CY 2023 Medicare Promoting Interoperability Program Overview Webinar
December 13, 2022

Hello, everyone. Thank you for joining today's calendar year 2023 Medicare Promoting Interoperability Program Overview Webinar.

During this webinar, CMS will provide updates on changes to the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals in calendar year 2023. The presentation will include an overview of the program and highlight updated CEHRT requirements, modifications to the program objectives and their measures, scoring requirements, new Electronic Clinical Quality Measures, or eCQMs, and lastly, important dates and where to find resources.

At the end of the presentation, CMS subject matter experts will address as many questions as time allows. Now I'd like to introduce today's speaker, Jessica Warren, Program Lead for the Medicare Promoting Interoperability Program. Jess, you may begin.

Thanks so much, Enzo, and thank you and welcome to everyone who's joining us today. We're really excited to share the calendar year 2023 Medicare Promoting Interoperability Program overview with you.

Before we begin, just a few housekeeping items. First, if you're having any technical issues, please feel free to reach out in the chat. We have a team ready to help you. Next, the information presented today will be specific to the Medicare Promoting Interoperability Program requirements, so that would be for eligible hospitals and CAHs only for calendar year 2023 EHR reporting period. We are not going to be discussing the MIPS Promoting Interoperability performance category, nor answering any questions on that program or future rules.

During our Q&A session, we cannot take questions on future rulemaking or future years of the program. And as another reminder, the slides and the recording of today's session will be posted to the Promoting Interoperability Program website in a few weeks. For any questions that are not addressed live or in the chat, we will respond outside of the presentation. And last, I'm very excited to share that Elizabeth Holland, the brains behind all things PI Program, is on the webinar with us today.

Elizabeth will help address questions in the chat, and, Elizabeth, feel free to interject throughout the presentation. We're super happy that you're here to join us today.

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One more slide.

One more.

There we go.

So, a brief overview of the history for those new to the Medicare Promoting Interoperability Programs, we were originally introduced as the EHR Incentive Program in 2011 under the HITECH Act of 2009, a

series of three stages one, two, and three, all aimed to encourage eligible professionals, eligible hospitals and CAHs to adopt, implement, and upgrade certified EHR technology, thereby demonstrating meaningful use of health IT.

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As we progress through Stages 1, 2 and 3, we've maintained our underlying focus on the adoption and implementation of CEHRT through an evolution of objectives, measures, and eCQMs tailored to meet our goals.

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Beginning in 2018, CMS launched a new phase of EHR measurement for our programs that was then renamed the Medicare and Medicaid Promoting Interoperability Program, where we shifted our focus from the adoption of CEHRT to the interoperability and improving patient access to health information. With the end of the Medicaid Promoting Interoperability Program on December 31 of '21, we were 'once again renamed the Medicare Promoting Interoperability Program, and that began January 1 of 2022.

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The Medicare Promoting Interoperability Program, as you know it today, includes a set of objectives, measures, eCQMs, and other requirements that together define whether an eligible hospital or CAH has met the minimum standards to be considered a meaningful user. For those who do not meet the minimum program requirements, meaning they're not meaningful users of CEHRT, they receive a downward payment adjustment.

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Eligible hospitals and CAHs must meet the minimum requirements to be considered a meaningful user of CEHRT every year to avoid the annual downward payment adjustments. For eligible hospitals, the downward payment adjustment is a reduction to the applicable percentage increase (API) through their inpatient payment rate for the corresponding year. For CAHs, however, their Medicaid reimbursement will be reduced from 101% to 100% of their reasonable cost for the corresponding year.

As a quick reminder, for those unable to meet the minimum program requirements, we do offer a maximum of five hardships per CCM per lifetime, and information on the hardship application process can be found on the PI webpage.

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And one more side.

All right.

So now we'll go over a few of the program changes specific to calendar year 2023, and then we'll do a deeper dive in just a little bit. So, we'll go in order here.

The Query of PDMP measure is now required, worth 10 points. And we have included Schedule II opioids and also Schedule III and IV drugs. In our published final rule, we do include a table showing examples not completely inclusive, but examples of which drugs are classified under which drug class. The Health Information Exchange Objective has a new option for completing the measure, completing the objective, and that's called Enabling Exchange under TEFCA measure. Again, we'll go into further detail in just a little bit.

For the Public Health and Clinical Data Exchange Objective, the levels of active engagement have been consolidated and renamed. Option one is a combination of the existing levels one and two. This is now called Pre-Production and Validation. Option two is the existing level three, and it is now called Validation and Data Production. Also new is the requirement to submit your level of active engagement.

We've made several scoring adjustments. These include a reduction from 40 to 30 points for the HIE Objective, a reduction from 40 to 25 points for the Provider to Patient Exchange Objective, an increase from 10 to 25 points for the Public Health and Clinical Data Exchange Objective, and an increase from 10 to 20 points for the e-Prescribing Objective.

Also keep in mind that the Query of PDMP is required, so it's no longer worth bonus points. It has an allocated 10 points.

For eCQMs, a few reminders. The Severe Obstetric Complications and Cesarean Birth eCQMs are voluntary in 2023, but policy states that they will become mandatory in 2024. In alignment with the hospital IQR program, beginning with 2023, we're also going to require four quarters of data to be submitted for eCQMs.

Next slide, please.

So before getting into the specific objectives, measures, and other requirements, we'll go over a quick overview on timelines. So, the reporting year begins on January 1, and it will end on December 31 of 2023. During the entire calendar year, eligible hospitals and CAHs may choose any consecutive 90-day period as their chosen EHR reporting period. This information is reported and or attested during our reporting period, and that would be January 1, between January 1 and February 29 of 2024. For those who do not meet the minimum requirements for the program, they may be eligible for a hardship exception. That application is due prior to September 1 of 2024. And another reminder that you may only have five hardships per CCM per lifetime. And with regard to payments, neutral or negative payment adjustments are considered and applied on January 1, 2025.

Next slide, please.

So, a few highlights on scoring. The successful completion of all requirements allows up to 100 possible total points, where a minimum total score of 60 points is required to be considered a meaningful user. This means that eligible hospitals and CAHs must report on and or attest to all required measures, eCQM requirements, and other requirements for the program, regardless of the final score. You can't leave any category blank. When calculating measure and objective scores, CMS will round to the nearest whole number to a maximum of up to 105 points, and that's inclusive of the five bonus points.

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Basic overview of the point distributions we just discussed, broken down by objective and measure. We do have a table similar to this in the 2023 final rule that's been released. And another reminder for the HIE Objective just because it could be a little confusing, there is one main objective, the HIE Objective, and you have three different options, three different measures, to complete the requirements of the objective.

So, the first option is the Support Referral Loops by Sending or Receiving. That's option one. Option two is the Bi-Directional, and option three is the TEFCA. You only need to choose one of those options to complete the objective requirements.

Next slide, please.

A few reminders for CEHRT requirements. Beginning in calendar year 2023, eligible hospitals and CAHs are now required to use 2015 Edition Cures Update criteria. This was finalized for hospitals and clinicians in the 2021 PFS final rule. In some situations, your chosen vendor may be in the process of product deployment during your chosen EHR reporting period but pending certification. In these cases, the product must be updated to the 2015 Edition Cures Update criteria by the last day of your chosen 90-day EHR reporting period, up to and including the last 90 calendar days in the year. Another reminder that the EHR reporting period will increase from 90 to 180 days, but not until calendar year 2024. Finally, eligible hospitals and CAHs must provide their EHR CMS identification code from the Certified Health IT Product List, the CHPL, available on healthit.gov when submitting your data.

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As discussed previously, the Medicare Promoting Interoperability Program has aligned with the Hospital IQR Program in requiring that eligible hospitals and CAHs begin submitting a full year's worth of data beginning with calendar year 2023. This means that for 2023, you must report on three self-selected eCQMs and the required Safe Use of Opioids eCQM.

In 2023, for voluntary selection, are the Severe Obstetric Complications and Caesarean Birth eCQMs. We'll have the list in the next table.

So next slide, please.

So, this is the complete list of eCQMs available for self-selection in 2023. This same exact table is found in our 2023 final rule. As we just discussed, the Severe Obstetric Complications and Caesarean Birth eCQMs are optional for self-selection in 2023. But in 2024, they will be made mandatory. The Hospital Hard Opioid Related Adverse Event and Global Malnutrition Composite Scores are also made for voluntary self-selection.

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And one more.

The e-Prescribing Objective consists of two measures: the e-Prescribing measure and the Query of PDMP measure. They're both required, worth 10 points each. Though we don't have any changes to the e-Prescribing measure for 2023, we do have a few changes for Query of PDMP.

It is no longer optional; it is required. There are no bonus points. It now has 10 assigned points. And we're no longer limiting to Schedule II opioids. We're now opening the measure to Schedule II opioids, Schedule III and IV drugs. Both measures do have exclusions available.

And for the Query of PDMP, there are three exclusions available for 2023, but be mindful that the new third exclusion is time limited and applicable to 2023 EHR reporting period only.

Next slide, please.

So new for 2023, under the Health Information Exchange Objective is an additional third measure as an option to completing the objective requirements. So just to recap, because this one's a little bit confusing, the first option includes completing the sending and receiving loops, so the Support Electronic Referral Loops by Sending Health Information.

It says for at least one transition of care or referral to eligible hospital or CAH that transitions or refers its patients to another setting of care or provider of care. The second part to that to complete this as option one is Support Electronic Referral Loops by Receiving and Reconciling Health Information.

This states that for one, at least one, 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, or for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient.

The eligible hospital or CAH conducts clinical information reconciliation for medications, medication allergy, and the current problem with using CEHRT. So, both of those together are option one.

The second option is completing the HIE Bi-Directional Exchange, and I think we should have it on -- No, okay, so I'll go over the description. The eligible hospital or CAH must attest to the following three things.

Participating in an HIE in order to enable secure bi-directional exchange of information to occur for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department, all unique patient records stored or maintained in the EHR for these departments during the EHR reporting period in accordance with applicable law and policy.

Number two, participating in an HIE that is capable of exchanging information across a broad network of unaffiliated exchange partners, including those using disparate EHRs and not engaging in exclusionary behavior when determining exchange partners.

Third, using the functions of CEHRT to support bi-directional exchange within HIE, so this is independence of option one. This is option two, bi-directional.

New to 2023 is our third option, and this is called Enabling Exchange under TEFCA.

This says that the eligible hospitals or CAH must attest to the following, participating as a signatory to a framework agreement. This is a term defined by the common agreement, and it's published under ONC's Federal Register rule on their website in good standing and enabling secure bi-directional exchange of information to occur in production for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department, and all unique patient records stored or maintained in the EHR for these departments during the EHR reporting period in accordance with applicable law.

Second part of this is using the functions of CEHRT to support bi-directional exchange of decent information in production under this framework agreement. And, once again, a reminder that you only have to choose one of the three options to meet program requirements. You don't have to use all three.

Next slide, please.

So, for the Provider to Patient Exchange Objective, we have no new updates to the objective itself minus scoring that we just discussed a few minutes ago. The measures is worth 25 points. Reporting is by numerator and denominator. There are no exclusions available.

Next slide, please.

So, the Public Health and Clinical Data Exchange Objective, we have a few updates for the 2023 EHR reporting period. Eligible hospitals and CAHs must report on four measures which include Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Lab Result Reporting.

The AUR measure was finalized for inclusion in the 2024 EHR reporting period, so we will not require that for 2023. Also new for 2023, we require that eligible hospitals and CAHs report their level of active engagement with a public health agency. As we discussed earlier, the options have been consolidated and renamed.

Next slide, please.

Not new for 2023, there are five bonus points available for those who choose to submit the Public Health Registry or Clinical Data Registry. You only have to choose one. You don't have to submit for both, and it's five points altogether, not five points per bonus registry chosen.

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We don't have any updates to the Security Risk Analysis Measure, but for a general recap, all eligible hospitals and CAHs must conduct or review a security risk analysis of their CEHRT. This allows the hospital to address the encryption and security of data, allowing them the opportunity to remediate any deficiencies found within the system. There is no score assigned to the measure. However, it is required, and you submit with a yes or no attestation.

This measure does not need to be completed within your chosen 90-day EHR reporting period. You can complete it at any time during the calendar year.

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For the SAFER Guides measure, we also do not have any changes for 2023. But again, another quick recap. The SAFER Guides measure consists of an eligible hospital or CAH attesting to whether or not they have completed a self-assessment on all nine of the SAFER Guides. And as a quick reminder, you can find all of the SAFER Guides on the ONC webpage.

Yes and no are both acceptable. We just require that you attest, yes, we completed the self-assessment, or, no, we did not complete the self-assessment. The only penalty is for leaving the statement blank, or I think there might be an N/A option. So yes and no are both acceptable. No does not mean any kind of penalty. Just don't leave it blank.

The self-assessment does not need to be completed during the chosen EHR reporting period. You can work on the initial assessment throughout the year. After you complete the initial self-assessment, the goal is that you don't have to do the full self-assessment in each of the subsequent years unless you're working with a new vendor, or you have major updates to your EHR system.

So, after you do the complete initial assessment, you just update annually as necessary. And again, the guides are found on the ONC webpage.

Next slide, please.

In addition to the Security Risk Analysis and the SAFER Guides self-assessment, we have two other program requirements to meet the minimum program standards. Included are attesting to the acting to limit or restrict the compatibility or interoperability of CEHRT attestations. You may remember this as the information blocking attestation.

Second, the (ONC) Direct Review Attestation. Both are program requirements. Neither are scored, and we don't have any changes for 2023.

Next slide, please.

New to 2023 is the public reporting of certain eligible hospital and CAH information, which will be posted on a CMS or a compatible webpage.

We will be posting with a preview period, the name of your hospital, your CCN, Meaningful Use Designation, which is not new, and your total score. This information will be made public. Notices will be sent out prior to the preview period, and we will assist with any discrepancies that are brought up prior to posting. And we should note that all of this data will be pulled directly from your unit submission, so just be cognizant that what you submit is accurate.

So, this is everything for the policy portion of the presentation. I will hand it back to Enzo. Thanks, everyone, for joining.

Okay, thank you. Jess, thanks for presenting. If we can please go to the next slide for Q&A. Okay, so we will now move into the Q&A portion of today's session.

If you would like to ask a question, please ask it through the Q&A box, or you, if you'd like to ask a question verbally, please use the hand-raising feature. If you do want to ask a question live via audio, please note that you must have a working microphone. I know that Elizabeth has been working hard in the chat box to answer a lot of questions, but we will just address as many questions as time allows.

And so, for our first question, Kelly, if we're able to go back to slide 9, assuming that for a CAH, it is only Medicare inpatient reimbursement. Can you just clarify that, Jess, or Elizabeth?

It is acute care services, and they're paid under the reasonable cost method.

Okay, thank you.

We do have a couple SAFER Guides questions if we can go to slide 13, please.

I know people find this hard to believe, but to fulfill the SAFER Guide measure a yes or a no will satisfy the measure. So, I know there's been a number of people asking that. But, yes, that is correct. A yes or no does fulfill the measure. Just don't leave it blank. A blank does not fulfill the measure.

Yeah, that was a couple of the questions that we have. We've been seeing a kind of recurring theme.

You know, is it a yes, no? Or if I, you know, if I attest no, is there any negative impact? I don't know if you -- I know you kind of just addressed that. I don't know if there's anything else that you want to mention there.

Nope, both answers are fine. It's new. And at first, it could be a little time consuming. We're cognizant of that. So, you can complete it. You can choose not to complete it. Now that we've had it open since 2022, of course, we encourage people to start working on it. Any subsequent self-assessments are going to be much easier if you start working on it now. So, we suggest just taking your time working on the initial. It'll be much easier later on. I think there's a lot of great information, but it's your choice. You can or you cannot. Just don't leave it blank. Blanks are not good. But yes and no, is totally fine.

Okay, and then one more SAFER question that came in earlier, Jess, if SAFER Guides were done in 2022, do they also need to be redone in 2023?

You don't have to go through the same level of -- when you do your initial self-assessments, unless you change EHR vendors or you have a massive upgrade to your system, largely, the information will be the same, and that's perfectly fine. You can go through, make sure there are no updates.

If there are no updates, you know, you can -- however you're documenting your assessment, you can just sign off for this year, and then you've completed it. If there's nothing to update or change, there's nothing to update or change. Just acknowledge that you look through it. You acknowledge there's nothing new, and that satisfies it.

Okay, thank you.

Another question, should we generate the CHPL CEHRT ID for the 90-day PI reporting period or for the full calendar year since the eCQMs are a full calendar year submission in 2023?

For the PI EHR reporting period.

Sorry, Elizabeth, were you clarifying it or was that the answer?

Yeah, that's the answer.

Okay.

Thank you.

And then if we can go again back to slide 9, Kelly, can you just talk a little bit more about the hardship, and can you maybe repeat what you said about the max of five exemptions?

Sure.

So, each eligible hospital or CAH, defined by your individual CCN, can apply for a maximum of five hardships. So, it's five hardships per CCN for the lifetime of that CCN.

If you have questions about merges, you can reach out to us about your particular situation. But generally speaking, you can apply five times to be omitted from the program requirements. There's either a neutral or a downward payment adjustment for hospitals.

And for CAHs, you would be going from 101% to 100%, so there is a little bit of a drop, but it's not a negative like with the hospitals. I think we have it on slide 12 the timelines.

So, let's say you're going into the reporting period, and you know for certain you're not going to meet -- Oh, there you go. So, let's say between January and the end of February, you realize you're not going to meet the requirements of the program. It's impossible; it's not going to happen.

On our PI webpage under the cms.gov, we have applications, and the requirements listed out for the hardship application process, we do review all of those manually within the PI team. And if you have any questions about your particular circumstance, always reach out to us, and we can take a look.

Sometimes there are glitches. Sometimes there are submission errors. Sometimes you simply just can't complete it for a variety of reasons. So, we're happy to help throughout that process. And we'll put this in the chat, but could we repeat about the slides when they're going to be available?

Yes.

Thank you, Elizabeth.

Yes, the slides and a recording from today's session will be posted to the Promoting Interoperability Programs Events page, hopefully, by the end of the year, you know, within one to two, maybe three weeks at most.

And then that also leads me to let everyone know that the 2023, you know, resources and content and spec sheets will be available within the coming weeks as well.

If we can go to slide 15, Jess or Elizabeth, if one of you are able to kind of go back over, we're getting a lot of CEHRT questions, if you're able just to go over the CEHRT guidelines for 2023 as they are, you know, changing a little bit.

Sure.

So, prior to 2023, technically ending December 31 of 2022, we allowed hospitals and CAHs to use the original existing 2015 Edition Cures. Or you could use the 2015 Edition Cures Update, or you could use a combination of those technologies. But as we finalized a couple years ago, effective January 1 of 2023, we require that hospitals move over to the 2015 Edition Cures Update.

Now, it gets a little confusing because you don't have to have the updates by January 1 of 2023. Let's say you're choosing the final 90 days in 2023. As long as you have the Cures Update by the last day of that 90-day period, you're fine. You meet the requirements.

So, you don't have to have it at the start of the year, but you do have to have it during the time of your chosen 90-day period.

Okay, thanks, Jess.

Ah, our next question, will there be two separate questions on attestation, one for SAFER Guides and one for Security Risk Analysis?

Yes. Right, there are.

There are other attestations as well, such as the ONC Direct Review attestation. So, you have to complete all the required attestations.

Generally, they require a yes answer with the exception of the SAFER Guides, which you can attest yes or no.

Okay, thank you both.

At this time, we can switch to our audio questions.

Our first question comes from Chris Baumgardner. Kelly, are you able to unmute Chris's line? Chris, you are unmuted. Go ahead and ask your question.

Hi, can you hear me, okay? Yes, we can. Great, thank you.

So, I work for a public health agency, and I was curious about the slide that showed the up to 25 points total for all four measures. Does that mean a hospital could, for example, only get the points for the immunization registry but choose -- maybe they weren't able to get connected to syndromic, case reporting, or lab. Would they get some sort of partial points for just that one, or do they have to meet all four?

There's no partial points.

Okay.

However, if you claim exclusions, you can still fulfill the measures if they're applicable.

Okay.

If you claim four exclusions, the 25 points will be redistributed to -- I believe it's the Provide Patient Access Measure.

Thank you.

The up to I wasn't certain what that meant, so I was trying to figure that out.

Yeah, it's just zero or 25. And if you get a zero, you fail PI.

Okay.

Thank you.

Okay.

Oh, go ahead, Jess. Oh, sorry.

I just wanted to add -- sorry to jump in, Elizabeth and Alle, but you don't have to be in level two option two of the level of active engagement. You can be in option one, just starting the communications. So, you don't have to be all the way there with all of the registries. So basically, if you registered for a particular registry five years ago, that would still count. Right.

Okay, thank you both.

Our next question comes from Sally Lee. Sally, you may -- I'm sorry, your line is unmuted. You may be self-muted, Sally, so you do need to unmute yourself on your end. Sally Lee, do you have a question?

Okay. If you do have a question, please just raise your hand again, and we will call on you.

Our next question comes from Jonathan Emerson.

Hello, can you hear me? We can.

So how do the requirements affect a facility that uses more than one EHR software? For example, if our facility has a clinic that uses a totally separate software that's not compatible with our primary software, do we still -- how do we meet the PI requirements if that's, you know, all of our software is not compatible with each other?

So, may I clarify that the clinics are outpatient?

Right.

Okay, so we would -- and, Elizabeth, feel free to correct me, but -- we would just have the requirements for the inpatient side.

There's a separate program for the outpatient requirements, but they don't tap into PI at this time. So, for Promoting Interoperability, we would just look at the EHR on the inpatient side alone.

Okay, that answers my question.

Thank you.

Okay, great.

Okay, our next question comes from Ally Murray. Ally, go ahead and ask your question. Just please make sure that your line is unmuted on your end.

Hi, I was curious for the eCQM part of PI if CMS has any plans to implement rolling the eCQM submission similar to the abstracted measures.

I may need you to repeat that one more time.

Sorry.

For the eCQM portion of the PI requirements, is there any plan to move towards rolling submission similar to the abstracted measures?

To a rolling submission?

Yes. Like submitting Q1 and Q2 as opposed to waiting until September, October.

Oh, no, we've never had any discussions on that. I'm happy to bring it to the Hospital IQR Team, but no. We require, for 2023, and beyond that the full calendar year of eCQM data is submitted. But the way that our system works, it doesn't actually open until January. But I'm happy to bring it as feedback to the team.

Okay, great.

Thank you.

Sure.

Okay, and as a reminder, to those asking, the slides will be posted along with a recording to the PI program's website within a couple of weeks, so just stay tuned to the Events page.

Our next question on the audio comes from Jessica Garcia. Jessica, you may begin. Your line is unmuted. Jessica, do you have a question?

Okay.

We will move on to our next question.

Tim Stewart. Tim, your line is unmuted. You may begin.

Okay, Tim, if you do have a -- Oh, yeah, we can hear you.

Okay.

Thank you.

So right now, for ELR and ECR, our EHR vendor says they're not capable of doing that, and we've got an exemption because we've got a registry of intent to do that. On ELR and ECR, the state said they're not prepared to do that yet, so I think we're okay for this year. But for 2023 is the EHR going to have to be able to do that if the state is capable of receiving it?

There's two things in play.

One of the things we finalized was requiring hospitals to move through the stages of active engagement. We delayed that requirement to 2024. So, in 2023, you could also be at option one, just like you could be in option one registration for 2022. So, if it still continues that your state is not ready, we do have exclusions for that, and you can claim exclusions, and that would fulfill the measure, the exclusion, if you can't be in production. I hope that helps.

Thank you.

Okay, our next question comes from Corinne Matthews.

There I go. Can you hear me?

We can hear you.

Great.

So, I just want to piggyback on that last question.

If we have a letter of intent for ECR, but we're not in production, we're still in testing, in that case, we would claim the exclusion? We wouldn't claim the credit for being in attesting phase with a letter of intent?

You can be in the testing phase, yes.

Okay, so we would claim it as inactive engagement?

Yes.

Okay.

The problem we're going to run into is -- so we delayed our policy from moving from option one to option two after one year, till 2024.

So, in 2024, you could still be an option one, but in 2025, you're going to have to be an option two or be able to claim one of those exclusions.

Okay.

Very good.

Thank you.

Okay, our next question comes from Shamika Bishop. Shamika, your line is unmuted.

Can you hear me? We can hear you.

Okay, great.

My question is in regards to the measure on sending and receiving of referrals. Does it qualify if a provider in the organization refers the patient to another provider inside the same organization? Do those kinds of referrals count for that metric?

They could, but the hospital has to make a decision whether they want to include all of them or exclude all of them.

Okay, okay, thank you.

Okay, our next audio question comes from Alicia Snipes.

Hello, so quick question. With the third option, the HIE Bi-Directional interface, do the inbound messages have to be for every single patient or only a certain percentage?

It is a numerator denominator measure if you're talking about the support, the two support measures.

No, the one stating you have a bi-directional interface -- -Okay, then it has to be for all patients.

Okay, thank you.

Okay, our next question comes from Feng Wei Zong.

You may begin. Your line is unmuted.

Hi, can you hear me?

We can hear you.

Great.

I think I'll follow up that question.

So, well, for the inbound one we have to receive for the outpatient, but not every outside provider has a capable -- joined HIE, you know, vendors and can send the information to us. So, when we get a penalize, you know, for not receiving the information from the outside vendors through the HIE. And also, the vice versa for sending the information out because we use HIE vendor to send out information to the outside providers, but not every provider in the same HIE vendor we use. And also, they may not have capability to do the, you know, by receiving the message. So, we'll has to be penalized for that.

For the Bi-Directional Exchange measure, as long as you make all your data available, and you're able to pull data from what's in the HIE, you'll be fine. We're not going to penalize you for other providers who don't have their information in that exchange.

Great, thank you.

And I also post another question in the Q&A is because the hospitals are wondering even we claim for the HIE Bi-Directional, if the school -- because the option one, the choice one, option one, is the one you can do either sending or receiving the message with the scores, percentage scores, to, you know, to the testing. But for hospital choose HIE bi-directional options, do we also need to demonstrate high scores for HIE sending and receiving as the evidence for the audit?

You only have to do -- you either have to do the two support measures, the HIE measure or the TEFCA measure. So, if you are claiming the HIE measure, you don't have to have any documentation for the two support measures.

Excellent.

Thank you so much.

So, will those answers be in the document? Because I want to keep those answers to show to the audit in the future just in case, we got audit.

Sorry, are you able to repeat your question? [Inaudible] questions that we're answering are going to be available somewhere in writing.

Yes.

Okay, thank you.

And I'm not sure that we're going to put them out in writing.

Okay, thanks, Elizabeth.

Our next question comes from Jessica Garcia. Jessica, go ahead. Your line is unmuted.

Hi, can you guys hear me?

Yes, we can hear you now.

Perfect.

My question was in regards to the SAFER Guide. I just want to confirm that there is nine of the assessment part of the program requirements. Is it different for outpatient and hospital, or is it the same guide for both of them?

Okay, everything we're talking about on this webinar is for eligible hospitals and CAHs. It's not for outpatient. It's not for rural health clinics. It's just for eligible hospitals and CAHs.

Okay.

Okay, thank you.

Our next question is from Corinne Matthews.

Corinne, go ahead. Your line is unmuted.

Great.

Thank you very much for taking our questions.

I wanted to go back to the previous question about the bi-directional HIE and the evidence files and hear what you might suggest would be appropriate to include in your evidence file. Would it be your contract with the HIE?

I believe we are going to put out information on what data you need to retain for data validation purposes. I know we do that on the clinician side, and I believe we're also going to do that on the hospital side.

Okay.

That'll be very helpful.

There'll be examples of exactly what you would need to retain.

Okay, appreciate that.

Thank you.

Okay, and our last question for audio, Randi Terry.

Can you hear me? We can hear you.

Okay.

So, the question is we are switching hospital EHR vendors halfway through the year. So, we can get the quality report out of one vendor for, let's say, the first four months and then quality reports out of the other vendor for the next eight months. We have found no vendor or any separate vendor that can combine those two together. Is it acceptable to send in two different files for the two different EHR vendors because we've not found anybody to combine them?

I don't think we can answer that because I think that's an IQR question because PI takes the submissions that you send in for IQR and uses them for PI. So, Jess, how do you want to handle that?

So, who do I ask?

Oh, actually, if you can share your information with the host in the chat, I can connect you with the IQR team.

Okay, thank you.

Okay, we have just a couple more questions that came in through the chat box while we were doing audio questions.

One for CEHRT.

Can you just talk about what the penalty is for not meeting the CEHRT requirements in 2023 or for 2023, I should say?

It would depend on whether you were -- it would depend on several things. If you're not meeting the CEHRT requirement, you will fail. Therefore, if you fail, if you still have hardship exceptions left, you might be eligible to apply for one of those. But if you do not, it will affect the update, your market basket update, if you're an eligible hospital, and it will reduce your CAH reimbursement from 101% to 100%.

Okay, and then our last question in the Q&A box for right now.

Do we need to submit our SAFER Guide attestation before the end of this year or when the window opens in 2023?

You will do all your data submission when the window opens.

Okay, thank you, Elizabeth.

That concludes our Q&A portion of today's presentation.

Thank you all for joining us today.

As we mentioned, we will share the slides, the recording, and the transcript in the coming weeks to the Promoting Interoperability Program's website.

Again, some of the 2023 resources will also be coming in the coming weeks as well. Again, thank you all for joining, and we hope you all have a great afternoon.