft version. We don't know if that will happen again, but it's definitely possible.

ONC is also seriously considering allowing optional certification against USCDI v2 instead of USCDI v1 using the SVAP process during 2022 (probably in the fall). If this happens, there may be inconsistencies in the versions being used, the need to confirm that all FHIR exchanges are based on the same version of US Core (or IGs that use US Core as its baseline starting point for resources), and some additional confusion and complexity unless or until everyone is using the same version again in the future (which would require additional regulation).

Welcome to the Wild West.

Women's History Month

March is Women's History Month, but did you know it's also Brain Injury Awareness month, Hemophilia Awareness Month, and Multiple Sclerosis Awareness month? Women are less likely than men to be hemophiliacs because they need the gene in both of their X chromosomes, but they're more likely to suffer from MS than men (and, of course, anyone can suffer from a brain injury, although recent research shows some indication that brain injuries may affect women differently than men). Here are some resources to help you learn more:

- [CDC page on Hemophilia in Women](#)
- [Johns Hopkins on why women are more prone to MS than men](#)
- [Nature article on the effects of sports concussions on women](#)
- Center for the Advancement of Women in Science and Medicine's Gender Equity events:
 - [Part 1 on Mar 1 at 12pm](#)
 - [Part 2 on Mar 31 at 12pm](#)

Have a favorite article or event of your own? Let us know at newsletter@mahealthdata.org.

Wrapping Up

Before we go, here's a reminder of upcoming health data exchange deadlines including those from ONC and CMS (including the CMS rule that's currently frozen, as noted by *):

2022

JAN 1

- PAYER → PAYER EXCHANGE (OFFICIAL)
NO SURPRISES ACT (NSA) ENFORCEMENT BEGINS
- EMERGENCY SERVICES CLAUSES
 - RULES AND PAYMENT MODELS FOR OUT-OF-NETWORK PROVIDERS AT IN-NETWORK FACILITIES
 - PATIENT CONSENT REQUIREMENTS FOR SIGNING AWAY OUT-OF-NETWORK PROTECTIONS FOR NON-EMERGENCY SERVICES
 - GOOD FAITH ESTIMATES FOR UNINSURED/SELF-PAY PATIENTS COVERING A SINGLE PROVIDER/FACILITY
 - DISPUTE RESOLUTION FOR UNINSURED/SELF-PAY PATIENTS
 - EXTERNAL REVIEW ELIGIBILITY
 - GAG CLAUSE PROHIBITION
 - COORDINATION OF CARE CLAUSES (GOOD FAITH EFFORT)
 - INSURANCE ID CARDS (GOOD FAITH EFFORT)
 - PROVIDER DIRECTORY (GOOD FAITH EFFORT)
 - DISCLOSURES, EDUCATION, NOTIFICATIONS, AND PROMOTION (GOOD FAITH EFFORT)

CURRENT

APR 1

INCREASING THE FREQUENCY OF FEDERAL-STATE DATA EXCHANGE (OFFICIAL)

JUL 1

INCREASING THE FREQUENCY OF FEDERAL-STATE DATA EXCHANGE (ENFORCED)

OCT 6

INFORMATION BLOCKING USES EHI (NO LONGER LIMITED TO USCDI)

DEC 27

NSA: REPORTING REQUIREMENTS FOR PLAN AND PHARMACY DATA (ENFORCED)

DEC 31

PROVIDER FHIR APIS

2023

JAN 1

NSA: CONSOLIDATED GOOD FAITH ESTIMATES FOR UNINSURED/SELF-PAY CONTAINING ALL PROVIDERS/FACILITIES FOR A SINGLE SERVICE

DEC 31

FULL EHI EXPORT SUPPORT

TBD

NSA: ESTIMATE AND DISPUTE CLAUSES FOR INSURED PATIENTS
PAYER → PAYER EXCHANGE (ENFORCED)
ELECTRONIC PRIOR AUTHORIZATION *
PAYER → PROVIDER APIS *
PAYER → PAYER EXCHANGE OVER FHIR *
PRIOR AUTHORIZATION FEATURES IN EXISTING EXCHANGES *

* CMS RULE THAT'S CURRENTLY FROZEN

And that's it, folks. Loved it? Hated it? Have an idea for next time? Send us feedback and suggestions about this newsletter at newsletter@mahealthdata.org or send us feedback and suggestions about anything else at info@mahealthdata.org.

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