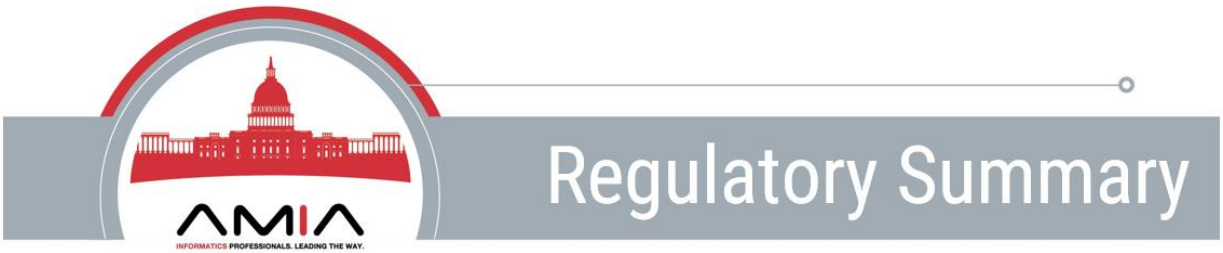

CMS FY 2019 IPPS FINAL RULE
Title: FY 2019 IPPS Final Rule
Action: Final Rule, CMS, 8/17/18
Agency/Docket Number: CMS-1694-F
Summary: CMS established new requirements or revised existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now referred to as the Promoting Interoperability Programs). In addition, they finalized modifications to the requirements that apply to States operating Medicaid Promoting Interoperability Programs.
Focus of AMIA Interest: VIII.A.11.d.(2),(3), VIII.D.2, 3, 4, 5(a), 5(b), 6, 7, 8, 9(b)(d)(e)(f), XII

A. Hospital Inpatient Quality Reporting (IQR) Program

(2) Reporting and Submission Requirements for eCQMs for the CY 2019 Reporting Period/FY 2021 Payment Determination

To align with the Medicare and Medicaid Promoting Interoperability Programs (previously known as the Medicare and Medicaid EHR Incentive Programs), CMS is proposing to extend the same eCQM reporting and submission requirements as FY2018, such that **hospitals would be required to report one, self-selected calendar quarter of data for four self-selected eCQMs** for the CY 2019 reporting period/FY 2021 payment determination. **CMS is inviting public comment on its proposal.**

Final Rule: **"**for the CY 2019 reporting period/FY 2021 payment determination, we are: (1) requiring the same eCQM reporting requirements that were adopted for the CY 2018 reporting period/FY 2020 payment determination (82 FR 38355 through 38361), such that hospitals submit one, self-selected calendar quarter of 2019 data for 4 eCQMs in the Hospital IQR Program measure set; and (2) requiring that hospitals use the 2015 Edition certification criteria for CEHRT. These changes are in alignment with changes or current established policies under the Medicare and Medicaid Promoting Interoperability Programs (previously known as the Medicare and Medicaid EHR Incentive Programs)."

(3) Changes to the Certification Requirements for eCQM Reporting Beginning with the CY 2019 Reporting Period/FY 2021 Payment Determination

For the Hospital IQR Program, CMS is proposing to **require hospitals to use only the 2015 Edition certification criteria for CEHRT beginning with the CY 2019 reporting period/FY 2021 payment determination.** There are certain functionalities in the 2015 Edition of certified electronic health record technology that were not available in the 2014 Edition that will increase interoperability and the flow of

information between providers and patients. **CMS is inviting public comment on our proposal to require hospitals to use the 2015 Edition certification criteria for CEHRT beginning with the CY 2019 reporting period/FY 2021 payment determination.**

Final Rule: **"**After consideration of the public comments we received, we are finalizing our proposal to require hospitals to use the 2015 Edition certification criteria for CEHRT when reporting eCQMs beginning with the CY 2019 reporting period/FY 2021 payment determination as proposed."

D. Proposed Changes to the Medicare and Medicaid EHR Incentive Programs (now referred to as the Medicare and Medicaid Promoting Interoperability Programs)

2. Renaming the EHR Incentive Program

In this proposed rule, CMS is proposing scoring and measurement policies to move beyond the three stages of meaningful use to a new phase of EHR measurement with an increased focus on interoperability and improving patient access to health information. To better reflect this focus, **CMS is renaming the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability (PI) Programs**, and the new name will apply for Medicare fee-for-service, Medicare Advantage, and Medicaid. CMS believes this change will help highlight the enhanced goals of the program and better contextualize the program changes discussed in the following sections.

3. Certification Requirements Beginning in 2019

The FY 2018 IPPS final rule allowed for CEHRT flexibility in 2018, letting health care providers in the Medicare and Medicaid EHR Incentive Programs to use either the 2014 or 2015 Edition of CEHRT, or a combination of both Editions, in 2018. **Beginning with the EHR reporting period in CY 2019, the 2015 Edition of CEHRT is required pursuant to the definition of CEHRT under § 495.4.** CMS is not proposing to change this policy and believes it is appropriate to require the use of 2015 Edition CEHRT beginning in CY 2019. In reviewing the state of health information technology, it is clear the 2014 Edition certification criteria are out of date and insufficient for provider needs in the evolving health IT industry. It would be beneficial to health IT developers and health care providers to move to more up-to-date standards and functions that better support interoperable exchange of health information and improve clinical workflows.

Final Rule: "We received many comments regarding the requirement to use the 2015 Edition of CEHRT beginning in 2019. As we stated in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20516), we were not proposing to change the requirement. Because the requirement was not a subject of this rulemaking, we are not responding to the comments we received, although we will consider them to inform our future policy making in this subject area."

4. Proposed Revisions to the EHR Reporting Period in 2019 and 2020

CMS is proposing the EHR reporting periods in 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency would be a **minimum of any continuous 90-day period within each of the calendar years 2019 and 2020.** This would mean that EPs that attest to a State for the State's Medicaid Promoting Interoperability Program and eligible hospitals and CAHs attesting to CMS or the State's Medicaid Promoting Interoperability Program would attest to meaningful use of

CEHRT for an EHR reporting period of a minimum of any continuous 90-day period from January 1, 2019 through December 31, 2019 and from January 1, 2020 through December 31, 2020, respectively.

Final Rule: "After consideration of the public comments we received, we are finalizing as proposed that the EHR reporting period is a minimum of any continuous 90-day period in CY 2019 and 2020 for new and returning participants in the Promoting Interoperability Programs attesting to CMS or their State Medicaid agency."

5. Proposed Scoring Methodology for Eligible Hospitals and CAHs Attesting Under the Medicare Promoting Interoperability Program

a. CMS is proposing a **new performance-based scoring methodology with fewer measures, and moving away from the threshold-based methodology that it currently uses.** The performance-based scoring methodology would apply to eligible hospitals and CAHs that submit an attestation to CMS under the Medicare Promoting Interoperability Program beginning with the EHR reporting period in CY 2019. This would include "Medicare-only" eligible hospitals and CAHs (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) as well as "dual-eligible" eligible hospitals and CAHs (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). CMS is not proposing to apply the performance-based scoring methodology to "Medicaid-only" eligible hospitals (those that are only eligible to earn a Medicaid incentive payment for meaningful use of CEHRT, and 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) that submit an attestation to their State Medicaid agency for the Medicaid Promoting Interoperability Program.

If CMS does not finalize a new scoring methodology, it would maintain the current Stage 3 methodology with the same objectives, measures and requirements, but CMS would include two new proposed opioid measures, if finalized.

b. **CMS is proposing a new scoring methodology to include a combination of new measures, as well as the existing Stage 3 measures of the EHR Incentive Program, broken into a smaller set of four objectives and scored based on performance and participation.** The smaller set of objectives would include:

1. e-Prescribing (1 required, 2 optional measures);
2. Health Information Exchange (2 required measures);
3. Provider to Patient Exchange (1 required measure); and
4. Public Health and Clinical Data Exchange (1 required measure).

Under the proposed scoring methodology, eligible hospitals and CAHs would be required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual measure-level. Each measure would be scored based on the eligible hospital or CAH's performance for that measure, except for the Public Health and Clinical Data Exchange objective, which requires a yes/no attestation. Each measure would contribute to the eligible hospital or CAH's total

Promoting Interoperability (PI) score. A total score of 100 points would be possible through the proposed scoring methodology, and eligible hospitals and CAHs scoring below 50 points would not be considered meaningful EHR users.

CMS also considered an alternative approach in which scoring would occur at the objective level, instead of the individual measure level, and eligible hospitals or CAHs would be required to report on only one measure from each objective to earn a score for that objective. Under this scoring methodology, instead of six required measures, the eligible hospital or CAH's total Promoting Interoperability score would be based on only four measures, one measure from each objective. Each objective would be weighted similarly to how the objectives are weighted in the proposed methodology, and bonus points would be awarded for reporting any additional measures beyond the required four. **CMS seeks public comment on this alternative approach, and whether additional flexibilities should be considered,** such as allowing eligible hospitals and CAHs to select which measures to report on within an objective and how those objectives should be weighted, as well as whether additional scoring approaches or methodologies should be considered.

In CMS' proposed scoring methodology, the e-Prescribing objective would contain three measures each weighted differently to reflect their potential availability and applicability to the hospital community. In addition to the existing e-Prescribing measure, CMS is proposing to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement. The Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement measures would be optional for EHR reporting periods in 2019. These new measures may not be available to all eligible hospitals and CAHs for an EHR reporting period in 2019 as they may not have been fully developed by their health IT vendor, or not fully implemented in time for data capture and reporting. Therefore, CMS is not proposing to require these two new measures in 2019, although eligible hospitals and CAHs may choose to report them and earn up to 5 bonus points for each measure. **CMS proposes to require these measures beginning with the EHR reporting period in 2020, and CMS is seeking public comment on this proposal.**

In order to meet statutory requirements and HHS priorities, the eligible hospital or CAH would need to report on all of the required measures across all objectives in order to earn any score at all. Failure to report any required measure, or reporting a "no" response on a yes/no response measure, unless an exclusion applies would result in a score of zero. **CMS is seeking public comment on the proposed requirement to report on all required measures, or whether reporting on a smaller subset of optional measures would be appropriate.**

CMS believes that the 50-point minimum Promoting Interoperability score provides the necessary benchmark to encourage progress in interoperability and also allows us to continue to adjust this benchmark as eligible hospitals and CAHs progress in health IT. **CMS seeks comment on whether this minimum score is appropriate, or whether a higher or lower minimum score would be better suited for the first year of this new scoring methodology.**

The tables below illustrate the proposals for 2019 and 2020 scoring methodologies and existing Stage 3 requirements:

Proposed Performance-Based Scoring Methodology for EHR Reporting Periods in 2019

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	Bonus: Verify Opioid Treatment Agreement	5 points bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Required) <u>Choose one or more additional:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points

Proposed Performance-Based Scoring Methodology for EHR Reporting Periods in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	5 points
	Query of Prescription Drug Monitoring Program (PDMP)	5 points
	Verify Opioid Treatment Agreement	5 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points

Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	35 points
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Required) <u>Choose one or more additional:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points

Proposed Scoring Methodology Example

Objectives	Measures	Numerator/Denominator	Performance Rate	Score
e-Prescribing	e-Prescribing	200/250	80%	8 points
	Query of Prescription Drug Monitoring Program (PDMP)	150/175	86%	5 bonus points
	Verify Opioid Treatment Agreement	N/A	N/A	0 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	135/185	73%	15 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	145/175	83%	17 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	350/500	70%	35 points

Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Required) <u>Choose one or more additional:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	Yes Yes	N/A	10 points
Total Score				**83 points**

Existing Stage 3 Objectives, Measures and Reporting Requirements for the Medicare EHR Incentive Program for Eligible Hospitals and CAHs

Objective	Measure (Stage 3 Threshold)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis (Yes/No)	Report
Electronic Prescribing	e-Prescribing (>25%)	Report and meet threshold
Patient Electronic Access to Health Information	Provide Patient Access (>50%) Patient Specific Education (>10%)	Report and meet thresholds
Coordination of Care Through Patient Engagement	View, Download or Transmit (at least one patient) Secure Messaging (>5%) Patient Generated Health Data (>5%)	Report all, but only meet the threshold for two

Health Information Exchange	Send a Summary of Care (>10%) Request/Accept Summary of Care (>10%) Clinical Information Reconciliation (>50%)	Report all, but only meet the threshold for two
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting Syndromic Surveillance Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	Report Yes/No to Three Registries

CMS is seeking public comment on whether this redistribution is appropriate for 2019 and 2020 respectively, or whether the points should be distributed differently. CMS also seeks public comment on how the Promoting Interoperability Program should evolve in future years regarding the future of the new scoring methodology and related aspects of the program.

Final Rule: "We are finalizing that eligible hospitals and CAHs are required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual measure-level. Each measure is scored based on the eligible hospital or CAH's performance for that measure, except for the measures associated with the Public Health and Clinical Data Exchange objective, which require a yes/no attestation. Each measure will contribute to the eligible hospital or CAH's total Promoting Interoperability score. The scores for each of the individual measures are added together to calculate the total Promoting Interoperability score of up to 100 possible points for each eligible hospital or CAH. A total score of 50 points or more will satisfy the requirement to report on the objectives and measures of meaningful use under § 495.24, which is one of the requirements for an eligible hospital or CAH to be considered a meaningful EHR user under § 495.4 and thus earn an incentive payment and/or avoid a Medicare payment reduction. Eligible hospitals and CAHs scoring below 50 points will not be considered meaningful EHR users. We are finalizing that for an eligible hospital or CAH to earn a score greater than zero, in addition to completing the actions included in the Security Risk Analysis measure, the hospital must submit their complete numerator and denominator or yes/no data for all required measures. The numerator and denominator for each performance measure will translate to a performance rate for that measure and will be applied to the total possible points for that measure. The eligible hospital or CAH must report on all of the required measures across all of the objectives in order to earn any score at all. Failure to report any required measure, or reporting a ''no'' response on a yes/no response measure, unless an exclusion applies will result in a score of zero."

Final Rule: "After consideration of the public comments we received, we are finalizing our proposal for scoring the Public Health and Clinical Data Exchange objective as proposed but with the following

modification. Instead of requiring eligible hospitals and CAHs to report the Syndromic Surveillance Reporting measure and one additional measure of their choosing, we will allow them to choose both of the measures that they will report. **Eligible hospitals and CAHs must select two of the following measures to report on: Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Electronic Reportable Laboratory Result Reporting**. As stated in section VIII.6.e. of the preamble of this final rule, we believe the Syndromic Surveillance Reporting measure should not be required as we understand some hospitals and local jurisdictions are not able to send and receive syndromic surveillance files. In addition, allowing eligible hospitals and CAHs to report on any two measures of their choice promotes flexibility in reporting and allows them to focus on the public health measures that are most relevant to them and their patient populations.

6. Proposed Measures for Eligible Hospitals and CAHs Attesting Under the Medicare Promoting Interoperability Program

a. Measure Proposal Summary Overview

CMS is proposing to remove six measures. Two of the measures – Request/Accept Summary of Care and Clinical Information Reconciliation – would be replaced by the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, which combines the functionalities and goals of the two Stage 3 measures it is replacing. Four of the measures – Patient-Specific Education; Secure Messaging; View, Download or Transmit; and Patient Generated Health Data – would be removed because, according to CMS, they have proven burdensome to health care providers in ways that were unintended and detract from health care providers' progress on current program priorities.

CMS is also proposing to add three new measures. For the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment. For the Health Information Exchange objective: Support Electronic Referral Loops by Receiving and Incorporating Health Information, which builds upon and replaces the existing Request/Accept Summary of Care and Clinical Information Reconciliation measures, while furthering interoperability and the exchange of health information. CMS is also proposing to rename some of the existing Stage 3 measures and objectives: Send a Summary of Care would become Support Electronic Referral Loops by Sending Health Information. In addition, the Patient Electronic Access to Health Information objective would become Provider to Patient Exchange, and Provide Patient Access would become Provide Patients Electronic Access to Their Health Information.

CMS is proposing to eliminate the Coordination of Care Through Patient Engagement objective and all of its associated measures. Finally, it is proposing to rename the Public Health and Clinical Data Registry Reporting objective to the Public Health and Clinical Data Exchange objective and is proposing to require attestation to the Syndromic Surveillance Reporting measure and at least one additional measure of the eligible hospital or CAH's choosing from the following: Immunization Registry Reporting; Electronic Case Reporting; Public Health Registry Reporting; Clinical Data Registry Reporting; and Electronic Reportable Laboratory Result Reporting.

Lastly, CMS is proposing removal of the exclusion criteria from all of the Stage 3 measures they are planning on retaining, except for the measures associated with the e-Prescribing objective, Public

Health and Clinical Data Exchange objective, and the new measures. CMS is also proposing to remove the exclusion criteria related to broadband availability because FCC data showed that no counties have less than 4 Mbps of broadband availability and 2016 Modified Stage 2 attestation data for eligible hospitals and CAHs showed that no eligible hospital or CAH claimed an exclusion based on broadband availability. In addition, CMS does not believe that an exclusion based on the number of transitions or referrals received and patient encounters in which the provider has never previously encountered the patient is warranted for any of the measures associated with Health Information Exchange objective. This exclusion applies for the Stage 3 Request/Accept Summary of Care measure and the Clinical Information Reconciliation measure.

CMS is also seeking public comment on a potential new measure Health Information Exchange Across the Care Continuum under the Health Information Exchange objective. Under this proposed measure, an eligible hospital or CAH would send an electronic summary of care record, or receive and incorporate an electronic summary of care record, for transitions of care and referrals with a provider of care other than an eligible hospital or CAH. The measure would include health care providers in care settings including but not limited to long term care facilities, and post-acute care providers such as skilled nursing facilities, home health, and behavioral health settings.

Final Rule: "After consideration of the public comments we received, we are finalizing the changes to the objectives, measures, and exclusion criteria as proposed for eligible hospitals and CAHs that submit an attestation to CMS under the Medicare Promoting Interoperability Program beginning with the EHR reporting period in CY 2019, including Medicare-only and dual-eligible eligible hospitals and CAHs, with the modifications"

b. Measure Proposals for the e-Prescribing Objective

CMS has identified two new measures which align with the broader HHS efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes and promote more informed prescribing practices. (1) Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP) and (2) Proposed Measure: Verify Opioid Treatment Agreement.

(1) Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP)
Integration of the PDMP with health information technology systems supports improves access to PDMP data, minimizes changes to current workflow and overall burden and optimizes prescribing practices. The intent of the Query of the PDMP measure is to build upon the current PDMP initiatives from Federal partners focusing on prescriptions generated and dispensing of opioids.

Proposed Measure Description: For at least one Schedule II opioid electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH uses data from CEHRT to conduct a query of a PDMP for prescription drug history is conducted, except where prohibited and in accordance with applicable law.

Denominator: Number of Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or CAH during the EHR reporting period.

Numerator: 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 prohibited and in accordance with applicable law.

CMS understands that PDMP integration is not currently in widespread use for CEHRT, and many eligible hospitals and CAHs may require additional time and workflow changes at the point of care before they can meet this measure without experiencing significant burden. For instance, many eligible hospitals and CAHs will likely need to manually enter data into CEHRT to document the completion of the query of the PDMP action. In addition, some eligible hospitals and CAHs may also need to conduct manual calculation of the measure. Even for those eligible hospitals and CAHs that have achieved successful integration of a PDMP with their EHR, this measure may not be machine calculable, for instance, in cases where the eligible hospital or CAH follows a link within the EHR to a separate PDMP system. For the purposes of meeting this measure, CMS also understands that there are no existing certification criteria for the query of a PDMP. However, CMS believes that the use of structured data captured in the CEHRT, can support querying a PDMP through the broader use of health IT. **CMS is seeking public comment on whether ONC should consider adopting standards and certification criteria to support the query of a PDMP, and if such criteria were to be adopted, on what timeline should CMS require their use to meet this measure.**

CMS notes that the NCPDP SCRIPT 2017071 standard for e-prescribing is now available and can help to support PDMP and EHR integration. **CMS is seeking public comment especially from health care providers and health IT developers on whether they believe use of this standard can support eligible hospitals and CAHs seeking to report on this measure, and whether HHS should encourage use of this standard through separate rulemaking. CMS is seeking public comment on the challenges associated with querying the PDMP with and without CEHRT integration and whether this proposed measure should require certain standards, methods or functionalities to minimize burden.**

(2) Proposed Measure: 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 they electronically prescribe a Schedule II opioid using CEHRT if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days. An opioid treatment agreement is intended to support and to enable further coordination and the sharing of substance use disorder (SUD) data with consent, as may be required of the individual. Because of the debate among practitioners, CM is requesting comment on the challenges this proposed measure may create for health care providers, how those challenges might be mitigated, and whether this measure should be included as part of the Promoting Interoperability Program. CMS also acknowledges challenges related to prescribing practices and multiple State laws which may present barriers to the uniform implementation of this proposed measure. CMS is seeking public comment on the challenges and concerns associated with opioid treatment agreements and how they could impact the feasibility of the proposal.

***Proposed Measure Description*:** For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the eligible hospital or CAH using CEHRT during the EHR reporting period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a

6-month look-back period, the eligible hospital or CAH seeks to identify the existence of a signed opioid treatment agreement and incorporates it into CEHRT.

CMS is not proposing to define an opioid treatment agreement as a standardized electronic document; nor is it proposing to define the data elements, content structure, or clinical purpose for a specific document to be considered a "treatment agreement." For this measure, **CMS is seeking public comment on what characteristics should be included in an opioid treatment agreement and incorporated into CEHRT,** such as clinical data, information about the patient's care team, and patient goals and objectives, as well as which functionalities could be utilized to accomplish the incorporation of this information. **CMS is also seeking public comment on methods or processes for incorporation of the treatment agreement into CEHRT, including which functionalities could be utilized to accomplish this.** CMS seeks public comment on whether there are specific data elements that are currently standardized that should be incorporated via reconciliation and if the "patient health data capture" functionality could be used to incorporate a treatment plan that is not a structured document with structured data elements.

Denominator: 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 response transactions during a 6-month look-back period.

Numerator: 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 in CEHRT.

Final Rule: "We are finalizing the Electronic Prescribing objective as proposed with the following modifications. The e-Prescribing measure is worth up to 10 points in CY 2019 and up to 5 points in CY 2020. The Query of Prescription Drug Monitoring Program (PDMP) measure is optional in CY 2019 and worth up to 5 bonus points and is a required measure beginning in CY 2020, worth up to 5 points. The Verify Opioid Treatment Agreement measure is optional in CY 2019 and 2020, and worth up to five bonus points. We intend to reevaluate the status of the Verify Opioid Treatment Agreement measure for subsequent years in future rulemaking. An exclusion is available for the e-Prescribing measure as described in section VIII.D.6. of the preamble of this final rule. If an exclusion is claimed for the e-Prescribing measure for CY 2019, the 10 points for the e-Prescribing measure will be redistributed equally among the measures associated with the Health Information Exchange objective. We are finalizing a policy beginning in CY 2020 that an eligible hospital or CAH that qualifies for the e-Prescribing measure exclusion is also excluded from reporting on the Query of PDMP measure. In addition, separate exclusion criteria are available for the Query of PDMP measure beginning in CY 2020 as described in section VIII.D.6. of the preamble of this final rule. If an exclusion is claimed for the Query of PDMP measure in CY 2020, the points will be equally redistributed among the measures associated with the Health Information Exchange objective. Since the Verify Opioid Treatment Agreement measure is optional and eligible for bonus points, no exclusions are available."

c. Measure Proposals for the Health Information Exchange (HIE) Objective

(1) Proposed Modifications to Send a Summary of Care Measure

CMS proposes to change the name of the Send a Summary of Care measure to Support Electronic Referral Loops by Sending Health Information to better reflect the emphasis on completing the referral loop and improving care coordination.

Proposed name and measure description: Support Electronic Referral Loops by Sending Health Information: For at least one transition of care or referral, the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

CMS notes that stakeholders have raised concerns that the summary care records shared according to the CCDA standard included excessive information not relevant to immediate care needs, which increased burden on health care providers. Accordingly, CMS is proposing that eligible hospitals and CAHs may use any document template within the CCDA standard for purposes of the measures under the Health Information Exchange objective. While eligible hospitals' and CAHs' CEHRT must be capable of sending the full CCDA upon request, CMS believes this additional flexibility will help support efforts to ensure the information supporting a transition is relevant.

For instance, when the eligible hospital or CAH is referring to another health care provider, the recommended document is the "Referral Note," which is designed to communicate pertinent information from a health care provider who is requesting services of another health care provider of clinical or nonclinical services. When the receiving health care provider sends back the information, the most relevant CCDA document template may be the "Consultation Note," which is generated by a request from a clinician for an opinion or advice from another clinician. However, eligible hospitals and CAHs may choose to utilize other documents within the CCDA to support transitions, for instance the "Discharge Summary" document.

(2) Proposed Removal of the Request/Accept Summary of Care Measure. CMS is proposing to remove the Request/Accept Summary of Care measure based on our analysis of the existing measure and in response to stakeholder input.

(3) Proposed Removal of the Clinical Information Reconciliation Measure. CMS is proposing to remove the Clinical Information Reconciliation measure to reduce redundancy, complexity, and provider burden.

(4) Proposed New HIE Measure: Support Electronic Referral Loops by Receiving and Incorporating Health Information. This measure would build upon and replace the existing Request/Accept Summary of Care and Clinical Information Reconciliation measures.

Proposed measure name and description: Support Electronic Referral Loops by Receiving and Incorporating Health Information: For at least one electronic summary of care record received for patient encounters during the EHR reporting period for which an eligible hospital or CAH was the receiving party of a transition of care or referral, or for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient, the eligible hospital or CAH conducts clinical information reconciliation for medication, mediation allergy, and current problem list.

Denominator: 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.

Numerator: 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: (1) Medication – Review of the patient's medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy – Review of the patient's known medication allergies; and (3) Current Problem List – Review of the patient's current and active diagnoses.

For the proposed measure, the denominator would increment on the receipt of an electronic summary of care record after the eligible hospital or CAH engages in workflows to obtain an electronic summary of care record for a transition, referral or patient encounter in which the health care provider has never before encountered the patient. The numerator would increment upon completion of clinical information reconciliation of the electronic summary of care record for medications, medication allergies, and current problems.

Final Rule: "We are finalizing the Health Information Exchange objective as proposed. The Support Electronic Referral Loops by Sending Health Information measure is worth up to 20 points. There are no exclusions available for the measure. The new measure, Support Electronic Referral Loops by Receiving and Incorporating Health Information, is worth up to 20 points. An exclusion is available for this measure in CY 2019, as described in section VIII.D.6. of the preamble of this final rule. If the exclusion is claimed, the 20 points would be redistributed to the other measure within this objective, the Support Electronic Referral Loops by Sending Health Information measure, which would be worth up to 40 points."

d. Measure Proposals for the Provider to Patient Exchange Objective

(1) Proposed Modifications to Provide Patient Access Measure

Proposed name and measure description: Provide Patients Electronic Access to Their Health Information: For at least one unique patient discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23):

- The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her 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.

(2) Proposed Removal of the Patient Generated Health Data Measure

CMS is proposing to remove the Patient Generated Health Data (PGHD) measure to reduce complexity and focus on the goal of using advanced EHR technology and functionalities to advance interoperability and health information exchange.

(3) Proposed Removal of the Patient-Specific Education Measure

CMS is proposing to remove the Patient-Specific Education measure as it has proven burdensome to

eligible hospitals and CAHs in ways that were unintended and detract from health care providers' progress on current program priorities.

(4) Proposed Removal of the Secure Messaging Measure
CMS is proposing to remove the Secure Messaging measure as it has proven burdensome to eligible hospitals and CAHs in ways that were unintended and detract from health care providers' progress on current program priorities.

(5) Proposed Removal of the View, Download or Transmit Measure
CMS is proposing to remove the View, Download or Transmit measure as it has proven burdensome to eligible hospitals and CAHs in ways that were unintended and detract from eligible hospitals and CAHs progress on current program priorities.

Final Rule: "We are finalizing the Provider to Patient Exchange objective with modifications. The Provide Patients Electronic Access to Their Health Information measure is worth up to 40 points beginning with the EHR reporting period in CY 2019. No exclusions are available for this measure."

e. Proposed Modifications to the Public Health and Clinical Data Registry Reporting Objective and Measures

CMS is proposing to change the name of the objective to Public Health and Clinical Data Exchange. CMS is proposing that eligible hospitals and CAHs would be required to attest to the Syndromic Surveillance Reporting measure and at least one additional measure from the following options: Immunization Registry Reporting; Clinical Data Registry Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Electronic Reportable Laboratory Result Reporting. CMS seeks public comment on the proposal to require reporting on this measure.

In addition, CMS intends to propose in future rulemaking to remove the Public Health and Clinical Data Exchange objective and measures no later than CY 2022, and is seeking public comment on whether hospitals will continue to share such data with public health entities once the Public Health and Clinical Data Exchange objective and measures are removed, as well as other policy levers outside of the Promoting Interoperability Program that could be adopted for continued reporting to public health and clinical data registries, if necessary. As noted above, while CMS believes that these registries provide the necessary monitoring of public health nationally and contribute to the overall health of the nation, CMS is also focusing on reducing burden and identifying other appropriate venues in which reporting to public health and clinical data registries could be reported. CMS is seeking public comment on the role that each of the public health and clinical data registries should have in the future of the Promoting Interoperability Programs and whether the submission of this data should still be required when the incentive payments for meaningful use of CEHRT will end in 2021. Lastly, CMS is seeking public comment on whether the Promoting Interoperability Programs are the best means for promoting the sharing of clinical data with public health entities.

Final Rule: "We are finalizing the Public Health and Clinical Data Exchange objective as proposed with the following modifications. Eligible hospitals and CAHs must submit a yes/no response for any two measures associated with the Public Health and Clinical Data Exchange objective to earn 10 points for the objective. Failure to report on two measures or submitting a "no" response for a measure will earn a

score of zero. Exclusions available for this objective are discussed in section VII.6.e. of the preamble of this final rule. If an exclusion is claimed for one measure, but the eligible hospital or CAH submits a "yes" response for another measure, they would earn the 10 points for the Public Health and Clinical Data Exchange objective. If an eligible hospital or CAH claims exclusions for both measures they select to report on, the 10 points would be redistributed to the Provide Patients Electronic Access to Their Health Information measure under the Provider to Patient Exchange objective."

f. Request for Comment - Potential New Measures for HIE Objective: Health Information Exchange Across the Care Continuum

CMS wants to introduce additional flexibility to allow providers a wider range of options in selecting measures that are most appropriate to their setting, patient population, and clinical practice improvement goals. For this reason, CMS is seeking public comment on a potential concept for two additional measure options for the Health Information Exchange objective for eligible hospitals and CAHs.

New Measure Description for Support Electronic Referral Loops by Sending Health Information Across the Care Continuum: For at least one transition of care or referral to a provider of care other than an eligible hospital or CAH, the eligible hospital or CAH creates a summary of care record using CEHRT; and electronically exchanges the summary of care record.

New Measure Denominator: Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) was the transitioning or referring provider to a provider of care other than an eligible hospital or CAH.

New Measure Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created and exchanged electronically using CEHRT.

New Measure Description for Support Electronic Referral Loops By Receiving and Incorporating Health Information Across the Care Continuum: For at least one electronic summary of care record received by an eligible hospital or CAH from a transition of care or referral from a provider of care other than an eligible hospital or CAH, the eligible hospital or CAH conducts clinical information reconciliation for medications, mediation allergies, and problem list.

New Measure Denominator: The number of electronic summary of care records received for a patient encounter during the EHR reporting period for which an eligible hospital or CAH was the recipient of a transition of care or referral from a provider of care other than an eligible hospital or CAH.

New Measure Numerator: The number of electronic summary of care records in the denominator for which clinical information reconciliation was completed using CEHRT for the following three clinical information sets: (1) Medication--Review of the patient's medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy--Review of the patient's known medication allergies; and (3) Current Problem List--Review of the patient's current and active diagnoses.

CMS seeks public comment on whether these two measures should be combined into one measure so that an eligible hospital or CAH that is engaged in exchanging health information across the care continuum may include any such exchange in a single measure.

CMS seeks public comment on whether the denominators should be combined to a single measure including both transitions of care from a hospital and transitions of care to a hospital. CMS is also seeking public comment on whether the numerators should be combined to a single measure including both the sending and receiving of electronic patient health information. CMS is seeking public comment on whether the potential new measures should be considered for inclusion in a future program year or whether stakeholders believe there is sufficient readiness and interest in these measures to adopt them as early as 2019. For the purposes of focusing the denominator, CMS is seeking public comment regarding whether the potential new measures should be limited to transitions of care and referrals specific to long-term and post-acute care, skilled nursing care, and behavioral health care settings.

CMS also seeks public comment on whether additional settings of care should be considered for inclusion in the denominators and if a provider should be allowed to limit the denominators to a specific type of care setting based on their organizational needs, clinical improvement goals, or participation in an alternative payment model. Finally, CMS is seeking public comment on the impact the potential new measures may have for health IT developers to develop, test, and implement a new measure calculation for a future program year.

7. Proposed Application of Proposed Scoring Methodology and Measures Under the Medicaid Promoting Interoperability Program

CMS is not proposing to require States to adopt the new scoring methodology and measures that it is proposing. Instead, it is proposing to **give States the option to adopt the new scoring methodology proposed above.** Any State that wishes to exercise this option must submit a change to its State Medicaid HIT Plan (SMHP) for CMS' approval. If a State chooses not to submit such a change, or if the change is not approved, the current objectives, measures, and scoring would remain the same. **CMS requests public comment on whether it should modify the objectives and measures for eligible professionals (EPs) in the Medicaid Promoting Interoperability Program in order to encourage greater interoperability for Medicaid EPs.** In connection with these proposals regarding the scoring methodology and measures, **CMS is also proposing to require "dual-eligible" eligible hospitals and CAHs (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) to demonstrate meaningful use for the Promoting Interoperability Program to CMS, and not to their respective State Medicaid agency, beginning with the EHR reporting period in CY 2019.**

Final Rule: "After consideration of the public comments we received, we are finalizing the our proposals as proposed."

8. Promoting Interoperability Program Future Direction

In future years of the Promoting Interoperability Program, CMS will continue to consider changes which support a variety of HHS goals, including: reducing administrative burden, supporting alignment with the Quality Payment Program, advancing interoperability and the exchange of health information, and promoting innovative uses of health IT. CMS believes a focus on interoperability and simplification will reduce health care provider burden while allowing flexibility to pursue innovative applications that improve care delivery. One strategy CMS is exploring is creating a set of priority health IT activities that

would serve as alternatives to the traditional EHR Incentive Program measures. For example, CMS is **seeking public comment on whether participation in the Trusted Exchange Framework and Common Agreement (TEFCA) should be considered a health IT activity that could count for credit within the Health Information Exchange objective in lieu of reporting on measures for this objective.** To qualify for this activity, an eligible hospital or CAH would demonstrate that they are using CEHRT from a developer who participates in or serves as a health information network which has adopted the TEFCA. Eligible hospitals and CAHs could also be required to demonstrate that they are active participants in a health information network and routinely sharing health information to support care transitions. They could also be required to demonstrate that their CEHRT enables the use of an open API to exchange information with the network.

CMS is also considering a health IT activity in which eligible hospitals and CAHs could **obtain credit if they maintain an open API which allows patients to access their health information through a preferred third party.** This could be the open API maintained to comply with the terms of the TEFCA or a standalone offering as long as the API offers ongoing persistent access to outside parties. Under this approach, an eligible hospital or CAH that attests to making such an open API available for the purposes of ensuring patients have access to their health information would receive full credit for the Provide Patient Access measure under this objective. Finally, CMS is considering **developing a health IT activity which would allow eligible hospitals and CAHs to obtain credit under the Public Health and Clinical Data Exchange objective for piloting emerging technology standards.** A priority outcome for the draft Trusted Exchange Framework is enabling bulk data queries which health care providers and other stakeholders can utilize to conduct effective population health management across their entire attributed population. However, technical infrastructure to support this use case on a widespread basis is still in development. HHS could develop a health IT activity under which an eligible hospital or CAH would participate in a pilot, and eventually implement in production, use of an API based on the emerging update to the FHIR standard which would allow population level data access through an API in lieu of reporting on measures under the Public Health and Clinical Data Exchange objective. **CMS welcomes stakeholder comments on the concept of adopting health IT activities, and specifically on the health IT activities described above. CMS also welcomes recommendations for other health IT activities through which eligible hospitals and CAHs could earn credit in lieu of reporting on specific measures, and which add value for patients and health care providers, are relevant to patient care and clinical workflows, support alignment with existing objectives, promote flexibility, are feasible for implementation, are innovative in the use of health IT and promote interoperability.**

Finally, CMS is specifically seeking public comments on the following questions:

- What health IT activities should CMS consider recognizing in lieu of reporting on objectives that would most effectively advance priorities for nationwide interoperability and spur innovation? What principles should CMS employ to identify health IT activities?
- Do stakeholders believe that introducing health IT activities in lieu of reporting on measures would decrease burden associated with the Promoting Interoperability Programs?
- If additional measures were added to the program, what measures would be beneficial to add to promote our goals of care coordination and interoperability?

- How can the Promoting Interoperability Program for eligible hospitals and CAHs further align with the Quality Payment Program (for example, requirements for eligible clinicians under MIPS and Advanced APMs) to reduce burden for health care providers, especially hospital-based MIPS eligible clinicians?
- What other steps can HHS take to further reduce the administrative burden associated with the Promoting Interoperability Program?

9. Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the Medicare and Medicaid Promoting Interoperability Programs

b. CMS plans to continue to align the CQM reporting requirements for the PI Programs with the Hospital IQR Program. In order to move the program forward in the least burdensome manner possible, CMS is proposing to reduce the number of eCQMs in the Medicare and Medicaid Promoting Interoperability Programs eCQM measure set from which eligible hospitals and CAHs report, by **proposing to remove eight eCQMs (from the 16 eCQMs currently in the measure set) beginning with the reporting period in CY 2020.** The eight eCQMs CMS is proposing to remove are:

- Primary PCI Received Within 90 Minutes of Hospital Arrival (NQF #0163) (AMI-8a);
- Home Management Plan of Care Document Given to Patient/Caregiver (CAC-3);
- Median Time from ED Arrival to ED Departure for Admitted ED Patients (NQF #0495) (ED-1);
- Hearing Screening Prior to Hospital Discharge (NQF #1354) (EHDI-1a);
- Elective Delivery (NQF #0469) (PC-01);
- Stroke Education (STK-08) (adopted at 78 FR 50807);
- Assessed for Rehabilitation (NQF #0441) (STK-10); and
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (NQF 0496) (ED-3).

CMS recognizes that some hospitals and health IT vendors may prefer earlier removal in order to forgo maintenance on those eCQMs proposed for removal. **CMS is therefore inviting public comment on the proposal, including the specific measures proposed for removal and the timing of removal from the Medicare and Medicaid Promoting Interoperability Programs.**

d. For CY 2019, CMS is proposing the same CQM reporting periods and criteria as established in the FY 2018 IPPS final rule, which would be to report **one self-selected calendar quarter of CY 2019 data, and the submission period for the Medicare Promoting Interoperability Program would be the 2 months following the close of the calendar year, ending February 29, 2020.** For eligible hospitals and CAHs that report CQMs by attestation under the Medicare Promoting Interoperability Program as a result of electronic reporting not being feasible, and for eligible hospitals and CAHs that report CQMs by attestation under their State's Medicaid Promoting Interoperability Program, CMS previously established a CQM reporting period of the full CY 2019 ('consisting of 4 quarterly data reporting periods). CMS also established an exception for eligible hospitals and CAHs demonstrating meaningful use for the first time under their State's Medicaid EHR Incentive Program, which would be any continuous 90-day period within CY 2019. CMS is proposing that the submission period for eligible hospitals and CAHs reporting CQMs by attestation under the Medicare EHR Incentive Program would be the 2 months following the close of the CY 2019 CQM reporting period, ending February 29, 2020.

For the CY 2019 reporting period, CMS is proposing that the reporting criteria under the Medicare and Medicaid Promoting Interoperability Program for eligible hospitals and CAHs reporting CQMs electronically would be as follows: **for eligible hospitals and CAHs participating only in the Promoting Interoperability Program, or participating in both the Promoting Interoperability Program and the Hospital IQR Program, report on at least 4 self-selected CQMs from the set of 16 available CQMs**. For eligible hospitals and CAHs that report CQMs by attestation under the Medicare Promoting Interoperability Program as a result of electronic reporting not being feasible, and for eligible hospitals and CAHs that report CQMs by attestation under their State's Medicaid Promoting Interoperability Program, for the reporting period in CY 2019 – report on all 16 available CQMs. **CMS is requesting public comments on these proposals.**

e. For CY 2019, CMS is proposing to continue its policy regarding the electronic submission of CQMs, which requires the use of the most recent version of the CQM electronic specification for each CQM to which the EHR is certified. For the CY 2019 electronic reporting of CQMs, this means eligible hospitals and CAHs are required to use the Spring 2017 version of the CQM electronic specifications and any applicable addenda available on the eCQI Resource Center webpage at: https://ecqi.healthit.gov/. In addition, CMS is proposing that eligible hospitals or CAHs must have their EHR technology certified to all 16 available CQMs. An EHR certified for CQMs under the 2015 Edition certification criteria does not have to be recertified each time it is updated to a more recent version of the CQMs. **CMS is requesting public comments on these proposals.**

f. CMS is seeking stakeholder feedback on ways that it could address these and other challenges related to eCQM use. Specifically, it is inviting comment on the following:

- What aspects of the use of eCQMs are most burdensome to hospitals and health IT vendors?
- What program and policy changes, such as improved regulatory alignment, would have the greatest impact on addressing eCQM burden?
- What are the most significant barriers to the availability and use of new eCQMs today?
- What specifically would stakeholders like to see us do to reduce burden and maximize the benefits of eCQMs?
- How could CMS encourage hospitals and health IT vendors to engage in improvements to existing eCQMs?
- How could CMS encourage hospitals and health IT vendors to engage in testing new eCQMs?
- Would hospitals and health IT vendors be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would explore less burdensome ways of approaching quality measurement, such as sharing data with third parties that use machine learning and natural language processing to classify quality of care or other approaches?
- What ways could CMS incentivize or reward innovative uses of health IT that could reduce burden for hospitals?
- What additional resources or tools would hospitals and health IT vendors like to have publicly available to support testing, implementation, and reporting of eCQMs?

Final Rule: "After consideration of the public comments we received, we are adopting our proposal as proposed."

XII. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid Participating Providers and Suppliers

In light of the widespread adoption of EHRs, along with the increasing availability of health information exchange infrastructure predominantly among hospitals, CMS is interested in hearing from stakeholders on how it could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs **(that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care Facilities**) **to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.** Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested.

CMS is specifically inviting stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs/RfPs for interoperability and electronic exchange of health information:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?
- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?
- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?

- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

CMS additionally invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. The agency is particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records.