Stage 1 Business Analysis

California Department of Technology, SIMM 19A.3 (Ver. 3.0.9, 02/01/2022)

1.1 General Information

1. **Agency or State entity Name:** 4260 - Health Care Services, Department of

   If Agency/State entity is not in the list, enter here with the organization code.

   N/A.

2. **Proposal Name and Acronym:** Advancing Interoperability and Prior Authorizations Project

3. **Proposal Description: (Provide a brief description of your proposal in 500 characters or less.)**

   - **42**

4. **Proposed Project Execution Start Date:** 7/1/2025

5. **S1BA Version Number:** Version 1

1.2 Submittal Information

1.3 Business Sponsorship

1. **Executive Champion (Sponsor)**

   Title: Deputy Director, Chief Data Officer

   Name: Linette T. Scott, MD, MPH

   Business Program Area: Enterprise Data and Information Management

   Title: Assistant Deputy Director

   Name: Michael Freeman

   Business Program Area: Health Care Benefits and Eligibility

2. **Business Owner**

   Title: Assistant Deputy Director

   Name**:** Philip Heinrich

   Business Program Area: Enterprise Data and Information Management

3. **Product Owner**

   Title: Chief, Health Information Management Division

   Name: Elison Alcovendaz

   Business Program Area: Enterprise Data and Information Management

TIP: Copy and paste or click the + button in the lower right corner on any section to add additional Executive Champions, Business Owners, or Product Owners with their related Business Program Areas as needed.

1.4 Stakeholder Assessment

The Stakeholder Assessment is designed to give the project team an overview of communication channels that the state entity needs to manage throughout the project. More stakeholders may result in increased complexity to a project.

1. **Indicate which of the following are interested in this proposal and/or the outcome of the project. (Select 'Yes' or 'No' for each.)**

   State Entity Only: No

   Other Departments/State Entities: Yes

   Public: Yes

   Federal Entities: Yes

   Governor's Office: No

   Legislature: No

   Media: No

   Local Entities: Yes

   Special Interest Groups:

   Other: Yes

2. **Describe how each group marked 'Yes' will be involved in the planning process.**

- **Other Departments/State Entities:** DHCS will work collaboratively with the California Health and Human Services Agency (CalHHS) to ensure that implemented data exchange standards and technology align with and support broader efforts at the state level.
- **Federal Entities**: DHCS will seek enhanced federal funding through the Advanced Planning Document (APD) process. DHCS will work with CMS when submitting the APD to secure planning and implementation dollars.
- **Local Entities**: Providers and county administrators will be impacted by replacing existing disparate prior authorization systems and processes. DHCS will engage with county administrators and providers throughout the project lifecycle, including during the discovery phase, to better understand the prior authorization ecosystem and potential impacts for implementing a new service; during implementation, to ensure effective and efficient organizational change management of policies and procedures.
- **Special Interest Groups**: DHCS will engage and inform key stakeholders, advocacy organizations, and provider, plan, and county associations on the intent, impacts, and expected outcomes of this project. The groups will assist DHCS in identifying and providing insight on potential impacts to Medi-Cal members, providers, managed care plans, and counties. DHCS will also engage with Medi-Cal managed care plans and their associations on policy and system requirements pertaining to implementation of the APIs.
- **Other**: Inform entities that develop Electronic Health Record systems of opportunities in connecting with DHCS and enabling prior authorization workflows to be in a more automated state to reduce paperwork and ensure data integrity. Align roadmaps with these entities to facilitate early adoption and utilization of the APIs.

1.5 Business Program

1. **Business Program Name:** DHCS Interoperability
2. **Program Background and Context:** (Provide a brief overview of the entity's business program(s) current operations.)

   The provisions in the CMS Advancing Interoperability and Improving Prior Authorization Processes final rule build on the infrastructure, technology, and policies of prior CMS interoperability regulations, while focusing on improving provider and payer access to member health information and reducing the burden of prior authorization transactions. Achieving compliance with the API and reporting requirements of the CMS Advancing Interoperability and Improving Prior Authorization Processes final rule, will require direct support from the following programs/areas within DHCS:

   - **Program Operations (PO)** supports several key systems used for operating Medi-Cal and is responsible for Treatment Authorization Request (TAR) adjudication. The new standards and specifications mandated by the CMS prior authorization API and reporting requirements will impact the systems, policies, and processes managed/maintained by PO

in support of treatment authorization request transactions. PO will work closely with other programs/areas to achieve compliance with the CMS prior authorization requirements by overseeing changes to existing systems, policies, and processes associated with Treatment Authorizations.

- **Health Care Benefits and Eligibility (HCBE)** provides leadership for benefits and eligibility policy planning, development, implementation, and evaluation of covered health care services and delivery systems under Medi-Cal and the Children's Health Insurance Program (CHIP). HCBE oversees the uniform application of federal and state laws and regulations regarding Medi-Cal and CHIP covered services and policies. The HCBE divisions will work closely with others to achieve compliance with the CMS interoperability regulations including supporting the design, development, and implementation activities for the three APIs; overseeing change management and contractual compliance for Fiscal Intermediaries (FI) and Business Operations vendors; identifying and facilitating policy, process, and required changes with integrated systems to support data exchange and interoperability.
- **Health Care Delivery Systems (HCDS)** develops, implements, and monitors health care delivery to Medi-Cal members through managed care and the Integrated Systems of Care divisions. HCDS provides policy, program, and operations support for systems, policy and oversight of Medi-Cal managed care health plans, Program of All-Inclusive Care for the Elderly (PACE) Organizations, Fee-For-Service (FFS) providers, contracted private organizations that administer Home and Community Based Services (HCBS) waivers at the local level, and the California Children Services (CCS) County health jurisdiction entities. HCDS is also responsible for adjudicating service and treatment authorizations from CCS and HCBS FFS providers. The new standards and specifications mandated by the CMS prior authorization API and reporting requirements will impact the multiple systems, policies, and processes managed by ISCD in support of the processing of service and treatment authorizations. HCDS will work with others from the department to address any policy or process changes necessary to achieve compliance with the API provisions of the CMS Advancing Interoperability and Improving Prior Authorization Processes final rule.
- **Enterprise Data and Information Management (EDIM)** partners with DHCS programs to meet data and information needs, including data architecture, modeling, and design; data analysis and reporting; data fulfillment and publishing; data governance; data exchange and integration support; and business intelligence services. EDIM plays a vital role in Medi-Cal's participation in national health information technology interoperability initiatives, e.g., guiding enterprise adoption of standards and participating in CMS Systems and Technologies Advisory Interoperability Workgroup. EDIM will manage data exchange planning and implementation efforts; facilitate the adoption and promotion of standards and specifications; oversee and manage data quality strategy and reporting; and update policies, procedures, and agreements regarding data exchange and interoperability.
- **Enterprise Technology Services (ETS)** manages department-wide information technology (IT), including IT strategic direction, enterprise architecture, IT governance, portfolio and project management, IT application and infrastructure operations, and

modernization of DHCS' Medi-Cal Enterprise System. ETS will be responsible for providing project management for all activities at an enterprise level to achieve compliance with the CMS API and reporting requirements. ETS will oversee all planning, design, and oversight of technology architecture needed to support complex information exchange and health information access for patients, providers, and payers in accordance with interoperability standards. ETS will oversee all technical teams responsible for architecting, building, deploying, managing, and maintaining the APIs, data architectures, and supporting systems.

3. **How will this proposed project impact the product or services supported by the state entity?**

   - The CMS Advancing Interoperability and Improving Prior Authorization Processes final rule requires implementing and maintaining the Payer-to-Payer API and Provider Access API, for purposes of streamlining exchange of member data with payers and providers. These services are not currently available for payers or providers today. DHCS will leverage existing API technology and software to implement and maintain these two APIs. Upon implementation of the APIs, providers and payers (including DHCS) will be able to request member data on demand and integrate efficiently into their own systems to build a more comprehensive member health record.
   - Additionally, the CMS final rule requires the implementation of a FHIR-based Prior Authorization API to automate the end-to-end prior authorization lifecycle from within the providers' electronic health record system. This service is not currently available today. Upon implementation of the Prior Authorization API, providers will be able to search for services and/or items requiring prior authorization, identify documents required, submit the request package (including the documentation), and inquire on the status of the request; all from within the provider's native electronic health record system. In today's environment, providers must refer to electronic manuals and contracts to determine which services and/or items require authorization and the documentation necessary for approval. There are multiple systems, standards, and specifications used for receiving and processing authorizations depending on the services and/or items being requested. Additionally, there are downstream systems that ingest prior authorization data, these systems may be impacted with the adoption of new standards and specifications and may require updates to accommodate for these changes.

TIP: Copy and paste or click the + button in the lower right corner to add Business Programs, with background and context and impact descriptions as needed.

1.6 Project Justification

1. **Strategic Business Alignment**

   Enterprise Architect

Title: Enterprise Strategy & Services Branch / Senior Enterprise Architect

Name: Ioana Alcouffe

Strategic Plan Last Updated? 8/11/2023

Strategic Business Goal: DHCS Strategic Goal 1 - Be Person-Centered

Alignment: Implementing the Payer-to-Payer and Provider Access APIs and enhancing the Patient Access API ensures that members and providers have the right information at the right time, in the right setting, to make informed decisions about care and treatment through shared decision-making.

Strategic Business Goal: DHCS Strategic Goal 2 - Increase Meaningful Access

Alignment: Implementing the Prior Authorization API and centralizing Prior Authorization transactions through an enterprise-level service will improve timely access to services and/or products across delivery systems by streamlining standards, specifications, policies, and procedures associated with prior authorization requests.

Strategic Business Goal: DHCS Strategic Goal 3 - Achieve Excellence in Health Outcomes

Alignment: Implementing the new standards and specifications required by the CMS final rule will enable data exchange for populations, supporting DHCS' objective of implementing and sustaining population health management capabilities using analytics.

Strategic Business Goal: DHCS Strategic Goal 5 - Strengthen Operations

Alignment: Implementing the Prior Authorization API and centralizing Prior Authorization transactions through an enterprise-level service will streamline department systems maintenance, processes, and policy oversight regarding prior authorization transactions. The Prior Authorization API will support the automation of complex business procedures using modern technology and industry-adopted standards and specifications, overall reducing the burden on the department, providers, and patients to seek services and items requiring authorizations.

Strategic Business Goal: DHCS Strategic Goal 6 - Leverage Data to Improve Outcomes

Alignment: Implementing the Payer-to-Payer and Provider Access APIs, required by the CMS final rule, will enable more seamless data exchange between the department and other entities. Streamlined health information exchange will enable DHCS to leverage data to drive better decisions and improve transparency and accountability.

TIP: Copy and paste or click the + button in the lower right corner to add Strategic Business Goals and Alignments as needed.

Mandate(s): Federal

Bill Number/Code, if applicable: Centers for Medicare and Medicaid Services Advancing Interoperability and Improving Prior Authorization Processes final rule (CMS-0057-F).

Add the Bill language that includes system-relevant requirements:

Provider Access API: Impacted payers must implement and maintain a Provider Access API consistent with the technical standards finalized in the CMS Interoperability and Patient Access final rule (85 FR 25558), including the HL7 FHIR Release 4.0.1 standard. Providers can use the API to access current patient data from payers, including adjudicated claims and encounter data (excluding provider remittances and patient cost-sharing information), all data classes and data elements included in a content standard at 45 CFR 170.213 (USCDI), and prior authorization information. **https://www.federalregister.gov/d/2024-00895/p-39**; 42 CFR 431.61(a).

Payer-to-Payer API: Impacted payers must implement and maintain a Payer-to-Payer API to exchange patient data when a patient moves between payers to ensure continued access to their health data and support continuity of care between payers. Specifically, the Payer-to-Payer data exchange will include adjudicated claims and encounter data (excluding provider remittances and patient cost-sharing information), all data classes and data elements included in a content standard at 45 CFR 170.213 (USCDI), and certain information about the patient's prior authorizations. Impacted payers will be required to request data from a patient's previous payer, with the patient's permission, no later than one week from the start of coverage or at the patient's request. Impacted payers will then be required to integrate any data they receive in response to that request into the patient's record, which could facilitate care continuity as patients move between payers. **https://www.federalregister.gov/d/2024-00895/p-40**; 42 CFR 431.61(b).

Prior Authorization API: Impacted payers to implement and maintain a Prior Authorization API. Providers can use the Prior Authorization API to determine whether a specific payer requires prior authorization for a certain item or service, thereby easing one of the major points of administrative burden in the existing prior authorization process. The Prior Authorization API will also allow providers to query the payer's prior authorization documentation requirements directly from the provider's system, which could facilitate the automated compilation of necessary information to submit a prior authorization request. **https://www.federalregister.gov/d/2024-00895/p-42**; 42 CFR 431.80(b).

Updates to existing API Standards and Specifications: Impacted Payers must adopt updated standards and specifications, including **https://www.federalregister.gov/d/2024-00895/p-45**, 42 CFR 431.60(c)(4)(ii)(B)

- HL7® FHIR® US Core Implementation Guide (IG) version 6.1.0.
- HL7® SMART Application Launch Framework IG Release 2.0.0.
- FHIR® Bulk Data Access (Flat FHIR) IG v1.0.0.

Metrics Reporting: Impacted payers must annually report to CMS certain metrics about patient data requests made via the Patient Access API. **https://www.federalregister.gov/d/2024-00895/p-38**; 42 CFR 431.60(f). Additionally,

impacted payers must publicly report certain metrics about their prior authorization processes, which will enhance transparency **https://www.federalregister.gov/d/2024-00895/p-43**; 42 CFR 440.230(e)(3).

TIP: Copy and paste or click the + button in the lower right corner to add Bill Numbers/Codes and relevant language as needed.

2. **Business Driver(s)**

Financial Benefit: No

Increased Revenue: No

Cost Savings: No

Cost Avoidance: Yes

Cost Recovery: No

Will the state incur a financial penalty or sanction if this proposal is not implemented? Yes

If the answer to the above question is "Yes," please explain:

Federal regulatory compliance is necessary to avoid potential loss in enhanced CMS federal funding.

Improvement

Better Services to the People of California: Yes

Efficiencies to Program Operations: Yes

Improved Equity, Diversity, and/or Inclusivity: No

Improved Health and/or Human Safety: No

Improved Information Security: No

Improved Business Continuity: No

Improved Technology Recovery: No

Technology Refresh: No

Technology End of Life: No

1.7 Business Outcomes Desired

Executive Summary of the Business Problem or Opportunity:

As the single state agency responsible for administering Medi-Cal and CHIP in California, DHCS must comply with enacted federal interoperability regulations, including but not limited to, the CMS

Advancing Interoperability and Improving Prior Authorization Processes final rule. The primary goal of this effort is to bring DHCS into compliance with the CMS final rule, in doing so, the following gains shall be made by the Department.

- **Avoid a loss in Enhanced Federal Funding –** To avoid a loss in Enhanced Federal Funding, DHCS must achieve compliance with federal interoperability regulations. Enhanced Federal Funding provides reimbursement of up to 90 percent. If DHCS fails to achieve compliance with interoperability regulations, it may be subject to a reduction of the 90 percent reimbursement to 50 percent until corrective action plans are satisfied. By implementing the required technology, within the timeline approved by CMS, DHCS will avoid a loss of Enhanced Federal Funding.
- **Improve shared decision-making between members, providers, and payers –** Shared decision-making is crucial in a person-centered delivery model, emphasizing collaboration among members, payers, and healthcare providers to empower members, improve health outcomes, and reduce health disparities. Shared decision-making necessitates accessible, comprehensive, up-to-date, and accurate electronic health information for members, providers, and payers. Implementing Payer-to-Payer and Provider Access APIs, aligned with the CMS standards and specifications, will streamline information sharing across disparate technology systems. This will reduce administrative burdens and create an environment conducive to shared decision-making, thereby enhancing care, and promoting healthier populations.
- **Improve timely access to care –** Timely access to care is crucial for promptly addressing health issues or concerns. Delays can lead to worsened conditions/complications, increased costs, dissatisfaction and distrust with healthcare providers and payers, and added stress, and burden for members and providers alike. Implementing the Prior Authorization API, following CMS standards and specifications, automates and standardizes the prior authorization process. This reduces administrative delays, speeds up necessary care approvals, and enables real-time communication for providers to address issues promptly. Improving efficiency and transparency in prior authorization promotes earlier intervention, enhances emotional well-being, ensures better continuity of care, and increases trust, satisfaction, and patient empowerment while lowering complications and costs.

While implementing the FHIR APIs holds anticipated business value, DHCS acknowledges that the actual value realized depends entirely on their adoption and use due to factors beyond DHCS' control, as such, DHCS will be recommending "Structural" and "Policy" metrics as defined below:

Objective ID: 1

Objective: Avoid a loss in enhanced federal funding due to noncompliance with the Final Rule, by achieving compliance.

Metric: (Policy) Loss of enhanced federal funding avoided by complying with the Final Rule.

Baseline: DHCS has lost $0 dollars in related federal funding due to non-compliance with the Final Rule. DHCS is not currently compliant with the federally mandated dates outlined in the Final Rule.

Target Result: There shall be no loss in enhanced federal funding due to noncompliance with the CMS final rule.

Objective ID: 2

Objective: Improve shared decision-making and access to care between members, payers, and providers by streamlining data exchange across third party health technology systems using FHIR APIs.

Metric: (Structural) Implement the Prior Authorization API, Payer-to-Payer API, and the Provider Access API, in accordance with the CMS Advancing Interoperability and Improving Prior Authorization Processes final rule (CMS-0057-F).

Baseline: The Prior Authorization API, Provider Access API, and Payer-to-Payer API do not exist today.

Target Result: Providers and Payers can access health information maintained by the department and request/respond to prior authorization transactions, using third-party applications of their choice, via DHCS' FHIR APIs..

TIP: Copy and paste or click the + button in the lower right corner to add Objectives as needed. Please number for reference.

TIP: Objectives should identify WHAT needs to be achieved or solved. Each objective should identify HOW the problem statement can be solved and must have a target result that is specific, measurable, attainable, realistic, and time-bound. Objective must cover the specific. Metric and Baseline must detail how the objective is measurable. Target Result needs to support the attainable, realistic, and time-bound requirements.

1.8 Project Management

1. **Project Management Risk Score:** 0.3

   (Attach a completed Statewide Information Management Manual (SIMM) Section 45 Appendix A Project Management Risk Assessment Template to the email submission.)

2. **Project Approval Lifecycle Completion and Project Execution Capacity Assessment**

   Does the proposal development or project execution anticipate sharing resources (state staff, vendors, consultants, or financial) with other priorities within the Agency/state entity (projects, PALs, or programmatic/technology workload)?

   Answer: Yes

   Does the Agency/state entity anticipate this proposal will result in the creation of new business processes or changes to existing business processes?

Answer (No, New, Existing, or Both)**:** Existing Processes

1.9 Initial Complexity Assessment

1. **Business Complexity Score:** 1.5

   (Attach a completed SIMM Section 45 Appendix C to the email submission.)

2. **Noncompliance Issues:** (Indicate if your current operations include noncompliance issues and provide a narrative explaining how the business process is noncompliant.)

   Programmatic regulations: Yes

   HIPAA/CIIS/FTI/PII/PCI: Yes

   Security: No

   ADA: No

   Other: No

   Not Applicable: No

   Noncompliance Description:

   Programmatic Regulations - This effort will support DHCS compliance with the CMS Advancing Interoperability and Improving Prior Authorization Processes final rule. As the State Medicaid Agency, DHCS is specifically named as an entity required to comply.

   Reference to the final rule in question is listed below:

   https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability#h-10

   HIPAA – This effort will support DHCS' path to compliance with the HIPAA Administrative Simplification requirements for prior authorization transactions. Currently, there are DHCS delivery systems that do not support HIPAA requirements for prior authorization. Implementation of the CMS FHIR-based Prior Authorization API will help address these issues.

3. **Additional Assessment Criteria**

   If there is an existing Privacy Threshold Assessment/Privacy Information Assessment, include it as an attachment to your email submission.

   How many locations and total users is the project anticipated to affect?

   Number of locations: The adoption of prior authorization transaction standards and specifications outlined in the CMS final rule has the potential to impact all providers that must submit a prior authorization request to DHCS for processing.

   Estimated Number of Transactions/Business Events (per cycle): Currently unknown.

Approximate number of internal end-users: NA.

Approximate number of external end-users: NA.

1.10 Funding

Planning

1. Does the Agency/state entity anticipate requesting additional resources through a budget action to ***complete planning*** through the project approval lifecycle framework? Yes

   If Yes, when will a budget action be submitted to your Agency/DOF for planning dollars?

   8/5/2024

2. Please provide the Funding Source(s) and dates funds for planning will be made available:

   Click or tap here to enter text.

Project Implementation Funding

1. Has the funding source(s) been identified for ***project implementation***? Yes

   If known, please provide the Funding Source(s) and dates funds for implementation will be made available:

   DHCS will seek 90/10 FFP through an Implementation Advance Planning Document (IAPD) with CMS. DHCS has a state Budget Change Proposal request for State Fiscal Year 2025-26.

   Will a budget action be submitted to your Agency/DOF? Yes

   If "Yes" is selected, specify when this BCP will be submitted: Budget Change Proposal State Fiscal Year 2025-26.

2. Please provide a rough order of magnitude (ROM) estimate as to the total cost of the project: **Choose an item.**

End of agency/state entity document.

Please ensure ADA compliance before submitting this document to CDT.

When ready, submit Stage 1 and all attachments in an email to ProjectOversight@state.ca.gov.

Department of Technology Use Only

Original “New Submission” Date: **9/6/2024**

Form Received Date: **9/6/2024**

Form Accepted Date: **9/6/2024**

Form Status: **Completed**

Form Status Date: **9/6/2024**

Form Disposition: **Approved**

If Other, specify: Click or tap here to enter text.

Form Disposition Date: Click or tap to enter a date.

Department of Technology Project Number (0000-000): **4260-251**