Cheat Sheet
IPPS: Direction of the
Promoting Interoperability Program (May 2019)

I. Background

On May 3rd the Centers for Medicare and Medicaid Services (CMS) published their proposed inpatient prospective payment system rule. CMS' fact sheet on the rule can be found here.

Contained in the rule are seven requests for information (RFIs) related to the future direction that CMS may take related to the Promoting Interoperability Program. They are each outlined below.

II. High-level takeaways

CMS is pondering the following actions:

1. Continued focus on opioids under both Promoting Interoperability and new quality measures.
2. More focus on improving efficient use of EHRs including measuring provider's efficient use of EHRs.
3. Posting Promoting Interoperability performance on Hospital Compare.
4. Changes to the "Provide Patients Electronic Access to Their Health Information" measure including requiring immediate access to data for patients and persistent access via APIs.
5. Offering an alternative measure under the Provider to Patient Exchange objective that would focus on offering patients access to their complete electronic health data via the EHI export capability.
6. Patient matching strategies
7. Incorporating more patient-generated measures into the program.
8. Attesting to performance of an assessment based on one of the ONC SAFER Guides

III. RFIs on Future Direction of the Promoting Interoperability Program

A. Opioids: Request for Information (RFI) on Potential Opioid Measures for Future Inclusion in the Promoting Interoperability Program

CMS is seeking comment on potential new measures for OUD prevention and treatment that could be included in future years of the Promoting Interoperability Program. CMS is seeking comment specifically on possible OUD prevention and treatment measures that include the following characteristics:

1. **All settings:** Are applicable to all hospital settings (for example, rural, urban, small hospitals, large hospitals);
2. **Measurement:** Are represented by a measure description, numerator/denominator or "yes/no" attestation statement, and possible exclusions;
3. **Evidence:** Include evidence of positive impact on outcome-focused improvement activities, and the opioid crisis overall;
4. **Leverage the capabilities of CEHRT, including:** automatic calculation and reporting of numerator, denominator, exclusions and exceptions, and timing elements to reduce quality measurement and reporting burdens to the greatest extent possible;
5. **Clinical concepts:** Are based on well-defined clinical concepts, measure logic and timing elements that can be captured by CEHRT in standard clinical workflow and/or routine business operations. Well-defined clinical concepts include those that can be discretely represented by available clinical and/or claims vocabularies such as SNOMED CT, LOINC, RxNorm, ICD-10 or CPT; and
6. **Workflow:** Align with clinical workflows in such a way that data used in the calculation of the measure is collected as part of a standard workflow and does not require any additional steps or actions by the health care provider

B. Opioids Quality Measures: RFI on NQF and CDC Opioid Quality Measures

The agency is seeking comment about the following measures aimed at reducing OUD:

NQF Quality Measures:
CMS is seeking comment on the following three NQF measures for possible inclusion in the Promoting Interoperability Program and any modifications that may be necessary to maximize their use in the Promoting Interoperability Program:

- Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940). 817
- Use of Opioids from Multiple Providers in Persons Without Cancer (NQF #2950).

- Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer (NQF #2951).

CDC Quality Improvement (QI) Opioid Measures

CMS is seeking comment on which of the 16 CDC QI opioid measures have value for potential consideration for the Promoting Interoperability Program. The agency is further seeking comment on whether we should consider a different type of measurement concept for the OUD prevention and treatment measures, such as reporting on a set of cross cutting activities and measures to earn credit in the Promoting Interoperability Program

C. EHR Use Efficiency: Request for Information (RFI) on a Metric to Improve Efficiency of Providers within EHRs

CMS is seeking stakeholder feedback on a potential metric to evaluate health care provider efficiency using EHRs. Specifically, CMS is looking at the following questions:

1. What do stakeholders believe would be useful ways to measure the efficiency of health care processes due to the use of health IT? What are measurable outcomes demonstrating greater efficiency in costs or resource use that can be linked to the use of health IT-enabled processes? This includes measure description, numerator/denominator or “yes/no” reporting, and exclusions.
2. What are specific technologies, capabilities, or system features (beyond those currently addressed in the Promoting Interoperability Program) that can increase the efficiency of health care provider interactions with technology systems, for instance, alternate authentication technologies that can simplify health care provider logon? How could we reward health care providers for adoption and use of these technologies?
3. What are key administrative processes that could benefit from more efficient electronic workflows, for instance, conducting prior authorization requests? How could we measure and reward health care providers for uptake of more efficient electronic workflows?

D. Hospital Compare: RFI on Including Medicare Promoting Interoperability Program Data on the Hospital Compare Website

The agency is seeking comment on posting Medicare Promoting Interoperability Program measure(s) on the Hospital Compare website, specifically:

1. Of the six required measures and one bonus measure that would apply for an EHR reporting period in CY 2020, how many and which ones should we consider posting?

2. What process should be in place to allow eligible hospitals and CAHs the opportunity to review the data prior to publication? This includes comment on how many days the preview period should be for eligible hospitals and CAHs to review data prior to publication and a correction process for those who may have identified an error in their data.
3. We are seeking comment on posting the data on the our Hospital Compare website, found at: www.medicare.gov/hospitalcompare

E. MyHealtheData: RFI on the Provider to Patient Exchange Objective

As part of the MyHealthEData initiative, CMS is taking a patient-centered approach to health information access and moving to a system in which patients have immediate access to their computable health information and can be assured that their health information will follow them as they move throughout the health care system from provider to provider, payer to payer.

Last year CMS asked stakeholders for input on a measure under PI that would give providers credit for maintain an "open API," or standards-based API, which allows patients to access their health information through a preferred third-party application. The feedback they received was that this could open the door to security and privacy concerns. CMS responded in this rule by noting that this does not necessarily meant that anyone could get access. Also, patients would have to authenticate themselves to the provider

ONC has proposed to make the standards-based API criterion part of the 2015 Edition base EHR definition, which would ensure that this functionality is ultimately included in the CEHRT definition required for participation in the Promoting Interoperability Program. If finalized, ONC has proposed that health IT developers would have 24 months from the publication of the final rule to implement these changes to certified health IT products.

1. Immediate Access

The existing Provide Patients Electronic Access to Their Health Information measure specifies that hospitals provide the patient timely access to ***view online, download, and transmit (VD & T)*** their health information, and that patient health information must be made available to the patient within 36 hours of its availability to the hospital.CMS says that understanding the need for patients to have "access to their complete health information, including clinical information from the eligible hospital or CAH's CEHRT, and appreciating the new technical flexibility a standards-based API provides," they seek comment on:

a. Whether hospitals should make patient health information available immediately through the open, standards-based API, no later than one business day after it is available to the eligible hospital or CAH in their CEHRT.
b. The barriers to more immediate access to patient information.
c. Are there specific data elements that may be more or less feasible to share no later than one business day.

2. Persistent Access and Standards-based APIs

CMS says the existing ***Provide Patients Electronic Access to Their Health Informationmeasure*** does not specify the overall operational expectations associated with enabling patients' access to their health information. For instance, the measure doesn't specify a timeframe – it just says provide in a timely manner - by which this should occur.

a. Should the measure be updated to require persistent access?

CMS says they continue to probe the role of APIs. They state, "use of FHIR-based APIs could help push forward interoperability regardless of EHR systems used providing standardized way to share information." They seek comment on:

1. If ONC's proposal for a FHIR-based API certification criteria is finalized, would stakeholders support a possible bonus under the Promoting Interoperability Programs for early adoption of a certified FHIR-based API in the intermediate time before ONC's final rule's compliance date for implementation of a FHIR standard for certified APIs?

3. Available data

CMS refers to ONC's proposal to update 2015 CEHRT's EHI export criteria as reducing clinician burden which calls for vendors to have the ability for a provider or patients to export data for a single patient or all patients.

CMS is seeking comment on an **alternative measure under the** **Provider to Patient Exchange objective** (again the requirement under here is to provider timely access for patients to VD&T their data AND offer it via API) that would require health care providers to use technology certified to the EHI criteria to provide the patient(s) their complete electronic health data contained within an EHR. Specifically, CMS seeks comment on:

a. **Effectiveness:** Do stakeholders believe that incorporating this alternative measure into the Provider to Patient Exchange objective will be effective in encouraging the availability of all data stored in health IT systems?

b. **Scoring:** In relation to the Provider to Patient Exchange objective as a whole, how should a measure focused on using the proposed total EHI export function in CEHRT be scored?
c. **Bonus:** If this certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure? Should this measure be established as an attestation measure?
d. **Burden:** In the long term, how do stakeholders believe such an alternative measure would impact burden?
e. **Valuable Data Elements:** What data elements do stakeholders believe are of greatest clinical value or would be of most use to health care providers to share in a standardized electronic format if the complete record was not immediately available? In addition to the above questions, we have some general questions that are related to health IT activities, for which we are also seeking public comment:
    i. **Bi-directional exchange:** Do stakeholders believe that we should consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long term care, behavioral health, and home and community based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should we consider when implementing a health information exchange across the care continuum health IT activity in the Promoting Interoperability Program?
    ii. **High priority areas:** What criteria should we employ, such as specific goals or areas of focus, to identify high priority health IT activities for the future of the program?
    iii. **Other activities:** Are there additional health IT activities we should consider recognizing in lieu of reporting on existing measures and objectives that would most effectively advance priorities for nationwide interoperability and spur innovation?

4. Patient Matching

CMS is seeking comment for future consideration on:

a. Ways for ONC and CMS to continue to facilitate private sector efforts on a workable and scalable patient matching strategy so that the lack of a specific UPI does not impede the free flow of information.
b. How they may leverage their program authority to provide support to those working to improve patient matching.

F. Patient-generated data: RFI on Integration of Patient-Generated Health Data into EHRs Using CEHRT

CMS says they are, "continuously seeking ways to prioritize the advanced use of CEHRT functionalities, encourage movement away from paper-based processes that increase heath care provider burden, and empower individual beneficiaries to take a more impactful role in managing their health to achieve their goals." Recognizing they removed the PGD measure from the Promoting Interoperability program, they are nonetheless looking for ways to include this into the program in the future as "technologies and standards continue to evolve." They reference a white paper by ONC on the topic of PDG. Related to the actions clinicians could take as outlined in this paper, CMS is interested in new PGD elements that could (1) represent clearly defined uses of health IT; (2) are linked to positive outcomes for patients; and (3) advance the capture, use, and sharing of PGHD.
CMS says that a future program element related to PGHD would not necessarily need to be implemented as a traditional measure requiring reporting of a numerator and denominator.

CMS is inviting stakeholder comment on:

- **Use cases:** What specific use cases for capture of PGHD as part of treatment and care coordination across clinical conditions and care settings are most promising for improving patient outcomes? For instance, use of PGHD for capturing advanced directives and pre/post-operation instructions in surgery units.
- **Bonus:** Should the Promoting Interoperability Program explore ways to include bonus points for health care providers engaging in activities that pilot promising technical solutions or approaches for capturing PGHD and incorporating it into CEHRT using standards-based approaches?
- **Unscheduled procedures:** Should inpatient health care providers be expected to collect information from their patients outside of scheduled appointments or procedures? What are the benefits and concerns about doing so?
- **Best practices:** Should the Promoting Interoperability Program explore ways to reward health care providers for implementing best practices associated with optimizing clinical workflows for obtaining, reviewing, and analyzing PGHD?
- **Bi-directional data:** We believe the bi-directional availability of data, meaning that both patients and their health care providers have real-time access to the patient's electronic health record, is critical. This includes patients being able to import their health data into their medical record and have it be available to health care providers. We welcome input on how we can encourage and enable health care providers to advance capture, exchange, and use of PGHD.

G. Safety: RFI on Engaging in Activities that Promote the Safety of the EHR

As CMS continues to advance the use of CEHRT in health care, the agency is seeking comment on how to further mitigate the specific safety risks that may arise from technology implementation. Specifically, they seek comment on ways that the Promoting Interoperability Program may reward hospitals for engaging in activities that can help to reduce errors associated with EHR implementation. CMS is requesting comment on SAFER Guides including:

a. **Attestation on use of Guides:** A potential future change to the program under which hospitals would receive points towards their Promoting Interoperability Program score for attesting to performance of an assessment based on one of the ONC SAFER Guides. The SAFER Guides (available at: https://www.healthit.gov/topic/safety/safer-guides) are designed to help healthcare organizations conduct self-assessments to optimize the safety and safe use of EHRs in nine different areas: High Priority Practices, Organizational Responsibilities, Contingency Planning, System Configuration, System Interfaces, Patient Identification, Computerized Provider Order Entry, Test Results Reporting and Follow-Up, and Clinician Communication.**Points for conducting assessment:** CMS might consider offering points towards the Promoting Interoperability Program score to hospitals that attest to conducting an assessment based on the High Priority Practicesand/or the Organizational Responsibilities SAFER Guides which cover many foundational concepts from across the guides. Alternatively, CMS might consider awarding points for review of all nine of the SAFER Guides. CMS is also inviting comments on alternatives to the SAFER Guides, including appropriate assessments related to patient safety, which should also be considered as part of any future bonus option.