Nevada Department of
Health and Human Services
PATIENT PROTECTION COMMISSION

Patient Health Records Plan

As required by Nevada Revised Statutes (NRS) 439.918.1.(c)

December 2022

Steve Sisolak
Governor

Richard Whitley, MS
Director

Dr. Ikram Khan
Commission Chairman

Malinda Southard, DC
Executive Director

Nevada Department of Health and Human Services (DHHS)
Patient Protection Commission

Patient Health Records Plan

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Patient Protection Commission
Mission, Vision, and Values

"The Commission is designed to provide a forum for all stakeholders to come to the table and work together on the critical task of improving health care access and affordability in Nevada."

-Governor Steve Sisolak

Signed by: ________________________________ ________________

Dr. Ikram Khan
Commission Chairman
Date

Signed by: ________________________________ ________________

Malinda Southard, DC, CPM
Executive Director
Date

Signed by: ________________________________ ________________

Kiley Danner, MPH
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Date

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Table of Contents

Document Control Sheet

Name of Plan: Patient Health Records Plan

Per Nevada Revised Statutes (NRS) 439.918.1.(c); this Plan shall be ***updated annually*** *with new information and updates as appropriate to all Sections in this Plan.*

Date:	Action Taken (Plan review or update, etc.):	PPC Staff Leading Action Taken:
12/9/2022	Plan developed and submitted for feedback from Commission and the public.	Kiley Danner
12/21/22	Plan agendized for Patient Protection Commission approval.	Malinda Southard

Section I - Introduction

Commission Introduction

The Patient Protection Commission (PPC) was created in 2019 through Senate Bill (SB) 544 sponsored by Governor Steve Sisolak and approved by the Nevada State Legislature. The PPC was codified to Nevada Revised Statutes (NRS) Chapter 439. The PPC was developed to systematically review issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care.

Assembly Bill (AB) 348, approved during the 2021 Legislative Session, moved the PPC from the Governor's Office to the Department of Health and Human Services (DHHS) and designated the Commission as the sole state agency responsible for administering Nevada's participation in the Peterson-Milbank Program for Sustainable Health Care Costs. It is through this program that the PPC is leading the charge for development and implementation of Nevada's health care cost growth benchmark, aimed at curbing the climbing cost of health care in the state.

Since early 2021, the PPC has successfully led implementation of the health care cost growth benchmark program in Nevada and is initiating collection and public reporting of performance against the benchmark to help advance health care affordability in the state, now as 2023 approaches. The PPC offers a unique opportunity for Nevada to hear from both industry and patient stakeholders, as they come to the table and work together on the critical task of improving health care quality, access and affordability in Nevada.

Commission Members

The Commission's membership includes seats as described in NRS 439.908, and a list of current membership may be found here on the PPC's website. All PPC members are appointed by the Governor. Additionally, the Director of DHHS, the Commissioner of Insurance, the Executive Director of the Silver State Health Insurance Exchange and the Executive Officer of the Public Employees' Benefits Program all serve as ex officio, nonvoting members.

Plan Purpose and Scope

AB 348 as passed during the 2021 Legislative Session (NRS 439.918.1) paragraphs (c) and (d) mandates the Commission shall:

Establish, submit to the Director and annually update a plan to increase access by patients to their medical records and provide for the interoperability of medical records between providers of health care in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any other applicable federal law or regulations.

Make recommendations to the Director and the Legislature concerning: the analysis and use of data to improve access to and the quality of health care in this State, including, without limitation, using data to establish priorities for addressing health care needs; and ensuring that data concerning health care in this State is publicly available and transparent.

The intent of the Patient Health Records Plan is to be a public document including helpful resources to the community to improve patient access to their medical health care records, including improving access electronically, and a resource to health care providers regarding health record interoperability requirements and resources. Finally, it is meant as a platform to make recommendations to the Director of the Department of Health and Human Services and the Nevada Legislature concerning the analysis and use of data to improve access to and the quality of health care, establishing priorities for addressing health care needs, and ensuring health care data transparency.

Section II – Increase Access by Patients to Medical Records

Patient Education

Talking to Your Doctor

You may ask your health care provider about their specific procedures for obtaining your medical record or find information in their *notice of privacy practices*. Oftentimes, they will have a specific form you must fill out to request your medical record. If they do not have a form for requesting your medical record, you should check to see what information they require. Generally, your request for your health care records should include:

- The date of your request
- Your name, address, and telephone number or other contact information
- Any previous name you may have used (such as maiden name)
- Your date of birth
- Date(s) of treatment or service
- A description of the information you would like to see or receive a copy of:
  - Which part of the medical record you want, or the entire record
  - Medical condition you are asking for information about
  - Specific test results
  - Which medical devices you want a record of such as heart monitor or X-rays
- Whether you want to see your medical record, receive a copy for your records, or both
- If you are requesting a medical record for someone else as their personal representative, include your name and relationship to the patient

Note: Your health care provider may require you to include your Social Security number in your request. Some health care providers use Social Security numbers to identify medical records and may need it to locate your medical record. Currently, there is nothing prohibiting private health care providers from requiring this in the HIPAA Privacy Rule or Social Security Act.

Right to Amend (Correct) Your Medical Record

If you read your medical record and something is not accurate or is missing, you have the right to have information *added* to make it accurate or more complete. Your health care provider may accept or deny your request to amend your medical record. If they accept, they must add the information to your record. If they deny, they must tell you. You then have the right to add a short statement to your record that explains your position.

Note: You do not have the right to have information removed or altered from your medical record.

Complaints

If you feel that your rights have been violated, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. (Ref. 1.)

Access to Doctor Visit Notes

As of April 2021, federal law requires U.S. healthcare organizations to provide patients with access to their electronic health records, including outpatient visit notes. Previous studies have shown that patients who read their visit notes report feeling more in control of their care, remembering their care plan better and trusting their clinicians more. Patients with a single chronic condition, such as diabetes, report that they better understand their medications and potential side effects.

In a paper published in the *Journal of the American Geriatrics Society*, clinician-researchers at Beth Israel Deaconess Medical Center (BIDMC) in Boston, Massachusetts, examined survey data to assess how patients with multiple chronic conditions perceived the benefits and risks of the increased transparency offered by open visit notes. The cross-sectional study examined patients' self-reported experiences from three healthcare organizations with up to seven years of experience offering patients access to their notes through online patient portals.

"Managing multiple chronic conditions and juggling various medications can be a time-consuming and frustrating experience for older patients and their care partners," said corresponding author Catherine M. DesRoches, DrPH, executive director of OpenNotes* at BIDMC. "Findings from this study suggest that these patients and their care partners could receive important benefits from accessing their notes. Healthcare organizations should work to maximize patient engagement with this newly available health information both through patient portals and through other methods to ensure that patients and the healthcare systems reap the full benefit of this increased transparency."

DesRoches and colleagues invited more than 136,000 patients to participate in a survey via patient portals at three healthcare organizations in the United States: BIDMC in Massachusetts, University of Washington Medical Center in Washington State, and Geisinger Health System in Pennsylvania. More than 21 percent of patients responded. After the researchers excluded patients younger than 65, the analytic sample included 7,688 patients who had read at least one clinical note on the patient portal in the previous 12 months.

Fewer than five percent of older adults reported being more confused or worried after reading their notes. However, DesRoches acknowledges that figure may be misleading. Because of the self-selective nature of surveys, respondents were likely more technologically savvy and/or enthusiastic about outpatient notes than the average patient. Additionally, respondents were majority white and female, had at least a high school education, were retired, and English speakers, and the majority had no more than two chronic conditions.

"The overall lack of diversity among respondents limits our ability to draw inferences for minority, low income, or less educated patient populations who are already marginalized by the 'digital divide' in health care," said DesRoches. "Previous studies show that older patients are less likely to be offered information about patient portals, and when offered, they are less likely to register for and use them. Although access to online information offers promise to patients, health systems should strive to ensure that all older patients have access to appropriate information in a format that is most usable and useful for them." (Ref. 2.)

* *OpenNotes is based at the Beth Israel Deaconess Medical Center in Boston, Massachusetts a major Harvard Medical School teaching hospital. OpenNotes studies the effects of open and transparent communication on patients, care partners and clinicians. OpenNotes is not a product or software*.

Nevada Office of Consumer Health Assistance (OCHA)

The Office for Consumer Health Assistance (OCHA) assists health care consumers and injured workers understand their rights and responsibilities under their health insurance plans and/or workers' compensation insurance policies. OCHA informs and educates consumers who need a better understanding of employer group plans, managed care, individual health insurance policies, Employee Retirement Income Security Act (ERISA) self-insured plans, Nevada Workers' Compensation, Medicare or Medicaid and, when necessary, advocates on their behalf to resolve disputes. OCHA also provides resource information to the uninsured and under-insured for access to healthcare, prescription medication assistance programs. OCHA is located at 3320 W. Sahara Ave., Suite 100, Las Vegas, Nevada 89102; or may be reached by calling the Governor's Consumer Health Advocate at (702) 486-3587 or (888) 333-1597, or email at cha@govcha.nv.gov.

Aging and Disabled Population

General Resources

The Nevada Department of Health and Human Services Aging and Disability Services Division (ADSD) provides a multitude of programs and services for seniors, each listed below and hyperlinked to the related webpage for additional information.

- Adult Protective Services (APS)
- Aging and Disability Resource Centers - ADRC
- Communication Access Services (CAS)
- Community Advocates
- Community Options Program for the Elderly (COPE)
- Eldercare Toolkit For State Employees
- Home and Community Based Services Waiver for the Frail Elderly (FE)
- Homemaker Program
- Long Term Care Ombudsman
- Managed Care Expansion (MCE)
- Medicare Assistance Program (MAP)
- Personal Assistance Services (PAS)
- Home and Community Based Services (HCBS) Waiver for Person's with Physical Disabilities (PD)
- Senior Medicare Patrol (SMP)
- Senior Tax Assistance Program (STAR)
- State Health Insurance Assistance Program (SHIP)
- State Pharmacy Assistance Program (SPAP) - Senior Rx
- Taxi Assistance Program (TAP)

Nevada State Long Term Care Ombudsman Program

The Nevada State Long Term Care Ombudsman Program (LTCOP) is authorized by the federal Older American's Act. Federal law requires each state have a Long Term Care (LTC) Ombudsman Program managed by a State Long Term Care Ombudsman. The program was initiated to improve the quality of care in America's nursing homes.

LTC Ombudsmen receive complaints on behalf of residents who reside in LTC facilities. LTC facilities include homes for individual residential care, residential facilities for groups and nursing homes. LTC Ombudsmen conduct investigations with the resident's consent and attempt to resolve the complaints to the satisfaction of the resident. LTC Ombudsmen work with the resident to address their concerns using person centered advocacy. Services provided by the LTCOP are confidential. LTC Ombudsmen do not share the name of the individual who filed a complaint. Any resident living in LTC facilities is eligible for services.

In addition to resolving complaints, the LTC Ombudsmen conduct unannounced quarterly visits to LTC facilities throughout the state. The purpose of these visits is to speak with residents about the care they receive and to inform residents about services provided by the LTCOP. LTC Ombudsmen also inform LTC facility staff about the role of the LTC Ombudsman during visits. The LTCOP serves a vital public purpose, and the program provides assistance to thousands of long term care residents each year.

Ombudsman Services:

- Assist resident with concerns related to day-to-day care, health, safety, and personal preferences.
- Provide information to the community regarding long term care in Nevada;
- Provide education to residents, families, facility staff and others on a variety of issues related to aging, long term care and resident rights; and
- Provide in-service training for long term care professionals regarding trends and best practices to improve the

quality of care for residents

Who Can Make a Report to the Ombudsman Program?

- All residents of long-term care facilities;
- Friends and relatives of persons living in long term care facilities;
- Health care professionals; and
- Long term care facility staff members.

How to Make a Report to the Ombudsman Program?

To report concerns in long-term care facilities, please contact LTCOP Helpline at **1-888-282-1155** or complete the complaint form: **LTC Ombudsman Inquiry/Complaint Form**.

Note: The Aging and Disability Services Division's Adult Protective Services focuses on investigations regarding abuse, neglect, including self-neglect, isolation, exploitation and abandonment involving community members and those in a long term care setting for vulnerable persons, age 18-59, in addition to older persons 60 years and older.

The CARE Act

The Caregiver Advise, Record, Enable (CARE) Act is a Nevada law established in 2015 (now Nevada Revised Statutes (NRS) 449A.300-330) that prepares family caregivers for when a loved one returns home from the hospital. The law requires hospitals to:

1. Provide hospital patients the opportunity to designate a family caregiver.
2. Inform your caregiver when you are to be discharged to another facility or back home.
3. Provide an explanation and demonstration of any medical tasks your caregiver will need to perform at home such as managing medications or dressing wounds.

Tips to Ensure the CARE Act helps you while in the hospital

- Talk to the hospital staff (nurse or hospital social worker) caring for you or your loved one about the opportunity to designate a caregiver.
- If you have any concerns, ask about and reach out to departments within the hospital that are dedicated to addressing patient concerns, such as Patient Relations, Patient Advocate, Guest Relations, Ombudsman, or Customer Service.
- Be proactive in asking to set up a time for you or your caregiver to receive instructions and/or demonstrations from hospital staff about any aftercare that will need to be performed at home.

Complaints/Grievances

If you believe that you did not receive all the support provided by the CARE Act, you can file a complaint with the Nevada Bureau of Health Care Quality and Compliance (HCQC) by calling 1-888-333-1597 or writing to:

Northern Nevada
727 Fairview Drive, Suite E
Carson City, NV 89701

Southern Nevada
4220 S. Maryland Pkwy, Suite 810, Bldg. D
Las Vegas, NV 89119

The Nevada HCQC licenses hospitals in the state and is charged with investigating complaints against them.

- An investigation could take several days or weeks to complete depending on the type of complaint.
- If the investigation finds there was a violation, HCQC issues a report outlining the problem and the hospital responds with a plan defining how they will make corrections.
- You should hear from HCQC about how they responded to your complaint.

Section III – Provide for Interoperability by Providers

This section includes both federal and state requirements and information related to patient health care record interoperability and is meant to be a resource for health care providers.

Federal Requirements

The Patient Access and Interoperability rule

The Interoperability and Patient Access final rule (CMS-9115-F) of 2020 aims to put patients first, giving them access to their health information when they need it most and in a way they can best use it. This final rule is focused on driving interoperability and patient access to health information by liberating patient data using the Centers for Medicare and Medicaid Services (CMS) authority to regulate Medicare Advantage (MA), Medicaid, Children's Health Insurance Program (CHIP), and Qualified Health Plan (QHP) issuers on the Federally-Facilitated Exchanges (FFEs).

Lack of seamless data exchange in healthcare has historically detracted from patient care, leading to poor health outcomes, and higher costs. The CMS Interoperability and Patient Access final rule establishes policies that break down barriers in the nation's health system to enable better patient access to their health information, improve interoperability and unleash innovation, while reducing burden on payers and providers. Patients and their healthcare providers will have the opportunity to be more informed, which can lead to better care and improved patient outcomes, while at the same time reducing burden. In a future where data flows freely and securely between payers, providers, and patients, we can achieve truly coordinated care, improved health outcomes, and reduced costs.

Privacy, Security, and Standards

Ensuring the privacy and security of patient information is a top priority for CMS. Identifying the right standards can help data flow securely and efficiently. CMS, in partnership with the Office of the National Coordinator for Health Information Technology (ONC), has identified Health Level 7® (HL7) Fast Healthcare Interoperability Resources® (FHIR) Release 4.0.1 as the foundational standard to support data exchange via secure application programming interfaces (APIs). CMS is adopting the standards for FHIR-based APIs being finalized by HHS in the ONC 21st Century Cures Act rule at 45 CFR 170.215. These requirements support the privacy and security of patient information.

CMS is taking additional steps to provide payers and patients opportunities and information to protect patient data and make informed decisions about sharing patient health information with third parties. For instance, as part of this final rule a payer may ask third-party application developers to attest to certain privacy provisions, such as whether their privacy policy specifies secondary data uses, and inform patients about those attestations. CMS is also working with payers to provide information they can use to educate patients about sharing their health information with third parties, and the role of federal partners like the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC) in protecting their rights. Patients have a right under HIPAA to access their health information. They also have a right to know their health information is exchanged in a way that ensures their privacy and security. CMS is working to balance these important issues in a way that empowers patients to be in charge of their healthcare.

New Policies

This rule finalizes new policies that help liberate health information and move the healthcare system toward greater interoperability. CMS has just reissued the proposed Interoperability and Prior Authorization Proposed Rule with a few updates (Fact Sheet). It is proposed only as of December 2022, but is **targeting mid-2023 to be finalized** with compliance dates in Jan 2026.

Overall, the rule is looking to standardize the prior authorization (PA) process and timelines to improve patient and provider experience and continues to strive for data sharing to build a cumulative patient health record to improve outcomes and cost. This will build upon the initial rule and potentially include items outlined in greater detail below as the *December 2022 CMS Proposed Rule update* in orange text, such as:

1. Prior Authorization (PA) submission for providers through their electronic health records (EHR) system.
    - i.e., creating application programming interfaces (APIs) to handle workflow for required PA documentation and PA submission.
2. Payer-to-Payer data exchange.
    - i.e., APIs to exchange certain patient data between payers.
3. Provider access to patient data.
    - i.e., APIs to exchange certain patient data with providers.
4. Improving existing Patient Access information for members.
    - i.e., potentially adding new data elements to patient APIs.

Patient Access API:

CMS-regulated payers, specifically MA organizations, Medicaid Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP FFS programs, CHIP managed care entities, and QHP issuers on the FFEs, excluding issuers offering only Stand-alone dental plans (SADPs) and QHP issuers offering coverage in the Federally-facilitated Small Business Health Options Program (FF-SHOP), are required to implement and maintain a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice. Claims data, used in conjunction with clinical data, can offer a broader and more holistic understanding of an individual's interactions with the healthcare system, leading to better decision-making and better health outcomes. These payers are required to implement the Patient Access API beginning January 1, 2021 (for QHP issuers on the FFEs, plan years beginning on or after January 1, 2021).

December 2022 CMS Proposed Rule update: The *Interoperability and Patient Access* final rule includes a finalized policy requiring Medicare Advantage (MA) organizations, Medicaid managed care plans, Children's Health Insurance Program (CHIP) managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs) (collectively referred to as "impacted payers"), to facilitate enhanced data sharing by exchanging data with other payers at the patient's request, starting January 1, 2022 by implementing a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Patient Access API. CMS also required impacted payers to incorporate and maintain the data they receive through this payer-to-payer data exchange into the enrollee's record, with the goal of increasing transparency for patients, promoting better coordinated care, reducing administrative burden, and enabling patients to establish a collective patient health care record as they move throughout the health care system.

In a CMS proposed rule (scheduled to be published on December 13, 2022), starting January 1, 2026, via the already-established Patient Access API, CMS will require the regulated payers to include information about patients' prior authorization decisions to help patients better understand their payer's prior authorization process and its impact on their care. This proposed rule would also require impacted payers to report annual metrics to CMS about patient use of the Patient Access API.

Provider Access API:

December 2022 CMS Proposed Rule update: In order to better facilitate coordination of care, and support movement toward value-based payment models, CMS is proposing to require impacted payers to build and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. CMS is proposing that they make patient claims and encounter data (excluding cost information), data elements identified in the United States Core Data for Interoperability (USCDI) version 1, and prior authorization requests and decisions available to in-network providers beginning January 1, 2026. As this data would be shared upon the provider's request, CMS is also proposing to require payers to provide a mechanism for patients to opt out of making their data available to providers through this API.

Provider Directory API:

CMS-regulated payers noted above (except QHP issuers on the FFEs) are required by this rule to make provider directory information publicly available via a standards-based API. Making this information broadly available in this way will encourage innovation by allowing third-party application developers to access information so they can create services that help patients find providers for care and treatment, as well as help clinicians find other providers for care coordination, in the most user-friendly and intuitive ways possible. Making this information more widely accessible is also a driver for improving the quality, accuracy, and timeliness of this information. MA organizations, Medicaid and CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities are required to implement the Provider Directory API by January 1, 2021. QHP issuers on the FFEs are already required to make provider directory information available in a specified, machine-readable format.

Interoperability Standards for APIs:

December 2022 CMS Proposed Rule update: In the December 2020 CMS *Interoperability and Prior Authorization* proposed rule (85 FR 82586), CMS proposed to require the use of certain Implementation Guides (IGs) for the implementation of the APIs in that proposed rule.

After careful consideration of these IGs, their development cycles, and CMS' role in advancing interoperability and supporting innovation, CMS believes that while these IGs will continue to play a critical role in supporting interoperability, they are not ready to propose them as a requirement. These IGs will continue to be refined over time as stakeholders have the opportunity to test and implement with their technology. CMS will continue to monitor and evaluate the development of the IGs and for future rulemaking consideration. Therefore, while CMS is strongly recommending payers use certain IGs for the Patient Access, Provider Access, Payer-to-Payer, and PARDD APIs, they are not proposing to require their use.

Payer-to-Payer Data Exchange:

CMS-regulated payers are required to exchange certain patient clinical data (specifically the U.S. Core Data for Interoperability (USCDI) version 1 data set) at the patient's request, allowing the patient to take their information with them as they move from payer to payer over time to help create a cumulative health record with their current payer. Having a patient's health information in one place will facilitate informed decision-making, efficient care, and ultimately can lead to better health outcomes. These payers are required to implement a process for this data exchange beginning January 1, 2022 (for QHP issuers on the FFEs, plan years beginning on or after January 1, 2022).

December 2022 CMS Proposed Rule update: In an effort to ensure a patient's data can follow them throughout their health care journey, CMS is proposing to require that payers would exchange patient data when a patient changes health plans with the patient's permission. Those data would include claims and encounter data (excluding cost information), data elements identified in the USCDI version 1, and prior authorization requests and decisions. For all impacted payers, CMS is considering a proposal that would require this exchange only if the patient opts in to data sharing. Finally, CMS is proposing that if an enrollee has concurrent coverage with two or more payers, these impacted payers must make the enrollee's data available to the concurrent payer at least quarterly.

Improving Prior Authorization Processes:

December 2022 CMS Proposed Rule update: Prior authorization is an administrative process used in health care for providers to request approval from payers to provide items or services. The prior authorization request is made before those medical items or services are rendered. While prior authorization has a role in health care, in that it can ensure that covered items and services are medically necessary and covered by the payer, patients, providers, and payers alike have experienced burden from the process. It has also been identified as a major source of provider burnout and can become a health risk for patients if inefficiencies in the process cause care to be delayed. Providers expend resources on staff to identify prior authorization requirements that vary across payers and navigate the submission and approval processes, which could otherwise be directed to clinical care. Patients may unnecessarily pay out-ofpocket or abandon treatment altogether when prior authorization is delayed. In an attempt to alleviate some of the burden of prior authorization processes and to improve the patient experience, CMS is proposing a number of policies to help make the prior authorization process more efficient and transparent.

Prior Authorization Requirements, Documentation and Decision (PARDD) API:
CMS is proposing to require impacted payers to build and maintain a FHIR API (PARDD API) that would automate the process for providers to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their electronic health records (EHRs) or practice management system. CMS notes that under HIPAA, covered entities are required to use the current adopted standard for prior authorization transactions, which is the X12 278 version 5010. This proposed rule does not propose to modify the HIPAA rules in any way, nor would they hinder the use of that standard.

Denial Reason:
CMS is proposing to require impacted payers to include a specific reason when they deny a prior authorization request, regardless of the method used to send the prior authorization decision, to both facilitate better communication and understanding between the provider and payer and, if necessary, a successful resubmission of the prior authorization request.

Prior Authorization Time Frames:
CMS is proposing to require impacted payers (not including QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. CMS is, however, also seeking comment on alternative time frames with shorter turnaround times, for example, 48 hours for expedited requests and five calendar days for standard requests.

Prior Authorization Metrics:
CMS is proposing to require impacted payers to publicly report certain prior authorization metrics by posting them directly on the payer's website or via publicly accessible hyperlink(s) on an annual basis.

If finalized, these prior authorization policies would take effect January 1, 2026, with the initial set of metrics proposed to be reported by March 31, 2026.

Electronic Prior Authorization Measure for MIPS Eligible Clinicians and Hospitals and Critical Access Hospitals (CAHs):
CMS is proposing a new electronic prior authorization measure for MIPS eligible clinicians under the Promoting Interoperability performance category of MIPS, as well as for eligible hospitals and critical access hospitals (CAHs) under the Medicare Promoting Interoperability Program. To meet the measure, a prior authorization must be requested electronically from a PARDD API using data from certified EHR technology (CEHRT).

Under this proposal, MIPS eligible clinicians, eligible hospitals, and CAHs would be required to report the number of prior authorizations for medical items and services (excluding drugs) that are requested electronically from a PARDD API using data from CEHRT. (Ref. 6)

Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges:

This final rule will update requirements for states to exchange certain enrollee data for individuals dually eligible for Medicare and Medicaid, including state buy-in files and "MMA files" (called the "MMA file" after the acronym for the Medicare Prescription Drug, Improvement and Modernization Act of 2003) from monthly to daily exchange to improve the dual eligible beneficiary experience, ensuring beneficiaries are getting access to appropriate services and that these services are billed appropriately the first time, eliminating waste and burden. States are required to implement this daily exchange starting April 1, 2022.

Public Reporting and Information Blocking:

Beginning in late 2020, and starting with data collected for the 2019 performance year data, CMS will publicly report eligible clinicians, hospitals, and critical access hospitals (CAHs) that may be information blocking based on how they attested to certain Promoting Interoperability Program requirements. Knowing which providers may have attested can help patients choose providers more likely to support electronic access to their health information.

Digital Contact Information:

CMS will begin publicly reporting in late 2020 those providers who do not list or update their digital contact information in the National Plan and Provider Enumeration System (NPPES). This includes providing digital contact information such as secure digital endpoints like a Direct Address and/or a FHIR API endpoint. Making the list of providers who do not provide this digital contact information public will encourage providers to make this valuable, secure contact information necessary to facilitate care coordination and data exchange easily accessible.

Admission, Discharge, and Transfer Event Notifications:

CMS is modifying Conditions of Participation (CoPs) to require hospitals, including psychiatric hospitals and CAHs, to send electronic patient event notifications of a patient's admission, discharge, and/or transfer to another healthcare facility or to another community provider or practitioner. This will improve care coordination by allowing a receiving provider, facility, or practitioner to reach out to the patient and deliver appropriate follow-up care in a timely manner. This policy will be applicable 12 months after publication of this rule. (Ref. 4.)

Note: The Fast Healthcare Interoperability Resources (FHIR) database and the Application Programming Interface (APIs) that facilitate access to Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP – Nevada Medicaid) recipient data went live July 9, 2021. The NVMedicaid App went live on January 21, 2022, with the MyBenefits and MyProvider Modules, allowing recipients to access digital ID cards, benefits and eligibility information, provider search, and Primary Care Physician selection. The MyHealth Module, which allows recipients to view their claims information via connection to the FHIR database, went live on March 10, 2022.

The Privacy Rule

Federal regulation has provided patients with the right to access their medical records. The Privacy Rule, adopted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and modified by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, established the patient's right of access, including the right to receive a paper or electronic copy of his/her medical records and to request that records be sent to an individual's designee. The HITECH Act promoted the widespread adoption and meaningful use of health information technology, and required providers and hospitals participating in the Medicare and Medicaid electronic health records (EHR) incentives programs to exchange electronic health information for transitions of care and allow patients to electronically view, download, and transmit their digital health data. However, access to digital health data by patients remains limited in practice.

To address some of the implementation challenges, the Cures Act calls for specific policies to promote patient access. Specifically, it encourages partnerships between health information exchange organizations and networks and healthcare organizations to promote patient access to their electronic health information in a "single, longitudinal format that is easy to understand, secure, and updated automatically." In addition, the U.S. Department of Health and Human Services and the Office for Civil Rights are directed to educate healthcare professionals on their obligation to provide patients with access to their electronic health information, to provide guidance to health information exchanges related to best practices to provide patient access and make patients aware of their right to access their health information. (Ref. 5)

The Cures Rule

As of April, 2021, the federal rule on Interoperability, Information Blocking, and ONC Health IT Certification—which implemented the 21st Century Cures Act—went into effect. Known as the "Cures Rule," this national policy requires healthcare providers give patients access to all of the health information in their electronic medical records "without delay" and without charge. "Blocking" patients from their own health records is against the law and may result in fines for hospitals and physicians.

In October 2022, the definition of electronic health information (EHI) in the 21st Century Cures Act expanded beyond the United States Core Data for Interoperability (USCDI) Version 1 to include *all electronic Protected Health Information* (ePHI) that patients have a right to access under the Health Insurance Portability and Accountability Act (HIPAA).

EHI could include:

- Medical records and billings records about individuals maintained by or for a covered healthcare provider;
- Enrollment, payment, claims adjudication, and case or medical management record systems; or
- Other records used, in whole or in part, by or for the covered entity to make decisions about individuals.

Nevada State Requirements

Overview

As noted by the Nevada State Medical Association, practicing physicians in Nevada must be aware of their responsibility relating to medical records retention, disclosure, and inspection guidelines, as regulated under NRS 629.051 – 629.061. Unless a longer period is required under federal law, each provider must retain patient medical records for 5 years after their receipt or production. NRS 629.051 further clarifies that health care records may be retained in written form, or by microfilm or any other recognized form of size reduction, including, without limitation, microfiche, computer disc, magnetic tape, and optical disc. Records may be created, authenticated, and stored in an electronic health system. A physician must post, in a conspicuous place in each location at which healthcare services are provided, a notice to patients that their health records will be destroyed in accordance with NRS 629.051.

Although state law requires physicians to retain health records for 5 years, HIPAA regulations require medical records be kept for 7 years and Medicare Advantage plans require records to be maintained for 10 years. Further, NRS 629.051 section 7 states that health care records of a person who is less than 23 years of age on the date of the proposed destruction of the records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law.

NRS 629.061 commands providers of health care make available for physical inspection health care records of a patient within 10 working days after the request by: 1) the patient or a representative with written authorization; 2) the personal representative of the estate of a deceased patient; 3) a trustee of a living trust created by the deceased patient; 4) the parent/guardian of a deceased patient; 5) an investigator for the Attorney General's office; and 6) an authorized representative or investigator of a state licensing board. Additionally, NRS 629.061 describes the allowed reimbursement for the costs of copying health care records and other records, such as X-rays.

For more information on Nevada's regulatory requirements for physicians, visit NRS-629, NRS 630, and NRS 633.

During the 2011 legislative session under SB150, regulatory changes were made to protected property stored in a storage space. If a physician puts "protected property," which includes medical records, in a storage facility, they must 1) notify the storage unit owner of the content of the unit, 2) notify their professional licensing board where the records are being stored and provide a copy of that letter to the storage unit owner, and 3) provide a second person's contact information. NRS 108.4755, Section 1.c.1 and 2 govern this requirement. (Ref. 3.)

Section IV – Recommendations

This section is intended to provide annually updated recommendations to the Director of the Department of Health and Human Services and the Nevada Legislature concerning the analysis and use of data to improve access to and the quality of health care, establishing priorities for addressing health care needs, and ensuring health care data transparency, as required in NRS 439.918.1(d).

Analysis and Use of Data to Improve Access and Quality of Health Care

To improve quality, access and transparency in Nevada's health care system through the health care cost growth benchmark program, the Commission requests all Nevada health insurers to submit total medical expenses for their Commercial, Medicare and Medicaid members.

In an April 2022 informational webinar outlining the total medical expense (TME) data request in support of the health care cost growth benchmark, the state distributed the Data Specification Manual to Nevada health insurers, giving the details for how to submit the requested data to the Department of Health and Human Services (DHHS), Office of Analytics; and gave an opportunity for any initial clarifying questions from the health insurers. During the webinar, the state requested all data submissions by August 30, 2022. The DHHS Office of Analytics has begun data validation communications with the health insurers for all data submissions as of October 3, 2022.

As noted in the Nevada Data Specification Manual, the following Nevada health insurers were requested to submit aggregate, de-identified, data for Nevada's baseline benchmark analysis for the following types of plans.

Insurer	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care
Aetna	Yes	Yes	
Anthem	Yes	Yes	Yes
Centene	No self-insured No partial claims	*	Yes
Cigna	Yes		
Humana	No partial claims	No	
Renown Health	No partial claims	*	
UnitedHealthcare	No self-insured No partial claims	Yes	Yes

* Per the Data Specifications Manual, Centene and Renown Health were not listed as Insurers required to submit Medicare Managed Care data. However, the Nevada Division of Insurance reports these insurers as operating in this market.

For those insurers who have not submitted requested data, the Commission remains hopeful they will submit this data in the future to support the state's request to improve transparency and affordability in our health care system.

Recommendation

The Commission therefore requests DHHS to ensure sufficient staff support to collaborate with the insurers in submitting the correct data; both for the baseline data request and subsequent data requests; validating the data; etc.; and recommends all Nevada health insurers, including those governed by the federal Employee Retirement and

Income Security Act (ERISA) to voluntarily submit aggregate, de-identified total medical expense (TME) data in support of Nevada's health care cost growth benchmark. The baseline data request is the first step for measuring performance against the benchmark, and that the cost growth benchmark is a mechanism to ultimately improve affordability, which in turn can improve access.

Using Data to Establish Priorities for Addressing Health Care Needs

A cost growth benchmark program is a cost-containment strategy that limits how much a state's health care spending can grow each year. As one of the many steps in the process of better understanding health care cost drivers in Nevada and working to slow health care cost growth and improve access for all Nevadans through the Nevada health care cost growth benchmark, the Commission has requested two phases of reporting using health care data from Nevada Medicaid and the Nevada Public Employees' Benefits Program (PEBP). Throughout these analyses, PEBP is being used as a proxy for the commercial health insurance market in Nevada, as due to the project timeline, the state does not yet have full access to and analysis of the commercial health insurer TME data to measure. This first benchmark aggregate analysis is expected to be complete and publicly available in April 2023.

The Phase 1 reports provided an overview of what is driving health care costs in the state and were presented to the Commission in April. These overview reports break down spending by age, gender, and costs according to utilization, services, and where those services are provided. A copy of the Phase 1 reports may be found here under Working Documents.

The Phase 2 reports requested of Nevada Medicaid and PEBP will dive deeper into the analysis to determine *why* spending may be high or low in a given category and takes into account price vs. utilization. The Phase 2 reports will focus on hospital and pharmacy spending and are expected to be provided to the Commission and publicly available in January 2023.

Recommendation

Using data found in both health care cost growth benchmark phases of analysis and reporting, the Commission will be making well-educated recommendations concerning health policy to help curb the climbing cost of health care in our state in 2023. The Commission therefore recommends codifying the health care cost growth benchmark as an integral state program as identified in one of the Commission's bill draft requests (BDRs): Assembly Bill 6. If the cost growth benchmark legislation passes, the cost driver analyses will occur an annual basis and allow the state to track cost growth trends and drivers over time.

Ensuring Data Concerning Health Care in this State is Publicly Available and Transparent

In 2021, the Commission proposed a bill – Senate Bill 40 approved by the Nevada State Legislature for an all-payer claims database (APCD) in an effort to improve the transparency of health care data in the state. Due to funding, the APCD has not yet been operationalized, but is anticipated in 2023 due to federal funding opportunities now available.

Recommendation

The APCD and health care cost growth benchmark are inter-related. Use of the APCD will inform recommendations for legislative and executive branch proposals that will reduce the rate of spending growth, improve health care and patient outcomes, and support and sustain better primary care, all in an equitable manner. Therefore, the Commission recommends codifying the health care cost growth benchmark, as proposed in 2023 Assembly Bill 6, in addition to supporting DHHS or legislative resource allocation specific to establishing the APCD.

Section V – Resources and References

Patients

- Understand why your medical records are important and how to get them: https://www.whereismymedicalrecord.org/
- Nevada Care Connection: https://www.nevadacareconnection.org/care-options/
- AARP Family Caregiving Resources: https://states.aarp.org/nevada/caregiver-resources
- Nevada State Long Term Care Ombudsman Program: https://adsd.nv.gov/Programs/Seniors/LTCOmbudsman/LTCOmbudsProg/

Providers

- Nevada State Medical Association; Record Guidelines: https://nvdoctors.org/practice-resources/benefits-services/cme-accredited-provider-info/
- To view the CMS Interoperability and Patient Access final rule, visit https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index.
- To view the ONC 21st Century Cures Act final rule, visit, https://healthit.gov/curesrule
- Section 4004 of the 21st Century Cures Act defines practices that constitute information blocking and authorizes the Secretary of Health and Human Services (HHS) to identify reasonable and necessary activities that do not constitute information blocking (referred to as "exceptions"), and are identified here: https://www.healthit.gov/sites/default/files/page2/2020-03/InformationBlockingExceptions.pdf.
- HHS also notes information related to what circumstances may a covered entity deny an individual's request for access to the individual's personal health information (PHI) here: https://www.hhs.gov/hipaa/for-professionals/faq/2046/under-what-circumstances-may-a-covered-entity/index.html
- To view The Office of the National Coordinator for Health Information Technology, Patient Engagement Playbook, visit: https://www.healthit.gov/playbook/pe/. The Playbook is an evolving resource for clinicians, practice staff, hospital staff, and other innovators: a compilation of tips and best practices collected from clinicians and health systems like yours.

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