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Interoperability and Patient Access Proposed Rule Listening Session

Moderated by: Nicole Cooney
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Nicole Cooney. Thank you, you may begin.

Announcements & Introduction

Nicole Cooney: Good Afternoon Everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS and I'll be your moderator today. I'd like to welcome you to this Medicare Learning Network listening session on the Interoperability and Patient Access Proposed Rule.

During today's session, CMS experts will briefly cover provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for submission. Before we get started, all registrants received an email around 12 PM Eastern Time with the slide presentation for today's call.

If you do not receive the presentation, you may email at us at mlneventsteam@cms.hhs.gov. That's mln as in Medicare Learning Network, events with an S, team so mlneventsteam@cms.hhs.gov. Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A session. If you have inquiries, contact press@cms.hhs.gov.

At this time, it's my great pleasure to introduce our CMS Administrator Seema Verma, who will provide opening remarks. Administrator Verma?

Presentation

Seema Verma: Good Afternoon and thank you for joining us for this call to discuss two proposed rules released last month from CMS and the office of the National Coordinator for Health Information Technology. Together, these two ground breaking rules ensure Americans have access to their medical records in a digital format, increase the seamless flow of health information, reduce burden on patients and providers, and foster innovation by unleashing data for researchers.

This is an unprecedented step towards a health care future where patients are able to obtain and share their health data securely and privately with just a few clicks. This is just the beginning of a digital data revolution that truly empowers American patients.

I want to discuss briefly why we've done this and why this CMS rule is so important for the future of our health care system. Our nation is in the midst of the greatest health care challenge and perhaps our entire history if nothing is done to better control health care costs. By 2027, we will be spending almost one in every five dollars on health care, a cost crisis that will destroy our economy.

To address this, rather than increase government control of health care decisions, this Administration has chosen to unleash the most powerful force for change in our country, the American people.

To that end, last year myself along with Jared Kushner and Chris Liddell from the White House Office of American Innovation hosted a series of listening sessions in 2017. And in 2018, we introduced the MyHealthEData Initiative to further our objectives to empower patients, unleash innovation, and focus on results. And the three of us just put out an op-ed on this issue and it just went live in Fortune Magazine just earlier today, so I encourage you to take a look at that.

In any case, these proposed rules deliver on this commitment and builds on the work that we've been doing in the MyHealthEData Initiative over the past year. As most, if not all of you know, last year we overhauled the Meaningful Use Program to focus on promoting the seamless transfer of medical records throughout the health care system.

For the first time, hospitals trying to avoid penalties and doctors looking for incentive payments must meet increased standards for privacy and security, use the most recent certified electronic health records that allow data to be shared electronically with their patients and ensure that they are communicating seamlessly with other providers about their patient's care.

Last year, we also launched Blue Button 2.0, and this allows nearly 40 million Medicare beneficiaries to share their claims data in an API format with applications that help them manage their health. So there are now over 1,500 developers with access to this data in a controlled development environment and 17 actually using Blue Button data to build new apps.

And because of this, patients can now use their claims data to organize their medication list, share data with their doctors, donate their data to researchers, and help them understand and engage in their health. Consumers routinely perform many daily tasks on their mobile phones, banking, shopping, paying bills, scheduling, using secure applications.

And we believe that obtaining their health information should be just as easy, convenient, and user friendly. So, at CMS, we are doubling down on our commitment to empower patients by requiring health plans to follow our lead with releasing claims data in our Interoperability and Patient Access Proposed Rule.

We have proposed that by 2020, all health plans doing business in Medicare, Medicaid, and through the Federal Exchanges be required to share claims and other health information with patients electronically through an API and allow those patients to take their information with them when they change plans.

Making this information available through an API will allow easy integration for use by more patients, allowing them to be true partners in their health care. The proposal would enable them to more easily share their information with providers, family, caregivers and others. Combined with the nearly 40 million beneficiaries and traditional Medicare who already have access to Blue Button, this would bring the total number of patients with electronic access to their health claims to a 125 million.

We are also proposing that claims data follow patient as they move from plan to plan allowing a single access point for patients, sharing critical information for plans. Sharing claims data is just one piece of our path to a health care system that seamlessly shares data.

We're also putting an end to information blocking. The days of holding patient's data hostage are over. Our proposed rule includes a policy to publicly identify doctors, hospitals, and other health care providers who engage in information blocking or simply put we're going to expose the bad actors who are purposely trying to keep patients from their own information.

Patient data doesn't belong to the doctor, hospital or electronic health record company. It belongs to the patient. Increasing quality and driving down cost requires an informed care team and using the strongest lever we have at CMS, we're making it a condition of participation in Medicare.

We are requiring that all hospitals must send electronic notifications to designated health care providers when their patients are admitted, discharged or transferred from the hospital to improve transitions of care between medical settings to increase patient's safety, coordination, and improve overall care.

In the rule, we also included additional proposals that help courage the seamless flow of health data and so I'm going to go through some of those additional proposals. First, we are requiring health plans to make provider directory data available via an API including timely updates to such data for the majority of plans covered by CMS programs.

We are furthering care coordination for over 11 million dual eligible beneficiaries by increasing the frequency of data sharing among federal systems, state systems, and the dual eligible individual's health plan. To help inform our next phase of policies around interoperability, our proposed rule also contains two requests for information.

First, we want to hear from you about how we can put the weight of CMS behind patient identity and patient matching. This is a critical issue that must be solved to promote coordinated care and patient safety, and we need your help.

Second, we also want to hear about how we can improve health IT adoption and data sharing in Post-Acute Care settings. We need to make sure that every provider a patient interacts with across the health system can collect and share data.

Our work to facilitate seamless access to data is not over. We must continue to support standards development ensuring that the HIPAA designated record set is made available electronically. In this proposal, we reference the fast health care interoperability resource or FHIR standard and are thrilled to continue to support the industry and maturing the standard that will facilitate our move towards the health care system that effectively shares data and put patient at the center— puts patient at the center.

We have taken another step forward on our commitment to empowering patients and the MyHealthEData Initiative and the steps that we've taken so far should reinforce the message that we've been sending to the health care industry since this administration came into office.

The time of keeping patients in the dark in order to trap them in a closed system so that they'll never leave and never seek lower costs and higher quality options is over. We are proposing a major step. But you don't have to limit yourselves to our requirements. I encourage every health care provider to continually find new ways to empower their patients through making it easy, to receive and understand their health care information and by increasing price and quality transparency.

Thank you for your time this afternoon.

Nicole Cooney: Thank you so much Administrator. I'd like to introduce our presenter, Alexander Mugge, Deputy Chief Health Informatics Officer. Alex?

Alexander Mugge: Thank you and thank you all for joining the call today. I'd like to take this opportunity to expand on some of the proposal that the Administrator just covered in her remarks and to provide some additional detail that may be helpful in formulating your comment letters or that may spark some questions you may have, which we can review at the Q&A at the end of my presentation.

First, I'd like to highlight some of the unique features of the CMS Interoperability and Patient Access Proposed Rule. This rule represents a first phase the policies that CMS is drafting to promote patient access to the health information as well as advanced interoperability among health care providers, payers, and other members of the health care industry.

This rule is really a first of its kind. It reaches all the entities that CMS regulates. So, unlike some of our other rules that are focused on a particular aspect of the health care ecosystem, this rule really looked across the board at all of the entities that we regulate in this phase.

With the ONC rule that the Administrator mentioned, the Office of the National Coordinator rule that was released on the same day as the CMS Patient Interoperability and The Patient Access Rule. We are demonstrating as a cross agency federal department efforts to promote interoperability and engage all payers in the health care space and ensuring the data can be shared freely in a safe and secure manner.

So why did we do this rule? Maybe a question that you are asking yourself. Didn't HIPAA give access to patient access to their data already, isn't this already taken care. Yes, HIPAA technically gives patients the right to access their data. But in some instances, we're seeing that this is still not happening. Patients are struggling to access their health information; they're struggling to get their records from one provider to another. And they're struggling to get all of their information in one place.

We've heard a variety of excuses for why this is happening, a variety of reasons. The data is still being held in silo systems. We've heard that there are technical issues, information blocking issues. We've even heard HIPAA used as an excuse for why data is not flowing to patients and other providers. And so, we'd like to take this opportunity in this rule to encourage the sharing of data as well as to dispel some of those misunderstandings about HIPAA and the technical capabilities that are out there.

So, I want to go through each of these proposals. We have the proposal separated in the rule by some that are dedicated to Health Plans and Payers and some that are intended for clinicians and hospitals. I'm going to start with the proposals for health plans and payers. And when I talk about Health Plans and Payers, I am specifically talking about Medicare Advantage Organizations, Medicaid Managed Care Organizations, Medicaid Fee-For Service, CHIP Manage Care Organizations, CHIP Fee-For Service, and the Qualified Health Plans in the Federally Facilitated Exchanges.
So, quite a broad reaching group of health plans and payers that cover approximately a little over 85 million patients. So the first proposal we have in this phase is a proposal to require these health plans to build an openly

accessible API or Application Programming Interface to allow patient access to their health care information and that health care information could include claims and encounter data including cost information as well as lab test data if the health plan has that available.

So what does it mean for patients? This would mean that a patient who is enrolled in any one of the health plans that I just mentioned would be able to download an application to their smartphone or other device and be able to access all of their information in one place and the display that they have chosen by whichever application they have chosen to use.

This would also allow patients to view their data in a different way than perhaps what is shown in the traditional explanation of benefits, and to share that information with caregivers and the providers and others just with the click of a button.

The second proposal that we have for health plans and payers in reference to the provider directories is, we are proposing that these parties make their provider directories available through an open access API to not only their enrolled beneficiaries and patients, but also to the public at large for the purposes of perspective enrollees reviewing in network division as well as for the purposes of referrals, clinicians could use these API to locate an in-network provider for one of their patients before sending them off for a referral or for other purposes that care coordination is needed.

The third proposal that we have is the Payer-To-Payer Data Exchange Proposal. Now under this proposal, we understand that in the current atmosphere, we have payers and health plans to already exchange information for the purpose of the care coordination of their patients. The difference in this proposal and what we have everything here is that if the patient were to specifically ask the health plan to exchange information, they would be required to do so and to gather all of that patient information in one place up to 5 years back.

So, let me give an example on this one. So, if 5 years ago, I was enrolled in health plan A, and four years ago I was enrolled in health plan B, and I continue to churn through the market moving from payer-to-payer. Now here, we will say, 2020 because that's when the proposal is proposed to be effective. If it's 2020, and I go back to my health plan and say I want you to get my information from health plan A and health plan B.

My current health plan will go out to those plans, pull my information together, aggregate it into one location, and make that available to me through that patient access API, so that I could access it on my smartphone. That would give patient's insight to their treatment history, to their prescription drug history, the providers who have billed for services to that patient, all that information would be in one place and they'll be able to look back on five years or more of their health information.

The next proposal that we have is to require health plan to join a trust network and what this would enable health plan to do is it really better facilitates the exchange of information between not only health plans, but also with providers and health systems. As long as they are enrolled in the trust network that really just better enable that flow of information from one entity to another.

The last proposal that we have in this category, I'm going to say is really not for health plans, but as a payer proposal targeted at the State, the communication between State Medicaid Agencies and CMS. So, this is a

proposal for dual eligibles and to better improve the care that dual eligibles are currently receiving, so for those patients that are enrolled in those Medicare and Medicaid plans.

In the current market, states can exchange beneficiary enrollment information with CMS as little as monthly. And the challenge here is that if the data file is sent on the first of the month and a patient enrolled in a Medicaid plan on the second of the month. If the data is not updated with Medicare on a regular basis, that patient may go as long as a month without having that coordination of benefits they may be unduly billed for a service and their experience when they visit the doctor is confusing and not conducive to their best care.

In addition, it requires CMS and the states to reprocess claims, which is a waste of resources. So, in this proposal, we are suggesting that states would send data to CMS daily, which would eliminate some of those challenges and would really create better beneficiary experience for that dual eligible population.

Those are all the proposals that are aimed at health plans and payers. I'm now going to shift to the proposal intended for providers. So specifically, our first proposal has to do with the practice of information blocking or when a clinician or hospital intentionally withholds information from the patient or another health care provider.

Currently in our Promoting Interoperability Program or what was previously known as the Meaningful Use Program, we have attestations whereby clinicians and providers must attest that they are not knowingly or willingly participating in the practice of information blocking. If a provider is unable to affirm that they are not information blocking and instead say that, no there is that possibility they are information blocking, we would publicly report the names of those providers on the CMS website.

This proposal is very specifically encouraged to deter folks from information blocking and to really root out as the Administrator refers them as bad actors who are withholding information and not contributing that information to the patient's care.

The second proposal that we have is related to our NPPES Provider Directory. Last summer, the NPPES Provider Directory was updated to accept, fields with provider's digital endpoint or we'll call it their digital address or it's sort of a form of secure email if you will, but NPPES is now capable of collecting that digital endpoint information for all providers, which would facilitate better care coordination in the digital space and allow providers to find each other in the digital space to exchange secure information.

But that only works if providers are actually putting their information into the NPPES database. The proposal that we have in this rule would suggest that we publicly report the names of those providers who do not put their digital contact information into NPPES by a certain date. This is again to encourage the flow of information between providers, help them to find one another in the digital atmosphere, and exchange information.

So, it is critical that contact information be made available so the providers can find one another and make that happen. The final proposal that we have for providers is really geared towards the hospital. We are proposing as a condition of participation in Medicare that hospitals would send an electronic notification upon admission, discharge, or transfer of their patients to any health care providers to have an established care relationship with that patient.

So, what that would mean is if a patient is admitted to the hospital, their provider would immediately be notified that there has been a change in their health status and that they have been admitted. When they're discharged, the provider would also be notified of the discharge so the provider can reach out to or better care-coordinate for that patient.

So, this can be used for a variety of care-coordination or for notifications during transfer of a patient to another facility and really improve the patient experience and ensure that they don't fall through the crack.

That's all for the proposals of the rule. We also have three RFIs — two or three. The first one is for our center for Medicare and Medicaid Innovation Models. In this proposed rule, CMS has established that all future CMMI models will include some sort of interoperability requirements going forward.

So, any future model will have interoperability requirements built into it. However, because the model is very significantly between what providers are included in that model as well as the requirements of the model, those interoperability requirements could look different across the different models and this proposal/RFI is looking for feedback on what that should look like going forward.

The second RFI is in relation to patient matching. One of the greatest barriers to interoperability that we hear about is the inability to correctly match patient record that they're coming into our system and so not being able to get a full picture of that patient's care. Without the ability to link those records, we really - it's challenging to move forward with many other interoperability proposals because the patient data is kept separate.

This RFI, we are asking questions on how CMS and the Office of the National Coordinator can better promote the practice of patient matching, and how to get to a point where industry is able to do this more consistently and effectively.

The final RFI is in regard to Post-Acute Care providers and— seeking comment on how we can better encourage the adoption of health IT and Post-Acute Care settings as well as how to advance interoperability among those settings.

So that is the extent of the proposals in RFIs of the rule. I want to stress some of the impact for the different health care stakeholders that this rule has. As I mentioned at the beginning, this rule is very far reaching, and it impacts many of the entities that CMS regulates as well as patients. So to highlight for patients just some of the benefits of this proposed rule, we believe that this rule will improve patient access to their information, will better engage them in their health care and would make them better consumers of health care, making them more aware of their treatments and their history and helping them to just be better consumers and facilitators of their own care.

For providers, I again want to stress that this is a first phase of policies that CMS is looking at to improve interoperability in this phase. Some of the benefits that the proposal here give providers will give them more comprehensive data on their patients so they can provide better care and better treatment. And also facilitate easier access between providers to information for health information exchange purposes for care coordination and other means.

Then finally for payers, I want to highlight some of the benefits here. This is one of our first steps into engaging health plans and payers in interoperability and health IT space. So historically, many of our health IT efforts and interoperability efforts have been focused on clinicians and hospitals. This rule is bringing health plans into that phase along with the clinicians of the hospitals to get all payers and health care industry working together to advance health information exchange.

Secondly for payers, this will provide better care coordination as they'll have access to more information to better facilitate their patient care, which will improve their relationship with their patient and improve the coordination with those patients as they move throughout the health care network.

This also we've already seen with our Medicare Blue Button 2.0 Initiative how access of this information can reduce fraud for health plan. For example, we had a beneficiary who was reviewing their Blue Button claims information and noticed that there was a piece of equipment that was being billed to them on a regular basis, but that they were not receiving in their care facility and they were able to alert Medicare of this inappropriate billing and put a stop to that.

So, this is a really another way for payers to better engage that patients and being consumers and also ensuring that their billing is always accurate. So, we've talked at you for quite a bit. I'm going to wrap up my part of this talk and open it up for questions, so I will hand it back over.

Question & Answer Session

Nicole Cooney: Thank you. Before we get started on the Q&A session, I'd like to set a few ground rules for today. First, we're looking to take clarifying questions to help you submit your formal comments on the rule. Today's call is not the forum for specific questions about your medical practice or place of business and we ask for your understanding in that there may be questions today that we cannot answer because CMS must protect the rule making process and comply with the Administrative Procedure Act.

And it's also important to note that verbal comments on today's call do not take the place of submitting formal comments on the rule in the final side in the presentation that was emailed to you. There is a link to the final rule and the details in the formal comment process are contained within that document.

I do have a lot of folks on the line with us today in an effort to get to as many participants as possible. I'm going to spend about three minutes on each question and answer, each sort of dialogue exchange, and I appreciate everyone respecting that time and understanding if I do have to break in.

And also, as a final reminder, today's session is being recorded and transcribed.

Dorothy, we're ready for our first question.

Operator: To ask a question, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking your question. So, anything you say or any background noise will be heard

in the conference. If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits.

Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Your first question comes from the line of Kim Sweet.

Kim Sweet: Hello and thank you for taking my call. My name is Kim Sweet from Scroggins Grear and we deal with a number of medical practices. We're actually accounting and taxes, and I help them understand a lot of these processes and they're very, very confused out there and aren't getting any support.

So, one of the things I would like to mention or ask about is as I'm not seeing the support on the provider side even into the final rules as I read through them and there are a lot of providers who actually want to do this, but they're not getting the support. Their EHR vendors are not accommodating. Their EHR vendors don't understand the requirements. They are also misleading the providers, causing them to fail on their process.

And all the providers are told is well your best option is to change the vendor and that's not financially stable plus you could be walking into the same or more problems. So, my question is, is CMS doing anything to make the vendors more accountable and to support the providers so that providers have some place to go when you are having a big problem with an EHR vendor and they get support for those problems and issues?

Alexander Mugge: Thank you for your question and to your point, EHR vendors are not specifically addressed in the CMS rule. However, the Office of the National Coordinator also came out with an information blocking and 21st Century Cures Act rule also on February 11th and is published in the Federal Register as of yesterday.

Their rule is very specific to the practices of EHR vendors and the certification criteria and data sharing requirements of the EHR vendors. So, in that sense that their rule will very much support what you are asking about. In addition, we are --

Kim Sweet: Is there a link to that where I can get access to that? Is that possible?

Alexander Mugge: Of course, yes. It is also in the Federal Register and if we have contact information, we can supply the link or well you can always add it to the slide deck when it gets posted as well. Okay

Kim Sweet: That would be wonderful, thank you very much.

Alexander Mugge: Sure

Operator: Your next question comes from a line of Mark Mancini.

Mark Mancini: Hi, this is Mark Mancini from Little River Medical Center. I appreciate your presentation that's the information I love to hear, very excited about it. So, the only concern I have is here in Lovely Myrtle Beach, South Carolina, we have one HIE, which hardly any providers let alone hospitals use.

So, my question and concern is while we can build these interfaces in the EMRs, we don't have the ability to enforce the hospital and providers, mostly hospitals to share this information. We're not seeing it now. Is there anything that can be done to ensure that they interface this way rather through their own custom portals that we have to jump through hoops on or still like we do now have the fax stuff back and forth instead of using direct messaging like we want to?

Alexander Mugge: Thank you. It's good to get some of that feedback and it's painful to hear that folks are still using the fax machine to exchange such vital information. I will again highlight that the ONC rule has really targeted the policies for EHR vendors to make some of their data sharing capabilities more enhanced their data sharing capabilities and proof some of the API that would enable providers to connect directly as opposed to requiring an HIE.

The proposals in this rule, I get there are couple of them that support what you're asking. So for information blocking by taking a hard stand against information blocking, we are requiring that if a patient or other provider is requesting data from a hospital, they would be required to share that information for care coordination purposes or treatment purposes or they would be considered as information blockers and since we have taken such a strong stand against that and there are ramifications to information blocking.

Secondly by updating the NPPES Provider Directory and putting those that you mentioned the direct contact information in that directory, it should better enable folks, providers to find one another an additional space and exchange that information, so that is a good resource to be using to find those other providers and make sure that data flow is happening.

And finally, I want to just highlight again that we believe you know-- we strongly are stating that this rule is a first phase of policies that will be geared towards that interoperability among health care providers. We are actively reviewing other policies that would better enable that data sharing that you're asking about and just help facilitate some of that among clinicians of all the hospitals, and we welcome your comments on the rule on how to make that happen.

Nicole Cooney: Thank you so much.

Operator: Your next question comes from the line of Eric Leiderman.

Eric Leiderman: Yeah, Hi. I work Kaiser Permanente which is in a number of states across the US. My question is and I might have missed that it's a long set of pages to read, but I don't understand how the risk is intended to be mitigated when patients elect to send their data to third party apps. So that there was a well-documented, well-publicized article in the Wall Street Journal last week through their investigative reporting found that fifteen apps currently on the market says that encourage people to ensure their personal sense of health information everything from blood sugars to menstrual period, we are being immediately uploaded to Facebook even when the user did not have a Facebook profile and apparently according to the article, none of these applications included any mention of their doing so in their terms and conditions.
So, I'm wondering if there's something in the rule that addresses, and these are not HIPAA covered entities.

Alexander Mugge: Thank you for that question. I do again want to highlight how critical privacy and security is to making interoperability happen and to the safety of patients and that's something that we keep in mind and is at the forefront of all of our planning on these proposals. So, thank you for the chance to talk about that.

We understand that we – this - is that these policies would be authorizing patients to share their health information with non-HIPAA covered entities and the entities that are more governed by the FTC. We are actively engaging in conversations on how to better secure that information, but particularly we're looking at a set of potentially standard terms and conditions that would make it very clear to patients how their information would be used and to ensure that that type of data sharing would not be — would not happen unless a patient authorized it.

So— certainly there are things to consider in that space and that is something that we are actively engaged in and working on with our federal partners. So, thank you for raising that again.

Eric Leiderman: I'm sorry, just clarification. So, you're working on perhaps including additional language in this proposed rule or in a separate proposed rule?

Alexander Mugge: No, apologizes. This terms and conditions that we're working with would be more like I suggested use terms and conditions that would not be something that is done through rule making and I'm not trying to interpret anything that we have in this rule as being such, but more you know engaging patients in understanding, educating patients and understanding what it in the terms and conditions, making terms and conditions easily usable for patients so they know what they're agreeing to and not just clicking through a bunch of screens without reading those terms.

So, working on a variety of ways to get all from that patient education to working with our partners at FTC and with our internal data team etcetera. So, I think it's something that we're attacking from all angles. Again, we don't specifically have anything in the rule making process about that, this is something that we are working on more holistically across the entire A to Z and really across the Federal government.

Nicole Cooney: Thank you so much for your question.

Operator: Your next question comes from the line of Lisa Sachwitz.

Lisa Sachwitz: Hi, thank you for the good presentation today. My question has to do with FHIR, the Fast Health care Interoperability Resources. Can you tell us if that is necessary for 2019 MIPS reporting? When I read through the measure specs for provide patients electronic access to their health information, there are references to using an API. So, I'm not sure if that's a necessary item or not.

Alexander Mugge: That's a great question. Yeah, so starting with the 2019 reporting period for the MIPS Promoting Interoperability Program, we are requiring that providers use the 2015 Edition of certified EHR technology. That 2015 addition does include API capabilities that the EHR vendors have coded in API and EHR in that 2015 Edition.

However, that API does not have to be FHIR based API, it maybe the EHR vendor's proprietary API. It maybe FHIR, it may not be. So, for 2019, it does not require to be in that format. However, in the ONC proposed rule

that again was released on the same day as the CMS rule. There is discussion in there about requiring FHIR-based API for EHR vendors in the future. So ultimately you know if those proposals were finalized, then the providers would have access to the FHIR-based API and may potentially be using that for data submission.

Lisa Sachwitz: Thank you.

Alexander Mugge: Sure.

Operator: Your next question comes from a line of Rose Don.

Rose Don: Good Morning, thank you very much for the presentation. I have a very quick question. Early information that was pushed out by the health care press implied that providers will no longer be permitted to charge patients for copies of their medical records. Was this early press interpretation correct?

Alexander Mugge: So, good question. The - First, I wanted to highlight that patients having access to their health information is a right afforded to them by HIPAA. So, patients should be able to access information in any format that they choose and if it is available - readily available to the provider, they should be making that information available at no cost.

The ONC rule that was published did include some language around patient access at no cost and so those reports were in a sense correct that is not something that is addressed in this rule, but if you wanted to learn more about that, I strongly encourage you to take a look at the language in the ONC rule.

Rose Don: Thank you.

Operator: Your next question comes from a line of Susan Hicks.

Susan Hicks: My question was actually answered previously, thank you.

Operator: Your next question comes from the line of the Victoria Jones.

Victoria Jones: Hi, this is Victoria Jones from Yavapai Regional Medical Center. On the requirement for hospitals to electronically notify other providers when a patient is admitted and discharged and so forth, did it make clear how that notification is to be done such as a secure email or by what method it would be done, you would have the ability to notify that provider by the new directories being updated making those addresses more available so that you could send that information out, could you clarify that?

Alexander Mugge: Yes. Thanks for the opportunity to clarify that. So, in the proposal, we specify that ADT messaging or Admission, Discharge, And Transfer messaging which is a standard that is available through most if not all EHR systems currently to send those alerts.

Does that help answer your question?

Victoria Jones: Yes, and so does that make it clear by what method that alert goes out through like a secure email transmission?

Alexander Mugge: So, it's not a secure email transition, it's a more of a direct —I'm trying to think of the correct word—it's a more of a direct electronic notification. It doesn't come through like a regular body of an email, but it is a form of technology that's built into EHR. So it should be – it will be – it should be readily available in your EHR and your EHR vendor should be able to provide you more information on how to use that if you haven't already.

Victoria Jones: All right, thank you.

Operator: Your next question comes from the line of the Alexis Sheener.

Alexis Sheener: Good morning and thanks again for this webinar. I actually had a question similar to the last one regarding the hospitals via electronic notification, but the question I had was more specifically involved the what is needed to be sent to the notifying provider, would it be a full like your saying ADT where it says CCDA that needs to be sent for each notification?

Alexander Mugge: Yes. So that would include the patient name. We have proposed patient name and their - some demographic information as well as their diagnoses. And those are the sort of fields that we have highlighted in the rule and we are seeking comment on additional information or other means for communicating that information would be helpful.

Alexis Sheener: Thank you.

Alexander Mugge: So please submit comments if you have additional thoughts on that or any feedback that we might need to hear.

Alexander Mugge: Thank you.

Alexis Sheener: Thank you.

Operator: Thank you. Your next question comes from a line of Robin Hook.

Robin Hook: Hi, this is Robin Hook from Eyefinity, Inc. Thank you for taking my call. Our question is revolving around the interoperability comment of what information is provided on the API for the patients specifically claims. When you say claims, are you physically wanting the physical claim that we have like the 1500 Form that we would send to insurance, can you elaborate on this for us please?

Alexander Mugge: Yes, of course. So that would be the information that is currently included in the explanation of benefits. We're not asking for additional information beyond that. So it would be that claims of information would be from EOB and any lab test information that is made available, so not the full claim form, but some of the information is included in there like the cost of the claim, providers name or if it's for prescription drugs that is being billed etcetera.

So I guess the best resource, the answer that would be what's in the EOB.

Robin Hook: Okay, thank you very much.

Operator: Your next question comes from the line of Mindy Tree.

Mindy, your line is open. There's no response from that line.

Your next question comes from the line of Jillian Holloway.

Jillian Holloway: Hi there, thanks for taking my question. In section five Health Information Exchange and Care Coordination Across Payors, there's a language that states instead of a lengthy HRA process data will be exchanged. Is this implying that the requirements around conducting a health risk assessment may be changed or subject to change and may not be required in the future?

Alexander Mugge: That is not addressed in this rule and we don't- we do not -we are unable to interpret anything on this call. So, if you have any additional questions, you can definitely submit them in a formal comment, and we would address them in the final rule.

Sorry, not trying to dodge your question, there is something that we can't answer or it'll fall outside the scope.

Jillian Holloway: Yeah, no problem. Thank you.

Operator: Your next question comes from a line of Osman Sesay.

Osman Sesay: Hi. Thanks, having this call. My question is what if a patient comes to a hospital and the provider doesn't have a direct address and that patient can only access the record that the patient brought in, but they have a way to download, print and the provider is not part of a HIE, how does that work?

And my second question is, what if the patient comes to the hospital. The patient is never transferred to the hospital, but you still have the capability to receive a CCD by direct messaging and you can go ahead and incorporate, you have the functionality, but you don't really receive patients from other hospitals or from other providers that have the EMR system.

Alexander Mugge: Thank you for your question. I think so let me attack this from a couple of different angles, so in terms of a patient getting their information to the hospital so patients under these proposals would need to authorize or share their data with the hospital so the patient in that sense acts as an intermediary to get the information to the hospital. And then I think your other question may have been in regard to the ADT messaging, but can you maybe restate that?

Osman Sesay: So, the other question is not the ADT as a direct message. Say if I have the hospital and another hospital transfer patient to me, there's a capability I can incorporate that data. So, I can reconcile that data with the current data that patient has at my hospital for that visit. What if my hospital doesn't receive patients to incorporate the data in, but I have the functionality for the loop that refers a loop measure that's what I'm talking about.

Alexander Mugge: Okay. So, you're referring to the promoting interoperability measures for hospitals?

Osman Sesay: Correct for hospitals when they receive patients from another hospital and if they have the capability to incorporate it, but they never received any direct message say incorporating data into their system, but they have the functionality. Will they be able to meet the measure in this case?

Alexander Mugge: So unfortunately, those measures are not a part of this rule, and we don't have anybody here from that program that will be able to specifically address your question, but suggest reaching out to that team or asking a question through their rule process, I believe they're usually in the IPPS Physician Fee Schedule rules. So, I suggest you reach out to them for technical support.

Osman Sesay: Okay, thank you. What about if the provider doesn't have a direct address that the patient come visit and you want us to notify them, and the only way we can send something over to the messages is a ADT and they're not part of HIE and they don't have a direct address for us to send the discharge CCD's over to them when a patient is being discharged.

How do we go about doing that? Do we get penalized or if we have the capability that they do we don't share, we get penalized, but if they don't and we're prepared to share we'll be okay?

Nicole Cooney: Hi, this is Nicole. Unfortunately, we don't seem to have the folks in the room that can address that question. We're running out of time for this particular exchange. I think you may want to email your questions to the Quality Payment Program. Their service desk is QPP in Quality Payment Program at cms.hhs.gov.

I'm sorry that we can't help you more directly, but I think those folks will be able to. Thank you very much.

Operator: Your next question comes from a line of Michelle Johansen.

Michelle Johansen: Thank you for taking my call. And I guess my question is in line with the gentleman from Kaiser. What is it that the administration is proposing to do to safeguard the data? I know that we have state actors, particularly from China and Russia and as well as non-state actors that are constantly attempting to get into health care systems all the time in addition to government systems and I'm just curious as to what types of controls and safeguards will be put in place not for the part you know once the beneficiary transfer it, which is really also important, but in the interoperability what kind of controls are being considered for just overall security? Thank you.

Alexander Mugge: Right. So, as you have pointed out if a patient requested their data to be sent somewhere. They do have the right to access that data and they have the right to send that data to anyone they want, and so they should be able to access the information and share it with any third party application of their choosing outside of that in terms of security with interoperability overall that is nothing to talk specifically about in this proposed rule, but privacy and security is something that we put above all else when talking about data exchange particularly when it involves patient information.

So, you know I think that there are many many different efforts going on to ensure the security patient data. I think you know in the Administrator's opening comments, you know she highlighted all the different ways that we currently do electronic exchange for banking, for shopping online. There are many different ways that people put their information out in the public and in many cases, people feel that the benefits of that outweigh the risks.

And so, you know we certainly think that health data needs to be protected above all else and are working with our Federal partners to try to ensure that that happens. OCR recently put out an RFI on their HIPAA rules to determine you know kind of what the public input is on how to better ensure the safety of health information.

So, there are many, many different efforts going on to ensure that this data is secured like never before. However, we do believe that the benefits of interoperability and the patient's safety that would come out of interoperability and data exchange are critical and so we want to pursue making sure the patients have that information while also making sure that it is securely exchanged.

Michelle Johansen: Thank you very much.

Alexander Mugge: Thank you.

Operator: Your next question comes from the line of Patrick Holly.

Patrick Holly: Hello, this is Patrick Holley. I work on behalf of Aledade in Bethesda Maryland. I had a question regarding the provider directory. We had plenty of issues, when comes time to attest to promoting interoperability where a lot of my practices aren't able to send the health information exchange or send to the specific secure messaging and I was wondering exactly how does this NPPES provider entry, how does that help connect to other providers that they're not able to see in the EHR directory.

Alexander Mugge: So, the NPPES directory when it was updated opened up the field for providing your direct contact information on your digital endpoint information. So what that is intended to do it to be a complete directory of all providers with an additional endpoint and any provider can obtain a digital endpoint or direct address for using these purposes and so what that directory is intended to do is to connect providers for the purposes of care coordination, referrals, etcetera and in this rule what we have done is encouraged providers to make sure that they are entering their information by suggesting that if they are not able to do that or they choose not to do that that they will be publicly reported on a CMS website.

Does that help to answer your question?

Patrick Holly: Yes, that help so…

Nicole Cooney: I'm not sure if you went on mute or if your line dropped.

Patrick Holly: Can you hear me now?

Nicole Cooney: Yes.

Patrick Holly: Are you able to hear me now?

Nicole Cooney: Yes.

Patrick Holly: So, I was basically saying is this directory somewhat of a free directory where you're pretty much just telling providers, "hey put your stuff here and if you don't, we'll report you." But I guess what I'm trying to

figure out is will they be able to use this directory also outside of the EHR to find different vendors to send to- I mean different providers to send information to?

Alexander Mugge: Yes. The directory is publicly available, currently on the CMS NPPES website. So, you'd be able to access that information without the use of an EHR.

Patrick Holly: Okay. Is that a paid feature to where they have to pay to get access to the NPPES?

Alexander Mugge: Nope. The NPPES directory is currently publicly available and free to access.

Patrick Holly: All right. I think that's all I have.

Nicole Cooney: Thank you.

Patrick Holly: All right, thank you.

Operator: Your next question comes from a line of Donna Page.

Donna Page: Hi, this is Donna Page from Contra Costa Regional Medical Center and I had a question about the information blocking and how it would apply to behavioral health and AODS or the Alcohol and Other Drug Use Substance Abuse.

Can you hear me there?

Nicole Cooney: Give us one second.

Donna Page: Okay.

Alexander Mugge: Apologies for that. Sorry and thank you for your question. So, the policies in this rule really essentially use the patient as an intermediary to exchange information so the patient will be requesting their information and could then share whatever information they wanted to with another provider. So, in that way, they're really controlling some of that more sensitive information and can decide where that goes or who it's shared with.

Donna Page: And that includes provider to provider?

Alexander Mugge: I'm sorry. So that was about the patient access API. If you're referring more about provider-to-provider sharing information intraoperatively.

Donna Page: Yeah intraoperatively information blocking, is it information blocking if we hold back behavioral health in alcohol and drug abuse?
Alexander Mugge: So, all current - In the instances of interoperability effort trying to get data to flow more freely and certainly for treatment purposes, it is important for providers to have as much information as they can. We are not proposing any changes to any other laws around patient privacy and withholding that information to all current laws still apply.

Donna Page: Okay.

Alexander Mugge And also, because you're asking about information blocking and what may or may not constitute information blocking, I just strongly recommends that you take a look at some of the summaries they are at the overall ONC proposed rule which really covers some of those exceptions to information blocking.

Donna Page: Okay. I just wondered if we were going to get penalized for holding back those particular types, will we end up on the naughty list?

Alexander Mugge: On the naughty list, so and this particular proposal on this rule is for those providers who essentially attest to withholding data, so no as long as you know aren't meeting the definition of information blocking, but again I suggested that you take a look at the ONC rule on what they have proposed as information blocking and what the exceptions to information blocking would be under their proposed regulation.

Donna Page: Thank you.

Operator: Your next question comes from a line of Sean Hewitt.

Sean Hewitt: Hi hello and thank you for taking all of our questions. I'm sure that's challenging answering everything on the fly. I'm with Wells Sky. We're software and services company for especially for post-acute care. My question has to do with the 2015 Edition certified EHR technology. We work with a lot of providers that are certainly interested in you know promoting interoperability, they want to participate in things like care-coordination and transitions of care, but they don't they don't necessarily perform all of the functions that fall under the 2015 standards of certified EHR.

So there are some restrictions for them being able to use a certified platform and what I mean by that is think about OT/PT. speech, they want to participate with transitions of care, but they don't do anything with implantable devices are there not ordering and prescribing, and managing medications, but for their EHR to be certified that software then now has to address those things that they're not necessarily offering. So, I guess my question is with the PAC you know participation with promoting interoperability, is there going to be any consideration to some sort of modularization certification of those standards for certified EHR?

Alexander Mugge: So, I think that falls out a little outside the scope of this proposed rule; however, the ONC 21st Century Care Rule, again that rule is very much geared at policies for EHR vendors and there's quite a bit of conversation there about the maintenance of certification, and what certification should look like going forward, which would I think probably better address your questions. So, certainly feel free to send that comment to ONC's rule or to both rules and we would be happy to address it in final rule making.

Sean Hewitt: Okay. Thank you.

Operator: Your next question comes from the line of Merry Itskowitz.

Merry Itskowitz: Hi Alex, I'd like to thank you in the Administrator for doing such a great job, so hang in there. My question has to do with the example that you gave before for payer-to-payer exchange of data going back 5

years, so the clock starts at 2020. We would go back to you know for that patient that you mentioned we'd be going back to 2015 and 2016 as appropriate right. The clock starts from their 5 years back, is what I'm trying to get out.

Alexander Mugge: That is correct and then in the proposed rule, we also talk about how that aggregated information should follow the patient throughout the health systems. So, as they moved from payer-to-payer, health plan-to-health plan, they would continue, would be able to continue to aggregate that information and bring it with them. So that when they change plans that doesn't mean that they lose all of their health information.

Merry Itskowitz: Right and the vision is for us to do this through the trusted exchange network and/or you know some type of exchange network that we would have available to us correct?

Alexander Mugge: So, the type of exchange network that is a separate proposal in a rule not related to that's one. They are separate and distinct. So, with this proposal, we have some discussion and that the health plan may exchange the data using for example the patient access API that in the first proposal. So they can link directly to one another and also we understand that health plans currently do some data exchange using an HIE or other means and that would still be acceptable as well as long as the data is moved from health plan-to-health plan at the patient's request, so they have access to their aggregated information in one place.

Merry Itskowitz: Okay, so that it would be outside of the trusted exchange network and then if that and when that becomes available that could have the potential to assist as well.

Alexander Mugge: Yes, I would say yes that's accurate.

Merry Itskowitz: Okay, and I won't press you anymore. Thank you.

Alexander Mugge: Thank you.

Operator: Your next question comes from the line of Susan Santos.

Susan Santos:Hi, Good Afternoon and thank you for this great information and taking my call. My question is that the state has a very successful HIE, that is widely used already for interoperability. How will this or how will the Blue Button impact each individual state's HIE?

Alexander Mugge: So, the patient access API or what your referring to Medicare Fee-for services version of that is the Blue Button 2.0 API, those provide access to the patient. So, the patient then can either get the information for their own purposes or they can share that with other providers or caregiver team. The HIE is you know are certainly still a good resource for providers sharing data amongst each other and this would not take the place of that or really interact with that because again this is data exchange directly with the patient as opposed to other HIPPA of covered entities.

Susan Santos: Okay, I ask the question because our HIE does have the capabilities that the patient can also sign-in and review their medical history based on what where they have gone in the state. So, I didn't know if that was maybe that's a question for another time.

Alexander Mugge: And that's sounds like you have an excellent HIE in your state and as you stated that it is really strong one in patient engagement and this I think would act as a supplement to that not necessarily a replacement.

Susan Santos: Okay.

Alexander Mugge: Thank you for sharing that information and thanks for your question.

Susan Santos: Thank you.

Operator: Your next question comes from the line of the Rashad Brubaker. Rashad your line is open.

Rashad Brubaker: Hello, can you hear me?

Nicole Cooney: Yes.

Rashad Brubaker: Hi, I'm Rashad from McKesson. And I have a question regarding the promoting interoperability for 2019 and moving forward. So, providers are required to use the 2015Edition in 2019 and our practices and vendors have invested on this technology. So, we want to understand with the proposed rule, how you see the future of the public health registry from here?

Alexander Mugge: So, the public health reporting measures that are apart of Promoting Interoperability Programs are still required as part of those programs. This rule does not actually touching any of those requirements. And I can't look into the future and tell you the future of those particular measures, but they are still part of the program currently.

Rashad Brubaker: Okay, thank you.

Operator: Your next question comes from the line of Penny Morris. Penny your line is open.

Penny Morris: Hey, this is Penny Morris with Care and Mental Health, can you hear me?

Nicole Cooney: Yes.

Penny Morris: Great. I had a question specific to the directory for providers' direct messages, when I was looking through the final rule, I did not see that it was specific to having direct messages. But that it was for the endpoint types in the NPPES. So, I was wondering if there's going to be clarification on not to be a direct email address as opposed to a regular email address to encourage those health information exchange and referral. Referrals being sent from the EHR to EHR.

Alexander Mugge: All right. Thank you for that question to clarify by that yes, so we do say digital and pointed digital contact information specifically because we are you know it is clearly stated they were not limiting it to the direct addresses though that is certainly one form that can be put into NPPES, and I just want to highlight which I'm glad you pointed out, but really strongly emphasize that this is in regards to digital endpoint an email address

does not count. So, a provider should not be entering their Gmail or Yahoo or other you know private information, but it really should be their digital endpoint information which is certainly different and more secure.

Penny Morris: Alright. Thank you.

Operator: Your next question comes from a line of Julie Grows.

Julie Grows: Can you hear me?

Nicole Cooney: Yes.

Julie Grows: My question is similar to the person who was asking about physical and occupational and speech therapy. For the independent providers who are not even required they're non-MIPS qualifying, so we're not using EMRs or EHRs, we would like to, but they're cost prohibitive. But we would like to be included in being able to share our information and receive information. How can you address the needs of the small independent providers?

Alexander Mugge: So, certainly as you mentioned you know EHRs are available you don't have to be MIPs eligible clinician to obtain EHR; however, we understand that some practices are not financially able to do that. I think you know that's not actually something that is discussed in this rule. So, it's a bit out of the scope of the call, but there are other ways of sharing data and if there are also other EHRs out there that they are available that may have different costs to suggest potentially looking into some of those other options.

Julie Grows: So then, this goes back to a much prior call where the person was asking about those people that needs some other guidance and what those options are and how to be included? Where to get that information? That would be helpful.

Alexander Mugge: Great, thank you. I appreciate that feedback and you know while not specific to necessarily to anyone type of practice, we do have the RFI in this proposed rule, that talks about for Post-Acute Care settings and improving the health IT adoption and interoperability among both Post-Acute Care setting and they you know did experience similar issues. So, I guess my suggestion is just to submit a comment on that for consideration and now certainly we would like to hear more.

Julie Grows: And will you be telling us how to submit comments?

Alexander Mugge: Yeah.

Julie Grows: I haven't see that instructions at that stage?

Alexander Mugge: On the last slide…
Julie Grows: Last page…

Alexander Mugge: Yeah, on last slide, that we reviewed.

Julie Grows: Oh right, yep. I got it. Great. Okay. Thank you.

Operator: Your next question comes from the line of Pamela Parker.

Pamela Parker: Hello, Thank You for this helpful session. My question is it could be that I'm not understanding the whole picture here yet. I'm with the special needs plan Alliance by the way— is around, it sounds like a kind of a minimum dataset, the USCDI data that would be exchange payer-to-payer in -for the dually eligible. And what I'm wondering is if - that one of the biggest problems that Medicaid and Medicare plans have and we're working toward integrating those plans and services better.

And one of the biggest problems is that a person may be in a Medicare plan, it's a different from their Medicaid plan, in neither plan knows necessarily where the person is for the other side that they're not providing. So, I'm wondering if that minimum dataset that's to be exchanged between payers actually includes plan enrollment information or if it's just understood that somehow that would be part of any kind of data exchange.

I didn't see it in the list of items that would be included, but I didn't go back to the basis of it either to know whether that kind of information would be I think enrollment dates and disenrollment dates would be really important for that group.

Alexander Mugge: Thank you for the question. First, I want to make sure that I clarified that in the proposal that we have that is specific to dual eligible, we are talking about states exchanging information with Medicare and so, in that instance we did not specify the USCDI. But in more relation to the in the MMA and enrollment file that would be exchanged.

And then in terms of the payer-to-payer exchange between plans in the information of exchange that's where we do talk about the USCDI you know we say it is at a minimum of the USCDI. If you have additional data fields that you feel would be helpful or that you like to give us some feedback on that. Particularly, proposed requirement we certainly welcome your formal comment and encourage you to submit that for consideration. Thank you for raising that.

Pamela Parker: Thank you, yes, I did understand the difference. But I was thinking that the section that will be very helpful will be the payer for the duals would be the payer-to-payer piece and so getting that to have the right data is going to be important, Thank You.

Operator: Your next question comes from a line of Jennifer Boyd.

Jennifer Boyd: Hey all, I just want to say thanks for the call today. I really hate to back track, I know this has come up a couple of times, but really just making sure that I understand, so that we can help providers as we're out working with them, through our Quality Improvement Organization contract. And one of the questions, I just wanted to make sure that I'm understanding that's come up is digital contact information that's going into NPPES. There is an opportunity for providers to share their direct secure email address is that correct?

Alexander Mugge: So, I hesitate to say that we would call an email address it is a direct address or digital endpoint which is very different than your standard email.

Jennifer Boyd: So, when I say direct secure email address, I'm looking more from the direct email addresses that comes from EHR vendors. So, we know HIE is not a part of Meaningful Use, it's not part of the MIPS program, it's not you know anything that's going to go away, but trying to understand around educating our providers, you know if they've got back to the direct address that's been provided by their vendor which should be something that they can utilize to exchange data from their EHR to another EHR without having to use an external health information exchange resource. Is that the address that they can put them into the NPPES system?

And then my other question is what happens when you have providers that have multiple direct addresses?

Alexander Mugge: So the example that you're mentioning that the other direct addresses that would be an example of a digital endpoint that could be put into NPPES and because of question has come up so many times, I do also suggests that folks officially comment on it, so that you know we have the opportunity to address it in the final rule and in particularly because that second piece of your question is not explicitly addressed. I would say that you know please also comment on that and we look forward to addressing it in the final, thank you.

Jennifer Boyd: Okay thanks appreciate it.

Operator: Your next question comes from the line of Valorie Vigil.

Valorie Vigil: Hi, thank you, can you hear me okay?

Nicole Cooney: Yes.

Valorie Vigil: Okay great. So, I have –I'll just do them all at once because they're related questions. So I oversee the EHR or now API program in New Mexico so one of my questions is, if there are providers who do not, have not participated or never obtained an EHR or in some cases providers who are not upgrading to 2015 Edition EHR, how will that be handled or addressed and I think it kind of came up in the previous question of you know how will these providers be able to follow this rule and also it's been raised by some of our providers about the vendor cost and some vendors possibly going out of business and not wanting to you know upgrade to 2015 Edition EHR and I also understand that there's a certification cost or fee to be certified on the Medicaid side, but not for the MIPS side. And then, one more question the provider directory, we noticed that we see some turnover with you know providers moving from one practice to another, but they're not really often great at updating their information. So, how will the NPPES you know make sure that information is the most updated?

And my last thing is, will you be sending out a link when you- to once you post or somewhere where you will post the transcription for this call? Thank you.

Nicole Cooney: So, I can take the last question first. This is Nicole. The transcript and the audio recording will be on our National Provider Call detail page and there was a link to it in your confirmation email for today's call. But you can short address for it go.npc.cms.gov and that is the page you can find the detail page for today's call by date and that's where the slides will be posted once we have them ready for posting and that's also where the transcripts and the audio will be in about 7 business days, I would say. And we'll also announce the availability in our MLN Connects newsletter, once that information is posted.

The rest of the question is?

Valorie Vigil: Sorry about that.

Alexander Mugge: I'm sorry we try to make sure that we have written them down, so that we don't forget anything. So, for the first question for those do not have an EHR or have not upgraded, the policies in this rule specifically applied to those public reporting of information walking specifically applied to those MIPS eligible clinician, who are participating in the Promoting Interoperability Program to participate in those programs they are required to have 2015 Edition certification.

So that would be only for folks who have that or have upgraded, if they do not unfortunately and if they are still MIPS eligible clinician, they would certainly their MIPS score would be impacted, if they were not able to participate in that. For a shorter answer here is the question is that for those who do have any EHR or haven't upgraded, I do think they are at a disadvantage for exchanging information clearly, but it depends on whether or not the proposal in this rule applies to them as to whether there would be any sort of impact there.

You mentioned some concerns about vendors, not wanting to upgrade for there will be certification costs for one side or another, I understand that there is certification costs, but I don't think it's specifically for one type of, for Medicaid or Medicare. There is a certification costs and that's something that you could address with the Office of the National Care Coordinator ONC who lead the certification program. But I don't think that we can think anything beyond that on this call.

And then, lastly for the provider directories question, and the providers moving throughout that health care system and not updating their data. If they're Medicare provider, they are required to update their information in PECOS in order to receive payment. You know I understand that they may not update their information everywhere, but in this rule, we have specifically stated that health plans who are making those provider directories available should update them with some frequency.

So at least every 30 days as what we proposed to make sure that health plans are at least making the most current information available that they are aware of. But I understand the provider turnover is a challenge as well. So, thank you for all of those questions.

Valorie Vigil: Thank you.

Nicole Cooney: Thank you so much. Dorothy, I think I have time for one more question.
Operator: Your final question comes from a line of David Heller. David your line is open.

David Heller: Yes, I'm wondering how this will affect the current HIM policies. In most hospitals when people that request their health information and I have to fill out forms and takes quite a long time. Is this going to I hope change that?

Alexander Mugge: So, we're not proposing any changes to current laws about patient access. We are only proposing additional enhancements to the patient access. You know in this proposed rule, we are you know particularly focused on getting patient access to their health plan information and you know certainly looking at

other ways to ensure that patients have access to their health information overall, so they can make the best and most informed decisions about their care. So, if you have a specific concern along the proposals and how patients are accessing their information, we certainly would welcome your comments. So, we could take a look at that and address it in the final rule but thank you for raising that.

David Heller: Yeah, I just see a long entrenched HIM and most facilities that are very, it's hard to get patient information out to them and they have to wait for a while and what I'm reading in this proposed rule is interoperability and it should just be transparent. Is that? Am I correct in thinking that? In following the HIPAA rule.

Alexander Mugge: Sorry, could you just repeat that?

David Heller: In following the HIPAA rule, I'm with a large safety-net hospital in Dallas and to get your health care information takes quite a while going through the HIM department. But then what I read everywhere else since I'm in charge of interoperability and promoting interoperability as it should be transparent. And they ought to be able to get it through API. Am I missing something?

Alexander Mugge: No, not necessarily, so Promoting Interoperability Programs on the patient access measure there is reference to patient having access through an API. I think you know this kind of comes back to some of the challenges that we reference at the very beginning of the call that while we have certain rules in place and then well HIPPA provides the patient the right to access their information in some instances, we're still not seeing that information flowing efficiently, which is why we've been revising some of our policy is, why we did overhaul the Meaningful Use Program to include more information on that patient access measure and some of the other efforts that we are continuing to pursue.

So, you know acknowledging the patients are really still struggling to get the information quickly and easily that's some of what the overall interoperability effort is intended to tackle in this particular rule. You know we're not addressing specifically what you're asking about. So certainly, encourage you to submit a comment or to take a look at the Promoting Interoperability Program rules that they put out, that had more information on those API's and how hospital should be using them for patient they access.

Nicole Cooney: Thank you so much.

David Heller: Thank you. I appreciate it.

Additional Information

Nicole Cooney: Thank you, we're out of time now. As I mentioned, the audio recording and written transcript will be available in about 10 business days on our call webpage. We will also announce their availability in the MLN Connects newsletter. And again, my name's Nicole Cooney, I'd like to thank our presenter, Alex Mugge, our Administrator, and also thank you for participating in today's Medicare Learning Network Listening Session on the Interoperability and Patient Access Proposed Rule. Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.