Hello, everyone. Thank you for joining today's 2019 IPPS Final Rule and Changes to the Medicare Promoting Interoperability Program Webinar. During this webinar, CMS will provide updates on major changes to the Medicare Promoting Interoperability Program for calendar years 2019 and 2020. The presentation will include background on the EHR reporting period, the 2015 Edition CEHRT requirement, the new performance-based scoring methodology, and objective and measure changes. At the end of the presentation, CMS subject-matter experts will be available to address as many questions as time allows. Now I'd like to introduce today's speakers. Dylan Podson, Social Science Research Analyst at CMS, and Jessica Wright, Nurse Consultant at CMS. Dylan, you may begin.

Thank you very much, Stephanie. As mentioned, my name is Dylan Podson. You can actually hit "Next" onto the next slide since I believe you've covered everything on the front page.

Right here we have a brief rundown of the topics that we'll be discussing today. If, by the end of the session, you feel as though a detail's been omitted or you need any more clarification, as was just mentioned, there will be a time for questions if possible at the end of the presentation. Next.

Next, if you can change the slide. Thank you. Oh, okay, with the delay. All right. I'll remember. All right. Well, the program's name was changed from the Medicare and Medicaid EHR Incentive Programs to the Medicare and Medicaid Promoting Interoperability Programs. The change was made because the former name, EHR Incentive Programs, does not adequately reflect the current status of the programs as the incentive payments under Medicare have ended, with the exception of Subsection "D" -- Puerto Rico Hospitals -- which will end under Medicaid in 2021. We believe that the new name highlights the enhanced goals of the program and better aligns with the focus of the measures and objectives of the program. In addition, the new program name reflects a change in how we view patient data and its safe transmission in Electronic Health Records systems. Next.

All right. Well, we are finalizing that the EHR reporting period is a minimum of any continuous 90-day period in both calendar years 2019 and 2020 for new and returning participants of the Promoting Interoperability Programs attesting to CMS or their state Medicaid agency. Eligible professionals, eligible hospitals and CAHs may select an EHR reporting period of a minimum of any continuous 90-day period in calendar year 2019 from January 1, 2019 through December 31, 2019, and in calendar year 2020 from January 1, 2020 through December 31, 2020. The applicable incentive payment year and payment adjustment years for the EHR reporting period in 2019 and 2020, as well as the deadlines for attestations and other related program requirements will remain the same as established in prior rule-making. We are finalizing the continuous 90-day EHR reporting period for calendar years 2019 and 2020 in order to provide the additional flexibility for eligible hospitals and CAHs. This flexibility will allow more time to upgrade their certified EHR technology to the new Stage 3 requirements and functionalities that are now required in the 2015 Edition of CEHRT, as well as to provide additional time to meet and adjust to the proposed new scoring methodology. Next.

All right. Beginning with the EHR reporting period in calendar year 2019, participants of the Medicare and Medicaid Promoting Interoperability Programs are required to use the 2015 Edition of Certified Electronic Health

Record Technology, also known as CEHRT. We are requiring this because the 2014 certification criteria are out of date and insufficient for provider needs in the evolving health I.T. industry. In addition, we believe it is beneficial to help I.T. developers and healthcare providers to move to a more up-to-date standard and functions that better support interoperability changes of health information and to improve clinical workflows. The 2015 Edition will also better streamline workflows and utilize more comprehensive functions to meet patient safety goals and improve care coordination across the entire continuum. Maintaining only one edition of certification requirements would also reduce the burden for health I.T. developers because they would no longer have to support two different certification standards that have increasingly distant sets of requirements -- one of the major improvements of the 2015 Edition of the application program interface, or API functionality. API functionality supports healthcare providers and patients electronic access to their health information. It also contributes to quality improvement and offers greater interoperability between systems. The 2015 Edition also includes certification criterion specifying a core set of data known as the common clinical data set that healthcare providers have noted are critical to interoperability exchange and can be exchanged across a wide variety of settings and use cases. It aims to support a common set of data collapses that are required for interoperable exchange and identified as a predictable, transparent, and collaborative process for achieving those goals. In addition, and lastly, one of the measures we are finalizing is to provide patients electronic access to their health information, which has technical requirements that are updated in the 2015 Edition. The 2015 Edition provides patients with access to their data in a manner that is helpful to them in alliance with the API requirement in the Promoting Interoperability Program. This includes a new function that supports patient access to their health information through e-mail transmission to any third party the patient chooses and through a second encrypted method of transmission. Next.

All right. For the Promoting Interoperability Program, we finalized a new performance-based scoring methodology that has fewer objectives and measures that moves away from the threshold-based methodology that we currently use. The performance-based scoring methodology includes a combination of new measures, as well as the existing Stage 3 measures broken into a smaller set of four objectives. We believe this is a significant overhaul of the existing program requirements, which includes six objectives scored on a pass/fail basis. The smaller set of objectives includes Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. We will be going into further detail in the subsequent slides. We believe that this change will be more flexible and less burdensome and allow eligible hospitals and CAHs to put their focus back on the patients. By this, we mean that the performance date scoring methodology will encourage hospitals to push themselves on measures that are most applicable to how they deliver care to patients instead of increasing thresholds on measures that may not be as applicable to an individual hospital. Previously, if an eligible hospital or CAH did not perform well on a certain measure and did not meet the threshold, then they would not qualify as a meaningful user for the objectives and measure scoring. Now if an eligible hospital or CAH has an area that is challenging, they have to submit at least one unique patient, or claim, or claim an exception and not be automatically disqualified because they did not meet the threshold. They can still participate in the program to earn the required 50 points. For the EHR reporting period beginning in calendar year 2019, the new performance-based scoring methodology applies to eligible

hospitals and CAHs that submit an attestation to CMS under the Medicare Promoting Interoperability Program. This would include Medicare-only eligible hospitals and CAHs, or, in other words, those that are eligible for an incentive payment under Medicare for meaningful use of CEHRT and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use. It also applies to dual-eligible hospitals and CAHs or those that are eligible for an incentive payment under Medicare for meaningful use of CEHRT and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use and are also eligible to earn a Medicaid incentive payment for meaningful use. So, it includes both. However, the last bullet point that's important here that we'd like to talk about is that it does not apply to Medicaid-only eligible hospitals, those that are only eligible to earn a Medicaid incentive payment for meaningful use of CEHRT, and yet they are not eligible for an incentive payment under Medicare for meaningful use and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use. These are the ones that submit an attestation, to a state Medicaid agency for the Medicaid Promoting Interoperability Program. Eligible hospitals and CAHs must earn a minimum total score of 50 points in order to satisfy the requirement to report on the objectives and measures of meaningful use, which is one of the requirements for an eligible hospital or CAH to be considered a meaningful EHR user and earn an incentive payment, and/or to avoid a Medicare payment reduction. Next.

Next, we're going to review what is being changed and removed from the Promoting Interoperability Program and then move into a detailed review of the objectives and measures of the program. Next.

We are removing the coordination of care through Patient Engagement Objective and its associated measures, including the View, Download, or Transmit measure, the Patient Generated Health Data measure, and the Secure Messaging measure. These measures required healthcare providers to be accountable for the actions of others, and that is something that is typically outside of their control. In addition, we received feedback regarding barriers, such as patients who are located in remote and rural areas, who may not have actual technology to access these information, such as computers, the Internet, and/or e-mail that would negatively affect an eligible hospital or CAHs and their ability to successfully meet these measures. We are also removing the Patient-Specific Education measure within the Patient Electronic Access to Health Information Objective. We found this measure increased burden and did not further interoperability. In addition, it did not leverage the advancement of health I.T. For example, the primary focus of this measure is on the use of CEHRT and to identify patient resources specific to their health care and their diagnosis. However, the education resources did not need to be maintained within or generated by CEHRT. So, even though the CEHRT identifies the patient-educational resources, the process to generate them could take additional time and interrupt the healthcare provider's workflow. In addition, there could be redundancy in providing educational materials based on resources identified by the CEHRT because educational resources would be identified using patient's medication and problem lists. If there are no changes to a patient's health status or treatment, there would likely be many resources and materials that present the same type of information and would not be meeting the intent of the measure, as well as the fact that it could also increase burden to the healthcare provider in seeking additional resources to provide. Finally, one that we are also removing is the individual measure of the request -- Accept Summary of Care and the Clinical Information

Reconciliation, and we're actually combining their functionality into a new measure called Support Electronic Referral Loop by Receiving and Incorporating Health Information -- something that will be discussed later in detail in this presentation. Next.

The tables that you'll see here shows the objectives and measures that we are changing the names of. It's a bit of an overview of what we've been going over, but in one place, you can just see what they would have been called in the previous year as to what they'll be calling moving forward. I'll read them out loud, that the Patient Electronic Access to their Health Information Objective is now being revised to be called the Provider to Patient Exchange. The current measure within this objective, Provider Patient Access Measure, is being changed to Provider Patient Electronic Access to Their Health Information. We are not making any changes to the name of the Health Information Exchange Objective. However, the Send a Summary of Care Measure is being renamed to Supporting Electronic Referral Loops by Sending Health Information. Again, it's a mouthful, but we'll be going over it a little bit later in further detail. The Public Health and Clinical Data Registry Reporting Objective is being named to the Public Health and Clinical Data Exchange Objective. On a side note, we are maintaining the e-Prescribing Objective name and the measures Public Health and Clinical Data Exchange with slight modifications to the reporting requirements only. Next.

Here you'll see on the next slide, there we go, thank you, that there's a scoring methodology for the eligible hospitals and CAHs attesting under Medicare in calendar year 2019. As you can see, it reflects the reduction in the number of objectives from six previously to four. We will be going into each objective and measure in-depth in the following slides, but this outlines an overview of the objectives and measures of the program and the maximum points that are available for each. Beginning at the top, we have the Electronic Prescribing Objective with its three measures -- e-Prescribing, with a maximum of 10 points available, as well as the two new opioid measures -- the first being the Query of Prescription Drug Monitoring Program and Verified Opioid Treatment Agreement, that are both optional for calendar year 2019, and available for five bonus points each. Now, regarding these, our intent was to refer to these bonuses as a full five bonus points regardless of the eligible hospital or CAHs performance rate in calendar year 2019, and yet I believe in the next upcoming five slides, you'll see some examples of how these scores would come about in an example. Next is the Health Information Exchange Objective with two measures. The first thing -- Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Incorporating Health Information, which are both worth a maximum of 20 points each. The Provider to Patient Exchange is the next objective, and it has one measure -- Provide Patients Electronic Access to Their Health Information. This measure is worth 40 points, which reflects that the patients having access to their health information is the crux of the Promoting Interoperability Program. The last objective that we'll briefly go over here is the Public Health and Clinical Data Exchange Objective, which requires reporting to two public health or clinical data registries and is worth 10 points. For both calendar year 2019 and 2020, eligible hospitals and CAHs are required to report on all required measures, as previously mentioned. Next.

This slide shows an example of a possible score based on an eligible hospital or CAHs performance. For e-Prescribing, if you'll follow along from the top, they received a performance rate of 80%, which gave them 8 points

out of the maximum 10 points available. The hospital attempted the Query of PDMP measure with a rate of 33%. So, they were given the five bonus points. You'll see that the bonus measures, if a hospital submits their numerator and denominator, they will get the bonus points regardless of the performance rate. The hospital did not submit a numerator and denominator for the Verified Opioid Treatment Agreement, so they were not awarded any bonus points for this measure. There was not a minimum of one attempt, and so they would not earn the five points as with the previous one of the query. You can see the chart continues further down and reflects the hospital's performance on the remaining objectives and measures, and the total points for the Promoting Interoperability Program at the end of the day was 83 points. So, this hospital satisfies the requirement to report on the objectives and measures of meaningful use, which is one of the requirements to be considered a meaningful EHR user and the ability to earn an incentive payment and/or to avoid a Medicare payment reduction. Eligible hospitals and CAHs must report on all required measures as previously mentioned. So, for 2019, that would be everything but the Query of PDMP and the Verify Opioid Treatment Agreement measures, which would be considered bonuses and optional at this time. This means that as long as they submit a numerator of one or claim any applicable exclusion, they need the criteria for reporting on a required measure. They can have a measure where they do poorly -- for example, if they had one out of 50 -- as long as they do well in other categories and get at least a total score of 50 points, and as long as they had a score of over 50 points, then they would be meeting the requirement -- the reporting requirement for the objectives and measures. Next.

Moving into 2020, the biggest difference between calendar year 2019 and 2020 is the Query of Prescription Drug Monitoring Program, where it becomes a required measure. To ensure the total available points for the program equals 100 -- not including bonus points -- the e-Prescribing measure is now worth a max of five points in 2020, and the points are redistributed to make up for this. The only measure available for bonus points at this time would be the Verify Opioid Treatment Agreement. We are also removing the exclusion criteria for the Support Electronic Referral Loops by Receiving and Incorporating Health Information in 2020. Next.

You'll see a similar chart of the one that we had just gone over a few slides ago. However, this is not for calendar year '19. This would be for calendar year 2020. In this particular example, the eligible hospital or CAH earned a total of 83 points, which is above the required expectation of 50 to participate. Next.

The table that you'll see right now actually reflects the measures with exclusion criteria for both calendar year 2019 and 2020. I'll break it down a little bit further. For calendar year 2019, we're removing exclusion criteria from all measures except for the e-Prescribing measure, the new Health Information Exchange measure, and Supporting Electronic Referral Loops by Receiving and Incorporating Health Information, as well as the measures associated with the Public Health and Clinical Data Exchange Objective. For calendar year 2020, we will maintain the exclusions for the e-Prescribing measure and the Public Health and Clinical Data Exchange Objective. We will be adding exclusions for the Query of PDMP as it is a required measure for calendar year 2020. So, it's a difference from the year prior. Lastly, as I previously noted, we are removing the exclusion criteria for the Support Electronic Referral Loops by Receiving and Incorporating Health Information, which has been mentioned previously on the slide. Next.

We will take some time at this point now to go through the Electronic Prescribing Objective and a bit more detail about the three measures below. One note to make here is for consistency of language and understanding, especially as this is over the phone, I do want to note that the objective itself is titled with "Electronic." Capital "E," fully spelled out, "Electronic" written out, and that the measure underneath it is using the lower-case letter "e" with a hyphen, then the word "Prescribing." You can see this here. It's a subtle difference, but I wanted to make sure that it's clear as we go through the next few slides so that the objective title, as well as the measure aren't confused interchangeably, as they're not. Next.

The first measure that we'll be going over is e-Prescribing. This measure looks at hospital-discharge medication orders for permissible prescriptions both for new and changed prescriptions and they're queried for a drug formulary and transmitted electronically using CEHRT. The maximum points available in the calendar year 2019 is 10 points, and the maximum points available in 2020 is five points. The numerator equals the number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically -- so several conditions that need to be met. The denominator contains the number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period. For the e-Prescribing measure calculation, eligible hospitals and CAHs have the option to include or exclude controlled substances as they are treated uniformly across patients and all available schedules in accordance with applicable law. For the other measures in the Electronic Prescribing Objective, eligible hospitals and CAHs reporting on the Query of PDMP and Verify Opioid Treatment Agreement measures have to include Schedule II opioid prescriptions in the numerator and denominator. Exclusions are available for this measure for any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions, and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their EHR reporting period. So, one of those two could apply. If an exclusion is claimed in 2019, the 10 points available would be redistributed equally among the Health Information Exchange Objective. For calendar year 2020, if an exclusion is claimed for the e-Prescribing measure, an exclusion is automatically given for the Query of PDMP measure. Therefore, 10 points -- five for which would be each of those measures would be redistributed to the Health Information Exchange Objective. Next.

Moving on to Measure Number Two, the Query of PDMP. Let's go into some details. A Prescription Drug Monitoring Program, as mentioned -- also called the PDMP -- is an electronic database that tracks prescriptions of controlled substances at the state level and that they play an important role in patient safety by assisting in the identification of patients who had multiple prescriptions for controlled substances or may be misusing or overusing them. Query of PDMP is important for tracking the prescribed controlled substances and improving prescribing practices. The intent of the Query of PDMP measure is to build upon the current PDMP initiatives from federal partners, focusing on prescriptions generated and dispensing of opioids. For this measure, the Query of the PDMP for prescription-drug history must be conducted prior to the electronic transmission of the Schedule II opioid prescription. Also, eligible hospitals and CAHs have the flexibility to Query the PDMP using CEHRT in any manner allowed under their state law. In calendar year 2019, this is an optional measure and worth five additional bonus points. So, if a hospital or CAH attempts to complete the

measure and submit a numerator of at least one patient, then they would receive the five bonus points. Beginning in 2020, it would be a required measure still worth five points, but no longer optional. The numerator of the measure is the number of Schedule II opioid prescriptions in the denominator for which data from CEHRT is used to conduct a Query of a PDMP for prescription-drug history except where prohibition and in accordance with applicable law. There are several cases that we understand out there where this is a bit more complicated with state law, and that's something that we want to be, obviously, in constant accordance with. The denominator is the number of Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or CAH during the EHR reporting period. There are no exclusions available for this measure in calendar year 2019 because the measure is not required at that time. However, in 2020, there are exclusions available which are listed out on the table on the slide that you can see. If an exclusion is claimed in 2020, the points would be redistributed to the Health Information Exchange. Next.

On Measure Three, we'll be going over the Verify Opioid Treatment Agreement. The intent of this measure is for eligible hospitals and CAHs to identify whether there is an existing opioid treatment agreement when an electronically prescribed Schedule II opioid using CEHRT if the total duration of the patient's Schedule II opioid prescription is at least 30 cumulative days within a six-month look-back period. So, a number of conditions that need to be met there. We believe seeking to identify an opioid treatment agreement will further efforts to coordinate care between healthcare providers and foster a more informed review of patient therapy. However, we understand that there are differing opinions on the use of opioid treatment agreements, and also that hospitals are at varying stages of being able to complete this measure. Therefore, we have made the measure optional for both calendar year 2019 and 2020, and that the five bonus points would be optional for each year. Since it is an optional measure, if an eligible hospital or CAH attempts to complete the measure and submit a numerator of at least one patient, they receive the five bonus points. The numerator for the measure is the number of unique patients in the denominator for whom the eligible hospital or CAH seeks to identify a signed opioid treatment agreement and, if identified, incorporates the agreement into CEHRT. On the other hand, the denominator is the number of unique patients for whom a Schedule II opioid was electronically prescribed by the eligible hospital or CAH using CEHRT during the EHR reporting period and the total duration of Schedule II opioid prescriptions is at least 30 cumulative days, as identified in the patient's medication history request and the response transactions occurred during a six-month look-back period. So, obviously some similarities for the numerator. Because the measure is optional for both years, there are no exclusions available for the measure at this time. Next.

The next slide is actually just a review, a bit of a short-and-sweet table that will hopefully compile a bunch of the information that's been shared here today. The table displays the high-level overview, including the Prescribing Objective, its associated measures. It shows the points available for each year and if there are exclusions available. Throughout the review of the Electronic Prescribing Objective Measures, we use the term "Schedule II Opioid Prescriptions" quite frequently. We define opioids as Schedule II controlled substances under 21CFR1308.12 -- that's 21CFR1308.12 -- as they are recognized as having a high potential for abuse, with potential for severe psychological and/or physical dependent. Thank you. Next.

Next, we will be going over the Health Information Exchange Objective, or the HIE. Objective. These measures are of particular importance because of the role they play within the care continuum. In addition, these measures encourage and leverage interoperability on a broader scale and promote health I.T.-based care coordination. The two measures which we will be going over within this objective are the Support Electronic Referral Loops by Sending Health Information and the Support Electronic Referral Loops by Receiving and Incorporating Health Information. Next, please.

Starting with the first one, first measure within the HIE. Objective is the Support Electronic Referral Loops by Sending Health Information. This measure looks at transitions of care referrals where the eligible hospital or CAH that transitions or refers their patients to another setting of care or provider of care, firstly, creates a summary of care record using CEHRT and, secondly, electronically exchanges the summary of care record. The measure itself is worth 20 points in both calendar years 2019 and 2020. The numerator of the measure is the number of transitions of care and referrals in the denominator where a summary of care record was created and exchanged electronically using CEHRT. The denominator is the number of transitions of care and referrals during the EHR reporting period for which the eligible hospital or CAH inpatient or emergency departments, and that's plans of service 21 or 23, was the transitioning or referring provider to a provider of care other than an eligible hospital or CAH. The measure allows for any document template within the consolidated clinical document architecture, or CCDA, standard to be used. CEHRT supports the ability to send and receive the CCDA templates according to releases 1.1. and 2.1 to support interoperability and exchange. The 2015 Edition Transitions of Care certification criterion are at 170.315, subsection B, subsection number one. So, that's 170.315(b)(1), which requires that the health I.T. modules support the Continuity of Care document referral note, and in inpatient settings only, discharged summary document templates. At a minimum, all CEHRT will be able to support exchange of those three document types. Therefore, testing should not be necessary. However, that does not preclude developers of CEHRT in supporting additional document templates. Next.

The Measure Number Two looks to see if an eligible hospital and CAHs conduct clinical information reconciliation for medication, medication allergy, and current problem list for received transitions of care or referral, or for patient encounters during which the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient. The measure is worth up to 20 points in both calendar years 2019 and 2020 -- similar to the one before it. The numerator is equivalent to the number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: First, Medication, which is the review of the patient's medication, including the name, dosage, frequency, and route of each medication. Number 2, Medication Allergy, which is a review of the patient's known medication allergies, and, Number 3, the Current Problem List, which is a review of the patient's current and active diagnoses. The denominator looks up the number of electronic summary of care records received using CEHRT for patient encounters during the EHR reporting period for which an eligible hospital or CAH was the receiving party of a transition of care or referral and for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient. Lastly, in 2019, there will be an exclusion available for those who may not have this capability fully available or

fully developed by their health I.T. vendor, or if it is not fully implemented in time for an EHR reporting period in 2019. If an exclusion is claimed, the points would be redistributed to the other measure in the HIE Objective, which is the Support Electronic Referral Loops by Sending Health Information measure, making it worth now up to 40 points. Next.

What you'll see here, as is a common theme after every section, is a wonderful table, high-level review of the two HIE measures we've just covered, their maximum points available in 2019 and 2020, as well as the availability of exclusions. Next.

Next, we are going to review the Provider to Patient Exchange Objective, which has one measure titled "Provide Patients Electronic Access to Their Health Information." Next.

So, for this first and only measure, it is looking at patients who have been discharged from the eligible hospital or CAH inpatient or emergency department -- place of service 21 or 23, respectively -- where the patient or authorized representative is provided timely access to view online, download, and transmit their health information, and the eligible hospital or CAH ensures the patient's health information is available for the patient or patient-authorized representative to access using any application of their choice that is configured to meet the technical specifications of the API in the eligible hospital or CAH's CEHRT. For both calendar years, the measure is worth up to 40 points. You can see that this measure is highly weighted 40 points because we feel it truly gets to the core of improved access, and exchange of patient data in promoting interoperability is really the crux of the Medicare Promoting Interoperability Program. This exchange of data between healthcare providers and patients is imperative to continue to improve interoperability, data exchange, and to improve patient-health outcomes. We also believe that it is important for patients to have control over their own health information, and through this highly-weighed measure within the Provider to Patient Exchange Objective, we are aiming to show our dedication to this effort. The numerator for this measure is the number of patients in the denominator, or patient-authorized representative, who are provided timely access to health information to view online, download, and transmit to a third party, and to be able to access using an application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT. The denominator for the number of unique patients discharged from an eligible hospital or CAH's inpatient or emergency department -- place of service number 21 or 23 -- during the EHR reporting period. At this time, there are no exclusions available for this measure. The definition of timely hasn't changed, Eligible hospitals and CAHs must provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge. Next.

Again, as you'll see here, just a brief review. This one measure available within the Provider to Patient Exchange Objective, which is the Provide Patients Electronic Access to Their Health Information is worth up to 40 points in calendar years 2019 and 2020, and there are no exclusions available for either year. Next.

On we move to the Public Health and Clinical Data Exchange. These slides will further detail the fourth and final objective. This particular objective structure is slightly different from the preceding ones in that it's comprised of any two of the six available measures. This allows for a

bit of flexible reporting on the part of the provider, and we will explain further on the ensuing slides. Next.

Regarding the Public Health and Clinical Data Exchange Objective, it's measuring that an eligible hospital or CAH attests yes to being in active engagement with a public health agency -- a PHA -- or clinical data registry -- a CDR -- to submit electronic public health data in a meaningful way using CEHRT for two measures within the objective. The optional, the available measures include Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Electronic Reportable Laboratory Result Reporting. There is no numerator or denominator for these measures, but rather is based on an eligible hospital or CAH attesting to being in active engagement with a public health agency or clinical data registry. The objective is worth 10 points total. There are multiple exclusions available for the six measures. Those have not been changed by the final rule. We will be issuing measure specifications at a later date, but if anyone would like to review the exclusions that are available, they can review the 2018 spec sheet, which we might be able to share with the attendees at a later point in time. If an exclusion is claimed for one of the two measures, the 10 points may still be awarded for this objective if the eligible hospital or CAH attests yes to being in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using their CEHRT. If an exclusion is claimed for both measures selected for reporting in the objective, the 10 points will be redistributed to provide patients electronic access to their health information measure under the eligible hospitals and CAHs, which do not have to submit exclusions for all six measures, it would not be necessary. Our hope and expectation is that eligible hospitals and CAHs will select measures they have the ability to report on. However, we are not requiring them to exhaust exclusions for the six measures in order to receive the points or have the points redistributed. For example, if they select two measures and submit exclusions, but had the ability to report on the other four, but did not select them, they are still meeting the requirement. We are frequently asking if reporting on more than two measures for this objective would earn the eligible hospital or CAH any additional points or bonus points. However, the answer is no. Next.

This slide here, the Public Health and Clinical Data Exchange Objective Review, is similar to before, listing the available measures, maximum points available in 2019 and 2020, as well as any exclusions are available. Next.

At this point, I'll be switching over to my colleague, Jessica Wright.

Thank you, Dylan. Next slide, please.

Another requirement to participate in the Promoting Interoperability Program includes completing the action of the Security Risk Analysis measure. The requirements are the same as currently required in modified Stage 2 and Stage 3 of the Promoting Interoperability Program. However, the measure will no longer be scored. The Security Risk Analysis may be conducted outside of the P.I. reporting period. However, the analysis must be unique for each EHR reporting period. The scope must include the full Promoting Interoperability Reporting period and must be conducted within the calendar year of the reporting period. We have included additional tools and resources on this slide that eligible hospitals and CAHs may want to review to assist with completing the Security Risk Analysis measure. Next slide, please.

The next topic will focus on the Medicare Promoting Interoperability Program Attestation Requirements. Next slide.

So, in addition to reporting on the required objectives and measures of the Promoting Interoperability Program, there are program attestation requirements. As listed on the screen, these are expectations of the P.I. Program, they include the following: Providing the EHR certification number, the Emergency Department Admissions designation for the denominator of applicable measures, identify the performance period and method for Clinical Quality Measures, or CQM, attesting "yes" to the Prevention of Information Blocking Attestation, attesting "yes" to the ONC Directed Review Attestation, submitting "yes" for the Security Risk Analysis measure, and completing the Attestation Disclaimer. Next slide, please.

The next topic that we're going to review is the Medicare Promoting Interoperability Clinical Quality Measures, which you will hear referred to as CQMs or eCQMs. Next slide.

The eCQM reporting period in calendar year 2019 for the Medicare Promoting Interoperability Program has no changes. Beginning in calendar year 2020, we are removing eight of the 16 CQMs from the Medicare/Medicaid Promoting Interoperability Programs to align with the Hospital IQR Programs. We believe this will reduce the certification burden on hospitals, improve the quality of reported data by enabling eligible hospitals and CAHs to focus on a smaller more specific subset of CQMs while still allowing some flexibility to select which CQMs to report that best reflect their patient populations and support internal quality improvement efforts. For calendar year 2020, the reporting period is one self-selected calendar quarter of calendar year 2019 data, and the submission period for the Medicare Promoting Interoperability Program would be the two months following the close of the calendar year ending February 29, 2020. Next.

For hospitals participating in the Hospital IQR Program for the calendar year 2019 reporting period, the reporting requirement is to report on four of the available eCQMs for one self-selected quarter by the submission deadline of February 29, 2020. Meeting the Hospital IQR Program eCQM requirement also satisfies CQM electronic reporting requirement for the Medicare Promoting Interoperability Program. This data would be reported utilizing EHR certified to the 2015 Edition of the ONC Standard using the 2018 eCQM annual update for calendar year 2019, along with the applicable agenda posted on the eCQI Resource Center. The 2019 CMS QRDA Implementation Guide for HQR is the required reference material on the eCQI Center. Next slide.

The last topic of today's presentation is Participation of Subsection (d) Puerto Rico Hospitals in the Medicare Promoting Interoperability Program. Next slide.

The rule-formalized participation of Subsection (d) Puerto Rico Hospitals in the Promoting Interoperability Program. This means that Puerto Rico hospitals are eligible for incentive payments for being a meaningful EHR user and also for payment reductions for hospitals that are not meaningful EHR users. We are finalizing the codification of policies for Subsection (d) Puerto Rico Hospitals and amending our regulations under parts 412 and 495, such that the provisions that apply to eligible hospitals would include the Subsection (d) Puerto Rico hospitals unless otherwise indicated. Next slide.

Before we start taking questions, we would like to review two resources included in the Appendix of these slides. The two slides review the objectives and measures for both calendar years 2019 and 2020 respectively. Next slide.

So, the first slide is for calendar year 2019, and as you can see, it provides a quick glance of the information we've already reviewed. It outlines the objectives and measures, the maximum points available, if there are exclusions, and what those exclusions would be, and how the points are distributed if an exclusion is claimed. Next slide.

The next slide reviews the same information that is for calendar year 2020. And that concludes the slide portion of the webinar.

Thank you. 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 the phone, please dial 1-866-452-7887. Again, that's 1-866-452-7887. If prompted, please provide the conference I.D. number 3179986.

Our first question, "Is the continuous 90-day period tied to a quarter -- meaning do we have to pick a specific quarter or can a period overlap quarters?"

Hi. Thank you for that question. So, no. The reporting period is not tied to a calendar quarter, and it can overlap, and we also wanted to address -- We've been seeing a lot of questions in the chat about the 2019 specification sheet. We are actively working to get those out, and we'll have those out as soon as possible. We understand the need for them, and, again, are working quickly to get them out to you all.

Okay. Our next question, "Slide 4 is confusing. Does the provider need to be on the 2015 version for the 90 days of the reporting period to be successful for reporting P.I. measures?"

No. An eligible hospital or CAH can begin their EHR reporting period before their EHR technology is certified. Certification needs only to be obtained prior to the end of the EHR reporting period. If healthcare providers begin the EHR reporting period prior to the certification of their EHR technology, they're taking the risk that their EHR technology will not enable them to satisfy the requirements of being a meaningful EHR user. But the functionality does have to be in place for the duration of the reporting period.

Okay. Our next question is, "For the Provider to Patient Exchange measure, do you receive 40 points for just one accessing patient or does the measure ensure all or as many as possible, but at least one of your patients have access?"

So, the scoring for the Provide Patients Electronic Access to Their Health Information measure is performance-based. So, the score earned is based upon the numerator and denominator that's submitted. So, the eligible hospital or CAH must submit at least one unique patient in the numerator or claim an applicable exclusion to satisfy the requirement on all required objectives and measures of meaningful use.

Okay. Thank you. Do we have any questions on the phone?

Yes. Our first question is from Kim Sweet.

Yes. Hi, everyone. This is in regards to the Public Health Registry and the exclusions. I just want to verify. I think I understood what you said, but I wanted to make sure that I understand this. If you cannot do any of the measures, do you have to exclude for all five measures, or do you only need to exclude for two of them? And the same thing with if you only have one measure out there for the public health that you can report on, do you have to exclude for the remaining four, or can you just exclude for one?

Okay, I'm going to try and break that down. So, the first part of the question was, do you have to claim exclusions for all six of the measures? And you do not have to. You only have to submit two exclusions. We encourage eligible hospitals and CAHs to report on measures that they can submit data for. However, they don't have to exhaust all exclusions. And then the second part was if you report on one and claim an exclusion on the other that that's sufficient? I believe that's what I heard, please correct me if I'm wrong. But that's okay as long as you report on one and you claim one exclusion for one of the other measures.

Okay. Thank you very much.

Our next question is from [Indistinct]

Yes. Hello? Hello?

Yes. Go ahead.

Yes. So, I have two questions in the same line. So, when you say that public health reporting, they can apply for exclusion, is there going to be any kind of application, or when they do the attestation, that's when they check box on the exclusion? And, if they are reporting on the same measure in that category -- only one measure -- sorry -- only one, they don't disqualify, right? Because it clearly says that they have to report for two measures in public health reporting category.

Okay. So, for your first question about do you have to apply for the exclusion, when you do your attestation, you would claim the exclusion there, and then the second part, the question was...

It must report for two measures, but if you claim the exclusion, that counts as reporting for two measures, and then we take the weight of that measure and we distribute it to another measure.

Okay. Our next question, "For avoiding the penalty for small practices, if they choose not to report on the public health and clinical data exchange, is that okay?"

So, eligible hospitals and CAHs are required to report on all the required measures or claim exclusion. If exclusions are claimed, the points for that would be redistributed to another measure, and if you choose not to report on an objective or measure that is required, you will earn a zero and be subject to a downward payment adjustment.

And a reminder that this webinar only relates to eligible hospitals and critical access hospitals, not to clinicians or eligible professionals.

Okay. Thank you for your questions. Jessica, you can close the call.

Thank you. We would like to thank all those who attended today's webinar. We apologize if your question was not answered during the Q&A portion and ask that you submit any outstanding questions to the QualityNet Help Desk by e-mailing QNetSupport@hcqis.org or by calling QualityNet directly at 1-866-288-8912. And that concludes today's webinar.

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

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