2021 Medicare Promoting Interoperability Program Overview Webinar
January 12, 2021

Hello, everybody, and thank you for joining today's webinar on the Medicare Promoting Interoperability Program requirements for 2021. During today's webinar, CMS will provide updates on the requirements and review notable changes for the Medicare Promoting Interoperability Program for 2021. During the webinar, CMS subject matter experts will discuss the EHR reporting requirements; the 2015 Edition Certified EHR Technology, or CEHRT, requirements; the objectives and measures and how you will be scored; eCQM submission; and important dates and resources. After the presentation, CMS will address as many 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.

Alright, thank you very much. Hello, and good afternoon, everyone. As was said, my name is Dylan Podson, and I am a Social Science Research Analyst for the Medicare Promoting Interoperability Program, which is a member of the Division of Value-Based Incentives and Quality Reporting under the Quality Measurement and Value-Based Incentives Group at the Center for Clinical Standards and Quality for CMS. I know that's quite the alphabet soup, but the main important things we'll be going over today. And as such, the purpose of today's webinar will be to provide a brief educational overview for eligible hospitals and CAHs that are participating in the Medicare Promoting Interoperability Program, so that both longtime stakeholders, who have been participating for a few years, and new attendees will feel more familiarized with these changes and various requirements. Next.

First off, to start, we actually just have a few disclaimers here, which you can read on the screen, and I'll mention a few more. Just some notices reminding the audience that the educational materials presented here today have come from established policy and regulations, which should be consulted in full for final guidance. One thing which is not listed there, but I'd like to bring up, is just to reiterate that today's presentation and its content is only for the Medicare program, so we will not be discussing much about Medicaid, and that it is specifically for those eligible hospitals and critical access hospitals. Therefore, this is not a presentation for physicians or clinicians. Lastly, one more thing I'd like mention before we get started is that this presentation will not be addressing specifics related to the COVID public health emergency, nor will it address CMS's pandemic response, due to the fact that the Promoting Interoperability Program has not had its policy altered because of it. Thank you. And with that said, we will get into the content. Next. Thank you.

So, today, we'll be going over the sections listed here pertaining to the 2021 Hospital Inpatient Prospective Payment System -- also known as an acronym of IPPS -- and Long-term Acute Care Hospital -- LTCH -- the final rule, so the IPPS 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 September 18th and has been available there for public use on the Federal Register. Next.

Throughout today's presentation, we'll actually be breaking down components of the Medicare Promoting Interoperability Program, which will include the key elements that align with CMS's programmatic goals of advancing the utilization of CEHRT, reducing provider burden, advancing interoperability

in healthcare settings, and improving patient access to their personal health information. Next.

The following few slides will actually highlight a specific requirement. Each of them will be highlighting a specific requirement of the program which must be met in order to be considered a meaningful user and to avoid a downward payment adjustment. This will make more sense as we kind of build the program up brick-by-brick, but we'll go section-by-section so it hopefully makes sense. Next.

Not to jump ahead too fast, but, first, let's actually look at some specific changes which occurred throughout the past year and are updates in the 2021 final rule that have changed since the 2020 year. The latest rules do not include many drastic changes, so the majority of its policies should sound familiar enough to participants from previous years. The new and noticeable changes we'd like to draw attention to, however, are as follows and included on the slide above. The first would be maintaining the Electronic Prescribing objective's Query of Prescription Drug Monitoring Program measure as optional and worth 5 bonus points. Number two, in the middle, is a slight name change to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, which is now Receiving and Reconciling, so "reconciling" is the word that has replaced "incorporating." And number three, finally, on the right, is an incremental rise for the number of quarters of eCQM data that must be reported each year. Next.

So, starting off with some familiar territory, you'll see here that the EHR reporting period continued last year of any continuous 90 days has not been changed for 2021, meaning that the 90-day length is a self-selected continuous minimum period affixed anytime between January 1, 2021, and December 31, 2021. We have continued this EHR reporting period for calendar year 2021 in order to provide the additional flexibility for eligible hospitals and CAHs, because consistency, we believe, will allow for more time to upgrade certified EHR technology to the latest requirements and functionalities that were required and have since been required in the 2015 Edition CEHRT. As well, there's a final point that just to provide additional time for providers and participating hospitals to meet and adjust to the latest scoring methodology, although I think you'll, throughout today's presentation, that it has not changed too dramatically. Next.

Next are the CEHRT requirements. And just a bit of contextual history, to ensure that everyone is going to be landing on the same page, beginning with the EHR reporting period in calendar year 2019, participants of the Medicare and Medicaid Promoting Interoperability Programs were required to adopt 2015 Edition of Certified Electronic Health Record Technology, also lovingly known as CEHRT. We required this change, this update, this amendment, due to the fact that the previous 2014 Edition criteria was out of date and insufficient for provider needs in the evolving health IT industry. In addition, we believed it was most beneficial to health IT developers and healthcare providers to move to more up-to-date standards and functions that would better support interoperable exchange of health information and to help improve clinical workflows. As you may know, and has been established for, I guess, just a couple years now, the 2015 Edition contains new functionality which streamlines workflows and utilizes more comprehensive tasks to help meet patient safety goals and improve care coordination across the continuum. To bring a bit of breaking news update to this presentation, before concluding this slide, I would like to make one mention of some finalized changes to the 2015 Edition CEHRT requirements. Just recently,

CMS's Physician Fee Schedule Final Rule included edits which would allow hospitals the flexibility of moving forward to either use A) technology certified to the 2015 Edition CEHRT, or criteria for CEHRT -- that's what you're seeing here, that's what was finalized in 2019, that's what's been around. The second option is technology certified to the 2015 Edition Cures Update, as finalized in the 21st Century Cures Act Final Rule. Or C) a combination of both. I know that that's not necessarily listed here on the slide and has kind of been hot off the press in recent times. However, more information will come out throughout the year, throughout next year, and providers with questions are encouraged to head to and read the associated section from either the 21st Century Cures Act Final Rule or CMS's Physician Fee Schedule Final Rule. Next.

Alright, with all the CEHRT definitions out of the way, and the history and the past, we are now going to review each of the objectives and measures in detail, one-by-one. Next slide.

Starting off, the Electronic Prescribing objective has remained intact from last year's rule, with the following two measures. Although, to be clear -- and you'll see it up here at the top right of that slide -- the Query of PDMP will continue as an optional measure worth 5 bonus points if completed. We believe that keeping this measure as optional for an additional year will allow for the various state PDMPs to continue their development towards a more robust and mature functionality. Obviously, we still believe in the measure. We think it has a wonderful goal of helping to have some impact on the opioid epidemic that the country is facing. However, the Query of PDMP measure is evolving with the technology associated with it. Next.

The e-Prescribing Measure, which is under the Electronic Prescribing objective -- not to get confusing -- looks at hospital discharge medication orders for permissible prescriptions for both new and changed prescriptions, in that those which are queried for a drug formulary and transmitted electronically using CEHRT. And so, for these slides, everything I'll be saying will more or less be included on that helpful table, and yet I'll try to just kind of jump around and pick some of the high points. As you'll see, the maximum points available for this measure is 10. And the numerator equals the number of prescriptions in the denominator which were generated, queried for a drug formulary, and as mentioned before, transmitted electronically. The denominator, on the other hand, contains the number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, for patients discharged during the EHR reporting period. Exclusions are available for this measure for any eligible hospital or CAH -- that these are the important parts there you'll see at the bottom -- that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their EHR reporting period, So, just an option in case that were to apply to the hospital or CAH. Next.

So, we've mentioned it before, and I'll go to a bit more detail, but if I wasn't clear earlier, a Prescription Drug Monitoring Program, also called a PDMP, which we probably throw that around a bit too often, but the PDMP is an electronic database that tracks prescriptions of controlled substances at the state level, and they play an important role in patient safety by assisting in the identification of patients who have multiple prescriptions for controlled substances, or may be misusing or overusing them. We believe that the Query of PDMP is important for tracking the prescribed controlled

substances and improving prescribing practices. The intent of the Query of PDMP Measure is to build upon the current PDMP initiatives from federal partners focusing on prescriptions generated and the dispensing of opioids across the nation. I think one more note, since I won't go into too much more detail, but for this measure, the Query of PDMP prescription drug history must be conducted prior to the electronic transmission of the Schedule II opioid prescription. Also, one note to kind of highlight here -- eligible hospitals and CAHs have the flexibility to query the PDMP using CEHRT in any manner allowed under their state law. So, at one point, CMS was stressing a bit more impact on integrated PDMPs with EHR. And while that might be the end game, the goal, the desired effect, really, at this time, if the PDMP is not integrated and is simply queried outside of their EHR, as long as they're using the information via CEHRT, it would still count. But, again, the only caveat I'll say is that this is obviously still optional, so it's out there for hospitals to test with. Okay, next slide.

Moving on to a different objective, we have the Health Information objective here, otherwise known as HIE. These two measures are of particular importance because of the role they play within the care continuum. In addition, these measures encourage and leverage interoperability on a broader scale and promote health IT-based care coordination. They remain unchanged from previous years, except for the new title of the second measure here, which I alluded to earlier. But in case I was a bit confusing with it, what we'll say is that it's now called the Support Electronic Referral Loops by Receiving and Reconciling Health Information Measure. Basically, we feel it's a slight name change which does not have any other impact to how it's measured. We feel that this more aligns with the intended and subsequent actions of the measure, where integrating it into the EHR is not as important or necessarily required as much as reconciling the health information. Next slide.

So, the first measure under the HIE objective that we'll look at in a bit more detail is the Support Electronic Referral Loops by Sending Health Information. This 20-point measure looks at transitions 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, basically fulfills the following two criteria. First, they have done so in creating a summary of care record using CEHRT. That's the sort of standard you'll hear us kind of beat the drum over and over again. And number two is that it was electronically exchanged. The summary of care record was electronically exchanged using this. So it's a bit of a "two sides to the same coin" situation. The numerator of the measure is the number of transitions of care and referrals in the denominator, where a summary of care record was created and exchanged electronically using CEHRT. Essentially, a bit of a paraphrasing of what the definition is, the measure description is, up above. The denominator, on the other hand, is the number of transitions of care and referrals during the EHR reporting period for which the eligible hospital or CAH had an inpatient or emergency department, which is the POS 21 or 23 -- so, 21 and 23 was the transitioning or referring provider to a provider of care other than an eligible hospital or CAH. So, we will have all these definitions and descriptions up here for you to review at a later point in time, in case it's too much at once. But, hopefully, these little points here and there about what the numerators and denominators are kind of help to spell out how each hospital is required to measure these various components. Next slide.

The next measure under the HIE objective is the Support Electronic Referral Loops by Receiving and Reconciling Health Information. The measure looks to see if eligible hospitals and CAHs conduct clinical information reconciliation for, number one, medications; two, medication allergies; and three, current problem lists. And this would be for received transitions of care or referral, or for patient encounters through an EHR reporting period in which the eligible hospital or CAH has never before encountered the patient. Much like the previous measure, under the HIE objective, this measure is worth up to 20 points. Next slide.

Great. Now we are going to move on to review the Provider to Patient Exchange objective, which has only one measure underneath, titled Provide Patients Electronic Access to Their Health Information. Next slide.

Thank you. The Provide Patients Electronic Access to Their Health Information Measure is looking at patients who have been discharged from the eligible hospital or CAH inpatient or emergency department -- again, POS 21 or 23, respectively -- where the patient or authorized representative is provided timely access to view online, download, and transmit their health information; and the eligible hospital or CAH ensures the patient's health information is available for the patient to access using any application of their choice, as long as it is configured to meet the technical specifications of the API in the hospital's CEHRT. In short, that would mean there are some third-party applications, but we tend to call these patient portals -- it's what they would typically be most referred as -- and where the information would be located, how it would be accessed, and the functions that would be required of it. You can see that this measure is highly weighted, at 40 points, because we feel it really gets to the core of improved access and exchange of patient data in promoting interoperability. This exchange of data between healthcare providers and patients, we feel, is imperative to continue to improve interoperability, data exchange, and to improve health outcomes as a whole. We also believe that it is important for patients to have full control and access over and to their own health information. And we believe that we're aiming to show our dedication to this effort via this measure. Next slide.

Moving on to the fourth and final objective of the program, titled Public Health and Clinical Data Exchange. This particular objective structure is fairly different from some of the preceding ones, in that it is comprised of any two of the six available measures. We'll go into a bit more detail, but we think that this allows for a bit of flexibility in reporting on behalf of the provider. Again, we'll have a bit more later, but this slide is just to quickly summarize some of the key aspects of the Public Health and Clinical Data Exchange objective, which were not really changed in the final rule and should appear the same as last year's. For instance, reporting a yes or no attestation on any two measures is worth up to 10 points. And the measures each contain an exclusion which can be claimed, which would initiate the 10 points to be redistributed elsewhere. I'll go over a bit of the redistribution exclusions right now, since I don't think that I'll touch upon it as we break down the measure. So, essentially, all six available measures have exclusions associated with them, and if claimed, the points would be redistributed as follows. There's essentially two options, although we won't get a bit more detailed than that. If one exclusion is claimed for one of these measures, however another measure -- the second measure -- is attested to, the 10 points would be granted for the objective for the Public Health and Clinical Data Exchange objective. However, the alternative scenario is that if two exclusions are claimed, then the 10 points would be

redistributed to the Provide Patients Electronic Access to Their Health Information Measure. So, again, each slide will have a bit more of this information. And because there are six of them, I'm just trying to kind of briefly summarize, instead of going into each one at length. Next.

So, a bit more of a visual slide to help clarify, essentially, that this measure is assessing that an eligible hospital or CAH attests yes to be in active engagement with a public health agency, also known as a PHA, or a clinical data registry, a CDR, in which to submit electronic public health data in a meaningful way, using CEHRT. And the key caveat there is having to pick two of the six measures underneath the objective. You'll see that they're listed there as Syndromic Surveillance Reporting; Immunization Registry Reporting; Electronic Case Reporting; Public Health Registry Reporting; Clinical Data Registry Reporting; and finally, Electronic Reportable Laboratory Result Reporting. There is no numerator or denominator for these measures, but, rather, it's based on an eligible hospital or CAH attesting, again, to being in active engagement with one of these public health agencies or clinical data registries. Not one, since I possibly misspoke there. It would be, obviously, two would be needed to satisfy the measure. Ultimately, these are worth 10 points total. Our hope and expectation is that the participating hospitals will select measures that they currently have the ability to report on. However, to be clear, we are not requiring them to exhaust exclusions for all six or even the remaining four in order to receive the points or to have their points redistributed.

In a related topic, we're frequently asked if reporting on more than two measures of this objective would earn the hospital any additional points or bonus points, and the answer is no. We're really only looking for two of the six, and of course, the caveat there being that there are exclusions available if that's not feasible for the hospital. Next.

As I mentioned, in a bit, for the sake of time and to avoid some duplicative details, I will not be addressing individually all six of the objectives' available measures. But you can be assured that each of these slides contain all the information necessary in order to see if they would be selected for your particular hospital or program. So we're going to go next, and we're going to resume in a few more slides, so let's head to -- I apologize for this -- it's slide 26, which is the Security Risk Analysis measure. I know there may be a bit of a delay. Thank you. Sorry about that.

So, if we kind of think of the objectives and measures as one sort of functional aspect related to performance-based scoring methodology, basically we're going to be shifting away from that and look at a different type of measure and requirement for the Promoting Interoperability Program. This stand-alone measure, which is the Security Risk Analysis measure, requires the participants to complete each associated action. However, as much as it's required, it will not be scored. And so that's kind of why I differentiated slightly. We are requiring the Security Risk Analysis Measure to protect electronic protected health information, EPHI, created or maintained by CEHRT through the implementation of appropriate technical administrative and physical safeguards. In terms of reporting, the Security Risk Analysis may be conducted outside of the self-selected EHR reporting period. However -- and we won't overthink this too much -- but there's a couple caveats here that the Security Risk Analysis must be unique for each reporting period -- essentially, each year. The scope must include the full reporting period to cover the entire time that the EHR reporting period has been picked and must be conducted again within the calendar year of the

reporting period. So it's something that will be consistently required, year after year, but can't be not necessarily one-and-done. It must be repeated for each reporting period, year after year. Next.

So, as I just briefly mentioned in the previous slide, we're now going to be looking in a bit more depth at the performance-based scoring methodology and how it applies to eligible hospitals and CAHs that submit an attestation to CMS under this Medicare Promoting Interoperability Program. Eligible hospitals and CAHs must earn a minimum total score of 50 points in order to satisfy the requirement to report on the objectives and measures of meaningful use, which is one of the requirements to be considered a meaningful EHR user and to avoid a downward payment reduction. So, it will keep coming up in the following slides and even an example at the end, but essentially just to say that for all of the performance-based scoring objectives and measures that have been discussed today, the points have to be over the minimum threshold of 50, or else the participating hospital will not be considered a meaningful user and may be subject to a downward payment adjustment. Next slide.

So, speaking of scoring, these slides will look a bit familiar. They're a bit of a higher-level overview of the information that was just spoken about on each of the objectives and measures. Specific to Electronic Prescribing, I just want to give a little bit of note here that you may see the term -- or we have used the term -- about Schedule II opioid prescriptions. I just wanted to clarify that we define opioids as Schedule II controlled substances under 21 CFR 1308.12, as they are recognized as having a high potential for abuse, with a potential for severe psychological or physical dependence. So, in the measure specification sheets or in the rule, you might see Schedule II popping up as sort of a definitive kind of a measure of whether a prescription would be counted or not. And this is a bit of an emphasis on why we've chosen that. Next slide.

So, here for the Health Information Exchange, we just have a high-level review of the two measures, their maximum points, and just to reiterate that there are no exclusions available for these. Next slide.

The one measure available within the Provider to Patient Exchange objective -- as we've said, is the Provide Patients Electronic Access to Their Health Information Measure -- is worth 40 points, and there are no exclusions available. Next slide.

And lastly, this is just a simple review of the Public Health and Clinical Data Exchange objective, which lists the optional measures, of which any two out of six will be chosen, for a maximum total of 10 points. Next slide.

So, here is the example I was alluding to a bit earlier. You can see everything kind of in one compact place. This slide is a hypothetical example of a possible score based on a fictional hospital or CAH's performance. I'll go through just a couple little points here, but I think it's just a great resource to keep on hand and, kind of, with all the at-length definitions and numerators, denominators, it can get a bit heady and a bit wordy. So we think this is a great kind of asset to tack on and, in your own time, use as a resource to say, "Okay, really when it boils down to what points am I getting and how did it get to that point?" So, just as pointing to one of these for e-Prescribing at the top there, you'll see that they received a performance rate of 80%, which gave them 8 points out of the maximum of 10 totally available. And on the next line, the row, the hospital

attempted the Query of PDMP Measure by attesting yes. So, because it was a yes/no attestation, it does not have a numerator or denominator, there is no performance rate. However, because they tried to query at least one time, and they put yes as their attestation, they receive the full 5 bonus points. So I won't go too much further with each of these. It follows the same logic.

But you can see the chart continues and reflects the hospital's performance on the remaining objectives and measures, such that their total points for the Promoting Interoperability Program was 83. Since they successfully attested to every one of the objective measures, and scored over the 50-point minimum threshold, this hypothetical hospital satisfied the necessary requirements of meaningful use, which allows them to be considered a meaningful EHR user and allows them basically to avoid a downward payment reduction.

Again, just in summary, eligible hospitals and CAHs must report on all required measures. Really, the only thing that is optional here is the Query of PDMP, as we've gone over. However, for the rest, this means that as long as they submit a numerator of 1 or claim an applicable exclusion, then they will have, in fact, met the criteria for reporting on the measure, which would be the same for all of them. People ask, so it is possible, where a hospital has a specific measure, that they've performed poorly in. For example, a 1 out of 50, or, let's say, e-Prescribing, if it was 1 out of 10. Essentially, as long as they do well in all the other categories, and report on all the measures, and if they get that score of a total score of over 50 points, then they would meet the necessary requirements. So we hope that that gives hospitals kind of both room for improvement but the sort of strength to rely upon the areas where they're performing at a higher level. Next slide.

So, again, taking a bit of another pivot away from what we've been discussing previously, the next few slides and topics that we're going to review is the clinical quality measures, separate and different from the previous measures we've been discussing. These, you'll typically hear referred to as eCQMs, electronic clinical quality measures. Next slide.

So, electronic reporting serves to further the CMS and HHS policy goals to promote quality through performance measurement and, in the long term, improve the accuracy of the data and to reduce reporting burden for providers. We expect that, over time, hospitals will continue to leverage their EHRs to capture, calculate, and electronically submit their quality data, build and refine their EHR systems, and should be, in other words, gaining more familiarity with reporting eCQM data. Again, as eCQM reporting continues to advance, and hospitals have gained several years of experience with successfully collecting and reporting eCQM data, it is important to further our policy goals of leveraging EHR-based quality measure reporting in order to incentivize higher data accuracy, promote interoperability, increase transparency, and reduce long-term provider burden. So, that was some contextual background for today and for the slide that you're viewing right now.

The eCQM requirements for 2021 have remained at self-selecting four of the eight available measures to report on. That's the first bullet. You'll reflect and remember that just last year, they were cut down from 16 available to eight, so now we're picking four of the eight. However, the second bullet is that the reporting period itself -- and this has changed --

has been increased from one self-selected calendar quarter of data up to two quarters. Increasing the number of quarters for which hospitals are required to report eCQM data, we feel, will produce more comprehensive and reliable quality measure data for both patients and providers. Lastly, the eCQM submission period for the program is the two months following the close of the calendar year. I believe, if I'm not mistaken, we had a leap year last year, which meant February had 29, but typically it would be February 28th, the end of the second month. Next slide. Next slide.

Great. So, to close out the program requirements, displayed here are the final few miscellaneous attestation statements which must be responded to with a yes in order to ensure proper compliance. As you see in the two bullets at the bottom, they are the Prevention of Information Blocking Attestation and the ONC Direct Review Attestation. So, you can think of these and the security risk analysis as kind of they're just as important as anything else in the program, in terms of responding with a yes and being completed. However, they are not scored via a performance-based scoring methodology as you saw with the other objectives' measures. Next slide. And we can go one more slide.

So, essentially, here -- and again, this is why we keep stressing the importance of coming to our website and saving this presentation and looking at the slides, keeping them on hand -- because this graphic has an example of important calendar year dates, which range, if we're kind of going left to right, from when the initial reporting year concludes; next, kind of in the middle, is the attestation deadlines and hardship exception details; and then finally, on the right-hand side, to the final payment adjustments, which, of course, come a bit well after. Next slide. And one more slide.

We've included various links here I've kind of been mentioning and alluding to throughout today's presentation, that we think it's really important that these resources kind of be bookmarked, saved, kept in your back pocket. Various links and things here will take you to the main pages or documents that were referenced or cited today, including copies of today's webinar. One area I would like to specifically draw attention to are the 2021 measure specification sheets. They essentially contain everything you've heard today with those real specific deep-dive slides that include numerator, denominator, calculations, definitions, exclusions, things like that. A lot of contextual information per measure is included there. And I would recommend to keep an eye on our Promoting Interoperability landing website, where they'll be included shortly. You'll be able to find previous years' spec sheets, such as 2019 and 2020, that are currently there. For the latest, 2021, they'll be up shortly, as well. So, that concludes this portion of the presentation. And what I'll do is turn it over for the Q&As.

We are now going to start the question and answer portion of the webinar. For today's question and answer session, you can ask a question via chat or phone. To ask a question via phone, please dial 1-833-376-0535. Provide conference ID 4309315 if prompted, and press *1 to add your name to the question queue. As a reminder, CMS will answer as many questions as time allows.

Okay, thanks, Stephanie, and thanks, Dylan. As we wait for folks to dial in to ask their questions over the phone, Dylan, a couple of questions that came in while you were presenting. First, let's start with CEHRT. Just wondering if you could circle back on kind of the basic CEHRT requirements, including when the 2015 Edition needs to be implemented, as well as

certified by. And then, additionally, we had one commenter ask, if their EHR is not certified, are they exempt from the 21st Century Cures requirements.

Thank you. And, yes, that is a great question. And I do apologize, because there's a lot of kind of... It's essentially very simple, and yet it's one of these things that has a lot of kind of sticky language revolving around it. One thing I can say is that the 2015 Edition functionality -- so, if we're talking specifically about something being certified, being functional, essentially the functionality must be in place by the first day of the EHR reporting period, so it is operational, it's functional, it has every requirement that would be needed on the first day of the reporting period that the hospital has selected. But the vendor's product itself, the specific EHR that they purchased and that they're using, would need to be certified to the 2015 Edition criteria by the last day of the EHR reporting period. The eligible hospital or CAH must be using the 2015 Edition functionality for the full EHR reporting period of 90 days. However -- and I think we have these -- should have put it here -- but we have this kind of on various spec sheets and things like that, that in many situations, the product can and may be deployed while pending certification. We know that there are these ONC bodies and review panels and boards that they can tend to take some time. And so, of course, we're doing this to give some flexibility to each hospital. So the key here, again, is that it must have passed complete certification by the final day of the self-selected 90-day period but can be implemented earlier, at the beginning, with its functionality, pending certification. So I hope that might at least cover a bit of what one of the questions was. Thank you.

Okay, thanks, Dylan. Let's do one more before we go to the phone line. A couple PDMP questions came in while you were touching on that. One thing I think might be helpful to confirm, Dylan, is the Query of PDMP Measure is worth 5 bonus points in 2021, as opposed to 10 bonus points, which I know it is in MIPS. Are you able to touch on that quickly to clarify?

Yes. No, it's a great question. And our team here at CMS and in CCSQ, we work on a bit of both sometimes, so even for internally, it can get a bit confusing. So, there is that kind of odd overlap between the two rules when they go out. So, yes, just to clarify, the optional Query of PDMP Measure is still, for IPPS, for eligible hospitals and CAHs, is only for full 5 bonus points. That is for 2021. I probably can't speak too much more about it, but, obviously, as different rules come out and they kind of each leach and learn from each other, it may change for 2022. However, at this point, just to clarify, yes, it's still worth the full 5 points.

Okay, thanks. And then one other Query of PDMP question that came through, a couple different ways and times, so I've kind of tried to summarize all the questions, but, "Does the Query of PDMP -- does the actual query need to be done through your EHR, or can external sources be used to conduct the query?" And kind of going off of that, "What type of documentation would be required to show the query, if not interfaced within the EHR?"

That's a great question, again. And it does get a bit tricky. As I might have mentioned in today's presentation, I think the intended, desired outcome of the measure, in the future or at least as it's been predicted and planned, would be that hypothetically, in this real-world scenario, the state's PDMP would be integrated within the EHR, kind of this one-click button, boom, instant results, it comes right up to verify and indicate what might be happening with this patient. However, we've tried to design the

language for the PDMP such that it would still count if the state's PDMP were not integrated in with the e-vendor or the EHR, simply that they use the information from CEHRT, from the EHR -- such as a patient name, a patient date of birth, a patient ID, SSN, whichever it might be -- but that they use their information from CEHRT, if they use CEHRT, in order to then go and check the PDMP, to go and query it. So, again, yeah, it is fine if they are not associated. We know that there are many states that are not there, or it's financially not feasible at this time, or is in a pending process. And then, with this second question, because we don't have that listed in any specific detail, in terms of for audits or paper trail or anything like that, I think what we just generally tell people is that a screenshot. I know it sounds archaic or trivial, but if there's no other sort of recordkeeping for when or where the query was performed, I suppose just a quick screenshot and kept on file with the hospital's records or the patient records would be sufficient.

Okay, great. Thanks. Stephanie, did we have anyone on the phone line?

There are no questions at this time. If you would like to ask a question, please press *, then the number 1 on your telephone keypad. Again, that's *1.

Okay, then I will keep going with some of the questions that we received. So, for e-Prescribing, somebody did ask, "If a patient is discharged from the hospital to a skilled nursing facility, does that count as an exclusion for e-Prescribing?"

Hmm. Just think if they were discharged from an eligible hospital to a SNF, whether it would still count. I -- and I'm trying to look at the exclusion -- I don't... It is a matter of whether they would have the internal pharmacy or not, although we're [audio drop]. So, again, everything that I could answer in these questions is kind of coming off the top of my head, but I believe, from what we've heard, is that it would count in that sort of case, if we're talking about the electronic prescription being sent over.

Okay. Thank you. Moving on to the Support Electronic Referral Loops measures, one person did ask, "For the Support Electronic Referral Loops by Receiving and Reconciling Health Info, could you clarify if the patient must be discharged within the reporting period to qualify for the denominator? So, for example, if a patient was admitted during the reporting period and had a qualifying CCD received during that reporting period, but then was discharged after that reporting period, would the patient qualify for the denominator in that specific period?"

If I'm looking strictly based off the definitions of the denominators for this, it would be "the number of electronic summary of care records received using CEHRT for patient encounters during the EHR reporting period," blah-blah-blah, "where they were the receiving party of a transition of care." Yes, at least as the question is stated. And again, we're kind of making some generalities here. But from what I've seen and heard, it would still apply. I know that they might be extending the patient stay. The encounter might extend beyond the 90 days, but if it was received and reconciled, that's kind of the important aspect that we get at it. The information that was received was reconciled during that 90-day time, or more than 90 days -- but whatever the self-selected reporting period would be -- then it would count. Correct.

Okay, thank you. Stephanie, anyone on the phone line yet?

There are no questions at this time.

Okay. We will keep going. And you may have answered this a little bit in the previous question, Dylan, but one person under Support Electronic Referral Loops asked if you could give an example of a hospital receiving a referral loop and reconciling the health information. For example, is that like a hospital contacting a physician's office in the middle of the night, requesting an electronic summary of care?

Trying to make it as clear as possible. It would be that the one hospital has sent the information to the receiving hospital. The receiving hospital has to check this information -- the summary of care record, the CCDR, whatever, USCDI will be coming out and developing. But, basically, this record that is received by the, in other words, receiving hospital, they have three things to check for, which is medication, which is reviewing the patient's medication, including the name, dosage, frequency, and route of each medication. So medication is number one. Number two, they have to look for is the medication allergy -- review of the patient's known medication allergies. That one is kind of self-evident. And number three is the problem list, which is a review of the patient's current and active diagnosis. These three things are kind of the key things that that receiving and reconciling hospital is looking for. It might be possible that the patient doesn't have a medication allergy. It may say "none" there or "NA" or whatever. But all we're asking that receiving hospital to do is to check this, check it up against their EHR records of that patient, and to reconcile it with their records. Essentially, the whole spirit of this is to make sure that these hospitals and these points of care are communicating with each other so that one patient has the most latest, up-to-date, accurate, and consistent medical record, since we know we've always been a -- different possible vendors and possible EHRs and other different specialists, and they ask the exact same questions every time, "Are you still on this medication? Are you still on that?" And you haven't been on it in years or something. So the goal would be so that when the patient is moving from point of care to point of care, when they're being discharged and referred to another place, that the receiving entity is doing their due diligence to take that information, incorporate it, and reconcile it with their own records. Thank you.

Okay. Thank you. Moving on the Public Health and Clinical Data Exchange objective, one person did ask, if they are engaged with more than two public health registries, is there any value to indicating that when they are attesting?

No. I think, overall, we think that's great. Obviously, the idea is that the more, the merrier. It's better for states and national agencies, interstate agencies, et cetera, to be benefiting from this traffic and exchange of information. However, no, unfortunately, at this time, specific to 2021, they're just picking two out of the six, for a total of 10 points.

Okay. Thank you. Stephanie, do we have anyone on the line yet?

We do have a question from Raghavender Enjamuri.

Yeah, hi. Can I speak?

Sure, go ahead.

Yes, go ahead.

First of all, thanks for the session. It's really helping us a lot. And I just have one quick question here. You mentioned opioid and PDMP, Prescription Drug Monitoring Program, I believe. As of now, we implemented opioid drug. It's about a 5-bonus-point program. So we have this one. So, is name getting changed to PDMP? What exactly the difference between OPR or PDMP? I believe both are for substance-abuse drugs.

Correct. If I understand your question correctly, I guess it's just to confirm or clarify that -- and I do apologize if we use the term, the acronym, PDMP too often. Really all it stands for is a state -- Maryland, Virginia, California, Oklahoma -- their specific Prescription Drug Monitoring Program, which are typically, hopefully, most often referred to as PDMPs -- these electronic databases from the state, hosted by the state -- I believe that's the case in every state -- that tracks prescriptions of controlled substances, such as opioids, at the state level. Personally, I've gone to my own dentist or my physician, and they've been able to pull up their notepad and show me, and if I had just had surgeries or any other medication that was prescribed like that. And this is what we want to emphasize -- and the point of it being in existence -- is to really help providers and hospitals and clinicians really play an important role in patient safety, identifying patients who have multiple prescriptions for these opioids or controlled substances going on, and to have a bit more of a... In some states, it can be a very instantaneous search popped up right in the office, where they're able to identify, "Okay, 'X' patient has six concurrent prescriptions for Oxycodone," or something like that. I'm giving a vague example. So, yes, I apologize if you had more to that question, but, essentially, the measure of querying the PDMP, is really just, yes, at your hospital, checking once for one patient, at minimum, to look into that state drug-monitoring program, and to see just what information is made available. That's it at this time. We don't ask -- the measure doesn't ask -- that anything else must be done.

Well, I'm sorry, I just have another question on the same point. So, as of now, we just implemented opioid agreement plan. So we have a report, we can pull those substance abuse, controlled substance, maybe those two drugs, with this report.

Mm-hmm.

So, maybe by this next year, 2021. So, is it going to be changed to PDMP, so the name will get changed to "opioid" to "PDMP"? Is that right?

I'm not sure about which state you'd be speaking of, or which program this might be?

New York.

Off the top of my head, I'm not sure what the PDMP is called in New York? Of course, they have different names kind of all over the place, different acronyms. I would say, hypothetically, based on your question, if this is what the state is using as an electronic database kind of at the high level, at the state level, from the New York Health Department, then I would say that would suffice in querying, yes.

Alright, so, could I just have one last one? So, you said, for the 2021, the reporting year and the next, what will be the submission time? Is it going to be changed for the next year? Like, we have from January 4th to March 31st every year, so what would be the next reporting period?

At least for the sake of today's presentation, we would only be talking about this current calendar year of 2021, so from January 1st to December 31st. That's the year in which hospitals can select their 90-day reporting period.

Okay, thank you.

Alright, thanks a lot for your answer. Thank you very much for your patience.

Stephanie, do we have anyone else on the line?

No additional questions at this time.

Okay, thanks. A couple more questions that came in during the webinar, Dylan, regarding scoring. You indicated that a hospital could submit a numerator of one and still have completed the measure, and even if the score is low, as that is the key to get a total score to 50 points. Can a hospital enter zero while understanding that the hospital still needs to achieve the overall score of 50? Let me know if you need me to repeat that.

No, thank you. Yeah, that's a wonderful question. It's one that we kind of get from time to time, and we're working on being a bit more explicitly clear about it. In short, no. The answer is no. So, if for e-Prescribing, for example, they were zero out of 200. Or for some random reason, if the Support Electronic Referral Loops by Receiving and Reconciling. Or let's go, say, by Sending Health Information. Again, if that was zero out of zero, or zero out of 10, although, yes, they did report on it, the definitions say that there must be at least one, or a minimum of one, for at least one, et cetera, et cetera. So, I do apologize if that was not more clear throughout the presentation. But, yes, while they do have to be at 50, and they can score low in certain areas, I believe we have several fact sheets on the website and other parts in the rule, where it does clarify that it cannot be basically a zero. Thank you.

Sure. Okay, and then we did get a good amount of CQM-related questions. I think it would be helpful if you can clarify the reporting require-- not requirements, but timing for CQMs. We got a lot of questions if the two self-selected quarters must be continuous or, for example, is it just any two quarters. For example, could you report for Q1 and Q4, for example?

Yes. That sounds great, yeah. The two self-selected quarters do not have to be back-to-back. They don't have to be continuous. That's why we don't say something like they have to be six months complete. Or they don't have to be 180 days or whatever it might be. Essentially, yeah, two self-selected quarters out of the four. And that is calendar-year quarters, so not to be confused with fiscal or any other thing that might be used at a business. But really, yes, two quarters throughout the year, and that would be from January to the end of December. In terms of the submission period for these, because, of course, the fourth quarter is going through the end of December, they couldn't be submitting it during that time until it were completed. And so, for things like internal housekeeping, data cleaning, et cetera, the

eCQM submission period for the program is the following two months at the end of that calendar year. So, for example, this year, they would be picking two quarters out of 2021, and of course, that's a whole another kind of attestation webinar, and we have guides and things like that out there. But the eCQMs must be submitted, the information must be reported and submitted in the two months following the end of the year. So that would be January and February of 2022.

Okay. Thank you. Stephanie, do we have anyone on the line?

No questions at this time.

Okay, I will keep going. We did get some questions on the additional requirements and the additional measures. One question was, "Does marking a yes for Prevention of Information Blocking serve as a prerequisite for a successful attestation?"

If I could paraphrase, because I don't have the exact language of the Information Blocking in front of me, it would essentially be that you cannot attest that you are an information blocker, that you have participated in, I believe it's, knowingly and willfully blocking patient information. You cannot say yes to that and still proceed with the program. It is a requirement that you not be blocking patient information. And so I do apologize. I guess that some of the language can be a bit misconstrued, but on the sort of QualityNet reporting and attestation website, the full kind of language is listed there, when they would go to report. But in my own words, and trying to get more layman-speak, it would be that you cannot say that, "Yes, I have withheld this patient's information from them or from another hospital or something like that." It's an intentional act that for years now has been kind of building up in importance and in notoriety. And CMS and ONC remain more committed than ever to really be serious about this, for patient safety, for patient exchange, health access, state access, things like that. So, hopefully, that kind of paraphrase clarifies a little bit. The only reason I'm not getting specific to what the exact question might be is because, one, I don't have the language in front of me, and, two, I don't want to, I guess, make more of a mess out of it. But, hopefully, that makes a bit more sense.

Okay. Thanks. And while you have been answering questions, we have still been getting a good amount of questions about the 2021 specification sheet. So just want to reiterate what you mentioned earlier, that those will be coming very soon. They will be posted to the PI website. So, I know that there's quite a few folks asking. So, again, those will be coming.

Yes, and I do apologize for hyping something that is, of course, not made available as of this recording on January 12th, but I would recommend that anyone who is curious or this is news to them or whatnot, that they can still go to the main page that we have linked there, of our PI landing page at CMS. And you could look at the 2020 specification sheets. Obviously, the vast majority of that information would be consistent and still relevant, but not to formulate your 2021 plans off of, since, of course, we've gone over a few changes here today. But in terms of at least keeping an eye on the site where they'll be, as well as kind of a format of what information and content is there, which, again, includes all sorts of great stuff that you might have seen on the slides today, plus more. So, I'm not being a tease and tantalizing something that isn't quite yet available. However, it's just a great resource to keep in mind for staff, et cetera. Thank you.

Sure. And then, for the additional requirements, another question. If you could just explain a little bit more about -- and I know you kind of touched on this for CQMs, as well -- but the difference in reporting period versus reporting -- or, I'm sorry -- calendar year. So, somebody was asking, if they have a lot of hospitals within their system, and it takes them all year to get complete, can you just clarify on the actual reporting period for that? And that's for Security Risk Assessment.

Yeah. For the Security Risk Assessment, again, it is my understanding that it must be completed within the calendar year -- the same calendar year that your EHR reporting period is. So, for this, the reporting year I'm looking at, the people either following along or for hearing this upon recording, I'm looking at slide 38, which is the 2021 EHR reporting timeline, I think that does a really great job of talking about the reporting year, attestation deadlines, things like that. However, yes, the reporting year that we've been discussing all for today is the calendar year of 2021. So, that begins January 1st, just a couple weeks ago, and ending at the end of December -- December 31st. So, within that time period is pretty much, of course, when your EHR reporting period is selected and when the Security Risk Analysis would have to be completed by. However, by looking at slide 38, and we have plenty of resources on our website, that there's much more information out there available, in terms of those attestation deadlines, how to report via the Hospital Quality Reporting System -- we call it QualityNet, QNet -- and things like that. Of course, there's things, for time purposes -- and it could be a bit more brief -- we might not have gone into today, such as hardship exceptions or the attestations system. However, I think a lot of this information is on our website, and some of these slides should help clarify that, as well.

Okay, thank you. Do we have anyone on the phone?

We do have a question from Frank.

Yes. Hello?

Hello. Hello, Frank.

Okay, I have two questions, basically. I believe you already spoke about that, but I want to be very clear. The reporting period for the Promoting Interoperability Program for 2021 -- that is, this year -- is 90 days, not 180 days. It's 90 days.

Yes, you are correct. Yes, to make it short and simple, yes, it is a minimum of 90 days. And the hospital or CAH gets to pick the specific 90 days. And I guess, to be clear, the EHR reporting period of 90 days is specific to the objective scoring measures and objectives that kind of constitute that performance-based scoring methodology, which was that example we gave of the hospital making 81 points. That 90-day that they picked to report on that information -- all those measures, numerator, denominator -- that is, at minimum, yes, 90 days.

Okay. My second question is of some kind related with these different criteria that we must comply -- four different criteria. And the question is, as you show on the table, and you almost just explained, do you need to have numbers, you need to have information, on every of the different

criteria -- the four criteria? You can't attest with one of them with a zero?

Yes, that is correct. We feel that in the IPPS, in this program for hospitals, we think that the way that we've set up the various objectives and measures, with their numerators or denominators or exclusions, we think that it is sufficient and to be expected that there should be at least the 1 there. For example, the Support Electronic Referral Loops by Receiving and Reconciling Health Information, in America, even for rural hospitals or smaller hospitals, we think it would be very unlikely -- I mean, highly unlikely -- we see an example -- but where they would say, "We did not receive one transferal or referral, or a transition of care of a patient."

That's exactly my question, if you have the case that you have one of those transfers that you don't have in that 90-day period, a case, or you don't have even one case.

Well, I would say to that hypothetical situation, it would actually not be just limited to the 90 days. I would say that -- I guess I would have to ask if they didn't have one for the entire year, because, obviously, if they didn't have one all the way up through December, but then, December 15th, they got one, then I would recommend, of course, that that hospital select that period as their 90-day period, which would include the one. However, again, we have not heard of a case where a hospital did not receive one for the entire year, to make it more or less impossible to report on.

Okay. Alright, thank you. Thank you so much.

Thank you very much, sir.

Okay, is there anyone else on the phone line?

We do. Kimberly Stanhope.

Hi. I have two questions. They're kind of both related to scoring. Going back to someone else's question previously about the Health Information Exchange, Sending and Receiving Information, I think the previous question was, "Can you report a zero in that, and not have the points redistributed but still get a 50 or above and pass?" Since that one is broken out into two separate types -- sending and receiving -- say, could you get a zero for sending but the full 20 points for receiving, and would that be okay?

No, it's actually a great question, but no, because they are two separate measures under that Health Information Exchange objective, we treat them kind of independently. So each one must stand on its own and be reported upon. So, yes, you're right that it's kind of two sides to the same coin. In one role, you play the sender-submitter using CEHRT, using EHR to send this information out when a patient is discharged, versus the receiving and reconciling, meaning that, yeah, your hospital has been given and sent and submitted this information to you, and then it is your job as the recipient to, used to be, "integrate," but now we use the word "reconcile" to take that information into, yes, "reconcile" it with your current records. So, to answer your question, yeah, they don't kind of get combined together. They're two separate rules, two measures, and they both must be reported on with a minimum of one.

Okay, and then my other question is about the eCQMs. I know we have to report on four of the eight that are specified. Do we just have to report data? Is there any kind of scoring? Is there any kind of pass/fail for those? What is that like?

No, it's a great question. Yes, in short, it is a lot simpler. And, no, we do not score them. We don't rank or have these sort of calculations where the points matter or total or get added up, at least in the strictest sense of hitting the 50-point minimum. Think of the eCQM requirements as being "separate" from that, kind of detached from that in the sense that, no, they are not scored, measured in that manner, to where it would be kind of held against a hospital or negatively impact the hospital. And just to clarify, if I heard you correctly, is that, yes, you pick four of the eight. And so, in years prior, there was 16, and I believe it was you picked eight of the 16. But just to be clear, for 2021, it is still you're picking four, at your leisure, of the eight that are made available.

Okay. Who -- Or, I guess, what number? I've kind of had some trouble getting information when I have these types of questions. What would be the best place to call or to direct these type of questions to?

I would say, one of the best is if you were to actually go to our Medicare Promoting Interoperability Program website on the cms.gov website. [Audio Drop] I think, the Listserv there, you can kind of get up-to-date information. I don't have their e-mail address memorized, but there is a help desk -- a sort of QualityNet help desk with a public e-mail address that is available and posted on our website for these sort of great policy-specific questions. That help desk is available throughout the year. We work with them quite diligently and frequently. Again, I do apologize. You'll probably have to do just a little searching of our website. That is another resource where you wouldn't have to wait for the next year's overview webinar to kind of ask a specific question.

Okay, thank you.

Okay, thanks. And to clarify, the QualityNet can be found on the Registration & Attestation page of the PI website. And the e-mail is qnetsupport@hcqis.org, if that's helpful for anyone.

Appreciate it.

Thank you, sir. Do we have anyone else on the line?

We have another question from a Tom Kurtz.

Hi. Thank you. So, I have a question about the Reconciling and Receiving Referral Loops question. We're in a community where a majority of our local physicians and providers are employed and are on the same EMR as our inpatient EMR. So if we have a patient that is inpatient, and we, out of our own ambulatory system, look at problem lists of allergies, medications, and those types of things, is that considered a numerator and denominator? Or do we have to have a CCD that's exchanged through the HIE outbound and inbound to meet that measure?

Thank you. It's actually a really good question and a bit of a tricky one. I know, on our specification sheet for that measure, we kind of talk about situations where it may be, like you said, internal to the team, family

system, with shared EHR access. The formal policy -- I'll be frank. The formal policy doesn't have that much explicit information where we wrote into the Federal Register that it could or could not look a certain way under the circumstances. But at the same time so, we have to look at what the definition is, and make sure that it still applies. So, on the one hand, I'm hearing that you're saying that you could go into the system and just kind of check and see if they had allergies or something, because the patient was transferred from one clinic or one department to another. I will admit, it's a bit of a gray area. I believe, in the past, we've kind of erred on the side of, yes, including those, of saying that it would count, as long as, again, the sort of measure description were met, in the sense that we don't have a lot of definition from some of these words and terms. But if they were -- if it was sent via the EHR, via CEHRT -- and that could be direct messaging or it could be via the vendor portal or something like that -- but I think you can obviously hear that it's a bit more complicated. But I don't think we would want to get in the practice of saying that that would not count, especially for -- I'm here out of Baltimore, Maryland, and so there's many within the Maryland system that just have these sort of larger systems. Johns Hopkins is in the state of Maryland, et cetera. So, in that case, at least as far as far I'm understanding it or hearing it, I would say that they would count. I would just recommend and encourage you to go back to the measure's definition, description, and as long as you kind of follow what that's saying, we would feel that in-system kind of transfers and referrals would still count, even if they're using the same EHR program. I apologize. Was that close to what you were asking?

Yeah, that makes total sense. It's one patient, one record, so it's one problem list, one allergy list, one medication list, regardless of the care setting the patient comes from. So, either whether it's referred from an inpatient and discharged home with their follow-up with the family provider, or if they're an inpatient or an ER visit and they open up the record, all of their provider information is already in there. So we would count that in the numerator and denominator.

Mm-hmm. Yes, as long as the other part there of the reconciliation for those things has been done. And we're kind of leaning on faith there and, of course, taking the hospital's word when they're saying that, "Yes, we did. We didn't just take the patient and understand that it's the same person, but that we went into their record, looked at their medication list, their allergy list, and their current problems, and reconciled whatever sort of information, if any, needs to be updated." That's kind of the spirit of it.

Great. Thank you.

Thank you.

Okay. And it is just about 2:30. I think that we'll conclude our Q&A portion. Dylan, do you want to go ahead and close out today's session?

Yes, yes. That was wonderful. There was a lot of really great questions and things that we'll incorporate in the future, to make sure that we highlight. We always love hearing these. So, basically, thanks to all the participants who joined us for today's webinar, for those listening to the recording at a later date. Again, just to repeat, we encourage you to visit the various resources that were included with the webinar, or via the respective links under the Resources page, as well as to keep a copy of the slides. Think they will be posted on the Promoting Interoperability Program Events

webpage. I think that's on a slide just a little bit before this. So, after that, thank you again for your participation. And have a wonderful day.