2020 Medicare Promoting Interoperability Program Webinar
January 16, 2020

Hello everyone. Thank you for joining today's 2020 Medicare Promoting Interoperability Program webinar. During the webinar, CMS will provide updates on major changes to the Medicare Promoting Interoperability Program from calendar year 2020. The presentation will include background on the program, EHR reporting requirements, certified EHR technology requirements, and objective and measure changes. At the end of the presentation, CMS subject matter experts will be available to address any questions as time allows. Now, I'd like to introduce today's speaker, Dylan Podson, Social Science Research Analyst at CMS. Dylan, you may begin.

All right, thank you very much. Welcome everyone. Again, my name is Dylan Podson. I'll be hosting today's webinar, and yes, at the end we look forward to some questions, as time allows. Next slide.

Just as a brief quick reminder, a bit of a note that the educational materials that will be presented today have come from established federal registered policy and regulations, which should always be consulted in full for final guidance, and so, as much as today's information is taken from those various documents and rules and legislation, it is an educational webinar so, please refer to the original source. Next slide.

As you briefly heard in that introduction, today we're going to be going over the sections that are listed here today. Returning to today, it's a long one, the 2020 Hospital Inpatient Perspective Payment System, also known as IPPS, and the Long-term Acute Care Hospital Final Rule for the Medicare Promoting Interoperability Program. As many of you may already be aware, the IPPS final rule was released to the public last August 2nd. It's been out there in the public for a little while for review, and that is on the federal register. Next slide.

We'll just begin with a brief overview, a bit of a history lesson at first, and then we'll kind of go into more specifics. Next slide.

So, going back to the historical origins of the entire modern program that we're currently implementing today. It originally started with these three various stages, which each had their own particular agenda and sort of baby-step task building towards the program as you know it today. After these three stages were accomplished, the program's name was officially changed in 2018 from the EHR Incentive Programs to the Promoting Interoperability Programs that you'll hear us use today. The change was made because the former name, we felt, did not adequately reflect the current status of the programs' goals and intentions, especially as several aspects of the programs changed, including the incentive payments under Medicare, which have now ended. Next slide.

So, if that was dating back from 2011 to 2018, here we are a bit more in the current realm of things. We believe the new name highlights -- Promoting Interoperability Programs -- we believe that highlights the enhanced goals of the programs and better aligns with the focus on the measures and objectives that we'll be hearing more about today. In addition, the program name also reflects how we view patient data as a primary goal of pretty much everything we do around here, and its safe interoperable transmission across and between various electronic health medical records. To coincide with this shift, in calendar year 2019, as some of you may have recalled the webinar

that we conducted last year, there was a great deal of overhaul, program changes, name changes, measure changes, but in today's presentation, you'll be hearing more about where we're at today with calendar year 2020 and what has remained the same and what might have been tweaked. But I can assure you it's not nearly as extensive or robust or confusing as that, so we don't expect too many problems. Next slide.

Continuing on with the program overview. As has been the case for some time now, you'll see in this slide, Promoting Interoperability Programs remains steadfast in its dedication to utilize the 2015 Edition CEHRT via a series of reportable objectives and measures to really reduce burden, advance interoperability, and improve patient access to their health data. These were goals that have been in the works for many years now, as you can see back to the earlier stages, and yet we've finally come to a point where we think that the scoring methodology is best suited to promote those things. Next slide.

All right, so that was a bit of a brief history lesson of how we got to where we are today. After this, we will be going a bit more into the specific requirements for the current year, calendar year 2020. Next slide.

Starting off with the EHR reporting period. It was established last year to be any continuous 90-day reporting period, and this has not changed for 2020, and as something that was finalized last year, in last year's rule, it will also remain in effect for 2021. So, for 2020 and 2021, it will be the same as what you're seeing here. The 90-day reporting period length is a self-selected continuous minimum period between any time that could be reported between January 1st, 2020, and December 31st, 2020, and so, to try to break that down a bit more, self-selected, it can be the 90-day minimum that the provider or hospital chooses. It has to be continuous, so there cannot be breaks between the 90 days, and minimum in the sense that it could be 100 days, it could be 200 days, it could be 300, or even the entire year, if they were to choose to do that as the reporting period for them. However, the minimum that we've set and that you should be familiar with is that it must be this minimum of a 90-day period. We've continued this EHR reporting period in order to provide the additional flexibility for hospitals and CAHs. We think that such flexibility allows for more time for them to strengthen their CEHRT, their certified EHR technology, to the latest requirements and functionalities that are now required in the 2015 Edition. As we understand, it was a bit of a big overhaul upgrading from 2014 to 2015. As such, we understand that additional time is needed to make sure that all the scoring methodology with the 2015 Edition upgrade operates smoothly as expected, with as few bugs as possible. We finalized that as I think you'll see here in the second bullet. I apologize for the delay, but it gets us something that's pretty important there. We have finalized that both for measures that have a numerator and denominator -- they're only going to increment based on actions that have taken place and occurred during that self-selected EHR reporting period and so, if you pick the 90 days and one of your numerator/denominator calculations, you have patients sending transfers or referrals outside that time, it would not count towards at least this program's scoring methodology. So, again, it must take place within that self-selected 90 days for the numerator/denominator calculation. Next slide.

So, it's the big thing that we always tend to talk about, and first, we have a bit of history again to kind of get everyone on the same page with where we're at with the 2015 Edition CEHRT. Beginning with the EHR reporting

period, as we've just stated, participants of the Medicare and Medicaid Promoting Interoperability Programs were required to adopt this new standard of certified electronic health record technology. As you'll see and have known, it is abbreviated as CEHRT. We required this originally because the previous 2014 Edition certification was, we believe, out of date and insufficient for the providers, and needed to adapt and evolve with the health IT industry and what the capabilities are at this time. In addition, we believed it was beneficial to the health IT developers, as well as health care providers, to move to the more up-to-date standards and functions that would better support interoperable exchange of health information and improve the clinical workflows. The 2015 Edition CEHRT contains brand new functionality, which was absent in previous editions, which we understand is to streamline these workflows and utilize a more comprehensive task list to meet patient safety goals and improve care coordination across the continuum. The 2015 Edition CEHRT also includes certification criteria specifying a core set of data known as the Common Clinical Data Set that health care providers have noted to be crucial and critical to interoperability exchange to be exchanged across a wide variety of settings and use cases. It aims to support a common set of data classes that are required for interoperable exchange and identifies a predictable, transparent, and collaborative process for achieving these goals. Now, to get to, again, some of the more important information that you'll see on the slide here. Something that might have been discussed last year and yet has not been finalized that we would like to really help clarify is that the 2015 Edition functionality must be in place by the first day of the EHR self-selected reporting period, but the vendor's product itself has to be certified to the 2015 Edition criteria by the last day of the reporting period. The eligible hospital or CAH must be using the 2015 Edition functionality for the full duration of the EHR reporting period. However, as we've heard and understood and accepted, in many situations, the product may be initially deployed with the full functionality while still pending that final certification. To repeat one more time, the key here is that it must have passed that complete certification by the final day of the continuous 90-day reporting period. So, without having made too much of a word jumble puzzle there, I hope that that makes a bit more sense, and we did hear a lot of questions over the past year about this in terms of when the functionality must be in place, and when the certification must be completed. So, hopefully this gives a bit more of a straightforward delineation of when the reporting period can begin with functionality while still waiting upon that final approval of certification by the end of the reporting period. Next slide.

So, over the next few slides, to get more into the meat and potatoes of the more specific objectives and measures, which will be set and scored, we'll be hitting each one in detail. Next slide.

It's safe to say that this slide contains a bit of the majority of the larger promoting interoperability changes, which did occur from calendar year 2019 and its final year to calendar year 2020, and the current final rule in which we find ourselves under, specifically, as it pertains to the query of Prescription Drug Monitoring Program, which from here on out, we'll call the query of PDMP measure, as well as the Verify Opioid Treatment Agreement measure, and we'll get to that shortly. Don't worry. The Query of PDMP measure will continue as optional in 2020 and will be worth five bonus points. Important to note is that the previous numerator and denominator scoring definition for the query of PDMP that was in place in the past has now been replaced by a yes/no attestation response, which does away from the

numerator/denominator calculation. That is something that was retroactive to 2019, so, it probably was a part of the reporting experiences then and will, for this year, continue to be a yes/no attestation, optional, and worth five bonus points. We believe that it's the same sort of issues that we've heard from stakeholders, and that we appreciate and respect the opinions that have come in, that this extra optional year would allow for the various state PDMPs to continue the development towards a more robust and mature functionality, including possible integration into the EHR itself. Now, as for there's something missing from this slide, as you may recall and remember. As for the previous year's Verify Opioid Treatment Agreement measure, the entire measure has been removed from the program for calendar year 2020 due to comprehensive industry review and collaborative feedback. And so, just to get everyone on the same page, as you might have recalled, that was a measure that would have been listed here last year. And, yet, however, currently, the Electronic Prescribing objective really only contains these two, with the e-Prescribing being expected and the query of PDMP optional. Next slide.

All right, and I apologize if some of the text is a bit small, but what we're going to do is, once we introduce each of the objectives, we'll then be diving down into the measures with a bit more detail. I won't be saying exactly everything that's on the slides here, the majority of which has not changed and is in the final rule. However, they're important to get down to how they'll be scored if exclusions are available, the maximum points available, things like this, as you tell. So, the measure that we're currently on now, the e-Prescribing measure, not to be confused with the Electronic Prescribing objective, looks at hospital discharge medication orders for permissible prescriptions, both for new and changed prescriptions, that are queried for a drug formulary and are transmitted electronically using CEHRT. That's sort of key there. Not faxed or e-mailed or printed out but created and transmitted electronically using CEHRT. The numerator equals the number of prescriptions that the denominator has generated, querying for a drug formulary and transmitted electronically, while the denominator contains the number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed, and this is other than -- the sort of exception is you'll see other than controlled substances. This is for patients who have been discharged during the EHR reporting period. Exclusions are still available for this measure, and it's any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions, and that there are no pharmacies that accept electronic prescriptions within ten miles at the start of the EHR reporting period. And so, you'll see that this is not changed in 2019, and these sorts of exclusions still apply. For calendar year 2020, the last piece I believe I'll note for this slide, is that if the exclusion is claimed for the e-Prescribing measure, ten points would end up being redistributed equally among the measures under the Health Information Exchange objective, which you will also commonly hear referred to as the HIE. We can go to the next slide.

Again, very similar as to what you've heard from calendar year 2019, but from last year's final rule, the measure of the query of PDMP is an electronic database that tracks -- or the PDMP is an electronic database that tracks prescriptions of controlled substances at the state level, and it plays an important role in patient safety by assisting in the identification of patients who may have multiple prescriptions for controlled substances, and/or may be misusing or overusing them. Querying the PDMP as part of this measure, we believe, is important for tracking the

prescribed, controlled substances and improving prescribing practices to hospitals, clinics, and providers who may not be aware that these patients are receiving potentially copious amounts of controlled substances, opioids elsewhere, in addition to what is being prescribed at discharge. The intent of the Query of PDMP measure is to build upon the current PDMP initiative, which has come all the way from various federal partners who are focusing on these sort of prescription generations and over-dispensing of opioids, which has led, or at least in part contributed, to the epidemic that we're facing today. For the measure of the query of PDMP, for prescription drug history, it must be conducted, the query must be conducted prior to the electronic transmission of the Schedule 2 opioid prescription. It's meant to be a preventative approach prior to prescribing. Eligible hospitals and CAHs have the flexibility to query the PDMP and CEHRT in any manner allowed under their local state laws. You can see here the numerator -- oh, no, I apologize, because this one has come from a numerator/denominator calculation back to a yes/no attestation, it would simply be a yes or no. There are currently no exclusions available for the measure, given that it is optional, and it's not required and would only be available for the five bonus points if it were chosen to be attempted at least once. Next slide.

Moving on to a new objective, we're going to review the Health Information Exchange or HIE objective. These measures that fall under the HIE are of particular importance because of the role they play within the care continuum in a health care setting. In addition, these measures encourage and leverage interoperability on a broader scale and promote health IT-based care coordination. Both the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure are both worth up to 20 points each. They both utilize a numerator/denominator calculation, and, I believe for the first time for calendar year 2020, neither has a possible exclusion. There were instances in the past where an exclusion was available; however, we feel that we've gotten to the point where information such as this, utilizing the 2020 Edition CEHRT, is readily available, common, and, as we said here, a bit of a crux to the entire Promoting Interoperability Programs. Next slide.

So, starting off with the first of the two, the first measure within the HIE objective is the Support Electronic Referral Loops by Sending Health Information. It looks at transition of care or referrals where the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care has a bit of a two-part expectation. First, in which they create a summary of care record using CEHRT and, second, that they electronically exchange that summary of care record to a receiving provider or hospital setting. The numerator here is the number of transitions of care and referrals in the denominator in which a summary of care record was created and exchanged electronically using CEHRT -- it's a bit of a repetition, I apologize -- while the denominator is the number of transitions of care and referrals during that EHR reporting period for which the eligible hospital or CAH in-patient or Emergency Department was the transitioning or referring provider to a provider of care other than the eligible hospital or CAH that they are coming from. Again, I apologize, not to be a tongue twister, I'm sure you can read over more of the numerator/denominators here in terms of spotting the sort of differences, and yet, as you've seen, the common theme is not just that patients are either being taken in or discharged or their summary of care is being forwarded to a PCP or somewhere else, but specifically utilizing explicitly the functionality of 2015 Edition CEHRT, so no more back things. The measure

here allows for any document template commonly within the Consolidated Clinical Document Architecture, also known as C-CDA. These sorts of standards are the ones that are preferred to be used. CEHRT supports the ability to send and receive the C-CDA template and encourages greater interoperability and exchange. At a minimum, the CEHRT will be able to support the exchange of these document types; however, it does not preclude the developers of CEHRT in supporting additional documentation templates, and so there is sort of a base requirement in terms of what to expect to see created and sent over to CEHRT. However, there is room for individual basis to potentially create or send more. Next slide.

So, now a bit of an inverse, on the receiving end, the next measure will be the Support Electronic Referral by Receiving and Incorporating Health Information. The measure looks to see if eligible hospitals and CAHs attempt clinical information reconciliation. The big three that we focus on here specifically are for medications, medication allergies, and current problem list. And this would be for received transitions of care or referrals, or for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patients. The numerator is equivalent to the number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets. That's what we mentioned just previously there -- medication, which is reviewing the patient's medication, including the name, dosage, frequency, and route of each medication. The second being medication allergies, which is a review of a patient's known medication allergies. It's pretty common. And number three, the current problem list, which is a review of the patient's current and active diagnoses. The denominator, however, looks at the number of electronic summary of care records received using CEHRT for patient encounters during the EHR reporting period for which an eligible hospital or CAH was the receiving party of a transition of care or referral, and for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient. I believe it should be on both the 2019 and 2020 indication sheets for this particular measure. However, I believe a common question that we've seen is, you know, what if the receiving hospital or CAH gets information and it's blank, or there's multiple versions of it with multiple data from various patient visits for a single patient? And I think we've allowed the flexibility here that even if portions might be blank, and, again, we can convert in the specification sheets and in the final rule, I believe that it is still -- on the receiving end, it would still count toward this measure to have received sort of partial information on these three that are listed, as that is not something which would be under the receiving hospital's control or, really, anything they could sort of do about that. And the attempt is to reconcile at least one of these with the most relevant information for the patient that they are leaving from the transition or the referral. So, it is not to be as exhaustive as perhaps it sounds. But the attempt is to get the information via CEHRT to have sent the patient referral over. Next slide.

Next, we're going to review the Provider-to-Patient Exchange objective, which has only one measure underneath it titled "Provide Patients Electronic Access to Their Health Information." We'll have a little bit more information on the next slide. Thank you.

The Provide Patients Electronic Access to Their Health Information measure is looking primarily at patients who have been discharged from the eligible hospital or CAH inpatient or Emergency Department, where the patient or

authorized representative is provided timely access to view online, download, and transmit their health information, and that the eligible hospital or CAH ensures that the patient's health information will be available to access using any application of the patient's choice that is configured to technical specifications of the API within the eligible hospital or CAH's CEHRT. And so, there's various means that a patient may want to receive this information using the functionality of CEHRT, and they should also be at the API, and they should all be made available. You can see that this measure is highly weighted at 40 points because we feel it really gets to the core of improving access and the exchange of patient data in promoting interoperability, what it all comes down to, and it really is the crux of the program. This exchange of data between healthcare providers and patients is absolutely imperative to continue to improve interoperability, data exchange, and improve health outcomes, which is the ultimate goal for the beneficiaries. We also believe that it's important for the patients to have control, naturally, over their own health information, and so, this highly weighted measure within the objectives, we're sort of aiming to show the dedication for that. Gone are the days of trying to carry around the folders and collecting all the stuff from your provider before you find a new one, and missing sheets. And so, we really are moving away from that and trying to incentivize, as much as possible, this comprehensive, efficient, simple access to a patient's health medical records upon request and upon discharge especially. You can see here, I've been going over a bit of the numerator/denominators, and they get a little bit lengthy, so I'll skip this one. I think one last aspect before we move on, at least for this in particular, is that there is a word that tends to get used in there about timely, it's about having timely access, so the patient is able to access their health information. Well, the definition of timely hasn't changed. Eligible hospitals and CAHs, we have stated, must provide patients the ability to view online, download, and transmit their health information within 36 hours of its availability to the eligible hospital or CAH. In the final rule, and in previous rules, as well as patient information and factsheets that comes from our promoting program, you will see there are certain caveats and exclusions from this, such as if the information that was to be shared could contribute, potentially, to patient harm, and that is up to the hospital or provider's discretion in terms of what the test or result outcomes could be that would actually do more damage to be sharing via an online portal, as opposed to being able to hold it off until maybe a follow-up visit to be conducted. So, just something interesting to note but, in general, we do hold that timeframe as the minimum requirement. Next slide.

The following slides will further detail the fourth and final objective, titled the Public Health and Clinical Data Exchange objective. This particular objective is structured slightly different. Actually, a little bit more different from preceding ones, in that it's comprised of six available measures in which the eligible hospital or CAH is able to pick to report on two of the six. This allows for a bit of flexibility in the reporting on the part of the provider. This slide we'll be moving through is to quickly summarize some of the key aspects; for instance, while reporting an attestation to any two that they have chosen of the six would be worth ten points, up to ten points, depending on the reporting, and that the measures each contain an exclusion, which can be claimed, which would ultimately have the potential for redistributing the points elsewhere. Let's see if I can summarize this somewhat quickly. So, all six have their own exclusions. Some are slightly worded differently, and if claimed, the points would be redistributed as follows, and again the information will be on the

slide a little bit later on. So if one exclusion is claimed from one of the six, one of the two that they have actually chosen of the six, but one measure is attested to, so one exclusion and one measure they have attested to, the ten points would be granted for the Public Health and Clinical Data Exchange objective. However, if two exclusions were claimed for two of the six that they pick, then the ten points would be redistributed, not to this objective but, actually, to the Provide Patients Electronic Access to Their Health Information measure. And, so, again, if that comes off a bit odd at times, please bear with us, it is written elsewhere, I believe even in this presentation, with a little more detail as to the scenarios that would lead to the option of one being taken for exclusion, the other one being attested, et cetera. Next slide.

This is just a continuation, mostly repeating a bit of the information that you just heard us go over. The Public Health and Clinical Data Exchange objective is measuring that the eligible hospitals and CAHs are attesting "yes" to being in an active engagement with these public health agencies, PHAs, or clinical data registries, CDRs, in order to submit their electronic public health data in a meaningful way, again, using CEHRT for two of the six they have chosen. The possible measures, as you'll see here, include syndromic surveillance reporting, immunization registry reporting, electronic case reporting, public health registry reporting, clinical data registry reporting, and electronic reportable laboratory result reporting. As I'm sure you can tell by now, there is no numerator or denominator for these measures but, rather, it's based on an eligible hospital or CAH attesting to be in such active engagement with the public health agency or clinical data registry. I believe we can go to the next slide.

All right. So, while we won't be repeating the specifics of what we've been going over here for all six possible measures, of which two would be chosen under the objective, given that the reportings have plenty of overlap in terms of the attestation, the exclusions, maximum points available, things like that, that's consistent across there. However, we have included in the additional slides, which I apologize I will be breezing a bit through for the sake of time, for which it highlights a bit more about the exclusion available, particular to that measure if chosen by the eligible hospital or CAH, and the specific redistribution of [inaudible] if that exclusion is claimed. And so, we will skip the next slide, and I'll just be showing you examples of how this information is repeated across all six measures. But we will not be kind of breaking down into each one.

Thank you. So, just a couple seconds on each one just to give everyone an idea, as I believe that this will be shared after the fact, and another opportunity for identifying a sort of quick way of reviewing this information will be that the 2020 IPPS measure specification sheets contain all this information, even in greater detail, giving guidance for patient certification standard, et cetera. So, we can skip to the next slide.

All right. Here is the Public Health Registry Reporting measure. Next slide.

The Clinical Data Registry Reporting measure, again, all the information is consistent across there. Next slide.

I think for the last one, yeah, so the Electronic Reportable Laboratory Results Reporting measure. Next slide.

All right. So, moving a little bit away from some of the more specific measures and objectives, we do have other requirements which are necessary in order to participate in the Promoting Interoperability Program, which include completing the actions of the Security Risk Analysis measure. However, not to be confused by the word use there of a "measure," it is not a scored measure in the traditional sense that it rests under a larger scored objective and only requires a yes or no attestation to be completed. We are requiring the Security Risk Analysis to protect electronic protected health information, EPHI, created or maintained by CEHRT through the implementation of appropriate technical, administrative, and physical safeguards. The Security Risk Analysis may be conducted outside of the promoting interoperability reporting period. However, the analysis must be unique for each of the annual PHI reporting periods, and the scope of the Security Risk Analysis must include the whole promoting inoperability reporting period. So, it can happen outside of the minimum 90 days. However, it must be able to be in compliance with the timeframe applicable for the 90-day reporting period selected by the eligible hospital or CAH. The very last piece is that it must be, I believe as I stated slightly earlier, it must be conducted within the same calendar year of that reporting period and so, for 2020, that would be January 1st through December 31st. Next slide.

All right. So, we'll be going over the scoring methodology a bit more, I believe, for each of the different measures and objectives. However, I think we spent a fair good amount of time on the details earlier, and so I don't think we'll have to make as much for each of these. Next slide.

All right, again, not too many major changes. As I'm sure you've seen a sort of common theme for calendar year 2020, not an overall and not meant to ruffle too many buttons. We believe the scoring methodology listed here is more flexible, less burdensome from several years in the past, which allows eligible hospitals and CAHs to put their focus back on the patients, as opposed to reporting. By this, we mean that the performance-based scoring methodology will encourage hospitals to push themselves on measures that are most applicable to how they deliver care to patients instead of increasing thresholds on measures that may not be applicable to an individual hospital. Previously, as stated, if an eligible hospital or CAH did not perform well on a certain measure and did not meet the threshold, then they would not have qualified as a meaningful user for the objectives and the scoring section. Now, however, especially for calendar year 2019, and then moving forward with calendar year 2020, if an eligible hospital or CAH has an area that is challenging, they have to submit at least one unique patient of claim and exception, and they would not be automatically disqualified because they did not meet some threshold. Eligible hospitals and CAHs must now earn a minimum total score of 50 points in order to satisfy the program's requirement to report on the objectives and measures of meaningful use, which is one of the requirements for the eligible hospital or CAH to be considered, what we call, a meaningful EHR user. To be considered a meaningful EHR user, in essence, means in order to avoid a Medicare downward payment reduction, and so, meeting that 50-point minimum out of the total of a hundred is enough to get you to check that box. All right, next slide.

Here, you'll see the scoring methodology outlined. This is basically just a combined aggregated chart of all the previous information that you've seen in terms of points, point availability, maximum points, things like that. And so, attesting to the program in calendar year 2020, these are the four required objectives that are expected to be reported upon. Next slide.

Again, I won't spend too much time. This is a bit of a repeat, more of a bit of a visual simplified manner of what we've discussed on the larger more text-based boxes and tables. But we have the Electronic Prescribing objective here, and you'll spot that the e-Prescribing measure is underneath. The Query of PDMP is under that, however, the e-Prescribing is maximum points of ten. The Query of PDMP is optional for 2020 and will still be eligible for a full five bonus points if they are attempted. Next slide.

Here, we have a high-level review of the two HIE measures and their maximum points available for calendar year 2020. Again, I believe as we stated earlier, there was one change in the fact that for either of these, there is no longer an exclusion available, given that we feel that there is sufficient time for vendors, hospitals and CAHs to adopt the 2015 Edition CEHRT standards and functionality, and to be comfortable and familiar enough with both the sending, receiving, and incorporating of patients' health information. Next slide.

A review of the one measure here underneath the Provider-to-Patient Exchange Objective. Again, this, as mentioned earlier, is worth 40 points with no exclusion available, and so, this could be utilizing the API of the various means. You know, we've heard apps are very common, as well as portals. Next slide.

And, yes, just a bit of a repetition here. Just a review of the Public Health and Clinical Data Exchange objectives, listing the possible measures, which two can be chosen, and the ten maximum points available for picking two of them. Next slide.

All right, so here is a scoring example. So, this is a fictional hypothetical example of the calendar year 2020, let's say a hospital who has reported for this year. I'm not going through all of the specific details, however, as you can see, starting at the type for e-Prescribing, they received a performance rate of 80 percent, which gave them eight points out of the maximum ten points available. The reason they received a performance rate of 80 percent, if you look to the columns to the left, it's just the numerator divided by the denominator, so we have, what, 200 over 250. It gives you the performance rate, which is what distinguishes you from achieving the max points available to what ends up being the score on the far-right side. Again, in this an example. The hospital attesting to attempting at least one query of the PDMP, and so it is not, again, especially no longer a numerator/denominator calculation, and so saying yes, attesting to that, means that they would have earned the side bonus points, which is the max available, and the score that they received is the full five bonus points. The chart continues and reflects down from there across the various performances, through the remaining objectives and the measures, and the total points for the Promoting Interoperability Program in this example is a total of 83. So, this hospital or CAH has successfully satisfied the requirement to report on the objectives and measures of being over 50 points and would be considered a meaningful EHR user, such that they would be avoiding a Medicare downward payment reduction. Just as a quick reminder, eligible hospitals and CAHs must report on all required objectives. This is not a category where they can skip and choose across them. While individual measures may have exclusions apply, all four objectives must be reported upon. This being said, as long as they submit a numerator of any -- actually, I'm repeating myself a bit -- we have the 83 points over 50, they're a meaningful user and have successfully completed the program for the year. And we've used examples like these in the past,

but hopefully this is sort of an example just to give a hypothetical of what it would look like. Next slide.

All right. Nearing the very end, I apologize for taking up your full time. Just very briefly, we're going to be referencing a bit about the Electronic Clinical Quality measures, which you will often hear to as CQMs or eCQMs. Next slide.

Thank you. In order to further align the Promoting Interoperability Program and to further align with the Hospital IQR Program, the CQM requirements for 2020 have been reduced from an available set of 16 total down to 8, a total of 8, to better simplify the effort to participants who would be reporting. In conjunction, the reporting period for these eCQM components is defined as one self-selected calendar quarter of calendar year 2020, and so, that's an important distinction to make from the previous objectives and measures under the Promoting Interoperability Program of a 90-day period, that's minimum continuous success. Here, we have a self-selected calendar quarter. We believe that this alignment, and which we intend to increase further into the future, will reduce the certification burden on hospitals and improve the quality of reported data, enabling eligible hospitals and CAHs to focus on a smaller, more truncated specific subset of CQMs, while still allowing the flexibility to pick and choose, which they feel best reflects their patient populations, their current circumstances, and support the internal quality improvement efforts of their practice. Next slide.

All right. Here we are at the home stretch. So, we've included at the very end a short appendix here containing miscellaneous information for reference as necessary thanks to bookmark and just to take into account. I know we're still early in the year, but things are helpful. As you'll see on the slide here, we have the 2020 EHR reporting timeline with various timeframes and windows around when reporting and attesting, hardship exception, applications, and payment adjustments, as needed, would be due or would be expected to have come in, as they are scheduled for the forthcoming year. So, whether you see the presentation at a later date or take a picture of this, these are a great opportunity to sort of have a gauge of how the year is going to progress, when your reporting should be testing, et cetera. Next slide.

This, I believe, was thrown just at the very end. Typically, we would kind of put it at an earlier spot, but it's a bit of repeat of common information that kind of gets touched upon in various places. But most importantly, just to summarize, bolded here are the current requirements for participation in the Medicare Promoting Interoperability Program. It shouldn't come as any surprise. These have not been updated too much in any way. I believe, as you can see, from the CQMs have reduction. However, certainly, we think that it's still always useful to keep this full list in mind, given that they are, at the end of the day, the very foundational pillars of the program, with extra context and requirements, that it must be satisfied in order such that providers can successfully participate in a program's scoring methodology, as we would hate for something like this to be mixed up, such as Security Risk Analysis or submitting yes to some of these ONC requirements and miss out on the opportunity to attest for the year's scoring. And next slide.

I believe -- yes, I believe this is the last one. Here we are, we have additional resources, which should be -- we would hope, would be able to answer a majority of the questions you might have, as well as for your

pleasure and excitement to take a deeper dive into the full rules text, as certainly lengthy, spells out much more than what was included here, has the sort of be-all, end-all policy that we follow, and that this information has been pulled from. Yes, just one brief reminder I'd like to note before the end of the presentation is that this presentation has been focusing on IPPS for eligible hospitals and CAHs, and while, as I'm sure you've heard across many other conferences and presentations, promoting interoperability, especially with CMS, is continuing to more closely align with the MIPS-eligible clinician, and the PFS, Physician Fee Schedule, rule is important to maintain and to follow very carefully each of their program-specific rules, with their own tailored policy language, their own requirements, and their own caveats. And so, just so there's no misunderstanding, the information you learned here today can be carried over one for one across another program that you may or may not be involved in. Lastly, the very last thing I'll say is that please keep an eye out on the IPPS 2020 Measure Specification Sheets that I've mentioned a few times throughout this presentation. Hopefully in years past you've been able to utilize the '18 and '19 ones, which offer a bit more guidance, clarification, even some laymen's terms rephrasing of the policy, which has been shared and put in the final rule. Those specification sheets for this year will be shortly headed up on the CMS PI landing site, and I strongly encourage you to use those as reference points for the current rules and materials that have been discussed today, which, hopefully, could answer your questions, and, if not, we're always here to help. So, I apologize for maybe running all the way through the whole time, but that is the end of the slides here, and I'll pass it back over.

Okay. Thank you, Dylan. We're going to start the Q&A section really quickly. As we are running a little short on time, we're just going to ask a couple of trending questions that we've seen come from you all. So, to start, we have a question from Peggy Johnson. On Slide 9, how does the change for actions occurring during the reporting period take into account that hospitals have up to 36 hours after discharge to send PCDA?

All right, I'm on slide 9 under the EHR reporting period, correct?

Yes. She's asking how the change for actions occurring during that reporting period take into account that hospitals have 36 hours after discharge to send PCDA.

I believe the 36 hours is only in regards of allowing the patient to have access to their health information upon discharge. We're still talking about the same example here, correct? I mean, according to the question?

Yeah.

To my understanding, I don't believe, from what I'm seeing here, or from the reporting period, would have any change from that. The reporting that the eligible hospital or CAH would do in terms of calculating their objectives, measures, numerators, denominators, attestation, all of that, whether it's 90 or 300 days, I don't think that has an impact or an effect on when the patient is discharged and is expected to have that access to whatever records that were just completed within that timeframe, again, via possibly an app or a web portal. These are common examples. And if only just to rephrase, so the important sort of caveat is that there is a component of words in there that do say that the 36 hours is -- I don't want to say waivable, but it can be loose on changed if the information were to cause

the patient any amount of considerable harm upon receipt of that information. But, I believe they are two separate and slightly unrelated timeframes, at least in regards to the reporting period for CMS, and the ability for the patients to have access to their health records..

Okay. Thank you, Dylan.

I'm sure there are a few examples of that, and so it's going to be here. Thank you.

I think our last question that we're going to be able to ask, given the time constraint, is from Robin Hook, and she said that, we understood that all EHR vendors needed to be certified by January 1st, 2019. Is this not true?

So, yes, this was a new language, which was proposed in the 2020 NPRM, and we received comment on it and were able to finalize it for the calendar year 2020. We had all of last year, and slightly before, many, many, many conversations, which were excellent and robust and passionate in order to help try to clarify a bit more explicitly what it means when we say that you must adopt 2015 Edition CEHRT. We felt that it was a bit vague or, by putting that timeline, still did not clarify how that would affect the 90-day reporting period in terms of when you start and when you end. And so, I will say again, all this information is and has been posted in the 2020 final rule. I believe this is from August 2nd. But, unless I'm having a total mind blank here, the information that you see here is correct in terms of functionality being in place on the first day of the reporting period and certification having been approved and finalized by the last day of the reporting period, because the complaint and the conversation that we heard was, whether through ONC or the testers or the contractors, those can take weeks, if not months, actually. Scratch weeks. It could take months, and so, sometimes the hospitals and CAHs could not wait until they had achieved that final certification and so, they can now begin, as long as they're utilizing the full functionality the entire time, and it is successfully certified by the end.

Okay. Thank you, Dylan. That is going to conclude our Q&A portion for the webinar, and you can now close the call.

All right. Thank you very much. I appreciate everyone's time today. Have a good one.

This concludes today's conference. You may now disconnect. Speakers, please hold the line.