2022 Medicare Promoting Interoperability Program Overview Webinar
December 2, 2021

Hello, everyone. Thank you for joining today's Calendar Year 2022 Medicare Promoting Interoperability Program Overview webinar. During this webinar, CMS will provide updates on changes to the Medicare Promoting Interoperability Program for the calendar year 2022. The presentation will include an overview of the program, updates on the EHR reporting requirements, certified EHR technology requirements, electronic clinical quality measured changes and objectives, measures and scoring requirements. At the end of the presentation, CMS subject matter experts will be available to address any questions you may have as time allows. Now I'd like to introduce today's speaker, Jessica Ward, program lead for the Medicare Promoting Interoperability Program. Jess, you may begin.

Thank you so much for the introduction, and I'd just like to say welcome to everyone for joining us for the Calendar Year 2022 Medicare Promoting Interoperability Program Overview webinar. Next slide, please.

We've got some obligatory disclaimer language here. Next slide, please.

So during this presentation, we'd like to start by giving a brief overview of the Medicare Promoting Interoperability Program, where we started, what we've done, and where we are now. We'll follow this with highlights from the calendar year 2022 changes that we finalized for participating, eligible hospitals and CAHs. And finally, we'll review current and upcoming objectives and measures. We will conclude the webinar with a Q&A session at the end. Next slide, please.

So first, we'll start off with a little bit of background history on the Medicare Promoting Interoperability Program. Next slide, please.

Under the HITECH Act, the EHR Incentive Programs were established in 2011. This was a 3-stage approach which encouraged eligible professionals, eligible hospitals and CAHs to adopt, implement, and upgrade certified EHR technology. In doing so, they demonstrated meaningful use of health IT. And the three stages are very simple -- stage 1, stage 2, and stage 3. Next slide, please.

As mentioned in the previous slide, the EHR Incentive Programs included three progressive stages -- Again, stage 1, stage 2, and stage 3. The main focus was for eligible professionals, eligible hospitals and CAHs to adopt and implement certified EHR technology and demonstrating this through completing the requirements of our program objectives and eCQM requirements. During this time, we were acting under the 2014 edition of Certified EHR Technology Standard Requirements. Next slide, please.

In 2018, the EHR Incentive Programs were renamed the Medicare and Medicaid Promoting Interoperability Programs. As we began moving further into stage 3, this new name reflected our shifting efforts towards interoperability and improving patient access to their health information. Progressing further, in 2019, we overhauled the Medicare reporting requirements to align a little bit closer with the stage 3 focus areas.

We should also note that as of December 31, 2021, this is the last day for participation in the Medicaid Promoting Interoperability Program. So effective January 1, 2022, we will officially be called the Medicare Promoting Interoperability Program, and you will see that reflected in our rules and on our program page. Next slide, please.

The Medicare Promoting Interoperability Program has several key focus areas. Those include advancing certified EHR technology and functionality, reducing burden, continuously advancing interoperability, and improving patient access to health information. We achieve this by requiring that participating, eligible hospitals and CAHs report on our required objectives, measures, and eCQM requirements. For those who score above our minimum threshold, they are then considered meaningful users and would avoid any downward payment adjustments. For those who do not meet the minimum scoring threshold, they're not considered meaningful users and would thereby receive a downward payment adjustment. Next slide, please.

So up next, we can review program changes, beginning with calendar year 2022. And this is for eligible hospitals and CAHs. Next slide, please.

Finalized changes to the Medicare Promoting Interoperability Program for calendar year 2022. First for the EHR reporting period, we will continue with any continuous 90 days for a calendar year 2021, calendar year 2022, and calendar year 2023 EHR reporting periods. We should note that we are transitioning to any continuous 180 days, beginning with the calendar year 2024 EHR reporting period. For e-prescribing, the PDMP measure will remain as is. It will remain optional, but we have increased it to 10 bonus points for completion. For the health information exchange objective, we have added the bi-directional exchange measure as an alternative to reporting on the two existing measures, which would be sending and receiving information. The bi-directional option is worth the same 40 points as the sending and receiving would be combined. The public health and clinical data exchange objective will require reporting on four of the public health and clinical data exchange measures. This would be worth 10 points. And for those choosing to report on the public health registry and the clinical data registry, these remain optional and available for 5 bonus points for the completion and reporting. Next slide, please.

So a few more updates for the calendar year 2022 EHR reporting period. We are increasing the minimum scoring threshold from 50 to 60 points, so this would mean that you would need to earn 60 points to be considered a meaningful user and avoid a downward payment adjustment. For those earning less than 60 points, you would receive a downward payment adjustment and not be considered a meaningful user. In addition to the required security risk analysis, we are also now requiring that eligible hospitals and CAHs attest to having completed an annual self-assessment anytime during the calendar year of the nine SAFER Guides. This is under the Protect Patient Health Information objective, and we have a little bit more detail on this later on in the slide deck. We have removed statements two and three from the three required attestation statements under the prevention of information blocking requirement. We should note

that statement one remains required and unchanged. Last, we have adopted two new electronic clinical quality measures -- eCQMs -- beginning with the calendar year 2023 each EHR reporting period and we are removing three eCQMs, beginning with the calendar year 2024 EHR reporting period. And again, we have a little bit more information further down in the slide deck. Next slide, please.

So here we have a quick diagram showing the Medicare Promoting Interoperability Programs EHR reporting period timeline for calendar year 2022. I'll give everybody just a minute to review this. We follow the same pattern every year. The dates may change, so we'll have Listservs sent out. So just keep an eye on that. And then it would be a great idea to maybe print a copy of this from the slide deck for quick access as you go through the calendar year. Next slide, please.

Alright. So scoring methodology. We did briefly touch upon this, but to go a little bit more in detail, eligible hospitals and CAHs must earn a minimum of 60 out of 100 possible points to be considered a meaningful user. When you are considered a meaningful user, you would avoid the downward payment adjustments. We do want to note that there are opportunities to earn up to 15 additional bonus points. We've got bonus points for the PDMP reporting and also for the public health registry reporting. It is a requirement that participants report on all required measures, regardless of final scores, to be considered a meaningful user. So if you skip on any of the requirements, it doesn't matter if you score above 60 points, you're no longer a meaningful user. So just keep that in mind. When we count rates and calculate total scores, we do round to the nearest whole number. Next slide, please.

And then here we have our objectives and measures table. This -- You've probably seen this in each of our final rules and our proposed rules. This is our table for calendar year 2022 and gives a list of all of our objectives, all of our measures, all the points that are allocated with each of those. We do have a link at the end of the presentation for any future references to the final rule where this is housed. So I'll give you just a second to look through this. Next slide, please.

CEHRT requirements. For calendar year 2022, we will continue to allow eligible hospitals and CAHs to use 2015 Edition certification criteria, 2015 Edition Updated criteria, or a combination of these two criteria. As a reminder, CEHRT functionality must be in place by the first day of the chosen EHR reporting period through to the last day of the reporting period that you've chosen by each of the eligible hospitals or CAHs. We are not required at this time to use exclusively the 2015 updated criteria. So just keep in mind that you have a little bit more time to make those updates to your systems before it becomes required. Next slide, please.

So eCQM requirements. We had touched on this a little bit earlier, but to give a little bit more detail. We do align our eCQM requirements with the hospital IQR program. Currently for calendar year 2022, we're slated to have 9 eCQMs available for reporting. We require that eligible hospitals or CAHs report on three self-selected eCQMs, plus the safe use of opioid eCQMs, which is a new requirement. And that they report on all of these

eCQMs for three self-selected quarters of data. We would like to know that for eCQM recording, we are required to report on quarters, but for EHR reporting on basic promoting interoperability measures, we allow for any 90 and soon to become 180 days. We have added two eCQMs, as mentioned earlier, to the measures set for calendar year 2023. Those would include hospital harm, severe hypoglycemia, and hospital harm, severe hyperglycemia. And you'll see that in the first bullet on the bottom there. For calendar year 2024, we are removing three eCQMs from the measure set and those would include discharged on a statin medication, exclusive breastfeeding, and admit decision time to the E.D. And you will find those in the middle tab on the bottom. Last, we are requiring that 2015 Edition Updated CEHRT technology be used for all available eCQMs beginning with the calendar year 2023 EHR reporting period. And again, as a reminder, these policies have been finalized under both the hospital IQR program and under the PI program. And for any additional information on the exact policy language, again, we have a link to the final rule at the end of the presentation. Next slide, please.

Alright. And this is our standard eCQM requirement table. I'll give you a minute to look at this. This is for calendar year 2022, not including all the changes for 2023 and 2024. But you can get an idea of everything that we have. And again, this is pulled directly from our final rule, which is linked at the end of the presentation. Next slide, please.

Alright, now, we can get into some of the objectives and measures for calendar year 2022. Next slide, please.

Alright. So to begin, e-prescribing overview. So the e-prescribing measure on the left, that remains unchanged from previous years. There are exclusions available, still worth 10 points. None of the language for the measure has changed. It remains as is. For the PDMP measure, on the right-hand side, we are still allowing it as an optional measure for completion. Completion would earn you 10 bonus points. There are no exclusions available, and it still remains as a yes/no attestation statement. Next slide, please.

Under the Health Information Exchange objective, the support electronic referral loops by sending and receiving health information measures, they remain unchanged. Together, the completion is worth 40 points. There are no exclusions available, but what we did add is the bi-directional exchange through health information measure, and this would be an alternative to reporting on the sending and receiving measures. It would be worth 40 points for completion. Yes/no and no exclusions available. Next slide, please.

Under the public health and clinical data exchange objective, an eligible hospital or CAH is considered in one of the levels of active engagement with a public health agency by reporting on four measures worth up to 10 points with exclusions available. So the four required are the immunization registry, syndromic surveillance reporting, electronic case recording, and electronic reportable laboratory result reporting. So I'll give everyone just a minute to read through this. And again, it would be worth 10 points total for reporting on all four measure -- or being an active engagement under all four of these measures. Next slide, please.

So continued, public health and clinical data exchange. We have the opportunity to earn 5 bonus points where an eligible hospital or CAH may report on the public health registry and the clinical data registry. So 5 points for both. No exclusions available. And they're now optional. Next slide, please.

Alright, so for the security risk analysis measure, this remains unchanged -- required. Yes/no attestation is... how we'll answer it. And we have no changes to this requirement. Next slide, please.

Alright. So the SAFER Guides. I think this may be everyone's favorite new measure. So we can talk about this just for a minute. So this is new for calendar year 2022. ONC established the SAFER Guides back in 2014. They made updates to the guides in 2016. They've been available for use by hospitals, CAHs, and eligible professionals since inception. We are requiring under IPPS that eligible hospitals and CAHs conduct an annual self-assessment on all nine SAFER Guides at any point in the calendar year. Eligible hospitals and CAHs may report that they did complete the self-assessment by stating yes, or that they did not complete the self-assessment by stating no. Yes and no are both acceptable answers. Neither rule affects the total score or their status of being a meaningful user or not. Neither will affect payment adjustments. We're trying to gauge... ...how many people are using the guides, how they're using them. And trying to start using them in everyday practice. Next slide, please.

So actions to limit or restrict the compatibility or interoperability of CEHRT, i.e., information blocking. So previously we required that eligible hospitals and CAHs attest to three statements supporting the prevention of the information blocking requirement. And they were simply statement 1, statement 2, and statement 3. For calendar year 2022, we finalized the removal of statements 2 and 3, and we are now only requiring that eligible hospitals and CAHs attest to statement 1. Statement 1, the language and requirement remain unchanged. Next slide, please.

Alright, so as we mentioned a few times throughout the presentation, we have several resources available for eligible hospitals and CAHs. We have fact sheets, we have specification sheets, we have links to final rules, and we have links to proposed rules. We have links for the CMS website, links to subscribe for our Listserv. And then, of course, there will be a transcript. There will be a recording of our webinar from today. And then always remember that you're more than welcome to reach out directly to the team through the Quality Net Help Desk, if you have any program-specific questions that may arise, especially with the changes that are upcoming for calendar year 2022. Next slide, please.

So we've completed the bulk of our presentations. If anybody has any questions, Elizabeth Holland should be joining any second now. And you have me to help answer any questions. And I will turn back the slide deck to the moderator to get this part going. Thank you, everybody.

We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask questions via phone, dial 1-833-376-

0535. If prompted, use the passcode 3165820 and press star 1 to add your question to the queue.

Okay. Thanks, Stephanie.

Jess, before we jump into the Q&A portion, we're hoping you can go back over a couple of slides that people asked about. If we could please go to Slide 10, if you can just talk a little bit more about the changes to the public health and clinical data exchange objective.

Sure.

Um, let me just move over to that slide. I actually might switch it to the other slide. Let me pull it up real quick. Maybe slide 20. Is that okay?

Yeah, we can see that. Slide 20. Are you able to just talk a little bit more about it and then the changes?

Sure.

Except I think we need -- I'm sorry. Go ahead.

Oh, no, go ahead.

I think we actually need to go to slide 22.

It's the public health -- Or 21 -- the public health and clinical data exchange objective.

Oh, okay, got it. Sure. So we made several changes to the public health and clinical data exchange objective overview. We have our objectives and we have our individual measures. So we are currently in the process of doing a revamp on the registries that people report to. So we still have our same levels of active engagement. I believe it's level one, level two, and level three. But what we did was we shifted our focus a little bit on honing in on those registries that are maybe more high-priority areas. And then for those that are not high-priority areas, we're leaving those as optional. So just to get talking about them, required would be the immunization reporting registry. So we're asking that you submit and receive immunization information to be available, public health immunization registries. The next one would be requiring the reporting on syndromic surveillance reporting, and that would be data to and from emergency departments. Electronic case reporting, so submitting case reporting of reportable conditions. Electronic reportable laboratory reporting. Submitting your electronic lab reports. And again, the levels of engagement would not change. I would have to look those up. I don't have those offhand. I'm sorry. So these would be required. You would be required to submit a yes/no attestation. There are exclusions available if you're not able to meet the requirements of one of the levels of engagement, and this is effective calendar year 2022 EHR reporting period. And now for the next slide.

The next slide on 22. These are the existing registry reporting...
...requirements that we had. These are now optional and worth bonus
points. So the public health registry reporting was existing. It's no
longer required, but it's optional for reporting and the same with
clinical data registry reporting. This used to be required, but now it is
optional and worth bonus points. So we used to have six registries
available for reporting. And I believe it was four you had to choose from
of the six. Now we're requiring four. And then you have the option of
reporting or not reporting on two. And then I think when Elizabeth joins,
we can touch back on this one.

I'm here now, Jess.

Oh, thank you. This is Elizabeth's specialty area. So I'm not sure if you
heard, but there were questions about slides 21 and 22 for the public
health and clinical data exchange objective changes.

Okay, I missed that part. So what is the question?

Oh, they wanted -- I'm sorry. Just a little bit more details about what
the changes are specific to the public health and clinical data exchange.
There are now four required and then two optional. I think it was
more of a general, "We want more information."

Yeah, basically, we worked with the Centers for Disease Control and
Prevention in this pandemic time, and there was really a gap in data that
they had available. So we worked together to figure out what we could do
to help there be more data available, so this is what we came up with,
especially, like, immunization reporting and prevalence reporting are
really important in this time. And so that's part of why this policy was
proposed and finalized. So certainly ask additional questions if you have
them.

Okay. Thank you, both.

And then while we're on these slides, we did get a couple of questions
if we could go to Slide 20. People just want more information as well
on the new bi-directional measure, if you can kind of just go back
over that one more time.

Sure.

Elizabeth, did you want to touch on bi-directional or do you want me
to go back over it?

I can touch on this.

So, in a general sense, we try to align our policies between what we do
for MIPS eligible clinicians with what we do for hospitals in the
Promoting Interoperability Program. So last year, we came up with the
idea to have a bi-directional exchange measure to really push people to
exchange information both ways. Um, and also because the two existing
measures that support electronic referral is by sending information and
the report electronic referral by receiving and reconciling information

has been problematic for a lot of hospitals and CAHs. So to try to give people another option and just show how important bi-directional exchange is, we created this new measure. Therefore, that's why if you report the two existing measures, you would submit your numerator and denominator and could score up to 20 points per measure, or you can not submit those measures and have implemented a bi-directional exchange. And we do have lots more information about what that means in our Federal Register final rule. And in addition, we will have a specification sheet posted shortly specifically on that measure. But if you do that measure, it's a yes/no attestation and you would earn 40 points just because we believe it's so important to have that bi-directional aspect. I hope that helps.

Okay. Thanks, Elizabeth. Um, just a couple more things to go over before we really jump into the Q&A. If we could go to Slide 12 quickly. Jess and Elizabeth, it might be helpful to clarify. A couple of people are asking about the attestation deadline. There's some confusion around it closing in March or February. I don't know if you want to clarify, but the attestation deadline for 2021 was pushed back to March of 2022, whereas for 2022, the attestation deadline will be February of 2023. There's no change there.

Hmm. As of right now, no.

Yeah, generally what happens is we set the deadline and then we start looking to see how the attestations are coming through and if we had any systems issues which might impact the ability for hospitals to send their attestation data. So we would not extend the deadline until actually we were in February of 2023. And so I would not recommend waiting to March 1st because you don't know if we are going to be extending. Some years, we do extend. Some years, we don't. But as soon as attestation opens, I would recommend attesting.

Thanks, Elizabeth. Okay, and then one last question or one last thing to go over about the SAFER Guides. Can you just talk a little bit more about where the SAFER Guides live, how people can get more information on those? Quite a couple -- A couple of questions coming in on more information on the SAFER Guides.

Sure. So I did respond to question number 49 with a link to the SAFER Guides. I'm not sure if everyone is able to see it or not. But if you go on to the ONC web page, HealthIT.gov. I honestly just Google "SAFER Guides, ONC," and it pulls me right up to it. I did share the link, but if you give me one second, I can get the actual address again. So it's HealthIT.gov... /topic... /safety... /safer-guides. And again, it's under question number 49.

Thank you. And we'll have that link sent out to everybody so that they can get that.

Great, thanks so much.

Sure. Okay. At this time, do we have anyone on the phone line with a question?

There are no questions at this time. If you would like to ask a question, press star 1.

Okay. Our first question. "Can you clarify the rounding used in the scoring methodology?

Is the score rounded to the nearest whole number or is it rounded up?"

To the nearest whole number. Elizabeth, correct me if I'm wrong, but I think it is rounded up to the nearest whole number. I don't believe it rounds down.

I'm not aware of the hospital rules. Sorry.

That's okay. We can get further clarification just to check on the rounding rules. We can submit that out.

Okay, great, thank you. Our next question, "Can the self-selected eCQMs be reported at the end of the year for three quarters? Or do they need to be recorded at the end of each quarter?"

Oh, no, you can self-select any three quarters within the calendar year. That's fine. Just note that for PI requirements, for our measures, we're on 90 days. And in the future, 180 days not on quarters. So if that affects anything on which calendar quarters you choose to report for eCQMs.

I think the question was also asking when you need to submit them. So you would submit them through the data submission period in January and February?

Mm-hmm. Yep.

Okay. Our next question for -- It's another SAFER Guides question. Somebody noticed that in the IPPS rule, hospitals are required to attest to all nine ONC SAFER Guides. However, in IPPS permits, clinicians are only required to attest to one -- the high-priority ones. Is there a difference in the requirements? Was it intentional? I think he wants to know the background on that.

Um, sure, uh... I don't know if you want to take this, Elizabeth, but it definitely was intentional. We deliberately required all nine SAFER Guides for the hospitals and only one SAFER Guide, the introductory SAFER Guide for MIPS.

And just to clarify, in the first year, you can say, "Yes, you reviewed them" or no, you didn't review them, and still you will fulfill the requirement.

Okay. Thank you, both. I'm just checking, do we have any phone questions?

No phone questions at this time.

Okay, we will continue. We're getting a lot of questions about

the bi-directional measure, if you can go over that one more time. People are asking if you can elaborate more on how the measure can be satisfied, what exactly qualifies as a yes attestation.

Okay, so to make it very simple, and this is in our regulation, we have three attestation statements. And I can't -- I can't say, "Oh, yes, that would work. No, that doesn't work." You need to look at the attestation statements and determine if you fulfill those requirements. I'm going to read the attestations now. The first one is "Participating in an HIE in order to enable secure bi-directional exchange of information to occur for all unique patients admitted to or 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 and policy." Okay, that's the first one. The second one is "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." And the third one is "Using the functions of certified EHR technology to support bi-directional exchange with an HIE." So if you feel when you read those three statements that your hospital fulfills that, you can attest yes.

Okay. Thanks, Elizabeth. We'll let you know if we get any more questions about that. Um, somebody had asked, "Can you please explain more about the three levels of active engagement from the public health and clinical data exchange objective?"

-Okay, so the three levels of active engagement have been in place since, I believe, 2014 or 2015. And if you're at any of these three levels, you will fulfill the measure. So the first one is registration. That means you state your registration and you're waiting for the registry to process you. And if the registry is not yet up and running, it may be that that registration processing takes a while, but as long as you have registered, you can fulfill active engagement. The second level is -- is testing and validation. That means that you've been registered and now you are sending dummy data or test data with the registry to make sure it's received and can be ingested by the registry. And the third level is production. You're actually sending your data to the registry on a regular basis. As I said, all three will fulfill a measure.

Okay. Thanks, Elizabeth. Any other phone -- any phone questions?

Yeah.

No questions at this time.

Okay. A little bit of like a hardship-type question here, but, "If your state does not have electronic case reporting, will a letter from the state saying that allow for meeting the measure that requires the measure?"

We don't require documentation. You may want to retain documentation in case of audit. But as long as you -- If you look at the exclusions

for case reporting, if you can claim one of those exclusions, you would just claim it. And that -- that's all the submission needs to be.

Thanks. And then a couple of questions, if you could go over the SAFER Guides one more time, the security risk analysis measure and the info blocking statement. We've gotten a couple of questions on if they're all required, if one is required, if they're optional. If you could just go back over like slide 23 to 25, that might be helpful.

Sure. Okay. So for security risk analysis, this is a required measure. There are no points associated with it. A yes/no attestation is required. This has been in place for several years now and has remained unchanged since inception.

Since 2011.

Yeah. So essentially, the eligible hospitals and CAHs need to conduct a security risk analysis of their certified technology, addressing encryption and security of data. And like Elizabeth said, I think this was back in maybe stage 1 or stage 2 and has remained a requirement since. Definitely required. You don't get anything for it, unfortunately. It's here to stay, and it's remained unchanged since.

This is actually a HIPAA requirement. A HIPAA requirement. I'm sorry. And so we are requiring that you do this. Once a calendar year, you either conduct a new review or you review your previous review and address any issues, and you need to do a full security risk analysis every time you upgrade or switch to a different certified EHR technology product. And again, for this one, if you do attest no, you would get no points for Promoting Interoperability. You would be subject to the payment adjustment.

Mm-hmm. And I think the next easiest one is probably slide 25, and that would be the information blocking or, as it's known, the restricted compatibility or interoperability of CEHRT. Essentially the same thing. This was made a requirement, I want to say...2017. And it has remained unchanged until around calendar year 2022. So essentially, we ask that eligible hospitals and CAHs attest to information blocking or attest to not information blocking. So we had three statements that were required answers. Again, no points. The same penalties as with security risk analysis. It's a requirement. And the Interoperability number-one final rule we did finalize that we were going to begin publicly reporting those who attested to being information blockers as per their responses through statements 1, 2, and 3. That was the most recent policy change that we had regarding the statements. With the Cures Act final rule that came out in May of 2020, there's been a big push towards information blockers. And with that, we looked over what our policy stated, what our attestation statements stated, what we were asking hospitals and CAHS to attest to kind of just in the scheme of all things information blocking. So we finalized our proposal to remove statements 2 and 3. They were sort of redundant and no longer necessary with where the landscape is right now. So all we're requiring is statement 1, and that has remained unchanged since its inception in 2017. And now for the SAFER Guides. I think of the SAFER Guides kind of like, um, security risk analysis and the information

blocking, it's required. Um, we're requiring a response, but you don't get anything for answering it. Now, the SAFER Guides are kind of funny because, as Elizabeth mentions, right now, we're just trying to gauge who's doing it and who's not. So there's really no penalty to attesting, "Yes, I completed all nine SAFER Guides self-assessments" or, "No, I didn't complete the self-assessment." Now, we have not started drafting -- I saw a question in the chat. We have not started drafting policy for 2023. And definitely not for any subsequent years. So we don't know what this will look like in the future. But for calendar year 2022, you can say, "Yes, I did it" and "No, I did not do it." Still is required, So you have to submit an answer, but your answer does not have to be yes or no. It's just an honest answer. And I think I also saw in the chat something related to the SAFER Guides about whether we are releasing any kind of tables or documentation or assistance for self audits for the SAFER Guides? We don't have any of that available. I don't believe ONC has that information available either on their web page. It's kind of -- You submit, honestly, honestly, how you... You attest honestly to whether you did or did not complete the self assessment. And then again, you can do it any time during the calendar year. That's fine. And again, yes and no are perfectly fine answers for 2022.

Okay, thank you both. Do we have any phone questions? Stephanie, do we have any questions on the phone?

Hi, can you hear me? Yes, we have a question from Stephanie Battista.

Oh, hi, Stephanie, we can hear you. Go ahead.

Hi, thanks. I did put this in the chat, but I'm not sure if it got missed or not. I'm asking about the public health requirements for the immunizations. If we are submitting our immunization information up to our public health agency but the Public Health Agency is not capable of bi-directional, so we can't query can we still attest yes, that we're an active engagement. We're just waiting for them to be ready to do the query, work with us?

Right, so that would fulfill it because you registered, and so if you're not able to do the bi-directional yet, that's okay because you have registered. We have registered and we are exchanging but only exchanging one way. Okay, so if it's not bi-directional, we don't have to claim exclusion for that.

No, I mean, if you feel comfortable that if you're asked, you're fulfilling level one of active engagement.

Awesome. Thank you.

We have another question from Jamie Jones.

Hi, can you hear me?

Yep.

Hi. My question is regarding the bi-directional HIE measure. and the the wording about all patients, does that mean we have to send for all patients or we have the functionality to do it? Because there are others that we cannot send to because they don't have the capability to receive information.

As long as this -- the bi-directional exchange functionality is... ...implemented. I mean, I understand there could be situations where somebody sends you a summary of care not through the HIE, but sends it to you directly, so there could be instances where that's not happening. But for the most part, most of the information should be exchanged through the bi-directional functionality.

Okay, thank you. Okay. And as a reminder, if you'd like to ask a question, I know we have just a couple of minutes left, but please be sure to press star 1 so that you are added to the queue to actually ask your question. Do we have any more phone questions?

We do have one additional caller. Will you please state your name before asking your question?

Yes. Hi, this is Toma Hudson. I'm with Parkview Health. Can you hear me?

We can.

Yep.

Okay, great. Um, I have two questions, one being -- And they are also about the bi-directional. So I was curious. It appears that the bi-directional exchange does not focus at all on reconciliation. So I was curious why, since I know receiving information does not guarantee that it's reconciled into the chart. And the second one is, is HIE being used as a broad word so that it also includes a HIST and that we send and receive with everyone that we see because it's not -- We only use HIEs for certain portions. We use our HIST 100% of the time. And I guess if it's not, it seems like we are expected to reconcile. And yet someone that uses an HIE is not expected to reconcile. Just curious. I'm trying to understand that.

I mean, certainly if you receive information that's not in your charts and you want to incorporate it, you do the reconciliation and then you choose to incorporate, that's certainly recommended. But we did not add that as a requirement to the HIE, the bi-directional exchange measure. It's certainly something we could think about in the future. But at this point, we do not specifically call that out, but we do expect that people would continue to do that to make sure.

We use a HIST, so, of course, for us, it's for that. And so it just seems like that's a real bye when it comes to, you know, if you use an HIE all the time, "Oh, great, you have received the information," but you don't have to reconcile it because that's something we continue to work on with our clinicians to make sure they're looking at external information and reconciling information that is pertinent to that patient. So I was just curious. Thank you.

Great, thank you for that feedback.

Do we have more questions on the phone?

We do. The next one is from Rene Pepp.

Yes. Hi, good morning. This is Rene Pepp calling and I had a question. We're planning to do our 21st Cures upgrade next year sometime around June or July. Does the 90 days reporting period need to start after the implementation of the Cures Act?

It does not, because in 2022, you still have the flexibility to use either the 2015 edition or the Cures Edition or a combination of the two, so you can choose to report on any 90 days. But for 2023, all of 2023, you will be required to use the 21st Century Cures Edition.

Okay, thanks, Elizabeth. Do we have any more on the phone?

We do. Our next question is from [inaudible] Perez.

Hi, can you hear me well?

We can.

Yes, this is [inaudible] Perez from New York-Presbyterian. This question relates to sending summaries of care measure. We have a question regarding the transition of care definition. I know that that's a term that has been defined in previous rendition of the PI program. The last reference we have based on 2020. And it stays at a minimum. This includes all discharges from the inpatient department and after admission to the emergency department when follow-up care is ordered. We wonder if that closed means that we should only include inpatient admissions when follow-up care is ordered. and do not include them when follow-up care is not ordered. Wonder if you can clarify that.

I don't believe we changed our policy. I think it remains what we stated. I don't remember recently as making any modifications to the policy.

Which means we should include them only when follow-up care is ordered?

I can try to get you a reference. So you have it in writing, if that would be helpful.

Okay, thank you.

Okay. I think we have time for maybe one more question. Do we have anyone else on the phone line?

We do have another question. Caller, please state your name before asking your question.

Hi, this is Tim.

Go ahead, Tim, with your question.

Oh, great, thank you. So my question relates to electronic case reporting and -- and... Is it the option to work with your local Department of Public Health or the other option is to work with a national agency to be able to share that information? It's a little unclear and obviously I haven't done a deep dive on what the requirements are, but it seems like that there might be options to be able to move forward with electronic reporting.

Yes, I believe we would accept either.

-Okay, and then I guess the other piece of it is it's sort of if at the state level they're not ready, but at the national level, they are, you know, one would think about potentially exercising exclusion because at the state, it is, at the national level -- I mean, at the state, they're not ready, but at the national level, they could be ready.

Right. So if you can meet the...

Exclusion.

...the exclusion and feel comfortable claiming it, you can certainly do so.

Yeah, the exclusion's a little vague. It just, you know, public health agency, right? So it doesn't stipulate whether or not you're working with your state agency or your national agency that might be available.

Yeah, I think we're looking more locally than national public health. But certainly as long as you retain your documentation of why you made the decision you are making, you will be fine.

And then just a --

Just to confirm that there are four in that sphere, you know, syndromic surveillance, electronic reporting, um, case management, I forget the fourth, but you need to do all four of them. Unless you can explain an exclusion for any individual.

Right.

Great, thank you very much.

Okay. We're a minute over. Jess and Elizabeth, unless you have anything else, I think we can pass it back to Stephanie to close out today's webinar.

Thank you.

Okay. Stephanie, we can close out.

That concludes today's Q&A portion and the webinar. I would now like...

Thank you for joining us today. You may now disconnect. Speakers, please hold the line.