2021

A Deeper View of the Finalized CY 2022 IQR and PI Programs

Based on the FY 2022 IPPS Final Rule

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About this White Paper

On August 2, 2021, CMS filed its annual Inpatient Prospective Payment System (IPPS) final rule (unpublished version). Emphasis of this white paper is on the finalized updates to the Promoting Interoperability (PI) Program, the electronic Clinical Quality Measures (eCQMs) for the Inpatient Quality Reporting (IQR) and PI Programs; and briefings on CMS' requests for information to advance digital quality measures (dQMs) and close the health equity gap in CMS hospital quality programs.

For highlights of content provided in this white paper, please refer to the associated blog posted on emids website: Taking a Look at the Finalized CY 2022 IQR and PI Programs.

The Promoting Interoperability (PI) Program Objective Measures, Attestations, and Scoring

Changes finalized for the Promoting Interoperability (PI) Program reporting in calendar year (CY) 2022 (or otherwise noted) are:

- A minimum threshold increase from 50 to 60 points to be considered a Meaningful electronic health record (EHR) User.
- An information blocking attestation requirement for only Statement 1.
- An EHR reporting period increase, beginning with CY 2024, from a minimum of any continuous 90-day period to any continuous 180-day period for new and returning EHs and CAHs.
- An increase in bonus points from five to ten for the Query of Prescription Drug Monitoring Program (PDMP) measure.
- A new optional bi-directional exchange measure worth 40 points.
- A Yes attestation requirement reporting change from two of any six to four specific Public Health measures; with two optional.
- A new attestation requirement for completing an annual assessment of all nine Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) during the EHR reporting period.

PI Program Scoring

The following table provides an update to the points available for the PI program objectives and measures as finalized for CY 2022.

FY 2022 IPPS Final Rule: Medicare Promoting Interoperability Program Performance-Based Scoring Methodology for EHR Reporting Period in CY 2022			
Objective	**Measure**	**Maximum Points**	**Provisions**
Electronic Prescribing	e-Prescribing	10 points	No Change
	Bonus: Query of PDMP (Yes/No Attestation)	10 points (bonus)*	Change
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points	No Change
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points	No Change
	OR		
	Health Information Exchange Bi-Directional Exchange* (Yes/No Attestation)	40 points*	New
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	Not Finalized
Public Health and Clinical Data Exchange	Required: Report the following 4 measures:* (Yes/No Attestation) • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting	10 points	Change
	Optional: Report 1 of the following measures: (Yes/No Attestation) • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (bonus)*	Change
Protect Patient Health Information	Security Risk Assessment (Yes/No Attestation)	No Points	No Change
	Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) (Yes/No Attestation)	No Points	New
Notes: • The Security Risk Analysis measure, SAFER Guides measure, and attestations required by section 106(b)(2)(B) of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are required but will not be scored. • eCQM measures are required but will not be scored. • *Signifies a final policy adopted in the FY 2022 IPPS final rule.			

PI Scoring Considerations

- Organizations will need to assess what measures require further adoption efforts in order to increase points from 50 to the newly required minimum threshold of 60.
- EHs/CAHs can report the two existing HIE measures at 20 points each, and associated exclusions; or choose the new alternative measure. Total points for the HIE objective cannot exceed 40 points.
- If an organizations is unable to attest to the four required public health and clinical data objective measures or are not eligible for exclusions, they would not be able to count points for the other objectives and measures and would receive a score of zero points for the PI program.
- If organizations claim applicable exclusions for all four required public health measures, CMS will redistribute the points to the Provider to Patient Exchange objective.

PI Program Measure Changes

Query of PDMP Measure

CMS is maintaining the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional for CY 2022 and has increased its available bonus from five to ten points. That makes a total of 20 points available for this objective and it is in alignment with the clinician Merit-based Incentive Payment System (MIPS) Promoting Interoperability (PI) performance category.

Considerations

- With current efforts to improve the technical foundation for EHR-PDMP integration, the Medicaid provider provisions in the SUPPORT for Patients and Communities Act, the ongoing review of alternative measure approaches, and stakeholder concerns about the current readiness across states for implementation of the existing measure, CMS states that at least one more year is needed prior to potentially requiring the Query of PDMP measure.
- While this remains a yes/no attestation measure, EHs and CAHs will need to have supporting documentation to ensure the system is working as required.

Health Information Exchange (HIE) Bi-Directional Exchange Measure

CMS is adding this new HIE measure as a yes/no attestation to the HIE objective as an optional alternative to the two existing measures beginning with the EHR reporting period in CY 2022. This measure will be worth 40 points. EHs/CAHs can report the two existing measures at 20 points each, and associated exclusions; or choose this new alternative measure. Total points for the HIE objective cannot exceed 40 points. A similar measure was also included in the MIPS PI performance category for CY 2021 reporting.

Considerations

- The new optional measure requires bi-directional engagement be enabled for all unique patients admitted to or discharged from the EH or CAH inpatient or emergency department and all unique patient records stored or maintained in the EHR for these departments during the EHR reporting period **without** exclusion, exception, or allowances made for partial credit.
- The new measure is more expansive than the denominators of the two existing HIE measures. It would include transitions and referrals where the recipient of the transition of care may be unknown; where the EH or CAH may not be the referring health care provider; where the transition of care may happen outside the scope of the EHR reporting period; and potentially other scenarios.

- Some HIE arrangements may not have the capacity to enable bi-directional exchange for all unique patients and would not meet the standard described in the attestation statements required to fulfill the measure.
- CMS would exclude exchange networks that only support information exchange between affiliated entities, or networks that only facilitate sharing between health care providers that use the same EHR vendor.
- A provider's EHR could generate a Consolidated Clinical Document Architecture (C-CDA) using a certified health IT module, and subsequently transmit that document to an HIE using technology that is not part of a certified health IT module. The measure does not limit EHs or CAHs to the use of a single solution for all instances of bi-directional exchange.
- Functional requirements described in the attestations would be satisfied by the ability for certified EHR technology (CEHRT) to send a C-CDA to an HIE for every patient encounter, transition, or referral; and the ability to retrieve a C-CDA from an HIE using CEHRT when a patient arrives for an encounter, referral, or transition.

Provide Patients Electronic Access to Their Health Information measure

CMS did not finalize their proposal to modify the Provide Patients Electronic Access to Their Health Information measure, which would have required EHs and CAHs to ensure patient health information remains available for patients to access indefinitely and to make data available for encounters with a date of service on or after January 1, 2016, beginning with the EHR reporting period in CY 2022.

Public Health and Clinical Data Exchange Objective measures

Beginning with the EHR reporting period in CY 2022, CMS is requiring EHs and CAHs to report a "yes" on four of the six existing Public Health and Clinical Data Exchange Objective measures or requesting the applicable exclusions for a total of ten points. The remaining two measures are optional and available to select one of the two for an additional five bonus points; bonus points cannot exceed a total of five points and there are no exclusions.

The four required measures are: Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Laboratory Result Reporting. The two optional measures are: Public Health Registry Reporting and Clinical Data Registry Reporting.

Considerations

- While the need to have the right data is important, placing the weight of having to submit all four when CMS reduced this measure to only requiring two is quite hefty. Organizations now have to work with state agencies, vendors, and registries to ensure they can meet the requirement.
- For providers who are only just now beginning to address these changes (towards the end of third quarter 2021), there is very limited time to implement all the changes required to ensure full compliance with this criterion of the Medicare PI program.
- Organizations will have to set up their information technology (IT) systems to send data to the National Syndromic Surveillance Program (NSSP), Electronic Case Reporting (eCR), Immunization Information Systems (IIS), and Electronic Laboratory Reporting (ELR). Doing so will entail both IT and administrative effort.
- EHR systems need to be certified to the appropriate Office of the National Coordinator for Health Information Technology (ONC) criteria. For example, for the **Electronic Case Reporting** measure, Health IT developers have until December 31, 2022, to make certified technology available to the

new certification criteria. EHs and CAHs will need to coordinate timing of their 90-day EHR reporting period in CY 2022 with their EHR vendor's eCR capabilities.

- Change to **Syndromic Surveillance Reporting** measure requires that the data for submission to NSSP needs to be sourced from the Emergency Department (ED), place of service 23. This could pose a challenge for hospitals who have an outsourced ED, in order to be able to set up data collation and reporting.
- For the **Immunization Registry Reporting** measure, organizations will need to work on IT upgrades to allow for bi-directional feeds.

Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

CMS added a new measure to the Protect Patient Health Information objective that requires EHs and CAHs to attest to having completed an annual assessment of the ONC-released Safety Assurance Factors for EHR Resilience (SAFER) Guides beginning with the EHR reporting period in CY 2022. An EH or CAH must attest "yes/no" to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year of the EHR reporting period. This measure is required, but in CY 2022 it will not be scored, and reporting "yes" or "no" will not affect the total score for the PI Program. The goal of this measure is for EHs and CAHs to regularly assess their progress and status on important facets of patient safety.

SAFER Guides is a series of nine user guides that support hospitals' ability to address EHR safety in three areas.

- Foundational: High priority practices; organizational responsibilities.
- Infrastructure: Contingency planning; system configuration; system interfaces.
- Clinical Process: Patient identification; computerized provider order entry (CPOE) with decision support; test results reporting with follow-up; clinician communication.

Considerations

- The self-assessment does not require an organization to confirm it has implemented each practice fully in all areas, nor will the organization be scored on how many of the practices the organization has fully implemented.
- Several of the SAFER Guides require an initial assessment that may not change significantly unless an EH or CAH made significant system upgrades or a transition between systems.
- Organizations that opt to perform their own security risk assessments (SRAs) would need to ensure they also incorporate SAFER Guides. Likewise, third party vendors that perform SRA on behalf of the EH/CAH would need to do the same.

Information Blocking Attestation Statements Change

CMS will only require attesting to the information blocking Statement 1 and has removed Statements 2 and 3 from the PI Program's prevention of information blocking requirement beginning with the CY 2022 EHR reporting period. CMS has also modified the definition of "Meaningful EHR User".

- **Statement 1**: Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
- **EHR Meaningful User**: Number (ii) of the Meaningful EHR User definition was modified from "Support for health information exchange and the prevention of information blocking" to "Actions to limit or restrict the compatibility or interoperability of CEHRT."

CMS' Requests for Information (RFIs)

Transitioning to dQMs by 2025

CMS intends to fully transition to digital quality measures (dQMs) by 2025 and is considering defining and developing dQM software as end-to-end measure calculation solutions that retrieve data from primarily Fast Healthcare Interoperability Resources (FHIR)-based resources maintained by providers, payers, CMS, and others; calculate measure score(s), and produce reports.

CMS requested comments on four potential future actions to enable the transformation:

1) Leverage and advance standards for digital data and obtain all EHR data required for quality measures via provider FHIR-based Application Programming Interfaces (APIs).
2) Redesign quality measures to be self-contained tools.
3) Better support data aggregation.
4) Work to align measure requirements across CMS reporting programs, other Federal programs and agencies, and the private sector where appropriate.

CMS will continue working with other agencies and stakeholders to coordinate and inform any potential transition to dQMs by 2025; and will consider and address commenters input through separate and future notice-and-comment rulemaking.

Considerations

- The healthcare industry has made some progress in transitioning to dQMs for process measures, but the outcome measures will be more complex. Clinical data has a lot more nuanced context for computing the quality measures and currently, the FHIR resources do not adequately describe all the data elements that are available or required for these measures.

Closing the health equity gap in CMS programs and policies

CMS intends to close the health equity gap in CMS programs and policies by making reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for hospitals, providers, and patients.

In the FY 2022 IPPS proposed rule, CMS requested comments on three potential future expansions of the CMS Disparity Methods, including:

- Future potential stratification of quality measure results by race and ethnicity.
- Improving demographic data collection.
- The potential creation of a Hospital Equity Score to synthesize results across multiple social risk factors.

CMS will continue working with hospitals, the public, and other key stakeholders to identify policy solutions that achieve the goals of attaining health equity for all patients through additional RFIs and future rulemaking.

Considerations

- As with any changes in CMS programs, it is important to look at data standardization and recommendation of measures that would be appropriate to utilize for health equity.

Electronic Clinical Quality Measure (eCQM) Updates for IQR and PI Programs

eCQMs

CMS is removing three eCQMs beginning in CY 2024 and adding two new eCQMs in CY 2023 reporting year; and they are requiring EHs and CAHs to use only certified technology updated consistent with the 2015 Edition Cures Update to submit eCQM data beginning in CY 2023.

The following table provides a view of the eCQMs required for reporting in CY 2022, 2023, and 2024.

eCQMs for EHs and CAHs in Calendar Years (CY) 2022, 2023, and 2024 for IQR and PI Programs					
CY 2022	**CY 2023**	**CY 2024**	**Short Name**	**Measure Name**	**NQF #**
2022	2023	Removed	ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
2022	2023	Removed	PC-05	Exclusive Breast Milk Feeding	0480
2022	2023	2024	STK-02	Discharged on Antithrombotic Therapy	0435
2022	2023	2024	STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
2022	2023	2024	STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
2022	2023	Removed	STK-06	Discharged on Statin Medication	0439
2022	2023	2024	VTE-1	Venous Thromboembolism Prophylaxis	0371
2022	2023	2024	VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
2022	2023	2024	Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing	3316e
	2023	2024	HH-02	Hospital Harm – Severe Hyperglycemia Measure*	3533e
	2023	2024	HH-01	Hospital Harm – Severe Hyperglycemia Measure*	3503e

Note: The * indicates new eCQMs for 2023, and Blue font indicates the 8 eCQMs for CY 2024 and subsequent years.

Considerations

- After considering stakeholder concerns, CMS did not finalize their proposal to remove the STK-03 eCQM and will retain this eCQM in the IQR and PI programs' measure set.
- CMS finalized the adoption of two additional eCQMs beginning with CY 2023. EHs and CAHs can self-select to report on one, both, or neither of the two new eCQMs as they are only required to report on: (a) Three self-selected eCQMs and (b) the Safe Use of Opioids—Concurrent Prescribing eCQM (Safe Use eCQM), for a total of four eCQMs.

Hybrid measures

CMS is adopting a second Hybrid Measure, the Hybrid Hospital-Wide Mortality (Hybrid HWM) measure. It will have one volunteer reporting period and timing for mandatory reporting is aligned with the Hybrid Hospital-Wide Readmission (Hybrid HWR) measure. Payment determination will be affected beginning in FY 2026.

The first Hybrid measure CMS adopted for reporting in the IQR program is the Hybrid HWR measure. Implementation of this measure started with two voluntary reporting periods which are running from July 1, 2021 through June 30, 2022, and from July 1, 2022 through June 30, 2023. Hospitals will then be required to report the Hybrid HWR measure beginning with the reporting period which runs from July 1, 2023 through June 30, 2024, impacting the FY 2026 payment determination and subsequent years.

In the FY 2022 IPPS final rule, CMS finalized adoption of the Hybrid HWM measure into the Hospital IQR Program, beginning with voluntary reporting period which would run from July 1, 2022 through June 30, 2023, followed by mandatory reporting beginning with the reporting period which runs July 1, 2023 through June 30, 2024, affecting the FY 2026 payment determination, and subsequent years.

The Hybrid HWM measure uses three main sources of data for the calculation of the measure: (1) Medicare Part A claims data; (2) a set of core clinical data elements from a hospital's EHR; and (3) mortality status obtained from the Medicare Enrollment Database. The Hybrid HWM measure uses nine of the ten core clinical data elements used for reporting on the Hybrid HWR measure, with platelets being the only additional data element used specifically for the Hybrid HWM measure.

CMS will allow hospitals to submit a patient's core clinical data element (CCDE) and linking variables for both the Hybrid HWM and HWR measures using a single submission to further minimize provider burden related to reporting of these measures.

Considerations

- As with the Hybrid HWR measure, it would be beneficial for organizations to take part in voluntary submission of the Hybrid HWM measure as CMS will provide organizations with a feedback report.
- Even though the Hybrid measure is not classified as an eCQM, the effort to map, extract and validate core clinical data elements from the EHR will be similar to eCQMs.
- As an example, hospitals over the years have added more values for labs and vital signs since the original EHR build, causing challenges in capturing all the right values when mapping the Hybrid measure. This takes some time and testing, which is one reason why CMS is giving hospitals the voluntary time period to address potential data collection issues before mandatory reporting is required.
- CMS states that EHR data elements used in the measure specifications were readily available for the patient population and feasibly extracted from most commercial EHR systems, but there will still be an impact to hospital resources to capture and report the data.

Sources

- **IPPS Final Rule Full Title**: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Changes to Medicaid Provider Enrollment; and Changes to the Medicare Shared Savings Program. Unpublished version filed on 8/2/2021; Published in Federal Register on 8/13/2021.
- **CMS Fact Sheet, 8/2/2021:** Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F)
- **QualityNet Webinar**: Reporting the Hybrid Hospital-Wide Readmission Measure to the Hospital IQR Program; Tuesday, May 18, 2021.

Acronyms

Application Programming Interface **(API)**; Calendar Year **(CY)**; Centers for Medicare and Medicaid Services **(CMS)**; Certified EHR Technology **(CEHRT)**; Common Clinical Data Set **(CCDS)**; Computerized Provider Order Entry **(CPOE)**; Consolidated Clinical Document Architecture **(C-CDA)**; Core Clinical Data Element **(CCDE)**; Critical Access Hospital **(CAH)**; Digital Quality Measures **(dQMs)**; Electronic Case Reporting **(eCR)**; Electronic Clinical Quality Measures **(eCQMs)**; Electronic Health Record **(EHR)**; Electronic Laboratory Reporting **(ELR)**; Eligible Hospital **(EH)**; Emergency Department **(ED)**; Fast Healthcare Interoperability Resources **(FHIR)**; Fiscal Year **(FY)**; Health Information Exchange **(HIE)**; Hospital Harm **(HH)**; Hybrid Hospital-Wide Mortality **(Hybrid HWM measure)**; Hybrid Hospital-Wide Readmission **(Hybrid HWR measure)**; Immunization Information Systems **(IIS)**; Information Technology **(IT)**; Inpatient Quality Reporting **(IQR)**; Inpatient Prospective Payment System **(IPPS)**; Merit-based Incentive Payment System **(MIPS)**; National Syndromic Surveillance Program **(NSSP)**; Office of the National Coordinator for Health Information Technology **(ONC)**; Perinatal Core Measure **(PC-05)**; Promoting Interoperability **(PI)**; Public Health Emergency **(PHE)**; Query of Prescription Drug Monitoring Program **(PDMP)**; Request for Information **(RFI)**; Safety Assurance Factors for EHR Resilience Guides **(SAFER Guides)**; Security Risk Assessment **(SRA)**; Social Determinants of Health **(SDOH)**; Stroke measures **(STK-02, -03, -05, -06)**; Venous thromboembolism **(VTE)**.

About emids Regulatory Review Board (eMRB)

Collaboration of content for this white paper was provided by eMRB subject matter experts, covering important quality reporting topics for our customers and partners. Points of view and interpretation were relevant at time of authorship; however, they are subject to change over time. For more information about these changes, contact us at engage@emids.com.